NHS Greater Glasgow & Clyde

NHS BOARD MEETING **28th June 2016**

Medical Director **Paper No: 16/35**
Nurse Director

Vale of Leven Inquiry: Executive Review Short Life Working Group Final Report

Recommendation:-

The Board is asked to note the conclusions of the Short Life Working Group.

Purpose of Paper:-

At its meeting on 15th December 2015 the NHS Board concluded that a Short Life Working Group (SLWG) should be formed to review in detail the progress made to date against each recommendation set out in the Vale of Leven Inquiry Report.

The Acute Services Committee received an interim report on 15th March 2016 and a further update report on 17th May 2016 in preparation of this final report to the NHS Board.

This paper sets out the status of the recommendations from NHS Greater Glasgow & Clyde's perspective and the conclusions of the SLWG.

Key Issues to be considered:-

The Inquiry Report set out 75 recommendations. 65 of these fell to NHS Boards to implement. NHSGGC has completed 62; 3 recommendations, which relate to wider areas of work across the organisation, are ongoing.

The SLWG has reviewed in detail the actions taken against each recommendation in the Vale of Leven Inquiry Report and the supporting written evidence. It is assured that those actions fulfil the requirements of the recommendations. It is satisfied that there are no significant gaps requiring attention and that actions have been embedded and mainstreamed where appropriate.

Monitoring and oversight of any ongoing areas of work will continue through the relevant professional or Directorate/Board structures.

Any Patient Safety /Patient Experience Issues:-

None

Any Financial Implications from this Paper:-

None

Any Staffing Implications from this Paper:-

None

Any Equality Implications from this Paper:-

None

Any Health Inequalities Implications from this Paper:-

None

Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome:-

No

Highlight the Corporate Plan priorities to which your paper relates:-

An effective organisation

Author Dr Jennifer L Armstrong
Tel No 0141 201 4611
Date 21st June 2016

Greater Glasgow and Clyde NHS Board

NHS Board Meeting
28 June 2016 **Paper No. 16/35**

Medical Director
Nurse Director

Vale of Leven Inquiry: Executive Review Short Life Working Group Final Report

1. Background

The Vale of Leven Hospital Inquiry published its final report on 24 November 2014. The Inquiry was set up by Scottish Ministers to investigate the occurrence of *Clostridium difficile (C. diff)* infection at the Vale of Leven Hospital (VOLH) from 1 January 2007 onwards. It would also investigate the deaths associated with C diff which occurred between 1 December 2007 and 1 June 2008.

The report made 75 recommendations, all of which were accepted by the Scottish Government. 65 of the recommendations fell to NHS Boards, 9 to the Scottish Government and one to the Crown office and Procurator Fiscal Service.

The Scottish Government wrote to all NHS Boards asking that they assess themselves against the 65 NHS Board recommendations in the report and responses were submitted in January 2015.

The Scottish Government established an Implementation Group to oversee the implementation of all 75 recommendations. Further guidance is awaited from the Scottish Government in relation to the implementation of the recommendations.

The NHS Board and relevant Committee of the NHS Board have received updates on progress within NHSGGC against the relevant recommendations. At its meeting on 15th December 2015 the NHS Board concluded that a Short Life Working Group (SLWG) should be formed to review in greater detail the progress made to date against each recommendation.

On 19th January 2016, the Acute Services Committee approved the terms of reference for the SLWG.

2. Terms of Reference

The terms of reference asked that the SLWG:

- Review in detail the actions completed and partially completed against each NHSGGC recommendation;

- Seek assurance, through review of the supporting written evidence, that the actions taken fulfil the requirements of the recommendations;
- Seek assurance regarding the rationale and expected completion timescales for any outstanding actions;
- Identify gaps/areas requiring further attention;
- Seek assurance from the Scottish Government in relation to the recommendations relating to the Scottish Government and those where Scottish Government Health Department advice has been sought;
- Provide a report to the Acute Services Committee on its findings.

Membership of the SLWG comprised:

- John Brown, Chairman, NHSGGC
- Ian Lee, Vice Chair, NHSGGC
- Ross Finnie, Board Member, NHSGGC
- Morag Brown, Board Member and Chair, Staff Governance Committee
- Susan Brimelow, Board Member, NHSGGC
- Dr Jennifer Armstrong, Medical Director, NHSGGC
- Dr Margaret McGuire, Nurse Director, NHSGGC
- Fiona Alexander, NHSGGC Area Clinical Forum Representative

The SLWG was formally established in January 2016 and undertook to report back to the Acute Services Committee and the NHS Board in June 2016. An interim report was submitted to the Acute Services Committee in March 2016.

3. Process

During January and February Board Officers undertook further work to set out an up to date NHSGGC position against each of the recommendations. The SLWG met on **23rd February 2016** to begin the process of working through the range of evidence available at that stage. This confirmed that there had been significant progress over the previous year against each of the 65 NHS Board recommendations; however, the group was keen to see evidence of the sustainability of actions to meet all of the recommendations, and to understand how actions taken had been embedded and mainstreamed where appropriate.

The Acute Services Committee received and noted an interim report, as required by the SLWG terms of reference at its meeting on **15th March 2016**.

The SLWG met again on **13th April 2016** to consider the evidence set out in an updated progress report. This report sought to describe how the actions taken had been embedded and mainstreamed. The group was satisfied, subject to some further small updates, that the written evidence reviewed was robust and provided assurance that the actions taken fulfil the requirements of the recommendations set out in the Inquiry Report.

At its meeting on **17th May 2016** the Acute Services Committee received and noted a further update report including the updates required by the SLWG following its meeting on 13th April 2016, and the full progress report on all of the recommendations made in the Inquiry Report.

4. Status of the Inquiry Recommendations

Of the 65 recommendations that fell to NHS Boards to implement, NHS GGC has completed 62, and 3 are ongoing (recommendations 21, 30 & 39). The ongoing actions relate to the mainstreaming or roll out of

wider areas of work across the organisation and are not specific to the events at the Vale of Leven which gave rise to the Inquiry.

In respect of the recommendations relating to the Scottish Government and those where Scottish Government Health Department advice has been sought, it is noted that the Scottish Government has tasked the Scottish Antimicrobial Resistance & Healthcare Associated Infection Group (SARHAI) with looking at the Inquiry recommendations and the responses from Boards to those recommendations. There are some issues however, which require further consideration nationally at this stage. Where known, updates on the Scottish Government/SAHRAI position are included in the progress report.

The full progress report is attached as Appendix 1.

5. Conclusion

Having reviewed in detail the actions taken against each recommendation and the supporting written evidence, the SLWG is assured that those actions fulfil the requirements of the recommendations. It is satisfied that there are no significant gaps requiring attention and that actions have been embedded and mainstreamed where appropriate.

The SLWG recognises that for many of the recommendations, the actions and evidence of mainstreaming highlighted are in fact part of other wider work streams/programmes and have not been initiated specifically in response to the Inquiry Report or its recommendations. They are therefore ongoing initiatives and programmes of improvement work which have wider applicability across the Board area. Monitoring and oversight of these areas of work is routinely undertaken and will continue through the relevant professional or Directorate/Board structures.

6. Recommendation

The Board is asked to note the conclusions of the SLWG.

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Date 20 June 2016

Response to Vale of Leven Hospital Inquiry Report
May 2016 Update for Executive Leads and NHSGGC Chairman

RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
CHAPTER 6 – NATIONAL STRUCTURES AND SYSTEMS		
1. Scottish Government should ensure that the Healthcare Environment Inspectorate (HEI) has the power to close a ward to new admissions if the HEI concludes that there is a real risk to the safety of patients. In the event of such closure, an urgent action plan should be devised with the Infection Prevention and Control Team and management.	**SGHD.** **SGHD has established work streams to address recommendations. Note attached describes 'leads'.**  SARHAI_05_161.doc x	
CHAPTER 7 – NATIONAL POLICIES AND GUIDANCE		
2. Scottish Government should ensure that policies and guidance on healthcare associated infection are accompanied by an implementation strategy and that implementation is monitored.	**SGHD.** **As above**	
3. Health Boards should ensure that infection prevention and control policies are reviewed promptly in response to any new policies or guidance issued by or on behalf of the Scottish Government, and in any event at specific review dates no more than two years apart. *Pamela Joannidis*	**STATUS - COMPLETE** All Infection Prevention and Control Standard Operating Procedures (SOPs) are update every two years on a rolling programme. Submitted to the Acute Infection Control Committee & the partnership Infection Prevention and Control Support group for comment and amendment prior to approval at the Board Infection Control Committee. All documents are placed on a desktop icon which is available to all staff. This also links staff to the National Policy Manual which underpins the local SOPS. All 34 IPCT policies and SOPs are up to date.	Continue to update the manual and add any additional documents as required, e.g. emerging infections or new policy requirements An example of this would be the CPE/GRO policy which has been sent to the March Committees for approval. This policy is new to NHSGGC.  IPC SOP CPE CRO Draft Dec 2015.doc

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RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
	These are reviewed, developed and published in accordance with the SOP approved at BICC. Policy review dates etc are tracked as an administrative function (i.e. not via an automated system). The policy review dates and updates are scheduled and followed up by the IPC Policy Group lead by the IC Nurse Consultant. **Evidence** Link to manual: http://www.nhsggc.org.uk/your-health/public-health/infection-prevention-and-control/ Standard Operating Procedure for Development and Approval of IPC Policies, SOPs and Patient Information in NHSGGC  SOP Policy Development and Ap	
4. Scottish Government should develop local Healthcare Associated Infection (HAI) Task Forces within each Health Board area.	**SGHD** **Update on SGHD response/actions to date** In January 2015 NHSGGC had sought clarity from SGHD on the definition of the composition and purpose of the local HAI task force.	

