



The **Regulation** and
Quality Improvement
Authority

RQIA
Infection Prevention/Hygiene
Announced inspection

South Eastern Health and Social Care
Trust

Downe Hospital

15 and 16 February 2011

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1.0 Inspection Summary

This is the report of the announced inspection undertaken to the South Eastern Health and Social Care Trust (SEHSCT) and the Downe Hospital on 15 and 16 February 2011. The trust and hospital were assessed against the Draft Regional Healthcare Hygiene and Cleanliness Standards.

The inspection found that the **SEHSCT** 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 ensure that low compliance scores reported on the dashboard audit system is acted upon.

During the inspection of the **Downe Hospital** the following areas were inspected:

- Ward 1 Medical
- Ward 2 Medical

The new Downe Hospital opened to the public on Sunday 28 June 2009 and is situated on the outskirts of Downpatrick. With a staff of more than 300 it provides inpatient services, including mental health and dementia services, a consultant-led emergency department, day procedure unit, outpatients, rehabilitation and maternity services.

The hospital is divided into smaller wings springing from a central entrance. There is extensive natural lighting, courtyard gardens and artwork and most of the patient beds enjoy views over the scenic Downshire Estate.

The hospital provides the following services:

- Consultant-led emergency department
- Inpatient wards
- X-ray
- Day procedure unit
- Children's centre
- Rehabilitation
- Outpatients
- Mental health and psychiatry of old age
- Maternity (including midwifery led unit)

- GP out of hours
- Nursing rapid response service

Inspection Outcomes

Wards 1 and 2 achieved an overall compliant score, and Ward 2 was compliant in all seven sections.

Ward 1 was partially compliant in two sections: patient equipment and hygiene practices. The inspection highlights the need for improvement in relation to the cleaning of patient equipment and particularly the section in hygiene practices relating to hand hygiene, it was of concern that this section was minimally compliant.

As a result of the findings for Ward 1 a follow up inspection will be carried out within three months.

The inspection resulted in 25 recommendations for the SEHSCT and the Downe Hospital, a full list of recommendations is listed in Section 13.

A detailed list of preliminary findings is forwarded to SEHSCT 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 introduced a Health Care Associated Infection Steering Group which is lead by the Chief Executive, membership of the committee encompasses all directorates.**
- **An electronic dashboard computer software programme has been introduced, this provides up to date information on audits and performance against care bundles.**
- **The Infection Prevention and Control team have developed an extensive network of Infection Prevention and Control link**

staff. Currently 110 staff are registered for the E-Learning programme.

- The Patient and Client Experience have a dedicated department which carry out environmental audits and staff training.
- The SEHSCT is an accredited centre for BICS (British Institute Cleaning Science) training which is provided to 'Cleaners Operative Proficiency Certificate' (COPC) Level 1.
- Trust Chairman and non-executive directors carry out an annual audit programme of unannounced visits.
- Good evidence was available to support effective lines of communication between the Infection Prevention and Control Team and Patient Experience staff.
- User involvement through participation in department audits.

The RQIA inspection team would like to thank the SEHSCT and, in particular, all staff at the Downe 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 | Ward1 | Ward 2 |
|----------------------|-----------|-----------|
| General environment | 95 | 95 |
| Patient linen | 94 | 94 |
| Waste | 87 | 97 |
| Sharps | 93 | 100 |
| Patient equipment | 84 | 98 |
| Hygiene factors | 99 | 99 |
| Hygiene practices | 84 | 98 |
| Average score | 91 | 97 |

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

Table 2

| General environment | Ward 1 | Ward 2 |
|--------------------------------------|---------------|---------------|
| Reception | 97 | N/A |
| Corridors, stairs lift | 100 | N/A |
| Public toilets | N/A | 100 |
| Ward/department - general (communal) | 97 | 98 |
| Patient bed area | 98 | 96 |
| Bathroom/washroom | 98 | 93 |
| Toilet | 93 | 96 |
| Clinical room/treatment room | 100 | 96 |
| Clean utility room | 88 | 91 |
| Dirty utility room | 90 | 96 |
| Domestic store | 100 | 95 |
| Kitchen | 97 | 100 |
| Equipment store | 100 | 100 |
| Isolation | 95 | 94 |
| General information | 83 | 84 |
| Average score | 95 | 95 |

Table 3

| Patient linen | Ward 1 | Ward 2 |
|------------------------|---------------|---------------|
| Storage of clean linen | 88 | 88 |
| Storage of used linen | 100 | 100 |
| Laundry facilities | N/A | N/A |
| Average score | 94 | 94 |

Table 4

| Waste and sharps | Ward 1 | Ward 2 |
|---------------------------------------|---------------|---------------|
| Handling, segregation, storage, waste | 87 | 97 |
| Availability, use, storage of sharps | 93 | 100 |
| Average score | 93 | 100 |

Table 5

| Patient equipment | Ward 1 | Ward2 |
|--------------------------|---------------|--------------|
| Patient equipment | 84 | 98 |

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

Table 6

| Hygiene factors | Ward 1 | Ward 2 |
|---|---------------|---------------|
| Availability and cleanliness of wash hand basin and consumables | 98 | 100 |
| Availability of alcohol rub | 100 | 100 |
| Availability of PPE | 100 | 100 |
| Materials and equipment for cleaning | 95 | 96 |
| Average score | 99 | 99 |

Table 7

| Hygiene practices | Ward 1 | Ward 2 |
|--------------------------------------|---------------|---------------|
| Effective hand hygiene procedures | 57 | 100 |
| Safe handling and disposal of sharps | 100 | 100 |
| Effective use of PPE | 78 | 100 |
| Correct use of isolation | 82 | 100 |
| Effective cleaning of ward | 94 | 90 |
| Staff uniform and work wear | 96 | 100 |
| Average score | 84 | 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 SEHSCT 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 17.

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 17).

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 evidenced that a range of policies and procedures have been developed and implemented to support the requirements of the standard statement and a policy development and communication process has been established within the trust.

The Safe and Effective Care department co-ordinates the process for the consultation, issue and dissemination of all trust-wide policies. All policies and procedures are issued for trust wide consultation to a representative group, and the final policy is issued on the trust policy intranet site at the start of each month for all staff to read. New policies are also discussed at ward or department monthly meetings. This was verified by the review of ward minutes.

In addition all new or reviewed policies are tabled at the trust policy committee and nursing governance committee meetings. Hygiene and cleanliness policies are also highlighted in a quarterly 'Hygiene/Cleanliness Improvement' newsletter.

Most of the Patient Experience (PE) staff do not have direct access to the trust's intranet site. Information is disseminated through a cascade of meetings from the management and co-ordinator team meetings, to ward/department team meetings in line with the policy for effective communications within the PE department.

The policies viewed were up to date, and within review timescales. A new policy, jointly drafted by the Infection Prevention and Control (IPC) team and PE titled 'The Cleaning and Decontamination of the Care Environment and Equipment Guidance and Principles', is currently awaiting signature by relevant directors. The IPC team are to be commended on their work on the policy 'Guidance for Safe Handling of Laundry'. This has been forwarded to the editorial board of the

Regional Infection Prevention and Control manual as the draft document for comment and possible inclusion within the manual.

