Lincolnshire Partnership NHS
NHS Foundation Trust

Infection Prevention & Control

Annual Report 2013/14 and Work Plan for 2014/15

Foreword

As the Executive Lead for Infection Prevention and Control, I am pleased to introduce you to Lincolnshire Partnership NHS Foundation Trust's Annual Infection Prevention and Control Report for 2014-2015.

Here in the Trust we understand that the provision of safe, effective care is at the heart of everything we do. Fundamental to this is evidence of good infection, prevention and control practice which gives our patients, carers, staff and the public confidence in the care that is being delivered and received.

An integral part of this confidence comes from our ability to demonstrate accountability for what we do. This is achieved through our compliance with the Health and Social Care Act 2008 and NICE guidance PH36 Prevention and Control of Healthcare Associated Infections: Quality Improvement Guide.

Within this area of practice 2014 has been a most important year for the trust as it has seen us transform the infection prevention control service by bringing its delivery back into management of the trust. This has ensured a locally determined and delivered service which better meets the needs of the people we serve.

We are proud of the progress and improvements we have made in the year ensuring that we build further on them to provide the safe, effective and clean care that the public of Lincolnshire are entitled to.

Michelle Persaud
Executive Lead for Infection Prevention and Control
Interim Director of Nursing and Quality

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Purpose of the report

To provide assurance to the Board of Directors of compliance with the Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance (commonly known as the Hygiene Code), and also in relation to NICE guidance, particularly PH 36 Prevention and Control of Healthcare Associated Infections: Quality Improvement Guide. In April 2014, new NICE guidance QS61 Infection Prevention and Control was introduced. The action plan for 2014-15 is therefore constructed to ensure compliance with the new guidance while addressing any outstanding issues from the previous year, reflecting the recommendations of the internal Infection Prevention and Control audit and incorporating the assurances required by the Combined Clinical Commissioning Groups for Lincolnshire (Appendix B).

Key issues, options and risks

Good Infection Prevention and Control (IPC) is essential to ensure that people who use Trust services receive safe and effective care. Effective prevention and control of infection must be part of everyday practice and be applied consistently by everyone working within the care environment, whether this is a hospital setting or in a patients home. While the risks of infection within a Mental Health Trust may not be on a par with those of an acute Trust, they still need to be considered within a robust risk based approach, taking into account the overall infection risks of the general population. It can be challenging to get the balance right between the direction of travel within Mental Health Services towards recovery based care, where service users are encouraged to take more personal responsibility for their wellbeing, having greater levels of choice and managing their own risks; and being able to demonstrate compliance with the Health and Social Care Act 2008 standards. However, this does not suggest that we should be complacent either as individual clinicians or as an organisation. An outbreak of serious infection can be as devastating on a mental health unit as it can be on any other inpatient area, and can equally be prevented using the same measures and precautions.

The publication of an annual report is a requirement of the Health and Social Care Act 2008 to demonstrate good governance and public accountability. It provides assurance about systems and processes in relation to IPC. The Health and Social Care Act 2008: Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections sets out 10 criteria against which a registered provider is measured on how it complies with the registration requirements for cleanliness and infection control. It sets the basis of the IPC work plan, which is monitored via the Trust's Infection Control Committee. This report summarises progress against the work plan for 2013/14 and also outlines the key priorities and challenges for the 2014-15 work plan.

In February 2014, the Trust commissioned an internal audit of performance against the 10 criteria of the Hygiene Code within the Health and Social Care Act 2008. The outcome was a finding of Moderate Assurance, which was not unexpected in light of the changes taking place within the service provision. It was extremely useful in highlighting areas of good practice and generating an action plan which, when achieved, the Trust is confident will achieve an outcome of substantial assurance.

As part of the IPC audit, site visit observations revealed no significant concerns and overall, the environments were found to be clean, tidy and pleasant inpatient areas. This finding supported the results of the Trust's routine cleanliness audits. On speaking to staff, it was clear that IPC considerations are embedded within the consciousness and practice of the staff members, particularly in areas where the risks are considered to be greatest. In some cases, evidence was hard to find due to lack of consistent documentation and, although protocols were in place and appeared to be managed well locally, there were inconsistencies in how they were applied across the inpatient areas. This may have been down to the difficulty finding and navigating the guidance and policies provided. Some policies were found to be in need of significant review and change. This was identified as a high priority action for the work plan for 2014-15.

