



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

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

**Belfast Health and Social Care Trust**

**Musgrave Park Hospital**

**9 and 10 March 2011**

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## 1.0 Inspection Summary

This is the report of the announced inspection undertaken to the Belfast Health and Social Care Trust (BHSCT) and the Musgrave Park Hospital on 9 and 10 March 2011. The trust and hospital were assessed against the Draft Regional Healthcare Hygiene and Cleanliness Standards.

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

The findings of the inspection indicated that further work is required to ensure that key policies are regularly reviewed, staff are aware of procedures and that an Infection Prevention and Control strategy is available.

Work is also required on the development of a training policy and to ensure the uptake of infection prevention and control (IPC) mandatory training. The trust should ensure robust audit processes are in place and should also strengthen and develop user involvement which assists with the overall process of public assurance.

During the inspection of the **Musgrave Park Hospital** the following areas were inspected:

- Withers 6A
- Meadowlands 2 (M2)

The hospital is a non-acute hospital delivering a range of regional specialist healthcare services which has a reputation for excellence as well as education and research.

Included on the hospital site are a range of specialist orthopaedic and rehabilitation services available to people from all over Northern Ireland. Services provided include:

- Anaesthetic, theatres and sterile services
- Cancer and specialist services
- Imaging services
- Osteoporosis service
- Pharmacy
- Regional limb fitting service
- Regional wheelchair service
- Rheumatology unit
- Withers wards - trauma and orthopaedics
- Meadowlands – rehabilitation, specialising in care of the elderly
- MITRE Rehabilitation Unit – orthopaedic and rehabilitation physiotherapy, sports medicine

- Spinal cord injury unit
- Regional brain injury unit
- Direct access allied health professional services
- Military medical unit

## **Inspection Outcomes**

Withers 6A has undergone recent refurbishment which has improved hand washing facilities, storage and the general environment. In both wards compliance levels achieved are to be commended, inspectors observed that within both wards the environments were generally clean, tidy and in good repair. A number of issues were identified for improvement but overall the observation of staff indicated that they were compliant with hygiene and infection prevention and control practices.

The inspection resulted in 29 recommendations for the BHSCT and the Musgrave Park Hospital, a full list of recommendations is listed in Section 13.

A detailed list of preliminary findings is forwarded to BHSCT 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

- **A joint Infection Control and Environmental Cleanliness committee has been established with one lead director.**
- **There are effective internal monitoring systems in place to provide assurance on environment cleanliness and infection prevention and control.**
- **The implementation of a trust-wide inter professional learning and development team.**

- **An assurance strategy is in place to ensure ‘Board to Ward’ governance.**
- **An electronic audit system is being introduced across the trust to assist in carrying out environmental cleanliness audits.**
- **An internal audit carried out by the trust’s audit department to ensure that appropriate and effective IPC services are available.**
- **The IPC team have been shortlisted for the trust’s Chairman’s award in recognition for the work and service provided.**

The RQIA inspection team would like to thank the BHSCT and, in particular, all staff at the Musgrave Park 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**

<b>Areas Inspected</b>	<b>6A</b>	<b>M2</b>
Environment	90	87
Patient Linen	100	94
Waste	90	95
Sharps	88	91
Equipment	89	81
Hygiene Factors	99	92
Hygiene Practices	96	98
<b>Average Score</b>	<b>93</b>	<b>91</b>

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

**Table 2**

<b>Environment</b>	<b>6A</b>	<b>M2</b>
Reception	79	100
Corridors, stairs lift	64	100
Public toilets	89	69
Ward/department - general(communal)	97	95
Patient bed area	98	92
Bathroom/washroom	89	76
Toilet	90	95
Clinical room/ treatment room	92	95
Clean utility room	90	88
Dirty utility room	83	80
Domestic store	95	68
Kitchen	92	82
Equipment store	97	100
Isolation	95	78
General information	100	85
<b>Average Score</b>	<b>90</b>	<b>87</b>

**Table 3**

<b>Patient Linen</b>	<b>6A</b>	<b>M2</b>
Storage of clean linen	100	88
Storage of used linen	100	100
Laundry facilities	N/A	N/A
<b>Average Score</b>	<b>100</b>	<b>94</b>

**Table 4**

<b>Waste and Sharps</b>	<b>6A</b>	<b>M2</b>
Handling, segregation, storage, waste	90	95
Availability, use, storage of sharps	88	91
<b>Average Score</b>	<b>89</b>	<b>93</b>

**Table 5**

<b>Patient Equipment</b>	<b>6A</b>	<b>M2</b>
Patient equipment	89	81

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

**Table 6**

<b>Hygiene Factors</b>	<b>6A</b>	<b>M2</b>
Availability and cleanliness of wash hand basin and consumables	95	94
Availability of alcohol rub	100	100
Availability of PPE	100	90
Materials and equipment for cleaning	100	84
<b>Average Score</b>	<b>99</b>	<b>92</b>

**Compliant:** 85% or above

**Partial Compliance:** 76% to 84%

**Minimal Compliance:** 75% or below

**Table 7**

<b>Hygiene Practices</b>	<b>6A</b>	<b>M2</b>
Effective hand hygiene procedures	100	100
Safe handling and disposal of sharps	100	100
Effective use of PPE	95	100
Correct use of isolation	89	100
Effective cleaning of ward	100	100
Staff uniform and work wear	93	89
<b>Average Score</b>	<b>96</b>	<b>98</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 BHSCT 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 provided by the BHSCT evidenced that a range of policies and procedures have been developed and implemented for both environmental cleanliness and infection prevention and control to support the requirements of the standard statement. Documentation reviewed evidenced that while the Infection Prevention and Control team (IPCT) have assisted in the development of some policies there is no timetable for the review or development of IPC policies within the IPC 2010/11 work plan. There is a standard policy template which assists with the development of trust policies; this ensures all policies have identified roles and responsibilities, scope, objectives and a review date. Documentation available identified that some policies had past their date for review; management of medical devices, hand hygiene and dress code policy. A system for communicating key policies and procedure is in place within the trust however at ward level staff were unaware of the trust's nursing/midwifery and allied health professional cleaning manual.

The trust environmental cleanliness strategy, annual report 2009/10 and environmental cleanliness policy were reviewed. These outline the frequency of audits at ward level and the process for reporting upwards to the trust Board. Flowcharts also demonstrate the escalation of unresolved issues. In the absence of a revised regional strategy for environmental cleanliness, the trust continues to review and develop its own environmental cleanliness strategy.

Inspectors were informed that currently there is no Infection Prevention and Control (IPC) strategy however inspectors were provided with a detailed Health Care Associated Infection (HCAI) reduction quality improvement plan, associated IPCT objectives/work plan and a quality ward improvement delivery plan (QWIP). It was noted that some objectives within the QWIP had no timescale for achievement. A

review of documentation evidenced that a quality ward improvement team (QWIT) has been established to support service groups in meeting QWIP objectives. Discussion with trust representatives indicated that they were in the process of developing a three year IPC strategy.

In the submitted self assessment, the trust confirmed that all staff have access to the intranet or access through their line manager. Systems have been put in place to ensure that all staff have the knowledge and capability to access hard copies of the relevant policies and procedures. Discussion with nursing staff on the wards evidenced that they were aware of, and had access to, the regional online infection prevention and control manual.

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

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

A review of the information provided by the trust indicated an overall score of 84 per cent for EC, an improvement of 13 per cent, and 91 per cent for IPC was achieved in the controls assurance standards. An EC and IPC action plan progress report addresses issues identified from the self assessment.

The 2009/10 action plan progress reports contain updates on the progress of the action plans against each criterion however agreed timescales of the actions required were not always evident.

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

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

### **6.1.3 Annual Reports**

The Environmental Cleanliness annual report for the year 2009/10 outlines the trust's position in relation to environmental cleanliness and it also advises the trust Board of the controls and systems in place to

support the delivery and maintenance of high quality environmental cleanliness within the BHSCCT. The report summarises the governance arrangements, the monitoring and audit arrangements and recommendations for the forthcoming year.

The annual report for infection prevention and control was available for the year 2009/10 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 outlines 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 2009/10 was 62 compared to 86 the previous year, a reduction of 28 per cent.
- The number of cases of Clostridium difficile infections in the trust in the year 2009/10 was 163 compared to 327 the previous year, a reduction of 50 per cent.

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

The annual report and information gained on the inspection highlights that there has been progress made with implementing the 'Saving Lives Programme' 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*

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

#### **6.1.4 Risk Management**

A comprehensive risk management strategy is in place and includes the production of risk registers at various levels within the trust. The strategy is based on the Australian/New Zealand standard 4360:2004 on risk management.

