THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY
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UNANNOUNCED HYGIENE INSPECTION REPORT

NORTH WEST INDEPENDENT HOSPITAL
BALLYKELLY

23 NOVEMBER 2010

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The Inspection Team

The members of the team were:

- Liz Colgan -Senior Inspector, Infection Prevention and Hygiene team
- Winnie Maguire -Inspector, Independent Sector
- Margaret Keating - Inspector, Infection Prevention and Hygiene team
- Sheelagh O'Connor - Inspector, Infection Prevention and Hygiene team
- Jo Brown - Inspector, independent Sector
- Lyn Gawley - Inspector Infection Prevention Hygiene team

1. Background Information

1.1 The Role and Responsibilities of the Regulation and Quality Improvement Authority (RQIA)

The Regulation and Quality Improvement Authority (RQIA) is a non-departmental public body, established with powers granted under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. It is sponsored by the Department of Health, Social Services and Public Safety (DHSSPS), with overall responsibility for assessing and reporting on the availability and quality of health and social care services in Northern Ireland and encouraging improvements in the quality of those services.

The Regulation and Improvement Authority is empowered under The Health and Personal Social Services (Quality, Improvement and Regulations (Northern Ireland) Order 2003 and Independent Healthcare Regulations to inspect independent healthcare facilities. One inspection is required and this may be announced or unannounced and may be undertaken at any time of the day or night. The service is also inspected to determine compliance with the requirements of the Independent Health Care Regulations (Northern Ireland) 2005 and Draft Independent Health Care Minimum Standards for Hospices March 2005.

In his statement of 23 January 2008, The Minister for Health, Social Services and Public Safety, Michael McGimpsey, announced a package of new initiatives aimed at tackling Healthcare Associated Infections.

One of these measures was the commencement of a rolling programme of unannounced hygiene inspections. The RQIA have now commenced this programme of inspections. This report details the findings of the visit to the North West Independent Hospital, Ballykelly.

1.2 Approach and Scope

The unannounced hygiene inspection was a snapshot of hygiene and infection control standards within the specified functional areas on the day of the visit and should not be taken as a representation of standards in the hospital over a period of time. The unannounced hygiene inspection collected information through direct observations of the areas visited, some observation of clinical practice, staff and patient questioning and review of key documentation in the wards and departments visited.

The inspections focus on promoting public confidence as a clean, tidy and well maintained environment is an important foundation to promote patient confidence and support other infection prevention measures. Cleanliness is not a full indication of safe care but rather is used as an indicator. Good hygiene and infection control practices are measures, which can be taken to provide safe care, however, they will not provide a guarantee that patients will not contract an infection as a result of care. Not all HCAIs can be prevented, however, consistent application and compliance with cleaning and infection control principles can reduce or minimise the risk. Health care associated infections and cleanliness are challenges faced by all health care environments and the message that this is "everybody's business" needs to be firmly embedded in a "Board to Ward" approach were everyone takes responsibility for their behaviour and practice.

The inspections support the following key documents/campaigns:

- *'Changing the Culture'*
- *'Cleanliness Matters'*
- *'Ward Sisters Charter'*
- *'Clean your Hands' campaign*
- *'Regional Infection Control Manual'*

The RQIA as a driver for continuous improvement believes that unannounced inspections are a valid approach to assess patient experience as good hygiene and infection control practices should be available on a constant and ongoing basis.

The inspection team included RQIA staff with the relevant knowledge and experience.

1.3 The Audit Tool

The audit tool used for the hygiene inspection was based on an adapted version of the Infection Control Nurses Association (ICNA) toolkit. The decision to use this toolkit was based on the principle that a multi disciplinary approach to hygiene and infection control standards is required.

The standard sections of the audit tool used for the hygiene inspections are listed below. Additional sections for specific specialised areas will be added as required.

- Environment
- Handling and Disposal of Linen
- Waste Handling and Disposal
- Safe Handling and Disposal of Sharps
- Management of Patient Equipment (General)
- Hand Hygiene
- Kitchens
- Clinical Practices

The audit tool used in 2008 has been revised to include additional areas such as Decontamination and Disinfection Knowledge, and clinical practices that could be reviewed in the time period. The questions do not cover all aspects of the practice but can give some indication that appropriate infection control measures are in place. Various elements within the tool now include staff questions and the Hand Hygiene and Personal Protective Equipment sections include observation of practice. These two observational areas are normally carried out over a period of time however these may be observed as part of the inspection. The hand hygiene audit includes three questions for patients.

The standard audit has eight sections. Each section is devised to achieve a particular standard that covers a number of areas. All criteria within each section are marked *yes/no* or *non-applicable*. Inspectors/reviewers are informed that it is not acceptable to record a non-applicable response where an improvement in a standard must be achieved for example when a national standard is not being met. However, if a standard is absent or not observed then it can be marked as non-applicable.

