Royal Victoria Eye & Ear Hospital

Infection Control Annual Report

2015

Compiled by

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Approved by: CE

Date: March 2015

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1.0 Executive Summary

The Royal Victoria Eye and Ear Hospital (RVEEH) is committed to the provision and maintenance of an effective and efficient infection prevention and control service within the organisation, in order to provide a suitable environment and appropriate practices that ensure safe, high quality healthcare for patients, staff, visitors and the public, in line with current legislation and evidence-based practice.

This is achieved by;

Continual monitoring of services and consulting with all relevant disciplines of staff. Good working relationships across clinical services and between directorates. Service amendments and improvements based on feedback, internal and external audits, regulations and national and international standards and guidelines.

This annual document reports on the infection prevention and control service, including surveillance of infection in RVEEH for 2015.

Post surgical site infections remains relatively low, however, there has been an increase in post op cataract endophthalmitis See section 3.6.1.

The hospital was inspected by the Health Information Quality Authority (HIQA) in April 2015. The unannounced inspection focused specifically on observation of the day-to-day delivery of hygiene services with particular focus on environment and equipment cleanliness and adherence to hand hygiene guidelines. Areas assessed were ENT OPD, the West Wing and HLW. All areas were observed to be generally clean. However, it was noted the West Wing and HLW require painting in some areas. HIQA noted that the hospital needs to build on compliances achieved to date regarding hand hygiene, to ensure that good practice is improved and maintained, and national targets are sustained. Refer to RVEEH web site for a summary of their findings and recent QIP.

A self-assessment of Antimicrobial Stewardship in all public acute hospitals was undertaken in 2015; a report of announced assessments in some hospitals is expected to be published in 2016. The IPCT and Pharmacists commenced antimicrobial stewardship audits in September. See section 3.3 for a report summary

Identified risks were documented and evaluated through the Hospital's Integrated Risk, Quality & Safety (IRQS) Committee, which meets quarterly and is chaired by the Medical Director. All departments are responsible for completing a risk assessment in their area and recording in a risk register. The major risks identified by the infection control team are as follows

Table 1 - Identified Registered Risks

Risk	Risk to Whom	Risk Rating	Risk Category
1 No conventional ventilation in theatres	Patient	15	High
2 Some clinical hand wash sinks in the hospital are not compliant with HBN 00-10 Part C standard	Patient//Staff	8	Moderate
3 Non-compliance with Infection Control standards due to lack of en-suite isolation rooms.	Patient	15	High
4 Risk of legionnaires disease. Legionella risk assessment non-conformances to be actioned according to risk assessment	Patient/Staff	8	Moderate

2.0 Introduction

This annual document reports on the infection prevention and control service, including surveillance of infection in RVEEH.

It includes information on:

- Progress and achievements against the Infection Prevention Control Team (IPCT) annual programme to prevent and control HCAIs;
- Specific targets relating to the prevention and control of HCAIs;
- Key Performance Indicators (KPI), including the HSE Infection Control indicators;
- The resources made available to prevent and control HCAIs
- Recent independent external audits including HIQA audit in April 2015 and DGSA in June and December 2015.

The Infection Prevention and Control Team (IPCT) are comprised of a Consultant Microbiologist (10 hours per week) and two Clinical Nurse Specialists Infection Control who share one WTE position. The Surveillance Scientist, based in the National Maternity Hospital, also contributes to the surveillance service in RVEEH. A work plan and IPCT programme, Appendix 1, is developed annually and the team meets weekly to discuss all matters relating to infection prevention and control. The team has representation on the following committees: Infection Prevention & Control committee (IPCC), Drugs, Therapeutics & Antimicrobial Stewardship, Integrated, Risk, Quality & Safety, Hygiene and Decontamination and Clinical Nurse Managers Committee.

The IPCC is chaired by Mr D Dunne, Chief Executive. It is a multidisciplinary committee which is responsible for the development and review of the service to prevent and control HCAIs;

Appendix 1 details the annual work plan and programme which are reviewed signed off annually;

Appendix 2 details committee membership and attendance in 2015;

Appendix 3 details Terms of Reference.

3.0 Surveillance

Standard 11: Healthcare associated infections and antimicrobial resistance are monitored, audited and reported through a systematic surveillance programme

Surveillance involves a range of procedures including scientific, technical, communication, information and data management, and quality control. Surveillance in the RVEEH includes the following:

- RVEE Hospital acquired infections
- Antimicrobial resistance
- Surgical site infections
- Patient device related infections
- Notifiable infectious diseases

Table 2 - RVEEH key performance indicators (KPI's)

HCAI Key Performance Indicators	Target	2011	2012	2013	2014	2015
Rate of post-operative endophthalmitis (elective cataract surgery)	≤0.1%	0.05%	0.08%	0.10%	0%	0.16%
Rate of post intravitreal injection endophthalmitis	≤0.05%	0.03%	0.02%	0%	0.04%	0.06%
Rate of post-operative ENT Infection	≤1%				0.48%	0.37%
Number of RVEEH acquired MRSA **colonization**	≤2	1	0	0	1	0
Number of RVEEH acquired MRSA infection	≤2	0	1	0	0	1
Number of MRSA blood stream infections	≤1	1	0	0	0	0
Device related infections (PVCs)	≤5	2	3	1	1	2
PVC related blood stream infection	≤1	0	0	0	0	0
Clostridium difficile Infection	≤2	0	0	0	0	0

