

Index No: IPC 2

Infection Prevention and Control Policy

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Index No. IPC 2	Infection Prevention and Control Policy
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Approval and Authorisation

Completion of the following signature blocks signifies the review and approval of this process.

Name	Job Title	Signature	Date
Dr Manjula Natarajan	Consultant Microbiologist Director of Infection Prevention and Control		
Liz Libiszewski	Director of Nursing and Quality		

Local Committee approval (where applicable)

Name of Committee	Name of Chairperson	Date of Approval
Infection Control Committee	Lorene Read	Jan 2012

Change History

Version	Date	Author	Reason
1		Pam Howe	New Policy
1.1	July 2010	Pam Howe	Review of Committee TOR and Reporting mechanisms
1.2	Jan 2012	Pam Howe	Update and review in view of change in reporting mechanism

Impact Assessment

Undertaken by	Date
Pam Howe	Aug 2010
Pam Howe	Dec 2011

A translation service is available for this policy. The Interpretation/Translation Policy, Guidance for Staff (I55) is located on the library intranet under Trust wide policies.

Contents

Page	Content	
1	Title	
2	Contribution list	
3	Approval and Authorisation	
4	Contents	
5	Introduction, Aim	
6	Objectives, Definitions, Links to Standards	
7	Responsibilities	
11	Related Policies, Education and Training	
12	Reviewing and Monitoring	
14	APPENDIX 1 KGH FT Infection prevention and Control TOR	
16	APPENDIX 2 Infection Control Organisational Structure and Reporting Chart	
17	Check list	
20	Check List	
22	EqIA	

Introduction

The Trust takes its obligations under Equality Legislation very seriously and aims to provide fair and equitable treatment to, and value diversity in, its staff, patients and visitors. In doing so it aims to ensure that its actions and working practices comply with both the spirit and intention of the Human Rights Act (1998) and the forthcoming Equality Act which aims to consolidate existing equality legislation relating to the six strands of diversity i.e. race, gender, disability, religion/faith, sexual orientation and age. This protocol is for the benefit of all staff, patients, carers and visitors regardless of their diverse background.

Prevention and control of healthcare associated infection (HCAI) is a key part of the Kettering General Hospital (KGH) NHS Foundation Trust's (the Trust) overall clinical governance and risk management strategy. KGH NHS Foundation Trust is committed to improving the quality of care throughout the Trust and promoting high standards of infection prevention and control practice.

The Health Act (2006 and 2008) Code of Practice states that the prevention and control of healthcare associated infection is a high priority for all parts of the National Health Service and Infection Control is the responsibility of all staff and volunteers within the Trust.

Sustainable reductions in healthcare associated infections (HCAs) like MRSA and *Clostridium difficile* require the proactive involvement of every member of staff across all healthcare settings. All staff have a role to play in reducing HCAI and making that contribution is crucial. These roles are outlined in the Health Act 2006/08, Saving Lives: reducing infection, delivering clean and safe care, Reducing Healthcare Associated Infections: from trust board to ward, (2008), NICE Quality Improvement Guide: Prevention and control of healthcare associated infections (2011) and the Health and Safety at Work Act (1974).

This overarching policy is intended to outline an organisational approach to complex issues relating to infection prevention and control. It is relevant to all staff working within the Trust and refers to external bodies that are available to give advice and support infection control activities.

All Trust's Infection Control policies, codes of practice and guidelines are accessible to staff via the Trust's intranet site. These documents provide evidence-based guidance that forms the basic information that staff require for effective infection prevention and control.

All Trust staff are required to adhere to this and the related supporting policies, codes of practice and guidelines pertaining to infection prevention and control procedures in line with the Trust's policies for policies and guidelines.

Aim

- The policy sets out the clinical and quality governance arrangements for the Trust's infection prevention and control strategy.
- It confirms the Trust's commitment to the prevention and control of infection, and is achieved through the implementation of policies, codes of practice and guidelines supporting this overarching policy and the promotion of training and education in infection prevention and control procedures.

- It references the way in which the Trust will meet good infection prevention and control principles and practice in line with the 12 clinical care protocols identified in the Health Act 2008.
- It outlines the information that is available to patients and the public about the arrangements for preventing and controlling healthcare associated infection (HCAI)
- It sets out how the Trust will meet its training requirement to ensure that all staff receive adequate training in relation to reducing the risk of healthcare associated infection (HCAI).

Objectives

- To provide clear policies, codes of practice and guidelines for staff to ensure compliance with this Infection Prevention and Control strategy
- To provide training and educational opportunities for all staff to ensure they are appropriately trained in infection prevention and control procedures.
- To ensure there is a Trust Infection Control Committee (ICC), which monitors the development of new guidance and reviews existing policies and guidelines. These will be included in the KGH Infection Control Annual Report, which will set priorities and timescales for implementation.
- To have in place a skilled and resourced Infection, Prevention and Control Team (IPaCT), headed by the Director for Infection, Prevention and Control (DIPC)
- That each Clinical Management Teams' (CMT) Heads of Nursing, together with Associate Medical Directors (AMD)/ Clinical Directors monitor local adherence the policies producing actions plans and reports to the Trust Infection Control Committee (ICC).
- To encourage staff to report incidents relating to infection control in accordance with the Trust's incident reporting Policy. This reporting will include non-adherence with infection prevention and control procedures.
- To ensure that detailed investigation and root cause analysis is undertaken following serious incident requiring investigation (SIRI) events that relate to infection control to determine system failure or care delivery problems.