Milliward et al (1993) reported that weighting of criteria did not significantly influence overall scores. The 'epic2: National Evidence - Based Guidelines for Preventing Health Care - Associated Infections in NHS Hospitals in England' (2007) states that all recommendations are endorsed equally and none is regarded as optional.

The audit tool also is considered as an evolving document that will be reviewed and adapted as required.

In addition the team were advised on the use of digital cameras provided to record areas of particular concern. Team members agreed that images should be taken only of the environment and at no time would images of patients, staff or visitors be included. Where appropriate, images have been included in the report.

1.4 Preparation

The team met prior to the inspection with the inspectors from the independent Health Care Team to finalise arrangements for the visit and to identify areas to be audited.

The hygiene inspection of this facility on 23 November 2010 was unannounced.

2. The Inspection

The inspections are not intended to be paper based, they seek information from observations in functional areas, and this is supplemented by documentary and photographic evidence where appropriate. Some areas of direct questioning and observation of clinical practice have been included.

Inspectors/reviewers are aware of and follow the RQIA's Inspection Protocol.

If the inspector/reviewer identifies any serious concerns during the review, they should bring this to the attention of the Team Leader in the first instance. Any area of serious concern that requires immediate action will be brought to the attention of the person in charge and Senior Management before the team leave the premises. These concerns will be reported to the RQIA's Senior Management Team in accordance with the Hygiene Inspection Escalation Policy.

Inspectors/reviewers are also advised to note areas of good practice or any additional observations that could pose a risk to patients or staff.

Prior to the feedback session to the Northern West Independent Hospital representatives, inspectors/ reviewers had a debrief session to review and agree findings. The key findings of the inspection were outlined to the following Hospital representatives:

- Mrs E Dallas - Registered Manager
- Sister F Carmichael - Ward Manager

Audit scores and compliance levels are not given at this feedback session, as the audit tool requires to be quality assured before final results are issued.

The inspection team wishes to thank the staff of the North West Independent Hospital who willingly facilitated this visit, and responded constructively during the feedback session.

2.1 Main Findings

This section discusses the main findings of the inspection giving a collective overview of areas visited under each section of the audit tool. Each section begins with references or good practice statements. The findings are first formatted into bullet points that give a detailed account of the findings for individual wards and departments (Appendix 1). The full report is agreed by all members of the team and then forwarded to the hospital.

2.2 Areas Visited

- Surgical Wards
- Day Procedure Unit (DPU)

The following table outlines the scores achieved by each section of the audit tool.

Areas Visited	Surgical Wards	Day Procedure Unit
Environment	86	86
Linen	75	69
Waste	94	100
Sharps	85	82
Patient Equipment	90	85
Hand Hygiene	87	91
Kitchen	83	70
Clinical Practice	91	86
AVERAGE SCORE	**86**	**84**

Level of Compliance
Green - Compliant 85% or above
Amber - Partial compliance 76% - 84%
Red - Minimal compliance 75% or below

2.3 Environment and Facilities

Areas Visited	Surgical Wards	DPU
Scores	**86**	**86**

Introduction

Good hygiene is an integral and important component of the overall strategy for preventing health care associated infections.

The environment must be visibly clean, free from dust and soilage and acceptable to patients, their visitors and staff.

Reference: The 'epic2: National Evidence - Based Guidelines for Preventing Health Care - Associated Infections in NHS Hospitals in England' (2007).

Main Findings

The North West Independent Hospital is situated in the town of Ballykelly, between Coleraine and Londonderry. It was first opened in 1989 and was purchased in 1996 by Dr C Stewart. Mrs E Dallas is the Registered Manager and is supported operationally by Sister F Carmichael. The hospital provides inpatient/outpatient medical, surgical and paediatric services, three operating theatres (and endoscopy suite) with a recovery room, X-ray department, Pharmacy and Physiotherapy services.

The hospital is registered to provide care and treatment to patients over the age of one year and all services are Consultant-led. There are 98 medical consultants, supported by anaesthetics and other specialities.

Patients admitted to the hospital are nursed at ward level which also encompasses the Day Procedure Unit. The hospital has 36 beds, most of them in single rooms. Each single room has an en-suite bathroom/shower room, a colour television, a radio and direct-dial telephone. Larger rooms are available for parents who wish to stay overnight with a child. The main reception area is bright, welcoming and well presented, the corridor leading to the wards is tidy, generally clutter free and offers a waiting area with clean, impermeable, easy to clean furniture and fittings (Picture 1).

Picture 1 - Presentable, clean and tidy seating area

There are two surgical wards each with nine en-suite shower rooms, the general environment in both wards was well presented, clean, tidy and fresh smelling. The day procedure unit was busy with admissions, discharges, room cleaning and bed making which resulted in a cluttered corridor containing domestic trolleys, linen skips and laundry trolleys. It was noted that the corridor was clean, tidy and clutter free at the end of the operating session, however, there are some issues raised in both areas that require attention.

