The Regulation and Quality Improvement Authority

Unannounced
Augmented Care Inspection
Ward 4F
Royal Victoria Hospital
17-18 October 2019

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

Contents

1.0 Profile of Service

An unannounced inspection was undertaken to the Royal Victoria Hospital on 17 October 2019.

- Ward 4F (Neurosurgery)

Ward 4F is a 27 bedded Regional Acute Neurosurgical ward. It is located within A block of the Royal Victoria Hospital in the Belfast Health and Social Care Trust (BHSCT). Although funded for 27 beds there were 6 beds closed during the inspection.

Previous infection prevention and hygiene inspection reports of the Royal Victoria Hospital are available on the RQIA website www.rqia.org.uk

Service Details

Responsible Person: **Mr. M Dillon**	Position: **Chief Executive Officer** **Belfast HSC Trust**

What We Look for

Inspection Audit Tools

This augmented care ward was assessed against the following regionally agreed standards and audit tools:

- Regional Augmented Care 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

The table below summarises the overall compliance levels achieved in each standard/section. Scores were allocated a level of compliance using the categories described below.

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

Inspection Tools	Compliance Level
Regional Augmented Care Infection Prevention and Control Audit Tool.	**93**
Regional Infection Prevention and Control Clinical Practices Audit Tool.	**87**
Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool.	**96**

This inspection team comprised of four inspectors from RQIA's HSC Healthcare Team. Details of our inspection team and Belfast Trust representatives who participated in a local feedback session delivered in the Royal Victoria Hospital on 18 November 2019 can be found in Section 7.0.

Through discussion, examination of documentation and observation of practices, we found that infection prevention and control (IPC) governance arrangements were good. Ward staff had a good knowledge and awareness of how to manage infections. The trust IPC team were available to provide support and advice as required.

Local and regional audits were undertaken to improve IPC practices and mandatory and non-mandatory surveillance programmes were in place. We observed that the core clinical space around patients' beds and the number of single occupancy rooms was not within the current recommended specification. The ability to isolate patients with suspected or confirmed infections was being impacted by numbers of available nursing staff.

An up to date overarching trust water safety plan and individual risk assessment were in place. Local screening policies/procedures were in place to inform clinical and IPC practice. Work is required to embed the infection communication protocol into practice.

Staff displayed a clear understanding on the principles of aseptic non-touch techniques (ANTT) with good adherence to ANTT procedures.

Independent validation audits were being carried out on the ward in relation to the management of invasive devices. Some work is required to improve action plans, policy and documentation for invasive devices.

Staff who obtain blood cultures were knowledgeable in the correct technique however compliance with best practice in obtaining a blood culture was not being monitored. Up to date antimicrobial guidelines and a dedicated ward pharmacist was in place. We observed good microbiology ward support which ensures that there is direct microbiological advice at the bedside.

Guidance and care pathways on the management of Clostridium *difficile* infection (CDI) and Meticillin Resistant Staphylococcus Aureus (MRSA) were available and known to staff, although both policies have passed their review date. It had been 1142 days from the last MRSA bacteraemia; staff were commended for this achievement. An antibiotic policy is in place to guide staff on prescribing treatment for CDI; however adherence to this policy is not routinely audited as part of antimicrobial prescribing audits.

While staff displayed good knowledge on the management of a nasogastric feeding tube there were occasions when this was not reflected in practice, improvement work is required.

The ward was in good decorative order and a high standard of environmental cleanliness was observed throughout. Patient equipment was clean and in a good state of repair. Staff demonstrated good practice in the management of linen, sharps and the disposal of waste. We observed good practice in the use of personal protective equipment and hand hygiene. Hand hygiene was performed at the correct moments, and at the correct location, within the flow of care delivery.

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

RQIA would like to thank the Belfast Health and Social Care Trust and in particular staff at the Royal Victoria Hospital Ward 4F for their assistance during this 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: Regional Augmented Care Infection Prevention and Control Audit Tool

The Regional Augmented Care Infection Prevention and Control Audit Tool contains six sections. Each section aims to consolidate existing guidance in order to improve and maintain a high standard in the quality and delivery of care and practice in augmented care. This will assist in the prevention and control of healthcare associated infections.

