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 25th January 2013 and 22 February 2013
Report from:	Chief Nursing Officer
Date:	Minutes dated 25.01.13 and 22.02.13 to Trust Board 25.03.13

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	**25th January 2013** • Draft minutes approved at IPCC on 22nd February 2013 – no significant amendments • Points of note as reported to Trust Board on 25th February 2013 **22nd February 2013 – draft minutes** • Decontamination group to refocus on RCA findings regarding CJD to ensure Trust compliance with national guidance. This will be reflected in new policy. • Operational reports form Divisions: key issues around training compliance, commode audit results and completion of deep cleaning schedule due to extra capacity and activity pressures. • IPN report – improvements noted in time to isolation standard, HPV compliance on discharge 100%, need to reduce time to treatment for C.Difficile patients. • New Chlorine Dioxide system to be installed by 31st March 2013 • PLACE assessment due April – June 2013 – this replaces the PEAT inspection. • Chronic Wound project underway in community

Risks Identified:	Compliance with C.Difficile target

Minutes of Infection Prevention and Control Committee

Date **25th January 2013**

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
	Vanessa Whatley	**(VW)**	Infection Prevention Lead Nurse
	Sandra Roberts	**(SR)**	Head of Hotel Services
	Professor Ray Fitzpatrick	**(RF)**	Director of Pharmacy
	Dr Janet Anderson	**(JA)**	Non-Executive Director
	Dr Mike Cooper	**(MC)**	DIPC/Consultant Microbiologist
	Ian Badger	**(IB)**	Medical Director – Division 1
In Attendance	Rose Baker	**(RB)**	Head of Nursing
	Iris Fitzgibbon	**(IF)**	Senior Matron – Division 2
	Julie Sharp	**(JS)**	Nurse Manager Occupational Health
	John Burrows	**(JB)**	Environmental Manager Estates & Facilities
	Gail Gunning	**(GG)**	Infection Prevention Administrator
Apologies	Tracey Slater	**(TS)**	Senior Matron - Adult Community Service Group
	Katie Spence	**(KS)**	Locum Consultant in Public Health
	Jonathan Odum	**(JO)**	Medical Director
	Tom Butler	**(TB)**	Acting Head of Estates
	Dr Suneil Kapadia	**(SK)**	Medical Director – Division 2

Item No		Action
1.	**Apologies**	
	Tracey Slater, Katie Spence, Jonathan Odum, Tom Butler, Dr Suneil Kapadia	
2.	**Minutes and Actions of meeting 21st December 2013**	
	The minutes were agreed as true and action sheet updated with one amendment on page 2 under matters arising last sentence should read: **MC** to put together a business case for in-house testing and to include a further £5,000 for on-call outbreak funding for infection prevention.	
3.	**Matters Arising**	

Item No		Action
	None Discussed.	
4.	**Occupational Health & Well Being – Reported by Julie Sharp**	
	Sharps Report • 39 sharps incidents reported during Q3 2012/13, showing an improvement on Q3 2011/12 of 50. • 7 of the 39 were splash incidents, 5 unknown sources, 34 from known sources, none report this quarter from known blood born virus patients. • The highest number of incident appear to have occurred in cardiology and cardiothoracic, 9 in total including 2 domestics. • Data has been escalated to Infection Prevention and Margret Simcox in Health & Safety, who is to be escalating this further through Governance Groups, so lessons can be learnt. The data will also be presented at Health & Safety Reps Forum. • DATIX incident forms continue to improve with only 4 out of 39 not being submitted. **CE** asked what the reasons were for non-completion of DATIX, **JS** did not have information but said that one incident was a staff member from Synergy and did not have access to DATIX; this has been fedback through Governance to action. Sharps Management Steering Group This group has been in place for the past 12 months chaired by Mary Brassington and was set up to ensure E U Directive compliance for sharps safety devices are in place by May 2013. The 3 main areas being, hypodermic needles, cannulae and blood collection. **Hypodermic needles** were trialled by the Emergency Department (A&E), Phlebotomy and the IV team with B Braun emerging as the most favourable on price but lower in quality by a very small margin according to A&E staff scores but this was thought to be a training issue. The company returned to the department for a period of intensive 1:1 training and management confirmation that the product is acceptable has been received. The change in provider will be communicated Trust wide following the next Infection Prevention & Control Committee (IPCC) meeting and the Just in Time ordering system means that existing non-safety stock can be cleared and replaced in 2 weeks enabling us to meet the HSE deadline. **Cannulae** will remain with Vygon, the current supplier who will only be manufacturing safety cannulae. The exceptions to this are ITU and Theatres to meet the clinical standards in these areas. **Blood collection** equipment will move to BD Vacutec products which brings the Trust in line with other pathology departments in the region thus matching other laboratory service providers in the marketplace. There are a small number of special devices which will be addressed separately and long lines used by Theatres, ITU, Oncology and the IV Team will remain in use	

