



The **Regulation** and
Quality Improvement
Authority

RQIA
Infection Prevention/Hygiene
Announced inspection

Southern Health and Social Care Trust

Daisy Hill Hospital

9 and 10 February 2011

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1.0 Inspection Summary

This is the report of the announced inspection undertaken to the Southern Health and Social Care Trust (SHSCT) and the Daisy Hill Hospital on 9 and 10 February 2011. The trust and hospital were assessed against the Draft Regional Healthcare Hygiene and Cleanliness Standards.

The inspection found that the SHSCT has organisational and governance systems in place to comply with standard one of the 'Regional Healthcare Hygiene and Cleanliness Standards'.

The findings of the inspection indicated that further work is required to ensure that key policies/procedures and strategies are available, processed efficiently and are available for all staff to access on the trust intranet.

Further work is required on providing assurance on training needs assessments and the uptake of mandatory training. The trust should also strengthen and develop user involvement which assists with the overall process of public assurance.

During the inspection of the **Daisy Hill Hospital** the following areas were inspected:

- Male Medical and CCU Ward
- Female Surgical Ward

The hospital is a local general hospital based in the border city of Newry. It is part of the Southern Health and Social Care Trust, provides health and social services to the council areas of Armagh Craigavon, Banbridge, Newry and Mourne and Dungannon and South Tryone. Facilities in the hospital include:

- 24 hour Emergency Department
- Medicine
- Surgery
- Obstetrics
- Gynaecology
- ENT
- Paediatrics
- Coronary Care Unit
- Surgical High Dependency Unit
- Day Procedure Unit
- Radiography Department
- Outpatients Departments
- Theatres
- Haemodialysis Unit

The professions allied to medicine (Physiotherapy, Occupational Therapy, Cardiology Investigation, Chiropody and Dietetics) are all on site, together with a 24 hour laboratory service.

Inspection Outcomes

The **Male Medical Ward and Female Surgical Ward** have undergone recent refurbishment, this is still ongoing at present to improve storage facilities in both areas. The compliance levels achieved are to be commended, inspectors observed that both environments were clean, tidy and in good repair. A small number of issues were identified for improvement but overall the observation of staff indicated that they were compliant with hygiene and infection prevention control practices.

The inspection resulted in 21 recommendations for the SHSCT and the Daisy Hill Hospital, a full list of recommendations is listed in Section 13.

A detailed list of preliminary findings is forwarded to SHSCT within 14 days of the inspection to enable early action on identified areas which have achieved non complaint 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.

Notable Practice

The inspection identified the following areas of notable practice

- **The trust has met its target reductions in the number of MRSA and Clostridium *difficile* infections. Of particular note is the 77 per cent reduction in Clostridium *difficile* infections which is the largest reduction of any of the trusts within Northern Ireland.**
- **The SHSCT is an accredited centre for BICS (British Institute Cleaning Science) training for domestic staff. The trust has adapted this training to suit the needs of the service. A strategy is in place to ensure all staff receive this level of training which provides staff with a 'Cleaners Operative Proficiency Certificate' (COPC) Level 1.**
- **An electronic dashboard computer software programme has been introduced, this provides up to date information on**

audits and of performance against care bundles and other interventions aimed at reducing infection.

- There are effective internal monitoring systems in place to provide assurance on environment cleanliness and Infection prevention and control.
- The support services team within the trust have adopted the full principles of the NPSA guidelines, on the colour coding of equipment.
- The Infection Prevention and Control team within the trust has an active interest in driving improvement through research and has received regional and international recognition for their approach and the publication of research papers.
- User involvement through participation in- department audit.
- Staff knowledge regarding Root Cause Analysis at ward level.

The RQIA inspection team would like to thank the SHSCT and, in particular, all staff at the Daisy Hill 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 organisations to target areas that require more specific attention.

Table 1

Areas inspected	Female Surgical	Male Medical
General Environment	94	95
Patient Linen	100	100
Waste	95	98
Sharps	97	97
Equipment	97	95
Hygiene Factors	97	96
Hygiene Practices	98	98
Average Score	97	97

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

Table 2

General Environment	Female Surgical	Male Medical
Reception	n/a	100
Corridors, stairs lift	94	94
Public toilets	n/a	95
Ward/ department - general(communal)	92	96
Patient bed area	91	95
Bathroom/washroom	92	97
Toilet	98	96
Clinical room/ treatment room	100	91
Clean utility room	98	n/a
Dirty utility room	93	89
Domestic store	95	100
Kitchen	77	93
Equipment store	n/a	91
Isolation	96	93
General information	97	96
Average Score	94	95

Table 3

Patient Linen	Female Surgical	Male Medical
Storage of clean linen	100	100
Storage of used linen	100	100
Laundry facilities	n/a	n/a
Average Score	100	100

Table 4

Waste and sharps	Female Surgical	Male Medical
Handling, segregation, storage, waste	95	98
Availability, use, storage of sharps	97	97

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

Table 5

Patient Equipment	Female Surgical	Male Medical
Patient equipment	97	95

Table 6

Hygiene Factors	Female Surgical	Male Medical
Availability and cleanliness of wash hand basin and consumables	97	89
Availability of alcohol rub	100	100
Availability of PPE	100	100
Materials and equipment for cleaning	90	96
Average Score	97	96

Table 7

Hygiene practices	Female Surgical	Male Medical
Effective hand hygiene procedures	100	100
Safe handling and disposal of sharps	100	100
Effective use of PPE	100	100
Correct use of isolation	90	100
Effective cleaning of ward	100	95
Staff uniform and work wear	93	94
Average Score	97	98

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 inspections. 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 has devised draft Regional Healthcare Hygiene and Cleanliness standards. RQIA has revised its inspection processes to support the publication of the standards which were compiled by a regional steering group in consultation with service providers. Standard 1.0 relates to organisational systems and governance. To ensure compliance with this standard, a new inspection process and methodology has been developed, in consultation with the regional steering group.

RQIA's infection prevention/hygiene team has planned a three year programme of announced and unannounced inspections in acute and non acute hospitals in Northern Ireland, 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 Announced Inspections

The purpose of the announced inspection of the SHSCT was to assess and confirm organisational and governance arrangements in place and to ensure that they have been effectively implemented.

4.1 Announced Inspection Process

Announced inspections commence with a process of self-assessment, include an onsite inspection and end with the publication of a report. The inspection flowchart is attached in Section 15.

4.2 Self Assessment

The trust is asked to provide a summary of how they comply with the criteria set out in Standard 1 of the draft Regional Healthcare and Cleanliness Standards. The self assessment is signed by the Chief Executive to confirm that the assessment accurately reflects the arrangements in place within the trust to ensure compliance.

4.3 Pre-Inspection Analysis

The completed self-assessment and documentation is reviewed by RQIA. This analysis provides RQIA with an initial framework of evidence which is validated through the inspection process.

4.4 Onsite Inspection

The announced inspection process enables RQIA to engage directly with trust senior and middle management staff in relation to infection prevention and control and environmental cleanliness issues. This is followed by an inspection of ward environments using the draft Regional Healthcare Hygiene and Cleanliness audit tool. The inspection process involves observation, discussion with staff, and review of relevant documentation.

For this inspection the team consisted of three inspectors, from RQIA's Infection Prevention/Hygiene Team and one peer reviewer. A lead inspector was responsible for co-ordinating the inspection and ensuring the team was in agreement about the findings reached. Membership of the inspection team is outlined in Section 13.

4.5 Feedback and Report of the Findings

The process concludes with a feedback of key findings to trust representatives, highlighting examples of best practice and high risk identified during the inspection. The trust representatives attending the feedback session is outlined in Section 13.

The findings, report and follow up action will be in accordance with the 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 16).

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 draft '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 draft '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.
- 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 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 which equate to a level of compliance as follows:

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

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

6.0 Standard 1.0: Organisational Systems and Governance

The following sections summarise how the systems and governance arrangements in the trust/organisation comply with the criterion of Standard 1.0 of the Regional Healthcare Hygiene and Cleanliness Standards.

