



The **Regulation** and
Quality Improvement
Authority

RQIA
Infection Prevention/Hygiene
Unannounced Follow up Inspection

Southern Health and Social Care Trust

Craigavon Hospital

21 September 2011

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1.0 Inspection Summary

The unannounced inspection undertaken to three wards of Craigavon Area Hospital on the 23 June 2011 identified one ward, Ward 4 South, as having issues of minimal compliance within standards 2- 7 of the Regional Healthcare Hygiene and Cleanliness Standards. In accordance with the follow up process an unannounced inspection was undertaken on the 21 September 2011.

Inspection Outcomes

On the inspection of 23 June 2011, 20 recommendations were made in relation to Standards 2-7. Twelve have been addressed, eight have been repeated and there are six new recommendations.

The inspection team reviewed the progress on Ward 4 South and found 76 per cent of the preliminary findings have been addressed. The majority still requiring action are in relation to the age of the building, and continues to be a challenge for staff.

Improvements and Developments since the previous inspection

There has been significant improvement, six of the seven standards are now compliant. Improved staff practices was noted in cleaning of environment, management of waste and hygiene factors.

Key Areas for Improvement

The standard on patient equipment while moving from minimally compliant to partial could be improved. The roles, responsibilities and standard expected in relation to the cleaning of patient equipment still requires further clarification as the inspectors found some equipment to be dusty or stained.

A summary of the recommendations following the re-audit is listed in Section 13.

A detailed list of the findings from the re-audit is forwarded to Southern Health and Social Care Trust within 14 days of the inspection to enable action on recurring or new areas which have achieved non compliant scores. The draft report which includes the high level recommendations in a Quality Improvement Plan is forwarded within 28 days of the inspection for agreement and factual accuracy. The draft report is agreed and a completed action plan is returned to RQIA within 14 days from the date of issue. The detailed list of preliminary findings is available from RQIA on request.

The final report and Quality Improvement Plan will be available on the RQIA website. Reports and action plans will be subject to performance

management by the Health and Social Care Board and the Public Health Agency.

The RQIA inspection team would like to thank the staff at Craigavon Area Hospital for their assistance during the inspection.

The following tables give an overview of compliance scores noted in areas inspected by RQIA:

Table 1 summarises the overall compliance levels achieved.

Tables 2-7 summarise the individual tables for sections two to seven of the audit tool as this assists organisation to target areas that require more specific attention.

Table 1

Areas inspected	4 South June 2011	4 South September 2011
General environment	72	89
Patient linen	87	95
Waste	82	90
Sharps	86	86
Patient Equipment	72	83
Hygiene factors	81	98
Hygiene practices	88	94
Average score	81	91

Compliant: 85% or above
Partial Compliance: 76% to 84%
Minimal Compliance: 75% or below

Table 2

General environment	4 South June 2011	4 South September 2011
Reception	N/A	N/A
Corridors, stairs lift	61	77
Public toilets	N/A	N/A
Ward/department - general (communal)	66	80
Patient bed area	66	86
Bathroom/washroom	77	90
Toilet	85	98
Clinical room/treatment room	67	84
Clean utility room	78	95
Dirty utility room	89	94
Domestic store	65	95
Kitchen	54	86
Equipment store	68	94
Isolation	78	88
General information	79	96
Average score	72	89

Table 3

Patient linen	4 South June 2011	4 South September 2011
Storage of clean linen	88	96
Storage of dirty linen	86	94
Laundry facilities	N/A	N/A
Average score	87	95

Table 4

Waste and sharps	4 South June 2011	4 South September 2011
Handling, segregation, storage, waste	82	90
Availability, use, storage of sharps	76	86

Compliant: 85% or above
Partial Compliance: 76% to 84%
Minimal Compliance: 75% or below

Table 5

Patient equipment	4 South June 2011	4 South September 2011
Patient equipment	72	83

Table 6

Hygiene factors	4 South June 2011	4 South September 2011
Availability and cleanliness of wash hand basin and consumables	87	100
Availability of alcohol rub	77	100
Availability of PPE	93	100
Materials and equipment for cleaning	65	95
Average score	81	98

Table 7

Hygiene practices	4 South June 2011	4 South September 2011
Effective hand hygiene procedures	94	100
Safe handling and disposal of sharps	100	100
Effective use of PPE	90	100
Correct use of isolation	78	90
Effective cleaning of ward	71	79
Staff uniform and work wear	96	93
Average score	88	94

Compliant: 85% or above
Partial Compliance: 76% to 84%
Minimal Compliance: 75% or below

2.0 Background Information to the Inspection Process

RQIA's infection prevention and hygiene team was established to undertake a rolling programme of unannounced inspections of acute hospitals. The Department of Health Social Service and Public Safety (DHSSPS) commitment to a programme of hygiene inspections was reaffirmed through the launch in 2010 of the revised and updated version of 'Changing the Culture' the strategic regional action plan for the prevention and control of healthcare-associated infections (HCAIs) in Northern Ireland.

