# SURVEILLANCE POLICY FOR INFECTION PREVENTION AND CONTROL

**POLICY**

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| **Reference** | ICP 19 |
| **Approving Body** | Infection Prevention and Control Committee |
| **Date Approved** | 12/08/2022 |
| **For publication to external SFH website** | **Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:** |

| **YES** | **NO** | **N/A** |
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| X | | |

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| **Version** | v6.0 |
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| **Sponsor (Position)** | Director of Infection Prevention and Control |
| **Author (Position & Name)** | Nurse Consultant Infection Prevention and Control – Sally Palmer |
| **Lead Division/ Directorate** | Diagnostic and Outpatients |
| **Lead Specialty/ Service/ Department** | Infection Prevention and Control Team |
| **Position of Person able to provide Further Guidance/Information** | Nurse Consultant, Infection Prevention and Control |

| **Associated Documents/ Information** | **Date Associated Documents/ Information was reviewed** |
|---|---|
| Not Applicable | Not Applicable |
| Template control | June 2020 |

# CONTENTS

## 1.0 INTRODUCTION

All National Health Service (NHS) organisations are required to have infection prevention and control at the heart of good management and clinical practice, to ensure effective public health protection, and to minimise the risk of hospital acquired infections (HAI).

No risk is more fundamental than the risk of infection (DH 2015). Surveillance is an essential component for the prevention and control of infection; it involves the systematic collection of data on infections that occur naturally in populations and as a direct result of healthcare interventions, its analysis and dissemination to facilitate appropriate action. High quality information on healthcare associated infection (HCAI) is essential to tracking progress, investigating underlying causes and instituting prevention and control measures (DH 2015).

In undertaking surveillance and providing information on that surveillance confidentiality for patients and staff is maintained at all times in accordance with the provisions of the Human Rights Act and the relevant guidelines on confidentiality (Caldicott).

## 2.0 POLICY STATEMENT

This policy identifies the need for surveillance of alert organisms and alert conditions. It also addresses mandatory reporting requirements of certain infections or healthcare associated infection events in accordance with national guidelines. The purpose of this policy is to set out the HCAI surveillance and reporting arrangements for the Trust.

This clinical policy applies to:

**Staff group(s):**

- Infection Prevention and Control Team
- All clinical staff
- All non-clinical staff within a clinical area

**Clinical areas(s):**

- All clinical areas across all hospital sites.

**Patient group(s):**

- All patient groups – adult, maternity, paediatrics

**Exclusions:**

- None

## 3.0 DEFINITIONS/ ABBREVIATIONS

### 3.1 Definitions

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|---|---|
| **Surveillance:** | Surveillance is an essential component of the prevention and control of infection; it consists of the routine collection of accurate data on infections among patients or staff, its analysis and the dissemination of the resulting information to those who need to know so that appropriate action can result. |
| **Public Health (Control of Disease) Act 1984:** | Outlines the diseases, which should be considered under the Act and the individuals who have specific responsibilities to ensure compliance with the legislation. |
| **Public Health (Control of Disease) Act 1984 as amended by the Health and Social Care Act 2008:** | this is an informal document which has been prepared to assist the reader to observe the effects of the amendments introduced by the Health and Social Care Act 2008 and should not be relied upon for any other purpose. |
| **Health protection legislation guidance 2010:** | The Department of Health and the Public Health England, in consultation with the Chartered Institute of Environmental Health, published guidance on updated health protection legislation covering the amended Public Health (Control of Disease) Act 1948 and new regulations made under it, which came into force on the 6th April 2010. The guidance explains notification requirements of registered medical practitioners and laboratories testing human samples as well as health protection powers available to local authorities and justices of the peace. |
| **Public Health (Infectious Diseases) Regulations 1988:** | Outlines additional diseases that are reportable and outlines management arrangements. |