A review of the strategy indicated that risks, priority levels and an explanation of actions required with timescales are identified.

A sample of the different services group risk registers were reviewed. Risks have been identified in relation to IPC, estates and environmental cleanliness.

The summaries provided evidenced that all risks have been reviewed with a proposed action and rescored accordingly. The risk register table has not been colour coded in the residual risk score column making it difficult at first glance to identify that the risk has been reviewed in line with the risk management strategy. It is suggested that the risk register is appropriately colour coded for easy of understanding.

### **Recommendations**

- 1. The trust should ensure that all policies and procedures are reviewed and updated as necessary.**
- 2. The trust should develop an Infection Prevention and Control policy review/development timetable and an Infection Prevention and Control strategy.**
- 3. The trust should ensure controls assurance documentation clearly outlines agreed timeframes for actions required.**

## 6.2 Criterion 1.2

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

### 6.2.1 Training and Development

There is a detailed corporate induction programme available for infection prevention and control and support services and the trust is committed to train all employees to comply with its legal obligations. All staff must attend the corporate induction as part of mandatory training with the exception of medical staff in training where separate arrangements are in place.

A trust-wide inter professional learning and development team has been established. The development of a draft trust-wide statutory and mandatory training policy and training programme gives managers a tool by which they can determine the mandatory and statutory training requirements for their staff.

A sample of the Patient and Client Support Services (PCSS) training matrix outlined the basic education and training requirements for staff which included infection prevention and control training for all staff commensurate to individual requirements.

The training programme does not indicate that the induction training received by medical staff includes infection prevention and control training. The training programme is difficult to read and should be reviewed to include infection prevention and control training for all relevant staff groups.

The infection prevention and control team (IPCT) are in the process of reviewing the existing resource file for all wards on essential IPC advice and guidance; which will also be available on the trust intranet site. This is to be commended as a trust initiative in ensuring up to date IPC information is available for staff.

The BHSCT is an accredited centre for BICS (British Institute Cleaning Science) training for domestic staff. Discussion with staff identified that not all staff receive this level of training which provides staff with a 'Cleaners Operative Proficiency Certificate' (COPC) Level 1. Representatives of the trust advised that there is a learning and development team within PCSS who could drive this initiative forward.

The IPCT in conjunction with PCSS are developing an induction training pack specific to the needs of PCSS staff. This is to be used by PCSS supervisors to train staff on induction and will be monitored and reviewed by IPC. IPC already quality assure PCSS training in some

areas. PCSS are currently running a supervisor development programme, retraining staff in audit and cleaning skills. The implementation of the personal contribution framework for all staff within PCSS ensures staff have the opportunity to reflect on the training they have received and any future training they require commensurate with their role and responsibilities.

Mandatory training records for infection prevention and control training were available for review, however these records do not indicate the ratio of staff uptake for training as the IT system to support this is not yet developed. PCSS advised that the introduction of a new time management system for staff rotas would also allow them to monitor staff training in the future. Discussion with staff at ward level indicated that they had received their mandatory update training.

The trust has introduced other initiatives such as IPC link nurse study days and targeted training for doctors and nurses to support the introduction of Aseptic Non Touch Technique (ANTT). Training and guidance on hand hygiene, decontamination, MRSA and pandemic flu have also been carried out along with external training provided at the Beeches Management Centre. The IPCT contribute to the contents of training delivered by Queens University and accept foreign IPC exchange students, facilitating professional development. IPC training has been rationalised within the trust therefore a cascade approach has been adopted for some training; pandemic flu and ANTT.

The DHSSPSNI regional hand hygiene campaign has been rolled out within the trusts acute services and is now being introduced and implemented within the trusts community facilities and among community staff.

In November 2010 the trust launched a new education and learning site on the intranet. Discussion with staff representatives indicated that the trust have e-learning programmes available for staff training however due to the lengthy IPC training package, training will only be carried out in this way as part of staff personal self development.

## **Recommendations**

- 4. The trust should finalise the draft statutory and mandatory training policy and review the training programme to ensure it is easy to read and includes infection prevention and control training for all relevant staff groups.**
- 5. The trust should develop BICS (British Institute Cleaning Science) training for all domestic staff.**
- 6. The trust need to review and improve the recording and monitoring systems that are currently in place to ensure compliance with mandatory training.**

### 6.3 Criterion 1.3

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

#### 6.3.1 Roles and Responsibilities

The roles and responsibilities in relation to environmental cleanliness and infection prevention and control are clearly identified within the EC and IPC annual reports. Responsibility for governance arrangements rests with the trust Board through to the offices of the Chairperson and Chief Executive. Inspectors were advised that the Chief Executive is currently reviewing the structure within service groups to ensure each trust site has a responsible director on site. Documentation provided evidenced that environmental cleanliness and infection prevention and control was a standing item on the trust Board and the governance assurance committee agenda. The assurance committee provides reports on EC and IPC to the trust Board. 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 until April 2010 was the designated lead director responsible for Infection Prevention and Control. The Director of Nursing and Patient Experience is now the designated lead director for Infection Prevention and Control and environmental cleanliness. The Director of Nursing and Patient Experience is accountable to the assurance committee, executive team and trust board in relation to the effective strategic leadership and management of this area. The Director of Nursing and Patient Experience is also responsible for providing analysis and assurance on operational performance. The directors of all service groups support the implementation of the environmental cleanliness strategy and the Infection Prevention and Control and patient safety delivery plan.

The Head of Patient and Client Support Services is responsible and accountable for the environmental cleanliness controls assurance standard and the management of patient and client support services. The co-directors of Patient and Client Services will ensure the development, implementation, monitoring and review of cleaning strategies, practices and plans.

Following the change in lead director a joint Infection Prevention and Environmental Cleanliness committee has been established. Documentation evidenced that terms of reference for this have been agreed.

There are a range of supporting sub groups established to oversee environmental cleanliness and Infection Prevention and Control. These include:

- Sector environmental cleanliness groups
- Environmental cleanliness and food hygiene standards group
- EC leadership walkarounds
- Safety walkarounds
- Patient and client safety forum
- Healthcare acquired infection (HCAI) root cause analysis review group
- Quality ward improvement team (QWIT)
- Peri-operative/critical care improvement team (POCCIT)
- Patient and client safety steering group
- Medical devices procurement group

The trust need to assure that all staff understand their responsibility and accountability for infection prevention and control. This should be included in job descriptions, objectives, competency based assessment and development plans of all staff within the trust ('Changing the Culture 2010'). The review of the job descriptions provided for a domestic supervisor, medical staff, physiotherapist and staff nurse would indicate that accountability for infection prevention and control has not been outlined. The trust advised that a competency based assessment is being introduced.

There is a standard clause in trust job descriptions for environmental cleanliness which is generic and covers all staff. A sample of job descriptions was reviewed which indicated that was present.

The review of the organisation structures in place indicated the roles and responsibilities for environmental cleanliness and Infection Prevention and Control are clearly defined. PCSS are currently working with facility management systems consultancy to review their operational programme and its effectiveness taking into account cleaning, staffing, resources and standardisation of practices; a report will soon be published.

## **Recommendations**

- 7. The trust should ensure that accountability for infection prevention and control is outlined in all job descriptions.**

## 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 safety walkabouts are undertaken in acute hospitals within the BHSCT. The walkabouts are carried out on a scheduled basis and involve senior managers, visiting managers and can include the Chairman of the Board, the Chief Executive and the Director of the Service. The walkabouts include touring wards and departments and speaking to staff to review the top three safety issues at ward level which incorporates infection prevention and control and environmental cleanliness. The Chief Executive also undertakes ad-hoc visits to departments throughout the trust.

This system is not yet fully formalised as there are no formal reports produced however if issues arise these are noted for action, responsibility designated and a timescale set.

Documentation evidenced that a programme of scheduled environmental leadership audits will be carried out by PCSS co-directors and senior managers and action plans produced in line with draft regional healthcare hygiene and cleanliness standards and audit tool.

An independent internal IPC service audit is being carried out by the trust audit department.

#### 6.4.2 Environmental Cleanliness Audits

Cleaning is monitored on a daily basis by PCSS. Domestic staff regularly check all areas including public toilets. PCSS observational audits are carried out with the supervisor and the ward sister on a daily basis to ensure effective cleaning of an area. Discussion indicated that due to staffing levels these are not always done on a daily basis, and as they are only a ten minute observational exercise they are not always effective.