In the day procedure unit, the vertical blinds in the clinical room were dirty in appearance, with some of the strings broken and dust was observed inside and behind radiators. Some of the external windows had streak marks present and the corridor skylight was dirty. In the en-suite bathrooms, the seals at some of the baths are old and worn and should be replaced, the floor coving in one area was separating from the wall and the fabric of one bath mat was perished and should be replaced.

The en-suites in the surgical wards were generally well presented, however, some pull cords without covers were grubby and coving was stained in places. Not all en-suites have foot operated lidded waste bins. It is good practice to have foot operated lidded bins in toilet areas to prevent the spread of contamination by hands touching the lids.

There are no formal hard copies of environmental audits; staff report only visible environmental inspections are carried out. The practice of formal environmental audits followed by appropriate actions would be beneficial to all staff and patients.

In the clinical room of the surgical wards, veneer on one of the drugs trolleys was missing making the trolley difficult to clean effectively and in one of the clean stores, excess boxes of IV fluids were stored on the floor impeding detailed cleaning of the floor. In the day procedure unit, the edges of some of the shelving were worn, exposing the wood and there were some drill holes present in the walls.

Each ward has a dirty utility room. In the surgical wards one was tidy and clutter free, one was cluttered and commodes were blocking access to the hand washing sink. Veneer was missing from shelving exposing bare wood and floor coving was coming away from the wall in places allowing damp to penetrate to the flooring underneath. Some commodes spot checked were not clean underneath and available trigger tape was not being used to identify clean commodes (Picture 2). Bedpans and urinals were stored tidily in cubbyholes but were not inverted to aid the drying process.

Picture 2 - Dirty underneath of a commode

IV stands were stored inappropriately in the small dirty utility of the day procedure unit where greater attention to detail is required when cleaning difficult to reach floor corners and edges. The domestic sink and sluice bowl were stained and the wooden frame was worn in appearance. There is one domestic store supplying both areas, buckets while clean and dry were not stored inverted.

At present staff changing facilities are not available for all staff; at the feedback session the registered manager advised the inspectors that processes are in place for the provision of additional changing facilities.

2.4 Handling and Disposal of Linen

Areas Visited	Surgical Wards	DPU
Scores	**75**	**69**

Introduction

The provision of an adequate laundry service is a fundamental requirement of direct patient care.

Guidelines for these arrangements are set out in HSG (95) 18.

The Health and Safety at Work legislation outlines obligations related to the protection of staff that handle and launder linen.

"The Dress Code Policy" DHSSPS requires facilities to put in place arrangements for the laundering of staff uniforms".

Main Findings

Both areas achieved minimal compliance in this section of the audit tool. It is noted that scoring was affected by minimal observations of the handling and disposal of linen by staff although changes in storage could easily improve compliance levels.

The North West Independent hospital has its own main laundry in the basement which supplies the hospital. The inspectors noted there was no written guidance regarding the use of the washing machines and staff have not received guidance on home laundering. Wooden shelving in both the main linen store and in the surgical wards' store was exposed; the floor was also dusty in the surgical ward linen store.

The day procedure unit does not have a linen store; in both the surgical wards and day procedure unit, clean linen is stored uncovered on trolleys in the corridors (Picture 3). To prevent contamination of linen, it is good practice to store linen in its packaging or appropriately covered until ready to use. The inspectors observed one sheet on a bed in the day procedure unit had a black mark present. As staff placed plugs and leads on beds when vacuuming, this may have attributed to the mark.

Picture 3 - Stocked linen trolley in corridor of day procedure ward

2.5 Waste Handling and Disposal

Areas Visited	Surgical Wards	DPU
Scores	94	100

Introduction

The safe segregation, handling, transport and disposal of waste can, if not properly managed, present risks to the health and safety of staff, patients, the public and the environment. The key legislation pertaining to healthcare organisations are broadly defined under the following legislation guidance:

- *"The Waste Collection and Disposal Regulations (NI) 1992"*
- *"The Waste and Contaminated Land (NI) Order 1997"*
- *"The Controlled Waste Regulation (NI) 2002"*
- *"The Hazardous Waste Regulations (NI) 2005"*
- *"Health Technical Memorandum 07:01 Safe Management of Healthcare Waste"*

The overall management of waste within the Hospital was not reviewed, the inspection focused on general observations at ward and department level.

Main Findings

The day procedure unit achieved full compliance and staff are to be commended for their hard work, commitment and good practices. The surgical wards achieved high compliance, and had used medicine bottles been disposed into a black lidded burn bin instead of a magpie box, full compliance would have been achieved.

