Trust Board Meeting in Public: Wednesday 13\textsuperscript{th} September 2017

TB2017.94

<table>
<thead>
<tr>
<th>Title</th>
<th>Infection Prevention and Control Annual Report 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status</td>
<td>For information</td>
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</tbody>
</table>
| History | Hospital Infection Prevention and Control Committee meeting  
| | TME 31 August 2017 | |

<table>
<thead>
<tr>
<th>Board Lead(s)</th>
<th>Dr Tony Berendt, Medical Director</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key purpose</td>
<td>Strategy</td>
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</tbody>
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|                        | Strategy | Assurance | Policy | Performance |

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Executive Summary

1. **Methicillin-resistant Staphylococcus aureus (MRSA) Bacteraemia**
   Zero avoidable MRSA bacteraemias are permitted. There were 5 avoidable MRSA bacteraemias and one unavoidable (taken >48 hrs after admission) assigned to the OUHFT during 2016/2017. Themes from cases have been identified and will form the basis for learning opportunities for 2017/18.

2. **Clostridium difficile**
   There were 53 OUH apportioned cases identified after three days of admission for 2016/2017 against an upper set limit of 69.

3. **Methicillin-sensitive Staphylococcus aureus (MSSA) Bacteraemia**
   There were a total of 41 incidents of post-48 hour MSSA bacteraemias. In over a quarter of the cases (n=14) a source could not be attributed for the bacteraemia. Twelve cases were thought to be attributable to an intravascular device. The focus of learning and action in 2017/18 will be directed at line care.

4. **E.coli bacteraemias**
   During 2016/17 there were 385 pre-48 hour and 111 post-48 hour E.coli bacteraemias reported. NHS England have set challenging targets going forwards for the whole health economy around reduction of Gram negative blood stream infection (BSI), with an initial focus on E.coli BSI.

5. **Mycobacterium chimaera**
   It has been recognised that this organism has caused severe infections in a small proportion of patients who have had cardiac surgery. Over 1700 letters were sent to patients that had undergone cardiac valve surgery where a heater cooler was used during their operation at the OUH. A case of M.chimaera infection in a patient who had surgery in the OUH in March 2016 has been identified.

6. **Candida auris in Neuro Intensive Care Unit**
   The OUH is one of three trusts in England to have a significant outbreak of C.auris.

7. **Newborn Care Unit Serratia marcescens Incident**
   An outbreak of Serratia marcescens causing invasive infection in 5 pre-term neonates was managed in the Neonatal Intensive Care Unit between October 2016 and December 2016.

8. **Cleaning**
   A Cleaning Partnership Group has been established, chaired by the Deputy Chief Nurse.

9. **West Wing Theatres - Cleaning**
   Concern was raised in June 2016 that West Wing Theatres were dirty and activity was stopped for a number of hours whilst an assessment could be made and an action plan established.
10. **MRSA Screening**
   The MRSA protocol was updated and approved at the December Clinical Policy Group. The cohort of patients requiring screening has been reduced in line with updated evidence and local assessment.

11. **Surgical Site Infection Surveillance**
   A Trust-wide SSI Group was established in March and reports through the Hospital Infection Prevention and Control Committee (HIPCC). The Group has two aims. Firstly to ensure that all surgical specialties commence SSI surveillance and then secondly to reduce rates of SSI.

12. **Recommendation**
   The Trust Board is asked to note the contents of this annual report.
Director of Infection Prevention and Control (DIPC Annual) Report

1. The Director of Infection Prevention and Control (DIPC) Annual Report reports on infection prevention and control activities within the Oxford University Hospitals (OUH) NHS Foundation Trust for April 2016 to March 2017. The Report covers Infection Prevention and Control for the four sites; John Radcliffe Hospital, Churchill Hospital, Nuffield Orthopaedic Centre and Horton General Hospital.

2. The Hospital Infection Prevention and Control Committee (HIPCC) (formerly Hospital Infection Control Committee) reports to the Clinical Governance Committee which reports monthly to Trust Board and quarterly to the Quality Committee. The Decontamination Committee reports to HIPCC. The newly formed Cleaning Partnership Group also reports to HIPCC.

3. HIPCC is now meeting on a monthly basis.

Description of Infection Prevention Activities

4. The team is multidisciplinary and consists of a Director of Infection Prevention and Control (DIPC), Deputy DIPC and Infection Control Doctor (appointed July 2016), Infection Prevention and Control Nurse Manager, Infection Prevention and Control nursing team, Antimicrobial Pharmacists, Antimicrobial Audit Assistant, Infection Prevention and Control Administrator, Consultant Infectious Disease/General Physician lead for Antimicrobial Management/training and audit, Scientists, Statistician and PhD students. As necessary, members of the wider microbiology/infectious diseases team are co-opted on to the team.

5. Dr Tony Berendt (Medical Director) is the DIPC and reports directly to the Chief Executive and Trust Board. The Infection Control Doctor/Deputy DIPC and Infection Prevention and Control Manager report to the DIPC and hold weekly meetings with the Infection Prevention and Control team.

6. The role of Decontamination Lead was taken on an interim basis by the Infection Control Manager.

7. The Infection Prevention and Control nursing team, microbiology/infectious diseases medical staff and staff from pharmacy all contribute to delivering the infection prevention and control service at the OUH Trust. In order to deliver a safe service, there is a close working relationship with the microbiology laboratory, Estates and Facilities, clinical and managerial staff within the trust.

Staffing within the Infection Prevention and Control team

8. The staffing at the end of March 2017 within the Infection Prevention and Control Team is as follows:

- Infection Control Doctor (OUH) /Deputy DIPC
- Infection Control Doctor (Oxford Health)
- Infection Prevention and Control Manager (band 8C)1.0 WTE
- Antimicrobial Stewardship Medical Lead
• Infection Prevention and Control Senior Nurse (band 8A) 0.8 WTE
• Infection Prevention and Control Nursing staff (band 7) 3.4 WTE
• Infection Prevention and Control Nursing staff (band 6) 1.0 WTE
• Infection Prevention and Control Nursing staff (band 5) 1.0 WTE
• Infection Prevention and Control Administrator 1.0 WTE
• Data Analyst 1.0 WTE
• Antimicrobial Pharmacists 1.4 WTE (0.9 x band 8b and 0.5 x band 7)

Figure 1

The flow diagram below illustrates the line management for the Infection Prevention and Control team.

