



## St George's Healthcare NHS Trust

### **Protocol for Reporting Healthcare Associated Infections (HCAI) to the Health Protection Agency.**

<b>Policy Number:</b>	<b>Clin.2.0 Appendix D</b>
<b>Version:</b>	<b>V2.0</b>
<b>Authorisation Committee:</b>	<b>Policy Approval Group</b>
<b>Date of Authorisation:</b>	<b>22/07/2010</b>
<b>Name and Job Title of Author:</b>	<b>Selma Mehdi, Infection Control Nurse</b>
<b>Name of Accountable Committee or Individual:</b>	<b>Infection Control Committee</b>
<b>Executive Director Sponsor</b>	<b>Alison Robertson, Director of Infection Prevention and Control</b>
<b>Key individuals and or committees consulted during drafting:</b>	<b>Infection Control Committee</b>
<b>Date issued:</b>	<b>18/08/2010</b>
<b>Review date:</b>	<b>06/2013</b>
<b>Target audience:</b>	<b>All Trust Staff</b>
<b>Number of pages:</b>	<b>7</b>

<b>Document History</b>			
<b>Version</b>	<b>Date</b>	<b>Review date</b>	<b>Comments</b>
V.1.0	2007	2009	
V.2.0	April 2010	April 2013	

## Contents

Paragraph		Page
	Executive Summary	3
1	Introduction	4
2	Definitions	4
3	Roles and Responsibilities	4
4.1	Reporting MRSA Bacteraemias	4
4.2	Reporting <i>Clostridium difficile</i> Associated Infection	5
4.3	Reporting Glycopeptide Resistant Enterococci Bacteraemia	5
4.4	Reporting Surgical Site Infections (SSI)	6
4.5	Reporting an SUI following HCAI	6
5	References	6

## Related Policies

[Serious Untoward Incident Policy](#)

## **Executive Summary**

Accurate reporting of HCAIs (Healthcare Associated Infections) is important for the individual Trust and for the NHS as a whole. It allows Trusts to identify local trends in HCAI as well as the NHS to monitor the performance of the Trust in comparison to other similar Trusts.

This protocol describes the mechanism for reporting HCAI data to the Health Protection Agency (HPA) and the mechanism of reporting SUIs related to HCAI. It will ensure that accurate HCAI data and SUIs resulting from HCAI are reported in a timely manner

The protocol applies to members of the Infection Control Team (ICT) in particular the Infection Control Doctor (ICD) and their nominated deputy, the Director of Infection Prevention and Control (DIPC) and the Chief Executive.

This protocol is an appendix to the Infection Control Policy. Refer to the Infection Control Policy for information on the criteria, responsibilities and systems required to prevent and control Healthcare Associated Infections (HCAIs).

## **1. Introduction**

St George's Healthcare Trust participates in a number of mandatory and voluntary surveillance of infection programmes run by the HPA. This protocol describes the mechanism for reporting HCAI data to the Health Protection Agency (HPA) and the mechanism of reporting SUIs related to HCAI. Adherence to this protocol will ensure that accurate HCAI data is available and SUIs resulting from HCAI are reported in a timely manner

Accurate HCAI data allows Trusts to identify local trends in HCAI and enables the NHS to monitor the performance of the Trust in comparison to other similar Trusts.

## **2. Definitions**

Healthcare associated infections: are infections that are acquired in hospital or as a result of healthcare interventions.

Health Protection Agency (HPA): The Health Protection Agency's role is to provide an integrated approach to protecting UK public health through the provision of support and advice to the NHS, local authorities, emergency services, other Arms Length Bodies, the Department of Health and the Devolved Administrations. The Agency was established as a special health authority (SpHA) in 2003.

MRSA bacteraemia: bloodstream infection caused by meticillin-resistant *Staphylococcus aureus* – an important cause of HCAI.

*Clostridium difficile* Infection (CDI): diarrhoea or colitis caused by infection with the bacterium *Clostridium difficile* and detected by a positive test for *Clostridium difficile* toxin.

GRE bacteraemia: bloodstream infection caused by enterococci resistant to glycopeptide antibiotics such as vancomycin and teicoplanin – a relatively rare HCAI.

Surgical Site Infection (SSI): an infection that occurs when micro-organisms get into the part of the body that has been operated on and multiply in the tissues.

Infection Control Doctor (ICD): a consultant clinician with responsibility for controlling HCAI (since January 2010 – Dr Richard Holliman)

## **3 Roles and Responsibilities**

The ICD is responsible for managing the entry of data on the HCAI data capture system and return of paper results to the HPA

The Chief Executive is responsible for signing off data on the HCAI data capture system on the 15<sup>th</sup> day of the following month

### **4.1 Reporting MRSA Bacteraemias**

The Mandatory MRSA Bacteraemia Surveillance Scheme is managed by the HPA on behalf of the Department of Health.

Episodes of MRSA bacteraemia are reported via the HPA web based surveillance system by the ICD or deputy within 72 hours of identification in the Department of Medical Microbiology. If within 14 days of the first culture the same patient has another positive blood culture it is counted as part of the initial episode and should not be reported. Duplicate reports more than 14 days apart are treated as separate episodes and must be reported.

Accuracy of data is checked by the ICD or deputy during the first week of the following month. Once validated the ICD informs the CE that the data are ready to sign off. The sign off must be completed by the 15<sup>th</sup> of that month.

Two weeks after the end of each quarter, the HPA will send a request by email to the ICD for the following data; total number of *Staphylococcus aureus* bacteraemias, total number of MRSA bacteraemias, total number of blood cultures taken and total number of positive blood cultures. The data are usually required to be returned with 4 weeks of the request and is completed by the ICD or deputy.

