Northern Lincolnshire and Goole Hospitals NHS
NHS Foundation Trust

NLG(13)330

DATE	**24/09/2013**
REPORT FOR	**Trust Board of Directors – Part A**
REPORT FROM	**Professor Carrock Sewell (Acting Medical Director)**
CONTACT OFFICER	**Viv Duncanson**
SUBJECT	**C Difficile Review Action Plan**
BACKGROUND DOCUMENT (IF ANY)	
REPORT PREVIOUSLY CONSIDERED BY & DATE(S)	**Infection Control Committee – 16/09/2013**
EXECUTIVE COMMENT (INCLUDING KEY ISSUES OF NOTE OR, WHERE RELEVANT, CONCERN AND / OR NED CHALLENGE THAT THE BOARD NEED TO BE MADE AWARE OF)	
HAVE THE STAFF SIDE BEEN CONSULTED ON THE PROPOSALS?	
HAVE THE RELEVANT SERVICE USERS/CARERS BEEN CONSULTED ON THE PROPOSALS?	
ARE THERE ANY FINANCIAL CONSEQUENCES ARISING FROM THE RECOMMENDATIONS?	
IF YES, HAVE THESE BEEN AGREED WITH THE RELEVANT BUDGET HOLDER AND DIRECTOR OF FINANCE, AND HAVE ANY FUNDING ISSUES BEEN RESOLVED?	
ARE THERE ANY LEGAL IMPLICATIONS ARISING FROM THIS PAPER THAT THE BOARD NEED TO BE MADE AWARE OF?	
WHERE RELEVANT, HAS PROPER CONSIDERATION BEEN GIVEN TO THE NHS CONSTITUTION IN ANY DECISIONS OR ACTIONS PROPOSED?	
ACTION REQUIRED BY THE BOARD	**Consider report**

Northern Lincolnshire and Goole Hospitals NHS
NHS Foundation Trust

North Lincolnshire NHS
Primary Care Trust

North East Lincolnshire NHS
Care Trust Plus

TRUST *Clostridium difficile* RCA REVIEW ACTION PLAN 2013/14

Section 1 : **Actions brought forward from Trust wide and Site specific *C. difficile* Action Plan 2012/ 2013**
Section 2 : **Actions brought forward from 2013/14 Site specific C. difficile Action Plan**
Section 3: **Actions identified from RCA reviews**

Author: Viv Duncanson

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TRUST *Clostridium difficile* RCA REVIEW ACTION PLAN 2013/14: as at 10/09/13

Key: NLAG | N Lincs PCT | NE Lincs CTP | Lincs PCT

Section 1 : Actions brought forward from Trust wide and Site specific *C. difficile* action plan 2012/ 2013

Reference		Action	Lead	Timescale	Verification	ACTION STATUS
Actions brought forward from Trust wide and Site specific *C. difficile* action plan 2012/ 2013	13.01.01 (previous ref 12.02.06)	Further support required to progress antimicrobial associated issues / practice. Review membership of antimicrobial steering group. • Medical staff representation • Nursing staff representation Jan 2013: Further review of TOR and membership required	Dr Scott Andy Karvot	End of August 2012 Achieved New deadline August 2013	Attendance at meetings	Jul 2012: Agreed at ICC. CEO will ensure medical representation. Jan 2013: Further review of committee TOR and membership required. May 2013: to be ratified at May ICC meeting. Ratified to invite Clinicians ad hoc when required. June 2013: ASG TOR altered to accommodate comments made at May ICC meeting. Finalised document posted on Trust intranet.
	13.01.02 (previous ref 12.02.13)	Working group to be formed to review of turnaround times from specimen taking to receipt of result. Use A3 project principles	Dr Cowling	End of March 2013 New deadline End of May 2013	Identification of issues complete with actions and measurable outcomes	Jan 2013: 1st meeting held. Data currently being gathered. Feb 2013: Progressing, On target to meet set deadline May 2013: More rapid testing techniques introduced all sites.