The aims of the inspection process are:

- to provide public assurance and to promote public trust and confidence
- to contribute to the prevention and control of HCAI
- to contribute to improvement in hygiene, cleanliness and infection prevention and control across health and social care in Northern Ireland

In keeping with the aims of the RQIA, the team will adopt an open and transparent method for inspection, using standardised processes and documentation.

3.0 Inspections

The DHSSPS have devised Regional Healthcare Hygiene and Cleanliness standards. RQIA has revised their inspection processes to support the publication of the standards which were compiled by a regional steering group in consultation with service providers. One of the standards relates to organisational systems and governance. To ensure compliance with this, a new inspection process and methodology process has been developed in consultation with the regional steering group.

RQIA's infection prevention/hygiene team have planned a three year programme of announced and unannounced inspections in acute and non-acute hospitals in Northern Ireland in a rolling three year programme to assess compliance with the DHSSPS Regional Healthcare Hygiene and Cleanliness standards.

The inspections will be undertaken in accordance with the four core activities outlined in the RQIA Corporate Strategy, these include:

- **Improving care:** we encourage and promote improvements in the safety and quality of services through the regulation and review of health and social care
- **Informing the population:** we publicly report on the safety, quality and availability of health and social care
- **Safeguarding rights:** we act to protect the rights of all people using health and social care services
- **Influencing policy:** we influence policy and standards in health and social care

4.0 Unannounced Inspection Process

Trusts receive no advanced notice of the onsite inspection. An email and telephone call will be made by the Chief Executive of RQIA or nominated person 30 minutes prior to the team arriving on site. The inspection flow chart is attached in Section 14.

4.1 Onsite Inspection

The inspection team was made up of two inspectors, from RQIA's infection prevention/hygiene team. One inspector led the team and was responsible for guiding the team and ensuring they were in agreement about the findings reached. Membership of the inspection team is outlined in Section 12.

The inspection of ward environments is carried out using the Regional Healthcare Hygiene and Cleanliness audit tool. The inspection process involves observation, discussion with staff, and review of some ward documentation.

4.2 Feedback and Report of the Findings

The process concludes with a feedback of key findings to trust representatives including examples of notable practice identified during the inspection. The details of trust representatives attending the feedback session is outlined in Section 12.

Organisations are forwarded a detailed action plan of preliminary findings within 14 days of the inspection; this does not include the findings of the overall organisational systems and governance. The action plan is returned with the agreed draft report. The draft report contains the high level recommendations of the inspection and is forwarded to each organisation within 28 days of the inspection for agreement and factual accuracy checking and returned within two weeks. The detailed action plan is available on request from RQIA.

The findings of the inspection will be followed up in line with infection prevention/hygiene inspection process (methodology, follow up and reporting).

The infection prevention/hygiene team escalation process will be followed if inspectors/reviewers identify any serious concerns during the inspection (Section 15).

A number of documents have been developed to support and explain the inspection process. This information is currently available on request and will be available in due course on the RQIA website.

5.0 Audit Tool

The audit tool used for the inspection is based on the Regional Healthcare Hygiene and Cleanliness standards. The standards incorporate the critical areas which were identified through a review of existing standards, guidance and audit tools (Appendix 2 of Regional Healthcare Hygiene and Cleanliness standards). The audit tool follows the format of the Regional Healthcare Hygiene and Cleanliness standards and comprises of the following sections.

1. **Organisational Systems and Governance:** policies and procedures in relation to key hygiene and cleanliness issues; communication of policies and procedures; roles and responsibilities for hygiene and cleanliness issues; internal monitoring arrangements; arrangements to address issues identified during internal monitoring; communication of internal monitoring results to staff

This standard is not audited when carrying out unannounced inspections however the findings of the organisational system and governance at annual announced inspection will be, where applicable, confirmed at ward level.

2. **General Environment:** cleanliness and state of repair of public areas; cleanliness and state of repair of ward/department infrastructure; cleanliness and state of repair of patient bed area; cleanliness and state of repair of toilets, bathrooms and washrooms; cleanliness and state of repair of ward/department facilities; availability and cleanliness of isolation facilities; provision of information for staff, patients and visitors
3. **Patient Linen:** storage of clean linen; handling and storage of used linen; ward/department laundry facilities
4. **Waste and Sharps:** waste handling; availability and storage of sharps containers
5. **Patient Equipment:** cleanliness and state of repair of general patient equipment
6. **Hygiene Factors:** hand wash facilities; alcohol hand rub; availability of personal protective equipment (PPE); availability of cleaning equipment and materials.
7. **Hygiene Practices:** hand hygiene procedures; handling and disposal of sharps; use of PPE; use of isolation facilities and implementation of infection control procedures; cleaning of ward/department; staff uniform and work wear

Level of Compliance

Percentage scores can be allocated a level of compliance using the compliance categories below. The categories are allocated as follows:

Compliant	85% or above
Partial compliance	76 to 84%
Minimal compliance	75% or below

Each section within the audit tool will receive an individual and an overall score, to identify areas of partial or minimal compliance to ensure that the appropriate action is taken.

