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

Minutes from meeting held 20 September 2022
Via Teams
10.00 – 12.00

Present:

GJ – Grace Johnston, Infection Prevention & Control Manager (Chair)
CC – Caroline Clark, Chief Nurse, Combined Child Health
GP – Gavin Payne, General Manager of Facilities & Estates
LMc – Lesley McManus, Interim Nurse Manager, Older Adults Inpatient Service
AMc – Alison McGruther, Chief Nurse - Aberdeenshire CHP
FM – Fiona Mitchell, Nurse Manager, Elderly Services
GMcK – Grace McKerron, Chief Nurse
DS – Dawn Stroud, Senior Infection Prevention & Control Nurse
VB – Vhairi Bateman, Chair of Antimicrobial Management Team / Infection Prevention & Control Doctor
LR – Lesley Roberts, Safer Workplace Programme Lead
MJM – Malcolm Metcalfe, Deputy Medical Director for NHSG

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**	William Moore (WM) Janice Rollo (JR) Leonora Montgomery (LM) Andrew Wood (AW) William Olver (WO)	
2	**Minutes of last meeting 5 July 2022**	The minutes from 5 July 2022 were ratified by the Committee with the following amendment Item 2 – Minutes of the last meeting should have read **24 May 2022** not 22 March 2022. AS amended. Item 4.1 – wording changed from "GMcK stated that care and comfort rounding is being trialled in Medicine at present" to "GMcK stated that stopping the care and comfort rounding in Medicine is being trialled at present"	
3	**Action Tracker**	**Meeting 5 July 2022** **4.1 Recent HIS Inspection for Awareness – Safe Delivery of Care Report – Forth Valley Hospital** In the event of the HIS Inspectors arriving at ARI Is a process being followed due to the lack of front door staff and reception area within the Aberdeen Royal Infirmary (ARI concourse); at present works are ongoing. CW will investigate works and feedback on timeframe for completion. Various updates received from CW. Last one dated 15/7/22 was "Concourse HAI SCRIBE being removed tonight. It is ready to come down just now (12.23pm) but cannot be removed when area is highly populated due to H&S Risks". Completed. Remove action. GMcK raised the question that although ARI main concourse is now open the reception desk is no longer manned. Has the process been updated to reflect this or is the previous process (where the Inspectors are	

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3	**Action Tracker cont.**	asked to attend Aberdeen Maternity Hospital (AMH) reception) still applicable? JR to be consulted regarding present arrangements.	**AS**
		Add the issue of ARI concourse works to the Front Door SBAR. Sonya Duncan completed this. Close action.	
		JR to ensure interim Inspection Communication Flowchart is devised and circulated for enactment JR completed this and shared flowchart. Close action	
		5.1 Sector Reports	
		Aberdeen City CHP	
		2 f) High – Porters have not yet managed to install a cleaning schedule CW will take this to the Health & Safety Expert Group. Neil Duncan is progressing waste audits at present. CW will also look into cleaning schedules / processes and feedback to the Committee.	
		CW spoke with Neil Duncan and sent an update regarding Waste via email 13/7/22. AS forwarded to the Committee 14/7/22 Close action	
		HAI Education Group	
		2 g) High – IPCT concern that DGH and Moray HAI Groups are not meeting frequently enough to give assurance on oversight DGH / Moray HAI Sub Group to formally advise IPCT of their merger and send all papers AS.	
		No update available.	
		Infection Prevention & Control Team (IPCT) Roundup	
		IPC Surveillance & HAI Screening - MRSA and CPE screening compliance remains challenging Need an evidenced plan to take this forward. GJ / GMcK will discuss prior to the next Clinical Governance Committee (CGC) meeting (12 August). GMcK / GJ did not discuss however Noha El Sakka – Infection Prevention & Control Doctor (PCD) presented a plan to the NHSG CGC on 12/8/22. Close action	
		A discussion then took place at to why this compliance continues to be challenging, Suggestions were that this could be due to the Electronic Patient Record (EPR) and electronic Patient Placement Tool (PPT) or simply due to the level of pressure and workload staff are experiencing. VB will take this to the floor for discussion and any comments. Will feedback. GJ will asked for this to stay on the ARI HAI Sub Group agenda to be discussed. GJ will look into the criteria for Carbapenemase Producing Enterobacteriaceae (CPE) screening on the National Tool.	**VB** **GJ**
		Audit & Assurance Are the Safe and Clean Care SACCA's being input into Illuminate? GJ fedback that SACCAs data is being entered onto SNAP Survey. Matthew Toms & his team are working on Being able to pull reports on this data from Illuminate.	