Regional Augmented Care Infection Prevention and Control Audit Tool Compliance Levels

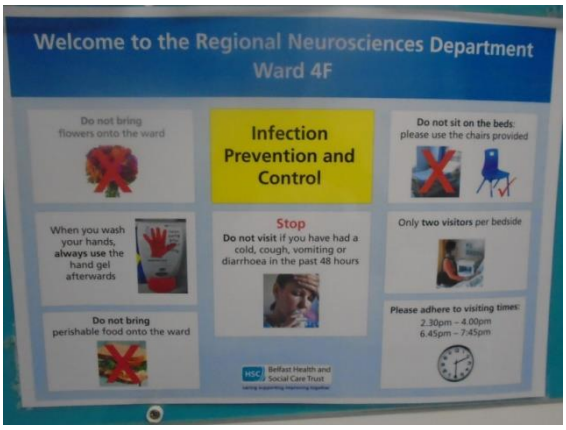
Areas Inspected	
Local Governance Systems and Processes	91
General Environment – Layout and Design	83
General Environment – Environmental Cleaning	100
General Environment – Water Safety	100
Clinical and Care Practice	86
Patient Equipment	100
Average Score	**93**

Local Governance Systems and Processes

Areas of good practice

- During the inspection, the ward sister displayed good leadership, management and knowledge on IPC and the necessary measures to take in managing infection within the ward.
- Throughout the inspection ward staff reported that they had a strong relationship with the IPC team who were very supportive in providing advice and assisting with IPC initiatives.
- The ward had a number of nominated IPC link staff that attends IPC hospital link meetings.
- We observed evidence that incidents relating to IPC were appropriately reported and acted on. A multidisciplinary approach was taken to these incidents and minutes from staff meetings highlight that staff receive timely feedback from such incidents.
- Local and regional audits were undertaken to improve IPC practices and environmental cleanliness. Audit results evidenced good compliance with IPC performance indicators and were clearly displayed for visitors to the department. Additionally inspectors were provided with evidence of independent validation of ward based IPC audits. Inspectors noted that robust action plans had been completed where previous audits identified poor practices.
- Reviewed ward documentation evidenced a range of meetings, from management level to frontline staff which feed into each other.

- Key IPC information is reported to staff through the safety briefs which were undertaken daily within the department.
- Occupational Health guidance was available on the trust intranet site to provide advice and guidance for trust staff in managing common infectious conditions.
- Mandatory and non-mandatory surveillance programmes were in place. The trust surveillance programme was effective in identifying an increased incidence of MRSA within the ward in 2018 which allowed for interventions to be implemented and swiftly managing this safety incident.
- We observed a range of leaflets and posters to inform visitors to the department of the importance of hand hygiene and actions to minimise the risk of infection e.g. not to visit if you have a cold, cough or vomiting (Picture 1).



Picture 1: IPC Visitors Guidance Poster

Areas for improvement

- IPC training is mandatory within the trust, 69 per cent of ward staff have completed this training. Inspectors were informed that challenges faced with staffing recruitment had meant that it is difficult to release staff to attend the mandatory IPC training. Managers were working to address this issue.
- During the inspection, we observed that some patients, who were identified with an infectious organism, were not always isolated in a side room even though side rooms were available. Staff reported that these patients, due to the nature of their condition would additionally need enhanced observation and with a limited availability of staff, risk based decisions are taken resulting in some patients being cared for in multi-bedded bays. We were informed that these placement decisions were risk assessed in consultation with members of the IPC team. For one patient who fits this group, we could not evidence a documented individual risk assessment or variance to best practice within the nursing notes.

Action for Improvement

1. **For patients identified with infectious organisms and isolation cannot be facilitated, ward nursing staff should ensure that an individual risk assessment is clearly documented within the patient nursing notes. Robust monitoring of this practice should be in place to provide ongoing assurance.**

General Environment - Layout and Design

Areas of good practice

- There was a separate clean and dirty utility rooms and clean storage areas allowing for clean to dirty workflow. Clinical hand wash sinks were positioned appropriately to prevent splashing of patients, beds and equipment.
- Clinical support spaces throughout the ward were available and used effectively to ensure a clutter free environment.
- Inspectors evidenced that ventilation systems were routinely monitored, serviced and cleaned by estates department.

