MINUTES OF INFECTION PREVENTION AND CONTROL COMMITTEE MEETING HELD ON THURSDAY 24TH FEBRUARY 2011 10.00AM, BOARD ROOM, CLINICAL SKILLS AND CORPORATE SERVICES CENTRE, 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 G Martinelli	(Consultant – Cardiothoracic)	(GM)
	Ms S Roberts	(Hotel Services Manager)	(SR)
	Ms C Wiley	(Lead Nurse IP&C – WCPCT)	(CW)
	Mr B G Millar (Part)	(Medical Director)	(BGM)
	Mr I Little	Head of Estates	(IL)
	Ms A Watts	(Matron Representative)	(AW)
	Dr J Odum (Part)	(Medical Director – Division 2)	(JO)
	Dr J Anderson	(Non-Executive Director)	(JA)
	Dr R Fitzpatrick	(Director of Pharmacy)	(RF)
In Attendance:	Ms M Washer	(Decontamination Lead)	(MW)
	Ms H Flavell	(Matron Representing Division 1)	(HF)
	Ms S Reilly	(Matron Representing Division 2)	(SR)
	Ms R Baker (Part)	(Head of Nursing Division 1)	(RB)
Apologies received:	Ms M Gay	(Director of Community Services)	(MG)

Action

2. Minutes of Meeting held on 27th January 2011

The Minutes were accepted as a true record.

3. Matters Arising from the Minutes

There were no matters arising.

4. Decontamination Update

MW reported on Q3 2010/11:

Facilities Upgrade Progress

- Head & Neck Outpatients C6. Building work had been delayed due to difficulties in identifying a reverse osmosis plan that would not delay the service. Problem now resolved and anticipated date for completion of the project is 20th March 2011.

- Incidents. 10 reported incidents, the top three being –
  - Wet sets
  - Failure to appropriate decontaminate equipment within wards
  - Housekeeping/environmental issues

  All incidents were graded yellow and did not cause harm to patients or staff.

Synergy Non-Conformities

All non-conformities were rated green and yellow and remain within the contractual limit. CE requested that in future the graph showed the percentage rate so as to provide easily identifiable non-conformities. **MW**

Synergy Issues/Progress

A twelve hour processing system introduced in Critical Care Theatres proved very successful in reducing fast tracking and costs. A contract variation is being developed between the Trust and Synergy. This service will be rolled out to other theatres.

The introduction of new tunnel washers, the twelve hour processing service and procurement of additional instrumentation will ensure an improved service and will cap fast track at 4%.

Little Sisters
MW to check that no Little Sisters were on C6. **MW**

The full decontamination report was noted by the Committee.

MW left the meeting at this point

5. Reports of LNIP

5a RWHT

SM highlighted the following issues from her report:

Influenza
Towards the end of January the number of cases began to fall. A full Trust RCA/investigation will be completed and recommendations made from lessons learned.

D&V
Two cases on D15 identified from 19th January, confirmed as norovirus. The bay was reopened on 28th January following 72 hours clear of symptoms.

Audits
A weakness in several audit forms return to IPT had been noted, i.e. the name of the clinical area audited was omitted, making it impossible for IPT to allocate a score. The IPT is reviewing the issues around this anomaly.

MRSA 30 Day Screening
Significant improvement in compliance since April 2010, however there were still patients who exceed this time frame despite IPT reminding them that a screen is required.

Urinary Catheter Point/Period Prevalence Survey
IPT at RWHT and West Park will conduct a urinary catheter survey on 7th March. In prevalence survey the number of specified events is counted in a specified population at a point in time (point prevalence) or over a short period (period prevalence). The rationale for the survey is to assess the burden of urinary catheters/urine tract infections related to urinary catheters in the Trust population and to assess the need for health services and to examine the trends in disease prevalence or severity over time.

