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

Minutes from meeting held 9 September 2025
Via Teams
10.00 – 12.00

Present:

ANd – Astrida Ndhlovu, Deputy Infection Prevention & Control Manager (Chair)
JW – Julie Wells, Chief Nurse MH&LD Service
CC – Caroline Clark, Chief Nurse, Combined Child Health
DR – **Dave Russell**, Public Representative
WS – Wayne Strong, Head of Maintenance and Technical Services
DS – Dawn Stroud, Senior Infection Prevention & Control Nurse
NM – Naomi Mandel, Public Representative
RM – Rachel Mennie, Antimicrobial Specialist Nurse
RL – Rachael Little, Team Lead - Quality Improvement & Assurance
CK - Charlene Kierzkowski, Nurse Manager, Intermediate Care Services (deputising for Julie Warrender)
MT – Margaret Taylor, Care Home Lead Nurse, Moray CHP (deputising for Helen Chisholm)
FM – Fiona Mitchell, Deputy Chief Nurse, Acute
PG – Paul Gough, Head of Business Services & Performance, Facilities (attending for / supporting Wayne Strong)
AW – Andrew Wood, Health and Safety Specialist, Health & Safety Department
NH – Neil Hendry, Lead Nurse, Aberdeenshire HSCP (deputising for Alison McGruther)
HCo – Helen Corrigan, Consultant Nurse, Health Protection Team

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**	Grace Johnston (GJ) Will Olver (WO) Amanda Foster (AF) Julie Warrender (JWa) Kathryn Auchnie (KA) Sarah Campbell (SC) Fiona McCallum (FMc) Helen Chisholm (HC) Alison McGruther (AMcG)	
2	**Minutes of last meeting 1 July 2025**	The minutes from 1 July 2025 were ratified by the Committee with no amendments. JW confirmed the narrative highlighted as Kerry Ross and AS amended.	
3	**Action Tracker**	**<u>Meeting 1 July 2025</u>** **4.4 CDI TURAS Module Compliance** The compliance data for this should be being reported on the sector reports. AMcG advised that Aberdeenshire CHSCP have a Microsoft form that is completed by ward areas on compliance; figures seem to be acceptable but will feedback to confirm this for the next meeting. NH confirmed this has been completed and is embedded within the Aberdeenshire CHSCP sector report. Close	

Item	Subject	Action to be taken and Key Points raised in discussion	Action
		GJ will contact Jane Ewen to discuss the situation around lack of compliance and put forward some of the points raised at the meeting. NH advised that there were reports run and tabled at the HAI Education Group regarding compliance of these modules. **Opportunity for some quality improvement work in terms of understanding the barriers around completing these modules** AS still to email Chief Nurses for volunteers to set up a group and meet to discuss how this QI work can be taken forward to improve compliance levels. **Validate the data extracted from TURAS. Approach to assist with the QI work taking place** ANd contacted NES and was redirected to the TURAS helpdesk. Awaiting a response. Will feed back at the next meeting **<u>Meeting 14 January 2024</u>** **4.3 Seasonal Pressures and IPC Measures - Staff vaccination rates and the fact that uptake has been poor this year** GJ was to discuss with JBa to agree a way forward. CC gave an update advising that JBa has spoken with the Chief Nurses. CC attended the Occupational Health Flu Programme Short Life Working Group (SLWG) chaired by Jill Matthew on behalf of JBa. There are a number of ideas to take forward, one of which is peer vaccination. MT asked how NHSG are aware that staff are attending appointments to receive their vaccinations; how is this data collated if staff do not attend a staff clinic? CC advised that OHS will not be aware if staff have received their vaccine as this is confidential information to the staff member. Chief Nurses have been having conversations around this and the fact that this vaccine is voluntary. Collecting this data or even asking this information could be perceived as putting pressure on staff to have it. 100% of staff are offered the vaccine and the aspiration is that 100% will but data cannot be collated as to how many do external to NHSG clinics. ANd wondered whether staff could be encouraged to inform OHS if they receive it externally to the organised clinics; perhaps this is something the SLWG could explore further. **5.1 Sector Reports** **Facilities & Estates - NNU** AS explained to PG that the Facilities & Estates Sector Report for January 2025 did not include required information on the NNU and that WS was going to resubmit it to the Committee as an update. It has not been received. PG then gave an update on the ventilation works so far but AS fed back that it was historic information that was not included. Previous minutes state "*an issue that within neonatal unit that wasn't included in the sector report. WS said that he would add it to the sector report and resubmit the report so that the committee members had a copy*" A discussion then took place regarding the reason for / content of the sector report with PG questioning the criteria for what is added for each meeting. The report has no action owners named and e.g. PG would suggest that the NNU issue is potentially a high risk, however, all other entries within the report are either a low or a medium risk. There are risks regarding water, leaks, plant design, fabric issues and roof design. The yellow zone in its entirety seems to be included but no specifics are noted and there are mentions of a plant room, equipment and non-clinical areas. What should / should not be included, what are the actions and how are things resolved and removed? ANd explained that the sector reports were to highlight any concerns / issues that Facilities and Estates may have across NHSG which can be discussed as a group and then escalated to the Clinical Governance Committee (CGC) and HAI Executive Committee (HAIEC) so that they are aware of the HAI risks.	

