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

Minutes from meeting held 21 May 2024
Via Teams
10.00 – 12.00

Present:

GJ – Grace Johnston, Infection Prevention & Control Manager (Chair)
ANd - Astrida Ndhlovu, Deputy Infection Prevention & Control Manager
SC - Sarah Campbell, Clinical Nurse/Midwifery Manager, Women's Services
AMc – Alison McGruther, Chief Nurse, Aberdeenshire CHP
WS – **Wayne Strong**, Head of Maintenance and Technical Services
JWa – Julie Warrender, Deputy Chief Nurse, ACHSCP
FR – Fiona Robertson, Chief Nurse, Moray
PH – Paula Holton Infection Prevention & Control Nurse, IPCT
JW – Julia Wells, Chief Nurse, Mental Health
CW – Chantal Wood, Deputy General Manager, Facilities & Estates
GMcK – Grace McKerron, Chief Nurse
JB – June Barnard, Nurse Director for Secondary & Tertiary Care - Acute
AC – Aileen Cameron, Quality Improvement and Assurance Co-ordinator, Quality Governance & Risk Unit
RL – Rachael Little, Quality Improvement and Assurance Advisor, Quality Governance & Risk Unit
HC – Helen Corrigan, Health Protection Nurse Specialist, Health Protection Team
AW – Andrew Wood, Risk Management Advisor, Corporate Health and Safety
RM – Rachel Mennie, Antimicrobial Stewardship Specialist Nurse IPCT

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**	Dawn Stroud (DS) William Moore (WM) Caroline Clark (CC) Will Olver (WO) Juliette Laing (JL)	
2	**Minutes of last meeting 12 March 2024**	The minutes from 12 March 2024 were ratified by the Committee with no amendments.	
3	**Action Tracker**	**Meeting 12 March 2024** **4.2 Measles Preparedness** This action is closed, however, ANd stated that more work needs to be undertaken regarding Measles and the correct placement of patients / completion of the Patient Placement Tool (PPT). JB fedback that the Executive Director of nursing has sent out communication regarding the completion of the PPT to Portfolio Executive Leads (PELs) and obviously this will be followed up on. **4.3 Data Exceedance** Action is closed but still a work in progress. JB was happy that there is s system in place and that information will reported through the Acute HAI Sub Group; where it will be kept on the agenda at present.	

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3	**Action Tracker cont.**	**4.4 Clinical Scientist / Antimicrobial Stewardship (AMS) Specialist Nurse Posts** Ijeoma Okoliegbe has been appointed as Clinical Scientist and Rachel Mennie has been appointed as AMS Specialist Nurse. Close action **5.1 Sector Reports** **Education Roundup** Continuing to pursue medical representation on the HAI Education Group. **Meeting 16 January 2024** **5.1 Sector Reports** **ARI – Clinic C infrastructure not fir for purpose. Potential move in an area can be secured.** GJ is still awaiting an update from Tom Power / Jason Nicol regarding this. This will be monitored along with other built environment issues and picked up within the ARI HAI Sub Group sector reporting. **Compliance with Statutory / Mandatory Training** GJ awaits a reply from Tom Power / Jason Nicol. Is a concern across the Organisation. GMcK updated that there is a risk on the Nursing Directorate Risk Register about compliance with statutory / mandatory training and in light of the Agenda for Change (AfC), non-pay elements and there has been a Short Life Working Group (SLWG) set up which has met once and is being chaired by Jason Nicol / Janine Langler. Unsure of how to feed into this group. GJ will liaise with Jason Nicol on how to connect with this group. **Meeting 21 November 2023** **5.1 Sector Reports - Aberdeenshire HSCP - Trolleys with wheels and brakes should be on a maintenance schedule – this would include Ultrakarts. Discussions needed as to who maintains this equipment** GJ still awaiting reply from Mark Cowan. **Meeting 19 September 2023** **5.3 Risk Register - Risk ID 2839 – New PPE for High Consequence Infectious Diseases (HCID).** This needs to be explored further regarding allocation of the risk present on the Risk Register. **Meeting 10 January 2023** **5.1 Sector Reports** **Facilities** **2 i) Water Safety – Banff Health Centre – High TVCs. Flushing of outlets continues – IPCT to confirm next stage** Update from Colin Cruickshank was that further samples were taken 2 April 2024 and these still show high Total Viable Counts (TVCs) pre flush. More work to be undertaken. Legionella risk assessment planned for 6 June 2024.	**GJ**