6.1 Criterion 1.1

The trust has established and communicated policies and procedures in relation to key hygiene and cleanliness issues (including environmental cleanliness, infection prevention and control, cleaning, waste management, sharps handling, linen management, equipment management, decontamination, disinfection, staff uniform and work wear, inoculation injury, planned programmes for mattress and curtain replacement)

6.1.1 Policies and Procedures

A review of the documentation, provided by the SHSCT, evidenced, that a range of policies and procedures have been developed and implemented to support the requirements of the standard statement. A framework document is available, to assist with the development of trust policies. This ensures that there is a standard framework for all policies, and that all policies have a communication and implementation plan.

There are a number of key policies which are still in draft such as the environmental cleanliness strategy. Discussion with representatives from support services staff, indicated that this document will be completed on receipt of the revised Cleanliness Matters Strategy. An environmental cleanliness policy and process flowchart are available, these outline the frequency of audits at ward level, and the process for reporting upwards to the trust board, the flowchart also includes the escalation of unresolved issues.

Inspectors were informed an Infection Prevention and Control (IPC) Strategy is not available, however, inspectors were provided with a detailed Health Care Acquired Infection (HCAI) Improvement Plan and associated work streams, from which the IPC action plan is devised. Discussion with trust representatives indicated a willingness to develop an overall strategy for this area.

In the submitted self assessment, the trust confirmed that all staff have access to the intranet however discussion with staff would indicate that this is not true for all groups of staff. Work is ongoing at present to ensure that all staff have the knowledge and capability to access the relevant policies and procedures. Discussion with nursing staff on the wards evidenced that they were aware of and had access to the Regional Online Infection Prevention and Control Manual.

6.1.2 Compliance with DHSSPS Standards

The review of compliance with the DHSSPS Controls Assurance Standards in relation to Environmental Cleanliness (EC) and Infection Prevention and Control (IPC) indicated that both internal assessments achieved an overall compliance score in all areas within the standards.

The environmental cleanliness annual report indicated, that an overall score of 90 per cent was achieved in the controls assurance standard and that an action plan has been devised to address areas of partial compliance.

A review of the information provided by IPC indicated that an overall score was not available, and that when full compliance was not achieved, the written comments did not reflect the action required, to address the outstanding issues. The trust should review this document to ensure that actions required are clearly identified.

The trust self assessment outlined the importance of fully completed and detailed action plans. The review by inspectors of the environmental cleanliness 2011/12 action plan, noted that this contained full details of the actions required and provided guidance on agreed timescales. The trust are currently revising their templates for these reports which will reflect any amendments to the standards made by the DHSSPS NI, these are to be in place by 31 March 2011.

The analysis of the trust documentation confirms that environmental cleanliness and infection prevention and control remain a trust priority, and that a programmes of activities have been developed and implemented, to assist, in the reduction of health care associated infections. Work has continued to achieve compliance with the following:

- The Quality Standards for Health and Social Care DHSSPS 2006
- Saving lives High Impact Interventions (DH 2007)
- Environmental Cleanliness Standards DHSSPS 2005
- Controls Assurance Standard for Infection Control DHSSPS v 2009

6.1.3 Annual Reports

The environmental cleanliness annual report for the year 2009/10 was available for review, this report outlines the trust's position in relation to environmental cleanliness. The report also advises the trust board of the controls and systems in place, to support the delivery and maintenance, of high quality environmental cleanliness within the SHSCT. The report summarises the governance arrangements, the monitoring and audit arrangements and training developments, it also includes the key priorities for the forthcoming year.

The annual report from the Clinical Director for infection prevention and control was available for the year April 2009 - March 2010. This provides a summary of the key IPC initiatives and activities, undertaken by the trust, and provides an assessment of performance against agreed targets for the year. The following information indicates that the trust has met its target reductions in the following areas:

- The number of MRSA blood stream (bacteraemia) infections in the trust in the year 2009/2010 was 15 compared to 16 the previous year, a reduction of six per cent
- The number of cases of *Clostridium difficile* infections in the trust in the year 2009/2010 was 37 compared to 164 the previous year, a reduction of 77 per cent which is the largest reduction of any of the trusts within Northern Ireland.

To support and promote best practice, it would have been beneficial if the specific actions introduced by the trust to achieve this massive reduction had been included in the annual report.

The annual report and information gained on the inspection highlights that there has been progress made with implementing the 'Saving Lives Programme'. This programme is aimed at reducing infection and delivering clean safe care, and to ensure compliance with high impact interventions. The concept of care bundle or high impact interventions can be used to describe a collection of evidence based processes needed to care effectively for patients undergoing particular treatments with associated risks such as:

- Care bundle to prevent surgical site infection
- Urinary catheter care bundle
- Peripheral intravenous cannula care bundle
- Central venous catheter care bundle
- Care bundle to reduce the risk from *Clostridium difficile*

Hand hygiene compliance remains a priority and audits undertaken report a high compliance rate across the trust.

6.1.4 Risk Management

A comprehensive risk management strategy is in place, and includes the production of risk registers at various levels within the trust. The strategy is based on the Australian/New Zealand Standard 4360 on risk management.

A review of the strategy indicated that risks which fall into the amber area, require prompt action however the meaning of prompt has not been defined and no timescales are identified. A sample of the acute services risk register summary was reviewed. Risks have been

identified in relation to IPC and EC, risk assessments are currently being reviewed and updated to populate the risk register.

The summary provided was updated in January 2011 however the review of this summary indicated that not all risks have been updated on a regular basis. The trust needs to ensure that risk registers which include key information on infection, prevention and control have identified timescales, are kept up to date and clearly outline the current position in relation to the identified risk.

Recommendations

- 1. The trust should ensure that all staff have and are competent to access the policies and procedures on the trust's intranet.**
- 2. The trust should develop an Environmental Cleanliness and Infection Prevention and Control Strategy.**
- 3. The trust should ensure IPC controls assurance documentation clearly outlines actions required to address the outstanding issues. New templates which reflect amendments made to the standards by the DHSSPSNI should be implemented in the agreed timeframe.**
- 4. The trust needs to ensure that risk registers and key information on infection, prevention and control and environmental cleanliness have identified timescales, are kept up to date and clearly outline the current position in relation to the identified risk.**

6.2 Criterion 1.2

The trust has effectively communicated policies and procedures in relation to key hygiene and cleanliness issues to staff, including through appropriate induction and ongoing training commensurate with their roles

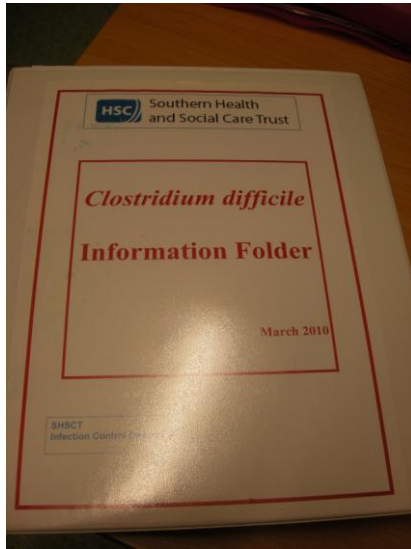
6.2.1 Training and Development

There are detailed corporate induction handbooks available, for infection prevention and control and support services. The trust is committed to providing training to all its employees, to ensure compliance with its legal obligations, and emphasises that all staff, must attend the corporate induction as mandatory training.

A trust wide process is in place to communicate key policies and procedures, and a trust wide training matrix has been developed. This training matrix provides managers with a tool, by which they can determine the mandatory and statutory training requirements, for their staff.

The training matrix includes a training needs analysis, to identify basic education and training requirements for each staff group. A review of this plan indicated that the training identified, does not include infection control training for all staff, commensurate to their individual requirements. The training received by medical staff is not included; or the training needs for bank and agency staff.