Reference		Action	Lead	Timescale	Verification	ACTION STATUS
	13.01.03 (previous ref 12.02.14)	Antimicrobials audit: Review of : • audit standards • data collection systems • method of presentation	Andy Karvot	Commence Dec 2012 End of July 2013	Robust audit system. Feedback and measurable improvements in practice	Feb 2013: Standards have been modified to take out those impractical to measure and to add 2 specifics related to *Start Smart then Focus.* AK and the Quality and Audit department are actively looking for junior doctor volunteers to continue data collection. In the longer term AK, Chris Pipkin and Robin Howes will explore automated systems to collect robust data July 2013: Pharmacy teams now using extended template. Issues highlighted regarding on going resource required to input audit data. Aug 2013: AK liaised with Wendy Booth who supports on-going Q&A involvement in principle. AK to discuss details with Audit dept manager. AK to encourage path lab contacts to complete an easier-to- use data recording / collection tool & to discuss further developments in antibiotics audits with Mike Urwin Sept : paper to Sept ICC meeting
	13.01.04 (previous ref 12.02.15)	Issues highlighted concerning understanding of the current nutritional risk tool. Launch of the new MUST tool will address the above.	Hazel Moore	New action identified Feb 2013 End of Oct 2013	Use of the MUST tool at ward level	April 2013: Preparations underway regarding launch of the MUST tool. May2013: Training underway, to be launched in July July 2013: Training commenced, Deadline reviewed as to be included in to the fluid balance pathway. Sept 2013:Implemented within surgery and gynae on 2/9/13, implementation on medicine from 16/9/13. Will be embedded by end of Sept.
	13.01.05 (previous ref 12.02.16)	Ensure that bank staff undertake C. diff training Ensure bank staff are aware of training sessions / arrange specific bespoke sessions for bank staff	Jackie Fenwick	New action identified Feb 2013 Deadline end of August 2013	Bank staff training records 106 staff at DPOW 84 staff at SGH	April 2013: communication to all bank staff to attend *C. difficile* meeting. Monitoring of attendance commenced. May 2013: training commenced 24 /106 DPOW staff and 24/ 84 SGH staff attended so far. To be managed and monitored by JF. July 2013: 64 (33%) of single contact staff have attended so far. Training compliance for permanent nursing and ward staff excellent: 100% DPOW Medical Group 100% DPOW surgical group 100% SGH surgical group 93% SGH medicine group. Aug: 72 bank staff attended (37%) Reminder sent out 7/7/13 Sept: 72 bank staff attendance

Reference		Action	Lead	Timescale	Verification	ACTION STATUS
	13.01.06 (previous ref 12-07.04)	Feed in to **e-prescribing** system that a facility is required to highlight complex cases and antibiotic prescribing.	Andy Karvot	End of May 2012 Specific action achieved To be kept open to ensure action is addressed Proposed launch June 2013: B6/B7	Complex cases able to be identified	Andy Karvot has liaised with David Owen. Capability to flag is available. Need to ensure process is included and utilised. Dec 2012: System development still on going. Jan 2013: Review by IC: still require this information on e-prescribing system. Feb 2013: Highlighted that e prescribing will not have the facility to flag complex cases, but it will be able to flag that patients should not receive certain antibiotics and allergies. April13 : presentation given to ICC May 13: Decision that complex cases will not be able to be highlighted by the system. ACTION CLOSED BY ICC
Ward C5 DPOW Date of specimen 10/5/12 Date of DIPC review 06//07/12 HAI Deemed not preventable.	13.01.07 (previous ref 12.15.02)	Consider including escalation to the dietician and physio re complex cases in order that prompt intervention / monitoring can be introduced.	Nursing documentation group Angie Davies	Sep 2012 Paper version completed New deadline for electronic version Nov 2013	Components included in electronic nursing records	Oct: Added to complex case escalation list. Nov 2012: Handed over to documentation steering group for future-proofing – components will also be included in the electronic records. Dec2012: Nursing documentation steering group progressing this action with Robin Howes. Feb 2013: On target to meet deadline Sept : Work is on-going and progressing.

Reference		Action	Lead	Timescale	Verification	ACTION STATUS
Ward 28 SGH HAI Date of specimen 13/4/12 Date of DIPC review 11/7/12 Deemed possibly Preventable.	13.01.08 (previous ref 12.16.01)	NEW ACTIONS IDENTIFIED One off audit to be performed for surgery Follow up to be specifically targeted Consider introducing zero tolerance process	Andy Karvot Andy Karvot/ Liz Scott	Commence Jan 2013 Deadline April 2013 New deadline to be agreed		May 2013: Audit planned on both main sites in May. To be reviewed and taken forward by antimicrobials steering group. June 2013: One off audit of surgical prophylaxis on-going. Completion estimated to be August. Depending on the findings of the audit, Dr. Scott, Dr. Cowling and AK to meet with Clinical Director for surgery to ensure he understands that there will be a zero tolerance for the use of cefuroxime in surgery, outside the Trust's Antibiotic Formulary and Prescribing Advice for Adults. July 2013: On-going. AK to prepare a paper forSept ICC to highlight difficulties/ obstacles Sept 2013: September 2013: Audit completed and presented to Surgical Directorate Audit Group at DPOW: No inappropriate use of cefuroxime on that site. Agreed that laminated summary of prophylaxis guidelines will be supplied to DPOW theatres. SGH audit not yet complete. Actions await findings.

