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

Minutes from meeting held 2 July 2024
Via Teams
10.00 – 12.00

Present:

GJ – Grace Johnston, Infection Prevention & Control Manager (Chair)
ANd - Astrida Ndhlovu, Deputy Infection Prevention & Control Manager
AMc – Alison McGruther, Chief Nurse, Aberdeenshire CHP
WS – **Wayne Strong**, Head of Maintenance and Technical Services
JWa – Julie Warrender, Deputy Chief Nurse, ACHSCP
DS – Dawn Stroud, Senior Infection Prevention & Control Nurse, IPCT
JB – June Barnard, Nurse Director for Secondary & Tertiary Care - Acute
HCo – Helen Corrigan, Health Protection Nurse Specialist, Health Protection Team
AW – Andrew Wood, Risk Management Advisor, Corporate Health and Safety
LA – Laura Angus, Quality Improvement, Old Age Psychiatry (deputising for Julia Wells)
HC – Helen Chisolm. Chief Nurse, Moray
GK – Garry Kidd – Assistant Director of Infrastructure & Sustainability

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**	Rachel Little (RL) Aileen Cameron (AC) Will Olver (WO) Juliette Laing (JL) Vhairi Bateman (VB) Grace McKerron (GMcK) Julia Wells (JW) Linda Oldroyd (LO) Chantal Wood (CW)	
2	**Minutes of last meeting 21 May 2024**	The minutes from 21 May 2024 were ratified by the Committee with no amendments.	
3	**Action Tracker**	**Meeting 21 May 2024** **5.4 HAI Executive Committee Update – Responsibilities for flushing** Meeting has been arranged for week commencing 9/7/24 for initial conversations with Colin Cruickshank and one of the nurse managers to work out if there is a way to try and improve upon the assurance of water flushing within NHSG. **Meeting 16 January 2024** **5.1 Sector Reports** **ARI – Clinic C infrastructure not fit for purpose. Potential move in an area can be secured.** PAD Team have confirmed that project is being costed and was to go to the Asset Management Group (AMG) meeting 26/6/24. Awaiting update.	

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3	**Action Tracker cont.**	**Compliance with Statutory / Mandatory Training** GJ emailed Jason Nicol 25/6/24 with regard to how to connect with the Short Life Working Group (SLWG) that he co-chairs. Awaiting reply. GJ is also aware from recent Healthcare Improvement Scotland (HIS) inspection documentation that both Lothian and Borders Health Boards have a high level of compliance; have fed this back to Jason and suggested that perhaps a conversation can be had as to how they are achieving this. Unsure as to whether these figures are overall training or just Infection Prevention & Control (IPC). **Meeting 21 November 2023** **5.1 Sector Reports - Aberdeenshire HSCP - Trolleys with wheels and brakes should be on a maintenance schedule – this would include Ultrakarts. Discussions needed as to who maintains this equipment** Mark Cowan confirmed that this equipment is not maintained by the Medical Equipment Management Services (MEMS). The Original Equipment Manufacturer (OEM) should provide a service schedule and the responsible department i.e. facilities / catering should agree whether this is required and who should perform the task, either the Estates Team or a service contract with the OEM. WS confirmed that responsibility for these is being discussed at present but may become part of the Facilities & Estates remit. **Meeting 19 September 2023** **5.3 Risk Register - Risk ID 2839 – New PPE for High Consequence Infectious Diseases (HCID).** Action Plan has been drafted and national advice will be available once consultation has closed. Will revisit then. 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** GJ proposed to close this action as no longer IPC. Any thoughts? ANd fedback that there were actions taking place but it can be closed at present and any actions can come back to this Committee if applicable.	
	Item 4.1	**Infrastructure Review Update** GK shared slides with the Committee and gave an update on the piece of work that NHSG has been instructed to undertake by the Scottish Government. Nationally, to support health boards, the Scottish Government allocate around £350 million per annum in capital funding and of that around £150 million, is allocated directly to health boards in the form of what is referred to as a “formula capital allocation”. This is the money that NHS Grampian have available to support any backlog maintenance of our properties, equipment replacement etc. and NHSG typically receive just over £13 million	