The matrix is difficult to understand and should be reviewed to include infection prevention and control training to all relevant staff groups. The trust needs to assure that all staff understand their responsibility and accountability for infection prevention and control. This should be included in job descriptions, objectives, competency based assessment and job plans of all staff within the trust (Changing the Culture 2010). The trust advised that they are currently reviewing how, competency based assessment would best be introduced. The review of the documentation provided would indicate that this has not been outlined for all staff, for example occupational therapists and domestic staff.



Picture1: Clostridium *difficile* Information folder

The infection prevention control team has developed a Clostridium *difficile* folder (Picture 1) for all wards. This is to be commended and may help to explain the massive reduction achieved and the considerable emphasis and effort made by the trust in this area.

The SHSCT is an accredited centre for BICS (British Institute Cleaning Science) training for domestic staff. A strategy is in place to ensure all staff receive this level of training, which provides staff with a 'Cleaners Operative Proficiency Certificate' (COPC) Level 1. This is an excellent initiative which is commended.

A review of the support services induction handbook, evidenced that this is a comprehensive document, it is easy to follow and contains all the required information. Currently, a support services competency assessment; is not in place, to reflect the training given. There are domestic services practice audits carried out, to ensure that staff are adhering to trust policy on the National Colour Coding, and that they are performing tasks in accordance with BICS training.

Mandatory training records for infection prevention and control training were available for review, however these records do not indicate the ratio of staff uptake of the training as the IT system to support this is in development. Discussion with staff at ward level indicated that they have received their mandatory update training.

The trust have introduced other initiatives, such as targeted training, for doctors and nurses. This training provides support, for the introduction of the pilot project, on the reduction of infections associated with IV cannulation. Training and guidance on undertaking blood cultures has been developed in conjunction with the Beeches Training Centre, for some medical and specialist nurses.

The Cleaner Hands Campaign has been rolled out within the trust and additional training is available for link nurses and auxiliary staff.

Discussion with staff representatives indicated that the trust have decided to develop e-learning programmes for specific groups of staff including medical staff.

Recommendations

- 5. The training matrix should be reviewed to ensure it fully addresses the needs of all staff and that competency based assessments continue to be developed.**
- 6. The trust need to review and improve the recording and monitoring systems that are currently in place to ensure compliance with mandatory training.**

6.3 Criterion 1.3

The trust has established clear roles and responsibilities for key hygiene and cleanliness issues with clear lines of accountability throughout the organisation, including at Trust Board level

6.3.1 Roles and Responsibilities

Roles and responsibilities in relation to environmental cleanliness and infection prevention and control are clearly identified. Responsibility, for governance arrangements, rests with the trust board through to the offices of the Chairperson and Chief Executive. The trust board operates in accordance with its standing orders and environmental cleanliness and infection prevention and control is a standing item on the agenda. The Chief Executive has overall responsibility on behalf of the Board of Directors of the trust. There are mechanisms in place to help assure 'Board to Ward' governance. Environmental cleanliness and infection prevention and control are also standing items on the governance and senior management team (SMT) committees.

The Medical Director is the designated lead director for the clinical aspects of Health Care Acquired Infection (HCAI). They are accountable to the senior management team, and trust board in relation to the effective strategic leadership and management of this area. The Medical Director is also responsible for providing expert analysis and assurance on operational performance.

The Director of Acute Services is responsible and accountable for the environmental hygiene aspects of HCAI, in line with the management of domestic and catering services.

There are a range of committees and sub groups established to oversee environmental cleanliness:

- Environmental Cleanliness Committee Quarterly
- Environmental Cleanliness Subgroup Quarterly
- Environmental Cleanliness CAS Working Group
- Domestic Services Working Group
- Food Hygiene Committee Quarterly
- Food Hygiene Subgroup Quarterly
- Food Hygiene CAS Working Group

In 2009 the trust reviewed its structure for HCAI and established the following forums to replace the Infection Control Committee:

- HCAI Strategic Forum Bi-monthly
- HCAI Operational Forum Bi-monthly
- HCAI Clinical Forum 6-weekly

Currently, the terms of reference for these groups are under review, to update membership and the frequency of the meetings.

There is a standard clause in trust job descriptions which is generic and covers all staff. More recently specific clauses have been agreed for insertion in the job descriptions of Ward Managers and Heads of Homes/Facilities and their deputies in relation to their responsibility for cleanliness. A sample of job descriptions was reviewed; this indicated that this is not the case in all job descriptions, for example the domestic and occupational therapist. The trust should continue this work to ensure that all grades of staff are included.

The review of the organisation structures in place indicated the roles and responsibilities for Environmental Cleanliness and Infection Prevention and Control are clearly defined.

Recommendations

- 7. The trust should continue to work to ensure that all job descriptions contain a more specific reference to infection prevention and control and environmental cleanliness.**
- 8. The terms of reference for the HCAI Forums should be updated to reflect current membership and frequency of meetings.**

6.4 Criterion 1.4

The trust has established effective ongoing internal monitoring arrangements in relation to key hygiene and cleanliness processes and procedures

6.4.1 Audits

Leadership walkabouts are undertaken in acute hospitals, smaller hospitals and in community facilities in the SHSCT. The walkabouts involve the Chairman of the Board, the Chief Executive and the director of the service. The walkabouts, include touring wards and departments and speaking to staff to review infection prevention and control, environmental cleanliness and estates issues.

This system is not yet fully formalised as there are no formal reports produced, however, if issues arise these are noted for action by the accompanying director.

Environmental Cleanliness Audits

Cleaning is monitored on a daily basis by the domestic services team. Domestic staff regularly check all areas including public toilets and sign off sheets are used to record these checks.

Domestic services practice audits are carried out, to ensure that all staff adhere to the trust policy on National Colour Coding and that they perform tasks in accordance with BICS training.

The Cleanliness Matters toolkit is used to undertake departmental audits, the frequency of these is determined by risk. Annual Managerial Audits are carried out by the Locality Support Services Managers using the Infection Control Nursing Association (ICNA) Toolkit.

Responsibilities for all of the cleaning elements, outlined in the environmental cleanliness toolkit, have been agreed through the trust's environmental cleanliness committee. This ensures that every cleaning element is identified as the responsibility of either domestic services, nursing or estate services.

Audits are conducted each month, for domestic services staff to ensure compliance with the trust's "Dress Code" policy.

6.4.2 HCAI Performance

There is a performance dashboard, on the trust intranet site, for all infection prevention and control audits. Inspectors were provided with the opportunity to view this system at ward level and found it to be comprehensive and easy to use.

The ward manager undertakes a number of self audits, in relation to infection prevention and control, which are collated by the Infection, Prevention and Control team and shared with senior managers. These ward lead weekly audits include:

- Commode audit
- Hand Hygiene audit
- Bare Below the Elbow
- Environment

The audit outcomes are available on the intranet and are displayed on ward dashboards. The dashboard also includes the results of antimicrobial audits and a sample of audits to be used.

As part of their audit process the Infection, Prevention and Control team also select wards and departments to audit and a yearly schedule is in place. In addition, audits are also undertaken on care bundles. Of particular note is the work undertaken on peripheral line care, several initiatives have been introduced to ensure compliance with best practice.

The project involved:

- Establishing a baseline surveillance and evaluation of current practices.
- Implementation of best practice based on current evidence with emphasis on 'Aseptic Non Touch Technique' (ANTT).
- Introduction of a standardised peripheral line insertion pack and trolley.
- Development and implementation of a Peripheral Cannula Observation Chart to improve documentation.
- The provision of additional training for nursing staff, doctors and medical assistants.
- Continuous surveillance and audit to assess the impact of interventions and sustain continuous improvement.
- Introduction of mandatory yearly updates to nursing staff and all new junior doctors joining the trust.

This proactive approach is beginning to see significant results, in the reduction of infections in this area, and it is anticipated that in the future this will be rolled out across the trust. Unfortunately, this is on hold at present due to staffing constraints, inspectors were informed that staff interviews were to be held in the week following the inspection.

