NHS GRAMPIAN
Infection Prevention & Control Strategic Committee (NHSG IPCSC)

Minutes from meeting held 19 September 2023
Via Teams
10.00 – 12.00

Present:

GJ – Grace Johnston, Infection Prevention & Control Manager (Chair)
AMc – Alison McGruther, Chief Nurse - Aberdeenshire CHP
CW – Chantal Wood, Deputy General Manager, Facilities & Estates
AW – Andrew Wood, Risk Management Advisor, Corporate Health and Safety
KA – Kathryn Auchnie, Clinical Nurse Manager, Combined Child Health
WS – **Wayne Strong**, Head of Maintenance and Technical Services
JB – June Barnard, Chief Nurse Acute
FMc - Fiona McDonald, Specialist Antibiotic Pharmacist (attending for Vhairi Bateman)
LD – Laura Davidson, Nurse Manager, Elderly Services (attending for Julie Warrender)
LG – Lesley Gow, Nurse Manager, Surgical (attending for Fiona Robertson)
LA – Laura Angus, Quality Improvement, Old Age Psychiatry (attending for Julia Wells)
AC – Aileen Cameron, Quality Improvement and Assurance Coordinator, Quality Improvement and Assurance Team (attending for Rachel Little)
SC - Sarah Campbell, Interim Clinical Midwifery Manager. Obstetrics
DS – Dawn Stroud, Senior Infection Prevention & Control Nurse

AS - Anneke Street, PA to Infection Prevention & Control Manager (Minute taker)

Item	Subject	Action to be taken and Key Points raised in discussion	Action
1	**Introduction and Apologies**	Julie Warrender (JWa) Grace McKerron (GMcK) Fiona Robertson (FR) William Olver (WO) Vhairi Bateman (VB) Rachel Little (RL) William Moore (WM) Caroline Clark (CC) Diane Vass (DV) Malcolm Metcalfe (MJM)	
2	**Minutes of last meeting 4 July 2023**	The minutes from 4 July 2023 were ratified by the Committee with no amendments.	
3	**Action Tracker**	**Meeting 4 July 2023** **5.1 Sector Reports** **ARI** **Content within the ARI report.** GJ will liaise with GMcK with regard to various points **Children's Services** Report will be submitted retrospectively.	

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3	**Action Tracker cont.**	**Meeting 21 March 2023** **5.1 Sector Reports** **Facilities and Estates** **Ventilation issues in positive pressure rooms in Ward 112** Report received with information added. Closed action, **Sector Report for meeting 21 March 2023** HAI risk exposure ratings completed. Close action **Meeting 10 January 2023** **5.1 Sector Reports** **Facilities** **2 i) Water Safety – Banff Health Centre – High TVCs. Flushing of outlets continues – IPCT to confirm next stage** Ongoing discussions being had. Will update as soon as possible. **Meeting 22 November 2022** **Aberdeenshire CHP** **1 c) High – Aberdeenshire currently have 4 2c General Practices to manage** AS contacted FR with regard to the above action. FR reported that there were no 2C practices within Moray at present and suggested that the action could be closed.	
4	**Matters Arising** **Item 4.1 (a)** **Item 4.1 (b)**	**Unannounced – Acute Hospital Safe Delivery of Care Inspection Gartnavel General Hospital - NHS Greater Glasgow & Clyde** AC spoke to the report advising take the learning which is relevant to NHS Grampian in relation to HAI has been detailed. A largely positive report with 1 recommendation and 3 requirements. Hand hygiene was noted as variable throughout the report and but specifically surrounding meal times with missed opportunities both for staff and patients. Missed opportunities were also noticed before and after patient contact and when touching patient surroundings. Also highlighted was that cleaning products were not always locked away in line with COSHH regulations meaning that patients / public could access them. **Unannounced – Acute Hospital Safe Delivery of Care Inspection Ninewells Hospital - NHS Tayside** This was a lengthier report due to Ninewells having an Emergency Department (ED). There were 5 areas of good practice, 1 recommendation and 7 requirements. Issues noted was the overuse of gloves and as above, there were also missed opportunities for hand hygiene for both for staff and patients at mealtimes. Each area had side rooms where patients could be isolated for infection control reasons if required, and this included ED and donning and doffing of Personal Protective Equipment (PPE) was in line with guidance. There was, however a lack of storage meaning large care equipment was being stored in corridors, which could impact on effective cleaning as well as making the	