### 3.2 Abbreviations

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|---|---|
| **Trust** | Sherwood Forest Hospitals NHS Foundation Trust |
| **Staff** | All employers of the Trust including those managed by a third party on behalf of the Trust |
| **HPU** | Health Protection Unit |
| **CCDC** | Consultant of Communicable Disease Control |
| **DHSC** | Department of Health &Social Care |
| **HCAI** | Healthcare Associated Infection |
| **HAI** | Hospital Acquired Infection |
| **DIPC** | Director of Infection Prevention and Control |
| **IPCC** | Infection Prevention and Control Committee |
| **ICD** | Infection Control Doctor |

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|---|---|
| **CEO** | Chief Executive Officer |
| **MRSA** | Meticillin resistant *Staphylococcus aureus* |
| **MSSA** | Meticillin sensitive *Staphylococcus aureus* |
| **GISA** | Glycopeptide-intermediate *Staphylococcus aureus* |
| **GRE** | Glycopeptide resistant enterococci |
| **MRA** | Multi-resistant *Acinetobacter baumannii* |
| **VRE** | Vancomycin-resistant enterococci |
| **ESBL** | Extended spectrum Beta-Lactamase |
| **RCA** | Root Cause Analysis |
| **THR** | Total hip replacement |
| **TKR** | Total knee replacement |
| **CSF** | Cerebrospinal fluid |
| **TB** | Tuberculosis |
| **UKHSA** | United Kingdom Health Security Agency |
| **CPE** | Carbepenamase Producing enterobacteriacae |
| **SSIS** | Surgical Site Infection Surveillance |

## 4.0 ROLES AND RESPONSIBILITIES

The Trust acknowledges its' duties under the Health and Social Care Act 2010 (DH 2015) and specifically recognises and demonstrates compliance with the following extracts which forms the Code of Practice, criterion 1;5 and 8 have specific relevance to the substance of this policy.

| Compliance criterion | What the registered provider will need to demonstrate |
|---|---|
| **1** | **Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.** |
| **5** | **Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.** |
| **8** | **Secure adequate access to laboratory support as appropriate.** |
| **9** | **Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections**. |

### 4.1 Trust Board

It is the duty of the Trust Board to monitor assurance that the arrangements, which the organisation has in place to prevent and control infections, are effective. The Trust Board delegates authority to the Chief Executive.

### 4.2 Chief Executive

As the accountable officer, the Chief Executive (CEO) is ultimately responsible for ensuring that there are adequate structures, effective control mechanisms and clear lines of accountability for infection prevention and control throughout the Trust. To 'sign off' mandatory surveillance figures on the HCAI data capture system website each month.

### 4.3 Director of Infection Prevention and Control (DPIC)

The Director of Infection Prevention and Control (DIPC) has Trust wide responsibility for the development of strategies and policies for the management of infection prevention and control. The DIPC is accountable to the CEO and the Board for the achievement of the Trust's goal for infection prevention and control and to ensure that a robust infrastructure is in place of infection prevention and control within the Trust. To 'sign off' mandatory surveillance figures on the HCAI data capture system website each month in the absence of the CEO.

### 4.4 Consultant Microbiologist

Reporting of statutory requirements set by the Department of Health & Social Care (DHSC) is reported by the Consultant Microbiologists via CoSurv. The Consultant Microbiologists will ensure results are promptly reported to relevant clinicians responsible for care of the patient/staff member. Sentinel events will be reported on the day the specimen is reported, this will include scrutiny of all positive samples of:

- Blood cultures
- Cerebrospinal fluid (CSF)
- Samples from ITU, haematology and theatres
- Post-operative wound swabs and pus
- Urine samples

### 4.5 Nurse Consultant for Infection Prevention and Control

The Nurse Consultant for Infection Prevention and Control provides support to the DIPC and takes responsibility for leading and developing the strategic direction of infection prevention and control throughout the Trust. The Nurse Consultant will ensure that the IPCT monitors, report and audits alert organism and alert conditions that meets national mandatory surveillance scheme. Report to the Public Health England any unusual or exceptional event, any omissions involving an actual infection or an infection risk to patients or staff utilising the Datix reporting scheme. The Nurse Consultant will horizon scan for new guidance and documents relating to infection prevention and control. The Nurse consultant acts as the local administrator for the UKHSA surveillance schemes.