Summary of performance against 2013/14 Action Plan

Key initiatives for 2013/14 included:

- The re-provision of the IPC service. In 2013, the Trust served notice to withdraw from the contract it had with United Lincolnshire Hospitals NHS Trust (ULHT) for provision of infection, prevention and control services. With the exception of microbiology services (which are provided by external contract) the service has been provided entirely in-house since January 2014. This was achieved by the reconfiguration and refinement of the Matron posts. *This was fully achieved.*

- Medical devices including supply, maintenance and decontamination was an area identified within the 2013-14 work plan for development. This work was not fully completed in 2013-14 and has, therefore been taken forward into the 2014-15 Work Plan and will be monitored via the Infection Control Committee. *This will be taken forward through the 2014-15 action plan.*

- Hand hygiene training and decontamination compliance – to achieve and sustain 95% compliance. *This was achieved within Inpatient Services and will be taken forward for further work in the 2014-15 action plan to achieve Trust wide compliance.*

- Improved integration between the IPC service and Hotel Services to improve and develop robust services. *This was achieved and will continue to be further developed throughout 2014-15.*

Criterion 1
Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.

Governance arrangements
The Board of Directors has a collective responsibility for keeping to a minimum the risk of infection. The Board discharges this responsibility in the following ways:

The Interim Director of Nursing and Quality is the designated director with responsibility for IPC (DIPC). This post reports directly to the Chief Executive and to the Board of Directors.

The Trust board has a nominated Non-Executive Director as board champion for IPC, Mary Dowglass.

In accordance with NICE PH36 Quality Improvement Statement 1, the Trust Board demonstrates leadership in IPC by being proactive in ensuring continuous quality improvement by leading on and regularly monitoring compliance with all relevant objectives, latest guidance and up to date policies and procedures.

Infection control team
The Trust now has 0.6 WTE dedicated time from their own IPC Nurse who is able to draw on support and guidance from the Senior Health Protection Nurses at Public Health England, the Infection Prevention and Control Lead Lincolnshire NHS CCGs Federated Infection Prevention and Control Function, Occupational Health Specialists, Tuberculosis Specialist Nurse and Facilities and Estates management. In addition the Trust's Matrons and a representative from the Medical Consultant body have a key responsibility for oversight of clinical practice, and a network of link nurses are in place representing each inpatient unit.

Infection Control Committee
The Infection Control Committee is chaired by the Interim Director of Nursing and Quality and on a quarterly basis, reviews progress against the annual IPC work plan, the Hygiene Code and any internal or external audits. The ICC ensures timely delivery of the annual report to the Board and the Quality Committee. It provides direction and support for the IPC Lead in the implementation of new initiatives or directives both internally in response to information reported through the governance structure and externally through National initiatives and drivers. It also approves the IPC work plan for recommendation to the Board.

Infection control audits
Each inpatient area is audited on a biannual basis. Reports with resultant action plans are then developed collaboratively with the clinical teams. Progress against recommended actions is tracked by the Matrons and the Infection Control Committee. In addition the Trust carries out IPC unannounced visits and inspections of Trust sites.

Patient Led Assessments of the Care Environment (PLACE) and Cleanliness Audits

Audits of the general environment against the PLACE criteria are carried out annually and reported publicly through NHS England for comparison with Trusts providing similar services. These audits include service user representatives as a matter of course so that real, service user specific feedback can be gained and used to continually improve the environment and standards of practice. An action plan from each PLACE assessment is drawn up and discussed with unit managers, with a more formal follow up approximately 6 months after PLACE to ensure items are being actioned. Cleanliness audits are carried out routinely by the Hotel Services/Housekeeping Supervisors (this will now be via the MICE audit with clinical input) and reported back through the Patient Environment Action Group (PEAG) which is chaired by the Associate Director of Estates & Facilities Management and attended by the matrons for specific service areas. Biannual cleanliness audits using an electronic audit tool are also carried out by the Hotel Services Advisor and action plans generated which are monitored for compliance through ward managers and Hotel Services/Housekeeping Supervisors. They are also reported through to the IPC Lead for assurance.

Following PLACE audit feedback in 2013-14 identifying some issues with food provision around quality and choice, local nutrition groups have been set up by the Matrons. These have had a significant impact on the satisfaction ratings of the patients. There has been a new nutrition patient experience survey developed to support addressing the issues around food and its provision; and this has seen very high levels of engagement. Action plans generated from feedback have contributed to much higher levels of satisfaction from patients. The nutritional patient surveys are now embedded across the inpatient units. Each unit ensures that surveys are completed with a minimum of 50% of patients, and are submitted bimonthly. Results are reported as part of the Trust's heat map (Outcome 5).

Policies and procedures

The Trust's ICP policies are available on both the Trust intranet and external website. These set out the framework for safe and effective practice. The policies are currently undergoing a major review and rewrite in order to meet the actions resulting from the internal IPC audit conducted earlier in the year.

Criterion 2
Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

Supply and provision of linen and laundry
The linen contract and local laundry arrangements comply with CfPP01 04. Compliance of local arrangements is audited as part of the routine infection control audit programme.