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3	**Action Tracker cont.**	GJ also asked the Committee members to remind staff undertaking the SACCAs to ensure an email address is entered into the system so that they receive the Audit Tool report. **Item 5.2 HAI Education Programme 2022/23 (for ratification)** AS sent to the Committee 7/9/22 for ratification by midday 14/9/22. More narrative was added to the report at this time and the final (ratified) document was then sent 14/9/22. Close action. **IPC Standard 8 – the Built Environment** GMcK will add narrative to the Work Programme regarding HIS Inspection that was discussed at the Leadership Council meeting. Narrative added 30/8/22. Close action. **<u>Meeting 23 November 2021</u>** **5.1 Sector Reports – Dr Gray's** DV will send an updated Sector Report containing training figures to AS. No update given and no report received. GJ will liaise with DV.	**GJ**
4	**Matters Arising** **Item 4.1**	**Recent HIS Inspection for awareness - Safe Delivery of Care Report – University Hospital Crosshouse, NHS Ayrshire and Arran** The Inspection Report, Improvement Action Plan and SBAR were shared for information GMcK confirmed that she had worked on the SBAR with JR and Aileen Cameron and spoke to its contents. When inspectors visited on the 3 May 2022 the hospital was at its highest level of response at code purple, however, the inspection went ahead. 6 wards were inspected the 3 day visit time and the inspectors then returned on 24 May and to review some of the concerns that they had witnessed on their first visit; at this time they inspected a further 10 wards. 13 requirements were identified from this visit and in the SBAR it can be seen that under each detailed requirement is listed the evidence and NHSG should look to have to support if we experience a similar visit e.g. requirements 1 and 2 are around systems and pathways: • Requirement 1 - must ensure systems and pathways used to direct patient to other services are up to date and accurate. • Requirement 2 – must ensure that people in hospital are treated with privacy and dignity and that all patients have suitable access to facilities to meet their hygiene needs. Suggested evidence includes: • comfort rounds – where they are performed • policy – ensure locked door policy is in place (JR is working on this) • correct use of language – e.g. return to Standard Infection Control Precautions (SICPs) NOT referring to Winter Respiratory Guidance or Red Amber Green Pathways • ensuring risk assessments are in place for our priorities of care for additional beds in any of our areas Common themes for all Healthcare Improvement Scotland inspections seem to be around hand hygiene (that the 5 key moments are observed and practiced), patient placement, respiratory pathways, IPC guidance, use	

