The Regulation and Quality Improvement Authority

Unannounced Critical Care Inspection

Antrim Area Hospital Critical Care Unit
Year 3 Inspection

5 and 6 June 2018

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

Contents

1.0 Profile of Service

The RQIA three year improvement programme of unannounced inspections to critical care areas commenced in Antrim Area Hospital Critical Care Unit, Northern Health and Social Care Trust (Northern Trust) on 9 June 2014.

The unit provides intensive care services to patients with life threatening illness, following major, complex surgery and following serious accidents.

Service Details

Responsible Person: **Dr. Tony Stevens**	Position: **Chief Executive of the Northern Health and Social Care Trust**

What We Look for

Inspection Audit Tools

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

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

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

The focus of this year three unannounced inspection was to assess practice against standards contained within two inspection tools. Only those standards that had been identified in previous inspections as requiring improvement (in order to achieve year three compliance) were assessed. During this inspection we also reviewed the critical care unit's improvement plans (current and/or previous) and discussed any quality improvement initiatives established and in place since the unit's last inspection visit.

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

This inspection team found evidence that the Critical Care Unit (CCU) in Antrim Area Hospital has continued to improve and implement regionally agreed standards.

The unit was bright, tidy and in excellent decorative order. From June to November 2017, reconfiguration work was carried out which offered improvements to the clean and dirty utility rooms. Cleaning by support service cleaning staff and nursing staff, was of a very high standard. Inspectors noted that although the core clinical space of the unit did not meet current recommended requirements; staff were working within these limitations to deliver safe and effective care.

We found ongoing improvements with the clinical practice standards assessed. Improvement was most notable in the management of blood cultures. Staff had worked hard in providing ongoing training and monitoring staff practices which resulted in a zero incidence of blood culture contamination.

After reviewing improvement plans with the unit sister, we were satisfied that all necessary actions had and continue to be progressed. Details of these can be found in section 6.
We were informed of some positive improvement initiatives within the unit that have been included within the body of this report.

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

The RQIA inspection team would like to thank the Northern Health and Social Care Trust and in particular all staff at the Antrim Area Hospital Critical Care Unit for their assistance during the inspection.

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

3.0 Inspection Findings and Quality Improvement Initiatives

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

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

	Year 1	Year 2	Year 3
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

Only those standards that had been identified in previous inspections as requiring improvement (in order to achieve year three compliance) were assessed.

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

The Regional Critical Care Infection Prevention and Control Audit Tool

The table below includes the areas of the audit tool that were assessed during this inspection and also gives the compliance rates in these areas in both year two (2015/16) and this year three (2018/19) inspection.

Table 1: Regional Critical Care Infection Prevention and Control Audit Tool Compliance Levels

Areas Inspected	Year 2	Year 3
General environment – layout and design	68	68
Clinical and Care Practice	87	100

The unit was bright, tidy and in excellent decorative order. Environmental cleanliness was of a high standard. From June to November 2017 the unit has been reconfigured, repainted, flooring replaced and the lighting upgraded. The unit has now separate clean and dirty utility rooms with additional storage facilities (Picture 1). Each bed space now has a new bed, mattress and clinical bedside trolley. A new bespoke nurse's station is an excellent addition.

All of these changes have contributed to a clutter free environment; staff told us it has improved the work flow.

Picture1: Newly refurbished clean utility room

As no changes have been made to bed space configuration/space within the unit since the initial inspection, the core clinical space and linear distance at the patient bed area remains unchanged. Spacing therefore does not comply with 80% of the minimum dimensions recommended by the Department of Health (DoH) and outlined in the audit tool. There were two single rooms available for isolation in the unit; a ratio of two rooms per eight beds. This is not in line with numbers recommended by the DoH and outlined within the audit tool.

Full compliance was achieved in the Clinical and Care Practice element of the inspection tool. Guidance is now in place identifying staff roles and responsibilities in relation to the reporting of laboratory results to the receiving or transferring units. This guidance was clearly displayed at the nurse's station.

Although there were no patients identified with an alert organism during this inspection, staff were fully aware of the need to isolate patients who present a risk of transmission. Guidance was available for staff on the isolation of patients'.

The hand hygiene practice of visiting staff was raised as a concern during the initial inspection of the unit. However during this inspection, we observed adherence to best practice guidance from all staff.

The Regional Infection Prevention and Control Clinical Practices Audit Tool

The table below includes the areas of this audit tool that were assessed during this inspection and also gives the compliance rates in these areas in both year two (2015/16) and this year three (2018/19) inspection.

Table 2: Clinical Practices Compliance Level

Area inspected	Year 2	Year 3
Aseptic Non Touch Technique (ANTT)	94	94
Taking Blood Cultures	81	100
Antimicrobial Prescribing	88	93
Surgical Site Infection (SSI)	89	100
Enteral Feeding or tube feeding	87	100

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

Aseptic non touch technique (ANTT) within the unit continues to be fundamental in the safe management of invasive devices, and susceptible body sites. We were advised that ANTT competency assessments and ongoing monitoring of practice continues for all unit staff. We observed a consistent and standardised approach by unit staff in the application of ANTT principles. We were informed that the trust ANTT policy has been revised by the infection prevention and control (IPC) team. This awaits review by the trust policy standards group before being published on the trust intranet site.