The 'Cleanliness Matters' toolkit is used to undertake departmental audits, the frequency of these is determined by risk. Annual managerial audits are carried out by PCSS managers, facility managers, infection prevention and control staff and a service user representative.

Responsibilities for all of the cleaning elements outlined in the environmental cleanliness toolkit have been agreed through the trusts Environmental Cleanliness committee. This ensures that the cleaning

of every element is identified as the responsibility of domestic services, nursing and estate services. An electronic system is being introduced across the trust to assist in carrying out the audit process.

### 6.4.3 HCAI Performance

There are performance scorecards available for all implemented infection prevention and control care bundles. These include:

- Urinary catheter care
- Renal catheter care
- Central venous catheter care
- Peripheral vascular catheter care
- Care bundle for the ventilated patient
- Care bundle to prevent surgical site infection
- Hand hygiene audit
- Bare below the elbow audit

The ward manager also undertakes independent mattress audits in relation to infection prevention and control. Scorecards also include audit scores for environmental cleanliness and HCAI surveillance. Inspectors were provided with a sample of these scorecards and found them to be comprehensive and easy to use. Scorecards are shared with senior managers and the information then disseminated to ward staff. At present individual department scorecards cannot be accessed by other departments and are not shared on a central intranet site. Discussion with staff indicated that this was part of the future development plans.

As part of their audit process the infection prevention and control team carry out independent audits of the ward environment and commode and toilet cleaning. Audit results were fed back to each service group and PCSS. In addition audits are also undertaken on *Clostridium difficile* patient isolation, hand hygiene and MRSA management. Of particular note is the work undertaken to implement best practice based on current evidence with emphasis on 'Aseptic Non Touch Technique' (ANTT).

The project involved:

- Baseline audits of practice
- The provision of training for medical staff
- The provision of training for nurse development leads, link nursing staff to cascade train
- Introduction of a procedure tray
- Engagement with Queens University to ensure inclusion in medical student training
- ANTT training package devised for use

- Continuous surveillance and audit to assess the impact of interventions and sustain continuous improvement

Due to service pressures this proactive approach has not been rolled out across all the trust however it is anticipated that this will be taken forward in 2010/11. The IPC work plan for 2010/11 does not outline a future audit programme based on IPC policies. Discussion and documentation indicated that the lead person for this objective had left the trust and that service needs made it difficult to develop an audit programme. Inspectors noted on discussion with staff that the results of IPC audits were not centrally accessible on the intranet.

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

#### **6.4.4 Root Cause Analysis**

The trust have devised and implemented a process of Root Cause Analysis (RCA) following a diagnosis of MRSA bacteraemia, *Clostridium difficile* clusters and where MRSA or *Clostridium difficile* is listed on Part 1 of a death certificate. Inspectors were provided with samples of cases subject to root cause analysis and these evidenced that a thorough process is in place. Cases subject to RCA are also raised and discussed at the root cause analysis review group and learning disseminated to all service groups. Inspectors were advised that RCA training had been carried out for all staff involved in the RCA process, however inspectors were disappointed to note in evidence provided that microbiological support for the RCA process may be reduced due to service demands.

#### **6.4.5 Medical Devices**

To support the Medical Devices steering group the trust has developed a number of sub groups to ensure that a safe and systematic approach is taken to all aspects of medical devices across the trust and includes:

- Purchase and supply
- Use and maintenance of medical devices
- Decontamination
- Point of care testing
- Medical alert systems

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

The terms of reference for the Medical Devices steering group indicates that infection prevention and control is represented on this group.

There is a Management of Medical Devices procedures and guidelines, September 2009, policy available. The trust should ensure this policy is reviewed and updated as necessary.

Discussion with ward staff evidenced knowledge of the management of medical devices procedures and guidelines.

#### **6.4.6 User Involvement**

The trust has developed a 'Getting Relationships Right' Communication Strategy and the 'Belfast Way' 2008-13', key documents in ensuring that service users, communities and key stakeholders as well as staff teams are involved in service development and the delivery of care.

The trust has prioritised a number of areas including the development of a carers strategy, training for carers, workshops and establishing links with existing patient/client support groups. Documentation identifies central nursing and the medical director's office as having designated responsibility for these initiatives however there are no timescale to indicate if or when these initiatives will be achieved.

The PCSS team carry out monthly user satisfaction surveys.

Currently there is user involvement within some sectors in environmental cleanliness audits and meetings however the trust acknowledges that renewed efforts are required to improve user involvement in the future. Documentation received identified there is user involvement or patient advocacy at the environmental cleanliness and food hygiene standards group and at trust Board meetings. Inspectors were unsure if there is user involvement in the joint infection prevention and environmental cleanliness group meetings as the minutes of this group does not identify the designation of the attendees.

#### **Recommendations**

- 8. Formalised action plans and reports should be developed for safety leadership walkarounds and the effectiveness of ten minute observational environmental audits reviewed.**
- 9. The trust should develop a central intranet site for all staff to access HCAI scorecards and IPC audit results.**
- 10. The IPCT need to develop an audit programme.**

- 11. The trust should ensure continued microbiological support for the RCA process.**
- 12. The 'Getting Relationships Right' communication strategy to include a timescale for actions to be achieved.**

## 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.

IPC independent audits and action plans provided evidence that audit results are reported to the relevant departments and that action plans incorporate agreed timelines and roles and responsibilities.

IPC performance is monitored at assurance and trust Board meetings; the IPC lead attends these meetings. Surveillance data is collected on Clostridium *difficile* isolates, MRSA and MSSA bacteraemia and some surgical site infections. High impact interventions (HII) compliance data is followed up by the senior manager, lead nurse and nurse development lead in each area. Infection prevention and control and environmental cleanliness are monitored through the governance structure by the Chief Executive and trust Board who receive update reports from the assurance committee.

Environmental cleanliness audits are carried out as outlined in the PCSS work plan. A report is issued and actions that arise are dealt with immediately through domestic supervisors and the ward manager. Estates services issues are raised with the estates action help desk. Information on environmental cleanliness audit scores across the trust are included in the performance scorecards. If audit scores in very high and high risk areas fall below the standard set out in the trusts environmental strategy the escalation process is initiated and an EC report and actions is forwarded to senior staff.

Documentation reviewed evidenced that the recording and reporting format used for carrying out monthly audits differed from that used for weekly/daily audits. It also identified that the manual and electronic toolkit used to carry out the audits differ as they attribute responsibility for some elements of the toolkit to different staff groups even though designated responsibility for elements has been agreed through the trusts environmental cleanliness committee. Inspectors noted that documentation identified some degree of disparity in audit scores between departmental and managerial audits in some sites.

A process which identifies responsibilities to develop an action plan for issues identified following environmental cleanliness audits is in place. The escalation process outlines that unresolved issues from the environmental cleanliness audit process are added to the service group risk register.

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. For areas where a domestic rapid response team is not available out of hours, nursing staff have access to cleaning equipment. At ward level nursing staff demonstrated good knowledge of cleaning practices.

The IPC team provide intensive support to service groups who are implementing the HII care bundles to clinical areas and monitoring through independent compliance audit.

HII care bundle data is reported on a monthly basis to the DHSSPS and the HSC Safety Forum. The data is also available on the Institute for Healthcare Improvement (IHI) Extranet and the BHSCT has shown improvement in reducing HCAs.

The IPCT respond to requests from local media for information. The results of audits are displayed in some ward notice boards however this practice is not reflected in all areas. The format in which information is displayed could be confusing especially to patients and the general public. The trust should provide a more user friendly approach to this display and to emphasis and celebrate the results obtained.

## **Recommendations**

- 13. The trust should review and standardise the EC audit documentation and audit tools in use.**
- 14. Processes should be reviewed to ensure that audit results for patient and public information is displayed at ward level, is user friendly and representative of trust achievements.**

## 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.**

Discussion advised that HCAI and environmental cleanliness performance data is disseminated through the line management structures to all staff. The review of the available documentation evidenced that these are not standard items at all staff meetings.

There are scorecards available at ward level of all the relevant key performance indicators for the ward:

- Environmental cleanliness
- Hand hygiene audits
- Bare below the elbow
- Care bundles

PCSS compile a monthly corporate report which outlines the results and compliance rates of all EC audits carried out within very high and high risk areas. This report is broken down by sector and service group and is e-mailed to all service managers, governance managers and senior management. The report allows reporting against trends and failures over a twelve month period. Environmental cleanliness audit scores and failures are shared with estates and ward managers by domestic managers.

