The Regulation and Quality Improvement Authority

RQIA
Infection Prevention/Hygiene
Unannounced Follow up Inspection

Northern Health and Social Care Trust

Mid Ulster Hospital

31 May 2011

informing and improving health and social care
www.rqia.org.uk

Contents

1.0	**Inspection Summary**	**1**
2.0	**Background Information to the Inspection Process**	**5**
3.0	**Inspections**	**6**
4.0	**Unannounced Inspection Process**	**7**
4.1	Onsite Inspection	7
4.2	Feedback and Report of the findings	7
5.0	**Audit Tool**	**8**
6.0	**Environment**	**10**
6.1	Cleaning	10
6.2	Clutter	11
6.3	Maintenance and Repair	11
6.4	Fixture and Fittings	12
6.5	Information	12
7.0	**Patient Linen**	**14**
7.1	Management of Linen	14
8.0	**Waste and Sharps**	**15**
8.1	Waste	15
8.2	Sharps	15
9.0	**Patient Equipment**	**17**
10.0	**Hygiene Factors**	**18**
11.0	**Hygiene Practice**	**20**
12.0	**Key Personnel and Information**	**22**
13.0	**Summary of Recommendations**	**23**
14.0	**Unannounced Inspection Flowchart**	**24**
15.0	**RQIA Hygiene Team Escalation Policy Flowchart**	**25**
16.0	**Action Plan**	**26**

1.0 Inspection Summary

As a result of the announced inspection carried out on 12 and 13 January 2011 a detailed action plan was submitted to RQIA. As part of the follow up process an unannounced follow up inspection was undertaken to Mid Ulster Hospital, on the 31 May 2011. The purpose of the inspection was to re-audit Ward 6, which in the initial inspection identified three non compliant sections within standards 2- 7 of the draft Regional Healthcare Hygiene and Cleanliness Standards.

Inspection Outcomes

The inspection team reviewed the progress and found 56 per cent of the actions have been addressed. The majority of those still requiring action are in relation to refurbishment, replacing old and worn fixtures and fittings, maintenance and repair. The decision on whether the ward is to be decanted permanently or temporarily until Ward 6 is refurbished has resulted in a postponement of assessed repairs by estates and replacement patient furniture from the Braid Valley and/ or Mid Ulster sites. This has had a significant impact on the issues still requiring action.

At the January inspection, 12 recommendations were made in relation to Standards 2-7. Four have been addressed, eight have been repeated and there are no new recommendations. The hospital was assessed against the draft Regional Healthcare Hygiene and Cleanliness standards and the following area was inspected:

- Ward 6

The **Mid Ulster Hospital** is situated on the outskirts of Magherafelt and offers the following range of services; a minor injuries unit, day procedures, children's ambulatory unit, theatres, pharmacy, endoscopy, radiology, Ward 2 medical, Thompson House which includes Ward 6, Care of the Elderly, and outpatients.

A summary of the recommendations following the re-audit is listed in Section 13. A detailed list of preliminary findings has been forwarded to the trust, which is available on request.

Issues stated for the second time are highlighted with an asterisk in the attached action plan in Section 16.

The report and the quality improvement plan are available to view on the RQIA website. Reports and action plans will be subject to performance management by the Health and Social Care Board and the Public Health Agency.

The RQIA inspection team would like to thank the staff at 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 the organisation to target areas that require more specific attention.

