

## MINUTES OF THE INFECTION CONTROL COMMITTEE MEETING

HELD ON TUESDAY 15 MAY 2012  
BOARDROOM, DMH

**Present:** Dr David Allison, Consultant Microbiologist, CDDFT (Chair)  
Dr John Sloss, Consultant Microbiologist, CDDFT  
Tricia Gordon, Senior Nurse Infection Control, CDDFT  
Laurence Lines, Clinical Matron Infection Control, CDDFT  
Dr A Foden, Consultant Physician, CDDFT  
Claire Skull, Surveillance Nurse, CDDFT  
Sue Thompson, Infection Control Nurse, CDDFT  
Helen Welburn, Occupational Health Nurse Specialist, CDDFT  
Jean Armstrong, Lead ICN, NHS County Durham & Darlington  
Neil Williams, PFI Manager, CDDFT  
Steve Morley, Head of Clinical Engineering/SSD, CDDFT  
Phil Sturdy, Associate Director of Estates, CDDFT  
Sam Goss, Risk Management/Health & Safety, CDDFT  
Angela Ridley, Lead Senior ICN, Tees, Esk & Wear Valley NHS  
Foundation Trust  
Janet Gibson, Nurse Consultant, HPA (deputising for Dr Deb Wilson)

1 **Apologies**

Diane Murphy, Acting Director of Nursing, CDDFT  
Dr Deb Wilson, Consultant in Communicable Diseases, HPU  
Bill Headley, Director of Projects and Facilities, CDDFT  
Dr Annie Abraham, Consultant Acute Medicine, CDDFT  
Dr Deepa Nayar, Consultant Microbiologist, CDDFT  
Paul Fish, Acting Associate Director Nursing/Clinical Standards, CDDFT  
Stuart Brown, Antibiotic Pharmacist, CDDFT  
Kay Stewart, Matron, ITU, CDDFT  
Alison McCree, Associate Director Facilities, CDDFT  
Mr A Humphrey, Consultant Orthopaedic Surgeon, CDDFT

2 **Minutes of Last Meeting**

The minutes of the last meeting were accepted as a true record.

3 **Matters arising**

***Ice machines*** – an alternative option to ice machines which provides a hot and cold water system had been discussed at the last meeting and was to be trialled on ward 43 and evaluated. No feedback was available at the meeting and this is to be followed up.

**Action: TG**

**Point Prevalence Survey** – TG advised that the full International Report on the PPS will be published on 23/5/12. Feedback will be given at the next meeting.

**Action: TG**

#### 4 **HCAI Update**

##### **Clostridium difficile Summary**

As this was the first meeting of the New Year, DA informed the Committee that CDDFT had reported 53 Trust apportioned Clostridium difficile cases against a trajectory of 59 for the year 2011/2012. The Clostridium difficile target for the year 2012-2013 is 47 which includes the Community Hospitals within the Trust. This represents a tight target for the year. AF advised DA at this point that EDG had approved a stricter approach to Co-amoxiclav prescribing.

##### **MRSA Objective/RCA Summary**

The Trust's trajectory is 2 for the year 2012-2013 compared to the previous year's target of 3.

##### **MSSA Data**

DA reported 15 cases within the Trust for the year 2011/2012.

##### **E Coli Data**

DA reported 255 cases to the end of March 2012.

The following figures were reported for April 2012:

MRSA bacteraemia	0
MSSA	5
E-Coli bacteraemia	20
Clostridium difficile	5

#### 5 **Infection Control Annual Work Programme**

TG discussed the above document which had been circulated to the Committee and briefly outlined the key priorities for 2012-2013 which will include more focus on MRSA/Clostridium difficile, hand hygiene and challenging behaviours. This Work programme would now be sent to Quality & Healthcare Governance Committee. Action Plans for Clostridium difficile and MRSA are monitored weekly at the Clinical Escalation Meeting.

#### 6 **Documents for Approval**

##### ***POL/ICC/0002 Hand Hygiene***

Further updated in line with NHSLA and guidance re water contamination with pseudomonas.

##### ***POL/ICC/0009 CJD***

Three yearly review with no significant changes made to policy. Annexes updated regarding posterior eye surgery in high risk patients.

***POL/ICC/0017 Clostridium difficile***

C diff process more clearly defined regarding specified roles and Pathology Lab testing and flowchart re testing sequence updated.

***POL/ICC/0019 Gastrointestinal Infections***

Three yearly review with only minor word changes.