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4	**Matters Arising**	of Personal Protective Equipment (PPE) and workforce and completion of risk assessments. GJ also reminded the Committee that inappropriate glove use is also an issue and asked that staff be reminded to ensure they are using PPE appropriately. **Item 4.2** **Safer Workplaces Update / Exit Strategy** LR spoke to the report submitted The Safer Workplaces Team (SWP) were in place from January 2021 and in the latter stages were embedded within the IPC Team. Stats update: • 1160 Assurance visits • 325 Personal Protective Equipment (PPE) visits • 84 Kind to Remind visits • 21 COVID Outbreak Support visits There is a great deal of learning to be passed on and how the Organisation will approach ongoing processes after moving forward. The Teams channel will remain available (through the SWP SRO) and lessons learned have been developed. The main issues have been: • Hand hygiene compliance – over use of gloves, which gives a false sense of security. Both clinical and non-clinical areas required support during step down and benefitted from the "sign posting role" and the team has been a valuable resource. • the wearing of PPE – staff need guidance to individually risk assess patients in accordance with Transmission Based Precautions (TBPs) and students were witnessed as unprepared / lacking training and rely on placements to gain experience. There have also been difficulties in changing medical staff's attitudes towards best practice surrounding PPE and hand hygiene. The kay takeaways from the PPE issues are surrounding masks and challenged many staff: • masks were worn on chins, hanging from ears etc. or put into pockets for re-use • the guidance on mask wearing was constantly changing which was confusing • clarity of guidance for individual areas was required and simplification of messages that staff were receiving and practical implementation was needed so that impact was witnessed by staff In summary SWP integrated into IPC to provide better support to NHSG staff until the end of September, the exit strategy was approved by the Weekly Systems Decision Making (WSDM) Group and lessons learned need to be embedded by all managers moving forward. GMcK then formally thanked LR for all her hard work leading the programme and the Team for all their efforts. GJ agreed and stresses that the SWP have assisted IPC in various ways throughout the programme's duration. VB then commented on what has been learned from what the SWP Team has observed. Local work has been presented in real time within our organisation and what can be done with the findings rather than waiting for the HIS Inspectors to visit, encounter issues and make mandatory recommendations to us. Pressures on the system are accountable.	

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4	**Matters Arising cont.**	GMcK agreed and asked how NHSG manage this as an organisational issue moving forward. GJ suggested pulling together the themes from the HIS and SWP reports and presenting a combined paper to the WSDM Group to illustrate potential failures within NHSG should HIS visit. GJ asked the HAI Sub Group Leads if they had any comments. FM, CC and AMc all agreed with what had been discussed but had no suggestions on how to improve compliance at that moment. FM, however, fedback that discussions had been had regarding the possibility of a "Champion" or Link Nurse within areas. GJ agreed that this could be a way forward and would be keen to hear feedback if this was implemented. LR reminded the Committee that there were approximately 200 SWP Champions within NHSG already. Will share the details of these staff members with GMcK so that this information is available. GMcK suggested that the SWP Update / Exit Strategy be sent to the HAI Sub Group Leads to discuss / address at their meetings. LR will update the report and AS will ensure it is sent to HAI Sub Group Leads.	**LR / AS**
	Item 4.3	**DL(2022) 29 - Updates to COVID-19 asymptomatic testing guidance for patient testing; adult care home staff testing; extended use of face mask guidance and launch of COVID and Flu Vaccination Autumn / Winter 2022** This document was circulated 22 August 2022 and a Short Life Working Group was set up to discuss the changes and implications this would have for NHSG. However DL(2022) 32 was published on 14 September 2022 and further changes have been made in relation to the testing regime. GJ added that she hoped that those Committee members that this is relevant to have representation on this Group. If representation is required please contact GJ / GMcK and an invite can be sent. The group meets every 2 weeks. The main points in DL(200) 29 were: • The use of Fluid Resistant Surgical Masks (FRSMs) and whether this would continue until March 2023; this is still relevant and so should continue to be implemented. • COVID testing - this has now been superseded by DL(200) 32 with a step back in asymptomatic testing • Promotion of COVID and Flu vaccinations for Autumn / Winter. GJ asked the Committee to ensure they are sighted on the DL documents to ensure correct compliance moving forward.	
	Item 4.4	**Embedding of IPC Standards** The IPC Standards were published by HIS and are for all Health and Social Care. The previous standards (from 2015) have been refreshed with 2 new standards having been set and all were to be implemented by 8 August 2022. A letter was sent to Chief Officers (and others) seeking assurance of cognisance and confirmation that Self Assessments were being undertaken – this generated some discussion and questions on how to apply them to such a variety of complex areas with different staff groups, patient groups, environments etc. The Standards are pragmatic and not all of them apply to all areas, it is recommended that the booklet is read as it gives examples of evidence. Need to be assured that the Standards are being met – don't have to meet all the criteria just evidence that each area are aware of them and applying them, as best as possible. If not yet achieved yet, please evidence that Teams are considering and trying to implement.	