6.0 Environment

STANDARD 2.0 GENERAL ENVIRONMENT

Cleanliness and state of repair of public areas; cleanliness and state of repair of ward/department infrastructure; cleanliness and state of repair of patient bed area; cleanliness and state of repair of toilets, bathrooms and washrooms; cleanliness and state of repair of ward/department facilities; availability and cleanliness of isolation facilities; provision of information for staff, patients and visitors.

General environment	4 South June 2011	4 South September 2011
Reception	N/A	N/A
Corridors, stairs lift	61	77
Public toilets	N/A	N/A
Ward/department - general (communal)	66	80
Patient bed area	66	86
Bathroom/washroom	77	90
Toilet	85	98
Clinical room/treatment room	67	84
Clean utility room	78	95
Dirty utility room	89	94
Domestic store	65	95
Kitchen	54	86
Equipment store	68	94
Isolation	78	88
General information	79	96
Average score	72	89

6.1 Cleaning

Following the inspection in June 2011, the staff in Ward 4 South have made significant improvements to cleaning practices this has resulted in a compliant scores for ten sections of the standard and an overall compliant score. Staff should be commended for their efforts in achieving this result. The recurring issues in the two partially compliant sections relate to damage to walls, floors, doors and worn furniture.

Support Services revised the work schedules with good effect, skirting, touch points on doors and light switches which were an issue in the first inspection, were all clean. There was little evidence of dust, with the exception of the horizontal surfaces in the female shower room and the radiator in the female toilet. The presence of limescale on taps

remains an issue and will require constant attention to avoid any build up.

During the first inspection it was noted that sluice hoppers were stained. On the re-audit the inspectors observed the sides of the sluice hoppers, in both dirty utility rooms, had faecal stains. Nursing staff should ensure all debris is removed in the sluice hoppers by flushing after use.

6.2 Clutter

The inspectors recognised that staff are now more aware of the need for a clutter free environment, and efforts are being made to reduce stock levels. Clutter and storage will continue to be addressed as it an element in the Releasing Time to Care project which has recently commenced in the ward.

6.3 Maintenance and Repair



Picture 1: Refurbished shower room

The hospital is nearly forty years old; floors, walls, doors, finishes and some sanitary areas are old and worn. Senior representatives within the trust are currently engaging with Health Estates Investment Group, to secure additional capital, to address these issues. In the interim some shower and toilet facilities have been upgraded, and small repairs have been made to damaged floor tiles. (Picture 1)

6.4 Fixtures and fittings

A programme of replacement for damaged and fabric chairs is in place, the inspectors noted that some of the patients bedside chairs were new. However not all of the chairs have been replaced; damaged stools had been removed from the patient area, but were present at the nursing work stations.

6.5 Information

A review of posters and information leaflets has been carried out by ward staff, a new leaflet rack has been ordered, and a notice board has been repainted. A second notice board in the corridor has been replaced, however the board is finished in felt material which can not be effectively cleaned. An information notice board has been placed in

the staff room which displays details of dashboard audits, and action plans. (Picture 2)



Picture 2: Information notice board

Following the previous inspection, new nursing cleaning schedules and check lists have been introduced, for example, a commode check list sheet is now completed daily.

Recommendations

- 1. The trust should continue to work to improve storage and maintain a clutter free environment. (Repeated)**
- 2. The trust should continue to work on the repairs and maintenance of the ward and public environments and to replace damaged fixtures and fittings. (Repeated)**
- 3. The trust should ensure any replacement fixtures can be effectively cleaned.**

7.0 Patient Linen

STANDARD 3.0 PATIENT LINEN

Storage of clean linen; handling and storage of used linen; ward/department laundry facilities.

Linen	4 South June	4 South September
Storage of clean linen	88	96
Storage of used linen	86	94
Laundry facilities	N/A	N/A
Average score	87	95

7.1 Management of Linen



Staff should be commended for maintaining and improving on compliance in the management of linen. The two recommendations, one in relation to the packaging of clean linen during transportation and the second regarding appropriate linen storage have been actioned. The clean linen store has been refurbished, linen is stored off the floor and all linen observed was in protective plastic covers (Picture 3). The only new issue inspectors identified during the re-audit related to the damaged framework of both the clean and used linen trolleys.

