MINUTES OF INFECTION PREVENTION AND CONTROL COMMITTEE MEETING HELD ON TUESDAY 21ST DECEMBER 2010 10.00AM, ROOM 4, WMI, NEW CROSS HOSPITAL

Present:	Mr D Loughton (Chair)	(Chief Executive)	(DL)
	Ms C Etches	(Director of Nursing & Midwifery)	(CE)
	Dr M A Cooper	(DIPC)	(MC)
	Ms S Morris	(LNIP)	(SM)
	Dr R Fitzpatrick	(Director of Pharmacy)	(RF)
	Dr G Martinelli	(Consultant – Cardiothoracic)	(GM)
	Dr J Anderson	(Non-Executive Director)	(JA)
	Ms M Gay	(Director of Community Services)	(MG)
	Ms S Roberts	(Hotel Services Manager)	(SR)
In Attendance:	Ms Y Hague	(R&D Directorate Manager)	(YH)
	Ms R Baker	(Head of Nursing - Division 1)	(RB)
	Ms Z Young	(Head of Nursing – Division 2)	(ZY)
Apologies received:	Dr J Odum	(Medical Director – Division 2)	(JO)
	Ms G Evans	(SHA Representative)	(GE)
	Mr B G Millar	(Medical Director)	(BGM)
	Ms C Wiley	(Lead Nurse IP&C – WCPCT)	(CW)

Action

2. Minutes of Meeting held on 25th November 2010

The Minutes were accepted as a true record subject to the following amendment:

Mini RCAs (Page 3)
There had been difficulty producing the mini RCAs for DRHABs within 48 hours due to starting to use the ESR system. Efforts were in hand to resolve the problem.

3. Matters Arising from the Minutes

3.1 (5b) Prontoderm Foam Evaluation
SM to check whether RWHT IPT had evaluated the effectiveness of this product. **SM**

3.2 (5b) Systems Manager
Recruitment had not yet taken place. SM to take up with AfC office to ascertain reason for delay. **SM**

3.4 (9) ICCU Low C.*Difficile* Rate
MC had not yet had an opportunity to investigate the reasons for the low rate of C.*Diff.* in this department. **MC**

4. Research & Development Update

YH referred to the R&D report circulated to members of the Committee and which concentrated on quality and safety requirements for the Trust in relation to research and innovation activity.

CE thanked YH for summarising the report, however felt that its content did not link in with this infection prevention committee and suggested YH discuss the points raised in her report with JO as Medical Director. **YH**

5. Reports of LNIP

5a RWHT

SM highlighted the following issues from her report:

Hepatitis C

Surveillance continued around the incident on Renal at Pond Lane, which had impacted on RWHT, and results coming back are negative as expected.

MRSA Acquisition

There had been an increase in RWHT acquired MRSA on D20 since October. The ward internal process of screening assurance revealed a lack of understanding of the validation process. Staff will undergo awareness training. Following observation of practice and environmental practice by IPT an action plan was developed and circulated to the Matron and Ward Manager. A PGD trained nurses will undertake a refresher course in December.

Blood Spillage Policy

The Policy has been ratified and is available on the Intranet site. IPT were due to launch the Policy and provide each clinical area with a blood spillage kit, however only 15 of the 60 kits ordered were delivered but have been re-ordered. IPT will provide training sessions for the launch of the kit when all have been received.

Norovirus Policy

The Policy has been ratified and is available on the Intranet. A Norovirus toolkit has been issued to each in-patient clinical area.

Legionella

IPT has worked with Estates to review how Legionella is monitored and managed within the Trust. Estates have no evidence that weekly flushing is conducted by the clinical areas. It is imperative that the Trust has in place systems and processes to reduce the risk from Legionella multiplying in peripheral parts of the water system. Regular flushing and logging of flushing is vital as lapses have been shown to cause a critical increase in Legionella at the outlet. RB was asked to inform Matrons that it is their responsibility to complete the Legionella record and ensure the log is returned to Estates. **RB**

Following a meeting which clinical governance attended, a decision was taken to review the Legionella policy, implement a Legionella Committee (in line with the Policy), ensure Legionella is on the corporate and divisional risk registers, and include Legionella at divisional clinical governance meetings as a standard item on the agenda. DL recommended a Legionella Policy Steering Group be established to ensure the Trust is compliant with the Policy. IPT will also arrange Legionella awareness sessions for January 2011. **SM**

DL asked that Ivan Little, Estates & Facilities Manager, be a member of IPC Committee. SR to arrange.