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4	**Matters Arising**		
	Item 4.1 a)	**Unannounced – Acute Hospital Safe Delivery of Care Inspection Aberdeen Royal Infirmary (ARI) - NHS Grampian** RL advised that work is continuing and thanked all those involved for the significant contributions to the Healthcare Improvement Scotland (HIS), Safe Delivery of Care Improvement Action Plans. NHSG are expecting communication from colleagues at HIS shortly regarding the 18 week follow up and progress update to the action plan; this is predicted to be the week beginning the 3 June 2024. Work is ongoing and there has been a deadline set for 16.00 23 May 2024 for all responses to be submitted; this is to allow review and sign off by the PELs and their Senior Leadership Teams (SLT) on 27 May 2024 after which the document will go to the Chair and Chief Executive for review and sign off on 28 May 2024 Consistency of responses is important and those who have access to the MS Teams channel will see that there are references to different actions across both visits e.g. in the ARI improvement Action Plan there have been references made to similar actions that were identified during the DGH visit. The meeting scheduled for 28 May 2024 will ensure that the appropriate colleagues are in attendance to support the final review and sign off before it progresses through the next steps.	
	Item 4.1 b)	**Unannounced – Acute Hospital Safe Delivery of Care Inspection Dr Gray's Hospital (DGH), Elgin – NHS Grampian** See narrative above.	
	Item 4.1 c)	**Summary Report of External Inspections to NHS Scotland Boards 1 March – 31 March 2024** RC fedback that the March report was submitted for information but noted that the Committee may not find anything of interest as this was an Ionising Radiation (Medical Exposure) Regulations IR(ME)IR inspection at ARI	
	Item 4.1 d)	**Summary Report of External Inspections to NHS Scotland Boards 1 April – 30 April 2024** There were 3 inspections detailed on this report one of which was an IR(ME)IR and RC suggested that members would like to review the other 2 inspection reports. **NHS Tayside – Kingsway Care Centre – IPC Inspections of Mental Health Services** There were 4 requirements noted in the report – the 2 of interest to the Committee are: • extraction fans and the need for these to be kept clean; there was some confusion about who held responsibility for cleaning these fans. • IPC information should be recorded within patient care plans; this has been learning for NHSG also **NHS Forth Valley - Forth Valley Royal Hospital – Acute Hospital Safe Delivery of Care Inspection** There were 12 requirements noted in the report – the 3 relevant to the Committee are: • must ensure effective processes are in place to ensure the safe management and care for patients with Peripheral Venous Cannulas (PVCs) within the emergency department and clinical assessment unit. This was highlighted during recent NHSG inspections also.	

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4	**Matters Arising cont.**	• must ensure all staff comply with hand hygiene, the use of gloves and appropriate wearing of jewellery. Work is ongoing within NHSG surrounding the Dress Policy • must ensure that all staff comply with the safe management of waste including sharps and linen, all patient equipment is clean and ready for use, including mobile patient privacy screens, the hospital environment maintained and equipment stored in a manner to enable effective cleaning, cleaning products are stored safely and securely. GJ stated that these were very useful in terms staff areas / clinical areas that members are responsible for and some relevant requirements have been noted. On the subject of ventilation grills and cleaning this Committee have had discussions around this before and have been assured that this has been implemented and is embedded to ensure all are clear as to who is responsible for what. WS confirmed that this was the case. With regard to IPC information being recorded within patient care plans, this was raised at the last Royal Cornhill Hospital (RCH) mental Health Inspection, This was due to the fact that IPC call the wards rather than visit and no Electronic Patient Record (EPR) system is in place as yet. GJ queried with JW as to whether this was any further forward. JW confirmed that work on this is still in the early stages and the system is not yet in place. Must take the opportunity to learn from these inspections. JB raised the issue of fans being used within NHSG and whether there is a cleaning regime in place for them and awareness of who holds the responsibility for this. GJ replied that there are fans across the Organisation and a risk assessment available which should be completed prior to use in any area. WS stated that the cleaning of bladed fans was not a Facilities responsibility. SS advised that within clinical areas there is a process to clean fans between patient use and that this is included on the ward checklist; unsure if all wards are aware of this. GJ suggested that, perhaps, the risk control notice for bladed fans needs to be reissued along with communication around decontamination.	
	Item 4.2	**Visiting Animals within Healthcare Settings** NHSG follow the Public Health Scotland (PHS) guidance around animals visiting healthcare settings. This gives advice on what is / isn't acceptable and what can put into place to try and reduce the risk to patients and staff; when considering bringing animals into the care setting, IPC and Health Protection Team (HPT) must be contacted to discuss responsibilities. To clarify, not all animals are suitable e.g. exotics, reptiles, snakes or fish that acquire specialist foods, caged birds and rodents, ruminant animals and feral. Any animals brought in must be registered with a licensed vet, have comprehensive parasite prevention, be healthy, clean and toilet trained. A risk assessment should be completed before the visit takes place to include suitability of the animal, the area and assessment of those who are going to be present. Please could all members share with their teams to ensure compliance. CW commented that, in her experience, IPC were not usually approached before animals were allowed to visit and there was no formal process in place with regard to the checking if an animal was registered with a vet. In addition, it is increasingly noticeable the amount of people who exercise their pets on NHSG hospital sites. Notices were put up but blatantly ignored, this is tricky to control.	

