The Royal Wolverhampton Hospitals NHS
NHS Trust

CHAIRMAN's SUMMARY REPORT

This summary sheet is for completion by the Chair of any committee/group to accompany the minutes required by a trust level committee

Name of Committee/Group	Infection Prevention and Control Committee (IPCC) held on 29th June 2012 and 27th July 2012
Report from:	Chief Nursing Officer
Date:	Minutes dated 29.06.12 and 27.07.12 to Trust Board 24.09.12

Action required by receiving committee/group:	☑ For information ☐ Decision ☐ Other

Aims of Committee: Bullet point aims of the reporting committee (from Terms of Reference)	To provide strategic direction and decision-making for IPCC. To review the Trust and operational performance against IPCC targets.

Drivers: Are there any links with Care Quality Commission/Health and Safety/NHSLA/Trust Policy/Patient Experience etc.	• Care Quality Commission (CQC) compliance • NHSLA • NICE guidance

Risks Identified:	Compliance with C.Difficile target

Minutes of Infection Prevention and Control Committee

Date	**29th June 2012**		
Venue	**Board Room, Clinical Skills Building**		
Time	**10am – 12noon**		
Present:	Cheryl Etches (Chair)	**(CE)**	Chief Nursing Officer
	Dr Mike Cooper	**(MC)**	DIPC/Consultant Microbiologist
	Mari Gay	**(MG)**	Deputy Chief Nursing Officer
	Ian Badger	**(IB)**	Medical Director – Division 1
	Sandra Roberts	**(SR)**	Head of Hotel Services
	Ros Jervis	**(RJ)**	Consultant in Public Health WCPCT
	Philip Turley	**(PT)**	Governor
	Professor Ray Fitzpatrick	**(RF)**	Director of Pharmacy
	Dr Suneil Kapadia	**(SK)**	Medical Director – Division 2
	Vanessa Whatley	**(VW)**	Infection Prevention lead Nurse
In Attendance	Gayle Nightingale	**(GN)**	PA to Chief Nursing Officer
	Iris Fitzgibbon	**(IF)**	Senior Matron Division 2
	Tom Butler	**(TB)**	Deputy Head of Estates
	Gail Gunning (Minutes)	**(GG)**	Infection Prevention Secretary
Apologies			
	David Loughton	**(DL)**	Chief Executive Officer
	Jonathan Odum	**(JO)**	Medical Director
	Ivan Little	**(IL)**	Head of Estates
	Rose Baker	**(RB)**	Head of Nursing – Division 2
	Dr Janet Anderson	**(JA)**	Non-Executive Director – Division 2

Item No		Action
1.	**Apologies and Welcomes**	
	It was noted that attendance for the meeting is not quorate for decisions to be made until arrival of **SK** (Division 2). Apologies received: David Loughton, Ivan Little, Rose Baker, Dr Janet Anderson Welcomes: **CE** introduced Gayle Nightingale as her new Executive PA	
2.	**Minutes and Actions of meeting held on 25th May 2012**	
	10:05am - **SK** in attendance – meeting quorate Minutes were agreed, with the following actions outstanding:	

Item No		Action
	2.1 Action No 1 Mary Brassington to liaise with Tony Stanyard (Head of Procurement) on information on business case for sharps safety devices – to be chased and bought back to next meeting.	
	2.2 Action No 2 Mary Brassington to put together a letter for David Loughton to send to Jonathan Wedgewood to ask why sharps device products are not being trialled jointly with other hospitals. – **CE** to chase and bring back to next meeting.	**CE**
	2.3 Action No 4 Ivan Little to meet and discuss with David Loughton assurance given for water flushing at WPH following May IPCC meeting – **TB** to chase.	**TB**
3.	**Matters Arising**	
	GAP Analysis and Action Plan – Water Sources **MC** gave feedback from the Department of Health (DoH) preliminary guidelines for minimising risk of pseudomonas from water sources in augmented care areas. A sub-group legionella meeting was arranged to discuss and have worked through the various recommendations, which were found to be fully compliant within the vast majority of areas. An action plan was put into place for those areas that still require work to be carried out, most of which were fairly minimal and some already in place or on-going. The main action is to revise the water safety plan to take into account the pseudomonas recommendations and in terms of patient safety these actions give assurance that water in augmented care areas are safe. The latest set of tests show that the Trust has now gone 6 months since isolation of pseudomonas from outlets in NNU. The decision has been made to remove filters once the new flow straighteners have been received from the suppliers and continue to monitor. **CE** asked if the 6 months negative testing was due to the new filters being put in place, **MC** answered no. Filtered water is not tested, filters are removed before testing with new filters being replaced following and only the testing being carried out is on remedial work, disinfection and flushing of affected outlets. **CE** asked if there was any knowledge regarding visits being generated from CQC. **MC** had said he was not aware of any, but at the time of Belfast incidence in December there had been interest from SHA and National HPA in what was happening within RWHT. **MC** did not speak to the organisations directly but had spoken to Barrett Patel (Regional Microbiologist) and **MC** had said he would have been happy to speak to the SHA directly if required, but received no further contact. **CE** referred to point 19 on Gap Analysis – Do not top-up spray, alcohol or other cleaning containers and asked if these are emptied washed, cleaned and refilled, **MC** replied yes or replaced with new ones. **SR** to check if house-keeping are making up any hyperchloride sprays etc. **RJ** asked if PCT Estates were involved as regards to West Park Hospital in the gap analysis guidance around augmented care principles. **MC** replied that they were not involved with the gap analysis, but it was discussed at the Legionella Steering Group	**SR**

Item No		Action
	Committee meeting with Richard Leek in attendance. The report for the Gap Analysis and Action Plan for RWHT was approved by the IPCC.	
4.	**IPCC – Terms of Reference**	
	The IPCC discussed and agreed the TOR with the following amendments to be made: • Head of Hotel Services to be added to the membership • Consultant in Public Health to be amended to read PCT. **RJ** is not part of Wolverhampton City Council until 31/3/2013 and still currently employed by the PCT. • Divisional Directors to read representation from both divisions 1 and 2.	**VW**
5.	**Decontamination – Terms of Reference** **CE** gave feedback on a meeting that was arranged following receipt of a letter from Dr Donald Dobie in which he raised concerns of the size of the organisation post TCS in regards to arrangements for decontamination within the new organisation and challenges that TCS brings. The meeting was chaired by Maxine Espley with the theory being to address the requirement of a Decontamination Officer. Following discussions at the meeting it was found that there was a fair bit of resource already within the organisation within staff roles and adding individual responsibilities quite a bit of manpower hours was already being used. It was felt that an accountability meeting would be required, which used to take place within the previous organisation and as a result of the meeting a set of TOR have been compiled for a Decontamination Committee which the CEO has agreed to chair. The frequency of the meetings will initially occur on a monthly basis and if agreed at IPCC these will possibly move onto a bi-monthly meeting once the committee has been established. **CE** did not feel that a quarterly meeting would be sufficient. **SK** asked what were the decontamination principles and practices between IPCC and the decontamination group being organised. **CE** explained that although a quarterly report comes through IPCC this mainly refers to information from within RWHT. Under Service Level Agreement with the PCT, decontamination advise for community is required e.g. GP Practices, Dental Practices, Health centres etc. RWHT would not accountable for compliance within independent contractors, this would be retained within the PCT. The IPCC agreed the TOR for Decontamination with the following amendments: • Membership names to be removed, just job title are required • Papers for the meetings to be circulated to PCT Public Health to decide if attendance to these are required by members of PCT – **CE** to feedback to **DL** • Representation from GP to be included to membership • Reporting to IPCC on a monthly basis, until next revised in line with the changing of the organisation.	**VW** **CE**
6.	**Divisional Reports**	