Hydrogen Peroxide Vapour HPV)

IPT had been working in collaboration with Hotel Services and Procurement to implement this technology as an in-house package. Training for Hotel Services will commence shortly with the aim of implementing HPV from the first week of

January 2011. SR confirmed that her staff being trained in the use of HPV would be highly skilled. **SR**

ANTT
Following the recent HSE inspection, the official ANTT DVD has been removed from the KITE site as it portrayed an individual in the background re-sheathing a needle. The DVD will be re-shot and uploaded to the KITE site mid-December. The makers of the official DVD have been made aware of the Trust's concerns.

Levels 1 and 2 IP training
E-learning packages for induction and mandatory training are complete and on the KITE site.

HSE Inspection
Following the HSE inspection an external sharps audit will be carried out and completed in December. IP training will include issues highlighted at the inspection. CE asked for the results of the external audit to be circulated appropriately. The IP Clinical Audit Report on sharps management had been circulated to the Committee members. **SM**

5b **WCPCT**

MG presented highlights from the joint report:

DRHABs
There had been two instances this month.

IPCT Snapshot Audits
Temporary closure of sharps boxes had not been in place in Wards 1, 2, 3, NRU and OPD but this had been addressed at the time of the audit.

Head Nurse Walkabouts
All ward commodes at West Park were found to be damaged. A representative for showcase commodes was to attend and a trial of this design of commode would be undertaken on Ward 3. MG assured DL that the damaged commodes would be replaced.

PEAT
Funding from the PEAT budget will be used for 'decontamination tags' to provide documented evidence when a piece of equipment has been cleaned.

Storage boxes for West Park patients to store their personal belongings will be purchased from PEAT funding.

The full reports were noted and accepted by the Committee.

6. **Divisional Reports**

GM reported on **Division 1**

'Red' areas on the scorecard:

1 x MSSA bacteraemia and 3 x DRHABs – Oncology/Haematology. GM will pursue the DRHABs issue with Sue Rowlands.

Antibiotic prescribing training showed several amber areas and focus would be given to this issue.

There was a possibility of trialling a new 'silver' dressing following insertion of Hickman lines.

A concern had arisen with domestic staff wearing jewellery and misusing PPE on D1 and D2. SR reported that spot checks take place regarding dress.

GM to meet with CE to discuss the possibility of nurses being rained in ultrasound devices. **GM/CE**

ZY reported on **Division 2**:

Performance management has commenced with departments to improve results on the scorecard.

1 x MSSA on D15. An RCA was not available at this stage as the patient had moved through different wards and work was still ongoing to produce the RCA.

There were nine amber areas against C.*Difficile*, five instances of DRHABs and ZY summarised the RCAs.

Vascular Access
CE said the situation illustrated by the scorecard was unacceptable and an improvement must be made by the end of this year. DL would discuss the matter with JO and then both of them meet with the Vascular surgeons around breaches in clinical standards. **DL/JO**

HIIs
Several amber areas.

RCAs
ZY queried whether RCAs were beneficial in a useful way. ZY and SM to meet outside of this meeting and decide. **ZY/SM**

Vaccination
ZY said she had received a request to support a measles programme and for the directorate to help. DL was under the impression that this had been done. DL and CE to discuss the position regarding vaccinations for measles, and flu outside of this meeting. **DL/CE**

The contents of the reports were noted by the Committee.

7. Environment Report

SR reported:

Catering
Roll out programme is complete. All catering staff will be transferred after Christmas. Patient satisfaction surveys around the service will be carried out in March/April 2011.

Technical Audit Report
The format of this report has been changed and there was a minor amendment to the reporting of Estates issues. Maintenance issues will not be included, only Estates cleanliness issues, i.e. high level items such as dust on grilles, lights, etc. Maintenance issues will continue to be reported via the Helpline and Ward Environment audits.

