The Regulation and Quality Improvement Authority

Unannounced Augmented Care Inspection

10 North Haematology Ward
Belfast City Hospital

15-16 September 2016

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1.0 Profile of Service

The three year improvement programme of unannounced inspections to augmented care areas commenced in the Belfast City Hospital Haematology Ward on 15 and 16 September 2016.

The Belfast trust Haematology inpatient service is located on ward 10 North of the Belfast City Hospital. The ward comprising of 28 beds delivers complex care and treatments such as chemotherapy and stem cell transplantation to haemtological patients from across Northern Ireland.

Service Details

Responsible Person: **Dr Michael McBride**	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

This inspection is the first of a three year cycle of inspection carried out within this area. Compliance scores for the first inspection are 85 per cent, rising to 95 per cent by the end of the third inspection.

Year 1

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

Inspection Tools	**Year 1 Compliance Level**
Regional Augmented Care Infection Prevention and Control Audit Tool.	**92**
Regional Infection Prevention and Control Clinical Practices Audit Tool.	**92**
Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool.	**98**

Through discussion and examination of documentation 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.

It was reported that there is a heavy reliance on bank and/ or agency staff although we were informed of recent recruitment initiatives to address staff deficits.

We observed that the core clinical space around patients' beds was not within the current recommended specification. The number of single occupancy rooms was not in line with current NICE guidelines for haematological disorders. We were provided with evidence that a business case to support these guidelines had been discussed with the Health and Social Care Board (HSCB).

A water management plan and risk assessment was in place. We observed records of patient placement and movements within the ward. Local screening policies were in place and patients were isolated when appropriate to negate the risk of transmission of infection.

Nursing staff demonstrated good aseptic non touch technique (ANTT) knowledge and practice in the management of invasive devices. Quality

improvement tools were in place to monitor ANTT compliance with invasive devices; however audits of ANTT compliance were not carried out for medical staff. The in-house Infusional Services team who provide specialist treatment for those patients who require intravenous infusions, is a positive initiative. Policies for the insertion and on-going management of invasive devices were available however a number had passed their review date.

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. The contamination rate of blood cultures within the ward is consistently low.

Up to date antimicrobial guidelines were in place and we were informed that they were cascaded to medical staff as part of their trust induction. We observed good microbiology ward support which ensures that there is direct microbiological advice at the bedside. We were informed that pharmacy support within the ward has reduced.

Up to date guidance and care pathways on the management of CDI and MRSA were available and known to staff. It had been 1457 days from the last MRSA bacteraemia; staff are commended for this achievement. Audit tools have been developed to monitor adherence with the management of patients identified with CDI and MRSA. These audit tools should be completed by ward staff when appropriate.

We observed that the ward had a high standard of environmental cleanliness and was in good decorative order. 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.

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

Escalation procedures were not required for this inspection. The 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 the Belfast City Hospital for their assistance during the inspection.

It should be noted that 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 on 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 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	Sept 2016
Local Governance Systems and Processes	96
General Environment – Layout and Design	77
General Environment – Environmental Cleaning	100
General Environment – Water Safety	100
Clinical and Care Practice	90
Patient Equipment	88
Average Score	**92**

Local Governance Systems and Processes

Areas of Good Practice

- During the inspection, the deputy band 6 charge nurse displayed good clinical leadership and knowledge of infection prevention and control (IPC).
- In anticipation of this inspection, ward staff had carried out some dry run exercises using the inspection tool. Staff had used the information generated from these exercises for learning and improvement.
- We were informed that when patients with infections are identified, staffing levels can be increased to assist in the delivery of care and ensure adherence to good infection prevention and control practices.
- We were informed that the IPC team provides good support for ward staff.
- 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.
- Mandatory and non-mandatory surveillance programmes were in place.

- We observed that attendance at mandatory IPC training was good. The ward manager had received a trust award for mandatory training records.
- Local and regional audits and the implementation of high impact interventions were undertaken to improve IPC practices and environmental cleanliness. Audit results were displayed for visitors to the ward (Picture 1).