Policies on the environment
The Trust has a number of policies in place in relation to cleaning services, building and refurbishment, waste management, infected linen, planned preventative maintenance, pest control, drinkable and non-drinkable water, legionella and road services. There is representation at the Infection Control Committee by the Estates and Facilities Department.

Cleaning services
NICE PH36 Quality Improvement Statement 5 states that people visiting any healthcare facility can expect those care settings to meet high standards of cleanliness with each Trust monitoring the condition of its premises to ensure levels exceed the minimum required standard. The Trust continues to make significant improvements in the overall assurances and processes for cleaning and will continue to monitor standards during 2014/15.

Medical devices
The Medical Devices Group is currently under review with a plan to be closely aligned to the Physical Healthcare Group, which is led by the Associate Matron and Infection Control Lead.

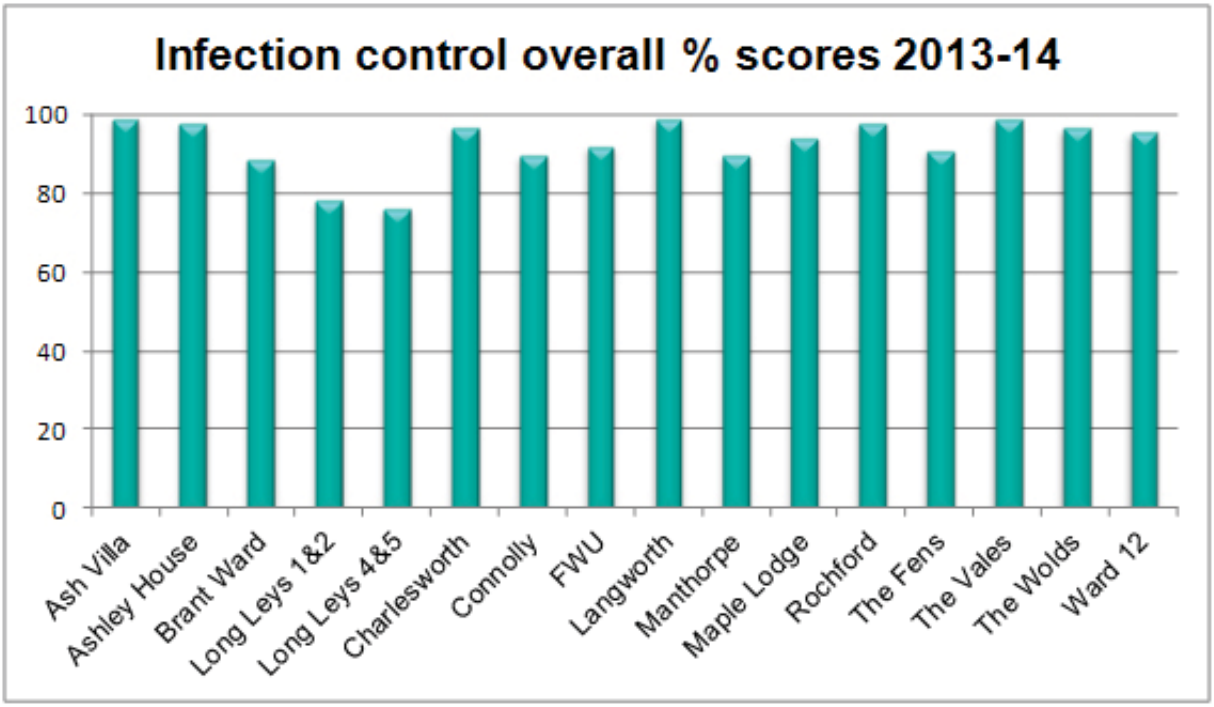
There is currently a central asset register with maintenance records held individually in each clinical area. There is need for standardisation of equipment and the updating of the asset registers, including how the Trust registers, updates and replaces equipment.
There are robust and well-designed cleaning processes and clearly identified responsibilities for cleaning and decontamination of equipment. This is evidenced by the cleaning manual, cleaning schedules and the use of visual cues such as ‘Green is Clean’ stickers.

The current outstanding challenges identified are:
- Inventory returns – maintaining an accurate up to date list of equipment in all units which is reviewed annually.
- Ensuring the consistent procurement of standardised equipment with associated maintenance arrangements across the Trust.

Appendix A updates the action plan from 2013-14 and identifies continuing amber actions to be completed in 2014-15. The Medical Devices group will ensure that the processes for the procurement, maintenance, replacement and procurement of equipment are robust as part of the work plan for 2014-15. This will report through the Physical Healthcare Steering Group in future.

Audit Scores for 2012/13
Reviewing clinical practice and the environment through continued audit is an established component of our IPC compliance process. Continuing audit against well established and

evidence based criteria ensures that we monitor and improve the standards of patient care and environments in order to demonstrate on going compliance.



