Appendix 1. *Clostridium difficile* Assurance Framework - Version 6 (16.02.15)

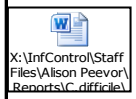
Key	
Off trajectory	1
On trajectory	6
Fully completed	8
Number of actions	15

Antibiotic prescribing

Area	Overall aim	Timescale	Action	Impact	Progress	Corrective Actions	Evidence	RAG rate
Improved antibiotic prescribing audit completion	100% of antibiotics are prescribed in line with antibiotic guidelines.	31.03.15	Trajectory to increase antibiotic prescribing audits by 10% each month until fully implemented.	Reported monthly in HCAI monthly report.	49 areas completed an audit in January 15	Revised drug sheet implemented in September 2014.Audits completed monthly, demonstratiing continued imrpovement.		
Awareness of 'SPARED' & 'ERA' campaign	100% of medical and nursing staff are aware and understand the campaign.	31.12.14	Trajectory to increase awareness and understanding by 10% each month.	Reported monthly at HCAI collaborative.	First audit completed in October 14 - 5/15 satff aware and had knowledge of campaign.	To be completed Janaury 15, delayed due to Ebola training.		
Full implementation of the revised drug sheet.	100% of wards / departments use the revised drug sheet to improve compliance with 'end date' and 'reason' for antibiotic'.	30.11.14	Audit wards/departments to ensure trajectory of 100% compliance is achieved.	Performance managed during daily reviews, antibiotic ward rounds and audits.	See above data			

Cleaning								
Area	**Aim**	**Timescale**	**Action**	**Impact**	**Progress**	**Corrective Actions**	**Evidence**	**RAG rate**
Consistent use of hydrogen peroxide for all cases of *C.difficile* toxin detected and not detected.	100% of rooms/ areas have an HP fogging for all cases of *C.difficie* toxin detected and not detected.	31.08.14	Trajectory = full 100% implementation.	Performance managed weekly. Reported monthly to the HCAI collaborative.	HP fogging used for all cases.			
Consistent use of hydrogen peroxide for all cases of potentially infectious diarrhoea.	100% of rooms/ areas have an HP fogging for all cases of *C.difficile* and potentially infectious diarrhoea.	31.10.14	Trajectory = full 100% implementation on the introduction of two additional machines.	Performance managed weekly. Reported monthly to the HCAI collaborative.	Three additional HP fogging machines have been available from 10.11.14			
Assurance monitoring of domestic cleaning within wards/departments.	100% of monitoring checklists to be returned weekly.	30.09.14	100% monitoring will allow escalation where appropriate.	Performance managed daily by Trust and PFI providers. Reported monthly at the cleaning services review.	Daily ward 'sign off' monitoring at JCUH for August 14 = 100%	To collate Trust wide data from FHN and PCH's.		
Improved awareness of cleaning responsibilities.	100% of designated clinical and domestic staff are aware of their cleaning responsibilities.	31.01.15	Monthly staff audit to demonstrate 100% compliance by 31.01.15 through 10% monthly increase.	Performance managed daily by ward/ department managers and IPC team. Reported monthly at HCAI collaborative.	First audit to be completed in October 14.	Audit result show general improvement in staff knowledge.		
Improved assurance of appropriate cleaning by clinical staff.	100% of clinical staff are aware of their responsibilities related to cleaning.	31.12.14	Weekly clinical matron HCAI monitoring checklist demonstrate 100% compliance by 31.12.14 through 10% monthly increase.	Performance managed daily by ward/department manager and IPC team. Reported weekly by clinical matron HCAI monitoring checklist. Achieve full compliance by 31.12.14	Weekly clinical matron HCAI checklist demonstrates = 66% compliance with week commencing 06.10.14	Outstanding returns to be discussed in the clinical standards meetings	 	

Communication								
Area	**Aim**	**Timescale**	**Action**	**Impact**	**Progress**	**Corrective Actions**	**Evidence**	**RAG rate**
Standardised stool chart	100% of wards to have fully implemented revised stool chart.	31.10.14	100% of wards/departments audited on the use of revised stool chart.	Performance managed daily by IPC team. Reported weekly by clinical matron HCAI monitoring checklist. Achieve full compliance by 31.10.14	Revised stool chart (version 2) was disseminated Sep 14.			
Hand hygiene								
Area	**Aim**	**Timescale**	**Action**	**Impact**	**Progress**	**Corrective Actions**	**Evidence**	**RAG rate**
Hand hygiene competency	100% of clinical staff will complete a hand hygiene competency.	31.12.14	Trajectory = 10% monthly increase each ward/department	Performance managed weekly by ward/department manager. Reported monthly. Achieve compliance by 31.12.14	Overall Trust at 31%.	Updated data now routinely included in monthly HCAI board paper.Focus within centres to continue to complete.	X:\InfControl\Staff Files\Alison Peevor\Reports\C.difficile\ X:\InfControl\Staff Files\Alison Peevor\Reports\C.difficile\	
Robust hand hygiene technique	100% of staff assessed will have robust hand hygiene technique.	31.03.15	Trajectory = 80% by 31.12.14 / 100% by 31.03.15	IPC team to conduct monthly audit. Reported monthly at IPAG. Achieve 100% compliance by 31.03.15	Second snapshot audit completed October 14. Compliance = 73%	Continue monthly audit within centres.		

Isolation								
Area	**Aim**	**Timescale**	**Action**	**Impact**	**Progress**	**Corrective Actions**	**Evidence**	**RAG rate**
Routine assessment of patients to be admitted via A&E will be asked about history of or potential exposure to infectious diarrhoea.	100% of patients who are to be admitted via A&E will be asked about history of or potential exposure to infectious diarrhoea.	31.12.14	Complete fortnightly audit of A&E patient notes.	Performance managed daily by department managers / senior medical staff. Report after each audit cycle. Achieve compliance by 31.12.14	Latest audit demonstrated reduced compliance = 45% compliance	Clinical lead and directorate manager reinforecd the need to ask patients. Include routine questions in A&E documentation currently being revised. Audit repeated 23.01.15		
Isolation of patients with infectious diarrhoea	100% patients assessed as risk of infectious diarrhoea are isolated appropriately	31.01.15	Triangulate the HP data and diarrhoea assessment tool use.	Performance managed daily by department managers. Report after each audit cycle. Achieve compliance by 31.12.14	Use of tool being revied as part of the clinical incident review panels,	Data to commence Janaury 15 due as tool now under full Trust wide use.		
Ownership of Infection prevention & control								
Area	**Aim**	**Timescale**	**Action**	**Impact**	**Progress**	**Corrective Actions**	**Evidence**	**RAG rate**
Appropriate staff attendance at clinical incident review panels	100% of panels are completed within 4 weeks of result and attended by appropriate clinical staff.	31.10.14	Review dates and attendance at panels.	Performance managed for each case. Reported monthly. Achieve compliance.	Collation of panel attendance has been reviewed for 14/15. Attendance by consulatnt = 13/22; clinical matron = 14/22;ward manager/sister 15/22; CCG representative 2/22.	Data to be shared with centres as a number action plans require completion. To be discussed at performance and clinical standard meetings. Review of ownership of review panels .		
Clinical incident review panel action plans are completed.	100% of panel action plans are completed within timescales.	31.12.14	Review action plans from 01.04.14.	Performance managed for each case. Reported monthly. Achieve compliance.	Collation of panel action plans has been reviewed for 14/15.	Outstanding returns to be discussed in the clinical standards meetings.	As above	