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	with the precaution of an individual risk assessment. Following approval of the standardisation of sharps safety devices, Procurement will submit an approval of purchases which gives the go ahead for the process. Finance will also be advised of the potential cost pressure of £18k to enable appropriate budgeting. IPCC agreed that a business case needs to be put through and ensure that it goes through the correct process. **JS** to feedback to Procurement. <u>Measles</u> Approximately 500 staff remain left to be screened at the Acute and 400 across Community sites. A communication went out to managers during November and has been recirculated this week listing staff outstanding. Occupational Health and Wellbeing have drop in clinics available throughout February and March, also supported by phlebotomy services. There is also the opportunity of OHWB attending wards and departments for groups of staff. There is now a database of 7,000 staff records, which is regularly updated. **CE** queried the amount of staff reported, **JS** to check. <u>Flu Vaccination</u> So far OHWB has given 3,571 vaccinations which is 52% of Trust staff; the flu campaign is now in the 5th month since commencing in October 2012. In the regional seasonal flu table league, the Trust retains top place in terms of numbers of staff vaccinated and 7th in terms of percentages due to our comparatively high headcount.	**JS** **JS**
5.	**Divisional Reports**	
	5a Division 1 - Reported by Mr Ian Badger The report was presented in the new format, which shows increase in red, particulary in antibiotic prescribing and **IB** said that he will be sending out e-mails to relevant areas. **DL** enquired if as part of induction was there still a test given for antibiotic prescribing. **MC** replied that there is an on-line test that is available on the Trust intranet through training and when face to face teaching takes place a major part is to go through a series of questions of various aspects. **CE** asked if it were known if the red areas on the report were due to consultants or junior doctors. **IB** replied that currently majority were Junior doctors. IPCC agreed that from 1st March 2013 that a mandatory on-line test would be available for antibiotic prescribing, to include junior medical staff and consultants. **MC** to discuss with Louise Nickell. **CE** commented that although it may take a little while to get with those not having undertaken training used to the new reporting structure she had noticed in the report in terms of poor hand hygiene it was encouraging to see	**MC**

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	that MDT members had taken ownership on improvement. **CE** also highlighted to the IPCC that due to high activity during December 2012 it was expected that this would be reflected within the indicators.	
	5b Division 2 - Reported by Rose Baker <u>Performance</u> 7 DRHABS were reported for January 2013, which shows an increase from the previous month, this was due to a patient issue and is being worked through. CHU have an on-going piece of work, a meeting has been held this week with matrons, senior sister and consultant with an action plan in place. <u>MRSA Bacteraemias</u> There are 2 included in the report with action plans be agreed at IPCC and reported back to Commissioners: 1. Oncology - The majority of the actions have been completed, the only current outstanding action is the electronic referral process for radiology and is in progress. Agreed and approved by IPCC. 2. Pre-48 hour community – Agreed and approved by IPCC. <u>Training</u> Report shows improvement from December 2012 for infection prevention, however antibiotic prescribing shows a lot of red and **RB** informed IPCC that **SK** had instructed division 2 that if mandatory training was not completed then further study leave would be not be approved. **CE** raised concerns on the 79% compliance care of the elderly for infection prevention level 2 and had said that this had not been acceptable. **RB** informed IPCC that an action plan was in place to rectify the situation. **VW** raised an issue on DRHABs in that CHU are still flagging and an action plan is in place. The IV Team have now put in over 120 lines in which 2 or 3 have developed DRHABs some of which have occurred more than 7 days after line insertion which does not stop the division leading on the investigation into cause. **VW** also pointed out that they all of those infections result from PICC lines used for TPN and further work was needed to look at how this can be minimised. **IB** commented how long this infection rate was and the high value of this service. **RB** mentioned that there are 2 RCAs for outbreak still on-going and cannot be currently closed off for Commissioners which means missing the deadline. **VW** informed IPCC that an interim report has gone to Commissioners and is sent every 30 days, including weekly updates and Commissioners are happy with this process. Once this continuous outbreak has been clear by two weeks a final report will be sent off to the Commissioners. **RB** to liaise with Carolyn Wiley information sent to Commissioners.	**VW** **RB**
6.	**Action on CDI – Reported by Vanessa Whatley**	
	The CDI objectives 2013/14 are 65 for Wolverhampton City CCG (80 2012/13), 39 of which are the target for Royal Wolverhampton Hospitals. The 39 does not	