Organisms subject to mandatory reporting
9. **Methicillin-resistant Staphylococcus aureus (MRSA Bacteraemia)**

9.1. Zero avoidable MRSA bacteraemia are permitted. There were 6 MRSA bacteraemia (taken >48 hrs after admission) assigned to the OUHFT during 2016/2017.

9.2. All OUH apportioned MRSA bacteraemia undergo a Post Infection Review (PIR) with OCCG and PHE. From this process five were deemed avoidable and one unavoidable.

**Table 1 Total Number of MRSA Bacteraemia apportioned to the Trust April 2016-March 2017**

<table>
<thead>
<tr>
<th>Month</th>
<th>Contaminant</th>
<th>Unavoidable</th>
<th>Avoidable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-16</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>May-16</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Jun-16</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Jul-16</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Aug-16</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Sep-16</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Oct-16</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Nov-16</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Dec-16</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Jan-17</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feb-17</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Mar-17</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**Table 2 Breakdown of Avoidable MRSA bacteraemias assigned to the Trust**

<table>
<thead>
<tr>
<th>Month</th>
<th>Source of MRSA bacteraemia</th>
<th>Lapse in care identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>June</td>
<td>Surgical Site Infection</td>
<td>The reducing Surgical Site policy states that all trauma patients should receive a chlorhexidine wash prior to their transfer to theatre. This patient did not receive a wash.</td>
</tr>
<tr>
<td>October</td>
<td>Probable contaminant</td>
<td>It was thought that this MRSA positive blood culture was not clinically significant and most likely to be a contaminant. All contaminants are considered to be avoidable.</td>
</tr>
<tr>
<td>November</td>
<td>Infected peripheral</td>
<td>There was poor documentation around</td>
</tr>
</tbody>
</table>
**January**

<table>
<thead>
<tr>
<th>cannula site insertion and on-going care of peripheral lines.</th>
<th>Probable contaminant</th>
</tr>
</thead>
<tbody>
<tr>
<td>It was thought that this MRSA positive blood culture was not clinically significant and most likely to be a contaminant. All contaminants are considered to be avoidable.</td>
<td></td>
</tr>
</tbody>
</table>

**February**

<table>
<thead>
<tr>
<th>Chest</th>
</tr>
</thead>
<tbody>
<tr>
<td>This patient was known to be MRSA colonised but did not receive decontamination as per the OUHFT MRSA protocol. However, it is unlikely that decontamination would have prevented the chest sepsis.</td>
</tr>
</tbody>
</table>

10. **Review of MRSA root cause documentation**

10.1 From April 2014 to date there were 17 MRSA post-48 hour bacteraemias, of which 6 were deemed unavoidable and 11 avoidable.

The following themes were identified.

- 5 contaminants
- 3 skin/soft tissue related (SSI, cellulitis etc.)
- 2 line related
- 4 unknown sources
- 2 chest related
- 1 permanent pacemaker

10.2 As a consequence of this review a number of work streams are being developed to focus on reducing the number of contaminants, improving line documentation on EPR, and to improve compliance to the MRSA protocol surrounding skin decontamination.

10.2.1 **Reducing Contaminants**

10.2.1.1 Blood culture contamination rates are reported in the literature as being in the region of 3-5% of all blood cultures. This increases workload in the diagnostic laboratory, and may lead to inappropriate investigation and management of the patient.

10.2.1.2 Almost a third of the post-48 hour MRSA bacteraemias since 2014 have been contaminants.

10.2.1.3 The rate of contamination in all the 2016 peripheral blood cultures in OUH was 3.2%. Work is on-going to compare this with earlier years
when a more active ‘Aseptic no-touch technique’ training programme was in place, and this will be a focus for 2017/18.

10.2.1.4 An online survey has been sent to all junior doctors to gain an understanding of blood culture taking. The outcome from this and from location-based data on rate of blood culture contamination will be used to direct where training and education are most required.

10.2.2 MRSA Protocol Compliance with Skin Decontamination

10.1.2.1 An electronic careplan for MRSA management has been developed and will prompt nursing staff to consider the need for skin decontamination. However, as an outcome from one of the PIR meetings, a request has been made for an EPR alert to be issued to medical staff when a patient has a positive MRSA screening swab to prescribe skin decontamination. A power plan will be available for the prescription.

10.1.2.2 The MRSA protocol was reviewed this year and based on the evidence from a Cochrane review the cohorts of patients requiring pre-operative skin wash with chlorhexidine has been amended.

10.1.3 Line Documentation

10.1.3.1 There are inconsistencies across the trust with the documentation of insertion and on-going care of vascular devices whereby some areas are recording on paper and other areas are using EPR. Furthermore, compliance to protocol is poor as identified in PIR meetings. Work has commenced in improving compliance and a recent email from the Deputy Chief Nurse has mandated that lines and devices should be recorded on EPR.

11 Clostridium Difficile

11.1 The OUH was set an upper limit of 69 cases of Clostridium difficile identified after three days of admission for 2016/2017.

11.2 The OUH had a total of 53 apportioned cases for 2016 / 2017. This is a further improvement on last year’s figure of 57 (upper limit 69).
11.3 All cases of *Clostridium difficile* identified in the microbiology department of the OUH Trust are investigated using Root Cause Analysis (RCA) and discussed at a monthly meeting where there are representatives from PHE, OCCG, Oxford Health Foundation Trust and the OUH Infection Prevention and Control service.

11.4 Each case is presented individually and discussed. Agreement is then reached as to whether the case is avoidable or unavoidable. Any actions are agreed and lessons learnt for the Health Economy.

11.5 The majority of cases for 2016/17 were deemed unavoidable.

**Table 4 Number of Post 72 hour Cases deemed Avoidable or Unavoidable following Health Economy Review**

<table>
<thead>
<tr>
<th></th>
<th>Avoidable</th>
<th>Unavoidable</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 cases</td>
<td>44 cases</td>
<td></td>
</tr>
</tbody>
</table>

12 **Themes in Lapses in Care**

12.1 Despite mostly being deemed unavoidable there were unfortunately lapses in care identified in around half the total number of post-72 hour cases of *C. difficile*.