2.6 Safe Handling and Disposal of Sharps

Areas Visited	Surgical Wards	DPU
Scores	85	82

Introduction

The safe handling and disposal of needles and other sharp instruments should form part of the overall strategy for clinical waste disposal to protect staff, patients and visitors from exposure to blood borne pathogens. *Reference:* The 'epic2: National Evidence - Based Guidelines for Preventing Health Care - Associated Infections in NHS Hospitals in England' (2007).

A report from Health Protection Agency in 2006 noted that needlestick injury had increased by 49 per cent in three years even though such exposures are largely preventable. *Reference:* Health Protection Agency "Eye of the Needle". United Kingdom Surveillance of Significant Occupational Exposure to Blood Borne Viruses in Health Care Workers.

Main Findings

It is encouraging to note the surgical wards achieved compliance; day procedure unit achieved partial compliance, however, in both areas risk factors were identified that need to be addressed. In both areas sharps trays with integral sharps bins were not available; as staff are at times using plastic kidney dishes to carry sharps, sharps are not always being disposed of directly into a sharps bin at the point of use. In the day procedure unit plastic kidney dishes were washed and left to dry on the radiator rather than washed and immediately dried and in the surgical wards the temporary closure mechanism was not always closed when the bin was not in use (Picture 4). A poster for the management of an inoculation injury was not displayed in the day procedure unit for staff to reference.

Picture 4 Kidney dishes and medicine tubs drying on a radiator

2.7 Patient Equipment

Areas Visited	Surgical Wards	DPU
Scores	90	85

Introduction

Medical devices and items of equipment that are shared may act as a receptacle by which microorganisms are transferred between patients that may result in infection.

All these devices must therefore be decontaminated between patient use. Depending on the item of equipment used decontamination will include cleaning, which may be followed by disinfection, or sterilisation and manufacturing instructions must be followed. *Reference: "The Northern Ireland Infection Prevention and Control Manual"* (2008).

“Directive 93/42 EEC” implemented into law by the Medical Device Regulation 2002 in general covers the Management of medical devices.

Main Findings

Both areas achieved compliance in this section of the audit tool. In the surgical wards compliance was affected by the practice of not storing equipment such as wash bowls and buckets inverted to aid the drying process and storing the laryngoscope blades, ambubag and mask on the resuscitation trolley out of their original packaging.

Nursing staff cleaning schedules were available in the day procedure unit, however they had not been completed since 11/10/10. Two glucometers checked required cleaning, there was tape residue present on the dressing trolley, the inside of a bedside suction canister was dusty, there was no liner present and the tubing end was exposed (Picture 5). In both areas inspected staff questioned did not know the symbol for single use equipment.

Picture 5 - suction canister, exposed tubing and no suction liner

2.8 Hand Hygiene

Areas Visited	Surgical Wards	DPU
Scores	87	91

Introduction

Compliance with the correct hand hygiene procedures is crucial to the prevention of health care associated infections. Hands are the most common route of transmission therefore

Hand Hygiene is the single most effective measure that can be taken to prevent the spread of infection.

Cross-transmission or the transfer of micro-organisms between people, which occurs directly via hands or indirectly via an environment surface such as a commode or wash bowl and overviews of epidemiological evidence, conclude that hand-medicated cross transmission is a major contributory factor in the current infection threats to patients. *Reference:* The 'epic2: National Evidence - Based Guidelines for Preventing Health Care - Associated Infections in NHS Hospitals in England' (2007).

In Northern Ireland the "*Clean your hands'* campaign highlights the significance that the Department of Health and Social Services and Public Safety place on effective hand hygiene.

Main Findings

Compliance was achieved in both areas, however scoring was slightly affected by the facilities provided and staff practice. The sink in both clinical rooms does not conform to HTM 64 as the water flows directly into the plughole increasing the potential for splash back contamination and a plug is present. In the surgical wards the paper towel and soap dispensers were installed above the equipment sink in the dirty utility room and not the hand washing sink. One member of staff was wearing a wrist watch; another was wearing a stoned ring and a member of staff did not wash hands after performing a clinical procedure.

In the day procedure unit there was limescale present on some of the taps in the en-suites and the clinical room hand washing sink had fine cracks present. One alcohol dispenser was empty and another dispenser was cracked underneath.

2.9 Kitchens

Areas Visited	Surgical Wards	DPU
Scores	83	70

Introduction

Good hygiene and food safety practices and informed staff are vital in the preparation, storage, distribution and service of food.

Health care facilities have a legal obligation to comply with the provisions and requirements of food hygiene legislation. The key legislation is:

- "The Food Safety (Northern Ireland) Order 1991"
- "The Food Safety (General Food Hygiene) Regulations (Northern Ireland) 1995"
- "The Food Safety (Temperature Control) Regulations (Northern Ireland) 1995"

Main Findings

Neither ward achieved compliance in this section of the audit tool. There is a small kitchen in both wards for the provision of tea, toast and snacks. An improvement in practice is required in both wards to achieve compliance. In both wards the inside of the microwave which is used to heat patient food required cleaning and there was no policy in place to ensure the practice of reheating is carried out correctly. Staff do not temperature probe the food following heating to ensure hot spots are not present. It is advised that advice is sought from the local environmental health officer. Staff are not recording dishwasher and freezer temperatures daily and the disposable roll was lying on top of the work top rather than in a wall mounted dispenser.

