The Regulation and Quality Improvement Authority

Unannounced Augmented Care Inspection

Royal Jubilee Maternity Hospital
Neonatal Unit
Year 3 Inspection

23 August 2017

Contents

1.0 Profile of Service

The three year improvement programme of unannounced inspections to augmented care areas commenced in the Royal Jubilee Maternity Hospital Neonatal unit on 18 July 2013.

The unit cares for premature babies, sick babies, any baby requiring special care and those babies who may need special attention during the first days of life.

Service Details

Responsible Person: **Mr. Martin Dillon**	Position: **Chief Executive of the Belfast Health and Social Care Trust**

What We Look for

Inspection Audit Tools

During a three year cycle all neonatal units were initially assessed against the following regionally agreed standards and audit tools:

- Regional Neonatal Infection Prevention and Control Audit Tool
- Regional Infection Prevention and Control Clinical Practices Audit Tool
- Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool

These Inspection tools are available on the RQIA website www.rqia.org.uk.

2.0 Inspection Summary

This is the third inspection of a three year inspection cycle undertaken within neonatal care units. Initially, in year one of this inspection cycle all neonatal units were assessed against all three audit tools: the regional neonatal infection prevention and control audit tool, the regional infection prevention and control clinical practices audit tool and the regional healthcare hygiene and cleanliness standards audit tool. Compliance was assessed in each separate area by taking an average score of all elements of each tool. The agreed overall compliance target scores were 85 per cent in the first year, rising to 90 per cent in the second year and 95 per cent in year three. The table below sets out agreed compliance targets.

	Year 1	Year 2	Year 3
Compliant	85% or above	90% or above	95% or above
Partial Compliance	76% to 84%	81 to 89%	86 to 94%
Minimal Compliance	75% or below	80% or below	85% or below

In this neonatal unit (Royal Jubilee Maternity Hospital), the overall year three compliance target of 95 per cent had already been achieved in relation to one of the three regional audit tools (the regional neonatal infection prevention and control audit tool) during the unit's unannounced inspection in 2015/16 (year two of the inspection cycle). Therefore the standards and areas assessed by this tool was not in the unit's year three inspection.

The focus of this year three unannounced inspection was to assess practice only against standards contained within the regional infection prevention and control clinical practices audit tool and the regional healthcare hygiene and cleanliness audit tool. Only those standards that had been identified in previous inspections as requiring improvement (in order to achieve year three compliance) were assessed. During this inspection we also reviewed the neonatal unit's improvement plans (current and/or previous) and discussed any quality improvement initiatives established and in place since the unit's last inspection visit.

The findings of this unannounced inspection were discussed with trust representatives, as part of the inspection process and can be found in the main body of this report.

This report can be read in conjunction with year one and two inspection reports which are available www.rqia.org.uk.

https://www.rqia.org.uk/inspections/view-inspections-as/map/royal-victoria-hospital/

This inspection team found evidence that the neonatal unit in the Royal Jubilee Maternity Hospital has continued to improve and implement regionally agreed standards.

Within clinical practices we found improvement in the management of invasive devices, enteral feeding, and blood cultures and MRSA (Meticillin-resistant Staphylococcus aureus). We have continued to observe good compliance and improvement with environmental cleanliness practice and procedures.

After reviewing improvement plans with the unit lead nurse, we were satisfied that all necessary actions had and continue to be progressed. Details of these can be found in section 6.

We were informed of some positive improvement initiatives within the unit that are included within the body of this report.

Escalation procedures were not required for this inspection. Our escalation policies and procedures are available on the RQIA website.

The RQIA inspection team would like to thank the Belfast Health and Social Care Trust and in particular all staff at Royal Maternity Hospital Neonatal Unit for their assistance during the inspection.

Please note: this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service provider from their responsibility for maintaining compliance with all relevant legislation, standards and best practice.

3.0 Inspection findings

The Regional Infection Prevention and Control Clinical Practices Audit Tool

The regional infection prevention and control clinical practices audit tool and regional healthcare hygiene and cleanliness audit tool provide a common set of overarching standards for all hospitals and other healthcare facilities in Northern Ireland. The audit tool covers a number of areas which are assessed individually using a number of standards.

Compliance targets in each individual area are the same as those set out earlier in relation to overall compliance scores.

	Year 1	Year 2	Year 3
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Partial Compliance	76% to 84%	81 to 89%	86 to 94%
Minimal Compliance	75% or below	80% or below	85% or below

The overall year three compliance target of 95 per cent had already been achieved in relation to one of the three regional audit tools (the regional neonatal infection prevention and control audit tool) during the unit's unannounced inspection in 2015/16 (year two of the inspection cycle). Therefore the standards and areas assessed by this tool were not assessed in the unit's year three inspection. Only those standards that had been identified in previous inspections as requiring improvement (in order to achieve year three compliance) were assessed.

As the full audit tool was not required for this inspection an overall score is not available. Only those individual areas which contributed to a compliance target of 95 per cent not previously been achieved were assessed.

The table below includes the areas of the audit tool that were assessed during this inspection and also gives the compliance rates in these areas in both year two (2015/16) and this year three (2017/18) inspection.

Table 1: Clinical Practices Compliance Level

Area inspected	Year 2	Year 3
Invasive Devices	82	97
Taking Blood Cultures	89	100
Enteral Feeding or tube feeding	88	100
Screening for MRSA colonisation and decolonisation.	94	100

We observed improvement in the completion of invasive device documentation in relation to the peripheral venous cannula, central venous catheters, blood cultures and enteral feeding. It is essential that accurate records of the insertion and ongoing management of invasive devices continue to be maintained. We observed that invasive lines were appropriately labelled to prevent wrong route administration, in line with the regional line labelling policy.

The unit had introduced new peripheral venous cannula recording documentation which includes a section to record the cannula batch number. The recording of the device batch number ensures effective traceability in the event that actions are required to reduce safety risks to patients and users for example remove or recall of a device.

Policies for commonly used invasive devices within the unit have been reviewed and updated since the previous inspection. The clinical educator has continued with a programme of update training for new and longer term staff in the insertion and management of invasive devices. Unit medical and nursing staff are also working together to develop a DVD on the insertion of long lines for staff to reference.

A process to monitor staff compliance with enteral tube feeding has been introduced. This helps ensure that a consistent and standard approach is taken to this procedure. We were informed that levels of MRSA amongst neonates within the unit are low. Staff were knowledgeable in management of neonates with MRSA.

The Regional Healthcare Hygiene and Cleanliness Audit Tool

Table 2: Healthcare Hygiene and Cleanliness Compliance Level

Areas Inspected	Year 1	Year 3
General environment	86	99

We observed compliance and continued improvement with the staff practices, systems and process to maintain good environmental cleanliness. The unit environment and patient equipment was clean and in good repair. The addition of a unit housekeeper has been a very positive step to support the running of the unit by for example organising and ordering stores, checking equipment and liaising with maintenance therefore allowing nursing staff more time to deliver care. Improvements have been made to unit facilities, with most recently the addition of a new medical consultation room.

There was good completion of documentation in relation to cleaning. Cleaning continues to be quality assured by patient client support staff (PCSS) supervisors. A new incubator is to be introduced to the unit and PCSS staff have received training on how to clean this, in line with the manufacturer's guidance. PCSS supervisors carry out quality checks on the cleaning of incubators, but they have not received the competency based training to carry out this role. Spot check audits of neonatal equipment are not carried out.

These issues are to be reviewed as outlined in previous improvement plan actions.

Clinical hand wash sinks were clean, well maintained and located near to the point of care. We observed good hand practice and there is ongoing peer auditing to provide assurance of adherence to best practice.

Picture 1: Hand Hygiene Audit

Quality Improvement Initiatives

Since the previous inspection on 16 and 17 September 2015, the neonatal unit had focused on a number of quality improvement initiatives.