Definitions

KGHFT	- Kettering General Hospital Foundation Trust
HCAI	- Healthcare Associated Infection
ICC	- Infection Control Committee
DIPC	- Director of Infection Prevention and Control
IPaCT	- Infection, Prevention and Control Team
CMT	- Clinical Management Team
AMD	- Associate Medical Director
KSF	- Knowledge and Skills Framework
PVL	- Panton Valentine Leukocidin (Staphylococcal infection)
MRSA	- Meticillin Resistance <i>Staphylococcus Aureus</i>
MSSA	- Meticillin Sensitive <i>Staphylococcus Aureus</i>
ESBL	- Extended Spectrum beta Lactamase
E-coli	- Eschericia coli
HII	- High Impact Interventions
RCA	- Root Cause Analysis

Justification for Document

LINKS TO STANDARDS/PERFORMANCE INDICATORS

The Health Act: Code of Practice for the Prevention and Control of Health Care Associated Infections (2008). The purpose of the Code is to help NHS bodies plan and

implement how they can prevent and control HCAI. It sets out criteria by which managers of NHS organisations are to ensure that patients are cared for in a clean, safe environment, where the risk of HCAI is kept as low as possible. Failure to observe the Code may either result in an Improvement Notice being issued by the Healthcare Commission, or in the Trust being reported for significant failings and placed on 'Special Measures'.

The Code relates to healthcare provided by all NHS bodies. Each NHS body is expected to have systems in place sufficient to comply with the relevant provisions of the Code, so as to minimise the risk of HCAI to patients, staff and visitors.

The Trust Board must have an agreement outlining its collective responsibility for minimising the risks of infection and the general means by which it prevents and controls such risks. Effective prevention and control of HCAI must be embedded into everyday practice and applied consistently by all staff following policies and protocols which are based on evidence based research to reduce the risk of infection

Infection Prevention and Control is a key Performance Indicator for Monitor, the Commissioning PCT and the Strategic Health Authority, therefore strict compliance with Infection Prevention and control protocols is monitored by the Trust board on a monthly basis by considering current infection rates and compliance with policies and protocols.

Responsibilities

The Board

- Implement and monitor a trust wide HCAI improvement strategy.
- Ensure that all staff are responsible for infection prevention relevant to their role, ensuring that all Trust staff have infection prevention and control included in their job description and annual appraisal
- Ensure all staff understand the legal requirements of the Hygiene Code and that staff are authorised to implement *Saving Lives* action plans at ward and department level, giving the responsibility for monitoring and reducing HCAI to CMTs
Ensure trust wide HCAI/environmental specific data across all clinical settings is signed off monthly by the board to assure progress
- Ensure a robust communication strategy, monitored by the board, that increases internal staff awareness and improves local public confidence in the Trust by engaging external audiences in Trust HCAI planning

Chief Executive

- Lead the Trust in delivery of policies and processes that impact on the delivery of lower rates of infection in line with National targets and local arrangements by making HCAI a top trust priority.
- Performance manage trust key individuals to deliver HCAI strategy, by setting HCAI related goals and holding key individuals responsible
- Ensure staff awareness on HCAI increases and that public confidence in the Trust improves

Director of Nursing and Medical Director

- Demonstrate clinical leadership that places HCAI as top priority and safety at the centre of trust practices and plans
- Ensure consistency of care across all clinical settings and that evidence based practice is applied to reduce HCAs and achieve high reliability
- Collaborate with Clinical and Managerial Leads for each CMT to ensure joined up approach to HCAI improvement

- Establish and manage an operational framework which monitors and assures improvements on HCAI

Human Resources Director

- Collaborate with Clinical and Managerial Leads for each CMT to ensure joined up approach to HCAI improvement
- Ensure all staff are able to articulate their role and know how to make sure their contribution to trust wide plan in HCAI by including infection prevention and control in all staff job descriptions, appraisal and KFS reviews.
- Ensure that attendance of all staff at IPaC educational sessions are recorded to provide assurance to the Trust Board of compliance

Finance Director

- Ensure financial impact of HCAI is understood across the Trust. Quantify savings from HCAI improvement and demonstrating financial impact on the Trust on effective use of resources.

Director for Infection Prevention and Control (DIPC)

- Has the strategic responsibility for Infection Prevention and Control within the Trust supported by the Director of Nursing and Quality. They will:-
- Oversee local infection policies and their implementation
- Be responsible for the Infection Prevention and Control Team
- Report directly to the Chief Executive and the Trust Board
- Have the authority to challenge inappropriate clinical hygiene practice as well as antibiotic prescribing decisions
- Assess the impact of all existing and new policies and plans on infection risks and make recommendations for change
- Be an integral member of the organisations quality governance and patient safety teams and structures
- Produce an annual report on the state of healthcare associated infection within the Trust and release it publicly.

Infection Management, Prevention and Control Team (IPaCT)

- Act as an expert group to provide guidance, interpretation and support the HCAI improvement plan and infection prevention and control issues for patients, staff and stakeholders
- To train, support and provide advice across the organisation to ensure that all staff are aware of the current infection prevention guidance relevant to their role and are equipped to implement and contribute

They are responsible for advising and supporting staff in carrying out infection prevention and control procedures through: - (This will encompass but not be limited to the list below)

- Training and education
- Policy and guideline development
- Advise on the management of patients with infection
- Advice and support on developing audit and surveillance programmes and action plans
- Provide support and advice clinically and across the Trust during outbreaks of Infection
- Advice regarding new builds/re-development.

- Monitor alert organisms.

