Infection Prevention 2017
Manchester Central
18th – 20th September 2017

Download the IP2017 Conference App now!

Conference Handbook

@IPS_Infection
#IP2017 | #IPS10

www.facebook.com/infectionpreventionsociety/
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Dear Delegates,

As President of the Infection Prevention Society and on behalf of the Board and Scientific Programme Committee, it is my pleasure to welcome you to Manchester for our annual international conference, Infection Prevention 2017.

In response to delegate feedback, we have created a programme that is both dynamic and informative by including sessions on the latest current and emerging threats, and state-of-the-art research on the optimisation of service/behaviour change to create a comprehensive series of lectures, specialist streams and meet-the-expert sessions. I encourage you to take every opportunity to ask questions of our speakers, network with colleagues and visit the exhibitor stands to discuss how the latest innovations and product developments can be used to support our vision that no person is harmed by a preventable infection.

The varied programme encompasses many of the key issues facing infection prevention and control teams, regulators, clinicians, policymakers and organisations, not just in the UK and Europe but across the globe. Please ensure that you attend our plenary sessions and our two keynote sessions from past president, Julie Storr who will present the E.M. Cottrell Lecture and Professor Sanjay Saint who will deliver this year’s Ayliffe Lecture. I would also recommend staying until the very end of conference as you will not want to miss Glenn Hunter, Consultant in Performance Innovation, English Institute of Sport with a session entitled “Zero’ Illness – insights from the world of Elite Sport”. The aim of this session is to provide an insight into the approaches taken in elite sport to reduce the impact of illness and infection on performance.

In addition to all of this, we have specialist streams on new to infection prevention, mental health, audit and surveillance, and international engagement sessions along with separate one-day conferences running concurrently to the main programme. In addition, the programme has been awarded 14 CPD credits from the Royal College of Pathologists and will be mapped to the IPS competences. Attending Infection Prevention 2017 you can also count as participatory learning for NMC revalidation.

One of the most interesting elements of any conference is the poster presentations and I would like to thank everyone that took the time to submit an abstract to be considered for presentation. This year we received our highest number of abstract submissions so do take the time to visit the poster display area and attend our poster pod sessions. In addition, please use the time in the programme to discuss the work that colleagues have undertaken to address key issues in practice.

We are proud to host the UK’s largest infection prevention exhibition. There is time allocated on the programme to allow delegates to view the exhibitions stands and network with industry colleagues. The exhibiting companies contribute hugely to the event’s success, and are always happy to discuss the issues you face.

I hope you enjoy the educational and social programmes including the conference dinner at the Mercure Manchester Piccadilly Hotel where we take the time to celebrate the achievements or our members, teams, branches and link practitioners, as part of our annual awards programme.

Finally, the members of the IPS Board and I look forward to meeting you over the next three days. Please visit us on the IPS stand to talk to us and consider becoming a member (if not already), take a selfie with our photo frame against our 10 year anniversary photo wall and read about the history of the IPS in our large walk through exhibition.

Dr Neil Wigglesworth
IPS President
INTRODUCTION

INFECTION PREVENTION SOCIETY BOARD MEMBERS

NEIL WIGGLESWORTH
President
@Neilwigg

PAT CATTINI
Vice President
@patcp66

CAROLE HALLAM
Secretary
@HallamCarole

PHILIP PUGH
Treasurer
@CBR_Phil

CLAIRE CHADWICK
Deputy Treasurer
@clairechadwick2

VALYA WESTON
Deputy Secretary
@valya_weston

CRAIG BRADLEY
Ordinary Member
@CraigBradleyF1

JACQUI PRIETO
Ordinary Member
@j acquiprieto1

EMMA BURNETT
Research & Development
@EmmaBurnettx

HELEN O’CONNOR
Education & Professional Development
@hloconnor1

KARENWARES
Scientific Programme Committee
@kdwares

JENNIE WILSON
Journal Editor
@TalkJennie

DEBBIE XUEREB
International Engagement Committee
@XuerebD

INFECTION PREVENTION SCIENTIFIC PROGRAMME COMMITTEE (SPC)

Co-ordinator: Karen Wares
SPC Member: Michael Nevill
SPC Member: Kathryn Topley
SPC Member: Evonne Curran

Deputy Co-ordinator: Craig Bradley
SPC Member: Elaine Ross
SPC Member: Martin Jones
SPC Member: Dona Foster

Co-opted Member from the IPS Education & Professional Development Committee: Andrea Denton

IPS CONFERENCE & EXHIBITION 18 – 20 September 2017, Manchester Central
The Infection Prevention Society would like to thank our Platinum Sponsor for their contribution to Infection Prevention 2017:

**PLATINUM SPONSOR**

**GAMA Healthcare**

Marking the 10 year anniversary of IPS, GAMA Healthcare is once again proud to be the Platinum Sponsor of the annual conference, the largest event in the UK dedicated to infection prevention professionals. The programme this year is very exciting and we would like to congratulate the IPS committee for all their hard work in organising this event. Over the past decade the IPS conference has grown in both size and reputation, and it is no surprise that it attracts many worldwide delegates further proving its growing international reputation.

Hospitals and Infection Prevention professionals are under intense pressure to reduce their HCAI rates and face day-to-day challenges that are constantly evolving. This conference provides a great forum to share knowledge, experiences and keep up-to-date with the latest science and thinking. This year our sponsored speaker **Dr Deverick Anderson**, Associate Professor of Medicine at the Duke University School of Medicine will discuss one of those challenges ‘Automated room decontamination devices – hydrogen peroxide and/or UV to reduce healthcare associated infections?’.

GAMA Healthcare has numerous exciting products and services which will be exhibited at the conference, so please come and visit us at stand 38 where we will be waiting to welcome you. GAMA Healthcare can provide you with the complete solution to training, monitoring and decontamination in a customised format designed specifically for your hospital. We, of course, also have some fun giveaways just for you!

We wish you all a great IPS conference.

**IPS CORPORATE MEMBERS**

The continued support and contribution of corporate members is imperative to maintain a cooperative approach to good practice. The IPS would like to take this opportunity to thank their corporate members for their continued support.

| 3M UK PLC | Dental Decontamination Ltd | NHS Supply Chain |
| All In One Medical | Diversey | Pal International |
| Aquilant Ltd | Drive Devilbiss Healthcare | PDI Ltd |
| Bard Limited | Ecolab Ltd | SCA Hygiene Products UK Ltd |
| Bio-Rite Ltd | Frontier Medical Group | Schülke UK Ltd |
| B.Braun | GAMA Healthcare | Sener PTY Ltd (CATH TAG) |
| Becton Dickinson UK Ltd | Getinge Lancer UK | Sharpsmart Ltd |
| Byotrol PLC | GOJO Industries – Europe Ltd | SureWash |
| Cepheid | Guest Medical LTD | Synergy Health (UK) Ltd |
| CHGIP | HPS Healthline Ltd | Teal Patents Ltd |
| Clinimax Ltd | Hygienna International Ltd | Vernacare Ltd |
| Clinisupplies Ltd | ICNet International | Vileda |
| Daniels Healthcare Ltd | Köhler Mira Ltd – Rada | Wybone Ltd |
| DDC Dolphin Ltd | MEG Support Tools | |
| Deb Limited | Mölnlycke Health Care | |

*Last updated 4/9/2017*

If you are a company interested in the benefits of corporate membership, visit the Infection Prevention Society Stand, No 19 for further details, or contact paul.harrison@fitwise.co.uk
CONFERENCE APP

For the second year running, IPS have a free conference app specifically designed for attendees to download and use throughout the conference. All event information available in this handbook is published in the app, including programme information and timings, speaker biographies, venue layout, in addition you will find exhibitor listings, exhibitor floorplan, venue layout and a scheduling tool to help organised your time at conference. All the information you may need is easily accessible from your smart phone, iPad or tablet device.

Plus you can utilise the voting function to vote for the best stand awards. To download the app, please visit your devices app store, search for IP2017 and follow the onscreen instructions. If you require any assistance please visit the registration desk.

VENUE INFORMATION

Manchester Central (MCC), Windmill St, Manchester, M2 3GX. Tel 0161 834 2700.

Security
A cursory bag check may be conducted for all attendees entering the building.

Medical Facilities
Stewards at MCC are first aid trained, please contact the Stewart’s on site for assistant, or visit the registration desk.

Local Amenities
Nearest ATM – there is a free ATM/cash machine in the Central Foyer. Alternatively, the closest banking facilities are: Royal Bank of Scotland, Mosley Street and Barclays, Mosley Street.

Train Stations – Piccadilly Station is a 20 minute walk from MCC or just a 5 minute taxi journey. Victoria Station is a 15 minute Taxi/Metrolink Tram journey from MCC.

Car Park – there is an NCP (National Car Park) directly below MCC that is open 24 hours a day all year round. It has 720 spaces including 18 disabled parking bays and there is direct access to MCC by lift, stairs and escalators. NCP parking charges apply, refer to the NCP website for details.
VENUE PLAN
CONFERENCE DETAILS

Registration Desk
The registration desk will be open at the following times:

- Sunday 17th September: 17:00 – 20:00 (Pre-registration only, no exhibition viewing or sessions)
- Monday 18th September: 08:00 – 17:40
- Tuesday 19th September: 08:00 – 17:35
- Wednesday 20th September: 08:00 – 15:00

Badging
You will be issued with a badge on site; you must wear this badge at all times within the MCC. The lanyard colours determine attendees as follows:

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<tr>
<th>Lanyard Colour</th>
<th>Access Group</th>
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<tr>
<td>Pink Lanyard</td>
<td>IPS Board &amp; SPC</td>
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<tr>
<td>White Lanyard</td>
<td>Exhibitors</td>
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<tr>
<td>Dark Blue Lanyard</td>
<td>Delegates &amp; Invited Guests</td>
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<tr>
<td>Sky Blue Lanyard</td>
<td>Care Home / Dental / Estates &amp; Facilities</td>
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<tr>
<td>Orange Lanyard</td>
<td>Speakers</td>
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<tr>
<td>Yellow Lanyard</td>
<td>Exhibition Visitors</td>
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Disabled Facilities
The MCC is fully accessible, if you require assistance while on site please alert a member of staff at registration or a steward.

Enquiries
If your query relates specifically to conference please visit the registration desk in the Charter Foyer. The IPS Stand is Stand No 19 within the exhibition, membership enquiries, branch enquiries and any other general IPS enquiries can be dealt with here.

Exhibition
Infection Prevention 2017 will host the largest infection prevention exhibition in the UK. Featuring a wide array of companies working within infection prevention, the exhibition provides the ideal opportunity to discuss your infection prevention requirements directly with representatives from a wide range of companies, discover new products and procedures, and arrange meetings with both existing suppliers and new companies. A floor plan and list of all exhibitors are available at the back of the handbook, published in the conference app and located on the large floor plans located within the venue.

Cloakroom / Left Luggage
There is a cloakroom located in the charter foyer, this is complimentary for all attendees.

Internet Access
Manchester Central offers free WiFi to all visitors, instructions are available on-site or ask at registration.
**Social Media – spreading the word**

@IPS_infection  
#IP2017 | #IPS10  
www.facebook.com/infectionpreventionssociety/

IPS encourages people to be active in posting information about the conference through social media. Please use #IP2017 and #IPS10 when you are posting messages.

You can also mention @IPS_Infection in your messages – some of these will be retweeted by the @IPS_Infection account to share the information with others, which can increase both the society and your own social media profiles.

Speakers twitter handles are provided in this handbook next to their profile, and delegate Twitter names will be printed on their delegate badges.

What we want to achieve is a real buzz around our conference; make people who cannot attend feel like they are almost here and maybe want to join us next year, and raise the number of followers we have to help get more important infection preventions messages out there. The society’s profile and influence, and therefore the benefits for members and others, are enhanced through our presence on social media.

**Mobile Phones**

Please ensure that mobile phones are switched to silent when attending sessions.

**Flash Photography**

Please refrain from taking pictures of speakers and their slides during their session as this can be distracting.

**Speaker Presentations**

After conference the presentations for all speakers who have given their permission for their presentation to be published will appear on the conference website. These will be available to view in three formats depending on the level of permission given:

- Slides only;
- Slides & Audio of Speakers;
- MP3 Audio.

You will be emailed a password to access these 7 days after the conference has closed.

**Conference & Exhibition Feedback and Certificate of Attendance**

A certification of attendance will be distributed by email to all attendees who complete both the general conference survey and the speaker survey. You confirmation email will also show which sessions you attended and how these map to the IPS Competences.

**IPS Stand**

The IPS Stand is situated inside the entrance of the exhibition at Stand No 19, please take the time to visit. The stand will be hosted by IPS Board and Branch members.
Are You New to Conference?
Welcome to your first IPS Conference, we hope this is your first of many. As well as being the ideal platform to learn, it is also a great location to network and meet like-minded colleagues. IPS prides itself in the friendly atmosphere it creates for both new comers and old hands, and we would like to make this experience an enjoyable one for you. Please visit the IPS Stand No 19 with any enquiries you have – we are always happy to meet new members.

PROGRAMME CHOICES OVERVIEW

Session Choices
You have a choice of up to four concurrent session to attend. Please see the enclosed programme and signage on the day for directions. We do try not to put similar sessions up against each other, but with so many interesting sessions this is not always possible.

As well as the main sessions there are specific streams you can attend; you are entitled to attend these as part of your registrations:

Monday 13:45 – 17:40 – New to Infection Prevention Stream (yellow on programme)
This stream of sessions is specifically aimed at those who are new to the area of infection prevention.

One Day Conferences
Monday 09:25 – 17:40 – In Care and at Home Sessions (pink on programme)
Tuesday 09:05 – 17:35 – Dentistry Sessions (green on programme)
Wednesday 09:00 – 14:55 – Estates & Facilities Sessions (purple on programme)
As the names suggests, these are aimed at those who specialise or have an interest in these areas of infection prevention.

Delegates are encouraged to arrive at sessions on time to ensure they can gain access; late entrants will be given pre-designated seats at the back of the room. Five minutes is included after each session to allow for movement between rooms.

Posters and Oral Presentations
Posters and oral presentations are an essential part of the conference’s educational content. This year’s entries were of an exceptional standard and we thank everyone for taking the time to submit their work. We hope this year’s entries inspire you to consider submitting for 2018. Full details on submitting an abstract can still be found on the conference website accessible via www.ips.uk.net.

Oral Presentations – Oral presentations are incorporated into the main conference programme and are listed in the programme printed in this handbook. Adjudication of the best oral presentation will be undertaken by an appointed judge, and the winner will be announced at the IPS Gala Dinner and Awards Ceremony.