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	The Scottish Antimicrobial Resistance & Healthcare Associated Infection Group (SARHAI) is a SGHD group tasked at looking at the responses from Boards to the VoL recommendations. SARHAI group members are still reviewing what would be appropriate governance structures within Boards. This remains unresolved nationally.	
CHAPTER 8 – CHANGES IN SERVICES AT THE VALE OF LEVEN HOSPITAL FROM 2002		
5. Scottish Government should ensure that where any uncertainty over the future of any hospital or service exists, resolution of the uncertainty is not delayed any longer than is essential for planning and consultation to take place.	**SGHD**	
6. Scottish Government should ensure that where major changes in patient services are planned there should be clear and effective plans in place for continuity of safe patient care during the period of planning and change.	**SGHD**	
CHAPTER 9 – THE CREATION, LEADERSHIP AND MANAGEMENT OF THE CLYDE DIRECTORATE		
7. In any major structural reorganisation in the NHS in Scotland a due diligence process including risk assessment should be undertaken by the Board or Boards responsible for all patient services before the reorganisation takes place. Subsequent to that reorganisation regular reviews of the process should be	**STATUS - COMPLETE** The Boards latest reorganisation has been completed successfully. The Board commissioned Aston to work with senior leaders to ensure team purpose and new objectives reflect the new management arrangements.	

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conducted to assess its impact upon patient services, up to the point at which the new structure is fully operational. The review process should include an independent audit. *Chief Executive's office – Anne McPherson*	iMatters has been rolled out across the Board/ The following revised Board structure is also now in place:  Revised Board Structure Jan 16	
8. In any major structural reorganisation in the NHS in Scotland the Board or Boards responsible should ensure that an effective and stable management structure is in place for the success of the project and the maintenance of patient safety throughout the process. *Chief Executive's office – Anne MacPherson*	**STATUS - COMPLETE** Specific handover arrangements were agreed. Local OD leads are now working in local teams to identify any future needs. The Chief Officer and Director of Human Resources are commissioning a change audit in some areas.	

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RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
CHAPTER 10 – CLINICAL GOVERNANCE		
9. Health Boards should ensure that infection prevention and control is explicitly considered at all clinical governance committee meetings from local level to Board level. *Andy Crawford*	**STATUS - COMPLETE** This requirement has been communicated through CG arrangements. To prompt this further a clinical governance toolkit has been developed which includes templates on Terms of Reference and Agenda for key clinical governance forums/committees. Both the ToR and agenda include IPC as a requirement for these groups to consider. **Evidence** **1. Template ToR**  \\ XGGC.SCOT.NHS.UK\ **2. Template Agenda**  \\ XGGC.SCOT.NHS.UK\	To enhance the value of the inclusion of IPC in CG forums we are meeting with the IC Team to develop guidance on appropriate content and role of CG Forum relating to IPC.
CHAPTER 11 – THE EXPERIENCES OF PATIENTS AND RELATIVES		
10. Health Boards should ensure that patients diagnosed with CDI are given information by medical and nursing staff about their condition and prognosis. Patients should be told when there is a suspicion they have CDI, and when there is a definitive diagnosis. Where	**STATUS - COMPLETE** Infection Control Team document in casenotes if a patient is diagnosed with CDI. If the patient is able an Infection Control Nurse will speak the patient and or a relative or carer.	We will monitor compliance with the above by auditing ICN and microbiology records. Audits will be undertaken yearly or more frequently as required. Embedding is a report on compliance with this process. Please note that is only applies to the IPCN notes and not general

RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
appropriate, relatives should also be involved. *Sandra McNamee*	CDI severity stickers are left – this enables the medics to assess the severity of the disease on a daily basis. Infomation leaflets are given to the patient and their relative/carers. **Evidence** 1. Screen shot of Infection control nurse record 2. Patient Information leaflet 3. Patient care plan Feb%202012%20-%20Care%20Plan%; C:\Users\mcnamsa547\Desktop Screenshot_CDI_XPs.jpg	nursing or medical notes. Clostridium difficile -abxOct_Nov15.docx
11. Health Boards should ensure that patients, and relatives where appropriate, are made aware that CDI is a condition that can be life-threatening, particularly in the elderly. The consultant in charge of a patient's care should ensure that the patient and, where appropriate, relatives have reasonable access to fully informed medical staff. *David Stewart*	**STATUS - COMPLETE** Communication with patients takes place as part of the scheduled Consultant ward rounds. Junior medical staff are available on the wards to speak to patients and carers outwith these times. Formal appointments with Consultants can be arranged by contacting their secretary – nursing staff can advise contact details. Importance of good communication and robust arrangements to ensure that this occurs has been emphasised to consultant staff. **Evidence**	Continue with arrangements in place.

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RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
	E-mail communication of 28/4/15 to the then Associate Medical Directors (now known as Chiefs of Medicine) for cascade to consultants:  E-mail communication to consultants.pdf	
12. Health Boards should ensure that when a patient has CDI patients and relatives are given clear and proper advice on the necessary infection control precautions, particularly hand washing and laundry. Should it be necessary to request relatives to take soiled laundry home, the laundry should be bagged appropriately and clear instructions about washing should be given. Leaflets containing guidance should be provided, and these should be supplemented by discussion with patients and relatives. *IPC Team*	**STATUS - COMPLETE** All patients who test positive for CDI are visited by an infection prevention and control nurse, who explains the condition and the precautions necessary to prevent spread, e.g. the requirement for isolation. Written information is left with the patient/relative and the patient/ relative/carers are advised that if they require further information the IPCN will visit again. The CDI information leaflet contains advice on hand hygiene, The issuing of written information is recorded in the IPC care plan (Please see evidence in number 10) Leaflets are available for relatives/carers on how to launder clothing. The issuing of this information is an instruction in the care plan and nurses are asked to sign that this has been done. There is also a guidance note for nurses with advice on the information they should be giving patients/relatives/carers with regards to home laundering. **Evidence**	The issuing of these leaflets is recorded in the IPCN nursing notes. We will include this in the audit report of the compliance with the CDI policy: an example of this is included in the evidence in recommendation 10. In addition a review of the contents of these leaflets will be undertaken with patient and relative to establish if the messages are relevant and understandable to members of the public.

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RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
	Laundry leaflets   29.08.12-PIL%20-% Patients%20Clothing 20Wash%20Clothes%%20Bag%20-%20inf	
CHAPTER 12 - NURSING CARE		
13. Health Boards should ensure that there is a clear and effective line of professional responsibility between the ward and the Board. *Margaret McGuire, Joyce Brown, Mari Brannigan*	**STATUS – COMPLETE** Medical professional accountability arrangements for GGC have been reviewed and clarified to ensure effective line of professional responsibility between ward and Board. **Evidence**  Medical Professional Accountability 2016 - NHSGGC has an established Board Wide Professional Nurse / Midwife/AHP Leaders group (NMAHP) that are charged with overseeing all issues related to professional nursing / midwifery /AHP standards and practice. The NMAHP provides further assurance of clear and effective lines of professional responsibility from ward to Board. In addition, the new professional structure ensures that a site based Chief Nurse is located on each of the main hospital sites.	

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RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
	A consistent Professional nursing reporting template has been agreed, after a first phase of testing further changes are now being considered which will be tabled at the next meeting of the group on the 15th February 2016: **Evidence**  Draft Reporting Template - Feb 16  Acute Professional Nursing Structure Apı  Partnerships Professional Nursing s  Chief Nurse Midwife NHSGGC (FINAL DRAI  Chief Nurse Professional Governa  Final Revised LN M Job description 22 De  BAND 7 senior charge nurse JD.doc	
14. Health Boards should ensure that the nurse in charge of each ward audits compliance with the duty to keep clear and contemporaneous patient records, and that there is effective scrutiny of audits by the Board. *Toby Mohammed, Mari Brannigan*	**STATUS – COMPLETE** Corporate nursing documentation audits are now embedded within the acute services. Local documentation audits are also embedded within the board and reported through professional nursing and line management governance structures. Improvements have been demonstrated through documentation audit.	

