



The **Regulation** and  
**Quality Improvement**  
Authority

**RQIA**  
**Infection Prevention/Hygiene**  
**Announced inspection**

**Northern Health and Social Care Trust**

**Mid Ulster Hospital**

**12 and 13 January 2011**

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## 1.0 Inspection Summary

This is the report of the announced inspection undertaken to the Northern Health and Social Care Trust (NHSCT) and the Mid Ulster Hospital on 12 and 13 January 2011. The trust and hospital were assessed against the Draft Regional Healthcare Hygiene and Cleanliness Standards.

The inspection found that the **NHSCT** 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.

The Director with responsibility for Infection Prevention and Control should be clearly identified in the trust's organisational structures. Further work is required to develop reporting and communication of HCAI reports, and the training needs assessments should be reviewed, as outlined in the body of this report. The trust should also strengthen and develop user involvement which assists with the overall process of public assurance.

During the inspection of the **Mid Ulster Hospital** the following areas were inspected:

- Ward 6 (care of the elderly)
- Day Procedure Unit

The hospital is situated on the outskirts of Magherafelt and offers the following range of services.

- Minor Injuries Unit
- Day Procedure Unit (DPU)
- Children's Ambulatory Unit
- Theatres,
- Pharmacy
- Endoscopy unit
- Radiology department
- Ward 2 and 3 which are medical wards
- Thompson House which includes Ward 6, Care of the Elderly
- The Outpatients department offers a range of services including community dental, audiology and eye clinics.

Following the recent reform of acute inpatient surgical services in the Northern Health and Social Care Trust (NHSCT), the Mid Ulster Hospital has enhanced its day surgery and endoscopy provision, as

well as continuing to provide medical services, outpatient services, diagnostics and rehabilitation. The refurbishment has increased the number of medical beds from 25 to 28 and provides patients with more space, increased privacy, with single sex bays and the provision of single rooms which assists in the overall management and prevention of HCAI's.

### **Inspection Outcomes**

The **Day Procedure Unit** has undergone recent refurbishment. The compliance levels achieved are to be commended, inspectors observed that the environment was clean, tidy and in good repair. A small number of issues were identified for improvement but, overall, the inspector's observations of staff indicated that the staff were compliant with hygiene and infection prevention control practices.

**Ward 6** is situated in an older building which has a number of challenging environmental issues. These are associated with the age and maintenance of the fabric of the building. As a result, the ward environment did not always reach an acceptable standard. The vast majority of the action points identified during the inspection of the ward related to the fabric and condition of the building and its fixtures and fittings, especially the hand washing sinks and dirty utility areas.

Observation of staff practices indicated that some improvement is required. These include the requirement that all staff are compliant with hand hygiene practices and that the appropriate Personal Protective Equipment (PPE) is available. Overall the staff observed during the inspection were generally compliant with all other aspects of hygiene and infection prevention control practices.

As a result of the findings for Ward 6 a follow up inspection will be carried out in three months.

The inspection resulted in 27 recommendations for the NHSCT and the Mid Ulster Hospital, a full list of recommendations is listed in Section 13.

A detailed list of preliminary findings is forwarded to the NHSCT 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 Infection Prevention and Control Team (IPCT) has developed an 'Isolation Risk Assessment Tool' completed on a daily basis by the ward manager. The tool identifies bed and room capacity and assists in the freeing up of isolation rooms for new admissions.**
- **An Infection Prevention and Control training DVD has been developed by the NHSCT which is accompanied by the use of a competency tool.**
- **The NHSCT is an accredited centre for BICS (British Institute Cleaning Science) training for domestic staff. A four year 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.**
- **There are effective internal monitoring systems in place which include community infection prevention and control audits which have been undertaken with the Cleanliness Matters team and this process is facilitated in acute settings when possible.**
- **Good evidence was available to support effective lines of communication between Infection Prevention and Control Team and Support Services staff, through the Infection Prevention and Control and Environmental Hygiene Committee (IPCEHC) and joint working arrangements to support the internal audit processes.**

The RQIA inspection team would like to thank the NHSCT and, in particular, all staff at the Mid Ulster 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	Ward 6	Day Procedure Unit
General Environment	80%	98%
Patient Linen	94%	100%
Waste	88%	91%
Sharps	94%	97%
Equipment	95%	98%
Hygiene Factors	86%	99%
Hygiene Practices	85%	99
<b>Average Score</b>	<b>89%</b>	<b>97%</b>

**Table 2**

General Environment	Ward 6	Day Procedure Unit
Reception	83	95
Corridors, stairs lift	84	n/a
Public toilets	n/a	98
Ward/ department - general (communal)	97	96
Patient bed area	86	99
Bathroom/washroom	79	91
Toilet	91	96
Clinical room/ treatment room	84	100
Clean utility room	86	100
Dirty utility room	66	100
Domestic store	79	100
Kitchen	96	98
Equipment store	91	n/a
Isolation	91	97
General information	84	97
<b>Average Score</b>	<b>80</b>	<b>98</b>

**Table 3**

Linen	Ward 6	Day Procedure Unit
Storage of clean linen	100	100
Storage of used linen	87	100
Laundry facilities	n/a	n/a
<b>Average Score</b>	<b>94</b>	<b>100</b>

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

**Table 4**

<b>Waste and Sharps</b>	<b>Ward 6</b>	<b>Day Procedure Unit</b>
Handling, segregation, storage, <b>waste</b>	88	91
Availability, use, storage of <b>sharps</b>	97	100

**Table 5**

<b>Patient Equipment</b>	<b>Ward 6</b>	<b>Day Procedure Unit</b>
Patient equipment	90	98

**Table 6**

<b>Hygiene Factors</b>	<b>Ward 6</b>	<b>Day Procedure Unit</b>
Availability and cleanliness of wash hand basin and consumables	75	96
Availability of alcohol rub	96	100
Availability of PPE	87	100
Materials and equipment for cleaning	86	100
<b>Average Score</b>	<b>86</b>	<b>99</b>

**Table 7**

<b>Hygiene practices</b>	<b>Ward 6</b>	<b>Day Procedure Unit</b>
Effective hand hygiene procedures	80	95
Safe handling and disposal of sharps	92	100
Effective use of PPE	63	100
Correct use of isolation	94	100
Effective cleaning of ward	81	100
Staff uniform and work wear	100	100
<b>Average Score</b>	<b>85</b>	<b>99</b>

**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 NHSCT 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 four inspectors, from RQIA's Infection Prevention/Hygiene Team. 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:

<b>Compliant</b>	<b>85% or above</b>
<b>Partial compliance</b>	<b>76 to 84%</b>
<b>Minimal compliance</b>	<b>75% or below</b>

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.

There are a number of key policies which are still in draft, such as the environmental cleanliness strategy; this has been sent to the Trust Board for approval. Discussion with representatives from support services staff in the trust indicated that this should be implemented by the end of February 2011.

Inspectors were informed that the Infection Prevention and Control (IPC) Strategy has been implemented, however the review of the strategy indicated that the overall trust delivery plan has not been completed. Inspectors were provided with an IPC delivery plan which has been developed for the acute services directorate. The trust should ensure the overall trust delivery plan is completed and details how the objectives will be delivered.

Discussions with staff and a review of the policies and procedures available on the trust intranet indicated that some recently updated policies have not been made available to staff.

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. This creates a risk in relation to accessing relevant policies, as some wards and departments have now discarded the old hard copy IPC manual. Work is on-going to ensure that all support services 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. Inspectors were informed that four domestic supervisors had received training that day on how to access policies and procedures on the trust intranet.

### **6.1.2 Compliance with DHSSPS Standards**

The review of compliance with the DHSSPS Controls Assurance Standards in relation to infection prevention control and environmental cleanliness indicated that in both the internal and external assessment the trust had achieved an overall compliance score. Analysis of the information provided in the self assessment and, following discussion with staff in relation to environmental cleanliness, highlighted that the strategy for replacing flooring scored particularly low. A review of corporate information outlined that the IPCT had achieved compliance with all standards and indicated that a high compliance score had been achieved.

The trust outlined that it is important that action plans contain full details of progress made and that where actions remain outstanding there should be details provided of the actions still to be taken. The review of the action plan for environmental cleanliness should provide full details are provided on progress. The trust is currently devising new templates for these reports for the year 2010/11, which will reflect any amendments to the standards made by the DHSSPS, these are to be in place by 31 March 2011.

The IPC Annual Report confirms that IPC remains a trust priority and the programmes of activities developed to reduce infection rates have been implemented and maintained. 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 2009

The IPC department has developed a communication strategy; this document is still in draft format.

### **6.1.3 Annual Reports**

The annual report of the Director with responsibility for Infection prevention and control was available for the year April 2009 - March 2010 and 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. 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 22 compared to 34 the previous year, a reduction of 35 per cent.
- The number of cases of *Clostridium difficile* infections in the trust in the year 2009/2010 was 102 compared to 168 the previous year, a reduction of 38 per cent.

The annual report also highlights that there has been progress made with implementing the 'Saving Lives Programme' of, reducing infection and delivering clean, safe care 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*
- *Renal* dialysis catheter care bundle

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

An annual report from support services was not available. There are action plans developed for areas which do not achieve 85 per cent compliance. Support services management stated that the development of an annual environmental cleanliness report was seen as a progressive step and that work would commence on producing a report for the 'end of year' (March 2011).

#### **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 DHSSPS has licensing arrangements for organisations within the HPSS to use the Australian/New Zealand Standard 4360 on risk management. A sample of a corporate risk register summary which is presented to the Trust Board was reviewed. Risks have been identified in relation to IPC and Environmental Cleanliness. The summary was updated in January 2011. The review of this summary indicated that not all risks have been dated, or have been updated, in line with the risk management strategy. The trust needs to ensure that risk registers and summary reports which include key information on infection, prevention and control and environmental cleanliness have identified timescales, are kept up to date and are processed in line with the trust's risk management strategy.

The NHSCT has developed a policy on 'Unscheduled/Scheduled Demand/Capacity Escalation Plan'. This plan has been developed to ensure that capacity is managed in a co-ordinated system both within and across the individual hospital sites within the trust to ensure that clinical risk is minimised. The IPC team is consulted on a daily basis to ensure that there is appropriate placement and isolation facilities. To assist this process, the Infection Prevention and Control Team has developed an 'Isolation Risk Assessment Tool' which is completed on a daily basis by the ward manager. The tool identifies bed and room capacity and assists in the freeing up of isolation rooms for new admissions.

The 'Unscheduled/Scheduled Demand/Capacity Escalation Plan' sets out professional standards for nurses; standards for medical staff are to be made available later in the year. A review of this plan indicated that support services are not included in the list the 'manager of the day' should work in partnership with. Support services can and do play a vital role in facilitating admissions and discharge and it is important that they are included in the protocol to avoid any delay in the movement and discharge of patients.

### **Recommendations**

- 1. The trust should ensure the overall trust IPC delivery plan is completed and includes details as to how the objectives will be delivered.**
- 2. The trust should ensure that all staff have access to the relevant policies and procedures on the trust's intranet.**
- 3. The trust should ensure that action plans contain full details of progress made and that where actions remain outstanding details should be provided on the actions still to be taken. New templates which reflect amendments made to the standards by the DHSSPS should be implemented in the agreed timeframe.**
- 4. An annual report of environmental cleanliness should be developed.**
- 5. The trust needs to ensure that risk registers and summary reports, which include key information on infection, prevention and control, and environmental cleanliness have identified timescales, are kept up to date and are processed in line with the trust's risk management strategy.**
- 6. The policy on 'unscheduled/ scheduled demand/ capacity escalation plan' should be reviewed to ensure that support services are identified as key personnel.**

## 6.2 Criterion 1.2

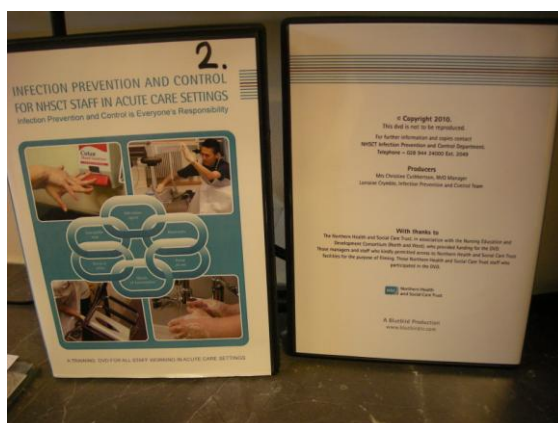
***The trust has effectively communicated policies and procedures in relation to key hygiene and cleanliness issues to staff, including through appropriate induction and ongoing training commensurate with their roles***

### 6.2.1 Training and Development

A trust wide training group has been established. This group is currently developing a trust training strategy. There are detailed corporate induction handbooks available for infection prevention and control and support services.

The IPC Team has carried out a training needs analysis to identify basic education and training requirements for each staff group and has developed a three year rolling programme. This includes one face to face session, DVD and competency assessment, directed reading or e-learning modules. A review of this plan indicates that training has been identified commensurate to individual requirements. The significant difference is in the training received by medical staff; this is only carried out for one hour every three years for consultants and senior registrars. For senior house officers (SHOs) and pre registration house officers (HOs), training is provided for each induction due to their rotational employment needs. The training needs assessment does not include the training requirements for bank and agency staff.

An Infection Prevention Control training DVD has been developed by the trust which is accompanied by the use of a competency tool, this is to be commended (Picture 1). Currently, support services are reviewing the DVD to identify which areas would be appropriate for their service and a competency tool is to be developed. In addition, a competency tool for medical staff is under discussion.



Picture 1 Training DVD developed by the IPCT in the NHSCT

The Northern Trust is an accredited centre for BICS (British Institute Cleaning Science) training for domestic staff. A four year strategy is in place to ensure all staff received 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 pack, domestic store and ward manual indicates that some of the work task sheets could be more detailed (see examples on National Patient Safety Agency (NPSA) cleaning manual), to back up practical training until BICS training is complete. Information is provided on infection control and waste management in the trust's induction programme, a section for reference could also be included in the store manual. Currently the support services competency assessment sheet is very basic; this should reflect the training given, for example, COSHH knowledge and use of disinfectant and understanding work schedules.

Mandatory training records for infection prevention and control training were available for review, these records evidence that the mandatory training of staff groups, with the exception of medical/dental staff, are in line to achieve the trust target of 95 per cent. Discussion with representatives at the feedback session indicated that the low numbers in attendance only related to consultant and senior registrars which is somewhat concerning, as they should be the role models for junior doctors. According to the available records, doctors/ dental staff in community/ primary health settings have not been included in the provision of training.

In the acute services directorate only 12 per cent of medical/ dental staff have received training this year. A system should be in place to assure attendance, which could be developed and evidenced at medical staff appraisals.

The trust has introduced other initiatives which include the National Patient Safety Agency hand hygiene WiFi game, available through the intranet site and the Cleaner Hands Campaign, which has been rolled out across the trust. Additional training is available for link nurses and auxiliary staff, which includes training on delivering results to patients/ relatives.

Discussion with staff representatives indicated that the e-learning programme is not actively being used at present, except for the section on pandemic flu, the training plan should be reviewed to ensure that the three year programme can be achieved. Discussion with staff at ward level indicated that they had received their mandatory update training.

The trust advised the inspection team that IPC mandatory training uptake is monitored through the multi disciplinary training unit (MDTU), with monthly returns provided by local managers.

## **Recommendations**

- 7. The training needs assessment plan should be reviewed to ensure it fully addresses the needs of medical/ dental, bank and agency staff.**
- 8. Development should continue with the adaptation of the training DVD and competency tool for support services and appropriate information should be made available for staff to back up practice until BIC's training is complete.**
- 9. The trust should review and improve the recording and monitoring systems 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

The roles and responsibilities in relation to infection prevention and control are clearly identified within the trusts 'Infection Prevention and Control Accountability Structure'. 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 Medical Director is the identified Director with responsibility for Infection Prevention and Control and chairs the Infection Prevention and Control and Environmental Hygiene Committee (IPCEHC) which includes nominated IPC and EH leads from each directorate. These nominated leads also chair directorate IPCEH groups.

The IPCEHC meets on a monthly basis and reports to the Governance Management Board, to provide regular updates on the progress against Priority for Actions (PFA) and IPC targets and to monitor progress with the IPC action plan.

The review of the organisation structures in place indicated that these do not clearly identify the Medical Director as the responsible person for Infection Prevention and Control.

The environmental cleanliness lines of accountability are outlined within the draft Environmental Cleanliness Strategy. The Chief Executive has overall responsibility and the Director of Planning, Performance Management and Support Services has directorate lead responsibility.

Trust committees and sub committees deal specifically with environmental hygiene, cleanliness and infection prevention and control matters. These matters are then cascaded down to department/ward level which was evidenced by reviewing a sample of the minutes of these meetings.

A review of job descriptions for various disciplines indicates that the responsibility for infection prevention and control is integral to all staff within the trust.

## **Recommendations**

- 10. The trust should ensure that the organisational structures clearly identify the director with lead responsibility for Infection, Prevention and Control.**

## 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 quarterly in acute hospitals and six monthly in the smaller hospitals in the NHSCT. The walkabouts involve members of the executive directors and non-executive directors touring wards and departments and speaking to staff. The walkabouts cover patient safety issues, as well as infection prevention and control, environmental cleanliness and estates.

Community services audits have been undertaken with the Cleanliness Matters team and this process is facilitated in/ or by acute settings, when possible.

Support services staff undertake daily observational audits, in conjunction with the ward manager, which are then signed off. A Cleanliness Matters audit is undertaken on a monthly, quarterly or bi-annual basis, dependent on the risk assessment for individual areas. The trust also ensures environmental cleanliness by undertaking bi-annual deep cleans.

Annual managerial environmental cleanliness audits are undertaken, however discussion with staff highlighted that there is no infection prevention control representative on these managerial audits. Estates issues relating to IPC/ environmental cleanliness are identified during the audit process.

### **HCAI Performance**

A dashboard of HCAI key performance indicators has been developed. This includes:

- Environmental cleanliness audits
- Hand hygiene audits
- IPC nurse audits
- Staff training by professional grouping
- Antibiotic prescribing
- Mattress audits
- Commode audits
- User Feedback

The inspection of the ward areas evidenced that audits are undertaken on hand hygiene, mattress, commodes and environmental cleanliness.

## **Root Cause Analysis**

The trust has devised and implemented a process of Root Cause Analysis on all *Clostridium difficile* cases aged over 65 years, this process is led by an infection prevention and control nurse with a remit for surveillance. The inspection team was informed that due to current temporary vacancies only clusters of *Clostridium difficile* were subject to the process. Currently the model and criteria are being revised to ensure reviews are more easily executed, with an electronic exchange of information. Inspectors were informed that the RCA process is also undertaken for MRSA bacteraemia.

## **Medical Devices**

The trust has established a medical devices management structure. This structure involves the trust Risk and Governance Co-ordinating Group, the responsible body within the trust for the management of medical devices and equipment, and ensures compliance with the relevant controls assurance standards relating to this area. This includes:

1. Medical Devices and Equipment Management
2. Decontamination
3. Purchasing and supply

This structure helps to ensure trust compliance with other best practice recommendations from bodies such as the Northern Ireland Audit Office, (NIAO), National Institute for Clinical Excellence (NICE) and Guidelines and Audit Implementation Network (GAIN).

There are five standing committees that deal with the different areas and a member of the IPCT sits on these committees.

## **User Involvement**

Review of the documentation received indicated that there is user involvement in the IPCEHC. It was apparent that users also comment on policies and delivery plans. The IPC team has developed a communication strategy and a media plan to help communication with the general public. These are currently being developed by support services staff.

The support services team has commenced piloting a questionnaire to users which is to be expanded across the trust. The IPC team provide updates for the internal 'Northern News' and relevant press releases are issued to the local media.

Currently neither group has user participation in their audit processes; this area should be developed as part of the overall process of public assurance and public participation.

## **Recommendations**

- 11. A member of the IPCT should be included in the annual managerial environmental cleanliness audit.**
- 12. The IPCT should continue to develop the Root Cause Analysis process.**
- 13. The trust should develop user participation in their audit processes, 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.

The results of IPC audits are reported to executive leads, action plans are developed, which incorporate agreed timelines and roles and responsibilities.

Action plans resulting from external reviews are monitored by directorate teams and progress is reported to the Directorate Governance Assurance Meeting and the IPCEHC.

Daily environmental cleanliness reports are dealt with immediately with the ward manager and domestic supervisor.

Monthly environmental cleanliness audits, action plans and score sheets are completed and issues arising are dealt with immediately through domestic supervisors and 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. Action plans are developed for estates issues identified during audits, however, action on some of these issues can be delayed due to lack of resources for backlog maintenance and / or capital investment.

IPC performance is monitored at Directorate Performance Meetings. An IPC nurse attends these meetings. Surveillance data is collected on *Clostridium difficile* and MRSA infections. The trust continues to collect MSSA data but IPC staff advised that at present this information is not routinely asked for by the Public Health Agency. High Impact Interventions (HII) compliance data is followed up by the lead nurse in each area. The governance directorate also contact the ward manager if there are deficits in the information provided. Reports are processed upwards within the trust, through the Assistant Director.

Currently the Intensive Care Unit (ICU) is gathering data on compliance using the ventilator assisted pneumonia (VAP) care bundle and a pilot is being undertaken to audit surgical site infection (SSI) compliance based on NICE guidelines. The IPCT and tissue viability nurse (TVN) teams are linking up to develop this work.

Inspectors were informed that MRSA screening is currently undertaken in the ICU, Neonatal, admissions from Nursing/ Residential Homes, Gynaecology and those with history of MRSA. "Changing the Culture" states that by June 2010 each trust with a Trauma and Orthopaedic

Unit will implement the agreed MRSA screening protocol. The trust needs to ensure that it is compliant in this area.

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 inspection team were informed that these audits are reported to the Senior Management Team (SMT) weekly and monthly to the Trust Board. They are also cascaded through trust performance reports.

On reviewing the monthly HCAI Performance Reports, the inspection team noted that the escalation process for low compliance scores, nil returns or no data supplied, is not clearly outlined. Additionally, it was noted that the dashboards do not include data on antibiotic use, which is reported on a quarterly basis.

### **Recommendations**

- 14. HCAI monthly performance reports should clearly outline the escalation process for low compliance scores, including nil return data supplied. Processes should be reviewed to ensure that monthly information is provided on the monitoring of antibiotic usage at ward level.**

## 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 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 its self assessment that HCAI performance data is displayed on white boards at the entrance to all facilities. The inspection to the wards only evidenced the results of environmental and hand hygiene audits.

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.

A HCAI Communication Strategy has been developed and regular targeted messages are provided internally and in the local press.

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

- the MRSA Nursing Home project
- a scrub contamination study
- a community decolonisation study
- the trust is planning a study to be carried out on the use of Difficile S, a joint study with a commercial company
- a study on post caesarean section showering and wound care is to be carried out with TVN
- a project of when, or if, a child with MRSA can be removed from the MRSA register

The minutes of domestic services staff meetings show environmental audit scores are discussed, infection control issues are highlighted and staff are informed of new policies being issued policies are held in the supervisor's office and can be accessed by staff.

Discussion with IPC and support services representatives highlighted 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.

### **Recommendations**

- 15. The trust should develop the use of the white board system to provide surveillance data and ensure 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 6	Day Procedure Unit
Reception	83	95
Corridors, stairs lift	84	n/a
Public toilets	n/a	98
Ward/ department - general (communal)	97	96
Patient bed area	86	99
Bathroom/washroom	79	91
Toilet	91	96
Clinical room/ treatment room	84	100
Clean utility room	86	100
Dirty utility room	66	100
Domestic store	79	100
Kitchen	96	98
Equipment store	91	n/a
Isolation	91	97
General information	84	97
<b>Average Score</b>	<b>80</b>	<b>98</b>

### 7.1 Cleaning

On the inspection of wards and departments, 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.

The Day Procedure Unit was exceptionally clean. Ward 6, whilst generally clean, required minor improvements particularly in the dirty utility areas and bathrooms. Attention should be paid to hand touch points such as light fittings, as there is a greater risk of transmission of bacteria from hand contact in frequently used areas. Particular care is

required to ensure that lime scale is removed from taps and fittings as recent evidence has shown that lime scale may harbour biofilms and 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 and patient bay areas of Ward 6 and only one issue was raised in the Day Procedure Unit, this related to the cleaning of a patient's bed table which was stained with food debris.

In both wards the cleaning of isolation areas was good, some dust was observed behind the radiator in the single isolation room opposite 6B, Bay 1 of Ward 6.

## **7.2 Clutter**

Both areas inspected showed evidence of a continued emphasis in providing clutter free environments, which provides effective utilisation of space. Good stock management was evident, which assists with effective cleaning. Areas for attention in Ward 6 were the cluttered surfaces in the clean utility room and the cluttered appearance of the domestic store and bathrooms.

## **7.3 Maintenance and Repair**

The Day Procedure Unit has been recently refurnished and is generally in a good state of repair.

Ward 6 is an older building which has environmental issues associated with the age and maintenance of the fabric of the building. Consequently this ward did not always reach an acceptable standard. The vast majority of the action points identified in this section related to the fabric and condition of the building. Paintwork damage was noted on walls and exposed wood was observed on the majority of 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 both areas defective flooring was observed (Picture 2), these should be repaired or replaced to ensure that gaps and cracks do not act as a reservoir for bacteria and hamper the cleaning process. The poorly laid flooring in the DPU has been referred to the contractor and agreement has now been reached for replacement.



Picture 2 Damaged Floor

In both areas some alteration is required to ensure areas used for isolation are in good repair. In Ward 6 the flooring was damaged and in the DPU paint was flaking in places and water damage was observed on the ceiling.

#### **7.4 Fixtures and fittings**

In Ward 6 fixtures and fittings in some areas were old and worn or not available, particularly in the bathrooms, the dirty utility rooms and the domestic store.

In contrast, the fixtures and fittings in the DPU were of good repair.

#### **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 in place to advise staff and visitors of isolation precautions in place.

A range of posters is in place for staff to reference, such as waste and sharps management, colour coding and segregation of linen. Inspectors noted that posters on the regional colour coding guidelines were not available for nursing staff.

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**

**16. Greater attention is required to ensure lime scale is removed from fixtures and fittings.**

**17. Environments should be maintained clutter free.**

**18. A review by estates should be undertaken of the fabric, fixtures and fittings of Ward 6 to ensure that issues identified in the detailed action plan are addressed.**

**19. The trust should develop detailed cleaning schedules.**

## 8.0 Patient Linen

### STANDARD 3.0 PATIENT LINEN

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

Linen	Ward 6	Day Procedure Unit
Storage of clean linen	100	100
Storage of used linen	87	100
Laundry facilities	n/a	n/a
<b>Average Score</b>	<b>94</b>	<b>100</b>

### 8.1 Management of 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 the Day Procedure Unit, good practice was observed in the handling and storage of used linen, used linen was placed immediately into the appropriate colour coded bags at the point of use and staff were observed to be wearing the appropriate personal protective equipment (PPE) when handling soiled/ contaminated linen.

Practices observed in Ward 6 require improvement in the following areas;

- Staff did not dispose of used laundry at the point of care
- Registered nurses and nursing auxiliary staff were observed carrying used linen from the bed area to the dirty utility area on a number of occasions.

#### Recommendations

- 20. Systems should be in place to ensure that staff adhere to regional guidance and trust policies in the handling of linen and additional training should be given where appropriate.**

## 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 6	Day Procedure Unit
Handling, segregation, storage, <b>waste</b>	88	91
Availability, use, storage of <b>sharps</b>	97	100

### 9.1 Waste

The inspection evidenced that there are arrangements in place for the handling, segregation, storage and disposal of waste in the areas visited, however, in some instances, these arrangements did not comply with local and regional guidance. In both areas the dirty utility rooms did not have a household waste bin for the disposal of paper waste.

Generally both clinical and household waste bins were clean and in a good state of repair. In Ward 6 the underside of a clinical waste bin was soiled and clinical waste bags were observed tied to the monitor trolley. In the Day Procedure Unit a clinical waste bin in the dirty utility area was rusted.

In Ward 6 inspectors observed that it is routine practice throughout the ward to use part of the twin linen store for clinical waste disposal and in the dirty utility areas a Bristol maid laundry skip was being used as a clinical waste bin.

Although an overall compliance score was achieved, a high risk related practice and potential hazard was observed in Ward 6. A needle and syringe had been disposed of incorrectly into the black lidded bin for the disposal of pharmaceutical waste.



Picture 3 Disposed of an unsheathed needle in the pharmaceutical waste bin

## 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 6, sharps trays were available but were not being used. Sharps not disposed of directly at the point of care increases the potential for a needle stick injury to occur. The temporary closure mechanisms, to prevent spillage and impede access, were not always in place when the sharps boxes were not in use.

In the Day Procedure Unit paper mache trays were used to line the integrated sharps tray. This practice increases the cost for disposables but also the cost of waste disposal and could encourage staff not to clean the reusable trays after use.

### Recommendations

- 21. 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 6	Day Procedure Unit
Patient equipment	90	98

Throughout both areas the cleaning of patient equipment was of a high standard and equipment was visibly clean, although in both areas the finish of the some equipment such as IV stands and hoists was damaged. In some instances a green trigger tape was used to identify if equipment was clean and ready to use. In the clean utility room in Ward 6 a pharmacy return bag was sticky and stained and in need of detailed cleaning.

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 manufacturers recall and that the appropriate infection prevention and control and safety practices are followed. Procedures are in place to ensure reusable items are appropriately decontaminated between patients. Patient washbowls were not stored inverted, as each patient had their own washbowl stored behind their locker which is good practice. If inverting washbowls is not practical, staff need to ensure that these are effectively washed and dried after use. In Ward 6 not all staff were 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**

- 22. 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 6	Day Procedure Unit
Availability and cleanliness of wash hand basin and consumables	75	96
Availability of alcohol rub	96	100
Availability of PPE	87	100
Materials and equipment for cleaning	86	100
<b>Average Score</b>	<b>86</b>	<b>99</b>

In Ward 6 the main issue identified was in relation to the cleanliness, condition and appropriateness of the hand washing sinks. There were a number of issues noted throughout ward 6 which affected compliance in this area.

Hand washing sinks in ward 6 were not always clean. In some areas they were old and worn or damaged and not all sinks were elbow operated. When elbow operated taps are not available there should be guidance for staff on the safe use of these taps. It is good practice to provide sensor or elbow operated taps in areas where clinical procedures are undertaken.

Hand wash sinks were not all overflow free (Picture 4), 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). This recommendation does not apply to staff residential accommodation, but does apply to patient areas including en-suite and general public toilet areas. (HTM 64)



Picture 4 Hand wash Sink in Clean utility room

The hand wash sink in the clean utility was not plug free, as hands should be washed under running water, a plug should not be available.

In the Day Procedure Unit access to hand washing sinks was blocked with equipment in the clinical and dirty utility rooms (Picture 5). The trust must ensure accessibility to, cleaning and maintenance of hand washing sinks, to promote and encourage good hand hygiene.



Picture 5 Access blocked to hand washing sink in dirty utility room

In both areas the underside of soap dispensers required cleaning. In Ward 6 the Hydrex holders were soiled and stained and there was no soap dispenser available for use in the treatment room, which could result in the inappropriate use of the Hydrex anti-septic solution for social hand washing.

There were no issues identified in the Day Procedure Unit in relation to availability or use of alcohol rub and PPE. The storage and use of material and equipment for general cleaning was excellent. In contrast, Ward 6 had no face protection available therefore staff could not

effectively protect themselves when in contact or anticipated contact with blood, body fluids or chemicals. Some equipment used for cleaning was not stored appropriately and required cleaning.

### **Recommendations**

- 23. The trust should review the condition and appropriateness of the hand washing sinks in Ward 6 and a risk based approach taken to their replacement.**
- 24. A systematic approach should be used for cleaning fixtures and fittings and equipment used for the general cleaning of the ward.**
- 25. All PPE should be readily available and used appropriately.**

## 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 6	Day Procedure Unit
Effective hand hygiene procedures	80	95
Safe handling and disposal of sharps	92	100
Effective use of PPE	63	100
Correct use of isolation	94	100
Effective cleaning of ward	81	100
Staff uniform and work wear	100	100
<b>Average Score</b>	<b>85</b>	<b>99</b>

The results of the audit indicate that effective hygiene practices were in place in the Day Procedure Unit. 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 noted for improvement in the Day Procedure Unit related to a member of staff's knowledge in relation to the use of antibacterial hand washing solutions. This member of staff stated they used the Hydrex solution because it was available at the sink. The inspection team is aware that the trust has taken a collective decision in relation to the placement and availability of antibacterial solutions at hand washing sinks; however systems should be in place to ensure that staff are aware of the correct procedures.

In Ward 6 staff practice in relation to effective use of hand rub could be improved. One staff member was observed not using the available hand rub on entering the ward and another member of staff was observed trying to apply alcohol rub whilst holding a pen. Staff and management need to ensure that staff on temporary placements are equipped with knowledge required to ensure safe practice, as inspectors observed that hands were not always washed prior to or after donning PPE. It was reported by staff that hand wipes for patients unable to wash their hands were not available and inspectors observed that in one instance a patient's finger nails required attention.

In Ward 6 single use aprons and gloves were worn when in contact or anticipated contact with blood, body fluids or in potential contact with contaminated items. Inspectors observed that aprons and gloves were changed between patients and between different episodes of care. However compliance with this section was affected by the lack of appropriate face and eye protection.

On the day of the inspection no patients required isolation in the Day Procedure Unit. In Ward 6 there were seven patients who required isolation precautions, four of these were being nursed in a cohort bay and one patient had been placed in precautionary isolation until laboratory results were received.

Inspectors observed that both nursing and domestic staff practices in relation to the application of isolation precautions and cleaning of these areas were good and in line with current practice guidance. A spot check of patient's notes evidenced that a care plan was in place for the identified alert organism. The trust has developed a care pathway. It would be good practice to ensure these are implemented in all areas.

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.

Discussion with staff in Ward 6 highlighted that they were not aware that the infection prevention and control team should be involved in the procurement of new equipment. However discussion with IPC identified that a representative from the team is a member of the clinical procurement group.

## **Recommendations**

- 26. Staff should ensure that best practice in respect of hand washing and use of alcohol rub is followed at all times.**
- 27. Appropriate eye and face protection should be available to ensure staff are protected from risks associated with contact from blood, body fluids, chemicals or contaminated items.**

## 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 S O'Connor - Inspector Infection Prevention/Hygiene Team  
Mrs M Keating - Inspector Infection Prevention/Hygiene Team

### Trust representatives attending the feedback session

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

Suzanne Pullins - Assistant Director, Medicine, Unscheduled Care  
Maire Bermingham - Assistant Director corporate Support Services  
Ann Hamilton - General Manager Domestic Services  
Roisin Doyle - General Manager Acute Care of Elderly  
Martine McNally - Trust Governance Manager  
Fiona Neely - Senior Nurse Infection Control  
Philip Bartney - Lead Nurse Older People  
Geraldine McKay - Lead Nurse Theatres  
Donna Hanna - Lead Nurse, Medicine  
Gayle Nelson - Governance Reform and Modernisation Manager  
Collette Scullion - Ward Manager DSS  
Francis Rocks - Support Services Manager  
Joe Cafolla - Estates

### 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.

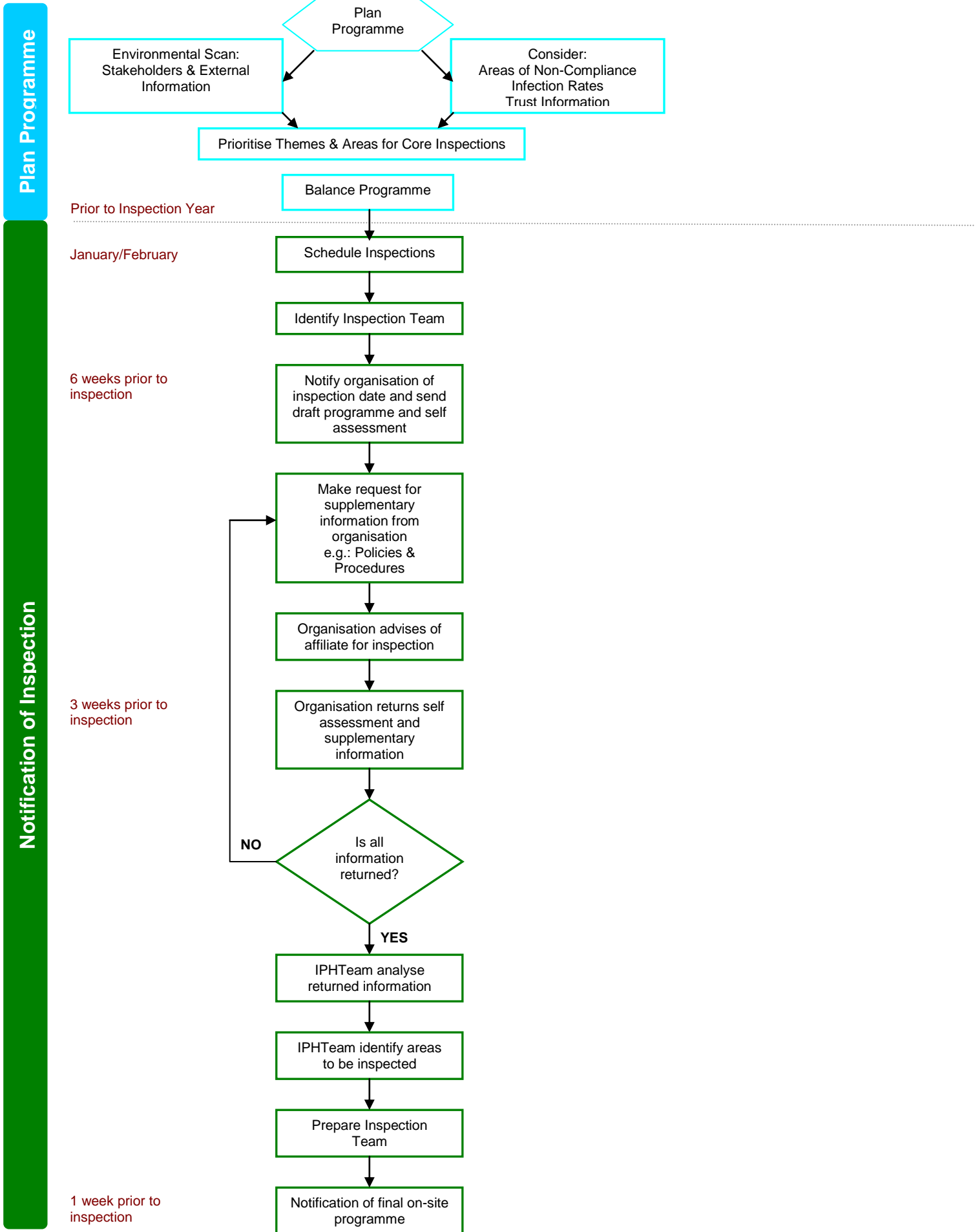
## **14.0 Summary of Recommendations**

- 1. The trust should ensure the overall trust IPC delivery plan is completed and includes details as to how the objectives will be delivered.**
- 2. The trust should ensure that all staff have access the relevant policies and procedures on the trust's intranet.**
- 3. The trust should ensure that action plans contain full details of progress made and that where actions remain outstanding details should be provided on actions still to be taken. New templates which reflect amendments made to the standards by the DHSSPS should be implemented in the agreed timeframe.**
- 4. An annual report of environmental cleanliness should be developed.**
- 5. The trust needs to ensure that risk registers and summary reports, which include key information on infection, prevention and control and environmental cleanliness have identified timescales, are kept up to date and are processed in line with the trust's risk management strategy.**
- 6. The policy on 'unscheduled/ scheduled demand/ capacity escalation plan' should be reviewed to ensure that support services are identified as key personnel.**
- 7. The training needs assessment plan should be reviewed to ensure it fully addresses the needs of medical/ dental, bank and agency staff.**
- 8. Development should continue with the adaptation of the training DVD and competency tool for support services and appropriate information should be made available for staff to back up practice until BIC's training is complete.**
- 9. The trust should review and improve the recording and monitoring systems currently in place to ensure compliance with mandatory training.**
- 10. The trust should ensure that the organisational structures clearly identify the director with lead responsibility for Infection, Prevention and Control.**
- 11. A member of the IPCT should be included in the annual managerial environmental cleanliness audit.**

- 12. The IPCT should continue to develop the Root Cause Analysis process.**
- 13. The trust should develop user participation in their audit processes, as part of the overall process of public assurance and public participation.**
- 14. HCAI monthly performance reports should clearly outline the escalation process for low compliance scores, nil return data, data supplied. Processes should be reviewed to ensure that monthly information is provided on the monitoring of antibiotic usage at ward level.**
- 15. The trust should develop the use of the white board system to provide surveillance data and ensure that the data supplied can be understood by staff, patients and visitors**
- 16. Greater attention is required to ensure lime scale is removed from fixtures and fittings.**
- 17. Environments should be maintained clutter free.**
- 18. A review by estates should be undertaken of the fabric, fixtures and fittings of Ward 6 to ensure that issues identified in the detailed action plan are addressed.**
- 19. The trust should develop detailed cleaning schedules.**
- 20. Systems should be in place to ensure that staff adhere to regional guidance and trust policies in the handling of linen and additional training should be given where appropriate.**
- 21. The trust should monitor the implementation of it's' policies and procedures in respect of the management of waste and sharps, to ensure that safe and appropriate practice is in place.**
- 22. 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.**
- 23. The trust should review the condition and appropriateness of the hand washing sinks in Ward 6 and a risk based approach taken to their replacement.**
- 24. A systematic approach should be used for cleaning fixtures and fittings and equipment used for the general cleaning of the ward.**
- 25. All PPE should be readily available and used appropriately.**

- 26. Staff should ensure that best practice in respect of hand washing and use of alcohol rub is followed at all times.**
- 27. Appropriate eye and face protection should be available to ensure staff are protected from risks associated with contact from blood, body fluids, chemicals or contaminated items.**

# 15.0 Announced Inspection Flowchart



**Episode of Inspection**

**Reporting & Re-Audit**

Day of Inspection

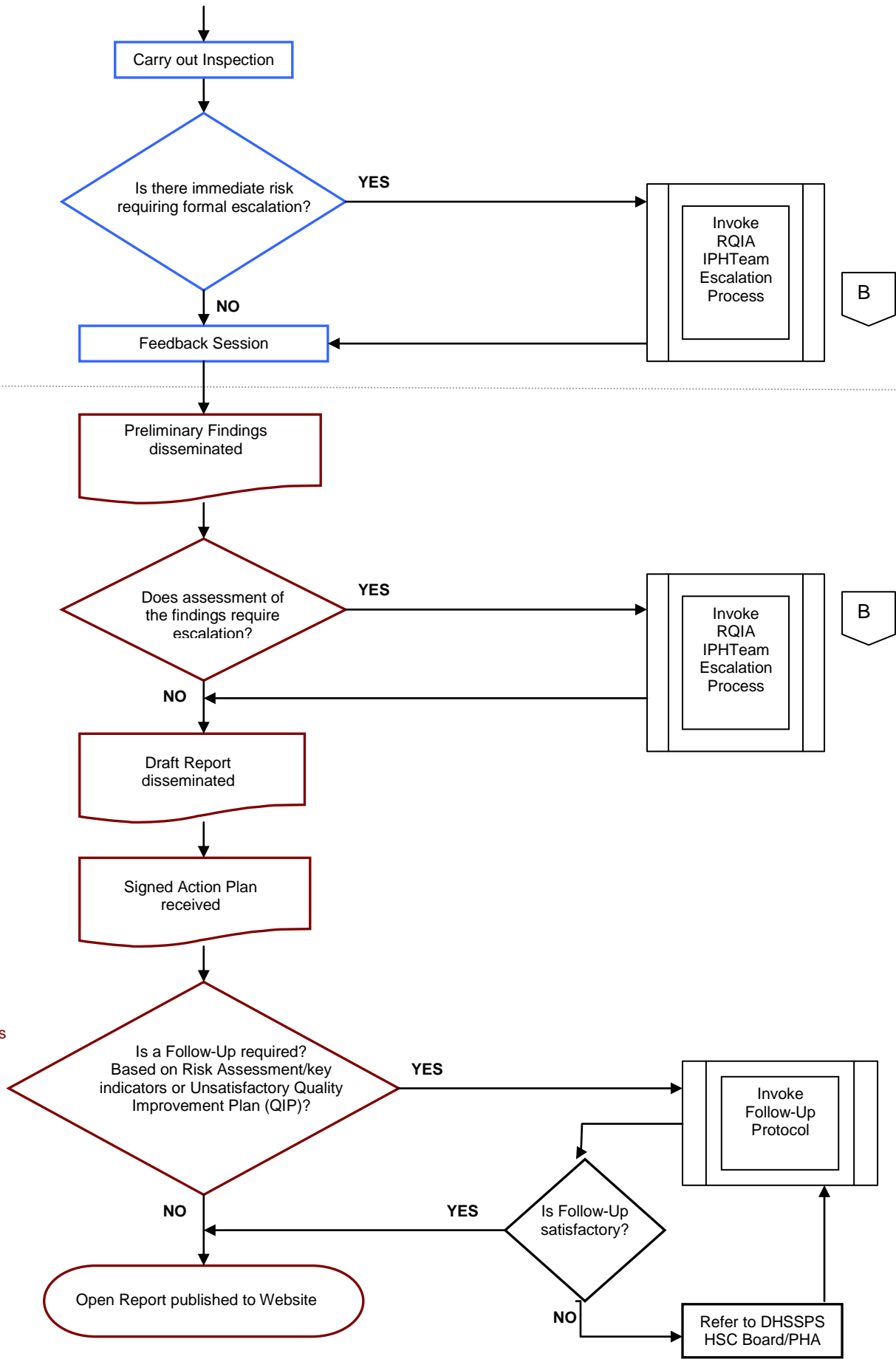
Day of Inspection

14 days after Inspection

28 days after Inspection

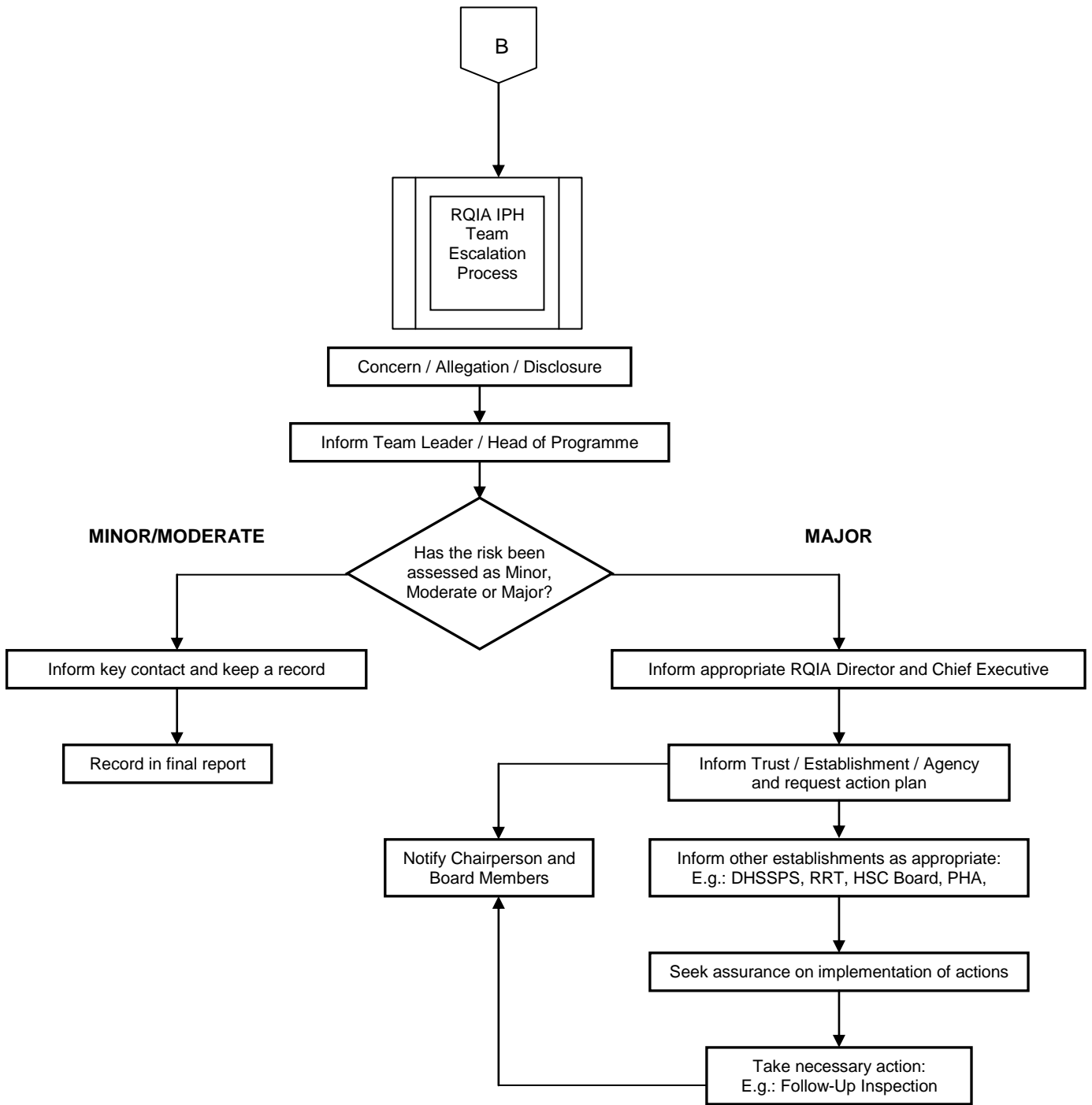
14 days later

Within 0-3 months



# 16.0 RQIA Hygiene Team: Escalation Process

## RQIA Hygiene Team: Escalation Process



## 17.0 Action Plan

### Action Plan Submitted by Trust

Number	Recommendation	Trust Position	Further action required	Lead Person	Timescales
1	The Trust should ensure the overall Trust IPC delivery plan is completed and details how the objectives will be delivered.	Four Directorate plans corporately form the Trust plan	Quarterly progress against plan will be collated on to corporate plans.	(DIPC)	1 <sup>st</sup> update April 2011
2	The Trust should ensure that all staff have access to the Trust policies and procedures on the Trust's intranet.	All Trust policies and procedures are available on the Trust intranet site. <b>All wards/facilities</b> have at least 1 PC with intranet access where staff can access policies and procedures easily.	No further action required.	(Director of SPPM) (AD Informatics)	Completed
3	The Trust should ensure that actions plans contain full details of progress made and that where actions remain outstanding there should be details provided on action to be taken. New templates which reflect amendments made to the standards by the DHSSPSNI should be implemented in the agreed timeframe.	Action plans for CAS developed annually and reviewed for mid-year Statement of Internal Control.	Implementation of new templates.	(DIPC)	Completed
4	An annual report of Environmental Cleanliness should be developed.	Environmental Cleanliness Annual report currently in draft form.	Need to ensure that the Annual Report is tabled at Trust Board and SMT meetings.	(AD Corporate Support Services)	Annual Report to be completed 30 <sup>th</sup> June 2011. To be tabled at Trust Board in September 2011. Environmental Cleanliness Strategy completed.

Number	Recommendation	Trust Position	Further action required	Lead Person	Timescales
5	The Trust needs to ensure that risk registers and summary reports which include key information on infection, prevention and control and environmental cleanliness have identified timescales, are kept up to date and are processed in line with the Trust's risk management strategy.	The Trust has a Corporate Risk Register in place which is reviewed monthly. Directorate Risk Registers are also reviewed monthly to feed into the Corporate Risk Register process. IPC and EC summary reports are updated on a monthly basis and presented at IPCEHC and GMB monthly.	Directorates must ensure that their Risk Registers are accurately kept up to date and timescales are reviewed.	Operational Directors	Domestic Services Risk register will be reviewed on a monthly basis.  Updated monthly on an ongoing basis.
6	The policy on 'unscheduled / scheduled demand / capacity escalation plan' should be reviewed to ensure that support services are identified as key personnel.	This has been raised at the Unscheduled Care Improvement Board meetings and Acute Reform meetings so that other Directorates are being made aware that there is a need to have the support services infrastructure available to meet times of increased activity. The escalation plan is currently under review to include Support Services Staff.	Directorates must ensure that Corporate Support Services representatives are included in all key meetings relating to capacity planning and re-modelling of services.	Operational Directors	Ongoing  September 2011
7	The training needs assessment plan should be reviewed to ensure it fully addresses the needs of medical / dental, bank and agency staff.	Bank nurses – most are already Trust contract holders and would have their needs incorporated. Agency nurses – agency must include IC training as part of their update for staff – checked by Sister when coming on duty for first time. All Medical students and doctors in training receive IPC training as part of their induction and	This will be reviewed on an ongoing basis	Operational Directors	Ongoing

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		scheduled teaching. At appraisal, medical/dental staff are asked to include training in infection control as part of their PDP.			
8	Development should continue with the adaptation of the training DVD and competency tool for support services and appropriate information should be available for staff to back up practice until BIC's training is complete.	As part of induction, Domestic Services staff receive Infection Control. Domestic Services Competency Tool in place. DVD and face to face Infection Control training is provided to Domestic Services staff. Training records are held by Domestic Services. Department. four year strategy in place to complete BICS training for all Domestic Services staff. Control of Infection Training DVD and Competency Tool adapted for Domestic staff. All new staff undergo Induction Training before entering the workplace and are prioritised for BICS Training. Domestic staff undergo Task Competency Testing to ensure correct cleaning practices are performed and additional "on the job" training for Domestic staff is undertaken as required.	Monitor progress against the 4 year strategy and ensure that all staff receive Infection Control training.	(AD Corporate Support Services)	Continually ongoing

Number	Recommendation	Trust Position	Further action required	Lead Person	Timescales
9	The Trust need to review and improve the recording and monitoring systems that are currently in place to ensure compliance with mandatory training.	We have a robust system established for nurse mandatory training where we offer 1000 face to face training places/yr – delivered by NEDC. Attendance recorded on their TAS system. Within medical education, training records are recorded on the tracker system.	A corporate training database needs to be developed and implemented.	Senior Management Team	December 2011
10	The Trust need to ensure that the organisational structures clearly identify the Director with responsibility for Infection, Prevention and Control.	The Integrated Governance Strategy and the Governance Accountability Framework clearly identifies the Director for IPC. Refer to attached Governance Strategy.	NFA	(DIPC)	Completed
11	A member of the IPCT should be included in the annual managerial environmental cleanliness audit.	Members of the IPCT attend the annual Managerial Cleaning Audits.	NFA	(AD Corporate Support Services) (Deputy Director of Nursing)	Action completed. Rolling programme ongoing.
12	The IPCT should continue to develop the Root Cause Analysis process.	RCA continues to be used for review of C Diff and MRSA cases when appropriate. These are reviewed at the IPCEHC regularly.	Will monitor the application of new IPC process	(DIPC)	June and Sept 11
13	The Trust should develop user participation in their audit processes as part of the overall process of public assurance and public participation.	New Patient and Ward Manager surveys in place as of January 2011 to ensure better rate of return and information received in relation to quality of Domestic services. Volunteer identified to participate in Leadership Walkabouts.	Review of response rates and information on views of service ongoing. In June 2011, the plan is to include the patient in the Patient Safety Leadership Walkrounds.	(AD Corporate Support Services)	Ongoing  June 2011

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14	HCAI monthly performance reports should clearly outline the escalation process for low compliance scores, nil return data, data supplied. Processes should be reviewed to ensure that monthly information is provided on the monitoring of antibiotic usage at ward level.	The HCAI monthly performance report is discussed and reviewed at IPCEHC and GMB on a monthly basis and areas <b>where low compliance is noted, action is taken by Directors with the appropriate area/facility.</b> Monitoring of antibiotic usage is audited on a monthly basis and is only available on a quarterly basis for inclusion in the HCAI performance report.	Trust Governance Manager to discuss with Antimicrobial Pharmacist the possibility of obtaining monthly audit scores and check if wards receive their compliance with antibiotic usage monthly.	(Head of Pharmacy and Medicines Management)	June 2011
15	The Trust should develop the use of the white board system to provide surveillance data and ensure that the data supplied can be understood by staff, patients and visitors.	The white boards are used in all wards and clearly display surveillance data.	To ensure that all wards are updating the white boards on a weekly basis.	Ward Managers	Ongoing
16	Greater attention to ensure lime scale is removed from fixtures and fittings is required.	Greater attention to the removal of limescale from fixtures and fittings being completed as part of the daily observational cleaning audits.	General Manager and Domestic Services Managers need to complete spot checks as part of the auditing process to ensure that corrective action is being taken as a follow up to the daily audits.	(AD Corporate Support Services) (General manager Trust Wide Domestic Services)	Ongoing
17	Environments should be maintained clutter free.	This has been a standard agenda item for the IPC&EH committee meetings since the beginning of 2011. Clutter on	Dump the Junk week arranged for June 2011. Ward Bed removal	Operational Directors	Ongoing

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		wards and corridors remains an issue and is being picked up on audits and Leadership Walkabouts.	protocol in place. Lead Nurses re-enforcing the de-cluttering message with Ward Managers.		
<b>18</b>	A review by estates should be undertaken of the fabric of Ward 6 and its fixtures and fittings to ensure that issues identified in the detailed action plan are addressed.	Action plan - identified issues almost all completed. Costings are being undertaken by Estates to then be considered by Assistant Director/Director to decide way forward.	Costings to be provided by Estates. Options then to be considered by Director.		May 2011
<b>19</b>	The Trust should develop detailed cleaning schedules.	Detailed Cleaning Schedules in place for Domestic Services.	Domestic Services Cleaning schedules to be updated in timely fashion when there is e.g. a change in cleaning product or new equipment introduced.  A review of nursing cleaning schedules will be undertaken.	( AD Corporate Support Services) (General Manager Trust Wide Domestic Services)  All Ward Managers	Ongoing review and updates as required.  June 2011
<b>20</b>	Systems should be put in place to ensure that staff adhere to regional guidance and Trust policies in the handling of linen and additional training should be given were appropriate.	The Trust Linen Services Manager in conjunction with Infection Control has been tasked with ensuring that education/awareness sessions on the handling of linen are in place for ward staff. Infection Control include as part of IPC training.	Trust Linen Services Manager preparing rolling programme for education/awareness sessions.	(AD Corporate Support Services) (Northern Trust Linen Services Manager)	Ongoing. Rolling programme to ensure all wards are targeted once a year.

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21	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.	Sharps management is monitored in the quality assurance audits carried out by IPCT.	Further audits will be undertaken in respect of waste and sharps.	IPCT	September 2011
22	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.	Staff have clear policies to follow for cleaning equipment and IPCN audits provide independent assurances.	Any deficits addressed through local action plans from audits	All Ward Managers	June 2011
23	The Trust should review the condition and appropriateness of the hand washing sinks in Ward 6 and a risk based approach taken to their replacement.	Minor capital works have been completed and awaiting costings. These costs will be considered by Assistant Director/Director.	Approval of minor capital works to be obtained and agreed by Assistant Director / Director		May 2011
24	A systematic approach should be used for cleaning fixtures and fittings and equipment used for the general cleaning of the ward.	Domestic Services Cleaning equipment standards checked as part of the audit process.	Reviewed as part of the daily observational audit process, Cleanliness Matters audits, IPC audits and Cleaning Managerial Audits.	(AD Corporate Support Services) (General Manager, Trust Wide Domestic Services)	Ongoing
25	All appropriate PPE should be readily available and used appropriately.	Trust has policies in place in relation to PPE.	All Ward Managers should ensure that appropriate PPE is available and used in line with Trust policies.	All Ward Managers	June 2011
26	Staff should ensure that best practice in respect of hand washing and use of alcohol rub is followed at all times.	Trust has policies in place in relation to hand hygiene and infection control. Weekly hand hygiene audits are undertaken	All Ward Managers should ensure that staff adhere to the hand hygiene policy.	All Ward Managers	Ongoing

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		and reported to SMT on a weekly basis. If compliance is low, then daily audits must be initiated by Ward Manager.			
27	Appropriate eye and face protection should be available to ensure staff are protected from risks associated with contact from blood, body fluids, chemicals or contaminated items.	IC audit those but up to Lead Nurse /Ward Manager to ensure systems are available.	Audits to continue to be undertaken by IPCT	All Ward Managers	Ongoing



The **Regulation** and  
**Quality Improvement**  
Authority

The Regulation and Quality Improvement Authority  
9th Floor  
Riverside Tower  
5 Lanyon Place  
BELFAST  
BT1 3BT

Tel: (028) 9051 7500  
Fax: (028) 9051 7501  
Email: [info@rqia.org.uk](mailto:info@rqia.org.uk)  
Web: [www.rqia.org.uk](http://www.rqia.org.uk)