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

**Minutes from meeting held 13 January 2026**
**Via Teams**
**10.00 – 12.00**

**Present:**

**GJ – Grace Johnston,** Infection Prevention & Control Manager (Chair)
**ANd – Astrida Ndhlovu**, Deputy Infection Prevention & Control Manager
**JM – Julia Mutch**, Chief Nurse, MH&LD Service
**CC – Caroline Clark**, Chief Nurse Combined Child Health
**WS – Wayne Strong,** Head of Maintenance and Technical Services
**RL – Rachael Little**, Team Lead - Quality Improvement & Assurance
**FMu – Fiona Murray,** Nurse Manager, Woodend Rehabilitation Service (deputising for Julie Warrender)
**AW – Andrew Wood**, Health and Safety Specialist, Health & Safety Department
**GMcK – Grace McKerron**, Chief Nurse
**AMcG – Alison McGruther,** Chief Nurse, Aberdeenshire CHSCP
**AF – Amanda Foster**, Public Representative attended part of the meeting)
**LC – Lisa Charles**, Domestic Services Manager, Aberdeen City (deputising for Fiona McCallum)
**DS – Dawn Stroud**, Senior Infection Prevention & Control Nurse
**DR – Dave Russell**, Public Representative
**HC – Helen Chisholm**, Chief Nurse Moray HSCP
**LMac – Lindsay MacLaren**, Chief Nurse, Ambulatory Care, Dr Gray's Hospital

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

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| 1 | **Introduction and Apologies** | Will Olver (WO) Sarah Campbell (SC) Fiona Mitchell (FM) Helen Corrigan (HCo) June Barnard (JBa) Naomi Mandel (NM)<br><br>GJ introduced Amanda Foster (AF) Public Representative to the Committee. | |
| 2 | **Minutes of last meeting 25 November 2025** | The minutes from 25 November 2025 were ratified by the Committee with no amendments. | |
| 3 | **Action Tracker** | **<u>Meeting 9 September 2025</u>**<br><br>**3 Facilities & Estates**<br><br>**Content of the sector report and criteria for what is added for each meeting**<br>GJ has not yet managed to liaise with FM on queries regarding the Facilities & Estates topics within the ARI report and what needs to be captured. Has spoken with Paul Gough regarding the Facilities & Estates report and will contact FM separately | |

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| | | **4.3 CDI Exception Report Quarter 4: October – December 2024**<br>The IPC Team has limited access to information and the Surveillance Team are experiencing delays in receiving feedback from GPs when questions are asked. ANd made contact with the team that looks at primary care documentation and they have replied asking what level of access IPC require so that the data in the system is not compromised.<br><br>**5.1 Sector Reports**<br><br>**Facilities & Estates**<br>Risk Management: It was noted that the new risk matrix is present on the NHSG Intranet but should not be utilised until Adverse Event Policy has been reviewed.<br>RL highlighted this issue to Michelle Hankin and was to confirm the process undertaken to ensure all staff are utilising the correct version. The tracker was updated to note that, in 2026, an internal risk audit will be undertaken reviewing actions, actions plans and the use of the new matrix. Close.<br><br>**Meeting 1 July 2025**<br><br>**4.4 CDI TURAS Module Compliance**<br><br>**GJ will contact Jane Ewen to discuss the situation around lack of compliance and put forward some of the points raised at the meeting.**<br>GJ spoke with Jane Ewen and this will be incorporated into the statutory / mandatory guidance work as gaining assurance from TURAS is an issue with staff feeding back that the system is not producing accurate data when running reports. Attempting to secure NHS Education for Scotland (NES) support to ensure reporting is factual and correct.<br><br>**Opportunity around this for some quality improvement work in terms of understanding the barriers around completing these modules**<br>AS still to contact 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.<br><br>**Validate the data extracted from TURAS. Suggestion that NES be approached to assist with the QI work taking place.**<br>This is the same situation as above.<br><br>**Meeting 14 January 2024**<br><br>**4.3 Seasonal Pressures and IPC Measures - Staff vaccination rates and the fact that uptake has been poor this year**<br>GJ has been attending meetings when able. Needs to be a bit more support and education / information for staff to try and encourage compliance and uptake of the vaccine. This will be led by Occupational Health Services (OHS) and Public Health for next year. Close<br><br>**Meeting 19 November 2024**<br><br>**5.1 Sector Reports**<br><br>**Items for Escalation - Staff removing clips from showers to enable fuller patient care. Increased risk of water borne infections**<br>Anti-tamper clips will be put in place and will only be removed in certain areas e.g. Burns and Plastics after a risk based | |