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	include full quota for West Park Hospital and is currently being challenged, which would potentially make the target 41. To meet these objectives work needs to commence as soon as possible. To date the Trust are under trajectory for external reportable CDI cases. A 3 month trial on CDI daily ward rounds took place on PCR positive patients from August – October 2012. An analysis of daily visits shows in the report a 20% decrease in figures compared to last year and time to isolate within 2 hours went from 46% to 58% show a dramatic increase though numbers are small. Those who could not be isolated were patients that were difficult to isolate mainly due to capacity issues. Treating patients in onset of symptoms within 24 hours went well with the assistance of medical staff, in which as soon as surveillance stopped shows a decline. HPV has increased during winter pressures with Norovirus and although there has not been a lot of bay closures, there have been a lot of affected wards closed. A key part of the report shows that CDI numbers have been good and CDI has not been associated with Norovirus. HPV on day 7 and HPV on discharge has increased and has been sustained during October/November December 100%. Environmental audit compliance has raised concerns in commodes not being 100% clean and a further discussion needs to take place. Severity of disease is difficult to view in small numbers but looks as if there has been less severe cases in comparison to previous 3 months and need to look at how this can be sustained and what could be done further. **DL** highlighted that the report showed dramatic improvement with monitoring of CDI patients which needs to continue and it would be good to see a further reduction on time to isolate by another 10%. **VW** commented that treatment on symptoms would also have impact coupled with isolation and further work on re-occurrences of CDI patients needed to be addressed with treatment. **PT** asked what was being done to address samples going missing potentially putting patients at risk. **VW** replied that the Infection Prevention Team are currently working with the laboratory to see what actions can be taken when specimens go missing or get damaged. Commode cleaning is another issue and in most areas relies on staff cleaning commodes with Actichlor plus and need to look at a business case to introduce a wipe to increase compliance. **CE** commented that if Commissioners funded band 7's in a supervisory capacity then a lot of areas mentioned above could be targeted, **VW** to discuss with **CE** forwarding information to Manjeet Garcha (Commissioners). Also commode audits are not impressive and both divisions need to go back discuss local plans and escalate to ensure that spot checks are taking place. **DL** asked if the business case to make band 7 ward managers supervisory would facilitate this and how long this would take to implement. **CE** said if agreed 15	**Divisions** **VW**

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	people would be required and could take 8 weeks to appoint. **VW** to arrange re-audit of commodes and bring back to next IPCC meeting. **VW** to prepare a business case for wipes for next meeting. **JA** enquired if they was an easier way to clean commodes other than using wipes for example washer disinfectant. **DL** agreed that there were alternatives but this would be more costly and time effective. **JA** asked if the committee were comfortable in making staff supervisory and would this achieve the targets required. **CE** said that by putting staff into a supervisory position made their expectations clearer and it was much easier to hold people to account. **CE/JA** to meet and discuss papers sent to Commissioners on measuring and monitoring of performance. **IB** asked if re-visiting recurrent CDI probiotics – **VW** liaise with gastroenterologists.	**VW** **CE/JA** **VW**
7.	**Estates Report – Reported by John Burrows**	
	<u>Legionella Steering Committee</u> • Current temporary and fixed Chlorine Dioxide plants are producing good reserves of Chlorine Dioxide. • Business case has been approved for a centralised Siemens Chlorine Dioxide plant and envisaged to be installed by end of March 2013. • Legionella re-sampling of previously contaminated outlets within Deanesly renal currently remain clear, final results will be provided by DMW29th January, but early indications show no signs of legionella. • Work surrounding Legionella risk assessments continue on Appleby Suite, Medical Illustration and Kitchens. • Daily monitoring of all plant on-going until new systems are installed. • Estates are still continuing in areas unoccupied with water management and flushing. Estates are currently liaising with Matt Reid (IP) with the view of reporting being more simplified with the use of Synbiotix. **DL** raised concerns that has been on-going for the past few months and needs to be feedback to give assurance. **JB** to discuss with **TB** and **VW** to take back discuss with Matt Reid. <u>Clinical Waste Incinerator</u> Has been in full production and is fully operational after a long shut down. <u>Pseudomonas Aeruginosa</u> • Samples have been taken in areas which were previously tested, with the official results being lower than previous testing. • Point of use filters still remain in areas. • Trials on chlorine wipes for taps etc. have been discussed at the Legionella Steering Group and is on-going.	**JB** **VW**

Item No		Action
	KPIs Attached to report – no concerns.	
8.	**Environment Report – Reported by Sandra Roberts**	
	PLACE – Assessment 2013 • Training day 24/1/13 - **SR** to give full report at next IPCC 22/2/13 • There will be a slightly different team conducting the audit with 2 patient representatives with 1 member of staff. • Many of the questions in the audit will be dementia friendly and it was suggested at the Environment Group when looking to replace curtains in the future to look at purchasing dementia friendly. **SR** to discuss with procurement cost of standardisation across the Trust and discuss with departments.	**SR** **SR**
9.	**LNIP Report – Reported by Vanessa Whatley**	
	Norovirus • April 2012 to date there have 265 bed days lost, with 204 patients affected and 46 staff in outbreak areas. • During December 2012 the figure for Norovirus has been very low. Annual Programme of Work • IV OPAT Team continues to work well, saving approximately 3 beds on current working over 300 bed days per month. • Surgical Site Infection (SSI) – 3 month base data has been completed, results are within the report. - 10.6% overall rate for the Trust. This does not include day surgery due to pending IT solution. **CE/VW** to meet and discuss targets and feedback at next IPCC. - 4.0% Inpatient stay - 4.2% Outpatient appointment or contact of patient or home visit - 2.4% Post discharge surveillance – communicating with over 90% patients after discharge. Training for ChloraPrep is completed across areas within the Trust, there are still issues with some areas that do not want to use ChloraPrep and is being managed by **IB.** Positive feedback has been received back in the use ChloraPrep. Further feedback on ChloraPrep to be discussed at next IPCC 22/2/13. Policies Amendment to ARO Policy in that MRSA screening will now be carried out within 24hours on admission and no longer 48 hours. IPCC agreed amendment. Code of Practice Attached to report • Isolation audit summary 4 patient in isolation - 96% compliance • Individual areas have been given actions. DRHABs	**VW/CE** **VW**