Discussion with staff indicated that at PCSS staff meetings infection control issues are highlighted and staff are informed of new policies being issued; policies and procedures are held in the supervisor's office for staff to access.

Each IPC nurse has responsibility for specific facilities to support and guide staff in the delivery of safe, effective and evidence based practice. Documentation reviewed did not evidence a formal IPC communication strategy to ensure a targeted approach to spreading the IPC message.

There is evidence of good governance arrangements in place to reduce HCAI by the implementation and monitoring of HCAI/IPC action plans and on-going training and development to enable staff to deliver on the trust's HCAI/IPC agenda.

Discussion with staff from the IPC team highlighted that they are at present not actively engaged in research however they have been involved in the following projects;

- Clostridium *difficile* and MRSA reduction plan
- Pilot daily admission flow chart
- Peripheral venous cannulae use in a tertiary hospital
- Development of the Northern Ireland Clostridium *difficile* ribotyping service
- Carbapenem-resistant enterobacteriaceae; indirect transmission in a regional ICU
- E Coli – a retrospective review of bacteraemias – pilot findings
- XDR-TB – preparedness for surgical intervention – no place for reticence or obfuscation

The IPC team have been shortlisted for the trusts Chairman's award in recognition for the work and service provided over the past year, a short video to promote the service is being developed.

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

## **Recommendations**

**15. The development of an IPC communication strategy.**

**16. IPC and EC to be a standing item on the agenda for staff meetings.**

## 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*

Environment	6A	M2
Reception	79	100
Corridors, stairs lift	64	100
Public toilets	89	69
Ward/department - general(communal)	97	95
Patient bed area	98	92
Bathroom/washroom	89	76
Toilet	90	95
Clinical room/ treatment room	92	95
Clean utility room	90	88
Dirty utility room	83	80
Domestic store	95	68
Kitchen	92	82
Equipment store	97	100
Isolation	95	78
General information	100	85
<b>Average Score</b>	<b>90</b>	<b>87</b>

### 7.1 Cleaning

The inspection of the wards generally evidenced good compliance in the majority of areas within the ward, with the 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 debris which in turn prevents the build up of bacteria and helps in the reduction of the potential risk for the transmission of infection.

Withers 6A was generally very clean, some minor improvements were required in the cleaning of walls, floors and skirting as dirt and stains were observed in the reception, corridors and stairs leading to the ward. It should be noted that no cleaning issues were identified in the reception, corridors and equipment store of Meadowlands 2.

In Meadowlands 2 dust and debris was observed in the corners and edges of the floors in the public toilet, bathroom, dirty utility room, domestic store and kitchen. Dust was present in the low shelving within the high density storage and the domestic store shelving. Greater attention to detail is also required when cleaning the sluice hopper, macerator and shower chair to prevent the build up of dirt and debris.

In both wards light pull cords were dirty, attention is required to ensure that hand touch points such as light fittings are clean as there is a greater risk of transmission of bacteria from hand contact in frequently used areas. It was noted that taps and fittings had limescale present, particular care is required to ensure that limescale is removed from taps and fittings as recent evidence has shown that limescale may harbour biofilms and the build up of limescale can interfere with good cleaning and disinfection by masking and protecting pathogens.

In Withers 6A the cleaning of an isolation area inspected was generally good. In Meadowlands 2 more attention is required to ensure the isolation area inspected is clean; particular attention is required to the floor edges as debris was observed, the frame of the bedside table was stained and the wall mirror had splash marks present.

## 7.2 Clutter

In both wards inspected there was evidence of a continued emphasis in providing clutter free environments, this provides effective utilisation of space and good stock management which assists with effective cleaning. It was observed that the communal room in Meadowlands 2 was being used as a storage area and therefore not accessible to patients. Access to the hand towel dispenser in the domestic store and the work surface in the clean utility room was blocked by boxes. Withers 6A has recently been refurbished which has improved storage throughout the ward (Picture 1) however excess toilet rolls in the isolation room should be removed to reduce clutter and prevent potential contamination.



Picture 1 Uncluttered storage units

### **7.3 Maintenance and Repair**

Withers 6A has recently been refurbished and was generally in a good state of repair however the flooring, doors and shirting in the corridors, stairs and public toilets leading to the ward was damaged.

In Meadowlands 2 the bathroom shower wall was water damaged with discoloured and flaky paint observed (Picture 2). Water damage was also observed in the corridor wall outside the bathroom, as a result of water leakage from the bathroom, the skirting edging and seal of the shower base were separating from the shower wall. The wall panel in the bathroom and the external windows throughout the ward were old, worn and dirty in appearance.



Picture 2 Shower wall damaged, discoloured and flaky paint

In both isolation areas inspected it was observed that the paint of the bedrails was chipped and in Withers 6A the laminate doors of the locker was chipped and the television remote control was taped together. Damage to equipment, especially in an isolation area, impedes the cleaning process and has the potential to act as a reservoir for bacteria.

In both wards, stains or damage was observed to the ceiling tiles and there was damage noted to some walls. It is important that all surfaces are sealed and intact to ensure that effective cleaning can be carried out.

### **7.4 Fixtures and fittings**

The hand washing sink in the clean utility room in Withers 6A did not have taps and the drain was missing.

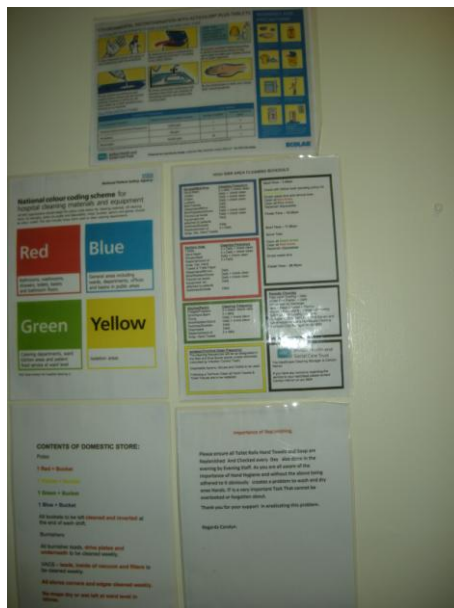
Meadowlands 2 shower fixtures and fittings were old, worn and had limescale present, while the metal chain flushing mechanisms on the toilets is difficult to clean and has no end toggle.

In both wards fixtures, fittings and equipment in some areas, especially the kitchen and sluice areas, were damaged, old and worn; laminate was missing from cupboards, taps were tarnished and worn and metal bedrails and chair castors were worn or rusted.

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

There was a range of posters in place for staff to reference such as waste and sharps management and domestic colour coding (Picture 3). However in Meadowlands 2 there was no colour coded poster clearly displayed for nursing staff to reference, no poster on the segregation of linen and no leaflets on hand washing.



Picture 3 Domestic colour coded information

In Meadowlands 2 inspectors noted that fridge temperature checks or records for the kitchen fridge had not been taken or recorded on the 8 March 2011. It is imperative that fridge temperature checks are taken and recorded on a daily basis to ensure all foodstuffs are stored at the correct temperature prior to serving to patients, and that any temperature recorded outside the designated temperature range can be actioned.

Meadowlands 2 nursing cleaning schedules while available were not detailed enough to cover all equipment used at ward level. Detailed

nursing cleaning schedules are required which outline all equipment to be cleaned. The trust's policy on cleaning roles and responsibilities was available at ward level.

### **Additional Issue**

In Meadowlands 2 the inspectors observed that the patient name board behind each patient bed was made of cork and had a felt cover. It is advised that as this fabric cannot be effectively cleaned, especially in an isolation room, that an alternative method of displaying patient details should be investigated.

### **Recommendations**

- 17. The trust should work to ensure all staff are aware of their roles and responsibilities to improve and ensure that environmental cleaning is carried out effectively and that patient equipment is fit for purpose.**
- 18. The trust should continue to work on the repair and maintenance of ward and public environments and to replace damaged fixtures and fittings.**
- 19. The trust should ensure all relevant information is available for patients, visitors and staff to reference.**
- 20. The trust should develop detailed nursing 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*

Patient Linen	6A	M2
Storage of clean linen	100	88
Storage of used linen	100	100
Laundry facilities	N/A	N/A
<b>Average Score</b>	<b>100</b>	<b>94</b>

### 8.1 Management of Linen

Withers 6A is to be commended in achieving full compliance in all sections of the management of patient linen, while Meadowlands 2 achieved full compliance in the storage of used linen.

Inspectors observed in Withers 6A effective arrangements in place for the storage of clean linen. Linen was stored in a separate store and was found to be clean, tidy and free from rips and tears.