Summary of action points from infection control audits

There were minor issues raised around environments and systems with individual wards and units, which were addressed through action plans using environmental budgets. Larger issues have been addressed through capital projects and on-going maintenance programmes through 2013-14 including the refurbishment of the Manthorpe Unit and Brant Ward at Witham Court. This will continue into 2014-15 with the planned refurbishment of Bungalow 3 at Long Leys Court.

Cleaning schedules are made publically available in all inpatient areas and these are reviewed. A programme of audits is undertaken for the environment and cleanliness though the Hotel Services Department. A comprehensive training and competency package is in place for all housekeeping staff. This is also reviewed to ensure that training meets the needs of the staff and the clinical environments.

Criterion 3
Provide suitable accurate information on infections to service users and their visitors.

The Trust makes available information relating to the prevention and control of Healthcare Associated Infections, MRSA screening and decolonisation, C.Difficile and other isolates and outbreaks as they arise. Availability of information is audited as part of the routine infection control audit programme. There is also up to date information posted on Infection Control notice boards which are managed by the link nurses under the supervision of the IPC Lead. One outcome reported through the internal audit was that some of this information is promoted inconsistently in different areas. This has been addressed by standardising the content of the Infection Control boards, more timely distribution of materials for local and national campaigns. A piece of work is commencing to standardise the care pathways used in the event of an infection or outbreak to ensure that the giving accurate and up to date information to service users and carers affected by infections is routinely evidenced. Easy read and other language versions of information are available and units display posters to advertise this.

Criterion 4
Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion.

Information relating to the status of patients is communicated as part of the discharge and transfer processes. A recommendation from the internal audit 2013 was to standardise this to better evidence that full information regarding identified risks is being communicated for all patients being admitted to, and discharged from, Trust inpatient areas. A new standard form is being developed as part of the review of policies and procedures that will meet the action identified in the audit. This will also ensure that the Trust meets the NICE PH36 Quality Improvement Statements 7 and 8.

MRSA Screening

A risk based policy for screening patients for MRSA colonisation was introduced in March 2009. All patients identified as high risk are screened on admission and at points throughout their episode of care. Compliance with screening is audited monthly and reported to the board through the IPC Lead. The Trust remains 100% compliant with the screening of high risk patients for MRSA on admission.

In 2013-14, 375 patients considered to be at high risk of MRSA were screened on admission. Of those, there were two positive results, three patients refused to be screened and one positive result was found in HMP Lincoln in a previously known patient.

Newly identified isolates 2013/14

	Numbers
Group G Strep	1
Group A Streptococcus	0
MRSA Colonisation (previously known)	2
MRSA Colonisation (screened after 48hrs)	3
MSSA	0
C. difficile	0
Glycopeptide resistant enterococci	0
Gentamicin resistant coliforms	0
Extended Beta lactamase organism	1
Escherichia coli resistant organism	1
GDH C Difficile pos	2

Witham Court – Langworth Ward 08.04.13 – 15.04.13. One patient started with vomiting 22hrs, followed by three patients after midnight with D&V. 17 beds on ward all full. No beds lost. Total seven patients and five staff affected. Ward deep cleaned and opened 15.04.13. Norovirus confirmed.

Criterion 5
Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.

All service users identified as high risk are routinely screened on admission; and during inpatient stays if there is any change in their presentation. There are care pathways in place to ensure that all interventions recommended for a particular incidence of infection are carried out in a timely manner and documented as such. These will be reviewed and replaced as part of the work plan for 2014-2015 in order to ensure that they meet the needs of the Trust's client group. All infections and outbreaks are reported to the Infection Control Committee and to Public Health England (PHE). There were no outbreaks or infections of sufficient severity to require reporting to PHE in 2013/14. Data on all infections and outbreaks are shared with the Senior Health Protection Nurse at PHE via their membership of the Infection Control Committee, unless they are notifiable infections, when the urgent responsibility falls to the Microbiology Department, the Consultant in charge of care and the IPC Lead.

There are also systems in place for routine reporting and surveillance by the IPC Lead and through the Microbiology Service Level agreement in accordance with NICE PH36 Quality Improvement Statement 3. This is to ensure that response to any infection or outbreak is appropriate, timely and effective in preventing the further spread of infection. This includes the routine daily reporting of identified isolates to the IPC Lead from the microbiology labs and the monthly return of MRSA screening figures and outcomes for reporting through the Trust Board. Identification of any problem areas, inadequate resources or systems and trends in the local and national health economy that need to be shared with partner organisations and other providers are captured and escalated if the risk cannot be resolved promptly.

Criterion 6
Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.

