The Regulation and Quality Improvement Authority

Unannounced Inspection
Augmented Care Settings

Bridgewater Suite

Belfast City Hospital
20-21 February 2019

Contents

1.0 Profile of Service

The three year improvement programme of unannounced inspections to augmented care areas commenced in Bridgewater Suite, Belfast City Hospital on 20 and 21 February 2019.

The Bridgewater Suite opened in June 2014 and is located within the Cancer Centre (Picture 1) providing an outpatient service and a day unit for the delivery of haematology and oncology treatments for patients. The Haematology service delivers a range of treatments including Systemic Anti-Cancer Therapy (SACT), administration of blood products and other supportive therapies and diagnostic bone marrow biopsy procedures. The Oncology service focuses on the care of patients with cancer diagnosis such as breast, lung, gastro-intestinal, ovarian, renal, skin, prostate, brain and bladder. Treatments range from the administration of cytotoxic chemotherapy drugs, biological therapies and more recently immunotherapies. Supportive therapies such as blood transfusions, intravenous fluids and electrolyte replacement are also provided.

Picture 1: The Cancer Centre, Belfast City Hospital

Service Details

Responsible Person: **Dr Cathy Jack**	Position: **Chief Executive Officer** **Belfast Health and Social Care 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 inspections 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.

Level of Compliance

	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

Table 1: Compliance Level

Inspection Tools	Year 1 Compliance Level
Regional Augmented Care Infection Prevention and Control Audit Tool.	89
Regional Infection Prevention and Control Clinical Practices Audit Tool.	77
Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool.	91

Bridgewater Suite is a modern facility with infection prevention and control (IPC) evidently factored into its function and design. Bridgewater Suite was in good decorative order creating a friendly and welcoming environment for patients, visitors and staff. Environmental cleanliness was of a high standard throughout, with evidence of best use being made of the limited storage facilities which were tidy and well organised overall.

The Bridgewater Suite was extremely busy during our two day inspection, however, staff were observed working in a calm and organised way. It was evident that staff have developed therapeutic relationships with many patients and their families, enhancing the patient experience at a difficult time in their lives, whilst promoting an effective and efficient service. The haematology and oncology teams share the same reception and waiting area, however, they operate as two independent clinics, with separate staff and management structures.

Staff in both the haematology and oncology clinics demonstrated good practice in the management of sharps and the disposal of waste. Patient equipment was clean and in a good state of repair. Overall, staff had a good knowledge and awareness of how to manage infections.

Local IPC screening policies were in place and we were told that patients can be isolated when appropriate to reduce the risk of the transmission of infection. The Trust IPC team were available to provide support and advice as required.

Conversely, through discussion and examination of documentation, we found that IPC governance arrangements and staff attendance at mandatory training required improvement. This was particularly evident for staff working in the oncology clinic, where we were told that protected time to undertake appropriate educational training opportunities had been a challenge.

We confirmed that the core clinical space of treatment beds and chairs was limited and does not meet current recommended guidelines set by the Department of Health (DoH).

A water safety risk assessment was completed in line with *Annex A of the CMO letter (REF HSS(MD) 16/2012) Water sources and potential Pseudomonas aeruginosa contamination of taps and water systems*. This letter also indicates that water testing in haemato-oncology units can be guided by the clinical surveillance of patients. We noted that the water safety risk assessment had passed its review date and that flushing of water outlets did not take place at weekends. Following our inspection we were provided with an updated version of the water safety risk assessment with documented evidence of a risk assessment undertaken in respect of the frequency of flushing of water outlets in Bridgewater Suite.

A number of policies/procedures/guidelines had exceeded their review dates. Aseptic non touch technique (ANTT) competency training for all clinical staff and update training on invasive devices must be addressed to improve compliance.

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 Bridgewater Suite, Belfast City Hospital 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: 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.