Table 1

Areas Inspected	13 January 2011	31 May 2011
General Environment	80	92
Patient Linen	94	100
Waste	88	86
Sharps	94	89
Patient Equipment	95	97
Hygiene Factors	89	92
Hygiene Practices	85	96
Average score	**89**	**93**

Table 2

General Environment	13 January 2011	31 May 2011
Reception	83	83
Corridors, stairs lift	84	94
Public toilets	n/a	98
Ward/department – general (communal)	97	96
Patient bed area	86	93
Bathroom/washroom	79	86
Toilet	91	96
Clinical room/treatment room	84	87
Clean utility room	86	89
Dirty utility room	66	78
Domestic store	79	88
Kitchen	96	98
Equipment store	91	94
Isolation	91	94
General information	84	100
Average score	**80**	**92**

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

Table 3

Patient Linen	13 January 2011	31 May 2011
Storage of clean linen	100	100
Storage of dirty linen	87	100
Laundry facilities	N/A	N/A
Average score	**94**	**100**

Table 4

Waste and Sharps	13 January 2011	31 May 2011
Handling, segregation, storage, **waste**	88	86
Availability, use, storage of sharps	97	89
Average score		

Table 5

Patient Equipment	13 January 2011	31 May 2011
Patient equipment	**90**	**97**

Table 6

Hygiene Factors	13 January 2011	31 May 2011
Availability and cleanliness of wash hand basin and consumables	75	89
Availability of alcohol rub	96	97
Availability of PPE	87	87
Materials and equipment for cleaning	86	96
Average score	**86**	**92**

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

Table 7

Hygiene Practices	13 January 2011	31 May 2011
Effective hand hygiene procedures	80	95
Safe handling and disposal of sharps	92	100
Effective use of PPE	63	90
Correct use of isolation	94	100
Effective cleaning of ward	81	95
Staff uniform and work wear	100	93
Average score	**85**	**96**

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

2.0 Background Information to the Inspection Process

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

The aims of the inspection process are:

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

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

3.0 Inspections

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

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

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

- **Improving care:** we encourage and promote improvements in the safety and quality of services through the regulation and review of health and social care

- **Informing the population:** we publicly report on the safety, quality and availability of health and social care

- **Safeguarding rights:** we act to protect the rights of all people using health and social care services

- **Influencing policy:** we influence policy and standards in health and social care

4.0 Unannounced Inspection Process

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

4.1 Onsite Inspection

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

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

4.2 Feedback and Report of the Findings

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

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

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

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

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

5.0 Audit Tool

The audit tool used for the inspection is based on the 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

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

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

3. **Patient Linen**: storage of clean linen; handling and storage of used linen; ward/department laundry facilities

4. **Waste and Sharps**: waste handling; availability and storage of sharps containers

5. **Patient Equipment**: cleanliness and state of repair of general patient equipment

6. **Hygiene Facilities**: hand wash facilities; alcohol hand rub; availability of personal protective equipment (PPE); availability of cleaning equipment and materials; staff changing facilities

7. **Hygiene Practices**: hand hygiene procedures; handling and disposal of sharps; use of PPE; use of isolation facilities and implementation of infection control procedures; cleaning of ward/department; staff uniform and work wear

Level of Compliance

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

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

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

6.0 Environment

STANDARD 2.0
GENERAL ENVIRONMENT

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

General Environment	13 January 2011	31 May 2011
Reception	83	83
Corridors, stairs lift	84	94
Public toilets	n/a	98
Ward/department – general (communal)	97	96
Patient bed area	86	93
Bathroom/washroom	79	86
Toilet	91	96
Clinical room/treatment room	84	87
Clean utility room	86	89
Dirty utility room	66	78
Domestic store	79	88
Kitchen	96	98
Equipment store	91	94
Isolation	91	94
General information	84	100
Average score	**80**	**92**

6.1 Cleaning

In the re-audit of this ward staff are to be commended for achieving an overall compliant score in the environment section. On inspection of the ward the inspectors evidenced good compliance with regional specifications for cleaning standards. The inspectors observed that regular cleaning mechanisms were in place to prevent the build up of dust and soil which in turn prevents the build up of bacteria and subsequently reduces the potential risk for the transmission of bacteria. The only new issue identified was cobwebs observed on the kitchen windows.

Recurring cleaning issues relate to the the PVC sliding doors at the entrance to Ward 6 which were still dirty at the bottom, toilet roll holders remain single roll and uncovered, and excess toilet rolls were still stored in some toilet areas. Underneath of some sink soap dispensers

and Hydrex dispensers remain grubby and the shower drain was still dirty. Lime scale was still noted on some taps and around the bath controls.