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4	**Matters Arising cont.**	AMc fedback that Aberdeenshire CHSCP) were slightly later in giving assurance due to the HAI Sub Group having been regrouped / refreshed, however, they did hold a workshop and completed the Standards across the care homes, day services, hospitals and the Community areas. There is now a live document to refer to and the Group are assured by the level of knowledge and engagement; this continues to be a work in progress. FM updated that Aberdeen City CHP had initially planned to compile one for all locations but it was decided that this was too complicated to do and separate ones for Inpatients, Community, Vaccination Centres and Care Homes were composed instead. Does the Service submit these for feedback or are they kept for local review? GJ confirmed that the Assessments are applicable to the Service and for them to be able to confirm / be assured that pertinent conversations are being had. If there are gaps between the Standards and what Teams are providing this is an opportunity to develop an action plan. If that action plan cannot be achieved by the Service, this needs to be identified and added to their Risk Register and potentially brought to this Committee for support / assistance in achieving compliance. LMc advised the Committee that the Mental Health & Learning Disabilities (MH&LD) service have had discussions around the Standards at their Multi-Disciplinary Team (MDT) meetings and have succeeded in compiling a Self-Assessment; this will be taken back to the HAI Sub Group for regular discussion and assurance that standards are being met.	
5	**Standing Items** **Item 5.1**	**Sector Reports** **<u>ARI</u>** A report was submitted GMcK planned to streamline the report but has been unable to reduce the length. Key issues overall include • Staff continue to be unable to comply fully with mandatory training / education. GJ added that this is a corporate objective which has been discussed in length at the HAIEC. There is a Group, led by Linda McKerron, who are looking at ways to improve compliance. • Safe and Clean equipment audits – ARI HAI group not assured that these are consistently happening across all areas. • Use of fans – can the RCN and guidance be re-distributed as not all areas are applying guidance to the use of bladed fans. GJ asked AS to redistribute the Bladed Fan Guidance Update regarding attendance at the Sub Group - attendance is better but not across all sectors consistently so this remains a risk.	**AS**

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5	**Standing Items cont.**	**1 New Areas of Concern raised by Divisions** **1 a) Facilities & Estates – Medium – Who is undertaking the cleaning of balancing vents within high risk areas** Confirmation has been received that this is the responsibility of Facilities & Estates and not Domestic Services, This has caused some debate and has been escalated to the Ventilation Lead / Maintenance Manager – discussions to be had. **1 i) Clinical Support Services – High - Ongoing leakage from dirty water pipes in the clinical support areas** This is surrounding Pharmacy, Level 0, Pink Zone. Was added to the Risk Register in July 2017. However, there have been increased incidences over the last two months. Remedial works have been completed after each episode, but incidents continue approximately every 3 to 4 months. This has been escalated to Yvonne Wright. GP responded that an analysis of the leaks was completed less than a year ago and no pattern could be found so no single point of failure can be established, could be a variety of things from blocked toilets, broken pipes etc. No easy solution due to the area being at the bottom of the stack. GJ added that she would need to find out a little more regarding the areas this is impacting upon. No one was aware of what this area was designed for when the building was built as this was 1970s. VB noted that it's never ideal to have lots of services running above occupied clinical space, particularly where there are services such as the aseptic suite. **4 Areas of Achievement / Good Practice / Shared Learning from HAI related Reviews (Level 1, 2)** **Medicine** Portfolio has identified requirement for review and action to improve HAI governance reporting structures with work commenced on this process. **CSS** Senior Management Assurance walk rounds have recommenced June - clinical waste streams. July – ventilation. August – Appropriate use of PPE Learning taken from walk rounds is shared and implemented. All findings documented on a centrally collated spreadsheet **Estates** Monthly HAI Audits of public areas, within ARI, to commence, as of 15/8/22; to be conducted alongside Lisa Leslie. **Children's Services** A report was submitted CC left the meeting and the report was not discussed. **Women's Services** No report was submitted and there was no representation at the meeting.	

