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 28th September 2012
Report from:	Chief Nursing Officer
Date:	Minutes dated 28.09.12 to Trust Board 26.11.12

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
Main Discussion/Action Points	• One MRSA bacteraemia case attributed to RWT • Testing for Pseudomonas continues across Clinical Haematology Unit, Coronary Care Unit and Neonatal Unit – a retesting exercise of 300 samples has been completed

	• Infection Prevention training – focus on Hand Hygiene compliance. Medical Director and Chief Nurse will target non-compliant staff • Planned Deep Clean of areas has continued against schedule to reduce risks from environmental contamination

Risks Identified:	Compliance with C.Difficile target

Minutes of Infection Prevention and Control Committee

Date	**28th September 2012**
Venue	**Board Room, Clinical Skills Building**
Time	**10am – 12noon**

Present:	David Loughton (Chair)	**(DL)**	Chief Executive Officer
	Cheryl Etches	**(CE)**	Chief Nursing Officer
	Philip Turley	**(PT)**	Governor
	Sandra Roberts	**(SR)**	Head of Hotel Services
	Professor Ray Fitzpatrick	**(RF)**	Director of Pharmacy
	Dr Suneil Kapadia	**(SK)**	Medical Director – Division 2
	Dr Mike Cooper	**(MC)**	DIPC/Consultant Microbiologist
In Attendance	Carolyn Wiley	**(CW)**	Operational Manager Infection Prevention
	Iris Fitzgibbon	**(IF)**	Senior Matron Division 2
	Charlotte Hall	**(CH)**	Deputy Chief Nursing Officer
	Brian Sweet	**(BS)**	Electrical Manager
	Beverly Morgan	**(BM)**	Senior Matron Division 1
	Gail Gunning	**(GG)**	Infection Prevention Administrator
Apologies	Jonathan Odum	**(JO)**	Medical Director
	Ros Jervis	**(RJ)**	Consultant in Public Health WCPCT
	Dr Janet Anderson	**(JA)**	Non-Executive Director – Division 2
	Ivan Little	**(IL)**	Head of Estates
	Vanessa Whatley	**(VW)**	Infection Prevention Lead Nurse
	Ian Badger	**(IB)**	Medical Director – Division 1

Item No		Action
1.	**Apologies**	
	Jonathan Odum, Ros Jervis, Dr Janet Anderson, Ivan Little, Vanessa Whatley, Ian Badger	
2.	**Minutes and Actions of meeting 31st August 2012**	
	Minutes were agreed with one amendment in agenda item 5b the title Renal Vascular Access to be taken out, with the following actions outstanding:	
	2.1 **SR** to look into a capital programme on netting and protection from pigeons.	**SR**
	2.2 Estates to review license for disposal, looking at alternatives and discuss further with **DL.** **BS** to follow-up outstanding action from IPCC 28/8/12.	**BS**
	2.3 **JB** to check if sampling of ice making machine can take place in the next lot of water sampling taking place in September and feedback. **BS** to check with **JB** outstanding action from IPCC 28/8/12.	**BS**