Posters – Posters will be displayed throughout the conference in a designated area at the rear of the exhibition hall. Posters are sorted by topic and each topic has been allocated a day in which the authors must stand by their posters to answer any questions from delegates. Adjudication of the best poster presentation will be undertaken by an appointed judge and, the winner will be announced at the IPS Gala Dinner and Awards Ceremony.
POSTER TALKS

On Monday and Tuesday there are designated sessions in which poster talks will be conducted, these will take place within the poster talk pods at the rear of the exhibition hall. A short list of posters will be selected to present and we encourage you to attend. The abstracts can be found in the separate abstract supplement provided at the registration desk and online via the conference website.

**Monday – 15:05 – 15:40**
Pod 1: Education and training / Antimicrobial prescribing and stewardship
Pod 2: Decontamination
Pod 3: Innovation and improvements in practice

**Tuesday – 10:25 – 10:55**
Pod 1: Epidemiology and surveillance of HCAI/Outbreaks
Pod 2: Standard precautions
Pod 3: Other topic (including wounds and invasive devices)

Posters that have been shortlisted for the best poster award before the conference and the top five will be marked on their display board.

SOCIAL EVENTS

Delegates and exhibitors were asked when registering if they wished to attend the events listed below, if you have not ordered a ticket and would like one visit the ticket collection desk to enquire about availability.

**IPS Fun Night**
**Date:** Monday 18th September
**Time:** 8:00pm – midnight
**Venue:** Revolución de Cuba, 11 Peter St, Manchester M2 5QR
**Dress Code:** Smart/Casual
**Ticket Collection:** social ticket desk located in registration area

IPS are hosting a fun night for conference delegates and exhibitors to socialise in an informal setting. This will take place at the popular rum specialist and cocktail bar, Revolución de Cuba. This site is convenient for attendees as it is located opposite Manchester Central Convention Complex. The evening will begin with a welcome drink and include a disco and for those who enjoy singing there will be the opportunity to indulge in some karaoke.

This event is free to attend, tickets must have been ordered in advance, strictly one ticket per delegate.

Please note that food is not provided, we recommend that you eat prior to arrival.
AWARDS AND PRIZES

IPS Gala Dinner and Awards Ceremony

Date: Tuesday 19th September
Time: 7:15pm – 1am
Venue: Mercure Manchester Piccadilly Hotel, Portland St, Manchester M1 4HP
Dress Code: Formal/Black Tie. Pink and blue attire optional.

The evening will begin with a wine reception, followed by a 3 course meal. The Annual IPS Awards, Exhibition stand awards and best Oral and Poster presentation awards will be hosted, acknowledging fellow professionals for their contribution to infection prevention. The evening will include entertainment from a band to allow you to dance the night away, as it is the 10th anniversary of IPS we have themed the gala dinner with the IPS colours, please feel free to dress in pink or blue.

The Annual IPS Awards:
- Brendan Moore Award
- IPS Team of the Year – Sponsored by Daniels
- Practitioner of the Year
- IPS Branch of the Year
- IPS Link Practitioner of the Year
- Honorary Membership Award
- Best exhibition stand awards
- Best oral presentation and poster presentation sponsored by Daniels

IPS Gala Dinner and Awards Ceremony Ticket Collection & Seating Plan

Upon collection of your ticket you will be instructed to allocate yourself a seat on the seating plan. You will not be given your ticket without doing this. If a company is supplying you with a ticket to attend, please contact them for your ticket as they will have pre-allocated your seat. If you wish to move your seat on the seating plan you must be in possession of your ticket. If you own a company purchased ticket only the company can move your seat.

The table seating plan will be open at the following times:

Monday 18th September 17:00 – 20:00
Tuesday 19th September 08:00 – 13:45 (amendments cannot be made after this time and anyone who has not collected their ticket will be allocated a seat for the evening).
BEST EXHIBITION STAND AWARDS

In recognition of the contribution to Infection Prevention 2017 from exhibiting companies and the efforts they put into their stand both prior to conference and on site. IPS offer our exhibitors four awards and would like you to vote for your favourite stands using the app. Eligible companies will be listed in the app for each category and you vote for who you think is most deserving of the award. The criteria to consider for each category are; eye catching; welcoming; informative and educational.

**Best large stand**: This is awarded to companies above 17m² +.
**Best medium stand**: This is awarded to companies above 8m² – 17m².
**Best small stand**: This is awarded to companies up to and including 8m².
**Best newcomer stand**: This is awarded to companies who have formed in the last two years.

IPS Annual General Meeting – Open to IPS Members Only

The IPS Annual General Meeting (AGM) will be held on Monday 18th September, from 12:10 – 12:30 in the Exchange Auditorium. As the AGM takes place directly after a session, all attendees will be scanned as they depart the AGM for recording purposes. IPS members are encouraged to attend as this is your Society and the AGM gives you an update on the Society.

Sessions Supported by a Company Educational Grant

Lectures which are sponsored by companies do not imply any endorsement of the company or their products. The content of the lecture is in no way influenced by the sponsoring company.

Session Chairs

Session Chairs have an important role to play during conference, helping deliver the overall message of conference by assisting the speakers and keeping the conference to time. This year some of the sessions will have the session chairs shadowed by others to help further their development, you will be introduced to both chairs. We would like to thank our session chairs for their contribution to the conference.

Company symposium

At Infection Prevention 2017 the following symposiums will take place, symposiums conducted during lunch will take place within the poster pods at the back of the exhibition. Please refer to the conference app for full symposium details.

**Monday 18th September – 12:40 – 13:10** (Lunch time symposiums)
Poster Pod 3 – RL Solutions

**Tuesday 19th September – 13:05 – 13:35** (Lunch time symposiums)
Poster Pod 1 – Nanosonics
Poster Pod 3 – ICNet

**Wednesday 20th September – 10:15 – 10:45**
Poster Pod 1 – 3M Healthcare
Poster Pod 3 – Diversey Care
## INTRODUCTION

### MAPPING TO THE IPS COMPETENCES

The table below will assist you in selecting sessions to further your learning based on the IPS Competency document. After conference you will be asked to evaluate conference and session speakers. Following this process you will receive your certificate of attendance and confirmation email which will indicate the sessions you attended and how these map to the Competency. This document is not exhaustive and further assistance can be obtained from the IPS stand.

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Monday 18 September 2017
Exhibition viewing opening hours are: 10:45 – 17:40

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</table>
| 08:40    | Welcome  
Karen Wares,  
IPS SPC Co-ordinator  
@kdwares                                                        |           |             |           |
| 08:45 – 09:00 | Opening Address  
Dr Neil Wigglesworth,  
IPS President  
@Neilwigg              |           |             |           |
| 09:00 – 09:35 | SESSION 1a  
Why is it so difficult for me to get people to follow basic infection control practices?!  
Professor Michael A. Borg  
Department Head of Infection Control, Mater Dei Hospital  
Chair of Infection Control Committee and the National Antibiotic Committee, Malta.  
Supported by an unrestricted educational grant from SRCL |           |             |           |
| 09:35 – 10:10 | SESSION 2a  
Everything you ever wanted to know about Clostridium difficile but never thought about asking!  
Professor Thomas V Riley  
Professor, Edith Cowan University, Murdoch University. |           |             |           |
| 10:10 – 10:45 | SESSION 3a  
Your Microbial Armour – the role of the human microbiome in infection prevention and control  
Nicola Fawcett  
MRC Clinical Research Fellow with Medical Microbiology Group at the University of Oxford and Chief Investigator of the Antibiotic Resistance in Microbiome Oxford (ARMORD) Study.  
@drnjfawcett |           |             |           |
| 09:25 | SESSION 1b  
Welcome and introduction  
Elaine Ross  
Infection Control Manager, NHS Dumfries & Galloway and Board Member of IPS.  
@EGRoss85 |           |             |           |
| 09:35 | SESSION 2b  
Basics of microbiology  
Dr Dona Foster  
Researcher in Microbiology and Healthcare Associated Diseases at University of Oxford and Lecturer at Oxford Brookes teaching on the Masters of Infection Control and Prevention. |           |             |           |
| 10:10 | SESSION 3b  
Essentials of wound care  
Valya Weston  
Head of Service/ Associate Director of Infection Prevention and Control, Alder Hey Children’s NHS Foundation Trust and Deputy Secretary of the IPS.  
@valya_weston |           |             |           |
## MONDAY – CONTINUED

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<th>Time</th>
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<th>Charter 1</th>
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<tr>
<td>10:45 – 11:30</td>
<td>Opening of the Exhibition, Exhibition Viewing, Poster Viewing and Refreshments</td>
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<tr>
<td>11:30 – 12:05</td>
<td>SESSION 4a E.M. Cottrell Lecture: Igniting Passion, Sparking improvement</td>
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<tr>
<td></td>
<td>Julie Storr Director and Consultant, S3 Global, contracted by World Health Organization. @julesstorr</td>
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<td>11:30 – 12:05</td>
<td>SESSION 4b Cleaning – what, with what and how often</td>
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<td>Christina Bradley Laboratory Manager HIRL, Queen Elizabeth Hospital Birmingham. @TinaBradley1</td>
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<tr>
<td>12:10 – 12:30</td>
<td>IPS Annual General Meeting Open to all IPS members</td>
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<td>12:30 – 13:45</td>
<td>Exhibition Viewing, Poster Viewing and Lunch</td>
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<td>12:40 – 13:10</td>
<td>Lunchtime Symposium, located in the poster talk pods within the exhibition Pod 3 – RL Solutions</td>
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<tr>
<td>13:45 – 14:20</td>
<td>SESSION 5a Bloodstream infections – epidemiology and prevention strategies</td>
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<td></td>
<td>Professor Jacqui Reilly Lead Consultant, Health Protection Scotland. @JacquiSRreilly</td>
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<td>See pages 26 &amp; 27 for full details</td>
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<td>14:25 – 15:00</td>
<td>SESSION 6a A national perspective on the IPC ambition</td>
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<td></td>
<td>Dr Ruth May Executive Director of Nursing, NHS Improvement, Deputy Chief Nursing Officer &amp; National Director for Infection Prevention and Control. @RMayNurseDir</td>
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<tr>
<td>14:45 – 15:00</td>
<td>SESSION 6b Oral Paper Presentations Abstract ID: 157 Abstract ID: 115</td>
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<td>See pages 28 &amp; 29 for full details</td>
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<td>11:30 – 12:05</td>
<td>SESSION 4c Barriers to cleaning</td>
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<td>Sharon Leitch Infection Prevention and Control Nurse, NHS Ayrshire &amp; Arran. @sharon_leitch</td>
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<td>14:25 – 15:00</td>
<td>SESSION 6d The basics of microbiology and immunity</td>
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<td></td>
<td>Dona Foster Researcher in Microbiology and Healthcare Associated Diseases at University of Oxford and Lecturer at Oxford Brookes teaching on the Masters of Infection Control and Prevention.</td>
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<td>15:05 – 15:40</td>
<td>SESSION 7a</td>
<td>Poster talks and poster viewing in designated poster viewing area within the exhibition</td>
<td>SESSION 7b Outbreaks in care settings – let’s get ready</td>
<td>SESSION 7c How to assess scientific posters: a practical guide</td>
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<td>Pod 1: Education and Training / Antimicrobial prescribing and stewardship</td>
<td>Dr Evonne Curran Independent Nurse Consultant, Infection Prevention and Control and SPC Member. @EvonneTCurran</td>
<td>Michael Nevill Director of Nursing, British Pregnancy Advisory Service. @michael_nevill</td>
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<td>15:40 – 16:25</td>
<td>Exhibition Viewing, Poster Viewing and Refreshments</td>
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<td>Networking and refreshments</td>
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<td>16:25 – 17:00</td>
<td>SESSION 8a</td>
<td>Types of evidence; Vascular access focus</td>
<td>SESSION 8b Norovirus – How can we minimise the impact?</td>
<td>SESSION 8d Essential IPC toolkit</td>
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<td>Steve Hill Procedure Team Manager, The Christie NHS Foundation Trust.</td>
<td>Judy Potter Lead Nurse/Director for Infection Prevention and Control, Royal Devon and Exeter NHS Foundation Trust</td>
<td>Sue Millward National Infection Prevention Lead, Nuffield Health. @NHInfPrevent</td>
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<tr>
<td>17:05 – 17:40</td>
<td>SESSION 9a</td>
<td>Vessel Health &amp; preservation in the UK: An update on the development, implementation &amp; evaluation of a multi-professional framework for making rational vascular access decisions for a range of patients</td>
<td>SESSION 9b The importance of community infection prevention and control</td>
<td>SESSION 9c How clean is your house?</td>
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<td>Dr Tim Jackson Consultant In Anaesthesia &amp; Intensive Care Medicine, Calderdale &amp; Huddersfield NHS Foundation Trust. @timjacks9</td>
<td>Tracey Cooper Assistant Director of Nursing – Infection Prevention, Betsi Cadwaladr University Health Board.</td>
<td>Christina Bradley Laboratory Manager HIRL, Queen Elizabeth Hospital Birmingham. @TinaBradley1</td>
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<td><strong>SESSION 10a</strong></td>
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<td>09:00</td>
<td>Meet the expert: C. difficile the irreducible minimum</td>
<td>Meet the expert: campaign: VERB work in an organised and active way towards a goal. – standing up for the good cause of IPC</td>
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<td></td>
<td>Dr Michael Weinbren</td>
<td>Claire Kilpatrick</td>
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<td></td>
<td>Consultant Microbiologist / Infection Control Doctor, Chesterfield Royal Hospital.</td>
<td>Director S3 Global (KS Healthcare Consulting), Independent, WHO Consultant Manager &amp; Technical Officer, WHO.</td>
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<td>09:05</td>
<td><strong>SESSION 11a</strong></td>
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<td>09:40</td>
<td>Incorporating infection prevention into the healthcare building</td>
<td>Surveillance for antimicrobial resistance in dentistry – no room for complacency</td>
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<td>Professor Satoshi Hori</td>
<td>Professor Andrew Smith</td>
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<td>Professor of Infection Control Science, Juntendo University. Director of Infection Control in 6 group hospitals.</td>
<td>Professor of Clinical Bacteriology and Hon Consultant Microbiologist for NHS Greater Glasgow and Clyde. Deputy Director of the Scottish Haemophilus, Legionella, Meningococcal and Pneumococcal reference laboratory.</td>
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<td>10:20</td>
<td>Automated room decontamination devices – Hydrogen Peroxide and/or UV to reduce healthcare-associated infections?</td>
<td>Fundamentals of behaviour change</td>
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<td></td>
<td>Dr Deverick J. Anderson</td>
<td>Dr Carmen Lefevre</td>
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<td></td>
<td>Associate Professor of Medicine, Duke University School of Medicine, USA.</td>
<td>Research Associate and Research Lead at UCL Centre from Behaviour Change (CBC)</td>
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<td>@Deverick_A</td>
<td>@carmen_lefevre</td>
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<tr>
<td>10:20</td>
<td>Respiratory risks in dental settings</td>
<td>Fundamentals of behaviour change</td>
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<td></td>
<td>Brian Crook</td>
<td>Dr Carmen Lefevre</td>
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<td>Health and Safety Executive, Microbiology Team, Health and Safety Laboratory.</td>
<td>Research Associate and Research Lead at UCL Centre from Behaviour Change (CBC)</td>
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<td>@carmen_lefevre</td>
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**Tuesday 19 September 2017**

