Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Public Board of Directors	Agenda item:	8
Date of Meeting:	28 March 2018		

Title of Report:	Infection Prevention and Control NHSI report
Status:	For information
Board Sponsor:	Helen Blanchard, Director of Nursing and Midwifery/DIPC
Author:	Yvonne Pritchard, Senior Infection Prevention and Control Nurse
Appendices	Appendix 1: IPC report and feedback from visit to RUH Bath 19/01/18 Appendix 2: IPC CDI improvement plan March 2018

1. Executive Summary of the Report

NHS Improvement were invited to visit the Trust in January 2018 to review infection prevention and control performance in relation to *Clostridium difficile* infections. This was a follow up visit from their initial contact in February 2017. The aim of the visit was to review progress against the original improvement plan, test assurance and provide support with further improvements as required. Policies relating to the management of patients with diarrhoea and vomiting, MRSA and influenza were also reviewed during the visit.

Interviews with the Infection Prevention and Control Team, Medical Microbiologists, Cleaning Services and Estates were held and visits to clinical areas were also undertaken.

At the end of the visit feedback was provided verbally and this included identification of areas of good practice and some suggestions for improvement. The final report was received during March 2018 and an action plan to address the suggested improvements is already underway. This plan also includes any ongoing actions following the visit in February 2017.

2. Recommendations (Note, Approve, Discuss)

This report is for noting.

3. Legal / Regulatory Implications

Health and Social Care Act 2008 Regulation 12: Safe Care and Treatment
Health and Social Care Act 2008 Regulation 15: Premises and Equipment

4. Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)

Risk Register ID:

- 180 Inadequate isolation facilities
- 1148 Failure to achieve the annual C diff reduction target

5. Resources Implications (Financial / staffing)

Potential financial sanctions if the *Clostridium difficile* target is exceeded.

6.	Equality and Diversity
None identified	

7.	References to previous reports
NHS Improvement report and action plan from the February 2017 visit presented to Board of Directors 26 July 2017	

8.	Freedom of Information
Public	

NHS Improvement

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13/02/18

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Infection Prevention and Control visit to Royal United Hospital Bath NHS Trust.

19th January 2018.

Background

NHS Improvement was invited by the Director of Nursing and Midwifery/Director of Infection Prevention and Control (DIPC)and Lead Infection Prevention and Control Nurse to review the Infection Prevention and Control (IPC) performance and assurance at the Trust, with a particular focus on Clostridium difficile infections (CDI), as the Trust expressed concern about the CDI rates rising slightly. This was a follow up visit as the initial contact was made in June 2017. The Trust also provided the Influenza and Norovirus policies for review as increased pressure in the system had been noted recently due to these infections.

The Trust's CDI performance to the date of the visit was 27 cases, [1] of which 9 had been successfully appealed with no lapses of care identified. This gives a performance of 18 cases against the target of 22. In 2016/7 the outturn was 27 cases against the target of 22.

Prior to the visit several documents were provided by the Trust, these were reviewed and enabled a triangulation of the assurance and identified areas for further exploration. The Trust demonstrated a keen desire to learn and reduce the number of CDI cases and review their processes.

Purpose of the visit

The aim of the visit was to test the Trust's assurance and support the Trust to make improvement in patient safety and arrest the current upward trend in in CDI cases and the MRSA colonisations. The review included:

- Trust Board assurance, to include ward to board governance processes and structures
- Review of antibiotic stewardship in relation to CDI
- Review of PIRs, including learning from root causes
- Key performance indicators and audit data
- Learning from near misses
- Management and treatment of patients with influenza

[1] Letter amended 9/3/18 reflecting information received from the Trust reflecting the information publically reported.

The visit was coordinated by the Trust and meetings were arranged with a range of staff with key roles on this agenda. All participants were honest, open and showed clear commitment to this important agenda.

Board Assurance

There is an Infection Control Group and regular reporting to the Board via the Management Board. Key performance indicators were providing assurance that did not triangulate with the IPC teams audit data for example hand hygiene audits.

The Infection Prevention and Control action plan presented showed a large number of completed actions, which demonstrates the hard work and commitment to the Infection Prevention and Control agenda, however it was not easy to see the fresh challenges and the way forward to continue the work.

The DIPC reports to the Board via the Quality committee and presents an annual infection prevention and control report to the Board.

The visit was coordinated by the Trust and meetings were arranged with a range of staff with key roles on this agenda. All participants were honest, open and showed clear commitment to this important agenda

Infection and prevention control team

There was an experienced IPC nursing team, led by Yvonne Prichard. The team consists of a band 8a, a band 7 and 2.5 wte band 6 nurses, who are well supported by the Director of Nursing and Midwifery/DIPC, covering approximately 660 beds.