12.2 Some cases had more than one aspect of lapse in care identified.
Table 5 Main Themes of Lapses in Care

<table>
<thead>
<tr>
<th>Lapse in Care</th>
<th>Number of Cases with this Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guideline not followed for sampling criteria</td>
<td>14</td>
</tr>
<tr>
<td>Delay in treatment</td>
<td>9</td>
</tr>
<tr>
<td>Failure to isolate promptly</td>
<td>5</td>
</tr>
<tr>
<td>Poor MDT communication</td>
<td>5</td>
</tr>
<tr>
<td>Inappropriate antibiotic prescribing</td>
<td>4</td>
</tr>
<tr>
<td>Incomplete fluid balance</td>
<td>3</td>
</tr>
</tbody>
</table>

12.3 Following review at the Health Economy the completed RCAs and outcome are fed back to the clinical team for discussion at directorate clinical governance level.

12.4 The Annual Plan for 2017/18 will feature learning from this review.

12.5 Reassuringly the table below demonstrates three years of being within cumulative limits of *C. difficile* set by Oxfordshire Clinical Commissioning Group.

Table 6 Three years of being within cumulative limits of *C. difficile* set by Oxfordshire Clinical Commissioning Group.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumulative Total</td>
<td>61</td>
<td>57</td>
</tr>
<tr>
<td>Cumulative Limit</td>
<td>67</td>
<td>69</td>
</tr>
</tbody>
</table>
12.6 The Fingertips data are inaccurate for 2015/16 as final number for OUH was 57 and are not shown for 2016/17.

13 Methicillin-sensitive Staphylococcus aureus (MSSA) Bacteraemia

13.1 Root cause analysis is conducted on all cases of MSSA bacteraemias to establish the source, whether it is a healthcare associated infection and to identify any learning.

13.2 There were a total of 41 incidents of post-48 hour MSSA bacteraemias.

13.3 In over a quarter of the cases (n=14) a source could not be attributed for the bacteraemia. However, 12 cases were thought to be attributable to an intravascular device. Clearly, the focus of learning needs to be directed at line care over the next few coming months.
Table 8 Cases of Post 48 hour MSSA bacteraemia (April 2016–March 2017)

<table>
<thead>
<tr>
<th>Month</th>
<th>Apr-16</th>
<th>May-16</th>
<th>Jun-16</th>
<th>Jul-16</th>
<th>Aug-16</th>
<th>Sep-16</th>
<th>Oct-16</th>
<th>Nov-16</th>
<th>Dec-16</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>Mar-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>No of MSSA bacteraemias</td>
<td>2</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>6</td>
</tr>
</tbody>
</table>

14 **E. coli Bacteraemia**

14.1 During 2016/17 there were 385 pre-48 hour and 111 post-48 hour *E. coli* bacteraemias reported.

14.2 April 2017 will see the introduction of additional Gram-negative bacteraemia surveillance. Trusts are now required to report cases of bloodstream infections due to *Klebsiella* spp. and *Pseudomonas aeruginosa*. There is a new government initiative to reduce healthcare associated Gram-negative bloodstream infections (BSIs) by 50% by financial year 2020/21, focussing initially on *E. coli*.

14.3 This will require a whole health economy approach as approximately three-quarters of *E. coli* BSIs occur prior to hospital admission. CCGs are leading on achieving the Quality Premium, aiming to reduce all *E. coli* BSIs by 10% this year.
Table 9 Cases of Pre- and Post-48 hour *E. coli* bacteraemia (April 2016 –March 2017)
Infection Control

New challenges

15  **Mycobacterium chimera**

15.1 *Mycobacterium chimaera* is a non-tuberculous mycobacterium. This type of mycobacterium is widespread in the environment, including tapwater, and is usually associated clinically with respiratory disease or with disseminated disease in the immunocompromised patient.

15.2 It is now recognised that *M. chimaera* has caused severe infections in a small proportion of patients who have had cardiac surgery. UK and international investigations have implicated heater cooler units used for cardiopulmonary bypass, transmitting infection from their water tanks via generation of a contaminated aerosol with particles reaching the operative field.

15.3 As of 30 June 2017, there were 37 cases of *M. chimaera* infection reported in the UK following surgery on cardiopulmonary bypass, of which 18 were known to have died. The median interval between surgery and diagnosis is 19 months but ranges from 3 to 68 months.

15.4 NHS England instructed Trusts to undertake a notification exercise.

15.5 Over 1700 letters were sent to patients and their GPs to notify them of the risk and of how to respond to concerns.

15.6 As a result of the notification exercise, a patient with *M. chimaera* mitral valve endocarditis operated on in the OUH in March 2016 has been identified. The patient is currently on treatment.

15.7 The perfusion team have been following manufacturer’s guidance on cleaning heater coolers since December 2015. Water testing from the PHE was not unavailable until March 2017 and was established in May 2017.

15.8 All heater cooler devices in the Trust will be retro-fitted with devices to prevent aerosolisation by December 2017. This is being funded by the manufacturer (LivaNova), and has been contracted out to a third party.

16  **Candida auris**

16.1 Public Health England issued an alert for *Candida auris* (*C. auris*) in July 2016. *C. auris* is a relatively new strain of Candida (Yeast) first identified in Japan in 2009. It is commonly resistant to the first-line antifungal, fluconazole and can develop resistance to other classes of antifungal agents. It appears to be unlike other pathogenic yeast species in its propensity for transmission between hospital patients. It has caused a major outbreak of infection in three intensive care units in the UK, two based in London, and the Neurological Intensive Care Unit (NITU) in the OUH.
16.2 *C. auris* can cause asymptomatic colonisation or clinical infections, e.g. surgical site, blood stream and device related infections. *C. auris* is thought to be transmitted by direct contact with someone who has an active infection, someone who is colonised with *C. auris*, or via contaminated objects/ the environment.

16.3 A look back of cases in the OUHFT was carried out following notification by PHE of a case of *C. auris* in a patient transferred from NITU to Wexham Park Hospital in September 2016. This highlighted 7 other cases of colonisation or infection from 2015/16. A point prevalence screen of all patients on NITU was then carried out and further cases were identified.

16.4 Screening of the NITU was introduced in November 2016 and continued to identify newly colonised patients despite enhanced Infection Prevention and Control measures (19.6 below).

**Table 10 Epi Curve for Candida auris January 2015-April 2017**
16.5 **Patient screening summary**

October 2016 - May 2017, over 15000 screens have been performed on 726 individual patients, 280 on NITU, 407 on the neuroscience ward, 39 elsewhere (including Adult ICU).

62 patients have become *Candida auris* colonised or infected since screening commenced, with 2 cases of candidaemia (3.2% infection rate).

To date: total of 70 cases of colonisation or infection, 69 of the 70 patients were admitted to NITU.