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 patient bed bay areas, general ward and dirty utility rooms of Ward 6.

6.2 Clutter

Staff are to be commended for maintaining a clutter free environment. This was evidenced by effective utilisation of space and good stock management which assists with effective cleaning. Patient areas such as the day room and bed areas were tidy and the clinical room, clean utility room, domestic store and bathrooms which were cluttered at the previous inspection were clutter free (Picture1).

Picture 1 Dirty utility room

6.3 Maintenance and Repair

Ward 6 is an old building which has environmental issues associated with the age and maintenance of the fabric of the building. Paintwork damage previously noted on walls and exposed wood observed on the majority of the doors, have been addressed which has improved the cosmetic appearance of the ward. However many horizontal surfaces and wooden cupboards remain damaged or unsealed resulting in surfaces not impermeable to moisture and therefore cannot be effectively cleaned. It is important that all surfaces are sealed and intact, to ensure that effective cleaning can be undertaken.

The main hospital reception remains in poor repair. Stained and damaged wall paper, chipped paintwork on radiators, damaged doors and the worn and chipped PVC coating of the leaflet rack reflect a tired and worn environment.

6.4 Fixtures and Fittings

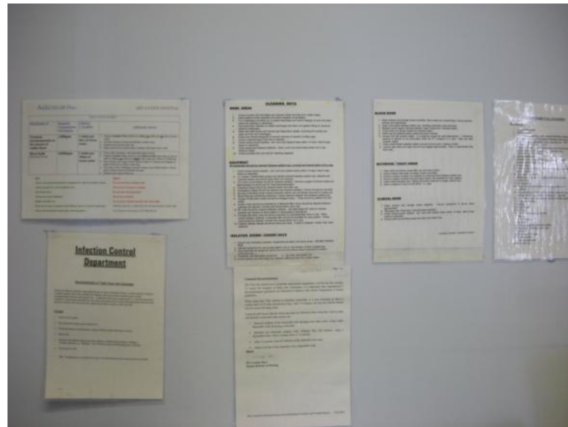
Fixtures and fittings in some areas remain old and worn or not available, particularly sanitary ware in the bathrooms, the dirty utility rooms and the domestic store. The wooden cupboards in the treatment room, equipment store and clean utility were damaged with the wood exposed (Picture 2) and the shower seal around the drain remains split. As stated previously these issues have been raised with the estates department for repair but work has been postponed until a decision is made on whether to refurbish or permanently decant the ward.

Picture 2 Worn wooden cupboard treatment room

In the bed bays, some wooden tables remain worn down to the bare wood, some bed frames were chipped and some chairs were old, worn and required upholstering. It was evident from the previous inspection that many damaged items of furniture have been replaced and staff confirmed there is a rolling programme for replacement furniture. Furniture has been sourced from the Braid Valley site and wards that have closed in the Magherafelt site.

6.5 Information

All issues stated at the previous inspection have been addressed and no new issues were identified. Staff are to be commended for achieving full compliance in this section of the audit tool. Hand hygiene posters were displayed at hand washing sinks and alcohol gel dispensers. Information leaflets on hand hygiene, common infections and infection prevention and control were available and there was a range of posters in place for staff to reference such as waste, linen, sharps management and colour coding (Picture 3).



Picture 3 Information posters in dirty utility room

Detailed cleaning schedules which outline staff responsibility for both domestic and nursing staff are up to date.

Recommendations

1. **Greater attention is required to ensure lime scale is removed from fixtures and fittings. (repeated)**

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

7.0 Patient Linen

STANDARD 3.0
PATIENT LINEN

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

Patient Linen	13 January 2011	31 May 2011
Storage of clean linen	100	100
Storage of used linen	87	100
Laundry facilities	N/A	N/A
Average score	**94**	**100**

7.1 Management of Linen

Staff are to be commended for achieving full compliance in this section of the audit tool. Good practice was observed in the storage of clean linen and the handling and storage of used linen and the issues raised in the previous audit have been addressed. 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. No recommendations were identified during this inspection.