The inspection of the ward areas evidenced that audits are undertaken on hand hygiene, mattress, commodes and environmental cleanliness. Inspectors were also impressed by the knowledge of all staff on the ward in relation to the peripheral line care.

6.4.3 Root Cause Analysis

The trust have devised and implemented a process of Root Cause Analysis (RCA) following a diagnosis of, *Clostridium difficile*, MRSA, bacteraemia and MSSA bacteraemia or where MRSA is mentioned on a death certificate. Inspectors were provided with samples of cases subject to root cause analysis, and these evidenced that a thorough process is in place. Cases subject to RCA are also raised and discussed at the general medicine mortality and morbidity meetings. Inspectors were impressed by the knowledge of the RCA process displayed by the ward manager and the staff on the ward, this is to be commended.

6.4.4 Medical Devices

To support the Medical Devices Steering Group the trust has developed an inpatient medical devices group. This helps to ensure that a clear and systematic approach is taken to all aspects of medical devices across the trust and includes:

- Purchase and supply
- Use and maintenance of medical devices
- Decontamination

There is an active decontamination committee in place to ensure that appropriate arrangements are in place for the effective decontamination of re-useable medical devices throughout the trust.

The terms of reference for the inpatient medical devices group is still in draft from May 2009. The lead infection, prevention and control nurse is a member of the relevant committee.

There is a draft policy from June 2008 on the interim guidelines on the management of medical device alerts. The trust should ensure that the terms of reference and draft policy are finalised.

6.4.5 User Involvement

The trust has developed a Personnel and Public Involvement Strategic Plan 2010-2013 'Promoting Wellbeing'. In developing the strategic plan the trust undertook an extensive consultation process with 1000 groups, 5000 service users, communities and key stakeholders as well as with the staff teams.

The trust has established and prioritised a number of areas including the development of a patient client experience committee and the appointment of a lead director for Personnel and Public Involvement.

The support services team have undertaken a questionnaire to users.

Currently there is some user involvement in environmental cleanliness audits. From the documentation received, there is no user involvement in either the environmental cleanliness committee or of the HCIA forums. This area should be developed as part of the overall process of public assurance and public participation.

Recommendations

- 9. The trust should ensure that the terms of reference of the inpatient medical devices group are formalised. The draft policy on the interim guidelines on the management of medical device alerts should be finalised.**

- 10. The trust should develop user participation in the relevant committees as part of the overall process of public assurance and public participation.**

6.5 Criterion 1.5

The trust has robust arrangements in place to ensure that issues identified during internal monitoring and audit are addressed in a timely and effective manner

6.5.1 There are systems in place to ensure action is taken from the results of internal monitoring.

There are systems in place to ensure action is taken from the results of internal monitoring.

The results of IPC audits are reported to the relevant directors, action plans are developed, and agreed timelines, roles and responsibilities are incorporated.

IPC performance is monitored at directorate and trust board meetings. An IPC nurse attends these meetings. Surveillance data is collected on *Clostridium difficile* and MRSA infections. Inspectors were informed that the trust continue to collect MSSA data, IPC staff advised that this is not currently required to be reported to the Public Health Agency. High Impact Interventions (HII) compliance data, is followed up by the lead nurse in each area. HCAI performance and infection control are also monitored by the Chief Executive, who receives a monthly briefing report, and performance is also presented at monthly trust board meetings.

Monthly environmental cleanliness audits, action plan and score sheets are completed. Issues arising are dealt with immediately through domestic supervisors and the ward manager. Estates services' issues are raised with the estates action help desk and a full report of audit results is sent to the General Manager for Domestic Services. Information, on environmental cleanliness audit scores across the trust, is included in the performance report, which is presented at the monthly at trust board meetings.

Daily environmental cleanliness reports are dealt with immediately with the ward manager and domestic supervisor. If audit scores in very high and high risk areas fall below 85 per cent, an exception report is sent to SMT and the appropriate action is taken by the Director of Acute Services.

A process is in place, which identifies the persons responsible for the development of action plans, for issues identified following Environmental Cleanliness or ICNA audits. An environmental cleaning flow chart identifies unresolved issues from the environmental cleanliness audit process.

A domestic rapid response team ensures that rooms or areas which require a terminal clean are cleaned in a timely manner by staff who

are specifically trained in the area. This allows the team to work in close conjunction with the ward managers and to facilitate efficient bed turn around. The team is regularly audited to ensure that this process is effective.

The IPC team are currently involved in producing monitoring results for the following care bundles:

- Central Venous Catheter
- Ventilator associated pneumonia
- Surgical site infection (caesarean sections and orthopaedics).

This data is reported on a monthly basis to the trust board, DHSSPS and the HSC Safety Forum. The data is also available on the Institute for Healthcare Improvement (IHI) Extranet and the SHSCT has shown consistent improvement in reducing HCAs.

On the ward the results of audits and dashboard results are displayed on various notice boards which should be commended. However, at times there was so much information displayed that this could be confusing, especially to patients and the general public. The trust should provide a more user friendly approach to this display and to emphasize and celebrate the results obtained.

Recommendations

- 11. Processes should be reviewed to ensure that monthly information provided at ward level is consistent and user friendly.**

6.6 Criterion 1.6

The trust has appropriate mechanisms for communicating the results of internal monitoring and audit to the relevant staff at all levels throughout the trust

6.6.1 HCAI and environmental cleanliness performance data is disseminated through the line management structures to all staff, and the review of the available documentation evidenced that this is a standing agenda item at staff meetings.

The trust confirmed, in their submitted documentation that the outcomes of all HCAI audits are available on the trust intranet. There are displays on ward dashboards of all the relevant Key Performance Indicators for the ward.

- Environmental Cleanliness
- Commode audits
- Hand hygiene audits
- Bare below the elbow
- Care Bundles

Environmental cleanliness departmental audit scores, for hospitals are sent to directors and to the environmental cleanliness committee members, on a monthly basis, to share with their staff groups. Environmental cleanliness audit scores and failures are shared with estates and ward managers by domestic managers. Environmental departmental audits are displayed in domestic stores.

The minutes of domestic services staff meetings, show that environmental audit scores are discussed, infection control issues are highlighted and staff are informed of new policies being issued. These policies are held in the supervisor's office for staff to access.

Each IPC nurse has responsibility for specific facilities, to support and guide staff, in the delivery of safe, effective and evidence informed practice, this involves ensuring action plans are implemented following IPC audits. Hand hygiene, environmental cleanliness and IPC issues are standing agenda items on all directorate and team meetings.

There is evidence of a culture from "Board to Ward" to reduce HCAI by the implementation and monitoring of HCAI/IPC action plans and ongoing training and development to enable staff to deliver on the trust's HCAI/IPC agenda.

The trust's Infection Prevention and Control Communications Strategy has been recognised at two prestigious awards events. The strategy, which includes the vibrant 'Clean Hands, Safe Hands' signage, was the winner in the Best Marketing Initiative category at the Greater Newry

Business Awards and was runner up in the healthcare category of the Chartered Institute of Public Relations awards in London.

Discussion with staff from the IPC team highlighted that they have been involved in the following research.

- MRSA and MSSA reduction plan,
- A project for the reduction of infection in IV cannula
- Review of and implementation of best practice training and guidelines for the overall management of blood cultures in conjunction with The Beeches Management Centre
- Development of a ten point action plan for *Clostridium difficile* and the development of a "time for isolation" audit tool
- Research paper published in the Journal of Hospital Infection. Damani, N., Wallace, S. (2011) "Does viral gastroenteritis really increase the reports of *Clostridium difficile* infection?". *Journal of Hospital Infection*. 2011 Feb; 77(2):171-2.
- Research paper published in The British Journal of Clinical Pharmacy." Reducing the use of "high risk" antibiotics through implementation of an antibiotic stewardship programme.Vol.2 December 2010. *Ann McCorry, lead antimicrobial pharmacist, Nizam Damani and Rajesh Rajendran, consultant microbiologists, and Patricia McCaffrey, consultant geriatrician, all at Craigavon Area Hospital, Northern Ireland; Donna Muckian, a staff grade doctor at Daisy Hill Hospital, Northern Ireland, and Patrick Loughran, medical director at Southern Health and Social Care Trust, Northern Ireland.*

Discussion with IPC and support services representatives highlighted that they feel that communication between the two groups has improved across the trust. The staff indicated that the profile of IPC and EC has been raised across the trust and there is a greater willingness at higher level to promote a board to ward approach.