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4	**Matters Arising cont.**	SS advised that some of the animals visiting the hospital are “Therapets” and work with a charity; the charity ensures all checks are completed. HC highlight that there is a difference between registered therapists and a pet being brought in to see their sick owner. A risk assessment should be completed but the lack of rigorous checks / training etc. shouldn't stop somebody seeing their pet for the last time before they die. It is a balance of risk and consideration of the patient experience as well. ANd highlighted that this topic was raised due to the increase in Cryptosporidium, an illness that causes diarrhoea and can be very detrimental to vulnerable patients. This is coming from farm animals and was to highlight that this policy extends beyond just our pets at home.	
	Item 4.3	**Clinical Scientist / Antimicrobial Stewardship (AMS) Specialist Nurse Posts** RM joined the meeting and introduced herself to the Committee explaining that her role sits within 2 teams – IPC and AMS. Ijeoma Okoliegbe – IPC Clinical Scientist was not able to join the meeting.	
5	**Standing Items**		
	Item 5.1	**<u>Sector Reports</u>** **<u>ARI</u>** A report was submitted **Key Issues raised by the ARI HAI Sub Group April meeting are:** 1. ARI HAI group not being quorate for the past 3 months, February, March and April. Asked Yvonne Wright to raise at Chief Nurse meeting. JB is aware also and reported that the portfolios have been asked to review their representation on this group i.e. not only to have an attendee but also to have a deputy in case of sickness, absence, holidays etc. Compliance will be monitored moving forward. In addition GMcK stated that reports are not being received and so this impacts on the information within this report. 2. HAI work programme around oversight groups having SACCA action plan oversight being unachievable. Have asked for exception reporting and also reports being run to gauge compliance and confirmation of 6 monthly audits being undertaken. Would appreciate a discussion around this. **Key Issues raised by the ARI HAI Sub Group May meeting are:** 1. Heat exhaustion 2. Compliance with dress policy. GMcK reminded the group that this does not sit with IPC and that there is a Short Life Working Group (SLWG) that meets weekly chaired by Katrina Robbins, however, individuals wanted this to be noted. Issues include general non-compliance with wrist watches, hair not tied back etc. **1 New Areas of Concern** **1 b) High - Leaking issue – Orange Zone, Surgical Block** Extensive roof repairs required	

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5	**Standing items cont.**	**1 c) Very High- Avoidable Staphylococcus aureus infection in Ward 108 resulting in patient death - staff concerns** Level 1 review in progress. **2 Progress Against Areas of Concern Previously Reported** **2 a) High –Patients being cared for in non-standard bed spaces including corridor care.** This can involve 3 corridor care patients at any one time and that this is increasing in some areas. **2 e) High – Breast Screening Clinic, Old Medical Block – leaking issues in various locations** Last report received was for April so this information may be out of date **2 f) Medium - Roof leaks, in various locations, within the Pink Zone.** Recent report not received so this information may be out of date **2 j) High - Ventilation in EOPD** No report received from Surgical so have no assurance around this. **2 k) High - Plastics Dressings Clinic** WS visited the area and was to do a more in depth assessment of the floor repairs. Will wait to hear if a plan for works has been formulated. GMcK has spoken to Denise Johnston specifically around surgery and have agreed a plan around main theatres and surgical representation; will hopefully be able to provide assurance around the report for the next IPCSC meeting. **5 Areas of Achievement / Good Practice / Shared Learning from HAI related Reviews (Level 1. 2)**. There are a number of positive things happening across the services. GJ fedback on some of the previous actions • The issue with the Eurobins was escalated to the Health Safety & Wellbeing Committee via the HAI Executive Committee (HAIEC) • Heat exhaustion / window situation within a specific area of Clinical Support Services (CSS). IPC are having conversations to try to address this. Need to be proactive and get information out to staff to consider. **Children's Services** A report was submitted but no attendance from the service to speak. **Women's Services** A report was submitted. SC confirmed that issues within the report had been added to the Infrastructure Issues relating to HAI document on the Teams channel and reported to Estates.	