Sharpsmart
Following the HSE inspection in 2010, IPT is working in collaboration with Heads of Nursing to review how sharps are disposed of and the use of temporary close mechanisms on the sharps container. Discussions have taken place with an alternative sharps container supplier (Sharpsmart) regarding their unique reusable system. Sharpsmart will be trialled for three months from 7th March in four clinical areas.

Infection Prevention Orientation Pack
IPT is designing an infection prevention orientation pack to

complement the Level 1 and Level 2 infection prevention induction training. The pack will be completed and implemented for the March induction training session.

Flooding
Further flooding in the basement storage area within NNU had been resolved by Estates.

BGM joined the meeting at this point

Audit Activity
CE referred to the poor result of 73% in the commodes audit for Ward D16 relating to cleanliness of commode seats. Discussion took place around the difficulties experienced with rust on the commodes resulting from necessarily harsh cleaning products. CE advised that the cost of replacement commodes would be obtained and DL informed. **CE**

5b WCPCT
CW presented highlights from the joint report:

MRSA/MSSA/C.*Difficile*
1 case C.*Difficile* to report for Provider Services. The RCA findings were multiple antibiotics for both IV and oral for a chest infection and further antibiotics for a urinary tract infection, which were prescribed in line with antimicrobial prescribing guidance. A deep clean of the ward was carried out. Mandatory infection prevention training compliance was reported as 80% and required action via the Head Nurse. The IP snapshot post incidence verified compliance with best practice.

Education & Training
IPC training sessions are now being accessed via the intranet and include refreshers for hand hygiene, blood cultures, MRSA and safe sharps management.

Outbreak Management
There were no outbreaks during January. The norovirus outbreak in December was contained on the ward.

PEAT
The PEAT pre-assessment at West Park took place in January. An external assessor from Coventry & Rugby Hospital formed part of the visiting team. Following an evaluation, funding from PEAT has been secured for 25 new commodes for wards at West Park. The commodes are the new innovative design recommended by Showcase and will be delivered in February.

CW confirmed that quarterly audits of mattresses were being carried out

Funding has also been obtained for new dispensers for detergent wipes to decontaminate equipment between each patient use. An installation date has yet to be arranged.

The full reports were noted and accepted by the Committee.

6. Divisional Reports

6a Division 1
CE formally apologised for circulation by the meeting administrator of the incorrect Division 1 data at January's meeting.

GM reported:

The scorecard showed 'red' non-compliance areas as follows:

MSSA bacteraemia: 1 x Cardiac
Device-related HABs: 2 x General Surgery; 2 x CHU

CE queried the conclusion for the MSSA patient and whether an RCA had been carried out. GM confirmed that this case was an unusual occurrence which would be discussed at a forthcoming meeting.

HII2 – Peripheral IV cannula care bundle: General Surgery

There were a number of 'amber' areas against the antibiotic prescribing training 12 month rolling compliance. MC reported that Clinical Directors receive an email naming individuals who are non-compliant. DL asked that Louise Nickell be approached to get involved in raising this issue with those concerned. **MC**

6b Division 2
JO reported:

The scorecard identified:

- Red or amber scores for all areas regarding antibiotic prescribing training. JO informed the group that each Clinical Director had agreed to review their database with a view to getting everyone trained.
- Red x 4 MSSA bacteraemia
- Red x 2 breaches in isolation policy/infection prevention
- Red x 2 C.*Diff.*
- HIIs. JO agreed that there were issues requiring investigation. CE reminded Matron HF that Matrons needed to target these issues. **HF**

Discussion took place between CE and JO regarding the 63% score for vascular access in RDU. JO reported that an MDT meeting had taken place which was very successful and all who need to have a plan for access has one. JO was confident that the score would improve to 80% over the coming months.

CE requested that in future two figures be reported, i.e. ratio with fistula and ratio without fistula. **JO**

JO went through the RCA supporting documentation around the MSSA bacteraemias and C.*Difficile.* CE drew attention to instances where patient names were identified and asked that this be avoided in future. **JO**

The contents of the Divisional reports were noted by the Committee.