All Oxford isolates sequenced belong to the South African clade.

No directly attributable mortality.
16.6 **Infection prevention and control measures introduced**

- Barrier nursing with isolation or cohorting of all positive patients. Long sleeved gowns.
- Enhanced clean whole unit daily (Acticlor plus 2000ppm) floors and level surfaces
- Terminal cleans for all vacated bedspaces
- Enhanced monitoring of cleaning and hand hygiene
- General ‘decluttering’ of the unit
- Restricted traffic - stopped use of unit as a ‘corridor’ to offices
- Removal of fans and forced air convection blankets
- Reduction of bedside stocks of equipment with stocks of single use items in the immediate patient environment discarded on discharge
- Single use equipment obtained where possible e.g. blood pressure cuffs
- Wipe clean pillows obtained (SleepAngel™)
- Regular meetings (formal and informal ‘brain-storming’)
- Introduction of Micafungin prophylaxis (single dose) for device related surgical procedures in colonised patients

16.7 The Financial cost to the OUH of the outbreak will be considerable (final figures to be confirmed).

16.8 Public Health England has visited the unit twice to conduct environmental screening and air sampling. To date *Candida auris* has been identified on passive air sampling, one oxygen saturation probe, one reusable axilla temperature probe and on a patient hoist. *Candida auris* was not identified in active air sampling.

16.9 Follow up screening identified *C. auris* on four axilla temperature probes and these have now been removed from the unit. Results of environmental screening and interventions can be found via the DOI link: https://doi.org/10.1101/149054

16.10 The Modernising Medical Microbiology (MMM) group are now working with the IPC team to investigate a number of epidemiological hypotheses using the IORD (Infections in Oxford Research Database).

16.11 MMM are also working with the IPC team to sequence a number of isolates to further inform IPC initiatives.

**Investigation of Infection prevention and control incidents**

17 **New-born Care Unit Serratia marcescens Incident**

17.1 An outbreak of *Serratia marcescens* causing invasive infection in 5 pre-term neonates was reported in the Neonatal Intensive Care Unit between October 2016 and December 2016. No environmental source was identified. Typing of
the *Serratia marcescens* isolates from blood cultures was consistent with a point source.

17.2 One baby died (one of the index cases) prior to identification of the outbreak.

17.3 Enhanced hand hygiene, adapted personal protective equipment and cohorting of colonised infants were instituted. The outbreak was terminated following introduction of the enhanced infection prevention and control measures.

17.4 There has been on-going transmission in a neighbouring Trust following transfer of a baby from Oxford who was not known to be colonised prior to transfer.

17.5 All parents of colonised and infected infants were informed by the neonatal unit duty consultant and/or the consultant clinical governance lead. An outbreak report was produced, and the neonatal consultant clinical governance lead presented the findings to HIPCC.

18 West Wing Theatres- Cleaning

18.1 Concern was raised in June 2016 that West Wing theatres were dirty. Activity was stopped for a number of hours whilst an assessment could be made and an action plan established.

18.2 On inspection of unoccupied theatres it was evident that there were a number of issues. High level dusting was not being performed and it was not clear when it had last been performed. Staff were not sure who was responsible for high level dusting.

18.3 A deep clean was conducted by theatre staff. All theatres were checked post clean by Infection Prevention and Control staff to ensure they were visibly clean prior to be used.

18.4 In addition, a one off deep clean was organised and conducted by an external company.

18.5 This incident became a SIRI investigation led by the Infection Prevention and Control team.

18.6 All the other OUHFT theatres have been visited by the Infection Control Team to ascertain the standard of cleaning.

18.7 The results of these inspections have been fed back to the clinical areas and areas have been asked to provide assurance that there is a robust cleaning schedule in place. Spot checks of theatres have continued throughout the year by both the IPC team and the Client Contract team. The spot checks have demonstrated improvement in the standard of cleaning across all theatres. A Standard Operating Procedure was drawn up by Theatres, Anaesthetics and Sterile Services Clinical Directorate which has been shared with other directorates through the Cross Divisional Theatres User Group.

19 Norovirus

19.1 Norovirus is the commonest cause of gastroenteritis in England and Wales. It is also known as ‘winter vomiting virus’, ‘small round structured virus’ or ‘Norwalk-like virus’. Outbreaks usually affect both patients and staff of all ages. Outbreaks of Norovirus gastroenteritis are common in semi-closed environments such as hospitals, nursing homes, schools and cruise ships. Norovirus may be spread
from person to person by the faecal–oral route, aerosol from vomiting, and environmental contamination.

19.2 Two outbreaks were reported this year, compared with 2015/6 where there was a total of 8 confirmed Norovirus outbreaks reported across the Horton and John Radcliffe Hospital Sites.

19.3 During December 2016 there was an outbreak of Norovirus on ward 5A. The outbreak involved 10 patients and 3 members of staff over a 4 day period.

19.4 During January 2017 there was an outbreak of Norovirus on ward 7D. The outbreak involved 11 patients and 4 members of staff.

19.5 Our local data are consistent with national data showing that reports of suspected and confirmed outbreaks of norovirus in hospitals continue to be reported at lower levels than in previous years, 22 per cent lower than the average number for the same period in the five seasons from season 2011/12 to season 2015/16, and 8 per cent lower than the same weeks last season.

19.6 The most commonly detected norovirus strains in circulation this season belong to the Sydney 2012 cluster of GII.4 noroviruses. This group of GII.4 norovirus strains have been circulating worldwide since 2012.

20 Influenza

20.1 During December 2016 the Trust admitted a significant number of patients with influenza or influenza like illness (ILI). There were greater than 50 confirmed positive cases during December, all of which were influenza A.

20.2 A high number of patients with ILI presented to the Trust. As a consequence it was difficult to isolate or cohort all affected patients. Juniper ward at the Horton General Hospital experienced a ward based outbreak where five long stay patients all tested positive for influenza at the end of December.

20.3 This provided the opportunity to review the immunisation status of the ward staff and encourage those had not yet had the influenza vaccine to reconsider their decision.

20.4 The percentage of staff immunised in the 2016/17 season was 65.1%

Table 12 Number of Positive Flu Samples in ITU Settings 2015-2017

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Positive Flu Samples</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>10</td>
</tr>
<tr>
<td>2016</td>
<td>20</td>
</tr>
<tr>
<td>2017</td>
<td>30</td>
</tr>
</tbody>
</table>
Audit and Compliance to Policy

21 Hand Hygiene

21.1 Compliance with hand hygiene remains a priority for the infection prevention and control service and is one of the most important measures in preventing the spread of infection in hospital. There is good evidence to demonstrate that improved hand hygiene can reduce healthcare associated infections including MRSA (Pittet 2000).
21.2 The hand hygiene policy was reviewed and updated with one major change of staff being required to be bare below the elbows on entering a clinical area rather than just at the point of care.

