Patient Safety Incident Response Plan for Infection Prevention and Control Related Incidents

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DOCUMENT CONTROL INFORMATION

Consultation Tracking	Date	Feedback received
IPC Team	22/01/2025	Minor grammar and spelling changes. Input into review of priorities.
Head of Governance	22/01/2025	No comments received.
Patient Safety Specialist	22/01/2025	No comments received.
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VERSION TRACKING

Version	Date	Author Name and Designation	Summary of Main Changes
1	November 2023	Victoria Clewer Lead IPCN	Creation of Patient Safety Incident Response (PSIRP) Plan for Infection Prevention and Control (IPC) Related Incidents.
2	January 2025	Victoria Clewer Lead IPCN	Review and update.

CONTENTS

Aims

The aim of this plan is to define the process to be followed for the management and investigation of infection prevention and control (IPC) related incidents.

Documents this plan relates to

The Royal Orthopaedic Hospital NHS Foundation Trust (ROH) Patient Safety Incident Response Policy and Plan.

NHS England: Midlands Infection Prevention and Control Patient Safety Incident Response Framework Matrix. Version 1 (2024).

General principles

Healthcare-associated infections (HCAIs) can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting. The term HCAI covers a wide range of infections.

The most well-known include those caused by methicillin-resistant *Staphylococcus aureus* (MRSA), methicillin-sensitive *Staphylococcus aureus* (MSSA) and *Clostridioides difficile* (*C. difficile*). HCAIs cover any infection contracted:
- as a direct result of treatment in, or contact with, a health or social care setting;
- as a direct result of healthcare delivery in the community;
- as a result of an infection originally acquired outside a healthcare setting (for example, in the community) and brought into a healthcare setting by patients, staff or visitors and transmitted to others within that setting (for example, norovirus).

Other IPC incidents may include new acquisition of an 'alert organism' within a healthcare setting and subsequent colonisation which can sometimes precede development of an HCAI. This may relate to a single patient or involve multiple patients constituting an outbreak. An alert organism is an organism that is identified as being potentially significant for infection prevention and control practices. Examples of alert organisms include MRSA, *C. difficile* and Group A *Streptococcus*. Colonisation is defined as the presence of microorganisms on a body surface (such as the skin, mouth, intestines, or airway) that does not cause disease in the person or signs of infection.

The aim of this plan is to detail the Trust's response to IPC related patient safety incidents and the IPC patient safety incident priorities for the year. The Trust's IPC priorities are based on a review of IPC incidents and identification of common learning themes.

Identification of IPC related incidents – reporting mechanisms

The IPC team receives notification of all mandatorily reportable healthcare-associated infections and relevant alert organisms, via a number of daily reports produced by Pathology and Informatics.

If not already known, the Infection Prevention and Control Nurse (IPCN) will advise ward staff of the patient(s) infection/colonisation status and give relevant advice to ensure patient safety.

The IPCN will report the relevant incident on the Trust's incident reporting system as soon as practically possible; nominating the ward/department the patient was admitted to at the time of the notification as the incident handler. For Surgical Site Infections (SSI), this will be the ward/department the patient was admitted to for their primary surgery.

Responding to IPC patients safety incidents

The Trust will take a proportionate approach to its response to IPC patient safety incidents to ensure that the focus is on maximising improvement through Quality Improvement work.

Most IPC incidents will only require local review within the service, however selected incidents, where it is felt that the opportunity for learning and improvement is significant, will be assessed in line with Trust's Patient Safety Incident Response Policy and Plan.

Appendix 1 outlines the response to reported IPC incidents occurring within the Trust.

IPC patient safety priorities

Following review of all the Trust's IPC related incidents, the Trust's IPC improvement priorities have been identified and are detailed in Table 1 below. These will be reviewed on an annual basis through the IPC committee and will align with the IPC annual programme of work.

Table 1. The Trust's Infection Prevention and Control Safety Priorities for the 2025/26.

Surgical Site Infections
Focus: *Minimising incidence of Surgical Site Infections in patients undergoing Arthroplasty (total hip/knee replacements) and Spinal surgery.*   • Standardisation of surgical practice.   • Pre-optimisation of patients prior to surgery.   • Appropriate selection, prescribing and administration of surgical prophylaxis.   • Pre, intra and post operative care according to Evidenced-based Practice (EBP) to reduce incidence of SSI.   • Thorough and consistent surveillance of SSI.   Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (2022) – criterion 3, 4 & 5.
Rationale
Infections of the surgical site account for approximately 16% of all HCAI, are estimated to double the length of post-operative stay in hospital and significantly increase the cost of care. The Study on the Efficacy of Nosocomial Infection Control (SENIC) showed that well-organised surveillance and infection control programmes that included feedback of infection rates to surgeons were associated with significant reductions in surgical site infection.

The Trust participates in mandatory SSI surveillance of total hip and total knee replacements as well as voluntary surveillance of spinal surgeries. Data as reported to the UKHSA shows in general a relatively low incidence of SSI reported for the number of operations per category/ speciality each quarter, however, increases in SSIs are reported throughout the year. Exact reasons for this are unknown but this phenomenon is also reported by similar Trusts participating in the same SSI surveillance categories. From audit of the theatre environment and observation of practices and standards, there are inconsistencies and irregularities which if addressed may have a positive impact upon SSI rates.