NICE PH36 Quality Improvement Statement 4 requires that Trusts prioritise the need for a skilled, knowledgeable and healthy workforce that delivers continuous quality improvement to minimise the risk from infections. This includes support staff, volunteers, agency/locum staff and contractors or those with honorary contracts such as students in nursing and other health and social care professions. Trusts are able to evidence that they are meeting these criteria by ensuring that IPC is included as part of the supervision and appraisal process, a routine agenda item in staff meetings, and that staff receive feedback on their performance related to IPC.

The Trust continues to monitor hand hygiene compliance particularly in regard to the World Health Organisation (WHO) 5 Moments of Hand Hygiene by the use of the Essential Steps audit tool which is reported back to the IPC Lead on a monthly basis by the Infection Control Link nurses who audit their team members. A submission rate of 80% of the expected audits was achieved and

of those 80%, 100% compliance was maintained throughout the year. There is focussed on-going work being done with the IPC link nurses to address compliance with this audit through the work plan for 2014-15.

IPC training, including Hand Hygiene training, is part of the Trust Induction Programme for all new staff and is also included in the annual mandatory training updates for all Trust staff.

Estates and Facilities

Hotel Services, in particular Housekeeping Services, are provided by the Trust's Estates and Facilities Management Department. The Estates Maintenance Service which is managed and monitored by the Estates and Facilities Management Department is provided through a service level agreement with NHS Property Services. Housekeeping services compliance with routine cleanliness is monitored and audited by the Housekeeping Supervisors and the Hotel Services Advisor who also provides specialist guidance and advice on cleaning and waste management in the event of infection or an outbreak, working in partnership with the Trust IPC Lead.

As recommended by NICE PH36 Quality Improvement Statement 10, there is evidence that the IPC Lead is routinely consulted in any capital project from the commissioning and design stage and also when any routine maintenance projects have a significant impact on hygiene or IPC.

Criterion 7
Provide or secure adequate isolation facilities.

Due to the nature of the patient population, and the availability of facilities, it can, at times be difficult to isolate patients to minimise the spread of infection. A local policy based on risk is in place and individual requirements for isolation are managed on a case by case basis. The IPC Lead and Matrons are available to advise and support the need for isolation as well as provide information to the service user and carers involved in the decision to isolate. This relies on good systems of communication and good quality information in order to attempt to minimise risk and manage infection on the least restrictive way possible. All ward staff should be familiar with the Trust's Care Pathways detailing the action required in the event of an occurrence or outbreak of infection.

Criterion 8
Secure adequate access to laboratory support as appropriate.

The Trust is supported by a service level agreement for to provide microbiology laboratory services which operates according to standards required for accreditation by the Clinical Pathology Accreditation (UK) Ltd (CPA). This is provided by Path Links at Boston Pilgrim Hospital. Routine reporting of new isolates to the IPC lead for continuous surveillance is a part of the overall package. This also includes clinical support and advice throughout the patient pathway, including not only the testing phase but also during the pre and post analytical phase and specialist medical advice available through telephone discussion.

Criterion 9
Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.

Following the IPC internal audit in 2013, one of the main issues identified was that, while comprehensive and fit for purpose for an Acute Hospital Trust, the policies and procedures were organised in such a way as to make them difficult to find and navigate and did not fit the needs of the clinicians and service users for whom they were designed to be of use. In the event of an infection or outbreak, it was difficult for a clinician seeking accurate and up to date guidance on the management of that infection to find clear information to be able to manage said infection or outbreak. There were also many policies that were unlikely to be of use within a Mental Health Trust. The action plan identified that the policies needed to be reviewed so that they were concise, practicable; and available to clinicians in an easily navigable form, particularly in case of need for urgent action out of hours. This has been actioned by the IPC Lead and will be completed and reported for assurance to the Infection Control Committee by the end of the first quarter of 2014.

Criterion 10
Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.

All inpatient clinical staff and housekeepers are required to have hand hygiene training on an annual basis and monthly audits are carried out through the Essential Steps framework.

The Trust provide personal protective equipment (PPE) for staff use where appropriate, the use of which is addressed in IPC training both at induction and mandatory training updates.

Food hygiene training is provided where appropriate or necessary through Hotel Services and the Learning and Development Centre and information about the management of waste streams is provided along with routine audit and training. An annual audit of sharps management by the company who provide sharps bins is completed but sharps management is also routinely checked as part of IPC audits.

The Trust will review the provision of retractable and/or safety needles in the first quarter of 2014 and has a plan for full implementation for 2014-15 in order to reduce the risk of sharps injuries for clinicians

The Trust had an uptake of 33% uptake for Flu vaccination in the year 2013-14. A significant increase on the previous year but still well below government targets of 75%. The most concerning finding was that the lowest uptake was from frontline clinicians which, in the case of an outbreak, would potentially severely compromise the Trust's ability to continue to deliver care to high standards. Work to address this is described in the work plan for 2014-15.