Areas for improvement

- The ward consists of four six bedded bays and five side rooms. The core clinical space around patients' beds for the delivery of care was not within 80 per cent of the minimum dimensions currently recommended for existing facilities by the Department of Health (DoH). Although the core clinical space did not meet current recommended requirements, staff were working within these limitations to deliver safe and effective care.
- There were five single rooms available for the isolation of patients within the ward. This is not in line with numbers recommended by the DoH and outlined in the audit tool; a minimum of four single rooms per eight beds is recommended.

Action for Improvement

2. **As part of any refurbishment/new build programme, the trust should comply with best practice guidance on design and planning.**

General Environment - Environmental Cleaning

Areas of good practice

- Environmental cleaning guidelines, audit and staff competency based training were in place and reviewed.
- On questioning, staff had good knowledge on appropriate cleaning procedures. There was a regular programme of de-cluttering in place.

- We were informed that the trust has a set 6 month deep clean programme.

General Environment - Water Safety

Areas of good practice

- An up to date overarching trust water safety plan and individual risk assessment were in place.
- We were provided with evidence that the trust carries out routine water sampling for Legionella and Pseudomonas *aeruginosa* from all water outlets within the ward.
- Evidence was available to confirm that results from water analysis were reported to the trust water safety group and the Augmented Care group for review.
- All water outlet flushing records were available and completed appropriately.
- Throughout the inspection we observed that hand washing sinks were used correctly - only for hand washing.
- One sink within the ward had been clearly identified for the drawing of water for patient hygiene purposes (Picture 2).

Picture 2: Clearly identified ‘safe source sink’

Clinical and Care Practice

Areas of good practice

- We observed that the ward maintains records of patient placement and movement within the ward.
- Local screening policies/procedures were in place which inform clinical and IPC practice. Screening records were reflective of local policy.
- We observed protocols in place to guide staff in the appropriate washing of patients to negate the risk of transmission of infection.

Areas for improvement

- A communication protocol was in place to advise that when patients are admitted or transferred to or from the ward, the sending or receiving wards/ facilities are explicitly made aware of positive screening/ sample results. However, some staff when questioned were unaware of this communication protocol and were uncertain as to their responsibilities in managing this information.

Action for Improvement

3. Ward management staff should ensure that all staff are aware of their responsibilities in line with the communication protocol for ensuring that sending or receiving wards are explicitly informed of any positive screening results.

Patient Equipment

Areas of good practice

- Specialist equipment inspected was clean and in a good state of repair.
- Staff displayed good knowledge on the use of patient equipment identified for single use only.
- There was guidance and routine auditing of the cleaning, storage and replacement of specialised patient equipment.

4.0 Inspection Findings: Regional Infection Prevention and Control Clinical Practices Audit Tool

The Regional Infection Prevention and Control Clinical Practices Audit Tool contain nine sections. The observations of key clinical procedures have shown to reduce the risk of infection if performed correctly. Each section aims to consolidate and build on existing guidance in order to improve and maintain a high standard in the quality and delivery of care and practice in augmented care. This will assist in the prevention and control of healthcare associated infections.

Regional Infection Prevention and Control Clinical Practices Audit Tool Compliance Levels

Areas Inspected	
Aseptic non touch technique (ANTT)	94
Invasive devices	81
*Taking Blood Cultures	78
Antimicrobial prescribing	85
Clostridium *difficile* infection (CDI)	96
Surgical site infection	100
Ventilated (or tracheostomy) care	N/A
Enteral Feeding or tube feeding	75
Screening for MRSA colonisation and decolonisation	89
Average Score	**87**

* Staff practice was not observed during the inspection.
Information was gained through staff questioning and review of documentation.

Aseptic Non Touch Technique (ANTT)

Areas of good practice

- An up to date ANTT policy and guidance was available on the Hub for all staff to access. Nursing staff receive annual training and competency assessment on the principles of ANTT. We were informed by the Clinical Educator that ANTT training and competency assessment for Medical staff has been arranged and is imminent. On discussion with Medical staff this was confirmed. Training updates were provided in line with trust policy.
- Staff displayed a clear understanding on the principles of ANTT with good adherence to ANTT procedures during the preparation and administration of intravenous (IV) antibiotics for patients.
- Independent validation audit scores of ANTT practices carried out on the ward confirmed good compliance by staff to the principles of ANTT.