Identified as an ongoing theme via:
- Incident reporting
- Audits – One Together Audits of the surgical environment and practices
- UKHSA Surgical Site Infection Surveillance mandatory surveillance categories data

Improvement Committee/Group

- Close monitoring through the SSI Prevention Group. Regular engagement with key stakeholders and progress meetings.
- Updates and SSI data shared at speciality MDT meetings.
- Reporting to the Infection Prevention and Control Committee.
- Update reports via the Director of Infection Prevention and Control (DIPC) to the Quality and Safety Committee and Board of Directors.

Cleanliness

Focus: *Improving the standard of cleaning of the physical healthcare environment and healthcare equipment.*

- Cleaning operatives are trained, competent and understand the implications ineffective cleaning has on patient safety.
- Clearly defined role and responsibilities for cleaning the healthcare environment and equipment.
- Well defined cleaning schedules, and methods for recording.
- Audit and timely feedback to address improvements.
- Cleaning methodology that is evidence based and considers the wider impact to staff/patient and environmental safety.

Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (2022) – criterion 2, 6 & 9.

Rationale

Cleanliness in healthcare environments is essential for infection control, patient safety, and the well-being of both patients and staff. A clean setting helps reduce the risk of healthcare-associated infections, minimises cross-contamination, and promotes faster recovery for patients. It also ensures compliance with health regulations, supports the health of healthcare workers, and boosts public trust in the facility. Overall, maintaining a clean

healthcare environment is critical for providing high-quality care and improving patient outcomes.

Repeated audit failures, particularly within the theatre department, has highlighted ongoing issues related to environment and equipment cleanliness, clinical staff understanding of roles and responsibilities and ongoing monitoring.

Identified as an ongoing theme via:
- Incident reporting
- Audits – Annual IPC audit, efficacy audits, Matron/IPC walk rounds etc.

Improvement Committee/Group

- TBALD
- Decontamination Group
- Reporting to the Infection Prevention and Control Committee.
- Update reports via the Director of Infection Prevention and Control (DIPC) to the Quality and Safety Committee and Board of Directors.

Supporting References

NHS England Patient Safety Incident Framework (2022) B1465-1.-PSIRF-v1-FINAL.pdf (england.nhs.uk)

https://www.nice.org.uk/guidance/qs61/resources/infection-prevention-and-control-pdf-2098782603205

Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance - GOV.UK (www.gov.uk)

Protocol for the Surveillance of Surgical Site Infection version 6 (publishing.service.gov.uk)

National IPC Manual

National Healthcare Cleaning Standards

Appendices

Appendix 1 - Chart outlining the response to reported IPC incidents occurring within the Trust.

The flowchart can be viewed online here: IPC PSIRP trust response flowchart.pdf

Appendix 2 – ROH IPCT Response Matrix

Key:

* (within 12 months if implant inserted and 30 days without) HOHA – Hospital Onset Healthcare Associated COHA – Community Onset Hospital Associated ALBs – Arm's length bodies (ICB, UKHSA, NHSE regional teams) DHO – Definite Hospital Onset PHO – Probable Hospital Onset UKHSA – UK Health Security Agency PSII – Patient safety incident investigation DCS – Data Capture System NOIDS – Notification of Infectious Disease System	SSISS – Surgical Site Infection Surveillance Service SSIPG – Surgical Site Infection Prevention Group DGM – Divisional Governance Meetings IPCC – Infection Prevention and Control Committee Q&SC – Quality and Safety Committee CQG – Clinical Quality Group IMT – Incident Management Team GP – General Practitioner MDT – Multidisciplinary Team Meeting

MRSA

Incident	Mandatory reporting	Incident reporting system	Patient communication	Regulatory duty of candour	Internal IPC review meeting	Response assessment	Internal governance
MRSA bacteraemia HOHA & COHA	UKHSA DCS	Yes	Result to be communicated to the patient by clinician	No	Yes	IPC review IPC safety priority or alternative response method	DGM IPCC Q&SC
MRSA bacteraemia On part 1 of the death certificate or severe harm	UKHSA DCS	Yes	N/A	Yes	Yes	PSII	DGM IPCC Q&SC
MRSA acquisition HOHA	N/A	Yes	Result to be communicated to the patient by clinician	No	Yes	IPC review IPC safety priority or alternative response method	DGM IPCC Q&SC

MSSA

Incident	Mandatory reporting	Incident reporting system	Patient communication	Regulatory duty of candour	Internal IPC review meeting	Response assessment	Internal governance
MSSA bacteraemia HOHA & COHA	UKHSA DCS	Yes	Result to be communicated to the patient by clinician	No	HOHA - Yes	IPC review IPC safety priority or alternative response method	DGM IPCC
MSSA bacteraemia on part 1 of the death certificate or severe harm	UKHSA DCS	Yes	N/A	Yes	Yes	PSII	DGM IPCC