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3.	**Matters Arising**	
	MRSA Bacteraemia – clarification of 3 cases during August/September Case no 1: Female oncology Walsall patient with a blood culture being taken on admission. A table top exercise took place over at Walsall on 14/9/12 where this case was discussed at length with a joint action plan implemented on lessons learnt. During the RCA investigation and subsequent meeting it was agreed that it was a pre-48 hour sample and so was attributed to Walsall PCT. Case no 2: Male Walsall GP patient arrived at A&E a pre-48 sample was taken and attributed to Walsall. This patient was catheterised 4 days prior to arriving at A&E. Both patients were colonised with MRSA, with various attempts to decolonise in Walsall. Looking at both cases these are poorly patients with a lot of risk factors and lessons learnt will be feedback when the joint action plans have been completed. Case no 3: Male patient (case no2) then had a further blood culture taken 14 days later, which does count again and subsequently attributed to Royal Wolverhampton due the patient being an in-patient. The patient had received treatment of Vancomycin IV antibiotics and is still an in-patient, investigations are taking place. Lessons learnt: Trust needs to implement the full screening of patients into the source of infection on arrival at emergency portals. Teaching and training is being put into place, with screen savers going onto PC desk tops to raise the profile. This is also being raised at SNOG and senior managers meetings. **SK** had said that focusing on taking swabs from all sites is appropriate, but from details of this patients journey this had been complicated and was more of Trust wide issue, that needed tightening up. A full action plan is being implemented to address these issues.	
4.	**Divisional Reports**	
	4a Division 1 - Report Beverly Morgan Performance Monitoring • Infection Prevention Training level 1 – Slight variance in Head & Neck and is being addressed by the Matron. • Infection Prevention Training level 2 – Shows good improvement, Orthopaedics still not as required, but is improving. • Antibiotic Prescribing Training – Shows an improving picture with 3 individuals outstanding on general surgery and 7 for Head & Neck. • 5 Moments – High profile within the division supported by IP and is continuing to make this a priority RCA • MSSA bacteraemia in critical care – summary sheet incomplete on RCA and has now been addressed. Device related, multiple lines inserted during resuscitation, including aortic balloon pump. • CDI X 2 investigated in Critical Care Unit (CCU) – no cause or link found between 2 patients in terms of care or standards. **MC** reported back 8 isolates patients who had been in or on CCU who had developed CDI during the course of the year, typing was received back on 5 which were all totally different. This suggests that there is no major	

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	environmental issue on CCU. Training IP have agreed a change of use theatre based assessment for ANTT, non-compliant staff can quickly move through from Beynon to achieve training. HII Care bundle 90% - no specific detail available CCU amber – due to line being taken out no longer being required Key Concerns • Discussions are underway with IP Microbiology regarding affective cleaning of TOE probes. This may require change in practice with chemical or product, which is to be discussed at decontamination meeting on 1/10/12. • Focus remains on 5 moments • De-clutter of ward with Executive walkabout is being arranged • Issue with dishwashers is being addressed on D1 and D2 • **CE** - Antibiotic Prescribing Training for Division 1 needs a further push – this is being addressed.	
	4b Division 2 – Reported by Suneil Kapadia Performance Monitoring There has been improvement, but there is still work to be done. The report presented at IPCC in April showed 13 ambers and 5 red on the first 3 rows, compared to 4 ambers showing on the current report for August. MRSA bacteraemia Discussed as above to be reported back to IPCC next month, awaiting Walsall to complete their RCA investigations. Vascular Access Still showing 78% but are trying to get to 80%, with few awaiting surgery or theatre. Dialysis on vascular access showed 238/307 in April – 235/302 in August, which shows that there has been no great change. **CE** had said although there had not been much improvement, it is moving in the right direction. Training NHSLA target for level 1 and 2 IP and Antimicrobial Prescribing for training is 95% but is showing 90% compliance on report. **IF** to alter template. ANTT – green HII Spot checks are taking place Key Concerns None reported.	**IF**
5.	**Estates Report**	
	Reported by Brian Sweet Legionella Control Steering Committee -28/8/12 Pseudomonas update – extensive repeat sampling has taken place during September and investigations are underway where there has been consecutive	