Exhibition viewing opening hours are: 09:00 – 17:35

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**Tuesday continued**

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<td></td>
<td>The IPS competency framework revisited: an interactive online assessment</td>
<td>Make doing the right thing easy! overcoming barriers to staff compliance with HAI screening</td>
<td>Fact and fiction... microbial risks and control in dental settings</td>
<td>Oral Paper Presentations</td>
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<td></td>
<td>Helen O’Connor Nurse Consultant/Deputy DIPC, Homerton University Hospital.</td>
<td>Professor Kay Currie Professor of Nursing &amp; Applied Healthcare Research. @CurrieKay</td>
<td>Peter Hoffman Consultant Clinical Scientist, Public Health England.</td>
<td>Abstract ID: 42</td>
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<td>Dr Jacqui Prieto Associate Professor / Clinical Nurse Specialist, University of Southampton.</td>
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<td>IPS R&amp;D projects – your opportunity to be involved in our latest studies</td>
<td>Barriers to decontaminating non-invasive devices</td>
<td>PHE studies on the transmission of prions and the efficacy of washer disinfectors</td>
<td>Oral Paper Presentations</td>
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<td>Dr Emma Burnett Lecturer and Researcher at University of Dundee, School of Nursing and Health Sciences in Infection Prevention and Control and Coordinator for IPS Research and Development Committee. @emmaburnettx</td>
<td>Sharon Leitch Infection Prevention and Control Nurse, NHS Ayrshire &amp; Arran. @sharon_leitch</td>
<td>Dr Jimmy Walker Scientific Leader in Water Microbiology and Decontamination at Public Health England and Secretary of the Central Sterilisation Club. @biofilmjimmy</td>
<td>Abstract ID: 140</td>
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<td>Dr Jacqui Prieto Associate Professor / Clinical Nurse Specialist, University of Southampton.</td>
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<td>Lunchtime Symposium located in the poster talk pods within the exhibition</td>
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<td>13:35 – 14:25</td>
<td>Pod 1 – Nanosonics / Pod 3 – ICNet</td>
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<tr>
<td>14:25 – 15:00</td>
<td>SESSION 16a</td>
<td>SESSION 16b</td>
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<td>Achieving perioperative normothermia</td>
<td>Moonlight and icebergs – recognising and recovering from a ‘Titanic’ moment</td>
<td>Infection prevention and control in dental labs</td>
<td>Oral Paper Presentations</td>
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<td></td>
<td>Dr Jeffrey Brown Consultant Anaesthetic, Southern Health and Social Care Trust Northern Ireland.</td>
<td>Elaine Ross Infection Control Manager, NHS Dumfries &amp; Galloway and Board Member of IPS @EGRoss85</td>
<td>Dr Rebecca Taylor Senior Dental Biosciences Lecturer, School of Healthcare Science, Manchester Metropolitan University.</td>
<td>Abstract ID: 50</td>
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<td>Abstract ID: 66</td>
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<td>See pages 42 &amp; 43 for full details</td>
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## Tuesday continued

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<tr>
<th>Time</th>
<th>Exchange Auditorium</th>
<th>Charter 1</th>
<th>Charter 2/3</th>
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<tbody>
<tr>
<td>15:05</td>
<td>SESSION 17a</td>
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<tr>
<td>15:40</td>
<td>Surgical skin preparation: translating the evidence into practical policy</td>
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<td></td>
<td>Professor Jennie Wilson</td>
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<tr>
<td></td>
<td>Professor in Healthcare Epidemiology in the Richard Wells Research Centre at the University of West London and IPS Journal Editor. @talkjennie</td>
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<tr>
<td>15:40</td>
<td>SESSION 17b</td>
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<tr>
<td></td>
<td>Exploring the impact of NHS litigation costs in infection control Issues</td>
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<td>Tracy Coates</td>
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<td></td>
<td>Safety and Learning Lead (NHS LA), NHS Litigation Authority and Independent Healthcare Consultant. @tracytwitte</td>
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<tr>
<td>15:40</td>
<td>SESSION 17c</td>
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<tr>
<td></td>
<td>How to make dental practice legionella management simple?</td>
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<tr>
<td></td>
<td>Piotr Leszkiewicz</td>
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<tr>
<td>15:40</td>
<td>SESSION 17d</td>
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<tr>
<td></td>
<td>Oral Paper Presentations</td>
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<td>Abstract ID: 67</td>
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<td>See pages 44 &amp; 45 for full details</td>
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### Exhibition Viewing, Poster Viewing and Refreshments

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<th>Time</th>
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<tr>
<td>15:40</td>
<td>SESSION 18a</td>
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<tr>
<td>16:25</td>
<td>Debate: This house believes all 5 moments of hand hygiene are equally important and need to be given the same amount of attention</td>
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<tr>
<td>17:35</td>
<td>For the motion: Professor Didier Pittet Hospital Epidemiologist of the Infection Control Programme and World Health Organisation (WHO) Collaborating Centre on Patient Safety, University of Geneva Hospitals &amp; Faculty of Medicine, Geneva, Switzerland. @DidierPittet</td>
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<tr>
<td>16:25</td>
<td>SESSION 18b</td>
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<tr>
<td>16:25</td>
<td>Spreading odontogenic infections and severe oral sepsis</td>
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<tr>
<td>16:55</td>
<td>Dr Riina Rautemaa – Richardson Consultant Medical Mycologist at the University Hospital of South Manchester and Senior Lecturer in Infectious Diseases and Medical Educational in the Institute of Inflammation and Repair, University of Manchester.</td>
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<tr>
<td>17:00</td>
<td>SESSION 19b</td>
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<tr>
<td>17:00</td>
<td>Dental infection control within the practice- the past, present and future</td>
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<td>17:35</td>
<td>Michelle Meredith Dental Education Programme Manager, Health Education England.</td>
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## Wednesday 20 September 2017

Exhibition viewing opening hours are: 09:00 – 14:20

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<tr>
<th>Time</th>
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<tr>
<td>08:50</td>
<td>Professor Ayliffe Memorial: Dr Neil Wigglesworth IPS President @Neilwigg</td>
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<td>09:00</td>
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## Programme

### Wednesday continued

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</table>
| 09:00 – 09:35 | **SESSION 20a** Ayliffe Lecture: Top ten pearls for success in infection prevention (& life)  
Professor Sanjay Saint  
Chief Of Medicine, University of Michigan and Va Ann Arbor.  
@sanjaysaint | **SESSION 20b** How do we prevent accumulation of antimicrobial resistant organisms in healthcare settings?  
Professor Satoshi Hori  
Professor of Infection Control Science, Juntendo University.  
Director of Infection Control in 6 group hospitals. | | |
| 09:40 – 10:15 | **SESSION 21a** Top 10 papers  
Professor Heather Loveday  
Professor of Evidence-based Healthcare, University of West London and past president of IPS  
@loveebhc | **SESSION 21b** Aspergillosis outbreaks: investigation and management  
Professor Malcolm Richardson  
Director of the NHS Mycology Reference Centre – a European Confederation of Medical Mycology Centre of Excellence, University Hospital of South Manchester, and Professor of Medical Mycology, University of Manchester. | | |
| 10:15 – 10:45 | Exhibition Viewing, Poster Viewing and Refreshments  
10:15 – 10:45 – Symposium located in the poster talk pods within the exhibition  
Pod 1 – 3M Healthcare  
Pod 3 – Diversey Care | | | |
| 10:55 – 11:30 | **SESSION 22a** Clinical human factors in the Acute Medical Unit (AMU) – a lesson for all hospital staff!  
Matsikachando Moyo  
Clinical Doctoral Research Fellow, University of Southampton.  
@matsika_moyo | **SESSION 22b** Engineering aspects of infection control  
George McCracken  
Head Of Estates Risk And Environment, Belfast Health and Social Care Trust. | **SESSION 22c** The Angkor Children’s Hospital, Cambodia  
Dr Carol Pellowe  
Retired Senior Lecturer, King’s College, London with a joint appointment at Guys & St Thomas Hospitals.  
Sally Belsham  
Link Practitioner, Infection Control Nuffield Hospital. | **SESSION 22d** Outbreak workshop: Let’s work another outbreak!  
Dr Evonne Curran  
Independent Nurse Consultant, Infection Prevention and Control and SPC Member.  
@EvonneTCurran |
| 11:35 – 12:10 | **SESSION 23a** Using psychological theory to improve infection prevention practice  
Dr Judith Dyson  
Senior Lecturer Implementation Science, University of Hull. | **SESSION 23b** Monitoring the patient environment  
Liz Jones  
Specialist Consultant in hospitals, care homes and other providers to improve patient service. | **SESSION 23c** Experiences of teaching in South Africa  
Christina Bradley  
Laboratory Manager HIRL, Queen Elizabeth Hospital Birmingham.  
@TinaBradley1 | **SESSION 23d** Surgical site infection surveillance: from ward to board  
Pauline Harrington  
Session organised by the IPS Audit & Surveillance Special Interest Group |
**Wednesday continued**

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<th>Time</th>
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<tr>
<td>12:15</td>
<td><strong>SESSION 24a</strong></td>
<td><strong>SESSION 24b</strong></td>
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<tr>
<td>12:50</td>
<td>Infection prevention – back to the future?</td>
<td>“The good, the bad and the ugly” – one Trust’s experience of managing an outbreak of salmonella</td>
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<td>14:20</td>
<td><strong>SESSION 25a</strong></td>
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<td>13:45 – 14:15</td>
<td>Design and implementation of new hospital build – problems and solutions</td>
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<td>14:20 – 14:55</td>
<td><strong>SESSION 26a</strong></td>
<td><strong>SESSION 26b</strong></td>
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<tr>
<td>14:20 – 14:55</td>
<td>Infections without borders</td>
<td>UV-C to Decrease Multidrug-Resistant Pathogens – Results from the BETR Disinfection Trial</td>
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<td>14:20 – 14:55</td>
<td>Professor Leo Visser Head of Department of Infectious Diseases, Leiden University Medical Centre (LUMC), Netherlands.</td>
<td>Dr Deverick J. Anderson Associate Professor of Medicine, Duke University School of Medicine, USA.</td>
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<tr>
<td>15:00 – 15:45</td>
<td><strong>SESSION 27a</strong></td>
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<td>15:00 – 15:45</td>
<td>‘Zero’ Illness – insights from the world of Elite Sport</td>
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<td>15:45 – 15:55</td>
<td>Close of conference</td>
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- **SESSION 24a**
  Infection prevention – back to the future?
  Martin Kiernan
  Visiting Clinical Fellow, Richard Wells Research Centre, University of West London.

- **SESSION 24b**
  “The good, the bad and the ugly” – one Trust’s experience of managing an outbreak of salmonella
  Gill Abbott

- **SESSION 25a**
  Design and implementation of new hospital build – problems and solutions
  Dr Jimmy Walker
  Scientific Leader in Water Microbiology and Decontamination at Public Health England and Secretary of the Central Sterilisation Club.
  @biofilmjimmy
  Dr Mark Garvey
  Associate Director of Infection Prevention, University Hospitals Birmingham NHS Foundation Trust.
  @dmarkgarvey

- **SESSION 26a**
  Infections without borders
  Professor Leo Visser
  Head of Department of Infectious Diseases, Leiden University Medical Centre (LUMC), Netherlands.

- **SESSION 26b**
  UV-C to Decrease Multidrug-Resistant Pathogens – Results from the BETR Disinfection Trial
  Dr Deverick J. Anderson
  Associate Professor of Medicine, Duke University School of Medicine, USA.
  @Deverick_A

- **SESSION 27a**
  ‘Zero’ Illness – insights from the world of Elite Sport
  Glenn Hunter
  Consultant in Performance Innovation, English Institute of Sport.

- **Close of conference**
  Dr Neil Wigglesworth
  IPS President
  @Neilwigg
Session 1a
Why is it so difficult for me to get people to follow basic infection control practises?!
Supported by an unrestricted educational grant from SRCL

Professor Michael A. Borg,
Department Head of Infection Control,
Mater Dei Hospital. Chair of Infection Control Committee and the National Antibiotic Committee, Malta.

Abstract
Despite a plethora of evidence-based guidelines and literature, implementation of correct infection prevention and control (IPC) procedures within healthcare organisations remains a challenge that infection preventionists continue to struggle against. Why is it often so difficult to spearhead effective IPC initiatives, even in relation to such basic practices such as hand hygiene and contact precautions?

This presentation will focus on possible human behavioural elements that influence IPC practices and attempt to identify why IPC implementation attempts can fail or remain sub-optimal. Principles of behaviour change – often spearheaded in industry – will be reviewed and possible ways of applying them to inform effective IPC strategies will be suggested.

Session 2a
Everything you ever wanted to know about Clostridium difficile but never thought about asking!

Professor Thomas V Riley,
Professor, Edith Cowan University, Murdoch University.

Abstract
Clostridium difficile causes a significant number of healthcare-related infections in the western world. Its highly resistant spores allow it to persist in healthcare facilities, causing diarrhoea primarily in patients who have recently been treated with antimicrobials. C. difficile infection (CDI) has been studied in detail in North America and Europe, where large outbreaks have occurred since the early 2000s. Little is known about CDI in other parts of the World, and even less about important aspects of the natural and evolutionary history of C. difficile. The One Health concept is a worldwide strategy for interdisciplinary collaboration and communication in all aspects of healthcare for humans, animals and the environment. In recent years, 70% of emerging or re-emerging infections have been vector-borne or zoonoses – animal diseases transmissible to humans. CDI should always have been considered a zoonosis, either direct or indirect. It would appear that C. difficile colonises the gastrointestinal tracts of all animals during the neonatal period, multiplies and is excreted, but cannot/does not compete well when other bacterial species start to colonise. Adult humans treated with antibiotics fool C. difficile into thinking it is colonising a neonatal gut. In the 1980s and 90s, there was an expansion of CDI in hospitals that continues today driven by cephalosporins, however, use of cephalosporins in production animals has now provided a massive reservoir of C. difficile outside the hospital. Evolution has guided the establishment of different clades of C. difficile around the World,
some more pathogenic than others. Continued education about, and surveillance of, CDI are required to monitor the burden of disease and prevent the emergence of virulent antimicrobial-resistant strains.