Gram Negatives

Incident	Mandatory reporting	Incident reporting system	Patient communication	Regulatory duty of candour	Internal IPC review meeting	Response assessment	Internal governance
E.coli, *Pseudomonas* or *Klebsiella* bacteraemia HOHA & COHA	UKHSA DCS	Yes	Result to be communicated to the patient by clinician	No	HOHA - Yes	IPC review IPC safety priority or alternative response method	DGM IPCC Q&SC
E.coli, *Pseudomonas* or *Klebsiella* device related bacteraemia on part 1 of the death certificate or severe harm	UKHSA DCS	Yes	N/A	Yes	Yes	PSII	DGM IPCC Q&SC

C.difficile

Incident	Mandatory reporting	Incident reporting system	Patient communication	Regulatory duty of candour	Internal IPC review meeting	Response assessment	Internal governance
C.difficile HOHA & COHA	UKHSA DCS	Yes	Result to be communicated to the patient by clinician	No	HOHA - Yes	IPC review IPC safety priority or alternative response method	DGM IPCC Q&SC
C.difficile – on part 1 of the death certificate or severe harm	UKHSA DCS	Yes	N/A	Yes	Yes	PSII	DGM IPCC Q&SC
C.difficile PII (two or more cases on a ward in a 28-day rolling period) or Outbreak	N/A	Yes	Result to be communicated to affected patients by clinician. Patients advised of outbreak on declaration. Discussion/ disclosure to patients if admitting to an open/ongoing outbreak	No (unless death related to PII or outbreak)	Yes	IMT to include ALBs IPC safety priority or alternative response method	DGM IPCC Q&SC

Surgical Site Infections

Incident	Mandatory reporting	Incident reporting system	Patient communication	Regulatory duty of candour	Internal IPC review meeting	Response assessment	Internal governance
Total hip replacement – Superficial, deep or organ/space infections*	UKHSA SSISS	Yes	Result to be communicated to the patient by clinician	No - unless death or harm	No	Data collection/SSI Register Quarterly thematic review if outlier based on UKHSA SSI risk rate.	DGM SSIPG Speciality MDT IPCC Q&SC
Total knee replacement – Superficial, deep or organ/space infections*	UKHSA SSISS	Yes	Result to be communicated to the patient by clinician	No - unless death or harm	No	Data collection/SSI Register Quarterly thematic review if outlier based on UKHSA SSI risk rate.	DGM SSIPG Speciality MDT IPCC Q&SC

| Spinal surgery – Superficial, deep or organ/space infections* | UKHSA SSISS | Yes | Result to be communicated to the patient by clinician | No - unless death or harm | No | Data collection/SSI Register Quarterly thematic review if outlier based on UKHSA SSI risk rate. | DGM SSIPG Speciality MDT IPCC Q&SC |

Other alert organisms

Incident	Mandatory reporting	Incident reporting system	Patient communication	Regulatory duty of candour	Internal IPC review meeting	Response assessment	Internal governance
HOHA alert organism – on part 1 of the death certificate e.g.: COVID 19 (PHO & DHO), Influenza	Dependent upon organism	Yes	N/A	Yes	Yes	PSII	DGM IPCC Q&SC
Significant alert organism exposure incident e.g., iGAS, TB, measles, monkeypox exposure, Hep A	Dependent upon organism	Yes	Result to be communicated to the patient by clinician	No - unless death or harm	Yes	IPC review IPC safety priority or alternative response method	DGM IPCC Q&SC
Significant alert organism acquisition incident e.g. Hepatitis B & C, TB, Listeria, Legionella	Dependent upon organism	Yes	Result to be communicated to the patient by clinician	No - unless death or harm	Yes	IPC review IPC safety priority or alternative response method	Divisional governance meetings IPCC
Alert organism outbreak leading to ward closure e.g.: Influenza, Norovirus, COVID-19	Dependent upon organism	Yes	Patients advised of outbreak on declaration. Discussion/ disclosure to patients if admitting to an open/ongoing outbreak	No - unless death or harm	Yes	IMT to include ALBs IPC safety priority or alternative response method	Divisional governance meetings IPCC
Outbreak of any alert organism (2 or more cases) where no significant lapses in care or patient harm identified e.g.	Dependent upon organism	Yes	Patients advised of outbreak on declaration. Discussion/ disclosure to patients if admitting to an open/ongoing outbreak	No - unless death or harm	Yes	IPC review IPC safety priority or alternative response method	Divisional governance meetings IPCC

influenza, norovirus, COVID 19							
Outbreak of any alert organism (2 or more cases) where significant lapses in care or patient harm identified	Dependent upon organism	Yes	Patients advised of outbreak on declaration. Discussion/ disclosure to patients if admitting to an open/ongoing outbreak	Yes	Yes	IMT to include ALBs IPC review IPC safety priority or alternative response method	Divisional governance meetings IPCC

Appendix 3 – Patient Safety Incident Response Framework Policy - July 2024.pdf

Appendix 4 – PSIRF Prompt Form for Bacteraemias.docx

Appendix 5 – PSIRF Prompt Form for CDI.docx

Appendix 6 - NHS England (2024) Midlands: Infection Prevention and Control Patient Safety Incident Response Framework Matrix. Version 1.