Item No		Action
	6a Division 1 - **Report Mr Ian Badger** Antibiotic Prescribing The report shows a line of red for antibiotic prescribing training in which **IB** could not explain lack of numbers of percentages which would mean that this is fewer than 70% compliant. **IB** is not convinced that numbers are not accurate and has e-mailed out to individuals to check on their compliancy. **CE** suggested that if the problem should occur during the next month that **IB** put together a small report to bring back IPCC meeting in July highlighting issues and compliances. **IB** to liaise with Louise Nickell for training information from data base. Hand Hygiene The 5 moments for hand hygiene compliance data was available for general surgery, but not for urology who have exactly the same ward staff, **IB** could not explain why there was no figure for this. Ophthalmology has shown a significant improvement, which had been showing red within the last two previous IPCC meetings. CDI Period of Increased Incidence (PII) There has been high incidence of CDI within the last month spread out across a number of different wards. **IB** asked **MC** if the typing had suggested a common theme, **MC** had replied no there was easy explanation. **CE** asked if typing has been received back from sampling taken from patients on D2, **MC** replied that results were back and showed two different types from three patients. **IB** had said that it was not impossible that the infection could have been contracted from the Queen Elizabeth Hospital, **VW** agreed as one the patients was negative a week before being transferred over to the QE and also D2 had been CDI negative for three months prior. There was no reason to think that there was an environment issue on D2 at the time of CDI increase. There had been contact from the QE patient to next patient, with regard to bed space and randomly the third patient came through the same bed space, but there was a small gap in between before that patient was admitted and showed a different strain of CDI - all three patients were very vulnerable. There were concerns at the time that the CDI might be 027, so housekeeping used HPV on the ward as a precaution, ward staff put lots of actions in place and there have been no further cases since. Upon requesting CDI testing for index case **MC** had discovered that the QE had already requested the testing a part of a PII 5 Moments **CE** raised concerns from Trust Board on hand hygiene compliance, there has been a downward trend and previously this was reported quarterly basis. The Board now require reports on a monthly basis until compliancy is reached across every area. A big push is needed with regard to hand hygiene with people routinely decontaminating their hands at every appropriate opportunity, so action and leadership needs to be taken within the divisions. The IP Team have organised a re-launch of the 5 moments campaign beginning	**IB**

Item No		Action
	first week of July 2012 with desk top screen messages in place to commence the week following. Outpatients 1 (male toilets) This was not legionella as stated in report - outlets removed and random sampling taken place. RCA No longer completed for CDI, standard data is collected by the IP Team from CDI ward round.	
	6b Division 2 – Reported by Dr Suneil Kapadia Hand Hygiene There has been an overall improvement compared to last month with substantial improvement compared to the beginning of the year. • Diabetes shows down in the report, but is 94% (green) for level 2 infection prevention training. • Hand hygiene for Emergency Services is disappointing showing red, in which it was better during earlier in the year. • West Park Hospital Rehab care of the Elderly/Stroke is a key concern for IP level 2 training showing red for hand hygiene which has been a gradual decline from early this year and **SK** will be liaising regarding these concerns. Antibiotic Prescribing Training The West Park Hospital was red during earlier this year but is improved and is showing amber. Vascular Access 76% with no substantial improvement for the foreseeable immediate future. **CE** asked how assured are we that we are persuading individuals to have fistulae. **SK** replied when asking patients several times on vascular access does this become difficult and is guided by information given by the surgeons, who are currently looking into this. **CE** agreed saying passive asking had been challenging and asked were patients aware of the risk? are they making an informed choice and given enough information. **CE** to discuss further with **JO.** DRHABS Central line insertion is attributed to a named consultant. **IB** was not convinced that this is appropriate document for IPCC. It was agreed that this was a very valid point.	**SK** **CE**
7.	**Estates Report**	
	Reported by Tom Butler Flushing of Outlets Assurances have been given on flushing of outlets within community and will be completed at Coniston House by either PCT Estates or RWHT Estates. **CE** asked in the absence of **DL** how the flushing of outlets was going on outlets within RWHT, **TB** replied that it is moving in the right direction 70% compliance and	

Item No		Action
	from week commencing 2/7/12 **TB/IL** will be visiting areas that are non-compliant across both divisions. **CE** said she had been disappointed at how many clinical areas have not responded. **TB** had said it had been moving slowly but is developing since being only in process for last 2/3 months. Queries were raised on the frequency of the flushing on outlets being carried out on a weekly basis with papers being submitted monthly. This needs further clarification **TB** to investigate and bring back to next meeting. <u>Water Outlet Management</u> Estates will be providing a twice weekly flushing service to various areas as listed in the report and daily within the new midwife led unit and new dirty utility unit OPD1. <u>Clinical Waste Incinerator</u> This has been slightly down due to a collapsed roller bearing. <u>Pseudomonas Aeruginosa</u> • Sampling has continued - no positives • Showers on CHU have been installed and commissioned with work now completed. <u>Key Performance Indicators</u> • There has been an issue on block 64 domestic hot water calorfier due to a delay in delivery of a safety valve, which should be delivered by 29/6/12 or latest 2/7/12. • Engineering hand hygiene compliance is down and is being addressed.	**TB**
8.	**Environment Report**	
	Reported by Sandra Roberts <u>Deep Clean</u> Housekeeping were busy during the month of May in rapid response in HPV cleans due to outbreaks of Norovirus and were able to deal with it because concentration could not take place on deep clean programme due to the winter pressure beds still being open with D7 just being closed. Three planned deep cleans were conducted during May in diabetic clinic, D21, cardiovascular, **SR** said this was thanks to Zena Young and Rose Baker helping in terms of capacity trying to release bays. The lack of the closure of D21/D7 has meant the piped oxygen programme has been put back which also links in with the deep clean programme and commenced on D7 27/6/12 which is on-going until September, with other deep cleans taking place when and where possible. Full access was gained on D2 and HPV took place during June. <u>PEAT Scores</u> These not officially allowed to be released until 18/7/12. The PEAT programme is being replaced by patient lead inspection programme, **SR**	