Picture 1: Displayed audit results

- There are IPC policies in place for staff reference when dealing with an infection
- A range patients and visitors information was available on infection prevention and control precautions.
- Throughout September 2016, the Belfast trust are running a campaign called SAFEtember. The aim of this campaign is to encourage staff to have a renewed focus on safety of trust services. A key initiative of this campaign, and to mark world sepsis day, was the facilitation of sepsis awareness sessions.
- Due to the demand for haematology beds, the trust had re-profiled ward 6 North to accommodate haematology patients. We were told that this initiative has been successful in reducing haematology patient outliers, improve patient experience and ensure equitable access to timely specialist care??
- Ward 10 North has been shortlisted for the trust chairman's award which recognises the work of staff and its benefit to patient care. The nomination for this award is based on staff going 'beyond the call of duty' to ensure patients' needs are met in light of staffing pressures

Areas for Improvement

- It was reported that there is a heavy reliance on bank and/ or agency staff although we were informed of recent recruitment initiatives to address staff deficits.

General Environment - Layout and Design

Areas of good practice

- The number of bed spaces does not exceed the number of commissioned spaces.

Areas for improvement

- 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 units by the DoH.
- In patient bays, the dimensions between bed head centres is less that what is currently recommended for existing units by the DoH.
- In patient bays, clinical hand wash sinks are in close proximity to patient beds. The positions of these sinks present a splash risk to the patient, the bed and the equipment at the bedside.
- There were no dedicated areas for equipment cleaning
- We were informed that the trust is aware of the limitations of the layout and design of the ward. The trust highlighted the challenges of not having enough single occupancy rooms to meet the needs of patients with haematological cancers categorised within NICE guidelines. It was reported that a business case for a substantial refurbishment and expansion of the ward to meet these guidelines had been recently discussed with the HSCB.

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.

General Environment - Water Safety

Areas of good practice

- We observed an up to date overarching trust water safety plan and annual unit risk assessment

- We were informed that the trust carries out a quarterly schedule of water sampling for Pseudomonas *aeruginosa* from all water outlets in augmented care areas.
- Evidence was available that results from water analysis are reported to the trust water safety and user group and the Augmented Care areas Sub 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.

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 are in place which inform clinical and infection prevention and control practice. Screening records were reflective of local policy.
- We observed that patients were isolated when appropriate to minimise the risk of transmission of infection.
- We observed protocols in place to ensure patients are washed appropriately to negate the risk of transmission of infection.
- We were provided with evidence that the IPC team are in the process of developing standardised care plans for the management of inpatients colonized/ infected with multi resistant organisms.
- The trust health care acquired infection (HCAI) improvement team has introduced a series of ward/ dept. walkrounds. The key aim of these walkrounds is to ensure that the key priorities for the trust HCAI improvement plan is embedded in staff practice.

Areas for improvement

- All staff should ensure that sending or receiving wards are explicitly informed of any positive screening results and provide evidence of the same. The introduction of the alert organism communication flowchart that had been introduced within the trust critical care units could assist in achieving this recommendation.

Patient Equipment

Areas of good practice

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

Areas for improvement

- We observed a portable x-ray machine with adhesive tape attached.

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	88
Taking Blood Cultures	83*
Antimicrobial prescribing	83
Clostridium *difficile* infection (CDI)	96*
Surgical site infection	100
Ventilated (or tracheostomy) care	N/A
Enteral Feeding or tube feeding	96*
Screening for MRSA colonisation and decolonisation	97*
Average Score	**92**

* 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 in place and accessible for all staff. Staff have received training on ANTT and can demonstrate when procedures are applied.
- All nursing staff have annual ANTT assessments and we observed evidence that ANTT audits of nursing staff practice were undertaken.