6.1.2 Compliance with DHSSPS Standards

The review of compliance with the DHSSPS Controls Assurance standards in relation to IPC and Environmental Cleanliness (EC) indicated that both the internal and external assessments achieved an overall compliance score. Analysis of the information provided in relation to environmental cleanliness, indicates that four medium priority actions require further work and one high priority action in relation to funding for the Downe hospital is still under discussion. The Infection Prevention Controls Assurance action plan documents five medium actions requiring further work, all of which are scheduled for completion by January 2011.

The trust should continue to develop the Controls Assurance standards action plans and ensure that full details are provided on progress.

6.1.3 Annual Reports

The annual report for IPC was available for the year April 2009 - March 2010. This outlines a summary of the key IPC initiatives and activities of the trust and provides an assessment of performance against agreed targets for the year. Initiatives reported on include multidisciplinary antimicrobial weekly ward rounds in the Downe and Lagan Valley hospitals and a trust-wide review of all antimicrobial prescriptions in wards where *C difficile* cases were being managed. In relation to education and training, the report acknowledges that only 71 per cent of staff were trained in infection prevention and control against a target of 80 per cent for the two years from April 2008 to March 2010. As a positive point, the trust has promoted the work of IPC link staff and held a conference to provide an opportunity for staff to discuss and share ideas.

The report also documented the trust has not met its target in relation to Healthcare Associated Infections (HCAI) reductions in the following areas.

| Healthcare associated infections | DHSSPSNI target 2009-10 | Trust figures 2009-10 | Over target |
|---|--------------------------------|------------------------------|--------------------|
| C difficile | 89 | 99 | 10 |
| MRSA | 20 | 28 | 8 |

The trust's stated action to reduce these figures was to review and implement the principles of Aseptic Non Touch Technique (ANTT). The inspectors found little evidence at ward level to support the implementation of this recommendation. While the inspection identified that the trust does have systems in place to prevent HCAIs, these

systems are not delivering the results required to reduce the levels of MRSA and C difficile to their target levels. A back to basic review of both systems and staff practice is recommended to help identify additional measures that need to be in place.

The annual report for the PE department details the levels and frequencies of audit which they carried out in respect of EC. The report showed the trust overall score was 89 per cent against the Regional Strategy standard of 85 per cent. Notably, the Downe and Lisburn sector achieved 91 per cent.

6.1.4 Risk Management

A comprehensive risk management strategy was in place and includes the production of risk registers of both corporate and directorate risks at various levels within the trust. The DHSSPS have licensing arrangements for organisations within the HPSS to use the Australian/New Zealand standard 4360 on risk management. Samples of a corporate risk register summary which goes to the trust Board was reviewed. Risks have been identified in relation to IPC and EC.

A sample of risk registers was reviewed, these showed inconsistencies in recording and reporting on identified risks. One risk register was fully completed whilst another lacked sufficient detail. The review of this summary indicated that not all risks were dated or have been updated in line with the risk management strategy. This was evidenced by the risk management strategy which was due for review on the 28 February 2010 and the policy statement on risk management due for review on the 20 December 2010. The trust needs to ensure that risk registers and summary reports which include key information on IPC and EC have identified timescales, are kept up to date and are processed in line with the trust's risk management strategy.

Recommendations

- 1. The trust should ensure that all staff have access to the trust policies and procedures on the trust's intranet.**
- 2. The trust should review the effectiveness of systems in place to reduce HCAI.**
- 3. The trust needs to ensure that risk documentation is consistent, includes key information, has identified timescales and is kept up to date and that policies are kept within their review dates.**

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

On appointment, all staff attend a one day corporate induction programme which covers Infection prevention and control, environmental and waste awareness and risk management. All staff then receive a specific induction tailored to their professional requirements.

The evidence provided shows that PE have a learning and development programme in place for the year 2010-11. An audit of training records for this programme is carried out by PE Quality Performance and Training team (QP&T) twice yearly. The audit for July 2010 shows that not all staff have attended mandatory training or updates, and has been highlighted for further action. Although the inspectors were shown a trust mandatory training matrix, which details the training requirements for each service group, there was no evidence of a training policy for these service groups. The inspection team were told that the trust has a computerised system for all staff which is used to records details of training attendance. The system is still being developed to allow the information to be translated in to a percentage of staff uptake which will help target future training needs. On the day of inspection the inspectors were also shown local systems drawn up by ward managers to record staff training needs and attendance.

The IPC team have developed an excellent induction package and a mandatory training package which includes sections on Aseptic Non Touch Techniques (ANTT) and urinary catheter care. Staff can access a DVD on ANTT for further learning. Additional training packages include sessions delivered on Clostridium difficile care pathways and addressing staff fears of patients cared for in isolation. There is an annual programme of training, offering dates and venues which is issued at the start of each year. However figures from the Infection Control Annual Report 2009-10, indicates only 71 per cent of staff have received infection prevention training set against the trust target of 80 per cent. The inspectors were informed by ward staff that only about 50 per cent of the staff have received ANTT training and are still undergoing competency assessments.

The SEHSCT 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 to be commended.

A review of the PE induction hand book evidenced that this is a comprehensive document which is easy to follow and contains all the required information, and includes a competency assessment review of staff standard of work. PE staff also attend annual infection prevention control training; the content of which is agreed and signed off by the IPC team.

Recommendations

- 4. The trust need to review and improve the recording and monitoring systems that are currently in place to ensure compliance with mandatory training.**
- 5. The trust needs to ensure that the Aseptic Non Touch Technique training programme is delivered to all relevant staff.**

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

The 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 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. The environmental sub committee report through the risk management committee and the infection control sub committee report through the safe and effective care committee. Both sub committees provide a progress up date three times a year and an annual report. The risk management and safe and effective care committees in turn report to the governance committee bi-monthly.

The Director of Nursing for Primary Care and Elderly Care and Governance is the designated clinical lead for all strategic and operational aspects of infection prevention and control. The Infection Control Doctor is part of the Medical Directorate is an member of the IPC team. The Director of Human Resources and Corporate Affairs is responsible and accountable for the environmental hygiene aspects of HCAI in line with the management of PE department.

A HCAI steering group has been established to support the Infection Prevention and Control committee, and reports to the Chief Executive and the Executive Management Team (EMT). The group, formed to monitor the trust HCAI rates, reduction initiatives and care bundles meets fortnightly to monthly and is led by the Medical Director.

A trust Environment and Waste committee considers all aspects of waste management and reports within governance structures and the escalation process to the Corporate Control committee and onwards to the Governance Assurance committee.

Roles and responsibilities for hygiene and cleanliness issues are outlined in a standard clause in every staff member's job description.

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 walkabout audits are carried out by the Chairman and non executive directors on a rolling programme of unannounced environmental visits completed throughout the year. The walkabouts include touring wards and departments and speaking to staff to review infection prevention and control, environmental cleanliness and estates issues. This follows an agreed assessment of compliance against standards with a report compiled and forwarded to the relevant directorate for action.