Item No		Action
	mentioned an article she had discovered recently which was written by Graham Jacob, which focused much more strongly on what patients think and feel – "It should look at what matters to them and see it through their eyes". Patients will have more decisions on how reports on valuated, but keeping the same issues on privacy, dignity, cleanliness etc. The two main changes will be on how data is collected then reported, which could be on an individual ward basis rather than a collective overview and there will be a requirement for planned improvement. There is also a pilot to trail the new programme, in which **SR** has put forward for getting involved. <u>Old/Unwanted Equipment</u> A list is attached to the environment report, which shows a lot of equipment being reported. <u>Deep Clean Programme April 2012 - March 2013</u> This attached to the environment report, which will be updated on a weekly basis. <u>Cleaning Scores</u> Shows no red or ambers reported, there has also recently been a change round of supervisors, who do not audit their own areas. With the change around it was thought that this could affect the scores, but these still remain consistent. **CE** asked **SR** if she was happy with the deep clean programme process, **SR** had said she was disappointed due to pressures of winter beds and Norovirus. With the pressure seeming to be a year round problem and did not seem to have a gap between April and September as of two years ago. The policy for cleaning frequency initially was in every area to be deep cleaned once a year, but as things have progressed further areas have requested deep clean and is much more frequent. **CE** said there had been issues with PII regarding deep clean process, **VW** had reported on D2 investigations showed on the documentation that the deep clean had been delayed 2 weeks in 2011 so the ward was still within their annual target. There had been an additional agreement that half way through the year D2 could be cleaned more frequently, but had never gone through **SR** for approval. If the frequency is increased in too many areas **SR** does not have the ability within budget for staff with main issue being capacity and access. **CE** reported that Trust Board, quality and safety report showed a downward trend on environmental standards submitted by matrons and has asked matrons for a more detailed report to take back to the Board. **CE** asked **SR** if there was anything that was being picked up from housekeeping in environmental standards that would cause this continual downward trend. **SR** had said that she had looked through the quarterly environmental report from the matrons and analysed checking on every single non-compliance, which was reported back to IPCC in May. There was a couple of areas reported that had also been in previous quarterly reports and were still outstanding, this was highlighted back to the matrons. There were also problems with the database during the last quarter and a lot data has been lost which could have had some effect on the report. **CE** to report back and discuss further with matrons.	**CE**

Item No		Action
9.	**LNIP Report**	
	Reported by Vanessa Whatley <u>Norovirus</u> The Root Cause Analysis has now been completed for the second Norovirus outbreak in mid-March – April and was agreed and approved by IPCC ready to go to the Commissioners. <u>Annual Work Programme</u> Objective 3: There will be no avoidable stream infection the main action being streamlining education for central line care, which has now been achieved. The IV Team is underway with recruitment in process and a training plan that has gone out via Trust communication, which is for junior medical staff that will be accessing these lines, along with nursing staff. The IV Team is being led by Sue Rowlands and staff will be in post full time from July following training and then from August there will be a limited service from the IV Team as staff come into post. From September there will be a full service and are currently looking at a full date for OPAC. Objective 8: The Code of Practice Health Care Associated Infections is being implemented and monitored. The quarterly report for compliance is appended within the report and the glove policy has been updated which also been attached to the report for approval. Hand hygiene awareness week is planned for week beginning 2nd July 2012 and will be Wolverhampton City show 7/8th July with the IP Team manning the stand promoting hand hygiene, teaching the public 5 moments. <u>New Guidance & Alerts</u> Report from Abertawe Bro Morgannwg University Health Board on transmission on Hepatitis B. This refers two patients who were admitted to a cardiothoracic ward in Wales who underwent cardiac surgery. Most likely contact was within the hospital in Wales where surgery took place. A report was published and is available on the internet and was previously discussed at IPCC. <u>The gap analysis</u> circulated with the IP report has since been updated on: Action 16: People/Looking for Assurance for anaesthetic dept review on IP practices relating anaesthesia. A meeting has now taken place with the lead anaesthetist, cardiothoracic surgery, this has been completed and assurance given. Action 14: Systems in place to track and trace medical devices used on individual patients. Assurance was not given that all these records were accurate but a spot check has now been completed and appropriate assurance has been given. Other red areas divisions are leading on an action plan, involving anaesthetist, fusionist and matron. Kim Corbett from the IP Team has met with them and in which they have agreed to take this forward.	

Item No		Action
	National Prevalence Survey Still waiting on national report for Wolverhampton, which was expected in June. Once results are published comparison to national results will be discussed as an agenda item. Raising Quality and Improving Safety Project (Community PID Project) Activity has been largely around chronic wounds during May where the entire district nurse work load was for all wounds was undertaken, 472 wounds were observed and audited, with several patients having more than one wound. The survey on approximately 45 patients looked at characteristic of the wound type with leg ulcers being the most common type at 25.6%, grade 2 pressure ulcers 15%, skin tears/trauma 13% and surgical wounds 10%. Clinicians were asked to describe the progression of the wound and in 57% of the cases recorded showed improvement. There is still some work to be done around the don't know areas with an action plan being put into place, particularly wounds that are classed as chronic and have been there for more than 6 weeks. Individual reviews for each patient are being planned and securing funding from Department of Health for equipment is being looked into. **CE** asked if PLG has a role within the IPCC group, **VW** had said once individual cases had been reviewed this is something than can be considered and that PLG is still being delivered as an outpatient's service in cardiothoracic services. There are several different dressings in place with a wound formula in final edit, which is halving the number wound dressing products available. **RF** informed the committee that this had gone through LMC where it was felt that there were still too many in place and this information had been fed back tissue viability nurses. **VW** had said that there has also been an increase in use of iodine and was currently being looked into by the tissue viability team. The Tissue Viability Team are also working through compression wound dressings, there a currently a limited number on the full level in which this is a quality issue. A major finding was 25% of the wounds were re-occurrences, in which Wolverhampton currently do not have any proactive wound prevention service where other PCT's are seeing huge benefits of having well led clinics. This is something that is being addressed within the action plan and is being discussed with the commissioners and public health. The Wound Steering Group met on 25th June 2012 and discussed the final wound analysis and recommendations are in progress. DRHABS This is to be discussed at IPCC on a quarterly basis; the analysis is attached to LNIP report with IV Team being a major action. It is hoped once the team are place we will start to see a reduction in line associated infections. Hygiene Code Improving – **CE** had said **MC** had given assurances of lead and timescale.	