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

In Meadowlands 2 issues relating to the clean linen store that require improvement are the cleaning of shelves, window frames and door touch points. Attention should be paid to the cleaning of hand touch points as there is potentially greater risk of transmission of bacteria from hand contact in areas frequently used.

#### Recommendations

- 21. The trust should ensure the storage of clean linen in an appropriate environment.**

## 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	6A	M2
Handling, segregation, storage, waste	90	95
Availability, use, storage of sharps	88	91
<b>Average Score</b>	<b>89</b>	<b>93</b>

### 9.1 Waste

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

In the dirty utility area of Withers 6A the household waste bin was soiled and damaged, the clinical waste bin was inaccessible and a yellow lidded burn bin was not labelled appropriately with the date of assembly or signature of the person who assembled it.

Inspectors observed in Meadowlands 2 that pharmaceutical waste was inappropriately disposed of into a sharps box, a clinical waste bag was tied to a monitor trolley and there was no outside waste compound to secure large waste bins and prevent access by the public.

### 9.2 Sharps

In Meadowlands 2 a sharps container was filled above the fill line and integral sharps trays were unavailable; the ward manager advised that these were being sourced by the infection prevention and control nurse. In Withers 6A greater attention to detail was required to ensure sharps trays were clean and ready for use.

In both areas sharps boxes in use conformed to BS7320 (1990)/UN9291 standards. Boxes were assembled correctly; labelled with the date, locality and staff signature. 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. It was observed during the inspection that the temporary closure mechanisms, to prevent spillage and impede access, were not always in place when the sharps boxes were not in use.

## **Recommendations**

- 22. 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	6A	M2
Patient equipment	89	81

The cleaning of patient equipment in Withers 6A was generally of a good standard and most equipment was visibly clean. In Meadowlands 2 cleaning and use of trigger tape, to identify equipment is clean, was evident but not consistently used.

In Meadowlands 2 kitchen there was a build up of limescale on the nozzle of the ice machine and a member of nursing staff was unable to describe the symbol for single use. Discussion 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.



Picture 4 Ambu bag removed from packaging

In both wards inspectors observed that tourniquets used for venepuncture were not disposable and that laryngoscope blades and the ambu bags on the resuscitation trolleys were removed from their sterile packaging (Picture 4). The Association of Anaesthetists of Great Britain and Ireland guidelines 'Infection Control in Anaesthesia' states that single use resuscitation equipment should be kept in a sealed package or should be sterilised between patients according to manufacturer's instructions. It also states that packaging should not be removed until the point of use for infection control, identification and traceability for safety and in the case of a manufacturer's recall.

Greater attention to detail is required to remove sticky labels and residue from equipment and also when cleaning commodes. Streak marks were present on the metal frames of the commodes in Meadowlands 2, suggesting that frames are not being rinsed and dried thoroughly after cleaning, in Withers 6A a commode bedpan bracket was dirty.

The inspectors observed in both wards that equipment in some instances were in a poor state of repair with metal frames and wheels exposed or rusted, especially the commodes in Withers 6A. Surfaces which are not intact compromise the cleaning process and can act as a potential reservoir for bacteria.

### **Additional Issue**

In Meadowlands 2 a trolley used by the fracture review nurse specialist was stored in the clean utility area. This trolley had a tray with exposed single use equipment and staff were unable to identify how and when this equipment was cleaned or if the single use equipment had been reused. At the time of inspection staff removed and disposed of the single use equipment.

### **Recommendations**

- 23. The trust and individual staff have a collective responsibility to ensure that staff knowledge is kept up to date and to ensure that equipment is clean, in a good state of repair and used correctly.**

## 11.0 Hygiene Factors

### STANDARD 6.0

#### STANDARD 6.0 HYGIENE FACTORS

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

Hygiene Factors	6A	M2
Availability and cleanliness of wash hand basin and consumables	95	94
Availability of alcohol rub	100	100
Availability of PPE	100	90
Materials and equipment for cleaning	100	84
<b>Average Score</b>	<b>99</b>	<b>92</b>

Withers 6A are commended for achieving full compliance in the majority of sections within hygiene facilities.

Hand washing sinks and fixtures and fittings in both wards were generally clean, working and in a good state of repair. In Wither 6A attention to detail is required to ensure all sinks are draining appropriately and in a good state of repair as it was observed that enamel in the hand washing sink in the treatment room was damaged and two sinks at ward level were blocked. In Meadowlands 2 the overflow in the toilet sink required cleaning. In both wards attention to detail is also required to ensure all hand towel dispensers are clean and in a good state of repair.



#### Picture 5 Clinical hand washing sink

Clinical hand wash sinks were elbow or sensor operated and overflow free (Picture 5). Overflows to sinks, basins, baths and bidets are not recommended, as they constitute a potential infection control risk more significant than the possible risk of damage due to water overflowing (WCs have an internal overflow).

In both wards the ratio of hand washing sinks do not meet the national guidelines for hand washing sinks to beds.

In Meadowlands 2 a range of powder free non sterile gloves were unavailable in the wall mounted glove dispensers for staff to easily access. The state of repair and cleaning of equipment used for general cleaning requires attention to ensure they are fit for purpose and clean; inspectors observed dusty mop buckets, domestic trolley, floor polisher, floor hazard cone, a vacuum cleaner and a damaged dust pan.

There were no issues identified in either ward in relation to availability or use of alcohol rub.

#### **Additional Issues**

There are no hand washing facilities directly outside the isolation rooms in Meadowlands 2. It is advised that there is a review of the placement of alcohol dispensers, with the view to placing a dispenser close to each wall mounted personal protective equipment dispenser.

In Meadowlands 2 it was observed that a combined sink and drainer at the nurses' station was used for hand washing rather than a clinical sink. It is advised that a review of the design and use of this sink is carried out to ensure staff have the appropriate facilities available for hand washing.

#### **Recommendations**

- 24. The trust should ensure that hand washing sinks are available in line with national guidelines or, based on a risk assessment approach, alternative processes put in place to facilitate hand hygiene**
- 25. The trust should ensure that hand washing sinks, fixtures and fittings and consumables are clean, working and in a good state of repair.**
- 26. Further attention to detail is required to ensure that equipment used for the general cleaning purposes of a ward are clean and in a good state of repair.**

## 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	6A	M2
Effective hand hygiene procedures	100	100
Safe handling and disposal of sharps	100	100
Effective use of PPE	95	100
Correct use of isolation	89	100
Effective cleaning of ward	100	100
Staff uniform and work wear	93	89
<b>Average Score</b>	<b>96</b>	<b>98</b>

Meadowlands 2 are commended for achieving full compliance in the majority of sections within hygiene practices.

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

In the both wards single use aprons and gloves were worn when in contact or anticipated contact with blood, body fluids or in potential contact with contaminated items. Inspectors observed that aprons and gloves were changed between patients and between different episodes of care. In Withers 6A a member of staff disposed of PPE incorrectly into a household waste bin due to the position and distance of the clinical waste bin.

On the day of the inspection patients in both wards required isolation and practices observed in relation to the application of isolation precautions were good and in line with current practice guidance.

A review of documentation in Meadowlands 2 evidenced that a patient centred care pathway for the identified alert organism was in place and completed by staff. However in Withers 6A the care plan of the patient in protective isolation did not indicate that the patient was in isolation or that any other infection prevention and control measures were in place. At the feedback session trust representatives advised that new care

planning documentation has recently been devised which will allow nurses to capture this information.

A review of COSHH data sheets indicated that nursing staff have access to a data sheet for Actichlor Plus disinfectant. Inspectors also noted that mechanisms are in place to ensure urgent cleaning is carried out as needed.