21.3 All clinical areas in the OUH report Hand Hygiene Compliance with the World Health Organisation (WHO) 5 moments of Hand Hygiene (2009) and as directed by OUH Hand Hygiene Policy. Each area has responsibility for conducting their own hand hygiene audits and for reporting them through their own directorate clinical governance structure.

21.4 The Infection Prevention and Control Service validates these data by undertaking Hand Hygiene audits and aims to complete this observation at least once a year in all inpatient and Day Treatment units across all four OUH sites. This compliance is also reported annually at the OUH Clinical Effectiveness Committee (CEC).

- For this financial year 44 in-patient areas were audited by the Infection Prevention and Control Service. Only three clinical areas (PICU, Ward E at the NOC and Horton CCU) demonstrated 100% compliance to the WHO 5 moments of Hand Hygiene.
  - The mean score was 57%, median 54%, mode score 48%
  - The lowest score was 23%

21.5 There are a number of limitations with this audit in so far as only 44 areas were validated and the results are unlikely to be truly representative as there is only one validation audit per area conducted over the year.

21.6 In an attempt to improve compliance with hand hygiene, increase training opportunities for staff, and to complete more than one validation audit per area, the Infection Prevention and Control team employed a band 5 nurse at the end of March 2017 to fulfil this role. Furthermore, a second band 5 post will shortly be advertised.

21.7 The IPC team now all have iPads and use an App to record hand hygiene compliance which is emailed directly to the ward manager.

22 Annual Sharps Audit

22.1 Daniels Healthcare provide an annual audit of sharp safety across the Trust for the purpose of raising sharps awareness, assessing practice and discussing problems.

22.2 Some areas may be listed but without audit figures. This was due to their being inaccessible (e.g. Closed due to infection, not open on that day, busy) at the time of the audit visit.

22.3 As per previous years the largest non-compliance area relates to the temporary closure not being closed when the sharps bin is not in use.

22.4 The Annual sharps audit was presented to HIPCC who supported the recommendation that each clinical area is responsible for addressing their own action plan. The breakdown of each directorate’s results was provided to Clinical Risk for distribution to the relevant clinical areas.
23  **MRSA Screening**

23.1 The MRSA protocol was updated and approved at the December Clinical Policy Group.

23.2 In the last decade there has been a significant decline in morbidity and mortality related to MRSA in England with annual bacteraemia rates falling from 17.7 (2005) to 3.2 (2011) cases per 100,000 bed days, and corresponding dramatic falls in surgical site infection rates attributed to MRSA, and death certificates mentioning MRSA infection. The NOW study was commissioned in 2011 to provide evidence on the most effective screening strategies.

23.3 Based on the NOW study, the updated guidance from the Department of Health ‘Implementation of modified admission MRSA screening guidance for NHS’ (2014) outlines a more focussed, cost-effective approach to MRSA screening. The recommendation from the NOW study is for Trusts to move to focussed screening programmes which are designed to promote a more efficient and effective method for identifying and managing high risk MRSA positive patients.

23.4 **Local Risk Assessments for the OUHFT**

23.5 A two year retrospective audit was undertaken to establish:

   The overall rate of MRSA admission positive screens

   The location of MRSA admission positive screens

23.6 It should be noted that the average MRSA screening compliance was 55% in 2014-2015 (excluding women’s and children’s). The total rate of MRSA positive admission screens identified in a two year retrospective audit (2014-2016) is 0.92%.

23.7 Based on this data and the NOW study the cohort of patients requiring MRSA screening has changed. It is envisaged that this will also have a cost saving impact of greater than £300,000/annum, in comparison with 100% compliance with our current policy, and over £100,000 per annum with 100% compliance with the new recommendation compared with current costs (based on average screening rate of 55%).

23.8 The new protocol was published prior to the development of EPR decision support to indicate which patients require testing. This has meant that it has not been possible to monitor compliance figures since the early part of Jan 2017. The EPR support was completed in May 2017, and we hope to monitor compliance from July 2017.
24 Surgical Site Infection Surveillance

24.1 A Trust wide SSI Group was established in March and reports through Hospital Infection Prevention and Control Committee (HIPCC).

24.2 The Group has two aims. Firstly to ensure that all surgical specialities commence SSI surveillance and secondly to reduce rates of SSI.

24.3 IPC are working closely with the Tissue Viability team on developing an EPR tool to record wound infection. This will mean that data can be extracted from EPR to produce quarterly SSI rates for all surgical directorates.
Cardiac Surgical Site Infection Surveillance

24.4 The cardiac surgery directorate have a robust prospective process for conducting surveillance.

24.5 Cardiac surgery received a High Outlier letter from PHE as it was found that the OUH rates of SSI in Coronary artery bypass graft in July to September 2016 were 7.3% rate (benchmark 4.3%).

24.6 This data was presented to HIPCC in February. No themes have been identified and the Advanced Nurse Practitioner is reviewing cases with the Matron and Clinical Lead.
Table 15 CABG Surgical Site Wound Infections (Benchmark 4.5%)

<table>
<thead>
<tr>
<th>Period</th>
<th>Superficial wound infections</th>
<th>Deep incisional wound infections</th>
<th>Organ / Space infections</th>
<th>Total</th>
<th>Final</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1 Apr-Jun 2016</td>
<td>(4/123) = 3.2%</td>
<td>(3/123) = 2.4%</td>
<td>(0/123) = 0%</td>
<td>(7/123) = 5.7%</td>
<td>Yes</td>
</tr>
<tr>
<td>Quarter 2 Jul-Sep 2016</td>
<td>(7/123) = 5.7%</td>
<td>(2/123) = 1.6%</td>
<td>(0/123) = 0%</td>
<td>(9/123) = 7.3%</td>
<td>Yes</td>
</tr>
<tr>
<td>Quarter 3 Oct-Dec 2016</td>
<td>(6/129) = 4.6%</td>
<td>(1/129) = 0.8%</td>
<td>(2/129) = 1.5%</td>
<td>(9/129) = 7%</td>
<td>Yes</td>
</tr>
<tr>
<td>Quarter 4 Jan-Mar 2016</td>
<td>(TBC)</td>
<td>(0/117) = 0%</td>
<td>(0/117) = 0%</td>
<td>(5/117) = 5.1%</td>
<td>No</td>
</tr>
</tbody>
</table>