### 4.6 Infection Prevention and Control Team

The Infection Prevention and Control Team (IPCT) will provide specialist advisory service for the prevention, surveillance, investigation and control of infection within the Trust. The IPCT will report surveillance data to the Infection Prevention and Control Committee (IPCC) and the HCAI meeting on a regular basis. Report to the Public Health England any unusual or exceptional event, any omissions involving an actual infection or an infection risk to patients or staff utilising the Datix reporting scheme.

### 4.7 Microbiology Laboratory Staff

The microbiology department will inform the IPCT of any alert organisms, alert conditions or notifiable disease that may potentially cause outbreaks of infection and/or are identified as multi-drug resistant organisms.

### 4.8 Trust staff

All healthcare staff has responsibilities to both individual patients and the wider population to actively participate in systems of surveillance. Staffs also has a responsibility to inform the IPCT of alert conditions, identified through clinical diagnosis, not laboratory tests that may potentially cause outbreaks of infection and/or are identified as notifiable disease.

## 5.0 APPROVAL

This policy has been approved at the Infection Prevention and Control Committee.

## 6.0 DOCUMENT REQUIREMENTS (NARRATIVE)

The Trust supports the principle that infections should be prevented wherever possible and that effective systematic arrangements for the surveillance, prevention and control of infection are provided within this policy.

Surveillance is an essential component of the prevention and control of infection in hospitals; it helps to identify risks of infection and reinforces the need for good practices. Preventing outbreaks depends on prompt recognition of one or more infections with alert organisms and instituting special control measures to reduce the risk of spread of the organism.

Surveillance also allows comparison with other units, forms part of clinical audit and clinical governance, assist in reducing the frequency of adverse events, and measurement of response to changes in practice. Surveillance is required to understand the extent, cost and effects of HCAI. It is the foundation of good infection prevention and control practice, and improving patient care. Surveillance forms the basis of infection prevention and control interventions, education and policy development.

### 6.1 Objective of surveillance

The objective of surveillance is to provide high quality information on healthcare associated infections (HCAIs) and anti-microbial resistant microorganisms to:

- Detect sentinel events
- Detect, monitor and review outbreaks of infections within the Trust
- Timely investigation and implement of control measures
- Evaluate control mechanisms
- Monitor trends of infections/diseases levels over time

There are agreed objectives and priorities for targeted surveillance of infection developed by the infection prevention and control team (IPCT) and endorsed by the Infection Prevention and Control Committee (IPCC) and the Trust Board.

### 6.2 The process of surveillance

The key elements of surveillance are as follows:

- Data collection using standard definitions
- Collation of data
- Analysis and interpretation of data
- Dissemination of information for action by appropriate persons

### 6.3 Mandatory surveillance

All mandatory surveillance data will be reported to the IPCC.

The Trust participates in all DHSC mandatory surveillance schemes for healthcare associated infections (HCAI). The data is collected by the Trust IPCT and is sent to the UKHSA on the HCAI Data capture website on a monthly base according to set protocols and parameters (PHE 2016).

- **MRSA enhanced surveillance system:**

MRSA bacteraemia surveillance is used by the DHSC and the Trust as infection prevention and control performance indicators. This mandatory DHSC surveillance was introduced in 2005 by the Health Protection Agency (HPA) and requires the IPCT to carry out an investigation into whether the MRSA bacteraemia was diagnosed in the first 48 hours of admission indicating community acquired, or post 48 hours of admission indicating Trust acquired. Once this has been established a Root Cause Analysis (RCA) will be undertaken to establish source of infection, risk factors and lessons learnt to improve practice. Information on patient identification, source of infection, medical speciality and risk factors will be supplied to the UKHSA via the HCAI Data Capture System secure website. The CEO must ensure that the MRSA bacteraemia data is entered on the website and 'signed off' by the 15th of each month.

- ***Clostridium difficile* enhanced surveillance:**

*Clostridium difficile* rates are seen as an indicator of prudent antibiotic use. All cases of *Clostridium difficile* in patients aged 2 years and older are reported to the UKHSA using the HCAI Data Capture System secure website. The DHSC and the Trust use this data as a performance indicator. All cases will be reported regardless of patient location at the time the specimen was taken. The case definition for healthcare acquired clostridium difficile has altered and there are 2 groups that will result in their cases being attributed to the Trust.