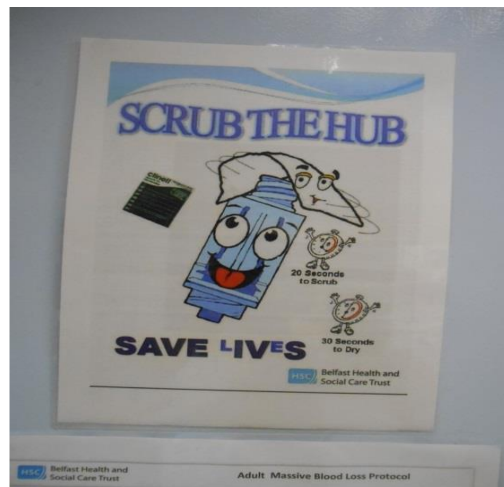
Areas for improvement

- We were informed that ANTT assessments of practice for medical staff are not carried out.

Invasive Devices

Areas of good practice

- The BCH has an in house Infusional Services nurse lead team. The team specialises in providing treatment for patients who require intravenous infusions. The team insert PICC lines for patients in 10 North and also provide a range of intravenous training and advice for staff. Nursing and medical staff were very complimentary of the work carried out by this team.
- Quality improvement tools were in place to monitor compliance with invasive devices best practice guidance.
- Staff displayed good knowledge in the management of invasive devices. We observed that ANTT principles were used when accessing invasive devices (Picture 2)



Picture 2: ANTT guidance poster when accessing an invasive device

Areas for improvement

- Policies/ procedures for the insertion and on-going management of invasive devices were in place however a number had passed their revision date without review.
- We were informed that there is no formal programme of update/ refresher training for staff in invasive device procedures.
- We reviewed the notes of three patients that had an inserted peripheral venous cannula. The batch number had not been recorded in two sets of notes and the gauge size had not been recorded in one set of notes. A management plan for a patient with a urinary catheter was not in place.

Taking Blood Cultures

Areas of good practice

- Although there was no opportunity to observe blood cultures being obtained. We spoke with staff who undertake the procedure who were aware of the correct technique.
- Blood culture incidence of contamination within the ward is consistently below 3% which suggests that blood cultures were being collected with proper attention to aseptic technique.
- The rationale for the blood culture request and the location it was obtained from was clearly documented within the patient notes reviewed.

Areas for improvement

- Compliance with best practice in obtaining a blood culture was not being monitored.
- Communications with ward nursing and medical staff on the rate of positive blood cultures and the incidence of contamination needs improvement, as ward staff were not aware of these rates. We were provided with evidence that this information is discussed at the Augmented Care Sub Group.

Antimicrobial Prescribing

Areas of good practice

- Up to date antimicrobial guidelines were in place and we were informed that they were cascaded to medical staff as part of their trust induction. The guidelines were available on the trust intranet site and an antimicrobial 'Microguide' app which is available on smart phones.
- A member of the microbiology team attend ward rounds daily which ensures that there is direct microbiological advice at the bedside and that antimicrobial prescribing is controlled.
- A trust wide antimicrobial steering committee was in place. This team centrally reviews audit results, anti-microbial usage and incidents.
- Relevant documentation for prescribed antimicrobials was available and appropriately completed.
- We observed evidence that antimicrobial usage is audited is in line with antimicrobial prescribing guidance.

Areas for improvement

- Electronic aided prescribing tools were unavailable to aid antibiotic prescribing within the ward however we were informed of future plans to introduce these.
- We were informed that there is no ward based pharmacist.

Clostridium *Difficile* Infection (CDI)

Areas of good practice

- Up to date guidance and a care pathway on the management of CDI was available and known to staff. Although there were no patients identified with CDI on the ward during the inspection, staff were knowledgeable in the IPC management of these patients.
- An antibiotic policy was in place for patients who have or are suspected to have CDI.

Areas for improvement

- An audit tool has been developed for ward staff to monitor adherence with policy if a patient is identified with CDI. This tool should be completed when appropriate.

Surgical Site Infection (SSI)

Areas of good practice

- Staff had a good knowledge of the post-operative wound management.
- The trust undertakes mandatory reporting SSI surveillance to the PHA on orthopaedic surgery, cardiac surgery, neurosurgery and caesarean section delivery.
- Results of SSI surveillance are reviewed within the relevant governance structures.