8.0 Waste and Sharps

STANDARD 4.0
WASTE AND SHARPS

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

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

Waste and Sharps	13 January 2011	31 May 2011
Handling, segregation, storage, **waste**	88	86
Availability, use, storage of **sharps**	94	89

8.1 Waste

Ward 6 maintained compliance in this standard. The inspection evidenced that there were arrangements in place for the handling, segregation, storage and disposal of waste in the ward, however, in some instances, these arrangements did not comply with local and regional guidance.

There were no new issues identified at this re-audit however the inspectors observed that it remains routine practice throughout the ward to use part of the twin linen skips for clinical waste disposal and in the dirty utility areas a Bristol maid laundry skip was being used as a clinical waste bin. In the previous audit the inspectors identified the lack of a household waste bin in the dirty utility room. Compliance was affected in this audit by the lack of household waste bins in bed areas and the treatment room and the issue of no household waste bin in the dirty utility is still outstanding. Household waste disposed of as clinical waste remains an expensive option for the trust.

8.2 Sharps

An issue identified at the previous audit related to staff not using the available sharps trays. While this issue has been addressed and staff now use the trays, on the day of inspection the trays were grubby and had residue of tape. This affected compliance. An issue identified a second time is the temporary closure mechanisms, to prevent spillage and impede access, were not always in place when the sharps boxes were not in use.

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.

Recommendations

3 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. (repeated)

9.0 Patient Equipment

STANDARD 5.0 PATIENT EQUIPMENT *Cleanliness and state of repair of general patient equipment.*

Patient Equipment	13 January 2011	31 May 2011
Patient equipment	**90**	**97**

The cleaning of patient equipment was of a high standard and equipment was visibly clean (Picture 4), although the finish of some equipment such as linen skips and hoists was damaged and the resuscitation trolley was dusty. Green trigger tape was used to identify if equipment was clean and ready to use (Picture 5).

Picture 4 Visibly clean portable nebuliser

Picture 5 Annex for storing clean equipment

Recommendations

4. **The trust and individual staff have a collective responsibility to ensure that equipment is clean and in good repair. (repeated)**

10.0 Hygiene Factors

STANDARD 6.0
HYGIENE FACTORS

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

Hygiene Factors	13 January 2011	31 May 2011
Availability and cleanliness of wash hand basin and consumables	75	89
Availability of alcohol rub	96	97
Availability of PPE	87	87
Materials and equipment for cleaning	86	96
Average score	**86**	**92**

Issues identified at the previous audit which have been addressed relate to equipment such as mop buckets, dust pans and brushes used for cleaning were stored appropriately and were clean and ready for use. Although the overall compliance was of a high standard, the main issue remains the cleanliness, condition and appropriateness of the hand washing sinks and consumables.

There was an overall improvement in the cleanliness of hand washing sinks however many sinks remain old and worn or damaged and not all sink taps were elbow operated. 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; 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). Trust representatives confirmed that consideration was being given to replacing hand washing sinks as part of the overall review of the facility when the decision concerning the ward has been reached.

The underside of the soap dispenser and Hydrex dispenser in the clean utility required cleaning and there was no soap dispenser available in the treatment room. Face protection was not available therefore staff could not effectively protect themselves when in contact or anticipated contact with blood, body fluids or chemicals. These issues were identified at the previous inspection and remain outstanding.