Areas for improvement

- We observed one instance of poor adherence to ANTT principles by a staff member whilst taking a sample of blood from a patient. The observation was addressed directly with the staff member and reported to the Ward Manager during the inspection.

Invasive Devices

Areas of good practice

- Staff had received online training and competency assessment, demonstrating good knowledge and practice in relation to the management of invasive devices. Policies and procedures were in place and accessible to support staff. Intravenous lines were labelled in line with the current regional line labelling policy.
- Information relating to the insertion of devices was recorded on a sticker and in patient care bundles. We recommend that, for traceability purposes, the information could be further enhanced to include the size and batch number of the device inserted.
- We were provided with evidence of independent validation audits being carried out on the ward in relation to the management of invasive devices and evidence of feedback to staff during ward safety briefs.

Areas for improvement

- We were not provided with evidence of action plans being implemented and reviewed within realistic timescales where audit results indicated poor compliance on the management of invasive devices.
- The peripheral venous catheter (PVC) policy was past its review date (May 2014). We were informed during feedback to the Trust that work to update this policy is progressing.
- Care bundles on the management of peripheral and central venous cannulas were available, the purpose of which is to promote standardisation in staff clinical practice in managing these devices safely. We noted gaps present in the documentation records for the management of two cannulas and no care bundle in place for a central venous access device.

Action for Improvement

4. The Trust should ensure that robust assurance mechanisms are implemented to promote compliance with best practice on the management of invasive devices. Policies to guide staff should be in date and reviewed in accordance with changes in regional/evidence based guidelines.

Taking Blood Cultures

Areas of good practice

- Medical staff demonstrated a good understanding of why and how to take blood cultures to prevent contamination and reduce the risk to patients. A policy was in place and up to date to support staff when taking blood cultures.
- A system was in place to compare the rate of positive and contaminated blood cultures with other trust wards/departments.
- We noted that whilst there was an increase in blood culture contamination rates for the ward during the first quarter of 2019, the results have greatly improved. During feedback to the Trust we discussed this increase and the actions taken to address it. The Trust confirmed that they had reviewed individual cases and provided enhanced ANTT awareness sessions for medical staff.

Areas for improvement

- Not all blood cultures taken could be evidenced in patient notes. Improvement is required in the documentation of taking blood cultures.
- We were informed that the use of blood culture packs is currently being considered by the Trust, the benefit of which would be to support staff adherence to standardising and promoting ANTT practices.
- Medical staff have yet to receive refresher training and competency assessment on taking blood cultures. Compliance with best practice in obtaining a blood culture was not being monitored.

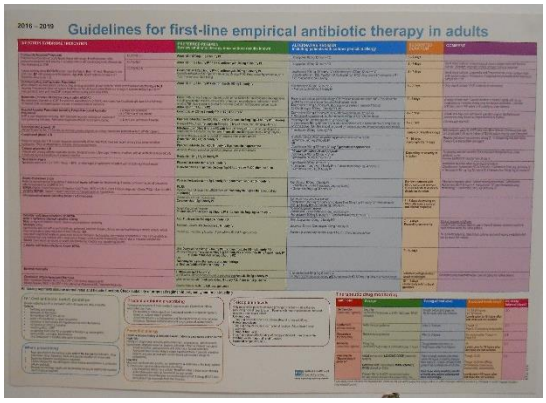
Action for Improvement

5. The Trust should ensure that robust monitoring measures are implemented to provide assurance on the management of taking blood cultures.

Antimicrobial Prescribing

Areas of good practice

- Up to date antimicrobial prescribing guidelines were available on the ward for Medical staff (Picture 3). An antimicrobial prescribing app is also used to support Medical staff in the safe prescribing of antibiotics to treat common infections.



Picture 3: Antimicrobial Prescribing Guidelines Displayed in the Ward

- Medical staff confirmed that they have received information and guidance on antimicrobial prescribing as part of their induction to the ward and staff training.
- A trust wide multidisciplinary antimicrobial stewardship team was in place. This group reviews antimicrobial usage, guideline concordance and other aspects of stewardship in line with its strategic objectives.
- The ward has a dedicated Pharmacist who carries out audits in respect of antimicrobial stewardship.
- Antimicrobial/Microbiology ward rounds occur on a weekly basis.

