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

Minutes from meeting held 18 March 2025
Via Teams
10.00 – 12.00

Present:

NE – Noha El Sakka, Consultant Medical Microbiology & Virology / Lead Infection Prevention & Control Doctor (Chair)
ANd – Astrida Ndhlovu, Deputy Infection Prevention & Control Manager
IO – Ijeoma Okoliegbe, Infection Prevention & Control Clinical Scientist
LD – Laura Davidson, Nurse Manager, Elderly Services, ACHSCP (deputising for Julie Warrender)
JBa– **June Barnard**, Nurse Director, Secondary & Tertiary Care, Acute
JL – Juliette Laing, Head of Decontamination & Linen Services
RL – Rachael Little, Team Lead, Quality Improvement & Assurance
AW – Andrew Wood, Health & Safety Specialist
DS – Dawn Stroud, Senior Infection Prevention & Control Nurse, IPCT
JW – Julia Wells, Chief Nurse, Adult Mental Health
RM - Rachel Mennie – Antimicrobial Stewardship Specialist Nurse, IPCT
AMcG – Alison McGruther, Chief Nurse, Aberdeenshire HSCP
CR – Caroline Reid, Clinical Nurse Manger, Community Teams, Child Health (deputising for Caroline Clark)
GMcK – Grace McKerron – Chief Nurse
HCo – Helen Corrigan, Consultant Nurse, Health Protection Team
SS – Sharon Smith, Nurse Manager, Women's Portfolio (deputising for Sarah Campbell)
WO – Will Olver, Infection Prevention & Control Doctor
DR – **Dave Russell**, Public Representative
NM – **Naomi Mandel**, Public Representative
SP - Shriya Pradhan, Guest Doctor, India

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**	NE introduced Dr Pradhan to the Committee who will be observing the meeting. NE also welcomed the Public Representatives and introduced them to the Committee. Helen Chisholm (HC) Julie Warrender (JWa) Chantal Wood (CW) Amanda Foster (AF) Grace Johnston (GJ)	
2	**Minutes of last meeting 14 January 2025**	The minutes from 14 January 2025 were ratified by the Committee with no amendments	
3	**Action Tracker**	**<u>Meeting 14 January 2024</u>** **4.3 Seasonal Pressures and IPC Measures** Staff vaccination rates / uptake has been poor this year. Suggestion that NHSG may devise a survey / audit to gauge staff feedback. GJ emailed Claire Louise Walker 27/2/25. No update as yet.	

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3	**Action Tracker cont.**	**5.1 Sector Reports** **ARI** **2 c) Medium - Eurobins dirty, lids flipped right back, doors unlocked** KA reported issues with dirty bins being delivered to clinical areas at RACH and porters advising all are the same. CW to liaise with Ted Reid. No update **2 e) Low - Yellow aprons still not released from procurement for ordering in wards/ theatres etc.** Concerns raised regarding wasting supplies if white aprons were not to be used. CW suggested that Facilities & Estates may be able to utilise the white aprons. Will ask the question and report back to the Committee. No update. **2 f) High – Plastics Dressings Clinic** Narrative to be updated as SBAR has been completed. GMcK updated that this is partially complete. Will update fully by the next meeting. **Facilities & Estates** New issue that was to have been added to the Facilities & Estates Sector Report by WS surrounding Neo Natal Unit (NNU) AMH. Does not seem to be in included in the report for this meeting. WS to resubmit updated report. No report received and no update. **Infection Prevention & Control Team (IPCT) Roundup** Non-compliance / drop in compliance with all screening. GMcK advised that this was not included in the Sector Report for 18/3/25 meeting. Have been focusing on compliance for all screening and have some assurance but there are anomalies in the system e.g. in wards 212 / 213. Reports show as non-compliant but compliance has been achieved; issues to be resolved. JBa updated that has met with GJ and pulled together a robust plan on how to improve compliance on Hand Hygiene audits, Multi-Drug Resistant Organism (MDRO) screening, reusable equipment, Venous Access Device (VAD) insertion MDRO Screening and 5 Factor Risk Assessment. This will be monitored through GMcK and the ARI HAI Sub Group. **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 has emailed all of the Senior Charge Nurses in the areas where this had been prevalent to advise to avoid this practice. Poster campaign will be resurrected to support this; will be taken to Water Safety Group (WSG). JBa added that staff were asked to cease this practice immediately. There are concerns within Burns and Plastics where a different way of working will need to be found, IPC Team will support. VB queries the narrative surrounding longer hoses – the IPC Team would not support this as there is greater risk of infection. JBa agreed and added that if there were opportunities to do things differently, it would be agreed with the IPC Team and WSG etc. in the first instance.	