Ventilated (or Tracheostomy) Care

Not applicable for this ward.

Enteral Feeding or Tube Feeding

Areas of good practice

- Enteral feed was stored and disposed of in line with best practice. Staff had good knowledge on the management of an enteral feeding system; insertion, administration, set up and care.

Areas for improvement

- We observed that there are currently no systems in place to monitor compliance with enteral feeding protocol and guidance.

Screening for MRSA Colonisation and Decolonisation

Areas of good practice

- At the time of the inspection it had been 1457 days since the last MRSA bacteraemia was identified on the ward. Staff are commended for this achievement.
- An MRSA screening and treatment policy and care pathway was in place.
- When questioned staff were knowledgeable in what precautions to take in managing a patient identified with MRSA.

Areas for improvement

- An audit tool has been developed to monitor adherence with the management of patients identified with MRSA. This audit tool should be completed by ward staff when appropriate.

5.0 The Regional Healthcare Hygiene and Cleanliness Audit Tool

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	98
Patient linen	98
Waste	98
Sharps	97
Equipment	97
Hygiene factors	99
Hygiene practices	99
Average Score	**98**

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

General Environment

Areas of good practice

We observed that the ward was in good decorative order and environmental cleanliness was of a high standard. The ward was tidy and well organised. This ensures effective cleaning can be undertaken. Cleaning staff followed agreed protocols and had access to adequate resources and cleaning equipment.

Patient Linen

Areas of good practice

We observed that patient linen was visibly clean, free of 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

We observed the safe segregation, handling, transport and disposal of waste and sharps.

Equipment

Areas of good practice

We observed that patient equipment was clean, in a good state of repair. Good auditing and monitoring processes were in place to ensure equipment was clean.

Hygiene Factors

Areas of good practice

We observed facilities and that a range of consumables available to enable hygiene practices to be carried out effectively (Picture 3). Clinical hand washing sinks were clean, located near to the point of care and only used for hand hygiene.

Picture 3: Clinical hand wash station

Hygiene Practices

Areas of good practice

We observed good practice in the use of personal protective equipment and hand hygiene. Hand hygiene was performed in line with the World Health Organisation (WHO) 5 Moments for hand hygiene.

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	
Reception	N/A
Corridors, stairs lift	N/A
Public toilets	97
Ward/department - general (communal)	100
Patient bed area	N/A
Bathroom/washroom	100
Toilet	100
Clinical room/treatment room	95
Clean utility room	N/A
Dirty utility room	95
Domestic store	100
Kitchen	98
Equipment store	96
Isolation	100
General information	100
Average Score	**98**

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	96
Storage of used linen	100
Laundry facilities	N/A
Average Score	**98**

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	98
Availability, use, storage of sharps	97

Standard 5: Patient Equipment

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

Patient Equipment	
Patient equipment	97

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	100
Availability of alcohol rub	97
Availability of PPE	100
Materials and equipment for cleaning	100
Average Score	**99**

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	95
Safe handling and disposal of sharps	100
Effective use of PPE	100
Correct use of isolation	100
Effective cleaning of ward	100
Staff uniform and work wear	100
Average Score	**99**

7.0 Key Personnel and Information

Members of the RQIA inspection team

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

Trust representatives attending the feedback session

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

Ms J Welsh	-	Director, Surgery & Specialist Services
Ms D Whiteman	-	Acting Service Manager, Oncology and Haematology
Ms J Cullen	-	Assistant Service Manager, Oncology
Ms P McKinney	-	Assistant Director
Mr B Goan	-	10 North Deputy Charge Nurse
Ms C Smyth	-	Infection Prevention & Control Nurse
Ms N Scott	-	Senior Manager Environmental Cleanliness
Mr S Trainor	-	Planning and Performance Manager
Mr K Taylor	-	Estates Operational Manager
Ms A Walsh	-	Ward Sister, Bridgewater Suite
Ms J Beckett	-	Deputy Ward Sister, Bridgewater Suite
Ms C Knowles	-	Patient Flow Coordinator
Ms R Bradley	-	Support Services Manager
Ms P Berkley	-	PCSS Operations Manager
Ms K Aughey	-	PCSS Operations Manager
Ms A Brown	-	PCSS Assistant Operations Manager
Ms R Maguire	-	PCSS Assistant Operations Manager