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5	**Standing Items cont.**	**Aberdeenshire H&SCP** A report was submitted. **1 New Areas of Concern raised by Divisions** **1 a) High – Symbiotic scores – change in scores as services adjust post COVID** There is a likelihood that when domestic staffing decreases that the symbiotic scores may drop; this is a concern and required to be escalated. AMc will meet Charles Gordon to discuss any gaps or how this can be dealt with if scores do decrease. GP had an update on this and informed the Committee that this has been taken to the Weekly Decision Making Group and escalated to the Chief Executive Team who have been successful in obtaining a level of extended funding to rebalance the staffing cohort across NHSG. GJ offered IPC support surrounding this and the potential failure to meet National Cleaning Standards due to lack of staff. **2 Progress Against Areas of Concern Previously Reported** **2 a) High - HSE issued and enforcement notice in house care home Edenholme - breaches in management of Legionella** There is no Legionella "plan" (as exists within NHS Grampian) for the Aberdeenshire Council owned / Partnership owned care homes. A piece of work has now commenced from this as assurance must be sought as to how this "plan" is being rolled out. VB posed the question, what role the NHSG IPCSC plays in care home assurances. A discussion then took place regarding Aberdeenshire being the only partnership who owns care homes and very sheltered housing. VB noted that she was uncomfortable with this risk being on the sector report and as to how is this issue is escalated and whether there is the correct expertise surrounding it. It is understanding how these buildings are being managed, what standards are being kept and with whom does the responsibility lie. GP suggested that this should be discussed at the WSG. As an organisation, we have a duty of care to patients and staff that are placed into these premises but we are not responsible for these premises. **2 b) High – Multiple Estates issues regarding leaking roofs and support required** AMc spoke of these issues and noted that these continue to be escalated via the Estates helpdesk and are noted on the Aberdeenshire Risk Register **2 c) Very High – Continued outbreaks within care homes and very sheltered housing** Outbreaks continue and are monitored via AHSCP, Care Home Oversight Board and assurance visits and support are delivered via the Care Home Assurance Nurse Team / HPT. PPE and Donning & Doffing Training continues however there is a large turnover of staff within privately owned care homes which does not help. **2 d) High – Concerns raised across the Shire vaccine centres with regard to environment and learning** Working closely with teams to ensure resolution. Cannot give any further update at present There is also an additional concerns which is not present on the report and relates to the Garioch Clinic - the private company has withdrawn due to non-payment of invoices. Have asked for an update and will feedback **Areas of Achievement / Good Practice / Shared Learning from HAI related Reviews (Level 1, 2** A paper detailing various inspections has been shared with the AHSCP Clinical and Social Work Governance Committee to highlight Health Improvement Scotland (HIS) plans going forward and to support teams with ongoing preparation work	

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		Aberdeen City CHP A report was submitted **1 New Areas of Concern raised by Divisions** **1 a) High – Tristel cleaning products not approved by Huntleigh for cleaning of Doppler probes** Tristel is not approved by manufacturer and Community teams do not have access to an ultraviolet (UV) machine. Risk assessment in place. Looking for IPC advice. VB suggested speaking with Fiona Smith – Senior IPC Nurse as she has been involved in work surrounding decontamination of invasive / non-invasive devices. FM will investigate costings and weigh up against probe use to determine whether the purchase of a UV machine would be cost effective. **1 c) High – Staffing shortages within Domestic Team has led to reduced cover in the evenings** Has not, at present, affected clinical areas as prioritisation has been put in place. Domestic management team has to been asked to escalate to Nurse management should cleaning of clinical areas become compromised. FM also raised an issue for concern not on the report regarding the Horizons Building. Lisa Leslie has performed a walk round and has highlighted a number of concerns to be addressed- waste disposal, old signage etc. Will report findings and a group will be assembled to put an action plan in place. **3 Mandatory HAI Education Training Compliance Figures** Compliance is variable - work to do. **4 Areas of Achievement / Good Practice / Shared Learning from HAI related Reviews (Level 1, 2)** Care Home Assurance Team continue to work with older adult care homes and MH&LD to support with outbreak management and ongoing implementation of IPC standards in conjunction with the Health Protection Team (HPT) and social work colleagues. There has been great collaboration between Allied Health Professional (AHP) and nursing services to complete the self-assessment for the new IPC standards. HAI walk rounds are taking place for inpatient settings and review visits have shown action plans are being taken forward and completed **Facilities** A report was submitted No New Areas of Concern were identified **2 Progress Against Areas of Concern Previously Reported** **2 c) Water Safety – Royal Cornhill Hospital Incident Management Team (IMT)** The IMT has been stood down however the Technical Group is ongoing. Work is ongoing to replace and upgrade the hot water system and will continue until the end of October 2022; after this time (test results permitting) normal service will be resumed in 2 wards. Intermediate testing looks hopeful; a more robust system.	