Table 2. Regional Augmented Care Infection Prevention and Control Audit Tool Compliance Levels

Areas inspected	**20-21 February 2019**
Local Governance Systems and Processes	86
General Environment – Layout and Design	78
General Environment – Environmental Cleaning	100
General Environment – Water Safety	95
Clinical and Care Practice	94
Patient Equipment	100
Average Score	**92**

Local Governance Systems and Processes

Areas of Good Practice

- Throughout the inspection, the manager and the deputy manager in the haematology clinic and the deputy managers in the oncology clinic demonstrated good leadership and knowledge of IPC.
- IPC policies were in place and accessible for staff to reference when dealing with an infection.
- Local audits were undertaken in both the haematology and oncology clinics to support and improve IPC practices and environmental cleanliness. Audit results evidenced good compliance with IPC performance indicators and were displayed for visitors to Bridgewater Suite. We were informed of plans to display this information on a new board in a more prominent area in the waiting room.
- Occupational Health guidance on the BHSCT intranet site was available to provide advice and guidance for all Trust staff in managing common infectious conditions.
- We were informed that there have been no notifiable IPC events recorded within the Bridgewater Suite. Established Trust surveillance programmes were in place to allow for the detection and implementation of preventative strategies.
- We observed a range of leaflets to inform visitors to the Bridgewater Suite of the importance of hand hygiene and actions to minimise the risk of infection (Picture 2).

Picture 2: Patient Information Leaflets.

- The involvement of key stakeholders when refurbishment work was carried out was evident from the minutes of meetings reviewed.

Areas for Improvement

- We reviewed documentation which confirmed a range of meetings, from management level down. Whilst we could evidence sharing of information at meetings with frontline staff within the haematology clinic, within the oncology clinic staff meetings were infrequent.
- Key IPC information was not accessible to deputy managers in the oncology clinic and we could not evidence that IPC information was shared with the wider staff group in a timely manner.
- There had been a high staff turnover in the oncology clinic with the appointment of ten new staff in October 2018. The area would benefit from additional educational support to promote staff development.
- We were informed that IPC nursing staff while they are supportive do not visit the unit on a daily basis but are contactable by telephone. We were informed that support from the IPC team had been limited due to staffing constraints within the team.

General Environment - Layout and Design

Areas of Good Practice

- The layout of Bridgewater Suite and its interior design creates a friendly and welcoming environment for patients, visitors and staff. It is a modern facility with IPC evidently factored into its function and design.
- Clinical hand wash sinks were positioned to allow for optimal workflow and prevent splashing of patients, beds and equipment.
- There are separate clean and dirty utility rooms and clean storage areas allowing for clean to dirty workflow.
- Single rooms are available which allow for the isolation of patients identified with an infection control risk.

Areas for Improvement

- The core clinical areas of Bridgewater Suite consist of a mix of treatment bays and side rooms for the delivery of a range of treatments. There are 3 multi chair treatment bays, 2 bays with 8 chairs and 1 bay with 6 chairs. The core clinical space of each chair space is 3.44 metre sq. Current allocated space is significantly lower than the minimum dimensions recommended by the DoH and outlined in the audit tool (Picture 3).
- The space limitation considerably inhibits staff members' ability to deliver care interventions without impinging on adjacent patients. Additionally, the core clinical space of side rooms does not meet the minimum dimensions recommended by the DoH and outlined in the audit tool.

Picture 3: Treatment Bay.

General Environment - Environmental Cleaning

Areas of Good Practice

- Environmental cleaning guidelines, audit and staff competency based training were in place and reviewed. We observed evidence of regular auditing of environmental cleaning. There was a regular programme of de-cluttering in place within Bridgewater Suite.
- Staff had good knowledge of the appropriate cleaning procedures. Staff were observed performing the correct four cloth technique for cleaning clinical hand wash stations.

General Environment - Water Safety

Areas of Good Practice

- An overarching Trust water safety plan and risk assessment for Bridgewater Suite were in place, however, the Trust water safety plan had passed its review date.
- Throughout the inspection we observed that hand washing sinks were used correctly i.e. for hand washing purposes only.

