Version 13 - Healthcare Associated Infection Action Plan - *C.difficile* focus - 16.02.15

Key	
Action not commenced	0
Action in progress, off target	5
Action in progress, on target	9
Action fully completed	57
Number of actions	71

Antibiotic Prescribing

ID	Task Name / Description	Resource Name(s)	Forecast Completion Date	Actual Completion Date	Status	Priority	Evidence	RAG
Antibiotic 1	Improve clinical engagement / Implementation of the 'SPARED' and 'ERA' antibiotic prescribing campaign.	Debbie Lockwood - 100.00%	30/05/2014	02/06/2014	Closed	High		Black
Antibiotic 2	No availability to record stop and review dates./ Revise drug sheet. Revised drug sheet will provide standard STOP and review dates to improve antibiotic prescribing compliance.	Debbie Lockwood - 100.00%	30/09/2014	01/09/2014	Closed	High		Black
Antibiotic 3	Improve evidence of the review of antibiotic audit at clinical incident reviews/ Incorporate antibiotic audit results in clinical incident review panel checklist/RCA and share with clinical teams.	Alison Peevor - 100.00%	31/08/2014	31/08/2014	Closed	High		Black
Antibiotic 4	Improve antimicrobial pharmacist/technician scope availability and work restrictions./ Antimicrobial pharmacist/technician roles to be reviewed.	Debbie Lockwood - 100.00%	31/10/2014	31/10/2014	Closed	High		Black
Antibiotic 5	Ensure antimicrobial prescribing practice is embedded within centres./ Medical director to implement a standard antimicrobial prescribing audit programme. Cheifs of Service asked to promote junior doctors involvement in ARED audit programme	Rob Wilson - 100.00%	30/09/2014	30/09/2014	Closed	High	See Anitbiotic 1	Black
Antibiotic 6	Assurance all old drug sheets are removed and all new patients will have the new drug sheet. Clinical matrons asked for assurance by 05.11.14	Alison Peevor - 100%	07/11/2014	22/12/2014	Closed	High		Black
Antibiotic 7	Ensure antimicrobial guidelines are available on all notes and drug trolley's	Debbie Lockwood - 100%	31/12/2014	23/01/2015	Closed	High		Black
Antibiotic 8	Provide a rigoruos process relating to the review of antibiotic prescribing as part of the overall clinical incident review panles.	Debbie Lockwood - 100%	30/11/2014	30/11/2014	Closed	High		Black

Antibiotic 9	Assess the use of a daily antibiotic review reminder. / Ward 4 to pilot a 'stamp' in January 2015.	David Reiach - 100%	31/03/2015		Open	High	Extended completion date	Green	

