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This strategy applies to all staff employed by NHS Greater Glasgow & Clyde and locum staff on fixed term contracts.

KEY CHANGES FROM THE PREVIOUS VERSION OF THIS STRATEGY

- Updated July 2017

Document Control Summary

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Lead Manager	Board Infection Control Manager
Responsible Director	Board Medical Director

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1. Introduction

The NHSScotland Quality strategy¹ provides a clear commitment to patients to ensure:

- clear communication and explanation about conditions and treatment;
- effective collaboration between clinicians, patients and others.

The importance of a culture of openness, transparency and candour was also a key recommendation of the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Frances Report)² and there is little doubt, that improving the type and clarity of information given to patients supports these principles and ensures patients and if appropriate their carers are key participants in the choices they make with regards to their care.

Infection Prevention and Control (IPC)

The Report into the outbreak of *C. difficile* in the Vale of Leven Hospital³ also made some key recommendations with regards to improving the quality of communication with patients and their carers; specifically the following recommendations:

11. Health Boards should ensure that patients and relatives where appropriate, are made aware that CDI is a condition that can be life-threatening, particularly in the elderly. The consultant in charge of a patient's care should ensure that the patient and, where appropriate, relatives have reasonable access to fully informed medical staff.

¹ NHSScotland Quality Strategy – Putting people at the heart of our NHS. SGHD May 2010

² Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry. London Stationary Office Feb 2013.

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12. Health Boards should ensure that when a patient has CDI, patients and relatives are given clear and proper advice on the necessary infection control precautions, particularly hand washing and laundry. Should it be necessary to request relatives to take soiled laundry home, the laundry should be bagged appropriately and clear instructions about washing should be given. Leaflets containing guidance should be provided, and these should be supplemented by discussion with patients and relatives.

22. Health Boards should ensure that any discussion between a member of nursing staff and a relative about a patient which is relevant to the patient's continuing care is recorded in the patient's notes to ensure that those caring for the patient are aware of the information given.

55. Health Boards should ensure that numbers and rates of CDI are reported through each level of the organisation up to the Chief Executive and the Board. Reporting should include positive reporting in addition to any exception reporting. The Chief Executive should sign-off the figures to confirm that there is oversight of infection prevention and control at that level.

69. Health Boards should ensure that if a patient dies with CDI either as a cause of death or as a condition contributing to the death, relatives are provided with a clear explanation of the role played by CDI in the patients death.

³ The Vale of Leven Hospital Inquiry Report. Crown Copyright November 2014

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2. Scope

The primary aim of this strategy is to set out some key principles which should be adhered to when communicating with patients with infections, and if appropriate their carers. It also describes the reporting of information/data from the point of care to the board ([Appendix 1](#)) which is intended to provide assurance to patients and the public and to describe the points at which proactive information (press statements) are released during significant incidents or outbreaks of infection. The strategy is linked to existing patient information leaflets and care plans to support its implementation in practice. This Strategy applies to all staff employed by NHS Greater Glasgow & Clyde (NHSGGC) and locum staff on fixed term contracts.

3. Principles of Communicating Diagnosis of Infection and Infection Risks

- Every patient should be informed of the risk of infection and the actions the board is taking to prevent healthcare associated infection (HCAI). NHSGGC issues each patient with an information leaflet at time of admission or with planned admission documents.
<http://www.nhsggc.org.uk/media/221368/29.08.12-PIL%20-%20Infection%20Control.pdf>
- If a patient is diagnosed with an infection the diagnosis should be discussed with the patient by one of the members of the clinical team if possible. The presentation of the facts and the assessment of ongoing support will be crucial in reducing the psychological effect of the diagnosis of infection which is often not the primary reason for admission.
- Patients newly diagnosed with MRSA / CDI will be visited by an Infection Prevention and Control Nurse (IPCN) and the condition and any precautions which modify their care will be explained to them or their carers.