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

### **Recommendations**

- 27. The trust and individual staff have a collective responsibility to ensure that all PPE is available and disposed of appropriately.**
- 28. The trust should ensure the continued development and implementation of care plans that reflect the infection prevention and control needs of the patient.**
- 29. The trust should ensure that the requirement for staff changing facilities as set out by the Department of Health building standard are incorporated into future new build plans.**

## 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

- Ms Brenda Creaney - Director of Nursing
- Mrs Olive MacLeod - Co-Director Nursing Governance
- Mrs Lorna Bingham - Deputy Assistant Director of Nursing Acute Services
- Mr Aidan Dawson - Co-Director Acute Services
- Mr Colin Cairns - Co-Director PCSS
- Mrs Nicky Vincent - Governance Manager, Acute
- Mrs Jacqui Austin - Governance Manager
- Ms Irene Thompson - Lead Nurse, Infection Prevention and Control
- Mr Earl Moffitt - Senior Manager PCSS
- Mrs Susan Corscadden - Senior Nurse, Infection Prevention and Control
- Mr Kevin Taylor - Divisional Operations Manager, Estates
- Mr Aidan Shaw - Operations Manager, MPH
- Ms Noreen Hoy - Nurse Development Lead, Trauma and Orthopaedics
- Ms Lucia Smyth - Support Services Manager, Greenpark
- Ms Lila Hill - Ward Manager, Meadowlands 2
- Ms Tanya Eccles - Ward Manager, 6B overseeing 6A
- Ms Nora Stevenson - Deputy Ward Manager, Meadowlands 2
- Ms Marcella Jenkinson - Deputy Ward Manager 6A
- Mr Philip Ramsey - Acting ASM
- Ms Moira Kearney - Assistant Services Manager, N'Rehab
- Ms Carolyn Herron - Assistant Support Services Manager, MPH
- Ms Geraldine Coyle - ASM Intermediate Care
- Mr Thomas Hughes - Infection Prevention and Control Nurse
- Ms Janeen McKeown - Infection Prevention and Control Nurse

### Apologies:

- Mr Colm Donaghy - Chief Executive

## **Supporting Documentation**

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

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

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

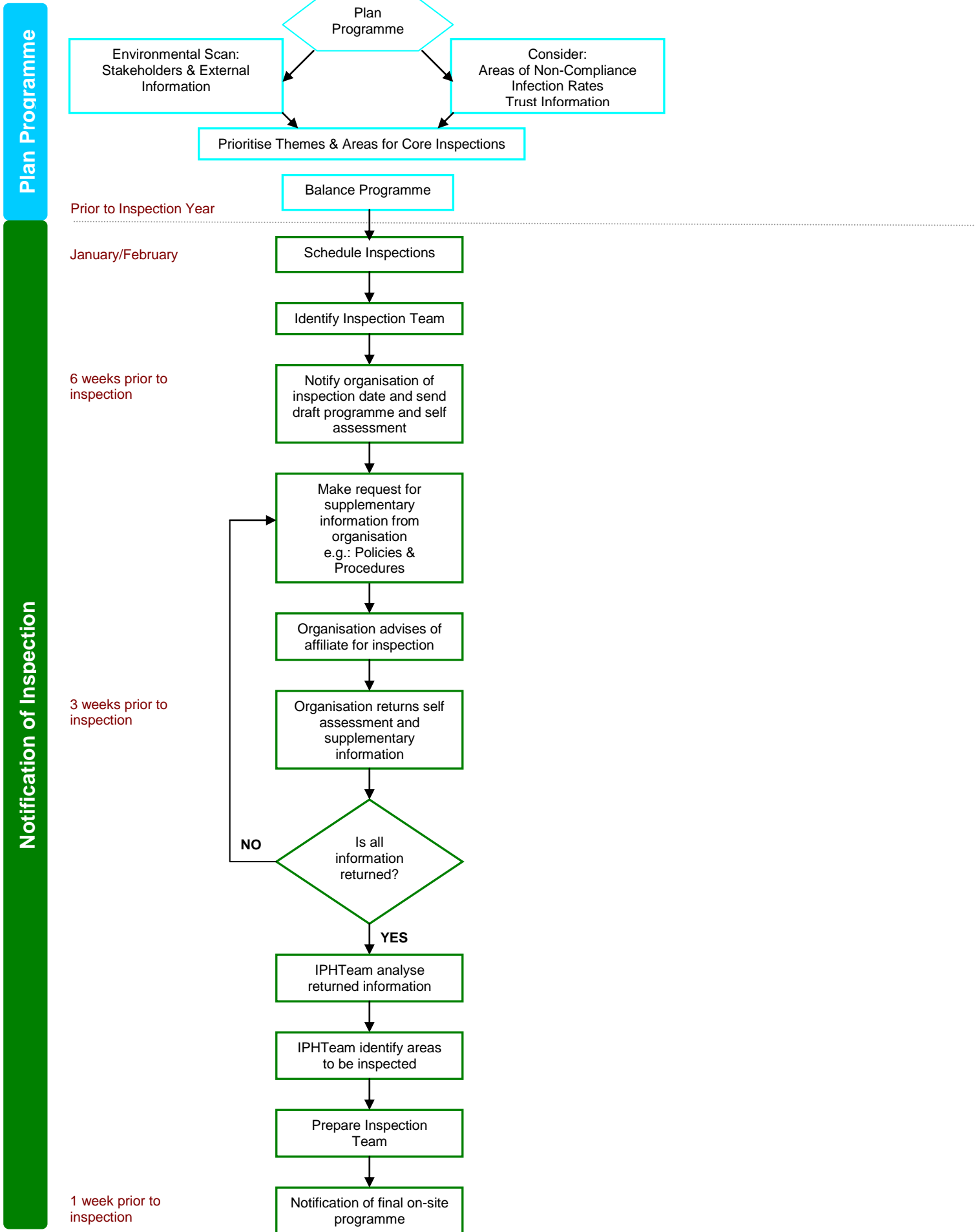
## **14.0 Summary of Recommendations**

- 1. The trust should ensure that all policies and procedures are reviewed and updated as necessary.**
- 2. The trust should develop an Infection Prevention and Control policy review/development plan and an Infection Prevention and Control Strategy.**
- 3. The trust should ensure controls assurance documentation clearly outlines agreed timeframes for actions required.**
- 4. The trust should finalise the draft statutory and mandatory training policy and review the training programme to ensure it is easy to read and includes infection prevention and control training for all relevant staff groups.**
- 5. The trust should develop BICS (British Institute Cleaning Science) training for all domestic staff.**
- 6. The trust need to review and improve the recording and monitoring systems that are currently in place to ensure compliance with mandatory training.**
- 7. The trust should ensure that accountability for infection prevention and control is outlined in all job descriptions.**
- 8. Formalised action plans and reports should be developed for safety leadership walkarounds and the effectiveness of ten minute observational environmental audits reviewed.**
- 9. The trust should develop a central intranet site for all staff to access HCAI scorecards and IPC audit results.**
- 10. The IPCT to develop an audit programme.**
- 11. The trust should ensure continued microbiological support for the RCA process.**
- 12. The 'Getting Relationships Right' Communication Strategy to include timescale for actions to be achieved.**
- 13. The trust should review and standardise the EC audit documentation and audit tools in use**
- 14. Processes should be reviewed to ensure that audit results for patient and public information is displayed at ward level, is user friendly and representative of trust achievements.**
- 15. The development of an IPC Communication Strategy.**

- 16. IPC and EC to be a standing item on the agenda for staff meetings.**
- 17. The trust should work to ensure all staff are aware of their roles and responsibilities to improve and ensure that environmental cleaning is carried out effectively and that patient equipment is fit for purpose.**
- 18. The trust should continue to work on the repair and maintenance of ward and public environments and to replace damaged fixtures and fittings.**
- 19. The trust should ensure all relevant information is available for patients, visitors and staff to reference.**
- 20. The trust should develop detailed nursing cleaning schedules.**
- 21. The trust should ensure the storage of clean linen in an appropriate environment.**
- 22. 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.**
- 23. The trust and individual staff have a collective responsibility to ensure that staff knowledge is kept up to date and to ensure that equipment is clean, in a good state of repair and used correctly.**
- 24. The trust should ensure that hand washing sinks are available in line with national guidelines or, based on a risk assessment approach, alternative processes put in place to facilitate hand hygiene.**
- 25. The trust should ensure that hand washing sinks, fixtures and fittings and consumables are clean, working and in a good state of repair.**
- 26. Further attention to detail is required to ensure that equipment used for the general cleaning purposes of a ward are clean and in a good state of repair.**
- 27. The trust and individual staff have a collective responsibility to ensure that all PPE is available and disposed of appropriately.**