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4	**Matters Arising cont.**	environment appear cluttered; lack of storage is a theme in all 4 inspection reports. Also noted as a requirement were cleaning responsibilities and clarity required on named domestic supervisors for each care so that nursing staff knew who to contact when required. Environmental repairs were needed in high patient movement areas and this became a requirement due to no agreed timescales for works to take place. Correct signage and Infection Prevention and Control (IPC) precautions in place where patients were known to / suspected of having transmissible infections.	
	Item 4.1 c)	**Unannounced - Infection Prevention and Control Inspections of Mental Health Services Inverclyde Royal Hospital - NHS Greater Glasgow & Clyde** This report includes 2 areas of good practice and 8 requirements. Again lack of storage was a central theme. There was good availability of Alcohol Hand Based Rub (ABHR) at the entrance to wards, however, due to risks to the patient group AHR was not available in communal areas; the risk assessment states that staff carry their own supply but it was noticed that this was not consistently applied. A lack of storage was raised again, which meant that clean linen was being stored on the floor and used linen was not being locked away. Linen buggies were being kept in communal shower rooms and other rooms were being used as storage areas, with items stored on the floor, including clean hoists meaning effective cleaning could not take place. Sharps bins were not labelled appropriately with temporary closures not in place. There was stained pressure relieving mattresses, however, the inspectors were assured in this area as the ward staff had been proactive in contacting the manufacturer as well as conducting regular mattress audits. Water flushing was raised with regards to 2 rooms that were not in use. Nursing staff were under the impression that the outlets were not plumbed in but an Estates colleague confirmed they were. Need to be clear as to responsibilities for water flushing and water flushing schedules.	
	Item 4.1 (d)	**Unannounced - Infection Prevention and Control Inspections of Mental Health Services Rohallion Secure Care Clinic - NHS Tayside** The report focused on 3 areas of good practice. The environment was found to be clean and fresh smelling, there were positive relationships between the IPC Team and the ward staff and the patient forums used were used to update patients on changes to guidance or ward issues in relation it infection prevention and control. There was 1 recommendation and 6 requirements with much the same issues as the other hospital inspections. Linen storage – staff are using this space as a changing facility and so outdoor clothing was in contact with clean linen; IPC had given advice for staff not to use this area for changing, however, the advice was not followed. There were contaminated mattresses which were not highlighted on the weekly checklist and 1 ward were using paper to cover doors / widows for privacy reasons which cannot be mitigated as effective cleaning cannot be performed. An area was also highlighted as frequently contaminated with faeces / urine and within this area there was window mesh and although Estates were aware of this issue, and the plan was to replace the windows, there was no agreed timescale for the works to be completed and this was recorded as a requirement. Temporary closure of sharps bins was noted, as in other inspections, and also the reduced domestic services cover at weekends. AC encouraged the members of the Committee to read the reports in full and consider the content in relation to their own areas. JB informed the Committee of the recent Ayrshire & Arran Health Board visit 24 – 25 August 2023. This was to undertake a “mock” unannounced inspection using Healthcare Improvement Scotland (HIS) methodology at various locations within Aberdeen Royal Infirmary (ARI). What they found was comparable with the feedback that AC reported on the above inspections variable hand hygiene, a broken sink that had been escalated a number of times but not yet resolved, Actichlor not being stored correctly in line with COSHH guidance, open sharps bins and storage issues.	

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4	**Matters Arising cont,**	Could AC please forward the feedback received from Ayrshire & Arran colleagues with AS who will share with the Committee. AMc thanked AC for the SBARs which are produced for each inspection and fedback that these were very helpful at local meetings to pick out key themes to discuss.	**AS**
	Item 4.2	**Scottish Healthcare Associated Infection (HCAI) Strategy 2023-2025** GJ shared the report on screen, the link in the chat facility and noted that this report was explained at the last meeting. This is a short term strategy for 2 years until recovery from the COVID pandemic then the longer term strategy will run from 2025~2030; is based on the World Health Organisation (WHO) Core Components (GJ will share this document in the chat also). The majority of the goals and delivery plan are the responsibility of the Scottish Government, Antimicrobial Resistance & Healthcare Associated Infection (ARHAI) and NHS Education for Scotland (NES), however, Boards will be expected to have engagement and work with all key stakeholders to take IPC programs forward. JB suggested this be treated as a formal request for all to take back to their portfolios / areas of responsibility to convert into a plan and to then bring information back to this Committee on how these pieces of work are to be progressed / completed.
5		GJ agreed and added that if this is not already included in the HAI Work Programme 2023/24 it needs to be to ensure progress is captured. Will investigate. Formal request required from June Brown or GJ.	**GJ** **JB / GJ**
	Item 4.3	**Formal IPC Incident Management Team (IMT) Report Escalation Process** GJ explained the flowchart to the new attendees at the meeting and summarised the An IPC IMT report would be written for an Incident Management Team (IMT) meeting where there is significant learning potential from an incident that has occurred. There has only ever been 2 or 3 reports written and the process for sharing that learning isn't as effective as it could be, therefore, an escalation flowchart was developed. This was tested after a previous IMT report and this has had some effect but not the desired effect t in terms of provision of assurance, achieving the recommendations and actions from the IMT report and therefore reducing the risk of recurrence of what actually occurred. This needs to be improved. The flowchart was tabled for discussion at the HAI Executive Committee meeting in August, but was not discussed due to the meeting not being quorate. Will be finalised and shared with this Committee for the next meeting.	
	Item 4.4	**Reducing Glove Use** A group of representatives from across the Organization have formed this group to determine a way to reduce glove use within NHSG and to ensure gloves are only used at appropriate times. There has been a staff survey conducted and the initial summary results were shared within the Team Brief on 18 September 2023. Committee member may wish to study the summary as it makes very interesting reading, particularly around some staff still gelling gloves and using Alcohol Based Hand Rub (ABHR) on top of gloves! There are other areas of concern and what is required is more education and communication evidenced, with Teams, surrounding general glove use.	