Item	Subject	Action to be taken and Key Points raised in discussion	Action
3	**Action Tracker cont.**	PG replied that some of the items on the report are not HAI risks and some that could be classed as this e.g. themes collated from audits performed by Lisa Leslie such as soiled bed frames, damaged doors, shower hose clips are not. ANd concurred and suggested that the main focus for this group are HAI related issues where there are concerns about IPC risks and how these can be addressed. In addition the issues that have been highlighted from independent audits could be IPC risks, Are they being addressed elsewhere and managed appropriately such that they do not need to be highlighted to this Committee? PG reiterated that if teams are being asked to give updates on specific issues within the report there is a need to understand the value of what issues the updates are referring to. PG to discuss with ANd outside of the meeting. WS confirmed that the narrative for the November report regarding NNU that was outstanding was input and stated that he will not be updating retrospective reports in future. (AS has not received this updated report). ANd asked if this action was to be closed. WS stated that it should be. FM advised that during the last 2 ARI HAI Sub Group meetings she was unsure of whether what was detailed within the Facilities & Estates report submitted should be included. Would benefit to either be part of the conversation between PG and ANd or receive some feedback to understand what is required moving forward. DR asked for assurance that any further Estates issues that arise within the NNU would be included in the report moving forward. Another discussion then took place regarding whether the recent fire risk within the NNU was an HAI risk due to the air handling unit having to be switched off for works / planned maintenance to be completed. CC advised that in response to DR's question regarding the specific areas it was useful to have this discussion. The NNU would be included on the Children's Services report and from a clinical service point of view, any HAI infection risks would be recorded here; this is where the crossover occurs. One example within the Children's Services report are the remedial works that Facilities & Estates were undertaking as a result of atypical infections; better that there is duplication within the reports though than not shown at all. **Meeting 19 November 2024** **5.1 Sector Reports** **ARI** **Items for Escalation - Staff removing clips from showers to enable fuller patient care. Increased risk of water borne infections.** WS fed back that there is a trial ongoing with a new type of clip which has an anti-tamper screw on it. Longer hoses have not been fitted. ANd enquired as to whether there have been issues / concerns with showering specific groups e.g. burns patients. WS replied that there are ongoing discussions between specific wards and Colin Cruickshank, but as a general rule, the new anti-tamper clips are being installed due to the risk of HAI. This is a requirement in terms of water management and the need to protect the water system but understand that there are other concerns which will also need to be addressed with certain areas.	**ANd**

Item	Subject	Action to be taken and Key Points raised in discussion	Action
		FM advised that this was not on the current ARI sector report as the report was submitted prior to the last meeting held but this will added as an item for escalation. There are issues for some clinical areas with regard to the anti-tamper clips as hoses are often removed to enable patients on trolleys to be showered. If this is not an option it will mean that the area will not be able to admit a specific type of patient, one of these being burns patients. There was a misunderstanding at the WSG that all burns are washed with sterile water but clinicians have produced best practice guidelines to show that this is not the case. ARI is a major trauma centre and so must be able to accept these patients, a compromise needs to be found. It was suggested that a risk assessment be written for these areas but it was felt that staff may not adhere to the guidance. It is a challenging situation but a balance needs to be found between the risk to the water system and NHSG, potentially, not being able to care for these patients. Hope to have a meeting soon to progress with this. GMcK joined the meeting at this point and had missed the discussion. Asked for confirmation (on the above plan) that the anti-tamper clips were to be fitted in all clinical areas except Burns and Plastics. WS replied that he could not comment on Burns and Plastics at this time as this involves further discussion with the clinical areas and Colin Cruickshank. Can confirm that the plan is for the clips to be installed in all other areas subject to discussions. GMcK asked for clarity on where this plan had been agreed as had not been part of / aware of these discussions. WS confirmed this had been a discussion at the WSG, decisions were minuted. GMcK queried if there had been any further consultation beyond the WSG and were there clinical colleagues in attendance at the meeting? WS replied that, yes, clinical colleagues do attend the WSG and Colin is having further discussions with the Burns Unit. GMcK will speak to WS regarding this outside of the meeting. **7.3 Cleaning Wipes within NHS Grampian - growing evidence suggests dry surfaces can harbour a biofilm and Boards are being encouraged to start using disinfectant wipes instead of detergent.** ANd has been working on an SBAR to propose a change of the cleaning wipes that NHSG utilise for shared equipment. Currently NHSG use the detergent wipes and if disinfection is required alcohol wipes are used or staff make up a chlorine solution using tablets into water. The proposal is to discover if NHSG can deviate from national guidance and move to using disinfectant wipes with the rationale that they are easier and quicker for staff to use and to capture patients that have not been tested where there could be a risk of infection which detergent wipes would not combat; in additions other areas within NHSG are utilising these wipes as are other Boards. SBAR is almost complete but need to discuss with JB **<u>Meeting 10 September 2024</u>** **5.1 Sector Reports** **Facilities & Estates** **2 aa) High - Decontamination Services – CDU, Mile End – Clean Room** WS advised that this update has not been added as previously mentioned but will be added to the next report; will not be updating earlier reports as previously indicated. Ventilation system is now functioning normally. WS asked for this to be closed.	
4	**Matters Arising** **Item 4.1 a)**	**Summary Report of External Inspections to NHS Scotland Boards (1 June – 30 June 2025)** A report was submitted RL gave an update on the report stating that there were no Healthcare Improvement Scotland (HIS) Safe Delivery of Care inspection reports published. There was, however, 1 IR(ME)R inspection noted for Western General Hospital which is incorrect and this is included, correctly, in the July report. There were also 13 Mental Welfare Commission (MWC) local visits	