Table 3 - HSE KPIs for RVEEH

RVEEH KPIs	RVEEH 2011	RVEEH 2012	RVEEH 2013	RVEEH 2014	RVEEH 2015
MRSA Blood Stream Infection per 1000 bed days used (BDU)	1	**0**	**0**	**0**	0
New cases of C difficile infection per 10,000 BDU	**0**	**0**	**0**	**0**	0
Antibiotic consumption (daily defined doses per 100 BDU)	46	56.8	55.8	51.1	56.5*
Alcohol hand sanitizer consumption (litres per 1,000 BDU)	**33**	**32.8**	48.1	49.2	66.5*
HSE hand hygiene audit compliance (≥90%)	May 75% Nov 78%	May 85% Nov 86%	May 90% Nov 83%	May 89% Nov 88%	May 85% Nov 86%

***Q1 & Q2 data only available at time of writing report.**

3.2 MRSA

MRSA screening is requested prior to admission on all patients in an at-risk category. The profile for 2015 was as follows:

Table 4: MRSA Profile for 2015

	2011	2012	2013	2014	**2015**
No.of MRSA screening swabs	-	-	2,502	3,402	4,097
No. of patients tested	-	-	632	681	834
Number of positive patients (%)	62	49	53 (8.4%)	59 (8.7%)	60 (7.2%)
Number of previously known carriers (%)	10	15	19 (35.8%)	24 (40.7%)	21 (35%)
Number of MRSA HCAI	1	1	0	0	1
MRSA decolonisation	41	23	36	34	24

The IPCT liaise with patients and their GPs when MRSA eradication is being carried out. Thirteen pre-op patients out of the twenty four were sucessfully decolonised and returned three consecutive clear MRSA swabs. Decolonisation was attempted in the remaining patients but they were not successfully cleared. However, surgery proceeded in all patients and recommened infection control precautions were adhered to. Dr S Knowles recommended intracameral vancomycin 1mg to be administered in OT to all patients undergoing cateract surgery who were positive or ever had a history of MRSA. This commenced in March 2015.

3.3 Antimicrobial Consumption and Stewardship

Hospital data is reported to the Health Protection Surveillance centre (HPSC) by the Pharmacy Department. This data is discussed at the Hospital's Drugs, Therapeutics & Antimicrobial Stewardship Committee.

*****See Appendix 6-7 for additional National and RVEEH Antimicrobial Data

Antimicrobial Stewardship (AMS)

HIQA commenced audits of antimicrobial stewardship in acute hospitals in 2015. The RVEEH completed an AMS self-assessment which was submitted to HIQA in July 2015. No feedback has been received to date.

AMS ward rounds and audit of in-patient antimicrobial prescribing commenced in September 2015 in the RVEEH.

Summary of 2015 AMS In-Patient Ward Rounds

- No. audited = 28 patients
- Allergies recorded: 27/28 (96.4%)
- Weight documented: 23/28 (82.1%)
- Prescribe in accordance with guidelines or consultation:15/28 (53.6%)

Non-compliances / no guidance

- Topical ofloxacin prophylaxis
- Use of sub-conjunctival gentamicin (9)

Surgical prophylaxis indications for sub-conjunctival gentamicin:

- Vitrectomy +/- membrane peel (5)
- Retinal detachment repair (2)
- Scleral buckle and cryo (1)
- Corneal graft (DSEK) (1)

Action: Feedback of AMS in-patient ward round audits at Ophthalmology post-graduate meeting is planned for January 14th 2016.

3.4 European Antimicrobial Resistance Surveillance Network (EARS-Net)

The Surveillance Scientist contributes RVEEH blood stream infection data to the European Antimicrobial Resistance Surveillance Network (EARS-Net). There was one blood stream infection (Group A Streptococcus) in 2015.

3.5 Table 6: No. of Common Transmissible Organisms in RVEEH 2011 – 2015

	2011	2012	2013	2014	2015
Acanthamoeba (ocular)	2	8	4	4	5
Adenovirus (ocular)	87	61	111	47	67
Chlamydia trachomatis (ocular)	7	9	11	11	7
Clostridium difficile	0	0	0	0	0
Gonorrhoea (ocular)	4	2	8	5	2
Group A Streptococcus (any site)	8	13	10	7	12
Hepatitis B	0	0	0	0	0
Hepatitis C	0	0	0	0	0
HIV	0	0	0	0	0
MRSA (BSI)	1	0	0	0	0
MRSA (healthcare acquired colonisation)	0	0	0	1	0
MRSA (HCAI acquired infection)	0	1	0	0	1
Mumps	0	0	0	0	0
Norovirus	0	0	0	0	0
Syphilis	0	4	4	0	0
Toxoplasmosis	1	0	0	0	0
TB Pulmonary	0	0	0	0	0
TB Extra-pulmonary	0	1	0	0	0
Vancomycin Resistant Enterococci (VRE)	0	0	0	0	1*

BSI: Blood Stream Infection ; HCAI: healthcare associated infection

*Known VRE carrier in patient transferred from another hospital; no infection detected