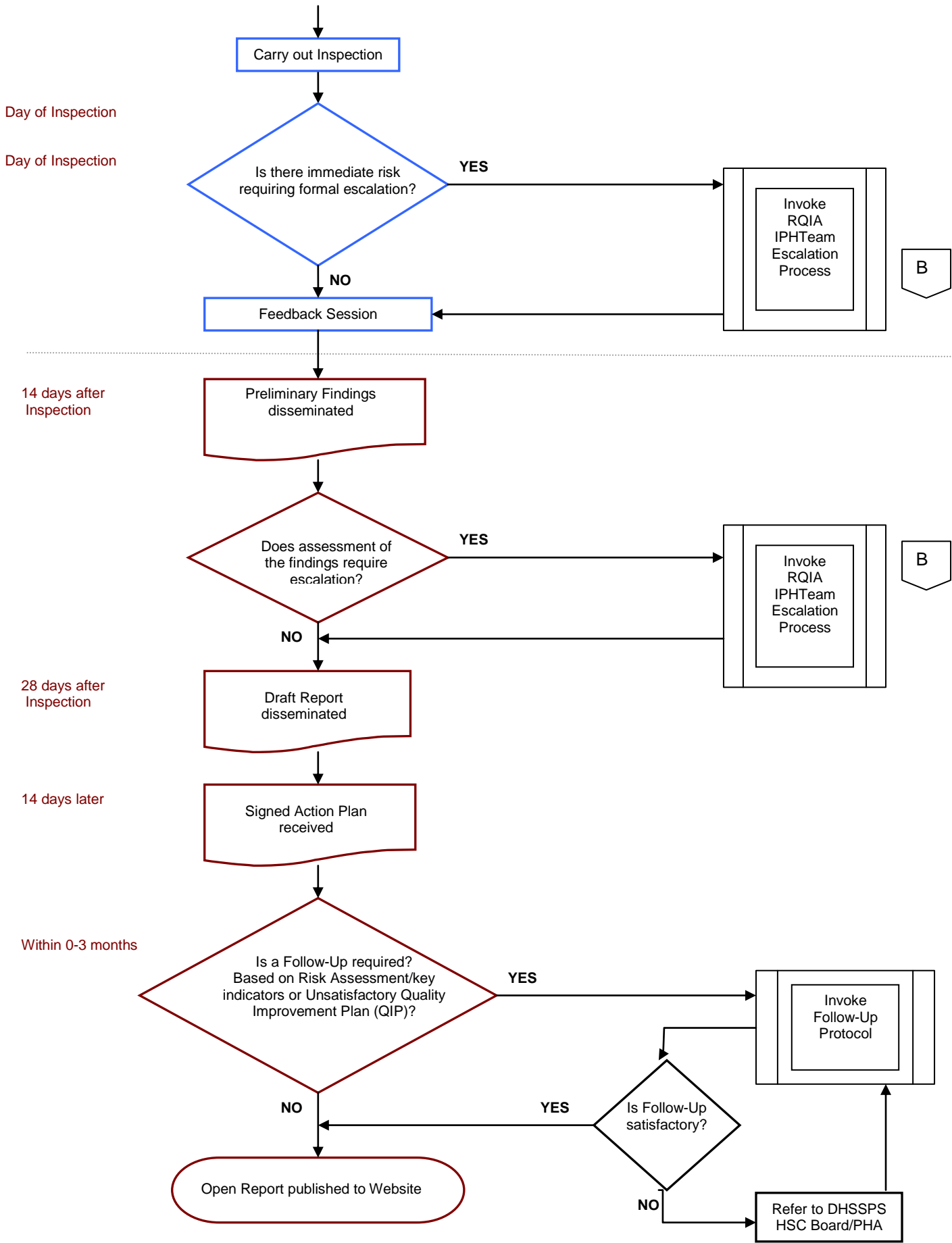
- 28. The trust should ensure the continued development and implementation of care plans that reflect the infection prevention and control needs of the patient.**
- 29. The trust should ensure that the requirement for staff changing facilities as set out by the Department of Health building standard are incorporated into future new build plans.**

# 15.0 Announced Inspection Flowchart



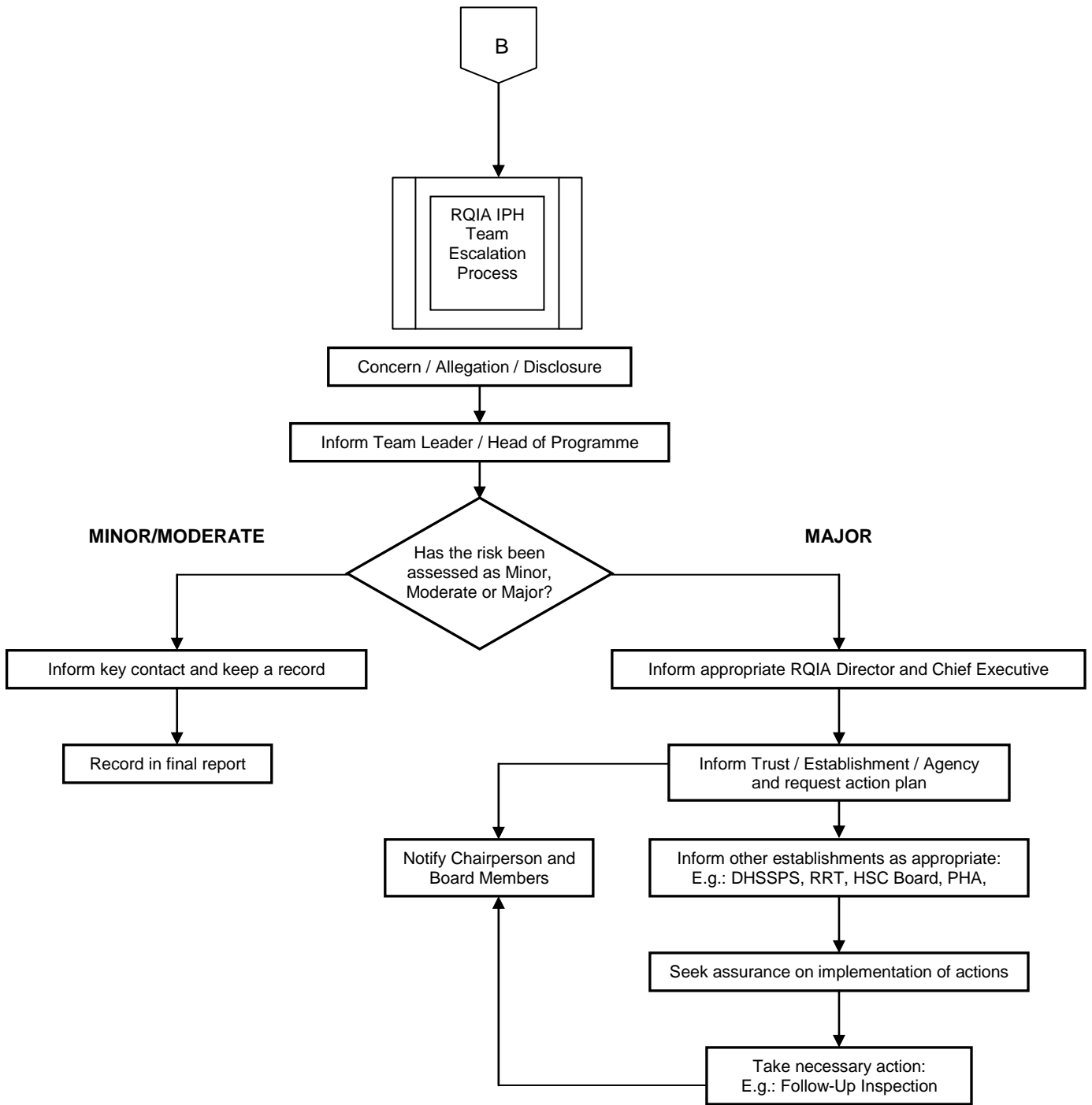
**Episode of Inspection**

**Reporting & Re-Audit**



# 16.0 RQIA Hygiene Team Escalation Process

## RQIA Hygiene Team: Escalation Process



## 17.0 Action Plan

### Recommendations

Location	Ref No	Recommendations	Designated Lead Department	Action required	Date for Completion Timescale
	1	The Trust should ensure that all policies and procedures are reviewed and updated as necessary.	Risk & Governance	<p>The Trust's Policy Committee and Standards, Quality and Audit Department are responsible for the availability of up-to-date policies, procedures and other guidance. All policies have a review date and a named author / owning department. The Standards, Quality &amp; Audit Department tracks this information and contacts the author coming up to the review date to ensure that it is reviewed.</p> <p>All 3 policies are currently under review. As part of the process, changes to the Dress Code policy were accepted at Standards and Guidelines Committee on 8 June 2011, and will go to Policy Committee along with Management of Medical Devices and Hand Hygiene in July 2011 for approval.</p>	Ongoing
	2	The Trust should develop an Infection Prevention and Control policy review / development plan, and an Infection Prevention and Control Strategy.	Nursing	<p>Workplan in place for 10/11 and 11/12.</p> <p>Strategy to be finalised.</p>	<p>Apr 2011</p> <p>Jun 2011</p>