Picture 3: Clean and tidy linen store

Recommendations

4. The trust should ensure laundry trolleys are free from damage and fit for purpose.

8.0 Waste and Sharps

STANDARD 4.0 WASTE AND SHARPS

Waste: Effectiveness of arrangements for handling, segregation, storage and disposal of waste on ward/ department

Sharps: Availability, use and storage of sharps containers on ward/ department

Waste and sharps	4 South June	4 South September
Handling, segregation, storage, waste	82	90
Availability, use, storage of sharps	76	86

In this standard improvement have been made to practices which have resulted in a compliance score for both sections.

8.1 Waste

The majority of issues highlighted from the June 2011 inspection have been addressed, however, damaged and rusted waste bins were again identified. Damaged or rusted waste bins can not be effectively cleaned and should therefore be removed and replaced.

There was no black lidded waste bin for the disposal of pharmaceutical waste, staff stated they had been ordered but there had been a delay in delivery. The incorrect disposal of paper waste in sharps bins was raised during the previous inspection, this is still an issue as paper waste was observed in several sharps bins.

8.2 Sharps

It was disappointing to note that although this section was now compliant, three issues highlighted on the first inspection in relation to availability, use and storage of sharps still require action. Not all sharps bins had the temporary closure mechanism in place when not in use. The sharps bin on the IV trolley was not secure. Equipment used as part of the Aseptic Non Touch Technique (ANTT) process such as sharps trays had traces of blood stains and were grubby (Picture 4).



Picture 4: Dirty sharps tray

Recommendations

- 5. The trust should ensure that waste bins are replaced when damaged or rusted. (Repeated)**
- 6. The trust should monitor the implementation of its policies and procedures in respect of the management of waste and sharps. (Repeated)**
- 7. Staff should ensure that equipment used in any Aseptic Non Touch Technique (ANTT) process is thoroughly cleaned after use.**

9.0 Patient Equipment

STANDARD 5.0 PATIENT EQUIPMENT

Cleanliness and state of repair of general patient equipment.

Patient Equipment	4 South June	4 South September
Patient equipment	72	83

This standard has moved from minimal compliance to partial compliance. A compliance score could have been achieved if all issues identified in the previous inspection had been actioned.

There has been improvement in the cleaning of some patient equipment, such as commodes, blood pressure cuffs and oxygen saturation probes. However six out of eight actions which were still outstanding relate to the cleanliness of equipment such as the resuscitation trolley, the drugs trolley, cardiac monitor, IV stands, the procedure trolley and stored patient wheelchair which were all dusty and/or stained. New cleaning issues noted were in relation to blood splatters on the inside of the blood glucose machine, and dust on the suction machine attached to the wall beside the resuscitation trolley.

A review of the effectiveness of the current cleaning schedules and staff practices should be undertaken as the equipment which required cleaning are part of a daily cleaning check list. Advice should be given to staff on the standard required when cleaning patient equipment, this should be followed by validation audits.

The inspectors observed that packaging containing oxygen masks and cannulae were damaged. The pierced bags were hung on the wall mounted oxygen valve behind the patients bed (Picture 5). The ward manager agreed to review this practice. The Association of Anaesthetists of Great Britain and Ireland guidelines 'Infection Control in Anaesthesia' states that single use resuscitation equipment should be kept in a sealed package or should be decontaminated between patients according to manufacturer's instructions. It also states that packaging should not be removed until the point of use for infection control, identification and traceability in the case of a manufacturer's recall and safety.



Picture 5: Pierced bags hung on valves

Recommendations

- 8. The trust should ensure that staff are aware of their responsibility in ensuring that equipment is clean at all times(Repeated)**
- 9. Staff should ensure that packaging on single use items remains intact at all times.**

10.0 Hygiene Factors

STANDARD 6.0 HYGIENE FACTORS

Hand wash facilities; alcohol hand rub; availability of PPE; availability of cleaning equipment and materials.

Hygiene factors	4 South June	4 South September
Availability and cleanliness of wash hand basin and consumables	87	100
Availability of alcohol rub	77	100
Availability of PPE	93	100
Materials and equipment for cleaning	65	95
Average score	81	98

The re-audit inspection found that three sections were now fully compliant and the fourth section compliant. Staff are to be commended for this improvement.

In the June inspection the underside of soap, hand towel and alcohol dispensers which were found to be dirty were clean, and staff were now able to state the correct dilution rate for disinfectant products. The inspectors were shown records which detailed staff attendance at training sessions following the previous inspection, on the use of Actichlor plus disinfectant. The inspectors observed bottles of disinfectant were made up and labelled daily, and that the use of other disinfectants have been withdrawn to standardise practice and solutions. In both dirty utility rooms, boxes of Actichlor plus were held in an unlocked metal cupboard. Staff are reminded that Actichlor plus must be locked away when not in use, in line with COSHH regulations.