3.6 Surgical Site Infection

Table 7: Total Surgeries indicating number of infections

Eye Surgey	2013			2014			2015		
	Total	Infected Patients	%	Total	Infected Patients	%	Total	Infected Patients	%
Cataract Surgery	2,860	3	0.10	2,427	0	0	2,505	4	0.16
Other Eye Surgery	2,726	0	0	2,948	2	0.06	2,430	2	0.08
Intravitreal Injections	3,988	0	0	4,516	2	0.04	4,866	3	0.06
ENT surgery				1,650	8	0.48	1,610	6	0.37

3.6.1 Eye Surgery

There was a total number of 4,935 eye operations carried out in 2015 excluding intraviteal injections. Post-elective cataract surgery 0.16% developed clinical evidence of endopthalmitis. This was an increase compared to recent years. The IPCT carried out an investigation and concluded that no outbreak occurred, cases were not linked to any particular surgeon, cases were not linked with any decontamination failure.

The following risk factors were identified

One patient had a known risk factor for infection (known MRSA colonisation). Surgical prophylaxis has been modified to reflect this risk (completed June 2015).

One patient developed a severe dermatitis secondary to surgical tape allergy. This may have contributed to development of infection. Hypoallergenic tape was used and this condition was not preventable. No other patient had risk factors for infection.

Risk factors for infection in the OT include (a) lack of mechanical ventilation, no air changes and no pressure differentials between rooms in OT and (b) multi-use conjunctival and skin disinfection with povidone-iodine.

Risk factors for infection in the MPR are (b) lack of engineering oversight of servicing and maintenance reports for the AHU's in both MPR's.

Table 8 ENT surgery

	2014			2015		
	Total	**Infected Patients**	**%**	**Total**	**Infected Patients**	**%**
Parotidectomy	24	0	0%	20	2	10%
Mastoid Exploration	39	1	2.5%	35	0	0%
Septoplasty	54	1	1.8%	35	0	0%
Fess -/+ septoplasty	56	0	0%	76	1	1.3%
Thyroid and Parathroidectomy	-	-	-	60	1	1.6%
Otoplasty	-	-	-	3	1	1.6%
Tympanoplasty & Combined approach Tympanoplsty	37	2	5.4%	43	0	0%
Submandibular gland excision+/-R/O stone	13	2	15.8%	7	1	14.2%
Other ENT Surgery	1,222	2	0.16%	1,376	0	0%

3.6.2 ENT Surgery 2015 :

There were 1,655 ENT surgical procedures.

There were seix post op infections which accounted for 0.37%.

All patients were re-admitted and commenced on the appropriate IV antibiotic.

Nine sputa samples from nine patients returned positive in 2015. Patients received appropriate treatment. All were community acquired infections.

4.0 Monitoring

Standard 1: (HIQA. HCAI) Structures, systems and processes are in place to effectively manage and implement the programme to prevent and control Healthcare Associated Infections

4.1 Hygiene and Infection Control Audits

The Hygiene Service Committee carries out monthly hygiene audits.There are 10 teams and each team is made up of two members from different disciplines. The results of these audits and a Quality Improvement Plan are fed back to the committee and evaluated at the monthly meetings. Where possible, any hygiene problems are acted on and corrected at the time of audit. The IPCT carried out two additional detailed Infection Control audits in March and August 2015. All completed audits are available on the shared intranet for staff to access. See Appendix 8 for a summary of the IPCT audits. The following are audited:

- Waste management
- Linen management
- Sharps management
- Training effectiveness
- Environmental Monitoring
- Facilities
- Environmental Cleaning
- Hand Hygiene
- Management of Patient equipment
- Peripheral IV and urinary catheter care bundles

4.2 Hand Hygiene

Standard 6: (HIQA. HCAI) Hand hygiene practices that prevent, control and reduce the risk of the spread of Healthcare Associated Infections are in place

Hand Hygiene education is provided to all clinical staff annually. 97% of RVEEH staff who have interaction with patients received hand hygiene education and training during the 2-year period 2013-2015. Observational hand hygiene audits were carried out monthly using the tool developed by the Health Protection Surveillance Centre (HPSC). Three clinical areas are observed monthly .The results are fed back to the HST, IRQS & IPCC committees and are available on the hospital's shared intranet. Hospital wide audits, which include seven clinical areas, take place in May and

October/November each year; results of these are submitted to the HSE and are published nationally.

Two hand hygiene awareness days were held by the IPCT in May and September 2015. An ultraviolet light cabinet was used to demonstrate hand hygiene technique to staff of all disciplines. Approximately seventy staff took part. On site education regarding the WHO 5 moments for Hand Hygiene was given to all who participated.

No complaints were received from patients or visitors regarding hand hygiene compliance in 2015.

4.3 Alcohol Gel Consumption

The HPSC audits the usage of alcohol hand sanitizer products in all hospitals quarterly. This is used as an indication of compliance with hand hygiene and usage is compared with other hospitals.

See appendix 4 for breakdown in staff discipline for hand hygiene audits

See appendix 5 for alcohol hand sanitizer consumption

4.4 External Audits

HIQA undertook an unannounced inspection of the hospital in April 2015. For a summary of findings and subsequent QIP see RVEEH web site.

Dangerous Goods Safety Advisor (**DGSA)**

Ther were two DGSA audits carried out in June and December 2015. The overall level of compliance with regulation and guidelines associated with segregation, packaging, transport and disposal of dangerous goods was found to be good.