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| | | approach is taken (i.e. a supported risk assessment) as showering is a part of the patient's specific treatment.<br>Close<br><br>**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**<br>This is on the agenda for an update to be given. | |
| **4** | **Matters Arising**<br>**Item 4.1 a)** | **Summary Report of External Inspections to NHS Scotland Boards (1 November – 30 November 2025)**<br>RL spoke to the report.<br><br>There were 2 Safe Delivery of Care inspections undertaken and 1 IR(ME)R inspection. The requirements, recommendations and areas of good practice are listed within the report. | |
| | **Item 4.1 b)** | **Summary Report of External Inspections to NHS Scotland Boards (1 December – 31 December 2025)**<br>RL spoke to the report.<br><br>At the time this report was published there was 1 Safe Delivery of Care Inspection undertaken and 1 IR(ME)R inspection. The requirements, recommendations and areas of good practice are listed within the report.<br><br>RL noted for the committee that Healthcare Improvement Scotland (HIS) have published a report that highlights the key findings from the programme of inspections for Safe Delivery of Care. This covers the period of 2021 up to the end of March 2025 and highlights some of the key themes.<br><br>AS to forward this to the committee members for considerations at the next meeting. | **AS** |
| | **Item 4.2** | **NHSG Cleaning Standards Group**<br>LC fed back that she and ANd have met up and there was recognition that the domestic department, as a team, do not meet to discuss cleaning. A group called the Domestic Cleaning Group has been established and monthly meetings have been arranged between assistant managers and service managers; this will feed into the Cleaning Standards Group so that all operational issues will be escalated appropriately which will benefit the organisation as a whole.<br><br>For awareness the National Cleaning Standards for 2025 have been shared and there is work ongoing around this.<br>Keen to share the information with all portfolios and attend areas to speak to nursing colleagues face to face regarding how this affects their area regarding risk ratings, monitoring etc.<br><br>GJ is keen to hear how this moves forward. | |
| | **Item 4.3** | **Decontamination Group**<br>This evolved form an Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) / Incident Reporting and Investigation Centre (IRIC) joint paper regarding decontamination of neurosurgical probes that was sent to the HAI Executive and discussed at the HAI Executive Committee (HAIEC) held in December. The paper seeks assurance for the decontamination of all medical devices and so is more far reaching than just neurosurgical probes. We are aware that the Central Decontamination Unit (CDU) reprocesses surgical instruments which require sterilisation, but decontamination of equipment out with that process is managed and overseen by individual services. Members of the Committee might be | |

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| | **Matters Arising cont.** | familiar with some of those that are used in your area but governance and assurance of this is sought and following a decision at the HAIEC the process by which this is obtained will be clarified by this group. The Decontamination Group will be established as a subgroup of the IPCSC so that this committee receives all relevant and pertinent information for discussion. Membership still needs to be considered but GJ asked if any of the committee members, presently involved with decontamination in their area, had any suggestions on who should be involved and whether, from their perspective, there may be gaps within their areas in terms of seeking assurance that effective decontamination is taking place<br><br>• Where is this discussed and monitored?<br>• Where do staff take questions on decontamination to?<br>• Is there any deviation from manufacturer's instructions and if so is a formal risk assessment undertaken?<br><br>LC asked the progress of the A-Z Guide to Decontamination document.<br>GJ replied that this was a very large piece of work for all concerned and that is nearing completion; it is on the HAI Work Programme which is discussed at regular meetings.<br>ANd confirmed that the bulk of the work has been completed and as soon as it is ready it will be transferring onto an interactive platform.<br><br>ANd queried whether any discrepancies around decontamination were present on any organisational risk register.<br>GJ replied that there was no awareness of any discrepancies as yet but this is the concern has been raised by the IRIC briefing paper. Issues would sit within the governance and assurance for each service and be present on the individual risk registers. | |
| | **Item 4.4** | **Hand Hygiene Improvement Programme update**<br>ANd gave an update to the Committee<br><br>The Hand Hygiene Improvement Programme has been running since the last World Health Organisation (WHO) Hand Hygiene Day on 5 May 2025 and in place is a program to ensure that the IPC Team undertakes at least 5 quality assurance hand hygiene audits per month. The audits themselves commenced in August 2025 and between then and December 2025 a total of 55 audits have been undertaken (this includes re audits in areas which had to be revisited) with the average score so far at 80.6%.<br><br>Alongside this, as part of the improvement program, IPC are delivering training and have so far trained 141 staff members in hand hygiene refreshers, which includes 5 moments for hand hygiene, glove use and using the glitter bug box. Additional sessions are planned to ensure that compliance continues to improve.<br><br>The Team have observed that there have been challenges where some areas are conducting fewer than the required 20 observations per month and work is still continuing to support / educate here, however, positive improvements have been seen in other areas where broken dispensers have been replaced and a general improvement in practice. Some good news has also been received from Royal Cornhill Hospital (RCH) who have commenced a trial of peer auditing that, if successful, could be shared across the organisation as good learning. | |
| | **Item 4.5** | **Health Protection Report volume 19 issue 12: News (18 and 19 December 2025) - Infections due to contamination of products used in healthcare settings**<br>GJ explained that this report highlights occasions where infections have occurred through the use of products within healthcare Microorganisms are typically opportunistic and so cause infections in vulnerable individuals. | |