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4	**Matters Arising**	per annum as a share of the overall capital resource in Scotland. At the time of the DL(2024) 02 being written the process for requesting extra monies (above the already allocated 13 million) to prepare a business case that would be sent to the Capital Investment Group in Edinburgh who would consider the merits of the case and allocate funding if available. This. however, was not sustainable as there were numerous business cases waiting to be considered with a total value in excess of £5 billion and with only £350 million available. There was also no way to be assured that the monies allocated in this way were actually being directed appropriately for the limited resource available and was, essentially "first come, first served". Business cases had to have a strategic context to them but there was no real prioritisation locally or nationally. The DL was introduced and Boards were written to via a director's letter instructing NHSG to take forward a different type of planning exercise. At present all new projects / proposals are on hold until Health Boards have completed this piece of work and what is expected is for NHSG to produce a Program Initial Agreement and this is a whole system service and infrastructure change plan (diagram in slide 3 referred to). NHSG are expected to build on all existing strategy documents, plans etc. and develop a whole System Service Plan which will define what our infrastructure requirements are. Financial parameters are given which NHSG will work to in order to identify our priorities and until the Service Plan is complete no investment will be considered. NHSG will still receive the annual formula capital allocation to deal with maintenance and equipment replacement, but no new investment will be forthcoming until the process is complete. There are 2 stages: 1. By January 2025 NHSG must have produced a maintenance only business continuity investment plan which will cover the next 5 to 10 years. The aim of this exercise is to look at how long NHSG can continue using existing assets and what risks are associated around this for the continuity of existing services. 2. By January 2026 NHSG are required to have available a much longer term whole system serviced infrastructure change plan. This will take account of where the Organisation have plans for service transformation, service development where, perhaps, services are in the wrong place; looking to redefine how / where services are provided (slide 4). This will simplify the process to access funding. This piece of work will be across the whole system and will be cross sector as well as the health system e.g. how NHSG deliver services to local communities. This will evidence the work taken forward in order to support planning assumptions and the expectation will be to demonstrate that NHSG have looked innovatively at how / where we deliver our services; this will define infrastructure requirements moving forward. How is this work progressing? The project initiation document to be produced and as part of that it was discussed and agreed that some changes were required as to how NHSG manage and govern infrastructure arrangements. The Asset Management Group (AMG) now has a revised Terms of Reference (ToR) and will operate as the steering group for this exercise and the membership has been improved to include the Portfolio Executive Leads (PELs) to ensure proper executive focus and strategic direction; this has been agreed by the Performance Assurance Committee of the Health Board. A standard business case template has been put in place which will be utilised for paying for all proposals coming forward with immediate effect. Any proposals less than £10 million will be expected to use this template which has various checks and balances built into it; one of those is looking for assurance that when proposals for investment are being scrutinised that they are engaging with the IPC Department particularly and	

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4	**Matters Arising cont.**	also the Estates Team and who are critical to the process, making sure that any proposals are properly thought through. There is still a considerable way to go before agreement is reached on how the organisation is approaching the second stage of the exercise, however, this is well underway in being taking forward for completion by January 2026. What is currently in place is a process where information held on all NHSG buildings is being collated and verified; this is taking place on one or two pilot sites presently and still have 98 buildings to include. In the coming months the plan is to visit each building and the services within that location to build a picture on the current physical and to ascertain what the current statutory compliance risks are. This will give a picture of what services we deliver in each building and what risks are associated with any potential failure of infrastructure etc. This information will build a risk assessed picture and will show where prioritised investment is required over the next 5 years or so. Once the prioritisation criteria has been agreed this will then formulate a plan. It is acknowledged that the list compiled will be of high and very high risk issues across all of NHSG's buildings, equipment base, digital assets etc. and that this is all to be part of the same exercise. When it comes to classifying these priorities, an agreement needs to be reached on how this is to be managed. It is important that when assessing risk that not just a score is given, need to be able to explain what the risks actually are so that they can be understood fully and any mitigations can be taken into account before the work is prioritised. GJ thanks GK for the presentation and enquired as to how any of the Committee members could find out further details or ask any further questions. GK confirmed that a Teams channel is to be set up to provide a knowledge and information sharing network and questions can be asked on this forum. Also looking to set up fortnightly / 3 weekly lunchtime sessions where information / updates can be discussed and shared with all who attend. JB asked whether there was a schedule for the 98 buildings being assessed. It is very important that the local teams are released during visits and with the operational pressures being facing at the moment, as much notice as possible would be very helpful. GK confirmed that there was an agreed lead point of contact for each of the services and the team are working through with them to ensure works are planned around clinical activity and services provided. GK will send the presentation to AS who will upload to the NHSG IPCSC Teams channel.	**AS**
	Item 4.2 (a)	**Unannounced – Acute Hospital Safe Delivery of Care Inspection Aberdeen Royal Infirmary (ARI) - NHS Grampian** Neither AC or RL were present at the meeting so JB gave a brief update. There have been time frames that NHSG have had to comply with in terms of our local action plans for both ARI and DGH. The last time frame that needed to be complied with was comply with was May / June, which was updating the action plans that are held internally and providing colleagues at HIS with an update that goals have been achieved by all dates specified. There are some actions that extend past June 2024 and although the report should now be live on the HIS website there are actions that will continue at a local level; it should be noted that compliance with NHSG action plans is not only for HIS specified recommendations but also good practice on a daily basis. JB encouraged all to view the action plans to see what has been completed to date and the actions that extend beyond June 2024; many of them are related to e.g. the Health and Care Staffing Act which NHSG knows will.	