Observations of non-comformances were reported back to the Health and Safety Department and acted on where necessary.

5.0 Facilities

Standard 3: (HIQA. HCAI) The physical environment, facilities and resources are developed and managed to minimise the risk of service users, staff and visitors acquiring a healthcare Associated Infection

5.1 Environmental Monitoring - Water Quality & Legionella Prevention

Irish Water Management Company (IWM) are now responsible for managing and maintaining the water system in the hospital.

Controls and tasks in place are:

- Quarterly external and monthly internal water temperature monitoring is carried out.
- Weekly flushing of infrequently used water outlets. This is carried out throughout the hospital. All documentation is held with the cleaning supervisor.
- Quarterly shower head cleaning carried out by IWM.
- Quarterly quality testing for indicator organisms (legionella) and total viable counts is carried out.
- All water tanks are cleaned annually
- Annual independent legionella risk assessment
- Bi-annual TMV servicing

The hospital received a legionella risk assessment report in January 2015. Following this assessment additional flushing controls for infrequentlu used outlets were put in place immediately and a review of the water system including temperature checks was conducted.

Upgrading of the water system is on going. The RVEEH water system is currently on the RVEEH risk register due to the age of the plumbing system.

5.2 Operating Theatre Environmental Monitoring

Quarterly bacterial counts are carried out in all operating theatres. Sporadically counts were above the accepted range. The Theatre Manager was advised to keep the number of people present during surgery to a minimum. Air conditioning remains

on at all times to maintain ambient temperature within range. See Appendix 9 for detail of bacterial counts.

5.3 Upgrading work

While the infrastructural challenges of an older building are accepted, the RVEEH as an acute hospital, providing surgical and other services strives to continue to improve the infrastructure and environment. The following areas were upgraded or refurbished in 2015.

- Ward 29 West Wing: Walls ceiling skirtings repainted.
- Bathroom for West Wing: New floor covering and undersink unit installed.
- Day Care Unit: Kitchen refurbished with new stainless steel units.
- Painting in Unit B Day Ward
- Corridor on second floor changing rooms/office area painted.
- Painting touch up in other areas as requested.
- Examination chairs in many departments were refurbished and/or reupholstered.

6.0 Policies, Procedures and Guidelines updated in 2015

The following policies were reviewed, updated and/or created in 2015

• IC Annual Report signed off 2014 • IC work plan signed off for 2014 • IC Work Plan and Programme 2015 1. Policy for the management of Sepsis 2. Policy for Legionella Management 3. Policy for Management of Multi Drug Resistant Organisms excluding MRSA 4. Policy for emergency management of Injuries 5. Policy for the Management of patients at risk of viral haemmorhagic fever 6. Policy for prevention and control of Multi drug resistant organisms 7. Policy for management of MRSA 8. Policy for patients with Clostridium Difficile 9. Policy for Enteral tube feeding 10. Policy for environmental monitoring in Theatres 11. Policy for the management the TSE. 12. Policy for Surgical Wound Site Infections. 13. Policy for Use of Multi Dose Vials. 14. Policy for Waste Management. 15. Policy for the Management of Aspergillosis. SK approved of all the above Infection Control policies on Q-Pulse. Signed hard copies are no longer required	Refer to Q pulse for approval date

7.0 Major Risks Identified by IPCT

7.1 Ventilation in OT

The ventilation system in the operating theatres does not meet internationally recognised standards for operating theatres. This increases the risk of post-operative infection. The situation has been highlighted to the HSE, the Hospital Management Group (HMG), the Medical Board and the Council in the past. The IPCT recommends that Operating Theatres design should comply with HBN 26 (Facilities for surgical procedures) and HTM 03-01 (specialised ventilation for healthcare premises). The design should have appropriate ventilation with a minimum of 25 air changes per hour. The instrument set-up area should be dedicated for use, have 35 air changes per hour. There should be appropriate pressure differentials between adjacent rooms in the theatre department to minimise airborne contamination of clean areas. This risk is currently on the hospitals risk register. The IPCT carry out air sampling in all operating theatres and the Central Decontamination Unit every 3 months. See Appendix 9.

An application has been submitted for planning approval to build a new cataract theatre on the ground floor to international standards. Plans are also being considered to retro-fit the existing 5 operating theatres with conventional ventilation and pressure differentials.

7.2 Isolation Room

The RVEEH does not have a single room with en-suite facilities for standard isolation purposes or with a positive pressure ventilated lobby for airborne isolation. A suitable location has yet to be agreed on. The matter has been brought to the attention of HMG. The IPCT reiterates the importance of proper isolation facilities in preventing the spread of infection in the hospital environment. Currently a bathroom is dedicated for the patient when isolation is required.

7.3 Hand Hygiene Facilities

A lot of existing sinks do not conform to the current recommended design standard for sinks in healthcare settings. Funding has been requested from the HSE to upgrade the hospitals hand hygiene sinks. The project to upgrade all hand hygiene sinks to comply with HBN 00-10 Part C standard is on going. The IPCT recommends the use of alcohol hand gel in areas where there are inadequate or insufficient hand washing sinks.