Session 2b
Basics of microbiology

Dr Dona Foster,
Researcher in Microbiology and Healthcare Associated Diseases at University of Oxford and Lecturer at Oxford Brookes teaching on the Masters of Infection Control and Prevention.

Abstract
Persons in care homes are generally at higher risk of infections due to age and co-morbidities. This session will discuss microbiology for practitioners in care homes. What types of infection are common, what are the transmission routes, how to prevent infections in staff and clients and where to get help.

Session 3a
Your microbial armour – the role of the human microbiome in infection prevention and control

Dr Nicola Fawcett,
MRC Clinical Research Fellow with Medical Microbiology Group at the University of Oxford and Chief Investigator of the Antibiotic Resistance in Microbiome Oxford (ARMORD) Study. @drnjfawcett

Abstract
There is increasing evidence that the microbes that colonise the human body play a key role in resisting colonisation and infection by pathogenic organisms. They may do this by direct competition and interaction, or by working with the human immune system, which relies on the presence of commensal microbes to function properly. We will then consider how existing interventions such as antibiotic use and antimicrobial products impact on the human microbiome both positively and negatively, and the implications for infection control. Finally we will explore the possibility of future interventions designed to manipulate the microbiome, to assist health and prevention of infection.

Session 3b
Essentials of wound care

Valya Weston,
Head of Service/ Associate Director of Infection Prevention and Control, Alder Hey Children’s NHS Foundation Trust and Deputy Secretary of the IPS. @valya_weston

Abstract
A knowledge of the anatomy of the skin, how it functions, along with the wound healing process are the basis for understanding the essentials of wound care and form a fundamental part of wound care management.

This presentation will describe how this knowledge can be applied in the care home setting to assist in the process of wound healing, whilst exploring the factors that may affect or prolong the healing process.

Additionally the presentation will describe how a thorough wound assessment can play an important role in assessing the progress of the wound healing process and can assist in detecting deterioration/ complications in the wound.

A wound infection can cause systemic problems and may prolong or delay the healing process. A knowledge of the signs and symptoms that may be present when a wound infection is suspected will assist the practitioner is seeking help to get the right treatment for their patient.

Finally the presentation will explore the different types of dressings that are available and which type of dressing is suitable for each type of wound.
Session 4a
E.M. Cottrell Lecture:
Igniting passion, sparking improvement

Julie Storr,
Director and Consultant, S3 Global,
contracted by World Health Organization.
@julesstorr

Abstract
We are our own secret weapon in protecting people from HAI. This session will stimulate delegates to consider how to maximize this power, shape the future and be effective advocates for IPC.

Session 4b
Cleaning – what, with what and how often

Christina Bradley,
Laboratory Manager HIRL, Queen Elizabeth Hospital Birmingham.
@TinaBradley1

Abstract
This session will discuss the importance of cleaning, selection of disinfectants, risk assessment and audit.

Session 4c
Barriers to cleaning

Sharon Leitch,
Infection Prevention and Control Nurse,
NHS Ayrshire & Arran.
@sharon_leitch

Abstract
In healthcare, patient care equipment is repeatedly reported as being unclean, which increases the risk to patients of acquiring a healthcare associated infection. Cleanliness issues are thought to be associated with lack of education, of undefined roles and responsibilities and work pressures. A recent study explored what prevents equipment from being cleaned and found three main barriers; roles and responsibilities, time and attitudes and beliefs. Current systems attempt to allocate responsibility but it is evident that hierarchical relationships exist between staff groups which results in some feeling frustrated. Other frustrations include difficulties with access to cleaning products and uncertainty of what to use and when. Staff are required to carry out eLearning modules to keep up to date with practice, but these are being completed haphazardly with sections being missed. Due to time pressures staff tend to work in silos with little or no communication which leads to cleaning omissions. Staff understand the implications of these omissions, including patient’s thoughts and feelings, this requires to be further explored.

Session 5a
Bloodstream infections – epidemiology and prevention strategies

Professor Jacqui Reilly,
Lead Consultant, Health Protection Scotland.
@JacquiSReilly

Abstract
This talk will overview the current epidemiology, burden and causes of healthcare associated BSI. It will examine the evidence for prevention, including that of Sepsis, from a population health perspective. This is important or IPC as organisms cross borders without passport control and the preventive effort does not stop or start at the hospital doors.
Session 5b – Oral Paper 1
Abstract ID: 150
Assessing the functionality and infection control implications of temporary isolation rooms
Brett Mitchell1,2, Anthony Williams1, Zorana Wong1, Jayne O’Connor3
1Avondale College of Higher Education, Faculty of Arts, Nursing and Theology, 2Griffith University, School of Nursing and Midwifery, 3Sydney Adventist Hospital, Infection Prevention and Control.

Background: Challenges with limited single rooms and isolation facilities in hospitals, have created an opportunity for temporary, portable isolation technology. This paper describes the process used to evaluate a new isolation room (RediRoom™) that can be installed in existing hospital ward areas. Our aim was to independently assess the functionality and infection control implications of this new room, in so doing, evaluate the approach used.

Methods: Using a crossover interventional study, a mixed methods approach involving direct observation, video recording, interviews using a descriptive phenomenological approach and individual questionnaires were used. Thirteen participants were randomly assigned to the RediRoom™ or a control room and required to completed a range fourteen different clinical (nursing) activities. The setting for the study was a clinical ward environment at an Australian higher education institution. The study was conducted over three days. A technical assessment from two infection control professionals was also undertaken using existing tools from the United Kingdom and Australia. These usefulness of these tools for new isolation approaches was evaluated.

Results: The use of social network analysis from video recordings enabled objective comparisons of clinician movement within the rooms and the time taken to undertake procedures. The movement and time taken to complete a range of clinical activities in both rooms was broadly consistent. The use of interviews and surveys enabled validation of video recording observation. A form of reflexive ethnography with participants and for researchers could be of value in similar studies in the future.

Conclusion: Our study attempted to simulate a clinical environment and clinical activities, to evaluate new isolation technologies. The multifaceted approach was largely successful, with our experience providing valuable lessons for others wishing to evaluate new technologies. We propose refinements to existing guidelines that are used to evaluate isolation rooms.

Relevant conflicts: Nil.

Session 5b – Oral Paper 2
Abstract ID: 155
No sitting ducks! The impact of point of care PCR testing on admission to hospital
Elaine Ross1, Martin Connor2, Adele Foster3
1NHS Dumfries & Galloway, 2NHS Dumfries & Galloway, 3NHS Dumfries & Galloway.

Background: During a period of extreme winter bed pressures, during which there had been cases of hospital acquired respiratory infection, a 360 bed district general hospital introduced a point of care testing polymerase chain reaction (PCR) platform located within the medical assessment unit. This could provide a rapid Influenza / Respiratory syncytial virus (RSV) test result within 30 minutes.

The positioning of a point of care testing platform within the clinical environment was a tactical measure designed to have maximum influence on patient placement, enhanced transmission based precautions, antiviral treatment and prophylaxis.

Aims: Establish if point of care Influenza / RSV rapid testing leads to a reduction in hospital acquired Flu and RSV. Establish if having a rapid PCR result increased the prescription of antiviral treatment or prophylaxis where indicated. Establish if this information could be used to maximise efficiency in the use of infection control interventions and bed management.

Method: Patients admitted to the medical assessment unit, who satisfied influenza algorithm requirements, were tested for Influenza
& RSV by PCR and placed and treated accordingly. This was audited by the Infection Prevention and Control Team.

Results:

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<tr>
<th></th>
<th>Flu A</th>
<th>RSV</th>
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<tr>
<td>HAI 7 days before POCT</td>
<td>7</td>
<td>1</td>
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<tr>
<td>HAI 11 days after POCT</td>
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Conclusions:
- No cases of HAI Influenza A or RSV occurred following introduction of POCT
- Point of care testing supported cohort nursing of symptomatic patients
- Use of single rooms was optimised
- Provision of influenza prophylaxis and treatment was standardised
- There were ‘No sitting ducks’: Point of care testing ensured that susceptible patient’s were not exposed to Flu A or RSV.

Acknowledgement: To Cepheid UK for the provision of the GeneXpert® RT-PCR and consumables for the study.

Session 5c
Striving for Improvement

Helen Pilley, Clinical Nurse Specialist, Infection Prevention, Cheshire and Wirral Partnership NHS Foundation.

Abstract
This session will focus on care providers who regularly have to make decisions in relation to Infection Prevention and Control activity in their premises, alongside their many other competing priorities. The reality is that there is only a finite amount of funds available and this seminar will aim to support care providers in making these choices.

Session 5d
New to infection prevention introduction

Karen Wares, Senior Associate Lecturer, Robert Gordon University. Deputy Clinical Director, GAMA Healthcare. @kdwares
Craigh Bradley, Lead Infection Prevention Specialist Nurse, University Hospitals Birmingham NHS Foundation Trust. @CraigBradleyF1

Abstract
It can be quite a daunting experience being a new infection prevention practitioner with people expecting you to know all the answers from day one. This session forms part of the “New to Infection Stream” at the conference, and the aim of this session is to introduce you to others in the same position as you, discuss the challenges that you may face in your infection prevention career and also provide you with some top tips that you can use along the way.
Session 6b – Oral Paper 1
Abstract ID: 157
Pilot evaluations of Beat the Bugs: A community education course on hygiene, self-care and antibiotics
Charlotte Eley¹, Vicki Young¹, Catherine Hayes¹, Gill Parkinson², Katie Tucker², Cliodna McNulty¹
¹Primary Care Unit, Public Health England, ²Kingfisher Treasure Seeker.

Background: e-Bug, operated by Public Health England, is an international health education resource for children teaching about antibiotics, hygiene and infection. An estimated 80% of all antibiotics are prescribed in the community and 50% of these are unnecessary. e-Bug collaborated with Kingfisher Treasure Seekers, to develop a 6 week community hygiene and self-care course called Beat the Bugs covering: an introduction to microbes, hand and respiratory hygiene, food hygiene, oral hygiene, antibiotics and a final session on self-care. Educating communities on hygiene and self-care is important to discourage inappropriate use of antibiotics.

Methods: Before and after knowledge questionnaires were completed during two pilot courses; one with adults with learning difficulties and one with young mothers at a Children’s Centre. Sessions were observed by researchers to increase validity and monitor fidelity. Follow-up participant focus groups and course leader interviews were conducted at both venues to explore their views on the course.

Results: Quantitative results showed an improvement in participant knowledge in each session; microbes and antibiotics sessions reported the highest improvement in knowledge. Qualitative results revealed that participants had retained knowledge, particularly around self-care. Participants reported behaviour change including an increase in appropriate hand washing and tooth brushing.

Conclusion: The Beat the Bugs course can be used as a tool for the public and community groups to increase awareness and change behaviour around hygiene, self-care and antibiotics. The course aims to increase the public’s confidence and knowledge on managing their own infections to subsequently reduce inappropriate antibiotic use.

The Beat the Bugs course is freely available to download from the e-Bug website www.e-Bug.eu/Beat-The-Bugs. Course feedback will be used to improve the course prior to further pilots.

Beat the Bugs supports current e-Bug resources in implementing NICE guidance NG63 to improve public knowledge and behaviour around hygiene, self-care and antibiotic use.

Session 6b – Oral Paper 2
Abstract ID: 115
Antimicrobial stewardship across a whole health and care economy
Karen Hawker¹, Marie Noelle Vieu²
¹South London Health Protection Team- PHE, ²Lambeth Council.

The Lambeth Southwark and Lewisham Infection Control Committee (LSLICC) agreed to review Antimicrobial Stewardship (AMS) across two boroughs using recommendations from NICE Guidelines and other national documents. Agreed aims are shown in Table 1:

Stakeholders were approached for interview using a semi-structured questionnaire and a focus event was held with the LSLICC. Results were tabulated and common areas for action identified.

Results Highlights: All organisations responded, although type of response was variable. Some stakeholders substituted written responses or copies of existing reports. All organisations had some level of plan or strategy, although not always documented. Organisations with prescribers had audit programmes. Most organisations had some type of communications activity with staff or public/patients including Antibiotic Awareness Week. Acute trusts tended to be more compliant, using toolkits such as Start Smart then Focus. One
Acute trust planned to appoint a sepsis/AMS specialist nurse.

One gap was a lack of updates for non-prescribers who may be administering antimicrobials and spotting early signs of infection.

Gaps identified in non-acute settings included lack of information on local resistance patterns and delays for microbiology results meaning diagnostics had little influence on choice of agents.

Social care staff were an unknown quantity. It was acknowledged that domiciliary and care home staff may be involved in administering antimicrobials. They can be best placed to spot early signs of developing infections, especially UTIs allowing early interventions and avoidance of antimicrobials. Uptake and availability of influenza vaccination was also an issue.

**Recommendations:**
- Resistance data to be obtained for non-acute settings.
- More generally available information including early signs of UTI and the importance of influenza vaccination in preventing need for antimicrobials.
- Influenza vaccination to be more available for Community & Social Care staff.
- A joint education initiative for non-medical staff including non-medical prescribers.

**Session 6c**

**Hydration of the frail elderly in care homes: barriers and facilitators**

**Professor Jennie Wilson,**
Professor in Healthcare Epidemiology in the Richard Wells Research Centre at the University of West London and IPS Journal Editor.
@talkjennie

**Abstract**

Age-related physiological changes including loss of thirst, reduced water reserves and diminished kidney function increase the risk of dehydration in older people. Dehydration has numerous harmful affects including increasing the risk of urinary tract and other infections, stroke, falls, constipation, confusion and hospital admissions. Maintaining hydration is a particular problem for residents in long term care settings. This presentation describes a study undertaken in 2 care homes in West London that explored the barriers to resident hydration and used service improvement methodology to optimise their fluid intake.