6.4.2 Environmental Cleanliness Audits

The PE department has devised an extended audit tool based on the Department of Health's Environmental Cleanliness Toolkit. Every element is identified as the responsibility of Cleaning Services, Nursing and Estate Services. Audit frequencies are determined by the risk category. Audits are carried out on a daily and on-going basis by the PE coordinators.

The QP&T team along with the ward or department manager carry out a schedule of audits, the frequency being determined by a risk category matrix using the electronic toolkit 'Maximiser'. Managerial audits are carried out by a senior manager, director and service users and follow the same elements of cleaning, nursing and estate services. A failure list is completed and forwarded to each service for action. The audit results are available on the trusts intranet web site, however the inspectors did not see any information on environmental cleanliness audit scores displayed at ward level.

6.4.3 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 and found it to be comprehensive and easy to use.

The ward staff undertake a number of self audits in relation to infection, prevention and control which are collated by the IPC team and shared with senior managers. These wards led weekly audits include:

- hand hygiene audits
- peripheral venous catheter audits
- urinary catheter audits

The audit outcomes are available on the intranet and are displayed on ward dashboards. In addition the wards currently undertake a commode audit on a manual paper system which is retained on the ward. Hand hygiene performance audit scores are displayed outside wards and departments on a monthly basis for patients, visitors and staff to view. Ward managers have responsibility for ensuring the dissemination of findings from audits and taking forward required action planning.

The IPC team and local managers undertake a range of IPC related audits on a regular basis. Evidence was shown of a yearly rolling programme, ranging from audits of infection control practice standards to high impact intervention care bundles. Written reports of results are provided to the local managers for action and onward escalation where relevant. Performance results are also presented at relevant multidisciplinary audit/governance meetings.

The Beeches Management Centre audit team provides a mechanism of internal monitoring of DHSSPS Controls Assurance Standards as part of an annual programme for the SEHSCT.

6.4.4 Root Cause Analysis

The trust has devised and implemented a process of root cause analysis on all C difficile, MRSA and MSSA cases. Each HCAI update includes a short synopsis on the type of infection and recommendations on how the infection was acquired and actions to avoid reoccurrence, however there was no evidence to show the recommendations had been acted upon.

6.4.5 Medical Devices

The trust has established a Medical Devices steering group which is responsible for the management of all medical equipment. The group is supported by the Procurement Advisory group and the Operational Advisory group to ensure that a clean 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
- staff training
- decontamination
- equipment on loan to patients

The Medical Devices steering group has issued a medical devices policy which covers all of the above. Documentation on group membership was not provided for review; the trust should ensure that IPC advises at all stages of the decontamination process.

6.4.6 User Involvement

PE have a user representative who participates in the managerial audits. Both IPC and PE survey patient levels of satisfaction by means of a questionnaire. PE ask questions on car parking, meals, cleanliness, laundry and portering services. A section on IPC was covered in the July to September 2010 questionnaire for three wards in relation to staff and patient hand washing and information on infection control. This is a good innovation and should be developed to include IPC as a standard section within the questionnaires

Recommendations

- 6. Information on HCAI is displayed both at the ward entrance and at the centre of the ward, however processes should be reviewed to ensure that environmental audit scores are included and that the information provided is consistent and user friendly.**
- 7. The trust should ensure that actions resulting from root cause analysis reviews are documented and that learning points are shared.**
- 8. The trust should continue to include the IPC section in all patient questionnaires.**

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.

The electronic toolkit used by patient experience calculates scores and generates failure lists which are sent directly via email to ward sisters/department managers, patient experience operational managers and estates department leads. Relevant action and escalation reporting is taken by each individual discipline. PE standard action plans show clearly the action required, by whom, the timescale and documents when the action is complete. The completed plan is then forwarded by the manager to senior operational managers within the patient experience team.

The HCAI steering group reviews the progress made in relation to information gathered by the dashboard system of audits. The IPC team are currently involved in producing and monitoring results for hand hygiene audits, peripheral IV and urinary cannula high impact intervention care bundles.

Hand hygiene audits for October to December 2010 showed Allied Health Professionals scoring on average 80 per cent and doctors 46 per cent. This would indicate, although the audits are carried out and information is gathered, that there is a failure to appropriately action and address areas of non compliance.

The information is reported by ward, and then broken down by directorate. Each manager can access their results online at any time. The infection prevention and control staff stated that each directorate is responsible for the follow up action on issues highlighted by the audits. However on the evidence supplied it was difficult to assess what correction or escalation plans had been put in place to improve poor scores. The peripheral IV cannula score for the Downe hospital averaged 80 per cent for the months July to December 2010, three of the these months scored a non compliant 76 per cent, 75 per cent and 79 per cent. Inspectors were informed that no actual audits of practice are undertaken to help improve compliance.

Similarly, following the review of the root cause analysis for HCAs while the evidence reflects recommendations are made, there does not appear to be any follow up recorded by the HCAI group. In October 2010 a meeting was convened to review the process as there were concerns about weaknesses in the system. As a result a new process has been adopted to address the method of sharing the findings and learning following root cause analysis.

On the ward the results of audit are displayed on various notice boards which should be commended. However, at times there was so much information displayed which could be confusing especially to patients and the general public. There was no information on the EC displayed. The trust should provide a more user friendly approach to this display and to emphasis and celebrate the results obtained.

Recommendations

- 9. The trust should ensure that audits of practice are undertaken to help improve compliance in peripheral IV cannula and hand hygiene.**

6.6 Criterion 1.4

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** Health Care Associated Infection (HCAI) 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. IPC information was displayed on ward dashboards however from a patient and visitor perspective these could be difficult to understand. These were:

- environmental cleanliness
- hand hygiene audits
- care bundles

Within the PE department, monthly reports outlining key findings from the audit programme are forwarded to senior PE managers. Quarterly reports outlining scores for cleaning, nursing and estates are forwarded to the EMT and reported via the relevant governance committees.

PE and estates present a report to the EMT six monthly and at the end of the year. The annual report is completed and submitted to the trust Board via the Corporate Control committee and placed on the Patient Experience and Cleanliness Matters intranet sites. Compliance results are shared with PE staff on a daily basis by coordinators following audits and via the PE team briefing system as part of the communication strategy.

The IPC annual report is presented to the IPC committee and presented to the trust Board. IPC performance is regularly reported through the IPC committee and the HCAI steering group and from assistant directors to their senior managers and to all staff. IPC link nurse meetings regularly highlight findings from audits and identify areas for action.

Department managers have an informal process to ensure feedback on the level of compliance and the required on-going corrective action in response to all audits. Dashboard information and performance are discussed at staff team meetings, ward manager meetings, relevant governance meetings, and included as part of performance management scorecards.

The governance and patient involvement department is to be commended for the newsletter they produce which highlights learning from the RQIA hygiene reviews. It provides information on recurring

non-compliance areas identified during inspections and gives guidance on correct procedures and practice with contact names and internet sites which can be used for more information.