I. **Hospital onset healthcare associated:** cases that are detected in the hospital on day two or more days after admission (admission date is day 1, and it was previously on day 4) (SFH responsible)
II. **Community onset healthcare associated:** cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous **four** weeks (SFH responsible)

If this is established the clinical team responsible for the patient care will be required to complete a RCA. The CEO must ensure that the *Clostridium difficile* data is entered on the website and 'signed off' by the 15th of each month.

- **MSSA enhanced surveillance system:**

MSSA can also cause severe and potentially life-threatening infections such as septicaemia. This mandatory DHSC surveillance was introduced in 2011 by the HPA and requires the IPCT to carry out an investigation into whether the MSSA bacteraemia was diagnosed in the first 48 hours of admission indicating community acquired, or post 48 hours of admission indicating Trust acquired. Once this has been established a Root Cause Analysis (RCA) will be undertaken to establish source of infection, risk factors and lessons learnt to improve

practice. Information on patient identification, source of infection, medical speciality and risk factors will be supplied to the UKHSA via the HCAI Data Capture System secure website. The CEO must ensure that the MSSA bacteraemia data is entered on the website and 'signed off' by the 15th of each month.

- **Gram Negative enhanced surveillance: including *Escherichia coli; Pseudomonas aeriginosa and Klebsiella spp***

This mandatory DHSC surveillance requires the IPCT to carry out an investigation into whether the *E. coli, Klebsiella spp* and *pseudomonas* spp bacteraemia was diagnosed as a community acquired or a hospital associated case:

I. **Hospital onset healthcare associated:** cases that are detected in the hospital on day two or more days after admission (admission date is day 1, and it was previously on day 4) (SFH responsible)
II. **Community onset healthcare associated:** cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks (SFH responsible)
III. **Community onset community associated:** cases that occur in the community (or within two days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous four weeks

Information on patient identification, source of infection, medical speciality and risk factors will be supplied to the UKHSA via the HCAI Data Capture System secure website.
The CEO must ensure that the *Gram-Negative* bacteraemia data is entered on the website and 'signed off' by the 15th of each month.

### 6.4 Laboratory based surveillance

- Staphylococcus aureus bacteraemia surveillance (MRSA and MSSA)
- *Escherichia coli* bacteraemia surveillance
- *Klebsiella spp* bacteraemia surveillance
- *Pseudomonas spp* bacteraemia surveillance
- Clostridium difficile infection, age over 2 years
- Beta Haemolytic Streptococcus group A, B, C and G
- Penicillin resistant Streptococcus pneumonia
- Norovirus
- Tuberculosis
- Legionella sp
- Fungi, including candida species, aspergillus sp (in haematology, ITU and Neonatal Unit)
- Verotoxin producing strains of Escherichia coli i.e. E. coli 0157
- Salmonella or Shigella species
- Giardia
- Influenza
- Covid-19
- Carbapenem producing enterobacteria

### 6.5 Surgical site infection surveillance

A surgical site is the incision or cut in the skin made by a surgeon to carry out a surgical procedure and the tissue handled or manipulated during the procedure.

A surgical site infection occurs when micro-organisms get into the part of the body that has been operated on and multiply in the tissues.

Surveillance data on surgical site infection rates can inform and influence steps taken to minimise the risk of infection, as well helping to clearly communicate the risks to patients. Some infections take time to develop and may not become apparent until after the patient has been discharged from hospital. NICE (2013) requires organisations to have systems in place to ensure that infections are identified.

UKHSA helps hospitals to identify infections according to set standards; and record incidents of surgical site infection (SSI), to help improve surgical practice and prevent further infections.

Mandatory Surveillance of surgical site infections started in April 2004, specifying that each trust should conduct surveillance for at least 1 orthopedic category for 1 period in the financial year.

The categories are:

- hip replacements
- knee replacements
- repair of neck of femur
- reduction of long bone fracture

The Trust undertakes to participate in the mandatory programme outlined by the UKHSA according to the set protocols.