Interventions included Protected Drinks Time, Drinks Menu, Mealtime Guides and new drinking equipment. At the beginning of the project few residents received more than 1000ml of fluid a day. Interventions resulted in more residents receiving drinks, an increase in average individual fluid intake to above 1500ml and a decrease in laxative use. However, effective change is dependent on consistent leadership and changing care delivery patterns.

**Session 6d**

**The basics of microbiology and immunology**

**Dr Dona Foster,**
Researcher in Microbiology and Healthcare Associated Diseases at University of Oxford and Lecturer at Oxford Brookes teaching on the Masters of Infection Control and Prevention.

**Abstract**

To effectively manage infections in hospitals, knowledge of microbes is required. This session presents a broad overview of microbiology and immunology to illustrate how differences between bacterial and viral species have implications for infection control policies and practice.
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<td><strong>Types of evidence; vascular access focus</strong></td>
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<tr>
<td>Dr Evonne Curran, Independent Nurse Consultant, Infection Prevention and Control and SPC Member. @EvonneTCurran</td>
<td>Steve Hill, Procedure Team Manager, The Christie NHS Foundation Trust.</td>
</tr>
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</table>

**Abstract**

This presentation will look at the different outbreaks that most commonly arise in care home settings. There will be a brief overview of the modes of transmission which lead to outbreaks, as well as the micro-organism survival times which makes it difficult to prevent and control them. But most importantly, the presentation will include how to prevent and prepare for outbreaks. Not all outbreaks in care homes can be prevented – but with good preparedness some can. For those outbreaks which cannot be prevented, detecting and notifying public health agencies early will reduce ill-health and prevent disruption to the care home, how to do this will be discussed.

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<td><strong>How to assess scientific posters: A practical guide</strong></td>
<td><strong>Norovirus – How can we minimise the impact?</strong></td>
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<tr>
<td>Michael Nevill, Director of Nursing, British Pregnancy Advisory Service. @michael_nevill</td>
<td>Judy Potter Lead Nurse/Director for Infection Prevention and Control.</td>
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**Abstract**

One of the most important parts of Infection Prevention conferences is the scientific posters. There is always some top-notch science on show, some of which will have implications on your day job. But where to start in accessing the important information for you? This practical guide, including a tour of some posters, will take you through the process of deciding which posters to visit, tips for quickly reviewing posters, and some ideas for making most of the new information you will gain.

**Abstract**

Norovirus is a highly contagious pathogen with potential for causing outbreaks in hospitals and other communal care settings. This presentation will discuss the impact that outbreaks and outbreak control measures of norovirus can have on individual patients, infection prevention teams and the organisation. Control measures for reducing the impact will be explored and some suggestions made as to why such control measures may or may not be successful.
Session 8c
Joining the dots – an investigation into an outbreak of CPE urinary tract infections in community care

Elaine Ross,
Infection Control Manager, NHS Dumfries & Galloway and Board Member of IPS.
@EGRoss85

Abstract
The delegates will be aware of risk of cross infection with this emerging antibiotic resistant pathogen in out of hospital settings.

In late 2013 an unusual E Coli was identified by the local Microbiology laboratory in a CSU submitted from a community setting via the GP.

Within 3 months 2 further unusual community E Coli with the same resistance pattern were identified.

The presentation will describe the investigation and subsequent identification of further linked cases within the community 3 years later together with an example, of horizontal gene transfer between species within a household context.

The need for communication between healthcare providers and agencies is highlighted, as is the requirement for the use of standard infection control precautions and single patient use equipment.

Session 8d
Essential IPC toolkit

Sue Millward,
Infection Prevention Nurse Consultant, Nuffield Health.
@NHInfectPrevent

Abstract
Infection Prevention and Control continues to evolve in response to patient safety and quality improvement initiatives as well as to local incidents and emerging global threat to health.

IPNs have a wide reaching, varied and pivotal role, responsible for supporting, advising and collaborating with colleagues, patients, visitors and other organizations’ in the prevention and control of infection through surveillance, audit, investigation and education.

Newly appointed Infection Prevention Nurses may find themselves in healthcare environments and situations in which they have never been to before (such as the laundry or HSSU) and asked questions they have no idea about. This can be quite daunting and this session will provide an overview of some of the lessons and tips from an experienced IPN which may help make the life of a new IPN a little bit easier!

Session 9a
Vessel health & preservation in the UK: An update on the development, implementation & evaluation of a multi-professional framework for making rational vascular access decisions for a range of patients

Dr Tim Jackson,
Consultant In Anaesthesia & Intensive Care Medicine, Calderdale & Huddersfield NHS Foundation Trust.
@timjacks9

Abstract
The IPS IV forum subgroup has been working on your behalf to develop a UK framework that fulfils the principles of Vessel Health & Preservation in Vascular Access: that the right patient receives the right line and in the right time. This work has achieved various milestones during the past 5 years. We now have a finalised framework of tools that can be adapted to a variety of clinical pathways throughout the UK to guide front-line clinicians to make the best vascular access choices for their patients, and this framework is being repeatedly evaluated in several local initiatives. The challenges that now exist are to work out how to implement the framework into the real world of the modern NHS, employing improvement strategies to make this a viable solution to improve the experience and clinical
outcomes for the millions of patients who receive vascular access as part of their journey through healthcare in the UK. This presentation will provide an update on where this journey has reached, and where we hope to go in future.

**Session 9b**

**The importance of community infection prevention and control**

*Tracy Cooper,*
Assistant Director of Nursing – Infection Prevention, Betsi Cadwaladr University Health Board.

**Abstract**

High profile measures to prevent healthcare-associated infection still focus predominantly on actions that can be taken within acute hospitals. However, in the UK approximately 90% of healthcare interactions take place outside hospitals, and the range of infections we face continues to grow and challenge the health of our population.

The scale and impact of ‘non-hospital’ infections is not well understood, and the influence of changing population characteristics such as an increasing older population and increasing levels of obesity lead to greater vulnerability and risks of infection.

The UK has committed to halving the number of gram-negative bloodstream infections by 2020. Analysis of E coli bacteraemia in England (2012-14) highlights 76% are unrelated to hospital care, and therefore community infection prevention activities will be vital to achieve significant reductions in these infections.

This session will consider the breadth of community infection prevention and control activities, why a focus outside acute hospitals is critically important at the present time, and how community infection prevention activity might evolve and grow.

**Session 9c**

**How are ‘wee’ today?**

*Emma Sneed,*
Commissioning Lead Nurse Infection Prevention, Worcestershire Clinical Commissioning Group.

*Sharon Stuart,*
Infection Prevention and Control Commission, South Warwickshire CCG.

**Abstract**

Ensuring quality of care is essential for those living in a residential/nursing setting. Not all CCG’s employ IPC nurses to work across the health economy to include care homes. This session will explore how commissioning IPC nurses can make a difference to patient care within long term care facilities. This includes working strategically to provide advice, support audit, education (to include a link nurse or link champion programme) and resources to support managers and care home staff to deliver safe and effective care.

**Session 9d**

**How clean is your house?**

*Christina Bradley,*
Laboratory Manager HIRL, Queen Elizabeth Hospital Birmingham. @TinaBradley1

**Abstract**

This session will discuss what decontamination is and how it can be achieved.
**Session 10a**

**Meet the expert: *Clostridium difficile* the irreducible minimum**

Dr Michael Weinbren, Consultant Microbiologist / Infection Control Doctor, Chesterfield Royal Hospital.

**Abstract**
Since 2006/7 the incidence of *C. difficile* disease has fallen dramatically and the question arises as to whether the irreducible minimum has been achieved. The concept of PII (Period of Increased Incidence) has been helpful in infection control management. However in later years most cases appear not to be linked (by ribotyping) when two or more cases occur at ward level. This presentation is a hypothesis with some supporting data that cross infection is still occurring but perhaps our resources now need to be targeted elsewhere.

**Session 10b**

**Meet the expert: campaign: ‘VERB work in an organised and active way towards a goal’ – standing up for the good cause of IPC**

Claire Kilpatrick, Director S3 Global (KS Healthcare Consulting), Independent. WHO Consultant Manager & Technical Officer, WHO. @claireekt

**Abstract**
There has been a rise in national hand hygiene campaigns in the last 15 years and almost 10 years ago the World Health Organisation (WHO) global campaign, SAVE LIVES: Clean Your Hands, was launched. The definition of ‘campaign’ is recorded as **verb: ‘work in an organised and active way towards a goal’**. This meet the expert session will describe:

- the connection between campaigning and an infection prevention and control multimodal improvement strategy
- the WHO recommendations for national hand hygiene campaigning within health care
- engagement in the annual 5 May global hand hygiene in health care campaign
- the future of working in an organised and active way in order to achieve the goal of bringing people together in support of global improvement and infection reduction, demonstrating the world’s commitment to this priority area of health care – audience interactive exercise
- that in a crowded market place, consideration should now be given to how infection prevention campaigning can complement and be aligned with other infection related priorities including sepsis and antimicrobial resistance.

**Session 11a**

**Incorporating infection prevention into the healthcare building**

Professor Satoshi Hori, Professor of Infection Control Science, Juntendo University. Director of Infection Control in 6 group hospitals.

**Abstract**
Juntendo University Hospital (JUH) built a new hospital tower with 23 floors in 2015. This is the first evidence-based healthcare facility incorporating infection prevention and control (IPC) specifications in Japan. The priority of IPC has been kept low in healthcare building constructions in our county, because of ignorance of the impact of IPC by hospital stakeholders. In order to prevent cost-reduction pressure, each specification was thoroughly considered in various aspects, such as cost-effectiveness, evidence-based, safety, and expected roles of JUH in the medical district. The positive and negative effects on antimicrobial-resistance and HAI acquision will be discussed in this session.
Session 11b
Surveillance for antimicrobial resistance in dentistry – no room for complacency

Professor Andrew Smith,
Professor of Clinical Bacteriology and Hon Consultant Microbiologist for NHS Greater Glasgow and Clyde, Deputy Director of the Scottish Haemophilus, Legionella, Meningococcal and Pneumococcal Reference Laboratory.

Abstract
The aim of this session is to provide practitioners with a basic overview of the different mechanisms of antimicrobial resistance that can be encountered during dental surgery. The session will commence using first hand clinical experience of a patient presenting to a dental hospital identified as a carrier of CPE’s, otherwise known as Carbapenemase (bacterial enzymes that inactivate carbapenems, a carbapenem is a broad spectrum antibiotic used to treat some resistant strains of bacteria) Producing Enterobacteriaceae (these are a large family of bacteria such as E.coli or Klebsiella species that are usually found in the gut but also found in dental plaque and oral mucosal swabs). We describe the infection prevention and control issues that arose and how they were resolved. Finally, since dental practitioners are the largest prescribing group for metronidazole, we will examine metronidazole use and abuse in dental practice and the silent rise of metronidazole resistance.

Session 11c
A human metapneumovirus outbreak in a psychiatric intensive support unit

Judy Carr,
Lead IPC Nurse, South Staffordshire and Shropshire Healthcare.

Abstract
The session covers the course of an outbreak of Human Metapneumovirus (hMPV) in a Psychiatric intensive care unit (PICU) over a Christmas and New Year period. As well as understanding the physical impact of this virus, the session will look at the difficulties in recognising and then managing the outbreak in this challenging environment.

Objectives
To give a basic knowledge around hMPV
To recognise the difficulties of controlling an outbreak of hMPV in a PICU
To share the lessons learnt and the areas where good practice which impacted on the control of the outbreak.

Session 11c
Revolutionising infection prevention and control in the mental health and LD setting

Jenny Boyce,
Lead Infection Prevention & Control Nurse, Northamptonshire Healthcare Foundation Trust.

Abstract
This session aims to show how the IP & C within a Mental Health & LD Trust was transformed following a merger of services in July 2011 and how the service has developed during the 5 years so that now there is a proactive, learning environment throughout the organisation.
Session 11c
One patient’s sex toy in another’s PICC line: An exploration of the complexities of delivering care in an acute mental health setting and how this might impact infection prevention and control practice to accommodate this

Tracey Jones, Infection Prevention and Control Nurse, Cheshire and Wirral Partnership Trust.

Rachel Vilches Sevillano, Ward Manager, Cheshire and Wirral Partnership Trust.

Abstract
This presentation will seek to reflect on the complexities of delivering IPC care in an acute mental health setting and evaluate the benefits of this reflective process both in terms of identifying possible future challenges and solutions to meet those challenges.

The presentation is a result of the experiences gained during the first year of employment as an IPC nurse in a variety of clinical environments and attending last year’s IPS conference. It is apparent that the intricacies of delivering IPC services both in mental health and learning disability are not as well understood as their acute care counterparts. To this end, this presentation seeks to aid further understanding of the current and possible future challenges faced by IPC practitioners in these clinical specialist areas. Consideration will also be given to the role of the IPS in supporting IPC practitioners working in these fields of nursing.

Session 12a
Automated room decontamination devices – Hydrogen Peroxide and/or UV to reduce healthcare-associated infections?

Dr Deverick J. Anderson, Associate Professor of Medicine, Duke University School of Medicine, USA. @Deverick_A

Abstract
Epidemiologically important pathogens can be transmitted through the healthcare environment. Organisms such as methicillin-resistant Staphylococcus aureus (MRSA), vancomycin-resistant Enterococcus (VRE), and Clostridium difficile persist in the environment, and routine cleaning practices lead to incomplete removal of pathogens. What strategies can be employed to improve hospital cleaning and disinfection and decrease this risk for our patients? Two automated room decontamination technologies, hydrogen peroxide and UV light, are increasingly used to provide adjunctive disinfection following standard chemical disinfection. These technologies are effective, but many issues remain to sort out: which one to use, in what rooms, how often, and what are the logistical advantages and disadvantages of one strategy vs. the other?

Session 12b
Fundamentals of behaviour change

Dr Carmen Lefevre, Research Associate and Research Lead at UCL Centre from Behaviour Change. @carmen_lefevre

Abstract
The importance of behaviour in preventing the spread of infection is increasingly recognised. For example, appropriate hand hygiene, correct use
of protective gloves and clothing, and cleaning procedures, some of the key measures in preventing infection spread according to the WHO, are all behaviours. For such measures to be effectively implemented we require a good understanding of what is required for a person to perform each behaviour. The most effective interventions to change behaviour target multiple parts of the health care system, including health care professionals, patients, and the public. Behavioural science provides methods for understanding behaviours and their influences, and for developing interventions that are most likely to be effective in their contexts. This talk will outline evidence-based principles of behaviour change and a systematic method for designing interventions to change behaviour. This involves defining a clear target behaviour, conducting a behavioural analysis to identify the facilitators and barriers of the target behaviour, and identifying the most suitable behaviour change techniques for the context. The talk will illustrate how these principles and methods can be applied to infection prevention, using examples of improving hand-hygiene and adherence to the ‘Sepsis 6’ guidelines in hospitals.