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5	**Standing Items cont.**	**1 New Areas of Concern** **1 a) High – Patient accommodation - 5 out of 9 rooms have been closed due to mould being identified** This is due to issues with water ingress via the roof. In addition the sitting room has also had to be separated by a screen due to water damage. It was decided at the last portfolio Health & Safety meeting that this be escalated to the Expert Group with an SBAR also being written, **1 b) High - HAI infrastructure issues within Antenatal Clinic** 3 rooms within the clinic have damaged paintwork resulting from water ingress with the Team Violet room ceiling particularly affected with a risk of spores. Clinic capacity is impacted. **2 Progress Against Areas of Concern Previously Reported** **2 d) High - AMH built environment** Ongoing concerns. Awaiting confirmation as to whether works are to go ahead and unsure if costings have been completed or approval has been granted. Senior management investigating. **2 e) High - Estates work within the Neonatal Unit (NNU) delayed due to further identified issues** Update as above in 2 d) 3 **Focus on Healthcare Improvement Scotland (HIS) Standards** Signage is visible for first aid and who to report if a member of staff sustains a needle stick injury. Signs located in each department, although there has been challenges in getting staff trained to be first aiders. Is this a known issue? CW replied that it is a known issue. Katherine Targett has confirmed that there has been a member of staff recruited and so, hopefully, this will improve the situation; contact Katherine for more information. **4 Mandatory HAI Education Training Compliance Figures** All Safe and Clean Care Audits (SACCAs) that were out of date now have dates in the diary to be undertaken. Reminders are being sent out on a monthly basis to areas who are overdue on their hand hygiene audits. One area has been problematic and SC has been having conversations to ensure compliance is addressed. 5 Factor Risk Assessment information has been included in the report. SC advised staff after the last Health & Safety meeting to prioritise the Clinical / Non Clinical Refresher training to focus on improving compliance. GJ asked whether SC if the red / amber areas had now completed their 5 factor Risk Assessments; attempting to find out how embedded this is in some areas. SC replied that Ante natal / Post Natal have completed and is confident that Labour will also have; will double check on Rubislaw. GJ noted that there seem to be a number of red and amber entries, some of which will be infrastructure related but for those that are not are there action plans in place and is any support required? SC confirmed there are actions in place but asked for some guidance surrounding the N/A option if used. Does this cause the percentage to worsen and show as non-compliance? FR advised that DS was looking into this for Dr Gray's Hospital (DGH) also as it seems to be an issue here also- has been found that the N/A option does lover the percentage. ANd informed the Committee that the SACCAT is in the process of being reviewed at present and any feedback would be appreciated to ensure the tool is fit for purpose and areas are not penalised for using the	

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5	**Standing Items cont.**	N/A option. ANd also asked if SC could feedback to this Committee on how issues, particularly around water ingress, are reported / escalated to Estates. SC replied that meetings have been held with Estates with Kathleen Sangster – Senior IPCN in attendance, to discuss these issues and to plan for works to be commenced, this will hopefully be soon. The Team Violet room, however, is a different discussion as this involves external roof works; unsure of when this will be progressed. GJ also enquired as to why SC thought the hand hygiene compliance had dropped – time constraints / motivation? SC fedback that the Senior Charge does have a designated staff member to take this forward, however they do not attend the Health & Safety meetings so perhaps it is a case of them attending to gain a better understanding of what is required. GJ suggested that any successes / solutions can be used as learning so please feel free to share them. **5 Areas of Achievement / Good Practice / Shared Learning from HAI related Reviews (Level 1. 2)**. • Local Health & Safety meetings now face to face and the general feeling is that there is better engagement and discussion within the group. Estates input has been missed at the last 2 meetings which is disappointing as this is an ideal time to discuss issues with the clinical environment that Estates could support or provide any update on • HAI and Health & Safety walk rounds continue with latest looking at public corridors, toilets and entry / exits. Concerns picked up on for Facilities, Estates and Domestic teams to action. **<u>Aberdeenshire H&SCP</u>** **A report was submitted** **1 New Areas of Concern** **1 a) High – Discrepancy identified with Symbiotix / Audit results for Donbank Ward, Inverurie Hospital** Work ongoing but positive outcome on the efforts made by Lisa Leslie and SCN Katie Anderson to ensure audits are being completed correctly. **3 Focus on Healthcare Improvement Scotland (HIS) Standards** A discussion around Standard 1 – Leadership and Governance was had at the HAI Sub Group meeting which resulted in the creation of a self-assessment reflection tool. This has been devised to ascertain what attendees gain from the meetings - does the meeting fit the needs of what Aberdeenshire CHP need it to do and how does it link into the Re inspection Ready Group. Will feedback on the self-assessment at the next meeting. **4 Mandatory HAI Education Training Compliance Figures** SACCA completion continues with good engagement; no key themes other than Estates issues. Still have issues with Illuminate and updating the reports. GJ suggested that Nikki Young – Senior Secretary could be contacted for assistance with Illuminate GMcK raised the issue around SACCA, audits and action plans; do the Chairs of the HAI Sub Groups review all of the actions from SACCA audits within their group? The ARI HAI Sub Group are not.	