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3	Action Tracker cont.	**Historical Issues – MUSC - Ward areas struggle to keep up with cleaning standards due to increased number of patients and no additional staff available. Will continue to monito via SACCAT and monthly equipment checks.** GMcK suggested this be closed and this action be picked up under the work GJ / JBa are undertaking around compliance. Close action. **7 AOCB** **7.1 Terms of Reference- Remove all titles from membership list and only include Chief Nurse (or nominated deputy) for all IJBs** GJ still to complete. **Portfolio name - Infrastructure and Sustainability to be amended to Infrastructure, Sustainability and Support Services** AS still to amend. **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.** An SBAR is being developed to suggest a switch from a detergent only wipe and a 2 step cleaning methodology for disinfection, to a combined detergent and disinfectant wipe. SBAR ready to be finalised and sent to June Brown. **Meeting 10 September 2024** **5.1 Sector Reports** **Dr Gray's / Moray HSCP** **1 c) Low – COVID Outbreak on Ward 7 – July 2024** JBa / Andrea Dryburgh will take this to the next Non Standard Patient Area (NSPA) Group meeting. **2 e) Low - Poor attendance at decontamination training in November** No update. **Facilities & Estates** **2 aa) High - Decontamination Services – CDU, Mile End – Clean Room** No updated report received. JL updated the Committee on the planned shutdown which will take place in May (covering the bank holiday) and tis will be to change the air handling unit fan. Looking at fitting an "Inline" fan which should, potentially, stop issues with numerous parts moving forward. Once the works have been completed environmental monitoring and a Hydrogen Peroxide Vapour (HPV) clean of the clean room will take place before reopening. **Meeting 2 July 2024** **5.1 Sector Reports** **ARI**	

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4	**Matters Arising**	**4 Mandatory HAI Education Training Compliance Figures – Surgical Self-Assessment document dates.** Some minor comments still to make but will be complete for the next meeting	
	Item 4.1 a)	**Acute Hospital Safe Delivery of Care Inspection Dr Gray's Hospital NHS Grampian Follow up visit (22 – 24 July 2024)** RL attended and gave an update on progress. In July 2024, Doctor Gray's Hospital received a follow up inspection following the Safe Delivery of Care Inspection methodology. The report was published in October 2024 and identified 5 areas of good practice, 2 recommendations and 12 requirements. Of the 12 requirements that were identified 10m of these were carried forward from the previous inspection and three had a new focus for improvement. The 8 week follow up Improvement Action Plan (IAP) was submitted back to colleagues in Healthcare Improvement Scotland (HIS) week commencing 10 March 2025 and NHSG are awaiting a response. The reports and IAP are available on the HIS website to view.	
	Item 4.1 b)	**Summary Report of External Inspections to NHS Scotland Boards (1 January 2025 – 31 January 2025)** A report was submitted	
	Item 4.1 c)	**Summary Report of External Inspections to NHS Scotland Boards (1 December– 31 December 2024)** A report was submitted. DR commented that the purpose of the topics identified within the Summary Reports is to inform and improve practices but some of the information is quite general with actions attributed to other Health Boards. How is this information screened to identify the actions that apply to Infection Prevention and how NHSG are going to adopt them? RL explained that the Summary Reports cover all external inspections undertaken by HIS including any Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) and Mental Welfare inspections. NHSG investigate common themes that have been identified across the different inspection reports to identify what actions are required round and to ensure that any lessons learned are being picked up and shared appropriately. JBa added that the Summaries are shared widely with teams across NHSG and the expectation is that they are shared through their governance processes and with the wider team. There is commonality of issues that have been found in other boards and NHSG need to learn from that in addition to ensuring best practice. DR then asked how NHSG would know which of the actions related to Infection Prevention and Control. RL replied that once feedback has been received from the Inspectors a meeting is held (either in person or virtually) and the Infection Prevention & Control Manager (or a representative) would be present at the meeting to ensure that anything, specific to Infection Prevention & Control is picked up. These issues would then be identified in the Action Plan that is developed to respond to any requirements or recommendations that have been identified.	
	tem 4.2	**Backlog Maintenance Presentation** WS gave a presentation to the Committee explaining that backlog maintenance is considered any works undertaken that are not general maintenance. Typically, NHSG have a monetary value of around £15k and anything that costs more than this will be classed as backlog as it will be a slightly bigger scope of work. There is governance around this, there is the Backlog Meeting that is held on a weekly basis and this group report up to the Physical Infrastructure Programme Board (PIPB) who in turn report to the Asset Management Group (AMG). Backlog is managed on a weekly basis undertaken by the team within	