In planning for the future development of a new neonatal unit, a mock up room has been developed, equipped to full neonatal specification. This has allowed staff to view and comment on the room layout and design, and inform them on how the new unit will function.

The introduction of a treatment room has improved clinical care. The room facilitates post-natal attendance at the unit for blood sampling and eye appointments. 'Home from home' spaces are to be developed within the unit to place neonates approaching discharge, who require only minimal care intervention. A new breast milk temperature recording tool has been introduced to ensure milk it stored and transported at its optimal temperature. A variety of groups continue to function and develop practices in care e.g. nutrition group.

A pictorial guide has been developed for parents outlining the expected neonate journey while in the unit. The lead nurse also plans to restart the parents group in order to receive input and experiences from parents who are and have used the neonatal service.

The lead nurse has developed some creative initiatives to improve unit staffing levels and ensure forward planning for future staff retirement and natural attrition. Nurse team working has been reviewed, with staff now rotating to different areas of the unit every four weeks.

This ensures all staff are given the same level of responsibility and opportunity to learning, improving staff satisfaction in their role and ultimately their knowledge and experience in neonatal care. Allied health professionals have been designated to the unit, this has been valuable in using their expertise to deliver short bespoke training sessions for unit staff.

Nursing handover is now electronic, reducing time spent by staff taking notes at handover and the structure of unit safety briefings have been reviewed.

The inspection team observed that staff within the neonatal unit are engaged and committed to quality initiatives and collaborative working in order to drive forward improvement in the delivery of care.

4.0 Key Personnel and Information

Members of the RQIA Inspection Team

Ms S O'Connor	Senior Inspector, Healthcare Team
Mr T Hughes	Inspector, Healthcare Team
Ms M Keating	Inspector, Healthcare Team

Trust Representative Attending local Feedback Session

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

Ms B Kelly	Head of Midwifery & Neonatology
Ms K Devenney	Senior Manager, Nursing
Ms S Hamilton	Service Manager/ Lead Midwife
Ms M O'Dowd	Practice Educator
MS R Gillan	Infection Prevention & Control Nurse
Ms G Doherty	Infection Prevention & Control Nurse
Ms J Boyle	Infection Prevention & Control Nurse

5.0 Improvement Plan – Year 3 (2017/18)

This improvement plan should be completed detailing the actions planned and returned to Healthcare.Team@rqia.org.uk for assessment by the inspector. The responsible person should note that failure to comply with the findings of this inspection may lead to further action. The responsible person should ensure that all actions for improvement are progressed within the specified timescales.

Reference number	Actions for Improvement	Responsible Person	Action/ Required	Date for completion/ timescale
Regional Augmented Care Infection Prevention and Control Audit Tool.				
None Required				
Regional Infection Prevention and Control Clinical Practices Audit Tool				
None Required				
Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool				
None Required				

6.0 Improvement Plan – Year 2 and Year 1 (Updated by the Trust)

Year 2 (2015/16)
The Regional Neonatal Care Infection Prevention and Control Audit Tool
The Regional Infection Prevention and Control Audit Clinical Practices Audit Tools

Improvement Plan – Year 2 (2015/16)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
Regional Neonatal Care Infection Prevention and Control Audit Tool.					
1.	Infection prevention and control staffing levels should be reviewed to facilitate daily visits to the unit.	IPC	A recent IPT was submitted by the Trust to the HSC Board. Unfortunately the funding allocation, which was very welcome, did not fully meet the needs of the Trust as outlined in our IPT. There are 22 augmented care areas in the BHSCT.	Ongoing	Ongoing close collaboration – with IPC Team including weekly IPC Team visits to NICU.
2.	The trust should continue to maintain staffing levels in line with BAPM recommendations.	BHSCT	This has been taken forward and the BHSCT are in the process of recruiting 8 band 6 staff. The vacancies have gone through 'scrutiny' and at the earliest, the advert will go to press during the week of 2nd November. Interviews would then take place during the week of 7th December.	February 2016	Recruitment remains a priority and current staffing levels support the 29 commissioned cots. Staff experience, skills and absence will

Improvement Plan – Year 2 (2015/16)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
					continue to influence the number of cots available to ensure safe patient care.
3.	Adherence to core clinical space recommendations and an improvement in the facilities available within the unit should be reviewed as part of any refurbishment/new build planning.	Project Team, New Maternity Hospital	It is recognised that the current facility does not adhere to core clinical space recommendations however this has been addressed in the design of the new maternity hospital.	Late 2019	The current projected completion of new build and commissioning process in preparation for opening is 2021.
4.	Terminal cleans should be signed off by domestic staff when carried out and the cleaning randomly validated by supervisors.	PCSS/NICU	From 1st October 2015 PCSS have implemented a discharge clean recording sheet. All discharge cleans are recorded and signed off by the Neo Natal Domestic Staff. PCSS supervisors then randomly select and check discharge cleans daily. Record Sheets are held with PCSS supervisors.	October 2015	In place and ongoing records kept.

Improvement Plan – Year 2 (2015/16)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
5.	All specialist equipment should be cleaned and adherence to cleaning guidelines routinely audited.	PCSS/NICU	PCSS Staff are responsible for the decontamination of incubators (all other equipment is the responsibility of Neo Natal staff) From 1st November 2015 PCSS Supervisors have been carrying out monthly checks with Neo Natal domestic staff to ensure that staff are following the correct process when decontaminating incubators. Records are held with PCSS Supervisor. i.e. • When an incubator has been cleaned PCSS staff will complete and sign record sheet which will include the incubators serial number • PCSS Supervisors will countersign on the record sheet • PCSS Supervisor will carry out on a monthly-basis verification of the incubator decontamination process with each member of the PCSS staff who work in the Neo Natal Unit to ensure competence.	November 2015	In place and ongoing records kept.

Improvement Plan – Year 2 (2015/16)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
			• All records will be held on file in the PCSS Supervisors office.		
6.	It is recommended that in regard to cleaning neonatal incubators competency based training and annual competency assessment for staff is carried out. This process should be supported by robust cleaning documentation.	PCSS/NICU	Competency based training to be performed and annual assessment of staff performing the procedure carried out. PCSS have contacted the company representative to arrange staff training during December. Annual assessment of PCSS staff performance in regard to equipment cleaning will be performed by NICU IPC lead nurse. This has been agreed with PCSS/ IPCT/Neo Natal Staff Groups.	December 2015	In place and ongoing records kept. Annual assessment is performed by PCSS Supervisor as the NICU IPC lead does not receive the specific training to dismantle, clean and reassemble the incubators.
7.	It is recommended that a risk assessment is carried out for the collection and storage of breast milk and specialised infant formula.	NICU-	We are currently developing an audit tool to ensure that the collection and storage of breast milk and infant formulas meet current guidance.	November 2015	A temperature check is performed and documented on all DEBM and milk coming from the milk kitchen on arrival to the unit.

Improvement Plan – Year 2 (2015/16)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
					Milk storage fridge/ freezer temps recorded daily and actioned if not within accepted temp range. Developing an information leaflet (led by NICU Dietitian) for parents regarding storage of EBM at home and safe transport to NICU, plan to have available September 2018. Currently exploring a labelling system similar to pharmacy labels for specialist readymade formula milks to reduce risk of errors in administration,

Improvement Plan – Year 2 (2015/16)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
					unable to define exact time for completion. When suitable system identified business case will be prepared however would endeavour to have in place by December 2018.
8.	It is recommended that the temperature of donor expressed breast milk is recorded on arrival to the unit.	NICU	To record temperature within the packed box of frozen donor breast milk on arrival from the Donor Milk Bank. The unit has contacted the milk bank and other NICU's in the region. A process has been put in place to record the temperature of frozen donor breast milk on arrival in our unit.	October 2015	In place and ongoing records kept.

Improvement Plan – Year 2 (2015/16)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
Regional Infection Prevention and Control Clinical Practices Audit Tool					
9.	It is recommended that Invasive devices and blood culture policies and guidelines are reviewed and updated.	NICU	Policies and procedures to be reviewed and updated. We have nursing staff with dedicated time to review and update our policies and procedures on a rolling programme.	Ongoing	Ongoing review and development of policies and procedures.
10.	It is recommended that staff adhere to trust policies and guidelines, this should include completing all relevant documentation (blood culture, invasive devices, orogastric/nasogastric).	NICU	All staff to be updated on completing documentation required pertaining to blood culture, invasive devices and nasogastric tubes etc. Several methods of communication are used i.e. daily safety briefs, monthly Sister's meetings, bi-monthly staff meetings, unit newsletter, email, notice boards, short 'teaching sessions' and staff appraisals.	November 2015	Ongoing update and education of staff regarding new/updated policies and procedures– e.g. Regional Guidance of line labelling. Communication continues by Safety briefs, staff meetings, emails, notices, '2 minute updates', afternoon short information sharing/ learning sessions.

Improvement Plan – Year 2 (2015/16)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
11.	It is recommended that electronic/computer aided prescribing tools should be available to assist with antimicrobial prescribing.	Pharmacy	An electronic prescribing tool is not currently available however consideration is being given for an agreed system for the new maternity hospital.	Late 2019	An electronic prescribing tool is not currently available however consideration was being given for the new maternity hospital.
12.	Compliance with the enteral feeding protocol and guidance should be audited and actions plans developed where issues are identified. Independent verification should be carried out if applicable.	NICU	To develop an audit tool for compliance with the enteral feeding protocol and guidance. The unit practice educator is currently developing a tool and networking with other HSCT. A pilot of the tool will be performed in Nov/Dec and adjustments made as required.	December 2015	In place and ongoing records kept.
13.	Adherence to the MRSA policy and care pathway should be audited. Independent verification should be carried out if applicable.	IPC	Audit to be performed on adherence to the MRSA tool and care pathway on the occasion of an identified MRSA in the neonatal unit.	With next positive MRSA isolate**.**	The tool is used when an identified MRSA in the neonatal unit.

Improvement Plan – Year 2 (2015/16)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
14.	Infection control audits should be carried out on achievement of isolation.	IPC	If babies are identified as requiring isolation an audit will be performed on achievement of isolation.	Current	This is current practice.

Year 1 (2013/14)
Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool

Improvement Plan – Year 1 (2013/14)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool					
Standard 2: Environment					
1.	Staff should ensure all surfaces including furniture, fixtures and fittings are clean and free from dust.	Nursing PCSS	Each baby's space and surrounding surfaces, fixtures and fittings is cleaned twice daily and recorded.	Complete	In place and ongoing records kept.
2.	A maintenance programme should be in place to ensure all building repairs are carried out.	Nursing Estates	Repairs required resulting from weekly Cleanliness Matters audits are reported to Estates via computer or telephone. There is no formal maintenance programme, however there has been ongoing refurbishment for the last four years.	Ongoing	In place and ongoing records kept, all repairs/damage reported to estates and record maintained of works to be done and completed.
3.	Storage facilities within the unit should be reviewed and improved.	Nursing Estates Redevelopment	Building has limited storage facilities and this will continue to be a problem despite current refurbishment. Solution is new build. Adequate storage will not be available until new build opens.	Dec 2016	Ongoing equipment and consumables management, maintaining a clutter-free environment.

Improvement Plan – Year 1 (2013/14)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
4.	Drugs fridge temperature checks should be carried out and recorded on a daily basis. Drugs fridges should be kept clean and free from paper labels.	Nursing PCSS	Fridges have been cleaned and paper labels removed. Temperature checks are now carried out and recorded daily.	Complete	In place and ongoing records kept.
5.	Hand washing sinks should be available in the domestic store and dirty utility room.		This room is under refurbishment	Jan 2014	Complete
6.	Information posters and leaflets should be readily available for staff and patients; inoculation injury and hand hygiene.	Nursing	Hand hygiene posters are now available at every sink. Inoculation injury pathway available on the intranet and in the unit.	Complete	Complete
7.	The draft 'cleaning of the bed space' policy should be finalised and detailed nurse cleaning schedules developed.	Nursing	Cleaning of bed space procedure now in place Nurse cleaning schedules will be developed.	Complete Dec 2013	In place and ongoing records kept.
Standard 3: Patient Linen					
8.	The linen store should be free from dust, debris and in a good state of repair.	Nursing PCSS	Dust and debris has been removed and this is now included in weekly cleaning schedules.	Complete	Complete and included in weekly cleaning schedules.