Definitions of surgical site infections are based on those published by CDC in 1992, and are classified as incisional (superficial or deep), or organ/space infection. (PHE 2013):

**Superficial incisional infection**: this is defined as a surgical site infection that occurs within 30 days of surgery and involves only the skin or subcutaneous tissue of the incision, and meets at least one of the following criteria:

**Criterion 1**: Purulent drainage from the superficial incision.
**Criterion 2**: The superficial incision yields organisms from the culture of aseptically aspirated fluid or tissue, or from a swab and pus cells are present.
**Criterion 3**: At least two of the following symptoms and signs:
- pain or tenderness
- localised swelling
- redness
- heat

and **a**. the superficial incision is deliberately opened by a surgeon to manage the infection, unless the incision is culture-negative
or **b**. the clinician diagnoses a superficial incisional infection.

**Deep incisional infection**: this is defined as a surgical site infection involving the deep tissues (i.e. fascial and muscle layers) that occurs within 30 days of surgery if no implant is in place, or within a year if an implant is in place and the infection appears to be related to the surgical procedure, and meets at least one of the following criteria:

**Criterion 1**: Purulent drainage from the deep incision but not from the organ/space component of the surgical site.
**Criterion 2**: The deep incision yields organisms from the culture of aseptically aspirated fluid or tissue, or from a swab and pus cells are present.
**Criterion 3**: A deep incision that spontaneously dehisces or is deliberately opened by a surgeon when the patient has at least one of the following symptoms or signs (unless the incision is culture-negative):

- fever (>38oC)
- localized pain or tenderness

**Criterion 4**: An abscess or other evidence of infection involving the deep incision that is found by direct examination during re-operation, or by histopathological or radiological examination.
**Criterion 5**: Diagnosis of a deep incisional surgical site infection by an attending clinician.

**Organ/space infection**: this is defined as a surgical site infection involving any part of the anatomy (i.e. organ/space), other than the incision, opened or manipulated during the surgical procedure, that occurs within 30 days of surgery if no implant is in place, or within one year if an implant is in place and the infection appears to be related to the surgical procedure, and meets at least one of the following criteria:

**Criterion 1:** Purulent drainage from a drain that is placed through a stab wound into the organ/space.
**Criterion 2**: The organ/space yields organisms from the culture of aseptically aspirated fluid or tissue, or from a swab and pus cells are present.
**Criterion 3**: An abscess or other evidence of infection involving the organ/space that is found by direct examination, during re-operation, or by histopathological or radiological examination.
**Criterion 4**: Diagnosis of an organ/space infection by an attending clinician

### 6.6 Alert conditions/organism surveillance

Alert organisms and alert conditions are those that may cause outbreaks. The IPCT will provide advice on the control measures and management of cases and will investigate clusters of cases. Alert organism surveillance is also referred to as 'target group of organisms', which comprises of a number of organisms that present an infection prevention and control hazard within the healthcare setting, either because of their potential virulence, their antibiotic resistance or both. Specific alert organisms and alert conditions are listed below:

| | | |
|---|---|---|
| Meticillin resistant *Staphylococcus aureus* (MRSA) | Glycopeptide resistant enterococci (GRE) such as Vancomycin resistant enterococci (VRE) | Measles |
| Glycopeptide-intermediate *Staphylococcus aureus* (GISA) | *Salmonella* species | Herpes zoster |
| Multi-resistant *Acinetobacter baumannii* (MRAB) | *Mycobacterium tuberculosis* | Rotavirus/Norovirus |
| Carbapenem producing enterobacteria (CPE) | *Stenotrophomonas maltophilia* | Shigella |

| | | |
|---|---|---|
| Group A β-haemolytic *streptococcus (S. pyogenes)* | Cryptosporidium | Poliomyelitis |
| Multi-resistant *Pseudomonas* | Neisseria meningitides | Mumps |
| Extended spectrum Beta-Lactamase (ESBL) producing organisms | Meningococcal septicaemia | Rubella |
| Legionella species | Respiratory syncytial virus, influenza | Scarlet fever |
| Viral haemorrhagic fevers | Viral hepatitis | Whooping cough |
| Cholera | Opthalmia neonatorum | Paratyphoid fever |
| Scabies | Diphtheria | *Clostridium difficile* |
| Covid-19 | Monkeypox | |