Areas for Improvement

- Water outlet flushing records were available and completed appropriately throughout Monday to Friday; however water outlets are not flushed at weekends. In accordance with the HTM 04-01 Part C, all taps that are used infrequently on augmented care units should be flushed regularly (at least daily in the morning for one minute).

Clinical and Care Practice

Areas of Good Practice

- We observed that patients could be isolated when appropriate to minimise the risk of transmission of infection.
- We observed evidence that records of patient placement were maintained which allowed for the retrospective identification of the location of patients within the oncology clinic.
- Trust wide IPC screening policies were available for guidance and used by staff when required.
- Staff recorded a patient's infection status on the transfer form when a patient required a direct admission to the hospital from Bridgewater Suite.

Areas for Improvement

- There was no bed/couch/space tracking system in place within the haematology clinic to identify patient placement in the event of an infection risk.

Patient Equipment

This section is not applicable. Patient equipment has been audited in the Regional Healthcare Hygiene and Cleanliness Audit Tool.

4.0 The Regional Augmented Care Infection Prevention and Control Clinical Practices Audit Tool

The Regional Infection Prevention and Control Clinical Practices Audit Tool contains 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.

Table 3: Regional Infection Prevention and Control Clinical Practices Audit Tool Compliance Levels

Areas inspected	20-21 February 2019
Aseptic non touch technique (ANTT)	80
Invasive devices	82
Taking Blood Cultures*	*63
Antimicrobial prescribing	83
Clostridium *difficile* infection (CDI)	N/A
Surgical site infection	N/A
Ventilated (or tracheostomy) care	N/A
Enteral Feeding or tube feeding	N/A
Screening for MRSA colonisation and decolonisation	N/A
Average Score	77

* 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 ANTT policy and guidance was in place and accessible for all staff. We evidenced that staff working in the haematology clinic had received training and competency assessment on the principles of ANTT and 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) treatments for patients.
- We were provided with evidence of peer ANTT audits carried out in the haematology clinic and the sharing of results with staff.

Areas for Improvement

- Only 50 per cent of staff in the oncology clinic had received up to date Aseptic Non Touch Technique (ANTT) competency assessment in line with Trust policy.
- We observed poor adherence to key ANTT principles during venepuncture procedures where a number of staff were observed to re-palpate skin following cleansing and immediately prior to needle insertion.

Invasive Devices

Areas of Good Practice

- Staff had received training and competency assessment and demonstrated good knowledge and practice in relation to the management of invasive devices. Policies and procedures were in place and accessible to support staff.
- Care bundles were in place and accurately completed to promote standardisation in staff clinical practice on management of invasive devices.
- All 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 placed in patient notes. We recommend that, for traceability purposes, the information be further enhanced to include the size and batch number of the device inserted.
- We were provided with evidence of independent validation audits on hand hygiene practices and the management of invasive devices carried out by the IPC team; results of which confirmed good adherence to IPC practices by staff.

Area for Improvement

- Staff who have been trained for many years have not received refresher training on the management of invasive devices. The peripheral venous catheter (PVC) policy was past its review date (May 2014) and required updating.

Taking Blood Cultures

Areas of Good Practice

- We were informed that since the opening of the Acute Oncology and Haematology Unit (AOHU) Helpline in April 2017 the practice of taking blood cultures within Bridgewater Suite is now a rare occurrence. The Trust blood culture policy had been reviewed and was available on the Trust intranet site to guide staff in this procedure. Staff demonstrated good knowledge in the collection of blood for blood culture processing. Nursing staff had received initial competency assessment training for the taking of blood cultures.

Area for Improvement

- Compliance with best practice in obtaining a blood culture was not being monitored.
- Whilst there was a system in place in the Trust to compare the rate of positive and contaminated cultures with other Trust wards/ departments, this information was not shared with managers in Bridgewater Suite.