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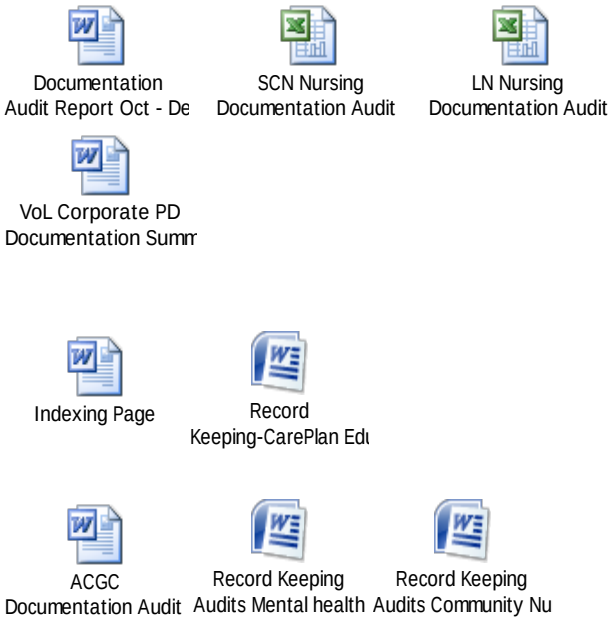
RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
	Evidence  	
15. Health Boards should ensure that nursing staff caring for a patient with CDI keep accurate records of patient observations including temperature, pulse, respiration, oxygen saturation and blood pressure. *Toby Mohammed*	**STATUS – COMPLETE** National Early Warning Score (NEWS) has been implemented across acute adult services. All patients now have their observations recorded on the NEWS charts with frequency of recordings being identified on the NEWS chart and patient care plan. This is monitored through documentation audit. See recommendation 14 for evidence. **Evidence**	

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RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
	NEWS Chart.pdf	
16. Health Boards should ensure that the nurse in charge of each ward reports suspected outbreaks of CDI (as defined in local guidance) to the Infection Control Team. Sandra McNamee	**STATUS - COMPLETE** Within NHSGGC clinical staff follow the guidance contained within the Loose Stool and CDI Transmission Based Precautions policies. Both policies are freely accessible within all clinical areas via the Infection Control Policy Manual displayed as a Desk Top Icon on all clinical area based computers. Compliance with the policies is reviewed during the Infection Prevention and Control Audit which is done at least yearly in every area. Learnpro module is now available for all staff and it is required that this is undertaken at least every three years as per the updated education strategy. **Evidence** • Policies • Number of modules (all IPC education completed) June 2015- Dec 2015.	All nurses are required to complete the learnpro outbreak module as part of the education strategy (embedded below). The IPCN receive updates from the laboratories several times per day and alerts are set up to automatically inform the IPCNs if two cases of CDI is identified in any ward in a two week period. The alert is also sent to the ADNIPC . It is unlikely that a SCN would be aware of this before the IPCN now but we encourage them to let us know if any patients present with symptoms. Again this can be monitored via the IPCN nursing notes . We collect information from the patient notes as to when they became symptomatic and when they were isolated and a sample sent. If any ward did not do this promptly this would be highlighted to the SCN and LN. There are occasions when patients cannot be isolated and the wards are required to complete a risk assessment (embedded). Checks are put in to reduce any risk to others, e.g. patients are nursed at the end of wards (so only one patient is next to them) and immediately adjacent to a sink.

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RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
	 Loose Stools Policy V3 - 28.11.13.pdf  C diff Policy V4 - 14.04.14 amended.p  Breakdown.doc	 education-strategy-v51-bicc-260115-upda  ra-ipc-failure-to-isolate-v1-web-101115-pl
17. Health Boards should ensure that where there is risk of cross infection, the nurse in charge of a ward has ultimate responsibility for admission of patients to the ward or bay. Any such decision should be based on a full report of the patient's status and full discussion with site management, the bed manager, and a member of the Infection Control Team. The decision and the advice upon which the decision is based should be fully recorded contemporaneously. Sandra McNamee/ Joyce Brown	**STATUS - COMPLETE** A Priority for Isolation of Patient guidance document has been developed and rolled out across NHSGGC. **Evidence** Guidance doc  nhsggc-priority-for-isolation-of-patients-pr	The assessment of this document is ongoing. Every patient with an alert organism/condition, e.g. CDI is visited by an IPCN and information is collected on how long the patient has been in hospital, how long and what type of symptoms they have, and the degree of risk they pose to others . Any conversations with the patients and the clinical staff caring for them is recoded in the IPCN nursing notes. Failure to isolate and the reasons why are returned to service directors in a monthly report (sample embedded). It is rare that this now occurs but if the SCN is concerned she can escalate to bed managers but they can also record this in the Boards Clinical Governance system datix which has a specific section regarding the failure to isolate patients and the reasons why  IPC Activity_South Clyde Sep 2015.doc
18. Health Boards should ensure that there is an agreed system of care planning in use in every ward with the appropriate documentation available to nursing staff. Where appropriate they should introduce pro forma care plans to assist nurses with care planning. Health Boards should ensure that there is a system of audit of care planning in place.	**STATUS - COMPLETE** A core generic care plan has been successfully rolled out across acute adult services. The care plan is sectioned using the activities of living and reflects the Nursing Admission Assessment document to enable coherence between assessment and care planning.	

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RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
Mari Brannigan,Toby Mohammed	Care plan audits are a component of the core audit schedule. Monitoring of compliance continues through local documentation audits. **Evidence** 1. Copy of Care Plan and Guidance form below:  285668 proof final March 2016.pdf	
19. Health Boards should ensure that where Infection Control Nurses provide instructions on the management of patients those instructions are recorded in patient notes and are included in care planning for the patient. Sandra McNamee	**STATUS - COMPLETE** Microbiology reports positive sample and these results are sent to the IPCNs electronically. Ward is telephoned and then visited by an IPCN that day. Proforma care plan is left in the nursing notes and a note is also made in the medical notes. If the patient is a 'new' referral the IPCN will discuss the diagnosis with the patient or their relative of carer. A patient information leaflet is also given to the patient or their carer. **Evidence** Please see recommendation 10.	Continue with this process and review care plans and documentation as scheduled. If possible the care plans will be included in the work stream which should follow on from the implementation of the electronic Nursing Admission Assessment (eNAD). It would be advantageous to have this information electronically available (immediate) to nursing and medical staff. At the moment this can be downloaded from the website (link on all desktops)
20. Health Boards should ensure that where a patient has, or is suspected of having, C.difficile	**STATUS - COMPLETE**	This year the IPC audit tool has been completely reviewed with a specific section dedicated to the

RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
diarrhoea a proper record of the patient's stools is kept. Health Boards should ensure that there is an appropriate form of charting of stools available to enable nursing staff to provide the date, time, size and nature of the stool. Stool charts should be continued after a patient has become asymptomatic of diarrhoea in order to reduce the risk of cross infection. Health Boards should ensure that all nursing staff are properly trained in the completion of these charts, and that the nurse in charge of the ward audits compliance. Sandra McNamee, Joyce Brown.	Where a patient has or is suspected of having C Difficile diarrhoea clinical nursing staff use the C Diff care plan and apply the C Diff and loose stool policies to the patients care.The Bristol Stool Chart is used in the monitoring of stools **Evidence** Please refer to previously supplied policies Bristol stool chart:  NHSGGC Bristol Stool Chart.pdf  SCN Nursing Documentation Audit	care of patients in isolation. The tool is embedded below. It is called Transmission Based Precautions and links to the terminology in the national IPC Manual. This audit is done in all wards at least yearly and results are fed back immediately to the SCN, LN and CN (electronic audit tool) the questions in the tool have been mapped to the following VOL recommendations: Recommendation 10: Q.9.1 Recommendation 11: Q. 9.1 Recommendation12: Q. 9.2 (HH) and Q. 9.3 Recommendation 14: All of section 9 Recommendation 15: Q. 2.5 Recommendation 16: Q. 9.4 Recommendation 18: Q.2.1 Recommendation 19: Q. 2.1 Recommendation 20: Q.2.5 Recommendation 37: Q. 2.4 Recommendation 41: Q. 2.4, 2.6 and 2.7 Recommendation 42: Section 6  infection control audit tool 2.xlsx

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RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
CHAPTER 12 - NURSING CARE (continued)		
21. Health Boards should ensure that a member of nursing staff is available to deal with questions from relatives during visiting periods. *John Stuart*	**STATUS – ONGOING** Staff will be available to deal with questions from relatives during visiting and this will be evidenced and assessed as part of CAS assessment process (observational audit). The universal patient feedback questionnaire will contain a question to evidence staff availability during visiting periods. Monitoring compliance with this has still to be implemented via the Universal Patient Feedback Questionnaire which will have a specific question on the availability of staff to answer questions on care during visiting times. The availability of staff during periods of visiting is in the policy.  Flexible Visiting Times Policy 28 March	Universal Feedback will be fully embedded in Acute wards by end of April 2016 with additional questions added in Phase 2 July 2016, which will include questions regarding this recommendation.
22. Health Boards should ensure that any discussion between a member of nursing staff and a relative about a patient which is relevant to the patient's continuing care is recorded in the patient's notes to ensure that those caring for the patient are aware of the information given.	**STATUS - COMPLETE** Acute services new generic care plan now in use in all acute inpatient areas. Space within care plan for discussion of care and negotiated care with patient and/or relative/ carer. Use of 'communication records' held within the	Ongoing monitoring as part of ward documentation audits and the audits undertaken by LNs as part of clinical sessions.

RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
Elaine Love, John Stuart	patients notes. This is monitored as part of ward documentation audits and the audits undertaken by LNs as part of clinical sessions. **Evidence** 1. Copy of the Generic Care plan also embedded in Recommendation 18 2. Copy of the audit tool also embedded in Recommendation 14.  285668 proof final March 2016.pdf  Record of communication with re	
23. Health Boards should ensure that a nurse appointed as Tissue Viability Nurse (TVN) is appropriately trained and possesses, or is working towards, a recognised specialist post-registration qualification. Health Boards should ensure that a trainee TVN is supervised by a qualified TVN. *Elaine Burt*	**STATUS - COMPLETE** There are 10 TV Nurses working within the Board. All have completed their professional portfolio. SPSP bundle testing complete. Pressure Ulcer Daily Risk Assessment (PUDRA) Bundle has been rolled out within the South Sector January 2016. North Sector will follow March 2016 and the other sectors following this. **Evidence**	

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RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
	NATVNS - NES Competencies.pdf NATVNS - NES Portfolio.pdf Wound Assessment Chart.pdf	
24. Health Boards should ensure that where a TVN is involved in caring for a patient there is a clear record in the patient notes and care plan of the instructions given for management of the patient. *Elaine Burt*	**STATUS - COMPLETE** TVNs complete NHSGGC wound assessment chart at each wound assessment review and this is filed in the patient's case record. **Evidence** 1. EPUAP Pressure Ulcer Classification Report 2. NHSGGC TV Audit – End of Year Report 2014/15 268608 EPUAP Grading Tool HQPDF - audit report 2014-2015.pdf	TVNs continue to monitor and review standards and quality of documentation recorded to ensure all elements of wound assessment and treatment are detailed consistently. Audit results are sent to Chief Nurses and information obtained from these audits allow targeted education to ensure compliance with required documentation. TV service will provide targeted education for areas identified within audit to commence April 16. There has been a short life working group set up (Feb, 2016) to develop wound assessment guidance – this is an NHSGGC led initiative- (there has been no formal discussions set for a national update). The remit of this group is to set out guidance for all clinicians involved in the documentation of wound assessment to ensure a consistency is applied across the Board.
25. Health Boards should ensure that every patient is assessed for risk of pressure damage	**STATUS - COMPLETE**	

RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
on admission to hospital using a recognised tool such as the Waterlow Score in accordance with best practice guidance. Where patients are identified as at risk they must be reassessed at the frequency identified by the risk scoring system employed. Compliance should be monitored by a system of audit. *Elaine Burt*	SPSP bundle testing complete. Pressure Ulcer Daily Risk Assessment (PUDRA) Bundle has been rolled out within the South Sector January 2016. North Sector will follow March 2016 and the other sectors following this. Agreement that the Acute Division will replace Waterlow risk assessment with PUDRA which focuses on daily risk assessment. Sector timetables for roll out, education and post implementation audit agreed. There will be no change to the use of risk assessment (Waterlow) for Partnerships. All hospital acquired pressure damage is investigated by a TVN as part of ensuring governance and determining and focussing improvement work. This information is shared within reports sent to Chief Nurses and also reviewed within Partnerships. This is recorded within datix which has been further revised to improve reporting. **Evidence** PUDRA Final October 2015.pdf Datix 2015	
26. Health Boards should ensure that where a patient has a wound or pressure damage there is clear documentation of the nature of the wound or damage in accordance with best	**STATUS - COMPLETE** The new Scottish Adaption of the European Pressure Ulcer Classification Tool & Scottish	Monthly reports are provided by Tissue Viability Service to Chief Nurses and Senior Nurses in Partnerships detailing pressure damage reported, grading and whether it was avoidable.

RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
practice guidance, including the cause, grade, size and colour of the wound or damage. The pressure damage or wound should be reassessed regularly according to the patient's condition. Compliance should be monitored by a system of audit. *Elaine Burt*	Excoriation & Moisture Related Skin Damage Tool - grading tool has been distributed to all clinical areas and available on TV webpages all clinical areas within NHSGGC. Ongoing Tissue Viability Nurse led education continues to be delivered across the board in relation to pressure ulcer grading and wound care. Pressure data reports demonstrate an improvement on accurate grading. NHS GGC Pressure Ulcer Prevention learnpro has been updated with new tools to continue to support education. If the patient has a wound or pressure damage this is currently recorded in the wound chart. If the wound is a pressure ulcer, this is also recorded on the front page of PUDRA. If the pressure damage has been caseload or hospital acquired a referral is requested to TVN via Trakcare, at the TVN review an investigation is completed to ascertain Avoidable or Unavoidable. (Datix flow chart previously attached) Datix is completed and the pressure damage is formally assessed by TVN and review undertaken to determine whether this has been avoidable or not (Red Day Review). The outcome of these reviews are sent to the SCN and Lead Nurse with monthly reports to Chief nurses. If this review highlights an immediate response improvement plans are commenced with local teams promptly and are	This has allowed improvement work and education to be focussed and best practice shared.

RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
	sent monthly to Chief nurses in Acute and Senior Nurses in Partnerships. The TV team review these reports to identify trends/hotspots and support ward / department areas to undertake improvement work. This targets any inconsistency with documented evidence of care, care planning for 'at risk' patients and evidence of transparency in reporting and recording. **Evidence** 1. PUDRA Assessment  PUDRA Final October 2015.pdf  PUDRA Guidance Sheet.pdf 2. Education & Training  TV Study Days 2016 v7.pdf 1. Audit Tool/Report  Tissue Viability Documentation Audit.	

RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
	2. Red Day Review  NHSGGC Pressure Damage RED Day Rev 3. Annual Review  Clyde Sector Quarterly Report 201 **http://www.staffnet.ggc.scot.nhs.uk/Acute/Division%20Wide%20Services/TissueViabilityServiceAcuteDivision/Pages/TissueViabilityService-AcuteDivisionHomepage.aspx**	
27. Health Boards should ensure that where a patient requires positional changes nursing staff clearly record this on a turning chart or equivalent. Compliance should be monitored by a system of audit. *Elaine Burt*	**STATUS - COMPLETE** Prescription of positional change is within the Core Generic care plan and is incorporated within Active Care. SCN and Lead Nurse documentation audits continue as part of ongoing monitoring and assurance. This audit includes Active Care monitoring to ensure a proactive approach to patient care and frequency of intervention. **Evidence** 1. NHSGGC Pressure Ulcer Prevention	

RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
	and management Policy 2. Active Care Checklist Pressure Ulcer Policy 2014.pdf Active Care Doc 1.pdf	
28. Health Boards should ensure that all patients have their nutritional status screened on admission to a ward using a recognised nutritional screening tool. Where nutritional problems are identified further assessment should be undertaken to determine an individual care plan. Appropriate and timely referrals should be made to dieticians for patients identified as being in need of specialist nutritional support. *Elaine Burt, Angela Carlin*	**STATUS - COMPLETE** MUST is included in the NAD and the Nutrition Profile, the scoring of which determines the requirement for onward referral for dietetics support. Compliance with nutritional screening is monitored via the Lead Nurse monthly documentation audit, and the CQIs. CSM Dietetics collects and presents data in relation to the timeliness of referrals to the dietetic service and presents to the FFN PIG. Further delivery of training will be planned, delivered and evaluated to ensure improvements in practice. **Evidence** CAS Standards – Page 18 Standard 8 FFN 1. Patient Nutrition Profile Chart 2. Guidance Document for completing MUST	

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RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
	Nutrition Profile.pdf Guidance Document for MUST.pdf CAAS Standards.pdf	
29. Health Boards should ensure that there is appropriate equipment in each ward to weigh all patients. Patients should be weighed on admission and at least weekly thereafter and weights recorded. Faulty equipment should be repaired or replaced timeously and a contingency plan should be in place in the event of delays. *Anna Baxendale, John Stuart, Angela Carlin*	**STATUS - COMPLETE** Online webpages re weighing scales live, information communicated through sectors. Staff are aware of the process for repairing faulty equipment and there is a contingency system in place for ongoing access to equipment in the interim. Patients are weighed on admission and at least weekly thereafter and this is recorded in the nursing assessment documentation (NAD). **Evidence** Resources and guidance hosted on StaffNet http://www.staffnet.ggc.scot.nhs.uk/Partnerships/Greater%20Glasgow%20and%20Clyde%20Services/FFN/Pages/ResourcesforMUST.aspx REVISED 246002-A PROOF 1.pdf	
30. Health Boards should ensure that where	**STATUS - ONGOING**	The development of the Care Assurance

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RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
patients require fluid monitoring as part of their critical care, nursing staff complete fluid balance charts as accurately as possible and sign them off at the end of each 24-hour period. *Joyce Brown*	A standardised chart is in use across the board which contains guidance on patients who require their fluid balance to be monitored. A clear message from Chief Nurses regarding the importance of accurate completion of Fluid Balance charts has been completed. Healthcare Support worker training in relation to completion of fluid balance charts. The section on 'End of bed documentation' in the Documentation Audit Tool, asks 'If appropriate is the fluid balance chart being recorded accurately'. . **Evidence** 1. Updated Fluid Balance Chart  New Fluid Balance Chart.pdf	process in all wards includes a link nurse for Food Fluid and Nutrition, and an element of the FFN standards included compliance with this recommendation. Further staff awareness sessions will be delivered by the FFN Dieticians who come in post end of May. In the interim and on going, are the documentations reviews undertaken routinely by SCNs and Lead Nurses.