The IPC team were involved with the management of the outbreaks; however there were examples where patients with suspected infections were being admitted into bays as a result of decisions made by the site management team. These decisions were being made without discussions with the IPC team about the risks and have been highlighted recently with the increase in Influenza in the local system.

The IPC nursing team also ran an active link network holding two conferences per year.

During the discussion it was suggested that the IPC element of the website could be expanded to include a statement about compliance with the Hygiene code and who the IPC team and DIPC are.

Medical Microbiologists

The microbiologists were not in a position to offer proactive support to the clinical teams and were working in a reactive way to deal with current issues as they arose. The CDI policy states that there will be weekly ward rounds to review CDI patients. The previous report from NHS Improvement advised this had not been occurring due to vacancies within the team,, however at the time of this review this was beginning to be addressed as the new consultant staff had taken up their posts. Microbiology ward rounds were also in the process of becoming a more formalised process undertaken in more ward and department areas to provide additional support.

The team had recently commissioned a critical friend review by another Microbiologist from outside of the local area. Part of this review focussed on antimicrobial stewardship. It would be useful to include the recommendations into the action plan once received.

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The Consultant Microbiologists had also identified that an antibiotic trend analysis would be useful to identify any prescribing issues in relation to CDI. It is recommended that the date to commence this is brought forward.

The Microbiology team had input into the doctors induction and alongside the pharmacists had commenced a prescribing skills station and mandatory training for prescribers which was positively evaluated.. They also included the junior doctors in the antimicrobial stewardship group, which should be commended.

CDT policy and management

There is a CDT policy that is based upon the current guidance and best evidence. It was recommended that there could be some minor changes made to the stool sampling element in the policy to reflect the current good practice occurring in the wards and departments of testing all stool samples of type 5,6 and 7.

A slight adjustment to the CDT root cause analysis process was discussed to allow greater discussion and to support learning around CDT lapses of care, if identified. It was also recommended that the training compliance for the e learning for prescribers was added to the RCA form which could highlight good prescribing practice in addition to required learning.

During the meeting the treatment and management of patients who were PCR positive (a test that detects all C.difficile strains including non-toxigenic/non-pathogenic strains), but who were toxin negative, was discussed. Management of these patients may alert teams before deterioration in their condition occurs.

MRSA Policy and management

There is an MRSA policy that is based upon the current guidance and best evidence, Patients known to be MRSA positive were tagged on the patient administration system. This enables risk patients to be identified early in their admission and screening to be promptly undertaken. The topical treatment protocol was well embedded and staff were aware of the MRSA treatment paperwork and regime.

The policy was unclear when maternity patients requiring a caesarean section should be screened for MRSA. It was suggested that this and the section regarding rescreening of patients whose operations had been cancelled is revisited. The IPC team may also wish to consider a flow chart or protocol for surgery or insertion of invasive devices in MRSA positive patient to address the need for additional treatment or consultation.

Influenza policy

This year has seen higher numbers of Influenza cases across the country. It would be useful for the Influenza policy to include a clear statement about when to discharge patients into community care institutions from closed bays or when on treatment, ie at least 5 days from the onset of symptoms. It is suggested that the Public Health England policy updated 2017 would be a useful reference.

The policy did not include information on where or how to obtain mask fit testing, although this was available in practice. It would also be useful to include information about when a retest is required such as a change of face shape including the growth of beards. The IPC team advised this information is already available so it would be a quick win to include the existing guidance as an appendix to the policy.

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Whilst walking through the corridors a number of posters recommending the staff flu vaccination programme were noted. These contained pictures of actual staff which made the campaign personable and accessible to all. The Trust should be congratulated for this approach.

Cleaning and environment

There are good working relationships between the facilities management and the IPC team. There was 24/7 cleaning available and a project to increase the hours of cleaning in A&E was so successful it was potentially going to be extended to other areas. Joint audits undertaken with the Matrons, Ward Managers, IPC nursing team and the cleaning teams and in addition an external auditor from Cheltenham Hospital had undertaken a peer review of the cleaning processes. A visual inspection of the cleaning is also on the Matrons regular check list audit.

A gap analysis against the cleaning standards was planned. It was recommended that this is undertaken as a priority.

The Estates department were undertaking scheduled cleaning of radiators which was good, however it would be useful for this programme to be discussed at the IPPC meeting which would not only provide assurance to the committee but allow for higher risk areas cleans to be undertaken as a priority.