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4	**Matters Arising cont.**	not be achievable in the coming year. This last Safe Delivery of Care Inspection utilised the new methodology which was new for NHSG and steps have been put in place to ensure that the organisation was compliant; this is a good opportunity to review those steps and obtain feedback so that there is further awareness for the next visit. GJ hoped that all on the call and colleagues in clinical / non clinical areas have access the improvement and the action plans and are participating in them. Water flushing compliance was reiterated again following the inspection as was the PVC bundle relaunch that is planned.	
	Item 4.2 (b)	**Unannounced – Acute Hospital Safe Delivery of Care Inspection Dr Gray's Hospital (DGH), Elgin – NHS Grampian** See narrative above	
	Item 4.2 (c)	**Summary Report of External Inspections to NHS Scotland Boards (1 May – 31 May 2024)** A report was submitted but AC was unable to attend to speak to it. **Areas for Improvement in NHS Ayrshire and Arran (East Ayrshire Community Hospital):** **Requirements:** 1. must ensure clinical waste is stored in a designated, safe and lockable area whilst awaiting uplift. General and clinical waste must be always segregated at the source 2. must ensure all hazardous cleaning products are securely stored and labelled appropriately, as per manufacturers guidelines GJ updated that the issue of clinical waste has already been escalated through this Committee and to the HAI Executive Committee (HAIEC) and onwards to the Occupational Health Safety & Wellbeing Committee and this was in regard to Eurobins across NHSG sites being left unlocked; Health and Safety are taking this forward. This was not featured in the NHSG HIS inspection reports but this is an ongoing issue which requires investigation. JB confirmed that the above requirement (number 2) was identified during the NHSG visit and a large piece of work was completed to ensure secure storage and appropriate labelling; this must be managed moving forward.	
	Item 4.2 (d)	**Summary Report of External Inspections to NHS Scotland Boards 1 – 30 June 2024** A report was submitted but AC was unable to attend to speak to it. **Areas for Improvement in NHS Lanarkshire (University Hospital Hairmyres):** **Requirements:** 1. must ensure that nursing staff are provided with necessary paediatric training to safely carry out their roles within the emergency department 2. must ensure staff are trained to ensure safe fire evacuation 3. must ensure that all patient documentation is accurately and consistently completed with actions recorded 4. must ensure safe intravenous line care practice to prevent the risk of infection and to ensure effective intravenous fluid management	

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		5. must ensure the appropriate management and monitoring is in place to ensure the safe administration of medicines and the safe storage of medicines 6. must ensure compliance with standard infection prevention and control precautions ensuring all staff and volunteers perform hand hygiene at the correct times and used linen is managed appropriately in line with guidance 7. must ensure all hazardous cleaning products are securely stored These seem to a reflection of what NHSG has experienced. GJ asked for all committee members to read the reports when able.	
	Item 4.3	**IPC Workforce Strategic Plan 2022~24: GAP Analysis & Risk Identification** A paper was submitted. There was a Short Life Working Group (SLWG) set up initially with broad representation requested. This group was to discuss and consider the gaps and risks from an IPC workforce point of view and this document is being pulled together from the comments received. Conversations have been had with Scottish Government who are interested in NHSG's thoughts on the IPC workforce. There are various gaps with 15 recommendations noted. Many of these were for NHS Education for Scotland (NES) or Antimicrobial Resistance & Healthcare Associated Infection (ARHAI) to take forward, however there were some local ones. The draft report has been shared with NHSG's HAI Executive Lead and now requires to be formally escalated to recognise / rectify the risks identified; those not rectifiable will require the risks to be mitigated. Recommendation 2 -"Identify and review the current specialist IPC roles – IPCD, IPC specialists, surveillance, healthcare scientist….." It has been recognised nationally that there is a shortage of specialists, however, NHSG has appointed, on a temporary basis, a Healthcare Scientist - Ijeoma Okoliegbe, who has a specialist set of skills and can support the Infection Prevention & Control Doctors (IPCDs) and the Infection Prevention and Control Nurses (IPCNs) work. The IPC team are also in discussions with the Health Protection Team (HPT) with regards to gaps / risks in Community and this has not yet been resolved. Recommendation 5 - "Identify and review what additional roles and resources are required within the AMS workforce…" The IPC Team have now appointed an Antimicrobial Stewardship Specialist Nurse – Rachel Mennie.	
	Item 4.4	**Staphylococcus aureus bacteremias (SABs) / DATIX Process** The situation surrounding SABs has improved significantly this year. IPC were concerned with regard to "closing the loop" when issues were identified. A process has been commenced where DATIX is used to alert the appropriate clinicians to potentially preventable SABs so that action can be taken, lessons learned and support can be provided. A flowchart will be produced and shared widely across NHSG. DATIX may prompt a level 2 review if the SAB was deemed potentially preventable and a level 1 if it is a significant consequence; this has provided assurance from an NHSG perspective now the process is in place. JB stated that the flowchart would be a welcome addition and was keen to understand how each of the	

