York Teaching Hospital NHS
NHS Foundation Trust

Infection Prevention Policy

Reporting Healthcare Associated Infections (HCAI) to the Health Protection Agency

Author:	Jane Balderson (Infection Prevention Nurse)
Owner:	Vicki Parkin
Publisher:	Compliance Unit
Date of first issue:	March 2010
Version:	2
Date of version issue:	February 2012
Approved by:	HIPC
Date approved:	February 2012
Review date:	February 2015
Target audience:	All Clinical Trust staff
Relevant Regulations and Standards	

Executive Summary

This policy addresses the requirements of the Trust to ensure accurate and timely reporting of Healthcare Acquired Infections (HCAI) to the Health Protection Agency (HPA).

Version History Log

Version	Date Approved	Version Author	Status & location	Details of significant changes
1		Jane Balderson		
2		Jane Balderson	Infection Prevention Nurse	Revised format Update of mandatory reporting

Contents

1 Introduction & Scope

This policy addresses the requirements of the Trust to ensure accurate and timely reporting of Healthcare Acquired Infections (HCAI) to the Health Protection Agency (HPA).

2 Definitions

Healthcare associated infection (HCAI) – infection acquired by a patient as a result of contact with a healthcare provider.

HCAI data capture system – web based computer database for recording HCAI episodes of bacteraemia and *Clostridium difficile*. The database is managed by the HPA.

Bacteraemia – organisms present in the bloodstream that may cause infection.

CDI – infection caused by *Clostridium difficile* and detected by a positive test for *Clostridium difficile*. Symptoms include diarrhoea.

Surgical site infections (SSI) – an infection of a wound following surgery.

Surgical site infection service (SSIS) – a data collection and analysis service managed by the HPA. A web link reporting system is used.

3 Policy Statement

It is a mandatory requirement that the following HCAI are reported:

- all cases of Meticillin Resistant *Staphylococcus Aureus* (MRSA) bacteraemia
- all cases of *Staphylococcus aureus* (MSSA) bacteraemia
- all cases of *Escherichia coli* (E coli) bacteraemia
- the total number of Glycopeptide Resistant Enterococci (GRE) bacteraemia
- all cases of *Clostridium difficile* infection (CDI) in patients aged two years and older

- At least 3 months each year of orthopaedic surgical site infection surveillance, including post discharge follow up.
- Outbreaks of bacterial, viral, infestation and influenza origin (confirmed or suspected)

4 Equality Impact Assessment

The Trust' statement on Equality is available in the Policy for Development and Management of Policies at Section 3.3.4.

A copy of the Equality Impact Assessment for this policy is at appendix A

5 Accountability

Corporate accountabilities are detailed in the **Policy for Development and Management of Policies** at section 5.

All healthcare professionals and volunteers are responsible and accountable to the Chief Executive for the correct implementation of this policy.

Professional staff are accountable according to their professional code of conduct. Medical staff are professionally accountable through the General Medical Council, and nurses are professionally accountable to the Nursing and Midwifery Council.

6 Consultation, Assurance and Approval Process

Consultation, assurance and approval process is detailed in section 6 of the **Policy for the Development and Management of Policies.**

The Stakeholder is the Hospital Infection Prevention Committee

7 Review and Revision Arrangements

The date of review is given on the front coversheet.

Persons or group responsible for review is the Hospital Infection Prevention Committee

The Compliance Unit will notify the author of the policy of the need for its review six months before the date of expiry.

On reviewing this policy, all stakeholders identified in section 6 will be consulted as per the Trust's Stakeholder policy. Subsequent changes to this policy will be detailed on the version control sheet at the front of the policy and a new version number will be applied.

Subsequent reviews of this policy will continue to require the approval of the appropriate committee as determined by the **Policy for Development and Management of Policies.**

8 Dissemination and Implementation

8.1 Dissemination

Once approved, this policy will be brought to the attention of relevant staff as per the **Policy for Development and Management of Policies**, section 8 and Appendix C Plan for Dissemination .

This policy is available in alternative formats, such as Braille or large font, on request to the author of the policy.

8.2 Implementation of Policies

The Policy will be disseminated through the Consultants; Clinical Directors; Directorate Manager; Matrons; and Ward Managers via emails and meetings.

