The Royal Wolverhampton NHS
NHS Trust

CHIEF EXECUTIVE'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 31 May 2013 and 28 June 2013
Report from:	Chief Nursing Officer
Date:	Minutes dated 31.05.13 and 28.06.13 to Trust Board 22.07.13

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
Main Discussion/Action Points	**<u>31 May 2013</u>** • Draft minutes approved at IPCC on 28 June 2013 – no amendments • Points of note as reported to Trust Board on 24 June 2013

	28 June 2013 – draft minutes
	
	• DRHABs – improved position for haematology/oncology which is being sustained
	
	• Fidaxomicin business case being developed to reduce C.Difficle recurrence
	
	• Hygiene code – progress being made on the two areas of amber ratings:
	  ○ Decontamination
	  ○ Waste Management

Risks Identified:	Compliance with C.Difficile target

DRAFT

Minutes of Infection Prevention and Control Committee

Date **28th June 2013**

Venue **Board Room, Clinical Skills Building**

Time **10am – 12noon**

Present:	David Loughton (Chair)	**(DL)**	Chief Executive Officer
	Jonathan Odum	**(JO)**	Medical Director
	Ian Badger	**(IB)**	Medical Director – Division 1
	Dr Suneil Kapadia	**(SK)**	Medical Director – Division 2
	Katie Spence	**(KS)**	Consultant in Public Health
	Vanessa Whatley	**(VW)**	Infection Prevention Lead Nurse
	Professor Ray Fitzpatrick	**(RF)**	Director of Pharmacy
	Dr Mike Cooper	**(MC)**	DIPC/Consultant Microbiologist
	Dr Janet Anderson	**(JA)**	Non-Executive Director
	Tom Butler	**(TB)**	Acting Head of Estates
In Attendance	Caroline Brammer	**(CB)**	Clinical Director Oncology
	Maurice Hakkak	**(MH)**	Group Manager - CHU
	Amanda Watts	**(AW)**	Matron - CHU
	Rose Baker	**(RB)**	Head of Nursing – Division
	Karen Bowley	**(KB)**	Matron Representative
	Lindsay Ibbs-George	**(LIG)**	Hotel Services
	Gail Gunning (minutes)	**(GG)**	Infection Prevention Administrator
Apologies	Cheryl Etches	**(CE)**	Chief Nursing Officer
	Sandra Roberts	**(SR)**	Head of Hotel Services
	Phillip Turley	**(PT)**	Governor

Item No		Action
1.	**Apologies**	
	Cheryl Etches, Sandra Roberts, Phillips Turley	
2.	**Minutes and Actions of meeting 31st May 2013**	
	Minutes of the meeting were agreed and action sheet updated with the following actions outstanding:	
	2.1 Outstanding action form IPCC 26/4/13 – **DL/CE/VW** to discuss Care Homes in South Staffs areas and Infection Prevention Team across Stafford. Action in progress discussed at Clinical Quality Review - awaiting further feedback	**DL/CE/VW**
	2.2 Action from meeting held 26/4/13 **SR** liaising with Claire Nash on tagging HPV machines, using safe hands system. This is in progress awaiting further feedback.	**SR**