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	adverse sampling count. Testing took place during last week and 3 weeks ago which have identified problems within Deanesly, where investigations on pipework by Estates are on-going. NNU brass flow straighteners have been fitted, with copper tails to be fitted within the next week. KPI's continue with high achievement showing green, with a slight dip on hand washing showing 98%. <u>Water Management</u> Continuing to improve with consultations on wards going ahead with 1:1 talks – areas are listed within the report. Estates management are providing a twice weekly flushing service on high risk areas – as listed in report. <u>Community KPIs</u> As listed in report A working group is being convened – issues around risk assessment. <u>Community Outlet Flushing</u> 100% <u>Clinical Waste Incinerator</u> Under achieving mainly due to maintenance issues, affecting performance. **DL** asked if the Trust able to contract out or are we managing to cope. **BS** answered that this had been done in the past but was not sure what was happening at this present moment in time. **PT** was there any capital to upgrade the incinerator, **DL** replied this is currently being investigated. <u>Legionella</u> **CE** discussed legionella, control measures are in place, results of retesting should be back by the end of next week. <u>Pseudomonas</u> **MC** discussed the routine testing that had taken place on high risk areas and the large number on outlets of low numbered pseudomonas and occasional outlets with high numbers, across CHU, CCU, delivery suite theatres and NNU. Various control measures were put into place and extensive retesting with 300 samples be taken. Reassurance was given that this was not as extensive as initially thought and other potential solutions are being sourced. A meeting was arranged for 25/9/12 with the attendance of HPA, who gave reassurance that everything needed was being done. **CE** asked to be included on circulation list of results when they arrive, **BS** to ask Tom Butler to forward results to **CE**, Dr Dobie and Dr Ashcroft. Pending results a further meeting may need to be arranged. **SK** to check if this is on a risk register.	**BS** **SK**
6.	**Environment Report**	
	Reported by Sandra Roberts <u>Unplanned Deep Cleans – August 2012</u> Night cleans were reduced with only 3 being carried out. **SR** thanked **BS** and the Estates Teams for the management to isolate fire alarms. <u>Planned Deep Cleans</u>	

Item No		Action
	Scheduled plans went ahead linked in with oxygen implementation programme. PLACE A presentation was included in the report on two training sessions that have taken place. There are a couple of differences between PEAT and PLACE, on how the actual audit is conducted on the pilot. There will be 6 teams of 2 people, so that there will be a staff and patient representative and will covering similar areas as previously in PEAT. The mechanism is considerably different; the majority on high risk areas will simply be pass or fail and it is not sure if a score will be downloaded as part of the pilot. The pilot commences Thursday 4/10/12 and once completed feedback will possibly be brought back to the next IPCC. The audit appears to be a lot more complicated with a lot of detail and every ward visited will be marked individually, so that there is no average or overview of the Trust. An action plan proposed by **SR** will be compiled following results, ready to be prepared when the audit is live April – June 2013. Emphasis appears to be more patient lead and steers away from Estates and Facilities, but **SR** is happy to lead on this and organise. Clarification is needed on the two week window on notification from patient lead organisation. Patient representatives are 2 Governors, 2 patients who attend the Environment Group, 2 provided by Sharon Reilly (Patient Liaison). Once the pilot audit has been completed this can be discussed further at IPCC to decide on how to take this forward. Damaged Furniture **CE** was disappointed on process in that de-clutter was discussed seven years ago and needs to sit within the divisions. **SB** had said a central place was trying to be located in order for Procurement to arrange repair of furniture. **VW/CH** have met to discuss this, but a more standardised procedure is needed.	
7.	**LNIP Report**	
	Reported by Carolyn Wiley NDM1 There have been no further cases reported, a conference call was held on 14/9/12 where this was discussed at length and a detailed action plan is in place which attached to the report and is currently being implemented. Pseudomonas Discussed under agenda item 5. 3 clinical specimens taken on NNU – patient safety measures are in place alongside the water plan. Annual Work Programme IV Team is now in place and pilot audit is going ahead gathering information. Continence and catheter management has moved forward, the agenda with a Urinary Catheter Management Policy being written. Compliance with NICE guidance with a gap analysis being in place. The main work being carried out is around catheter management which is currently showing red, with the aim for this to be green over the next few months. Surgical Site Infection (SSI Team) are now in place and operational, just waiting for an IT system to enable it to go paper free. This has been delayed and should be in place by November 2012.	