7.0 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	Female Surgical	Male Medical
Reception	n/a	100
Corridors, stairs lift	94	94
Public toilets	n/a	95
Ward/ department - general(communal)	92	96
Patient bed area	91	95
Bathroom/washroom	92	97
Toilet	98	96
Clinical room/ treatment room	100	91
Clean utility room	98	n/a
Dirty utility room	93	89
Domestic store	95	100
Kitchen	77	93
Equipment store	n/a	91
Isolation	96	93
General information	97	96
Average Score	94	95

7.1 Cleaning

The inspection of the wards evidenced good compliance with the regional specifications for cleaning standards.

It was observed that, in most instances, regular and effective cleaning mechanisms were in place. These mechanisms prevent the build up of dust and soil, which in turn prevents the build up of bacteria, and helps in the reduction of the potential risk for the transmission of infection.

The male medical ward was generally very clean, some minor improvement was required in the cleaning of shelving, as dust was observed in the clinical room and equipment store. Attention should be paid to hand touch points, such as computer keyboards and patient bed trolleys, as the underside of two of these trolleys had a residue of

food, and a computer keyboard was dusty. There is a greater risk of transmission of infection from hand contact in frequently used areas. In both wards limescale was noted on taps and fittings. Particular care is required to ensure that limescale is removed from taps and fittings as recent evidence has shown that limescale may harbour biofilms. The build up of limescale can interfere with good cleaning and disinfection by masking and protecting pathogens.

It should be noted that no cleaning issues were identified in the general ward, public toilets, bathrooms and the domestic store of the male medical ward.

In the female surgical ward dust was observed in the corners and edges of the floors in the patient bed areas and domestic store. More attention is required to ensure that raised toilet seats, bath hoists and shower chairs are clean (Picture 2).



Picture 2: Equipment in kitchen required cleaning

Some of the fixtures and fittings and equipment in the kitchen in female surgical ward required cleaning. In the female surgical ward the cleaning of an isolation area inspected was generally good; however the top of the toilet seat was stained.

In the male medical ward more attention is required to ensure the isolation area is clean; particular attention is required for hand touch points as the light switch had a built up of dirt and the underside of the bedside trolleys had a residue of food and liquid stains. The underside of the liquid soap dispenser had a residue of soap and there was no paper towel dispenser; paper roll is used for hand drying. The taps had a build up of lime scale and the TV hand control was grubby.

7.2 Clutter

In both areas inspected there was evidence of a continued emphasis in providing clutter free environments, this provides effective utilisation of space and good stock management which assists with effective cleaning. An area for attention in the female surgical ward was the

cluttered appearance of the domestic services area in the disposal store. The equipment stores in both areas have been identified for refurbishment, this is currently ongoing in the female surgical ward and is to commence shortly in the male medical ward.

7.3 Maintenance and Repair

In both wards there was paintwork damage noted on walls and exposed wood was observed on the doors and some horizontal surfaces. It is important that all surfaces are sealed and intact, to ensure that effective cleaning can be undertaken. In the male medical ward, wall damage was observed from a fitting that had not been repaired after removal and in various locations in both wards there was water damage to ceiling tiles.

7.4 Fixtures and fittings

The dirty utility areas in both wards have been refurbished to a high standard and are a good example of a well designed facility which provides an environment to promote best practice (Picture 3).



Picture 3: Refurbished dirty utility area

In both wards fixtures and fittings in some areas were damaged especially in the kitchens; wear and tear was noted on cupboards and in the female surgical ward some kitchen appliances were damaged.

The clinical room in the male medical ward did not have an equipment sink. In both wards the toilet roll dispensers are not enclosed and have a wood bar which can compromise effective cleaning.

7.5 Information

An agreed set of core HCAI public information leaflets are available for patients and visitors, hand hygiene posters were widely displayed throughout the hospital and the areas inspected. Clear instructions are available to advise staff and visitors of isolation precautions.

There was a range of posters in place for staff to reference, such as waste and sharps management, colour coding and segregation of linen.

Detailed cleaning schedules for both nursing staff and support services are required which outline all equipment that requires cleaning and specifies roles and responsibilities.

Recommendations

- 12. Greater attention is required to ensure that isolation areas are clean and that lime scale is removed from fixtures and fittings.**
- 13. All areas within the ward environment should be maintained clutter free.**
- 14. The trust should continue to work on the repair and maintenance of the ward and replacement of damaged fixtures and fittings.**
- 15. The trust should develop detailed cleaning schedules for both nursing staff and support services.**

8.0 Patient Linen

STANDARD 3.0 PATIENT LINEN

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

Linen	Female Surgical	Male Medical
Storage of clean linen	100	100
Storage of used linen	100	100
Laundry facilities	n/a	n/a
Average Score	100	100

8.1 Management of Linen

Both wards are to be commended in achieving full compliance in all sections of the management of patient linen.

In both areas inspected there were effective arrangements in place for the storage of clean linen. Linen was stored in a separate store and was found to be clean, tidy and free from rips and tears.

In both wards good practice was observed in the handling of used linen, used linen was placed immediately into the appropriate colour coded bags at the point of use and staff were observed to wear the appropriate personal protective equipment (PPE) when handling soiled/contaminated linen.

9.0 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	Female Surgical	Male Medical
Handling, segregation, storage, waste	95	98
Availability, use, storage of sharps	97	97

9.1 Waste

The inspection evidenced that there are arrangements in place for the handling, segregation, storage and disposal of waste in both the wards inspected which generally comply with local and regional guidance.

In the female surgical no clinical waste bin was available in the isolation room. In both wards clinical and household waste bins were clean and in a good state of repair. In the male medical ward one waste bin had a badly torn label and in the female surgical ward a clinical waste bag was observed tied to monitor trolley.

9.2 Sharps

In both areas sharps boxes in use conformed to BS7320 (1990)/UN9291 standards. Boxes were assembled correctly; labelled with the date, locality and staff signature and appropriately tagged on disposal. This is good practice as correct labelling ensures that if there is a spillage of sharps waste from the sharps box or an injury to a staff member as a result of incorrect assembly/disposal, the area the sharps box originated from can be immediately identified. Identifying the origin of the sharps box and its contents is imperative to assist in the immediate risk assessment process, carried out following a sharps injury, and also to ensure that staff who have incorrectly assembled/disposed of the sharps boxes can receive education on the correct procedures to follow.

In both wards sharps trays were available, more attention is required to ensure these are clean and that tape is removed to allow for effective cleaning. Sharps were disposed of directly at the point of care which helps to decrease the potential for a needle stick injury to occur. It was observed during the inspection that the temporary closure

mechanisms, to prevent spillage and impede access, were in place when the sharps boxes were not in use.

Recommendations

- 16. Waste management should comply with local policy and sharps trays should be tape free and cleaned after use.**

10.0 Patient Equipment

STANDARD 5.0 PATIENT EQUIPMENT

Cleanliness and state of repair of general patient equipment

Patient Equipment	Female Surgical	Male Medical
Patient equipment	97	95

Throughout both areas the cleaning of patient equipment was generally of a high standard and most equipment was visibly clean.

In the female surgical ward a hoist sling in the bathroom was dusty and in the male medical ward the top of the resuscitation trolley was dusty and a medicine trolley was badly damaged.

In the kitchen of the female surgical ward the ice machine was dirty at the dispenser nozzle which resulted in black particles in the ice (Picture 4). It is important that ice machines are effectively cleaned as they have been associated with outbreaks of e-coli.