Item No		Action
	RF joined the meeting at this point.	
	2.3 Outstanding action from IPCC 31/5/13 - Password to access database for inputting data on water flushing to be made ward based, not individually based. Action in progress awaiting further feedback.	**TB**
3.	**Matters Arising**	
	RB began with the chairing of the meeting with **DL** joining the meeting at this point and taking over as chair. **VW** pointed out that there was no representation from division 1 at this point, but IPCC were happy to continue with the meeting.	
	3.1 **Haematology/Oncology DRHAB's Report Update**	
	3.1.1 **Reported by Dr Caroline Brammer** Dr Basu from the Directorate conducted an audit looking at national benchmarking measures for line infections for oncology patients, in which there were none. The Directorate identified that there was a problem during the last year and various measures were put into place. There were no infections reported during March/April 2013. However there one was reported in May, which was an unavoidable catheter associated infection. The Directorate Team are currently working to reduce avoidable infections aiming to reduce as low as possible.	
	3.1.2 **Reported by Amanda Watts** • Accountability and responsibility has been given to the nursing staff • Observations are taking place on a daily basis • Spot checks are taking place monitored by Infection Prevention • Multiple approaches are be taken to sustain progress • Regular Scrutiny meetings are taking place, with the involvement of IP • Actions plans are being reviewed on a monthly basis • Regular Governance meetings are taking place • Academic meeting arranged for 2/7/13 – focusing on audit **VW/MC** were pleased with the actions that CHU have put into place and are working Sheffield working on improvement, benchmarking comparison. **DL** thanked the Directorate for their presentation and was pleased with their progress. **CB/AW/MH** left the meeting at this point **IB** joined the meeting at this point.	
4.	**Divisional Reports**	
	4a Division 1 – Reported by Ian Badger <u>Performance</u> The overall report shows many red areas. Reminders have gone out to appropriate staff within the directorate regarding compliance for mandatory training. Staff are being reminded to complete their mandatory training a month before the due date to avoid going red on the training database.	

Item No		Action
	Key Concerns DRHAB's - Cardiac • Pacing wires - these are usually inserted in theatre and should therefore have full asepsis. • PCI – Patients are usually handled well in terms of infection and is hoped that this is temporary, but is being monitored. DRHAB's - Urology • There are 3 patients that have complicated issues regarding interventions. A HII is being devised specifically for patients with nephrostomies. Information from investigations taken place have been shared with other directorates involved with the care of these patients. **DL** commented on the amount of red areas showing within the report and asked what could be done, to move responsibility from management to individuals. IPCC discussed how staff could be engaged to be responsible for their own mandatory training compliance. **VW** to liaise with Louise Nickell and put together a letter to go out to personnel with July payslips. Letters need to be approved by **JO** and **CE** before going out.	**VW**
	4b Division 2 – Reported by Suneil Kapadia Performance At the last IPCC in May the committee discussed that if following the divisional core meeting there was no overall improvement shown for Paediatrics performance then they should be invited to IPCC to present any issues. Paediatrics have since met and have a clear plan in place for staff. Following conversations with the staff **SK/RB** are assured that compliance will turn green. Care of the Elderly are to meet on a weekly basis to go through their mandatory training. There have been issues in that staff have been completing their training, but it has not been recorded on the training database. Emergency Services fortnightly meeting are to have mandatory training as part of a standard item on the agenda to discuss and improve on performance. The report for July IPCC for performance will not show any significant change, but will show a substantial improvement for August IPCC report.	
5.	**Action on C*difficile* – Dashboard - Reported by Vanessa Whatley**	
	• Actions continue for Fidaxomicin business case and will be presented at MMC in July. • The dashboard shows that there have been an increased number of delays in treatment from symptoms and diagnosis. When visiting the wards IP are reminding medical staff to commence patient treatment as soon CDI is suspected. It is hoped that there will be improvement within next month's report, but assistance from divisions would be appreciated.	