Table 16 Non CABG Sternal Surgical Site Wound Infections (PHE Benchmark 1.3%)

<table>
<thead>
<tr>
<th>Period</th>
<th>Superficial wound infections</th>
<th>Deep incisional wound infections</th>
<th>Organ / Space infections</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1 Apr-Jun 2016</td>
<td>(0/101) = 0%</td>
<td>(0/101) = 0%</td>
<td>(0/101) = 0%</td>
<td>(0/101) = 0%</td>
</tr>
<tr>
<td>Quarter 2 Jul-Sep 2016</td>
<td>(0/85) = 0%</td>
<td>(0/85) = 0%</td>
<td>(0/85) = 0%</td>
<td>(0/85) = 0%</td>
</tr>
<tr>
<td>Quarter 3 Oct-Dec 2016</td>
<td>(0/98) = 0%</td>
<td>(0/98) = 0%</td>
<td>(0/98) = 0%</td>
<td>(0/98) = 0%</td>
</tr>
<tr>
<td>Quarter 4 Jan-Mar 2017</td>
<td>(2/88) 2.3% (TBC)</td>
<td>(0/88) = 0%</td>
<td>(0/88) = 0%</td>
<td>(1/88) 2.3%</td>
</tr>
</tbody>
</table>
Wider Infection Prevention and Control Service

25 Continenence Service

25.1 The Continence service has two main work streams.

Provides training on catheterisation and catheter care and continence promotion through teaching sessions for Foundation Nurses, non-UK trained Nurses, Nursing Assistants and Medical Students and also provides Male Catheterisation training as part of the qualified nurses extended role which includes the completion of competencies.

Working with the Quality Improvement (QI) team and Oxford Academic Hospital Science Network to reduce Catheter Associated Urinary Tract Infection (CAUTI). The team work closely with the community AHSN CAUTI group which is producing a joint Catheter Passport – for patients with catheters, to enable better information sharing within the health economy. They are currently developing an elearning tool for recognising and avoiding CAUTI.

April 2017 was CAUTI awareness month and promotional events and training continued throughout the 4 Trust sites

25.2 The Continence service and the QI work stream have proposed that a strategic approach to the provision of education and assessment is agreed by the CAUTI Steering Group for implementation across the Trust. This approach to include 3 phases:

- **Phase 1**: Competence, E-learning and Communication - CAUTI Project. E-learning to raise awareness on catheter care and implications of CAUTI. EPR Documentation training to be carried out by QI Nurse, Infection, Prevention & Control Team (IPCT), Continence Service, Practice Development Nurses (PDN) and Clinical Educators (CE). Resources have been made available on Continence and Catheter Care intranet site including; competency documents, presentations, posters and e-learning.

  Yet to be implemented:

- **Phase 2**: Early removal of catheter utilising HOUDINI Tool
- **Phase 3**: Intermittent Catheterisation

25.3 Training and audits have been completed in the 3 pilot areas within medicine. This training included raising awareness by teaching and use of promotional information. Improved data collection – using EPR to record catheter insertion and continued care.

26 Antimicrobial Stewardship Management Team (AMST)

26.1 The Antimicrobial Stewardship Management Team (AMST) is responsible for the operational side of antimicrobial management, e.g. ensuring the introduction of procedures to promote prudent antimicrobial usage, the monitoring of antimicrobial usage, the dissemination of information and the updating of health care professionals. Also support development of guidelines and assessment of new agents.
26.2 The AMST is responsible for antimicrobial stewardship through MDT meetings with Infection Prevention and Control nurses, pharmacists and Microbiology/Infectious Diseases doctors. Activities include challenging clinicians to justify prescribing of antimicrobials.

26.3 The AMST meets monthly. The AMST has a core membership of

- Consultant Lead (Antimicrobials)
- Lead Pharmacist for Antimicrobial Stewardship
- Specialist Pharmacist - Antimicrobials
- Lead Nurse and Manager for Infection Prevention and Control
- Antimicrobial Audit Assistant
- Infectious Disease (ID)/ Microbiology consultant
- Paediatric ID consultant (or deputy)
- Other members of Antimicrobial Steering Group (ASG) are co-opted into meetings as appropriate.

26.4 AMST members are also members of the Antimicrobial Stewardship Group (ASG). ASG is a subgroup of the Medicines Management and Therapeutics Committee (MMTC) that meets every two months, including representatives from CCG and Oxford Health. ASG advises MMTC regarding antimicrobial formulary applications and checks antimicrobial guidelines.

26.5 AMST is represented at meetings of MMTC and HIPCC.

26.6 During 2016/17 the AMST have supported the implementation of activities related to Antimicrobial CQUINs. The CQUIN has two parts, the first aimed at reducing total antibiotic consumption and certain broad-spectrum antibiotics and the second focussed on antimicrobial stewardship and ensuring antibiotic review within 72 hours.

26.7 There are three parts to the reduction in antibiotic consumption indicator:

(a) Total antibiotic consumption per 1,000 admissions
(b) Total consumption of carbapenems per 1,000 admissions
(c) Total consumption of piperacillin-tazobactam per 1,000 admissions

26.8 Defined daily dose (DDD) of antibiotics dispensed by OUHFT to all inpatients and outpatients per 1000 admissions:

*Source: DDDs are from Acute Trust submissions for the 2016/17 AMR CQUIN made to PHE. Admissions are from hospital episodes statistics, available at HSCIC. Note that Q4 values are currently prepared using admission data from Q3.*
26.9 Defined daily dose (DDD) of piperacillin/tazobactam dispensed by OUHFT to all inpatients and outpatients per 1000 admissions:

<table>
<thead>
<tr>
<th>Period</th>
<th>Count</th>
<th>Value</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013/14</td>
<td>808,002</td>
<td>4,146.4</td>
<td>4,600.1</td>
</tr>
<tr>
<td>2014/15</td>
<td>900,195</td>
<td>4,445.4</td>
<td>4,736.5</td>
</tr>
<tr>
<td>2015/16</td>
<td>937,682</td>
<td>4,710.6</td>
<td>4,636.7</td>
</tr>
<tr>
<td>2016/17</td>
<td>922,207</td>
<td>4,506.8</td>
<td>4,610.0</td>
</tr>
</tbody>
</table>