7. Pharmacy report

RF reported:

Antibiotic interventions during January totalled 115, much lower than last month. This was due to a supply problem with the intervention recording duplicate booklets. This has now been resolved.

Allergy Box Interventions
The number of interventions continued to reduce and there were 10 interventions in January.

There were no instances where allergy boxes were not completed and drugs administered.

CE referred to the minutes of the February 2011 IPCC minutes stating that DL had requested a league table of areas around allergy box interventions be presented at future IPCC meetings. This would enable CE to meet with the implicated junior doctor or nurse involved in future incidents. RF agreed to produce a league table for the next meeting. **RF**

CE reminded RF that all incidents of allergy boxes not being completed, whether drug administration had taken place or not, should be recorded as an incident **RF**

Regional Snapshot Survey – December 2010
The Trust was 99.8% compliant with allergy box completion compared with the regional average of 96.7%. The Trust had fewer patients on antibiotics where the total course was greater than five days; 25.5% compared with the regional average of 30.3%.
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The Pharmacy report was noted by the Committee.

8. Performance

MC reported:

SPCC Charts – November 2010

Staph.aureus Bacteraemias

Division 1:	MRSA	0
	MSSA	1 CTW
Division 2	MRSA	0
	MSSA	4 2 RDU, 1 D18, 1 D19
MRSA Acquisition	A5	1
	D2	1

C. *Difficiles*

Division 1:	VSU	1
Division 2	D6	1
	EAU	1
	D16	1
	D7	2
	D21	1
	WPH	1

Regarding C.*Difficile* toxin positives and the new test, MC agreed to arrange for tests to be carried out at another laboratory for the next three months in order for their results to be compared with ours. **MC**

DRHABs
10 instances: 5 x lines (2 CHU, 1 RDU, 2 NNU); 4 x urinary catheters (2 D2, 1 D7, 1 D8); 1 biliary stent (1 D18).

Performance of Wards
Red areas: *Staph. Aureus* bacteraemias RDU

HABs – Contaminated Blood Culture Sets
1,024 blood cultures taken of which 94 were positive, 27 contaminants. Paediatric contaminants numbered 5.

The report was accepted by the Committee.

9. Environment Report

SR reported:

PEAT Update
The inspection went well. More areas were covered than on the original list and it is expected that the score will be 'excellent'.

Technical Audit Report
Last month's scores for high risk areas have been included for comparison purposes which will flag up any areas of concern in Divisions. This method of reporting will continue to be a feature of the monthly audit report

CE expressed concern around clutter in corridors and clinical areas, which was not to be tolerated. These issues would put the Trust in a bad light in the event of an unannounced CQC visit. **HF/SR**

The full report was noted and accepted by the Committee.

JO joined the meeting at this point and reported on Division 2 as above

10. Estates Management

IL reported:

Legionella Flushing Task & Finish Group
Remit to develop an effective mechanism for auditable control and monitoring flushing activities by user departments. A second series of trials (Cardiothoracic Ward) is being completed.

It is proposed that the Task & finish Group is subsumed into the new group in line with the Legionella Policy when it is approved at the end of March.

Clinical Waste Incineration
An increase of 10% in this type of waste had occurred in the last year, i.e. in excess of 900 tonnes per annum. High end waste will be more concentrated resulting in extra wear on the incinerator.

CE raised the issue confidentiality around disposal of carbon fax images. IL to identify the current method of disposal and advise CE. **IL**

KPI
It was expected that February and March would show improvement over January data.

IL stressed the importance of the group understanding that it takes between four and six months to conduct an audit of equipment and plant, which makes it a slow process.

Hand hygiene compliance at 83% in January is set to be 'green' next month.

Lift – Heart & Lung Centre

IL agreed to investigate problems with the patient lift, and other issues which RB would identify. **IL**

11. Any Other Business

No items were raised.

12. Date of Next Meeting

Thursday 31st March 2011, 10.00am, Board Room, Clinical Skills & Corporate Services Centre.