Item	Subject	Action to be taken and Key Points raised in discussion	Action
4	**Matters Arising**	across 6 different health boards 1 in Forth Valley, 3 in NHSG, 3 in Greater Glasgow and Clyde, 4 in Lothian, 1 in Tayside and 1 in Western Isles. Missing from the report there was also 1 visit to Queen Margaret Hospital, NHS Fife which is part of the new expansion of the HIS Safe Delivery of Care inspections. Also to note that in June 2025, HIS published, on their website, their Regulation Plan and that is for the period of 2025 to 2026.	
	Item 4.1 b)	**Summary Report of External Inspections to NHS Scotland Boards (1 July– 31 July 2025)** A report was submitted In July 2025, there was 1 IR(ME)R inspection report, which is the one for NHS Lothian. There were no Safe Delivery of Care inspection reports and again there was 13 MWC local visits across 8 different health boards and 1 within the Scottish Prison Service. The Committee will be aware that, previously, there have been individual Safe Delivery of Care reports provided looking at areas of good practice to be highlighted, any themes or trends and suggested evidence should we experience a similar inspection within NHSG. That template is still being considered and will be provided as soon as it becomes available.	
	Item 4.2	**NHSG Cleaning Standards Group** ANd gave a verbal update advising the Committee that the last meeting was held 4/9/25 and was well attended by Facilities & Estates, clinical colleagues, IPC and the independent auditor. Discussions were had about trying to focus on themes from various cleaning audits and to see how best to support these to make improvements. The group are still reviewing the Terms of Reference (ToR) which we've shared with Facilities colleagues to just compare with other meetings currently taking place. Two items were discussed for escalation to the group • Chill beams - Access and cleaning has been a challenge. Estates colleagues encounter challenges in accessing clinical areas to be able to carry out the Planned Preventative Maintenance (PPM) for cleaning chill beams and, as a result, beams have become very dusty and are directly under patient care areas. It was decided to escalate this issue to the IPCSC to ensure that discussions could be had in relation to having access to be able to clean these effectively as they pose an HAI risk. • Information has been given at that group was that there are new National Cleaning Standards been a published (v6 July 2025) and these contain 3 additional risk coded areas. Currently NHSG utilise the A-Z codes for cleaning, but K, L and M have now been added. Facilities are looking at the document to understand how it can be implemented within NHSG and IPC support has been offered if required. ANd asked for the document to be shared for the next meeting so that the Committee have sight of the requirements stipulated.	
	Item 4.3	**CDI Exception Report Quarter 4: October – December 2024** ANd gave a verbal update on the CDI exceedance for Quarter 3 and Quarter 4 of 2024. A meeting was held 2 weeks ago to discuss the action plan and HSG is on track with in terms of managing C difficile in NHS Grampian. There are a few actions that are still outstanding and these are being worked on. The action plan has been shared for the Committee's information and ANd will take any questions or comments. GMcK asked whether the action "conduct WGS riboyping for severe cases or suspected outbreaks" had been discussed and if was there a plan or outcome to share? ANd replied that there is guidance in terms of who is required to be sent for ribotyping. The issue that was raised in the report received from ARHAI was that some patients had been missed and so the action was to liaise with labs to emphasise the	

Item	Subject	Action to be taken and Key Points raised in discussion	Action
4	**Matters Arising cont.**	importance that this was done and to refer to the guidance. DR asked for clarity on action 4 which states that the situation has been exacerbated by the lack of shared information to patient data; where does this action sit and how has it been escalated? ANd advised that this is regarding the IPCT not having access to some systems and therefor unable to access the data. There is a lack of shared information between primary and secondary care for some of the community patients and, in addition, the IPCT are not directly privy to that information. GPs are contacted to assist but sometimes there is delayed communication in sharing the requested date. DR considered this to be an issue if the ongoing action has not been escalated. GMcK agreed and suggested that perhaps digital teams could be of some support. Would like to see the action strengthened to be very clear about what the action is and a system or process to be developed to ensure that there is an interface between primary care and secondary care. Suggest discussing these issues with Steve Baguley who may be able to assist; can an update to this be given at the next meeting please. HCo suggested that if the information required form the GPs is not deemed urgent it is often an idea to email their generic email facility; the Health Protection Team (HPT) find that they receive slow stream information back quicker this way. ANd replied that the Surveillance Nurses do use the generic email addresses but also call then information is delayed so that process is in place, however, they can be slow to reply and this impacts on reporting. There is to be another meeting to review the action plan and ANd will raise, again, the communication between primary and secondary care.	**ANd**
	Item 4.4	**IPCT led PAG / IMT Roles and Responsibilities** These documents was attached for the information of the Committee. These were developed to assist NHS colleagues attending Incident Management Team (IMT) and Preliminary Assessment Group (PAG) meetings to understand the roles and responsibilities of those attending meetings; these are for IPC Team Led IMTs / PAGs not Service Led. The documents have been shared with the HPT for this comments / approval and brought to this meeting to ensure clarity. GMcK commented that they documents were clear and concise and asked how they are to be used; will they be sent out with the agenda etc. for every PAG / IMT? ANd confirmed they would.	
5	**Standing Items** **Item 5.1**	**Sector Reports** **ARI** A report was submitted which FM spoke to No items were listed for escalation at the recent meeting, however, since then shower clips have become a topic (as discussed earlier) and FM will feed this back to the group. **Historical Issues** There have been 2 risk assessment completed • Euro bins dirty and lids flipped right back, doors unlocked - also picked up on recent fire walk round. Captured on SACCA audit • SACCA Audit - Advice from IPCT was that staff should not be washing hands with patients in close proximity and should move any equipment where possible Nurse manager to review and will then update for the next meeting.	