Cleaning

ID	Task Name / Description	Resource Name(s)	Forecast Completion Date	Actual Completion Date	Status	Priority		RAG	
Cleaning 1a	Ensure consistant use of hydrogen peroxide in acute hospital sites./ To ensure consistency with the use of HP across all Trust sites.	Myles McQuade - 100.00%	31/01/2014	31/01/14	Closed	High		Black	
Cleaning 1b	Increase the availability of Hydrogen Peroxide fogging in both Acute sites./ Business case has been approved, Negotiations with Carillion have been completed - purchase of an additional three machines is beign completed.	Myles McQuade - 100.00%	30/09/2014	06/11/2014	Closed	High		Black	
Cleaning 2	Improve clear guidance around cleaning responsibilities for nursing staff, domestic and housekeepers/ Develop a cleaning responsability matrix for clinical areas.	Julie Barlow - 100.00%	31/07/2014	31/07/2014	Closed	High		Black	
Cleaning 3	Improve of assurance regarding standard/electric bed cleaning/ Agree standard operation procedure.	Myles McQuade - 50.00% Denise Foster - 50.00%	18/07/2014	01/09/2014	Closed	High		Black	
Cleaning 4	Seek assurance around monitoring and standards of cleaning within the Trust./ A cleaning workstream is included within the HCAI collaborative workstreams and cleaning service review group.	Myles McQuade - 50.00% Julie Barlow - 50.00%	30/09/2014	21/08/2014	Closed	High		Black	
Cleaning 5a	Lack of external assurance of cleaning standards and monitoring./ Agreed external review is to be completed by Audit North. External audit received - awaiting agreement to any actions.	Jill Moulton - 100.00%	30/09/2014	21/10/2014	Closed	High		Black	
Cleaning 6	Improve monitoring of commode cleaning./ Implement daily senior sister led commode monitoring.	Alison Peevor - 50.00% Julie Barlow - 50.00%	06/06/2014	06/06/2014	Closed	High		Black	
Cleaning 7	Improve assurance that bed space are clean for admissions./ Develop a bed space checklist.	Julie Barlow - 100.00%	18/07/2014	18/07/2014	Closed	High		Black	
Cleaning 8	Improve assurance around all HCAI monitoring./ To incorporate actions cleaning 6 and 7 into a weekly HCAI monitoring checklist.	Julie Barlow - 50.00% Alison Peevor - 50.00%	07/07/2014	07/07/2014	Closed	High		Black	
Cleaning 9	Strengthen evidence to provide assurance that environmental decontamination is efficient./ Audit routine HP decontamination.	Myles McQuade - 50.00% Julie Barlow - 50.00%	31/10/2014	31/10/2014	Closed	High	Included in the Carillion monthly report.	Black	
Cleaning 10	Improve robust data around estates defects./ Produce robust regular report and action plan with clear timescales. Ful timeatbale created for ward 1,2, 4-12 JCUH.	Myles McQuade - 100.00%	30/09/2014	13/10/2014	Closed	High		Black	

Cleaning 11	Fully explore the neeed to implement a full deep cleaning programme. / To be discussed at transformational board and Trust board.	Ruth Holt - 100%	31/12/2014		Open	High	Deep clean programme for 8/10 wards starting 01.04.2015	Green	
Cleaning 12	Ensure appropriate storage of equipment is completed in clinical areas and a rolling programme of de-cluttering is introduced. / The second de-clutter event is taking place in November/December 2014.	Myles McQuade - 100%	15/12/2104	05/12/2014	Closed	High		Black	
Cleaning 13	Assurance is required regarding timely allocation of domestic staff during abscences at JCUH site. /Raised at the board to board meeting January15. Clocking in procedures are already in place, Carillion to monitor and feedback at next board to board meeting.	Myles McQuade - 100%	30/11/2014		Open	High		Amber	
Cleaning 14	Explore the provision of a dediacted bed cleaning team in high throughput wards. /	Myles McQude - 100%	31/12/2014		Open	High	Early discussion around nursing, domestic and housekeeper activity as been completed	Amber	

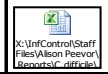
Communication

ID	Task Name / Description	Resource Name(s)	Forecast Completion Date	Actual Completion Date	Status	Priority		RAG	
Comm 1	Ensure consistent terminology of 'unconfirmed' Clostridium difficile within the region./ Awaiting outcome of regional review. Terminology is consistent with regional trusts and understood by staff.	Julie Barlow - 100.00%	31/07/2014	14/07/2014	Closed	Medium	Regional review completed.	Black	
Comm 2a	Standardise stool charts in use./ To review use of stool charts accross in-patient areas.	Julie Barlow - 100.00%	31/08/2014	31/07/2014	Closed	Medium		Black	
Comm 2b	Implementation of final standardised stool chart/ Revised stool chart disseminated week commencing 15.09.14	Julie Barlow - 100.00%	30/09/2014	15/09/2014	Closed	Medium		Black	
Comm 3	Increase communication and sharing of up to date C.difficile current status with CCG's & GP's/ Complete a number of engagement events for General Practitioners with specific inclusion of high sample rejection rate.	Richard Bellamy - 50.00% John Hovenden - 50.00%	30/09/2014	10/09/2014	Closed	Medium	Four GP events attended:	Black	
Comm 4	Ensure implementation of the changes to testing/reporting./ Fully implement revised testing and reporting of Clostridium difficile.	John Hovenden - 50.00% Monika Kalra - 50.00%	30/09/2014	18/09/2014	Closed	High	Insert revised SOP	Black	
Comm 5	Improve regular faecal sampling rejection rate audit./ Repeat trust faecal sample rejection rate (using larger co-hort). Provide evidence of any changes to rejection rate. Repeat survey has commenced February 15.	John Hovenden - 50.00% Monika Kalra - 50.00%	28/02/2015		Open	Medium	Repeat audit planned Feb 15	Green	