5	**Standing Items cont.**	**2 l) Water Safety – Adoption of SUP05** Protocol for water coolers has been devised and the WSG has approved the document. Stand-alone water coolers are not generally favoured however there are conditions and situations where they can be used safely (plumbed in / maintenance contract in place etc.) operational constraints will be in place to mitigate issues. **2 m) Support to delivery of capital works projects** Weekly meeting is in place where new project requests are reviewed between IPC Team and Estates Project Team leads. Should this be removed from the report? GJ replied that the group has not had the chance to fully test the prioritisation process as yet; suggest this is left on the report until this can be completed. **2 n) High - Inverurie Hospital Admin Block – Healthcare Environment Condition** Closed - not fit for purpose. Catering being performed at Jubilee Hospital, Huntly. Remove from report? GJ queried whether flushing is being completed in this area whilst closed. GP will investigate. VB who is making decision of building being unfit for purpose so that building no longer sits on an NHSG asset register? GP will take an action to determine the "mothballing" of this building and will feedback at next meeting, however, may not be taken off the asset register as there may be costings to rejuvenate the building although this would be a substantial undertaking. **2 o) Royal Aberdeen Children's Hospital IMT – Atypical Infections** Work ongoing to reduce water storage and improve turnover. A review is to be set up regarding the presence of Mycobacterium chelonae. GP will convene a meeting with VB / GJ etc. **2 p) Dr Gray's – Ward 7** Ward is now open for patients. GJ fedback that the HAI SCRIBE process was not fully completed prior to reopening; this is being finalised. **Dr Gray's / Moray (CHSCP)** No report was received. No attendance at meeting. **Mental Health & Learning Disabilities** A report was submitted **1 New Areas of Concern raised by Divisions** **1 b) Medium – Reduced pressure / flow in showers within Stratbeg, Loirston and Skene wards** Point of Use (POU) filters fitted last year following Problem Assessment Group (PAG) meetings held regarding water temperatures. Flow has been severely impacted. Meetings have been held to look at issues and potential for skin breakdown in patients in 1 area. Options have been investigated with IPC Team to ensure hygiene standards are met e.g. water free care. Next meeting to be held 29 September 2022. **2 Progress Against Areas of Concern Previously Reported** **2 a) High – COVID19** Report was submitted before updates were received and narrative needs to be updated surrounding DL(2022) 32.	**GP**