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4	**Matters Arising cont.**	One of the interventions developed is a poster. “Gloves Off” is the NHS Education for Scotland (NES) campaign and coincidentally NHSG have come up with the same title for this campaign; this works well as it reinforces the message provided nationally. The poster, NHSG developed, was also shared in the Team Brief 18 September 2023 and we would ask that areas display this please in appropriate areas (staff rooms etc.) to strengthen the message of not just Infection Control but also sustainability, environmental impacts, CO2 footprint and skin irritation etc. There is also a NES video that can be viewed. More interventions will be planned once the results of the survey have been looked at more thoroughly. Potentially, there may be some actions / discussions to be had in terms of leadership good / effective role modelling. GJ also advised the Committee that there is a useful video regarding the appropriate use of clinical wash hand basins. It also reinforces the message about the need for maintenance and access by our maintenance colleagues and our domestic colleagues for cleaning too. LC replied that this video has been downloaded on to Domestic Supervisors iPads for them to share with domestic staff across the organisation; has been effective and worthwhile.	
	Item 4.5	**Launch of new Empiric Strategy (from AMT meeting dated 20/7/23)** FMc informed the Committee that NHSG are moving to a new way of implementing NHSG antimicrobial guidelines. The empirical guidelines are the guidelines that guide prescribers in terms of choosing the most appropriate antibiotic when a patient has an infection and there is no other information about the organism itself; it is based on treating the most likely organisms for the particular infection. In recent years, however, this message has been disseminated via posters in all clinical / ward areas, online information and an App, however recently it has been difficult to keep information current and up to date (more guidance released and less capacity to update). The Antimicrobial Team (Team) have agreed, along with Area Drug and Therapy Committee, to work with the App only option. This means that adjustments to guidance and the informing of users can be done almost immediately. Hoping to have this advertised in the Team Brief by 25 September 2023 to explain to prescribers and healthcare staff that, firstly, in the acute sector, posters will be removed, that the more detailed PDF document will also be removed from the antimicrobial guidelines site and that, moving forward, users will be directed to the Antimicrobial Companion App; this can be downloaded onto hand held electronic devices and also has a desktop version. FMc shared her screen and explained the various pages to the Committee e.g. calculators for Vancomycin and Gentamicin dosing, the link to the Hospital / Primary Care guidance for adults and the Protected (Alert) Policy. Can also add other information as and when needed such as the changes that were made last year to Microbiology susceptibility reporting. IT are in the process of adding this to NHSG desktops for those who have access to Hospital Electronic Prescribing and Medicine Administration (HEPMA). There is also access via TrakCare on the evidence button and also access through the Web links which will circulated to encourage staff to download onto electronic devices that are used within the hospital environment. Will be asking Pharmacists to take down posters and encourage all staff to use the live version and at the same time information will be shared about the changes to the Clostridioides difficile (C. diff) treatment guidance; will be moving to using oral Vancomycin as the first line agent for C diff and information will be shared regarding this too. FMc asked for the Committee members to disseminate this information as actively as possible.	