In the day procedure unit there was debris present in the inaccessible corners, the white plastic kitchen trolley was dusty and worn and the rubber seals on both the fridge and freezer required cleaning. Fridge temperature records were inconsistently carried out and on a number of occasions were recorded as above the recommended 8°C. Records indicated no action was taken to address this issue. Ice cubes were stored loosely in the drawer of the freezer rather than in a sealed bag (Picture 6).

Picture 6 - Ice bags stored out of packaging in freezer compartment

Risk factors identified in the surgical wards include the underneath of the milk dispenser chamber was dirty and a separate hand washing sink is not available.

2.10 Clinical Practices

Areas Visited	Surgical Wards	DPU
Scores	91	86

Introduction

This section of the audit covers the use of Personal Protective Equipment (PPE), and includes a few questions to cover some aspects of care relating to enteral feeding, catheter care, peripheral intravenous lines and isolation. The general questions include staffs' awareness of the E-learning infection control programme and Regional Infection Prevention and Control Manual.

The questions do not cover all aspects of care but can give some indication that appropriate infection control measures are in place.

The use of PPE is based on legislation *"Personal Protective Equipment at Work Regulations (Northern Ireland) 1993".*

Insertion of invasive devices presents a risk of infection; also many patients requiring these devices have underlying conditions, which make them more susceptible to infection.

Reference: The 'epic2: National Evidence - Based Guidelines for Preventing Health Care - Associated Infections in NHS Hospitals in England' (2007) and the Regional Infection Prevention and Control Manual.

Main Findings

In this section of the audit tool, both areas achieved compliance. Risk factors common to both areas relate to two per cent Chlorhexidine gluconate in 70 per cent Isopropyl alcohol is not available for cleaning insertion sites or for cannulla access and leaflets for patients on common infections were not available. In the day procedure unit there was no eye protection available and staff questioned confirmed they were unaware and had no access to the infection control e-learning programme.

2.11 Additional Observations

Although not part of the audit some additional observations were made which may impact on cleanliness, infection control or patient safety.

These are listed in Appendix 1 and should be included in the Action Plan.

2.12 Good Practice

As part of the inspection areas of good practices were highlighted.

These are listed in Appendix 1.

2.13 Requirements/Recommendations

Areas of non-compliance for each area are detailed in Appendix 1. The hospital is expected to develop an improvement plan to ensure appropriate steps are taken to address each point of non-compliance. The improvement plan should be submitted to the RQIA within two weeks of receiving the report. Further visits will be undertaken in the future to ascertain the action taken to address the recommendations of the inspection.

QUALITY IMPROVEMENT PLAN

UNANNOUNCED INSPECTION

NORTH WEST INDEPENDENT HOSPITAL
BALLYKELLY

23 NOVEMBER 2010

NOTES:

The details of the Quality Improvement plan were discussed with the Registered Manager and Ward Manager as part of the inspection process.

The timescales commence from the date of inspection.

Requirements are based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, Independent Healthcare Regulations (NI) 2005 and must be met.

Recommendations are based on the Department of Health, Social Services and Public Safety's minimum standards for registration and inspection, promote current good practice and should be considered by the management of the home to improve the quality of life experienced by patients and residents.

The Registered Provider is required to record comments on the Quality Improvement Plan.

The Quality Improvement Plan is to be signed below by the Registered Provider and Registered Manager and returned to:

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

SIGNED:	______________________	SIGNED:	______________________
NAME: (print)	______________________ REGISTERED PROVIDER	NAME: (print)	______________________ REGISTERED MANAGER

Surgical Ward

Location	Regulation	Standard	Ref No.	Findings	Designated Department	Action Required	Timescale
Environment General	15(7)25(2)(C)	C18 C22	1.	Some light pull cords were grubby		Light pull cords are being replaced with clear heat shrink.	
			2.	There are no written copies of environmental audits, only visible environmental inspections		Environmental audits are being commenced in all areas.	
			3.	Staff changing facilities are not available for all staff		There are changing room facilities and staff are informed.	
Bathrooms/ Toilets			4.	Adhesive type stains were noted on the coving in the ensuite shower rooms		Maintenance has contacted floor specialist to advise re. glue remover – programme of cleaning to be started.	
			5.	Not all waste bins in the ensuite shower rooms had lids		Bins are being replaced with foot operated lidded bins	
			6.	Not all bins were foot operated. It is good practice to have foot operated lidded bins in toilet areas to prevent the spread of contamination by hands touching the lids			
Clinical Room/Clean Store			7.	In the clinical room, veneer on one of the drugs trolleys was missing, which compromises the cleaning		Veneer replaced to enable proper cleaning.	
			8.	In one of the clean stores, excess boxes of IV fluids were stored on the floor impeding cleaning of the floor		IV fluids are now stored off the floor.	
Dirty Utility			9.	Veneer was missing from shelving exposing bare wood		Veneer replaced.	
			10.	The floor coving was coming away from the wall in places. This allows damp to penetrate to the flooring underneath		Coving re-sealed.	

Location	Regulation	Standard	Ref No.	Findings	Designated Department	Action Required	Timescale
	15(7)25(2)(C)	C18 C22	11.	Some commodes spot checked were not clean underneath the seat		2 new commodes ordered. 1 new shower chair.	
			12.	Trigger tape was not used to identify that commodes were clean and ready to use		Trigger tape – now in use for commodes.	
			13.	Bedpans were stored tidily in cubbyholes but were not stored inverted		All bedpans are now stored inverted.	
Domestic Store			14.	Mops and buckets were not stored inverted		All mops and buckets are stored inverted.	
Handling and Disposal of Linen	15(7)	C18 C22	15.	The floor of the linen store was very dusty		Area cleaned and identified on cleaning schedule.	
			16.	The wooden shelving requires sealing		Shelving is now painted with gloss.	
			17.	A laundry policy for staff uniforms has not been issued for staff to reference		Policy completed. Info for all staff attached to Ward.	
Departmental Waste Handling and Disposal	15(7)	C18.21	18.	Used medicine bottles were disposed into a magpie bin in the sluice instead of a black lidded burn bin		Black bin insitu in sluice in L wing. Staff have been educated.	
Safe Handling and Disposal of Sharps	15(7)	C23	19.	The temporary closure mechanism was not always closed when the bin was not in use		Further notice for staff. Advised at Ward meeting.	
			20.	Sharps trays with integral sharps bins were not available as staff were observed using plastic kidney dishes to carry sharps		Sharps trays with integral sharps bins available in all areas. Staff have been instructed in use.	
Management of Patient Equipment (General)	15(7)	C20 C21 C22	21.	Patient wash bowls were clean and dry but not stored inverted		Wash bowls sent to CSSD and disinfected and sent back in a sealed bag.	

Location	Regulation	Standard	Ref No.	Findings	Designated Department	Action Required	Timescale
	15(7)	C20 C21 C22	22.	Laryngoscope blades were not stored in their original packaging		Laryngoscope blades are in original packaging. New laryngoscope ordered	
			23.	The ambubag and mask on the resuscitation trolley were stored out of their packaging		Ambubag and mask in original packaging.	
			24.	Staff were unable to describe the symbol for single use		Posters throughout Ward. Itemised on Ward Meeting.	
Hand Hygiene	15(7) 15(2)(a)	C18 C23	25.	The sink in the clinical room does not conform to HTM 64. As the water flows directly into the plughole this can result in splash back with potential for contamination if the plug hole is dirty		Water flow assessed and cannot see splash back from flow directly into the plughole. Maintenance Officer assessed. Discussed with RQIA 14.01.11.	
			26.	The hand washing sink in the dirty utility room was blocked by commodes and the paper towel and soap dispensers were positioned above the equipment sink		Areas have been cleared. Paper towel and soap dispenser repositioned.	
			27.	One member of staff was wearing a wrist watch; another was wearing a stoned ring		Further notice to all staff. Itemised at Ward meeting and in other Departments.	
			28.	A member of staff did not wash hands after performing a clinical procedure		Member of staff spoken to. Discussed at Ward meeting. Further posters.	
Ward/Departmental Kitchens	15(7)	C18.12 C19.7	29.	A hand washing sink is not available		Handwashing sink is now in place.	
			30.	The microwave was dirty in the inside		Microwave cleaned. Inserted into daily cleaning schedule. Staff advised not to use microwave.	

Location	Regulation	Standard	Ref No.	Findings	Designated Department	Action Required	Timescale
Ward/Departmental Kitchens	15(7)	C18.12 C19.7	31.	A local policy is not available for the reheating of patient food in the microwave		Policy to be devised. Environmental Officer contacted.	
			32.	The underneath of the milk dispenser chamber was dirty		New milk dispenser supplied.	
			33.	There is no daily recording of dishwasher and freezer temperatures		There is now a sheet to record dishwasher and freezer temperatures.	
Clinical Practices	15.7	C13 C22	34.	Two per cent Chlorhexidine gluconate in 70 per cent Isopropyl alcohol, stated for use in their policy document, is not available for cleaning insertion sites or for cannulla access		Policy to be reviewed in conjunction with the Pharmacist. Clinelle not licensed for skin cleansing yet in process.	
			35.	Leaflets for patients on common infections were not available		Leaflets for common infections are now available.	
Additional Issues	15.7	C18.2	36.	Clean linen is stored on trolleys in the corridors. To prevent contamination of linen, it is good practice to store linen in its packaging or appropriately covered until ready to use		Housekeeping – check linen for defects on arrival to NWIH. Linen is to be stored in enclosed bags on surgical ward.	
		C18	37.	The clinic routinely uses alcohol wipes for the cleaning of equipment. Alcohol wipes are not effective against *Clostridium difficile,* can accelerate the deterioration of fabric surfaces and are costly		We are in the process of identifying what equipment for alcohol wipes and what equipment we can use clean guard wipes.	
		C19.7	38.	Paper roll is available in the kitchen and stored on the workbench. Kitchen staff advised the need for a wall mounted paper roll dispenser had already been identified and a dispenser was to be installed		Dispenser installed.	