Issues regarding cleaning equipment have been addressed, mop handles were clean, the green mop and bucket have been removed from the dirty utility room to comply with the trust policy on colour coding of cleaning equipment.

Recommendations

- 10. The trust should ensure that all chemicals are stored in a locked cupboard in line with COSHH regulations. (Repeated)**

11.0 Hygiene Practices

STANDARD 7.0 HYGIENE PRACTICES

Hand hygiene procedures; handling and disposal of sharps; use of PPE; use of isolation facilities and implementation of infection control procedures; cleaning of ward/ department; staff uniform and work wear.

Hygiene practices	4 South June	4 South September
Effective hand hygiene procedures	94	100
Safe handling and disposal of sharps	100	100
Effective use of PPE	90	100
Correct use of isolation	78	90
Effective cleaning of ward	71	79
Staff uniform and work wear	96	93
Average score	88	94

A compliant score was achieved in five of the six sections, and the ward should be commended for achieving full compliance in three sections.

During the first inspection staff were observed using antibacterial solutions for social hand washing, this is no longer an issue as the bottles of antibacterial solution have been removed from the hand washing sinks. The results of this audit indicate that effective hygiene practices are in place in the ward. Hand hygiene practices observed complied with WHO (World Health Organisation) guidance on the correct technique to use for hand washing and the application of hand rub.

Inspectors observed the correct and appropriate use of personal protective equipment by nursing staff engaged in activities where their uniforms could become contaminated, such as bed making and equipment cleaning.

On the day of the inspection some patients required isolation and practices observed in relation to the application of isolation precautions were good and in line with current practice guidance. However a spot check of a patient's care plan noted that an assessment of the patient's on-going needs was not made daily, decisions were not documented and entries were not always signed and dated.

The section on effective cleaning has improved and moved from minimal to partial compliance. There was one recurring issue from the previous inspection and two new issues identified. COSHH data sheets were still not available in the domestic store and the member of domestic staff questioned could not locate them. The new issues identified were in relation to nursing staff knowledge. When questioned, nursing staff were not aware of the procedures to follow when cleaning blood and body fluid spillages or the colour coding system for cleaning equipment.

Two members of staff observed did not comply with the regional dress code guidelines and the trust's bare below the elbows policy.

Recommendations

- 11. The trust should ensure the continued development and implementation of the care plan that reflect the infection prevention and control needs of the patient. (Repeated)**
- 12. The trust should ensure that staff have access to COSHH data on all chemical products.**
- 13. The trust should ensure that all members of staff are familiar with and adhere to the regional dress code policy. (Repeated)**
- 14. Nursing staff should update their knowledge on cleaning blood and body spillages and the colour coding of cleaning equipment.**

12.0 Key Personnel and Information

Members of the RQIA inspection team

Mrs L Gawley - Inspector Infection Prevention/Hygiene Team
Mrs M Keating - Inspector Infection Prevention/Hygiene Team

Trust representatives attending the feedback session

The key findings of the inspection were outlined to the following trust representatives:

Dr G Rankin - Director of Acute Service
Ms T Reid - Head of General and Oral Surgery
Ms T McGuigan - Ward Manager 4 South
Ms A Law - Ward Sister 4 South
Ms K Corley - Support Services Manager
Ms M Johnstone - Senior Domestic Services Manager
Ms L Hamilton - Assistant Domestic Services Manager
Ms A Smyth - Domestic Services Manager

Supporting documentation

A number of documents have been developed to support the inspection process, these are:

- Infection Prevention/Hygiene Inspection Process (methodology, follow up and reporting)
- Infection Prevention/Hygiene Team Inspection Protocol (this document contains details on how inspections are carried out and the composition of the teams)
- Infection Prevention/Hygiene Team Escalation Policy
- RQIA Policy and Procedure for Use and Storage of Digital Images

This information is currently available on request and will be available in due course on the RQIA website.