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4	**Matters Arising cont.**	KA queried whether there would be separate guidance being released for Paediatrics in the near future. FMc confirmed that, eventually, all guidance will be held on the App but at the present time Paediatrics has not yet been checked / agreed. The process will be the rollout for the adults and the acute sector first, Primary Care will follow then Paediatrics and Obstetrics, hopefully in the next year. FMc will send AS all information and AS will cascade to relevant HAI Sub Groups (ARI, Mental Health & Learning Disabilities, Dr Gray's / Moray and Aberdeen City CHP (Woodend)). Relevant HAI Sub Group Leads will also cascade this information appropriately.	**AS**
	Item 4.6	**How to convey risk to staff on long-term biologics who have no contact with OHS (raised at IMT Children's Ward, DGH)** VB was not at the meeting to discuss this. GJ asked KA if she was aware of this and whether she could speak on the subject. KA fedback that this was a generic question raised during an IMT regarding staff on long term biologics being at risk in the clinical area from an ongoing fungal situation. Staffs conditions are often well managed via their GP and therefore do not involve Occupational Health Services (OHS); how would these staff be identified and the risk mitigated? Currently waiting reply from OHS. KA will deal GJ will raise this on the IPC report to the Occupational Health, Safety and Wellbeing Committee to be considered more widely.	
	Item 4.7	**International Infection Prevention Week (IIPW) 2023 (15-21 October 2023)** The "Gloves Off" campaign will be focused on during this week along with hand hygiene as this is still a recurring theme and links very closely with the glove use. GJ asked for the Committee's assistance in spreading the word regarding the actions the IPC Team will taking to engage with staff. AS will share the IIPW Teams background and we would ask that Committee member use this to promote the week. There will be a request for IPC related song requests publicised in the Daily Brief and these songs will be advertised on a daily basis; Emma Pettis is assisting. Any suggestions will be gratefully received! There will be a stand within ARI (location not yet decided) which will display posters, word searches etc. and this will be manned at specific times of the day. The IPC intranet page "Events" will have all the relevant information to view and there may be (if time allows) a fun video to watch made by members if the IPC Team.	**AS**
	Item 4.8	**Representation / attendance at NHSG IPCSC (Vale of Leven (VoL) learning** Numbers of attendees were dwindling for a while this is a reminder to all Committee members that if they are unable to attend to please ensure a deputy joins on your behalf; this will recorded in the minutes. This comes from the VoL report and recommendation 59 which states "health boards should ensure that attendance by members of committees in the infection prevention and control structure is treated as a priority and non-attendance should only be justified by illness or leave, or if there is a risk of compromise to other clinical duties in which event deputies should attend where practicable".	

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5	**Standing Items** **Item 5.1**	**Sector Reports** **ARI** A report was submitted GMcK was unable to attend the meeting and JB had just returned from leave so GJ spoke through the report **Key Issues** • Page 2 CSS/ ISCP – Mandatory Training (Nursing) Update Inpatient - 20% compliance. Improvement needs to be made. CW advised that the new waste module is available to some whereas others are still completing the old module so this may be skewing the figures. **1 New Areas of Concern raised by Divisions** **1 1) High – SSSTU- Decon back door and set up area, scrub sinks and door frames- water egress, potential for vermin** In readiness for reopening August 2023 SSSTU SACCA (completed May 2023) and Health & Safety (H&S) Workplace Inspection Checklist. Level Zero Ophthalmology injections and LA cataracts to move- All Safe and Clean Care Audits (SACCAs) and H&S Workplace inspection complete with estates requests. **1 j) High – Ward 209 Sluice frequently breaks down, sometimes on a daily basis.** Still awaiting a new sluice **1 k) High - Increased infections Theatre 8 pedicle screw patients IMT**. There has been some progress / feedback with this. GJ will liaise Vanessa Smith with a view to improving the situation. **2 Progress Against Areas of Concern Previously Reported** **2 l) Moderate / High - HAI mandatory training and completion compliance not assured across due to staffing gaps and current organisational pressures** Priority of education to be discussed at Acute HAI group to support priority of overall education. **2 l) Moderate – Increase in Staphylococcus aureus Bacteraemia (SAB) identified via Surveillance Nurse in Renal patient group** There is ongoing work surrounding this, however, improvement has been noted. **2 n) Very High – Wards 402 / 403 and 305 / 306: Further COVID outbreaks within these wards.** Discussions are ongoing, as part of the bed base review, regarding some actions that could be tried and may improve the situation but nothing been finalised as yet. **2 o) High - Breast Screening Clinic, Old Medical Block – leaking issues in various locations – roof defects - clinical and office areas.** Revised costs requested from contractor, for undertaking essential, less extensive repairs, to reduce the severity of the water ingress being experienced. It appears finance is not available for full, comprehensive repairs.	**GJ**