Item No		Action
	DL commented that a reminder needed to go out wards managers and matrons meetings. • Time to isolate remains static 80% • 30-day all-cause mortality remains low • It is 5 months since CDI was noted on a death certificate in Wolverhampton, however there is a coroner's report pending, where it is waiting to see if CDI features on the death certificates. It is not expected to be in 1A, but could be elsewhere in part1. • Asymptomatic cases have decreased to 0 in Q4 2012/13; moderate cases remain the same and severe cases also decreased. • Probiotics research continues to be investigated. National guidance has been released but appears to be dismissive for use probiotics. IP are currently interviewing for a Clinical Scientist, once appointed it is hoped that their first project will be to complete a pilot study on probiotics. • Detailed analysis is underway for post discharge CDI patients. • RWT on target for CDI cases, however CCG are slightly over which could have an impact. It is important that RWT continue to monitor as part of the Healthcare Economy.	
6.	**Hygiene Code Assurance & Action - Reported by Vanessa Whatley**	
	To be discussed as regular agenda item in regard to compliance of CQC recommendation outcome 8. A quarterly performance accelerator is currently used, in which there are persistent areas that are showing amber. The two main areas being focused upon are: 1. Decontamination – work to continue through regular decontamination meetings for assurance with the monitoring of audit data and risk register. 2. Waste management assurance – to be monitored at regular meetings once newly appointed waste manager is in post. **DL** requested that Pete Gibbons feedback on information until waste manager in post. **TB** to action.	**TB**
7.	**Estates Management Report - Reported by Tom Butler**	
	• Central and standby Chlorine Dioxide plant all producing good levels of Chlorine Dioxide. • A&E relative rooms – results of resampling for Legionella – all clear. • OPD2 dermatology area chlorinated – awaiting samples • Pathology still have high TVC counts across outlets. Capital Development are planning to chlorinate and resample. • Water Outlet Management still have areas of concern, which shown within the report. • Incinerator plant has been down due to tow gear box failures, which has now been rectified. • Pseudomonas – filters are still on clinical outlets NNU, CHU, ICU and delivery. Still awaiting new high copper tap from manufacturers. • Water safety plan is underway. **JO** joined the meeting at this point.	

Item No		Action
8.	**Environment Report – Reported by Lindsay Ibbs-George**	
	• Deep Clean Programme commenced May 2013 – details report • Portering hand hygiene compliance – access to Synbiotix has been obtained. The percentage for the last 3 months has risen by 20%, which will be continued to be monitored. PLACE inspection took place on 20/6/13 within the Acute hospital, which has appeared to have gone well. Information to be input for future feedback. • Meeting arrangement for operational hospital food with James Martin was cancelled by BBC and is waiting to be rearranged. • ICCU – project underway to resolve issues HPV clean. Bay A has been completed. • Technical audits continue with an average score of 97.88% cleanliness. • Monthly ward waste May 2013 – 10.52%**.** New menus to be launched July 2013.	
9.	**LNIP Report - Reported by Vanessa Whatley**	
	<u>Outbreaks</u> • No hospital outbreaks to report within the last month. • Community outbreak – 2 care homes affected, but results do not confirm this was Norovirus. The number of residents affected within the care homes have been low, with the care homes being re-opened within 3/4 days. <u>Annual Work Programme</u> • IV OPAT Team – business case has been agreed at June TMT. • 2 urinary catheter reports are attached within the IP report. Work is underway as part of CQUIN requirement. 1. Prevalence Study – 3 have been completed. 1st and 3rd of which shows an increase within the community of long term use of urinary catheters. Newcross shows 30% decrease in short term catheters. Surveillance has commenced from 1/4/13 which showed that 40-65 patients per month were discharged with a urinary catheter. This will continue to be monitored, working alongside WUCTAS checking which of the patients are urology patients, as these will be followed-up by Urology Hospital@Home Team. However, there is currently no process for follow-up on other patients going out into community other than district nurses replacing catheters. A meeting has been arranged with **VW,** Marcelle Rollings, Molly Henrquies-Dillon, Tracey Slater to discuss a process. There are currently over 400 patients to be reviewed. Processes are in place, but this requires the Trust to take this on board as an issue. The committee discussed that there were issues that needed to be addressed. Meeting to be arranged with **JO/CE/VW** to discuss and bring forward to IPCC July 2013. **2.** Community nurse on 3 month secondment visited 208 patients with long term catheters. She visited their GP's and viewed patient records. Community nurse feedback was that it was felt that if a large percentage of these patients had been offered a trial within 3 months they would no longer require a catheter. There needs to be a culture change and with the brining in the continence team under Corporate Services will assist in managing this process.	**VW**