The team are responsible for the practical aspects of infection prevention and control and includes Consultant Microbiologists, Director of Infection Prevention and Control, Infection Prevention and Control Nurses (IPCN), Practice Development and Surveillance Nurse (PDN), Support Nurses,;

2 Microbiologists (One with DIPC responsibility)		WTE 2
1 Lead Infection Prevention and Control Nurse	Band 8a	WTE 1
1 Infection Prevention and Control Nurse	Band 7	WTE 1
1 Practice Development & Surveillance Nurse	Band 6	WTE 0.80
2 Support Nurses	Band 6	WTE 2
1 Administration Assistant (part-time)	Band 3	WTE 0.80

The Infection Prevention and Control Team (IPaCT) is based at KGH, but have a service level agreement with Woodlands Private Hospital and liaise with both Community Infection Prevention and Control team and Northampton General Hospital IPaCT on a daily basis regarding specimen results processed at KGH FT

IPaCT provide surveillance of healthcare associated infections (HCAs) and expert advice and support to staff looking after patient care as well as staff working in non-clinical areas regarding the prevention and control of infections.

The team maintains a number of databases for MRSA, MSSA, E-coli bacteraemias, PVLs, Clostridium *difficile* and ESBLs and reviews the data and communicates relevant information to the appropriate departments. IPaCT provide reports monthly to the Quality Governance Committee via ICC minutes and includes information on all aspects of Infection Prevention and Control, including progress against the National and Local Targets

IPaCT, in conjunction with the Outbreak Management Team, (see Outbreak/Hotspot Management policy) manages outbreaks of infection.

IPaCT can be contacted by telephone (2482/2566) or by bleep (147/575/544) if immediate advice is required. Mon - Fri 08.00 – 17.00

A 24hr out of hour's service is provided by the on call Consultant Microbiologist and is accessed via the hospital switchboard. During Major outbreaks a member of IPaCT will also be available on call, via switchboard.

Clinical Directors, Assistant Directors of Operations, Associate Medical Directors, Service Managers, Heads of Nursing and Midwifery, Clinical Champions (if applicable)

- Ensure quality and safety is central to directorate plans to delivering clean and safe care by ensuring infection prevention and control is embedded in systems and processes at ward and CMT level.
- Ensure CMTs comply with the Code of Practice by demonstrating improvements in HCAI rates using Saving Lives High Impact Intervention (HII) audits, environmental audit scores and infection prevention and control training attendance
- Ensure broad use of good practice to reduce HCAs and monitor performance against agreed goals by using Saving Lives HII and Root Cause Analysis (RCA) to guide performance.

Consultants

- Provide clinical leadership whilst instilling a culture of zero tolerance on HCAI across the organisation by maintaining own knowledge of infection prevention and control
- Be a champion for HCAI prevention and improvement by education of more junior colleagues and leading by example; particularly regarding hand hygiene and antibiotic stewardship

Ward managers

- Demonstrate high levels of compliance to infection prevention and control policies, clinical protocols and environmental cleanliness.
- Implement Saving Lives HII audits and use the data to monitor compliance and improve ward based systems for infection prevention and control.
- With the support of IPaC, complete RCA for all specified incidents of infection and work with IPaCT and HoN to complete Action plans to rectify any non compliance with IPaC policies and protocols

Head of Facilities

- Ensure premises are 'fit for purpose', maintained, clean and in good repair
- Oversee effective implementation of guidance relating to National Cleaning Standards, laundry, water and waste disposal
- Comply with any relevant duties of the Hygiene Code and demonstrate this through evidence
- Oversee effective implementation of guidance relating to HTM regulations, new builds and refurbishments, Planned Preventative Maintenance, Ventilation, Water Management and waste disposal
- Ensure that IPaCT are involved and engaged with any new infrastructure or build
- Ensure that any Builders or Contractors working on site are compliant with Infection Prevention and Control policies

Allied Health Professionals

- Ensure infection prevention and control measures that are robust and evidence based are embedded in care delivery
- Understand local HCAI data to ensure relevant Infection Prevention and Control policies are adhered to and aseptic technique followed correctly

House keeping Staff

- Take individual responsibility to ensure a high standard of cleanliness and effective implementation of cleaning guidance.
- Oversee effective implementation of guidance relating to cleaning, decontamination, laundry and waste disposal
- Comply with relevant duties of the Hygiene Code and demonstrate this through evidence.

Practice Facilitators for Infection Control (PFfIC)

- Each clinical area to provide a link with IPaCT and be responsible for providing advice on the infection control guidelines devised for specific wards, departments and areas
- Assist the clinical team to use the policies in their everyday practice.
- Be responsible for quarterly hand hygiene observational audits and audits of Personal Protective Equipment
- Have a responsibility to disseminate information and education to clinically based staff that they have received during PFfIC meetings and Study Days.
- PFfICs will attend 6 meetings and two Study Days yearly.

Antimicrobial Pharmacist

- To support prudent use of antibiotics through the development of policies, training and audit.
- Work collaboratively with the Consultant Microbiologist Antibiotic Lead
- Develop systems and processes to ensure all staff responsible for antibiotic prescribing are supported.
- Co-ordinate antimicrobial prescribing audits across the Trust and present findings at the ICC, Antibiotic Forum and support CMTs to deliver action plans formulated following these audits

Microbiology Laboratory Staff

- Develop close links with IPaCT. The laboratory will be visited daily through the week to pick up specimen results for alert organisms.
- The IPaCT work alongside the laboratory staff to ensure specimens sent for processing are clearly and appropriately identified to assist with the processing

Occupational Health Department

- Regularly liaise with the IPaCT in regard to outbreaks of infection within the Trust and management of staff reporting with infections.
- Work in partnership to develop policies and protocols relevant for all staff

Kettering General Hospital NHS Foundation Trust Infection Control Committee

The Trust has an established Infection Control Committee (ICC) whose purpose is to direct the work of the Infection Prevention and Control Team and reports upwards to the Trust Board via the Quality Governance Committee. The terms of reference and membership for the committee are shown at Appendix 1

Health Protection Agency Unit East Midlands (EMHPA)

The HPA is an independent unit, which provides support to the Trust ensuring that it is able to cover its health protection responsibilities for communicable disease surveillance and control, chemical incidents and emergency planning.