***POL/ICC/0020 Ice Machines***

Three yearly review with minor changes and paragraph inserted highlighting that ice machines are not to be replaced when broken.

***Salmonella Patient Information Leaflet***

Three yearly review – minor word changes.

***MRSA Screening Patient Information Leaflet***

Three yearly review – no significant change.

All policies were agreed with a two week timeline for any final comments. If no further comments are received by 31/5/12 these policies will be sent to June Q&HCG Committee for final approval.

The following policies were approved by Quality & Healthcare Governance Committee (February 2012) and are now available via Staffnet.

*POL/ICC/0010 Ectoparasitic and Human Infestation*

*POL/ICC/0012 Safe Use and Disposal of Sharps*

*POL/ICC/0017 Management of Clostridium difficile*

*POL/ICC/027 Use of Gloves in a Clinical Setting*

7 **Infection Control Update**

A final Report on Theatre 6 (UHND) was discussed. All outstanding actions had now been completed. A programme of audits and testing had been carried out and all passed.

The outbreak statistics were discussed and there had been 15 outbreaks of diarrhoea and vomiting in total last year (April 2011-March 2012) and 8 periods of increased incidence of Clostridium difficile. Since April 2012 there had been three outbreaks of diarrhoea and vomiting within the Trust.

On Ward 14 in April there were 5 cases of MRSA reported where the patients had been screened negative on admission. The ward had been deep cleaned with Difficile S and environmental swabs taken. No further cases had since been identified and hand hygiene compliance was reported as 50/60%. It had been identified where attention needed to be focussed and a “secret shopper” would undertake covert surveillance to obtain a true reflection of compliance. The Ward Manager/Matron have identified strategies to increase compliance in this area and they are also looking at screening vascular patients.

8 **Joint HCAI Action Plan update**

The joint HCAI Action Group continues with monitoring of environmental cleanliness scores, Antibiotic prescribing and education on Clostridium difficile in care homes

9 **Mattress Decontamination**

Following the merger between Acute Trust and Community a review of the procedures for decontamination of pressure relieving systems in the community hospitals was carried out. Findings showed that the community hospitals had a mixture of owned and rented systems and the means of decontamination was dependent on the hospital and patient's infection status with a significant amount of decontamination being performed in-house. There was no consistent procedure in place or recording/monitoring of the equipment or cleaning. Various options were discussed and it was agreed that a business case for the introduction of satellite CELL's at RCH, SCH and WCH be submitted. This business case was upheld in early March and the Medical Devices Team is currently expanding CELL to incorporate all community hospitals.

10 **NICE Guidelines**

TG had carried out a gap analysis on the new guidelines and established that most of the guidance remained unchanged. The section on enteral feeding was sent to the Nutritional Screening Group to advise.

11 **Infection Control Assurance Framework 2012-2013**

TG summarised the above document. The objectives remain the same as last year, ie to have zero avoidable HCAI, to stay under trajectory for MRSA/C diff, to ensure lessons are learned from RCA, to comply with CQC, to comply with Hand Hygiene Policy and to ensure that theatre maintenance is undertaken and results comply with relevant HTM.

12 **Alcohol Gel Update**

Following a successful trial on the DEB Foam Sanitiser and agreement to move to using this product Trustwide, the installation at DMH began last week and should be completed by the end of this week. UHND and CLS will follow. It was originally envisaged that two areas on each site would use up the old gel supplies but it is now thought preferable for one site to use.

13 **Theatre Audits**

ST reported that on the back of the findings in Theatre 6 at UHND a rolling programme of audits had been established Trustwide rather than the previous practice of the audit being performed in one session per site. In addition a representative from the Patient Environment Team accompanied Infection Control to ensure that there was broader representation, including Cleaning and Estates Services. In total 5 audits will be carried out at DMH, 5 at UHND, 3

at BAH and 2 at SBH over the course of a year. Audit reports and action plans had been sent out following recent audits. A recurring theme had emerged which highlighted a problem with high-level dust and damage to furniture and flooring. This had been addressed in each case.

NW felt it would be useful to have representation on the audit team from people who would be involved in carrying out any remedial works and it was agreed that this would be addressed in future audits. An audit calendar is to be drawn up and sent to NW. Sam Goss (Risk Management) felt that it would also be useful to receive copies of the audits for information.