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4	**Matters Arising cont.**	Estates. WS then shared the live Register on screen and spoke to the content explaining that the scopes are scrutinised to understand where the major risks are (from both and Estates and a clinical point of view) and an amount of money is assigned based on the funding NHSG receives (it is a non-recurring budget). In 2024/25 NHSG received 6 million pounds and the year before it was 4 million. The amount of monies needed to return the NHSG estate back to a satisfactory condition are 200 million as a backlog or 660 million as a project cost. There are various systems utilised in backlog planning - the live Register, the CMMS (Maintenance Management) system and the Strategic Asset Management system. The backlog list (shared on screen) is simple and contains data on the scope, budget and the element, this is based on standards. In the standards, every building is broken down into individual areas, whether it be a roof, a structure, a heating system, a water system, ventilation system etc. So we try and break it down in terms of cost against the elements. WS then went on to explain how the works are risk assessed (by the 5 by 5 matrix) and taking into account clinical consequences of e.g. a leaking roof. At present the majority of NHSG risks are between building structure and heating and that is where the works are prioritised and money spent. All risks are categorised into the different areas and then the risk profile is looked in terms of the money required and how it will be broken down to proactive / reactive and the proposed spend. Proposed works are taken to the AMG for ratification and other aspects are looked into such as maintenance planning and the overall risks. There is still another £600 million of backlog to complete.	
	Item 4.3	**CDI Exception Report** ANd gave some background explaining that in February of this year, NHSG received a report from Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) Scotland highlighting a Clostridioides difficile Infection (CDI) exceedance for Quarter 3 2024 (July – September). There had been 39 CDI cases reported to ARHAI by NHSG during this period and of these, 26 cases (66.7%) were identified as healthcare associated infections (and incidence of 19.1 cases); the national figure (per 100,000 total occupied bed days) was 18.0. In the same report was a healthcare associated CDI funnel plot which was analysed for Quarter 3 2024 and which showed that the rate for NHSG was within the 95% confidence interval upper limit, however, the spike highlighted to the IPC Team a sharp trend which has not been seen for some time and this prompted a need for a comprehensive analysis. An action plan was developed and sent to ARHAI in March 2025 which focused on the following areas • data integrity and surveillance • Infection Prevention and Control. • Antimicrobial Stewardship • Microbial and epidemiological actions • Stakeholder engagement and interventions • monitoring and evaluation to assess effectiveness of any interventions that would be put in place There has been no reply from ARHAI since the report was submitted but any feedback received will be communicated to this Committee.	
5	**Standing Items** **Item 5.1**	**<u>Sector Reports</u>** **<u>ARI</u>** A report was submitted which GMcK spoke to Items for escalation include	

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		• shower clips being removed to allow showering of patients. Aware this has already been discussed above and is no longer a concern. • mattress audits and associated costs for some areas No report has been received from Clinical Support Services (CSS) due to a change of management. **1 New Areas of Concern** **1 b) High – Mattress Audits** Concerns are that mattresses are moving all over the hospital and when audits are completed and damage found the ward who has the mattress is responsible for funding the replacement. This has become an issue in some of the Medical Unscheduled Care (MUCS) and Surgical ward as they incur the cost. Is there the possibility of a collective fund to pay for replacement; conversations are being held out with this meeting. **1 c) Plastics Dressing Clinic move** Clinic has now relocated to the purple zone and will be removed from the report. **1 d) Orange Zone, Special Block – Clinical Pharmacology** Multiple roof leaks reported. Impacting on service delivery. 10 week project to complete works and will commence March 2025. **1 f) High - Staff wearing incorrect type of face fit mask they have been tested for / wearing an FFP3 having not been face fit tested.** Has been discussed at length and work undertaken regarding DATIX reporting and training on appropriately fitted masks. **1 g) High - Ventilation concerns in Ward 303** Unable to care for patients who require droplet or airborne precautions. High risk as this has the potential to affect flow from Ward 107 and ultimately the Emergency Department (ED) and Acute Medical Inpatient Admissions (AMIA). Investigations are ongoing. **2 Progress Against Areas of Concern Previously Reported** **2 e) High - Patients being cared for in non-standard bed spaces. Including corridor care** This has the potential for increased risk of infection and continues to be a concern for all teams. At the ARI HAI Sub Group there is a framework of mitigation which can be discussed but this remains a high risk. **2 n) High - Breast Screening Clinic, Old Medical Block. Leaking issues in various locations roof defects** All roofing works completed other than the 2 Mansard Roofs. Pre-start meeting scheduled for 4/2/25. **2 l) High - Orange Zone, Surgical Block. Reports of water ingress in Wards 301, 305, 306 & Endoscopy Department** Works transferred to the Projects Department due to the scale and complexity of works required. Surveys currently being progressed, to allow the architect to compile design proposals. **2 n) High - Clinic E - various heating and roof leaks, reported throughout the clinic** Temporary works have been undertaken to contain this. Options appraisal has been submitted and awaiting outcome. **4 Mandatory HAI Education Training Compliance Figures** Not assured that all training compliance is up to date. Work to be done around this but cannot provide assurance fully.	