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| 4 | **Matters Arising cont.** | The affected products covered in this report include ultrasound gel, environmental cleaning wipes, non-sterile alcohol free skin cleansing wipes used for first aid, patient hygiene wet wipes and other hygiene products, saline products for irrigation**,** inhalation and eye wash and the Carbomer eye gel which resulted in an attributable death. Serious complications such as bloodstream infections and pneumonia can occur and good clinical and IPC practice is key to preventing these and mitigating risk; this was the reason GJ wanted to flag the report and asked HAI Sub Group Leads to take this back to their individual meetings for sharing.<br><br>ANd wondered whether providing clinical teams with practical pointers on good IPC would be helpful; they aren't to know that a product may be contaminated unless IPC or Microbiology advise them. Perhaps give pointers on practical steps to take e.g. in terms of gels used - look at expiry dates before use<br>GJ agreed that this could be useful and perhaps should be available as a bulletin or shared learning from this report.<br>ANd / GJ will action this. | **ANd / GJ** |
| | **Item 4.6** | **DL 2025/27 Update on Indicators for Antibiotic Use**<br>This is the new director's letter which was issued regarding antibiotic use and clarifying the aims. There is the UK Antimicrobial Resistance National Action Plan for 2024 to 2029 and that includes aims and targets; antibiotic prescribing indicators for Scotland, primary care, secondary care and dental targets. Highlighting for awareness and this information will be shared and communicated to the appropriate teams.<br><br>DR commented that it was an interesting letter and drew the committee's attention to the dental prescribing narrative that states by 2029 Penicillin will be prescribed more frequently than Amoxicillin. During a consultation attended some years ago a consultant present stated that there are a large number of adults who have, noted in their records, an allergy to Penicillin. There was belief that this may not necessarily have been the case and that the adults were actually allergic to the liquid in which the penicillin was presented at this time. It was hoped that NHSG would carry out trials to prove this. Not aware that this trial has ever taken place. Do any of the committee member have cognisance of this being undertaken and the outcome?<br>GJ has been aware of similar conversations taking place throughout her career but this has tended to be referring to the older generations and has no factual evidence. Unfortunately neither RM – IPC Antimicrobial Stewardship Nurse nor VB – IPC Doctor (who represents the Antimicrobial Team) are in the meeting today but this question can be referred to them for comment / further information. | **GJ** |
| | **Item 4.7** | **HCID PPE Addendum**<br>ANd explained that the DL received askes NHS Boards to implement the High Consequences Infectious Diseases (HCID) Personal Protective Equipment (PPE) addendum (which can be found in the National Infection Prevention and Control Manual (NIPCM) by August 2026. NHSG has an HCID Protocol in place which advises clinical services how to safely assess and care for patients who are suspected or confirmed to have an HCID, however these patients can present in many ways e.g. through the Scottish Ambulance Service (SAS), GP Practices, the Accident and Emergency department or other sites e.g. Royal Aberdeen Children's Hospital (RACH) or Dr Gray's Hospital (DGH). NHSG are being asked to identify a group / lead to proceed with this implementation of the addendum, agree clinical areas that the addendum applies to and to report progress to those accountable. There is also a need to identify the number of staff in each priority area who require training in the PPE ensemble which, coincidentally, will be identical in all 4 nations. Currently within NHSG training the only PPE training available for the ensemble is for FFP3 masks which is provided by our Health and Safety Team; there is no similar provision for the rest ensemble. There has been PPE training identified that is available by a company in Sheffield however the cost for this is £600 per person and there has been no funding identified for NHSG staff, At present, any training is being undertaken by Ward 111 who have taken up the initiative to continue the training for the PPE previously used but NHSG need to acknowledge that there is a risk within the organisation with regard to capturing all staff that are required to be trained in the identified key areas. | |

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| **4** | **Matters Arising cont.** | The recommendation of the addendum is for the HAIEC to be aware and support whichever initiative is being taken forward. GJ added that at the last HAIEC meeting in December it was agreed that there would be a plan moving forward and the relevant people would contacted. Unsure if this has happened as yet but should be coming together within the next month and this committee will be updated as to progress.<br><br>DR asked if there was a procedure for identifying patients who have an HCID and who are attending the hospitals.<br>ANd replied that the difficulty is that patients presenting at the hospitals are doing so without knowing that they may have an HCID. They may present with a high fever and vomiting after travel from a country known to be prevalent for HCID but they are, by then, already within the hospital setting. When patients are assessed within their own homes and deemed to have the disease, but are not ill enough to warrant a hospital stay, their symptoms can be managed within the household environment. This issue is that most are unaware of their diagnosis until assessed within the hospital. In England there are centres specifically for HCID patients where there is specialised management of the disease, unfortunately, there are no such centres in Scotland.<br>DR added that these patients could present at a number of locations other than an emergency department and that this needs to be recognised and addressed.<br>GJ advised that there is an HCID Group which involves IPC, Health Protection / Public Health etc. and work is ongoing. The reason for bringing the addendum to this meeting is to ensure the Committee are aware of what is being undertaken and the details being finalised due to the slight change to guidance in the recently shared addendum. | |
| **5** | **Standing Items**<br>**Item 5.1** | **<u>Sector Reports</u>**<br><br>**<u>ARI</u>**<br>A report was submitted but FM was unable to attend the meeting.<br><br>The report was not discussed, however. GJ will meet with FM to discuss the content,<br><br>**<u>Children's Services</u>**<br>A report was submitted that CC spoke to.<br><br>**2 Progress Against Areas of Concern Previously Reported**<br><br>**2 a) Low - Extreme heat as windows not able to be opened in clinical areas due to ongoing building works**<br>Currently reduced to a low risk rating sue to the time of year but issues are not resolved and impact will be felt again when warmer weather arrives,<br><br>**2 b) High - Increasing leaks from burst pipes to radiators and heating units in ceilings**<br>Works still outstanding. Winter pressures precluding move of High Dependency Unit (HDU)<br><br>**2 c) Medium - Issue identified with ventilation in positive / negative and negative pressure rooms in RACH**<br>This issue is still outstanding.<br><br>**2 d) Medium - Atypical infections NNU. IMT's**<br>There have been big improvements in the data reporting for the Neonatal Unit (NNU) since works were undertaken, water light practice introduced and improvements around hand hygiene were made. Maintaining the standards will now be a high priority Additional cleaning is now also in place. | **GJ** |