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5	**Standing Items cont.**	**2 v) High - Ventilation in EOPD** Seeking update on alternative options of environment for undertaking injections and longer term plans to address this issue. **2 w) High - Plastics Dressings Clinic** Infrastructure is a concern and environment is not fit for purpose. **2 aa) High - use of surge beds across/areas 206/207,208 and 215 - Increased infection risk to patients and staff** Risk assessment in place. Implications discussed with senior managers / triumvirate. Derogations / terminology used to mitigate risk. **2 bb) High - Multi-bedded bay room doors removed from wards 206/7 prior to COVID. Inadequate spacing between beds** GJ had raised this issue with Fiona Murray (no longer in post) regarding actions required after IMT held. Bay doors to be reinstated to ensure patients can be effectively isolated. Unsure of progress with this; needs to be investigated and followed up. **2 h) Medium – Areas within CSS not permitted to have windows open due to infection risk for patients with ongoing building and site works** Clinical Support Services (CSS) have requested a reassessment of this and for a risk assessment (RA) to be provided. GJ commented that this has been completed and there is no change to the existing RA. GJ then raised the issue of TURAS reporting displaying incorrect figures for completions in Breaking the Chain of Infection, Hand Hygiene and Why Infection Control Matters (Corporate Induction). DS has spoken to Learning & Development and amendments will be made to the layout on TURAS once wording has been agreed for the Team Brief to communicate changes to staff. Tom Heywood will then move the Clinical and Non-Clinical Refresher to the Statutory Mandatory Training page. Should be completed by end of September. Reports can be run at present, however some “drilling down” is required. **5 Areas of Achievement / Good Practice / Shared Learning from HAI Related Reviews (Level 1,2)** **Estates:** Confirmation received that a Handyman will be starting with Estates, on 4/9/23, focusing purely on Symbiotics rectification works. GJ asked if this was in relation to the communication that was shared with regard to role which will assist in rectifying the issues identified in the SACCAs. WS explained the planned maintenance plan and how this will help will identify what is priority in the areas. There will be 3 staff on planned maintenance and 3 on reactive works (e.g. leaks). If there is too much work then contractors will be employed. The handyman will be focusing on purely Symbiotics work (e.g. handles, latches etc.) and they will work alongside the joiners. Non standardisation of paint is a big issue with many colours having been used over the years which makes touching up across the hospital very difficult. CW asked for the Committee’s support in minimising the colours used across the site as Estates would like to agree on a small number of colours that can be held in stock and then the rest of the hospital would be brilliant white, meaning touching up the paintwork will be an easier undertaking. Strong communication will be sent out regarding this and will hopefully ensure the hospital	

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5	**Standing Items cont.**	looks welcoming and clean / tidy. Project Team (Craig Slessor) are also aware of this ask to move to "corporate" colours. JB agreed and added that this showed consistency and familiarity, however LC reminded the Committee that drip trays need to be in place on all wall mounted hand gel dispensers, if not, the alcohol will strip the paint from the walls and the domestic team cannot clean effectively. WS confirmed that the handyman would be commencing in the yellow zone initially but the long term plan is that they would be attending an area for half a day at a time and managing to cover the whole hospital once a month. GJ questioned whether there is a checklist for painters? CW confirmed that there is and when she and WS visited Floors 5 & 6 in the Emergency Care Centre (ECC) were advised that is paint is flaking and the area is damp a specific treatment would be performed prior to painting. If the damp returned it would be clear that further investigation / works would be required. **Children's Services** No report was submitted. Report will be sent retrospectively - KA compiling as soon as possible.	**KA**
		Women's Services Report was submitted. **2 Progress Against Areas of Concern Previously Reported** **2 a) High – Aberdeen Centre for Reproductive medicine (ACRM) has seen a large decline in success rates following fertility treatments** This has been raised in previous reports, however, success rates seem to have increased, unsure why. Awaiting response from the IPC Team following a review of the area and an external agency interview was also performed. Could be linked to the general Aberdeen Maternity Hospital (AMH) built environment? **2 b) High - Urgent walk round planned for AMH built environment after 4th environmental concern raised** Still awaiting costings for contractors, not aware of any progression, however, works are planned to commence early October 2023 for Theatres. Service is attempting to move as 2 theatres are consistently used and this will impact on elective surgeries. **2 d) High – Water Safety at Inverurie Community Maternity Unit.** Would like to highlight that 3 out of 4 of the birthing pools are closed due to water issues and this is severely limiting women's choice with complaints having been received to lack of services. **4 Mandatory HAI Education Training Compliance Figures** 5 out of 15 areas are compliant with the SACCAs. There are a number of red areas for hand Hygiene in August so SC has approached senior charge midwives and nurses to request that information is uploaded (the audits have been completed but not uploaded to Illuminate). GJ will investigate the areas of concern around 2 a) and 2 c). Katie Coleville has been in discussions with June Brown (who GJ recently met with) and conversations are to be had as to how to proceed. Are both these	

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		issues recorded on the service's risk register? SC was unsure but discussions will be had with regard to what is present and what needs to be added. GJ also mentioned Standard 8 – Built Environment and the issues that AMH are experiencing. Estates and the IPC Team are working to improve the situation but this will take time. **<u>Aberdeenshire H&SCP</u>** A report was submitted. **1 New Areas of Concern** **1 a) High – Total Viable Counts (TVCs) found during water testing at Braemar GP Practice following refurbishment works** The water tank will be removed, which will eradicate the issues that have been found. Works will progress. **2 Progress Against Areas of Concern Previously Reported** **2 a) Very High – Aberdeenshire HSCP have had to take over the running of a private care home in Huntly** Seems to working well, NHSG nurses are employed within the care home/ The Care Inspectorate have visited and were assured. **2 d) High – Various concerns raised across the Shire Vaccine Clinics with regard to environment and cleaning** Discussions still being had as to whether current cleaning practices are sufficient; assurance is required as to the standard of work being performed **2 f) Very High – Aberdeenshire HSCP currently have 4 2c Practices that have across to NHSG** Discussions continue as to effective cleaning of these venues. **3 Focus on Healthcare Improvement Scotland (HIS) Standards** This was not discussed at the last HAI Sub Group meeting but is on the agenda for the meeting in October. GJ asked raised the ongoing Peterhead water works and IMTs being held and WS gave an update. A substantial amount of work has been completed and the venues were mechanically complete GJ asked for some assurance that Estates were around the issues of high Total Viable Counts (TVCs) at Braemar. WS confirmed that the water tank is to be removed. This issue is often seen in buildings that do not have inpatient services and where the water turnover is lower than usual resulting in issues such as high TVCs. A mains fed system will be put in place which should solve the problem.	