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5	**Standing Items cont.**	There were concerns about the number of Staph aureus bacteraemias (SABs) and Clostridioides difficile Infections (CDIs) across Renal and Ward 101. This is now in hand. Allied Health Professionals (AHPs) have been very successful in completing their mandatory training. DR asked if the training compliance figures were for staff directly employed by NHSG or do the figures include locums and temporary staff that are brought in on an ad-hoc basis. GMcK advised that the figures would include all staff working within NHSG whether that be locums, bank staff etc. **5 Areas of Achievement / Good Practice / Shared Learning from HAI related Reviews (Level 1. 2)** Surgery have done a lot of work around workplace inspections being recommenced and 5 Factor audits are being completed regularly. NE added that Ijeoma Okoliegbe, IPC Clinical Scientist had won a prestigious award - Chief Scientific Officer (CSO) of Scotland Healthcare Scientists award for quality in action. Congratulations were given. **<u>Children's Services</u>** A report was submitted which CR spoke to. **2 Progress Against Areas of Concern Previously Reported** **2 d) High - Atypical infections Neo Natal Unit (NNU) - IMT's** Remedial works have been undertaken and all planned works are now complete, however, there are ongoing cases and waterlight practice remains in place**.** VB added that these cases are multi drug resistant gram negative and particularly colonisations that are being picked up on screening tests with a few atypical infections so a bit of a "mixed bag". Have been seeing a response in some of the outcomes being measured to the change in practice and the works being completed. Ongoing works are still progressing through an Incident Management Team (IMT) process. Have been asked to share the learning around this with other centres across Scotland (and out with) regarding the introduction of waterlight care in Neonatology which has not been undertaken very often but we are now seeing an increasing body of evidence that it is a safe process to put in place. One of the things being monitored, as an outcome of introducing the change, is whether there are any adverse unintended consequences of the change in practice, in terms of other infection rates; have not seen anything to indicate that this is a concern and there appears to be some signs that it is helping. Some issues still remain relating to other themes e.g. compliance with screening and completion of the Patient Placement Tool (PPT) within the maternity service, in particular, and this is leading to the babies that are coming through to Neonatology. **4 Mandatory HAI Education Training Compliance Figures** CR shared her screen and explained that the figures shown in the report are for the whole of the Integrated Family Portfolio as unable to break down to Children's Services. Work still to do around Donning and Doffing and CDiff training. **5 Areas of Achievement / Good Practice / Shared Learning from HAI related Reviews (Level 1. 2)** Assurance walk rounds are undertaken weekly by Nurse Managers and Team Leads /SCNs. Good overall staff knowledge and compliance with IPC.	