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| 5 | **Standing Items cont.** | **2 e) High - Pest control issue in RACH (maggots and flies) – 2 Theatres & Surgical ward**<br>Remedial works still to be undertaken. Recorded on the risk register.<br><br>**4 Mandatory HAI Education Training Compliance Figures**<br>There are some red areas for the IPC Clinical Refresher training. CC will investigate this<br><br>**Women's Services**<br>A report was submitted but no one form the Service was available to speak to it.<br><br>**Aberdeenshire H&SCP**<br>A report was submitted and AMcG spoke to it.<br><br>There were no New Areas of Concern and no updates to the ongoing risks at present.<br><br>The Aberdeenshire HSCP HAI Sub Group met last week. It was well attended, lots of discussion and good feedback from the IPC nurses to say how well engaged the HSCP is around compliance with training and collaborative working together. So overall it was a very positive meeting.<br><br>All 5 factor risk assessments and Safe and Clean Care Audits (SACCAs) have been undertaken and are complete.<br><br>**Aberdeen City CHP**<br>A report was submitted and FMu spoke to it<br><br>No new areas of concern were reported.<br><br>**2 Progress Against Areas of Concern Previously Reported**<br><br>**2 a) High - Poor hand Hygiene compliance within ORU following Influenza outbreak**<br>This was identified via a quality assurance audit an action plan was produced and after re-audit the score was 95%. Risk rating now been reported as low.<br><br>**2 c) High – Poor mandatory training compliance in majority of areas but particularly inpatient areas.**<br>This is an ongoing issue previously discussed. Working with areas to try and improve compliance and hoping to see an improvement for the next meeting. The quality assurance and hand hygiene audits have been beneficial to many of the affected areas.<br><br>GJ fed back that it was interesting in terms of why staff were not completing mandatory hand hygiene. Keen to support in any deeper investigation around this if required.<br>FM replied that 1 area has been involved in a lot of change recently which is difficult for staff and this may be a contributory factor in addition to workload pressures,<br><br>**5 Areas of Achievement / Good Practice / Shared Learning from HAI related Reviews (Level 1. 2)**<br>5 factor risk assessments have been completed and SACCA audits undertaken and all inpatient areas across both Frailty and | |

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| 5 | **Standing Items** | Specialist Rehabilitation have been working on risk assessments for respiratory infections. These has been helpful during recent outbreaks which have been managed well. There was a recent Flu outbreak where a ward was closed; on this ward there is a group of challenging patients who are cognitively impaired and who walk with purpose. Staff managed to control the outbreak well.<br><br>**Mental Health & Learning Disabilities**<br>Report was submitted which JM spoke to.<br><br>There are no new areas of concern to report and no very high or high areas of concern previously reported.<br><br>**4 Mandatory HAI Education Training Compliance Figures**<br>As reported at the recent HAI Education Group meeting the service needs to work on the Clostridioides difficile (C diff) and donning and doffing mandatory training and there are still some hand hygiene scores to be uploaded.<br><br>All 5 Factor Risk Assessments and SACCA have been completed.<br><br>The service are aware that Healthcare Improvement Scotland (HIS) could visit to undertake an inspection at any time and remain ready for this**.**<br><br>**Facilities**<br>A report was submitted which WS explained had been streamlined since the last meeting and is more focused on HAI reporting<br><br>The report contains very little change in terms of what has taken place in the past month as the team have been dealing with the ongoing winter conditions and CDU issues.<br><br>**1 New Areas of Concern**<br><br>**1 a) Medium - ECC Ward 112 & 114 Bacterial infections**<br>This is being managed via the Incident Management Team (IMT) that is in place.<br><br>**2 Progress Against Areas of Concern Previously Reported**<br>No High or Very High issues are noted in the report. All issues are being managed i.e. mitigations are in place.<br><br>**4 Mandatory HAI Education Training Compliance Figures**<br>Having some issues with TURAS reporting at present but WS is aware that Hand Hygiene compliance is down for Estates and will work towards improving this and ensuring staff are completing the required modules and Breaking the Chain of Infection is at 85%<br><br>GJ explained that Breaking the Chain is training that is undertaken at Induction by all new NHSG staff and this does not have to be completed regularly. More important are the IPC Clinical / Non Clinical Refreshers and staff should be focusing on completing these. A discussion then took place regarding whether Estates staff should be completing the clinical or non-clinical module with DS suggested that it may be non-clinical although she is aware that domestics undertake the C Diff training also as they are classed as more patient facing.<br><br>WS added that neither the clinical nor non-clinical refreshers were in the list that he held as mandatory training for Estates | |