Recommendations

- 10. The trust should develop a way of displaying audit results and surveillance data, ensuring that the data supplied can be understood by staff, patients and visitors.**

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 | Ward 1 | Ward 2 |
|--------------------------------------|-----------|-----------|
| Reception | 97 | N/A |
| Corridors, stairs lift | 100 | N/A |
| Public toilets | N/A | 100 |
| Ward/department - general (communal) | 97 | 98 |
| Patient bed area | 98 | 96 |
| Bathroom/washroom | 98 | 93 |
| Toilet | 93 | 96 |
| Clinical room/treatment room | 100 | 96 |
| Clean utility room | 88 | 91 |
| Dirty utility room | 90 | 96 |
| Domestic store | 100 | 95 |
| Kitchen | 97 | 100 |
| Equipment store | 100 | 100 |
| Isolation | 95 | 94 |
| General information | 83 | 84 |
| Average score | 95 | 95 |

7.1 Cleaning

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

It was observed that in most instances regular and effective cleaning mechanisms were in place to 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 bacteria. However in both wards, two areas for improvement related to a build up of dust in the air vents and debris accumulating in the light fitting.

In Ward 1 staff should ensure that specialised patient equipment such as raised toilet seats and padded chairs are cleaned immediately after patient use in a systematic way to avoid the possible transition of any

infection. The sluice hopper should also be flushed and staff should ensure that all faecal deposits are removed.



Faeces on sluice hopper

Paper labels were noted on commodes and sanitary wear; these should be removed as they are a barrier to effective cleaning.

In Ward 2, more attention to cleaning is required in the dirty utility room where stains and splashes were noted on the walls, cupboard and doors.

7.2 Clutter

The hospital is new and good provision has been made for storage. Each ward had two equipment stores, a clean and dirty utility room, a disposal room and a separate domestic store. Patient bed areas are well spaced and bedside lockers were not overfilled. The side rooms are en-suite and in the bed bays the toilet and wash areas are located in an alcove of the bed area.



Sanitary facilities off bed areas

The trust has promoted a de-clutter on pay day initiative which is to be commended as it encourages staff to review and dispose of unwanted or broken items.

7.3 Maintenance and Repair

This is a new building and the finish to the walls and floors is of good standard; the walls in the sanitary areas have been finished in an easy clean cladding. However some damage to wall corners and paintwork was noted. As this is a new building, regular inspections should be made and planned maintenance programmes devised to preserve the fabric of the building. Staff should also be encouraged to take care when moving equipment to help reduce and avoid damaging walls and doors.

In Ward 2 the inspectors observed a gel like residue around the join of the taps in several areas; this should be investigated and removed as it has the potential to harbour bacteria.

7.4 Fixtures and fittings

The fixtures and fittings are in good repair.

7.5 Information

There is a range of posters in place for staff to reference such as waste and sharps management, cleaning colour coding guidelines and good staff knowledge was also shown during conversations with staff. Hand hygiene posters were widely displayed throughout the hospital and the areas inspected. A noticeboard with the latest infection control information for visitors is located at the entrance to both wards. The notice board included posters on the hand hygiene and coughing etiquette, plus results of hand hygiene audit compliance. No information was displayed to show environmental cleanliness compliance scores.



Information display board

The inspectors noted that posters on the segregation of linen were not available for nursing staff. More detailed cleaning schedules for nursing staff are required which outline all equipment that requires cleaning and specifies roles and responsibilities. Staff should refer to

the trust's recently published policy on cleaning and decontamination of the care environment and equipment for guidance.

Recommendations

- 11. More frequent cleaning is required for air vents and light fittings.**
- 12. Paper labels should be removed from patient equipment as they are a barrier to effective cleaning.**
- 13. A regular maintenance programme should be implemented to ensure minor damage is repaired.**
- 14. The trust should monitor the implementation of its policies and procedures in line with its 'Cleaning and Decontamination of the Care Environment and Equipment; - Guidance and Principles'.**
- 15. The trust should consider publishing the environmental cleanliness audit scores.**

8.0 Patient Linen

STANDARD 3.0 PATIENT LINEN

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

| Patient linen | Ward 1 | Ward 2 |
|------------------------|-----------|-----------|
| Storage of clean linen | 88 | 88 |
| Storage of used linen | 100 | 100 |
| Laundry facilities | N/A | N/A |
| Average score | 94 | 94 |

8.1 Management of Linen

Fresh linen was stored under the same conditions in both wards, that is on a wire cage and unwrapped. The metal of the cage framework was rusted in places and the cages were held in a multi purpose store with incontinence products and mattresses.



Cage with linen supplies

This is not an acceptable practice as there is potential for aerosol and hand contact contamination of the unpackaged linen. The trust's Infection Prevention and Control team and ward managers have already highlighted their concerns with the laundry provider.

In both wards good practice was observed in the handling and storage of used linen.

Recommendations

- 16. Linen should be packaged to minimise the risk contamination during transit.**

17. There should be appropriate safe storage of linen at ward level.

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 | Ward 1 | Ward 2 |
|---------------------------------------|--------|--------|
| Handling, segregation, storage, waste | 87 | 97 |
| Availability, use, storage of sharps | 93 | 100 |

9.1 Waste

The inspectors evidenced that there are arrangements in place for the handling, segregation, storage and disposal of waste, however in Ward 1 the bins were rusted and/or stained in the clinical and clean utility rooms. Ward 2 did not have a pharmaceutical waste bin and waste was therefore disposed of incorrectly.



Incorrect disposal of pharmaceutical waste

9.2 Sharps

In both areas sharps bins in use conformed to BS7320 (1990)/UN9291 standards. Bins 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 incorrectly assembled/disposed of the sharps box can receive education on the correct procedures to follow.

In Ward 1 the temporary closure mechanisms on the sharps boxes were not in place. Ward 2 had good practice throughout.

Recommendations

18. All waste bins should be cleaned and dried to prevent damage, and rusted bins should be identified and replaced.

19. The trust should monitor the implementation of its policies and procedures in respect of the management of waste and sharps to ensure that safe and appropriate practice is in place.

10.0 Patient Equipment

STANDARD 5.0 PATIENT EQUIPMENT

Cleanliness and state of repair of general patient equipment

| Patient equipment | Ward 1 | Ward2 |
|-------------------|--------|-------|
| Patient equipment | 84 | 98 |

In Ward 2 the cleaning of patient equipment was of a high standard and equipment was visibly clean. Staff should take advice on the correct storage of laryngoscope blades which were incorrectly stored out of their packaging.

Ward 1 achieved a partial compliant score; staff practice fell below the standard expected. Cleaning issues were identified in relation to a dressing trolley, blood pressure cuff, ANTT trays and mats and particularly the cleaning of a commode, were the practice observed could lead to cross contamination of bacteria. (See recommendation 14). Damage was noted to the frame work of an IV trolley and patient hoist; bed pans and urinals were not stored correctly. Throughout the visit a used bed pan, partly covered with paper tissue, was observed on top of the bedpan washer.



Used bed pan on top of washer disinfectator

Recommendations

- 20. 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 | Ward 1 | Ward 2 |
|---|-----------|-----------|
| Availability and cleanliness of wash hand basin and consumables | 98 | 100 |
| Availability of alcohol rub | 100 | 100 |
| Availability of PPE | 100 | 100 |
| Materials and equipment for cleaning | 95 | 96 |
| Average score | 99 | 99 |

In both wards the number of hand washing facilities met Department of Health guidelines, and there was good access to PPE and alcohol rub. There were a few issues in Ward 2 regarding the cleanliness of the cleaning equipment, and in Ward 1 a vacuum cleaner had been repaired with adhesive tape.