Item	Subject	Action to be taken and Key Points raised in discussion	Action
5	**Standing Items cont.**	. No reports received in July for Facilities & Estates or Integrated Specialist Care Portfolio (ISCP) but received for August meeting. Meetings may have fallen out of sync so will investigate. **1 New Areas of Concern** **1 a) High - Leak from ceiling in Dietetic Lead office -Possible asbestos in the ceiling - water is dirty** Cannot use office space but this is not a clinical area. Bucket in place to catch water. Update required for next meeting. **1 b) High - Ward 308 closure due to COVID outbreak** Layout of ward means it is a high risk area for outbreak. Now re-opened, reflect on any lessons learned and ensuring early identification of infection. **1 c) High - Ward 110 closure due to COVID outbreak** Patient walks with purpose. Ward has reopened and there are no concerns. **1 d) High - Non compliant hand hygiene audits in wards 104, 402 / 403, AMIA and ED** This is disappointing to see, so a lot of work in being undertaken with the teams. The Emergency Department (ED) is difficult due to the footfall and the number of external personnel that move through it. it is often these staff who contribute to the non-compliance so education can be difficult to undertake, however, all areas are working with their IPCNs to increase their compliance and hopefully there will be improved figures for the next meeting. **1 e) High - Ward 108 flushing records now electronic but concerns over assurance as not able to view data** Concerns were that the data was able to be viewed as regularly as needed and that the data seen was not providing the level of assurance needed. A meeting was held and the decision made to go back to paper records until the electronic system can be simplified. **2 Progress Against Areas of Concern Previously Reported** **2 j) High – Ward 216 shower issues – 3 out of use while work is underway to complete mould and ventilation issues** There have been issues with Pseudomonas and PAGs and IMTs have been held and in August there were further issues with Pseudomonas present within patient's wounds. No update was given at the recent ARI HAI Sub Group meeting but measures have been put in place. Will monitor. **2 m) High Clinic E - Various heating and roof leaks, reported throughout the clinic** There have been revised costs received put forward for potential solutions these are sitting with the Facilities & Estates. Will continue to report as high risk. **2 n) High - Orange Zone, Clinical Pharmacology - Multiple roof leaks reported impacting on service delivery** Repairs were being undertaken so FM will liaise with Facilities & Estates and remove this issue if it is complete. **2 t) High - Yellow Zone Glass Corridor – Level 1 – works ongoing corridor closed.** Has been added to this report but as discussed earlier is this an HAI risk? Due to be complete and corridor open in 2 weeks. **2 x) High - Safe Transfer of care - initial implementation required patients to be housed in non-standard bed spaces** Aware that Surgery have additional beds also. Risk assessment in place and monitoring the cleanliness of the environment via the SACCAs ensuring that they are being done at the 6 monthly point. Will continue to be a risk as long as there are non-standard bed spaces in use, which is daily at the moment. There is obviously an impact around being able to keep the environment and equipment clean. Using the SACCA ensures more data is available to be viewed.	

5	**Standing Items** **Item 5.1**	**2 z) High – Staff finding it difficult to shower patients due to clips on the shower hoses** As discussed earlier this is an ongoing issue and hoses are being removed from clips. Cannot be removed from the report until there is an alternative solution in place. If the solution is anti-tamper clips then areas that cannot use this system will have to be looked into and a solution sought. **2 aa) High - Mandatory training compliance is low across the portfolio** There are still problems with reaching acceptable compliance with figures currently 40 – 60%. Current operational pressures mean that staff cannot be released to complete their training. Will remain on the report. **2 ad) High - Ward 111 have had another non-compliant hand hygiene audit (3rd)** Although a PAG was held it has been closed with no further action. There has been no hand hygiene data uploaded to illuminate for July or August. FM has been in touch with the Nurse Manager and Charge Nurse to stress that updated audit data is required as a PAG cannot be closed while there is no assurance in place. ANd asked FM about the issue of the dirty chill beams that was raised at the NHSG Cleaning Standards Group. Should this be included in the ARI sector report and how will it be taken forward. FM will add to the report. **Children's Services** A report was submitted which CC spoke to. **1 New Areas of Concern** **1 a) High - Pest control issue in RACH (maggots and flies) – 2 Theatres & Surgical ward** Theatres were closed for approximately 2 weeks with the issue found to be dead birds in roof space. Reopened but continued to have an issue with flies. After a 2nd investigation there were found to be more dead birds and so some of the Theatres were close again. Remedial works saw Estates seal off roof space above theatres, extensive cleaning of accessible guttering in vicinity of theatres, replacement of damaged insulation and flashing repairs. A fault was also found in the plant room above theatres which had been leaking creating stagnant pools of water; this was repaired also. IMTs were held and deep cleaning undertaken. Further remedial works are required to roofing which will require shutdown of all theatres for a period of time; Estates preparing business case. A doctor's office within the Surgical ward (not a clinical areas) also experienced issues with maggots falling from the ceiling. This has been added to the risk register until such times as there has been a permanent fix undertaken. **2 Progress Against Areas of Concern Previously Reported** **2 a) Medium - Extreme heat as windows not able to be opened in clinical areas due to ongoing building works** This is not a new issue and has been on report for some time. **2 b) Medium - Increasing leaks from burst pipes to radiators and heating units in ceilings** This has also been present on the report for some time. **4 Mandatory HAI Education Training Compliance Figures** Mandatory training figures are satisfactory; some areas require attention but overall they are acceptable. There are 2 areas where SACCAs are out of date, the Senior Charge Nurses are aware that these need to be undertaken.	