13.0 Summary of Recommendations

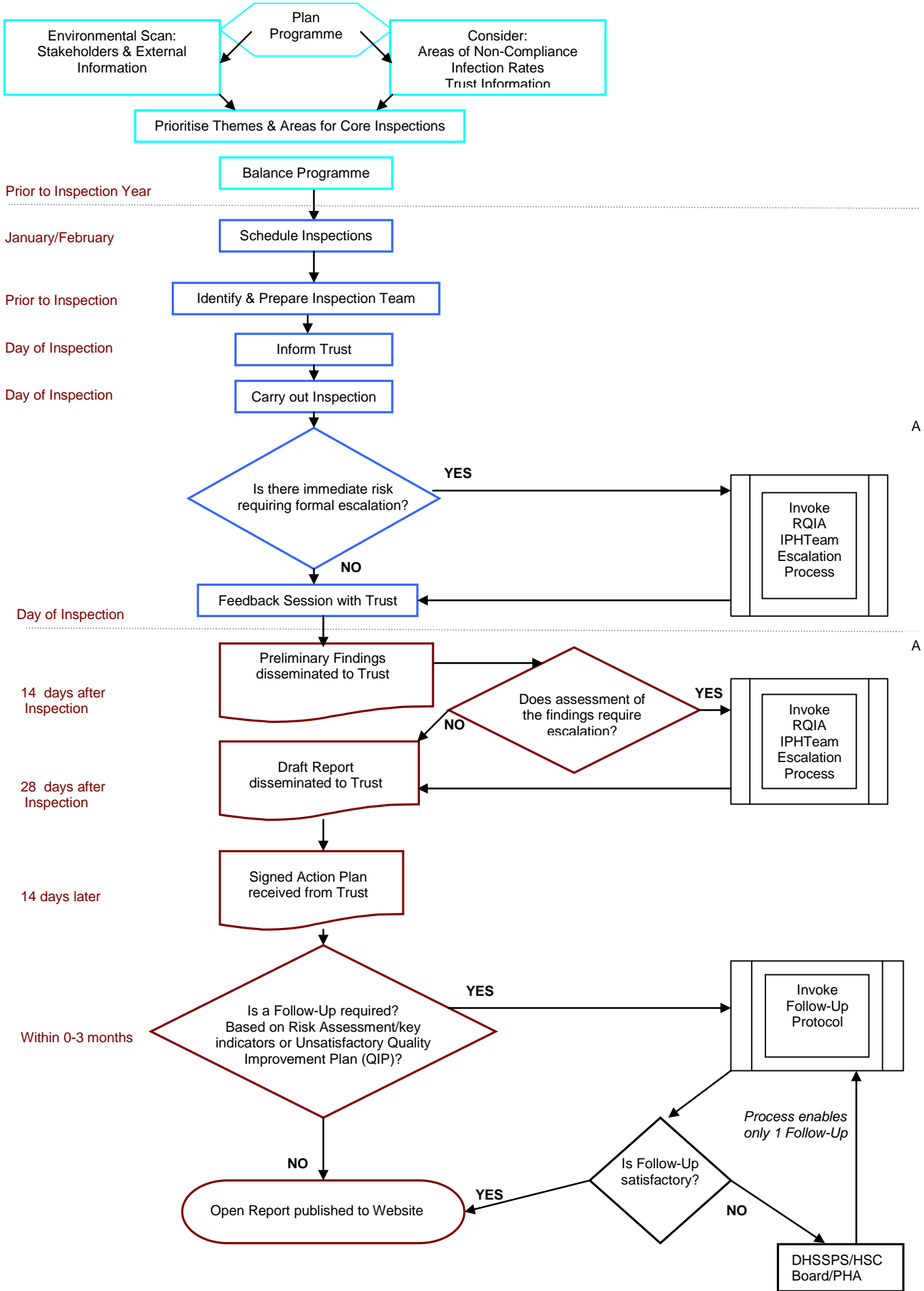
- 1. The trust should continue to work to improve storage and maintain a clutter free environment. (Repeated)**
- 2. The trust should continue to work on the repairs and maintenance of the ward and public environments and to replace damaged fixtures and fittings. (Repeated)**
- 3. The trust should ensure any replacement fixtures can be effectively cleaned.**
- 4. The trust should ensure laundry trolleys are free from damage and fit for purpose.**
- 5. The trust should ensure that waste bins are replaced when damaged or rusted. (Repeated)**
- 6. The trust should monitor the implementation of its policies and procedures in respect of the management of waste and sharps. (Repeated)**
- 7. Staff should ensure that equipment used in any Aseptic Non Touch Technique (ANTT) process is thoroughly cleaned after use.**
- 8. The trust should ensure that staff are aware of their responsibility in ensuring that equipment is clean at all times(Repeated)**
- 9. Staff should ensure that packaging on single use items remains intact at all times.**
- 10. The trust should ensure that all chemicals are stored in a locked cupboard in line with COSHH regulations. (Repeated)**
- 11. The trust should ensure the continued development and implementation of the care plan that reflect the infection prevention and control needs of the patient. (Repeated)**
- 12. The trust should ensure that staff have access to COSHH data on all chemical products.**
- 13. The trust should ensure that all members of staff are familiar with and adhere to the regional dress code policy. (Repeated)**
- 14. Nursing staff should update their knowledge on cleaning blood and body spillages and the colour coding of cleaning equipment.**