Areas for improvement

- Consideration should be given to the use of an interactive electronic computer aided prescribing tool which would further support practitioners in clinical decision making regarding prescribing of medications to patients.
- We were informed that the Mini Antimicrobial Stewardship Group (MASG) meets a minimum of twice yearly, however, evidence reviewed related to a meeting in April 2018. We were not provided with evidence of more recent meetings.
- Antimicrobial audit information displayed in the ward was out of date (2017). We were not provided with assurance of actions taken where audit results reflect poor compliance with antimicrobial stewardship.

Clostridium Difficile Infection (CDI)

Areas of good practice

- On the day of inspection the ward was 192 days without CDI, this is to be commended.
- Guidance is available for staff on the management of Clostridium *difficile* infection and staff can easily access and reference the Regional Infection Prevention and Control Manual for Northern Ireland, via the Trust intranet HUB, for advice.
- A policy is available for Post Infection Review of CDI clusters, 2019.

- We observed the 'IPC Matters – Management of Clostridium *difficile'* poster displayed on the ward notice board for staff to view. This guides staff on risk factors, identification and management of CDI.
- A CDI integrated care pathway is in place to ensure standardised staff practice and guide staff in the management of CDI.
- Staff displayed good knowledge on the management of CDI for example isolation precautions, waste management, environmental cleaning.
- A CDI audit tool is available on the Trust HUB for ward staff to self-audit adherence to best practice in the management of CDI.
- In 2018, the IPC team introduced a 'Management of CDI Review' document, to be completed by the IPC nurse when visiting the ward and reviewing care and treatment of a patient with CDI.

Areas for improvement

- The Management of Clostridium *difficile* infection (CDI) Policy, 2014, is past the review date of October 2017. We were advised during feedback to the Trust that this policy had been reviewed and update was near completion.
- An antibiotic policy is in place to guide staff on prescribing treatment for CDI. However adherence to this policy is not routinely audited as part of antimicrobial prescribing audits.

Surgical Site Infection (SSI)

Areas of good practice

- The Trust undertakes mandatory reporting of SSI surveillance to the Public Health Agency (PHA) on cardiac surgery, orthopaedic surgery, neurosurgery and caesarean section delivery. Results for neurosurgery surveillance was reviewed at weekly microbiology meetings.
- In 2018, the ward identified an increase in SSI rates and in conjunction with theatres and IPC regularly meets to review all neurosurgery practices. This resulted in a change in suture material used for surgical wound closure. Future work will include input from tissue viability specialist nurses.
- The ward is currently working with PHA to further develop how data is gathered and confirm data confidence.
- Staff displayed good knowledge on pre and post-operative care of a patient.

Areas for Improvement

- The ward is to continue on improving its surveillance system supported by review and update training, neurosurgical protocols; SSI reports/reporting mechanisms and a dashboard system.

Ventilated (or Tracheostomy) Care

N/A

Enteral Feeding or Tube Feeding

Areas of good practice

- Nurses insert nasogastric feeding tubes and displayed good knowledge of their management.
- There was good documentation for insertion of a nasogastric tube: who inserted the tube, size, route, PH, aspirate. There was no documentation of the type of feed administered; on discussion with the ward manager this is to be introduced.
- The ward clinical educator is progressing work to assess all ward staff competency for insertion of a nasogastric feeding tube and embed the self-assessment process for nasogastric feeding tube insertion and management.

Areas for improvement

- While staff displayed good knowledge on the management of a nasogastric feeding tube there were occasions when this was not reflected in practice. For example, single use water and syringes were not disposed of after use and work area around the patient was cluttered.
- Enteral feeding line labels were available on the ward; however there was variation in their use. For example staff labelled either the nasogastric tube, the feed giving set or did not use a label.
- There is no system in place to monitor compliance with the overall management of a nasogastric feeding tube.

Action for Improvement

6. The Trust should ensure that robust assurance mechanisms are implemented to promote compliance with best practice on the management of enteral feeding.

Screening for MRSA Colonisation and Decolonisation

Areas of good practice

- On the day of inspection the ward was 1142 days without an MRSA bacteraemia, this is to be commended.
- Guidance is available for staff on the management of MRSA and staff can easily access and reference the Regional Infection Prevention and

Control Manual for Northern Ireland, via the Trust intranet HUB, for advice.