Picture 4: Dirty ice machine nozzle causing black particles in the ice

Inspectors observed that all single use and sterile equipment was stored in the original packaging, which ensures, that there is appropriate identification and traceability, in the event of a manufactures recall, and that the appropriate infection prevention and control and safety practices are followed. In the female surgical ward inspectors found that some sterile supplies were out of date; a more effective stock management system is required.



Picture 5: laryngoscope handles and blades in a complete package

The trust has purchased laryngoscope handles and blades which come as a complete package which should be commended (Picture 5). Procedures are in place to ensure reusable items are appropriately decontaminated between patients. In both wards the system in place for checking that commodes are clean is good, audits are undertaken and the seat of the chair is fully detached and left with the underside up. Unfortunately on turning one of the commodes the right way up in the male medical ward a small urine stain was observed.

In the male medical ward a member of staff was not aware of the symbol for single use. Discussions with staff indicated that they were aware of the disinfectants in use and the appropriate dilution strengths to use for cleaning and for blood and body fluid spillage.

Recommendations

- 17. The trust and individual staff have a collective responsibility to ensure that staff knowledge is kept up to date; equipment is clean and in good repair.**

11.0 Hygiene Factors

STANDARD 6.0 HYGIENE FACTORS

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

Hygiene Factors	Female Surgical	Male Medical
Availability and cleanliness of wash hand basin and consumables	97	89
Availability of alcohol rub	100	100
Availability of PPE	100	100
Materials and equipment for cleaning	90	96
Average Score	97	96

In both wards the ratio of hand washing sinks do not meet the national guidelines on one hand washing sink to every four beds.



Picture 6: Limescale on hand washing sink tap

Hand washing sinks in both wards were generally clean, some attention to detail is required to ensure all sinks are clean and that limescale is removed (Picture 6). All sinks were elbow operated in areas where clinical procedures are undertaken.

Hand wash sinks were overflow free. Overflows to sinks, basins, baths and bidets are not recommended, as they constitute a constant infection control risk much more significant than the possible risk of damage due to water overflowing (WCs have an internal overflow).

In both wards paper towel dispensers are not enclosed. This was discussed with trust representatives who indicated that they are currently sourcing a suitable replacement. In both wards cleaning

chemicals were not stored under locked conditions in accordance with COSHH regulations.

There were no issues identified in either ward in relation to availability or use of alcohol rub and the use of PPE in both wards achieved full compliance which is to be commended. The storage and use of material and equipment for general cleaning required minor attention to ensure mop buckets are clean and stored properly.

Recommendations

- 18. Further attention to detail is required to ensure that fixtures and fittings and equipment used for the general cleaning of the ward are clean.**

12.0 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	Female Surgical	Male Medical
Effective hand hygiene procedures	100	100
Safe handling and disposal of sharps	100	100
Effective use of PPE	100	100
Correct use of isolation	90	100
Effective cleaning of ward	100	95
Staff uniform and work wear	93	94
Average Score	97	98

In both wards the results of audits undertaken indicate that effective hand hygiene practices were in place. Hand hygiene practices observed, complied with WHO (World Health Organisation) guidance on the correct technique to use for hand washing and appliance of hand rub. Observations indicated that staff decontaminated their hands at the appropriate moments for hand hygiene.

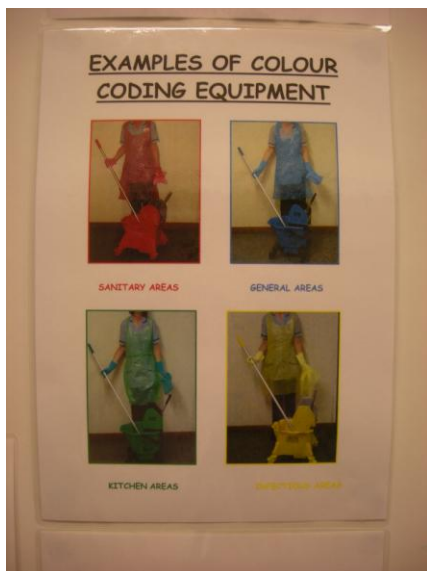
In the both wards, single use aprons and gloves were worn when in contact or anticipated contact with blood, body fluids or in potential contact with contaminated items. In the female surgical ward staff could not dispose of PPE correctly in the isolation room as there was no clinical waste bin. Inspectors observed that aprons and gloves were changed between patients and between different episodes of care.

On the day of the inspection no patients required isolation in the male medical ward. In the female surgical ward two patients required isolation precautions.

A review of documentation evidenced that a new patient centred care record has been devised. This clearly identifies if patients require specific infection control precautions.

Currently there is a regional shortage of some pre-printed information leaflets in respect of MRSA and *Clostridium difficile* and trusts have been informed that these are in the process of being revised and reprinted by the Public Health Agency. Discussion with staff also highlighted that currently these leaflets are printed in the same colour,

consideration should be given to reprinting these in a different colour for easier identification by staff and patients. In the interim, infection prevention and control staff are photocopying this guidance where required.



The NPSA guidelines, on colour coding of equipment have been fully introduced and this is the only trust to adapt the full principles of this guideline (Picture 7). Support services staff were observed wearing red aprons and gloves for cleaning sanitary areas and blue aprons and gloves for general areas. The trust should be commended on their in depth approach in this area.

Picture 7: Poster on colour coding equipment

A review of COSHH data sheets indicated that nursing staff do not have a data sheet for Actichlor Plus which is the disinfectant in use by the trust.

In both wards staff were unable to change into their uniform on arriving and prior to leaving work as appropriate facilities have not been provided.

Recommendations

- 19. Provision of appropriate equipment in isolation rooms is required to promote and support hygiene practices.**
- 20. Data sheets for disinfectants in use should be provided.**
- 21. The provision of appropriate staff changing facilities is recommended.**

13.0 Key Personnel and Information

Members of the RQIA inspection team

Mrs E Colgan	- Senior Officer Infection Prevention/Hygiene Team
Mrs L Gawley	- Inspector Infection Prevention/Hygiene Team
Mrs M Keating	- Inspector Infection Prevention/Hygiene Team
Mr S Trainor	- Senior Support Services Manager, BHSCT

Trust representatives attending the feedback session

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

Dr Loughran	- Medical Director
Heather Troughton	- Assistant Director, Surgery
Anita Carroll	- Assistant Director, Support Services
Kay Carroll	- Lead Nurse, Medicine
Colin Clarke	- Lead Nurse, Infection, Prevention and Control
Maggie Markey	- Senior Nurse, Infection Prevention and Control
Josie Matthew	- Infection Prevention and Control Nurse
Siobhan Rooney	- Ward Manager, Male Medical
Clare McArdle	- Sister, Female Surgical
Dorothy Morton	- Locality Manager, Support Services
Annette McKevitt	- 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