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	Hygiene Compliance Code is showing 2 yellows, 1amber an action plan is in place to move these forward to green. Completion of policies post TCS, is in progress the deadline to merge Acute/PCT policies is mid-October. The only policy slightly behind with the deadline is Decontamination, this policy is being progressed. Funding NDM1 **CE** discussed if funding had been resolved through HPA for screening of NDM1 patients and relatives. **VW** has been discussing this with HPA and **CW** to ask **VW** to feedback information. IP Policies –For approval Blood and Body Fluid Spillage Management Policy – Approved by IPCC Isolation Policy – Approved by IPCC	**CW**
8.	**Pharmacy Report**	
	Reported by Professor Ray Fitzpatrick High Risk Antibiotics Division 1 – use of Carbapenem show an increase, but was appropriate and all other antibiotics show a decrease. Division 2 – Use of Carbapenem, Cefuroxime decreased and Ciprofloxacin, Co-amoxiclav increased, but was in line with guidance. Pharmacy continues to query any prescribing with high risk antibiotics, to check that are being used appropriately. Antibiotic Interventions The report shows an increase during July, the reason being that pharmacy are classing non completion of antimicrobial prescribing stickers as an intervention. In which the report shows 30% of 96 are non-completion of antimicrobial stickers, so compared to the previous measure antibiotic interventions have gone down. DATIX - Allergy Box Interventions Division 1 – 0 reported during August Division 2 – 1 reported during August – EAU Overall trend shows performance over the last 12 months, throughout the Acute. Antibiotic Usage – Comparisons As reported at the last meeting the Trust is involved in Beta testing a software system which will allow comparison of medicine use with other Trusts. There is a graph attached to the report showing the use of Quinolone antibiotics for the last twelve months for 9 trusts in the West Midlands Beta test group. As can be seen our Trust is a very low user compared to other comparable Trusts. **CE** asked if the CDI rates could be mapped over the graph.	
9.	**Performance Report**	
	Presentation - Reported by Dr Mike Cooper Performance • MRSA Bacteraemia X 1 • *Staph. Aureus* Bacteraemia X 5 (Division 1 – Amber) (Division 2 – Yellow) • MSSA Bacteraemia – over target • MRSA patients continue to decline • MRSA Acquisitions – Continue at low level	

Item No		Action
	• CDI PCR Positives – Showed a peak in May, but has now reduced. A PII meeting was held to discuss increase on CHU. **MC** is in the process of sending of CHU isolates and has investigated back to April to check if there is any environmental source. • CDI PCR Positive (outside the Trust) – 17 PCR positives August, 9 positive from toxin test, 4 of which were attributed to RWHT. Within external target. • DRHABS – 3 bad months, it is hoped with IV Team in place that this will show improvement. There has not been a large change in practice, but the profile does need to be raised, working with the IV Team. • Blood Culture Contaminants – 1.75% 3 consecutive months below 2% <u>Training</u> • IP Training – 117 non-compliant, names to be forwarded to **CE.** Letter to be sent via Director of Nursing and Medical Directors to target staff that are non-compliant. • Antimicrobial Training – 29 non-compliant	**CW** **CE**
10.	**Any Other Business**	
	None Discussed	
11.	**Date of Next Meeting** **Friday 26th October 2012, 10am – 12noon Board Room, Clinical Skills Building**	

ACTION LOG
Infection Prevention Team Meeting
28th September 2012

ACTION NO	AGENDA ITEM	ACTION	LEAD	COMMENTS
1.	**2.1**	**SR** to look into a capital programme on netting and protection from pigeons.	**Sandra Roberts**	
2.	**2.2**	Estates to review license for disposal, looking at alternatives and discuss further with **DL.** **BS** to follow-up outstanding action from IPCC 28/8/12.	**Brian Sweet**	
3.	**2.3**	**JB** to check if sampling of ice making machine can take place in the next lot of water sampling taking place in September and feedback findings. **BS** to check with **JB** outstanding action from IPCC 28/8/12.	**Brian Sweet**	
4.	**4b**	**IF** to alter template for training compliance on report for Division 2 from 90% - 95% in line with Trust requirement.	**Iris Fitzgibbon**	
5.	**5**	Results from Pseudomonas testing to be forwarded to **CE,** Dr Dobie and Dr Ashcroft.	**Brian Sweet**	
6.	**5**	Pseudomonas to go onto risk register.	**Suneil Kapadia**	
7.	**7**	Funding for screening of NDM1 patients and relatives. **CW** to discuss with **VW** outcome from HPA discussion.	**Carolyn Wiley**	Completed e-mail.
8.	**9.**	DRHABs profile needs to be raised Infection Prevention to work alongside IV Team.	**Carolyn Wiley**	
9.	**9.**	Names of non-complaint staff on IP Training to be forwarded to **CE** for letters to go out to staff.		