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5	**Standing Items cont.**	AMc replied that she does not and given the time this would take it would be an exercise undertaken by the Lead Nurse / Location Manager and the Charge Nurse. GJ suggested that this is looked into as part of the HAI Work Programme as if the HAI Sub Groups are reviewing these actions it is taking away the responsibility of the service. FR suggested that the outstanding actions / reviews would be present on DATIX and therefore the service would be aware and so could manage. The Moray HAI Sub Group do not raise this at meetings and any outstanding actions would be picked up through the students and accountability discussions that are had with unit teams. GJ will reword the ratified HAI Work Programme to ensure it is clear where the action is allocated to. The report will then be recirculated to the Committee for information. **<u>Aberdeen City CHP</u>** A report was submitted. **1 New Areas of Concern** **1 a) Non-compliance with sharp bins and PVC Bundles** This has been picked up due to some of the HAI / action plan work being undertaken; working with Charge Nurses to understand why this is happening and what can be done to improve the situation and working with medical staff, particularly around Peripheral Venous Cannula (PVC) bundles, **2 Progress Against Areas of Concern Previously Reported** **2 b) High - Poor mandatory training compliance in majority of areas but particularly inpatient areas.** This has been discussed previously. GJ asked what was meant by the TUPE process. JWa explained that this process was staff transferring over to NHSG. **2 c) Medium - Various Facilities Concerns** Have incorporated various issues into this item; aware that there is a paper within the NHSG IPCSC Teams channel which can be updated with all infrastructure issues relating to HAI. GJ fedback that the document relates to work which Garry Kidd was to refer to at this meeting, however, he has been unable to attend. The information was to be used for the infrastructure review that is ongoing as a directive from Scottish Government and the data was to try and get a feel for any impact on patients. Entries should include issues that are impacting on patient flow or NHSG's ability to see patients. CW requested that anything added to the document please be logged with Estates also. **3 Focus on Healthcare Improvement Scotland (HIS) Standards** Narrative added for Standard 3 – Communication **4 Mandatory HAI Education Training Compliance Figures** Figures have been updated. GJ reminded the HAI Sub Group Leads that the Clinical / Non Clinical Refresher figures should be being reported on within the sector reports.	**GJ** **AS**

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5	**Standing Items cont.**	**Facilities** A report was submitted. **1 New Areas of Concern** **1 a) High - Decontamination Services – CDU, Mile End – Clean Room** Issue was identified as a blocked filter and there had been an issue with the planned maintenance that was in place; this has now been addressed and the system is working at the pressure it should. **1 b) Low - ARI - RO Plant - Plant Room 20 - Burkholderia has been detected in RO loop for dialysis** All results are now clear and this concern has been closed. **1 c) High – Equipment Register** This has been a proactive piece of work undertaken and has identified a risk in the system whereby there are a number of filters, around the site, which were unknown to Estates and due to a lack of asset tagging have not been maintained. MaTS action plan being progressed on asset tagging. **2 Progress Against Areas of Concern Previously Reported** **2 a) High – Woodend Theatres 5 & 6 closed due to water ingress** Work has been undertaken and further sampling, Awaiting results. **2 m) Major - Peterhead Health Centre & Hospital IMT – Legionella Counts** There are still issues with the health centre, not the hospital, so although the Legionella has been cleared, issues still remain with TVC's, this is due to a lack of water turnover with discrepancies around the flushing and how the system is being managed. WS has written a paper which has been submitted to the IMT recommending that the health centre be put into a waterless mode; will retain water for the toilets and the staff welfare area, but all other areas are to be discussed. **2 o) High - ARI – Purple Zone – Old Medical Block- Extensive masonry and roofing defects** Works are now 90% complete. Should have been fully complete by now but 2 areas of roof are landlocked and due to being unstable scaffolding had to be erected by a specialist. Expected to be complete in 6 weeks. Estates are aware of all roof issues. All are documented on the backlog maintenance list. Required roofing works are extensive with the largest repair being the Pink Zone; balconies 6 and 7 have been completed and balconies 2 to 5 will be commenced this year along with the Orange Zone Surgical block. **2 w) High – Dr Gray's – Ward 10 (Training Ward)** Gaps in flushing. When building is occupied it is the responsibility of the ward staff to undertake flushing and when unoccupied Estates will deal. Due to the nature of the ward occupancy is not regular and the system was not being flushed regularly; this is being addressed. System has been flushed extensively and samples taken to understand the extent of the problem. Staff advised not to use the water and there is no patient risk due to the nature of the ward. **2 x) Dr Gray's Ward 8 – Legionella** 1 shower is affected and will be removed and re plumbed in; works planned imminently.	