Item No		Action
	Glove Policy The IPCC agreed the glove policy with issues raised by **IB** on body substances and chemicals that should be listed as two separate issues – **VW** to amend. RCA Investigation report (Datix reference W21612) approved by IPCC to go forward to Commissioners.	
10.	**Pharmacy Report**	
	Reported by Professor Ray Fitzpatrick Antibiotics Division 1 – Graph shows decrease with exception to Ciprofloxacin, which was due to flooding within pharmacy. Division 2 – Graph shows increase, but are within the guidelines Antibiotic Interventions Were down from April looking at figure 5 shows a definite trend, but overall intervention rate is on the up with antibiotic training starting to take effect. Allergies There were 5 incidents during May – 3 for Division 1 – 2 for Division 2 Snap Shot Audit Results This was carried out in March with regional results received back, which indicate we are doing well and better than regional average in terms of compliance with allergy box completion. There were slightly fewer patients on antibiotics for >5 days, less than regional average and fewer patients on intravenous antibiotics from >48hours. Improvement is needed to the completion of the allergy box, in that it needs to be more specific. Timing of Antimicrobial Doses This issue was raised by Dr Anderson at the last IPCC meeting, so as part of CQUINS an antibiotic audit has to be completed. A snap shot of timing was carried out and showed antibiotics given four times a day tend to be prescribed over 16 hours per day, with those prescribed three times a day tending to be prescribed over 14 hours. This has been given to the Antimicrobial Stewardship Committee to assess whether practice needs to change and develop an action plan for improvement if change is recommended. **VW** had said that there was IV Group that would be meeting and would discuss reviewing insertion practices, but could also look at reviewing prescribing guidelines. **CE** asked **MC** if Co-amoxiclav usage on when being moved from allowed list to not allowed list it was thought that there would be a drop in CDI and is there any statistical link. **MC** had said this is difficult to say due to the way testing had changed at the same time and **VW** said that longer data would be required to see if there were any peaks in prescribing.	
11.	**Performance Report**	
	Dr Cooper gave presentation on report MRSA bacteraemia – 0	

Item No		Action
	MSSA - 1 on target MRSA acquisitions • Division 1 – 3 which marginally is above their target • Division 2 – above target due to problems on Deanesly around the way beds are used and patients are moved. There has been a lot of observation on practice taking place on the ward and they are very to make sure there are no reoccurrences. There has only 1 acquisition in June which was on D20 CDI PCR positives high – still within target with a full analysis being completed. • Division 1 – 9 • Division 2 – 9 **IB** asked due to higher rate of carriage does this mean that we are expecting a higher rate of infection and what could be done about this. **MC** answered if findings show that a lot of people are carrying CDI then it has to be asked where this is being picked up from which the most likely place is within the hospital. Therefore people are requested to decontaminate, their hands, equipment and ensure that the environment is as clean as possible. External target excludes West Park Hospital and will be shown separately on next month's graphs. DRHABS were down in June • Division 1 – 0 • Division 2 – 3 Contaminants higher there is a plan in place with expectation to reduce the number of contaminants considerably. <u>Hand Hygiene Compliance</u> Has been very slow, but there has been a big push on hand hygiene and staff in the Trust need to be at 95% to be in compliance with NHSLA. Overall there has been an increase. <u>Antimicrobial Prescribing</u> • Division 1 – over 80% • Division 2 – over 80%	
12.	**Any Other Business**	
	12.1 PhillipTurley posed a question to the committee from members of the public and asked if there was a directive to Doctors wearing stethoscopes around their necks when walking in and around the hospital site, outside of clinical areas. The committee had said that Doctors should be decontaminating the equipment in between each patient contact and germs in an outside area were less risky than within a clinical area. **CE** thanked **PT** for the question and said that perception to the public is not always inspiring, but from an IP and scientific point of view patients are not at an increased risk.	

Item No		Action
	12.2 **CE** picked up from a conference attended last week of a practice of bed and patient management and that a house-keeping representative attended every bed meeting. The principle being that first thing in the morning the knowledge of where clutter of discharges were happening would be known, so resources could be put in place appropriately to ensure quick turnaround of beds. The IPCC had said this is not carried out by housekeeping it is carried out by ward staff, with exception to WPH where it is carried out by the domestic. **SR** had said that there had been previous discussions regarding this and were looking at this through Best Practice with a view to trialling it.	
13.	**Date of Next Meeting**	
	Friday 27th July 2012 10AM Board Room, Corporate Service Centre	

ACTION LOG
Infection Prevention & Control Committee Meeting
29th June 2012

ACTION NO	AGENDA ITEM	ACTION	LEAD	COMMENTS
1.	2.	Mary Brassington to liaise with Tony Stanyard (Head of Procurement) on information on business case for sharps safety devices – to be chased and bought back to next meeting.	**Cheryl Etches**	**Brought forward from IPCC meeting held 25/5/12 – Action no1**
2.	2.	Mary Brassington to put together a letter for David Loughton to send to Jonathan Wedgewood to ask why sharps device products are not being trialled jointly with other hospitals.	**Cheryl Etches**	**Brought forward from IPCC meeting held 25/5/12 – Action no 2**
3.	2.	Ivan Little to meet and discuss with David Loughton assurance given for water flushing at WPH following May IPCC meeting.	**Tom Butler**	**Brought forward from IPCC meeting held 25/5/12 – Action no 4**
4.	3.	**SR** to check if house-keeping are making up any hyperchloride sprays etc.	**Sandra Roberts**	
5.	4.	The IPCC Terns of Reference to be amended as agreed in minutes.	**Vanessa Whatley**	
6.	5.	Decontamination Terns of Reference to be amended as agreed in minutes..	**Vanessa Whatley**	
7.	5.	Papers for decontamination meetings to be circulated to PCT Public Health to decide if attendance to these meetings are required by members of PCT – **CE** to feedback to **DL**	**Cheryl Etches**	
8.	6a	**IB** put together a small report on antibiotic prescribing compliance to bring back IPCC meeting in July if there is no improvement. Highlighting issues and compliances liaising with Louise Nickell for training information from data base.	**Ian Badger**	

9.	6b	**SK** to liaise with West Park Hospital Rehab care of the Elderly/Stroke on concerns of IP level 2 training showing red for hand hygiene which has been a gradual decline from early this year and.	**Dr Suneil Kapadia**	
10.	6b	**CE** to discuss vascular access with Jonathan Odum.	**Cheryl Etches**	
11.	7.	Queries were raised on the frequency of the flushing on outlets being carried out on a weekly basis with papers being submitted monthly. This needs further clarification **TB** to investigate and bring back to next meeting.	**Tom Butler**	
12.	8.	**CE** to report back and discuss further with matrons on environmental report issues.	**Cheryl Etches**	