**Action: ST**

14 **Skin Cleansing prior to Venepuncture**

TG reported that a number of years ago the Trust had moved to the use of Chloraprep Sepp as skin cleansing agent prior to blood culture sampling, cannulation and venepuncture in inpatient settings. Currently in the community and outpatients settings prior to venepuncture the skin is cleansed with 70% alcohol wipe which means we have 2 different practices. National guidelines and evidence in relation to venepuncture alone is limited however 70% alcohol and 2% chlorhexadine gluconate has been widely seen as best practice and is recommended as skin cleanser of choice for blood cultures. The Committee was asked to consider a move to the use of 70% alcohol and 2% chlorhexadine wipe (Blue Clinell wipe) as the product of choice prior to venepuncture. This product is regulated under the medical device directive and as such can only be used on medical devices; products which are intended to be used on the skin as part of a medical procedure require a product licence which this does not have. This was discussed and although moving to Blue Clinell wipe would offer a large cost saving of £68.37 per pack of 200 it was felt that the Trust should continue to use the current licensed product for blood culture sampling and a 70% alcohol wipe for venepuncture only.

15 **Surveillance/Catheter Group**

CS reported that the standardisation of equipment continues and a trial of Teleflex catheter bags is underway on Ward 2 (UHND) and Ward 4 (BAH). Updated documentation has now been circulated Trust wide and a point prevalence audit will be carried out in June and thereafter on a quarterly basis. Five education sessions on catheterisation are now being delivered Trustwide.

A three month period of orthopaedic surgical site surveillance of # neck of femur has been underway since 1 April 2012. To date 35 patients have been surveyed at UHND, and 37 at DMH (total 72) with no infections identified so far. Statistics for 2010/2011 surveillance periods are summarised below:

<b>2011</b>			
Site	No of patients	Infections	% Infection Rate
DMH	73	0	0%
UHND	83	5	6%
Trust rate 3.2% against 1.9% nationally			

<b>2010</b>			
Site	No of patients	Infections	% Infection Rate
DMH	63	2	3.2%
UHND	64	5	7.8%
Trust rate 5.5% against 1.7% nationally			

It is hoped to conduct a further three month period of joint surveillance from October-December 2012 as this has not been done for three years.

## 16 **Hospital Cleanliness Scores/PEAT Assessment Update**

AM had submitted a report to the Committee on hospital cleanliness scores. In setting cleanliness standards the Trust uses as its reference point, the National Specifications for Cleanliness in the NHS 2007.

The monthly audits for the year April 2011-March 2012 are summarised as follows:

	<b>BAH Wards &amp; Departments ISS</b>	<b>CLS Wards &amp; Departments Robertson's</b>	<b>DMH Wards &amp; Departments Trust</b>	<b>SBH Wards &amp; Departments Trust</b>	<b>UHND Wards Trust</b>	<b>UHND Departments BBW</b>
<b>April</b>	94%	92%	88.5%	93%	94%	85%
<b>May</b>	92.5%	93%	90%	92%	94%	87%
<b>June</b>	93%	93%	91%	92%	93%	87%
<b>July</b>	94%	93%	90%	94%	94%	No Audits
<b>August</b>	95%	94%	90.5%	92%	94%	87%
<b>September</b>	95%	94%	91%	93%	94%	88%
<b>October</b>	95%	95%	93%	93%	95%	92%
<b>November</b>	96%	95%	92.5%	89%	96%	93%
<b>December</b>	91%	89%	93%	No Audits	96%	92%
<b>January</b>	93%	94%	93%	90%	92%	95%
<b>February</b>	90%	92%	90%	91%	90%	90%
<b>March</b>	No Audits	No Audits	90%	90%	91%	93%

The average score across the Trust for the year works out to be 92%. The results of the audits are extracted each month for each of the divisions and then forwarded to the relevant manager for them to share with their staff in a bid to drive up standards and also to highlight the importance of cleaning not only as a domestic issue but as a Trust wide responsibility.

The Trust is required to submit Trust scores to the Department of Health on an annual basis as part of the PEAT Assessments. The scores are also reported to the Trust Board by the Executive Director of Estates and Facilities as part of the Estates and Facilities Report.

JA raised concerns around the scores at UHND as 6 months of the year the standard of 93% was not achieved. TG to raise this with Alison McCree regarding what action plans were put in place.