Comm 6	Triangualtion of data following testing/reporting and use of diarrhoea assessment tool./ Complete review of revised testing/reporting.	Alison Peevor - 100.00%	28/02/2015		Open	Medium	To be competed after above audit. Revised end date	Green	
Comm 7a	Ensure key messages are reaching frontline staff./ Implemenation of a weekly newsletter. Snap shot survey of frontline staff completed in August 2014.	Alison Peevor - 100.00%	11/07/2014	11/07/2014	Closed	High	 	Black	
Comm 7b	Develop comminication plan to ensure continued key messages are reaching frontline staff. Implemented newsletter, updated screensavers, posters, POD. Media campiagn posters underdevlopment.	Alison Peevor - 100.00%	30/09/2014	01/12/2014	Closed	High		Black	
Coom 8	Removal of any HCAI related jargon from internal and external information to improve communication with patients, staff and the public.	Alison Peevor - 100%	31/10/2014	31/10/2014	Closed	Medium		Black	
Coom 9	Reduce the volume of HCAI related information to ensure on key messages are shared. / Utilse the Trust Keys to share information.	Alison Peevor - 100%	31/10/2104	31/10/2014	Closed	Medium		Black	
Comm 10	Incraese information for the public at hopsital entrances. / Incorpoarte into the media campaign (Comm 7b)	Alison Peevor - 100%	30/11/2014	01/12/2014	Closed	Medium	See 7b	Black	
Comm 11	Introduce a foraml 'thank you' feedback process. / Draft process to be discussed the HCAI collaborative March 2015.	Alison Peevor - 100%	31/03/2015		Open	Medium	Draft process under development	Green	

Hand Hygiene

ID	Task Name / Description	Resource Name(s)	Forecast Completion Date	Actual Completion Date	Status	Priority		RAG	
Hand Hygiene 1	Update hand hygiene programme./ IPC team to develop hand hygiene action plan to refresh campaign within the trust.	Alison Peevor - 50.00% Claire Phillips - 50.00%	31/08/2014	31/08/2014	Closed	High		Black	
Hand Hygiene 2a	Develop a combined Cleanyourhands and microbial contamination monitoring tool./ Data collection was not related to clinical procedures.	Claire Phillips - 33.00% Joanne Dunmore - 33.00% David McCaffrey - 33.00%	31/08/2014	29/08/2014	Closed	High		Black	
Hand hygiene 2b	Implementation of revised hand hygiene data collection tool/ Trust wide use of standardised data collection to enhance the quality of the data relating to clinical procedures. To commence 01.10.14	As above	30/09/2014	01/10/2014	Closed	High	Insert tool	Black	