Minutes of Infection Prevention and Control Committee

Date	**27th July 2012**		
Venue	**Board Room, Clinical Skills Building**		
Time	**10am – 12noon**		
Present:	David Loughton	**(DL)**	Chief Executive Officer
	Cheryl Etches (Chair)	**(CE)**	Chief Nursing Officer
	Dr Mike Cooper	**(MC)**	DIPC/Consultant Microbiologist
	Mari Gay	**(MG)**	Deputy Chief Nursing Officer
	Ian Badger	**(IB)**	Medical Director – Division 1
	Sandra Roberts	**(SR)**	Head of Hotel Services
	Iris Fitzgibbon	**(IF)**	Senior Matron Division 2
	Philip Turley	**(PT)**	Governor
	Dr Suneil Kapadia	**(SK)**	Medical Director – Division 2
	Vanessa Whatley	**(VW)**	Infection Prevention lead Nurse
	Ivan Little	**(IL)**	Head of Estates
In Attendance	Julie Sharp	**(JS)**	Occupation Health & Well Being Nursing Service Manager
	Fiona McKean	**(FMcK)**	Pharmacist
	Gail Gunning (Minutes)	**(GG)**	Infection Prevention Secretary
Apologies	Professor Ray Fitzpatrick	**(RF)**	Director of Pharmacy
	Dr Janet Anderson	**(JA)**	Non-Executive Director – Division 2
	Ros Jervis	**(RJ)**	Consultant in Public Health WCPCT
	Dr Jonathan Odum	**(JO)**	Medical Director
	Rose Baker	**(RB)**	Head of Nursing – Division 2

Item No		Action
1.	**Apologies**	
	Professor Ray Fitzpatrick, Dr Janet Anderson, Ros Jervis, Dr Jonathan Odum, Rose Baker,	
2.	**Minutes and Actions of meeting held on 29th June 2012**	
	Minutes of the meeting were agreed as true and accurate.	
3.	**Matters Arising**	
	3.1 **SR** confirmed that house-keeping do not use spray with hyperchloride solution anywhere with the Trust.	

Item No		Action
	3.2 **IPCC Terms of Reference (revised from IPCC 27/7/12)** These have been amended and updated – Agreed by IPCC 3.3 **Decontamination Terms of Reference (revised)** These have been amended and updated – Agreed by IPCC	
4.	**Occupational Health & Well Being – Reported by Julie Sharp**	
	4.1 Update from Sharps Management Steering Group <u>Trial of Safe Needle Devices</u> Following up on the action requested by **DL** at IPCC in May for Mary Brassington to draft a letter in respect of the desirable option of involving the procurement consortium in a joint NHS Trust purchase of safety devices, **MB** met with procurement to revisit the current situation and obtain some current background facts. It was their original perception that any delay in purchasing the devices would compromise RWHT's ability to meet the EEC Directive deadline since most trusts locally appeared to be ahead and had already ordered and/or installed the equipment. However, it has now been established that RWHT are, in fact, ahead of other organisations and that at least one local trust has not even set up a similar group to our own SMSG as a first step to a positive purchasing policy and have not even discussed trial areas. It has also been established that the consortium will be ready to agree prices and place orders in December 2012. Suppliers have suggested that there may well be an unmanageable rush when the time comes to order so it would be prudent for RWHT to continue with our action plan albeit with a more flexible timeframe. It should also be noted that attendance at SMSG meetings has been very variable and the last one in July 2012 was not quorate but **MB** made the decision to maintain the momentum by making the decisions on actions which were on the agenda to debate. The minutes were forwarded the same day and a request for feedback made which yielded some response. Procurement approached the departments earmarked as appropriate for the trials and the subsequent reaction to this has been negative in some areas. **MB** met with **DL** on 26/7/12 the following actions were endorsed in principle to replace the plan tabled at the IPCC in May. • An open day where interested parties can view and handle products from the suppliers • Trials to then be set up but with time allowed for pre-trial training and changeover • A set number of units will be allocated to trial areas and time given to ensure that each department have the same number of units before changeover to another brand. This will simplify the logistics and provide outcomes that have greater validity.	

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	• An evaluation will then be made and recommendations communicated at a senior level. The SMSG recommendation is that information about the chosen products is managed at Director level in terms of cascading decisions about standardised purchasing in view of negative responses to the trial invitations. • Once final decisions have been made about the chosen brand, the best procurement route can then be determined, i.e., supply chain or consortium as more information on pricing may be available. **VW** informed the IPCC that when the IV Team are in place they would really like to be involved with the trial. **DL** has requested that he wants to meet next week with Procurement, Occupational Health and cross section to review and to explain the standardisation. **CE** had said that she thought that trial of a product had already been carried out. **DL** replied there have been several products that have already been trialled. **CE** had asked who is currently responsible for the lead of trialling sharps products, **JS** had said that **MB** is chairing the Management Steering Group, but is struggling to get support, which has been an issue and Procurement are mainly leading on this. **CE** had said this is a serious risk for the organisation, **DL** had said that why he had intervened to get this issue resolved. **CE** also asked with the meeting not being quorate and non-attendance, how this was being escalated to line managers and people who are not attending. **JS** replied that she was not aware if this was happening and would have to check, but **MS** has met with **DL** to discuss this issue. **DL** has also requested the league performance table by department for flu. **MB** is currently working on this.	**JS** **MB**
	4.2 NHSLA Sharps Monitoring Report <u>Quarter 1</u> There have been 41 sharps incidents during Q1, 9 of which are from community, with a vast improvement showing on Hotel Services and Division 2. From the 41 incidents dealt with, there were 2 members of staff injured from known HIV positive patients, where the patient was also a known to have Hepatitis C, but both were considered low risk, following risk assessments and are continuing to be followed up by Occupational Health. **VW** asked if both these members of staff had received treatment within one hour of their injury, **JS** replied yes and both dealt with by Occupational Health. Also from 41 sharps incidents, 3 of the injuries were from known Hepatitis C patients, 1 of which was also HIV positive as previously discussed as above. One of the patients was not a known Hep C at the time of the injury, but became apparent once patient had been tested which proves that the policy in place is working. These cases are being followed up by Occupational Health. The largest area requiring improvement in line with NHSLA is to get more staff	

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	to complete DATIX incident following needle stick injuries, a lot of work has been done with one suggestion is that when attending Occupational Health on follow-up a DATIX or incident form could be completed. E-mails are also going out to Line Managers and Governance Lead and this issue was also raised at the Sharp Awareness week in June. **IB** asked following needle stick injuries staff are followed-up by Occupational Health, but are they sent for re-training. **JS** said that a lot of work was done on individual practices and once the new safety devices are in place this will be something that will be addressed. **VW** asked if there was any member of staff that would participate in being filmed on their experience of taking PEP as a training exercise – **JS** to look arrange member of staff to take part. **CE** asked if the Divisions are informed of the needle stick injuries other than at the IPCC meeting. Currently Divisions are not informed, but it would be useful to know the numbers and individuals names. It was also suggested that each needle stick should be treated as an infection and considered as high risk until proved otherwise. **DL** had said that from today's meeting a target has been set to reduce the number of needle stick injuries by 50% within 6 -12 months.	**JS**
5.	**Review of Clostridium d*ifficile* –Vanessa Whatley** Data has been collected since January 2012, so the purpose of the report is to review the 6 months data and what else that could be done with regards to CDI. Division 2 has been completed but is not visible on the report circulated; **VW** apologised and will re-circulate the report. <u>Key Points</u> The use of Hydrogen Peroxide Vapour (HPV) continues to be variable for discharge cleans and in general over 60% compliant, but there have been times when it has been 100%. The 7 day HPV cleans are best practice rather than national guidance and have rarely being completed during last couple of months, decreasing compliance. This has been in spite of the ward rounds that are currently taking place every week and Infection Prevention Nurses and Doctor going out to every new case with 24 hours of diagnosis. From Monday 30/7/12 one of the Infection Prevention Nurses will be going out every single day to visit CDI patients. Isolation should occur on suspicion of CDI rather than on the result, but 40% of cases are taking more than 24hours to isolate patients. It is emphasised to Junior Doctors that is about treatment on suspicion. The ward with the highest incidence, D15, shows improvement but has had the highest incidence over the past 2 quarters and D7 whilst open as a medical ward was having a case per month. Focus needs to be made on temporary wards. Overall the algorithm was used really well once positive patients were identified; in instances where this did not happen were the areas with the highest numbers. Reoccurrences continue to be significant with up 3 cases per year, particularly in community, with the source being from the Acute. A list of high incident CDI cases has been put together and Infection Prevention are planning meet and review these	**VW**