Item	Subject	Action to be taken and Key Points raised in discussion	Action
5	Standing Items cont.	Hand hygiene has improved, this has been an issue previously within the Surgical ward which was continually failing. Improvement work has been undertaken and with some of the issues resulting from multiple visiting specialties but generally, staff have been receptive and the ward is now in a better position. DR raised the issue of the extreme heat and noted that the options of a heat management system and mechanical ventilation had been looked into. If there was a mechanical ventilation solution there would be some sort of screen or filter put in front of the mechanical device. Have Estates looked into putting a similar screen or filter into the window space to enable some windows to open? WS replied that with Royal Aberdeen Children's Hospital (RACH) it is difficult because it was designed as a natural ventilation building; it was designed to have the windows open. The issue, at present, is as that the windows cannot be opened due to the Baird and Anchor building works but as the majority of the outdoor works at the Baird are now complete perhaps as a group the possibility of allowing the windows to reopen needs to be discussed returning the building to as per design. There is some ventilation in RACH however installing a full ventilation system in that building will be too expensive. In reality screens for the windows would have to be very small; the only time we use screens is to prevent the suicide risk and these would not be practical for screening out particles, dust etc. which create an HAI risk. CC added that some areas within RACH would not benefit even when windows are opened e.g. Outpatients as this area becomes unreasonably hot due to a plant room being either above or below it. WS offered to visit and assess the problem to gauge whether anything can be done to help. **Women's Services** A report was submitted but no one form the Service was available to speak to it. **Aberdeenshire H&SCP** A report was submitted and NH spoke to it. **1 New Areas of Concern** **1 a) High - Water safety - Shower at KCH** Works have been undertaken to upgrade the shower. Initially this was in relation to the flooring due to the water escaping out under the door and into the corridor but more work was done than expected which was positive, however, there has now been Pseudomonas found in the water. At present it has not been found in any other outlets and contractors have returned 3 times to complete remedial work. A PAG was held 3/11/25 and from that the decision was made to flush the outlet for 3 minutes daily and record this for assurance purposes. One of the issues that has been found is that the water is still escaping under the door even after the works. The contractor is now suggesting that the water pressure be reduced in that shower to alleviate that problem. Further sampling is to take place and works undertaken to replace some parts of the pipe fittings; the water system within the area will need to be shut down for a minimum of 4 hours and there is no date at present for commencement. **2 Progress Against Areas of Concern Previously Reported** **2 d) High - Lack of Face Fitters and staff training for Face Fit Testing across teams in Aberdeenshire** There has been an improvement here with an increase in the uptake of face fit testing numbers and face fit testers so this has been reduced to medium. **4 Mandatory HAI Education Training Compliance Figures** The compliance rate for Aberdeenshire is 82% which is a great accomplishment. There are a couple of areas which have been problematic – safe management of linen and safe management of the care environment but these are being looked into.	

Item	Subject	Action to be taken and Key Points raised in discussion	Action
5	Standing Items cont.	The figures were collated and shared at the HAI Education Group in August and the form will be reissued for completion and updated figures submitted at the next meeting in October. All SACCAs are up to date, any key themes relate to backlog maintenance. Illuminate report data has improved but there is still work to be done around this. AW asked NH if the Face Fit Team had been approached regarding training needs. NH replied they had been contacted and in addition NH sits on the Face Fit Team Group. **<u>Aberdeen City CHP</u>** A report was submitted and CK spoke to it **1 New Areas of Concern** **1 a) High - Incorrect waste being put in bins outside Wheelchair Department** This waste has consisted of electrical items, bits of metal, card etc. leading to the porters are having to spend a lot of time segregating the items and disposing of them appropriately. JWa has undertaken some targeted work with the Wheelchair and surrounding Departments regarding appropriate waste and recycling. Team will contact Neil Duncan for any further support. **2 Progress Against Areas of Concern Previously Reported** **2 a) High – Key themes from SACCAs include shower hose brackets being broken and shower hoses on floors** This is in hand and shower hoses have been replaced / ordered for replacement. This is predominantly happening within Rosewell House. **2 b) Medium - Surge beds opened in Rosewell House being staffed by Agency and bank staff** All surge beds are now closed. There are no agency staff within the building or use of any supplementary staffing and in the closed areas water flushing is taking place. **2 c) High - Poor mandatory training compliance in majority of areas but particularly inpatient** All Senior Charge Nurses have been asked to focus on improving IPC mandatory training figures for the next meeting. Frailty and Rehabilitation were looked into recently as preparation for the next in-house meeting and the figures look to have improved which is positive. **5 Areas of Achievement / Good Practice / Shared Learning from HAI related Reviews (Level 1. 2)** Ward 304 has recently been closed with COVID but IPC were happy with the way that the area had responded, as a nightingale ward, as it was identified quickly and escalated appropriately enabling the ward to reopen. Since then the ward has been closed again and this was thought to be due to a patient who walked with purpose but again, it was identified quickly and control measures were put in place. GMcK asked a question regarding the 5 Factor HAI Audits stating that it would be helpful to know if the appropriate risk assessments are in place for the red and amber areas. CK will raise this with JWa who will confirm at the next meeting.	