Related Policies, Codes of Practice and Guidelines

This policy should be read in conjunction with the relevant Trust and Infection Control policies and procedures. Relevant policies, codes of practice and guidelines are available to staff on the intranet. Below is a list of related procedural documents. Staff are advised to contact the IPaCT if they have any concerns about the operation of any these documents or other infection reduction related concerns

NOTE: This is not an exhaustive list and other policies/guidelines will be added when necessary.

- Standard (Universal) Precautions
- Closure of wards, departments and premises to new admissions
- Isolation of Patients
- Meticillin Resistant *Staphylococcus aureus* (MRSA) Policy
- Meningococcal Infection Policy
- Prevention and Control of Tuberculosis
- Creutzfeld-Jacob Disease (CJD)
- *Clostridium difficile*
- Notification of Infections
- Aseptic technique

- Major Outbreak Control of Communicable Diseases
- Decontamination guidelines including, Cleaning, Disinfection and practical guidelines for cleaning equipment and the environment.
- Management of Indwelling Urinary Catheter
- Management of Intravenous Infusions/Catheters

Reasonable interpreting support will be provided to ensure that there is effective in-person communication between staff providing services and service users. Reasonable information support will be provided to service users, in formats which can be easily understood. Where there is a provision of service by the Trust followed by provision by other organisations, service staff should ensure that the referral process is 'seamless'. There should be no hindrance or delay in the person receiving services from the organisation to which referrals are made

Education and Training

IPaCT are responsible for ensuring there is a wide variety of infection control training available. The education and training will be evidence based and fulfil local and national strategies. This will encompass; (but not be limited to)

- All employees of the Kettering General Hospital NHS Foundation Trust who attend the Trust Induction training which includes; for non clinical staff 40 minutes and clinical staff one and a half hours of infection prevention and control training including specific diseases and hand hygiene technique.
- Infection control training shall be undertaken at induction and updated at annual refreshers for all trust staff.
- The IPaCT team will facilitate the e-learning module for infection prevention and control available through NHS learning for all staff unable to access refresher and other formal teaching sessions (<http://www.infectioncontrol.nhs.uk>)
- Line managers are responsible, with assistance from Staff Development and the Human resources Dept. for ensuring that all ward, department, clinical and administrative staff receive appropriate infection control training, for their level of skill and role.
- Any infection control training or assessments will be recorded and a record kept at departmental level and recorded by staff Development.
- A copy of the above assessments must also be sent to the infection control department on a quarterly basis. The number of staff trained in Infection Control either at induction or during annually updates must be reported by the CMTs as part of performance review with the Directors.
- Staff will be trained to a standard of equality and diversity training which is commensurate with their grading

Hand hygiene workshops are completed by the Practice Development /Surveillance Nurse and Support Nurses in their allocated areas. A record of attendance at these, and other infection prevention and control training sessions are kept by IPaCT. Staff Development Department hold mandatory training session records for induction and refresher training sessions.

Specific or individual training is carried out by the team for support staff including; physiotherapists and Occupational Therapists, contractors, agency workers and other support staff on an adhoc basis.

Process for reviewing and monitoring progress

The Infection Control Committee will be responsible for monitoring the effectiveness of this policy and associated policies and procedures for reducing healthcare associated infection.

They will do this in a variety of ways including:-

- Monitoring ongoing surveillance data relating to healthcare associated infection
- Receiving reports from the IPaCT from their use of a range of audit and observational tools in the operational areas of the hospital to monitor local compliance with policy.
- Monitoring Trust wide action plans for infection reduction and control
- Monitoring update of training and other initiatives designed to increase skills for staff in managing and reducing infection
- Monitoring the implementation of the annual Infection Prevention and Control Programme of work
- The Chair of the Infection Control Committee, the Chief Executive will report to the Trust Board and provide with the DIPC Bi- annual reports for consideration by the Trust Board

Associated policies, code of practice and guidelines will be subject to biannual review and be amended in the event of the publication of relevant evidence or national guidance.

Compliance with the policy and associated policies and guidelines will be undertaken following the Infection Control Annual Programme.

References

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Appendix 1

Kettering General Hospital Foundation Trust Infection Control Committee Terms of reference

Title

Kettering General Hospital Foundation Trust Infection Prevention and Control Committee.

1. Role

1.1 To co-ordinate the overall infection control strategy and monitor infection control performance on behalf of the Trust, by bringing together CMT Representatives, Estates, Facilities, Chairs of Working Groups, and Infection Control Specialists.

1.2 To provide assurance to the Quality Governance Committee and Trust Board with regard to compliance with Care Quality Commission and Monitor requirements for infection prevention and control

2. Tasks

2.1 To set an annual infection control programme in accordance with local, regional and national requirements, i.e. The Health Act (Hygiene Code), Saving Lives, NICE Guidelines and Standards for Better Health

2.2 To receive infection prevention and control reports from the Infection Prevention and Control Team (IPaCT), Clinical Management Teams (CMTs), Facilities, Estates and related working groups, e.g. Occupational Health, Decontamination, Antibiotic Steering group, the Primary Care Trust (PCT) and Health Protection Agency (HPA) in order to:-

- a) monitor progress against the annual programme,
- b) monitor progress against national requirements
- c) to identify issues of significant risk, both internally and externally

2.3 To agree the number, remit and expected life-span of specific infection-related working groups.

2.4 To ratify infection prevention and control policies and guidelines.

2.5 To produce an Annual Infection Prevention and Control Report.

2.6 To make recommendations to other committees and departments within the Trust on all infection prevention and control matters and techniques, and advise when necessary on the selection of equipment building design and patient pathways to prevent infections.