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5	**Standing Items cont.**	**4 Mandatory HAI Education Training Compliance Figures** GJ noted that the IPC training percentage was low at 40%. WS replied that there were issues with staff gaining access to TURAS and is aware that recording of training is not particularly accurate. CW stated that the Catering Team do their training on paper, as do some other areas and there is a slippage in this information transferring over to TURAS; this is being looked into. In addition Linen, Decontamination and Estates are all over 60% compliant with the non-clinical IPC refresher training. GJ fedback that as part of the Gloves Off campaign IPC have been delivering training sessions to porters and domestics which has been well received so will continue with these. **Dr Gray's / Moray HSCP** A report was submitted **1 New Areas of Concern** **1 a) Medium – Sluice in Ward 7** This has already been repaired due to inappropriate use. Issue with space to house machine – will require a project to move it. Discussions with Estates. **1 b) High – Peripheral Venous Cannula (PVC) Compliance** Work is needed across DGH with regard to compliance. **1 c) Medium – Patient Placement** Work ongoing around appropriate patient placement / transfer of patients to community hospitals from DGH. **1 d) Medium - Large amount of back log maintenance issues across the Community Hospitals** This is being reported through the Estates reporting system. GJ queried whether these are captured in the formal Estates & Facilities backlog maintenance program that Gavin refers to the Physical Infrastructure Programme Board. Aware that there is going to be a risk review of oversight of the all the infrastructure issues and would like to make sure that some of the issues mentioned today are captured within that for consideration. WS explained that he or the Estates officers are made aware of issues which will then be added to the backlog list – tends to be the higher risk, higher cost, higher profile issues that are added. The Committee were given some background on the new SAMs system being rolled out; the new system not only allows NHSG to manage risk but also holds general information about properties e.g. square meterage, location, photographs etc. Rollout is almost complete in terms of uploading of all the relevant data but there are some gaps in the information. GJ asked if there was a criteria for an issue to be added to the system e.g. minimum project cost. WS confirmed this was not the case; all infrastructure issues will be included – a "one stop shop". FR queried whether the space quality and functionality DGH strategy work (completed by Graham Legge and his team) will be included on the SAMs system also. WS confirmed that it would be. CW added that it would also be included in the paper that Garry Kidd is producing around the risk review / oversight	

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5	**Standing Items cont.**	**2 Progress Against Areas of Concern Previously Reported** **2 a) Medium - Ward 8 Dr Gray's Hospital (DGH) High Dependency Unit (HDU). Ward relocated for heating and floor to be replaced** Works have now been completed and this will be removed from the report. **2 b) Medium – Dr Gray's HIS Inspection report released 1 February 2024** Actions and Improvement Plan are being progressed. **2 c) High - Flooding within Dr Gray's impacted on Records Department** Incident Management Team (IMT) meetings are ongoing. **2 l) Medium – Flooring to be replaced within the main kitchen at Dr Gray's Hospital** This will have a big impact across DGH. Will update on progress. GJ informed the Committee that this was the last meeting that FR would be attending due to her retirement and thanked her for all her input given over the years. **Mental Health & Learning Disabilities** Report was submitted **2 Progress Against Areas of Concern Previously Reported** **2 f) Medium - Positive routine water samples for Pseudomonas Aeruginosa in Dunnottar Ward** This is ongoing and still a concern. Awaiting sampling. Karen McDougall (IPCN) is aware and has had discussions with Estates. **5 Areas of Achievement / Good Practice / Shared Learning from HAI related Reviews (Level 1. 2)**. • Successful hand hygiene celebration event **Education Group Roundup** The roundup report was submitted. **Mandatory Training** **Hand Hygiene module and assessment** Updating of the IPC documents is progressing **Audit & Assurance** **Hand Hygiene Audits** These are often a challenge and not always embedded in all areas. We were asked to request the Stage and Placement number of any Student Nurses found non-compliant during their quality assurance (QA) hand hygiene audits up to and including 05.04.24 to try and assist the he lecturers from universities ascertain where they need to target more education / training. Nikki Young has produced a document detailing the outcome of three staff groups.	