#### **4.2 Reporting *Clostridium difficile* Infection (CDI)**

The Mandatory Surveillance of CDI is managed by the HPA on behalf of the Department of Health.

Episodes of CDI are reported via the HPA web based surveillance system by the ICD or deputy within 72 hours of identification in the Department of Medical Microbiology. This includes all patients aged 2 or older with positive samples tested in the St George's laboratory irrespective of the origin of the patient.

Positive results on the same patient within 28 days of the first specimen should be regarded as a single episode. If a patient has a positive result more than 4 weeks after a previous positive, it is recorded as a new episode.

Accuracy of data is checked by the ICD or deputy during the first week of the following month. Once validated the ICD informs the CE that the data are ready to sign off. The sign off must be completed by the 15<sup>th</sup> of that month.

Two weeks after the end of each quarter, the HPA will send a request by email to the ICD for the following data; total number of episodes of CDAD, total number in patients aged 65 and older, total number in patients aged less than 65, total number acquired in the community and total number acquired in the hospital. The data are usually required to be returned with 4 weeks of the request and is completed by the ICD or deputy.

#### **4.3 Reporting Glycopeptide-resistant enterococci (GRE) bacteraemias**

Two weeks after the end of each quarter, the HPA will send a request by email to the ICD for the following data; total number of episodes of bacteraemia caused by GRE. The data are usually required to be returned with 4 weeks of the request and is completed by the ICD or deputy

#### **4.4 Reporting Surgical Site Infections (SSI)**

St George's participates in the Mandatory Surveillance of Surgical Site Infection in Orthopaedics and undertakes voluntary surveillance in other categories run by the HPA's Surgical Site Infection Surveillance Service.

The ICD will decide which SSI surveillance module is to be completed for the year in question. All NHS Trusts where orthopaedic surgery is performed are required to carry out a minimum of three months surveillance per year in at least one of the four orthopaedic categories:

Data are collected by the Audit and SSI Surveillance Nurse and entered directly via a web based data collection system. At 30 days after the end of the quarter summary data listing the number of patients studied and the number of infections recorded, are submitted to the HPA. Infection rates are calculated by the HPA and returned to the Trust.

#### **4.5 Reporting an SUI following HCAI**

A Serious Untoward Incident (SUI) will be declared following discussion between the Infection Control Doctor and the Medical Director and/or Director of Nursing and Patient Safety and Infection Prevention and Control. Once the SUI has been agreed and declared the Infection Control Doctor or Deputy will inform Risk Management for the SUI to be reported to NHS London in accordance with the [Trust's Serious Untoward Incident \(SUI\) Policy](#).

NHS London's Serious Untoward Incident Reporting Policy provides guidance on which HCAIs should be declared and reported as Serious Untoward Incidents. The guidance includes the following:-

HCAI which result in death and significant outbreaks of HCAI:

Death in which MRSA Bacteraemia or C difficile are recorded on part one of the death certificate (parts 1a, 1b or 1c)

Two or more cases of C difficile in the same ward within the same week and/or third case within the same ward and month.

Infection control outbreaks: The significance and impact of infection control outbreaks should be considered before reporting as an SUI. For example, an outbreak of Norovirus during the winter months need not be an SUI unless it has a significant impact on the ability of the trust to maintain its core services.

All HCAI SUIs should have a root cause analysis completed with the NPSA HCAI RCA template used.

The local HPU should be informed of all outbreaks whether or not the outbreak is a declared SUI.

## 5. References

Department of Health. (2008) *Changes to the mandatory healthcare associated infection surveillance system for Clostridium difficile infection (CDI) from 1 January 2008*, Professional letter from the chief Medical Officer and the Chief Nursing Officer. London: DH. Available from:

[www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Professionalletters/Chiefmedicalofficerletters/DH\\_082107](http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Professionalletters/Chiefmedicalofficerletters/DH_082107). (Accessed 16th April 2010)

Department of Health. (2007) PL CMO 4: *Changes to the mandatory healthcare associated infection surveillance system for Clostridium difficile associated diarrhoea from April 2007*, Professional letter from the chief Medical Officer and the Chief Nursing Officer. London: DH. Available from

[http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Professionalletters/Chiefmedicalofficerletters/DH\\_073767](http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Professionalletters/Chiefmedicalofficerletters/DH_073767). (Accessed 16th April 2010)

Department of Health (2005) *Mandatory Surveillance of Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemias*, Professional letter from the chief Medical Officer and the Chief Nursing Officer. London: DH.

Available from: <http://www.dh.gov.uk/assetRoot/04/11/25/90/04112590.pdf>. (Accessed 16th April 2010)

Department of Health (2003). *Surveillance of healthcare associated infection*, Professional letter from the chief Medical Officer and the Chief Nursing Officer. London: DH.

Available from: <http://www.dh.gov.uk/assetRoot/04/01/34/10/04013410.pdf>. (Accessed 16th April 2010)

Health Protection Agency. *Web Directory on Surgical Site Infection Surveillance Services (SSI/SS)*. HPA. Available from:

[http://www.hpa.org.uk/infections/topics\\_az/surgical\\_site\\_infection/default.htm](http://www.hpa.org.uk/infections/topics_az/surgical_site_infection/default.htm). (Accessed 16th April 2010)

NHS London (2009) *Serious Untoward Incident Reporting Policy Including the procedure to be followed for Safeguarding Children*.

Available from:

<http://www.london.nhs.uk/webfiles/Corporate/Serious%20Untoward%20Incident%20POLICY%2028%207%2009.pdf>. (Accessed 5<sup>th</sup> August 2010)