PEAT
We have been advised that our inspection will be completed by 16th February 2011. The inspection groups will consist of representatives from Hotel Services, Estates, Heads of Nursing/Matrons, Infection

Prevention, Patient Representatives and an external validator.

The report was accepted by the Committee.

8. Pharmacy report

RF reported:

The number of interventions was similar to last month and the number of allergy box interventions has much reduced since earlier in the year. There were two allergy box interventions in Division 1 – Oncology/Haematology and Surgery/Urology. Of the six incidents in Division 2, two were in ES/EAU. ZY confirmed that disciplinary action was being taken with doctors and nurses around allergy box completion. ZY was asked to check that the Deanery is advised when disciplinary action is taken against junior doctors. **ZY**

Antibiotic stickers were not being used a great deal and there will be a further push in the New Year stressing the importance of using the stickers.

The full contents of the report was noted and accepted by the Committee.

9. Performance

MC reported:

9a <u>SPCC Charts – November 2010</u>

<u>*Staph.aureus* Bacteraemias</u>

Division 1:	MRSA	0	
	MSSA	1	Durnall
Division 2	MRSA	0	
	MSSA	1	RDU

<u>MRSA Acquisition</u>	CW	1
	EAU	1
	D7/D22	1
	D8	1

<u>C. *Difficiles*</u>

Division 1:	NIL	
Division 2	A4	1
	D8	1
	D15	1
	D16	1
	ESS	1
	D18	1
	D19	1
	D20	1
	D21	1

<u>DRHABs</u>
9 instances (plus 2 at West Park). 6 x lines (2 CHU, 2 RDU, 1 Durnall, 1 D15); 3 x urinary catheters (plus 2 at West Park). 1 ASU, 1 D16, 1 D18. MC agreed to provide data around deaths as a result of DRHABs at future meetings.

Performance of Wards

Red areas:	MRSA acquisition	D15, D19, D20

HABs – Contaminated Blood Culture Sets

952 blood cultures taken of which 83 were positive, 18 contaminants. Paediatric contaminants numbered 2. CE expressed concern at the level of 21.7% of positives being contaminants. It was agreed that the target for next year would be to drive down the level to 15%. DL asked MC to calculate a target for Paediatrics, and also produce a league table of data relating to individual phlebotomists. DL would speak with JO to review how doctors carry out the practice of taking blood cultures as standards must be raised. **MC** **DL/JO**

9b Impact of Changing C.*Difficile*Testing Method

MC reported how the number of cases diagnosed may change in the short term due to the change in the testing method to a two-step algorithm for RWHT. This more sensitive and specific testing method is to be introduced in January or February 2011. The number of false positive test results will decrease but it is expected that these will be relatively few in number. True positive cases previously reported as negative but were actually false negative tests are likely to be much greater, although it is impossible to make a meaningful comparison with other laboratories that have made a similar change but previously used different testing methods and have a different disease incidence. A chart showing projections of C.*Difficile* case numbers and impact against target and stretch target in 2010/11 and 2011/12 was presented to the meeting.

DL requested MC approach Helen Davis and David Butterworth to advise the PCT that our method of testing will be changing. **MC**

9c Hand Hygiene Mandatory Training

MC referred to his and Louise Nickell's report, which was to seek approval from IPCC for changes to the hand hygiene mandatory training which would involve a more comprehensive educational content wider than hand hygiene alone. The proposal is to improve staff awareness, knowledge and understanding of IP issues with a revised IP mandatory training standard. The proposal has been acknowledged by the Preventing Harm Improving Patient Safety Committee.

A driver for this change has been the introduction of the mandatory training passport as part of the QIPP initiative and will allow transfer of 'in date' training for individuals transferring between one organisation and another so long as identified minimum standards of training outcomes are delivered in both organisations.

The proposal was accepted by the Committee.

The report was accepted by the Committee.

10. Any Other Business

No items were raised.

11. Date of Next Meeting

Thursday 27th January 2010, 10.00am, Board Room, Clinical Skills & Corporate Services Centre.