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5	**Standing Items cont.**	**Aberdeen City CHP** A report was submitted. **1 New Areas of Concern** **1 a) High – Leaks in X-Ray Room 4, Radiology** Room has had to be taken out of action on a number of occasions, issue has been raised with Estates. In addition there is also an issue with a lack of ventilation within the department which has prevented upgrading X-ray room 1; this has resulting in the use of equipment which has received end of life certification. This has been added to the Risk Register. Estates have reviewed but cannot provide a long term plan around either issue at present. **2 Progress Against Areas of Concern Previously Reported** **2 b) High – SCN at Rosewell House unable to provide report of completed mandatory training** This issue is due to staff being employed by Bon Accord Care and not NHSG. The deputy manager has been encouraging staff to print off certificates when they have undertaken and completed elearning modules so that this can be collated and reported on. Learning & Development are happy to provide reports and this is awaiting joint agreement to be written and confirmed. **2 e) High - Poor mandatory training compliance in majority of areas but particularly inpatient areas** This is a standing item on the Senior Charge Nurse (SCN) agenda to remind them to allow staff time to complete their training **2 f) High - HAI Inspection carried out at Horizons** 69 actions were identified as part of this inspection and an action plan has been compiled and is being worked through. Progress continues to be made and Lisa Leslie and IPC have assisted which has helped the good progress made to date. GJ will investigate which IPC Nurse covers Horizons and discuss this with them. **3 Focus on Healthcare Improvement Scotland (HIS) Standards** ACHSCP has a Buildings Team who oversee the safety of all partnership facilities, including domestic cleaning schedules, water outlet flushing checklists, compliance etc. Health and safety inspections take place. Multidisciplinary Team (MDT) walk rounds continue which include Estates, Facilities and Domestic Services. Water outlet monitoring records available via Estates, IPC audits are completed with improvement plans in place and Estates issues are recorded from the reporting of issues through to escalation. WS replied to LD with regard to the leaking within Radiology at Woodend saying this would be prioritised and Estates staff would visit to determine what works are required.	

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		Facilities A report was submitted. **1 New Areas of Concern** **1 b) High – Maternity Theatre 2 - Some signs of subsidence and internal damage within theatre areas** There is a general subsidence issue which is being monitored and there been no movement in the building in the past month. There are also problems with the drains and Estates are investigating whether this is "grey water" i.e. not raw sewage but water from sinks / showers etc. or rainwater coming back out of the ground. Many drains have collapsed and no drawings are available therefore dye is being used to ascertain where the water is going to. A few small repairs have been undertaken but no more will be progressed until a clear view of the problem is available. **2 Progress Against Areas of Concern Previously Reported** **2 c) Inverurie Birthing Pools** There is one pool still to be repaired and put back into service. If this pool is to be reinstated and be fully compliant it will require a full mechanical heater put back into system and new Integrated Panel System (IPS). If this is not completed it will not be compliant by today's standards. This work could take months. **2 l) Major – Peterhead Hospital and Health Centre – Legionella** There has been good progress made here. Mechanical works have been completed, 2 rounds of sampling have taken place and a third has just commenced; 3 clear samples must be received before the removal of the filters can begin. Generally, the results have been good, however, there have been areas which have not been satisfactory and have required work. There are 2 birthing pools and both are completely isolated from the rest of the water system, and are on mains supply. There was a recommendation from Estates that 1 of the pools be reinstated but this rejected, at present, and until the whole hospital can be deemed free of Legionella. When the results from the third round of sampling are received then discussions can take place with IPC on whether the majority of the filters can be removed leaving only a few in locations still requiring work. **2 n) High - ARI – Purple Zone – Old Medical Block. Extensive masonry and roofing defects, resulting in spalling and leaking issues.** Cost of repairs on the backlog are estimated at £250 - £300k. Need to understand how much money is left on the backlog and it may or may not be started by the end of the year; very much depends on priorities. **Dr Gray's / Moray HSCP** A report was submitted**.** **2 Progress Against Areas of Concern Previously Reported** **2 b) High - Fungal Contaminant found in ward 2 DGH (Children's Ward)** Work ongoing surrounding this. **2 c) High - Endophthalmitis cases within Ophthalmology DGH** There has been sampling completed and a laminar flow device has been bought. Air sampling has been passed as satisfactory. Sink is to be removed but room is back in use with risk assessments and a contingency plan in place.	