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5	Standing Items cont.	**Women's Services** A report was submitted which SS spoke to. No new concerns to be reported. **2 Progress Against Areas of Concern Previously Reported** **2 a) High - Water issues across Women's Services** Still a concern. A system disinfection is planned for the Antenatal Clinic at the end of the month. More taps have now been labelled as safe drinking water but there are still some outlets that remain unlabelled awaiting testing results coming back. **2 b) Medium – Patient Accommodation** Works are underway so risk rating has been downgraded from high to medium. **2 e) High – Built Environment** Urgent walk rounds are being undertaken due to ongoing concerns with built environment. Issues discussed regularly at local Health & Safety / IPC meetings **3 Focus on Healthcare Improvement Scotland (HIS) Standards** Standard 8 – Built Environment - **Health & Safety Walk rounds are embedded within the portfolio** – evidenced by notes compiled and actions assigned in local H&S Teams channel. **4 Mandatory HAI Education Training Compliance Figures** Some work required around Safe and Clean Care Audit (SACCA) compliance. Working on Hand Hygiene compliance; action plan for antenatal / postnatal wards was completed and subsequent audits have shown improvement. Only 1 area has been identified as out of date with the 5 Factor Risk Assessment data. GMcK commented that there were various red and amber scores for the 5 Factor Risk Assessment data. How are the risk assessments progressing? Is there assurance that all are in place? SS was unsure but would liaise with SC for an update. **5 Areas of Achievement / Good Practice / Shared Learning from HAI related Reviews (Level 1. 2)** Well underway with preparations for any Healthcare Improvement Scotland (HIS) Maternity inspections that may take place. Have spoken with NHS Tayside and taken learning from their most recent visit. SS felt that the issues raised around shower clips and mattress audits, under the ARI Sector Report update, would also pertinent to Women's Services. Will feed this back to SC. DR asked why certain information in this report had been redacted. GMcK replied that this was, probably, due to the areas in the report not relating to Women's Services. **Aberdeenshire H&SCP** A report was submitted and AMcG spoke to it.	**SS / SC**

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5	**Standing Items cont.**	**1 New Areas of Concern** **1 a) High – Lack of Domestic Cover in Community Hospitals** This topic has been discussed at length during Aberdeenshire HAI Sub Group meeting. The issue affects the majority of sites, but very well sited on by the Domestic Service Team who are very engaged at the meetings and with local teams. Recognise there are challenges across all of NHSG but concerns are regarding the impact and flow of patients and it is felt that a lack of domestics is impacting on the ability to fill beds. No updates to Areas of Concern Previously Reported **4 Mandatory HAI Education Training Compliance Figures** SCCA completion continues with good engagement. Still having issues with training data, will revisit. VB expressed concerns relating to **2 a) High – HSE issued an enforcement notice to Edenholme Care Home regarding the management of Legionella.** Have spoken before about the Legionella risk assessment status and the roles and responsibilities etc. What help is being given in terms of governance around this from those with nominated responsibility for water? This is something that may need to be escalated – may have previously been taken to the Water Safety Group (WSG) but there does not seem to be a clear steer. These are 3rd party owned / operated buildings are very complicated. Risk rating is sitting as high and, if this is correct, there should be control measures in place to protect staff and patients; seems to be a gap in governance. Can this Committee assist in escalation? There are many issues around the ownership and maintenance of a building that creates risks for the occupying group. Has to be a clear understanding of who owns and manages those risks and water is no different to any other risk. AMcG replied that the facilities contact at Aberdeenshire Council had advised that each care home would be dealt with individually. Can raise this with the Care Home Oversight Collaborative Group; there is a wider conversation to be had around this. Will update at the next meeting. VB suggested that this be escalated to the HAI Executive Committee under item 6.2. DR confirmed that he sits on the Clinical Governance Committee (CGC) is sure they would be interested in an issue like this as would perhaps the Population Health Committee. **<u>Aberdeen City CHP</u>** A report was submitted which LD spoke to. **1 New Areas of Concern** **1 a) Medium – High proportion of agency RN and Healthcare Support worker staff at Rosewell House.** These staff are required due the opening of a further 20 surge beds at Rosewell House. Attempting to ensure that substantive and agency staff are mixed within these areas but that is quite challenging at present due to the volume of absences. Continuing to work on this. Have had senior leadership with Karen Beaton overseeing the 20 surge beds but she will be taking up a new post next week; working on a plan to get more senior oversight. ANd commented that there have been repeated outbreaks of various kinds at Rosewell House and this has been escalated, by the IPC Team, at the Clinical Risk Management (CRM) meeting on a Monday. Wonder if the risk of medium is appropriate or whether it should be higher to gain some impetus and to have a more focused view about how this issue is resolved; unsure if this is just a staffing issue. LD will liaise with JWa on this and make a decision.	**AMcG** **GJ** **LD /JWa**