Membership

Lorene Read

Dr M. Natarajan

Dr E. Rizkalla

Mrs L. Libiszewski

Dr Andrew Chilton

Mrs P. Howe

Ms J. Lovell

Post vacant

Chief Executive KGHFT Chairman of the Committee

Consultant Microbiologist, Director for

Infection Prevention and Control KGH

Consultant Microbiologist KGH and Antibiotic Lead

Director of Nursing and Quality

Medical Director

Lead Infection Prevention and Control Nurse KGH

Infection Prevention and Control Nurse KGH

Antibiotic Pharmacist

Ms K. Ruffea	Practice Development /Surveillance Nurse	}	To attend as required
Mrs J. Cole	Infection Control Support Nurse		
Mrs S. Mellor	Infection Control Support Nurse		

Mrs J. Farrow Occupational Health Manager KGH

Head of Nursing & Clinical Leads for Surgery and Orthopaedics
Head of Nursing & Clinical Leads for Medicine
Head of Nursing & Clinical Leads for Clinical Services
Head of Nursing & Clinical Leads for Women and Child Health
Lead for Estates
Lead for Facilities
Decontamination Lead
Representative Health Protection Agency (HPA)
Representative Community Infection Control Nursing Team

Patient/Public representative Co-opted as required
The committee would have the power to co-opt any person necessary to assist in its deliberations.

Frequency of meetings

These should take place at intervals of 2 months, but extra ordinary meetings may be arranged at the discretion of the Chair e.g. at the time of an outbreak of infection.

Chairmanship

This would be the Chief executive of Kettering General Foundation Trust with Director of Infection Prevention and Control (DIPC) (namely the Consultant Microbiologist with responsibility for Infection Prevention and Control) acting as deputy in their absence

Quorum

Shall consist of seven members, IPaCT will only be counted as 1 member, which should include the Chair and representative from the Heads of Nursing

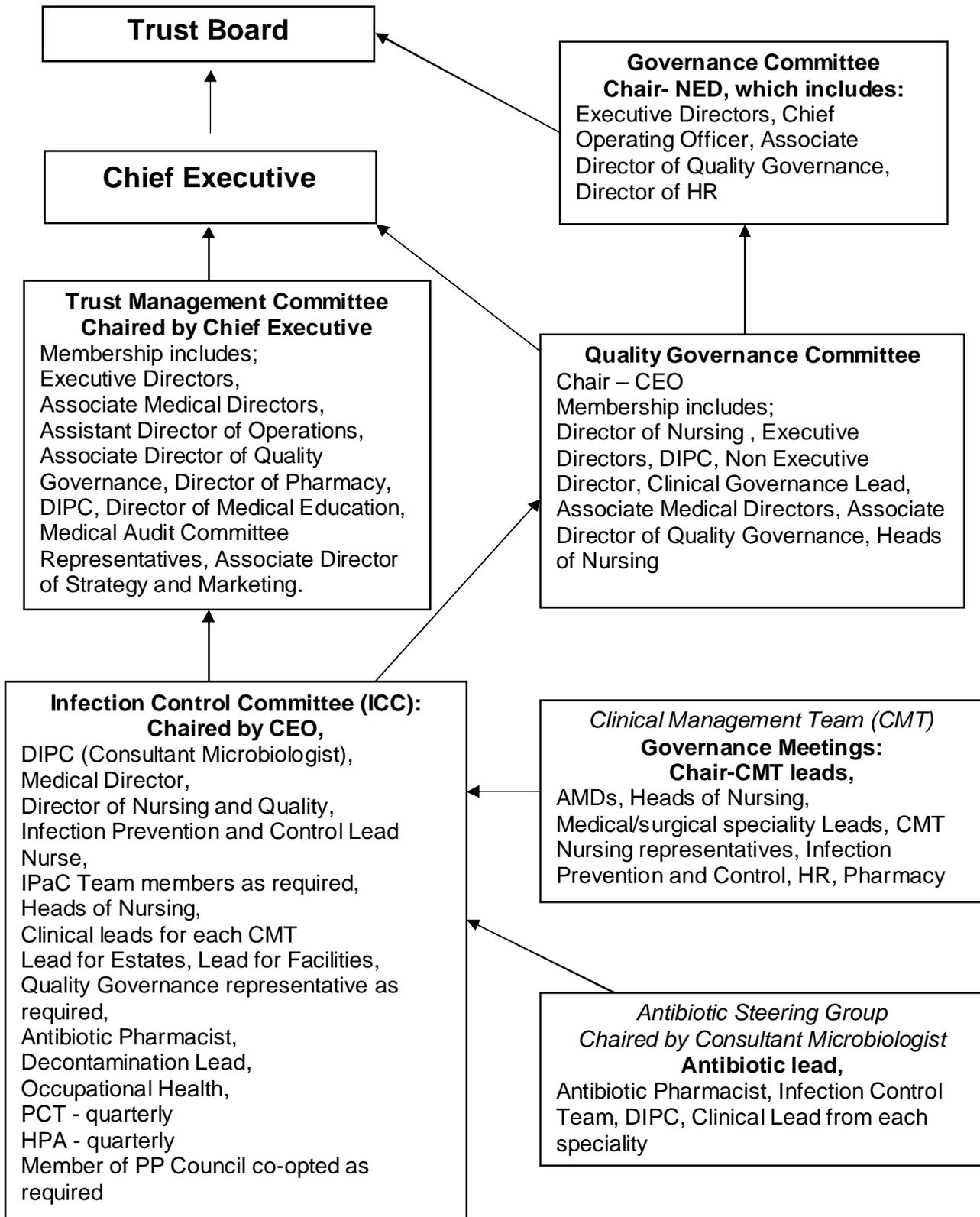
Reporting mechanisms

The ICC minutes are sent to the Quality Governance Committee via the DIPC/Lead Nurse for Infection Prevention and Control
The DIPC reports to the Trust management Quarterly
The ICC produces an Annual Report for the Trust Board and Public.
The DIPC/Lead Nurse report 6 monthly to the Trust Board
The DIPC, Director of Nursing and Quality and Lead Nurse report and participate monthly in the Northamptonshire Health Economy PCT Infection Prevention and Control Committee

