Appendix 1. *Clostridium difficile* Assurance Framework - Version 2 (14.11.14)

Key	
Off trajectory	0
On trajectory	10
Fully completed	6
Number of actions	16

Antibiotic prescribing

Area	Overall aim	Timescale	Action	Impact	Progress	Corrective Actions	Evidence	RAG rate
Improved antibiotic prescribing audit	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.	Third monthly 'ARED ' antibiotic prescribing audit in Sep 14 compliance 90% and over Allergies - 23/23 (100%) Reason - 7/40 (18%) End date - 9/40 (23%) Daily review - 16/40 (40%)	Revised drug sheet has been implemented in September 2014, which standardises 'reason' and 'end date'. Audits to be completed monthly.		
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 to be completed in October 14.			
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 dailty reviews, antibiotic ward rounds and audits.	First drug sheet audit to be completed in October 14			

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.	Awaiting JCUH data.		
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.			
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	Collation of themes table to be added 	

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.			
Profile of the current status of *C.difficile* in the Trust	Ensuring clinical and partnership staff are aware of the actions required to reduce *C.difficile.*	31.12.14	100% of staff surveyed are aware of and understand the fortnightly HCAI newsletter.	Monthly staff survey. Reported monthly on the newsletter. Achieve full compliance by 31.12.14	First audit to be completed in October 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	1184 staff completed (963 entered onto ESR.	First centre and trust compliance data completed. Currently reviewing the workforce data and sharing with centres. Data to be incldued in HCAI board paper.		
Robust hand hygiene technique	100% of staff assessed will have robust hand hygiene technique.	31.03.14	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	First snapshot audit completed September 14. Compliance = 74%	Continue monthly audit within centres. Data to be incldued in HCAI board paper.		

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	First audit completed Oct 14 4/20 (20% compliance)	Clinical lead and directorate manager reinforecd the need to ask patients. Latest audit shows 50% compliance.		
Isolation of patients with infectious diarrhoea	100% patients assessed as risk of infectious diarrhoea are isolated appropriately	31.12.14	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	First audit to be completed in October 14			
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..		
Clinical incident review panel action plans are completed.	100% of panel action plans are completed within timescales.	31.10.14	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	