Hand Hygiene 3	Ensure assurance if patients were being offered hand hygiene before meals and snacks/ Staff to encourage patients to wash hands or use dedicated wipe before meals and snacks.	David McCaffrey - 100.00%	30/05/2014	30/05/2014	Closed	High		Black	
Hand Hygiene 4	Ensure assurance that all clinical staff have completed hand hygiene competency training./ IPC link practitioners will complete 5 hand hygiene competencies per month on a three year rolling programme and IPC team to enter onto ESR system.	David McCaffrey - 100.00%	31/03/2015		Open	High	Trust target for all clinical staff to complete competency by 31.03.15 	Green	
Hand Hygiene 5	Ensure robust process of cleanyourhands peer reviews./ IPC team will complete 10 observations per month and clinical matrons to complete in an outbreak/incident occurence.	David McCaffrey - 100.00%	04/04/2014	04/04/2014	Closed	High		Black	
Hand Hygiene 6	Ensure assurance that IPC link practitioners have robust hand hygiene skills and knowledge./ Re-develop the IPC link practitioner role to incorporate expected skills and knowledge and training event planned 01.05.15.	David McCaffrey - 100.00%	31/05/2015		Open	High		Green	
Hand Hygiene 7	Ensure medical staff who are not compliant with good hand hygiene are routinely escalated to MD/ Medical Director to discuss routine escalation with chiefs of service and clinical directors.	Rob Wilson - 100.00%	30/09/2014	30/09/2014	Closed	High		Black	
Hand hygiene 8	Ensure dissemination of hand hygiene results./ Review the most appropriate method to disseminate hand hygiene results.	Julie Barlow - 100.00%	30/09/2014	01/10/2014	Closed	High		Black	
Hand Hygiene 9a	Ensure assurance regarding the quality of hand hygiene technique./ Complete a hand hygiene quality audit for three centres.	Julie Barlow - 100.00%	30/09/2014	25/09/2014	Closed	High		Black	
Hand Hygiene 10	Revise hand hygiene posters. / IPC team to develop posters to replace older versions.	Joanne Dunmore - 100%	31/12/2014	12/02/2015	Closed	High	EcoLab posters disseminated	Black	
Hand Hygiene 11	Ensure all staff are aware of 3 squirts for alcohol gel and 1 squirt for liquid soap. / Shared in newsletters, Tees Key (w/c 10.11.14),	Joanne Dunmore - 100%	31/10/2014	31/10/2014	Closed	High	See Comms 7a	Black	
Hand Hygiene 12	Explore possibility of including alcohol gel and liquid soap consumption on ward dashboard or heat map to enable the monitoring of hand hygiene. /	Alison Peevor - 100%	31/12/2014		Closed	High	Awaiting first dashboard - February 15	Black	
Hand Hygiene 13	Promote hand hygiene at the start of each ward round. / Professor Wilson to cascade to all consultants. /	Professor Wilson - 100%	30/11/2014	23/12/2014	Closed	High		Black	
Hand Hygiene 14	Explore the possibility of including hand hygiene promotion on patient appointment letters. /	Jo Dunmore - 100%	31/12/2014		Open	Medium	To be inserted on some letters. Awaiting feedback.	Amber	

Isolation

ID	Task Name / Description	Resource Name(s)	Forecast Completion Date	Actual Completion Date	Status	Priority	RAG	