Item No		Action
	Clinical Haematology, NNU still biggest risk.	
10.	**Pharmacy Report – Reported by Professor Ray Fitzpatrick**	
	Monitored Antibiotics In line with Trust guidelines Antibiotic Interventions – December 2012 The total number of reported antibiotic interventions was 89. Non-completion of antimicrobial prescribing stickers is now being recorded as an intervention, and these account for a significant proportion of the interventions. Allergy Boxes DATIX report – Deanesly shows repeatedly in the report and **RF** has escalated this to the Clinical Director. **RF** to arrange to meet with **DL** and invite Caroline Brammer, Maurice Hakkak to attend to discuss performance. Antimicrobial Prescribing KPIs Following audit guidance from the Department of Health, our KPIs have changed, and increased from 3 to 5 standards. Allergy box completion has been good, but seems to have fallen down on notification on review date.	**RF**
11.	**Performance Report – Reported by Dr Mike Cooper**	
	• Pre48 hour MRSA bacteraemia – PCT have reached target for year with still a further 3 months to go. • MSSA bacteraemia – 2 for December 2012 in which 1 was a contaminant the first taken by a phlebotomist within 4 years. Only 1 was counted against divisions – Division 1. • MRSA acquisitions – Division 1 marginally over target X 2, Division 2 were within target. • CDI – In target, this has been remarkable taken into consideration Norovirus outbreak during December 2012. It would be nice to think that the reason for being on target was due to HPV compliance and good work carried out by the cleaning staff. There are currently 4/5 CDI patients throughout the hospital in which are all on Ward C15, 3 are re-occurrences not previously associated with C15. • CDI toxin positives X 4 - attributed to New Cross • Contamination rates below 2%, which is the 7th consecutive month • Blood cultures taken chart shows an increase • DRHABS X 9 – **RB** asked if it would be possible to divide day case from inpatient area on CHU. **MC** agreed to action. • Hand hygiene training – shows a decline, with the most disappointing areas being medical/dental.	**MC**
12.	**Any Other Business**	
	None Discussed	
13.	**Date of Next Meeting**	

Item No		Action
	Friday 22nd February 2013, 10am – 12noon Board Room, Clinical Skills Building	

The Royal Wolverhampton NHS Trust

ACTION LOG
25th January 2013

ACTION NO	AGENDA ITEM	ACTION	LEAD	COMMENTS
1.	**4.**	IPCC agreed that a business case needs to be put through Procurement for sharps safety devices.	**Julie Sharp**	Fedback to Mary Brassington OHWB & Craig Stephens procurement
2.	**4.**	**JS** to check quantity of staff recorded on OHWB database.	**Julie Sharp**	Checked, the figure includes student nurses & also the database was including leavers even though highlighted as removed on system &this has now been rectified.
3.	**5.**	**MC** to liaise with Louise Nickell, on-line mandatory training for antibiotic prescribing.	**Dr Mike Cooper**	
4.	**5b.**	**VW** to look at PIC lines used for TPN.	**Vanessa Whatley**	
5.	**5b.**	**RB** to liaise with Carolyn Wiley Re: Norovirus outbreak information sent to Commissioners.	**Rose Baker**	
6.	**6.**	Division to discuss local plans for commode audit spot checks.	**Divisions**	
7.	**6.**	**VW** to arrange re-audit of commodes and feedback at next IPCC.	**Vanessa Whatley**	
8.	**6.**	**VW** to prepare business case for commode wipes for next IPCC	**Vanessa Whatley**	
9.	**6.**	**VW** liaise with gastroenterologists – re-visiting CDI probiotics.	**Vanessa Whatley**	
10.	**7.**	Water manager reporting to be simplified with use of Synbiotix. **JB** to discuss with **TB.** **VW** to discuss with Matt Reid.	**Vanessa Whatley** **John Burrow**	
11.	**8.**	Full report On PLACE assessment 2013 to be reported back at next IPCC.	**Sandra Roberts**	
12.	**8.**	Cost of standardisation of dementia friendly curtains to be discussed with procurement.	**Sandra Roberts**	
13.	**9.**	**CE/VW** to meet and discuss SSI targets and feedback at next IPCC.	**Vanessa Whatley**	
14.	**10.**	**RF** to arrange meeting with **DL,** Caroline Brammer and Maurice Hakkak to discuss Deanesly performance.	**Professor Ray Fitzpatrick**	
15.	**11.**	DRHABS report to be divided for CHU into day case/inpatient.	**Dr Mike Cooper**	

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The Royal Wolverhampton NHS Trust