7.4 Risk of Legionnaires

There is an old and complicated water system in RVEEH which challenges standard Legionella controls. Factors contributing to this include:

1. Structural deficiencies in the hospital's overall plumbing system.
2. Very long lead in pipe works to some outlets without returns.
3. Uninsulated pipes; hot and cold running side by side.
4. A number of infrequently used outlets. These are all flushed weekly

Appendix 1

Infection Prevention & Control (IPC) Plan for 2015
Royal Victoria Eye & Ear Hospital

Target	Action	Action by	Date Complete
To provide infection prevention and control education for staff and students in the Hospital Education forms a very important part of the Infection Control Program.	**The Infection Control Nurse provides training and education to all staff, patients and relatives. Training is preceded by a needs assessment. The training programme includes the following:** **1**. Provide **Hand Hygiene** education including demonstrations and lectures for all clinical staff annually. Hand Hygiene education is appropriate for grade of staff. Education is evaluated through questionnaire and observational audit. Hand Hygiene awareness days are held three times a year as part of the Hand Hygiene Education Program. This includes demonstration and analysis of technique using ultraviolet light box. Prompts are provided in the form of posters and leaflets in all departments. **2**. Provide general infection control education including lectures on waste disposal, isolation procedures and standard precautions and correct use of personal protective equipment. **3**. Ensure all staff aware of procedure for accessing infection control information on hospital intranet. **4**. Provide advice and updates on matters relating to IPC to all relevant clinical staff give advice and support regarding IPC policy and related issues. **5** Provide infection control education as part of the one day medical induction. 6 Provide data and information for some aspects of the "Bugs & Drugs" newsletter. **7** Bi-annual "Infection Surveillance newsletter"	SK/SF/MMcC SF/MMcC SF/MMcC SF/MMcC SK/SF/MMcC SF/MMcC SF/MMcC	See sign in and attendance sheet See monthly audit reports See sign in and attendance sheet See sign in and attendance sheet
Develop and review infection control policies, procedures and guidelines in accordance with legislation and evidence-based practice.	• Aspergillus Policy • Inntravascular Catheter Management Policy • Legionella Policy • Norovirus Outbreak Policy • Emergency Management of Injuries Policy • CJD Policy	SF/MMcC SF/MMcC SF/MMcC SF/MMcC SF/MMcC	Refer to q pulse re time approved

Policies for updating in 2015	• Tuberculosis Management Policy • MDRO Policy • Policy on development of IC policies • Care of surgical wound policy	SF/MMcC SF/MMcC SF/MMcC SF/MMcC	Refer to q pulse re time approved
Infection Control Audits of practice and facilities	• Bi annual IPCT audits. • Monthly IV care bundle audit. • HST audits of facilities (See audit schedule for 2015) Compile summary of outstanding issues. Report to IRQS on outstanding issues. Distribute results and feedback of the audits to all relevant CNMs and Heads of Departments. • Observational hand hygiene audits and send results to HSE, re-audit where necessary. Disseminate hand hygiene audits to relevant clinical staff and heads of Departments.	SF/MMcC SF/MMcC SF/MMcC SF/MMcC	March and September 2015 Monthly Monthly
Monitor and report rates of infection, healthcare associated infections, notifiable diseases antimicrobial resistance, antimicrobial consumption and alcohol gel usage.	1. Daily ward based and laboratory surveillance 2. Collect, analyse and report post-operative endothalmitis infection rates. 3. Collect, analyse and report data on infections and antibiotic resistant organisms 4. Collect and report data on statutory notifiable diseases 5. Collect and report data to the European Antimicrobial Resistance Surveillance Network (EARS-Net) 6. Collect and report data on alcohol gel use. 7. Collect and report data on antibiotic consumption. 8. Distribute quarterly surveillance reports to Infection Control Committee 9. Distribute quarterly or as required surveillance reports to all relevant clinical staff.	SF/MMcC SF/MMcC SF/MMcC SK SK SK SF/MMcC SK/JAOC EG/McC/SF SF/MMcC SF/MMcC	Daily As necessarily On-going As necessarily As necessarily Quarterly Quarterly Quarterly As necessarily
Investigate and lead on outbreak management	Monitor and control outbreaks in a timely manner. Provide information to staff and patients as required	SF/MMcC SF/MMcC	As necessarily
Identify infection risks and advise on appropriate action to prevent or minimize these risks	Liaise with patients, GPs and medical teams regarding patients colonized and infected with transmissible diseases or organisms. Analyse Infection Control related incidents and follow up to prevent these risks occurring in the future.	SF/MMcC SF/MMcC	On-going As required

Provide advice and support regarding infection prevention and control policy and related issues	• Patient isolation • Antimicrobial utilisation and antimicrobial resistance • Decontamination • Facilities and engineering, including new facilities, renovation, ventilation and water • Catering services • Household service • Laundry service • Waste management	SF/MMcC	In going and as required.
Attend regular meetings and educational seminars relevant to infection prevention and control	• Infection Control Committee • Infection Control Team meetings • Hygiene Committee • IRQS Committee • Antimicrobial stewardship committee • IPS Conference • HPSC Study Day • Other relevant conferences	SF/MMcC	See minutes of these committees
Produce an annual work plan and annual report	IPC Work Plan 2016 IPC annual report 2015	MMcc/SF MMcC/SF	