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		2 Progress Against Areas of Concern Previously Reported **2 c) High - Poor mandatory training compliance in majority of areas but particularly inpatient areas** Still working with Charge Nurses to try to improve this and it does seem to be getting better. This is being monitored at the local HAI Sub Group meetings and Charge Nurses are displaying training compliance with teams in staff rooms etc. Work still to be done around the C diff module and the Infection Prevention and Control Clinical / Non Clinical refresher. **<u>Facilities</u>** A report was submitted which WS spoke to. **1 New Areas of Concern** **1 a) Medium –Ashgrove House – Physio Department - Historical leaking issues, impacting on clinical delivery** Work has commenced on this but is being hampered by the presence of asbestos. **1 b) High – Surgical Block Roof - Clinical Pharmacology Department– Extensive water ingress across multiple locations** Again asbestos issues are causing a delay. Asbestos report was due yesterday. A plan is in place to carry out the works and these should progressing in the near future. **1 c) Low – Rubislaw Ward, AMH – Legionella counts in Clean Utility** Point of Use Filters (POUFs) fitted and investigations ongoing with Colin Cruickshank. **1 d) Medium - ARI Pink Zone – Ward 216 Showers have increased Pseudomonas counts** There is ongoing work revamping Ward 216 at present and ongoing discussions around drainage and how this should be cleaned. Discussions are ongoing regarding completing this work and the available resources and budget. **1 e) High - Decontamination Services – CDU, Mile End – Clean Room** This is surrounding the fan unit and has been mitigated to low risk due to ongoing work being managed. **1 f) High – Decontamination Services – Woodend** This is an issue around the airflow passing through the unit. Looking to replace doors and pressure balancing but those works have yet commenced. Discussions are taking place. **1 g) Medium - Decontamination Services – CDU Mile End – Heavy Metals / Clean Steam** Have heavy metals dropping out from the steam that has the potential to drop onto surgical instruments being decontaminated. Have undertaken works to correct the chemical imbalance, which has solved part of the issue but now seeing heavy metals present; having this analysed to understand whether this is iron, rust or something else. Once those heavy metals are identified a plan can be developed on how to fix the problem. **1 h) Low - Decontamination Services – Dental Hospital – LDU** The unit is not being utilised at present. There is work ongoing to understand the level of work required to fix the issue from both the water side (flexibles, issues with drains) and the ventilation side. JL advised the Committee that there was a recently developed issue that is not on the sector report and this relates to the Endoscopy Decontamination Unit. Spoke with DS 17/3/25 to advise that JL and WS will be in Elgin shortly.	

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5	Standing Items cont.	There needs to be a lot of support around the endoscopy washers that are being used by an agency on the weekend; this is raising a few concerns but hopefully will have more information moving forward. Will liaise with WS and add this issue to the report for the next meeting **2 Progress Against Areas of Concern Previously Reported** **2 j) High – Purple Zone ARI – Old Medical Block** Work is ongoing and almost finished, mansard roofs are 95% complete, so this will be removed from the report in the near future. DR and WS then had a discussion regarding heavy metals with JL noting that NHSG are working very closely with colleagues at NSS assure, who are the central decontamination authorised engineers and technicians to try and resolve this issue and taking regular steam samples every quarter. **Dr Gray's / Moray HSCP** A report was submitted but no one was available from the Service to speak to it **Mental Health & Learning Disabilities** Report was submitted which JW spoke to. **1 New Areas of Concern** **1 a) Medium – Shower room and multi bedroom 3 in Fyvie ward have mould-rooms currently closed** The mould from the shower room is impacting on the dormitory. IPC and Estates are involved and dealing. SACCAs are being undertaken and should be completed by the end of March. **4 Mandatory HAI Education Training Compliance Figures** Still encountering problems with the running of reports to show compliance with the clinical / non-clinical refreshers; staff appear on both reports and so there are clinical staff on the non-clinical staff list and vice versa; this is making the figures look much worse than they are. In contact with learning and development to try and resolve that. Will run these and include for the next meeting. **5 Areas of Achievement / Good Practice / Shared Learning from HAI related Reviews (Level 1. 2)** • The Service is in the process of preparing for an unannounced inspection from HIS. NHS Lanarkshire have had their first inspection so have been in contact with them to share in their learning. • Mattresses were changed as a test of change and the new ones are far more robust and require to be changed less frequently; same work now ongoing with pillows. • Have been involved in a national piece of work, piloting a new Mental Health & Learning Disability audit tool for the environment, which will now be shared with all services **Education Group Roundup** The roundup report was submitted and DS spoke to it.	**JL / WS**