14.0 Unannounced Inspection Flowchart

Plan Programme

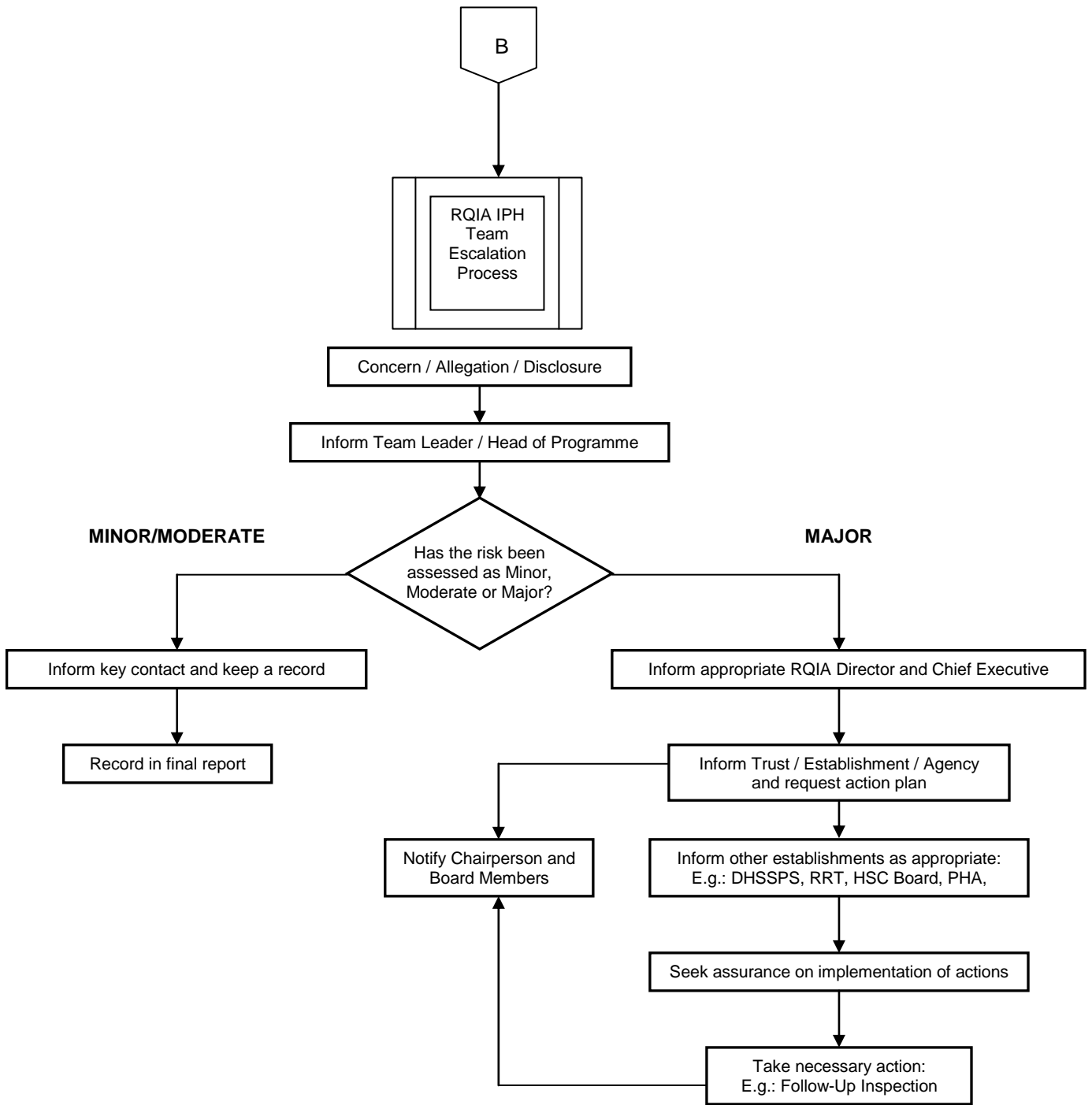
Episode of Inspection

Reporting & Re-Audit



15.0 Escalation Process

RQIA Hygiene Team: Escalation Process



16.0 Action Plan

Reference number	Recommendations	Designated department	Action required	Date for completion/ timescale
1.	The trust should continue to work to improve storage and maintain a clutter free environment. (Repeated)	Nursing, estates and facilities	<p>Ensure all clutter is removed from the ward area.</p> <p>Clutter has been removed from the ward area. The Trust operates a Dump the Junk days at CAH which ensures the wards are cleared on at least a monthly basis. Skips are also provided at CAH to enable Portering staff to remove items as required for Infection Prevention and Control concerns.</p> <p>The trust is currently working through the releasing Releasing Time To Care programme which will address excessive storage – module 2 specifically looks at the well organised ward including storage and monitoring of stock levels will be on going</p>	Complete ongoing
2.	The trust should continue to work on the repairs and maintenance of the ward and public environments and to replace damaged fixtures and fittings. (Repeated)	Domestic Services & Nursing & Estates	<p>Within ward areas Ward Managers are responsible for ensuring that works identified through the audit process are highlighted to Estates. Within public areas Domestic Services are responsible for ensuring that works identified through the audit process are highlighted to Estates.</p> <p>The Trust continues to prioritise capital and revenue funds for estates work towards areas of highest risk and this requirement will be considered as part of that process.</p>	On going
3.	The trust should ensure any replacement fixtures can be effectively cleaned.	Domestic Services & Nursing & Estates	The Trust continues to prioritise capital and revenue funds for estates work towards areas of highest risk and this requirement will be considered as part of that process. During procurement attention will be given to the ease of cleaning of items	On going

* indicates stated for a second time

Reference number	Recommendations	Designated department	Action required	Date for completion/ timescale
4.	The trust should ensure laundry trolleys are free from damage and fit for purpose.	Nursing	Damaged laundry trolley will be replaced All linen items despatched from the laundry are shrink wrapped to minimise the risk of contamination.	Complete
5.	The trust should ensure that waste bins are replaced when damaged or rusted. (Repeated)	Nursing and domestic	Damaged or rusted waste bins are reported to Ward Manager and replacement bins ordered as required	Complete
6.	The trust should monitor the implementation of its policies and procedures in respect of the management of waste and sharps. (Repeated)	Ward manager, infection control and waste manager	Checks in relation to waste and sharps management are included in Managerial Audits. In addition an annual audit is conducted by Daniels Co (who supply sharps boxes) on wards and after they audit they follow up with training as required. An Internal Audit on waste management has been undertaken at CAH and an action plan has been developed to address issues raised. As part of managerial audits sharps management is audited and actions plans put in place to address any issues raised	On going