There were no issues identified in either ward in relation to availability or use of alcohol rub and PPE and both wards achieved full compliance which is to be commended.

Recommendations

- 21. Staff should ensure that cleaning equipment is cleaned appropriately after use and that it is in good working order and fit for purpose.**

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 | Ward 1 | Ward 2 |
|--------------------------------------|-----------|-----------|
| Effective hand hygiene procedures | 57 | 100 |
| Safe handling and disposal of sharps | 100 | 100 |
| Effective use of PPE | 78 | 100 |
| Correct use of isolation | 82 | 100 |
| Effective cleaning of ward | 94 | 90 |
| Staff uniform and work wear | 96 | 100 |
| Average score | 84 | 98 |

In Ward 2 the results of the audit indicate that effective 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 performed hand hygiene at the appropriate moments of hand hygiene. The only issue which was identified for improvement related to lack of Control Of Substances Hazardous to Health (COSHH) data sheets for Actichlor Plus, the same issue was also raised in Ward 1.

In Ward 1 the effective hand hygiene procedures section was minimally compliant, staff observed, did not comply with hand hygiene practice in relation to the five moments of care as directed by WHO (World Health Organisation). The observation of staff practice regarding the use of PPE and the correct use of isolation resulted in a partially compliant score.

Some of the examples of poor practice observed were, a member of staff cleaning a commode did not wear an apron and did not wash their hands prior to leaving the dirty utility room, they did then use the alcohol rub on the other side of the corridor. A member of medical staff entered the clinical preparation room after taking blood, they did not remove their gloves or wash their hands. Another member of medical staff was observed wearing a long sleeved jumper and after being challenged by staff rolled up the sleeves. Approximately 30 minutes later inspectors observed that the medic had rolled the sleeves back down when attending to another patient. A student nurse did not decontaminate their hands immediately on leaving a patient. A

member of domestic staff did not wash their hands before commencing preparations for the lunch trays.

In relation to isolation facilities, the inspectors reviewed the care plan of a patient in isolation, the admission details or statement did not record that the patient had been placed in precautionary isolation due to their recent history and no care plan had been put in place. A member of catering staff was observed leaving the isolation room, they did not remove their PPE nor did they decontaminate their hands.

Ward 1 has been designated by the trust as an isolation ward in the event of an outbreak, and according to the trust, the ward had been closed in December and a full terminal clean carried out following such an outbreak. It was therefore disappointing that this section only achieved an overall partially compliant score and more importantly that the effective hand hygiene procedures section was minimally compliant.

The partial compliance score for both this section and the section on patient equipment would underline the recommendations in the governance section that an in-depth review of systems and practice in relation to the reduction to HCAI be carried out and acted upon immediately. See recommendation 2.

Recommendations

- 22. Staff should ensure that best practice in respect of hand washing, use of alcohol rub and the wearing of PPE is followed at all times.**
- 23. The trust should ensure that all staff comply with the regional dress code guidelines.**
- 24. Correct notation is made in patients care plans regarding isolation status.**
- 25. All staff are aware and comply with the universal precautions in place when a patient is in isolation.**

13.0 Additional Issues

13.1 Issue 1

As part of the trust-wide legionella management programme, sampling for legionella was undertaken. Increased counts were found in some areas in the Ulster and Downe hospitals. The trust is liaising with the Health and Safety Executive Northern Ireland (HSENI) and Health Protection Agency (HPA) and appear to be carrying out appropriate measures to reduce the bacterial load. A continual review of the hospital estate along with regular sampling is been undertaken. It must be noted that this has not resulted in any patients acquiring an infection

13.2 Issue 2

Minutes of the IPC committee showed that following a visit from the Environment Health Officer an Improvement Notice was placed on the Downe hospital in respect of temperature control and storage of food in fridges. Recent guidance on the storage of food temperatures following an outbreak of Listeriosis in a different trust has been revised and the trust has encountered difficulties in sourcing fridges that meet the new guidance. The trust has issued new guidance on the storage and disposal of food from fridges that comply with best practice and food safety. The trust representative stated that the Improvement Notice has since been removed.

14.0 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
Ms A Hamilton - Domestic Services Manager, NHSCT

Trust representatives attending the feedback session

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

Mr S McGoran - Director of Hospital Services
Mr E Molley - Director of Human Resources and Corporate Affairs
Ms C Cardwell - Site Co-ordinator, Downe Hospital
Mr J Livingstone - Asst Director Patient Experience
Ms L Kelly - Asst Director Safe and Effective Care
Ms B Arthurs - Clinical Manager Medicine
Ms S Baxter - Clinical Manager Surgery
Ms M Merron - Infection Prevention and Control Lead
Mr L Clarke - Senior Manager Safe and Effective Care
Ms R Milligan - Senior Manager Patient Experience
Mr C Fitzsimons - Operations Manager Estates Department
Ms M Dryden - Patient Experience Manager
Ms C Stewart - Ward Manager Ward 1
Ms N Magee - Infection Control Nurse
Ms E Parker - Staff Nurse Ward 2
Mr A Milligan - Staff Nurse Ward 2

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.

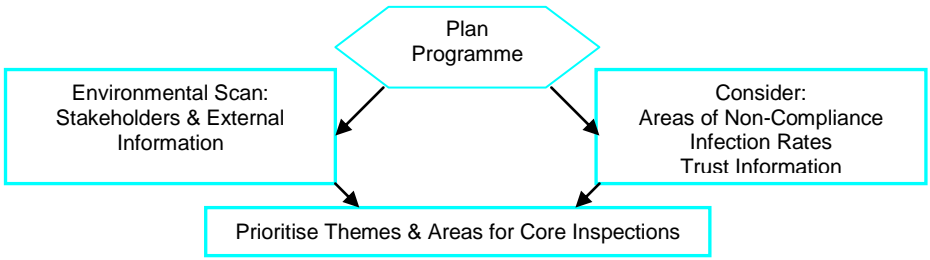
15.0 Summary of Recommendations

- 1. The trust should ensure that all staff have access to the trust policies and procedures on the trust's intranet.**
- 2. The trust should review the effectiveness of systems in place to reduce HCAI.**
- 3. The trust needs to ensure that risk documentation is consistent, includes key information, has identified timescales and is kept up to date and that policies are kept within their review dates.**
- 4. The trust need to review and improve the recording and monitoring systems that are currently in place to ensure compliance with mandatory training.**
- 5. The trust needs to ensure that the Aseptic Non Touch Technique training programme is delivered to all relevant staff.**
- 6. Information on HCAI is displayed both at the ward entrance and at the centre of the ward, however processes should be reviewed to ensure that environmental audit scores are included and that the information provided is consistent and user friendly.**
- 7. The trust should ensure that actions resulting from root cause analysis reviews are documented and that learning points are shared.**
- 8. The trust should continue to include the IPC section in all patient questionnaires.**
- 9. The trust should ensure that audits of practice are undertaken to help improve compliance in peripheral IV cannula and hand hygiene.**
- 10. The trust should develop a way of displaying audit results and surveillance data, ensuring that the data supplied can be understood by staff, patients and visitors.**
- 11. More frequent cleaning is required for air vents and light fittings.**
- 12. Paper labels should be removed from patient equipment as they are a barrier to effective cleaning.**
- 13. A regular maintenance programme should be implemented to ensure minor damage is repaired.**