Antimicrobial Prescribing

Areas of Good Practice

- 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.
- We were told that Bridgewater Suite does not have a dedicated pharmacist but has access to the pharmacist working in the adjacent satellite pharmacy department. The satellite pharmacy department is equipped with a sterile area for the preparation of chemotherapy drugs.
- We were informed that the prescribing of antimicrobials within the unit is an infrequent occurrence however support is available from the antimicrobial pharmacist when required.
- The electronic computer aided prescribing tool Regional Information System for Oncology and Haematology (RISOH) has been introduced into the oncology clinic, the benefit of which is intended to support practitioners when prescribing chemotherapy treatment. We were informed of plans to extend this computerised system to the haematology clinic in the near future.

Clostridium *Difficile* Infection (CDI)

Not applicable for this unit.

Surgical Site Infection (SSI)

Not applicable for this unit.

Ventilated (or Tracheostomy) Care

Not applicable for this unit.

Enteral Feeding or Tube Feeding

Not applicable for this unit.

Screening for MRSA Colonisation and Decolonisation

Not applicable for this unit.

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	20-21 February 2019
General environment	89
Patient linen	82
Waste	92
Sharps	92
Equipment	96
Hygiene factors	92
Hygiene practices	93
Average Score	**91**

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

General Environment

Areas of Good Practice

- The interior design of Bridgewater Suite created a friendly and welcoming environment for patients, visitors and staff. Fixtures, fittings and furnishings throughout the department were modern and finished to a high standard.
- Environmental cleanliness throughout the department was of a high standard. Sanitary areas were modern, clean and spacious. Although clinical space was limited throughout, staff kept the clinical areas tidy, well organised and clutter free allowing for effective cleaning practices.

Area for Improvement

- We observed that the equipment store room was cluttered and equipment was not organised. In order to promote effective cleaning practices and facilitate easy access of equipment, this room required decluttering and reorganisation. Improving storage systems (shelving, cupboards) would help to maximise space.

Patient Linen

Areas of Good Practice

- We observed that patient linen was visibly clean and free of damage.

Areas for Improvement

- The clean linen pod was stored in the equipment store. Bags of clean linen and pillows were disorganised and a bag of clean linen was on the floor. The cover of the linen pod was not closed to protect the clean linen from potential contamination (Picture 4).

Picture 4: Linen Pod

- The used linen skip in the dirty utility room was observed to be over two thirds filled.

Waste and Sharps

Areas of Good Practice

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

Areas for Improvement

- We observed that non-sharps waste for example paper packaging had at times been placed within sharps containers and some of the temporary closure mechanisms were not always deployed when containers were not being used.

Equipment

Areas of Good Practice

- Patient equipment was clean, in a good state of repair and managed appropriately to limit the risk of contamination with microorganisms. A trigger mechanism was in place to identify when equipment had been cleaned.

Actions for Improvement

- Improvement was required in the completion of the oncology equipment cleaning schedule.
- We observed gaps in the recording of the daily checks of the shared department resuscitation trolley.

Hygiene Factors

Areas of Good Practice

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

Areas for Improvement

- The domestic sluice was cluttered, stored items of domestic cleaning equipment were disorganised. Additionally we identified that some items cleaning equipment (mop bucket, wringer, cleaning trolleys) were not clean. These identified issues were addressed immediately by the domestic cleaning team when identified during the inspection.

Hygiene Practices

Areas of Good Practice

- All staff when questioned were knowledgeable on the principles of IPC including the use of personal protective equipment (PPE) and the management of sharps and waste.