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	repeated cases with Gastroenterology. 30 day mortality appears to have risen slightly, but numbers still remain low and attributable mortality decreasing. This will need to be reviewed on an annual basis. **DL** asked if the high risk patients were flagged on the PAS system, **VW** replied no this has been debated and is on the IC Net system which flags to IP Team as soon as patient is re-admitted with CDI, with IP Team informing the ward if this occurs. **DL** explained that this is fine from IP point of view but if this was to occur during the weekend then this would not be picked up until Monday morning earliest, **MC** had said it was limited was what could be put onto the PAS system, **SK** suggested that this could be put onto the Web Portal, in which **IB** said this would be helpful, but TD Web may be better due to that more personal view TD Web. **VW** to look into this and review. **VW** said that there were some areas that are having higher incidents than others and Infection Prevention are putting as much as possible into this. **DL** suggested that the Divisions look into this and **IB/SK** review area practices. **SR** discussed discharge cleaning teams and said that if beds could be cleaned on discharge with a dedicated team, trialling on best practice. This could help process and guarantee HPV, **SR/VW** to discuss further following IPCC meeting, looking to trialling on one or two wards.	**VW** **IB/SK** **SR/VW**
6.	**Divisional Reports**	
	6a Division 1 - **Report Mr Ian Badger** <u>Antibiotic Prescribing Training</u> Shows red and should be showing ambers as there is only one area that shows below 70% compliance (Head & Neck). Critical Care should read 100% due to the only non-compliant Antibiotic Prescriber being suspended for four years therefore could not be expected to have completed antibiotic prescribing training. **DL** asked why was this person still on the system, **IB** had said because they are still classed as employed. **MC** said that they should be taken off as the Trust need to 95% compliant in line with NHSLA. There has been improvement across the antibiotic training and has **IB** had said that study leave would not be allowed to members of staff who have not completed their mandatory training. **DL** had said that in the future that non-compliance of mandatory training could be linked to car parking permits, where staff would not receive permits unless their mandatory training had been completed. <u>RCA Summary</u> DRHAB patient was discussed (K29397) **IB** has stated that this is complicated case and is confident that the patients biopsy was not contributed to this. This patient is currently on D2 under the joint care of Brian Waymont and Frank Curran. <u>CDI</u> Needs to be explored why there have been two recently on D2 and also three during the previous month.	

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	Key Concerns - as outlined • Antibiotic prescribing is improving • 5 moments hand hygiene has been good over the last month • Dress code compliance on wards has not been good and needs to be addressed. **MC** had said that at the IPPC meeting at the Nuffield last week there was issue raised on concerns regarding a surgeon that had arrived for work wearing RWHT theatre blues. **IB** had said that this is not an issue provided that staff do not walk out of theatre in their blues, then return wearing the same ones. **MC** agreed saying it was not a problem provided that they are not travelling to and from work wearing their theatre blues. This individual has been spoken to by the Nuffield and **MC** is to find out this person's name and pass onto **IB.** **SK** suggested that the desk tops were a good way to make people aware of the dress code and to get the message across. **CE** had said there were two reasons for the dress code, one being an IP function and the other is that as a Trust we should show a professional element. **CE** to send out an e-mail to Heads of Departments to remind staff of the dress code policy.	**MC** **CE**
	6b Division 2 – Reported by Dr Suneil Kapadia Antibiotic Prescribing Training Is a little worse than last month but compared to the beginning of the year shows significant improvement, but there is still a lot of work to be done. Key Concerns **SK** is working closely with Oncology and Haematology to improve antibiotic prescribing. Vascular Access There is nothing further to add from last month's figures 76%, with the likelihood of improvement not being good. RCA's - DRHABS Most of the DRHABS are related to central lines and **SK** has recently received correspondence on that insertion of these is being carried out in an adhoc manner, with no co-ordinated approach. A pathway for the insertion of central lines is being devised and will take a little while to implement across the two divisions. **IB** said there must be a clear that line insertion must be done with ultrasound guidance. A dedicated session in the treatment room should be available with trained inserter. **VW** discussed that the IV Team will be taking on of this work. Discussion took place on the issue on accessing ultrasound guidance for line insertions, especially over weekends and people becoming de-skilled. **VW** has recently received enquiries from anaesthetists who are willing to share their skills in ultrasound guidance, but need hardware to carry out this procedure. **DL** asked how much this equipment would cost and for **VW** to look at sourcing an ultrasound machine for training purposes, as more skilled staff are required. **VW** also to look at organising training through using the IV Team.	**VW** **VW**

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	IB/SK to look at a plan how to have enough volume of staff with relevant skills to deal with line insertions for weekend and out of hours cover, also looking into numbers and bring back to IPCC meeting within two months. **CE** asked if it would unreasonable for a target of all green on IP training to be completed by next month. **IF** had said there had been an issue with data input through data training dept. **SK** had said that he would try his best for this to be green for next month and aiming to be green across the board. **IF** said the division had been working very hard and would feedback to Rose Baker that there is requirement to be green for next month and for Rose to feedback at next month's IPCC. Discussions took place around issues on the training database and how this needs to be centralised. **DL** said that these issues needed to be discussed further at Directors meeting.	**IB/SK** **IF** **RB**
7.	**Estates Report – Reported by Ivan Little**	
	<u>Legionella Control Steering Committee</u> – meeting took place on 26/6/12 • Risk assessments are now being taken on new bin wash facility next to boiler house as a consequence of A&E modifications that are being taken. • Estates are currently reviewing Chloride Dioxide installations across the site due to concerns of maintenance performance, findings of which will be reported back to IPCC in September 2012. • The Legionella Committee also agreed that swan neck taps are no longer to be used on any new schemes or day to day replacement across the Trust. • In terms of water out-let management the second month of monitoring shows that the Trust is still improving with 70% compliance and is still challenging departments on one to one basis to understand why reports are not being submitted. Main findings were that work is being completed but reports are not being submitted, however some departments have not been completing necessary paper work. <u>Clinical Waste Incineration</u> On-going sub-optimal performance, mainly due to maintenance activities latest of which is waste heat boiler tubes weeping. **DL** asked when the Trust receive that combined heat and power will this problem be resolved. **IL** replied no – it has its own heater boiler, basically there is a problem with the age of the plant and Estates are undertaking a financial review on whether it is viable to continue with the existing plant or look at alternatives. **DL** asked how much a new plant would cost in which **IL** replied £1.5 million and are looking at options to lease. <u>*Pseudomonas aeruginosa*</u> Several positive samples have been received back and a variety of actions are being taken. Further sampling is taking place today to understand the extent of the problem, with remedial actions already in place following a meeting held on 26/7/12. The brass flow straightener trial in NNU was successful; they are currently being manufactured and upon receipt will be fitted finally removing the outlet filtration.	**IL**