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5	**Standing Items cont.**	Student Nurses were found to be non-compliant on 5 / 24 observations (21%). These were all Stage 1, Placement 1 students. Need to explore further where there is a gap in knowledge and try to assist. The type of placements may also be a factor due to students not always placed in wards initially this needs to be considered when students commence their placements. **Education Reporting** The Clinical and Non-clinical IPC Refresher modules cannot be included in the mandatory training as this is not mandatory for all staff. NHS Education for Scotland (NES) are not able to resolve this issue at present this and is impacting the whole of Scotland. **Policies and Procedures** DS has been working with the Volunteer Policy Group, which is currently being held every two weeks, with a view to advising, along with other specialists, training requirements for volunteers. **Scottish Infection Prevention and Control Education Pathway (SIPCEP)** **IPC Zone on TURAS** This has been built on the IPC Zone on TURAS and is live. Has been out for comment to IPCT and HAI Education Group with comments required by 10 May; will them make the required changes and advertise. **Aseptic Technique Modules** There is an update on this in the report for the Committee to read. Work is ongoing with the HAI Education Group to embed and has been promoted on the main NHSG Intranet page via a banner. **Escalations** The HAI Education Group is still seeking medical representation to attend meetings. **Infection Prevention & Control Team (IPCT) Roundup** The roundup report was submitted **IPC Surveillance & HAI Screening** Quarter 1 figures January – March 2024 **NHSG** MRSA CRA 55% MRSA swabbing 46% CPE CRA 65% CPE swabbing N/A National figures expected at the end of this month **SABs** **Total Healthcare SABs** NHSG did not reach the upper control limit for total healthcare SABs (as stated in previous report), however did for total NHSG SABs; breached the warning limit for these once in Quarter. Figures are satisfactory for total healthcare SABs. Data continues to be monitored and shared via DATIX for preventable SABs, in addition to escalation via the relevant routes.	

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5	**Standing Items cont.**	**Incidents and Outbreaks** There have been 2 Preliminary Assessment Groups (PAGs) since the last IPCSC: • 1 x Ventilation • 1 x Hand Hygiene There have been 2 Incident Management Team (IMT) meetings: • 1 x Legionella • 1 x Enterobacter Cloacae ESBL The IPCT have also attended the following service-led meetings to provide advice and support: • 6 x Dr Gray's Health Records • 5 x Water Results • 1 x Legionella Other incidents/outbreaks that were managed but did not require an IMT or PAG include Influenza A and Norovirus. **Audit & Assurance** The SACCAT is currently under review based on feedback from users and changing guidance. **Built Environment** • IPCNs & IPCDs are looking at ways of working to enhance current practice. • The Healthcare Built Environment SOP requires to be embedded in NHSG to reduce delays and risk to patients and staff • There are concerns regarding the increase of works happening within NHSG requiring IPCN input, complexity of areas and also non-healthcare NHSG settings, such as GP Practices, requiring assistance. **Policies and Procedures** The Lone Worker policy for IPCNs has been drafted and is awaiting sign off **IPCT Workforce** Vacancies for AMS Specialist Nurse and IPC Clinical Scientist have been filled. Pleased to welcome Rachel Mennie as AMS Specialist Nurse and Dr Ijeoma Okoliegbe as IPC Clinical Scientist. **Areas of Achievement / Good Practice** • The IPCNs have compiled and presented a "How can IPC contribute and improve the patient journey while reducing's HAIs" poster for the Celebrating Excellence in Care Conference in April. • There is ongoing work by the IPCNs happening in May regarding the Gloves off Campaign and this involves domestics and porters • Hand Hygiene Day commenced 6 May and was well promoted across NHSG. Support was also given by various reps	

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	Standing Items cont.	ANd raised the issue the risk of no dedicated IPC cover for GP practices. Not only a risk of no IPC cover but also but also destabilises the team when issues occur and we have to respond in a very urgent manner e.g. water results. GMcK brought up the Healthcare Built Environment Standard Operating Procedures (SOP) and GJ updated that this was due for review. This document will, in time, be uploaded to the Built Environment intranet page that Facilities & Estates are working on. HC fedback that that the HPT are receiving more calls from NHSG staff looking for IPC advice on working in patient's homes / the community. The HPT often assist in these situations as staff have repeatedly been advised to ask for support from other departments and are frustrated. Need a clearer pathway for staff to know who to contact for advice. HC gave a brief background on a recent occasion; clarity is needed for all. GJ will speak with the Team regarding this, there have been no changes in policy.	
	Item 5.2	**HAI Work Programme Delivery Group** Report was submitted. This was not discussed.	
	Item 5.3	**Risk Register** Some of the risks had already been discussed during the meeting so GJ only raised pertinent risks **ID 3243 - Transmission of Multi Drug Resistant Organisms (MDROs) in the Healthcare Environment** This remains a risk across the Organization in terms of compliance with screening and the follow on risk for patients and staff. Due to patients not being screened, as per protocol, this results in the inability to isolate patients effectively as no MDRO status is known; this in turn impacts on staff. Need to continue to work with clinical colleagues. **ID 3498 – Healthcare Associated Infection (HAI) as a Consequence of Use of Non-standard Patient Areas** Patient Placement Too (PPT) is not being completed effectively and this has been shown by the snapshot audits that have been completed. Unfortunately there is no system / process in place which automatically collects this information (although information seems to be collected on TrakCare) so there is no way of running reports to assess compliance. Trying push forward with this as there is a risk to patients when not being accommodated in the appropriate place given the HAI risk that may be present. **ID 3499 – Inaccurate reporting of IPC Mandatory Learning via TURAS** This relates to the clinical non-clinical refreshers. Once this has been embedded and reports are being received; this can be closed. **ID 3566 - Information to support IPC advice and decision-making regarding HAI risk is not available** The environmental lab have ceased supporting the more widespread environmental sampling that IPC were accessing and there is no plan at the moment (that has been shared with the Team) as to how we can access this service.	