Item	Subject	Action to be taken and Key Points raised in discussion	Action
5	Standing Items cont.	**Facilities** No report was submitted. WS advised that as per earlier discussion there was no Sector Report submitted. There needs to be discussions had between PG WS and a few others around what should be included in the report. WS went on to report on some issues. **RACH Theatres:** The Committee are aware from an earlier update from CC that this area was shut down for a period of time. This issue is resolved and Theatres are back in action. **Chill beams:** This has already been mentioned and is going to be a very disruptive piece of work when it commences. Unsure at the present time how the to achieve the works and keep the parts of the site, in question, operational. **Blair Unit, Royal Cornhill Hospital**: There are significant areas of mould in some of the bathrooms in the unit and a couple of bathrooms have been closed down due to being particularly bad**.** **Ward 216 IMT:** Are introducing new drain covers to the ward. Trials are taking place at present and the chosen item will be rolled out after the process is complete. **Water Management, Fraserburgh Hospital:** The hospital has got Point of use Filters (POUFs) in place but aware that there are a number of dead legs and a number of leaks, very similar to Peterhead Community Hospital where there were high Legionella counts. NH asked for details regarding these works as was unaware of there being an issue. WS advised that this has been an entry on the Facilities and Estates sector report for some time now; also installing new boilers for the heating system at present which will also feed the water through to the hospital. Peterhead hospital's water issues have been addressed and after Fraserburgh's have been dealt with the move will be to address all community hospitals as monies allow. **Risk Management:** As a Committee we need to discuss risk, risk management and how issues are given the risk rating they are as there seems to be great variation in risk levels. If we cannot risk assess effectively the works cannot be prioritised correctly. ANd agreed and suggested that it could depend on where the risk is within the work area e.g. clinical teams focus the risk around patients. WS reminded the Committee that NHSG have a risk matrix to gauge priority and that is what should be used. Are the risks being artificially raised in some cases in the hope that it will then be dealt with quicker? Risk assessment must be consistent. FM reminded WS that the risks from the ARI sector report are decided upon by the people who submit their reports to the HAI Sub Group and so they have already been decided. FM merely brings them to this meeting as the Chair of that group. CC agreed with WS but suggested that clinical staff may be looking at it from a different angle. Agree, in principle, that as a board, it is no use to the Facilities & Estates Department if everyone is scoring their risk from a different perspective. When the new NHS Scotland risk matrix is launched that and having those conversations might help us all. GMcK added that this is a very relevant piece of work that needs to be undertaken not just for this group but for other groups also. There should not be different standalone risks across all of the risk registers. NHSG has a new corporate risk advisor in post so the Committee should consider linking in with them. Happy to be around and to support that work.	

Item	Subject	Action to be taken and Key Points raised in discussion	Action
5	Standing Items cont.	AW informed the Committee that the risk matrix, although it has been changed, will not be officially brought into line until the Adverse Event policy has been reviewed and this is not to be reviewed until next year. With regards to risk management, fully understand the comments made, but the same risk may be different in a different location, e.g. a water risk in one area may be minimal but could be deemed to be high in another place due to effects on the service. Must be cautious of taking a cross party look at all risks. WS commented that the new risk matrix seems to be available on the NHSG Intranet site. AW is aware of this and a note has been placed on DATIX to explain that the new matrix should not be used at present. RL will highlight the risk matrix with the new colleague who has commenced secondment as the new Corporate Risk Advisor and provide a response. **Dr Gray's / Moray HSCP** A report was submitted which MT spoke to. **1 New Areas of Concern** There is only 1 entry, however this is a medium risk around face fit testing so will not discuss. **2 Progress Against Areas of Concern Previously Reported** **2 c) High - PVC bundle compliance** There is ongoing work around this. Discussions Discussing have been had at SCN A&A meetings in DGH. All wards completed audit in either June or July but scores in many areas indicate improvements needed. Awaiting policy distribution and will provide training and awareness sessions. **2 d) Low - Theatres DGH – oversight / sign off of decontamination processes was carried out by Deputy Service Manager who has left her post.** This was a high risk but has been deemed low now that this post has been filled. **2 f) High - Lack of face fit tested staff at DGH & lack of understanding re aerosol generating procedures** There are now 6 trained face fits testers in DGH and they are working through prioritising staff groups to ensure staff are receiving the required training. **1 g) Medium - Inconsistent compliance with Patient Placement Tool led to patient with ESBL cared for in 4 bedded bay prior to identification** This risk has been lowered. The plan is to include the PPT within the documentation audit. A robust plan is in place to ensure completion of audits in September **Mental Health & Learning Disabilities** Report was submitted which JW spoke to. There was 1 new risk that occurred and this was not included on the report **Blair Unit, Royal Cornhill Hospital** The unit is undergoing significant refurbishment at present. 1 of the wards is significantly smaller at the moment than normal and the ventilation system has broken in the past couple of days which appears to have led to mould growing in a couple of the bathrooms. Estates attended 8/9/25 to assess, have not received an update as yet but this issue is being managed.	**RL**