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	CE asked if the Trust will be charged for the new straighteners, **IL** replied no. Sampling Results and KPI's The report shows green for this month, there has been a slight confusion over Trust wide data which is slightly different to local data. This has been investigated with findings showing there had been a late submission, but overall the report shows a pleasing healthy picture. Sampling results are attached to the report for information. **DL** had mentioned that concerns of levels of pseudomonas had been raised at meeting held on 26/7/12, which was under 10, but had said members of the meeting were not alarmed. **MC** had said there had been no clinical infections associated with these levels of increase.	
8.	**Environment Report - Reported by Sandra Roberts**	
	Planned Deep Cleans Getting back on track with the programme linked to the piped oxygen and are about a week behind, with no more delays. PEAT Hotel Services have been successful in taking part in new patient led inspection programme, which is looking to be quite considerably different than previous, with levels to aspire too. Arts Co-Ordinator Artwork has now been completed in the Children's Wards and A & E Department. Further work is on-going in the Fowler Centre and Neonatal Thought Garden. Ward Manager Environmental Audit Report Q1 Summary – attached 2 wards have now completed - D18 and ASU, after the closing date. The action points of the report, which is circulated to the Matrons, will be taken forward to Environment Group for discussion with the Matrons. **CE** asked if C3 would be getting a deep clean, **SR** replied yes it would be done now the ward has been closed. **CE** also enquired on the food audit asking if we were only looking at breakfast, **SR** replied no that the report just showed an example and that there were different aspirational levels, which will change the emphasis slightly and be much more Trust orientated with action plans being developed for individual areas. It will be a much more different inspection but will know more once the pilot scheme has commenced. **VW** had said that the Ward Manager Environmental Audit needed to be looked into in more detail during the next Environmental Group meeting, due to the number of damaged equipment around the Trust. **DL** had said information should be taken back to the Matrons to remind staff to remove damaged equipment from ward areas.	

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9.	**LNIP Report - Reported by Vanessa Whatley**	
	Clinical Incidents/Outbreaks CDI death has been reported on 1b on death certificate and has been reported as a Serious Incident (SI) in accordance with the SHA, DoH and Trust policy. This has gone back to the division within the last week for a RCA to be completed and within 30 days. A key point was emphasised to Junior Doctors at induction that Microbiologist were unaware of CDI being recorded on death certificate prior to issue. Scabies Outbreak occurred on D20 during June, an RCA has been completed to be approved at today's IPCC meeting. Annual Work Programme • The wound management practice survey linked to blood stream infection has been completed with work being carried out on current actions. A review of the funding within the PID project is being carried out working alongside the Commissioners. This currently funds the MRSA screening project, which is now at phase 8 of the 10 phase project and will be continuing. There is currently a vacancy within the project but the further member of staff is no longer required as the screening project is now at 2.1% within care homes (previously 9%) and so the spare funding will now be used to focus on chronic wounds. A draft proposal is being put together with a forecast budget already in place also working alongside the Tissue Viability Team. **VW** is arranging to meet with Ros Jervis and Dr Adrian Phillips for this to be signed off. • A full review of MRSA screening in the community has been undertaken reporting further reductions of MRSA in the community. The data is provided as an appendix to the report for information. • Some of the IV Team come into place during August, with the full members of the team being in place by September. The service will commence is September and will be advertised. • The catheter prevalence survey undertaken in May has been completed and a report has been attached, which is a standalone report for community and Acute contract as required by catheter CQUIN. The bulk of the report refers to the whole of Health Care Economy. The prevalence study shows 15% catheter rates in the Acute Trust; the removal of ITU takes this down to 14% and in the Wolverhampton City 9.53 per 10,000 population, with the vast majority of catheters being in long term for retention. The catheter steering Group meeting is scheduled for Monday 30/7/12 with the attendance of Urology, discussion of which will be reported back to the IPCC meeting in August. By the end of quarter 2 there has to be trial without catheter and pathway available, which is quite a challenge and is currently being worked on. The report has been submitted to the Commissioners with the deadline being 23/7/12.	**VW**

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	CE had asked is any lessons could be learnt from any other organisations, **VW** had said yes that Walsall had sent along their information and **VW** had shared this with one of our Urology Nurses who was very impressed. This will be a good place to start with as Walsall had the same CQUIN last year with the same Commissioners who are setting the targets so will be expecting similar results. The survey also shows a 15% drop in the use of urethral catheters from January – May 2012 compared to the survey carried out in 2011, it also shows a 50% drop within nursing homes. • The Surgical Site Infection group continue to meet and manage associated risks to the project. • The Norovirus winter report has been completed and is attached to the report, summarising all three bouts of Norovirus for 2011/12. There is focus in the action plan ensuring that testing takes place in-house for Norovirus with an interim solution for when the labs merge, but need a current plan for now to help with capacity issues. There is also discussions with Commissioners to look at sheltered housing as there is currently no service provided and how better advise is received. <u>Annual Report</u> The Infection Prevention Annual Report is attached for approval before going to TMT and Trust Board. This is the first report as a combined acute and community infection prevention team. This IPCC discussed and agreed the annual report with amendments to be made on the level of detail on page 23 and to be re-worded by **MC** regarding Pseudomonas before being made public.	**MC**
10.	**Pharmacy Report - Reported by Fiona McKean**	
	<u>Antibiotics</u> The number of antibiotic interventions have shown an increase since June. <u>Interventions</u> There were 9 allergy box interventions, 3 for Division 1, 6 for Division 2 <u>Antimicrobial Prescribing KPI's</u> The quarterly snap shot audit for allergy box completion was 100% <u>Antimicrobial Sticker Completion</u> Division 1 was red across the board except for cardiothoracic ward who were 100% Division 2 were red but scored 67% and are using the sticker, albeit not every time. <u>Missed Doses</u> There were missed does for both division 1 and 2, there was a discussion with senior roles on importance of not missing doses being emphasised. <u>Antimicrobial Stewardship Committee</u> • A Trust wide audit looking at 'Time to receive first dose of antibiotics in adult patients with sepsis' commenced 16/7/12 for seven days, results to be reported back at next meeting.	