Distribution of minutes

1. All members of the Committee
2. Steve Hone – Chairman
3. All AMDs/Clinical Directors KGHFT
4. All Directorate Managers KGHFT
5. QGC
6. Minutes on the Intranet Site

Infection Control Organisational Structure and Reporting Chart



Checklist Infection Prevention and Control Policy version 1.2

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

	Title of document being reviewed:	Yes/ No/ Unsure	Comments & Comment Author
1.	Title		
	Is the title clear and unambiguous?	Yes	
	If the document has been updated, has the title been changed?	No	
	Is it clear whether the document is a guideline, policy, protocol, procedure or guideline?	Yes	
2.	Rationale		
	Are reasons for development of the document stated?	Yes	
3.	Development Process		
	Is the method described in brief?	Yes	
	Are people involved in the development identified?	Yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders, users, patients, public, voluntary groups or other Trusts or organisations?	Yes	
4.	Content		
	Is the content of the document clear?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	Evidence Base		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited in full?	Yes	
	Are supporting documents referenced?	Yes	

	Title of document being reviewed:	Yes/ No/ Unsure	Comments & Comment Author
6.	Approval		
	Does the document identify which committee/group will approve it?	Yes	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	Yes	
7.	Dissemination and Implementation		
	Is there an outline/plan to identify how this will be done?	Yes	
	Does the plan include the necessary training/support to ensure compliance?	Yes	
8.	Document Control		
	Does the document identify where it will be held?	Yes	
	Have archiving arrangements for superseded documents been addressed?	Yes	
9.	Process to Monitor Compliance and Effectiveness		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Yes	
	Has a method of monitoring been agreed with timescales?	Yes	
	Is there a plan to review or audit compliance with the document?	Yes	
10.	Review Date		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so is it acceptable?	Yes	
11.	Overall Responsibility for the Document		
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the documentation?	Yes	

	Title of document being reviewed:	Yes/ No/ Unsure	Comments & Comment Author
12.	Has it been diversity impacted including the completion of the assessment tool?	Yes	

Individual Approval			
If you are happy with this document, please sign, date it and forward to the chair of the committee/group where it will hopefully receive final approval.			
Returned to author for amendments date:			
Name	Pam Howe IPaCN	Date	09.12.2011
Signature			

Procedural Documents Committee Checklist

Title of Document and version number: IPC2 Infection Prevention and Control Policy version 1.2		
Date checklist completed: 09.12.2011	Name of person checking document: Pam Howe	
Core Standard	Comments & Comment Author	
Is the document presented in the agreed corporate style and format and the template has been used ? (Title page, contribution page, Arial 12, numbered paragraphs, justified etc)	Yes	
Is this policy needed?	Yes	
Has a check been made if the policy already exists in this or similar form?	Yes	
Does it link to another policy/document?	No	
Is there a clear introduction?	Yes	
Is there a definition section to explain terms used?	Yes	
Is there evidence that consultation has taken place?	Yes	
Has an appropriate review period been identified?	Yes	
Have monitoring tools for compliance been identified within the document?	Yes	
Does it state how the document will be disseminated and is this appropriate?	Yes	
Have arrangements been made for retrieval and archiving?	Yes	
Are associated documents cited and referenced correctly?	Yes	
How will the effectiveness of the procedural document be measured?	Yes	
Title of Document and version number:		

Date checklist completed:	Name of person checking document:
Core Standard	Comments & Comment Author
Has the document been impact assessed and any necessary action taken as a result of this?	Yes
Has the data been inserted into the document properties?	Yes
Is the filename compliant and, if an update, the same as the original file?	
Is the content correctly paginated?	

Equality Impact Assessment (EqIA) Template for *Policies and Functions

Version 22.07.10 MASTER

Instructions: You are assessing your policy / function against six benchmarks of good practice. Please answer the questions shown under each of the benchmarks. In respect of the policy the assessment is against the affects of the policy in practice.

Policy	X	Function	<input type="checkbox"/>	New Policy	<input type="checkbox"/>	Existing Policy	X	New Function	<input type="checkbox"/>	Existing Function	<input type="checkbox"/>			
Staff member completing assessment Pam Howe Lead IPCN						Storage location of policy / function information: Infection Prevention and Control								
<i>Name of policy / function:</i> Infection Prevention and Control Policy														
<p>Summary of policy / function: Infection Prevention and Control Policy</p> <ul style="list-style-type: none"> The policy sets out the clinical governance arrangements for the Trust's Infection management, prevention and control strategy. It confirms the Trust's commitment to the prevention and control of infection, and is achieved through the development of policies, codes of practice and guidelines supporting this overarching policy and the promotion of training and education in infection prevention and control procedures. It references the way in which the Trust will meet good infection control principles and practice in line with the 12 clinical care protocols identified in the Health Act 2008. It outlines the information that is available to patients and the public about the arrangements for preventing and controlling healthcare associated infection (HCAI) It sets out how the Trust will meet its training requirement to ensure that our staff receive adequate training in relation to reducing the risk of healthcare associated infection (HCAI). 														
Who are the end beneficiaries of the policy / function?				Staff	X	Patients	X	Carers	<input type="checkbox"/>	Visitors	<input type="checkbox"/>	Other (please specify)		
Policy / Function review date:						Jan 2014			Date for repeating impact assessment:			Jan 2014		