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| 5 | Standing Items cont. | staff and DS advised that this is a perennial problem as this training is held in a separate part of TURAS which sometimes staff have an issue finding. Hopefully when everything moves over to protected learning time it will be much simpler for all to understand.<br>GJ offered assistance to help WS locate the correct learning for Estates colleagues.<br>GMcK shared a spreadsheet supplied by Sandi Powell – Learning and Development within the chat that may help.<br><br>WS then updated the committee on a future project that will commencing soon. The Swift Urological Response and Evaluation (SURE) project is a significant piece of work and there will be HAI concerns around the works that will require ongoing discussions.<br>GJ highlighted an ongoing IPC concern regarding works / projects commencing without the required SCRIBE process having been investigated and signed off; this will require further discussion with relevant parties moving forward.<br><br>GMcK raised the issue of the new windows that have been installed at Aberdeen Royal Infirmary (ARI). Have all of these replacements now been completed and is there a phase 2 of the plan of works?<br>WS replied that these works are very much finance driven. The North and West elevations of Phase 1 have been completed. There have, so far, been 52 windows replaced on various levels in phase 2 and have just commenced fitting the next 100. To put these works into perspective there are roughly 100 windows per level in phase 2 and 5 levels so this equates to 500+ windows in phase 2 alone; at £2000 per window this is a considerable cost to the organisation. In addition to this the Orange Zone will be having new windows fitted and roof repairs shortly.<br><br>ANd commented that the cleaning of the chill beams is not on the report. Is this being picked up elsewhere?<br>WS advised that there is a review ongoing to understand the scope of these works. Will update on this when able.<br><br>**<u>Dr Gray's / Moray HSCP</u>**<br>A report was submitted which LMac spoke to.<br><br>**2 Progress Against Areas of Concern Previously Reported**<br><br>**2 b) High - PVC bundle compliance**<br>Compliance has been low: Insertion bundle 50%, Maintenance 40% and care of site and dressing 100%<br>There is work underway to improve these scores and meetings have been held to discuss. Barbara is assisting with quality assurance work and education around bundles<br><br>**2 c) Medium - Lack of domestic support overnight in DGH**<br>Domestic services rosters have been revised meaning overnight domestic cover is now reinstated.<br><br>LC made a comment regarding the low turnaround of beds within DGH at night. Staff are being paid out of hours and not undertaking the volume of work that was expected. Has arranged a meeting with Alastair Pattinson and Fiona McCallum to discuss as the cost of this service is high; perhaps needs to be more communication with nursing colleagues.<br>GJ agreed that the service needs to be used effectively and efficiently. The reason for the request for domestic services out of hours was due to nursing staff having to undertake cleaning which was impacting on clinical care; supportive that the service remains in place<br><br>**2 d) High - Lack of face fit tested staff at DGH & lack of understanding re aerosol generating procedures**<br>A lot of work has taken place around this and compliance is now 76.6%. Moray CHSCP is showing 53.7% compliance, however, staff are being booked onto training weekly and so hopeful for an increase in compliance soon. | |

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| 5 | Standing Items cont. | **2 e) Medium - Inconsistent compliance with Patient Placement Tool led to patient with ESBL cared for in 4 bedded bay prior to identification**<br>Nurse managers have reiterated the importance of the Patient Placement Tool. Illuminate data suggests further improvement work is required.<br><br>ANd raised the fact that the IPC Team have noticed a drop in compliance with the PPT across NHSG. Currently there is a staff survey open for completion and the Team have placed posters with QR codes in all clinical areas for staff to access the survey. The results of this survey will be helpful to ensure understanding of any barriers or challenges and will make sure that the Team can tailor efforts for improvement. Asked LMac to encourage staff to complete within DGH.<br><br>LMac will liaise with staff with regard to completing the survey.<br><br>**4 Mandatory HAI Education Training Compliance Figures**<br>Hand hygiene compliance has been poor in December for Ward 6 and High Dependency Unit so work is ongoing around these areas. Dawn Stroud – Senior IPC Nurse undertook an audit and will be following up with a re-audit to gauge improvement.<br><br>SACCA audits are up to date.<br>Decontamination issues in Theatres have been resolved<br>Face fit testing levels have improved within DGH as mentioned previously.<br><br>**<u>HAI Education Group Roundup</u>**<br>A report was submitted which DS spoke to.<br><br>**Mandatory Training**<br>DS is continuing to work with Tracy Leete on the Protected Learning Time Workstream (PLTW). All 9 modules are discussed however DS has a particular interest in "Why infection control matters" (this is the name of the module, not Breaking the chain of infection) and this has recently been updated by NHS Education for Scotland (NES). This is to be the mandatory module for Infection Control and this will need to be completed every 3 years. A meeting was held on 7 January with NHSG's Learning & Development to ascertain what NHSG is required to provide and if there was anything missing from the modules or anything additional required; awaiting more information from Learning & Development. New system is due to go live by 2 March 2026.<br><br>**Education**<br>The pictorial guide to aid line insertions developed and tested within Children's Services is trialled in other areas in the hope that it can eventually be rolled out across NHSG.<br><br>**Education Reporting**<br>This continues to be a challenge.<br><br>**Policies & Procedures**<br>The AMR and HAI Education Framework is currently being updated by RM – Antimicrobial Stewardship Specialist Nurse and DS.<br><br>**Areas of Achievement / Good Practice**<br><br>• There was good attendance at the Tissue Viability study days last year and the team are hoping that these days can be repeated in 2026 | |