26.10 Defined daily dose (DDD) of carbapenems dispensed by OUHFT to all inpatients and outpatients per 1000 admissions:

<table>
<thead>
<tr>
<th>Period</th>
<th>Count</th>
<th>Value</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013/14</td>
<td>11,813</td>
<td>60.6</td>
<td>129.7</td>
</tr>
<tr>
<td>2014/15</td>
<td>16,589</td>
<td>81.9</td>
<td>144.0</td>
</tr>
<tr>
<td>2015/16</td>
<td>19,159</td>
<td>96.2</td>
<td>147.6</td>
</tr>
<tr>
<td>2016/17</td>
<td>13,927</td>
<td>68.1</td>
<td>135.5</td>
</tr>
</tbody>
</table>

26.11 Although the OUHFT CQUIN figures are favourable in comparison with 2015/16 data, the baseline period is 2013/14, and therefore we have not achieved the required reduction of 1% or more in total antibiotic consumption, piperacillin/tazobactam and carbapenems against the baseline.

26.12 Percentage of antibiotic prescriptions reviewed within 72 hours: Q4 target was >90% which was achieved.
26.13 This work will continue during 17/18 with the introduction of the Reducing the Impact of serious infections (Antimicrobial resistance and sepsis) CQUIN.

CQUIN update
- **2016/17 Antimicrobial Stewardship CQUIN:**
  Data has now been published by Public Health England.
27 Retained Estates Service
Legionella Prevention

27.1 There are three copper/silver ionisation systems installed on the JR site; JR1 in the tank room at level 8, JR2 in the caged area of level 0 and Neonatal ICU in the JR1 plant area. All three installations are up and running and have been put onto a common annual servicing, sampling and consumable renewal that runs parallel to the financial year. The copper silver ionisation is proving to be effective at reducing Legionella levels and also at identifying little used outlets.

27.2 On-going work across sites, to remove separate thermostatic mixing valves (TMV’s) and install point of use water outlets. Where TMV’s are not required, these water outlets are being replaced with direct hot and cold mixer outlets with cautions signs visible.
27.3 Churchill Site: Head & Neck. The copper/silver ionisation treatment programme is now well into its third year and has proven to be successful at reducing the legionella risk.

**JR2 Main Block – Water Tanks Replacement**

27.4 The tank changeover in JR2 is agreed for the tank located on level 8. This work is planned to progress in June/July 2017.

**Sewage leaks in Adult Intensive Care Unit (AICU)**

27.5 A number of sewage leaks have been experienced in AICU over the last year. Estates have investigated the issue which is thought to be linked to the Endoscopy Unit. It has been identified that wipes are being flushed down toilets which then snag on the calcified pipes causing a blockage. The problem was resolved with the replacement of a new soil pipe.

**Horton Site**

27.6 The replacement of the cooling coils in the Main Theatre air handling units has been completed for Air Handling Units (AHU’s) 1, 2 & 3.

**NOC**

27.7 The RO water treatment plant serving the TSSD has been upgraded to provide more resilience. The planned changeover went ahead in late December 2016. The sampling results were satisfactory and the new unit was brought into use as planned in early January 2017. There have been some operational reliability issues which were found to be failed components of original supply, however the improved resilience built into the new plant allowed for continued operation whilst new parts were sourced and installed.

27.8 A local alarming indication is to be installed in the manager’s office to alert the end user if the plant fails in operation.

**Decontamination Committee**

28.1 The Decontamination Committee meets quarterly and covers decontamination in Sterile Services, Endoscopy, decontamination of medical devices and patient equipment and environmental cleaning. This committee reports to the Hospital Infection Prevention and Control Committee.

28.2 The Trust endoscopy users, sterile services department and theatre report into this group.

28.3 The Decontamination lead is not yet appointed. This committee is currently being chaired by the IPC team.

28.4 Issues not yet resolved include:

28.5 ENT OPD in the West Wing: flexible nasendoscopes are currently decontaminated using the Tristel wipe system. The Getinge cleaning machine installed during early 2016 is fit for use but the department is addressing concerns regarding the ‘scope room’ (infection control, manual handling) before
the machine is used. The high turnover of scopes will necessitate ongoing use of the Tristel system.

28.6 Blenheim Head and Neck, Churchill Hospital: due to operational issues with the AERClens machines within this department, the “Tristel Trio” wipe system is used to decontaminate Nasendoscopes (as agreed at Trust Clinical Governance December 2013), rather than using an automated process. However a Tracking system is in place to enable patient look-backs for assurance and tracing purposes.

28.7 Churchill Theatres: the Reverse Osmosis (RO) Lower Loop which feeds the CISA system has caused concern over the latter part of the year with high cfu counts. One thought for these repeated high counts is because the RO has around 80 metres of piping before it reaches the washers. G4S have now purchased a new RO which is situated closer to the washers. This will be in use once all validation checks are completed.

28.8 JR endoscopy: the suite opened an additional procedure room this year. Plans are currently been drawn up for a complete refurbishment of the decontamination area. This will be presented at Trust board later in the year.

28.9 Horton endoscopy: opened the newly refurbished unit this year. There have been no issues with water results.

28.10 Last year's annual report noted issues with the Churchill Equipment Library. This is now resolved with an appropriate location having been found on the Churchill site.

28.11 Appendix 1 shows AER water results.

29 Performance and Quality Team cleaning validation audits

29.1 Compliance criterion 2 of the Hygiene Code (2010) states that Trusts must provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

29.2 As a means of providing this assurance, monthly cleaning audits are undertaken trust wide by the Nursing and Domestic teams (in terms of their respective cleaning responsibilities), whilst validation cleaning audits are undertaken by the Performance and Quality team who aim to undertake audits monthly in “very high risk” areas i.e. AICU, Haematology, Theatres and audit the majority of the remaining clinical areas at least once within a quarter.

29.3 The standard of cleaning across the Trust remains of concern. The Performance and Quality team are auditing using the PAS 2014 Symbiotix system. The threshold scores for very high risk areas is 98%, high risk 95% and significant risk 85%. All cleaning contracts are set to achieve 100% clean but their threshold scores are set to 2003 National Cleaning Standards, where very high risk is 95%, high risk 92% and significant 85%.