All alert organisms/conditions will be recorded on a database, which will be reviewed weekly/monthly to detect trends in infection. Identified trends will be reported to:

- IPCC
- DIPC
- Relevant Clinical Director
- Clinician responsible for care of patient/staff
- Relevant Ward sister/Department Leader
- Relevant Matron
- Relevant others (i.e. Consultant for Communicable Disease Control, Environmental Health Officer, General Practitioner)

### 6.7 Daily alert organisms

The IPCT receive an electronic report of new positive alert organisms linked from the laboratory computer system throughout the day. Relevant wards will be notified by the IPCT and any advice given. However it is still the responsibility of the clinical team to review the microbiology results prior to commencing treatment for their patients.

### 6.8 Notifiable diseases

In some instances 'alert' conditions are classed as Notifiable disease. This is a legal term denoting diseases that **must** by law, be reported to the 'Proper Officer' e.g. the Consultant for Communicable Disease Control (CCDC), who is based in the East Midlands Public Health for England (replaced Public Health England April 2013). Refer to the Public Health England web site for an up-to-date list of the disease that are notifiable: https://www.gov.uk/guidance/notifiable-diseases-and-causative-organisms-how-to-report.

It is the responsibility and statutory duty of the registered medical practitioner in charge of the patients care to notify the 'Proper Officer' of any patient suspected of having a notifiable disease or an infection which presents or could present harm to human health

Initial notification to the 'Proper Officer' can be verbal (do not wait for laboratory confirmation if a notifiable disease is suspected), this notification must be confirmed in writing, using the notification certificate, which is located on the Infection Prevention and Control Trust intranet site must be completed and forwarded to the 'Proper Officer' within three days of the verbal communication.

Medical staff, nursing staff, microbiology laboratory staff and consultant microbiologists **must also** report any suspected or confirmed notifiable diseases to the IPCT at the earliest opportunity.

The Microbiology Laboratory also has responsibility to notify the 'Proper Officer' on discovery of notifiable causative agents.

### 6.9 Ward surveillance

The IPCT must be advised of any suspected or confirmed infections i.e. clostridium difficile, influenza, TB. Where appropriate, the IPCT will visit the patient and advise on management.

### 6.10 Voluntary surveillance

**Norovirus outbreak and Influenza reporting tool:**
The Trust will participate in this surveillance, if a bay or a ward has been closed due to an outbreak of norovirus. This will give:

- A timely estimate of norovirus epidemics nationally
- Improved understanding of the burden of disease
- Help in the detecting the emergence of new epidemic norovirus variants

**Antimicrobial Resistant Organisms**
The IPCT undertakes to monitor all patients with recognised antimicrobial resistant organisms

**Other voluntary targeted surveillance**
The need for intermittent targeted surveillance of other types of infection will be determined in response to local epidemiological need and will be detailed in the infection prevention and control annual programme of surveillance; this may be in the form of surgical site surveillance or specific organisms or related to a condition i.e. catheter associated urinary tract infection related bacteraemia.

### 6.11 Serious Incidents

The Trust reports Serious Incidents (SI) associated with infection to the NHS England for onward reporting as appropriate. The Trust also communicates with the UKHSA (replaced Public Health England) the CCDC in order that they can provide appropriate advice and support for controlling outbreaks of infection. The DHSC (2003) states that 'untoward incidents associated with infection are those that produce, or have the potential to produce, unwanted effects involving the safety of patients, staff or others. Reportable incidents are those that:

- Result in significant morbidity or mortality
- Involve highly virulent organisms
- Are readily transmissible
- Require control measures that have an impact on the care of other patients, including limitation of access to healthcare services

Incidents can include:

- Outbreak of infection: two or more linked cases in a ward
- Infected healthcare worker or patient incidents necessitating consideration of a look back investigation (i.e. TB)

- Significant breakdown of infection control procedures with actual or potential for cross infection (i.e. release of products from a failed sterilisation cycle, contaminated blood transfusion)

### 6.12 Reporting procedure

Summaries of all mandatory and voluntary surveillance data will be reported at the IPCC, the HCAI forum and the IPCT meeting, in the IPC quarterly clinical governance report and the annual infection prevention and control report. The Trust performance scorecard also reports MRSA bacteraemia, MSSA bacteraemia, *E. coli* bacteraemia, and *Clostridium difficile* infection rates to the Trust Board.