There did not appear to be a difference between the scheduled clean and the special clean. Both of these used Actichlor +. The hospital do not currently use any additional methods of cleaning such as steam, Ultraviolet light (UVC) or hydrogen peroxide vapour (HPV). It was suggested that this was revisited with the possibility of undertaking a trial for use after high risk patients such as C difficile toxin positive patients had been discharged. Recently there had been a successful trial of sporicidal wipes undertaken for the cleaning of commodes. The cleaning policy was not provided at the time of the visit but would need to be amended to include these changes.

A Trust deep cleaning programme is in the planning stages subject to a business case for a decant ward. If this is not successful however the IPC and facilities teams need to discuss how high risk areas could be deep cleaned.

Clinical Visit

A total of two clinical areas were identified and visited on the day of the review. These were ACE short stay/OPU and Waterhouse. Any areas requiring escalation were identified at the time of the visit. In both of the wards visited staff were welcoming. The wards appeared clean and un-cluttered at the time of the visit. There was good compliance with hand hygiene and staff were naked/bare below the elbows.

ACE short stay/OPU

All curtains were in date and there was a regular programme for routine changes of curtains. Staff were observed to be undertaking correct cleaning of medical devices and were appropriately wearing personal protective equipment during the visit. Patients identified on patient centre with an alert, who required barrier nursing had the appropriate orange signs on the doors of the single rooms and these doors remained closed unless a risk assessment was completed and discussion with the IPC team had taken place.

This ward had employed a band 1 healthcare worked with the responsibility to clean and

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restock items. This had been positively evaluated and was really successful. All items on the ward appeared clean and dust free and were labelled appropriately.

It was noted that there were only orange and black waste bags on the ward. The staff advised that tiger bags were available but not on the ward, this could be revisited as some items such as incontinence pads could be placed into these bags and could represent a potential saving for the trust.

There was a really good process for the board rounds which included a sticker comprising of five elements including infection control. This combined with the to dip or not to dip stickers allows the rationale for decision making to be clearly visible. Staff were keen to promote this and it was suggested that it is written up to present at conferences to showcase the work. Healthcare associated infections and commode cleanliness were included in the safety crosses at the ward entrance and along with a commode cleaning certificate was a great example of good practice.

Waterhouse ward

At the time of the visit the ward appeared clean and clutter free. This ward had disposable curtains which were clean and in date. The staff on this ward found these curtains easy to use and preferred this product.

There were posters displayed to encourage patients to discuss with staff their normal bowel habit. This was a really proactive way for staff to identify what was normal or abnormal for the patient and assist staff with their risk assessment process.

A member of staff walked through the ward carrying linen and waste without the appropriate personal protective equipment, but they were appropriately challenged in a proactive, pleasant manner representing a good example of good practice and an open culture.

This ward also had safety crosses displayed which included E coli in addition to MRSA and CDI. They were also very proud to have achieved 97% uptake in staff flu vaccination placing them in the top of the medical division this should be congratulated – well done.

Summary

Issues were identified on the visit which should, if resolved help to improve outcomes for patients at the Trust. These were fed back at the time of the visit. The Trust had already identified some areas for improvement, however these suggested areas for improvement may assist the Trust to review this process.

Areas of good practice

- Good clear flow charts in IPC policy
- Matrons have IPC element in check list
- To dip or not to Dip trial on OPU evaluate and this should be written up for poster submission
- Stickers for to dip or not to dip in use
- Board round stickers include AMR, MRSA and CDI
- Whole audit days have IPC included
- Divisions report to IPPC

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- E learning package for all prescribers – Why not present this at a conference as good practice?
- Good CQUINN results
- AMR steering group works across the system
- AMR steering group has FY1 and 2
- Microbiology ward round being phased back in
- Prescribing station/stalls for Drs at induction
- Gap analysis against cleaning standard
- Peer review audit from Cheltenham Hospital Bath to reciprocate
- Estates schedule for radiators cleaning
- Additional cleaner for A&E eves and W/E

Suggestions for improvement

- Review action plan to reflect the hard work and continuing actions
- Think about UVC trial
- Consider follow up or treatment of GDH positive patients
- Estates to report back to IPPC with results of maintenance programme
- Bring forward antibiotic trend analysis
- E learning for prescribers training – add to RCA documentation to check if trained
- Consider the use of Tiger bags (offensive hygienic waste) on OPU as this could possibly save money
- Comment on website re who is DIPC
- Comment on website re hygiene code compliance
- No real difference between scheduled clean and special clean no steam UVC or HPV
- Looking at cleaner to support AMU
- Business case for decant ward to undertake deep clean programme as not in operation at present
- Amend policies to reflect current good practice
- Revisit MRSA policy for surgery , c section and invasive devices elements
- Revise cleaning policy to reflect changes
- Add statement about discharge to flu policy
- Revise flu policy re fit testing
- Clarify the period required before reopening in the diarrhoea and vomiting policy (48 hrs or 72 hrs)

Please thank all the staff I met on the visit for their time and commitment to the visit and the improvement plan. I hope that this report is helpful.