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5	**Standing Items cont.**	A seasonal vaccine clinic has been established at Royal Cornhill Hospital (RCH) for staff to utilise and this is being cascaded to patient groups also. **2 d) Medium – Raised levels of Total Viable Counts (TVCs) in hot water supply** Reassuring to hear the potential for opening dates for the 2 wards currently closed as discussed earlier by GP. VB fedback that there is a group concentrating on the remobilisation of Muick and Davan wards. Have had sight of the testing results and they do look improved however this was cold water testing and not tests being run on the hot water system. There may be an issue with the pipework in these wards but until the temperatures are fixed the issue won't resolve and the temperatures won't be fixed, until the entirety of the work is completed in the rebalancing. A risk assessment will have to be put in place when these wards open. Briefings and updates to staff should be given by the Technical Group. LMc confirmed that everything is being progressed through Recommissioning Group, which Russell Arthur is leading on. **4 Areas of Achievement / Good Practice / Shared Learning from HAI related Reviews (Level 1, 2)** Partnership working with the IPC Team is very helpful when dealing with COVID outbreak management **HAI Education Group Roundup** The roundup report was submitted DS gave the escalations from the last HAI Education Group meeting. Promotion of the Clinical Waste modules was requested as staff seem unaware that changes have taken place. Staff are struggling to find the time to complete mandatory / statutory training and a group has been formed to discuss how this training may look in the future. Skin Surveillance - staff have been trained as Cascade trainers, but there have been some difficulties maintaining numbers, so this is now going to be done as an e-learning package reducing the need for cascade trainers. The donning and doffing modules are currently being updated by IPCT and Health and Safety to incorporate guidance changes. These will be available in time for winter Compliance with swabbing for CP, CRE is an issue and a flow chart has been developed, it's currently with the IPC Team for comment and Jill McKenzie-Murray, from an education perspective, has signposted the need for compliance. It has been fedback from the Medical Devices Pharmacist and the Diabetic Nurses that single use insulin pens are being used on multiple patients (the needle is changed each time nut the pen is used multiple times). This will required educational input and DS has offered to speak with NHS Education for Scotland (NES) to enquire as to how this can be highlighted as bad practice to staff The "NHS Grampian Healthcare Associated Infection (HAI) / Antimicrobial Resistance (AMR) Education Framework for Staff" has been written for a while and requires to be discussed between DS and Jill McKenzie-Murray; will hopefully be out shortly for comment.	

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5	**Standing Items cont.**	**<u>Infection Prevention & Control Team (IPCT) Roundup</u>** The roundup report was submitted **IPC Surveillance & HAI Screening** Non-compliance with Multi Drug Resistant Organism (MDRO) screening compliance has been escalated and is being discussed at the Acute meetings (Health and Safety, and Clinical Governance), at the NHSG Clinical Governance Committee (CGC), NHSG Clinical Risk Meeting (CRM) and relevant HAI Sub Groups. Also an issue is the non-completion of stool charts and Peripheral Vascular Catheter (PVC) bundles; this may have something to do with the Electronic Patient Record (EPR). Full Staph aureus bacteraemia (SAB) surveillance has recommenced June 2022 ahead of the planned mandatory restart of October 2022. **Incidents and Outbreaks** There have been 6 PAGS since the last IPCSC: • 2 for COVID-19 incidents • 1 for MRSA • 1 for Staphylococcus aureus bacteraemia • 1 for hand hygiene • 1 for Endophthalmitis infections There have been 4 IMTs since the last IPCSC: • 1 for Pseudomonas aeruginosa • 1 for Water Safety • 2 for Endophthalmitis infections There have been 2 Technical Subgroup meetings: • 2 for Legionella **Audit & Assurance** With regard to the new IPC Standards whilst most at this meeting seem to have positive experience in in implementing the new Standards there is no assurance that implementation has been achieved across Grampian. The Safe and Clean Care Audits (SACCAs) are being updated due to guidance change. The IPC Team would also like to highlight that they are finding that the environmental audits are not being carried out on a monthly basis. These can be completed using the Compliance and Quality Improvement Data Collection Tool - Managing Patient Care Equipment and is more commonly known as an Equipment Audit. There have been various reasons given as to why these aren't being completed but Standard 7 of the new IPC Standards states that the organisation is to ensure that care equipment is cleaned, maintained and safe for use and assurance for this is with regular audit. We do not have this assurance at present. Need to look at ways to disseminate this message and ascertain why these audits are not being completed. **Areas of Achievement / Good Practice** The IPC Team has been nominated for the Scottish Health Awards – we will learn at the beginning of October if we have been shortlisted	