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		Mandatory Training DS is assisting Tracey Leete - Protected Learning Time Workstream (PLTW) Representative for NHSG (who is looking at mandatory training as part of a large group) with the Infection Control aspect. **Education** **Aseptic Technique** Laura Murray the Practice Education Facilitator (PEF) for Royal Aberdeen Children's Hospital (RACH) has been preparing a guide for the preparation administration of medications for peripheral and central access intravenous therapy. Before the guide is launched for use across NHSG a questionnaire will be available to enable the collection of more baseline data. **PVC Training and Bundles** The Vascular Access Device (VAD) training and bundles are now being reported on under the IPCT Roundup Report rather than this report which is where it been seen previously. **Scottish Infection Prevention and Control Education Pathway (SIPCEP)** NHS Education for Scotland (NES) are currently looking at the Aseptic Technique modules. There were 7 modules previously and these are to be condensed into a single one. No update on the progress of this as yet. **Infection Prevention & Control Team (IPCT) Roundup** The roundup report was submitted and DS spoke to it. **IPC Surveillance & HAI Screening** **MDRO screening compliance Quarter 4 October – December 2024** National MRSA CRA 81.4% NHSG MRSA CRA 65% - NHSG has been below National compliance consistently Quarters 1 - 4 National CPE CRA 83.3% NHSG CPE CRA 63% - NHSG has been below National compliance consistently Quarters 1 - 4 NHSG MRSA swabbing 57% **Clostridioides difficile** As part of this work the IPCNs will be adding an antimicrobial prompt as part of their notes in Trakcare: "***Medical staff should review and stop unnecessary antimicrobial treatments in accordance with local policies and ensure daily review of antibiotic regimens. For antimicrobial prescribing queries, please contact the duty Microbiologist."*** **Incidents and Outbreaks** There has been 1 Preliminary Assessment Group (PAG) led by the IPCT since the last IPCSC: • Influenza A .	

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5	**Standing Items cont.**	There have been 3 Incident management Team (IMTs) led by the IPCT since the last IPCSC: • 2 x Vancomycin-Resistant Enterococci (VRE) • 1 x Pseudomonas The IPCT have not been required to attend any service-led meetings to provide advice and support **Audit and Assurance** **Assurance Concerns** • VAD bundles - the relaunch meetings for these bundles continue to be held with represented representation across Grampian. The poor completion of these was highlighted during last year's HIS inspection and this work is as a result of those findings. • There was an audit of the Alcohol Based Hand Rub (ABHR) dispensers carried out across 33 areas of NHSG at the end of last year and into the beginning of this year. A report will be published in due course but the main concerns were around the cleanliness of these items. **Built Environment** • IPCNs and IPCDs are continually being asked to support works happening across NHSG in relation to the built environment, HAI Scribes etc. A Standard Operating Procedure (SOP) does exist for built environment and this needs to be embedded within the Organisation. • Baird and Anchor – IPC concerns as SILO working continues, IPC continue to advise on both the Baird Family, Hospital and the Anchor Projects and attend fortnightly walk rounds. Concerns previously listed, including construction risks on the lifetime of the buildings, remain. These concerns include - water ingress into internal fittings this is currently being assessed, construction debris and fungal contamination of ventilation, water and drainage systems and currently awaiting the Chief Executive Board decision regarding sink removal, Anchor treatment space plus ventilation and CFU. **Policies and Procedures** • A Candida auris protocol has not been developed for NHSG due to insufficient guidance, currently utilising the available limited National guidance when providing advice. **Areas of Achievement / Good Practice** • Have not added the award that Ijeoma Okoliegbe received yet (as NE reported earlier in the meeting) but this will be included. • Courses staff have attended / will be attending: 1 staff completed the HBE course in 2024 1 staff completed the IPC course in 2024 2 staff will be attending the LEO course in 2025 2 staff will be attending the LEO Senior Managers / Leaders Programme in 2025 2 staff will be attending the Leading Person-Centred Culture and Care programme in 2025	