Recommendations

5. **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. (repeated)**

6. **A systematic approach should be used for cleaning fixtures and fittings and equipment used for the general cleaning of the ward. (repeated)**

7. **All PPE should be readily available and used appropriately. (repeated)**

11.0 Hygiene Practices

STANDARD 7.0
HYGIENE PRACTICES

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

Hygiene Practices	13 January 2011	31 May 2011
Effective hand hygiene procedures	80	95
Safe handling and disposal of sharps	92	100
Effective use of PPE	63	90
Correct use of isolation	94	100
Effective cleaning of ward	81	95
Staff uniform and work wear	100	93
Average score	**85**	**96**

The results of the re audit indicate that effective hygiene practices were still in place in the ward. Hand hygiene practices observed complied with WHO (World Health Organisation) guidance on the correct technique to use for hand washing and appliance of hand rub. Observations indicated that staff performed hand hygiene at the appropriate moments of hand hygiene.

The only new issue noted for improvement in the ward related to two member of staff's knowledge in relation to the use of antibacterial hand washing solutions. A member of staff stated they used the Hydrex solution because it was available at the sink and habit. The inspection team was 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.

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 again affected by the lack of appropriate face and eye protection.

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 (Picture 6).

A spot check of patient's notes evidenced that a care plan and relevant care pathway was in place for an identified alert organism.

Picture 6 Audit scores on whiteboard

Recommendations

8 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. (repeated)

12.0 Key Personnel and Information

Members of the RQIA inspection team

Mrs L Gawley - Inspector Infection Prevention/Hygiene Team
Mrs S O'Connor - Inspector Infection Prevention/Hygiene Team

Trust representatives attending the feedback session

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

Supporting documentation

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

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

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

13.0 Summary of Recommendations

1. **Greater attention is required to ensure lime scale is removed from fixtures and fittings. (repeated)**

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

3. **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. (repeated)**

4. **The trust and individual staff have a collective responsibility to ensure that equipment is clean and in good repair. (repeated)**

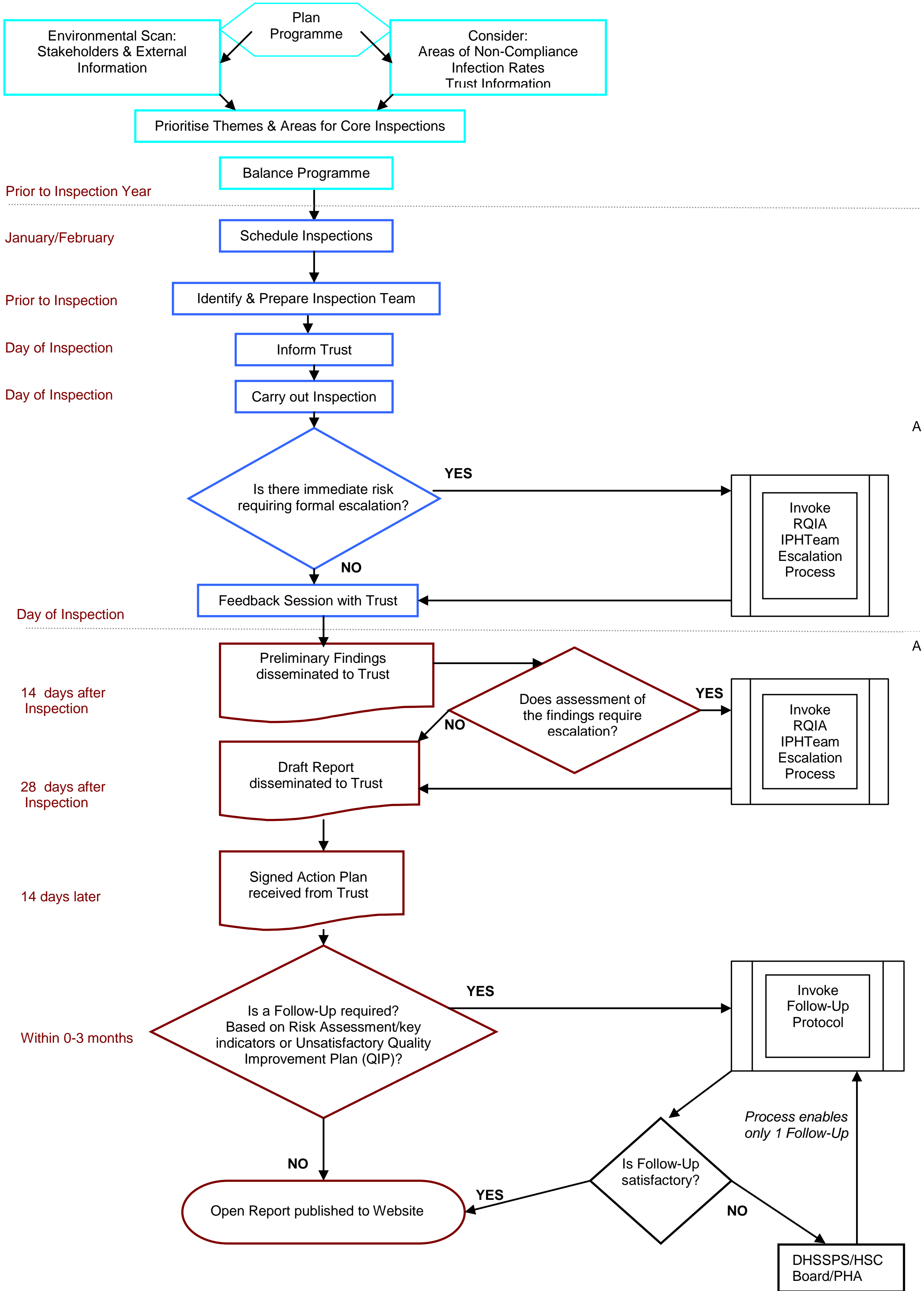
5. **The trust should review the condition and appropriateness of the hand washing sinks in Ward 6 and a risk based approach taken to their replacement. (repeated)**