Minutes of Infection Prevention and Control Committee

Date **22nd February 2013**

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
	Dr Suneil Kapadia	**(SK)**	Medical Director – Division 2
	Professor Ray Fitzpatrick	**(RF)**	Director of Pharmacy
	Dr Janet Anderson	**(JA)**	Non-Executive Director – Division 2
	Dr Mike Cooper	**(MC)**	DIPC/Consultant Microbiologist
	Tom Butler	**(TB)**	Acting Head of Estates
	Katie Spence	**(KS)**	Consultant in Public Health
In Attendance	Marion Washer	**(MW)**	Decontamination lead
	Jenny Hickman	**(JH)**	Hotel Services Manager
	Carolyn Wiley	**(CW)**	Operational Nurse Manager Infection Prevention
	Zena Young	**(YJ)**	Divisional Head of Nursing - Surgery
	Kerry Anelli	**(KA)**	Matron – Division 1
	Rose Baker	**(RB)**	Head of Nursing EMCS
	Gail Gunning	**(GG)**	Infection Prevention Administrator
Apologies	Dr Jonathan Odum	**(JO)**	Medical Director
	Ian Badger	**(IB)**	Medical Director – Division 1
	Vanessa Whatley	**(VW)**	Infection Prevention Lead Nurse
	Sandra Roberts	**(SR)**	Head of Hotel Services

Item No		Action
1.	**Apologies**	
	Dr Jonathan Odum, Mr Ian Badger, Vanessa Whatley, Sandra Roberts	
2.	**Minutes and Actions of meeting 25th January 2013**	
	Minutes of the meeting were agreed and action sheet updated.	
3.	**Matters Arising**	
	JH to discuss with **SR** and feedback at next IPCC March 22/3/13 cost comparison between disposable and re-usable dementia friendly curtains.	**SR**

Item No		Action
4.	**Decontamination Report Q3 – Reported by Marion Washer**	
	Head and Neck Outpatients C6 The decontamination room upgrade has been completed and the machines have been tested and commissioned. Staff training has been conducted and the service is now fully operational. Urology OPD There have been significant delays in getting the RO machine upgrade and this has been escalated to Mike Goodwin (Director of Estates and Facilities) who is now overseeing the work being carried out. Decontamination Incidents Quarter 3 2012/13 6 incidents were reported for Qtr3, which all were dirty instruments on trays, with no harm to patients or staff. Synergy Non Conformities 80 incidents were recorded against a processing volume of 33450 sets and single items. This resulted in a non-conformity rate of 0.24% which is within contractual limits. However Synergy accept responsibility for only 51of these with non-conformity rate of 0.15%. The top three non-conformities reported in quarter 3 were:- • Missing instruments/sets • Wrong items on tray • Dirty instruments There were no specific Synergy issues within the quarter Other Issues • Following receipt of MHRA alert MDA/2011/0096 regarding the decontamination of Laryngoscope handles, funding has now been awarded to move to a Trust wide, standardised fully disposable laryngoscope. Training of staff is currently being undertaken by the company of choice and the transfer is imminent. • The annual Trust wide decontamination audit for the acute setting took place on the 11th October 2012. The Trust's authorised person Tracey Miller accompanied the Decontamination Lead in the audit walkabout. The results of this audit are displayed in appendix 1 of the decontamination report. • The Trust Decontamination Officer (Acute) is currently preparing a business case to convert the decontamination of ultrasound probes to an automated service. **DL** enquired how often the Decontamination meetings took place, **MW** replied monthly with 10 -15 people in attendance. **DL** to attend next meeting scheduled for 4/3/12. **CE** asked if the decontamination audit was for both Acute and community. **MW** replied that this was just for the Acute and did know who covered community. **DL** enquired who was responsible for community dental, GPs etc... **CW** answered that provider dentists complete a dental audit that is carried out annually. Podiatry and GP's both use single use items and do not use any reprocessing. Tracey Millar is the authorised person for carrying out audit within the community, accompanied by John Iredale (Estates), but there is currently no report available to feedback through IPCC or the Decontamination Committee.	

Item No		Action
	CJD **CE** highlighted to IPCC on a recent death of a patient with CJD and a table top exercise that had taken place. **CE** said the organisation had not reflect badly, but however had the patient had certain procedures within the organisation we would have been found wanting. **CE** asked for this to be raised at the next Decontamination meeting. **MW** left the meeting at this point.	
5.	**Divisional Reports**	
	5a Division 1 – Reported by Zena Young Overall Performance – section 4 • Compliance on training over the month is down and needs further improvement. • 5 moments hand hygiene compliance – **ZY** unable to access database to acquire information. • CDI – 4 incidences during January 2013 • DRHABs – 5 incidences January 2013 RCAs as follows: 2 X Ward A5, 1 X Cardiothoracic – related to urinary catheter multiple insertions. Further work on protocols needs to be carried out, **ZY** asked **MC** if guidance on antibiotic prescribing for re-catheterisation is sufficient. **MC** replied that it was not thought to be of any benefit to routinely give antibiotics to cover re-catheterisation, but in certain circumstances is worthwhile, especially patients with known organisms within the urinary tract. Dr Mary Ashcroft is currently looking at re-writing antimicrobial prescribing guidelines. 1 X RCA on 6 month inpatient – protocols on TPN are currently being queried and the ward sister along with Sue Rowlands are scoping other hospitals to see if there is anything that can be learnt. Care bundle incident – patient was incompliant with treatment, but however, it was found there was scope for improvement on documentation from point of insertion. Key Concerns Commode cleaning – **ZY** has instigated twice daily checking by nurse in charge. Matrons will be reporting back information at the end of the month. Surgical wards – deep cleans scheduled ANTT training requirement – finalised with IP Team.	
	5b Division 2 – Reported by Dr Suneil Kapadia DRHABs None associated with urinary catheters. Performance • Red areas show slight increase • Antibiotic prescribing on emergency services shows decrease to 85%, but A&E are actually 100% and it is Acute medicine that has decreased - in context 7/52 people have not completed. • Care of the elderly/stroke shows increase 86% - actual for stroke 100%, 3/20 non completion for care of the elderly.	