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RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
CHAPTER 12 - NURSING CARE (continued)		
31. Health Boards should ensure that the staffing and skills mix is appropriate for each ward, and that it is reviewed in response to increases in the level of activity/patient acuity and dependency in the ward. Where the clinical profile of a group or ward of patients changes, (due to acuity and/or dependency) an agreed review framework and process should be in place to ensure that the appropriate skills base and resource requirements are easily provided. *Angela Carlin, Sandra Blades*	**STATUS – COMPLETE** **active progress and implementation of N&M workforce tools and dynamic assessment of workforce needs on a shift by shift basis** The Board implements the national nursing and midwifery workforce/ workload planning tools. The development and implementation of a roster policy and principles of monitoring and escalation guidance provides assurance that there are robust arrangements in place from the point of care to the Board to ensure that staffing and skills mix is appropriate. **Evidence** 1. NHSGGC Rostering Policy (Dec 15) 2. Paper no 13/83 – Nursing Workload and Workforce Review – Acute Services Division (Sept 2013)  NHSGGC Rostering Policy December 201  Item 16a - Nursing Workload+Workforce  Item 16b - Nursing Workload + Workforc	
32. Health Boards should ensure that there is straightforward and timely escalation process for nurses to report concerns about staffing numbers/skill mix.	**STATUS - COMPLETE** See above.	

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RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
Angela Carlin, Sandra Blades	There are local arrangements in place for safe to start, such as safety huddles where gaps in staffing numbers or skill mix are resolved. **Evidence**  MORNING SAFETY HUDDLE RHC.XLS	
33. Health Boards should ensure that where a complaint is made nursing practice on a ward this complaint is investigated by an independent senior member of Nursing Management. *John Stuart, Mari Brannigan*	**STATUS - COMPLETE** The Board's Complaints Policy has been updated August 2015 to reflect this requirement and this has been widely disseminated. All ward based complaints are investigated by the lead nurse who is not part of the ward based team. **Evidence**  Complaints Policy 2015 v 3 -July 2015.c **http://www.staffnet.ggc.scot.nhs.uk/Corporate%20Services/Complaints/Complaints%20Directory/Compl**	

RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
	aints%20Policy%202015%20v%203%20-July%202015.docx **http://library.nhsggc.org.uk/mediaAssets/Westmarc/complaints_leaflet_summary_nhsggc.pdf**	
CHAPTER 13 - ANTIBIOTIC PRESCRIBING		
34. Health Boards should ensure that changes in policy and/or guidance on antimicrobial practice issued by or on behalf of Scottish Government are implemented without delay. Andrew Seaton	**STATUS - COMPLETE** The antimicrobial management team is represented on SAPG (Scottish Antimicrobial Prescribing Group). National policy changes from SAPG are communicated through the Antimicrobial Management Team (AMT) to the antimicrobial utilisation committee of the Area Drugs and Therapeutic Committee (ADTC). The AMT ensures the implementation/ dissemination of policy through Directorates and primary care. **Evidence** Agenda and minutes of Antimicrobial utilisation committee meeting August and November 2015: AUC Agenda & Mins Aug 15.pdf AUC Agenda & Mins Nov 15.pdf Therapeutics handbook section on infection management in adults: http://ggcprescribing.org.uk/thb-infections/	Continued representation on SAPG and ongoing engagement with national agenda and guidance.

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RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
	Full infection guideline repository including paediatric and primary care guidance available via NHS GGC Staffnet. PDF of primary care guidance:  PC Paed Empiric Infection Mgt Guidelir  PC Adult Infection Mgt Guidelines.pdf Antimicrobial utilisation committee: Terms of reference:  AUC ToR.docm Antimicrobial Guideline approval process: http://ggcprescribing.org.uk/media/uploads/policies/section_7/auc_approval_of_guidelines.pdf **Forward Plan** Continued representation on SAPG and ongoing engagement with national agenda and guidance.	
35. Scottish Government should monitor the implementation of policies and/or guidance on antibiotic prescribing issued in connection with healthcare associated infection and seek assurance within specified time limits that	**SGHD.** As per recommendation 1	

RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
implementation has taken place.	 SARHAI_05_161.docx	
CHAPTER 14 - MEDICAL CARE		
36. Health Boards should ensure that the level of medical staffing planned and provided is sufficient to provide safe high quality care. *Dr David Stewart*	**STATUS - COMPLETE** Directorates review staffing levels on an ongoing basis. A review of junior medical staffing has taken place across all of the Board's acute sites; this took place in 2015 and some posts have been re-allocated where educational needs can be met. The next review is underway, with a view to engaging with NES in due course. Junior doctor rotas are subject to continuous contractual monitoring with twice yearly reporting to the Scottish Government. Issues are escalated upwards to medical and service management teams. Rotas are also subject to change, arising from government initiatives and EWT requirements. Issues relating to rotas and medical staffing levels are reported through the newly established Medical Education and Medical Staff Governance Group (remit attached below as evidence). **Evidence** Spreadsheets re redistribution of medical staff:	Medical staffing levels are subject to continuous review and will be reported through the Medical Education and Medical Staff Governance Group.

RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
	 07 05 15 - Summary of General Medical Sp Terms of Reference - Medical Education and Medical Staff Governance Group:  Terms of Reference - Medical Staff Governa	
37. Health Boards should ensure that any patient with suspected CDI receives full clinical assessment by senior medical staff, that specific antibiotic therapy for CDI is commenced timeously and that the response to antibiotics is monitored on at least a daily basis. *Andrew Seaton*	**STATUS - COMPLETE** The AMT has produced guidance (adapted from national guidance) on the recognition and management of CDI, including empirical management (before the diagnosis is microbiologically confirmed). Guidance takes into account, and is stratified for severity. Guidance is available in poster form in all clinical areas. Also available in the boards therapeutics handbook and electronically in the guideline section of the staff intranet via the handbook app. Confirmed cases are identified by infection control teams and are monitored daily Programme in place to review guidance. Use of daily severity stickers in case notes used to support patient assessment.	Continued engagement within GGC between AMT and IPC teams Identification and review of cases. (ongoing) Regular review and update of CDI management guidelines. (reviewed annually)

RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
	Evidence Guidance for management of CDI: http://app.ggcprescribing.org.uk/api/guideline/131/ New CDI cases are referred to site-based antimicrobial pharmacists and reviewed on antimicrobial ward rounds with liaison with clinical teams. Severity Sticker  draft 2014 - 21 02 12-A6-4 x CDI Severi	
38. Health Boards should ensure that clear, accurate and legible patient records are kept by doctors, that records are seen as integral to good patient care, and that they are routinely audited by senior medical staff. *Dr David Stewart*	**STATUS - COMPLETE** There are areas of good practice throughout the organisation, however, a lack of consistency has been identified. The good practice identified in relation to medical and DME specialties at the QEUH will be adopted systematically going forward. Medical documentation is part of routine audit at the Vale of Leven Hospital and is reported through Directorate Clinical Governance	The template for documentation audit, identified as good practice at the QEUH will be rolled out systematically, to be completed by end 2016. Review success of pilot use of Datix to support M&M case note review and consider roll out options - early – mid 2017. Timescales for full implementation, however, will not be clear until pilot is complete and early roll out has occurred to test the design assumptions.

RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
	arrangements. A formalised process for Morbidity and Mortality reviews is being established. It is proposed to incorporate consideration of adequacy of records in M&M. It has been embedded in the case note review tool. A pilot of using Datix to record the case note review is just about to start and includes consideration of record keeping related to consultant review and clinical communication. The pilot work is estimated to continue to end 2016/early 2017. The longer term plan is to support all M&M case note reviews through Datix which will provide regular data on this issue for all M&M meetings across GG&C; however, timescales for full implementation will rely on pilot completion and early roll out to test design assumptions. **Evidence** VoL Documentation Audit Summary Report December 2015  Documentation Audit Summary VoL Dec 20: Corporate Documentation Summary Report 2015	

RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
	 VoL Corporate PD Documentation Summ Medical/DME audit tool:  Medical Documentation Audit Report – M&M Project:  Item 3c-M&M project update paper.docx	
39. Health Boards should ensure that medical and nursing staff are aware that a DNAR decision is an important aspect of care. The decision should involve the patient where possible, nursing staff, the consultant in charge and, where appropriate, relatives. The decision should be fully documented, regularly reviewed and there should be regular auditing of compliance with the DNAR policy. *Dr David Stewart*	**STATUS – Active progress and action as required** Prompts for Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) consideration are present on both medical and nursing admission documentation. All doctors have access to DNACPR training - DNACPR training is included as a core element of junior doctor induction. It is mandatory for all training grades. A STAR training module has been available from 2012 and is mandatory for all consultants. Regular reminders have been sent to consultant staff regarding their obligation in this area. The "Deteriorating Patient" is a key clinical	Ensure compliance with DNACPR training. Roll out the deteriorating patient work. A more systematic plan for DNACPR audit will be included as a core component of the revised Acute Clinical Governance programme by end 2016.

RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
	safety priority for the NHS GGC quality programme and is also one of the workstreams in SPSP Acute Adult Care programme. The workstream aims to ensure that patients with physiological deterioration in acute care will have a structured plan and response. Improving discussion and communication about patients' ceiling of care, which includes discussion on DNACPR, is part of that work. Robust documentation of the patient's ceiling of care as well as documentation of discussions with patients and relatives is also part of that. Implementation plans in acute have been reset to increase the number of clinical teams involved in this work with some wards at QEUH and DME beds at Victoria ACH and Gartnavel active in this programme. All wards at the Beatson and RAH are involved. DNACPR audit has been included in the Division-wide documentation audit. In addition a number of ad hoc audits have taken place on a number of sites.	
40. Health Boards should ensure that the key principles of prudent antibiotic prescribing are adhered to and that implementation of policy is rigorously monitored by management. *Andrew Seaton*	**STATUS - COMPLETE** Prudent prescribing is a core part of junior doctor induction and junior doctor tutorial programmes throughout NHSGGC. NHSGGC is fully compliant with the national programme of antibiotic prescribing surveillance (prescribing indicators in secondary and primary care). In	Ongoing educational input from AMT to postgraduate and undergraduate teaching and small group teaching/ induction Ongoing antimicrobial surveillance and feedback to clinical teams.

RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
	addition NHSGGC surveys the volume of antimicrobial use and conducts hospital based point prevalence surveys annually. There is an active programme in primary care to promote prudent prescribing through the ScRAP programme. The AMT reports to the ADTC and the BICC which is chaired by the Medical Director. **Evidence** See AUC minutes (above) which illustrate compliance with national prescribing targets and review of antimicrobial utilisation data in primary and secondary care. PPT. presentation at November AUC showing antibiotic use and compliance with national prescribing targets and bench marking against other boards below:  2015 11 use AUC.pptx Primary care prescribing report from August 2015:  AUC Primary Care Antibacterial Report A	
41. Health Boards should ensure that there is no unnecessary delay in processing laboratory	**STATUS - COMPLETE**	Continue with current process and audit to ensure compliance.

RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
specimens, in reporting positive results and in commencing specific antibiotic treatment. Infection control staff should carry out regular audits to ensure that there are no unnecessary delays in the management of infected patients once the diagnosis is confirmed. *Isobel Neill*	Testing for *C.difficile* is performed 7 days/week on all 3 GG&C sites following the HPS recommended testing algorithm. Positive results are communicated in real time via ICNET Monday to Friday and via Laboratory Medical staff at weekends. Results are issued as soon as they are available to the hospital's electronic Clinical Portal and Trakcare Patient information systems. The *C.difficile* test turnaround times are monitored and audited monthly with the information presented to the monthly Microbiology Management Team Meeting which is attended by Senior Management and Senior Medical staff.	
	STATUS - COMPLETE Audit of the application of transmission based precautions is (which includes assessment or questions related to when to isolate) on an agreed rolling programme. Any positive patients are also visited by an Infection prevention and control nurse on the day of referral and isolation recommended. If patients are isolated this is recorded, if for clinical reason this is not appropriate this is also noted and follow up visits will support staff in the reassessment of the ongoing risk. **Evidence**	

RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
	IPCT audits and a audit of the management of CDI positive patients as requested by the medical Director in Dec 2015. Clostridium difficile -abxOct_Nov15.docx	
CHAPTER 15 - INFECTION PREVENTION AND CONTROL		
42. Health Boards should ensure that all those working in a healthcare setting have mandatory infection prevention control training that includes CDI on appointment and regularly thereafter . Staff records should be audited to ensure that such training has taken place. *Lyndsay Lauder*	**STATUS - COMPLETE** All new employees to NHSGGC undertake a mandatory Induction within the first three months of their employment. This includes a mandatory e-module on Infection Control. Completion of all mandatory e-modules is monitored through a learner management system, LearnPro, and lists of employees who have undertaken/completed the modules are available to managers and supervisors throughout the organisation to enable them up update individual and departmental training records. In addition to the above provision, all Acute services employees receive refresher training on a range of mandatory topics including Infection Control every 3 years. Training records of attendance are maintained within the L&E	**On going**

RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
	service. These are available to both managers and Infection Control leads for monitoring purposes. To supplement the HAI mandatory induction modules – a range of e-modules (set out below) are available on LearnPro for staff to utilise as required. The full range of training and education available to staff is set out in the attached. Infection Prevention & Control Education Strategy – Mandatory & Continuing Education. **Evidence** **Education Strategy for IC – Mandatory and Continuing Education (February 2015):**  201601271607.pdf **Additional below:** KSF Personal Development Plans LearnPro Mandatory Induction Programme Records Mandatory Refresher Training Records **Evidence** Most recent ASC report embedded.	

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RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
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43. Health Boards should ensure that Infection Control Nurses and Infection Control Doctors have regular training in infection prevention and control of which a record should be kept. *Sandra McNamee, Craig Williams*	**STATUS - COMPLETE** All ICD's (Doctors who have a sessional commitment to IC in their job plan) are members of the Royal College of Pathologists (RCPath) and will be part of the RCPath Continuing Professional Development (CPD) scheme which is reviewed annually at appraisal. Attached in the evidence section is a copy of the training status of IPCNs. There are four levels of training; certificate, diploma, degree, masters degree. All ICN must commence a course of training within one year of appointment but they can exit at any point but progression in terms of promotion is to a large extent dependant on their level of education. Recorded via e-Knowledge, Skills Framework (eKSF) and NES Revalidation Portfolio. The relevant line manager must sign off electronically through this system that the mandatory training has been undertaken. **Evidence** (status remains current)	

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	 23.07.13 - ICN Qualification Informat	
44. Health Boards should ensure that performance appraisals of infection prevention and control staff take place at least annually. The appraisals of Infection Control Doctors who have other responsibilities should include specific reference to their Infection Control Doctor roles. *Anne Cruickshank, Craig Williams*	**STATUS - COMPLETE** The position remains the same as at May 2016. In addition the Lead ICPNs have undergone further training with regards to NMC revalidation processes. **Evidence** Attached is the status re IPC qualifications for each of the teams which was requested by HEI (requires updating but is representative of current workforce).  Clyde - Confirmation Training of ICNs Aug  NW - ICN Team Oct 2011.doc  SE - Infection Control Nurses Qualif  SE - Infection Control Nurses Qualif	Continue to support staff to achieve levels of education suitable to their bandings and expected competences and continue to enourage and support additional training in order for IPCN to attain more senior posts.
45. Health Boards should ensure that where a manager has responsibility for oversight of infection prevention control, this is specified in the job description.	**STATUS - COMPLETE**	

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RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
HR Director – Anne MacPherson		
46. Health Boards should ensure that the Infection Control Manager (ICM) has direct responsibility for the infection prevention control service and its staff. *Tom Walsh*	**STATUS - COMPLETE** The Infection Control Manager within NHSGGC has direct management responsibility for the Infection Prevention and Control Service and all staff including medical staff. This is clearly stated in the ICM Job Description. **Evidence** Job Description: ICM  Current ICM JD.doc	
47. Health Boards should ensure that the ICM reports direct to the Chief Executive or, at least, to an executive board member. *Tom Walsh*	**STATUS - COMPLETE** The Infection Control Manager within NHSGGC reports directly to the Board Medical Director, an Executive Director of the NHS Board. This arrangement is clearly specified in the job description. **Evidence** Please see JD for ICM below:  Current ICM JD.doc	
48. Health Boards should ensure that the ICM is	**STATUS – COMPLETE**	Continue to report as organisation changes.

RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
responsible for reporting to the Board on the state of HAI in the organisation. *Tom Walsh*	The Infection Control Manager within NHSGGC prepares reports on the status of HAI for the following:- • NHS Board • Acute Services Committee • Board Clinical Governance Forum • Board Infection Control Committee • Acute Infection Control Committee • Partnership Infection Control Committee **Evidence** HAIRT report Report for ASC  NHSGGC_HAIRT_Dec 15_151215.docx  2015-09 IPC ASC Summary_September List of Reports from Point of Care to Board:  Point of Care to Board.pdf	
49. Scottish Government should re-issue national guidance on the role of the Infection Control Manager, stipulating that the Infection Control Manager must be responsible for the	**SGHD** **As per recommendation 1**	

RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
management of the infection prevention and control service.	SARHAI_05_161.docx	
50. Health Boards should ensure that there is 24-hour cover for infection prevention and control seven days a week, and that contingency plans for leave and sickness absence are in place. *Tom Walsh, Sandra McNamee*	**STATUS - COMPLETE** Out of hours advice in Infection Prevention and Control is provided by the on-call Consultant Microbiologist. At times of peak activity (e.g. norovirus) this is supplemented with on-call service from the Lead Infection Control Nurses. Clarification required at national level on the scope of a 24 hour service. **Update on SGHD response/actions to date** Clarification sought in January 2015 from SGHD. SARHAI group members have been asked to consider: 1. What is adequate and safe 24 hour cover 2. should NHS Boards should be asked what contingency plans they have in place should more than one outbreak occur – i.e. C. diff and Norovirus 3. ICDs often provide cover – is Education and Training sufficient 4. how we ensure that this is fit for purpose in the future	Await guidance from SGHD.