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5	**Standing Items cont.**	**<u>Mental Health & Learning Disabilities</u>** Report was submitted. **1 New Areas of Concern** **1 b) Medium - Positive routine water samples for Pseudomonas Aeruginosa in Dunnottar Ward** Tested positive in May 2023 in rooms 5 & 9; action plans and risk assessments are in place. Thermal Mixing Valves (TMVs) and strainers in place and daily flushing is recorded. Sampling to be redone. Escalated to Water Safety Group (WSG) Vaccine clinics have been held on site and good progress has been made in the vaccination of staff. A plan is in place for a patient vaccination programme and how this is to be implemented A good month has been had with Muick and Davan wards (that were closed due to high Total Viable Counts (TVCs)) having now reopened. Fyvie ward should reopen today. **3 Focus on Healthcare Improvement Scotland (HIS) Standards** Ongoing work continues with the built environment and quality improvement work. SACCAs are up to date and 5 factor risk assessments completed. **4 Mandatory HAI Education Training Compliance Figures** Noted improvement in training compliance for Waste Management **<u>HAI Education Group Roundup</u>** The roundup report was submitted. **Mandatory Training** **Hand Hygiene Module** DS fedback that she took the request to have the hand hygiene module as an annual update to Grampian Area Partnership Forum (GAPF) a few weeks ago and the request was declined. This has been escalated to this Committee and the HAI Education Group would like it to be escalated to the HAI Executive Committee for discussion / awareness. **Corporate Induction** There has been some confusion over what training staff receive when attending Induction and what is expected of them afterwards. DS highlighted the process and what is required to be completed within the report. **Education** The Short Life Working Group (SLWG) on improving compliance with Multi Drug Resistant Organisms (MDROs) continue to meet and changes are being made to the NHSG patient Placement Tool (PPT) to reflect guidance. **Audit & Assurance** DS has drafted an IPC induction sheet for new starts; this will be mainly used in clinical areas. When wording is complete this will be uploaded to the IPC intranet page and comms will be shared in the Daily Brief. Aware that areas have this information already in place but the new document lists all the IPC annual training required	

Item	Subject	Action to be taken and Key Points raised in discussion	Action
5	**Standing Items cont.**	plus the one biennial training which is the Clostridioides difficile (Cdiff) module and assessment. **Policies and Procedures** NHSG Healthcare Associated Infection (HAI) / Antimicrobial Resistance (AMR) Education Framework for Staff is now complete. **Scottish Infection Prevention and Control Education Pathway (SIPCEP)** IPC Zone on TURAS - will be developing a landing page on TURAS for IPC education. Work has commenced and hoping to have this organised shortly; Tom Heywood is assisting with the digital format. **Escalations** • TURAS does not provide an accurate report of IPC module completion as only get a broad data received , no "drilling down" is available which does not give sufficient clarity • The HAI Education Group do not accept the decision taken by GAPF that asking staff to complete the Hand Hygiene module annually will not improve compliance in audits (as mentioned above). More innovative ways to provide hand hygiene need to be considered. GJ asked for the Committee member's thought on the decision made by GAPF to decline the request by IPC to have the hand hygiene module as a yearly refresher. JB asked if any rationale was given to the rejection of this request and agreed that the issues discussed around hand hygiene today would counteract this decision. DS replied that the conversation had surrounding this at GAPF was a good one, however, the Forum did not feel that completing another module who necessarily improve hand hygiene compliance due to the wards auditing their own staff and not always IPC. It was felt that the education would be better achieved better in more innovative ways of teaching e.g. training with the Glitterbugs. During Preliminary Assessment Group (PAG) meetings held on non-compliance of hand hygiene it is always suggested that areas utilise the Glitterbugs to ensure staff are given training in hand hygiene. Very much reliant on individual areas to have the interest and time to undertake training staff as IPC do not have the capacity to visit all areas on a regular basis. GJ reiterated that having this module as mandatory would lend more weight to the priority of hand hygiene. The glove use survey highlights this as staff who responded stated that the information source for appropriate glove use were the hand hygiene modules. This information was not available when the suggestion was first put to GAPF and this part of the rationale for revisiting this request and escalating through structures to obtain that support. The Committee supported the plan to revisit the request and approach GAPF again. **<u>Infection Prevention & Control Team (IPCT) Roundup</u>** The roundup report was submitted **IPC Surveillance & HAI Screening** **Q2 National & local figures.** MRSA CRA 81% (NHSG 65%) CPE CRA 80% (NHSG 72%) CPE swabbing N/A	