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| **5** | **Standing Items cont.** | • Medical students are being checked on their dress code by the University of Aberdeen (UoA). If they are not complying with the uniform policy they are required to attend a meeting and if they fail to do this their medical programme will be halted<br><br>**<u>Infection Prevention & Control Team (IPCT) Roundup</u>**<br>The roundup report was submitted which DS spoke to.<br><br>**<u>IPC Surveillance & HAI Screening</u>**<br>At the January meeting quarter 3 data was reported on but there were no national figures available so to update:<br><br>**Multi-Drug-Resistant Organism (MDRO) screening compliance**<br>National MRSA CRA 84.8% therefor NHSG are significantly below the national level at 64%<br>National CPE CRA 87.2% and NHSG are again below the national level at 79%<br><br>**MDRO screening compliance for Quarter October - December 2025**<br>MRSA CRA 78% and increase of 14% from quarter 3<br>MRSA swabbing 67% (20 out of 30 patients swabbed as per policy) an increase of 20% from quarter 3<br>CPE CRA 88% an increase of 9% from quarter 3<br>CPE swabbing 0%, (1 out of 1 patient was not swabbed as per policy)<br><br>National figures are not yet available for Q1 January – March 2026.<br><br>**Incidents and Outbreaks**<br>There have been 2 Preliminary Assessment Group (PAG) meeting led by the IPCT since the last IPCSC<br><br>• 1 x Blood Borne Virus<br>• 1 x Influenza A<br>• 1 x Non sterile tray use<br><br>There have been 6 Incident Management Team (IMT) meetings led by the IPCT since the last IPCSC:<br><br>• 6 x Winter Viruses<br><br>These changed to meetings thereafter<br><br>The IPCT has attended 21 service-led meetings to provide advice and support**:**<br><br>• 6 x CDU (4 IMTs and 2 Sub-group meetings)<br><br>NHSG was highlighted by ARHAI as an exception in quarter 4 (October to December 2024) and identified as being above normal variation for healthcare associated Clostridioides difficile Infection (CDI) when analysing trends.<br><br>An action plan is in place and remains under review. Current CDI data based on the target of 61 cases for NHSG by the 31 March 2026 was on target in November with the actual cases numbering 40 and the target being 41.<br><br>ANd added that there are also targets for Staph aureus bactraemias (SABs) – 102 cases by end of March 2026 which has | |

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| 5 | Standing Items cont. | been exceeded already and E coli bactraemias (ECBs) – 169 cases for the same timeframe and this has also been exceeded. ANd encouraged all members present to engage in measures that can be used to reduce the incidence of SABs and E.coli bacteraemias such as device audits, hand hygiene, PVC / CVC bundles and aseptic technique.<br><br>GJ also informed the committee members that the updated Venous Access Device (VAD) Policy, bundles and audit are was now available to view on the Grampian Guidance page and will be advertised via the Brief and cascaded through management teams via email; please raise awareness within your areas and groups.<br><br>**Audit and Assurance**<br><br>**<u>Patients readmitted with a previous MDRO</u>**<br>Between 13 March and 12 October 2025, a total of 1994 patients were reviewed by the IPC Team.<br><br>• 95 patients (4.76%) were placed in a Non-Standard Patient Area (NSPA).<br>• Five Wards in ARI accounted for 65 (64.4%) patients placed in NSPA.<br>• Only 24.6% of these 65 patients had the Patient Placement Tool (PPT) completed on admission, 75.4% had not.<br><br>**Areas of Achievement / Good Practice**<br><br>• 13 Winter Preparedness update and Q&A Sessions were provided on Microsoft Teams by the IPC Team from 10 - 19 December to 2025 to support staff during the height of the Flu infections<br>• One of the IPCNs received a certificate of recognition from Robert Gordon University (RGU) In December. This was in acknowledgement of exceptional support to student education in practice and enhancement of the student's overall learning experience on placement | |
| | Item 5.2 | **HAI Work Programme 2025/26**<br>GJ spoke to the report explaining that this is the plan of work for reduction of HAI across the organisation. It is not just an IPC report although the team do lead on it.<br><br>**Delivery Area 1 – Leadership and Governance**<br><br>1 a) Update business Continuity Plan<br>A substantial amount of work is ongoing surrounding ICNet in terms of ensuring the system is as efficient as possible and sustaining the service.<br><br>**1 e) Winter Planning**<br>Will seek winter planning opportunities for 2026/27. From an IPC perspective the team could have been more involved in those discussions, need to ensure that IPC have more involvement moving forward.<br><br>**1 g) To ensure improved compliance with completion of PPT and PVC bundles**<br>This was referred to earlier in the meeting and GJ fed back that leadership around this is effective and progressing well, and will, hopefully, reduce ECB and SAB figures as we move into the next few months so NHSG do not continue to exceed expected targets. | |