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	This remains unresolved nationally.	

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RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
CHAPTER 14 - MEDICAL CARE (continued)		
51. Health Boards should ensure that any Infection Control Team functions as a team, with clear lines of communication and regular meetings. *Tom Walsh*	**STATUS - COMPLETE** The Infection Control Manager holds monthly meetings with all Infection Control Doctors and all Infection Prevention and Control Consultant/ Lead Nurses present. (The IPC Senior Management Team) The Infection Control Manager, Associate Nurse Director, Lead Infection Control Doctor, Nurse Consultant and Lead Nurse for Surveillance meet on a weekly basis. **Evidence** 1. IPC SMT Minute  Item 2 - SMT Minutes 28.10.15....	Continue with meetings.
52. Health Boards should ensure that adherence to infection prevention and control polices, for example C. difficile and Loose Stools Policies, is audited at least annually, and that serious non-adherence is reported to the Board. *Pamela Joannidis*	**STATUS - COMPLETE** IPCNs undertake a regular programme of monitoring of adherence to IPC policies through the new Infection Prevention and Control audit tool which incorporates Standard Infection Control Precautions (SICPs) Transmission Based Precautions (TBPs), Loose Stools and C. difficile.	

RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
	Action plans are produced from each audit undertaken and the SCN will be responsible for completion of this within a specific time scale. Results from the audits are included in the directorate monthly reports and are reported to the Chief Nurse at the time of the audit. All wards are monitored annually as a minimum. **Evidence**  IPC Activity_Regional Dec  infection control audit tool 2.xlsx	
53. Health Boards should ensure that surveillance systems are fit for purpose, are simple to use and monitor, and provide information on potential outbreaks in real time. *Ann Kerr, Pamela Joannidis.*	**STATUS - COMPLETE** Infection Prevention & Control have a web based software package (ICNet NG) which has a direct feed from the NHSGGC patient management system (Trakcare) and NHSGGC microbiology labs. This enables real time monitoring by IPC Nurses and the IPC data team of alert organism surveillance e.g. *Clostridium difficile* (CDI), *Meticillin-resistant Staphylococcus aureus* Bacteraemia.(MRSA) There is a weekly report that is issued to Directors and this lists any actual or potential outbreaks and also any patients who have died were CDI is noted as either a underlying or	

RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
	contributory factor in the patients death (example embedded) Trigger alerts have been established for wards, directorates and hospitals. Surveillance is undertaken - paper attached as evidence below. Monthly HAI CDI & MRSA tally sheets are collated by sector IPCTs and these provide the IPC with prospective ward, directorate & hospital level awareness of the burden of HAI throughout the month. Statistical Process Control (SPC) charts which are used to present monthly data on Hospital Acquired cases of MRSA & CDI are an established part of NHSGGC's surveillance system. **Evidence** Please refer to reports in recommendation 48.  Framework for local surveillance NHSGGC  IPC 18.11.15.doc	

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RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
54. Health Boards should ensure that the users of surveillance systems are properly trained in their use and fully aware of how to use and respond to the data available. *Ann Kerr*	**STATUS - COMPLETE** The ICNet system is managed centrally within the service by the IPC data team ensuring that all IPC team members have log on access to ICNet. Training sessions have been provided by the software company to all IPC users at initial set up and prior to when the system was upgraded in late 2013. ICNet update sessions are regularly given by the IPC data team, to IPC team members and super users i.e. system administrators. Ad-hoc training is provided by the data team to new IPC staff. User manuals are available electronically for staff to reference when required.	
55. Health Boards should ensure that numbers and rates of CDI are reported through each level of the organisation up to the Chief Executive and the Board. Reporting should include positive reporting in addition to any exception reporting. The Chief Executive should sign off the figures to confirm that there is oversight of infection prevention and control at that level. *Tom Walsh*	**STATUS – COMPLETE** • Ward SPC are issued monthly. • Directorate SPCs are issued monthly. • Two cases of HAI CDI in a single ward in a two week period are reported weekly to Board and Service Directors. • Site SPCs are contained in the HAIRT. • Summary tables on numbers per month are contained in the HAIRT. • Summary tables of the numbers per month across each of the major sites (Including community cases) are published on the	

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	NHSGGC website. This is updated monthly. • HAIRT is a standing agenda item on all of the IPC committees. • HAIRT is a standing item on the Boards Clinical Governance Committee. • HAIRT is submitted to the NHSGGC Board Meeting. HAIRT submitted for sign off to Chief Executive by Board Medical Director. **Evidence** Please refer to reports in recommendation 48.	
56. Health Boards should ensure that infection prevention and control groups meet at regular intervals and that there is appropriate reporting upwards through the management structure. *Tom Walsh*	**STATUS – COMPLETE** The Board, Acute and Partnership Infection Prevention and Control Committees meet on a bi-monthly basis. The minutes of the Acute and Partnership Committees are reviewed at the Board Infection Control Committee and are presented by the respective chairs. This also links with recommendation 9 with Infection Prevention and Control being a standing agenda item on all Clinical Governance Committees. **Evidence** BICC agenda and minutes below:	

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	 Item 2 - Minutes of BICC 05.10.15.doc  18-05-15 BICC Agenda.doc	
57. Health Boards should ensure that the minutes of all meetings and reports from each infection prevention and control committee are reported to the level above in the hierarchy and include the numbers and rates of CDI, audit reports and training reports. *Tom Walsh*	**STATUS - COMPLETE** Attached is the Board to Ward reporting framework for NHSGGC IPCT Service. Healthcare Associated Infection Reporting Template is a publically available document and includes numbers and rates of CDI **Evidence**  C:\Users\ mcnamsa547\Desktop Please refer to reports in recommendation48. Education uptake is now included although denominator data is not available – this means we cannot provide reports on the proportion of staff undertaking training.	Try and explore ways of obtaining denominator data.
58. Health Boards should ensure that there is lay representation at Board infection prevention and control committee level in keeping with local policy on public involvement. *Sandra McNamee*	**STATUS - COMPLETE** A public partner attends the BICC and the PICSG. Recruiting a member of the public to AICC has been problematic. **Evidence** Please refer to recommendation 56	**Actively recruit an additional public partner for the BICC**

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59. Health Boards should ensure that attendance by members of committees in the infection prevention and control structure is treated as a priority. Non-attendance should only be justified by illness or leave or if there is a risk of compromise to other clinical duties in which event deputies should attend where practicable. *Tom Walsh*	**STATUS - COMPLETE** Records of attendance in place for BICC, AICC and PICSG. **Evidence** Please refer to recommendation 56	
60. Health Boards should ensure that programmes designed to improve staff knowledge of good infection prevention and control practice, such as Cleanliness Champions Programme, are implemented without undue delay. Staff should be given protected time by managers to complete such programmes. *Joyce Brown, David Stewart, Mari Brannigan*	**STATUS - COMPLETE** Standard infection control precautions are part of mandatory training for all staff including senior medical staff and are supported by a LearnPro module. Infection control is a core component of junior doctor induction.	Arrangements for senior medical staff are currently being reviewed to ensure all mandatory training is communicated and managed consistently.
61. Health Boards should ensure that unannounced inspections of clinical areas are conducted by senior infection prevention and control staff accompanied by lay representation to examine IPC arrangements including policy implementation and cleanliness. *Pamela Joannidis*	**STATUS - COMPLETE** Currently Infection Prevention and Control Nurses monitor cleanliness with public partners and domestic and facilities colleagues via the facilities lead Public Partner Involvement in Cleaning (and Estates) Monitoring Initiative. Set up to monitor cleaning standards within NHSGGC, this initiative has been in place for several years although there have always been challenges recruiting public partners to this initiative. This system has been extended to include review of the application of IPC policies.	Continue with initiative and develop where appropriate. Initial feedback from public partners is that this is an interesting and informative experience.

RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
	Evidence Scanned audit documents signed by public partners  image2016-01-19-14 1857.pdf	
62. Health Boards should ensure that senior managers accompanied by IPC staff visit clinical areas at least weekly to verify that proper attention is being paid to infection prevention and control. ***Service Directors:-*** *Jonathan Best, Marie Farrell, Anne Harkness GaryJenkins, Aileen MacLennan, Kevin Hill*	**STATUS - COMPLETE** Infection control nurses visit all acute wards at least once per week. Visits to wards and departments are also triggered by referrals from the IPC lab system. All wards and departments are audited at least yearly. IPCN also participate in corporate inspection with members of the senior management teams in NHSGGC. IPCN carry out a PVC or CVC audit is a patient has a bacteraemia in discuss any issues with multidisciplinary team. IPCNs visit all patients who are confirmed positive with either CDI or MRSA and if able will discuss this with the patient and their relatives/carers if possible. If there are two cases of HAI CDI in a ward within a two week period the ward is visited every day and practice is reviewed by the IPCN with the nurse in charge of the ward.	