Reference		Action	Lead	Timescale	Verification	ACTION STATUS
Ward 11 SGH Date of specimen 3.12.2012 Date of DIPC review4/2/2013 HAI Deemed Preventable	13.01.09 (prev ref 12.27.01)	Review of antimicrobial prophylaxis prescribing for orthopaedic procedures Proposal to consider the use of co-amoxiclav.	Dr Scott / Dr Cowling	New action Feb 2013: New deadline end of August 2013		Proposal to consider the use of co-amoxiclav. Discussed at May orthopaedic meetings. May 2013:LS , AK and PC to met with the CD orthopaedics. June 2013: Delay in change of orthopaedic antibiotics prophylaxis agreed at meeting until ongoing investigation of increased rates of orthopaedic wound infection complete. Microbiologists to retrospectively investigate sensitivities of organisms isolated in orthopaedic wound infections. AK to find out from Mr. Bagga / Mr. Al Tayeb whether they had quantitative evidence to show that fluclox + gent caused an increased rate of AKI over cefuroxime. July 2013: PC met with the Ortho Directorate. Presented the data on the sensitivities of the isolates to the various possible prophylaxis antimicrobials. Outcome: the orthopaedics would like some time to consider the prophylaxis issue. Aug 2013: AK spoke to Mr. Al Tayeb who said that no firm evidence of increased AKI with flu lox / gent over cefuroxime, just a perception. AK wrote to Mr. Al Tayeb & Bcc'd Ortho CD. Should have further meeting with Ortho CD and interim Medical Director / interim DIPC to decide action (variability in orthpod prophylaxis causing issues with ePrescribing pilot). Sept 2013: On going

Reference	Action	Lead	Timescale	Verification	ACTION STATUS	Reference
Ward 17 SGH Date of specimen 14.12.12 Date of DIPC review 11/01/2013 HAI Deemed Not preventable	13.01.10 (prev ref 12.28.02)	Review antibiotic policy regarding empirical treatment for meningitis	Dr Cowling Andy Karvot	New action Feb 2013 Deadline end of April 2013	Policy reviewed and ratified.	Reviewed. No change required. As in line with National prescribing standards
Ward B7 DPOW Date of specimen 06/01/2013 Date of DIPC review 20/03/2013 HAI Deemed possibly preventable	13.01.11 (prev ref 12.33.01)	Antibiotic prescribing: Incorrect use of cephalosporins – custom and practice within the Orthopaedic service in contravention of Trust antimicrobial policy. Risks assesse for antimicrobials. Propose that co-amoxiclav be used for prophylaxis. Discussions with orthopaedic surgeons via Anthony Fitzgerald	Dr Vicca And Andy Karvot	End of April 2013	Agreement by stakeholders Change to policy	Dr Scott, Dr Cowling and AK to attend orthopaedic meeting (see 13.01-09 above). Outstanding Merged with 13.01.09
Ward C1H DPOW Date of specimen 15/01/2013 Date of DIPC review 22/03/2013 HAI Deemed Not Preventable	13.01.12 (prev ref 12.35.02)	B3 MRSA screening compliance to be closely monitored	Debbie Bagley	End of May 2013 and ongoing	Monthly MRSA screening reports. Non compliance monitored by Site IC group and escalated to General Manager	April 2013: Monitoring commenced For Feb screening results: 90.8% (79/87 screens), HOBS 100% (9/9) March results: HOBS 100% (3/3) April 2013: HOBS 100% May 100% achieved July:2013 Completed
Ward AMU DPOW Date of specimen 20/01/2013 Date of DIPC review 04/03/2013 HAI Deemed preventable	13.01.13 (prev ref 12.36.02)	Specimen turnaround time was 3 days. To be addressed as part of item 12-2.13	Dr Cowling	End of March 2013		Merged with 13.01-02
Ward B6 DPOW Date of specimen 21/02/2013 Date of DIPC review 20/03/2013 HAI Deemed possibly preventable	13.01.14 (prev ref 12-40.01)	Antibiotic prescribing: Incorrect use of cephalosporin's – custom and practice within the Orthopaedic service in contravention of Trust antimicrobial policy. Risks assessed for antimicrobials. Propose that co-amoxiclav be used for prophylaxis. Discussions with orthopaedic surgeons via Anthony Fitzgerald	Dr Vicca And Andy Karvot	End of April 2013	Agreement by stakeholders Change to policy	Merged with 13.01.09 13.01-09 13.01-11