Item	Subject	Action to be taken and Key Points raised in discussion	Action
		A PAG may take place, this is being discussed. **2 Progress Against Areas of Concern Previously Reported** All ongoing risks remain the same with no real changes to update on. **4 Mandatory HAI Education Training Compliance Figures** On track with all mandatory training but still experiencing problems with the clinical and non-clinical refresher data as the issue of "double counting" is still present. Some work still to do on Donning and Doffing. Have had some issues with uploading the hand hygiene data to Illuminate and are in discussions with Matthew Toms regarding this. 5 factor HAI audit data is as shown with Kildrummy ward showing as red due to this no longer being a clinical area. SACCAs will be completed this month. **5 Areas of Achievement / Good Practice / Shared Learning from HAI related Reviews (Level 1. 2)** • JW fed back on the questionnaires developed for patients and family carers on the cleanliness of the hospital (these will go back to the PEG (Public Empowerment Group) for their involvement and oversight). LA the Quality improvement Nurse, has completed an audit in the adult mental health wards looking at feedback on the estate and its cleanliness. There were 28 responses from patients and 27 from visitors and the feedback was very positive. **Education Group Roundup** The roundup report was submitted which DS spoke to. **Mandatory Training** **Protected Learning Time** DS has been supporting Tracy Leete with this from a subject matter expert perspective for IPC and through a senior infection control network meeting there was also contact with Elizabeth Lorimer, who has been the project manager; this was a very useful meeting with regards to general IPC education. Elizabeth gave an overview of the whole PLTW and asked the group how frequently we felt that IPC training should be done. **Education** **Aseptic Technique** The aseptic technique pictorial guide that has been developed by the PEF Team and RACH. They are still waiting to undertake an audit which will close the loop and the aim is for an update to be presented to the HAI Education Group for the next meeting on 7/10/25. This will be rolled out across NHSG for anyone who wishes to utilise it. **Additional Learning Opportunities with IPCT** IPC are accepting students from all nursing year groups and can potentially accommodate all healthcare groups to join them for an Additional Learning Opportunity. This option has become available as we no longer take students for full placements as they need to have far more clinical input than the team are able to give them resulting in us having to find them SPOKE placements. Places are available in both Aberdeen and Elgin Monday to Friday to have students from all staff / year groups to come and spend some time with us. If your areas have any students who would like to spend time with infection Control, please do get in touch via the generic e-mail address and you will be directed to an IPCN. **International Infection Prevention Week – 19th - 25th October 2025** IPC Team are planning to run an IPC road show to be held in the Suttie Centre. The proposed date is 23/10/25 and there will more communication around that closer to the time	

Item	Subject	Action to be taken and Key Points raised in discussion	Action
5	Standing Items cont.	**<u>Tissue Viability</u>** Ines Pereira has listed some study days. One is on 15/10/25, October at Curl Aberdeen and the other is on 16/10/25 at Moray College. **Audit & Assurance** The SLWG has updated the bundles for Peripheral Vascular Devices and Central Venous Catheters CVC); information is in line with the National Infection and Control Manual. This also ties in with the new Venous Access Device Policy (VADP). When the VADP has been ratified there will be communication circulated regarding the bundles, and device audit. **Education Reporting** Aware that there are issues on reporting Clinical / Non Clinical Refresher data. This is a national issue. As well as the reporting combining the two refreshers together it also shows that those staff, who are less than 1 year in post in Grampian are non-compliant, which is incorrect. Issues have been escalated. **Scottish Infection Prevention and Control Education Pathway (SIPCEP)** As part of NES' ongoing governance assurance process, they are reviewing the educational resources published in the Infection Prevention and Control (IPC) Zone. It has been identified that the SIPCEP improvement layer contains content that duplicates material available in the Quality Improvement Zone. To ensure consistency, reduce duplication across NES zones, and enhance value for learners, they will be undertaking a review of this layer as part of the broader IPC framework work currently in progress. In the interim, they will be unpublishing the SIPCEP improvement layer resources and users will be redirected to the Quality Improvement Zone for the most current and relevant materials. More information will be shared when available **Why Infection Control Matters module and assessment from NES, available on TURAS** This has been updated and is now live. **Escalations** Inaccurate TURAS reporting for IPC Refresher for Clinical Staff and for the IPC Refresher for Non-clinical Staff. Whilst the Uniform Policy is not owned by IPC, although there are aspects of IPC requirements are contained within it, concern exists across NHSG that the policy is not being adhered to. It is felt that education and strong messaging is required. **Areas of Achievement / Good Practice** Child Health have shared that they undertake statutory, mandatory and core training days to provide staff with knowledge that they require with the aim of improving practice. They have also shared further good practice having developed the "Ready to Round Checklist". The aim is to ensure that all staff are ready and prepared from an IPC perspective to carry out ward rounds. **<u>Infection Prevention & Control Team (IPCT) Roundup</u>** The roundup report was submitted which DS spoke to. **Multi-Drug-Resistant Organism (MDRO) screening compliance** **MDRO screening compliance Q2 April - June 2025**	