Hand hygiene training

The Trust has a target of a compliance rate of 95% for the year and following adjustment of attendance figures for long term sickness for inpatient areas had achieved 95.4%. Work to review the mandatory training requirements for some teams and being more flexible and imaginative about how training will be delivered is addressed in the work plan for 2014-15.

Work Plan for 2014/15

The action plan and key initiatives for 2013/14 have been reviewed by the Infection Control Committee and the new action plan for 2014/15 builds on the existing assurances and is intended to ensure adherence to the NICE quality standards QS 61 for IPC in addition to the criteria for the Hygiene Code reported through the Lincolnshire Combined Clinical Commissioning Groups and to fulfil the action plan generated from the internal IPC 2013 Audit to achieve full substantial assurance.

Key initiatives for 2014/15 to support the action plan and further develop the service:

- Examine, rationalise and ratify audit processes so they result in actions that give real benefits to patients and practitioners in terms of promoting best practice to achieve better outcomes. This will include the use of a new audit tool for biannual IPC audits which is more suited to mental health environments. This will be supported by the use of the Matron Infection Control, Environment and Cleanliness (MICE) audits which will be introduced on a monthly cycle supported by domestic supervisors from June 2014.
- Further develop the IPC Link Nurse role to establish a network of expertise and knowledge across the Trust. This will better manage infections and outbreaks, and support the IPC Lead in delivering the work plan throughout the Trust.
- Refresh, rewrite and rationalise IPC Policies and Procedures to meet the needs of service users, clinical teams and the Trust.
- Develop clear clinical processes for outbreak management to ensure that rapid, evidence based and effective care pathways can be followed.
- Re-examine programmes of delivery for Hand Hygiene and IPC training to ensure best use of time and expertise while meeting clinical need and Trust targets for compliance.
- Continue to work on the greater integration between IPC services and Hotel Services as described in the RCN report ‘Creating a Safer Environment for Care’ 2013.
- Review the Medical Devices strategy and implement this successfully across the Trust.
- In collaboration with the Lead Pharmacist, develop and deliver a strategy for improving the uptake for flu vaccination in both staff and patient groups.
- Increase the extent of patient and carer involvement in all aspects of IPC development and include this in the Infection Control Strategy.
- Develop collaborative working relationships with other local health and social care providers that includes clear lines of accountability, defined, shared and agreed governance structures and the development of shared targets and joint working to improve outcomes locally relating to HCAIs.
- Develop an action plan to evidence the implementation of reissued NICE Guidance for Infectious Disease Prevention and Control QS61 and demonstrate compliance with the quality statements and thereby the Combined Commissioning Group Outcome Indicator Set(2014-15) Domain 5.2:Treating and caring for people in a safe environment and protecting them from harm.

Executive Analysis

A major change in the provision of IPC service within the Trust has occurred in 2013-14. This has given the Trust an opportunity to review and reconfigure the service to better meet the needs of its diverse service user group and the environments in which we deliver care.

The Trust achieved the majority of the initiatives and targets it set itself for 2013-14 The work plan for 2014-15 focusses on further developing those initiatives and targets, particularly those highlighted by the IPC internal audit completed in March 2013. Progress has been made against those already. IPC is an already established part of clinical practice in teams and will continue to be embedded through development of initiatives, monitoring and Trust governance processes.

IPC remains a high priority. The Board is committed to providing safe, effective care to all service users and carers who access our services and safe working environments for the staff who provide that care. Infection Prevention and Control is an essential part of that provision.

At its meeting in August 2014, the Quality Committee received this report and approved the action plan for 2014/15.

Appendix A - Medical Devices

Care Quality Commission Compliance Check

Outcome 11: Safety, availability and suitability of equipment.

Regulation
16.- (1) The registered person must make suitable arrangements to protect service users and others who may be at risk from the use of unsafe equipment by ensuring that equipment provided for the purposes of the carrying on of a regulated activity is:

a. properly maintained and suitable for its purpose; and
b. used correctly.

(2) The registered person must ensure that equipment is available in sufficient quantities in order to ensure the safety of service users and meet their assessed needs.

(3) Where equipment is provided to support service users in their day to day living, the registered person must ensure that, as far as reasonably practicable, such equipment promotes the independence and comfort of service users.

(4) For the purposes of this regulation -
a. “equipment” includes a medical device; and
b. “medical device” has the same meaning as in the Medical Devices Regulations 2002.

Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Ensure equipment is adequate		
Requirement	**LPFT evidence**	**Status**
People are safe because, where equipment is provided or used as part of the regulated activity, the equipment is: • Available in sufficient quantities to meet the needs of people who use the service. • Safe to be used. • Suitable for its stated purpose. • Compliant with all relevant laws. • Installed, used and maintained correctly with reference to the specifications, manufacturer's instructions, legislation and appropriate guidance from expert bodies. • Properly maintained, tested, serviced and renewed under a recorded programme. • Stored safely and securely to prevent theft, damage or misuse.	The Trust's Medical Devices Policy covers all aspects of availability of equipment, safety checks, and maintenance arrangements. The Medical Devices Group will be reviewed and relaunched in order to monitor compliance . This will report exemptions to Infection Control Committee and Medicines Management Committee An approved product list has been established by the Medical Devices Group in conjunction with Clinical Engineering to inform all purchasing. A service level agreement is in place with UHLT Clinical Engineering for the maintenance and servicing of all medical equipment as required and teams have full instructions on how to access the service. A central budget is available for the replacement/ purchasing of any essential medical equipment. Local maintenance records are maintained by local teams and detailed in CQC folders.	
People's needs are met because staff using any equipment do so in a way that has regard to their dignity, comfort and safety and promotes their independence by: • Actively listening to their preferences and thoughts about the equipment they need and how it is used. • Supporting the person to understand how and why the equipment is being used. • Taking care in the way they use the equipment to make sure the person is comfortable and safe. • Using the equipment in a way that ensures the person's privacy and dignity.	As a mental health Trust LPFT uses a limited range of medical devices. The privacy and dignity of patients is addressed through staff training and the Privacy and Dignity policy. All staff receive training on the use of medical devices as required and maintain local records and uploaded onto OLM system through Learning & Development Team. Pertinent to the organisation is the use of resuscitation equipment which is covered in Basic Life Support and Intermediate Life Support mandatory training. Resuscitation training records are maintained by the Learning & Development Team.	

Manage risk through effective procedures about equipment suitability

Requirement	LPFT evidence	Status
People are safe because, where equipment is provided as part of the regulated activity, there are clear procedures followed in practice, monitored and reviewed. Wherever necessary these include: • Identification, assessment and review of risk. • Where risks are identified, a plan for how these are to be managed. • How the equipment is maintained and used. • Ensuring that all staff involved in using the equipment have the competency and skills needed, and where this is not possible, know what to do to ensure the people remain safe. • How staff will know what to do when a person who uses services refuses to allow use of the equipment. • The arrangements for adverse events, incidents, errors and near miss reporting. These should encourage local and, where applicable, national reporting, learning and promoting an open and fair culture of safety. • The training of people who use services about any equipment they are given to use themselves. • Best interest meetings with people who know and understand the person using the services to ensure that treatment and care are taken that reflect the person's best interest. • What will happen in the event of electricity, water or gas supply failure, or other emergencies, that affect the equipment used to meet the needs of people who use services.	There are established and effective risk assessment processes in the Trust. Risks identified with service users (including patients refusing treatment/assessment with equipment) would be managed as part of a multidisciplinary decision making process to meet the needs of the patient and include best interest assessment as required. Maintenance arrangements for all approved medical devices are detailed on the approved product list, There is an established SLA with ULHT Clinical Engineering for the maintenance and servicing of medical equipment. Staff receive mandatory training on the use of resuscitation equipment as required. Other low risk devices used in practice are covered by profession/ or local peer training. The Medical Devices policy provides clear guidance to staff on responsibilities around competence. Adverse incidents and near misses are reported on the Trust's electronic incident reporting system and managed through the incident management process; all reported incidents of this nature are reviewed on a quarterly basis by the Medical Devices Group and follow up action taken if required. Equipment is only provided to service users by Trust Occupational Therapists. Training for service users receiving equipment is detailed in The Prescription of Equipment by Occupational Therapists under The Lincolnshire Community Equipment Service (LCES) guidance document. The range and type of medical devices used by LPFT is such that they would be relatively unaffected by disruption to electricity, water or gas supplies. Some treatments such as ECT could be postponed but alternative arrangements could be put in place. Business Continuity Plans are in place for all services to ensure continued safe service delivery in emergency situations.	

Where people who use services receive care, treatment or support that involves the use of medical devices, the provider has:
 	
• Clear procedures that are followed in practice, monitored and reviewed for the use of medical devices. Wherever they are required these procedures include:
  • implementing guidance issued by experts or professional bodies in relation to the medical devices used
  • acting on alerts from an expert or professional body or a product manufacturer.
	The Medical Devices Group has produced a standardised product list in conjunction with ULHT Clinical Engineering to ensure all devices purchased meet current legislative requirements and identified best practice. This list is updated on a quarterly basis and provided to procurement to inform all purchasing.
	
	There is an established system managed by the Risk department to respond to any Medical Devices Alerts and identify, remove or replace equipment as required.	