7.	Staff should ensure that equipment used in any Aseptic Non Touch Technique (ANTT) process is thoroughly cleaned after use.	Ward manager	The ward manger will continually reinforce the requirement for staff to ensure that equipment used in any Aseptic Non Touch Technique (ANTT) process is thoroughly cleaned after use and will monitor same	Complete
8.	The trust should ensure that staff are aware of their responsibility in ensuring that equipment is clean at all times(Repeated)	Nursing staff, domestic, infection control and estates	The DHSSPS Cleanliness Matters toolkit which contains the 49 elements is used for internal Departmental Audits. The responsibility for cleaning each of the 49 elements was agreed through the Trust's Environmental Cleanliness Committee. Nursing and Infection Control are currently undertaking a more in-depth piece of work to identify the method of cleaning of patient equipment in clinical areas.	On going

* indicates stated for a second time

Reference number	Recommendations	Designated department	Action required	Date for completion/ timescale
9.	Staff should ensure that packaging on single use items remains intact at all times.	Nursing	Nursing staff reminded not to spear the packaging of items on to the valves behind the bed for oxygen masks and nasal cannulae	Complete
10.	The trust should ensure that all chemicals are stored in a locked cupboard in line with COSHH regulations. (Repeated)	Nursing & Domestic Services	Check all cupboards where chemicals are held to ensure they are lockable and fit cupboards where none are available. All cupboards are lockable.	Complete
11.	The trust should ensure the continued development and implementation of the care plan that reflect the infection prevention and control needs of the patient. (Repeated)	Nursing	Ensure care plans reflect the infection prevention and control needs of the patient. Addressed with Ward Sisters at monthly meeting. Ward Sisters to address with Nursing staff in each of their areas. Ward Sisters to complete ad hoc checks of care plans. Formal audit to be completed in November as part of the Trust well organised ward programme.	December 2011
12.	The trust should ensure that staff have access to COSHH data on all chemical products.	Nursing and domestic services	Training on-going – ward and department managers and domestic supervisors to ensure COSHH data sheets are available for all chemicals	On going
13.	The trust should ensure that all members of staff are familiar with and adhere to the regional dress code policy. (Repeated)	All staff	Dress code audits are conducted within Domestic Services. Within Nursing any contravention with all members of the MDT of the Dress Code Policy are raised immediately with staff at ward level. IPCNs monitor staff on a daily basis with regard to compliance with 'Bare Below the Elbow' policy. Those not complying are challenged at the time.	Complete with on-going monitoring
14.	Nursing staff should update their knowledge on cleaning blood and body spillages and the colour coding of cleaning equipment.	Nursing	Training has taken place in relation to blood and body fluid spillages Information on colour coding is available in all wards. Nursing in the SHSCT are using white gloves and aprons for nursing cleaning duties	Complete

* indicates stated for a second time



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