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- In the majority of cases there are patient information leaflets available for patients with Alert Conditions / Alert Organisms (AC/AO); this should support ongoing conversations with the Infection Prevention Control Team (IPCT) and Clinical Staff and the patient/carer. Clinical staff should record in the clinical notes that this information has been given. Where patient information leaflets are not available the IPCT will provide patient specific information.
- The consultant in charge of a patient’s care should ensure that the patient and, where appropriate carers, have reasonable access to medical staff and that they are fully informed if the infection is thought to be serious or life threatening. This must be documented in the patient’s notes.
- Carers who have to take home potentially contaminated laundry should be informed by the nursing staff that the laundry is contaminated and they should be issued with the information leaflet ‘[Washing Clothes at Home – Advice for Carers](#)’. The issue of this leaflet should be documented in the clinical notes. There is also ‘[NHSGGC Taking Laundry Home - Information for Healthcare Workers](#)’ which provides advice for nursing staff on what information to give carers.
- Health Boards should ensure that if a patient dies with an infection which is either the primary cause of death or a contributing factor in the death of a patient, relatives are provided with a clear explanation of the role played by the infection.⁴

⁴ [Death Certification \(Scotland\) Act 2011 - NHSGGC Guidance notes \(Draft\) 2015](#)

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4. Communicating Rates and Risks to the Public

Ward to Board Data

The following information will be available to the public via the Quality Improvement Information (poster) for Patients and Visitors:

- Most recent Infection Prevention and Control (IPCAT) audit score
- Days since the last case of MRSA on the ward
- Days since the last case of CDI on the ward
- Hand Hygiene audit score

Statistical Process Control Charts (SPCC) or Interval Charts with key AC/AO relevant to that area will be available for clinical staff and should be displayed in the ward area. A full list of where IPC data is reported is included in [Appendix 1](#).

The [Healthcare Associated Infection Reporting Template \(HAIRT\)](#) is presented to the NHS Board bi- monthly and is available on the IPC website.

The monthly table of totals of [CDI / SAB rates](#) are also available to the public and are available on the IPC website.

Communicating Incidents / Outbreaks

All outbreaks and incidents are assessed using the Hospital Infection Incident Assessment Tool (HIIAT) [Appendix 2](#). Any incidents/outbreaks which are assessed as AMBER require the NHS Board to prepare a holding press statement. The Outbreak Control Team (OCT) will determine if it is in the public interest for this to be issued proactively. All incidents which score RED require the NHS Board to issue a press release. The NHSGGC Communications

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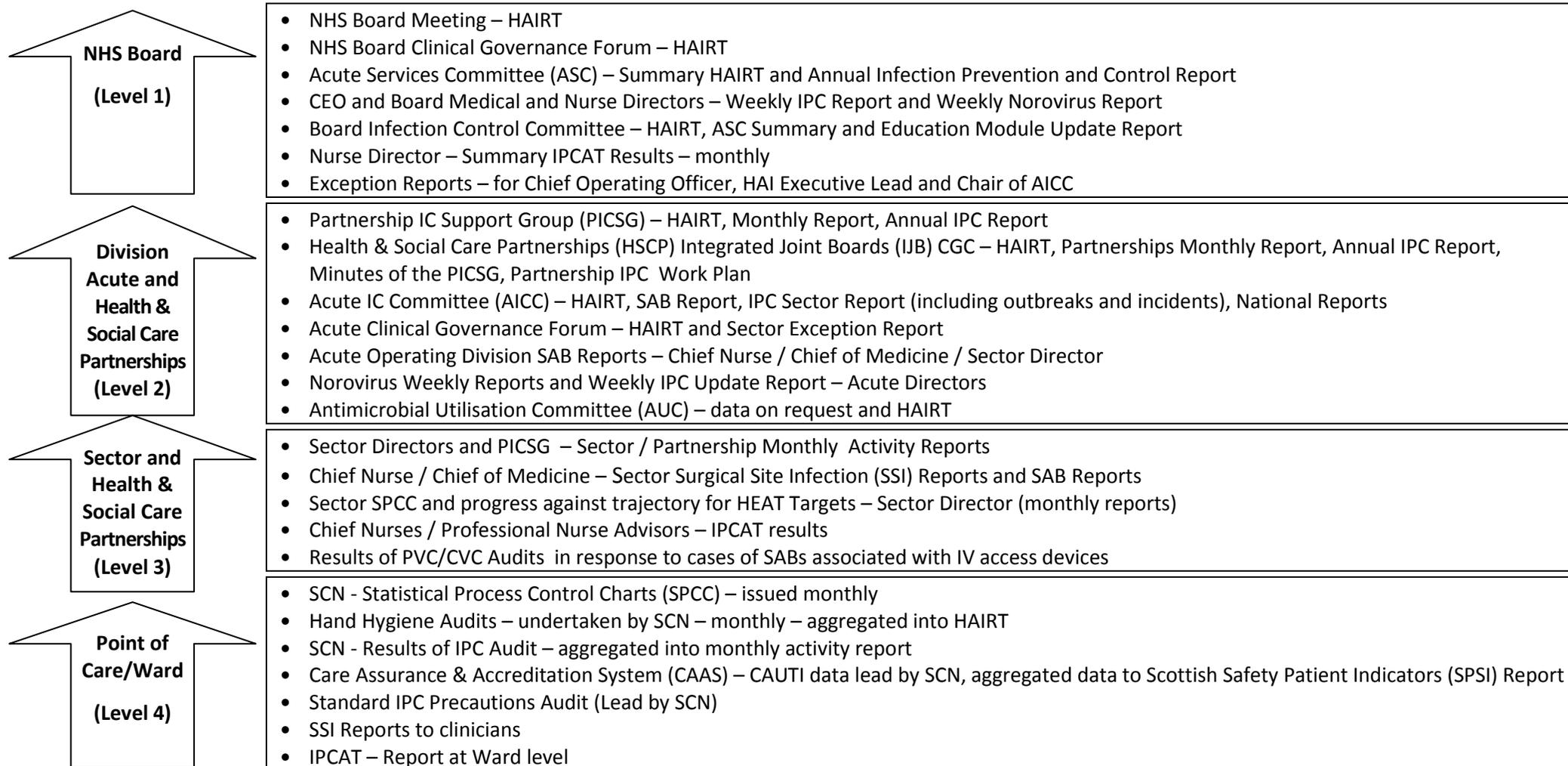
Officer will liaise with the Press Offices at Scottish Government Health and Social Care Directorates (SGH and SCD).⁵