Session 12c
Respiratory risks in dental settings

Dr Brian Crook,
Health and Safety Executive, Microbiology Team, Health and Safety Laboratory.

Abstract
Respiratory infections may pose a risk in a wide range of professions. Under ideal circumstances, physical barriers can be used to protect people from infection, but this is not practical in many cases. Consequently, respiratory protection may have to be relied upon. This presentation will review the proportionate use of respiratory protection against infection risk in the context of everyday and working life. Although not designated respiratory protection, other protective barriers such as surgical masks may provide practical solutions, and their effectiveness will be considered.

Session 14a
The IPS competency framework revisited: an interactive online assessment

Helen O’Connor,
Deputy Director Infection Prevention & Control at Hinchingbrooke Healthcare NHS Trust.
@hloconnor1

Abstract
The IPS have had competences for practice since 2000. They were revised in 2004 and subsequently in 2011. This revision provides a framework for all clinicians engaged in IPC, and demonstrates how they can be used to as part of individual performance management and re-registration for practice. The revised competences are presented in an online format.

Session 14b
Make doing the right thing easy! Overcoming barriers to staff compliance with HAI screening

Professor Kay Currie,
Professor of Nursing & Applied Healthcare Research.
@CurrieKay

Abstract
Background: Admission screening for selected multi-drug resistant organisms (MRDOs) is part of the hospital infection prevention and control strategy to prevent healthcare associated infections (HAIs). As new MDRO related HAIs emerge, the risks of transmission and treatment failure of these infections has resulted in admission screening for selected MDROs being introduced into the repertoire of patient admission processes. Detailed national policies and guidelines for
selected MDRO admission screening are available and screening procedures may appear deceptively simple. However, what may appear straightforward from an IPC perspective may be considered a ‘complex intervention’ in the context of embedding the screening practice into the everyday work of healthcare workers. The attitudes and beliefs of individuals, as well as group dynamics and organisational contexts, may influence intentions and actual screening behaviours, thereby influencing compliance levels and the effectiveness of ‘routine’ screening policies.

**Aim:** This presentation will use the findings of the recent AMR-BESH study, which sought to ‘Provide evidence of drivers, barriers and acceptability factors towards HAI screening policy in NHS hospitals’ to illustrate group and individual factors that may influence attempts to implement current and evolving HAI screening practice in hospitals.

**Methods:** Applying constructs from Normalisation Process Theory and Theoretical Domains Framework, qualitative data was gathered from four diverse NHS Boards via interviews with Infection Control Managers and Microbiologists (n=8) and from seven nursing staff focus groups (total n=38). Findings informed a national survey of ward nursing staff (n=450). Results were shared with key NHS stakeholders (n=27) and a modified Delphi technique used to generate pragmatic recommendations to enhance HAI screening policy and practice.

**Findings:** Individual’s beliefs and work-group clinical contexts influence screening compliance. Compliance is likely to be higher when: staff have knowledge of hospital’s policy and processes for screening; believe consequences of HAI are severe; have feedback on their screening compliance rates; screening is highly routinized in practice. Compliance is likely to be lower when acuity and patient flow pressures mean screening is perceived as less of a priority. The stakeholder Delphi study generated seven categories of recommendations to respond to identified screening challenges.

**Conclusions:** Implementing organisational systems to enhance staff understanding of HAI and ‘Make doing the right thing easy’ in busy clinical contexts are key components to enhancing HAI screening compliance.

**Session 14c**

**Fact and fiction...microbial risks and control in dental settings**


**Abstract**

We live in a world full of microbes – on us, in us and surrounding us. Some of these microbes are far more significant to infection transmission in the dental setting than others. This presentation will attempt to: 1) explore how dental settings and instruments are contaminated and by what, 2) identify the significance of contamination from various sources in dental settings and 3) outline the significance of decontamination of dental instruments and the environment. This should enable those performing or guiding decontamination to make rational decisions.

**Session 14d – Oral Paper 1**

**Abstract ID: 42**

**Studies from the TRACE rig: a unique model system to investigate the transmission of Carbapenemase-producing Enterobacteriaceae in hospital drains**

Susan Paton, Ginny Moore, James Walker Allan Bennett


Carbapenemase-producing Enterobacteriaceae (CPE) are increasingly important causes of healthcare-associated infection. Suspected reservoirs include hospital sinks, waste traps and drains. At PHE Porton a unique laboratory model incorporating stainless-steel utility sinks (SSUS), clinical hand-wash basins (CHWB) and
appropriate fixtures, fittings, water temperature and hardness levels to simulate a clinical setting has been designed and built. This controlled environment was used to investigate factors facilitating the colonisation, proliferation and dispersal of CPE.

Waste traps, known to be contaminated with CPE-containing biofilms were removed from hospital wards and installed within the model system. Taps associated with each SSUS and CHWB were flushed four times a day. Water and biofilm samples were taken from each waste trap to monitor the type and level of organisms (both CPE and non-CPE) before, during and after interventions. The effect of adding or removing hand-wash soap, detergent and synthetic dishwater to the flushing regimen was determined. The potential for aerosols to be released from contaminated waste traps was also assessed. Removing detergent from the flushing regimen significantly decreased the number of bacteria recovered from the waste traps. In contrast, the presence/absence of hand-wash soap had little effect on bacterial numbers. Twice-daily enrichment with synthetic dishwater led to a rapid increase in both the number and diversity of microorganisms isolated from the trap water, including CPE previously only isolated from the trap biofilms. Aerobiological sampling did not detect the presence of CPE in aerosols released during normal sink use.

The TRACE rig provides a safe self-contained system for studying contaminated traps in situ. Regular addition of nutrients resulted in a proliferation of organisms and the results suggest that aerosolisation of these organisms is minimal. This work demonstrates that sink trap microbiomes are influenced by the nutrient sources introduced to them, enforcing the importance of appropriate discard of hospital waste.

Session 14d – Oral Paper 2
Abstract ID: 135

Monoclonal colonisation of intensive care unit water network by Pseudomonas aeruginosa allows the assessment of the residual infectious risk associated to water treated with antimicrobial filters

Sophie Baranovsky1,2, Guilhem Royer2, Sophie Combaluzier1, Philippe Corne3, Sara Romano-Bertrand1,2, Estelle Jumas-Bilak1,2
1Healthcare Infection Prevention Department, University Hospital of Montpellier, 2Research Team "Hydric Pathogens, Health and Environments", University of Montpellier, 3Intensive Care Unit, University Hospital of Montpellier.

Just before the opening of a 20-bed intensive care unit (ICU), the whole new water network was highly contaminated by a unique clone of Pseudomonas aeruginosa ST299. All 65 water points-of-use in the ICU were immediately equipped with antimicrobial filters. During the first 18 months, monthly sampling campaigns of water sampled downstream and upstream filters were performed to check filters efficacy and to follow water network contamination. All clinical strains of P. aeruginosa isolated from hospitalized patients were collected. P. aeruginosa strains were genotyped by Multi-Locus Sequence Typing (MLST) and multiplex rep-PCR.

From March 2015 to August 2016, the water contamination varied between 200 to >10^4 CFU/100mL according to the tap. All P. aeruginosa strains belonged to the genotype ST299. From 464 samples of filtered water, 8% were positive for bacteria (from 1 to 100 CFU/100mL) including 2% positive for P. aeruginosa, indicating filters’ efficiency of 98%. From 320 clinical strains of P. aeruginosa isolated in 149 patients during the study, 279 isolated retrieved from 138 patients were compared to the water clone ST299 by multiplex rep-PCR. Fifteen clinical strains from 10 patients were identical to clone ST299. Despite the presence of antimicrobial filters onto all water points-of-use in the ICU, the prevalence rate of the ST299 was of 5.4% of all clinical isolates, corresponding to 6.7% of the patients colonized and/or infected by P. aeruginosa.

These results show that antimicrobial filters are not fully efficient and expose patients when the
water network is highly contaminated. The daily disinfection of filters is recommended to limit biofilm formation on filter surface. The microbiological survey of filtered water is needed in units hosting at-risk patients for P. aeruginosa infections, even when all water points-of-use are protected by filters.

Session 15a
IPS R&D projects – your opportunity to be involved in our latest studies

Dr Emma Burnett,
Lecturer and Researcher at University of Dundee, School of Nursing and Health Sciences in Infection Prevention and Control and Coordinator for IPS Research and Development Committee.
@emmaburnetttx

Dr Jacqui Prieto,
Associate Professor / Clinical Nurse Specialist, University of Southampton.
@jacquiprieto1

Abstract
The purpose of this session is to present the protocols of two research studies currently being undertaken by two teams within the Infection Prevention Society R&D network:

Defining an Optimal Infection Prevention Service (DOIPS): Adopting a mixed methods research design, this study aims to define an optimal infection prevention and control service in different contexts and settings within the UK and Ireland. This will inform a national infection prevention and control service.

Community Catheter Management (CCAMA) study: This study aims to determine the number of people with an indwelling urinary catheter managed by the district nursing service and includes the provision of demographic, referral and catheter management plan/passport details.

Session 15b
Barriers to decontaminating non-invasive devices

Sharon Leitch,
Infection Prevention and Control Nurse, NHS Ayrshire & Arran. @sharon_leitch

Abstract
In healthcare, patient care equipment is repeatedly reported as being unclean, which increases the risk to patients of acquiring a healthcare associated infection. Cleanliness issues are thought to be associated with lack of education, of undefined roles and responsibilities and work pressures. A recent study explored what prevents equipment from being cleaned and found three main barriers: roles and responsibilities, time and attitudes and beliefs. Current systems attempt to allocate responsibility but it is evident that hierarchical relationships exist between staff groups which results in some feeling frustrated. Other frustrations include difficulties with access to cleaning products and uncertainty of what to use and when. Staff are required to carry out eLearning modules to keep up to date with practice, but these are being completed haphazardly with sections being missed. Due to time pressures staff tend to work in silos with little or no communication which leads to cleaning omissions. Staff understand the implications of these omissions, including patient’s thoughts and feelings, this requires to be further explored.
Session 15c
PHE studies on the transmission of prions and the efficacy of washer disinfectors

Dr Jimmy Walker, Scientific Leader in Water Microbiology and Decontamination at Public Health England and Secretary of the Central Sterilisation Club. @biofilmjimmy

Abstract
Whilst there is a limited evidence base on the cross-infection risk associated with dental instruments, hepatitis B and Staphylococcus aureus have been transmitted to dental patients due to inadequate instrument decontamination. There have also been infection concerns with the use of hand-pieces and the accumulation of organic matter, oral microorganisms and human tissue in the lumens. Whilst prions transmission has never been associated with dental procedures there was sufficient concern for the DH to commission a bioassay study to investigate the potential risks of transmission via oral tissues and the small intestine. Transmission of prions via the oral route in the bioassays was of sufficient concern for endodontic files to be designated single use. PHE investigated the effectiveness of washer disinfectors to clean dental instruments in response to Health Technical Memorandum 01-05, Dental Decontamination. Equipment was tested according to ISO 15883 parts 1 & 2 by an independent engineer to determine the cleaning efficacy, using Edinburgh test soil and thermometric disinfection parameters. Thirteen WD were submitted by six manufacturers and there were concerns about three of the WD in term of their ability to clean the hand-pieces effectively. The results will be discussed from a microbiological risk perspective.

Session 15d – Oral Paper 1
Abstract ID: 140

Using a stand-alone air disinfection unit to reduce the risk from contaminated aerosols from heater-cooler units used for cardiothoracic surgery

Eleonora Dyakova, Siddharth Mookerjee, Moya Alexander, Hugo Donaldson, Gillian Bleeze, Henry Bishop, Danni Owens, Anan Ghazy, Kathy Bamford, Jon Otter
Imperial College London.

Introduction: A small number of patients undergoing cardiac surgery where cardiopulmonary bypass machines were used have developed a surgical site infection (SSI) with Mycobacterium sp., including one locally. We report the findings from an evaluation of a stand-alone air disinfection unit in reducing the risk of air contamination in cardiothoracic theatres in which water heater-cooler units (HCUs) are situated.

Methods: The Trust has five theatres that are used for cardiothoracic surgery. In August and September 2016, a Plasmair air disinfection unit was placed in one of the theatres (‘test’) and the other four used as controls. Active air sampling for fungi was performed in each of the theatres in July (before the unit was installed), September (during the use of the unit), and in November (after the unit was removed). Air samples were collected from the front and rear outlets of the HCUs. The mean fungal counts in test theatre were compared with counts from control theatres using T-tests.

Results: The mean fungal count in the test theatre was significantly lower than in control theatres during operation of the air disinfection unit (1 vs. 13 cfu per 500 L, p=0.01), but not before its installation (23 vs. 57 cfu per 500 L of air). The mean fungal count in the test theatre was significantly higher in the test theatre than in the control theatres after the air disinfection unit was removed (11 vs. 5 cfu per 500 L of air).

Conclusion: A stand-alone air disinfection unit resulted in a marked reduction in fungal contamination of the air compared with control
Theatres in which no intervention occurred. Our findings suggest that stand-alone air disinfection units may be a useful measure in mitigating the risk of contaminated aerosols associated with HCU.

Session 15d – Oral Paper 2
Abstract ID: 63

Patient safety outcomes benefit from collaboration between the sepsis lead Nurse and the infection, prevention and control team

Paula Evans, Rosie Dixon
Sherwood Forest Hospitals Nhs Foundation Trust.

Background: concurrently higher than expected Clostridium difficile infections. There was recognition that measures needed to improve sepsis care may have an adverse effect on antimicrobial resistance (AMR) and Clostridium difficile rates.

Method: In June 2015, as part of a service improvement project, the Sepsis Lead Nurse was incorporated within the Infection Prevention and Control Team (IPCT).

The Sepsis Nurse had access to all laboratory and IPCT surveillance systems. Infection related root cause analyses, bacteraemia case investigations and sepsis mortality reviews were conducted jointly.

Education, training and awareness campaigns were conducted jointly to demonstrate the relationship between infection, sepsis and AMR. All infection, sepsis and AMR audits were combined and managed electronically.