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5	**Standing Items cont.**	GMcK stated that the MDRO screening compliance is disappointing, thought the Organisation was on a positive trajectory with this. What has been learned from that increasing positive trajectory to try and move forward as this is discussed every month at the ARI HAI Sub Group. DS replied that until Quarter1 figures have been published and received it is hard to know if the work put into improving these figures has had any effect. ANd then informed the Committee that the IPC Team have recently developed a system of tracking previously alerted MDROs. If a patient has been discharged and are being readmitted we want to be aware of this so that these patients can be tracked and enable IPC to contact our clinical colleagues to prompt any screening or swabbing and ensure the completion of the PPT. Hoping that this will improve compliance. GMcK also added that she was aware that the report for the ABHR dispensers is awaited but how will this data be used and taken forward? Over half the dispensers audited were non-compliant. ANd replied that he starting point has been to share the report with our Facilities colleagues to afford them a chance to dissect the information and look at the recommendations. Once feedback has been from them the report will be shared with this Committee.	
	Item 5.2 a)	**HAI Work Programme 2024/25 (sign off)** ANd updated that the 2024/25 Work Plan was discussed at the HAI Work Program Delivery Group meeting on 7 March 2025. All actions were discussed those that had been completed were agreed and closed off. Any outstanding actions will be taken across and included in the 2025/26 document which is currently under development. Some of the important recurring topics that will be taken across to 2025/26 include • Compliance with the PPT • VAD management work • Assurance and monitoring systems to reduce the risk of infections and to drive continuous quality improvement • Optimising antimicrobial use • Work around healthcare built environment GMcK asked for a further 2 weeks to review the programme. NE asked for comments to AS. AS advised that the 2024/25 Work Programme was not for ratification but rather for information. These reports are ratified at the start of the year by the Committee and then information is updated throughout the year. The 2025/26 Work programme will be coming to the meeting shortly for ratification.	
	5.2 b)	**HAI Work Programme 2025/26 (for ratification)** The report was not available for discussion. Will come to the next meeting.	
	Item 5.3	**HAI Executive Committee Meeting Update** ANd updated that there were 2 escalations to the HAI Executive Committee (HAIEC) 1. The challenges faced by Domestic Services and the impact across the system to patient and staff safety when there was increased demand for domestic services during periods of staff absences; part of this was driven by Reduced Working Week (RWW) and the impact that it was having on staffing.	

Item	Subject	Action to be taken and Key Points raised in discussion	Action
5	**Standing Items cont.**	2. Low staff vaccination uptake. As noted in the Action Tracker we are trying to investigate the reason for the low numbers. This is also being addressed through Public Health in their meeting yesterday – they were quoting a reduction of about 10% on uptake. Need to understand the barriers are and address these. In relation to staff absences through sickness, these are discussed within other meeting across NHSG.	
6	**HAI Report to Clinical Governance Committee / Board** **Item 6.1** **Item 6.2**	**HAI Report to the Board (HAIRT) – January 2025** No comments were made and the majority of the Committee ratified the report. GMcK asked for a further 2 weeks. **HAI Report to the HAI Executive Committee (HAIEC) (new escalations)** • Water safety in 3rd party owned properties such as care homes.	
7	**AOCB** **Item 7.1** **Item 7.2**	**Facilities Management Team Cleaning Standards Group** ANd advised the Committee that IPC Team and Facilities Management Team are exploring the formation of a cleaning standards group which will form part of the governance structure and feed into this meeting on standards of cleanliness in line with the National Cleaning Services specification. The group will be able to discuss certain issues that were brought up in sector reports e.g. domestic cover within Community, low cleaning compliance and other issues relating to cleanliness. Discussion have been had with the Facilities Management Team on how to progress so that these meetings can commence. **Hand Hygiene Gel Dispenser Audit** The report was attached and ANd gave some background. In November 2024, the IPC Team joined the Independent Auditor on an audit in 1 of the wards in ARI. Several issues were found which needed to be addressed in relation to the dispensers including the availability of gel and the maintenance of the dispensers themselves. The Team decided that a wider audit was required to look at other dispensers within NHSG to identify any other issues. A total of 33 wards were audited – 20 in ARI, 4 in Woodend General Hospital (WGH), 5 in Gray's Hospital (DGH) and 4 in Royal Cornhill Hospital (RCH); in total 297 dispensers were audited. There was various compliance criteria looked at including availability of the dispensers, the gel available, expiry date, the dispensers operational status, labelling instructions and the cleanliness. As already mentioned, the biggest issue found was the cleanliness of the units both inside and out. When cleaning compliance was broken down the figures showed – ARI 97% and WGH, DGH and RCH were all below 75% which reflected significant compliance and hygiene concerns. The report has been shared with colleagues in Facilities and will be shared wider with clinical teams, Chief Nurses and the Director of Nursing with the recommendations that these concerns are rectified.	
8	**Date of Next Meeting**	20 May 2025 10.00 – 12.00 via Teams (with a 10 minute comfort break)	