9 Document Control including Archiving

The register and archiving arrangements for policies will be managed by the Compliance Unit. To retrieve a former version of this policy the Compliance Unit should be contacted.

10 Monitoring Compliance and Effectiveness

This policy will be monitored for compliance with the minimum requirements outlined below.

10.1 Process for Monitoring Compliance and Effectiveness

Evidence	Monitoring /Who by	Frequency
a. Web data entry in line with HCAI	Reports available from the web based systems.	As cases occur

data capture system.	Data entered by IPT	
b. Web data entry SSIS web link	Reports available from the web based systems Data entered by IPT	At least 3 months each fiscal year
c. Web data entry HPA web based norovirus outbreak system	Reports available from the web based systems Data entered by IPT	As outbreaks occur
d. Electronic reporting of outbreaks to the HPU.	Reports filed electronically Annual summary of norovirus outbreaks produced by IPT.	As outbreaks occur

10.2 Standards/Key Performance Indicators

HCAI data capture system and protocol

Surgical site infection surveillance protocol

Norovirus web based reporting

11 Training

See section 11 of the **Policy for Development and Management of Policies** for details of the statutory and mandatory training arrangements.

12 Trust Associated Documentation

YHFT [CORP.RL10] Policy for the Development and Management of Policies

YHFT [???] Serious untoward incident policy and procedure

13 External References –

14 Appendices –

Appendix A	HCAI data capture system
Appendix B	Surgical site infection surveillance
Appendix C	Outbreak incident report
Appendix D	Serious untoward incident (SUI) reporting
Appendix E	Equality Impact Assessment Tool
Appendix F	Checklist for the Review and Approval
Appendix G	Plan for the Dissemination of the Policy

APPENDIX A - HCAI data capture system

- All positive results from specimens tested in York Hospital laboratory, including inpatients, outpatients, regular attenders and General Practitioner specimens must be entered if they fit the reporting criteria

- IPT enter all positive results for a calendar month by the 14th day of the succeeding month

- The Chief Executive (CE) must 'lock down' the data for a calendar month by the 15th day of the succeeding month

Bacteraemia reporting criteria

- All MRSA, MSSA and *E Coli* bacteraemia cases are included.

- A second positive bacteraemia from the same patient that occurs more than 14 days after the last reported positive is recorded as a new episode.

- GRE bacteraemia figures and the total number of all blood cultures taken and the total number of all blood cultures positive are reported quarterly by the 12th day of the second month in the succeeding quarter.

Clostridium difficile infection reporting criteria

- All toxin positive *Clostridium difficile* infections are reported.

- A second toxin positive *Clostridium difficile* infection from the same patient that occurs more than 28 days after the last positive reported is recorded as a new episode.

- The total number of all stool specimens tested and the total number positive for Clostridium difficile toxin are reported quarterly by the 12th day of the second month in the succeeding quarter.

Appendix B - Surgical site infection surveillance

Using the HPA surgical site infection service (SSIS) protocol the Trust must participate for a minimum three month period each fiscal year in at least one of four orthopaedic surgical procedures.

The Trauma and Orthopaedic wards and IPT collect the data specified in the SSIS protocol for every patient admitted for the chosen orthopaedic surgery. The directorate choose the type of surgery. IPT collect data via the laboratory telepath database and Core Patient Database.

The data will be entered onto the SSIS web link (managed by SSIS). IPT is responsible for entering the data by the deadline set by SSIS.

The SSIS calculate infection rates and send an electronic report to the Trust. National infection rates are produced from the data collected from participating Trusts.

Appendix C - Outbreak incident report

When a bacterial, viral, infestation or influenza outbreak is declared as no longer active by the Trust, an electronic report will be sent by IPT to the North Yorkshire and Humber Health Protection Unit (HPU).

IPT also enter Norovirus outbreaks on the HPA norovirus web-based surveillance system. The report will include details of ward/ department closed, length of closure, number of patients and staff affected and the cause if known/ confirmed.

The HPA Norovirus outbreak definition is used to decide inclusion criteria for those outbreaks to report.

Appendix D - Serious untoward incident (SUI) reporting

In the event of a SUI being declared the SUI reporting procedure will be initiated by the Director declaring the SUI.