If there is any aspect of this report you wish to clarify please don't hesitate to contact me.

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Infection Prevention and Control Improvement Plan

Recommendation No:	1
Recommendation:	Review of antimicrobial stewardship with external expertise
Lead:	Sarah Wexler, Clinical Lead for Pathology

Actions required *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices and current performance; which can be attached as a separate document))*
External review of "Antibiotic Guideline: Empirical Treatment of Infections in Adults" and "Surgical Prophylaxis in Adults" and Antibiotic stewardship	31/03/18	Sarah Wexler, Clinical Lead for Pathology Dr Bernie Marden, Acting Medical Director	Green	Action carried over from 2017 improvement plan Review by an external microbiologist was undertaken in November 2017. A number of recommendations were made which included monthly antimicrobial stewardship group meetings and more antimicrobial stewardship ward rounds particularly in areas such as MAU. Two new consultant Microbiologists have joined the Trust, including an Infection Control Doctor. She has been requested by the Medical Director to review the guidelines. **This action will be carried forward by the Surgical Division.**

Examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)

Status

Author: Yvonne Pritchard, Senior Infection Prevention and Control Nurse
Version 3
Date: 22 March 2018

Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete
Grey	Action not currently being progressed

Recommendation No:	2
Recommendation:	Consider amendments to the MRSA, *Clostridium difficile*, Diarrhoea and Vomiting and Influenza Policies
Lead:	Yvonne Pritchard, Senior Infection Prevention and Control Nurse

Actions required *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices and current performance; which can be attached as a separate document))*
Consider the following amendments to the MRSA Policy: • State when the MRSA screen should be undertaken for patients having elective Caesarean sections • Suggest risk assessment of patients undergoing invasive procedures and whether decolonisation is required • Suggest a timeframe for re-swabbing if surgery is cancelled	31/03/18	Yvonne Pritchard, Senior Infection Prevention and Control Nurse	Green	19/03/18 Awaiting addition of amendments to published policy.
Amend the flowchart in Appendix 2 of the *Clostridium difficile* Policy.	31/03/18	Nichola Hartley, Infection Prevention and Control Nurse	Amber	
Consider rewording of the statement in 7.4 of the Diarrhoea and Vomiting Policy to provide more clarity.	31/03/18	Nichola Hartley, Infection Prevention and Control Nurse	Blue	Wording has not been changed as the statement is taken directly from the national guidelines for the management of norovirus outbreaks.
Add the reference to the PHE guidelines for the management of norovirus outbreaks.	31/03/18	Nichola Hartley, Infection Prevention and Control Nurse	Amber	
Add the fit testing guidance as an appendix to the Influenza Policy	30/06/18	Yvonne Pritchard, Senior Infection Prevention and Control Nurse	Red	Influenza policy is due for revision; the change will be made to the revised policy.
Add a statement to the Influenza Policy regarding discharge to other health or social care providers.	30/06/18	Yvonne Pritchard, Senior Infection Prevention and Control Nurse	Red	Influenza policy is due for revision; the change will be made to the revised policy.

Examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete

Recommendation No:	3
Recommendation:	Clearly identify the Executive Lead for Infection Prevention and Control and publish compliance with the Hygiene Code
Lead:	Helen Blanchard, Director of Nursing and Midwifery/DIPC

Actions required *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices and current performance; which can be attached as a separate document))*
Identify who holds the DIPC role on the Trust website	31/03/18	Yvonne Pritchard, Senior Infection Prevention and Control Nurse	Blue	Website updated on 19/03/18.
Publish a statement regarding compliance with the Hygiene Code on the Trust website	31/03/18	Yvonne Pritchard, Senior Infection Prevention and Control Nurse	Green	Statement to be agreed at Infection Prevention and Control Committee on 29/03/18.

Examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete
Grey	Action not currently being progressed

Recommendation No:	4
Recommendation:	Investigate the use of hydrogen peroxide and UVC light for enhanced decontamination of the environment
Lead:	Timm Schofield, Deputy Hotel Services Manager

Actions required *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices and current performance; which can be attached as a separate document))*
Contact manufacturers of hydrogen peroxide vapour systems and UVC technology for consideration of introducing one or both of these for enhanced environmental decontamination.	30/04/18	Timm Schofield, Deputy Hotel Services Manager	Amber	Manufacturers contacted, awaiting responses.

Examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete
Grey	Action not currently being progressed

Recommendation No:	5
Recommendation:	Gain assurance from Estates that works requested are being undertaken
Lead:	Brian Gubb, Acting Director of Estates

Actions required *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices and current performance; which can be attached as a separate document))*
Estates representative to report to IPCC on works requested and undertaken to maintain the fabric of the environment in wards and departments	31/03/18	Jamie Caulfield, Deputy Director of Estates	Grey	This is currently reported at the estates and facilities executive performance reviews, which is attended by the Head of Estates and Facilities and the DIPC.

Examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete
Grey	Action not currently being progressed

Recommendation No:	6
Recommendation:	Utilise antibiotic stewardship information in *Clostridium difficile* RCAs
Lead:	Yvonne Pritchard, Senior infection Prevention and Control Nurse

Actions required *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices and current performance; which can be attached as a separate document))*
Request information from the antimicrobial pharmacist regarding audit results for an area where a *Clostridium difficile* infection has occurred.	30/04/18	Yvonne Pritchard, Senior infection Prevention and Control Nurse Wendy Fletcher, Antimicrobial Pharmacist	Amber	Revised C diff RCA document to be launched on 01/04/18. New process will start at this point.
Include antimicrobial stewardship e-learning compliance in the *Clostridium difficile* RCA.	30/04/18	Yvonne Pritchard, Senior infection Prevention and Control Nurse Wendy Fletcher, Antimicrobial Pharmacist	Amber	Revised C diff RCA document to be launched on 01/04/18 including compliance with antibiotic stewardship elearning.

Examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete

Recommendation No:	7
Recommendation:	Improve waste streams in clinical areas
Lead:	Yvonne Pritchard, Senior Infection Prevention and Control Nurse

Actions required *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices and current performance; which can be attached as a separate document))*
Contact the waste team regarding the introduction of offensive waste bins and bags in clinical areas	30/04/18	Yvonne Pritchard, Senior infection Prevention and Control Nurse	Amber	Waste team contacted. Delay in progress as there is to be a change in waste leadership team.

Examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete

Recommendation No:	8

Recommendation:	Reintroduce a deep cleaning programme and standardise the systems and processes for cleaning of equipment for which the nursing staff have responsibility.
Lead:	Timm Schofield, Deputy Hotel Services Manager

Actions required *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices and current performance; which can be attached as a separate document))*
Plan a deep clean programme to include all inpatient areas.	31/05/18	Timm Schofield, Deputy Hotel Services Manager	Red	Business case for decant area to be agreed. Process for deep clean programme to be decided by Facilities and Infection Prevention and Control Team if a decant area is not provided.
Spring Clean Action Team to commence ward programme of de-cluttering, rationalisation of stock levels, equipment cleanliness audits and identification of small environmental improvement works.	31/03/18	Nichola Hartley, Infection Prevention and Control Nurse	Green	Planning meeting due to take place on 20/03/18, first ward to be commenced on 26/03/18.
Amend the Cleaning Policy to reflect Estates commitment to the programme of cleaning vents and radiators	30/04/18	Timm Schofield, Deputy Hotel Services Manager	Amber	Action carried over from 2017 improvement plan
Explore potential opportunities to appoint Band 1 support workers for wards / departments to support nursing staff with • Stock rotation • Cleaning of equipment (Discuss at June 2017 ward managers meeting)	30/06/18	Heads of Nursing	Green	Action carried over from 2017 improvement plan All of the inpatient areas within Surgery have a band 1 support worker. In Medicine there are a number of areas that do have a band 1 support worker. The medical division is working towards having one on every ward, and these are being looked at as part of the skill mix review.

Examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete

Recommendation No:	9
Recommendation:	Consider follow up or treatment of C diff colonised patients
Lead:	Julia Vasant and Emma Boldock, Infection Control Doctors

Actions required *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices and current performance; which can be attached as a separate document))*
Discuss follow up and treatment of C diff colonised cases with microbiologists.	31/05/18	Julia Vasant/Emma Boldock, Infection Control Doctors	Red	

Examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete