



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

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

**Western Health and Social Care Trust**

**Tyrone County Hospital**

**4 and 5 May 2011**

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## 1.0 Inspection Summary

This is the report of the announced inspection undertaken to the Western Health and Social Care Trust (WHSCT) and the Tyrone County Hospital on 4 and 5 May 2011. The trust and hospital were assessed against the Draft Regional Healthcare Hygiene and Cleanliness Standards.

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

The findings of the inspection indicated that key policies/procedures and strategies are available, processed efficiently and are available for all staff to access on the trust intranet.

Further work is required on providing assurance on training needs assessments and the follow up of individual absenteeism at mandatory training. The trust should also strengthen and develop user involvement which assists with the overall process of public assurance and ensure that key policies are regularly reviewed, updated and formatted according to the trust style guide.

During the inspection of the **Tyrone County Hospital** the following areas were inspected:

- Ward 12 Rehabilitation
- Day Procedure Unit

The hospital was built on its present site in 1899. During the past decade, the hospital has had a sustained period of expansion and refurbishment and offers the following range of services:

- Acute general medicine,
- Coronary care, (including cardiac ambulance),
- Stroke and orthogeriatric rehabilitation
- Diabetes Day Resource Centre
- Urgent Care Centre
- Ambulatory paediatrics
- ENT department
- Sub-regional Renal unit for the Western Trust Area
- Radiology department with spiral CT scanning,
- Day procedure unit
- Purpose built laboratory.

At the feedback, trust representatives confirmed that ministerial approval had been granted for a new hospital in Omagh.

## Inspection Outcomes

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 only non compliant score was regarding the lack of availability and cleanliness of wash hand basins in the Day Procedure Unit.

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

A detailed list of preliminary findings is forwarded to WHSCT 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

- **Monthly Chief Executive Accountability Meetings where non compliant environmental cleanliness and infection prevention and control scores are discussed and actions are implemented for improvement.**
- **There are effective internal monitoring systems in place to provide assurance on environment al cleanliness and infection prevention and control.**
- **An assurance strategy is in place to ensure ‘Board to Ward’ governance.**
- **The trust has met its target reductions in the number of MRSA and *Clostridium difficile* which includes a 37 per cent reduction in the number of cases of *C. difficile* and 50 per cent reduction in MRSA blood stream infections. The trust also achieved the highest target compliance and lowest**

infection rates in the region for both Orthopaedic surgery and Caesarian Section Surgery.

- The WHSCT is an accredited centre for BICS (British Institute Cleaning Science) training for domestic staff. A four year strategy is in place to ensure all staff receive this level of training which provides staff with a 'Cleaners Operative Proficiency Certificate' (COPC) Level 1. The certificate is presented to the staff member by the Chief Executive.
- An electronic audit system is being introduced across the trust to provide up to date information on key performance indicators, audits and performance against care bundles.
- Good evidence was available to support effective lines of communication between Infection Prevention and Control Team and Support Services staff.

The RQIA inspection team would like to thank the WHSCT and, in particular, all staff at the Tyrone County Hospital for their assistance during the inspection.

The following tables give an overview of compliance scores noted in areas inspected by RQIA:

**Table 1** summarises the overall compliance levels achieved.

**Tables 2-7** summarise the individual tables for sections two to seven of the audit tool, as this assists organisations to target areas that require more specific attention.

**Table 1**

Areas inspected	Ward 12	DPU
General Environment	90	90
Patient Linen	98	86
Waste	98	92
Sharps	100	91
Equipment	89	88
Hygiene Factors	93	88
Hygiene Practices	99	99
Average Score	95	91

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

**Table 2**

<b>General Environment</b>	<b>Ward 12</b>	<b>DPU</b>
Reception	82	93
Corridors, stairs lift	N/A	N/A
Public toilets	N/A	N/A
Ward/ department - general (communal)	85	88
Patient bed area	90	92
Bathroom/washroom	97	N/A
Toilet	92	90
Clinical room/ treatment room	86	86
Clean utility room	N/A	92
Dirty utility room	91	77
Domestic store	86	90
Kitchen	95	96
Equipment store	86	N/A
Isolation	92	N/A
General information	100	100
<b>Average Score</b>	<b>90</b>	<b>90</b>

**Table 3**

<b>Linen</b>	<b>Ward 12</b>	<b>DPU</b>
Storage of clean linen	100	89
Storage of used linen	94	82
Laundry facilities	n/a	N/A
<b>Average Score</b>	<b>97</b>	<b>86</b>

**Table 4**

<b>Waste and Sharps</b>	<b>Ward 12</b>	<b>DPU</b>
Handling, segregation, storage, <b>waste</b>	98	92
Availability, use, storage of <b>sharps</b>	100	91

**Table 5**

<b>Patient Equipment</b>	<b>Ward 12</b>	<b>DPU</b>
Patient equipment	89	88

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

**Table 6**

<b>Hygiene Factors</b>	<b>Ward 12</b>	<b>DPU</b>
Availability and cleanliness of wash hand basin and consumables	92	72
Availability of alcohol rub	100	100
Availability of PPE	85	80
Materials and equipment for cleaning	95	100
<b>Average Score</b>	<b>93</b>	<b>88</b>

**Table 7**

<b>Hygiene practices</b>	<b>Ward 12</b>	<b>DPU</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	100	94
Effective cleaning of ward	100	100
Staff uniform and work wear	100	100
<b>Average Score</b>	<b>99</b>	<b>99</b>

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

## **2.0 Background Information to the Inspection Process**

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

The aims of the inspection process are:

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

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

### 3.0 Inspections

The DHSSPS has devised draft Regional Healthcare Hygiene and Cleanliness standards. RQIA has revised its inspection processes to support the publication of the standards which were compiled by a regional steering group in consultation with service providers. Standard 1.0 relates to organisational systems and governance. To ensure compliance with this standard, a new inspection process and methodology has been developed, in consultation with the regional steering group.

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

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

- **Improving care:** we encourage and promote improvements in the safety and quality of services through the regulation and review of health and social care
- **Informing the population:** we publicly report on the safety, quality and availability of health and social care
- **Safeguarding rights:** we act to protect the rights of all people using health and social care services
- **Influencing policy:** we influence policy and standards in health and social care

## **4.0 Announced Inspections**

The purpose of the announced inspection of the WHSCT 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 WHSCT 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. A trust based approval/monitoring process for standards and guidelines which assists with the development of trust policies was updated in September 2010. This is to ensure a standard framework of implementation for all policies and that each policy has directorate governance and trust board approval, dissemination process to staff with assurances provided to the governance committee. However it was noted that not all policies follow a standardised style guide to include identified roles and responsibilities, scope, objectives and a review date and there was no specific policy for the handling of contaminated linen; a draft policy has been formulated by Infection Prevention and Control (IPC).

There are also a number of key policies which require updating such as the Environmental Cleanliness Strategy. Discussion with representatives from support services staff in the trust indicate that the trust was waiting on the Regional Review of Cleaning Services and the Cleanliness Matters Strategy in Northern Ireland to direct their strategy and reflect the recommendations.

There is an Accountability Framework document for environmental cleanliness and infection prevention and control which outlines the frequency of audits at ward level and the process for reporting upwards to the Chief Executive Accountability meetings, this flowchart also includes the escalation of unresolved issues.

The three Year Strategic Infection Prevention and Control (IPC) Plan incorporates the Annual Infection Reduction Programme and is due

completion in September 2011. The actions are based on priorities identified on the Trust Board Priority Risk Analysis, the objectives have been derived from root cause analysis findings, regional requirements and local surveillance findings. The Plan shows clear structure of governance responsibilities and accountability and links in with other professional groups.

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. In Tyrone county hospital, a room with a designated computer is available for all staff to access the intranet.

### **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 in all areas within the standards.

The Environmental Cleanliness Controls Assurance Standard 2010/2011 overall score was 88 per cent. The EC Steering Group is in the process of forming an action plan in response to the identified areas of partial compliance. The IPC Controls Assurance Standard 2010/2011 achieved an overall score of 93 per cent, an increase of four per cent from the previous year's score and an action plan progress report is in place. The action plan demonstrates that gaps in the control assurance standard are being addressed however 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

Trust representatives confirmed that while an Environmental Cleanliness annual report had not been published, reporting arrangements within support services were in place throughout the trust. Staff follow the Accountability Framework for EC and IPC and when the revised Cleanliness Matters document is in place, it is the intention to produce an annual report as directed by guidance within the revised document. It is recommended that the trust publish an EC annual report which outlines the trusts position in relation to environmental cleanliness and informs the trust board of the controls and systems in place to support the delivery and maintenance of high quality environmental cleanliness within the WHSCT.

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 11 compared to 19 the previous year, a reduction of almost 50 per cent.
- The number of cases of *Clostridium difficile* infections in the trust in the year 2009/10 was 69 compared to 109 the previous year, a reduction of 37 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. There are 8 evidence based care bundles related to IPC which are on-going in the WHSCT. These are:

- Ventilator Assisted Pneumonia (VAP)
- Peripheral intravenous cannulae (insertion and on-going)
- Surgical Site Infection (SSI)
- *Clostridium difficile*
- Renal lines (insertion and on-going)
- Central lines (Insertion and on-going)
- Urinary catheter (in a limited number of care areas)

- Decontamination

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 on risk management.

A review of the strategy indicated that there was no definition of the risk status categories, definition of timescales and the document itself was due for review in March 2009. A sample of the medical directorate risk register summary was reviewed, risks have been identified in relation to corporate objectives however timeframes for action are not included. The trust needs to ensure that the risk register strategy is reviewed and risk registers which include key information on infection, prevention and control have identified timescales.

#### **Recommendations**

- 1. The trust should update the Environmental Cleanliness Strategy.**
- 2. The trust should publish an Environmental Cleanliness annual report.**
- 3. The trust should ensure there is a policy for handling infected linen.**
- 4. The trust should ensure that all policies are reviewed and updated as necessary and follow a standardised style guide to include identified roles and responsibilities, scope, objectives and a review date.**
- 5. The trust should ensure that the EC Controls Assurance Standards action plan is finalised; address any gaps in the EC or IPC action plans and include timescales for the actions required.**
- 6. The trust needs to ensure that risk registers and key information on infection, prevention and control and environmental cleanliness have identified risk status categories and identified timescales.**

## 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.

IPC deliver a training session at the corporate induction with all staff attending the initial section which is followed by more detailed training for clinical staff, including doctors and allied health professionals. Following a pilot run in Altnagelvin, IPC have changed the format of their bi-annual update for all clinical staff. Trust representatives confirmed that the evaluation of this new format is very positive.

Support services in partnership with the training and quality department have initiated a draft training needs analysis to identify basic education and training requirements for support services staff. Needs are identified annually and attendance is recorded on the support services training matrix. This initiative should be commended as it assures that staff receive training commensurate with their role.

The WHSCT is an accredited centre for BICS (British Institute Cleaning Science) training for domestic staff. A strategy is in place to ensure all staff receive this level of training which provides staff with a 'Cleaners Operative Proficiency Certificate' (COPC) Level 1. The Chief Executive, Mrs Way, personally presents the certificate to each successful staff member. This is an excellent initiative which is commended.

A review of the support services induction hand book evidenced that this is a comprehensive document which is easy to follow and contains all the required information. Staff are trained in specific tasks by team leaders and then competency assessed. The trust's training and quality team independently audit support services staff for catering competencies and are also involved in managerial audits. The CEO and trust are aware of a deficit in training for team leaders and support services managers and the management development unit is currently bidding for more funding to address this issue.

There is a training needs analysis for nursing staff with a robust template available, a yearly plan and quarterly update on training. Training needs are linked to commissioning and government directives

such as Changing the Culture, are agreed yearly with professional leads, then reviewed by divisional and directorate leads. There is an escalation of risks if numbers attending training are below an acceptable level.

The Cleaner Hands Campaign has been rolled out within the trust and additional training is available for link nurses and auxiliary staff. The trust has introduced other initiatives such as training for IPC link personnel, training specific to specialist clinicians, lone worker training and enhanced IPC support when issues are identified in relation to care bundles and Antiseptic Non Touch Technique (ANTT).

The Infection Prevention and Control nurses (IPCNs) have focussed on delivering training and support at ward/department level to improve compliance with the “Saving Lives” care bundles and support the introduction of ANTT. IPCNs independently validate audit results. The auditing of ANTT competencies has been discussed within the trust however trust representatives confirm that it will be difficult to complete competency audits due to staffing levels.

Mandatory training records for infection prevention and control training were available for review. Although attendance was below the trust requirements, pandemic flu training and other training to update nursing skills have been identified as having a negative impact on attendance. The IPC team, in their Controls Assurance Standard self assessment, acknowledges that while attendance figures for IPC training is reviewed and discussed at Accountability and IPCC meetings, there is currently no system in place to identify individual absenteeism. Discussion with staff at ward level indicated that they had received their mandatory update training.

## **Recommendations**

- 7. The trust should review the present training for PCSS team leaders and managers and secure funding for training.**
- 8. 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. Responsibility for governance arrangements rests with the Trust Board through to the offices of the Chairperson and Chief Executive. The trust board operates in accordance with its standing orders and environmental cleanliness and infection prevention and control is a standing item at each meeting. 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. From the evidence reviewed it is apparent that environmental cleanliness and infection prevention and control are also standing items in the Corporate Management Team (CMT), Trust Nursing and Midwifery Committee meetings and Directorate Governance meetings.

The Integrated Governance Committee, the WHSCT EC Working group, the Risk Management sub-committee, the EC Working groups (north and south sectors) which include IPC and EC steering group and operative staff also have accountability and responsibility for EC.

The Executive Director of Nursing is the trust lead for environmental cleanliness with the Medical Director taking the lead for infection, prevention and control.

The IPC Committee is accountable to the Chief Executive and has a governance reporting structure from the Trust Board to the Clinical and Social Care Governance Committee, Directorate Governance Groups, and working groups of the Risk Management Sub-Committee and Quality and Standards Sub-Committee.

Chief Executive Healthcare Associated Infection (HCAI) Accountability meetings were held monthly until the end of 2010 when the trust decided to review the accountability framework and expand the remit to include a broader range of patient safety issues and not just EC and IPC. At these meetings each directorate reported on hand hygiene compliance, Root Cause Analysis (RCA) findings, evidence based care bundles, environmental cleanliness audits and attendance at IPC training. Nursing workshops have taken place to decide on the changes needed to the format and membership of the meetings and as to how this Accountability framework can be taken forward.

Monthly Accountability meetings are also held with the Assistant Director of Nursing to discuss performance and improvement.

Additional accountability meetings are held for low scoring departmental audits which are attended by the ward/facility manager and professional lead, Executive Director of Nursing and Assistant Director of Nursing to discuss improvement plans.

Low scoring managerial audits are attended by the full ward/facility team, Executive Director of Nursing, Assistant Director of Nursing and Assistant Director of Facilities for a more in depth account. This demonstrates accountability throughout the trust at all levels.

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 this was present. However the job descriptions provided for a healthcare assistant, children's nurse, medical staff, occupational therapist and senior infection prevention and control nurse would indicate that accountability for infection prevention and control was only outlined in nursing posts. 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 Organisation Structures in place indicated the roles and responsibilities for Environmental Cleanliness and Infection Prevention and Control are clearly defined.

## **Recommendations**

- 9. 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 walk rounds are undertaken in acute hospitals, smaller hospitals and in community facilities in the WHSCT. In the Annual Report the Trust Board confirmed their commitment to visiting and meeting with trust staff across the services and service locations through these walk rounds. Visits focus on safety issues and have generated a range of actions to improve services. Formal reports are produced identifying issues raised and an action plan to address the issues.

### **6.4.2 Environmental Cleanliness Audits**

Cleaning is monitored on a daily basis by the Domestic Services team. Domestic staff regularly check all areas including public toilets. The Cleanliness Matters toolkit is used to undertake departmental audits; the frequency of these is determined by risk. Annual Managerial Audits are carried out unannounced by the Head of Service/Lead Nurse, representative from IPC and estates, Training and Quality Management or Support Services and ward/facility sister with the objective of providing check and balance of self assessed audits. Discussions with staff in Tyrone County hospital and trust representatives confirmed that managerial audits have not all been carried out to schedule. This was further evidenced by the EC 2011 audit report which demonstrated low compliance in the auditing of certain areas. It is recommended that managerial audits are carried out according to the agreed schedule.

Responsibilities for all of the cleaning elements outlined in the environmental cleanliness toolkit have been agreed through the trust's Environmental Cleanliness Committee. This ensures that the cleaning of every element is identified as the responsibility of Domestic Services, Professionals and Estate Services. An electronic system has been introduced across the trust to assist in carrying out the audit process.

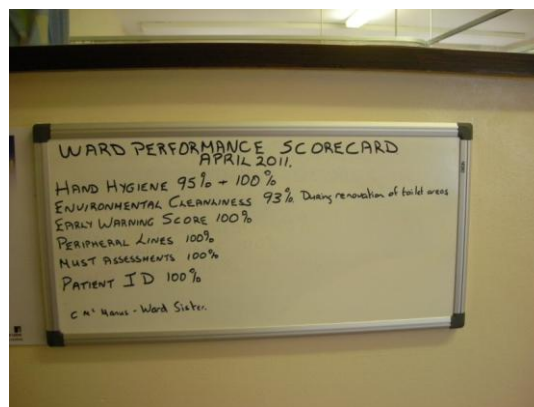
### **6.4.3 HCAI Performance**

Audit results are completed for wards, divisions and directorates. These are collated and low compliance scores or failures are brought to the attention of the Assistant Director of Nursing monthly accountability meetings. Each directorate maintains a Balanced Score Card. If the set criteria for achievement is not met in the following audits, these are reported on:

- Hand hygiene
- Environmental Cleanliness reports
- *Clostridium difficile* audit scores
- *Clostridium difficile* validation visits
- *Clostridium difficile* root cause analysis
- Peripheral line ongoing care HII
- Peripheral Intravenous cannula bundle insertion actions
- Staff training figures for IPC
- Early Warning Scores(EWS)
- Malnutrition Universal Screening Tool (MUST)bundle

The ward manager undertakes a number of self audits in relation to infection, prevention and control which are collated by the Infection, Prevention and Control team and shared with senior managers (Picture 1). These ward audits include:

- Commode Audit
- Hand Hygiene Audit
- Care bundles on peripheral vascular lines, urinary catheters,
- Early Warning Signs,
- MUST
- Falls



Picture 1 Ward audit scores

The trust is in the process of completing a performance dashboard on the trust intranet site for displaying infection prevention and control and environmental cleanliness audits. On discussion with trust representatives, staff are keen to continue with the current template as well as it identifies trends and failures.

As part of their audit process the infection, prevention and control team also select wards and departments to validate audits of practice on a continual basis as agreed with the Lead Nurse at monthly surveillance meetings.

Of particular note is the work undertaken to implement best practice based on current evidence with emphasis on 'Aseptic Non Touch Technique' (ANTT). The pilot to introduce ANTT within Neonatal Intensive Care on the Altnagelvin site continues. Training of trainers is completed and further training and audit interventions are planned to be completed by June 2011. The IPC team plan to incorporate ANTT into existing urinary catheter insertion bundle using a small pilot approach e.g. district nursing teams.

European Surveillance Antimicrobial Consumption (ESAC) was carried out across acute hospitals in the WHSCT. Following this a rolling audit of antimicrobial prescribing has been developed.

#### **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 *Clostridium difficile* RCA are also raised and discussed by the Lead Nurse at the monthly accountability meetings to the Assistant Director of Nursing. Inspectors were advised that RCA training had been carried out for all staff involved in the RCA process and participation by multi-disciplinary teams has improved.

Inspectors were impressed by the knowledge of the RCA process displayed by the staff on Ward 12, this is to be commended.

#### **6.4.5 Medical Devices**

The medical devices and decontamination working group sits within the Trust Risk Management and Sub-Committee which is accountable to the Integrated Governance Committee. The Assistant Directors assume overall responsibility for ensuring the Policy for the Management of Medical Devices is implemented in relation to the management and decontamination of medical devices within their respective directorates. Directorates are required to liaise with the Medical Devices and Decontamination Group to ensure medical devices needs are met.

A Medical Device Equipment Alert (MDEA) management process has been implemented by the trust for staff compliance. The minutes of the Acute Governance Meeting held in February 2011 identified a high volume of non-responses to the MDEA from the Acute Directorate. Discussions with trust representatives confirmed this issue is to be addressed at the May 2011 Acute Governance Meeting in regard to putting in place a tighter structure and additional measures.

#### **6.4.6 User Involvement**

Both IPC and EC Controls Assurance Standards identified the lack of patient and the public involvement in efforts to reduce HCAs. Recently an IPC nurse conducted a survey on *Clostridium difficile*; a Patients' Perspective which raised issues in the management of the infection and identified steps to improve multi disciplinary practice. This is a good initiative and is to be commended.

#### **Recommendations**

- 10. It is recommended that the trust ensures managerial audits are carried out according to the agreed schedule.**
- 11. The trust should develop user participation in the relevant committees as part of the overall process of public assurance and public participation.**

## 6.5 Criterion 1.5

***The trust has robust arrangements in place to ensure that issues identified during internal monitoring and audit are addressed in a timely and effective manner***

### 6.5.1 There are systems in place to ensure action is taken from the results of internal monitoring.

The results of IPC audits are reported at divisional and directorate governance meetings, Chief Executive accountability meetings and to professional leads. Action plans are developed, these incorporate agreed timelines and roles and responsibilities.

IPC performance is monitored at corporate management meetings and trust Board meetings; the IPC lead attends these meetings. Surveillance data is collected for National and Regional surveillance Initiatives.

National surveillance:

- Haemophilus Influenza type B
- Scalded Skin Syndrome
- Enhanced Pertussis surveillance
- Pnemocystis carinii
- Pneumococci
- Beta haemolytic streptococcus group A

Regional surveillance:

- Enhanced Meningococcal surveillance
- MRSA/MSSA bacteraemia
- *Clostridium difficile* surveillance
- Tuberculosis surveillance
- Orthopaedic Surgical Site Infection
- Post-Operative caesarean section wound infection

High impact interventions (HII) compliance data and root cause analysis on HCAs are followed up by the lead nurse, divisional and directorate lead, the Assistant Director of Nursing at the monthly accountability meetings and the Executive Director of Nursing.

The IPC team provide intensive support to service groups who are implementing the HII care bundles in clinical areas and then monitor compliance within the clinical areas through independent auditing.

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.

Non compliant scores are reported to the lead nurse and the domestic services manager who report to the Assistant Director of Nursing at the accountability meetings. Action plans with agreed responsibilities are then developed.

The evidence reviewed indicated that staff are achieving compliance with the scheduled weekly audits however quarterly and managerial audits have not all been completed as per schedule. This is evident in the Adult Mental Health and Disability Services. Discussions with trust representatives and evidence reviewed confirm that non compliant schedules are escalated to the monthly accountability meetings in the same format as non compliant EC audit results.

Accountability meetings can assist the estates service in prioritising estates issues identified during audits, however action on some of these issues can be delayed due to lack of ring fenced budgets and capital investment.

Documentation reviewed evidenced that there are tight controls on the reporting of non compliant scores within each directorate. The IPC lead meets with the Assistant Director of Nursing prior to the accountability meetings to review the data and information forwarded from each directorate. Following accountability meetings, the Executive Director of Nursing can ask the ward/department team, including Estates and Support Services, to an Exception Meeting to address outstanding issues such as poor audit scores and recurrent non compliance, to determine what action plans have been put in place and to decide if disciplinary measures need to be initiated. Ward teams are required to provide a written improvement plan which is discussed and monitored with their lead professional. This shows the commitment and a robust accountability framework at all levels within the trust to deal with infection prevention and control and environmental cleanliness risk factors.

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.

IPC and Support Services have collectively drawn up guidelines for cleaning procedures. Work is on target and it is anticipated that the guidelines will be approved at the July 2011 IPC Committee meeting. The Housekeeping Group has also invited the IPC lead to attend their meetings. This has been accepted and demonstrates further partnership working with these two disciplines.

## 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 and evidence provided, indicate that HCAI and environmental cleanliness performance data is disseminated through the line management structures to all staff. At present the trust is in the process of completing the trust dashboard which will provide a web based system for viewing audit scores within each directorate.

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 available on the trust intranet which all staff in Tyrone County Hospital have access to.

Audit scores are available at ward level of all the relevant key performance indicators for that ward and are documented on the whiteboard for staff, the public and patients to view. Information in the Day Procedure Unit was posted on a temporary stand. The absence of a fixed board would indicate a lack of permanency which was visibly displayed in other areas. Hand hygiene and EC scores are populated onto the Performance and Planning Share Point which is available to all staff.

Examples of performance indicators for the ward are:

- Environmental cleanliness
- Hand hygiene audits
- Care bundles e.g. Peripheral lines
- Who surgical checklist
- Early warning signs

Each IPC nurse has responsibility for specific facilities to support and guide staff in the delivery of safe, effective and evidence informed practice, this involves ensuring action plans are implemented following IPC audits. Hand hygiene, environmental cleanliness, RCA, HII care bundles and IPC mandatory training attendance are standing agenda items on all directorate and team meetings.

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 and initiatives;

- A funding application regarding an initiative to provide information on various IPC themes and not just on *Clostridium difficile*.
- A trial in the Altnagelvin site on air cleansing equipment in conjunction with the University of Ulster and industry.
- Raising the profile of IPC week in the trust NOW magazine.
- *Clostridium difficile infection* (CDI) project. This involves IPC monitoring staff giving out information leaflets and bringing staff nurses with them when carrying out CDI audits. The objective is to further educate staff.
- A survey conducted by an IPC nurse titled *Clostridium difficile: A Patient's Perspective*
- Initial talks with Northern Ireland Ambulance Service on documentation for the insertion of peripheral lines.

There is evidence of a culture from "Board to Ward" to reduce HCAI by the implementation and monitoring of both the IPC three Year Strategic Plan and the Executive Priority Assurance Framework. The latter is a tool to support the development and prioritisation of clear and deliverable plans owned and operated by the directorates. Directorate management are to review the matrix and develop delivery plans to provide assurance within the agreed timescale. The document is comprehensive however the format and use of a mixture of shades of the same colour is confusing. It is suggested that the format and colour differentiation are reviewed for ease of reading.

Discussion with IPC and support services 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**

- 12. The trust should ensure that all facilities are provided with a permanent visible display board for HCAI and EC results.**

## 7.0 Environment

### STANDARD 2.0 GENERAL ENVIRONMENT

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

General Environment	Ward 12	DPU
Reception	82	93
Corridors, stairs lift	N/A	N/A
Public toilets	N/A	N/A
Ward/ department - general (communal)	85	88
Patient bed area	90	92
Bathroom/washroom	97	N/A
Toilet	92	90
Clinical room/ treatment room	86	86
Clean utility room	N/A	92
Dirty utility room	91	77
Domestic store	86	90
Kitchen	95	96
Equipment store	86	N/A
Isolation	92	N/A
General information	100	100
<b>Average Score</b>	<b>90</b>	<b>90</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.

Ward 12 was generally clean, some minor improvement was required in the cleaning of shelving in the clinical room and equipment store. High level dust was observed at the front entrance, in the toilets, treatment room and Room 5, cobwebs were observed in the reception

and exterior windows of the patient bed area, dirty utility, equipment store and Room 5.

In the Day Procedure Unit cobwebs were noted in the ceiling light fittings in reception and the skylight window of the domestic store was dirty. More attention is required to ensure that raised toilet seats and the inside and exterior of toilet bowls are clean. In the dirty utility room the taps, sluice hopper and seal behind the sink were dirty. It should be noted that no cleaning issues were identified in the general ward, treatment room, clean utility room and kitchen of the Day Procedure Unit.

## 7.2 Clutter



Picture 2 Neat and tidy bed space

In Ward 12 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 (Picture 2).



Picture 3 Cluttered dirty utility

In contrast in the Day Procedure Unit, due to the lack of storage facilities, some areas had a cluttered appearance, in particular the dirty utility, catheter room and treatment room (Picture 3).

Due to the lack of available work surfaces in the treatment room of both wards, procedure trolleys were used as the work surface. Throughout the Day Procedure Unit they were also used to store equipment as adequate storage facilities were not available.

## 7.3 Maintenance and Repair

Paintwork damage on walls and exposed wood was observed on the doors, door frames and some horizontal surfaces of both wards. Flaking paint was observed on the ceilings in Ward 12. In the Day

Procedure Unit, damaged flooring had been partially repaired outside the kitchen and required repair in the dirty utility room. In the equipment store of Ward 12, the cracked and split flooring compromises the floor underneath. It is important that all surfaces are sealed, intact and repairs are completed to ensure that effective cleaning can be undertaken.

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

In Ward 12, the toilets, showers and bathrooms have been refurbished to a high standard and are a good example of well designed facilities which provide an environment to promote best practice.

In both wards some fixtures and fittings were damaged, especially in the patient bed areas, domestic store and treatment room. Wear and tear was noted on cupboards, shelves and patient lockers with laminate chipped or missing. Some tables and chairs were worn to the bare wood and in Ward 12 some chairs and footstools had torn upholstery which exposed the interior foam. Split fabric can act as a reservoir for bacteria and is not easily cleaned therefore any equipment with torn covering should be repaired/replaced.

There was no dedicated hand washing sink in the dirty utility room in the Day Procedure Unit and the dirty utility room facing the kitchen in Ward 12. This room is also used by support services to empty buckets.

#### **7.5 Information**

An agreed set of core HCAI public information leaflets was available for patients and visitors, hand hygiene posters were widely displayed throughout the hospital and the areas inspected (Picture 4). Clear instructions were in place to advise staff and visitors of isolation precautions in place.



Picture 4 Large visible hand hygiene poster in reception

## **Recommendations**

- 13. 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.**
- 14. All areas within the ward environment should be maintained clutter free.**
- 15. The trust should continue to work on the repair and maintenance of ward and public environments and to replace damaged fixtures and fittings.**

## 8.0 Patient Linen

### STANDARD 3.0 PATIENT LINEN

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

Linen	Ward 12	DPU
Storage of clean linen	100	89
Storage of used linen	94	82
Laundry facilities	N/A	N/A
<b>Average Score</b>	<b>97</b>	<b>86</b>

## 8.1 Management of Linen

Inspectors observed in Ward 12 effective arrangements in place for the storage of clean linen. Linen was found to be clean, tidy and free from rips and tears however the chipped framework of some linen skips for used linen negatively affected the scores.

In the Day Procedure Unit a hole was noted in the wall of the linen store and the skylight was dirty. Due to lack of storage space, used linen trolleys and clean linen trolleys covered with protective plastic were stored in the corridor and used linen bags were stored in the dirty utility room. This room was very small and staff confirmed linen bags containing used linen are sometimes stored on top of a commode.

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.

### Recommendations

**16. The trust should ensure that linen skips remain in good repair.**

**17. The trust should ensure the storage of clean and used 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	Ward 12	DPU
Handling, segregation, storage, <b>waste</b>	98	92
Availability, use, storage of <b>sharps</b>	100	91

### 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.

There was no secure external waste compound for Ward 12. Large locked yellow eurobins and laundry cages were stored at the back door, accessible to the public and presenting a poor impression to the public entering or exiting the hospital.

Issues in the Day Procedure Unit which affected the scoring were related to staff practice and the poor repair of some bins. In the clinical room, waste was not segregated in waste bins according to trust policy and in the catheter room a clinical waste bin was more than 2/3 full.

### 9.2 Sharps

Staff in Ward 12 are to be commended for achieving full compliance in this section of the audit tool and in the Day Procedure Unit an improvement in staff practice could easily improve compliance.

In both areas sharps boxes in use conformed to BS7320 (1990)/UN9291 standards. Boxes were assembled correctly and labelled with locality, one sharps container in the Day Procedure Unit was not dated or signed. It is good practice to correctly label boxes to ensure 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 also observed during the inspection that the temporary closure mechanism, to prevent spillage and impede access, was not in place when a sharps box in the clinical room was not in use.

### **Recommendations**

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

## 10.0 Patient Equipment

### STANDARD 5.0 PATIENT EQUIPMENT

#### *Cleanliness and state of repair of general patient equipment*

Patient Equipment	Ward 12	DPU
Patient equipment	89	88

The cleaning of patient equipment in both wards was generally of a good standard, most equipment was visibly clean. In Ward 12 the inspectors observed incorrect storage of patient bowls, urinals and bedpans, old, worn and chipped equipment and a commode which was rusted in places and had a torn seat. Surfaces which are not intact compromise the cleaning process and can act as a potential reservoir for bacteria.



Picture 5 Rusted commode chair

In the day procedure unit the underside of a commode was stained, rusted and the cushioned seat was damaged (Picture 5). Damage was noted to a hoist and a suction machine was dusty.

In both wards inspectors observed that laryngoscope blades, and in the day procedure unit the ambu bags, were removed from their sterile packaging. 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 decontaminated 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 in the case of a manufacturer's recall and safety.

## **Recommendations**

- 19. The trust and individual staff have a collective responsibility to ensure that staff knowledge is kept up to date; equipment is clean and in good repair.**
- 20. Staff should ensure that sterile and single use equipment remains in its original packaging.**

## 11.0 Hygiene Factors

### STANDARD 6.0 HYGIENE FACTORS

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

Hygiene Factors	Ward 12	DPU
Availability and cleanliness of wash hand basin and consumables	92	72
Availability of alcohol rub	100	100
Availability of PPE	85	80
Materials and equipment for cleaning	95	100
<b>Average Score</b>	<b>93</b>	<b>88</b>

In some of the bays in Ward 12 the ratio of hand washing sinks did not meet the national guidelines.

Common to both wards but more prevalent in the Day Procedure Unit was the supply of overflows and plugs at sinks which were designated hand washing sinks (Picture 6). Overflows to sinks, basins, baths and bidets are not recommended, as they constitute a constant infection control risk much more significant than the possible risk of damage due to water overflowing (Health Technical Memorandum (HTM) 64). Also as hands are to be washed under running water, a plug should not be available.



Picture 6 Handwashing sink in clinical room

Attention to detail was required in the Day Procedure Unit in cleaning the old and worn sink in the dirty utility, liquid soap dispensers and the underside of paper towel dispensers. Elbow operated taps or mixer taps with thermostatically controlled water were not available in the clinical room, sluice room, side room or catheter room. It is advised that a risk assessment of the availability of appropriate hand washing

facilities is carried out in both areas to identify prioritising replacement fixtures.

The inspectors observed in both wards a limited number of apron dispensers. It is advised that a review of the availability and location of PPE dispensers within each unit is carried out in partnership with Infection Prevention and Control team. In Ward 12 the ward manager confirmed a requisition had been placed for additional apron dispensers.

### **Recommendations**

- 21. The trust should ensure that hand washing sinks are available in line with national guidelines.**
- 22. The trust should ensure that hand washing sinks, fixtures and fittings and consumables are clean, working and in a good state of repair.**
- 23. The trust should risk assess the availability of appropriate hand washing facilities in both areas to identify prioritising replacement fixtures, or put in place alternative processes to facilitate hand hygiene practices.**
- 24. The trust should review the availability and location of PPE dispensers within each unit.**

## 12.0 Hygiene Practices

### STANDARD 7.0 HYGIENE PRACTICES

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

Hygiene practices	Ward 12	DPU
Effective hand hygiene procedures	100	100
Safe handling and disposal of sharps	100	100
Effective use of PPE	95	100
Correct use of isolation	100	94
Effective cleaning of ward	100	100
Staff uniform and work wear	100	100
<b>Average Score</b>	<b>99</b>	<b>99</b>

Staff in both wards are to be commended for achieving full compliance in five sections of the audit tool which reflects the good hygiene practices observed during the inspection process. In Ward 12 face/eye protection was not available to protect staff from potential splashes.

In the Day Procedure Unit inspectors were informed that there was a patient undergoing an endoscopy procedure who had had a previous health care acquired infection. The alert organism was identified on the patients care pathway however the pathway contained no reference to the isolation and standard precautions required.

### Recommendations

- 25. The trust should ensure the continued development and implementation of care plans that reflect the infection prevention and control needs of the patient and infection prevention and control practices of staff.**

## 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

- Mr Joe Lusby - Deputy Chief Executive
- Mr Edmund Hodgkinson - Consultant Physician
- Ms Fiona Beattie - Assistant Director Acute Services
- Ms Judith Houlahan - Lead Nurse/Head of Secondary Care for Older People
- Ms Maureen Kelly - Head of Support Services
- Mr Miles Smyth - Head of Specialist Services and Medical Engineering, Estates
- Ms Maeve Brown - Divisional Nurse
- Ms Clare Robertson - Infection Prevention and Control Nurse
- Mr Dermott Loughran - Senior Operator Manager Estates
- Ms Mary Melley - Outpatient Department Manager TCH
- Ms Allison Maclean - Support Services Manager
- Ms Carole Reid - Ward Manager Day Procedure Unit
- Ms Catherine Mc Manus - Ward Manager Ward 12
- Ms Dymphna Lynch - Infection Prevention and Control Nurse
- Mr Jason Doherty - Support Services Housekeeping

Video and Telephone link from outside Tyrone County Hospital site

- Ms Anne Witherow - Assistant Director Nursing
- Ms Wendy Cross - Lead Nurse Governance and Performance
- Ms Cherry Lynn - Divisional Nurse for Surgery and Anaesthetics
- Ms Mandy Gormley - Clinical Governance Manager

### 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

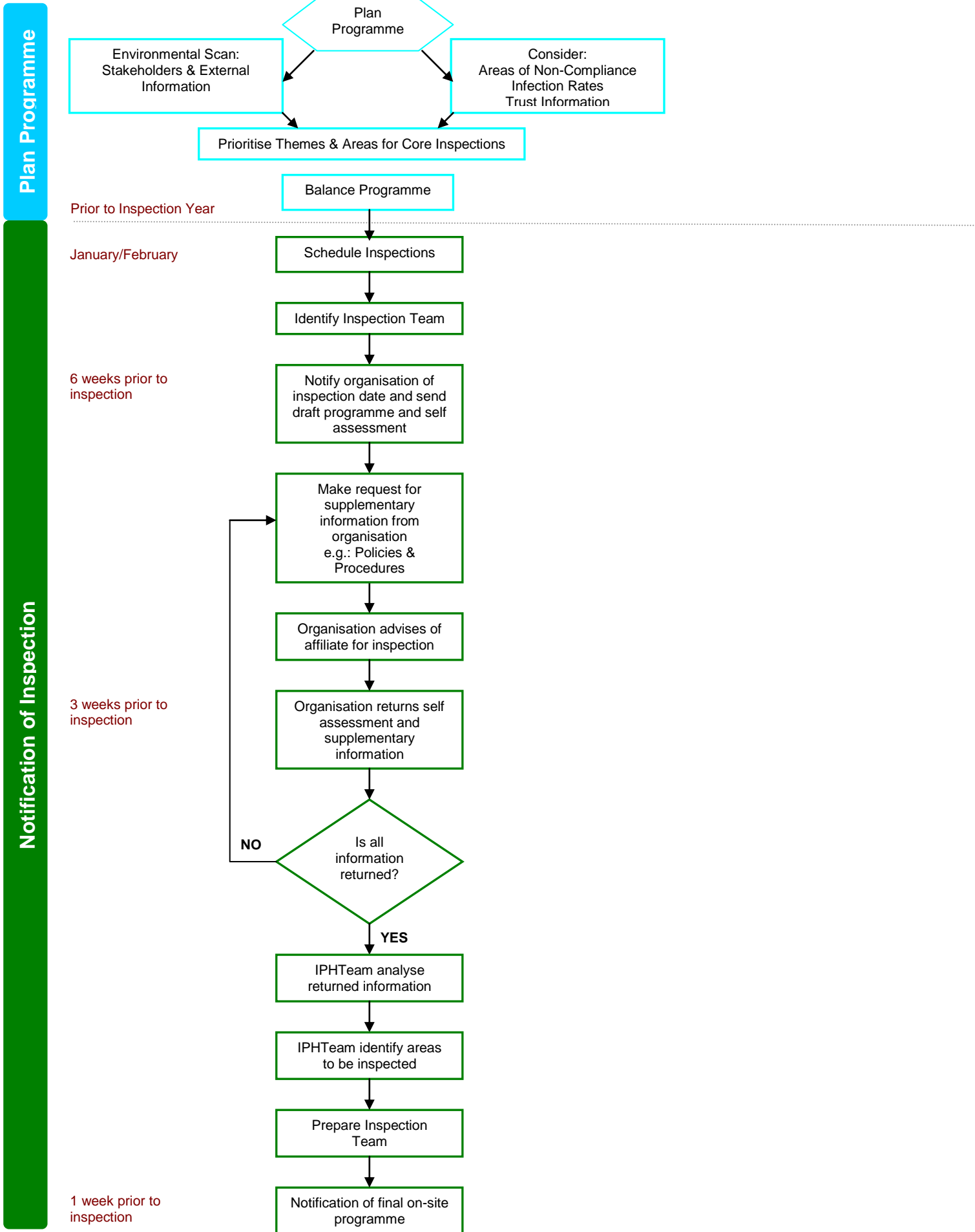
This information is currently available on request and will be available in due course on the RQIA website.

## **14.0 Summary of Recommendations**

- 1. The trust should update the Environmental Cleanliness Strategy.**
- 2. The trust should publish an Environmental Cleanliness annual report.**
- 3. The trust should ensure there is a policy for handling infected linen.**
- 4. The trust should ensure that all policies are reviewed and updated as necessary and follow a standardised style guide to include identified roles and responsibilities, scope, objectives and a review date.**
- 5. The trust should ensure that the EC Controls Assurance Standards action plan is finalised; address any gaps in the EC or IPC action plans and include timescales for the actions required.**
- 6. The trust needs to ensure that risk registers and key information on infection, prevention and control and environmental cleanliness have identified risk status categories and identified timescales.**
- 7. The trust should review the present training for PCSS team leaders and managers and secure funding for training.**
- 8. The trust need to review and improve the recording and monitoring systems that are currently in place to ensure compliance with mandatory training.**
- 9. The trust should ensure that accountability for infection prevention and control is outlined in all job descriptions.**
- 10. It is recommended that the trust ensures managerial audits are carried out according to the agreed schedule.**
- 11. The trust should develop user participation in the relevant committees as part of the overall process of public assurance and public participation.**
- 12. The trust should ensure that all facilities are provided with a permanent visible display board for HCAI and EC results.**
- 13. 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.**

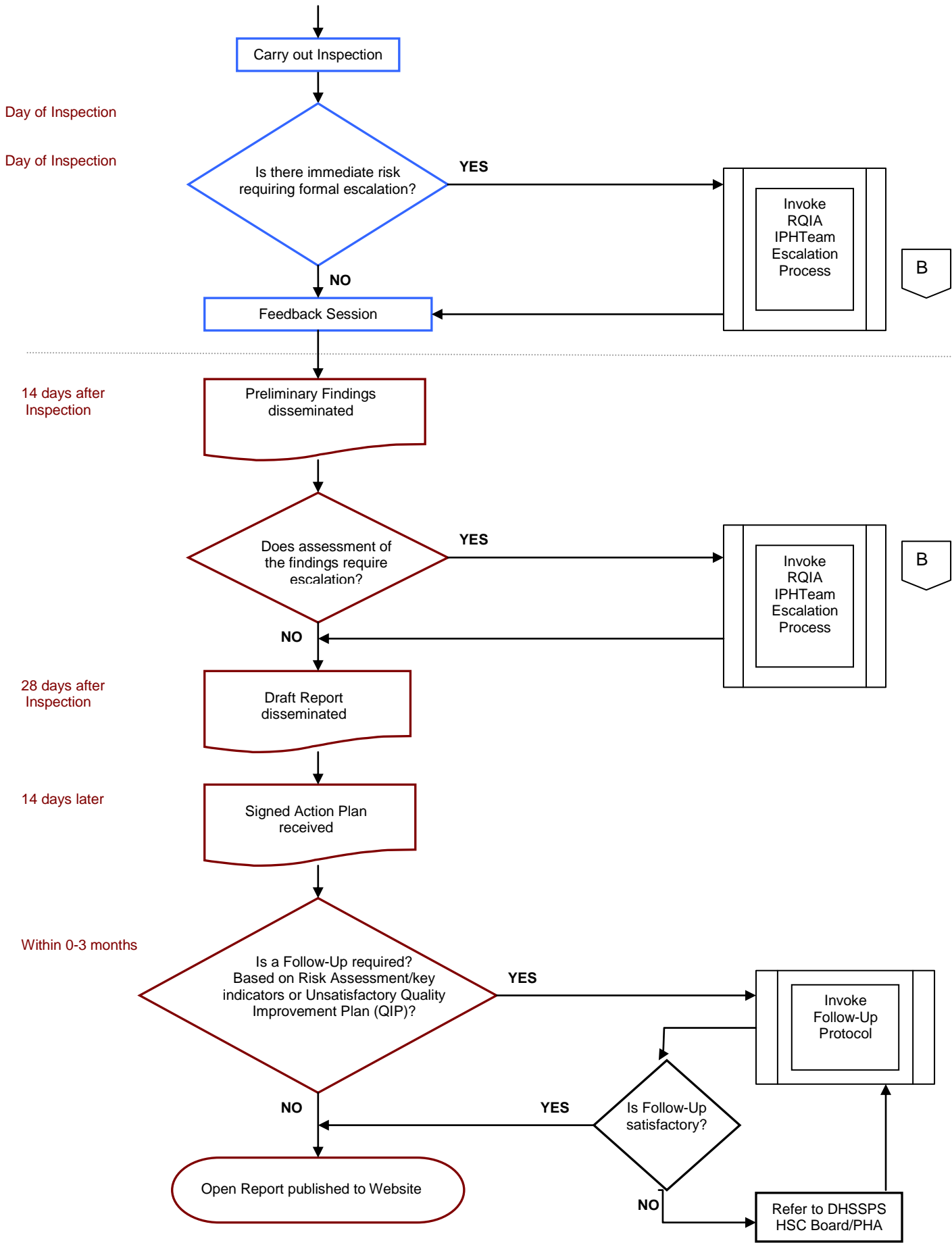
- 14. All areas within the ward environment should be maintained clutter free.**
- 15. The trust should continue to work on the repair and maintenance of ward and public environments and to replace damaged fixtures and fittings.**
- 16. The trust should ensure that linen skips remain in good repair.**
- 17. The trust should ensure the storage of clean and used linen in an appropriate environment.**
- 18. 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.**
- 19. The trust and individual staff have a collective responsibility to ensure that staff knowledge is kept up to date; equipment is clean and in good repair.**
- 20. Staff should ensure that sterile and single use equipment remains in its original packaging.**
- 21. The trust should ensure that hand washing sinks are available in line with national guidelines.**
- 22. The trust should ensure that hand washing sinks, fixtures and fittings and consumables are clean, working and in a good state of repair.**
- 23. The trust should risk assess the availability of appropriate hand washing facilities in both areas to identify prioritising replacement fixtures, or put in place alternative processes to facilitate hand hygiene practices.**
- 24. The trust should review the availability and location of PPE dispensers within each unit.**
- 25. The trust should ensure the continued development and implementation of care plans that reflect the infection prevention and control needs of the patient and infection prevention and control practices of staff.**

# 15.0 Announced Inspection Flowchart



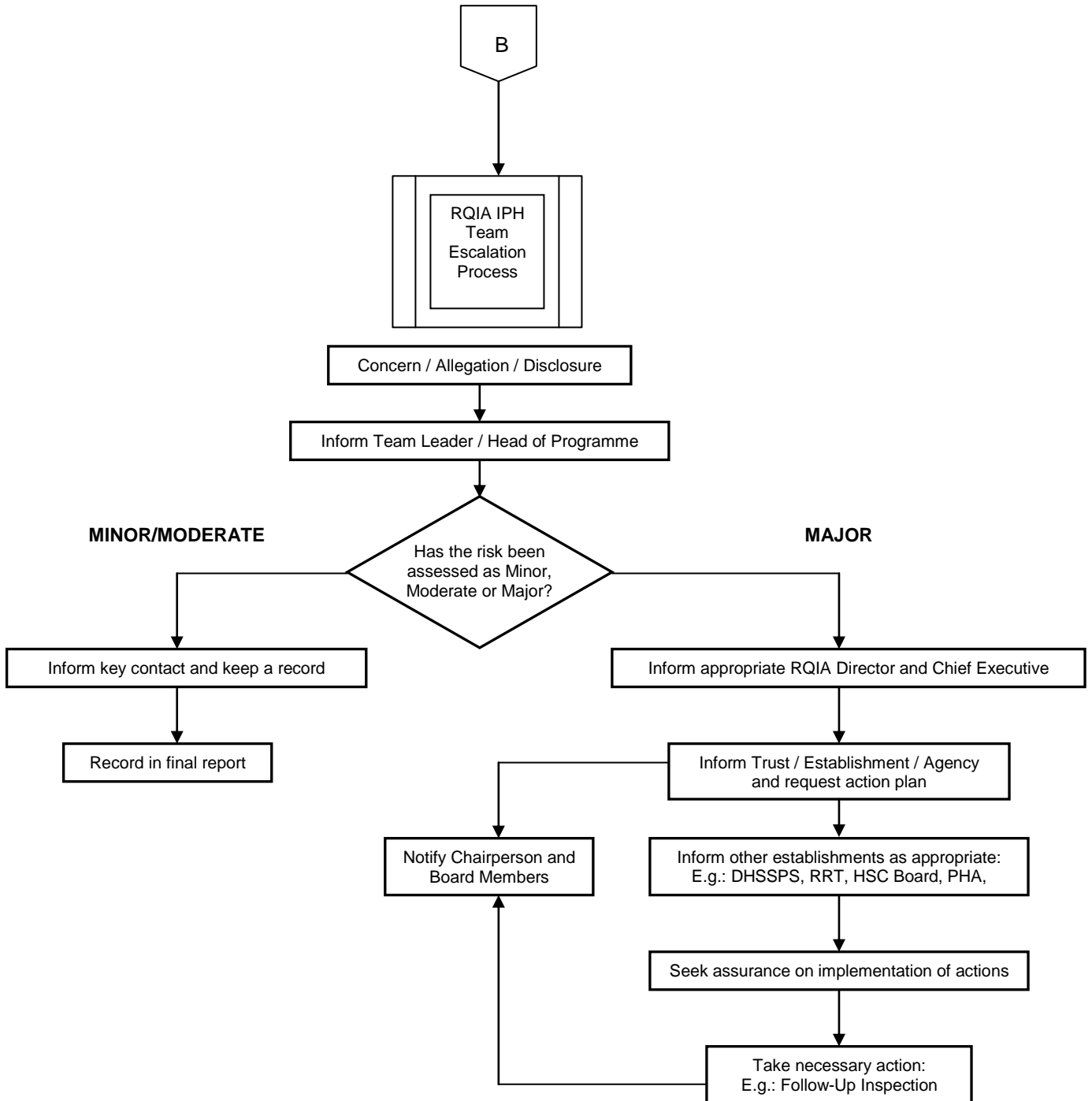
Episode of Inspection

Reporting & Re-Audit



# 16.0 RQIA Hygiene Team Escalation Process

## RQIA Hygiene Team: Escalation Process



## 17.0 Action Plan

### Recommendations

Reference number	Recommendation	Designated department		Date for completion/ timescale
1	The trust should update the Environmental Cleanliness Strategy	Professional Nursing	Work has commenced on the updating of the strategy but we are also waiting the updated regional strategy to ensure there is a harmonisation of approach	On-going and will depend on the release of the regional strategy to complete
2	The trust should publish an Environmental Cleanliness annual report.	Professional Nursing	Agreed an annual EC report will be published	Commenced and will be produced 11-12
3	The trust should ensure there is a policy for handling infected linen.	Support Services	This policy is currently being drafted for circulation for comment by other members of staff	August 2011
4	The trust should ensure that all policies are reviewed and updated as necessary and follow a standardised style guide to include identified roles and responsibilities, scope, objectives and a review date.	Medical Directorate	This recommendation will be tabled at the next Risk Management and Standards committee meeting in July 2011	July 2011
5	The trust should ensure that the EC Controls Assurance Standards action plan is finalised; address any gaps in the EC or IPC action plans and include timescales for the actions required.	Professional Nursing/ Infection Prevention and Control	Commenced and on going	October 2011
6	The trust needs to ensure that risk registers and key information on infection, prevention and control and environmental cleanliness have identified risk status categories and identified timescales.	Professional Nursing/ Infection Prevention and Control	Review of the risk register in relation to EC and IP and C commenced and will be updated in line with this recommendation	October 2011

Reference number	Recommendation	Designated department		Date for completion/ timescale
7	The trust should review the present training for PCSS team leaders and managers and secure funding for training.	Support services	Training and development plan for PCSS team leaders in development and will be delivered in conjunction with the Trusts' Management and Development Department. Team leaders currently complete BICS training	To be commenced October 2011 and will be ongoing
8	The trust need to review and improve the recording and monitoring systems that are currently in place to ensure compliance with mandatory training.	Human Resources	The Trust has just secured permanent funding for a staff member to manage an electronic data base to record all mandatory training Recruitment commenced	September 2011
9	The trust should ensure that accountability for infection prevention and control is outlined in all job descriptions.	Infection prevention and Control Human resources	Discussions commenced and on-going with HR regarding the form of words to be included in the Trust Job Descriptions which will clearly outline the roles and responsibilities of staff in relation to Infection prevention and Control	September 2011
10	It is recommended that the trust ensures managerial audits are carried out according to the agreed schedule.	Professional Nursing	Managerial audit schedules for the incoming year have been established and the team agreed to undertake The directors will receive a quarterly report high lightening the area which have not completed this activity to allow for corrective action to take place	Commenced and on-going

Reference number	Recommendation	Designated department		Date for completion/ timescale
11	The trust should develop user participation in the relevant committees as part of the overall process of public assurance and public participation.		On -going challenge for the Trust. Proactive measures taken but to date and it has been very difficult to secure agreement from members of the public to join these committees. Discussed at a recent Trust Quality and Safety committee meeting and agreed that we will try a different approach to securing public involvement.	Ongoing
12	The trust should ensure that all facilities are provided with a permanent visible display board for HCAI and EC results.	Professional Nursing	Wards and Departments have been advised to purchase boards for the purpose of displaying information Agreement on how this information will be presented will be discussed at the September 2011 Trust Nursing and Midwifery Governance Committee	Commenced and on going
13	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.	Support services Estates Professional Nursing	There is a monthly meeting of all heads of services and the issue of roles and responsibilities is discussed. Patient equipment is now included in the monthly audit programme currently being rolled out with the maximize electronic tool	Commenced and ongoing
14	All areas within the ward environment should be maintained clutter free.	Performance and Planning	A review of the de-clutter programme will be tabled at the next Environmental Cleanliness Steering Group to agree the de-clutter programme for 11-12.	July 2011
15	The trust should continue to work on the repair and maintenance of ward and public environments and to replace damaged fixtures and fittings.	Nursing and Estates Services	This is included in the annual backlog maintenance plan	ongoing

Reference number	Recommendation	Designated department		Date for completion/ timescale
16	The trust should ensure that linen skips remain in good repair	Support Services	This will be included in the management of the bed linen policy and will be included in the pt equipment checks	August 2011
17	The trust should ensure the storage of clean and used linen in an appropriate environment.	Support Services	Will be included in linen policy and will be highlighted in the audit tool	August 2011
18	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.	Infection Prevention Control/ Facilities Management	This is a joint responsibility between Facilities Management and Nursing/Heads of Departments and a joint policy has been approved by CMT which includes monitoring  This has been implemented in 2 pilot wards and will be extended to TCH	Commenced and will be on going
19	The trust and individual staff have a collective responsibility to ensure that staff knowledge is kept up to date; equipment is clean and in good repair.	Directors	The Trust has both a decontamination policy and a policy for the management of broken and faulty equipment. Staff will be reminded to follow the guidance in relation to these	On-going
20	Staff should ensure that sterile and single use equipment remains in its original packaging.	Directorates	This is an on-going issue which is highlighted in Infection Prevention and Control training programmes	On- going
21	The trust should ensure that hand washing sinks are available in line with national guidelines.	Capital Development/ Performance and Planning	These guidelines will be adhered to in future building programme including the plans for the TCH	Links with no.23 and in light of the new build once risk assessments carried out a decision will be made re replacement.

Reference number	Recommendation	Designated department		Date for completion/ timescale
22	The trust should ensure that hand washing sinks, fixtures and fittings and consumables are clean, working and in a good state of repair.	Performance and Planning	The Trust has both cleaning schedules and defect maintenance procedures in place Staff will be reminded of the correct process to follow to ensure fixtures and fitting are clean and also how to report broken and faulty equipment	Commenced and on- going
23	The trust should risk assess the availability of appropriate hand washing facilities in both areas to identify prioritising replacement fixtures, or put in place alternative processes to facilitate hand hygiene practices.	Infection Prevention Control  Planning and Performance	A clinical risk assessment will be conducted and a prioritised list of additional hand washing sinks or alternative processes developed  Estates will implement once the risk assessment of need is completed and funded	Work in progress
24	The trust should review the availability and location of PPE dispensers within each unit.	Infection Prevention Control	A review will be undertaken to ensure there is an adequacy of PPE dispensers within wards/department	September 2011
25	The trust should ensure the continued development and implementation of care plans that reflect the infection prevention and control needs of the patient and infection prevention and control practices of staff.	Professional Nursing	The Trust is launching a review of nursing record keeping and this will commence in the Autumn 2011  Infection Prevention Control flow charts with evidence based clinical guidance will be included within the new nursing records  Guidance on care planning will be included within this piece of work also However, in the interim staff have been working on a local resolution to their care plans in relation to day procedure area and the infection prevention and control requirements.	Due to commence in the Autumn 2011 depending on the funding regionally



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