The Royal Wolverhampton Hospitals NHS
NHS Trust

CHAIRMAN'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
Report From:	Chief Executive Officer
Date:	Minutes dated 29/09/2011 to TB 25/11/2011
Action Required by receiving committee/group:	X 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 Trust and operational performance against IPCC targets.
Drivers: Are there any links with Care Quality Commission/Health & Safety/NHSLA/Trust Policy/Patient Experience etc.	CQC – Health and Social Care Act
Main Discussion/Action Points: Bullet point the main areas of discussion held at the committee/group meeting which need to be highlighted	• Decontamination work continues in Head & Neck out-patients • IPCC received a report on SafeHands • Improvement in Vascular Access rate over the past six months – 73% • Review of RCA process to commence as USA study concluded their usefulness is limited • Review of CJD Policy commenced to ensure compliance with current guidelines • Pest Control Policy approved
Risks Identified: **Include Risk Grade (categorisation matrix/Datix number)**	No further risks identified for Board Assurance Framework or Trust Risk Register

Minutes of the Infection Prevention & Control Committee

Date of meeting: **Thursday 29th September 2011**

Venue: **Board Room, Clinical Skills Centre, New Cross Hospital**

Time: **10.00am – 12.00 noon**

Present:	Mr D Loughton (Chair)	Chief Executive	(DL)
	Ms C Etches	Chief Nursing Officer	(CE)
	Dr M Cooper	DIPC	(MC)
	Mr I Badger (Part)	Medical Director – Division 1	(IB)
	Ms S Roberts	Hotel Services Manager	(SR)
	Dr J Anderson	Non-Executive Director	(JA)
	Dr S Kapadia (Part)	Medical Director – Division 2	(SK)
In attendance:	Ms F McKean	Deputy Director of Pharmacy	(RF)
	Ms D Edwards	Acting Head of Nursing – Division 2	(DE)
	Mr M Reid	Infection Prevention Team	(MR)
	Mr G Tasker	Estates & Facilities	(GT)
	Ms M Washer	Decontamination Lead	(MW)
	Ms C Nash	Productive Programmes Manager	(CN)
	Ms V Whatley	SHA	(VW)
	Ms V Rowley	Note taker	
Apologies:	Ms M Gay	Deputy Chief Nurse	(MG)
	Prof. R Fitzpatrick	Director of Pharmacy	(RF)
	Ms C Wiley	LNIP	(CW)
	Mr I Little	Head of Estates	(IL)

Item No		Action
2.	**MINUTES OF MEETING HELD ON 28TH AUGUST 2011**	
	The Minutes were accepted as a true record.	
3.	**MATTERS ARISING FROM THE MINUTES**	
	NNU Flooring Phase 3 of the 12 week project to replace sub-standard flooring in this area was due to commence 03/10/11.	
4.	**DECONTAMINATION UPDATE**	
	MW updated the meeting on Quarter 1 2011/2012 data and	

	highlighted the following issues: Head and Neck Outpatients C6 Upgrade still not completed due to further Estates delays. The commissioning date is not yet known. A non-standard RO water system was purchased, due to lower cost, however on installation the machine was not capable of delivering adequate water levels to the AER machine. An additional water pump procured to support the RO unit did not resolve the problem. Following a meeting with all suppliers concerned in an effort to solve the issues, a decision was taken to have a different machine to replace the RO unit. The plant is now working and a QA will be carried out. Synergy Non-conformities were high at 47, all graded yellow, in Q1 and the situation was being addressed. The Manager of Synergy had left and a replacement Manager started 26/10/11. CJD Policy MC informed the meeting that the CJD Policy was not compliant with current guidelines around recycled instruments, which state that there should be a risk assessment for every patient whose treatment involved use of recycled instruments. MC was asked to work through this issue with MW and then write a report for DL to take to Trust Board. The Committee noted the content of the full report. *MW left the meeting at this point*	**MC/MW**
5.	**LNIP REPORT**	
	MR highlighted points from the report: Outbreaks/Clusters IPT continued to assist Sandwell and Dudley IPTs with outbreak cover until 01/09/11. Enhanced Environmental Audits following Positive CDI Result All incidents as outlined in the LNIP paper were reported at the time of the audit and resolved immediately. IP Nurse Walkabouts Amongst issues in other areas, a visit to ICCU/Cardiothoracic Theatres had revealed a staff fridge which was dirty and containing out of date food. IP Staffing IPT were in the process of recruiting to the team following departure	