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4	**Matters Arising cont.**	Portfolios and indeed other areas across the system, are using this information e.g. is this being fed through their individual governance meetings. Could this be added to the flowchart? Feedback from lessons learned will discussed at the ARI HAI Group meetings.	
	Item 4.5	**Hand Hygiene Competencies** DS spoke to the SBAR submitted explaining that the IPC team were approached by Matthew Toms to consider an alternative to the present hand hygiene training in order to reduce the number of mandatory and statutory modules and assessments being undertaken by staff. It has only been this year that staff have been asked to complete the hand hygiene module and assessment on an annual basis, previously it was a once only and hand hygiene updates were included in the clinical / non-clinical annual refreshers. DS / GJ and Matthew Toms met for a discussion and it was thought that one of the pros to implementing competencies was that it would be less time consuming for staff than completing the online training, however this could not be proven unless competencies were introduced; to be clear the online learning module and assessment would not be removed, they would still be considered an option. Senior Charge Nurses (SCNs) may have more awareness of their staff's competence regarding hand hygiene rather than waiting for a hand hygiene audit to be undertaken, however the other side of this is the Hawthorne effect – staff will wash their hands correctly if they are being watched. This method could also be easier for groups of staff who have issues accessing PCs although this issue seems to have been overcome now as domestic and facilities staff have had training delivered to them verbally. This alternative way does put pressure on the clinical areas to decide who is going to assess the competence of the different staff groups, it would not be appropriate for a Band 5 to suggest to a consultant, for instance, that they are not competent in their hand hygiene; those undertaking the competencies would need to be confident in declaring someone else to be competent or not and, in addition, they themselves need to be declared proficient. Would this add more work for the IPC Team to have to assess the competency of others before they are able to assess their staff? It could lead to teams becoming insular and it is worth noting that during the Gloves off campaign the TURAS Hand Hygiene module was reported by staff to be a good source of education. The monthly hand hygiene audits would still be carried out by wards / departments as would the quality assurance audits by the IPC Team during an outbreak, so there is still assurances in place. Matthew Toms will be approaching Human Resources (HR) to ask for support / advice surrounding this proposal, Recommendations, from discussions had, suggest that this should be trialled in the specific area that approached Matthew Toms regarding an alternative way of assessing staff competence with ownership being on the Chief Nurse, Nurse Manager and Clinical Lead with support from the IPC Team and it was decided to bring it to this Committee for comment. DS asked the Committee members to consider the SBAR and contact the IPC Team if they have any questions. HC commented that it was an interesting proposal and it would be beneficial to test out as the eLearning module training does not necessarily prove, day to day, that staff are competent in their handwashing. Not sure that the hierarchy element would be necessary if staff would be trained appropriately (perhaps refer to them as a "champion" of their area) similar to the responsible persons for skin checks rather than having levels of seniority. It is everybody's business (the Be Kind to Remind type messages) and if there was a keen individual who could ensure good practice is spread through the area this would be positive. Not all areas are on safe care, that would need to be considered and a way of recording implemented.	