Apologies:

Ms B Creaney	-	Director of Nursing and User Experience
Ms L Houlihan	-	Haematology Assistant Service Manager

8.0 Provider Compliance Plan

The provider compliance plan should be completed detailing the actions taken and returned to cscg.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 escalation action being taken. The responsible person identified should ensure that all recommended actions are taken within the specified timescales.

Reference number	Recommended Actions	Responsible Person	Action/ Required	Date for completion/ timescale
Regional Augmented Care Infection Prevention and Control Audit Tool.				
1.	As part of any refurbishment/new build programme, the trust should comply with best practice guidance on design and planning.	Corporate	Business Case for complete refurbishment of the ward was submitted in May 2014, this includes more storage, increased space and to assist with compliance of NICE guidelines for the management of Haematology patients	12-36 months
2.	Ward staff should ensure that sending or receiving wards are explicitly informed of any positive screening results.	Ward Sister	The Ward Sister is liaising with BCH Critical Care Unit about the flowchart they have introduced to see if this can be used or adapted for introduction in 10N.	February 2017
Regional Infection Prevention and Control Clinical Practices Audit Tool				
3.	All ward clinical staff should receive ongoing assessment of ANTT practice in line with trust policy.	Corporate	There is a trust wide issue with the medical staff not being trained on ANTT and the Medical Director is considering how best to achieve this. Currently on the	Nursing Immediate Medical

Reference number	Recommended Actions	Responsible Person	Action/ Required	Date for completion/ timescale
			Medical Staff Induction to Haematology the Ward Sister of 10 North shows ANTT practice of lines to all medical staff. All nursing staff have annual ANTT competencies completed.	Medical Directors Office to agree timeframe
4.	The trust should ensure that policies to guide staff in the management of invasive devices are timely reviewed and updated as appropriate.	Corporate	All of these policies are currently being reviewed and will be presented at standards and guidelines committee for approval when ready.	Corporate Nursing to agree timeframe
5.	Ward staff should ensure that all relevant information is recorded in relation to the insertion and ongoing management of invasive devices.	Ward Sister	Issue raised at staff meeting held on 25th October and all staff reminded of importance of documenting batch number and gauge of PVC on PVO charts. Also to be raised at next Governance meeting for medical staff who insert PVC's. Will be audited on weekly HII peripheral insertion and ongoing care bundles.	January 2017
6.	The trust should ensure that there is a formal programme of training including update/ refresher skills training for staff in the insertion and management of invasive devices.	Corporate	Any updates to procedures are circulated via the Trust communication processes.	Corporate Nursing to agree timeframe
7.	All ward clinical staff should be explicitly informed of the wards rate of positive blood cultures and the incidence of culture contamination.	Ward Sister	Results of blood culture contaminants are now placed on RQIA information Board so all staff can see false positive and contamination results	November 2016

Reference number	Recommended Actions	Responsible Person	Action/ Required	Date for completion/ timescale
8.	The trust should ensure that the haematology ward is supported by ward level pharmacy cover.	Corporate	The ward had a ward based pharmacist until August 2016. This issue will be raised with head of pharmacy	February 2017
9.	Ward staff should ensure that compliance with best practice is monitored when collecting blood cultures, enteral feeding and the management of patients identified with MRSA and CDI.	Ward Sister	The ward now self-audits the management of all MRSA and CDI patients using the infection control audit tool. The Ward now also self-audits compliance on a weekly basis of blood culture compliance. 10N extremely rarely has a patient with enteral feeding but all staff are aware of the policy and procedures on enteral feeding. Nursing staff use Trust NG tube position checklist when a patient has enteral feeding; the Ward Sister randomly checks that these forms are used correctly when a patient is receiving enteral feeding	November 2016
Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool				
No Recommendations				

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