Section 2 : Actions brought forward from 2013/14 Site specific C. difficile Action Plan

Reference		Action	Lead	Timescale	Verification	ACTION STATUS
Actions brought forward from 2013/14 Site specific C. difficile Action Plan	13.02.01	May meetings: Review the newly launched RCN guidance regarding the management of patients with diarrhoea. 1. Include patient perspective in C. diff policy 2. Circulate to NMAF members	VD TF	End of July 2013 End of June	Guidance reviewed and policy amended	June 2013: Guidance discussed at NMAF. To be linked to the nursing web site. Review underway with regards to addition to Trust C.difficile and norovirus policies July completed: small addition regarding patient dignity added to C.diff policy. Guidance also tabled at NMAF and has been uploaded to Chief nurse section of web site for further reference Completed
	13.02.02	Introduce “C.diff free for 100 days” and “C.diff free for 1 year” awards: Draft and agree process Design certificates Organise launch / presentations	VD / LB	Target date for presentations for first 100 day free August 2013		Process developed. 100 day free certificates produced. Presentations days with CEO were held in August on all 3 sites. To build on this concept using 200 days, 300days and 1 year free of C.diff

Reference		Action	Lead	Timescale	Verification	ACTION STATUS
Actions from meeting to discuss period of increased incidence on C5 DPOW 23/08/2013	13.02.03	Source door signs for all medical wards to designate / highlight which side rooms are classified as isolation rooms	Angie Davies	End of November 2013		
		In addition to incident forms , request that bed managers capture live data for cases when patients are not isolated	Angie Davies / Simon Buckley	End of September 2013		
		Deep clean isolation room 1 week	Dawn Ojadi	27/08/2013		Completed
		Ward to undergo routine deep clean 2nd week of September following refurbishment. Request that Tristel is used.	Dawn Ojadi	20/09/2013		
		How to clean a commode - Policy on a page refreshed and issued to all wards as a reminder of correct procedure to clean commodes.	IPCNs and QM's	30/08/2013		Completed
		Stool chart to form part of the patients pack of records for every patient	Dawn Ojadi	30/08/2013		
		All staff to receive a letter from Head of Nursing regarding the importance of following the C.diff policy including the consequences of failure.	Angie Davies	End of September 2013		Completed. Letter sent to all staff from H of N Meeting arranged for 19th Sept to discuss the issues with the nursing team from c5 Prompt sheet done and out on the wards.
		Devise and implement a competency check re C.diff knowledge for all ward staff.	Jo Jones / Dawn OJadi	End of Oct 2013		
		Introduce the prompt sheet / check list for shift leader	Angie Davies	End of September 2013		Prompt sheet done and out on the wards.

Section 3: Actions identified from RCA reviews

Reference		Action	Lead	Timescale	Verification	ACTION STATUS
13.03. Ward SSRU – SGH Date of specimen 18/2/2013 Date of DIPC review 17/4/2013 HAI Deemed: Not preventable	13.03.01	Dr Banerjee to raise awareness amongst his team that when contacting the Consultant Microbiologist a full history must be given.	Dr Banerjee	End of June 2013	Confirmation from Dr Banerjee	June 2013: feedback not received at time of update
	13.03.02	All relevant SSRU staff to attend C. difficile training at the earliest opportunity	S Garton	End of July 2013	OLM records	July 2013: This is currently being addressed. 22 / 33 staff have attended training. Sept: Completed. All staff have attended C.diff training

Reference		Action	Lead	Timescale	Verification	ACTION STATUS
13.04 Ward 24 SGH Date of specimen 9/2/13 Date of DIPC review 17/4/2013 HAI Deemed : Not preventable	13.04.01	The IPCT to review Lab protocol for C.difficile specimen testing with particular reference to patient who has a history of antibiotics and a change in bowel habits and odour.	P Cowling and ICT	End of July 2013	Verify if amendment necessary	Screening in excess of standard lab protocol may be justified in certain cases. To be handled on an ad hoc basis following case assessment by