Item	Subject	Action to be taken and Key Points raised in discussion	Action
5	**Standing Items cont.**	**ID 2654 - IPC Team's inability to provide thorough HAI SCRIBE to all built environment projects across NHS Grampian** The department has recruited new staff recently, however not all posts are permanent. The risk remains for NHSG, especially given the infrastructure concerns across NHSG where IPC input could be required. **ID 3096 – Lack of Governance process for IMT Reports** There are 2 IMT reports progressing through the governance process at present. Not yet assured that that is effective, so that will remain on until we have the assurance required. **ID 2839 - New PPE for High Consequence Infectious Diseases (HCID) - Availability of Stock & Resource for Training** This will close until national information has been shared with ARHAI. Once received NHSG will have clear guidance of what is required and this can then be addressed. The concern is in relation to the resources and change in practice where there is a wider staff group that's going to require training. **ID 3292 – NHSG non-compliance with National Guidance re Venous Access Devices** This is in relation to two different practices being used within NHSG. 1 complies with the updated ARHAI guidance and the other complies with the pre-existing guidance. Awaiting for the NHSG policy to be reviewed by Justine Collie and Robert Hobkirk. **ID 3054 – Sustainability of IT platform supporting Operational response to IPC** The ICNet contract has been extended for a further three years, however, assurances still required regarding allocation of IT support.	
	Item 5.4	**HAI Executive Committee Update** There were 3 escalations to the HAIEC at the last meeting • Eurobins being left unlocked. This was added to the Occupational Health Safety & Wellbeing (OHS&W) Committee report. • Water Management – Gaps in compliance are evident across the Organisation. 2 papers were submitted to the HAIEC, which had been previously been escalated to highlight concerns 1. Water concerns arising from IPCT investigations for awareness of Senior Management Team SBAR 2. Grampian Water Safety Management / Current Issues SBAR A discussion then took place on responsibilities for flushing and how this can be taken forward to ensure compliance. It was suggested that the NHSG IPCSC progress this, however, GJ was not keen to have this moved forward by this Committee and is happy to approach and discuss with a nurse manager who recently attended the WSG and is interested in the IPC aspect. GJ suggested she could meet with this member of staff and a representative from Facilities & Estates to work on a joint approach.	**GJ / Facilities & Estates**
6	**HAI Report to Clinical Governance Committee / Board**		
	Item 6.1	**HAI Report to the Board (HAIRT) – April 2024** The report was tabled and GJ explained the content.	

Item	Subject	Action to be taken and Key Points raised in discussion	Action
6	**HAI Report to Clinical Governance Committee / Board cont.**	Page 20 shows Facilities and Estates Domestic performance as below 90%. GJ has received narrative from CW regarding this so is able to share with the HAIEC / NHSG Clinical Governance Committee (CGC) if question on low scores. GMcK asked for the feedback / narrative that CW supplied. CW fedback that the Facilities Monitoring Tool (FMT) reports are done quarterly and at the last quarter there had been amber areas. Those were resolved and the most current reports are now compliant and green throughout. WS added that approximately two thirds of the remedial work that is reported are painting defects and this lowers the scores. GMcK also questioned the score of 47.6% for Royal Cornhill Hospital (RCH) in October 2023; there is narrative below that states "*2nd half of October's Domestic Monitoring not complete; management team aware".* CW replied that she assumed that the audits had not been undertaken but would investigate and report back. GMcK / JB asked for a week's extension to review the HAIRT before ratifying.	
	Item 6.2	**HAI Report to the HAI Executive Committee (HAIEC) (new escalations)** • Gaps in assurance from the ARI HAI Group due to low attendance at meetings	
7	**AOCB** **Item 7.1**	**NHSG HAI Education Delivery Plan 2024/25 (for ratification)** GMcK / JB asked for a week's extension to review the Delivery Plan before ratifying; the remainder of the Committee were happy to approve.	
8	**Date of Next Meeting**	2 July 2024 10.00 – 12.00 via Teams (with a 10 minute comfort break)	