29.4 The Infection Prevention and Control team have instigated closer working relationships with G4S and Carillion. The Client Contract team also organised Captains Tours attended by Contractors, client contract team and IPC team. In addition the IPC nursing team are undertaking ‘governance walk rounds’ with the matrons and ward sisters to review the standard of cleaning in the clinical areas and to ensure that the escalation process is understood.
29.5 Carillion are now using Symbiotix but to the 2003 threshold scores. G4S and the Horton in-house cleaning are now starting to use this system, and it is hoped that nursing staff will also use this audit tool. Therefore there will be one audit tool in use across the Trust but still with different threshold scores.

29.6 Following concern with poor cleaning scores raised by Infection Prevention and Control and at Trust Board level, a Cleaning Partnership Group was established, chaired by the Deputy Chief Nurse. The membership of this group includes all Soft Facilities Managers of G4S (Churchill and NOC sites), Carillion and Horton in-hospital team, plus divisional representatives, IPC and the Performance and Contract Quality team.

29.7 The aim of this group is to work collaboratively with the contractors to identify barriers to effective cleaning and work towards improving the standard of cleaning around the trust. In addition it is looking to standardise the auditing process and threshold scores.

29.8 This group reports to HIPCC and through the monthly IPC paper to Clinical Governance Committee.

30 Conclusion
30.1 This year has presented new challenges to the IPC team. There have been changes to the structure and membership of the team. The vast majority of the annual plan was achieved.

30.2 The annual plan for 2017/18 will reflect learning from throughout the year.

31. Recommendation
31.1 The Trust Board Prevention is asked to note the contents of this annual report.

Dr T Berendt
Medical Director / Director of Infection Prevention & Control

Report prepared by:
Lisa Butcher, Lead Nurse and Manager for Infection Prevention and Control
Katie Jeffery, Deputy DIPC and Infection Control Doctor
Lydia Rylance-Knight, Senior Nurse Infection Prevention and Control

May 2017 v1
July 2017 v2
Decontamination Committee Meeting  
Tuesday 4th April 2017

<table>
<thead>
<tr>
<th>Title</th>
<th>Endoscopy water results April 2016 - March 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status</td>
<td>For information</td>
</tr>
<tr>
<td>History</td>
<td>Paper for Decontamination Committee</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Board Lead(s)</th>
<th>Key purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strategy</td>
</tr>
</tbody>
</table>

### Executive Summary

1. This paper presents the microbiological testing results of the endoscopy washers of the Oxford University Hospitals April 2016 to date.

2. **Recommendation**

   The Decontamination Committee is asked to note the contents of this paper. This paper will form part of the Infection Prevention and Control Annual Report.
1. Purpose

1.1. The purpose of this paper is to provide the Decontamination Committee with the microbiological testing results of the Oxford University Hospitals Foundation Trust endoscopy washers.

1.2. Endoscopy is carried out on the John Radcliffe site, Horton General Hospital and Churchill hospital.

1.3. A weekly final rinse water Total Viable Count (TVC) test is undertaken on all AERs to provide assurance that the rinse water used after the disinfection cycle is free from microbial contamination and therefore would not pose an infection risk during subsequent patient use.

1.4. To ensure that the water used for final rinsing is of sufficient quality, the OUH Endoscopy departments either use a two stage filtration or Reverse Osmosis (R.O) system; with the aim of providing a TVC count of 0 colony forming units (cfu).

2. West Wing ENT

2.1. Flexible Nasendoscopes are currently decontaminated using the Tristel wipe system in the ENT OPD in the West Wing. The Getinge cleaning machine installed during early 2016 is fit for use but the department is addressing concerns regarding the ‘scope room’ (infection control, manual handling) before the machine is used. The high turnover of scopes will necessitate on-going use of the Tristel wipe system.

3. Horton ENT

3.1. Flexible nasendoscopes (5) in use for 1 ENT clinic of 4 hours per week, are currently decontaminated using the Tristel wipe system, scopes are stored for 1 week using an approved system and cleaned prior to re-use using Tristel wipe system. Scoping to move to use of Getinge washer disinfector once agreed for re-processing of nasendoscopes in line with West Wing ENT.

4. Blenheim Head and Neck, Churchill Hospital

4.1. Due to operational issues with the AERClenz machines within this department, the “Tristel Trio” wipe system is used to decontaminate Nasendoscopes, rather than using an automated process, as agreed at Trust Clinical Governance December 2013. A Tracking system is in place to enable patient look-backs for assurance and tracing purposes.

5. John Radcliffe Main Endoscopy
5.1. The JR provides an inpatient and outpatient service to approximately 18,000 patients per year undergoing Gastrointestinal Endoscopy. There are 4 Automatic Endoscope Reprocessors (AER's) situated within the unit and it manages a further 2 AER's on level 3 of the West Wing.
JR II - Endoscopy - Q3 16/17

JR II - Endoscopy - Q4 16/17
7. West Wing Endoscopy

West Wing Lancer - Q1 16/17

West Wing Lancer - Q2 16/17
8. Churchill Theatres

8.1. The Churchill Hospital uses 3 CISA AER’s (each with 2 “slots”) that are used to decontaminate endoscopes used by clinical teams within Churchill Theatres, the Churchill site and units external to the Churchill, such as NOC theatres and a Urology Clinic held in Bicester. This system differs from other AER’s used within the OUH in that the scopes are reprocessed and stored within a “cassette” which can then be transported to whether the scope is needed, rather than being reprocessed through an AER and then being placed in to a Drying cabinet at point of use.

8.2. The lower loop has continued to provide ongoing issues with high counts requiring regular remedial work. As such, it is understood from G4S that a new RO plant will be provided. Currently this RO plant has 80 metres of piping which is likely to be contributing to the regular high cfu counts.
9. Horton General Hospital

9.1. The Horton hospital Endoscopy Unit is currently being refurbished and will have 3 Wassenburg AERs which each reprocess 2 scopes at a time available from October 2016. There is also an ENT outpatient service with one AER.
10. West Wing Outpatients

10.1. The endoscopy washer in the out patient department is not yet being used. The department continue to use the Tristel 3 wipe system for several reasons. They have insufficient scopes to allow for the use of the machine, staff are not yet trained in how to use the machine and the room requires reconfiguration.

10.1.1. Discussions are taking place with the Trust Hard FM manager, Carillion and the service users to move this process forward.

10.1.2. The weekly water sampling has been erratic which is being dealt with by the Trust Client Contract team.

11. Recommendation

11.1. The decontamination committee are asked to note contents.

Dr Tony Berendt
Medical Director

Report prepared by:
Lisa Butcher
April 2017