Reference		Action	Lead	Timescale	Verification	ACTION STATUS
13.05 Ward 18 SGH Date of specimen 20/03/2013 Date of DIPC review 12/06/2013 HAI Deemed : Unpreventable	13.05.01	Recent audit had noted that the cleanliness of showers and toilets was not to standard (75%). This had also been noted in a previous DIPC review on another ward. In addition this issue has also been noted on Matrons audits. Although improvements since March have been made with the cleanliness of showers, toilets and bathrooms it was decided to bring the issue to Kirsty Edmondson Jones attention to ensure continued and sustained improvements.	Karen Dunderdale	End of June 2013	Confirmation from Karen Dunderdale	KD has communicated the issue to KEJ, in order that monitoring is on-going.

Reference		Action	Lead	Timescale	Verification	ACTION STATUS
13.06. Ward 17 SGH Date of specimen 14/3/2013 Date of DIPC review 17/4/2013 HAI Deemed: Preventable	13.06.01	To improve communication between medical and nursing staff, Dr Scott to write to CD's to remind their doctors to alert nursing staff directly if certain procedures / interventions (including loading doses of antibiotics) need implementing promptly	Dr Scott	End of April 2013	Email thread	Email sent to CD's
	13.06.02	Reminder that as previously agreed PIU should only be used for isolating patients as a last resort (due to the lack of clinical sinks and en-suite facilities). Tara Filby to liaise with Graham Jaques	Tara Filby	End Of April 2013	Email thread	Email sent to Heads of nursing and Operations centre
	13.06.03	Reinforce isolation policy to ward 17 staff	Sue Cooper	End of may 2013	Staff aware	Introduced a policy of the month. Isolation policy included

Reference		Action	Lead	Timescale	Verification	ACTION STATUS
13.07 Ward B6 DPOW Date of specimen 26/3/2013 Date of DIPC review 24/5/2013 HAI Deemed; Not preventable Incidental finding	13.07.01	Stoma nurse to liaise with IPCN regarding future cases where there is a query as to whether a sample is required.	Louise Salt	End of June 2013	All stoma nurses aware of requirement	Email sent. All stoma nurses and IPCN's aware. Completed
	13.07.02	Surgical patient outlier guidance to be completed and ratified: to include moving / outlying patient with stomas, especially with regards to orthopaedic wards	Simon Buckley	End of Sept 2013 New deadline End of Nov 2013	Ratified policy	June 2012: Medical outlier guidance completed. Surgical outlier policy drafted and out for comment Aug : On-going Sept Decision to join with SGH and draft a Trust wide outlier policy. New deadline allocated

Reference		Action	Lead	Timescale	Verification	ACTION STATUS
13.08 Ward 24 SGH Date of specimen 2/4/2013 Date of DIPC review 30/8/2013 HAI Deemed : Possibly preventable	13.08.01	Orthopaedic antibiotic prophylaxis not in accordance with Trust Antimicrobial Guidance	Dr Cowling Medical director Clinical Director Orthopaedics		Compliance /Agreement with Trust Antimicrobial Prescribing	Merged with 13.01.09

Reference		Action	Lead	Timescale	Verification	ACTION STATUS
13.09 Ward 16 SGH Date of specimen 12/4/2013 Date of DIPC review 29/5/2013 HAI Deemed: Not preventable	13.09.01	Ensure that all ward 16 staff are aware that any drug omissions should be documented on the prescription sheet.	Wendy Bainbridge	End of June 2013	All staff aware	Confirmation received from Ward Manager that information has been cascaded to all staff
	13.09.02	Raise the issue of not recording drug omissions at July 2013 NMAF meeting.	Tara Filby	End of July 2013 New deadline end of October 2013		Requested for July agenda. Raised at NMAF. Agreed that issue will be raised at Ward managers meetings In addition it was agreed to provide nursing staff with simple guidance in order to challenge antimicrobial prescribing. AK to lead August: Drafted to be taken to Sept NMAF
	13.09.03	Audit of specimen pathway from receipt of the specimen to the informing of the ward to ensure no acceptable delays occurred in the path lab. (this has been future proofed as per 13.01.02)	Peter Cowling	End of May 2013		Audit trail of specimen conducted. Lab process exemplary. Appears that specimen was taken on Friday evening and did not arrive at the lab until the next Monday.
	13.10.03	New action: as a result of findings from the specimen audit trial. Ward manager to ensure all staff are aware that for out of hours all specimens must be delivered to the lab promptly.	Wendy Bainbridge	End of June 2013	All staff aware	Confirmation received from Ward manger that all staff are aware