- We observed the 'IPC Matters – MRSA management and MRSA bacteraemia' poster displayed on the ward notice board for staff to view. This guides staff on screening and treatment of MRSA.
- An MRSA integrated care pathway is in place to ensure standardised staff practice and guide staff in the management of MRSA.
- Staff displayed good knowledge on the management of MRSA for example screening and treatment.
- An MRSA audit tool is available on the Trust HUB for ward staff to self-audit adherence to best practice in the management of MRSA.
- A policy is available for Post Infection Review of MRSA bacteraemia, 2019.
- Documentation was available to evidence review of events, audit, training, monitoring of staff IPC practice and learning during and following a declared outbreak of MRSA on the ward in 2018.
- Documentation was available to evidence a post infection review of events and learning following an MRSA bacteraemia on the ward in 2015.

Areas for improvement

- The Methicillin resistant *Staphylococcus aureus* (MRSA) Screening and Management of Colonised Patients Policy, 2013, is past the review date of December 2016. We were advised during feedback to the Trust that this policy had been reviewed and update was near completion.
- On review of an MRSA care pathway it was identified the pathway was not fully completed or discontinued when clinically indicated. The completion of a care pathway should be reviewed by ward and visiting IPC staff.
- Unlike the management of a patient with CDI, we were not advised of a document in place for the IPC nurse visiting the ward to use when reviewing care and treatment of a patient with MRSA. The implementation of a system of audit to assure practice, isolation and completion of documentation should be introduced.

5.0 The Regional Healthcare Hygiene and Cleanliness

The Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool provide a common set of overarching standards for all hospitals and other healthcare facilities in Northern Ireland. Inspections using the audit tool gather information from observations in functional areas including, direct questioning and observation of clinical practice and, where appropriate, review of relevant documentation.

The Regional Healthcare Hygiene and Cleanliness Audit Tool

Compliance Levels

Areas Inspected	
General environment	96
Patient linen	100
Waste	94
Sharps	92
Equipment	96
Hygiene factors	97
Hygiene practices	97
Average Score	**96**

A more detailed breakdown of each table can be found in Section 6.

General Environment

Public Areas (Entrance, Reception, Public Toilets, Corridors, Stairs and Lift)
The entrance and the reception area was clean, tidy and in good decorative order. There was evidence of ongoing improvement work; the application of surface protection on walls and doors was in progress. This will minimise the damage caused by the general flow of wheeled and pedestrian traffic. There was evidence of dust and debris on high and low surfaces in the public toilets requiring more attention to detailed cleaning and consideration to the frequency of the cleaning schedule.

Action for Improvement

7. **The standard of cleaning of the public toilets in the main hospital reception area should be improved. Robust monitoring of the public toilets is recommended to provide continued assurance of cleaning practices.**

Areas of good practice

- The ward consists of a combination of patient bay areas and single en-suite rooms. An advantage of having single patient rooms is that it assists in reducing the risk of transmission of infection causing organisms.

- Environmental cleaning in the ward was maintained to a high standard and this was reflected in the ward environmental cleaning score of 96 per cent. Despite being an older ward, fixtures and fittings were generally well maintained with evidence of ongoing improvement works.

- Staff when questioned, were aware of their roles and responsibilities in relation to cleaning of the environment. Detailed cleaning schedules were in place for domestic staff and signed off daily.

- Patient and non-patient areas of the ward were free from excess clutter and organised to allow for ease of cleaning.

Patient Linen

Areas of good practice

- We observed that patient linen was visibly clean, free from damage and stored in a clean and tidy environment. Staff managed linen safely to prevent the spread of microorganisms to those receiving care.

Waste and Sharps

Areas of good practice

- Sharps and waste were managed in line with best practice. Sharps boxes were dated and signed and temporary closures deployed when not in use. Waste was appropriately segregated and stored in a designated secure hold prior to collection.

Equipment

Areas of good practice

- Patient equipment including commodes and moving and handling aids were clean and well maintained.

- Sterile single use items remained in their packaging until they were ready for use and stored in a tidy storage area. (Picture 4)

Picture 4: Tidy and organised storage area.

Area for Improvement

- Gaps were noted in the cleaning schedules and the resuscitation trolley daily check record in use by nursing staff.