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	The processes described above are routinely and systematically implemented. An SPSP leadership (director-led) walk around programme takes place monthly. Corporate Unannounced visits are conducted routinely to monitor compliance with HEI and OPAH standards.  OPAH HAI Corporate Uannounced Inspecti **<u>Update on SGHD response/actions to date</u>** In January 2015 NHSGGC reported to SGHD that we believe we have a robust system in place to verify that proper attention is being paid to infection prevention and control; however, concerns was also highlighted to SGHD that the expected frequency of the management walk rounds suggested in this recommendation is extreme and could potentially leave Boards exposed in high risk areas. Discussion was sought with SGHD on this matter. SARHAI group members have been asked to provide advice to assist in identifying a definition for “senior managers” and, what is a realistic number of clinical areas to achieve this	

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	recommendation. This remains unresolved nationally.	
63. Health Boards should ensure that there is effective isolation of any patient who is suspected of suffering from CDI, and that failure to isolate is reported to senior management. *Sandra McNamee, Pamela Joannidis*	**STATUS - COMPLETE** Patients suspected of suffering from CDI should be isolated in accordance with the Priority for Isolation protocol. Failure to isolate patients is reported to senior management. **Evidence**  nhsggc-priority-for-is olation-of-patients-pr	
64. Health Boards should ensure that cohorting is not used as a substitute for single room isolation and is only resorted to in exceptional circumstances and under strict conditions of dedicated nursing with infected patients nursed in cohort bays with en-suite facilities. *IPC Team*	**STATUS – COMPLETE** NHS GGC actively seek to isolate all patients with alert organisms / conditions in a single room with ensuite facilities. Cohorting will only be used, as per National Policy Manual. **Evidence** Report on an audit of compliance with isolating patient with CDI.	

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	 Clostridium difficile -abxOct_Nov15.docx	
65. Health Boards should ensure that appropriate steps are taken to isolate patients with potentially infectious diarrhoea. *IPC Team*	**STATUS - COMPLETE** Currently ward staff must follow the NHSGGC IPC Loose Stools policy i.e. all patients with loose stools /potentially infectious diarrhoea, who meet the criteria of two episodes of loose stools in 24 hours (and no other non-infectious cause known) are isolated in a single room and TBPs applied. The IPCN will visit the ward to ensure that the patient is isolated in a single room in accordance with the Loose Stools policy. If for any reason a patient is not isolated in a single room, the IPCN will review medical notes to ensure a current risk assessment is in place on the suitability of the patient for isolation. Failure to isolate is reported to the senior management team as part of the monthly directorate reports, tabled at Directorate Clinical Governance Committees. A Priority for Isolation of Patient guidance document is now in place. **Evidence** IPC manual and report referred to in recommendation 64.	Continue to review guidance and audit compliance.

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	Directorate report recommendation 52 Priority for Isolation of Patient guidance referred to in recommendation 17  nhsggc-priority-for-isolation-of-patients-pr	
66. Health Boards should ensure that the healthcare environment does not compromise effective IPC, and that poor maintenance practices, such as the acceptance of non-intact surfaces that could compromise effective IPC practice, are not tolerated. *David Loudon*	**STATUS - COMPLETE** HAI related repairs are prioritised using the FM First on line tool. HAI SCRIBE annual update completed for Acute in June annually. HAI SCRIBE review required of Partnerships areas	
67. Health Boards should ensure that, where a local Link Nurse system is in place as part of the IPS system, the Link Nurses have specific training for that role. The role should be written into job descriptions and job plans. They should have clear objectives set annually and have protected time for Link Nurse duties.	**STATUS - COMPLETE** Two infection prevention and control standards are included in our Care Assurance System (CAS). Standard Infection Control Precautions (SICPS) and Catheter Associated Urinary Tract Infections (CAUTI). There are identified staff within clinical settings who are responsible for implementing and monitoring IPC standards along with the IPC team. IPCNs are linking with the ward nurses with the responsibility for monitoring these standards. A set of IPC objectives have been set for IPC Link Nurses. **Evidence**	

RECOMMENDATION	CURRENT POSITION	FORWARD PLAN/MAINSTREAMING
	CAAS IPC link nurse objectives below: 2015-02 CAAS IPC Link Nurse Objectives	
CHAPTER 16 – DEATH CERTIFICATION		
68. Health Boards should ensure that where a death occurs in hospital the consultant in charge of the patients care is involved in completion of the death certificate wherever practicable, and that such involvement is clearly recorded in patient records. Regular auditing of this process should take place. *Dr David Stewart*	**STATUS - COMPLETE** A short life working group has concluded work to define the new arrangements for death certification. The recommendations from this group have been implemented. Guidance notes and a flow chart were produced and circulated to all clinicians in early May 2015, before the new review process was implemented on the 13th May 2015. These outline that the senior clinician is involved and should be available for discussion about the cause of death The flow chart is also within the Online Induction which is circulated to all trainees in August. **Evidence** 1. Death Certification Guidance Note: New Death Certification process	

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	2. Death Certification Flow Chart: MCCD flow chart for induction 15.7.15.doc	
69. Health Boards should ensure that if a patient dies with CDI either as a cause of death or as a condition contributing to the death, relatives are provided with a clear explanation of the role played by CDI in the patient's death. *Dr David Stewart.*	**STATUS - COMPLETE** As part of the new arrangements for death certification, the short life working group has outlined the arrangements to allow relatives to discuss the content of the death certificate. This has been distributed to all medical and nursing staff. See Recommendation 68 above. Each copy of the NHSGGC bereavement booklet has a sticker which allows the ward to put the name and contact number of the senior clinician for contact at a later stage if required. **Evidence** See documents attached as evidence for Recommendation 68 above. 1. NHSGGC Bereavement Booklet & Stickers: 277499 New Bereavement (When LabelsforBereavementBooklets170415.do	
70. Crown Office and the Procurator Fiscal	**Crown Office.**	

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Service (COPFS) should review its guidance on the reporting of deaths regularly and at least every two years.		
71. Scottish Government should identify a national agency to undertake routine national monitoring of deaths related to CDI.	**SGHD**	
CHAPTER 17 - INVESTIGATIONS FROM MAY 2008		
72. Health Boards should ensure that a non – executive Board Member or a representative from internal audit takes part in an Internal Investigation of the kind instigated by NHSGGC. *Chief Executive's office* *(actioned by Chairman at the time of an Investigation requiring the involvement of a Non Exec.)*	**STATUS - COMPLETE** It is intended that should there be a need for that type of Internal Investigation within NHSGGC then the Chair or a Non Executive Member of the NHS Board will be a member of the Internal Investigation Team. Plans would be put in place at the time of such an Internal Investigation being undertaken.	
73. Health Boards should ensure that OCT reports provide sufficient details of the key factors in the spread of infection to allow a proper audit to be carried out, as recommended in the Watt Group Report. *Emilia Crighton*	**STATUS - COMPLETE** The Watt Group Report (2002) stated that although the Outbreak Report was well written, it did not have clear Lessons Learnt and Recommendations which were to be implemented and so audited. Since then, the Scottish Government Guidance – "Management of Public Health Incidents – Guidance on the Roles and Responsibilities of NHS Led Incident Management Teams", was issued in October 2011. This included the template for Outbreak Reports which included 'Lessons Learnt' and 'Recommendations'. It is the responsibility of the Chair of any Incident Management Team to ensure that all future Reports are presented in	

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	this format, and that the 'Recommendations' following on from the 'Lessons Learnt' are implemented and so can be audited. As a result of this Recommendation, the Director of Public Health wrote to all potential Chairs of Incident Management Teams and Outbreak Control Teams to remind them of the importance of following the Guidance and the template for the Report. NHSGGC's actions now fully comply with this recommendation.	
CHAPTER 18 – EXPERIENCES OF C DIFFICILE INFECTION WITHIN AND BEYOND SCOTLAND		
74. Scottish Government (whether through HPS, HIS, the HAI Task Force or otherwise) should as a matter of standard practice ensure that reports published in the United Kingdom and in other relevant jurisdictions on infection prevention and control and patient safety are reviewed as soon as possible, and that, as a minimum, any necessary interim guidance is issued within three months.	**SGHD** **As per recommendation 1**  SARHAI_05_161.docx	
75. Health Boards should review such reports to determine what lessons can be learned and what reviews, audits or other measures (interim or otherwise) should be put in place in the light of these lessons. *Tom Walsh*	**STATUS - COMPLETE** Previous reports were reviewed and findings incorporated into the overall NHSGGC Action plans following the VoL Outbreak. Future reports will be reviewed and a gap analysis undertaken to ensure that NHSGGC is	Extend this process to include all incident related to ventilation, increase in surgical site infections, decontamination. New process document embedded below – please note this document is still a draft.

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	compliant with the relevant recommendations. This will be approved through the appropriate Infection Control and/or Governance Committee. Review of Infection prevention and Control systems will be an on-going component of the Internal Audit Programme. Local outbreak policy has a section in the template report which asks clinical teams to make recommendations to prevent the outbreak happening again. **Evidence** Outbreak report RSV Beatson Oncology Centre  NHSGGC Outbreak Report B7 RSV Dec 15	 26.02.16 Incident Algorithm plus 2 apps