Reference		Action	Lead	Timescale	Verification	ACTION STATUS
13.10 Ward C5 DPOW Date of specimen 309/4/2013 Date of DIPC review 31/07/2013 HAI Deemed : Not Preventable	13.10.01	Ward manager to reinforce the importance of early sample collection with staff as per SOP	Sarah Rushby	End of August 2013	Assurance from Ward manager	Completed Reminder put in to ward newsletter
	13.10.02	Consultants and Nursing staff to remind their teams to check dates of samples to ensure relevant samples are requested and prescribing of antibiotics is based on up to date samples	Collette Cunningham	End of September 2013	To Be raised at medical Consultants and Ward managers meetings	
	13.10.03	To explore feasibility of develop an electronic reminder for teams to check that relevant samples have been taken when patients are isolated. Link this to hand over tool.	Angie Davies/ Viv Duncanson / Robin Howes	October 2013	If feasible include in next version	VD has discussed with Robin Howe be included in next release

Reference		Action	Lead	Timescale	Verification	ACTION STATUS
13.11 Ward C1K DPOW Date of specimen 30/05/2013 Date of DIPC review 23/08/2013 HAI Deemed : Possibly	13.11.01	Escalate to Medical Director for a mortality review: 1) to review decision to put on part 1C of the death certificate 2) Review the delay with carrying out the CTPA procedure.	VD to send RCA summary to Prof Sewell	Immediate		Summary of review emailed to Prof Sewell on 23/8/13. Reasons for concerns highlighted
	13.11.02	Antibiotic prescribing issues. To include issue of incorrect prescribing, in the meeting that is being set up with Collette Cunningham and the Medical CD. Also raise the issue at the medical audit group - September meeting	Andy Karvot	Sept 2013		On going
	13.11.03	Already identified in previous RCA: (13.09-02) Key principles for antibiotic prescribing to be drafted for nursing staff, in order to empower to challenge prescribers. To be ratified at September NMAF. Implement for all wards	Andy Karvot	End of October 2013		See 13.09.02

Reference		Action	Lead	Timescale	Verification	ACTION STATUS
13.12 Ward 24 SGH Date of specimen 08/06/2013 Date of DIPC review 30/08/2013 HAI Deemed : NOT PREVENTABLE	13.12.01	Ward staff to ensure that they communicate isolation cleaning requirements to domestic staff	Lorrie Cross	End of august 2013	Use of Tristel for cleaning of isolation rooms with patients with C.diff	Completed as evidenced by audit of additional C.diff case in July 2013. Correct disinfectant being used

Reference		Action	Lead	Timescale	Verification	ACTION STATUS
13.13 Ward 24 SGH Date of specimen 09/07/2013 Date of DIPC review 30/8/2013 HAI Deemed : NOT PREVENTABLE	13.13.01	Inspection visit by Chief Nurse / Head of Nursing/ ADIPC. No nursing issues identified. In view of 3 unrelated cases since April 2013, routine deep clean bought forward. Minor issues noted re deep clean technique. Escalated to Facilities Managment and dealt with immediately.	N/A	N/A	N/A	Completed

Reference		Action	Lead	Timescale	Verification	ACTION STATUS
13.14 Ward 17 SGH Date of specimen 17/07.2013 Date of DIPC review Tbc HAI Deemed :	13.14.01					
	13.14.02					
	13.14.03					

Reference		Action	Lead	Timescale	Verification	ACTION STATUS
13.15 Ward Blueberry DPOW Date of specimen 22/7/2013 Date of DIPC review Tbc HAI Deemed :	13.15.01					
	13.15.02					
	13.15.03					

Reference		Action	Lead	Timescale	Verification	ACTION STATUS
13.16 Ward C5 DPOW Date of specimen 7/08/2013 Date of DIPC review Tbc HAI Deemed :	13.16.01					
	13.16.02					
	13.16.03					

Reference		Action	Lead	Timescale	Verification	ACTION STATUS
13.17 Ward 3 Goole Date of specimen 10/08/2013 Date of DIPC review Tbc HAI Deemed :	13.17.01					
	13.17.02					
	13.17.03					