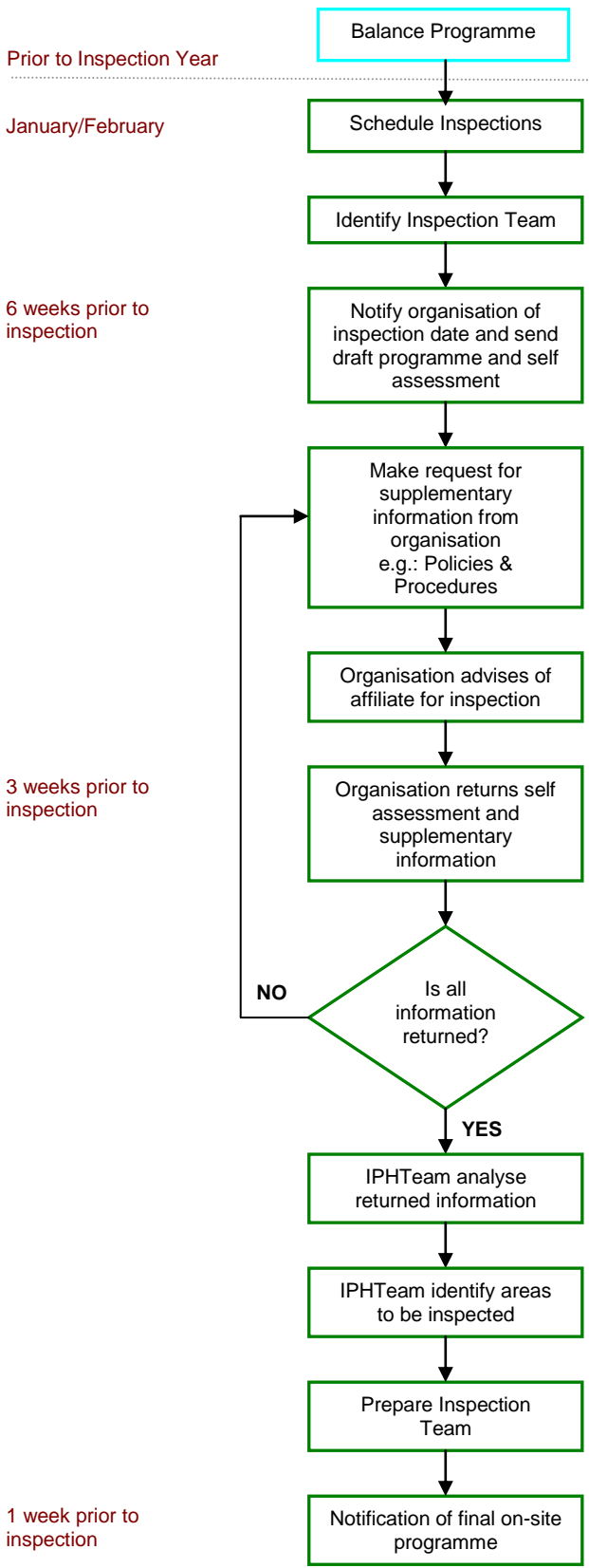
- 14. The trust should monitor the implementation of its policies and procedures in line with its 'Cleaning and Decontamination of the Care Environment and Equipment; - Guidance and Principles'.**
- 15. The trust should consider publishing the environmental cleanliness audit scores.**
- 16. Linen should be packaged to minimise the risk contamination during transit.**
- 17. There should be appropriate safe storage of linen at ward level.**
- 18. All waste bins should be cleaned and dried to prevent damage, and rusted bins should be identified and replaced.**
- 19. The trust should monitor the implementation of its policies and procedures in respect of the management of waste and sharps to ensure that safe and appropriate practice is in place.**
- 20. 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.**
- 21. Staff should ensure that cleaning equipment is cleaned appropriately after use and that it is in good working order and fit for purpose.**
- 22. Staff should ensure that best practice in respect of hand washing, use of alcohol rub and the wearing of PPE is followed at all times.**
- 23. The trust should ensure that all staff comply with the regional dress code guidelines.**
- 24. Correct notation is made in patients care plans regarding isolation status.**
- 25. All staff are aware and comply with the universal precautions in place when a patient is in isolation.**