Appendix E Equality Impact Assessment Tool

To be completed when submitted to the appropriate committee for consideration and approval.

Name of Policy:	**Reporting HCAI to the HPA**

1.	**What are the intended outcomes of this work?** *To document the processes followed in reporting healthcare acquired infections to the Health Protection Agency.*	
2	**Who will be affected?** *Infection Prevention Team*	
3	**What evidence have you considered?** Mandatory requirement from Department of Health	
a	**Disability N/A**	
b	**Sex N/A**	
c	**Race N/A**	
d	**Age . N/A**	
e	**Gender Reassignment N/A**	
f	**Sexual Orientation N/A**	
g	**Religion or Belief N/A**	
h	**Pregnancy and Maternity. N/A**	
i	**Carers N/A**	
j	**Other Identified Groups N/A**	
4.	**Engagement and Involvement**	

a.	Was this work subject to consultation?	Yes
b.	How have you engaged stakeholders in constructing the policy	Discussion at HIPC
c.	If so, how have you engaged stakeholders in constructing the policy	
d.	For each engagement activity, please state who was involved, how they were engaged and key outputs	
5.	**Consultation Outcome** Approved by Hospital Infection Prevention Committee *Now consider and detail below how the proposals impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups*	
a	Eliminate discrimination, harassment and victimisation	**N/A**
b	Advance Equality of Opportunity	**N/A**
c	Promote Good Relations Between Groups	**N/A**
d	What is the overall impact?	**N/A**
	Name of the Person who carried out this assessment: Jane Balderson	
	Date Assessment Completed 20th January 2012	
	Name of responsible Director Libby McManus (Director of Infection Prevention)	

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Equality and Diversity Committee, together with any suggestions as to the action required to avoid/reduce this impact.

Appendix F Checklist for the Review and Approval

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
1	**Development and Management of Policies**		
	Is the title clear and unambiguous?		
	Is it clear whether the document is a guideline, policy, protocol or procedures?		
2	**Rationale**		
	Are reasons for development of the document stated?		
3	**Development Process**		
	Is the method described in brief?		
	Are individuals involved in the development identified?		
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?		
	Is there evidence of consultation with stakeholders and users?		
	Has an operational, manpower and financial resource assessment been undertaken?		
4	**Content**		
	Is the document linked to a strategy?		
	Is the objective of the document clear?		
	Is the target population clear and		

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	unambiguous?		
	Are the intended outcomes described?		
	Are the statements clear and unambiguous?		
5	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?		
	Are key references cited?		
	Are the references cited in full?		
	Are local/organisational supporting documents referenced?		
5a	**Quality Assurance**		
	Has the standard the policy been written to address the issues identified?		
	Has QA been completed and approved?		
6	**Approval**		
	Does the document identify which committee/group will approve it?		
	If appropriate, have the staff side committee (or equivalent) approved the document?		
7	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?		
	Does the plan include the necessary training/support to ensure compliance?		
8	**Document Control**		
	Does the document identify where it will		

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	be held?		
	Have archiving arrangements for superseded documents been addressed?		
9	**Process for Monitoring Compliance**		
	Are there measurable standards or KPIs to support monitoring compliance of the document?		
	Is there a plan to review or audit compliance with the document?		
10	**Review Date**		
	Is the review date identified?		
	Is the frequency of review identified? If so, is it acceptable?		
11	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?		

Individual Approval			
If you are happy to approve this document, please sign and date it and forward to the chair of the committee/group where it will receive final approval.			
Name		Date	
Signature			
Committee Approval			
If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for			

maintaining the organisation’s database of approved documents.			
Name		Date	
Signature			

Appendix G Plan for dissemination of policy

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

Title of document:	
Date finalised:	
Previous document in use?	
Dissemination lead	
Which Strategy does it relate to?	
If yes, in what format and where?	
Proposed action to retrieve out of date copies of the document:	**Compliance Unit will hold archive**

Dissemination Grid

To be disseminated to:	**1)**	**2)**
Method of dissemination		
who will do it?		
and when?		
Format (i.e. paper or electronic)	**Electronic**	

Dissemination Record

Date put on register / library	
Review date	
Disseminated to	
Format (i.e. paper or electronic)	
Date Disseminated	
No. of Copies Sent	
Contact Details / Comments	