Date policy / function impact assessment completed: 09.12.2011		Signature of staff member completing assessment: <i>Pam Howe</i>	
Date impact assessment signed off by Equality & Diversity Lead: (On behalf of Equality and Diversity Steering Group)		Signature of Equality and Diversity Lead:	
<p>This policy or function is not intended (or ultimately intended) to engage with or involve beneficiaries (i.e. patients, staff, carers, members of the public or visitors) hence the rest of the template has not been completed X (please tick box if applicable)</p> <p>This overarching policy is intended to outline an organisational approach to complex issues relating to infection prevention and control and therefore it is not necessary to complete for Equality Impact Assessment</p>			
<p>1. Effective communication between staff and service users, from separate physical locations (e.g. from home to service within the hospital and vice versa or between different services within the hospital and its various service annexes)</p>			
1(a) Is this benchmark relevant to this policy or function?		Yes <input type="checkbox"/>	No <input type="checkbox"/> If No, go to the next benchmark
1(b) If the benchmark is relevant, please tick the equality group which may require additional support/ resources/ reasonable adjustments, in order to achieve it			
Age <input type="checkbox"/>	Gender <input type="checkbox"/>	Disability <input type="checkbox"/>	Race <input type="checkbox"/>
		Sexuality <input type="checkbox"/>	Religion/ Religious Beliefs <input type="checkbox"/>
Other (please specify)			
1(c) *In respect of the equality groups which may require support / resources / reasonable adjustments, what does the Trust have in place?			
<i>*Some examples of support / resources / reasonable adjustments that can be provided are shown on page 5</i>			
1(d) Additional information (e.g. recommendations for improvement, changes to policy / function, etc.):			

2. Service users can successfully travel to Hospital / Annex and within specific area of building where service is provided (Physical Access)

2(a) Is this benchmark relevant to this policy or function?		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	If No, go to the next benchmark						
2(b) If the benchmark is relevant, please tick the equality group which may require additional support/ resources/ reasonable adjustments, in order to achieve it												
Age	<input type="checkbox"/>	Gender	<input type="checkbox"/>	Disability	<input type="checkbox"/>	Race	<input type="checkbox"/>	Sexuality	<input type="checkbox"/>	Religion/ Religious Beliefs	<input type="checkbox"/>	Other (please specify)
2(c) *In respect of the equality groups which may require support / resources / reasonable adjustments, what does the Trust have in place?												
<i>*Some examples of support / resources / reasonable adjustments that can be provided are shown on page 5</i>												
2(d) Additional information : (e.g. recommendations for improvement, changes to policy / function, etc):												

3. Effective in-person communication between staff and service users

3(a) Is this benchmark relevant to this policy or function?		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	If No, go to the next benchmark						
3(b) If the benchmark is relevant, please tick the equality group which may require additional support/ resources/ reasonable adjustments, in order to achieve it												
Age	<input type="checkbox"/>	Gender	<input type="checkbox"/>	Disability	<input type="checkbox"/>	Race	<input type="checkbox"/>	Sexuality	<input type="checkbox"/>	Religion/ Religious Beliefs	<input type="checkbox"/>	Other (please specify)
3(c) *In respect of the equality groups which may require support / resources / reasonable adjustments, what does the Trust have in place?												
<i>*Some examples of support / resources / reasonable adjustments that can be provided are shown on page 5</i>												
3(d) Additional information (e.g. recommendations for improvement, changes to policy / function, etc):												

4. Service users can understand information provided												
4(a) Is this benchmark relevant to this policy or function?			Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	If No, go to the next benchmark					
4(b) If the benchmark is relevant, please tick the equality group which may require additional support/ resources/ reasonable adjustments, in order to achieve it												
Age	<input type="checkbox"/>	Gender	<input type="checkbox"/>	Disability	<input type="checkbox"/>	Race	<input type="checkbox"/>	Sexuality	<input type="checkbox"/>	Religion/ Religious Beliefs	<input type="checkbox"/>	Other (please specify)
4(c) *In respect of the equality groups which may require support / resources / reasonable adjustments, what does the Trust have in place?												
<i>*Some examples of support / resources / reasonable adjustments that can be provided are shown on page 5</i>												
4(d) Additional information (e.g. recommendations for improvement, changes to policy / function, etc):												
5. Taking into account cultural norms, preferences and practices of equality groups (e.g. preference for same sex service staff, dress code, key religious days and practices, food choices, etc.)												
5(a) *Is this benchmark relevant to this policy or function?			Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	If No, go to the next benchmark					
5(b) If the benchmark is relevant, please tick the equality group which may require additional support/ resources/ reasonable adjustments, in order to achieve it												
Age	<input type="checkbox"/>	Gender	<input type="checkbox"/>	Disability	<input type="checkbox"/>	Race	<input type="checkbox"/>	Sexuality	<input type="checkbox"/>	Religion/ Religious Beliefs	<input type="checkbox"/>	Other (please specify)
5(c) *In order to take into account cultural norms, preferences and practise of relevant equality groups, what support / resources / reasonable adjustments, does the Trust have in place?												
5(d) Additional information (e.g. recommendations for improvement, changes to policy / function, etc):												

*Further information about this benchmark is available on the Trust's Equality and Diversity section of the intranet and from the Equality and Diversity Lead

6. Addressing any adverse affects

6.a. In respect of each equality group, do the Trust's *audits (e.g. Serious Untoward Incident, PALS, Complaints, Grievances, Satisfaction Surveys, Workforce Statistics, Patient and Carer Equitable Access to Service and Outcome, Physical Access, Patient Equipment, etc.) show any of the equality groups to be more adversely affected in comparison with other equality groups within the Trust, within the region and within the country?