16.0 Announced Inspection Flowchart

Plan Programme



Notification of Inspection



Prior to Inspection Year

January/February

6 weeks prior to inspection

3 weeks prior to inspection

1 week prior to inspection

Episode of Inspection

Reporting & Re-Audit

Day of Inspection

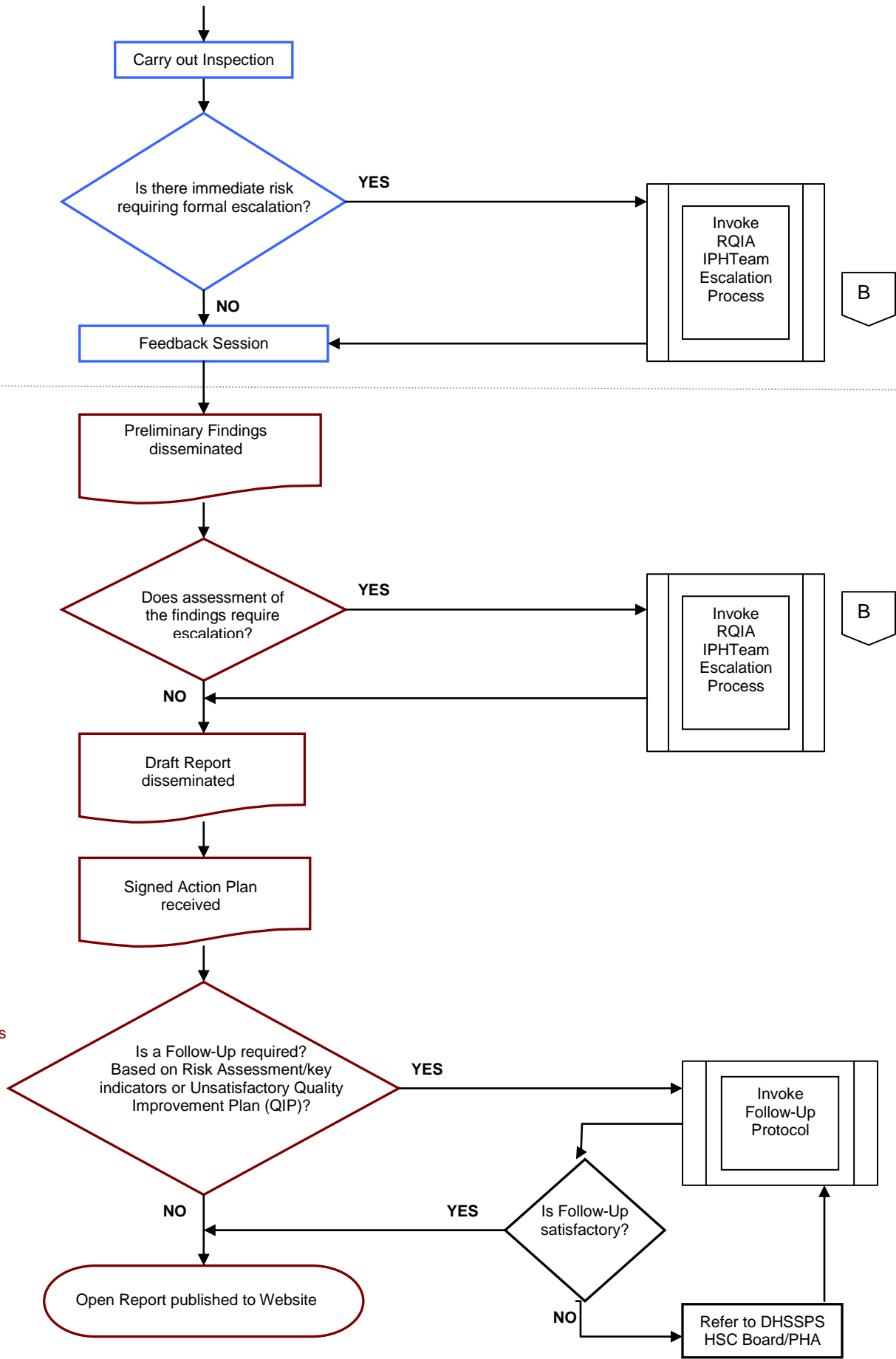
Day of Inspection

14 days after Inspection

28 days after Inspection

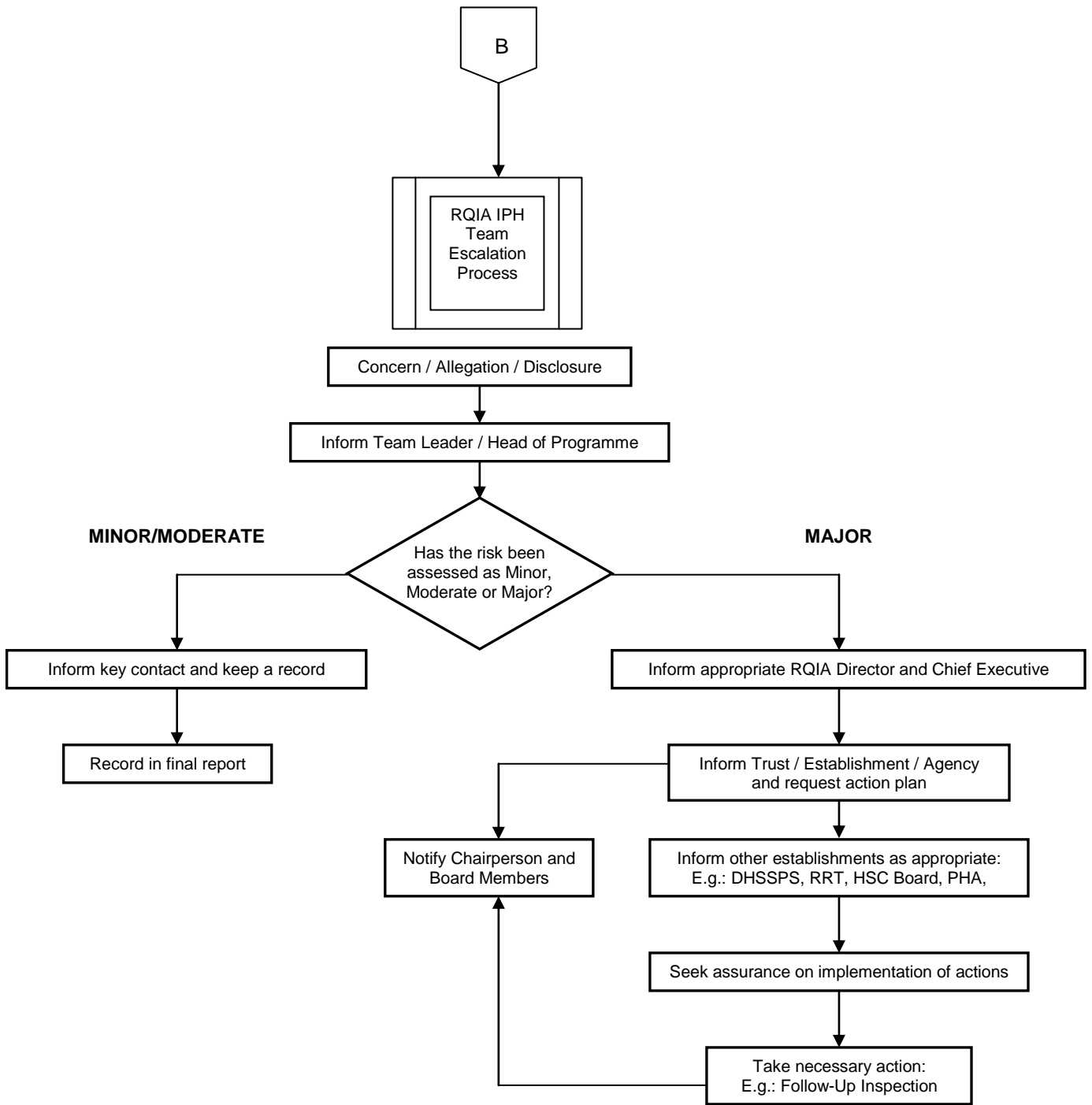
14 days later

Within 0-3 months



17.0 RQIA Hygiene Team Escalation Process

RQIA Hygiene Team: Escalation Process



17.0 Action Plan

Recommendations

| | Recommendations | Response |
|----|--|---|
| 1. | The trust should ensure that all staff have access to the trust policies and procedures on the trust's intranet. | <p>The IPC team have an annual programme of audits already in place which includes audit of staff access to IPC manual (included in evidence). During the audit if staff are not sure the IPCN will show them.</p> <p>Location of IPC policy and regional IPC manual is also included at IPC training. The Trust primary means of accessing policies/procedures is via the intranet site which is available on all PCs. Hard copy policies are maintained in strategic sites across the Trust – folders accessible in the bed manager's office in the Downe.</p> |
| 2. | The trust should review the effectiveness of systems in place to reduce HCAI. | <p>The Trust has an IPC Strategy and associated action plan which clearly identifies actions to reduce HCAI. In the year 2010-2011 the Trust has met its Target of 15 MRSA Bacteraemia, a reduction of 13 on previous year. For CDI the C diff target was missed by 15 cases but has reduced the number of cases by 29 on the previous year's total for 2yrs and over.</p> <p>In 2011-12 a 3 year IPC Strategy is in development and again includes annual action plans for HCAI reduction it also highlights the systems for reduction of HCAI.</p> <p>HCAI reduction initiatives are part of the governance/and performance managed via Directorate plans – We will forward this when endorsed by Trust Board June - July</p> |
| 3. | The trust needs to ensure that risk documentation is consistent, includes key information, has identified timescales and is kept up to date and that policies are kept within their review dates. | <p>The Trust has an established process in place for updating of legacy and highlighting South Eastern Policy review dates – including risk management policies</p> <p>The Assistant Director, Risk Management & Governance requests update on a quarterly basis from Directorates in respect of their Risk Registers. This includes a reminder to ensure that the documentation is fully populated. Guidance on the population of Directorate Risk Registers was last issued in March 2011. The Trust's new Risk Management Strategy and Policy was endorsed by the Trust Board at its meeting on 30 March 2011.</p> |

| | Recommendations | Response |
|----|---|---|
| 4. | The trust need to review and improve the recording and monitoring systems that are currently in place to ensure compliance with mandatory training. | IPC keep records of IPC training undertaken, training sessions are also recorded on the TAZ system. <i>The Trust</i> has a mandatory training matrix and compliance is reviewed through operational line management and professional accountability reviews where appropriate |
| 5. | The trust needs to ensure that the Aseptic Non Touch Technique training programme is delivered to all relevant staff. | Since June 2010 the Trust commenced a programme of training staff in ANTT. In the Downe Hospital 36 Nursing, 13 medical and 11 rapid response staff have been trained prior to Feb 2011. Since this time an additional 12 Medical staff have attended training. Ongoing training is being taken forward by local access to the ANTT training video via the Trust intranet and local record keeping of those who have completed same. ANTT training is incorporated into mandatory training and Dr induction. ANTT audits have commenced in selected wards across the trust and this will roll out across all areas. In response to finding additional ANTT training will be provided. |
| 6. | Information on HCAI is displayed both at the ward entrance and at the centre of the ward, however processes should be reviewed to ensure that environmental audit scores are included and that the information provided is consistent and user friendly. | The Trust HCAI Dashboard -Steering has a Dashboard development action plan which includes plans to incorporate environmental cleanliness scores into the Dashboard. There are also plans to make this information available to the public on notice boards. |
| 7. | The trust should ensure that actions resulting from root cause analysis reviews are documented and that learning points are shared. | The actions from root cause analysis reviews are added to the Trust's risk software Datix and are also shared to the Directors in a shared learning document. Assistant Directors are required to provide an update on implementation of shared learning initiatives to the HCAI Steering group. Directorate Governance Leads also play a roll in sharing learning thought reports and meetings. |
| 8. | The trust should continue to include the IPC section in all patient questionnaires. | This is already in place within the Trust and further audits have included these questions. |
| 9. | The trust should ensure that audits of practice are undertaken to help improve compliance in peripheral IV cannula and hand hygiene. | As reported at the review, ANTT/ IV cannula audits are being undertaken. These have commenced in selected wards across the Trust and will be rolled out across all areas through a planned programme. Audits have been undertaken in both wards in the Downe. Wards based and independent hand hygiene audits are in place in all wards. |

| | Recommendations | Response |
|-----|---|---|
| 10 | The trust should ensure that actions resulting from root cause analysis reviews are documented and that learning points are shared. | See no 7 above |
| 11. | The trust should develop a way of displaying audit results and surveillance data, ensuring that the data supplied can be understood by staff, patients and visitors. | <p>The HCAI Dashboard is the method of reporting on findings of Hand Hygiene, PVC and Urinary Catheters to ward manager who in turn report to their ward staff. The production of standard reports has been on the agenda of past meeting of the Steering group – and will be considered again at the next meeting.</p> <p>Hand Hygiene information is provided to patient on notice boards as included within the RQIA report.</p> |
| 12. | More frequent cleaning is required for air vents and light fittings. | Current discussion with Estates and Patient Experience to schedule a programme to address this |
| 13. | Paper labels should be removed from patient equipment as they are a barrier to effective cleaning. | This will be highlighted in next addition of newsletter which highlights learning to be shared from cleanliness and hygiene reviews |
| 14. | A regular maintenance programme should be implemented to ensure minor damage is repaired. | A regular programme is in place and response to adhoc requests are actioned within given timescales |
| 15. | The trust should monitor the implementation of its policies and procedures in line with its ‘Cleaning and Decontamination of the Care Environment and Equipment; - Guidance and Principles’. | The Cleaning and Decontamination of the Care Environment and Equipment; - Guidance and Principles’ was issued within the Trust in March 2011. The IPC team within their annual programme of audit have already included environmental audits and this will include review of equipment with the care environment. The IPC team on regular ward visits also monitor the cleanliness of equipment and identify areas for action. |
| 16. | The trust should consider publishing the environmental cleanliness audit scores. | See No 6 |
| 17. | Linen should be packaged to minimise the risk contamination during transit. | This is currently being addressed |
| 18. | There should be appropriate safe storage of linen at ward level. | Current discuss in place to address this issue |

| | Recommendations | Response |
|-----|---|---|
| 19. | All waste bins should be cleaned and dried to prevent damage, and rusted bins should be identified and replaced. | Patient Experience currently clean and dry bins. Rusted bins should be replaced immediately by Ward Managers |
| 20. | The trust should monitor the implementation of its policies and procedures in respect of the management of waste and sharps to ensure that safe and appropriate practice is in place. | In the annual IPC audit programme, already include in an annual audit of sharps disposal. The IPC team on regular ward visits also monitor safe sharps. The team also advise on corrective action, on receipt of IR1's associated with Sharps injuries. The issue of sharps disposal has also been highlighted at Nursing Governance meetings and the NME. The Newsletter highlighting the learning from RQIA reviews has included a section on management of sharps. |
| 21. | 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. | The IPC team have a programme of training for staff to allow them to maintain their knowledge and included within that training is information about equipment cleaning and decontamination. This is a response reflecting the corporate responsibility regarding this recommendation – the specific action regarding Ward 1 and 2 Downe are included in the other action plans submitted |
| 22. | The trust should monitor the implementation of its policies and procedures in line with its 'Cleaning and Decontamination of the Care Environment and Equipment; - Guidance and Principles'. (As per environment section.) | As per 15 – as per above comment. |
| 23. | Staff should ensure that cleaning equipment is cleaned appropriately after use and that it is in good working order and fit for purpose. | This is part of the staff responsibility – Awareness raised at team meetings and via recent issue of the newsletter on learning from cleanliness and hygiene reviews |
| 24. | Staff should ensure that best practice in respect of hand washing, use of alcohol rub and the wearing of PPE is followed at all times. | Ward based and IPC hand hygiene audits are in place. This is also monitored when IPC team visit wards to follow up patients e.g being managed in isolation such as C. Difficile hand hygiene is included in all training. |

| | Recommendations | Response |
|-----|---|---|
| 25. | The trust should ensure that all staff comply with the regional dress code guidelines. | The Medical Director has issued a memorandum stressing the need for compliance during hands on clinical care. Audits and challenging non-compliance is in place Trust-wide |
| 26. | Correct notation is made in patients care plans regarding isolation status. | This would be required practice – staff awareness raised regarding this requirement via team meetings and the recent issue of newsletter on learning from cleanliness and hygiene reviews |
| 27. | All staff are aware and comply with the universal precautions in place when a patient is in isolation. | Monitored during ward visits. |



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