Item No		Action
	• Gastro/ respiratory shows 85% - actual gastro 100% Study leave has been stopped to individuals who have not completed their mandatory training, with e-mails going out to senior colleagues and stopping employment of locum staff. <u>DATIX Incident W30760</u> **RB** discussed a pre-48 hour bacteraemia November 2012 and table top review that took place. There were examples of good practice, but there were also lessons to be learnt. An action plan is in place with most of the work being completed and taken back through the divisions. **RB** asked IPCC for the report to be agreed and forwarded to the commissioners. IPCC agreed. **CW** said that this had been lead through IPCC on behalf of the commissioners as part of the Service Level Agreement (SLA). **CE** congratulated IPCC on the results of their 5 moments hand hygiene results. **DL** congratulated the divisions on feedback from CQC visit.	
6.	**Action on Cd*ifficile* – Reported by Carolyn Wiley**	
	6.1 Dashboard **CW** gave feedback on graphs within the report: • PCR EIA (Internal targets) – post 48 hour 6-8weeks of discharge – against external figures show below target. • Environmental audits 95% average – **CE** commented that this figure was good considering how busy the organisation has been between December/January. • Trust attributed per 1000 bed days by ward – IP are working alongside areas that show high risk, looking at what work can be done. • Time to treatment – IP would like to see this being carried out within 24 hours and are currently averaging 30 hours. 57% of patients are treated within 24 hours. **CE** asked what needs to be done to make this happen, **CW** said that during the 3 month pilot of daily visits carried out by IP they were able to prompt getting patients onto treatment and further understanding is needed on the process mapping. **DL** commented that this could be carried out by band 7 supervisory ward manager which would make this more consistent. **SK** queried the time to compliance, whether this was the time the prescription was written or when medication taken as this could make the figures within the report inaccurate in regard to when medication was actually taken. **CW** to clarify. • Time to isolation - 3 month data shows 60% patients were isolated within 2 hours – which show an improvement. **CE** highlighted that 1/3 is taking 24hours or more, which shows that this remains a risk which requires managing and is complicated. • HPV compliance – best practice to HPV on day 7 achieving 50% but it was 1 of 2. • HPV compliance on discharge 100%	**CW**

Item No		Action
	• Quarterly reoccurrence on patient – average 20% national data, RWT currently 14%. IP Department are currently looking at more work that can be carried out which will be part of next year's annual work programme. • 30 day mortality – IP Department/**MC** are currently looking into regarding part 1 and part 2 death certificate baseline. • PCR – below target • Accumulative total days to onset of illness from admission - 80% of CDI patients are diagnosed with 10 days of arrival to hospital. Further analysis of the data on this is to be carried out by the IP Team as part of the Annual Work Programme. • Admissions CDI patients - 75 % emergency, 75% home, care homes. Annually 20 patient's investigation into these cases planned to understand more. • Severity – mostly moderate with less severe cases due CDI being picked up earlier. • Performance against regional average – below for both Acute and community. Community to expand care plan with discussions about a reoccurrence pathway with more treatments.	
	6.2 Results of Commode Audit A repeat of the commode audit has been carried out and still below standard. 4 days following the audit an IPN carried out a further audit on areas with low scores and found scores were 100%. This was due to raised awareness by the Matrons and Lead Nurses and needs to be sustained. The purchasing of wipes would make the cleaning of commodes quicker and a business case has put together by Matt Reid (IP), **CE** asked what the savings would be by purchasing wipes against use of tablets. **CW** to ask Matt Reid to calculate cost benefit and feedback following a 3 month pilot. **JA** asked what the cleaning process was for toilets on the wards, **JH** replied that housekeeping clean toilets 3 times per day on wards, but if toilets are visibly soiled then housekeeping would be re-called or if staff are not available staff on ward would clean. IPCC agreed for the business case should go ahead with a 3 month trial.	**CW/MR**
7.	**Estates Report – Reported by Tom Butler**	
	<u>Legionella Steering Committee</u> • Current temporary and fixed Chlorine Dioxide plants are producing good reserves of Chlorine Dioxide. • Orders have been placed with IWS who are part of South Staffordshire Water board for the new centralised Siemens Chlorine Dioxide system. This plant will be installed by 31st March. • Orders have been placed with Hydrop for the Installation of a new Compass Legionella Planned Preventative Maintenance and risk management system. • Deanesly Legionella retest samples are clear following replacements of outlets and flexible connections. • Renal Legionella retest samples found two low positive counts found in room GD12 and CAPD, table below shows engineering action plan: Outlets are being changed and with resampling being carried out – awaiting results.	