SF = Sinead Fitzgerald, Infection Control Nurse; MMcC = Margie McCarthy, Infection Control Nurse, SK = Susan Knowles, Consultant Microbiologist,

Signed_____ **Date**_____

Appendix 2 - Membership of Infection Control Committee

Committee Members		**No of Meetings Attended in 2015** (4 Meetings Held)
Chief Executive Officer	Danny Dunne (Chair)	3
Consultant Microbiologist	Dr Susan Knowles	4
Nursing Admin - Elspeth Finlay - Mary Casey		2 3
Infection Control Manager	Sinead Fitzgerald	4
Infection Control Manager	Margie McCarthy	4
Risk Manager	Deirdre Kelly	3
Theatre Manager	Mary O Doherty	4
Chief Pharmacist Clinical Pharmacist	Jane Anne O' Connor Ellen Gill	1 1
CDU Manager	Carol Gaskin	3
Catering Supervisor	Ann Gillick	1
ENT NCHD	Dr Lulianna Moariu	1

Appendix 3

Terms of Reference - Infection Control Committee

Creation Date: March 2015 **Chairperson:** Mr Danny Dunne CEO

Committee Members:

CEO (Chair)	Consultant Microbiologist	CNS Infection Control
Nursing Administration	Theatre Manager	CDU Manager
Pharmacist	Quality Officer	IC Link Nurse
Catering Manager	Risk Health and Safety Department	

Committee Reports To: Integrated Risk Quality & Safety Committee
Frequency of Meetings: Four times per year

Schedule of Meetings: Quarterly

Quorum for Meeting: 50% of membership plus one.

Distribution of Agenda and Minutes:

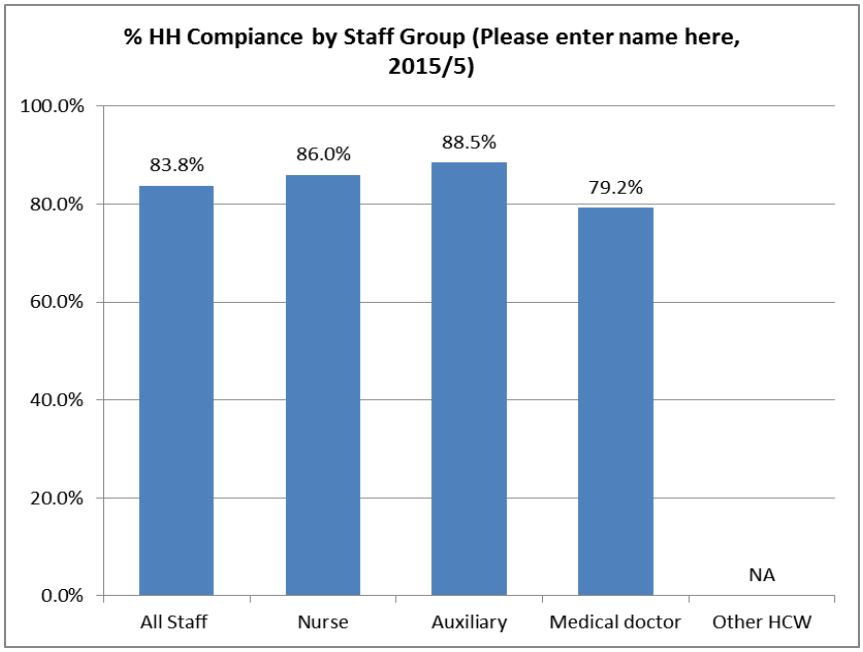
- The agenda and any relevant supporting documents will be circulated in advance of the meeting.
- Minutes shall be taken of the proceedings & action and will be presented at the next meeting of the Committee for approval.
- A summary report will be prepared for submission to the Integrated Risk, Quality & Safety Committee

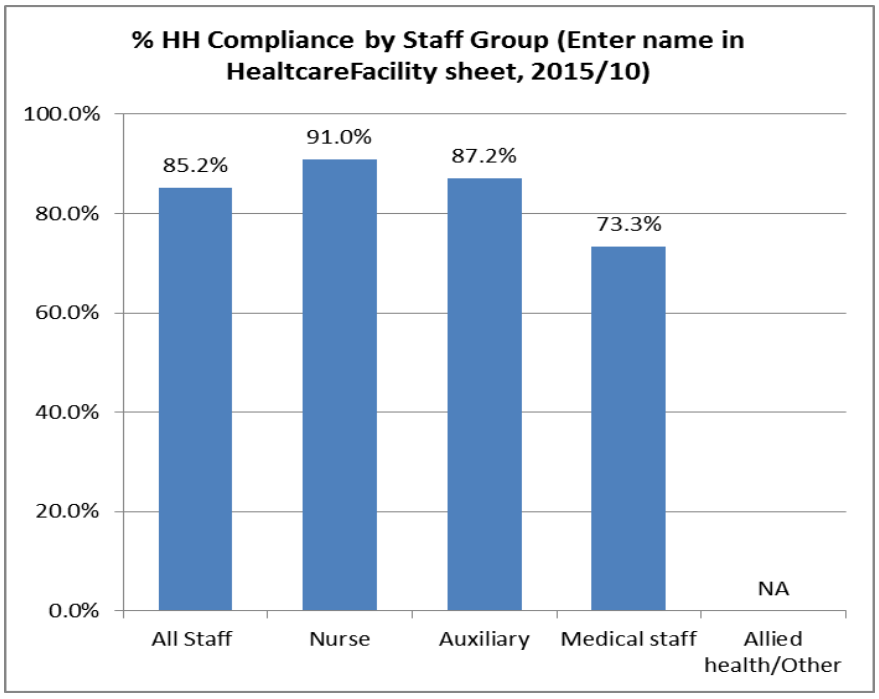
Role & Objectives of the Committee:

- Review and approve the annual infection prevention and control programme
- Advise and support the Infection Prevention and Control Team (IPCT) in the implementation of the programme
- Advise on resource requirements for the Infection Prevention & Control Programme
- To produce an annual report on Infection Prevention & Control
- To produce and review Infection Prevention & Control policies and guidelines regularly
- To audit the implementation of Infection Control Policies and Guidelines
- To promote and facilitate the education of all grades of hospital staff in Infection Prevention and Control
- To participate in national healthcare associated infection surveillance schemes, in addition to locally agreed surveillance programs including alert organism surveillance
- To provide advice and support during outbreaks and review outcomes
- To review and approve all infection prevention and control aspects of decontamination policies
- To provide relevant reports to Quality, Risk, Health & Safety
- To comply with legislative requirements i.e. Safety, health, Welfare at work Act 2005.
- To support and monitor the implementation of national standards policies and guidelines.

Appendix 4

Hand Hygiene Audits May (2015/5) and October (2015/10)





Appendix 5

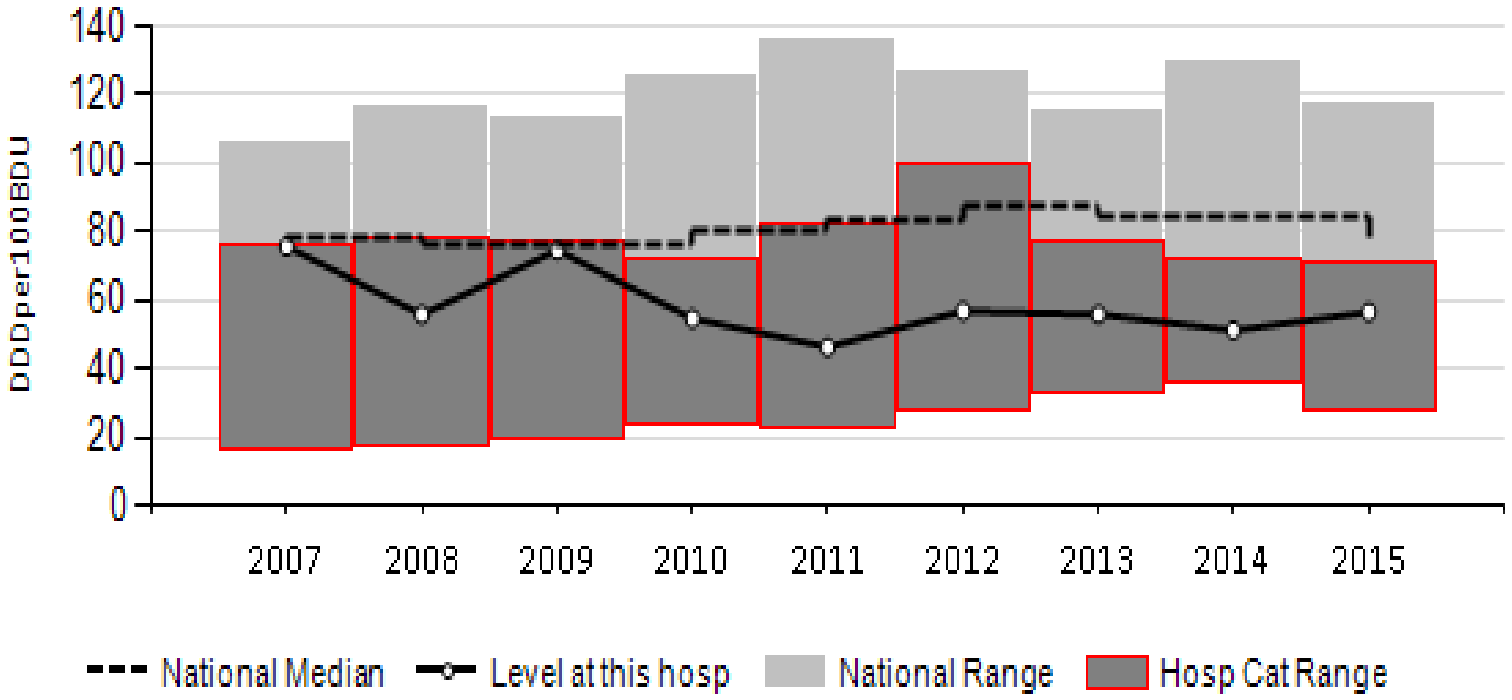
Alcohol Hand Rub Consumption Data by Acute Public Hospital, 2015 (Q2 & Q2)