	from the organisation of a further IPT member. The full LNIP report was noted by the Committee.	
6.	**SAFE HANDS UPDATE**	
	CN reported: SafeHands funding was originally agreed by the Trust and Department of Health to support and further improve infection prevention in terms of monitoring hand hygiene and the ability to trace contact between patients, equipment and staff. Benefits of the project now go beyond infection prevention to include other aspects of patient safety and improving staff and patient experience. <u>Tracking Badges</u> Tracking badges have not been used in the UK before, and cleaning methods used in America for cleaning the badges do not satisfy our stringent regulations. The project team has worked with IPT and Medical Physics to ensure our preferred method of cleaning is robust and meets IP and MHRA regulations. Tristel (chlorine dioxide) is the preferred option. Cleaning of tracking badges will be automated. Confirmation from the badge supplier that this method of cleaning is acceptable and will not affect the warranty is awaited. CE queried whether analysts would be interpreting the data. CN confirmed that in the long term analysts would be required for this purpose. CE stressed that the data would require managing in order for us to learn from it.	**CN**
	DL called for a meeting to be arranged between himself, CE, VitalPac, SafeHands and Information Department to discuss DL's vision and the way forward.	**CE**
	<u>MRSA Screening</u> The software package also allows staff to enter the MRSA screen date and status, to automatically alert staff when a re-screen is due. Further developments of the software will include monitoring and categorisation of side room use to improve Trust-wide visibility. The software system will eventually interface with the labs system. <u>SafeHands 'Stars'</u> DL had been informed that it is not possible to clean these stars. SR commented that cleaning was possible but Hotel Services did not have the resources to clean the stars on a regular basis. DL pointed out that it was the responsibility of the unit to find a solution and bear the cost. SR and CN were asked to investigate.	**SR/CN**

	Summary The SafeHands project has been delayed due to a number of issues and the revised date for Dementia to go live is week commencing 25/10/11. *CN left the meeting at this point*	
7.	**DIVISIONAL REPORTS**	
	7a Division 1 IB reported: Performance Scorecard There were red areas relating to antibiotic prescribing training for staff in General Surgery, Critical Care, Orthopaedics, Head & Neck, Ophthalmology. Clinical Directors in these areas have been told not to authorise study leave for those doctors who are non-compliant with the training, and to instigate disciplinary action if non-compliance continues. IB explained that the main reason given by staff for not being up to date with the training was that there were other issues taking up their time. MC commented that there was a teaching session held in August for FY1s and FY2s and those who attended were signed off as compliant. RCAs There were six C.*Diff.* cases, 2 MSSA and 5 DRHABs which were discussed and noted. 7b Division 2 SK reported: Performance scorecard Red areas around IP Levels 1 and 2 and antibiotic prescribing training. SK suggested that junior medical staff and SpRs be given a two week window to get up to speed on all IP training, and if they did not then their ID cards would be restricted in clinical areas. The comment was made that this penalty could apply across the board, not only to medical staff. DL requested SK to speak to others outside of this meeting for their views on this proposal and report back. Vascular Access 73% compliance in August was a much improved picture compared with six months ago. CE asked that figures excluding patients who refuse to undergo vascular access be shown in future on the scorecard. RCAs The RCAs relating to 13 cases of C.*Diff.,* 4 MSSA bacteraemia and 2 DRHABs were noted.	 **SK** **SK**