⁵ Outbreak policy for outbreaks of communicable or alert organisms in healthcare premises – NHS Greater Glasgow and Clyde Board Infection Control Committee

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Appendix 1 – NHSGGC Infection Prevention & Control Team Reporting Level and Schedules



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Appendix 2 – Hospital Infection Incident Assessment Tool (HIIAT)

Hospital Infection Incident Assessment (HIIA) Tool (Watt Risk Matrix Replacement)

Objective: To provide all those who manage and need to know about hospital infection incidents with a simple impact assessment tool.

Step 1 – Assess the infection impact on: Patients, Services, Public Health and Public Anxiety as Minor, Moderate or Major

	Patients	Services	Public Health	Public Anxiety*
Minor	Only minor interventional support needed as a consequence of the incident. No mortality.	No, or only very short term closure of a clinical area(s) with minor impact on any other service.	No, or minor implications for public health.	No significant increased anxiety or concern anticipated.
Moderate	Patients require moderate interventional support, but no mortality as a consequence of the incident.	Short term closure(s) having moderate impact on some services, e.g. multiple wards closed or ITU closed.	Moderate implications, i.e. there is a moderate risk of only moderate impact infections to other persons.	Increased concern and or anxiety anticipated.
Major	Life threatening illness or death as a consequence of the incident in one or more patient.	Significant disruption and impact on services, e.g. hospital closures for any period of time.	Significant implications for public health, i.e. there is a moderate or major risk of major infection to someone else.	Alarm within at least some areas of the community anticipated.

Step 2 Calculate the Impact: All Minor = GREEN; 3 Minor and 1 Moderate = GREEN; No Major and 2-4 Moderate = AMBER; Any Major = RED;

Step 3 Take actions are in line with HIIA Tool colour

<u>GREEN</u>	<u>AMBER</u>	<u>RED</u>
Manage within the NHS Board. Log on SHORS if an outbreak. Inform CPHM.	Report to SGHD. Engage with CPHM. Log on SHORS and report to HPS if an outbreak. Ask HPS for support if required** Consider issuing press statement (prepare holding statement)***	Report to SGHD. Engage with CPHM. Report HPS** Log on SHORS if an outbreak. Issue press statement***

* Public Anxiety: If a press statement was released today summarising the situation what would be the likely impact on public anxiety.

**Consider others who may be of assistance in managing hospital infection incidents: Food Standards Agency, Scottish Environmental Protection Agency (SEPA), Water Authority, Dental Public Health Consultant, Health and Safety Executive, etc.

*** The outbreak status should be confirmed prior to a press statement being issued – this should take no longer than 24 hours. **As far as is practicable, patients and relatives should be informed of an incident prior to press statement release.** All press statements should be shared with SGHD and Health Protection Scotland.

HPS: October 2011

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