6. **A systematic approach should be used for cleaning fixtures and fittings and equipment used for the general cleaning of the ward. (repeated)**

7. **All PPE should be readily available and used appropriately. (repeated)**

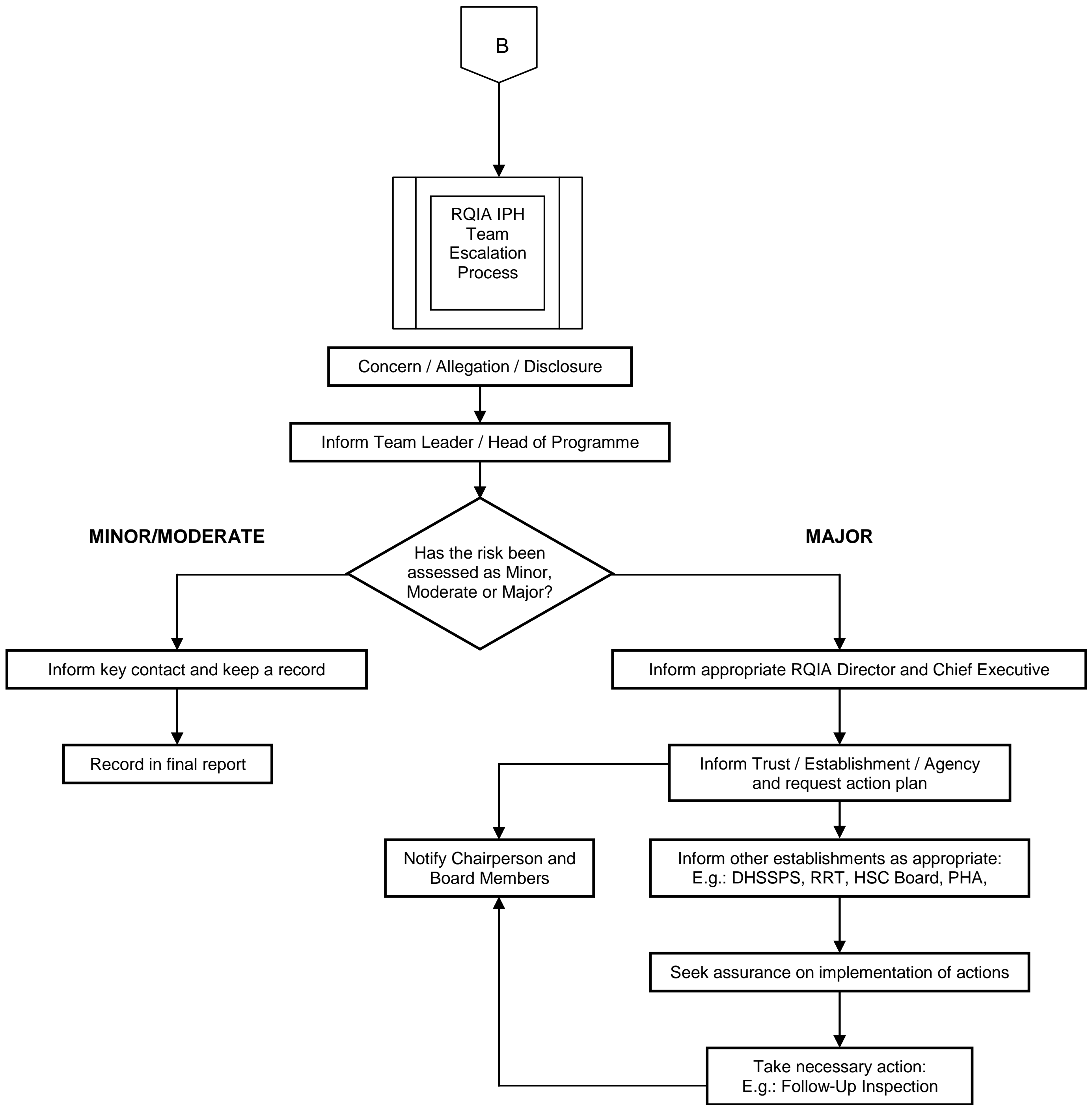
8. **Appropriate eye and face protection should be available to ensure staff are protected from risks associated with contact from blood, body fluids, chemicals or contaminated items. (repeated)**

14.0 Unannounced Inspection Flowchart



15.0 Escalation Process

RQIA Hygiene Team: Escalation Process



16.0 Action Plan

APPENDIX 2 SUMMARY RQIA RECOMMENDATIONS
MID-ULSTER ANNOUNCEDINFECTION PREVENTION / HYGIENE INSPECTION – JANUARY 2011

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)	1st 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. **All wards/facilities** 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 30th 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 scheduled teaching. At appraisal, medical/dental staff are asked to include training in infection control as part of their PDP.	This will be reviewed on an ongoing basis	Operational Directors	Ongoing

Number	Recommendation	Trust Position	Further action required	Lead Person	Timescales
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. 4 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
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

Number	Recommendation	Trust Position	Further action required	Lead Person	Timescales
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

Number	Recommendation	Trust Position	Further action required	Lead Person	Timescales
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 **where low compliance is noted, action is taken by Directors with the appropriate area/facility**. 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

Number	Recommendation	Trust Position	Further action required	Lead Person	Timescales
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 wards and corridors remains an issue and is being picked up on audits and Leadership Walkabouts.	Dump the Junk week arranged for June 2011. Ward Bed removal protocol in place. Lead Nurses re-enforcing the de-cluttering message with Ward Managers.	Operational Directors	Ongoing
18	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
19	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

Number	Recommendation	Trust Position	Further action required	Lead Person	Timescales
20	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.
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

Number	Recommendation	Trust Position	Further action required	Lead Person	Timescales
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 and reported to SMT on a weekly basis. If compliance is low, then daily audits must be initiated by Ward Manager.	All Ward Managers should ensure that staff adhere to the hand hygiene policy.	All Ward Managers	Ongoing
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
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel: (028) 9051 7500
Fax: (028) 9051 7501
Email: info@rqia.org.uk
Web: www.rqia.org.uk