	The full Divisional reports were noted by the Committee.	
8.	**PHARMACY REPORT**	
	FMcK reported: <u>Allergy Box Interventions</u> There were 14 interventions in August. A meeting with Governance has been arranged to identify the reasons for this high incidence. DL reiterated that staff responsible for not completing the allergy box should be disciplined. CE stated that 'allergy boxes' will be a 'Never Event'. <u>Datix Incidents</u> There were eight incidents in August, three of which related to Cardiothoracic. <u>June Regional Snapshot Survey</u> The survey identified us as 99.6% compliant with allergy box completion against the regional average of 96.7%. The Trust also had fewer patients on antibiotics and on intravenous antibiotics compared with other Trusts in the region. The Pharmacy full report was noted and accepted by the Committee.	
8.	**PERFORMANCE**	
	MC reported: <u>SPCC Charts – August 2011 data</u> <u>*Staph. aureus* Bacteraemias</u> Division 1: MRSA 0 MSSA 2 1 CW, 1 CCU Division 2 MRSA 0 MSSA 4 1 A6, 1 RDU, 2 D18 <u>MRSA Acquisition</u> D16 1 WP2 1 WP3 1 <u>C. *Difficiles*</u> . Division 1: CW 2 CCU 1	

	D2 1 D3 1 D6 1 Division 2 : Deanesly 1 EAU 2 D22 2 D15 2 D18 3 D19 1 D20 1 WP3 1 Not attributed to a ward 1 It was acknowledged that the situation on C.*Diffs.* was not good, however there was no obvious explanation for the high level of incidents. VW related that the SHA had a brainstorming session going through the American guidelines on C.*Diff.* and one finding was that RCAs do not give useful information. MC queried whether we should be carrying out C.*Diff.* RCAs. Following discussion, tt was agreed that C.*Diff.* RCAs should be completed only when C.*Diff.* resulted in death. MC, IB and SK were asked to collectively look into the issues around RCAs. HABs – Contaminated Blood Culture Sets 928 blood cultures taken of which 88 were positive, 27 contaminants (12 of these were taken by Phlebotomists; 6 sets were from children, i.e. 1 x NNU, 1 x A6, 1 x C1, 2 A&E, 1 unknown. Performance of Wards Red areas: *Staph. aureus* bacteraemias D18 MRSA acquisition Nil C.*Difficile* CW, EAU, D15, D18 The Performance Report was noted by the Committee. *FMcK left the meeting at this point*	**MC/IB/SK**
10.	**ENVIRONMENT REPORT**	
	SR reported: Pest Control Policy Minor amendments had been made to the Policy to take account of changes brought about by TCS. CE pointed out that this Policy would now come under the Chief Operating Officer as sponsor Director. The Policy was approved by the Committee. PAS 5748:2011 – Specification for the Planning, Application and Measurement of Cleanliness Services in Hospitals This Publicly Available Specification (PAS) was sponsored by the	

	Department of Health and the National Patient Safety Agency. The purpose of the manual is to give general and specific guidance on how to operate the provision of cleaning services within a healthcare environment. Whilst its development was facilitated by the British Standards Institution it is not to be regarded as a British Standard. PAS is expected to be used in conjunction with the Revised Healthcare Cleaning Manual published by NPSA in May 2009. On review, it was not felt that the Specification added anything significant to improve cleanliness standards and, therefore, it will not be implemented. Public Perception Information This is being developed to enable display of cleaning standards information in a more patient/visitor/staff-friendly manner. A sample of the cleaning frequencies and responsibilities chart was presented. CE queried the item stating that a nurse should clean bed frames daily. SR confirmed that this was not the final document and was still under review. The Environment report and Technical Audit report were noted and accepted by the Committee.	**SR**
10.	**ESTATES MANAGEMENT REPORT**	
	GT highlighted the following areas from the report: Legionella Flushing Programme The programme has been sent to all areas. Clinical Waste Incineration The incinerator had not operated normally this month and repair work needs to be undertaken. A major shutdown is planned for October. The full report and KPI performance were noted by the Committee.	
12.	**ANY OTHER BUSINESS**	
	12.1 ID Cards/Badges – Infection Risk JA asked if ID cards/badges presented an infection risk. It was pointed out that gel dispensers were available at ward entrances. DL reported that as part of the SafeHands project the possibility of having 'non-touch' doors was being explored. 12.2 Bed Pans - Disposal GT raised the question of used bed pans being carried through wards, and also suggested receptacles for disposal of bed pans be available in side rooms. DL recommended that GT discuss the matter with the IP team.	**GT**
13.	**DATE OF NEXT MEETING**	

	Friday 28th October 2011, Room 4, WMI.	