Isolation 1	Improve staff knowledge in relation to cleaning products for patients in isolation./ Information is included in weekly newsletter, included in Corporate Mandatory Awareness training and nurse cleaning training. Day to day support is provided by IPCN's.	Julie Barlow - 100.00%	30/09/2014	30/09/2014	Closed	High		Black	
Isolation 2	Showering of isolated patients./ It has been identified that some patients have been showering in ward showers whilst in isolation. Assuarnce gained from clincial areas this had stopped.	Julie Barlow - 100.00%	31/07/2014	31/07/2014	Closed	High		Black	
Isolation 3	Environment in tower block is un-suitable for patients in isolation/ Discussion to take place on which wards can be moved. First meeting planned to be in October 2014.	Ruth Holt - 100.00%	30/09/2014	31/01/2015	Closed	High	Discussion with managing directors and corpoarte team have taken place and agreed not feasible	Black	
Isolation 4	Ensure patients are routinely asked if they have had or been in contact with individuals with gastrointestinal infection in A&E.	Julie Suckling - 50.00% Adrian Clements - 50.00%	15/09/2014	15/09/2014	Closed	High	Monthly notes audit to commence Oct 14	Black	
Isolation 5	Ensure timely isolation of patients with potentially infectious diarrhoea/ IPC team developed diarrhoea assessment tool., completed pilot and Trust wide roll out planned September 2014. Tool disseminated and final version at the printers.	Julie Barlow - 100.00%	30/09/2014	08/10/2014	Closed	High		Black	
Isolation 6	Ensure performance management evidence around the management of the patient with diarrhoea/ Monitor the use of the diarrhoea core care plan and feedback to clinical teams.	Julie Barlow - 100.00%	31/10/2014	23/01/2015	Closed	High	Further audit to be completed weekly	Black	
Isolation 7	Ensure each side room has the provision of dedicated equipment. /	Jo Carter - 100%	31/12/2014		Open	High	Equipment costs/details collated. Sample equipment ordered /delivered. To agree final provision.	Amber	
Isolation 8	Explore the provision of en-suite shower facilities for all patients with *C.difficile.* / Discussed at IPAG 08/01/15, agreed and a operational process is to be developed.	Jo Carter - 100%	31/12/2014	08/01/2015	Closed	High	Awaiting process	Black	
Isolation 9	Explore the use of standardised approach to challenging poor practice and formal follow up regading non -complaince with policy. /	Angela Artley - 100%	31/12/2014	23/01/2015	Closed	High	Clinical matrons agreed process	Black	
Isolation 10	NEW -Developement of revised isloation signage	Jo Cater 100%	31/03/2015				Pilot completed, agreed at IPAG 12.02.15. To be printed and disseminated.	Green	

Ownership of IPC Issues

ID	Task Name / Description	Resource Name(s)	Forecast Completion Date	Actual Completion Date	Status	Priority		RAG	
IPC 1	Timely dates for case review panels/ To ensure that dates are set in the diary every week.	Julie Barlow - 100.00%	21/07/2014	21/07/2014	Closed	High	Routine fortnightly panels organised	Black	
IPC 2	Improve evidence to support fixed timescales for RCA and subsequent actions/meetings / Reinforced the timescales set to complete RCA's, attendance at clinical incidence review panels and completion of any actions.	Alison Peevor - 100.00%	31/08/2014	29/08/2014	Closed	High		Black	
IPC 3	Consider appealing trust attributed cases,/ Review and agree which cases can be appealed at clinical incident panels.	Ruth Holt - 100.00%	31/12/2014	31/12/2014	Closed	High		Black	
IPC 4	Identify if assurance panels are an effective learning tool for staff./ Complete survey within clinical teams of all cases from 01.04.14. To share findings on best practice of sharing lessons, Action plan completion review continuing and staff to be surveyed in January 2015. Panles are now managed within centres.	Alison Peevor - 100.00%	31/01/2015	31/01/2015	Closed	High	Completion date extened.	Black	
IPC 5	No CCG representation at Clinical Incident panels./ Invitation to CCG to attend Clinical Incident panels. Greater shared learning and agreement around outcome and possible appeal process.	Julie Barlow - 100.00%	31/08/2014	31/08/2014	Closed	Medium	See above for CCG attendance	Black	
IPC 6	Improve the number of medical champions/ Identify medical champions who will facilitate awareness and engagement relating to *Clostridium difficile* . Additional champions have been identified but not in all centres yet.	Rob Wilson - 100.00%	30/09/2014		Open	Medium	Still require some centre leads. Reminder sent to all cheifs of service with updated list Feb 15.	Amber	
IPC 7	Appoint non-executive dircetor as HCAI champion	Debrra Jenkins - 100%	31/12/2014	31/12/2014	Closed	High	Maureeen Rutter appointed	Black	
IPC 8	NEW - Introduction of ward / centre based HCAI dashboard	Alison Peevor 100%	28/02/2105	09/02/2015	Closed	High		Black	
IPC 9	NEW - Retrospective review of toxin not detected cases and possible conversion to toxin postive	Wendy Large 100%	31/03/2015		Open	High		Green