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4	**Matters Arising cont.**	JB added that it was an interesting concept but did have some concerns e.g. at present the SBAR focuses very heavily on SCNs and the nursing structures. As HC mentioned it is everybody's business and unsure that the right people have been identified in terms of that wider multi-disciplinary team (MDT); agreed with the comment regarding safe care and advised that health roster would need to be utilised if safe care is not available to record an individual's competence but not all areas have health roster and rollout has been paused at present. Keen to understand the evidence, literature reviews etc. to see if this type of change has been implemented elsewhere so that the Committee and others can make an evidence based decision. Also need to ensure that this is discussed with the chief nurses and wider conversations had, perhaps, within HAI Sub Groups. HCo also agreed with HC regarding the hierarchy point, any member of staff should be able to challenge poor practice; important to encourage and empower staff. Do not necessarily agree with the Hawthorne effect argument as, if this was the case, all hand hygiene audits undertaken (where staff are observed) would be 100%. If piloted would need to be able to evidence whether the pilot area actually improves their hand hygiene overall, this would give the traction to keep going with it. Is a fan of face to face training and feel that there could be room for a hybrid method and if successfully trialled could be introduced. DS thanked the members for their comments and stated that they are questions that the IPC Team have already asked themselves. With regard to the hierarchy comments DS has trained countless staff to carry out hand hygiene audits, many of them are Healthcare Support Workers (HCSWs) and they are very good but having been present when people have been challenged by different groups of staff when issues occur the potential for disregard is present. Will collate all comments.	
	Item 4.6	**PAG Process for non-compliant Hand Hygiene Audits (cascade to areas)** This is a reminder of the email that is sent out if a Preliminary Assessment Group (PAG) is required due to non-compliant hand hygiene audits. The information regarding the process to be taken is included in this email. The PAG should be convened and chaired by the Divisional General Manager (DGM) or equivalent senior manager, this reflects the importance of appropriate hand hygiene and when it's not carried out in effectively. Representation is also required from the team / discipline who have been non-compliant so that they can be involved in the conversations and decisions moving forward and to discuss how the IPC Team can support. The responsibility for a meeting to be scheduled, agenda to be prepared, minutes required to be taken and shared and action tracker to be completed is that of the area / service. For ease, templates for all these documents are included in the email sent. There has been some discussion recently around the scoring of the hand hygiene audits regarding opportunity and technique; these are the two things that a staff members has to get right to obtain a scoring percentage, however, if one of them is incorrect, then the score will 0%. The suggestion is that surely if either the opportunity / technique is correct there should be some kind of score for this. This was raised due to the fact that it could have a negative impact on staff morale but effective hand hygiene to reduce the risk of HAI to patients both opportunity and the technique must be correct; if the opportunity is not taken there is no technique to be seen.	
5	**Standing Items**		
	Item 5.1	**Sector Reports** **ARI** A report was submitted There were no escalation to the IPCSC from this report.	

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5	**Standing Items cont.**	No reports received from MUSC or CSS and Chief Nurses are dealing with this**.** **1 New Areas of Concern** **1 g) Unknown - Disposal corridor leaking pipe - New leak in corridor across from Theatres 1-4 disposal area** PIG® Roof Leak Diverter Bucket in place and working on plan to repair. **1 h) Unknown - Recovery – leaking tap - New leak from bed space 6 sink** Bed space currently not used. HAI SCRIBE has been signed off and awaiting confirmed date for works to be carried out. **1 i) Physiotherapy department – (non-patient area but in use by staff) - 4 sinks simultaneously overflowing with discoloured water**. Discussed with Estates, IPC Team and H&S Team. Await outcome from plumbers. DATIX – 428226 **1 j) High - Water ingress issues, within DOSA waiting room** Currently partitioned off and water containment in place. A plan is in place to install a macerator (Saniflow) and works should be completed between 5-8 July 2024. **1k) High - Clinic C – Water ingress issues** Room 9 and Spirometry Room 2 closures in place. Quotes have been received for the roof repairs. **2 Progress Against Areas of Concern Previously Reported** **2 a) High – Various water Ingress issues (Theatre 16, DOSA, Level 1 Theatre level)** More work to do surrounding this and will bring an update to the next meeting. GJ will check that the IPC Team are aware of these issues. **2 g) High - Breast Screening Clinic, Old Medical Block – leaks in various locations, roof defects in clinical and office areas** Good news as full roof replacement and extensive masonry repairs being undertaken. Internal repairs to follow. **2 h) Medium - Roof leaks in various locations within the Pink Zone. Defective felt coverings, on the balcony areas.** Repairs on Levels 6 & 7 have been completed. Levels 4 & 5 to be progressed imminently. Funds released via the Backlog Maintenance budget. **2 j) High – During recent HIS Inspections the standard of flooring has been highlighted as unsatisfactory** This was raised for 22 ward / clinical areas. Flooring rectification works being progressed in all 22 areas. High risk area works due for completion w/c 22/7/24. Separate HAI SCRIBE's to be submitted for ICU, ED, and AMIA) **4 Mandatory HAI Education Training Compliance Figures** Some changes can be seen in the figures from the last report; some good some not so good. GJ reminded the Committee that data on staff completion of the Clinical / Non Clinical Refresher training is required and should be included in all sector reports.	