Areas for Improvement

- Staff demonstrated a high standard of hand hygiene practices utilising the seven step hand hygiene technique. However, we observed inconsistent practice of staff in the application of alcohol hand sanitiser to hands following hand washing with soap and water, in line with best practice advised in an augmented care 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	20-21 February 2019
BWS Reception	88
Corridors, stairs lift	N/A
BWS Public toilets	100
Ward/department - general (communal)	98
Patient bed area	87
Bathroom/washroom	N/A
Toilet	100
Clinical room/treatment room	95
Clean utility room	N/A
Dirty utility room	100
Domestic store	70
Kitchen	80
Equipment store	63
Isolation	97
General information	87
Average Score	**89**

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	20-21 February 2019
Storage of clean linen	70
Storage of used linen	94
Laundry facilities	N/A
Average Score	**82**

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	20-21 February 2019
Handling, segregation, storage, waste	92
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	20-21 February 2019
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	20-21 February 2019
Availability and cleanliness of wash hand basin and consumables	100
Availability of alcohol rub	100
Availability of PPE	93
Materials and equipment for cleaning	76
Average Score	**92**

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	81
Safe handling and disposal of sharps	100
Effective use of PPE	100
Correct use of isolation	100
Effective cleaning of ward	95
Staff uniform and work wear	84
Average Score	**93**

7.0 Key Personnel and Information

Members of the RQIA inspection team

Ms J Gilmour	-	Inspector, Healthcare Team
Mr T Hughes	-	Inspector, Healthcare Team
Ms L O'Donnell	-	Inspector, Healthcare Team
Ms S O'Connor	-	Senior Inspector, Healthcare Team

Trust representatives attending local feedback session

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

Ms L Wilson	-	Acting Sister Bridgewater Suite Haematology
Ms J Gorman	-	Acting Deputy Sister Bridgewater Suite Haematology
Ms V Campbell	-	Deputy Sister Bridgewater Suite Oncology
Mc P Brooks	-	Deputy Sister Bridgewater Suite Oncology
Ms H Manson	-	Haemophilia Sister
Ms D McKelvey	-	ASM Oncology
Ms K Aughey	-	ASSM PCSS
Ms S Canavan	-	AOM PCSS
Ms D McParlan	-	Infusional Services Co-ordinator
Ms D Wightman	-	Divisional Nurse C & SM
Ms C Smyth	-	Infection Prevention and Control Nurse
Ms C Fitzsimons	-	Infection Prevention and Control Nurse
Mr N Henry	-	Assistant Services Manager Haematology
Ms K Devenney	-	Senior nurse Manager NUE
Ms S Lawson	-	Estates Officer Operations
Ms Gillian Traub	-	Co-director Cancer and Specialist medicine
Mr Paul Smith	-	Estates Services BCH

Apologies:

Ms B Creaney	-	Director of Nursing and User Experience

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	Actions for Improvement	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 of Bridgewater Suite, the Trust should comply with best practice guidance on design and planning to meet the requirements of core clinical space.	Service Manager/ASM/ Ward Sister	As part of the action plan for SACT Peer Review in September 2019 The Belfast Trust completed a multi-professional "walk-around" assessment of the Bridgewater Suite environment to scope potential options for alternative storage space to reduce clutter in treatment area including Estates. The Belfast Trust also recorded the concerns highlighted by the Peer Review team about Bridgewater Suite environment via the Oncology and Haematology Risk Registers.	Oct 2019

Reference number	Actions for Improvement	Responsible Person	Action/ Required	Date for completion/ timescale
			Paper submitted to Exceutive Team November 2019 regarding a proposal to secure additional space. Assessment and Treatment separated July 2020 as part of Covid planning. The Belfast Trust will compile a strategic options paper outlining the potential future provision of SACT day-care services, including consideration of location and environment The Belfast Trust will work in partnership with the HSCB to scope out and resource funding for modernisation of chemotherapy facilities.	November 2019 July 2020 June 2021 June 2021
2.	The Trust should implement enhanced water safety measures in line with best practice guidance: HTM 04-01: Safe water in healthcare premises, Part C: Pseudomonas aeruginosa – advice for augmented care units	Service Manager/ASM/ Ward Sister	Belfast Trust Water Safety team and IPC confirmed tap flushing only required when unit active.(see minutes attached)	Feb 2020
3.	A bed/couch/space tracking	Ward	Track and trace system in place. The	Completed