Improvement Plan – Year 1 (2013/14)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
9.	Used and soiled linen should be segregated as per trust policy. Soiled linen should be stored in the appropriate linen receptacle.	Nursing	The management of used and soiled linen has been reinforced with all staff in relation to Trust policy.	Complete	Complete, ongoing shared information and staff education e.g. Induction of new staff and daily safety briefs.
Standard 4: Waste and Sharps					
10.	All staff should ensure the correct segregation of waste.	Nursing	Correct segregation of waste has been reinforced with all staff.	Complete	Complete, ongoing shared information and staff education e.g. Induction of new staff and daily safety briefs.
11.	Waste bins should be clean and readily available for use. Waste bin labels should be intact.	Nursing	Waste bins have been cleaned and labels are intact.	Complete	Complete
12.	All sharps box temporary closure mechanisms should be in place when sharps boxes are not in use.	Nursing	Safe practice and the management of sharps have been reinforced with all staff.	Complete	Complete, currently involved in 'Improving Sharps Practice Project' with Health & Safety, Partnered with Nursing and User Experience.

Improvement Plan – Year 1 (2013/14)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
					This is a quality improvement and learning opportunity for our unit.
Standard 5: Patient Equipment					
13.	Patient equipment must be clean. Stored patient equipment should be ready for use with trigger tape in situ to identify that it has been cleaned.	Nursing	The correct use of trigger tape has been reinforced with all staff.	Complete	Complete and ongoing update and education for staff.
14.	Incubators that are dusty and waiting repair should not be stored in the clean equipment store. Incubators should be cleaned prior to repair.	Nursing	A decontamination room is now available. Incubators requiring repair will be cleaned here before being stored in the clean equipment room.	Complete	Complete.
Standard 6: Hygiene Factors					
15.	Damaged wooden alcohol dispensers wall mounts should be repaired and the inside of the domestic trolley cleaned.	Nursing	Domestic trolley cleaned, The one wooden dispenser wall mount will be removed during refurb work.	Complete	Complete.
16.	All chemicals should be stored in a locked, inaccessible area in accordance with COSHH regulations.	Nursing	With the opening of the new decontamination area this problem has been addressed.	Complete	Complete, Lockable COSHH cupboards in all clinical areas.

Improvement Plan – Year 1 (2013/14)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
Standard 7: Hygiene Practices					
17.	All staff should carry out hand hygiene prior to donning gloves.	Nursing	The Hand Hygiene policy has been reinforced with all staff. Hand Hygiene audits continue.	Complete and ongoing	Complete and ongoing.
18.	Needles should not be re-sheathed.	Nursing	Sharps policy reinforced with all staff.	Complete	Complete and ongoing.
19.	Nursing staff should be updated on the domestic colour-coded system, cleaning equipment and the procedure for routinely changing cleaning equipment.	Nursing	Nursing staff have been updated.	Complete	Complete and ongoing.
20.	Care plans in use for neonates with infection required more detail on the infection prevention and control practices in place.	Nursing	Staff encouraged to record more detail regarding infection and the management in the care plan.	Complete	Complete, staff encouraged to use and record relevant details in care plan.
21.	All staff should adhere to the trust dress code policy.	Nursing	Staff awareness of dress code policy has been reinforced.	Complete	Complete and ongoing monitoring of standard of dress and presentation. Staff emailed policy, 19/02/18. Issues addressed, when identified, by line manager.

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