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5	**Standing items cont.**	GJ queried the narrative in **2 m) High – Plastics Dressings Clinic.** "**IPC, management to discuss IPC supported SBAR for presenting to AMG for decision re temporary move**. Not aware of this action. Also queried was the Surgical Self-Assessment document under **3 Focus on Healthcare Improvement Scotland (HIS) Standards.** The deadline dates noted are October 2022 and January 2023. Could an update be provided please. **Children's Services** A report was submitted but no one from the service was available to speak to it **Women's Services** A report was submitted but no one from the service was available to speak to it. **Aberdeenshire H&SCP** A report was submitted AMc informed the Committee that at the time of writing the report there were no updates to be added, however, recently there seems to have been progress around some of the estates work across some of the sites. There seems to have been audits done that have picked up issues with paint work etc. and there was a plan to address that. **1 New Areas of Concern** **1 a) High – Braemar GP Practice now 2c Practice working as waterless** Following visit from Lead Nurse multiple issues had been identified as to how this is being implemented so an action plan is to be created to seek assurance. Seem to be in a better position now. Will update further at the next meeting. **2 Progress Against Areas of Concern Previously Reported** **2 a) Very High - Aberdeenshire Community Hospital Estates – multiple estates / compliance issues** These are various estates issues that have been flagged when SACCATs have been undertaken. Continue to have multiple issues especially at weekends. GJ queried whether this should be classed at very high; could it be reviewed? AMc stressed that these issues are regarded as very high by the group due to no funding to resolve the problems and so they continue, however, these issues do not impact on patient flow. GJ is worried that estates issues noted within the sector reports may not be captured in the work GK is undertaking so please ensure that issues are present on the risk register for the area. AMc will sense check this risk and refer back to the risk matrix. Will update, if applicable, for the next meeting. WS reiterated that the backlog maintenance budget sits at 600 million and works need to be prioritised. In addition the risk matrix must be used consistently to determine risk levels. Asked AMc to contact him after the meeting to discuss Aberdeenshire issues. **3 Focus on Healthcare Improvement Scotland (HIS) Standards** A Self-assessment took place with the HAI Sub Group looking at the leadership element of the standards and asking. Questions asked were: "was the group meaningful?" and "was there anything specific that the members	**GMck / GJ** **GMcK**

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5		thought that they should be getting from the meeting?" A form was sent out and feedback received was very positive. On the whole people have enjoyed coming together and enjoyed the communication aspect of the meetings; have tried to hold them as an integrated group where we have incorporated the care home element as well as other areas e.g. LD day centres. Some of the standards do not apply but do find that it is useful dialogue and individuals make contact and ask for support if there are any problems. GJ was interested in whether the format of group could be replicated and work in other areas. Has this exercise been discussed with anyone else? Might be worth a discussion after the positive feedback that has been received. AMc replied that Aberdeenshire is quite unique as it is the only area that owns nursing homes and very sheltered accommodation. Other areas will have other departments and services akin to this, but as these are owned buildings that NHSG nursing teams are working within. As well as maintaining a homely environment there's a lot of IPC learning that is undertaken. Happy to speak to HC and JWa at the next Chief Nurse huddle. **Aberdeen City CHP** A report was submitted. JWa advised that there were no new risks to escalate to the Committee. **2 Progress Against Areas of Concern Previously Reported** **2 b) High - Poor mandatory training compliance in majority of areas but particularly inpatient areas.** Clinical / Non Clinical Refresher training data has been discussed previously at local meetings. At the last meeting screen sharing took place to ensure those reporting training were aware of what was required. Hoping that this will ensure the correct information is provided for the next sector report. GJ suggested that the document (screenshots) on "How to check staff compliance for mandatory IPC Refresher Modules" could be shared again. AS will share. Also noted that there were 2 teams that had submitted the figures for Clinical / Non Clinical Refresher training so this is positive. **2 c) Medium - Various Facilities Concerns** These various issues are ongoing particularly around roofs - problems with youths climbing onto various the roofs. This has been reported to the police and has been a large piece of work. Not all issues sit with Estates but there is a lot of tape present in communal corridors which does look unsightly; all issues have been picked up during facilities audits and Estates are aware. **5 Areas of Achievement / Good Practice / Shared Learning from HAI related Reviews (Level 1. 2)**. There have been outbreaks in Ward 304 and Rosewell House and these have been managed well; however, Ward 304 have since experienced another outbreak which was prolonged and not managed as well. JWa suggested that this may be a consequence of nightingale wards. **Facilities** A report was submitted. **1 New Areas of Concern** There were no new areas of concern to escalate.	**AS**