Reference number	Actions for Improvement	Responsible Person	Action/ Required	Date for completion/ timescale
	system should be in place within the haematology clinic.	Sister/Deputy Ward Sister	tracking system is hand documented on a daily basis and up loaded onto a shared drive and kept.	August 2020
4.	Regular staff meetings should be established in the oncology clinic and information shared in a timely manner to ensure staff are kept informed.	Ward Sister / Deputy Ward Sister	• Occurs monthly – every 3rd week of month • To be held on alternate day to allow all staff to attend regularly • Minutes of meeting to be typed and sent to all staff • Agenda to be sent out prior to meeting • Deputy Ward Sisters to get opportunity to chair and minute staff meetings	Completed, April 2019
Regional Infection Prevention and Control Clinical Practices Audit Tool				
5.	The Trust should ensure that all policies to guide staff on the management of invasive procedures are reviewed and updated as appropriate.	Central Nursing	SG 16/09 Insertion and management of peripheral intravenous cannulae policy currently being reviewed and updated.	December 2020
6.	Competency assessment for ANTT training should be updated for staff working in the oncology clinic in line with Trust policy.	Ward Sister / DWS & ANTT Assessors	• Currently 100% trained (nursing staff) Bespoke ANTT training in Uunit completed June 2019. • All available staff have now been assessed • New assessors identified and training complete.	Completed August 2020

Reference number	Actions for Improvement	Responsible Person	Action/ Required	Date for completion/ timescale
7.	Assurance mechanisms should be in place to confirm adherence of all staff to ANTT principles and action plans developed where improvement is required.	Ward Sister/ DWS	Compliance with ANTT policy and policy shared with all staff. Competency assessments completed in line with Trust policy. ANTT folder in Sister's office.	August 2020
8.	A system should be introduced to monitor staff compliance with Trust policy when obtaining blood cultures.	Ward Sister/ DWS	Trust Policy in relation to obtaining blood cultures to be circulated to all staff and staff will be supervised to ensure compliance.	August 2020
9.	Training updates should be provided in accordance with changes in regional/evidence based guidelines and assurance mechanisms in place to promote adherence to best practice.	Ward Sister / DWS	SACT competency assessed yearly and cannulation practice observed also.	Completed August, 2019.
Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool				
11.	The equipment store room should be decluttered and equipment reorganised to allow effective cleaning practices and easy access to equipment.	Ward Sister/ DWS/ Housekeeper	Declutter and reorganise store to enable easy access to equipment, thus enabling effective cleaning practices by PCSS staff.	August 2020
12.	Robust mechanisms should be introduced to provide assurance that clean linen is stored and managed in line with Trust	Ward Sister/ DWS/ Housekeeper	Identified area for linen to be stored and the area maintained in accordance with Trust Policy. All staff to be made aware of	February2019

Reference number	Actions for Improvement	Responsible Person	Action/ Required	Date for completion/ timescale
	policy.		this through e-mail/ staff safety briefs and team meetings	
13.	Robust processes should be introduced to assure the decontamination of cleaning equipment.	Ward Sister/DWS/ Housekeeper	New cleaning schedule has been introduced.Use of trigger tape in place. All staff are made aware of their responsibilities with regard to cleanliness of the clinical area. This will be addressed on an ongoing basis through ward meetings/ team safety briefs / clinical Supervision	February 2019
14.	Robust mechanisms should be introduced to assure that staff are performing the correct hand hygiene procedures in line with best practice advised in an augmented care area.	All Staff	Hand hygiene audits carried out monthly. Independent audits carried out quarterly. Action plan initiated and completed if score non compliant. Trust policy shared and followed. Results to be displayed on communication board. Results to be discussed at ward monthly meetings. Hand Hygiene observed on HCAI walkrounds By Divisional Nurse.	Completed August, 2019.

The Regulation and Quality Improvement Authority

9th Floor

Riverside Tower

5 Lanyon Place

BELFAST

BT1 3BT

Tel 028 9536 1111

Email info@rqia.org.uk

Web www.rqia.org.uk

@RQIANews