Location	Regulation	Standard	Ref No.	Findings	Designated Department	Action Required	Timescale
Areas of Good Practice				Single ensuite accommodation			
				Posters and notices are laminated			
				Green trigger tape has been introduced to identify clean blood pressure monitoring equipment			
				Commodes audits have been initiated			
				Unannounced environmental swabbing is carried out in the wards and results disseminated to staff			

Day Procedure Unit

Location	Regulation	Standard	Ref No.	Findings	Designated Department	Action Required	Timescale
Environment General	15.7 25(2)(c)	C18 C22	1.	Cobwebs were observed in the corridor skylight and at the corners of the window in the clinical room		Cobwebs removed from skylight and corners of clinical room included in cleaning schedule.	
			2.	The vertical blinds in the clinical room were dirty in appearance, with some of the strings broken		Blinds removed.	
			3.	Dust was observed inside and behind all radiators		All types of duster tried. Long handled bottle cleaner to be ordered.	
			4.	Some of the external windows had streak marks present and the corridor skylight was dirty		Windows and skylight cleaned to be included in cleaning schedule.	
			5.	While the domestic supervisor advised that visual inspection checks are carried out on the environment there were no records available to demonstrate an environmental audit process was in place		Environment audits to be done. Commence in January.	
			6.	Staff changing facilities were not available		Changing facilities are available and staff advised.	
Bathrooms/ Toilets			7.	The seals at some of the baths are old and worn and should be replaced and the floor coving in one area was separating from the wall join		Seals replaced.	
			8.	The fabric of one bath mat was perished and should be replaced		Bath mat removed. New ones ordered.	
Clinical Room/ Clean Store			9.	The edges of some of the shelving is worn, exposing the wood		Edges replaced.	

Location	Regulation	Standard	Ref No.	Findings	Designated Department	Action Required	Timescale
	15.7 25(2)(c)	C18 C22	10.	There are some drill holes present in the walls which can act as a reservoir for bacteria and impedes the cleaning		Drill holes filled.	
Dirty Utility	15.7	C18 C21	11.	IV Stands were stored inappropriately in this area		IV stands removed.	
			12.	This room is small and cramped and attention to detail is required when cleaning difficult to reach floor corners and edges		Specific details on cleaning schedule.	
			13.	The domestic sink and sluice bowl were stained and the wooden frame worn		Sink and sluice bowl cleaned and wooden frame varnished.	
Domestic Store	15.7	C18 C22	14.	Mops and buckets were not stored inverted		Mops and buckets stored inverted.	
Handling and Disposal of Linen	15.7	C18 C23	15.	There was no designated linen store. Linen was stored uncovered on a trolley in the corridor		No linen is stored on the trolley, sealable bay to be introduced during daily use.	
			16.	One sheet on a bed had a black mark present. The inspectors observed that plugs and leads were placed on beds which may have attributed to the mark		Staff advised that all plugs/beds should be plugged in.	
			17.	The linen trolley had a worn, torn cardboard box present, used inappropriately for storage		Box removed.	
			18.	The wooden shelving in the main linen store was unsealed		Shelving is now sealed.	
			19.	A laundry policy for staff uniforms has not been issued for staff to reference		Laundry policy done. Info sheet to be given to staff with wage slip – January	
			20.	There was no written guidance regarding the use of washing machines		Written guidance done and laminated.	