**Action: TG**

## 17 **Theatre Ventilation Maintenance**

Following the last meeting when PS discussed inadequacies in air changes and pressure differentials within theatres, a programme of works had been agreed. He confirmed that work had commenced on Theatre 4 on 5/5/12 and the air handling unit has had an extensive overhaul and has been tested and has achieved 25 air changes per hour. This would be in excess of what the equipment was originally designed for and was excessively noisy however they are able to achieve 20 air changes per hour and with some work on the door they are able to achieve the correct differentials. Microbiological plates had been taken with results due back on Thursday 17/5/12. PS advised that the Theatre had been deep-cleaned and Bioquelled and a rolling programme has been set up for the rest of Theatres.

## 18 **Occupational Health**

HW reported that the new Needlestick Policy was available to view on Staffnet (no major changes from last version).

## 19 **Decontamination Update**

SM reported that the Decontamination Policy which had been submitted with the papers for this meeting had been updated and reviewed in line with the Trust's "Policy for Policies" and in line with NHSLA and CQC requirements. Any comments should be submitted within the next seven days before the Policy goes to Quality & Healthcare Governance Committee for final sign-off.

A Dental Briefing Paper which had been prepared by BH as an update on the current position within the Community Dental Service for Q&HCG Committee on the decontamination process and compliance was discussed. A Task & Finish Group has been set up to develop a series of improvement measures. In order to address infection control assurance gaps, audits had been established to understand the position at each premise. These are being reviewed and will input to the Task & Finish Group. The service is delivered from 12 locations across the county and this is currently under review. Local decontamination of surgical instrumentation has been the common approach for the community dental service which is difficult and costly to maintain. Temporary decontamination services have been supplied from CDDFT SSD during the past few months to ease pressure on patient clinics. The SSD is a compliant and validated service within the Trust and provides an ideal source for instruments to be fit for purpose. It had recently been agreed to move to a centralised model for instrument provision at several community dental sites. Five sites have been transferred to date. All sites are currently meeting essential requirements with the implementation of this service review and central processing of instruments this will bring us in line with best practice in accordance with HTM01-03. Policy roll-out and training will be overseen by Chris Rooney's team and it is hoped to fully complete the project by October 2012. A further meeting is to be held later this week to discuss minor concerns regarding CLS.

A Report by PS on automated endoscope reprocessing and water quality improvements was submitted and discussed. Since the installation of the Lancer Automated Endoscope Reprocessors (AER's) there has been an ongoing problem with the water quality of the final rinse water. A Water Quality Group was established to undertake a review of potential causes of water failure. Remedial works to address deficiencies were undertaken in 2010/2011 and final testing is currently underway. Pie charts were submitted and it was noted that as a result of these remedial works at DMH and SBH there had been a significant increase in the availability of the AER's due to the improved pass rate of final rinse water testing and it was noted that significant improvements had been achieved over the past 18 months.

LL gave an update on the work of the Water Quality Group around recent guidance on pseudomonas contamination following an outbreak at the Belfast Children's Hospital. On 31/3/12 DOH released the document "*Water Sources and potential Pseudomonas aeruginosa contamination of taps and water systems. Advice for augmented care units.*" The Water Quality Group is following and working through the recommendations outlined within this document which advises health care providers on assessing the risk to patients if water systems become decontaminated, what actions to take, protocols for sampling, testing and monitoring and developing a local Water Safety Plan. There is a meeting planned later this week with the Heads of the Augmented Care Unit to review progress and initial discussions have taken place with the Water Testing Laboratory in York. A draft protocol has been produced and it is hoped to implement this at the beginning of June which is well ahead of schedule.

## 20 **Infection Control Incident Reports**

These were discussed and the ICT were aware of the majority of the incidents which had been reported. Most of these had been addressed immediately. It was noted on Page 16 of the report under the category "MRSA bacteraemia post 48 hours" an incident relating to lack of staff in immunisation clinic had been incorrectly assigned to infection control.

## 21 **Risk register**

The Risk Register for Infection Control was presented and discussed. The only changes noted were the addition of Tissue Viability and water source contamination and Theatres. TG informed the Committee that the Risk Register was to be merged with the Clinical Governance and Patient Safety Risk Register in future.

## 22 **Health and safety**

No issues to report however TG advised that with the introduction of the new Deb Foam Hand Sanitiser there may be an increase in the number of referrals to Occupational Health as is sometimes the case when a new product is introduced.



23 **Any other business**

**Outbreaks in Care Homes** – Janet Gibson (HPA) deputising for Dr Deb Wilson informed the Committee that there is still a steady flow of outbreaks of a viral nature within Care Homes throughout the county with an increase in diarrhoeal reports.

24 **Date and time of next meeting**

Tuesday 18 September 2012, 2.30pm, THQ Boardroom, UHND.