**Recommend under section 6.d. that an audit should be carried if it isn't available or it doesn't provide data on all equality groups*

6.b. If so, how is this higher level of adverse affect justified?

6.c. If it is not justified, then, what action has the Trust taken / will be taking regarding reducing / eliminating the adverse affect?

6.d. Additional information (e.g. recommendations for improvement, changes to policy / function, etc):

Some examples of support / resources / reasonable adjustments that can be provided to equality groups, in order to enable them to achieve benchmarks, are shown below:

- Interpreting and Language Line Services can be used to establish telephone communication with people who don't speak English
- British Sign Language, Lip Reading Interpreting Service, Textphones (also called Minicomms) and Type Talk (national telephone relay service) can be used to establish communication with people who have speech and hearing impairments
- Provision of static and portable hearing loops can assist people with partial loss of hearing in communicating with hospital staff
- Printed material in English with a paragraph in the person's own language (detailing how they can obtain information in their own language) can be used to enable people from some ethnic minority communities, who don't read English, to have access to understandable information

- Use of signage in Braille and tactile format around the hospital can assist people with total sight loss to get to service delivery areas
- Nearby parking spaces, ramps, lifts and yellow nosed steps are some of the reasonable adjustments that can be made for people with physical disabilities to get to service delivery areas
- Use of large font printed material, picture based communication and 'Easy Read' language material are some of the ways to provide understandable information to people with learning disability

More examples are shown in the document 'Barriers and Solutions – Barriers equality groups may experience in using the NHS and some solutions to eliminating them'. This can be found in the Equality and Diversity section of the Trust's intranet. A copy can also be obtained by contacting Michelle Tyler on Ex. 1596

• **Implementation Plan For : Infection Prevention and Control Policy**

	ACTION	LEAD	TIMESCALE	PROGRESS/ OUTCOME	EVALUATION/ EVIDENCE	RAG RATING*
<p>Co-ordination of Implementation How will the implementation plan be co-ordinated? (Clear co-ordination is essential to monitor and sustain progress against the implementation plan and resolve and other further issues that may arise)</p>	Policy already in place	PH	On-going		ICC, TMC and QGC Minutes	
<p>Engaging Staff Who is affected directly or indirectly by the policy? Are the influential staff involved in the implementation? (Engaging staff and developing strong working relationships will provide a solid foundation for changes to be made)</p>	KGH staff follow the Hygiene Code based on the responsibilities set down in this policy	PH	On-going		ICC, TMC and QGC Minutes	
<p>Involving Service Users and Carers Is there a need to provide information to service users and carers regarding this policy? Are there service users, carers, representatives or local organisations</p>	KGH staff follow the Hygiene Code based on the responsibilities set down in this	PH	On-going		KGH staff follow the Hygiene Code based on the responsibilities set down in	

<p>who could contribute to the implementation? (Involving service users and carers will ensure that any actions taken are in the best interest of service users and carers and that they are better informed about their care)</p>	<p>policy. Patients and carers are potentially affected if these guidelines are not followed</p>				<p>this policy</p>	
<p>Communicating What are the key messages to communicate to the different stakeholders? How will these messages be communicated? (Effective communication will ensure that all those affected by the policy are kept informed thus smoothing the way for any changes. Promoting achievements can provide encouragement to those involved)</p>	<p>Basis of this policy is demonstrated at both Induction and refresher sessions provided for all trust staff</p>	PH	On-going			
<p>Training What are the training needs related to this policy? Are people available with the skills to deliver the training? (All stakeholders need time to reflect on what the policy means to their current practice and key groups may need specific training to be able to deliver the policy)</p>	<p>Basis of this policy is demonstrated at both Induction and refresher sessions provided for all trust staff</p>	PH	On-going			
<p>Resources Have the financial impacts of any changes been established? Is it possible to set up processed to re-</p>	N/A					

<p>invest any savings? Are other resources required to enable the implementation of the policy e.g. increased staffing, new documentation? (Identification of resource impacts is essential at the start of the process to ensure action can be taken to address issues which may arise at a later stage) (Engaging staff and developing strong working relationships will provide a solid foundation for changes to be made)</p>						
<p>Securing and Sustaining Change Have the likely barriers to change and realistic ways to overcome them been identified? Who needs to change and how do you plan to approach them? Have arrangements been made with service managers to enable staff to attend briefing and training sessions? Are arrangements in place to ensure the induction of new staff reflects the policy? (Initial barriers to implementation need to be addressed as well as those that may affect the on-going success of the policy)</p>	N/A					
<p>Evaluating What are the main changes in practice that should be seen from the policy? How might these changes be evaluated?</p>	Update of previous policy therefore not requiring any changes in					

<p>How will lessons learnt from the implementation of this policy be fed back into the organisation? What is the plan to audit the implementation of this policy? What will the reporting process be for the results of the audit? (Evaluating and demonstrating the benefits of new policy is essential to promote the achievements of those involved and justifying changes that have been made)</p>	practice					
<p>Rick Management Issues What are the risks for any changes to practice or patient care? How are these risks going to be managed? (It is important to understand if there are any clinical risks to patients as a result of the introduction of this policy and, if so, the risks need to be thoroughly assessed and mitigating actions put into place)</p>	N/A					
<p>Other considerations</p>						

KEY* RAG RATING =



= NOT STARTED



= IN PROGRESS



= COMPLETED