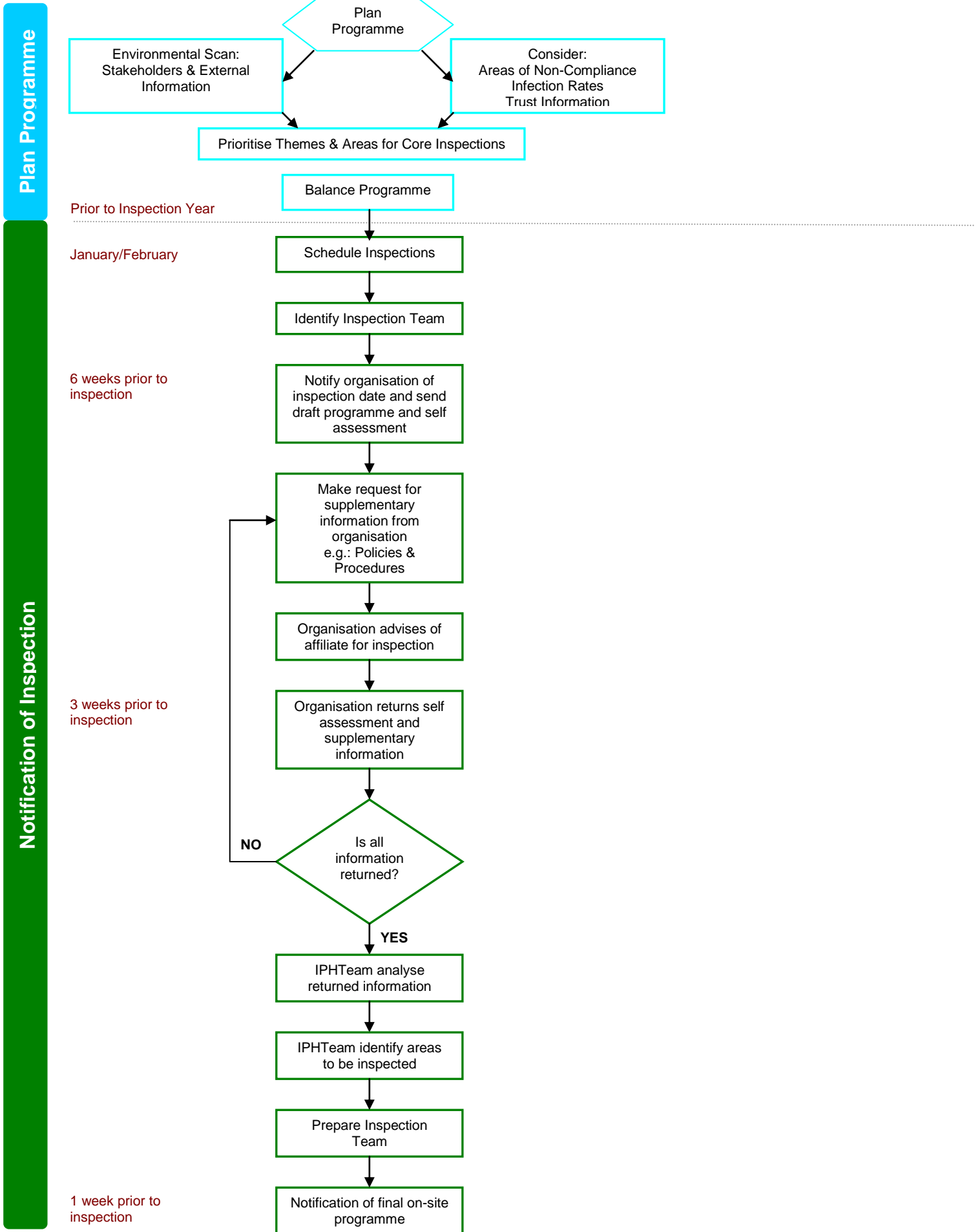
This information is currently available on request and will be available in due course on the RQIA website.

14.0 Summary of Recommendations

- 1. The trust should ensure that all staff have and are competent to access the policies and procedures on the trust's intranet.**
- 2. The trust should develop an Environmental Cleanliness and Infection Prevention and Control Strategy.**
- 3. The trust should ensure IPC controls assurance documentation clearly outlines actions required to address the outstanding issues. New templates which reflect amendments made to the standards by the DHSSPSNI should be implemented in the agreed timeframe.**
- 4. The trust needs to ensure that risk registers and key information on infection, prevention and control and environmental cleanliness have identified timescales, are kept up to date and clearly outline the current position in relation to the identified risk.**
- 5. The training matrix should be reviewed to ensure it fully addresses the needs of all staff and that competency based assessments continue to be developed.**
- 6. The trust need to review and improve the recording and monitoring systems that are currently in place to ensure compliance with mandatory training.**
- 7. The trust should continue to work to ensure that all job descriptions contain a more specific reference to infection prevention and control and environmental cleanliness.**
- 8. The terms of reference for the HCAI Forums should be updated to reflect current membership and frequency of meetings.**
- 9. The trust should ensure that the terms of reference of the inpatient medical devices group are formalised. The draft policy on the interim guidelines on the management of medical device alerts should be finalised.**
- 10. The trust should develop user participation in the relevant committees as part of the overall process of public assurance and public participation.**
- 11. Processes should be reviewed to ensure that monthly information provided at ward level is consistent and user friendly.**

- 12. Greater attention is required to ensure that isolation areas are clean and that lime scale is removed from fixtures and fittings.**
- 13. All areas within the ward environment should be maintained clutter free.**
- 14. The trust should continue to work on the repair and maintenance of the ward and replacement of damaged fixtures and fittings.**
- 15. The trust should develop detailed cleaning schedules for both nursing staff and support services.**
- 16. Waste management should comply with local policy and sharps trays should be tape free and cleaned after use.**
- 17. The trust and individual staff have a collective responsibility to ensure that staff knowledge is kept up to date; equipment is clean and in good repair.**
- 18. Further attention to detail is required to ensure that fixtures and fittings and equipment used for the general cleaning of the ward are clean.**
- 19. Provision of appropriate equipment in isolation rooms is required to promote and support hygiene practices.**
- 20. Data sheets for disinfectants in use should be provided.**
- 21. The provision of appropriate staff changing facilities is recommended.**

15.0 Announced Inspection Flowchart



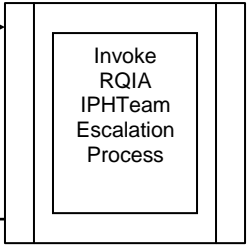
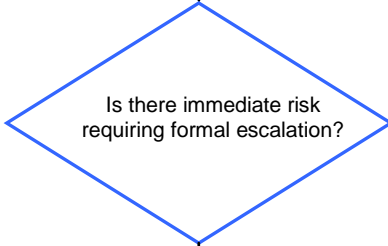
Episode of Inspection

Reporting & Re-Audit

Day of Inspection

Day of Inspection

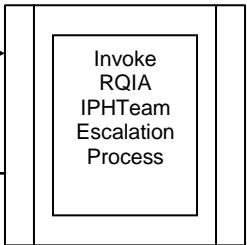
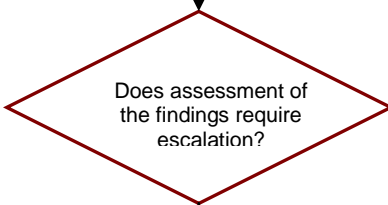
Carry out Inspection



B

14 days after Inspection

Preliminary Findings disseminated



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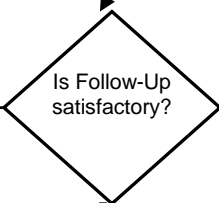
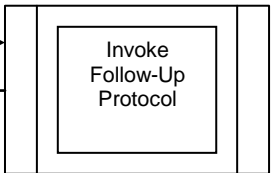
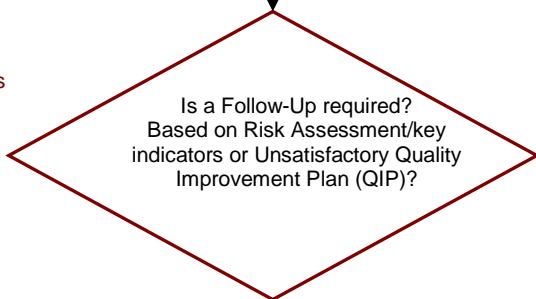
28 days after Inspection