### 6.13 Root Cause Analysis

Learning from experience is critical to the Trust in delivering a safe and effective service to patients. Root Cause Analysis (RCA) helps the Trust look at and to understand the underlying causes of patient safety incidents and to formulate a plan for improving safety. The RCA process includes notification of the area by the IPCT and an expectation that each area manages their own incidents and learning is shared within their division and where appropriate wider. The analysis is then used to identify areas for change, recommendations and sustainable solutions to help minimise the re-occurrence of the incident type in the future.

## 7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

| Minimum Requirement to be Monitored<br>(WHAT – element of compliance or effectiveness within the document will be monitored) | Responsible Individual<br>(WHO – is going to monitor this element) | Process for Monitoring e.g. Audit<br>(HOW – will this element be monitored (method used)) | Frequency of Monitoring<br>(WHEN – will this element be monitored (frequency/ how often)) | Responsible Individual or Committee/ Group for Review of Results<br>(WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who) |
|---|---|---|---|---|
| Surveillance of all positive blood cultures | IPCT | Audit | Monthly | IPCC and Divisional Governance/CCG |
| Mandatory reporting of MRSA, MSSA, E.Coli Blood Cultures and Clostridium Difficile infection to Public Health England | IPCT with final sign off by the CEO | Data input to UKHSA DCS Surveillance system | Monthly | IPCC |
| Surgical Site Surveillance | IPCT | UKHSA SSIS national database | Monthly | IPCC |
| ICNet Accuracy | IPCT | Cross Reference against automated data | Monthly | IPCC |
| RCA completion | IPCT | Local database review | Monthly | IPCC and Divisional Governance |

## 8.0 TRAINING AND IMPLEMENTATION

There are no specific training needs in relation to this policy, however all staff who are required to complete any aspect of the surveillance will require instruction based on need, all other staff will need to be aware of its contents. Staff will be made aware through:

- Matron
- Ward sister/Department Leader
- Infection Prevention and Control Link Representatives
- Team meetings
- Trust web site (IPCT policy page)

## 9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix A
- This document has been subject to an Environmental Impact Assessment, see completed form at Appendix B

## 10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

**Legislation:**

- Public Health (Control of Disease) Act 1984
- Public Health (infectious Diseases) Regulations
- Health Protection Legislation (England) Guidance (2010)
- The Health Protection (Local Authority Powers) Regulations (2010)
- The Health protection (Part 2 Orders) Regulations (2010)
- Health Protection (Notification) Regulations (2010)

**Evidence Base:**

Department of Health. (2015). *The Health and Social Care Act 2008. Code of practice for health and adult social care on the prevention and control of infections and related guidance.* London.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/449049/Code_of_practice_280715_acc.pdf

NICE (2013) Quality Standard 49 Surgical Site Infection : Statement 7, Surveillance
https://www.nice.org.uk/guidance/QS49/chapter/Quality-statement-7-Surveillance

PHE (2010)(updated 7th June 2022) Notifiable diseases and causative organisms: how to report https://www.gov.uk/guidance/notifiable-diseases-and-causative-organisms-how-to-report

PHE (2012) Guidelines for the management of norovirus outbreaks in acute and community health and social care https://www.gov.uk/government/publications/norovirus-managing-outbreaks-in-acute-and-community-health-and-social-care-settings

PHE (2013) Protocol for the Surveillance of Surgical Site Infection Surgical Site Infection Surveillance Service https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/364412/Protocol_for_surveillance_of_surgical_site_infection_June_2013.pdf