Hygiene Factors

Areas of good practice

- Clinical hand wash sinks were clean, located near to the point of care and only used for hand hygiene purposes. We noted that hand washing facilities and a range of consumables were available to enable hand hygiene practices to be carried out effectively.

- Posters reinforcing the correct hand hygiene technique were displayed appropriately at clinical hand wash sinks.

- Information on key performance indicators including hand hygiene and environmental cleaning audits were clearly displayed in the ward to promote public assurance of the ward's performance to IPC standards.

Hygiene Practices

Areas of good practice

- We observed excellent hand hygiene practices from all disciplines in line with best practice.

- Staff working on the ward adhered to the Trust uniform policy.

- When questioned staff were knowledgeable on IPC practices and procedures, including the management of needle stick injuries and the use of disinfectant for equipment and environmental decontamination.

Area for Improvement

- When questioned several staff were uncertain of the correct dilution rates of disinfectant required to decontaminate blood spillages effectively.

- We observed several visiting staff were not compliant with the bare below the elbow practice while in the clinical area.

6.0 Level of Compliance Tables

Standard 2: General Environment

For organisations to comply with this standard they must provide an environment which is well maintained, visibly clean, free from dust and soilage.

General Environment Standards Public shared areas	
Reception	90
Public toilets	97
Corridors, stairs lift	84

General environment Standards wards or departments	
Ward/department - general (communal)	90
Patient bed area	93
Bathroom/washroom	91
Toilet	98
Clinical room/treatment room	98
Clean utility room	100
Dirty utility room	99
Domestic store	94
Kitchen Area	95
Equipment store	94
Isolation	N/A
General information	100
Average Score	**96**

Standard 3: Patient Linen

For organisations to comply with this standard, patient linen should be clean, free of damage, handled safely and stored in a clean and tidy environment.

Patient Linen	
Storage of clean linen	100
Storage of used linen	100
Laundry facilities	N/A
Average Score	**100**

Standard 4: Waste and Sharps

For organisations to comply with this standard they must ensure that waste is managed in accordance with HTM07-01and Hazardous Waste (Northern Ireland) Regulations (2005).

Waste and Sharps	
Handling, segregation, storage, waste	94
Availability, use, storage of sharps	92

Standard 5: Patient Equipment

For organisations to comply with this standard they must ensure that patient equipment is appropriately decontaminated.

Patient Equipment	
Patient equipment	96

Standard 6: Hygiene Factors

For organisations to comply with this standard they must ensure that a range of fixtures, fittings and equipment is available so that hygiene practices can be carried out effectively.

Hygiene Factors	
Availability and cleanliness of wash hand basin and consumables	98
Availability of alcohol rub	100
Availability of PPE	94
Materials and equipment for cleaning	95
Average Score	**97**

Standard 7: Hygiene Practices

For organisations to comply with this standard they must ensure that healthcare hygiene practices are embedded into the delivery of care and related services.

Hygiene Practices	
Effective hand hygiene procedures	96
Safe handling and disposal of sharps	100
Effective use of PPE	100
Correct use of isolation	N/A
Effective cleaning of ward	92
Staff uniform and work wear	97
Average Score	**97**

7.0 Key Personnel and Information

Members of the RQIA inspection team

Mr T Hughes	-	Inspector, Hospitals Programme Team
Ms S O'Connor	-	Inspector, Hospitals Programme Team
Ms J Gilmour	-	Inspector, Hospitals Programme Team
Ms L O'Donnell	-	Inspector, Hospitals Programme Team
Ms R Brennan	-	Inspector, Hospitals Programme Team

Trust representatives attending the feedback session

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

Mr F Young	-	Co-Director Neurosciences
Ms M Stirling	-	Ward Sister
Ms C Lundy	-	Service Manager
M K Hughes	-	Clinical Co-ordinator Neurosciences
Ms C Kearns	-	Assistant Support Services Manager and Environmental Cleaning
Ms B Porter	-	Support Services Manager PCSS
M J McKeown	-	Interim Lead Infection Prevention & Control Nurse
Ms R Robb	-	Infection Prevention & Control Nurse

Apologies
None

8.0 Improvement Plan

This improvement plan should be completed detailing the actions planned and returned to RQIA's Healthcare Team via the web portal 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.

Please do not identify staff by name on the improvement plan.