People who use services receive care, treatment and support from a service that: • Takes into account relevant guidance, including that from the Care Quality Commission's Schedule of Applicable Publications.	This Guidance is addressed in the Medical Devices Management Policy. Lasers are not used in LPFT. Single use devices are specifically addressed in the Medical Devices Management Policy. There is an established system managed by the Risk department to respond to any Medical Devices Alerts and identify, remove or replace equipment as required. Any new guidance is reviewed by the Medical Devices Group and actioned accordingly.	

Providing personalised care through the effective use of medical devices

Requirement	LPFT evidence	Status

People who use services receive care, treatment and support that:
 	
• Ensures the medical devices used to meet their needs are:
  • not reused if they are manufactured for single use only
  • only modified in line with manufacturer's instructions or guidance
  • only purchased if they meet the necessary legal requirements
  • available when they are required for use
  • supplied with the necessary technical information so that the risk of using them incorrectly is minimised
  • permanently installed where appropriate, in accordance with manufacturer's requirements and published guidance
  • only used by the person, or by staff, once they know how to use and operate them correctly
  • monitored while being used and action taken if they do not appear to be working correctly
	The issues identified in section 11F are addressed through the Medical devices Management Policy.
	
	Single use devices are specifically addressed with instructions for disposal.
	
	The Medical Devices Group has produced a standardised product list in conjunction with ULHT Clinical Engineering to ensure all devices purchased meet current legislative requirements and identified best practice. This list is updated on a quarterly basis and provided to procurement to inform all purchasing.
	
	Routine maintenance and repair arrangements for all approved medical devices are detailed on the approved product list, There is an established SLA with ULHT Clinical Engineering for the maintenance and servicing of medical equipment.	

• routinely maintained in line with the manufacturer's instructions and by people who are competent to do so • repaired when they break down by people who are competent to do so • disposed of or recycled, safely and securely.	Staff receive mandatory training on the use of resuscitation equipment as required. Other low risk devices used in practice are covered by profession or local peer training. The Medical Devices policy provides clear guidance to staff on responsibilities around competence. Disposal of medical devices including WEE regulations is specifically covered in the Medical Devices Management Policy.	

Additional prompts for specific service types

Requirement	LPFT evidence	Status
When equipment is used in a person's own home: • Staff address any concerns in a timely manner where they have identified problems around the safety of the equipment.	Equipment is only provided to service users by Trust Occupational Therapists. Training for service users receiving equipment is detailed in The Prescription of Equipment by Occupational Therapists under The Lincolnshire Community Equipment Service (LCES) guidance document. Concerns would be addressed immediately or escalated through the line management structure. In incident report may also apply and be completed.	
People who use services receive care, treatment and support that: • Ensures equipment required for resuscitation or other medical emergencies is available and accessible for use as quickly as possible. Where the service requires it, this equipment is tamper proof.	The Trust has an established resuscitation policy that addresses the issues identified in this section. Local teams conduct daily checks of resuscitation equipment.	

NICE: Quality Improvement Guide IPC Action Plan 2013-14

Remaining amber actions. These are addressed within the Action Plan for 2014-15 (Appendix B)

- Evidence that the Board has an agreed set of key performance indicators for IPC which includes compliance with antibiotic prescribing policy.
- Evidence that the Trust promotes a culture of learning in relation to IPC, and ensures staff have time to participate in preventive learning activities.
- Evidence that all staff working in clinical areas, including specialist 'link practitioners', have sufficient time to fulfil their responsibilities on (and objectives for) IPC.
- Evidence that all staff working in clinical areas, including specialist 'link practitioners', have sufficient time to fulfil their responsibilities on (and objectives for) IPC.
- Evidence that staff are provided with feedback on their performance in relation to IPC (for example, on hand hygiene or when prescribing antimicrobial drugs). This includes evidence that they are given support to fulfil this role.
- Evidence of local arrangements to ensure IPC training and competencies are updated and checked at appropriate intervals.
- Evidence that local workforce planning and workforce reviews explicitly consider, and are informed by, the Trust's IPC strategy and local HCAI outcomes.
- Evidence of local arrangements for an annual review of training resources to ensure consistency with the national evidence base and professional and occupational standards.
- Evidence of a procedure for documenting and sharing information about infections and their treatment. This includes evidence of information sharing to manage and support patients with an infection on an on-going basis (including transfer and isolation arrangements for them) during admission, transfer and discharge.

Red rated actions

None currently

These outstanding actions will be taken forward for inclusion in the 2104-15 Work Plan in addition to the Action Plan formulated to demonstrate compliance with NICE Guidance for Infectious Disease Prevention and Control QS61 along with new initiatives to further develop the service. Action plans have been amalgamated to incorporate the internal Infection Control Audit and the aspects of the action plan for the Combined Clinical Commissioning Groups that is reported on monthly. All outstanding amber actions for 2013-14 are incorporated within this plan.

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