PHE (2016) Mandatory enhanced MRSA, MSSA and Escherichia coli bacteraemia, and Clostridium difficile infection surveillance https://hcaidcs.phe.org.uk/ContentManagement/LinksAndAnnouncements/HCAIDCS_Mandatory_Surveillance_Protocol_v4.0.pdf

Public Health England (2016) AMR Local indicators http://fingertips.phe.org.uk/profile/amr-local-indicators

**Related SFHFT Documents:**

This document should be used in conjunction with other relevant Trust Infection Prevention and Control and Trust policies such as:

- Infection prevention and control operating policy

This document should also be used in conjunction with these external documents:

- Health and Social Care Act 2008 (2010)
- Infection Prevention and Control annual programme of work

## 11.0 KEYWORDS

Outbreak; IPCT;

## 12.0 APPENDICES

- Appendix A – Equality Impact Assessment
- Appendix B – Environmental Impact Assessment

## APPENDIX A – EQUALITY IMPACT ASSESSMENT FORM (EQIA)

| | | | |
|---|---|---|---|
| **Name of service/policy/procedure being reviewed: Surveillance policy for IPC** | | | |
| **Existing service/policy/procedure: Existing** | | | |
| **Date of Assessment:04/08/2022** | | | |
| **For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)** | | | |
| **Protected Characteristic** | **a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?** | **b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?** | **c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality** |
| **The area of policy or its implementation being assessed:** | | | |
| **Race and Ethnicity** | None | N/A | None |
| **Gender** | None | N/A | None |
| **Age** | None | N/A | None |
| **Religion** | None | N/A | None |
| **Disability** | None | N/A | None |
| **Sexuality** | None | N/A | None |
| **Pregnancy and Maternity** | None | N/A | None |
| **Gender Reassignment** | None | N/A | None |
| **Marriage and Civil Partnership** | None | N/A | None |

| | | | |
|---|---|---|---|
| **Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)** | None | N/A | None |

**What consultation with protected characteristic groups including patient groups have you carried out?**

- **Sent to members of IPCC**

**What data or information did you use in support of this EqIA?**

- **National Guidance**

**As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?**

- **No**

**Level of impact**

From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact:

**Low Level of Impact** *(Delete as appropriate)*

For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.

**Name of Responsible Person undertaking this assessment:**
**Sally Palmer**

**Signature:**
**Sally Palmer**

**Date: 04/08/2022**

## APPENDIX B – ENVIRONMENTAL IMPACT ASSESSMENT

The purpose of an environmental impact assessment is to identify the environmental impact, assess the significance of the consequences and, if required, reduce and mitigate the effect by either, a) amend the policy b) implement mitigating actions.

| Area of impact | Environmental Risk/Impacts to consider | Yes/No | Action Taken (where necessary) |
|---|---|---|---|
| **Waste and materials** | • Is the policy encouraging using more materials/supplies?<br>• Is the policy likely to increase the waste produced?<br>• Does the policy fail to utilise opportunities for introduction/replacement of materials that can be recycled? | no | |
| **Soil/Land** | • Is the policy likely to promote the use of substances dangerous to the land if released? (e.g. lubricants, liquid chemicals)<br>• Does the policy fail to consider the need to provide adequate containment for these substances? (For example bunded containers, etc.) | no | |
| **Water** | • Is the policy likely to result in an increase of water usage? (estimate quantities)<br>• Is the policy likely to result in water being polluted? (e.g. dangerous chemicals being introduced in the water)<br>• Does the policy fail to include a mitigating procedure? (e.g. modify procedure to prevent water from being polluted; polluted water containment for adequate disposal) | no | |
| **Air** | • Is the policy likely to result in the introduction of procedures and equipment with resulting emissions to air? (For example use of a furnaces; combustion of fuels, emission or particles to the atmosphere, etc.)<br>• Does the policy fail to include a procedure to mitigate the effects?<br>• Does the policy fail to require compliance with the limits of emission imposed by the relevant regulations? | no | |
| **Energy** | • Does the policy result in an increase in energy consumption levels in the Trust? (estimate quantities) | no | |
| **Nuisances** | • Would the policy result in the creation of nuisances such as noise or odour (for staff, patients, visitors, neighbours and other relevant stakeholders)? | no | |