Reference number	Recommended Actions	Responsible Person	Action/ Required	Date for completion/ timescale
Regional Augmented Care Infection Prevention and Control Audit Tool.				
1.	**For patients identified with infectious organisms and isolation cannot be facilitated, ward nursing staff should ensure that an individual risk assessment is clearly documented within the patient nursing notes. Robust monitoring of this practice should be in place to provide ongoing assurance.**	Ward Sister, Clinical Educator, Nurse Development Lead and Clinical Coordinator.	Awareness sessions for staff to ensure they understand documentation required to explain variance when patient not isolated. Weekly audits of individual risk assessments documented within the nursing notes for those patients identified with infectious organisms and isolation cannot be facilitated and actions shared with staff to provide learning. This will ensure robust monitoring in order to provide ongoing assurance.	Review January 2020

2.	**As part of any refurbishment/new build programme, the trust should comply with best practice guidance on design and planning.**	Ward Sister, Co-Director, Estates Department, Clinical Coordinator, Service Manager, Chair of Division, Divisional Nurse and Clinical Director.	Liaison and planning to continue with Estates department and anti-ligature for current projects and any future programmes of refurbishment / new build to ensure best practice guidance is considered on design and planning.	ongoing
3.	**Ward management staff should ensure that all staff are aware of their responsibilities in line with the communication protocol for ensuring that sending or receiving wards are explicitly informed of any positive screening results.**	Ward Sister, Clinical Coordinator, Service Manager and Co-Director	Communication Policy to be reviewed to ensure responsibilities of all staff are clear and understandable All staff to sign that they are aware of the communication policy and their responsibilities Create process to document communication in relation to sending or receiving of any positive screening results	February 2019
Regional Infection Prevention and Control Clinical Practices Audit Tool				
4.	**The Trust should ensure that robust assurance mechanisms are implemented to promote compliance with best practice on the management of invasive devices. Policies to guide staff should be in date**	Ward Sister, Clinical Coordinator, Service Manager, Co-Director and Infection Control Team Leader	Continue to ensure that management of invasive devices is included in clinical skills programme and identified ongoing training. Ensure ANTT practice is audited for compliance and appropriate action to address areas of concern. All relevant policies currently being reviewed and progressed through standards and guidelines.	To be reviewed February 2020

	and reviewed in accordance with changes in regional/evidence based guidelines.		Weekly auditing of invasive devices to ensure compliance with Trust Policy. Feedback to staff regarding compliance. Monitoring of audit compliance to review trends. Discussion at Local Neurosciences Safety Improvement Meeting to ensure increased awareness and dissemination of information.	
5.	**The Trust should ensure that robust monitoring measures are implemented to provide assurance on the management of taking blood cultures.**	Ward Sister, Clinical Coordinator, Clinical Educator and Nurse Development Lead	Ensure that all staff have awareness and understand current guidelines Develop blood culture pack to aid staff with timeliness; process and documentation Ensure all staff are aware of and trained in ANTT Audit weekly to monitor improvement or areas for action as well as compliance Continue to monitor quarterly blood contaminants report as per the Augmented Care Sub Group Ensure that medical induction includes this as an identified learning point on the agenda Share outcomes with all staff to aid learning	Commenced 18/10/19 – ongoing review
6.	**The Trust should ensure that robust assurance mechanisms are implemented to promote compliance with best practice on the management of enteral feeding.**	Ward Sister, Clinical Coordinator, Clinical Educator, and Nurse Development Lead	Ensure that all staff are aware of updated best practice guidelines on the management of enteral feeding Ensure that staff have completed Naso Gastric self-assessment for same by end of January 2020 Liaise with dietetics to ensure that current guidelines are in line with best practice Monitoring of clinical practice and address areas of concern. Feedback to team members. Discussion and feedback regarding auditing of practice at the	1 October 2019 and ongoing

			Neurosciences Safety Improvement Team Meeting.	
Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool				
7.	**The standard of cleaning of the public toilets in the main hospital reception area should be improved. Robust monitoring of the public toilets is recommended to provide continued assurance of cleaning practices.**	PCSS Environmental Cleanliness Team Leader	Increased monitoring of toilets undertaken by Environmental Cleanliness Supervisors from 2 x daily to 4 x daily. Amendments made to Support Services Staffs cleaning schedules to ensure increase to the cleaning frequency of toilets	October 2019

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