Draft Report disseminated

14 days later

Signed Action Plan received

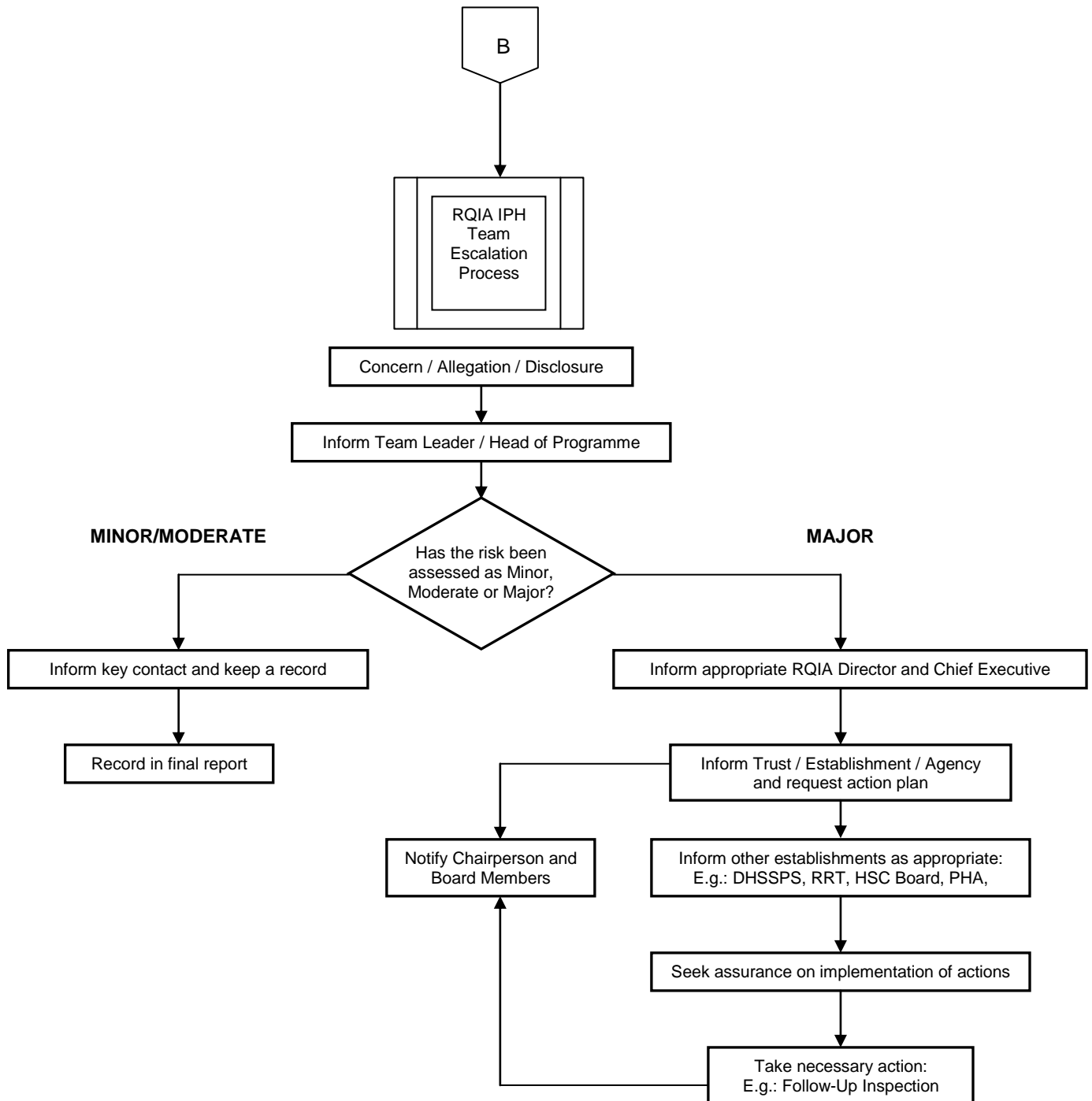
Within 0-3 months



Refer to DHSSPS HSC Board/PHA

16.0 RQIA Hygiene Team Escalation Process

RQIA Hygiene Team: Escalation Process



17.0 Action Plan

Recommendations Action Plan Submitted by Trust

Number	Recommendation	Action Owner	Timescale for Completion
1	The Trust should ensure that all staff have and are competent to access the policies and procedures on the Trust's Intranet.		Ongoing. Policies can be accessed via the Trust's Intranet The Infection Control and Prevention Procedures and Guidelines are available on the Trust's Intranet for staff to access. There is an overarching Regional Infection Control Manual to which all Trusts follow supplemented with Southern Trust guidelines.
2	The Trust should develop an Environmental Cleanliness and Infection Prevention and Control Strategy.		Environmental Cleanliness Strategy is in development. June 2011. Re: Infection Control Strategy, the Trust has developed a comprehensive Infection Prevention and Control strategy which is updated on a regular basis. Please see the Trust's HCAI Improvement Plan which forms the basis of the Trust's Strategy.
3	The Trust should ensure IPC controls assurance documentation clearly outlines actions required to address the outstanding issues. New templates which reflect amendments made to the standards by the DHSSPSNI should be implemented in the agreed timeframe.		SHSCT completed the new controls assurance standards documentation template for Infection Control for 2010/2011. An action plan has been developed to address the gaps identified in control assurance.
4	The Trust needs to ensure that risk registers and key information on infection prevention and control and environmental cleanliness have identified timescales, are kept up to date and clearly outline the current position in relation to the identified risk.		Continued focus through divisional governance processes. HCAI is referenced on the Medical Directorate risk register. Complete. Each service directorate reviews their risk register monthly and updates depending on risk mitigation or escalation. The SMT reviews the Corporate Risk Register monthly at the SMT Governance meeting and the Corporate Risk Register is discussed at Trust Board Governance Committee. IPC and EC are therefore dynamic issues on risk registers across the Trust services.
5	The training matrix should be reviewed to ensure it fully addresses the needs of all staff and that competency based assessments continue to be developed.		September 2011.

Number	Recommendation	Action Owner	Timescale for Completion
6	The Trust need to review and improve the recording and monitoring systems that are currently in place to ensure compliance with mandatory training.		Ongoing. Infection Control is one of the five corporate mandatory training elements. All training delivered to staff is recorded on HRMS. The Head of Education, Learning and Development is in the process of establishing Trust Wide Training Programmes in conjunction with Clinical Lead – Infection Prevention & Control.
7	The Trust should continue to work to ensure that all job descriptions contain a more specific reference to infection prevention and control and environmental cleanliness.		September 2011.
8	The terms of reference for the HCAI forums should be updated to reflect current membership and frequency of meetings.		The Trust will present revised terms of reference at the forthcoming Strategic Forum. May 2011.
9	The Trust should ensure that the terms of reference of the in-patient medical devices group are formalised. The draft policy on the interim guidelines on the management of medical device alerts should be finalised.		Part of the implementation of the Review of CSCG. End of June 2011.
10	The Trust should develop user participation in relevant committees as part of the overall process of public assurance and public participation.		August 2011.
11	Processes should be reviewed to ensure that monthly information provided at ward level is consistent and user friendly.		Ongoing via ward dashboard. Trust document outlining the agreed approach to Standardisation of Measures Boards within Acute and Older People and Primary Care Directorates – Guidance for Ward Managers. This work is now in progress.
12	Greater attention is required to ensure that isolation areas are clean and that lime scale is removed from fixtures and fittings.		Cleaning schedules being reviewed. lime scale removal undertaken by domestic services and estates June 2011.
13	All areas within the ward environment should be maintained clutter free.		Good practice identified via Releasing Time to Care is being shared with all Ward Managers. June 2011.
14	The Trust should continue to work on the repair and maintenance of the ward and replacement of damaged fixtures and fittings.		As a result of environmental cleanliness audit process an action list is created and shared with estates for action.
15	The Trust should develop detailed cleaning schedules for both nursing staff and support services.		Support services are reviewing cleaning schedules to include more detail of items to be cleaned and this will be complete by June 2011.
16	Waste management should comply with local policy and sharps trays should be tape free and cleaned after use.		Actions have been put in place to comply with policy April 2011.

Number	Recommendation	Action Owner	Timescale for Completion
17	The Trust and individual staff have a collective responsibility to ensure that staff knowledge is kept up to date; equipment is clean and in good repair.		Ongoing through KSF process.
18	Further attention to detail is required to ensure that fixtures and fittings and equipment used for the general cleaning of the ward are clean.		Support services are reviewing cleaning schedules to include more detail of items to be cleaned. June 2011.
19	Provision of appropriate equipment in isolation rooms is required to promote and support hygiene practices.		May 2011.
20	Data sheets for disinfectants in use should be provided.		Data sheets available for disinfectants complete April 2011.
21	The provision of appropriate staff changing facilities is recommended.		Scoping exercise to be undertaken June 2011.



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