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	Item 5.2	**HAI Work Programme Delivery Group Update (from meeting 29 April 2022)** No update will be made to the Work Programme until the next meeting which will be 4 November 2022.	
	Item 5.3	**Risk Register (September 2022)** **ID 2654 - IPC Team's inability to provide through HAI Scribe too all built environment projects across NHS Grampian** Continue to work with Projects, Maintenance Services & Technical and Property Asset Development Teams to streamline process and prioritise what built environment projects we can support with, capacity and resource are the issues. **Risk ID 2839 – New PPE for High Consequence Infectious Diseases (HCID)** There is no update Nationally on this, trying to prepare as best we can by obtaining the numbers of staff who will require training. **ID 3054 – Sustainability of IT platform supporting Operational response to IPC** This is ongoing regarding support. GJ to compile an SBAR regarding funding. Critical IT platform and will impact on all patients and staff if it is not available and supported for the IPC Team to utilise. If that isn't supported. **ID 3096 – Lack of Governance process for IMT Reports** Plan is in place for report escalation, being tested with RACH IMT report when completed which is imminent. Need to ensure governance process is effective. **ID 3119 – Technical Lead IPC Nurse post vacant** Still trying to recruit to ensure that the IPC Team are supported as best possible. **ID 3169 – Impact of SWP Team ceasing on 30 September 2022** Flagging this up to the Organisation due to risk this poses in supporting teams without IPC resource. **ID3197 - IPC Support to Baird and Anchor Project Risk** Have requested funding for this from the Baird and Anchor Project to support back fill of IPC Doctor and Nurse so that we can support as best as possible. If we don't have that funding then we don't have the skills and knowledge as there are not very many staff across NHSG that do have the appropriate experience. The IPC Team will have to adapt some work streams to ensure that that build goes ahead, however, there may be changes in the service that we deliver; working on this.	
	Item 5.4	**HAI Executive Committee Update (from meeting held 26 July 2022)** Points that we raised and at the last meeting were in relation to: • Mandatory / Statutory training – this has been discussed several time at the HAIEC; this on the Corporate risk register • Safer Workplaces which is ending September 2022 – has been discussed earlier in this meeting • Responsible person required to be aware of water flushing regime – this is a particular challenge for jointly owned / non NHSG premises. This was to be addressed at the WSG.	

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6	**HAI Report to Clinical Governance Committee / Board cont.**		
	Item 6.1	**HAI Report to the Board (HAIRT) –** July 2022 The July report was submitted. GMcK noted that the Committee are sighted on the CPE and MRSA non-compliance but raised the low rates for compliance with the required cleanliness standards for Aberdeenshire North & Moray Community in February 2022 and Aberdeenshire South & Aberdeen City in March 2022. GJ replied that she was aware that there have been concerns from the domestics' management team in terms of how they maintain the standard of cleanliness and whether that's associated with the low scores; unsure of the details but it is a concern in terms of the stability of the workforce. Perhaps education and training is required. GJ will take back to the teams to get some feedback.	**GJ**
	Item 6.2	**HAI Report to the HAI Executive Committee (HAIEC) (new escalations)** • Clarity required regarding the governance of water safety issues within IJBs • Learning from the Safer Workplaces ending in September – escalate common themes prior to HEI Inspectors visiting NHSG to inspect	
7	**AOCB**		
	Item 7.1	**Antimicrobial Stewardship** VB asked if this could be added to the agenda for the next meeting. Would be interesting to know how Teams are interpreting this and how they're evidencing it so that the Antimicrobial Team (AMT) know what they are working with. In addition it would be helpful to know what the awareness of the AMT is across NHSG. Perhaps the HAI Sub Group Leads would consider including something about antimicrobial stewardship in their sector reports? Discussion needed. AS will add to the next agenda	**AS**
	Item 7.2	**International Infection Prevention Week** This will be running from 16 – 22 October 2022 and the Team are considering going "Back to Basics" looking at Standard Infection Control Precautions (SICPs) and Transmission Based Precautions (TBPs) and reminding staff that the National Infection Prevention & Control Manual (NIPCM) can be accessed via a variety of avenues. All information will be available on the IPC Intranet page	
8	**Date of Next Meeting**	22 November 2022 10.00 – 12.00 via Teams (with a 10 minute comfort break)	