Item No		Action
	Flushing Show improvement for the month – Compass system identifies each tap against an identified person. Flushing is on-going in empty areas. Clinical Waste Incineration Incinerator remains operational throughput and waste being managed to optimise operational performance of plant. Pseudomonas Aeruginosa (PA) Work is on-going, with trails being carried out on automatic taps, sampling the mechanisms and Pseudomonas was found on brass flow straighteners, which was a modification to the new taps as recommended by the supplier Mira with further discussions on-going with suppliers. Trials to be arranged by Infection Prevention within CHU for the use of Chlorine wipes to disinfect outlet externals on an on-going basis: Pseudomonas is not being found from the water supply but is being found within the environment around to tap. KPI's 100% compliance.	
8.	**Environment Report – Reported by Jenny Hickman**	
	Unplanned & Planned Deep Cleans – January 2013 Details in report **SK** left the meeting at this point PLACE Assessment is required to take place between April – June 2013; a date has not yet been identified. Once a date has been given, the actual audit has to be undertaken within 6 weeks. The audit is quite different from the PEAT audit, in that the scoring criteria is either a pass or a fail. Patient representatives are 2 to every 1 Trust employee undertaking the audit and **SR** is providing training on 7/3/13. The pilot scheme was first undertaken by RWT Hotel Services and was initially found to be very complex, but paperwork has since been simplified. **CE** asked if are we confident that objective views are going to be taken into account in opposed to a single view. **JH** replied that with the new audit scoring takes place whilst visiting areas, followed at the end by a table top exercise to go through information to obtain a majority decision. **ZY** enquired on update of deep clean plans for Critical Care Unit (CCU) in regard to possibility to isolate CCU for HPV process. **JH** to ask **ST** to e-mail across information to **ZY.**	**JH**
9.	**LNIP Report – Reported by Carolyn Wiley**	
	RCA's CJD case discussed as above – details in report.	

Item No		Action
	Pre-term infant death due to pseudomonas aeruginosa An RCA and table review of the above incident has been held – details are in the report. **MC** said results back showed the typing of isolates from samples taken from the babies respiratory tract and blood cultures were identical, but were different from any type that have previously been isolated from water outlets in RWT. **MC** said there was no explanation to where this had come from and was unfortunately unavoidable. As a result of the table top exercise other areas on NNU have been identified and now have filters fitted. <u>Norovirus</u> Position statement is within the report; Norovirus continues in both Acute and community with full outbreak control measure in place. Norovirus patients are isolated promptly. In-house testing has helped to identify patients to support effective outbreak management, improve use of HPV and aid discharge. <u>Annual Work Programme</u> There is currently a lot of work being undertaken to look at reducing chronic wounds across the city which is moving forward quite well with staff and various protocols in place. PREVENT Charter indicators (community) • CDI treatment - 98% (1 patient non-compliant) • MRSA treatment – 91% patients were decolonised, with treatment completed and re-screening taking place. • MRSA screening in care homes (phase 8) – 99% compliant • IP care home audit - 49/79 care homes have so far submitted the PREVENT Charter audits for the 2nd quarter of this year. All 49 have been awarded a Silver award or higher. 100% bronze. Work has been carried out with homes that under perform. <u>Commode Audit</u> Discussed as above – work is being carried out to raise standards. Discussions have taken place within IP around championing someone on the ward to support cleanliness of equipment. This will possibly be band 7 ward sisters. <u>Policies</u> Amendment to IP04 – Transportation of clean and contaminated instruments, equipment and specimens this is due to Estates and Facilities Alert EFA/2013/001-January 2013**.** The national alert was looking at cars that have gone service or repair, where used sharps were found loose within the vehicle. The policy has been re-strengthened to support the alert - details are within the LNIP report. **RB** highlighted that there would a financial implication due to the amendment of the policy and asked how this would followed through with regard to transportation boxes or nursing bags to secure sharps boxes in vehicles. **CW** to review. <u>30 Day Review of MRSA Screening Compliance Data</u> **CW** informed the IPCC that she had discussed with Mark Beddow concerns raised by Mangeet Garcha (Commissioners) with regard to accuracy of screening (MRSA) compliance data within the report on the percentage variation. Informatics have published a report showing compliancy at 100% as opposed to 96% from data collected by IP. Mark Beddow informed **CW** that his figures were based on match census, matching swabs against admissions and is fairly confident that 96% is correct. The new IC Net programme (new feed) should assist in making these	**CW**