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	• The first quarter of the 'Antimicrobial Stewardship' CQUINs for the acute Trust and West Park Hospital, has been completed. The three indicators have been reported back to the Commissioners 1) A baseline self-assessment has been undertaken using South Manchester hospital scoring system, scoring 97 points we requirement being 80. An action plan for further improvement has been developed and is ahead of schedule. 2) A quarterly audit of prescribing antibiotics prophylaxis in surgical patients was undertaken divided equally between elective and emergency procedures. Proportion with allergy status recorded on the anaesthetic record was 96.7%. In 67% of patients antibiotic prophylaxis was given within 30 minutes prior to incision, for 30% timing was unclear due to unclear documentation. Prophylaxis prescribed in line with Trust antimicrobial guidelines was 43%. Whilst this is a small subset of patients we would expect a higher compliance with Trust guidelines. Unfortunately specific examples of this non-compliance were not recorded for comment. Therefore whilst these have been marked as non-compliance they may in fact have been suitable alternatives. **MC** said that it was important to say that the 43% were not actually appropriate and that it was just that only 43% were giving what was in the guidelines. It might have been that they were giving an alternative that was just as affective and need to match up what people are actually doing with what the guidelines say, which is where there is gap. 3) Snapshot analysis of antibiotic prescribing at monthly intervals on different wards, with concerns being on the percentage of patients receiving an antimicrobial with documented stop or review date is 51% and 41% and will re-designing how data is collected. • There is one CQUIN requirement for West Park Hospital, which is a snap shot audit, but this is proving to be difficult as there are few patients that are receiving antibiotics, these findings have gone back to the Commissioners to ask how they wish to take this forward. **VW** raised concerns on figure 4 of the report on use of antibiotics in which there has been no activity, but the use of antibiotics has doubled. **FMcK** replied this was due to the topping up of packs in A&E of co-amoxiclav. **CE** asked how this Trust's pharmacy compares trends on antibiotics against other organisations. **FMcK** replied that a quarterly audit, takes place with participation on regional audits which tells us that we are using fewer antibiotics. **CE** said that we need to compare data with a site that is similar to ourselves. **FMcK** to make comparison of antibiotics data with North Staffs and Coventry	**FMcK**

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11.	**CJD Policy – discussed by Dr Mike Cooper**	
	Meetings and discussions have taken place between **MC,** Sue Smith, Marion Washer and Bev Morgan to review the CJD policy following national guidelines that has changed significantly in that anterior eye surgery has moved into a low risk category. **DL** asked how many people will have been notified they are risk of CJD and by whom. **MC** estimated that nationally it would be in the hundreds or possibly below thousands. **DL** raised concerns on the cost implications of taxpayer's money in putting this policy in place and asked **MC** to write back to HPA raising the concerns and to tell them reasons why and to find another solution. **MC** to feedback to next IPCC meeting.	**MC**
12.	**Performance Report - Presentation given by Dr Mike Cooper**	
	MRSA bacteraemia – 0 MSSA bacteraemia – 0 on target MRSA Acquisition – far better than previous months and back on target <u>CDiff PCR Positives</u> 14 attributed to RWHT, showing improvement from May and is above target, Division 1 is below red zone, Division 2 green, internal target is not good, however on the main external target there were 6 toxin positives out of 19, which show how many more are being picked up by PCR, in which only 2 were attributable to RWHT, 1 attributed to WPH <u>DRHABS</u> This proved to be a bad month for DRHABS, with 4 cases on CHU and 4 on NNU. <u>Blood cultures contaminates</u> Were lowest to date with plans in place to change the working pattern of the Phlebotomists which might show further improvement. The report shows a lot green areas apart from CDI and DRHABS. <u>KPI's</u> Hand hygiene 90% green but needs to 95% for NHSLA compliance, **CE** had said to note that this is not a target set by NHSLA and was set by RWHT. <u>NHSLA</u> An action plan is to be in place for NHSLA feedback on any initiatives and any are to be forwarded **MC** or the training department to implement into the action plan. <u>Antimicrobial Prescribing Training</u> This hoped to be higher position next month with more junior doctors receiving their training.	
13.	**Any Other Business**	
	None discussed.	

Item No		Action
14.	**Date of Next Meeting**	
	Friday 31st August 2012 10AM Board Room, Corporate Service Centre	

ACTION LOG
Infection Prevention & Control Committee Meeting
27th July 2012

ACTION NO	AGENDA ITEM	ACTION	LEAD	COMMENTS
1.	4.1	**DL** requested a meeting with Procurement, Occupational Health and cross section to review and to explain the standardisation for safer needle devices.	**Julie Sharp**	
2.	4.2	League performance table by required for flu for Departments.	**Mary Brassington**	
3.	4.2	**JS** to look arrange member of staff to participate in filming experience of having to take PEP.	**Julie Sharp**	
4.	5.	Copy of review of CDI report to be re-circulated.	**Vanessa Whatley**	Completed.
5.	5.	**VW** to look into the use TD Web for flagging high risk CDI patients.	**Vanessa Whatley**	
6.	5.	Divisions look into areas with increased CDI incidents and review area practices.	**Ian Badger** **Suneil Kapada**	
7.	5.	**SR/VW** to discuss trialling dedicated discharge cleaning teams, using best practice.	**Sandra Roberts** **Vanessa Whatley**	
8.	6.	**MC** to forward member of staffs name wearing RWHT theatre blues at Nuffield Hospital.	**Dr Mike Cooper**	
9.	6.	E-mail to be distributed to Heads of Department to remind staff of the dress code policy.	**Cheryl Etches**	Completed.
10.	6b	**VW** to look at costing and sourcing of ultrasound machine for training purposes.	**Vanessa Whatley**	
11.	6b	**VW** to look at training for line insertion through IV Team.	**Vanessa Whatley**	
12.	6b	**IB/SK** to look at a plan how to have enough volume of staff with relevant skills to deal with line insertions for weekend and out of hours cover, also looking	**Ian Badger** **Suneil Kapada**	

		into numbers bringing back to IPCC meeting within two months.		
13.	6b	**IF** to feedback to Rose Baker that there is requirement to be green for next month on IP training and for **RB** to feedback at next month's IPCC.	**Iris Fitzgibbon Rose Baker**	
14.	7.	Findings of review of Chloride Dioxide installations to be reported back to IPCC in September 2012.	**Ivan Little**	
15.	9.	**VW** to report back from catheter working group meeting being held on 30/7/12 at next month's IPCC.	**Vanessa Whatley**	
16.	9.	**MC** to make amendments on Annual Report, rewording page 23 regarding Pseudomonas.	**Dr Mike Cooper**	Completed.
17.	10.	Comparison on antibiotic trends to be carried out Trust against other organisations.	**Fiona McKean**	
18.	11.	**MC** to discuss concerns of CJD Policy with HPA and feedback to next month's IPCC.	**Dr Mike Cooper**	