Location	Ref No	Recommendations	Designated Lead Department	Action required	Date for Completion Timescale
	3	The Trust should ensure controls assurance documentation clearly outlines agreed timeframes for actions required.	Nursing PCSS	Controls Assurance documentation is completed 6-monthly and is currently up to date. For each of the DHSSPS Controls Assurance Standards the Trust has an identified operational lead. Each CAS lead is responsible for ensuring substantive compliance with the relevant standards. Each lead produces an action and implementation plan and target dates should be appropriately set. All Controls Assurance Standards are reported on at Controls Assurance Committee.	Complete
	4	The Trust should finalise the draft statutory and mandatory training policy and review the training programme to ensure it is easy to read and includes infection prevention and control training for all relevant staff groups.	Human Resources	This policy is currently out for consultation with a view to being presented to Policy Committee for approval on 29 June 2011. Thereafter it will be formally launched across the Trust: Infection Prevention and Control is referenced in this policy document. IPC Training for all staff (including Medical staff) is available by applying through the Training Administration System (TAS). Infection Prevention Control staff provide infection prevention training at all Medical Staff inductions.	End of June 2011

Location	Ref No	Recommendations	Designated Lead Department	Action required	Date for Completion Timescale
	5	The Trust should develop BICS (British Institute Cleaning Science) training for all domestic staff.	PCSS	<p>New training facility being refurbished to become an accredited BICS training centre on RGH site.</p> <p>BICS accreditation of centre.</p> <p>Training for further staff to become BICS trainers and assessors to be carried out</p> <p>Location for second accredited centre to be identified</p> <p>Accreditation of new centre by BICS</p>	<p>Facility to be handed over August 2011</p> <p>October 2011</p> <p>March 2012</p> <p>June 2012</p> <p>October 2012</p>
	6	The Trust needs to review and improve the recording and monitoring systems that are currently in place to ensure compliance with mandatory training.	Line Managers and Trainers	<p>The responsibility for record keeping around training programmes is referenced within the training policy. Trainers who provide the portfolio of Trust programmes carry responsibility for maintaining the records. Managers are also expected to ensure that staff comply with statutory / mandatory training requirements.</p> <p>The time management system only applies to Patient and Client Support Services staff and will not indicate the ratio of staff trained in IPC across the Trust per discipline and service group.</p>	Complete

Location	Ref No	Recommendations	Designated Lead Department	Action required	Date for Completion Timescale
				The Trust is working as part of a regional project for a HR system that will address this issue. This is ongoing.	
	7	The Trust should ensure that accountability for infection prevention and control is outlined in all job descriptions.	Human Resources	A paragraph outlining the Trust's commitment to IPC has been added to all job descriptions and the Trust job description template that is used by managers. The recruitment and selection team also carry out a check on all job descriptions received into the department to ensure this paragraph has been included.	Complete
	8	Formalised action plans and reports should be developed for safety leadership walkrounds and the effectiveness of ten-minute observational environmental audits reviewed.	Risk & Governance PCSS	PCSS is currently restructuring and following this will reconsider its overall approach to observational audit throughout the Trust. The protocol for Safety Leadership Walkrounds is undergoing review and a position paper will be tabled at Executive Team.	Sep 2011
	9	The Trust should develop a central intranet site for all staff to access HCAI scorecards and IPC audit results.	Nursing	Awaiting confirmation from IT on request for IPC site.	Jun 2011
	10	The IPCT to develop an audit programme.	Nursing	In place as per workplan.	Apr 2011

Location	Ref No	Recommendations	Designated Lead Department	Action required	Date for Completion Timescale
	11	The Trust should ensure continued microbiological support for the RCA process.	Medical Director Nursing	The Trust will ensure continue commitment to this process.	Ongoing
	12	The 'Getting Relationships Right' Communication Strategy to include timescale for actions to be achieved.	Corporate Communications	An update of the Communications Strategy commended in April 2011.	Jun 2011
	13	The Trust should review and standardise the EC audit documentation and audit tools in use	PCSS Environmental Cleanliness Group	PCSS Environmental Cleanliness Group will establish any outstanding issues of audit standardisation process. Agree a standardised audit which will be used in all areas. This will include standardised responsibilities.  Systematic roll out of the agreed standardised audit using the Maximiser system.	Sep 2011  Dec 2011  Commencing Feb 2012
	14	Processes should be reviewed to ensure that audit results for patient and public information is displayed at ward level, is user friendly and representative of Trust achievements.	Nursing	Standardisation of balanced score cards and development of IT solution underway	Sep 2011
	15	The development of an IPC Communication Strategy.	Nursing	Included in IPC strategy (see Ref. No. 2)	Jun 2011
	16	IPC and EC to be a standing item on the agenda for staff meetings.	PCSS	The need to place IPC and EC on agenda for staff meetings has been raised with other Directors by the Director of Nursing and User	Jun 2011

Location	Ref No	Recommendations	Designated Lead Department	Action required	Date for Completion Timescale
				Experience.	
	17	The Trust should work to ensure all staff are aware of their roles and responsibilities to improve and ensure that environmental cleaning is carried out effectively and that patient equipment is fit for purpose.	Nursing	Role and responsibilities policy in place.  Cleaning statements document for all wards and departments finalised and disseminated.	Complete  Jun 2011
	18	The Trust should continue to work on the repair and maintenance of ward and public environments and to replace damaged fixtures and fittings.	Estates	This is ongoing as part of Estate daily maintenance and refurbishment programmes.	Ongoing
	19	The Trust should ensure all relevant information is available for patients, visitors and staff to reference.	Nursing	Posters and leaflets are available on all wards.	Complete
	20	The Trust should develop detailed nursing cleaning schedules.	Nursing	Role and responsibilities policy in place.  Cleaning statements document for all wards and departments finalised and to be disseminated.	Complete  Jun 2011
	21	The Trust should ensure the storage of clean linen in an appropriate environment.	Nursing	Guidance regarding storage of linen in Regional Infection Prevention Manual.	Complete
	22	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.	PCSS Nursing	The Trust will pilot and roll out across all facilities the use of an electronic tool to audit waste management compliance against policy, procedure and RQIA requirements. This process	Pilot to be completed by Sep 2011.  Roll-out

Location	Ref No	Recommendations	Designated Lead Department	Action required	Date for Completion Timescale
				will supplement the existing audit tools used by PCSS, IPC and also existing external audits conducted by Daniels (sharps box suppliers).	programme across Trust to be completed by Apr 2012
	23	The Trust and individual staff have a collective responsibility to ensure that staff knowledge is kept up to date and to ensure that equipment is clean, in a good state of repair and used correctly.	Nursing	Role and responsibilities policy in place.  Cleaning statements document for all wards and departments finalised and to be disseminated.	Complete  Jun 2011
	24	The Trust should ensure that hand-washing sinks are available in line with national guidelines or, based on a risk-assessment approach, alternative processes put in place to facilitate hand hygiene.	Estates	This included in any plans for future capital works.	Ongoing
	25	The Trust should ensure that hand-washing sinks, fixtures and fittings and consumables are clean, working and in a good state of repair.	Estates	This is ongoing as part of Estates daily maintenance and refurbishment programmes.	Ongoing
	26	Further attention to detail is required to ensure that equipment used for the general cleaning purposes of a ward are clean and in a good state of repair.	Nursing PCSS	Role and responsibilities policy in place.  Cleaning statements document for all wards and departments finalised.  PCSS will build into cleaning schedules for areas the need to ensure equipment used for the general cleaning purposes of a ward are clean and in a good state of repair.	Complete  June 2011  Jul 2011

Location	Ref No	Recommendations	Designated Lead Department	Action required	Date for Completion Timescale
	27	The Trust and individual staff have a collective responsibility to ensure that all PPE is available and disposed of appropriately.	Nursing PCSS	<p>The Trust has a process for the provision of appropriate PPE.</p> <p>All staff must follow information, instruction and training with regards to disposal of PPE in compliance with Trust Policy and Procedure.</p> <p>Information on correct disposal of PPE is discussed at ward staff meetings and displayed in posters. Compliance will be checked through electronic audit.</p>	<p>Complete</p> <p>Complete</p> <p>Apr 2012 (Electronic Audit of Waste stream).</p>
	28	The Trust should ensure the continued development and implementation of care plans that reflect the infection prevention and control needs of the patient.	Nursing	Launch due of new nursing documentation	Aug 2011
	29	The Trust should ensure that the requirement for staff changing facilities, as set out by the Department of Health building standard, is incorporated into future new build plans.	Estates	This is included in any plans for future development works.	Ongoing



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