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5	**Standing Items cont.**	**2 Progress Against Areas of Concern Previously Reported** **2 y) High - Decontamination Services – CDU, Mile End – Clean Room** issues with Central Decontamination Unit (CDU) have been escalating over the past week with regards to air flow / air pressure from the clean room into the washroom; extensive works undertaken that are still ongoing. An Incident Management Team (IMT) has taken place. Presently the process of changing out the heater battery, the chiller battery, the chiller itself and new panels are being fitted for the washers inside the clean room. Repairs will be made to all doors and ceilings to ensure this area is back up to spec – this will be happening over the next few weeks. GJ asked for it to be noted that the Infection Prevention & Control Doctor (IPCD) expressed concerns with the IPC Team at the IMT, who took these concerns on board, regarding the HAI risk with continued use of the CDU. The IMT felt that the risk to the Organisation associated with closing the CDU was greater. There will have to be a monitoring process for clinicians to scrutinise any increase in HAIs as a result of the concerns that IPC have raised regarding the functioning of the clean room. Waiting for assurance as to how this will happen. WS confirmed that a new particle counter will be delivered today to assist the monitoring of the room / equipment and environment. **4 Mandatory HAI Education Training Compliance Figures** GJ stressed the importance, again. of the reporting for Clinical / Non Clinical Refresher training. **<u>Dr Gray's / Moray HSCP</u>** A report was submitted **1 New Areas of Concern** **1 a) Low – Ward 6, Dr Gray's Hospital (DGH) QA Hand Hygiene Audit score of 75%.** Actions put in place. Area was re-audited with a score of 95% and a Preliminary Assessment Group (PAG) meeting was held 28 June 2024. **1 b) Low – Mice in Emergency Department** Pest control measures in place **1 c) Low - Flooring replacement required in Stroke Ward following water ingress** Flooring has now been replaced. **2 Progress Against Areas of Concern Previously Reported** **2 c) High - Flooding within Dr Gray's impacted on Records Department** No update available. **2 n) High - Water flushing identified as very poorly completed in areas visited within DGH as part of the HIS unannounced Inspection 9 -11 October 2023** Work still ongoing to gain assurance on improvement. **2 s) High - Compliance with Peripheral Venous Catheter (PVC) Bundles** Meeting has been arranged for 11 July 2024. 2 Level 2 Reviews have been commissioned.	

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5	**Standing Items cont.**	GJ asked for the risk rating for this issue to be added. In relation to Standard 4 under **3. Focus on Healthcare Improvement Scotland (HIS) Standards** GJ suggested that HC could add the PVC bundle audits here, when implemented. GJ felt that including the 5 Factor Risk Assessment table in the report was beneficial; helpful to see where the red and amber issues are in terms of physical environment. There do seem to be a number of red scores for the Safe and Clean Care Audits (SACCAs) is there any support IPC can provide to assist with this? ANd agreed that visual information is helpful but also suggested that actions taken to rectify the red and amber elements on the report could also be included to provide assurance. **<u>Mental Health & Learning Disabilities</u>** Report was submitted **1 New Areas of Concern** **1 a) Low – Raised Total Viable Counts (TVC) Levels – Fyvie Ward** Control measures put in place and assurance checks have been done. IPC nurses are aware. Pseudomonas has also been discovered in side rooms. Assurance checks have been completed, communication has been disseminated and a meeting was held w/c 24 June 2024; has been added to the risk register. LA also advised the Committee that JW has put into place an adaptation of the workplace inspection assurance check that is completed monthly and sent nurse managers; this is to gain assurance around compliance. GJ noted that the shower room has been used for storage purposes and has, therefore, not been flushed appropriately. This has been an issue in other areas within NHSG and asked whether there was any learning that MH&LD could share in an attempt to reduce the risk of recurrence in other areas. LA replied that the adaptation of the workplace inspection assurance checklist performed monthly ensures Senior Charge Nurses (SCNs) have oversight of all the storage areas to prevent recurrence. GJ added that various areas are performing health & safety walk rounds on a monthly basis now and perhaps water safety could be added to the checklist. Will investigate. GJ queried **2 c) Medium – Identified ventilation issues in wards that have windows permanently locked**. Is this present on the risk register and are there ongoing conversations being had? LA confirmed that work is ongoing around the ligature reduction wards and ventilation. Heat stress is a factor at present. No compliance data present for **4 Mandatory HAI Education Training Compliance Figures.** Could these be provided for the next meeting please. GJ noted the questionnaires that were developed for patients and family carers on the cleanliness of the hospital under item 5 **Areas of Achievement / Good Practice / Shared Learning from HAI related Reviews (Level 1. 2)** has been present on the report for some time. Would be interesting to see some of the responses / feedback from the family and cares, if appropriate. LA replied that this was a piece of work that she had progressed mainly due to the difficulties in engaging public representation at local meetings. Questions ranged from providing appropriate hand hygiene products to staff dress code / uniforms. LA interacted with patients and carers to advertise the questionnaire and a good response was received. May repeat the exercise later in the year.	**GJ** **JW**