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| 5 | Standing Items cont. | **Delivery Area 2 – Education and Training**<br><br>**2 e) Water Light / Waterless Practice in the event of abnormal water results.**<br>This topic was mentioned earlier in the meeting surrounding RACH water issues. If there is a need to implement water light practice within an area this tends to be in response to an issue that has come to light. A Standard Operating Procedure (SOP) is being developed to assist the clinical service / IPC and Estates and ensures there is a routine practice to follow, although responses are individualised to the particular incident or concern. This document, when complete, will not be shared routinely, but will be available when an area requires it. It will come to this committee for information prior to roll out.<br><br>**Delivery Area 3 – Communication**<br><br>**3 a) Consider how to improve communication of HAI data throughout the organisation**<br>Working with IT colleagues to develop a dashboard for staff to visualise KPI results to support improvement. This work continues and is almost complete.<br><br>**Delivery Area 4 – Assurance and Monitoring Systems**<br><br>A gentle reminder to all attendees that consistent reporting and regular attendance is required to the IPCSC so that assurance can be gained around infection control practices and risks; continuity is key. The assurance is required from a patient safety perspective so that this committee can then provide ongoing assurance to our governance framework, Clinical Governance Committee (CGC), HAI Executive Committee (HAIEC) and NHSG Board; if ongoing assurance cannot be provided this needs to be looked into and support provided to enable this to happen.<br><br>**Delivery Area 5 – Optimising Antimicrobial Use**<br><br>Antimicrobial stewardship activity continues. Antimicrobial resistance is a real concern and stewardship reduces the risk of that. This is a global issue which needs to be prioritised more in coming months.<br><br>**Delivery Area 8 – The Built Environment**<br><br>This is a considerable volume of the IPC team's workload. GJ added that in the 6 years that she has been in post it has risen exponentially, It is largely as a result of general built environment conditions and projects / builds that are undertaken as NHSG evolve as an organisation to try and deliver services as best it can. Issues encountered have been around assurance of water flushing, compliance with the National Infection Prevention Control Manual (NIPCM) Chapter 4, which is very specifically about built environment, and includes support to Facilities & Estates and projects such as the Baird & Anchor.<br><br>DR asked a question surrounding the format of the report and items on it that have been completed. The time scale seems to run from April 2025 to March 2026, is there a benefit in showing this as many of the actions are ongoing. Should the report be more specific about trying to achieve certain items in a specific time frame?<br>GJ explained that the incomplete actions from this year (2025/26) will move over onto next year's work program (2026/27) and there will be some included indefinitely as they are ongoing as part of the role and the work of the organisation to reduce HAI risk. There may be a different way to present the information so that the ongoing work is captured differently. The report is organised into tabs align with the IPC Standards which Healthcare Improvement Scotland (HIS) audit NHSG on but perhaps the ongoing actions could be documented on a different tab. Is this the suggestion?<br>DR suggested that the timescales need to be made clearer.<br>GJ will review the layout of the report to see if this can be achieved. | **GJ** |

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| | **Standing Items cont.** | | |
| | **Item 5.3** | **HAI Executive Committee (HAIEC) Meeting Update**<br>The original meeting date had to be rescheduled due to availability of key attendees and so the meeting took place on 10 December 2025.<br><br>Escalations to the committee included:<br><br>**Shower hose clips**<br>It was raised that that there was lack of consultation with clinical teams, which was not helpful. The way forward was a risk assessment for exceptions such as Burns and Plastics where there is a need for longer hoses to ensure correct patient care. One query that was outstanding was in relation to the posters, unsure if these are available and prominently displayed within areas. This was not discussed detail but WS seemed happy with the current status. If there is anything outstanding from this needs to be revisited.<br><br>GMcK advised that to the best of her knowledge the posters have been put up in numerous wards and this was completed in July 2025 as advised by Colin Cruickshank.<br>GJ surmised that this could now be closed as complete.<br><br>**Access for the Facilities & Estates team to address issues with chill beams**<br>The issue seems to be the demands on the Facilities & Estates team which has meant that they have not been able to progress with this. This is being monitored by the committee and was raised with WS. Needs to be recommenced.<br><br>**Sustained funding for cleaning of the Neonatal Unit (NNU)**<br>CC did confirm that the funding will be for the duration of the occupation in the current NNU at the Aberdeen Maternity Hospital (AMH).<br><br>**Difficulty in accessing medical colleague representation at various meetings**<br>GJ was given a suggested contact and will liaise with them for some advice / assistance. This is a challenge for this committee and for the HAI Education Group also. | |
| **6** | **HAI Report to Clinical Governance Committee / Board** | | |
| | **Item 6.1** | **HAI Report to the Board (HAIRT)**<br>There is no report available at present as the national figures have only just been released.<br><br>The HAIRT for January 2026 will be included for ratification at the March meeting. | |
| | **Item 6.2** | **HAI Report to the HAI Executive Committee (HAIEC) (new escalations)**<br><br>• Cleaning of floors within wards / bays / side rooms is not consistent across the organisation resulting in risks to patients due to infection or wait times for beds | |
| **7** | **AOCB** | | |
| | **Item 7.1** | **Disinfectant Wipes SBAR**<br>ANd spoke to the SBAR explain that, currently, decontamination processes within NHSG for shared equipment and surfaces involve the use of detergent impregnated wipes and these are used when there is no soiling or body fluids involved and not a suspected case of infection. | |