Item No		Action
	JA enquired if the 60% insertion related patients were completed by the District Nursing Team and asked if they had been trained in infection prevention. **VW** said that during work carried out last year through CQUIN requirements, this had been identified as an issue, along with training requirements for female catheterisation. This has now been addressed, with training classes in progress since February 2013, run by Clinical Skills Team. <u>ARO Policy</u> This has been updated in-line with NHSLA requirements for a more detail audit. To be circulated following the meeting for comment.	**VW**
10.	**Pharmacy Report - Reported by Professor Ray Fitzpatrick**	
	• Monitored antibiotics - no major trends • Antibiotic interventions – same as previous month, none completion of stickers. • Allergy box interventions – 2 reported in May. Only 1 DATIX was reported for non-completion, division 2 A21. • Regional antibiotic snap shot audit results carried out in December 2012 and March 2013 are highlighted within the pharmacy report. • Allergy box completion – 100% compliance. Regional average 99%. • Treatment sheets review – remain below regional average, however the new treatment sheet has been approved by LMC and is due to be launched in August 2013. **JO** enquired if monitored antibiotics were only prescribed on the advice of a Microbiologist. **MC** answered Cefuroxime is only used in speicfic circumstances and Carbapenems are checked by ward pharmacists for appropriate use.	
11.	**Performance Report - Presentation by Dr Mike Cooper**	
	• MRSA bacteraemia – 0 • MSSA bacteraemia – above target showing an increase during May. • MRSA acquisitions – higher in May. Division 1 X 4, Division 2 X 4. Cluster on Cardiology ward was due to a patient admitted being inappropriately screened leading to further cases. There was no identified link between the 2 cases on A14. • CDI PCR positive – most have been from Division 2. PII meetings have taken place with C18 to discuss 9 cases reported over 4/5 months. Samples were sent off for typing, in which 8 of the 9 were different types. The 2 cases that were of the same type were from different month, so it is difficult to identify a link. HPV's have been carried out. Originally CDI toxin/PCR testing was averaged at approximately 50% of PCR positives were toxin positives. They are showing within the report to be a 1/3, in which only 2 which attributed to RWT, so well within the external target. CCG are slightly over. • DRHABs - increased slightly, 2 urinary related catheters from C24, IP have with the ward to discuss. • Blood culture contamination rate – slightly increased. **MC** has been in discussions with Phlebotomy regarding this increase. • Score card – disappointing but consistent.	

Item No		Action
	• Hand hygiene compliance – discussed as above (4a). • Antimicrobial compliance – show an increase.	
12.	**Any Other Business**	
	WV informed the committee that the Epic Guidelines, which is the national guidelines for infection prevention is currently under review.	
	Date of Next Meeting	
	~~**Friday 26th July 2013, 10am – 12noon Boardroom, Clinical Skills Building**~~ **Cancelled** **Friday 30th August 2013, 10am – 12noon, Board Room Clinical Skills Building**	

ACTION LOG
Infection Prevention Team Meeting
28th June 2013

ACTION NO	ACTION	LEAD	COMMENTS
1.	Outstanding action form IPCC 26/4/13 – **DL/CE/VW** to discuss Care Homes in South Staffs areas and Infection Prevention Team across Stafford.	**David Loughton Cheryl Etches Vanessa Whatley**	Action in progress discussed at Clinical Quality Review - awaiting further feedback
2.	Action from meeting held 26/4/13 **SR** liaising with Claire Nash on tagging HPV machines, using safe hands system. .	**Sandra Roberts**	In progress awaiting further feedback
3.	Outstanding action from IPCC 31/5/13 - Password to access database for inputting data on water flushing to be made ward based, not individually based. .	**Tom Butler**	Action in progress awaiting further feedback
4.	**VW** to liaise with Louise Nickell on mandatory training compliance letter to go out to staff with July payslips. Letters to be approved by **JO** and **CE** before going out.	**Vanessa Whatley**	
5.	**TB** to discuss with Pete Gibbons feedback on information for waste management assurance compliance.	**Tom Butler**	
6.	Meeting to be arranged between **JO/CE/VW** to discuss follow-up process of patients being discharged into community with urinary catheters.	**Vanessa Whatley**	Arranged 15/7/13
7.	ARO Policy update to be circulated for comment.	**Vanessa Whatley**	Circulated 2/7/13 – **Completed.**