Results: Audit data show compliance with sepsis treatment bundle delivery, consistently >90% for 17 consecutive months in emergency admissions and 12 consecutive months in in-patients. Despite the increase in administration of specific groups of antimicrobials to support sepsis treatment, overall antimicrobial prescribing has reduced 6.75%. Simultaneously the rates of Clostridium difficile have been reduced by 59%. Sepsis related mortality has been halved and is now classified as low, compared with its classification as high in 2015.

Discussion: The collaborative working between the Sepsis Lead Nurse and IPCT has improved patient safety outcomes. Improved education and understanding of infection and its relationship to sepsis, has resulted in better antimicrobial prescribing and administration practices. There has also been a concurrent reduction in incidence of Clostridium difficile infections. Joint involvement in root cause analyses and sepsis mortality reviews highlighted potentially avoidable events which subsequently directed IPCT work streams. The bacteraemia reviews highlighted further improvement to patient safety could be gained by collaboration with Primary Care and has led to joint working across the wider healthcare economy.

Session 16a
Achieving perioperative normothermia

Dr Jeffrey Brown,
Consultant Anaesthetic, Southern Health and Social Care Trust Northern Ireland.

Abstract
By the end of my talk I would anticipate that delegates will have an increased understanding of, The reasons why patients experience hypothermia in the perioperative period; The complications associated with perioperative hypothermia; Techniques for preventing perioperative hypothermia; Institutional strategies aiming to avoid perioperative hypothermia and Reliable methods for measuring core temperature.
Session 16b

Moonlight and icebergs – recognising and recovering from a ‘Titanic’ moment

Elaine Ross, Infection Control Manager, NHS Dumfries & Galloway and Board Member of IPS. @EGRoss85

Abstract
The session will describe the experience of an adverse Healthcare Environment Inspectorate report on staff in an ICU District General Hospital. It will explore underlying reasons for the findings in the report and why warning signals were not acted upon. It will relate the recovery to models including the change curve, Kubler Ross and Kotters model for leading change amongst others. This would be applicable to management and healthcare workers in the prevention of adverse events and recovery where required.

Aims and Outcomes:
The delegate will have an:
Understanding of the inspection process in Scotland.
Understanding of reason for resistance to change and become aware of how these may be overcome.
The personal impact of adverse publicity on healthcare workers’.

Session 16c

Infection prevention and control in dental labs

Dr Rebecca Taylor, Senior Dental Biosciences Lecturer, School of Healthcare Science, Manchester Metropolitan University.

Abstract
Whilst dental technicians may not often have direct contact with patients, the laboratory environment has been shown to become contaminated via a number of routes with implications for both the patient and dental team. Items received from dental practices such as impressions, models and wax try-ins may not have been disinfected appropriately leading to cross-contamination of dental equipment. Further contamination from the adjustment and repair of prostheses and appliances leads to the potential contamination of newly produced prostheses. The circumstances and mechanisms of microbial transmission are distinct to that of the dental surgeries and hence this presentation is aimed at dental technicians however the issues raised are relevant to the whole dental team as effective communication practices are essential in improving infection prevention in dentistry. The current guidelines and regulations associated with infection control and the consequences for failing to implement infection control procedures will be introduced alongside disinfection techniques and the importance of laboratory cleanliness.

Session 16d – Oral Paper 1

Abstract ID: 50

Top to bottom: Implementation of CAUTI care bundles in NHS Scotland

Debbie Waddell¹, Kay Currie¹, Jo Booth², Professor Jacqui Reilly¹
¹Safeguarding Health through Infection Prevention Research Group, Glasgow Caledonian University, ²Glasgow Caledonian University.

Introduction: Urinary Tract Infections remain the most prevalent healthcare-associated infection in NHS Scotland (Health Protection Scotland, 2017). Catheter-associated urinary tract infection (CAUTI) is one of the most prevalent healthcare-associated infections globally and is the most common experienced in hospitals (Saint et al, 2016). The Scottish Patient Safety Programme developed a CAUTI care bundle to promote CAUTI reduction. Following this recent innovation in patient safety, there is an opportunity for Healthcare professionals to learn from the implementation, embedding and normalising of CAUTI care bundles in everyday practice.
Methods: Normalisation Process Theory (NPT) (May et al, 2009) has been used to study the implementation of complex healthcare interventions in various areas of healthcare. Using qualitative methodology, semi-structured interviews were adopted to explore participants’ (n=68) perceptions of the implementation process. Participants were recruited from National strategic organisations, NHS Board level implementers and Local ward level nursing staff to determine the barriers and facilitators of CAUTI care bundle implementation. Framework analysis methods were applied to explore how these participants’ made sense of the work of implementing the CAUTI care bundle (coherence); how they engaged with it (cognitive participation); enacted it (collective action); and appraised its effects (reflexive monitoring).

Results: Overall there was a view that CAUTI care bundles met the needs of patients, staff and the organisation. A common challenge to implementation was the perception of disconnection and hierarchical influence from both Board and Local participants. There was a further feeling that CAUTI care bundles could be a ‘tick-box exercise’. Data illustrated that organisational support, leadership, staff education and stakeholder ‘buy-in’ were most influential in achieving successful implementation.

Conclusions: Despite participants’ initial expectations that the implementation of the CAUTI care bundle would have numerous advantages, its implementation exposed several barriers. This study highlights the complexity of implementing and embedding complex interventions into clinical practice.

Session 16d – Oral Paper 2
Abstract ID: 66

Norwegian scabies: The seven year itch

Maryam Jan, John Tsang, Dave Harvey, Lorraine Young
Wirral University Teaching Hospitals.

Background: This report describes a scabies outbreak following a case of Norwegian scabies on an orthopaedic ward, and the lessons learnt from this incident. The index case was confirmed to have Norwegian scabies by skin scrapings on the 23rd February 2017, with the outbreak considered over by May 2017.

Methods: An outbreak meeting was held and an action plan enacted. The orthopaedic wards were closed to new admissions and other wards were opened up to accommodate new inpatients. Staff on closed wards wore scrubs. Visiting was restricted. All patients on the affected wards were to have daily skin assessments and symptomatic patients were to be referred to dermatology. Permethrin was distributed to staff members who had been identified as a contact. Helpful guidance was obtained from the Northern Australian guidelines (1). This included a grading system and tailored treatment for the index case with permethrin, ivermectin and salicylic acid.

Results: 21 symptomatic staff members were treated. 174 staff contacts identified and 360 patient letters were sent to contacts. One orthopaedic ward was closed to admissions for a period of 2 weeks and re-opened in March 2017.

Conclusion: Infection control and occupational health worked together to execute the action plan, however there were delays in coordinating the treatment day of contacts. Lessons learnt included: delayed diagnosis due to late recognition of Norwegian scabies, uncertainty amongst staff on how to deal with a case of suspected scabies, and recognition of the difficulty in organising mass treatment for all staff and identified contacts. Implementation of a stepwise coordinated treatment plan for contacts in different risk or work group cohorts could yield a timelier response. In addition, consideration should be given to the use of ivermectin for contacts.

Declaration of conflicting interest: No conflicts of interest to declare.
**Session 17a**

**Surgical skin preparation: translating the evidence into practical policy**

**Professor Jennie Wilson,**
Professor in Healthcare Epidemiology in the Richard Wells Research Centre at the University of West London and IPS Journal Editor.  
@talkjennie

**Abstract**
The surface of the skin is colonized by a diverse range of microorganisms which, in this location, are harmless to their host. However, when skin is incised microorganisms colonising the skin may gain access to the sterile tissue beneath. Here they may be able to multiply and subsequently cause infection in the wound. Whilst cleaning the skin with soap and water removes dirt, skin secretions such as sweat and sebum, together with superficial microorganisms, this will not remove microorganisms that live in the folds, sebaceous glands and hair follicles. Strategies to remove microorganisms from the surface of the skin are therefore an important measure to reduce the risk of surgical site infection (SSI). These methods include pre-operative showers, hair removal and skin disinfection. This presentation will explore the evidence underpinning the efficacy of pre-operative skin disinfection, how products are used, the implications of conflicting guidance and the practical problems associated with choosing a decontamination method or agent.

**Session 17b**

**Exploring the impact of NHS litigation costs in infection control issues**

**Tracy Coates,**
Safety and Learning Lead (NHS LA), NHS Litigation Authority and Independent Healthcare Consultant.  
@tracywittee

**Abstract**
This session will discuss the new strategy of NHS Resolution in learning from claims and contributing to improving patient safety.

It will discuss the financial cost to the NHS of the diverse infection related claims held within the claims management database of NHS Resolution and explore some of the themes and cases from the data held within the system. It will encourage examination on the hidden costs to patients, staff and organisations that this can have and how this can support learning for the future.

**Session 17c**

**How to make dental practice legionella management simple?**

**Piotr Leszkiewicz,**

**Abstract**
Do you know how to keep your dental practice water system free from legionella bacteria and protect your staff and patients from contracting potentially fatal form of pneumonia called Legionnaire’s disease?

Under general health and safety law, as an employer or person in control of a premises you have health and safety duties and need to take suitable precautions to prevent or control the risk of exposure to legionella bacteria.

This session will show you practical and proportionate application of health and safety law and make legionella management simple.

Legionella Management – Keep It Simple.
SPEAKER INFORMATION

Session 17d – Oral Paper 1
Abstract ID: 67
DAISY: Daily assessment of infection severity a tool to guide management of Clostridium difficile Infection
Victoria Clewer, Kerry Holden
University Hospitals Birmingham, Queen Elizabeth Hospital.

Background: C. difficile is one of the most common causes of healthcare associated infection and is responsible for 15 to 25% of all cases of antibiotic associated diarrhoea. Treatment of C. difficile is fairly limited and is guided by clinical presentation. As C. difficile has reduced in incidence over the past 10 years clinicians are now less experienced in its treatment and often make late decisions to escalate therapy and refer to specialists. Here we describe the DAISY tool; an innovative aide to guide therapy and referrals.

Methods: DAISY is based on known markers of severity primarily published in the Department of Health’s Clostridium difficile: how to deal with the problem from 2009. The tool is presented as a ready reckoner table that allows clinical staff to determine the severity of clinical infection from mild, moderate, severe and life threatening. Clinicians can then use this daily assessment to guide therapy and prompt escalation and referral. The tool is used primarily by the infection prevention nurse specialists during nurse-led C. difficile ward rounds.

Results: Since introduction of the DAISY tool which is used primarily by the nurse-led C. difficile ward round there has been an improvement in the time to disease resolution by 55% and an increase in the number of referrals to gastroenterology for complex C. difficile disease management advice. Escalation of therapy has improved, particularly to faecal microbiota transplantation. The C. difficile recurrence rate is 5%, significantly lower than the national average.

Conclusions: In this poster we demonstrate the benefit of using a simple ready reckoner tool to quickly and accurately assess the severity of clinical C. difficile disease. We have found that implementing the tool for daily assessment has improved treatment escalation and referrals.

Declaration of conflicting interest: No conflicts of interest to declare.

Session 17d – Oral Paper 2
Abstract ID: 30
A quasi-experimental study of the effectiveness of admission risk assessment and pre-emptive patient cohorting in the control of MRSA cross-transmission
Lisa Ritchie¹, Professor Jacqui Reilly¹, Angus McFadyen³, Chris Robertson¹, Jo Booth²
¹Health Protection Scotland, ²Glasgow Caledonian University, ³akm-stats.

The isolation of hospital patients, usually in single rooms, is intended to interrupt the transmission of pathogens between patients. However, there is a lack of evidence regarding effective isolation responses in the absence of adequate numbers of single rooms; and there remains an uncertainty about patient isolation and cohorting effectiveness within the context of MRSA.

A prospective study over a 16 month period in two district general hospitals to find out whether pre-emptive cohorting those patients identified at ‘high risk’ of MRSA on admission affects the transmission of MRSA in general medical wards. Admission and discharge screening swabs taken on all patients ascertained the incidence of MRSA colonisation and infection throughout the study. Patients staying more than one week had a MRSA screen performed every week until they were discharged. The study consisted of three phases: The first three month phase established baseline colonisation and infection rates with MRSA. During this time patients assessed at risk of MRSA colonisation and/or infection were isolated in single rooms. In the second phase, of six months, patients at risk of MRSA were pre-emptively cohorting. Original practice was reinstituted for the final three month phase.

Of the 4562 patients in the study sample, 3641 (79.8%) had a full set of MRSA admission screen swabs. Of those 3641 patients, a total of 154 (4.2%) had a positive MRSA laboratory test result during their hospital stay; 116 (3.2%) of whom had a positive MRSA laboratory test result on admission. Thus 38 (1.0%) patients in this study sample were considered to have acquired MRSA during their hospital stay.

Results of the study will be presented. This study showed that patient cohorting may not in its self
be an effective control measure, to controlling the transmission of MRSA amongst medical patients in an acute hospital setting.

Session 18a – Debate
This house believes all 5 moments of hand hygiene are equally important and need to be given the same amount of attention

For the motion:
Professor Didier Pittet,
Hospital Epidemiologist of the Infection Control Programme and World Health Organisation (WHO) Collaborating Centre on Patient Safety, University of Geneva Hospitals & Faculty of Medicine, Geneva, Switzerland.
@DidierPittet

Against the motion:
Professor Michael A. Borg,
Department Head of Infection Control, Mater Dei Hospital. Chair of Infection Control Committee and the National Antibiotic Committee, Malta.

Session 18b
Spreading odontogenic infections and severe oral sepsis

Dr Riina Rauteamaa-Richardson,
Consultant Medical Mycologist at the University Hospital of South Manchester and Senior Lecturer in Infectious Diseases and Medical Educational in the Institute of Inflammation and Repair, University of Manchester.

Abstract
An increase in the number of locally invasive odontogenic infections requiring hospital care has recently been observed in many countries. It is more difficult to estimate the incidence of systemic dental infection complications as these patients typically present at various hospital Emergency Departments lacking understanding of oral diseases. Therefore, the dental source of the systemic infection is often missed. Medically compromised patients seem to be more susceptible to systemic rather than local spread of infection. Therefore, taking the patient’s immunological status into consideration is important when assessing patient’s risk for systemic spread of a dental infection. Poor dental health and the presence of multiple potential infection sources are other risk factors for systemic spread and severe systemic response. The systemic response to a dental abscess is most severe in the absence of dental treatment. Antimicrobial therapy alone is ineffective in preventing the spread of infection. Therefore, although it is possible that a dental procedure provokes a flare-up of a pre-existing infection, leaving the infection focus untreated is equally a risk for severe infection complications. The aim of this session is to update the participants on the epidemiology of odontogenic infections and provide tools to identify patients at risk for severe outcomes.
WEDNESDAY 20 SEPTEMBER

Session 20a

Ayliffe Lecture: Top ten pearls for success in infection prevention (& life)

Professor Sanjay Saint, Chief Of Medicine, University of Michigan and Va Ann Arbor. @sanjaysaint

Abstract
Professor Sanjay Saint will give the Ayliffe Lecture in which he will discuss some of the tips that he has obtained during his nearly two decades conducting clinical investigation into preventing hospital infection. His research has taken him to nearly 100 hospitals in the United States, Japan, Italy, Switzerland, and England, and he will discuss the “pearls” he has learned along the way.