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5	**Standing Items cont.**	The work surrounding this was mentioned above in the HAI Education Report with regards to training sessions and the PPT work. **Incidents and Outbreaks** 3 Preliminary Assessment Group (PAG) meetings • 2 Hand Hygiene • 1 water Issues • 1 Hand Hygiene PAG led by the Service but supported by the IPC Team 9 Incident Management Team (IMT) meetings • 2 Cluster of Atypical Infections (now closed and being taken forward by the Service) • 3 Legionella • 1 Endophthalmitis • 1 Enterobacter cloacae ESBL • 1 Decontamination of Probes • 1 recurrent roof leak 1 Non IPCT Chaired PAG (chaired by Decontamination) • Water sampling issues 6 Non IPCT Chaired IMTs • 4 Asbestos / Dirty Laundry (chaired by Public Health / Decontamination / Estates (plus 2 re-opening meetings) • 1 Water issues (chaired by Decontamination) • 1 Periventricular leukomalacia (PVL) in Asylum Seekers (chaired by health protection Team (HPT)) **Audit and Assurance** IMT / PAG Escalation Process document is still being updated and will be tabled at the HAIEC meeting once complete. **Built Environment** The team continue to receive a lot of requests for assistance with both new builds and ongoing maintenance of the built environment; this does put a significant amount of pressure on the Team's capacity to support. **IPCT Workforce** Have been able to recruit 3 x full time band 6 IPC nurses and a Deputy Infection Prevention & Control manager (DIPCM). Pre-employment checks are being completed.	
	Item 5.2	**HAI Work Programme Delivery Group** This is a big piece of work that many services and departments are involved in. The HCAI Strategy 2023~25 (discussed above) will be added to the report in due course so that the actions that were discussed earlier can be taken forward. The issue of the NHSG Sharps Group having been paused has also been added to the report as a concern; may be worth HAI Sub Group Leads flagging up this up this at their local meetings.	

Item	Subject	Action to be taken and Key Points raised in discussion	Action
5	**Standing Items cont.** **Item 5.3**	**Risk Register (September 2023)** CW asked for **Risk ID 2839 - New PPE for High Consequence Infectious Diseases (HCID) - Availability of Stock & Resource for Training** to be amended and a new Risk Owner added**.** GJ / CW will discuss and GJ will amend **ID 3243 - Transmission of Multi Drug Resistant Organisms (MDROs) in the Healthcare Environment** This is ongoing I**D 3374 – Antimicrobial Stewardship (AMS) Nurse Specialist role remains unfilled** Hoping to progress with filling this post in the near future. **ID 3246 - Lack of confirmation / response from Scottish Vaccination and Immunisation (SVIP) regarding environmental standards** GJ will be liaising with the vaccination team to find a solution and to be able to close this risk. Need a risk based approach to assess buildings for suitability. **ID 2654 - IPC Team's inability to provide through HAI SCRIBE too all built environment projects across NHS Grampian** This remains a challenge with many requests for the IPC Team's assistance / involvement, however, 3 IPCNs have been recruited recently (1 to help specifically with built environment). Positive from IPC perspective. **ID 3096 – Lack of Governance process for IMT Reports** As discussed earlier this is ongoing. Process is not as effective as it could be and process is still being updated. **ID 3054 – Sustainability of IT platform supporting Operational response to IPC** ICNet contract ends December 2023. Still in discussions with National Procurement to try and extend the contract. This is a big risk to the Organisation. **ID 3292 – NHSG non-compliance with National Guidance re Venous Access Devices** National guidance has changed surrounding cleaning and time device can be left in situ. NHSG has not adopted national guidance and continues to follow local policy. Risk Assessment has been completed and Justine Collie / Robert Cockburn are updated the NHSG policy at present. **ID 3119 – Technical Lead IPC Nurse post vacant** This post has been verbally offered as a Deputy IPC Manager post and will hopefully be filled shortly. **ID 2839 - New PPE for High Consequence Infectious Diseases (HCID) - Availability of Stock & Resource for Training** Awaiting National steer and guidance in terms of PPE required and support with rollout across Scotland.	**GJ / CW**
	Item 5.4	**HAI Executive Committee Update** The last meeting held (15 August 2023) was not quorate and so there were no concerns escalated therefore there is no feedback. Issues will be escalated at the next meeting on 17 October 2023.	

Item	Subject	Action to be taken and Key Points raised in discussion	Action
6	**HAI Report to Clinical Governance Committee / Board cont.** **Item 6.1** **Item 6.2**	**HAI Report to the Board (HAIRT)** There is no report due at this time **HAI Report to the HAI Executive Committee (HAIEC) (new escalations)** GJ informed that the Committee that the previous concerns highlighted would carry over to the HAI Executive Committee meeting in October • increase is SABs • IMT Report Process There were no other issues raised.	
7	**AOCB**	No AOCB was raised.	
8	**Date of Next Meeting**	21 November 2023 10.00 – 12.00 via Teams (with a 10 minute comfort break)	