Location	Regulation	Standard	Ref No.	Findings	Designated Department	Action Required	Timescale
Departmental Waste Handling and Disposal	15.7	C18 C23		No risk factors identified			
Safe Handling and Disposal of Sharps	15.7	C23	21.	There were no sharps trays with integral sharps boxes available		Integral sharp box now available.	
			22.	Sharps were not disposed of directly at the point of use		Integral sharp box now available.	
			23.	There was no poster available on the management of an inoculation injury		Posters now in place.	
			24.	Plastic kidney dishes were used to transport sharps. These were washed and dried on the radiator rather than washed and immediately dried		Kidney dishes are washed and dried immediately.	
Management of Patient Equipment (General)	15.7	C20 C21 C22	25.	While nursing cleaning schedules were available, they had not been completed since 11/10/10		Cleaning schedules allocated to staff member on duty on a daily basis.	
			26.	Two glucometers checked required cleaning		To be included in cleaning schedule.	
			27.	There was tape residue present on the dressing trolley		Trolley tape residue removed. Staff advised at Ward meeting.	
			28.	The inside of a bedside suction canister was dusty, there was no liner present and the tubing end was exposed		CSSD Manager obtaining new system.	
			29.	Staff were unaware of the symbol for single use		New poster on view. Itemised at Ward meeting.	
Hand Hygiene	15.7 15(2)(a)	C18 C23	30.	The sink in the clinical room did not comply with HTM64 as it had a plug present		New sink to be inserted.	
			31.	There was limescale present on some of the taps in the en-suites and the clinical room hand washing		Removal of limescale to be included in cleaning schedule. Identifying	

Location	Regulation	Standard	Ref No.	Findings	Designated Department	Action Required	Timescale
				sink had fine cracks present		appropriate cleaner. New sink to be inserted.	
	15.7 15(2)(a)	C18 C23	32.	One alcohol dispenser was empty and another dispenser was cracked underneath		Housekeeping advised and dispenser replaced.	
Ward/ Departmental Kitchen	15.7	C18.12 C19.7	33.	There was debris present in the inaccessible corners		Included in cleaning schedule.	
			34.	The white plastic kitchen trolley was dusty and worn		Trolley replaced.	
			35.	The rubber seals on both the fridge and freezer required cleaning		Included in new cleaning schedule.	
			36.	There was no freezer temperature records present		Temperature now recorded.	
			37.	Fridge temperature records were inconsistently carried out and on a number of occasions were recorded as above the required 8°C. No action was taken to address this issue		Temperature now recorded daily and staff advised to report if any action is required.	
			38.	The microwave plate was dirty		Same cleaned. Placed on cleaning schedule.	
			39.	The microwave is used to reheat patients food, however, there was no policy in place to ensure this practice is carried out correctly. Staff do not temperature probe the food following heating to ensure hot spots are not present. It is advised that advise is sought from the local environmental health officer		Temperature probed is available. Policy to be completed. Kitchen Supervisor to contact Environmental Health.	
			40.	Ice cubes were stored loosely in the drawer of the freezer rather than in a sealed bag		Kitchen advised to only fill bags ¾ to avoid spillage.	
			41.	The disposable roll was lying on top of the work top rather than wall mounted		Disposable roll is now wall mounted.	

Location	Regulation	Standard	Ref No.	Findings	Designated Department	Action Required	Timescale
Clinical Practices	15.7	C13 C22 C23	42.	There was no eye protection available		Eye protection now available. Poster in place.	
			43.	Two per cent Chlorhexidine gluconate in 70 per cent Isopropyl alcohol stated for use in their policy document was not available for cleaning insertion sites or for cannula access		Policy to be reviewed with the conjunction of Pharmacist. Clinelle not licensed for skin cleansing yet.	
			44.	Information leaflets were not available on common infections		Information leaflets now available.	
			45.	Staff questioned were unaware and had no access to the infection control e-learning programme		Access to e-learning to be organised and cost implications to be assessed.	
Additional Issues	15.7	C18	46.	The temperature in the clinical room was excessively warm		Notice to advise all staff to keep radiator at a level temperature.	
		C21	47.	Trigger tape was not always used to identify if equipment had been cleaned		Staff advised re use.	
		C21	48.	Staff questioned while using a detergent based spray also used alcohol wipes for cleaning. Continued use of alcohol can damage some surfaces On questioning, staff were unaware that alcohol is not advised for cleaning and hand disinfection if a patient has diarrhoea or is diagnosed with Clostridium *difficile*		Discussion with Infection Control. We are in the process of identifying what equipment for alcohol wipes and what equipment we can use clean guard wipes.	

Location	Regulation	Standard	Ref No.	Findings	Designated Department	Action Required	Timescale
		C23	49.	Vinyl gloves are in use throughout the unit for all practices, however, it is advised by the Infection Control Nurses Association that these are used during low risk procedures. Vinyl gloves are not recommended for tasks where there is a high risk of contact with blood or blood-stained body fluids. It is advised that there is a review of the types of gloves in use within the unit to ensure staff are using the correct gloves, with the correct protection for all care activities		Blue nitrile gloves are to be introduced for tasks where there is a high risk of contact with blood or blood stained fluids and developed in other Departments.	
		C20	50.	On questioning staff it was advised that equipment and reference information is kept on the surgical side of the unit. It is advised that sharps information, eye protection, etc, is kept on both sides of the unit for staff to reference and use in an emergency situation		Information placed in DCU.	
Areas of Good Practice				Infection prevention and control training DVD has been introduced			
				Cleaning schedule for designated areas			
				Infection prevention and control manual available for staff			