Item No		Action
	figures more definitive.	
10.	**Pharmacy Report – Reported by Professor Ray Fitzpatrick**	
	Monitored Antibiotics No particular trends Antibiotic Interventions Average for month with vast amount being around dose frequency, prescribing advise and non-completion of prescribing sticker. Allergy Boxes 7 interventions during January 2013 – ensuring that the box is filled in correctly and not left blank. DATIX Incidents 2 reported for January 2013, where allergy boxes were not completed. **RF** highlighted wards/areas within the report that had completed a full year without any allergy box offences: Define Medicines Use Comparison Software is now in-place that allows the Trust to compare with other Trusts usage of medicines. Co-Amoxiclav was added to the list of antibiotics with a high risk of predisposing patients to Clostridium D*ifficile* associated diarrhoea, 18 months ago. As a result the antibiotic guidelines have been amended, use of Co-Amoxiclav has been monitored through this committee and pharmacists have been querying all prescriptions for this antibiotic. Figure 13 in the pharmacy report shows our use of Co-Amoxiclav compared to other Acute hospitals in the region over the last two years and demonstrates an improving performance being the second best performing Trust within the region. **JA** inquired on interventions on dose frequency asking is 23% majority of interventions being looked at and why this needed to done so often. **RF** replied this was due to wrong dosage i.e. frequency. **JA** highlighted that GMC have recently published new guidance on prescribing and said she was concerned with the percentage of wrong dosage of antibiotics given. **CE** highlighted that there had not been good compliance in antibiotic training.	
11.	**Performance Report – Reported by Dr Mike Cooper**	
	• MSRA bacteraemia - within target for the year • New MRSA positives – trend downwards – within target based on last year's figures. • MRSA Acquisitions – remains low and within target with no clusters • CDI - Down below target based on PCR results – Division 1 above target, Division with target. - Toxin results – 12 PCR positive, 6 toxin positive in which 2 of the 6 were attributable to RWT, all 6 were Wolverhampton cases. Excluding West Park from figures show within the graphs RWT on target for the year. - Next year's targets will be for 39 and will include West Park. - Rolling 30 day target – on general downward trend • DRHABs – Division 1 X 5 cases, Division 2 X 5 cases • Blood culture contaminants – over 2.5% for January – February is looking better	

Item No		Action
	• Hospital Acquired bacteraemia - 29 patients with DRHABS, 10 device related DRHABs • Score card – shows all greens • Hand hygiene – January 2013 93% overall with medical & dental lowest compliance • Antimicrobial Prescribing Training – 90.9% January 2013 **CE** asked the IPCC in terms of training what further could be done. **MC** attended an Induction Mandatory Training Group meeting (IMTG) 21/2/13, where discussions took place regarding mandatory training. **DL** said that refusal of study leave should be applied to both divisions for non-compliance of mandatory training from 1/3/13. **MC** to liaise with Louise Nickell.	**MC**
12.	**Any Other Business**	
	DL raised concerns regarding Corona Virus and asked in the event of an emergency what precautions were in place should a patient present with this at A&E or Walk-in Centres. **DL** asked if there was an identified person that would be available 24/7 to take swabs, bloods etc wearing full PPE including face mask. **CE** commented that fit testing of masks has taken place in line with HPA guidance but corporately there needs to be a policy/process in place and available equipment. **CE** asked operationally are staff in A&E aware what is required of them, **RB** commented that there had been briefings with staff. **SK** felt that he had no confidence in that A&E may be aware but over the weekend this could be a problem for staff. **CE** suggested there were 2 requirements: 1. Corporately - this needs to be resolved by this afternoon so there is clear message (including both A&E and walk in centres). 2. Operationally – portals need to be geared up. **RB/SK** to feedback at this afternoon's Trust Management Team meeting.	**RB/SK**
13.	**Date of Next Meeting**	
	Friday 22nd March 2013, 10am – 12noon Board Room, Clinical Skills Building	

The Royal Wolverhampton NHS Trust

ACTION LOG
Infection Prevention Team Meeting
22ND February 2013

ACTION NO	ACTION	LEAD	COMMENTS
1.	Cost comparison between disposable and re-usable dementia friendly curtains.	**Sandra Roberts**	
2.	**CW** to clarify compliance time on CDI dashboard whether this was the time the prescription was written or when medication taken.	**Carolyn Wiley**	
3.	**CW** to ask Matt Reid to calculate cost benefit of use of commode wipes against tablets, following 3 month pilot.	**Carolyn Wiley** **Matt Reid**	
4.	**JH** to ask **ST** to e-mail across information to **ZY** on update of deep clean plans for CCU in regard isolation for HPV process.	**Jenny Hickman** **Sandra Roberts**	
5.	**CW** to review cost implications on change to IP04 – Transportation of clean and contaminated instruments, equipment and specimens Policy due to Alert EFA/2013/001-January 2013**.**	**Carolyn Wiley**	Daniels range of products sent Divisional 2 lead to support risk assessment.
6.	**MC** to liaise with Louis Nickell compliancy for mandatory training. No study leave allowed unless this has been completed.	**Dr Mike Cooper**	
7.	**RB/SK** to feedback on at this afternoon's Trust Management Team meeting on what precautions are in place for Corona Virus.	**Rose Baker** **Dr Suneil Kapada**	