Item	Subject	Action to be taken and Key Points raised in discussion	Action
5	**Standing Items cont.**	**Education Group Roundup** No report was available as no recent meeting was held. **Infection Prevention & Control Team (IPCT) Roundup** The roundup report was submitted **IPC Surveillance & HAI Screening** **Quarter 1 figures January – March 2024** **NHSG** MRSA CRA 55% MRSA swabbing 46% CPE CRA 65% CPE swabbing N/A National figures expected at the end of this month **Scotland** MRSA CRA 79% CPE CRA 78% Swabbing results not published For Quarter NHSG are below the national figures in both MRSA and CPE CRA **Quarter 2 figures April – June 2024** **NHSG** MRSA CRA 69% MRSA swabbing 37% (7 out of 19 patients swabbed as per policy) CPE CRA 74% CPE swabbing N/A as no patients with positive CRA The Quarter 2 figures show that NHSG have improved for both MRSA and CPE CRA, however, the MRSA swabbing has further deteriorated. GJ added that the IPC team are working with the Electronic Patient Record (EPR) Team to obtain larger sample sizes as this may improve the compliance percentage; at present NHSG use the National methodology which relates to the size of the Board. Once the larger sample size of information is available the 2 datasets will be used until sure that we are representing the correct data. **Incidents and Outbreaks** There have been 2 Preliminary Assessment Groups (PAGs) since the last IPCSC: • 1 x Water • 2 x Hand Hygiene :	

Item	Subject	Action to be taken and Key Points raised in discussion	Action
5	**Standing Items cont.**	There have been 3 Incident Management Team (IMT) meetings: • 2 x Legionella • 1 x Enterobacter Cloacae ESBL The IPCT have also attended the following service-led meetings to provide advice and support • 1 x Dr Gray's Health Records • 3 x CDU issues • 1 x Legionella **Built Environment** IPCNs & IPCDs are looking at ways of working to enhance current practice. • The Healthcare Built Environment SOP requires to be embedded in NHSG to reduce delays and risk to patients and staff • There are concerns regarding the increase of works happening within NHSG requiring IPCN input, complexity of areas and within NHSG settings, such as GP Practices, requiring assistance. • Baird & Anchor update: a recent water ingress report has been completed. The IPC Team continue to support both builds with ongoing weekly site visits and regular Teams meetings and we are awaiting feasibility reports. **Areas of Achievement / Good Practice** • IPCT has developed a Landing Page on TURAS where NHSG staff are sign posed to IPC training. This will be added to and updated as required. Currently, a sub-page relating to Patient Placement and Admission Screening is out for comment.	
	Item 5.2	**HAI Work Programme Delivery Group** Report was submitted. GJ asked all Committee member to please read the document and update as appropriate**.** One piece of recent work undertaken was the updating of the SABS / Clostridium difficile (Cdiff) posters for the quality boards to make them more interesting and visually appealing.	
	Item 5.3	**Risk Register** **ID 3498 – Healthcare Associated Infection (HAI) as a Consequence of Use of Non-standard Patient Areas** GJ or ANd attend these meetings, chaired by JB, to contribute IPC advice towards discussions. This is a balance of risk with patients requiring healthcare and the acute sector bed situation. No new risks have been added and mitigations remain in place.	

Item	Subject	Action to be taken and Key Points raised in discussion	Action
5	**Standing Items cont.** **Item 5.4**	**HAI Executive Committee Meeting Update** There has been no HAIEC meeting since the last NHSG IPCSC and therefore there is no update. The escalations raised at the 21 May 2024 meeting will be included for the next HAIEC meeting as will any escalations from today's meeting.	
6	**HAI Report to Clinical Governance Committee / Board** **Item 6.1** **Item 6.2**	**HAI Report to the Board (HAIRT)** There is no report due at this time. The July 2024 HAIRT will be submitted at the next meeting. **HAI Report to the HAI Executive Committee (HAIEC) (new escalations)** There were no new escalations raised by the Committee The item raised from 21 May 2024 meeting is included in the HAIEC report • Gaps in assurance from the ARI HAI Group due to low attendance at meetings JB added that the Chief Nurses have discussed and have a plan moving forward to address this issue.	
7	**AOCB** **Item 7.1**	**NHS Education for Scotland, Infection Prevention and Control (IPC) Education Team Newsletter** This is received by the department on a regular basis from NHS Education for Scotland (NES) but due to the format in which it is sent we cannot share with others. AS copied and pasted the contents into a word document for reference today. GJ highlighted the educational resources to the Committee, so that, if they feel any staff could benefit from the training advertised, this can be pursued.	
8	**Date of Next Meeting**	10 September 2024 10.00 – 12.00 via Teams (with a 10 minute comfort break)	