Session 20b

How do we prevent accumulation of antimicrobial resistant organisms in healthcare settings?

Professor Satoshi Hori, Professor of Infection Control Science, Juntendo University. Director of Infection Control in 6 group hospitals.

Abstract
Microorganisms, especially bacteria can change their characteristics by genetic modifications, such as transformation, conjugation, transduction, and point mutation. These genetic modifications had been proven in in vitro experiment and widely used in the field of genetic science as well as agriculture. The acquisition of antimicrobial resistance may also occur as the consequence of those genetic modifications. The hospital bacteria may survive in inanimate environment contaminated with hospital dusts and water. If those ecological niches are left in the healthcare settings, hospital bacteria will start to exchange their antimicrobial-resistant genes and then accumulate antimicrobial resistance mechanisms in each organism. Particularly in gram negative bacteria, genetic exchange can occur even over the spices. In order to prevent from emerging multi drug resistant organism in healthcare settings, these ecological niches should be eradicated.

Session 21a

10 years of IPC evidence – are we better informed?

Professor Heather Loveday, Professor of Evidence-based Healthcare, University of West London and past president of IPS. @loveebhc

Abstract
This presentation will offer a personal and reflective overview of the 10 (maybe a few more) most significant publications during the 10 years that the Infection Prevention Society has been in existence.

Session 21b

Aspergillosis outbreaks: investigation and management

Professor Malcolm Richardson, Director of the NHS Mycology Reference Centre – a European Confederation of Medical Mycology Centre of Excellence, University Hospital of South Manchester, and Professor of Medical Mycology, University of Manchester.

Abstract
Information on environmental exposures and the association with infection has primarily been derived from outbreaks of aspergillosis in hospital settings. Over 60 outbreaks have been reported involving over 500 patients. Outbreaks are
primarily attributed to airborne infections related to construction and renovation activities combined with improperly functioning ventilation systems. The most frequent nosocomial source of Aspergillus infection seems to be contaminated air, but Aspergillus has also been recovered from hospital water supplies and plumbing systems. Clusters of cutaneous aspergillosis have occurred in burn wounds due to dressings and linen contaminated with Aspergillus spores during hospital construction. Although the association between construction and invasive aspergillosis has often been reported, there is an apparent poor correlation of the Aspergillus spp. recovered from the hospital environment and species isolated from patients with aspergillosis. A number of typing methods are being evaluated in Manchester based on short (STRAf) or hypervariable tandem repeats (TRESP).

Session 22a
Clinical human factors in the Acute Medical Unit (AMU) – a lesson for all hospital staff!
Matsikachando Moyo,
Clinical Doctoral Research Fellow, University of Southampton.
@matsika_moyo

Abstract
During this session I will introduce and define clinical human factors in basic terms; show why clinical human factors matter to infection prevention practice; demonstrate how techniques adopted from qualitative research methods can be used to identify pertinent clinical human factors and offer some suggestions on how to make clinical environments and artifacts ‘user friendly’ so as to improve infection prevention practice.

Session 22b
Engineering aspects of infection control
George McCracken,
Head Of Estates Risk And Environment, Belfast Health and Social Care Trust.

Abstract
This presentation will provide an insight into engineering elements of infection control which may not be at the forefront of clinical thinking on a day to day basis. It will examine all aspects of the built environment to consider its impact on the delivery of high quality safe and effective care.

Session 22c
The Angkor Children’s Hospital, Cambodia
Dr Carol Pellowe,
Retired Senior Lecturer, King’s College, London with a joint appointment at Guys & St Thomas Hospitals.
Sally Belsham,
Link Practitioner, Infection Control Nuffield Hospital.

Abstract
Due to a call for help in the IPS weekly bulletin, we spent November 2016 at the Angkor Children’s Hospital in Siem Reap, Cambodia looking at their infection control practices. Working in a resource poor country with limited paediatric services, this experience highlighted the unique problems practitioners face, yet how much can be achieved. This presentation will discuss the work we undertook and the ongoing challenges which IPS could assist with.
Session 22d
Outbreak workshop: Let’s work another outbreak!

Dr Evonne Curran,
Independent Nurse Consultant, Infection Prevention and Control and SPC Member.
@EvonneTCurran

Abstract
In this workshop we are going to manage a published outbreak. The audience will be presented with the data as it unfolded to the Outbreak Management Team and be asked to assess: what is happening?, so what? and what will happen next if nothing changes? These are the 3 questions that make up an individual or team’s situation awareness (work of Mica Endsley). Participants are asked to have available the Health Protection Scotland Outbreak Checklist and Algorithm – though this is not essential. (http://www.hps.scot.nhs.uk/resourcedocument.aspx?id=240)

As outbreaks rely on teamwork all participants will be encouraged to use those sitting close by to help and to advise. So come along and be ready to put to the test your outbreak detection and management skills.

Session 23a
Using psychological theory to improve infection prevention practice

Dr Judith Dyson,
Senior Lecturer Implementation Science, University of Hull.

Abstract
It’s often assumed that if (we) health care practitioners deliver care that is less than optimal it’s because we do not know the evidence; we lack sufficient knowledge. Therefore support in practice is often limited to telling practitioners what is best (guidelines, emails, educational meetings). In fact there are a great many factors that may impact on the quality of care we give our patients. If we seek to understand what determines our practice behaviours and we tailor practice support according to these we are more likely to positively influence (or improve) patient care. Psychological theory is an approach to understanding and supporting practice that is effective and accessible.

Session 23b
Monitoring the patient environment

Liz Jones,
Specialist Consultant in hospitals, care homes and other providers to improve patient service.
@bettercareliz

Abstract
A good environment for care is important for patients, visitors and staff. There are obvious links with infection (though for many years these appeared to be disputed), but the value of a good environment goes well beyond this. This session will look at some of the ways in which environments affect care, and will consider how they might be monitored and improved. The main focus is hospitals, but many of the principles can be applied to other care settings.

Session 23c
Experiences of teaching in South Africa

Christina Bradley,
Laboratory Manager HIRL, Queen Elizabeth Hospital Birmingham.
@TinaBradley1

Abstract
To give an overview of my experience teaching in South Africa with a few hints and tips.
Session 23d
Surgical site infection surveillance: from the ward to board
Session organised by the IPS Audit & Surveillance Specialist Interest Group


Abstract
The validity of SSI data relies on hospital staff being trained to undertake SSI surveillance, strict adherence to the protocol, full engagement and ownership of the surveillance by surgical teams, leadership from the Director of Infection Prevention Control and Chief Executive, adequate resources and patient education in recognising signs of infection.

Data submitted to the Surgical Site Infection Surveillance Service are quality checked, individual reports are made available for hospitals to review and data are centrally analysed to identify hospitals with SSI risk falling below or above the expected limits. Quarterly outlier identification is not confirmatory of a problem but intended as a trigger for further investigations to plan and implement actions where needed to improve patient care.

Surgeons, hospitals’ governance teams, Care Quality Commission, and Clinical Commissioners should have a good understanding of the SSI surveillance process to facilitate interpretation of hospital reports and gauge whether there are patient safety concerns which need to be addressed.

Session 24a
Infection prevention – back to the future?

Martin Kiernan, Visiting Clinical Fellow, Richard Wells Research Centre, University of West London. @emrsa15

Abstract
This paper will reflect on progress in Infection Prevention, reflecting on how the past could be beneficial as the specialty moves forward, particularly in the area of education and professionalism.

Session 24b
“The good, the bad and the ugly” – one Trust’s experience of managing an outbreak of salmonella


Abstract
The session will identify the issues relating to the identification and management of an outbreak of salmonella at an acute Trust and discuss the preventative interventions which were subsequently implemented.

Salmonella is a common cause of bacterial gastroenteritis in the United Kingdom with Salmonella bacteria widely distributed in domestic and wild animals. Human sporadic cases typically peak between July and September. However, outbreaks of infection associated with larger numbers of cases are not uncommon.

Between 25 May and 18 June 2014, 32 cases of Salmonella enteritidis O9g PT 14b in patients, staff and visitors were linked to the Birmingham Heartlands Hospital. Of the patients infected, 17 had spent the whole incubation period of the disease in the hospital. The outbreak focused
mainly on a cluster of cases on two related orthopaedic trauma wards. A local Outbreak Control Committee was formed to co-ordinate multi-disciplinary management of the outbreak and to carry out an investigation to understand the source of this outbreak and enable suitable control measures to be put in place to prevent further cases.

It was apparent that a multi-disciplinary approach was key to the successful management and containment of the outbreak. There were a number of simple infection prevention and control measures that were implemented during the outbreak and subsequently replicated throughout the Trust. Outbreaks of salmonella in hospitals are preventable and there is a need for effective infection control policies, appropriate training of staff, simple surveillance systems and readily available expert advice to ensure outbreaks are rapidly controlled and consequently prevented.

References:


Session 24c

Preventing #surgical #infections – an approach to achieving #implementation and successful outcome in African hospitals

Alexander Aiken,
Honorary Assistant Professor in Infectious Disease Epidemiology, London School of Hygiene and Tropical Medicine.

Abstract
It has been recognized that surgical site infections (SSI) are the most frequent healthcare associated infection in developing countries. Specific prevention measures can be highly effective but are often poorly implemented for a number of reasons. Several approaches have been tested, demonstrating success in reduction of SSI in high-income countries. But until now there has been very limited evidence from low and middle income countries. A World Health Organisation (WHO) and Johns Hopkins Medicine project was undertaken in four African countries between 2013-2015 and data collected on process indicators and SSI outcome data. The project showed that a multimodal implementation strategy, focused on technical and adaptive improvements (known as the surgical unit-based safety programme - SUSP), was feasible and could substantially reduce the risk of SSI. Intervention effects were shown to be sustained when the programme was fully embedded in routine hospital practice. This presentation will describe some of the practical aspects that led to successful implementation and improvement, will additionally outline other WHO work aimed at providing SSI implementation resources and will be of interest to all working in the field of surgical safety.

Session 25a

Design and implementation of new hospital build – problems and solutions

Dr Jimmy Walker,
Scientific Leader in Water Microbiology and Decontamination at Public Health England and Secretary of the Central Sterilisation Club. @biofilmjimmy

Dr Mark Garvey,
Associate Director of Infection Prevention and Control, University Hospitals Birmingham. @drmarkgarvey

Abstract
The Chief Medical Officer’s report on infections and the rise of antimicrobial resistance in 2013 stated that the design, construction and maintenance of healthcare facilities have a
SPEAKER INFORMATION

substantial bearing on the development of healthcare-associated infection. Designing the healthcare facility is only one aspect of protecting patients. Infection prevention and control (IPC) teams need to work with designers, architects, engineers, facilities managers and planners to ensure that the facility, when opened is fit for purpose. This presentation will discuss the work that went on prior to the opening of a new build hospital and will identify a number of the issues and problems that were identified along the way as well as solutions that were implemented to ensure patients were protected. Other scenarios will be included to provide helpful advice for IPC staff involved in new builds, refurbishments or where current scenarios could be considered as a potential risk to patients.

Session 26a
Infections without borders

**Professor Leo Visser,**
Head of Department of Infectious Diseases, Leiden University Medical Centre (LUMC), Netherlands.

**Abstract**
Recent epidemics showed how densely connected we are as a global community. We are only as safe as the most fragile states. Air travel, population growth, encroachment on previously sparsely populated areas in Africa and Asia, climate change, civil unrest and conflict amplify the risk of outbreaks and epidemics. We should be prepared for the unexpected and make infectious control practices work.

Session 26b
UV_C to decrease Multidrug-Resistant Pathogens – Results from the BETR disinfection trial

**Dr Deverick J. Anderson,**
Associate Professor of Medicine, Duke University School of Medicine, USA. @Deverick_A

**Abstract**
The Benefits of Enhanced Terminal Room (BETR) Disinfection study was performed to determine efficacy of three enhanced terminal disinfection strategies - UV-C, bleach, and bleach+UV-C – compared to “standard” terminal disinfection with quaternary ammonium. This pragmatic, cluster-randomised crossover trial included nine hospitals over a 28-month period; 21,395 patients met all study inclusion criteria and were evaluated for acquisition of any of four target organisms: methicillin-resistant Staphylococcus aureus (MRSA), vancomycin-resistant Enterococcus (VRE), Clostridium difficile, and multidrug-resistant Acinetobacter spp. The incidence of target organisms among exposed patients was significantly lower after adding UV to standard cleaning strategies (n=76; 33·9 cases per 10 000 exposure days; relative risk [RR] 0·70, 95% CI 0·50–0·98; p=0·036). The primary outcome was not statistically lower with bleach (n=101; 41·6 cases per 10 000 exposure days; RR 0·85, 95% CI 0·69–1·04; p=0·116), or bleach and UV (n=131; 45·6 cases per 10 000 exposure days; RR 0·91, 95% CI 0·76–1·09; p=0·303) among exposed patients. Similarly, the incidence of C difficile infection among exposed patients was not changed after adding UV to cleaning with bleach (n=38 vs 36; 30·4 cases vs 31·6 cases per 10 000 exposure days; RR 1·0, 95% CI 0·57–1·75; p=0·997). In summary, the addition of UV-C to terminal disinfection strategies led to a decrease in acquisition of epidemiologically important pathogens, mostly due to decreases in acquisition of MRSA and VRE.
Session 27a
‘Zero’ Illness – insights from the world of Elite Sport

Dr Glenn Hunter,
Consultant in Performance Innovation,
English Institute of Sport.

Abstract
The session will explore:
• What is elite sport and why does illness and infection matter
• The impact of injury and infection on the world of elite sport
• Our insights and challenges
• Our successes and failures
• Suggestions and top tips
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EXHIBITION FLOOR PLAN

Infection Prevention 2017
18-20 September Manchester Central

IPS CONFERENCE & EXHIBITION 18 – 20 September 2017, Manchester Central
Infection Prevention
11th ANNUAL CONFERENCE
1st to 3rd OCTOBER

Scottish Event Campus
Glasgow, United Kingdom

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