	Your Rate	National Overall	National Low	National High	National Median	Your volume (L)	Your BDU
2008	16.5	20.4	8.5	32.4	18.1	147.4	8950
2009	22.9	24.9	9.5	35.2	20.3	163.1	7135
2010	35.6	21.5	6.2	34.8	18.8	230.0	6466
2011	33.4	30.4	12.9	43.4	21.3	217.9	6518
2012	32.8	32.5	13.4	138.1	23.8	192.7	5869
2013	48.1	32.0	17.3	72.9	26.3	255.8	5320
2014	49.2	29.8	14.9	55.5	27.7	268.6	5454
2015	66.5	28.9	10.7	67.7	27.6	174.7	2628

¥ Data for 2015 Q2 are provisional; [a] denominator is presented only when a numerator was provided

Appendix 6

RVEEH Antibiotic usage 2007 - Q2 2015



2015 (Q1 & Q2)

Appendix 7 Antibiotic group usage 2015 (Q1 & Q2)

Measure	Year	Level	% Change	Nat Median	Decile
DrugType:Antibiotic	2015	56.51	10%	78.36	2
AlertAgents:A_AntiGPosAgents	2015	1.90	101%	2.31	4
AlertAgents:B_Gen2Cephs	2015	0.58	-46%	2.21	2
AlertAgents:C_Gen3Cephs	2015	1.44	-43%	1.38	6
AlertAgents:D_fQs	2015	13.27	30%	5.74	10
AlertAgents:E_BroadSpecPens	2015	14.32	-3%	26.82	2
AlertAgents:F_Carbapens	2015	0.00	-100%	1.77	1
AlertAgents:G_Clinda	2015	0.57	-46%	1.24	2
A_Alerts:4_P_Van	2015	1.03	65%	1.78	3
E_Alerts:1_O_CoAmox	2015	4.02	-34%	13.35	1
E_Alerts:2_P_CoAmox	2015	9.45	22%	5.92	9
E_Alerts:3_P_Tazo	2015	1.69	87%	7.28	2
IVProp:SwitchIV	2015	11.47	20%	6.41	10
IVProp:AllIV	2015	51.44	-7%	51.44	5
DrugType:Antifungal	2015	1.50	50%	1.31	7
DrugType:Antibiotic_Cost	2015	2.88	-41%	4.14	3

Appendix 8 Infection Control Audit Summary March 2015

Audit Summary Table	March 2015							
	DCU	In-patient	HLW	ENT OPD	A&E	EYE OPD	Pacu	OT
Waste Handling and Disposal Audit								
Linen Audit	67%	91%	90%	n/a	n/a	n/a	83%	90%
Handling and Disposal of Sharps Audit	100%	100%	96%	100%	96%	96%	92%	100%
Hand Hygiene facilities & Audit	97%	91%	97%	97%	82%	84%	88%	92%
Use of Personal Protective Equipment Audit	100%	100%	100%	100%	100%	100%	97%	100%
Management of Patient Equipment Audit	98%	96%	91%	100%	96%	100%	97%	100%
Care of Peripheral Intravenous Lines Audit	n/a	see care bundles	see care bundles	n/a	n/a	n/a	100%	100%

Audit Summary Table	September 15								
	DCU	**West Wing**	**HLW**	**ENT OPD**	**A&E**	**EYE OPD**	**PACU**	**CU**	**OT**
Waste Handling and Disposal Audit	92.0%	91.0%	96.0%	91.0%	83.0%	86.0%	96.0%	95.0%	96.0%
Linen Audit	92%	92%	100%	N/A	N/A	N/A	83%	83%	92%
Handling and Disposal of Sharps Audit	92%	100%	100%	100%	100%	100%	100%	100%	91%
Use of Personal Protective Equipment Audit	100%	93%	100%	100%	100%	100%	100%	100%	100%
Management of Patient Equipment Audit	100%	97%	100%	100%	100%	100%	96%	100%	91%
Care of Peripheral Intravenous Lines Audit		83%	Care bundles	N/A	N/A	N/A	100%		100%

QIP & Action plan availavle on Infection Control shared drive on the hospital intranet.

Appendix 9

Operating Theatre & CDU Bacterial Counts 2015

Settle Plates March 2015

Acceptable levels 0-20cfu				
	Trolley	Ledge	Attendees	Air con on
ENT OT 1	8	10	4	yes
ENT OT 2	30	39	6	yes
EYE OT 1	27	23	4	yes
EYE OT 2	15	13		yes
EYE OT 3	47	36	6	yes

Acceptable levels 0-20cfu	**June 2015**			
	Trolley	Ledge	Attendees	Air con on
ENT OT 1	19	16	2	yes
ENT OT 2	15	19	2	yes
EYE OT 1	17	11	3	yes
EYE OT 2	6	6	2	yes
EYE OT 3	3	12	0	yes

Acceptable levels 0-20cfu		**Sept 2015**		
	Trolley	Ledge	Attendees	Air con on
ENT OT 1	15	20	6	yes
ENT **OT** 2	19	31	**7**	yes
EYE OT 1	5	12	4	yes
EYE OT 2	6	7	2	yes
EYE OT 3	4	7	5	yes

Acceptable levels 0-20cfu			**Dec 2015**	
	Trolley	Ledge	Attendees	Air con on
ENT OT 1	2	14	3	yes
ENT OT 2	15	22	2	yes
EYE OT 1	20	5	2	yes
EYE OT 2	3	5	2	yes
EYE OT 3	15	non conformity	3	yes