Item	Subject	Action to be taken and Key Points raised in discussion	Action
5	**Standing Items cont.**	Wards covered are 109, 112, 205, 217, 403, 5 DGH NHSG MRSA CRA 67% (down from 75% in Quarter 1) NHSG MRSA swabbing 60% (down from 63% in Quarter 1) 24/40 patients were swabbed as per policy National MRSA CRA **(awaiting figures)** NHSG CPE CRA 85% (same as Quarter 1) NHSG CPE swabbing 100% (1/1 patient swabbed as per policy) National CPE CRA **(awaiting figures)** **Incidents and Outbreaks** There have been 2 Preliminary Assessment Group (PAG) meeting led by the IPCT since the last IPCSC • 1 x Staphylococcus aureus bacteraemia • 1 x Pseudomonas There have been 4 Incident Management Team (IMT) meeting led by the IPCT since the last IPCSC: • 4 x Increase in Mycobacterial line infections The IPCT has attended 18 service-led meetings to provide advice and support on Pest Infestation **CDI Data Exceedance** This has been discussed earlier in the meeting. **Audit and Assurance** **<u>Hand Hygiene Programme</u>** The Hand Hygiene Improvement Programme will run from August 2025 to February 2026. This will follow a structured stepwise approach based on the World Health Organisation Multimodal Strategy on HH improvement. A minimum of five Hand Hygiene (HH) Assurance Audits will be conducted per month by the IPCT during this period. This doesn't affect the monthly hand hygiene audits carried out by the clinical teams. **<u>Readmission of patients with a previous Multi Drug Resistant Organism (MDRO)</u>** The IPC Team have been looking at the readmission of patients with previous MDROs and we provide a report on a monthly basis. From 13/6/25 to the 12/7/25 a total of 386 patients with a history of MDROs were readmitted, 86 of which were excluded due to being either day cases, outpatients or readmissions to Aberdeen Maternity Hospital (AMH). 55% of those did not have a PPT completed, which is down from 58% in the May / June data. 65% of patients that were placed in a Non-Standard Patient Area (NSPA) did not have a PPT completed, which is down from 71% on the previous month. As a team, we continue to promote the use of the PPT for safe and appropriate placement of patients. **<u>National Cleaning Services Specification</u>** ANd has already fed back that a new version of this has been released.	

Item	Subject	Action to be taken and Key Points raised in discussion	Action
5	**Standing Items cont.**	**Built Environment** **Baird and Anchor Update** • Room Data Sheets & Environmental Matrix review continues. • Await results of air sampling and report for the ANCHOR centre. Commencement of Water & Ventilation Groups. • IPC concerns regarding fan coil units within corridors that require ongoing access, & clean to dirty air flows. • Discussions also continue regarding construction phase water management plan. • Silo working continues with further smaller projects commencing within both Baird and ANCHOR. **IPCT Workforce** 2 long term sick 1 Maternity Leave This leads us to having to prioritise work and evaluate. In addition meetings need to be considered and whether there is a need to attend all. DR asked a question around discussion that have been had on Environmental monitoring of air quality being outsourced. Has this been resolved? ANd was unaware of this. DR will investigate further.	
	Item 5.2	**HAI Work Programme 2025/26** ANd asked the Committee members to access the document and provide any updates they feel are pertinent.	
	Item 5.3	**HAI Executive Committee Meeting Update** There were no escalations from this Committee to the HAIEC	
6	**HAI Report to Clinical Governance Committee / Board**		
	Item 6.1	**HAI Report to the Board (HAIRT) – July 2025 (for ratification)** The report was included in the papers. AS asked for members to review the document and email with any amendments or ratification by 16/9/25 so that the report can be sent to the HAIEC for approval.	
	Item 6.2	**HAI Report to the HAI Executive Committee (HAIEC) (new escalations)** ANd suggested the following be escalated • Shower clips AS suggested this may already be an escalation, included in the report to the HAIEC but will investigate • Chill beams	**AS**

Item	Subject	Action to be taken and Key Points raised in discussion	Action
7	**AOCB** **Item 7.1**	**Hand Hygiene Improvement Programme** ANd gave an update stating that the program is ongoing and in August IPC audited 8 wards and out of that 8 only 2 achieved a full compliance whilst the others were scored low. We are issuing shared learning and asking for an action plan for areas that have not reached the compliance. The team continue to raise concerns in areas where low levels of compliance are identified. Some of the issues we have come across are • some clinical areas are not completing 20 observations which are required per month • some areas completed 2 or 2 observations and because there is a note on the audit document that states " I have got no further audits to add" when that is selected, even if only 1 audit has been completed the system marks the audit at 100%. Have spoken with Health intelligence to see if there is a work around for this in terms of having staff complete those 20 audits • Illuminate scores are different from what is required nationally. 90% is classed as full compliance, whereas national compliance starts from 95%. Health intelligence is looking into this also. The planned actions from an IPC perspective are to undertake refresher training with the Glitterbugs to raise compliance on the wards, to work more closely with SCNs and to continue auditing throughout of September. Updates will be shared as to how the programme is progressing.	
8	**Date of Next Meeting**	25 November 2025 10.00 – 12.00 via Teams (with a 10 minute comfort break)	