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| 7 | **AOCB cont.** | When staff are required to disinfect they are asked to undertake a two-step process; this involves a detergent wipe, already mentioned, and a 70% alcohol wipe (which comes from a red tub) or they would be required to make up a solution of chlorine adding a tablet to water and wipe using a cloth.<br><br>The proposed change noted in the SBAR is that NHSG change from a complicated 2 step process involving chlorine to a wipe that contains both detergent and disinfectant. This will ensure a much simpler and less time consuming method of disinfection that staff are more able to comply with and provides assurance that cleaning and disinfection is taking place effectively; the feeling is that the current cleaning methodologies are time consuming and do not offer this assurance at present.<br><br>ANd went on to explain the risks associated with the detergent wipe approach only stating that, sometimes, there are patients who have unidentified infections and are colonised with a pathogen that is not identified through routine screening. The patient may have missed their screening opportunity and the colonisation may be below the limit of microbial detection or not present pending a positive lab result. Staff would then be using the detergent wipe without knowing that the patient has any form of infection; the combined detergent and disinfection wipes being proposed carry out a double action of cleaning as well as disinfecting at the same time.<br><br>Within the SBAR it is cited that some of the recent studies have demonstrated a 2 in 1 disinfection wipe is a highly effective method of reducing pathogens on surfaces and reusable equipment where detergent based cleaning often fails to eradicate microorganisms. Within NHSG the use of Non Standard Patient Area (NSPA) beds is a concern and due to staff constraints and evidence from an IPC perspective, patients with MDROs are being placed in beds where effective decontamination may be impacted. Also cited is the annual cost saving which can be realised from this change as well as the time that will be given back to staff to concentrate on clinical care rather than decontamination.<br><br>In closing the SBAR recommends that NHSG introduce this combined detergent / disinfectant wipe for routine cleaning of surfaces and reusable non-invasive equipment. The recommendations also state that manufacturer's instructions should continue to be followed for equipment requiring specific cleaning instruction and that the use of chlorine should continue in certain circumstances e.g. when dealing with a patient with CDI as the combined wiped would not eradicate the C diff spores. All training, education and support are available from the company as and when required.<br><br>HC thanked ANd for the SBAR and agreed that the change would save time, money and provide assurance around effective decontamination. Need to assess all risks, but in favour of this moving forward. The sooner this can be progressed to a system that staff are more likely to be able to comply with the better.<br><br>GMcK asked ANd to explain the long term risks in adopting these wipes which ANd did, however, GMcK was not content to sign off on this recommendation until further discussions can be had.<br>GMck and will have a conversation out with the meeting to ensure clarity<br><br>DR asked whether there were any national standards or guidelines associated with this type of activity and how do NHSG look at those to ensure there are no unintended consequences.<br>ANd replied that the current process within NHSG is what is recommended nationally but that is not to say that the organisation cannot undertake something different depending on local situations. The SBAR states that this would be a derogation against national guidance and as a result there will need to be a risk assessment in place, however, there are other boards already using these wipes for the same reasons.<br><br>GJ summarised and confirmed that NHSG are still following national guidance in terms of (not the products) but the chemicals and level of decontamination being undertaken. IPC are suggesting that changing to a wipe that contains both detergent and disinfectant would be an advantages in terms of cost, time and perhaps a higher rate of compliance from a staff perspective. | **ANd / GMcK** |

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| **7** | **AOCB cont.** | GJ concluded that there was no majority consensus to be able to move this forward due to concerns around risk. Add potential risk narrative to the SBAR and bring back to the next meeting on 17 March 2026.<br>Once the Committee are happy to approve this change of practice the SBAR should be sent to the Equipment and Medical Devices Group for comments / approval. | |
| | **Item 7.2** | **Healthcare Built Environment - sector report risk rating discussion**<br>This was not discussed due to lack of time and will add to the agenda for the next meeting. | |
| | | GJ also fed back that the Water light SOPs should also be completed and available to present at the meeting on 17 March 2026. | **IO** |
| | | ANd raised an issue with the cleaning of floors. At the beginning of December it was brought to the IPC team's attention that the cleaning of floors within wards / bays / side rooms is not consistent across the organisation. When a patient is discharged there is the perception that, if that patient did not have an infection, the floors did not need to be cleaned before the next patient was admitted into that area.<br><br>A meeting was held between Site & Capacity, IPC, Facilities and some clinical colleagues to discuss this and it was agreed that it is national guidance for floors to be cleaned in between patients regardless of infection status, however, there were other patient risks across the organisation, such as long waits in the Emergency Department (ED) and the stacking of ambulances, which were being impacted from staff waiting for the floors to be cleaned. There are 2 risks here<br><br>a) patients facing long waits in ED for a bed<br>b) the infection risk for a patient coming into an area that has not been cleaned appropriately.<br><br>It was decided to bring this to the committee for awareness and escalation through the organisation as a risk to prompt discussions on how this could be mitigated.<br><br>AMcG replied that there is the same impact within community hospitals but not the same pressure as an acute hospital on turnover of beds.<br>HC was glad that this was being raised and recognised that flow pressures across the organisation are significant.<br>GJ felt that this should be captured as an organisational risk and will speak with June Brown, as HAI Executive Lead, to discuss where this should be recorded. | **GJ** |
| **8** | **Date of Next Meeting** | 17 March 2026 10.00 – 12.00 via Teams (with a 10 minute comfort break) | |