The trust blood culture policy has been recently reviewed and is available on the trust intranet site to guide staff in this procedure. When we questioned staff, they continued to have a good knowledge of this procedure as outlined in the policy. Blood culture packs are in use in the CCU; the use of these packs ensures all equipment to carry out this procedure is standardised and in one easily located pack. We observed good recording of the collection of blood for blood culture processing within medical notes. Blood culture incidences continue to be monitored. Throughout this year, the incidence of contamination within the unit has remained at zero per cent. This incidence provides evidence of the robust staff training and the routine monitoring of staff practice in carrying out this procedure.

We were informed that the trust microbiology team continue to provide good support in relation to antimicrobial prescribing, with daily visits to the unit. Inpatient records we observed evidence of information on antimicrobials prescribed. During the initial inspection of the unit, we identified that antimicrobial usage should be audited in line with current prescribing guidance. This is an area of improvement that still needs to be progressed as we were provided with no evidence of this audit activity.

In 2017, the unit participated within the Regional Point Prevalence Survey (PPS) 2017. The trust awaits results of the survey from the Public Health Agency (PHA). This survey will provide important information for unit staff on antimicrobial usage and stewardship.

Compliance with enteral feeding guidance/protocol continues to be audited to ensure a consistent and standardised approach to this procedure. We observed that oral feeding tubes were labelled and clearly identified in nursing care records. When we questioned staff, they had a good knowledge of the enteral feeding procedure in line with trust policy.

Surgical site infection (SSI) surveillance within the trust is being carried out for caesarean section. A trust care bundle is in place which contains a list of interventions to reduce the risk of surgical site infection. When unit staff were questioned, they were knowledgeable of the pre and post-operative actions to reduce the risk of SSI.

Quality Improvement Initiatives

From June to November 2017, the unit has been reconfigured. In order to facilitate the construction work the unit moved to ward C7 within the hospital. Staff reported that this was an enormous challenge and that significant time went into planning the move to ensure the relocation of the unit went smoothly. Despite this challenge staff reported that patient safety was not compromised, with no concerns were raised by patients or relatives.

We were informed of ongoing nurse training days in relation to the management of invasive device. Teaching simulators for example, a practice arm was purchased which allow staff to practice their skills in venepuncture, cannulation and catheterisation.

When noise exceeds recommended limits it is reported that it can have implications for the psychological and physiological health of patients. In an effort to minimise the effects of noise on patients' recovery within the unit, anaesthetic staff carried out an audit of noise levels. Sources of noise included alarms from medical devices, staff conversations, telephones and day-to-day activities like closing doors and opening packages. The findings of the audit identified the need for unit staff to reduce the amount of noise experienced by the patients by using simple yet effective methods for example ear plugs.

In order to support patients who have been critically ill and cared for in the CCU a pilot CCU follow up clinic was set up in Antrim Area Hospital. Patients who had been critically ill within the unit are invited to attend the clinic as an out-patient where they can access support and guidance when they are recovering at home. A survey of patient satisfaction was carried out in a quality improvement project. The project concluded that 100% of patients involved in the survey found the clinic useful and a business case has been put forward for funding of the clinic.

The inspection team observed that staff within the Antrim Area Hospital Critical Care unit were engaged and committed to quality initiatives and collaborative working in order to drive forward improvement in the delivery of care.

4.0 Key Personnel and Information

Members of the RQIA Inspection Team

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

Trust Representative Attending local Feedback Session

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

Ms M O'Hagan	Director
Ms E Eneaney	Director of Nursing
Ms M West	Assistant Director
Ms S Pullins	Assistant Director of Nursing
Ms K Johnston	Lead Nurse, Anaesthetics & ICU
Ms S Kinoulty	Clinical educator ICU
Mr A Abraham	Consultant ICU
Ms L Crymble	Senior Infection Prevention & Control Nurse
Ms E Moody	Infection Prevention & Control Nurse
Mr A Dines	Domestic Services Manager
Ms K Maxwell	Senior Building Officer, Estates

5.0 Improvement Plan – Year 3 (2018/19)

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.

Improvement Plan – Year 3 (2018/19)				
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**
Regional Infection Prevention and Control Clinical Practices Audit Tool				
No additional actions for improvement				
Regional Critical Care Infection Prevention and Control Audit Tool				
No additional actions for improvement				
Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool				
No additional actions for improvement				

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

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.

Year 2 (2015/16)

Regional Critical Care Infection Prevention and Control Audit Tool

Improvement Plan – Year 2 (2015/16)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
Regional Critical Care Infection Prevention and Control Audit Tool					
1.	It is recommended that all trust policies have a revision date appended to the approval date and all policies are reviewed and updated as required to ensure continued accuracy.	IPC	The IPC Team are currently reviewing and updating all IPC policies that are due for review.	March/April 2016 Subject to approval at Policy Standards Group	There is a programme for the update of Trust IPC Policies. Following approval by the Policy and Standards Group a new date for review will be applied to each policy.
2.	It is recommended that an occupational health policy to negate the risk of the	OH	ICU Lead Nurse has shared copy of OH Guidelines with all staff. Policy has been available for staff	12 February 2016	Updated guidance for staff made available on

Improvement Plan – Year 2 (2015/16)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
	transmission of infection is developed for staff guidance.		guidance since February 2016.		staff intranet Feb 2017.
3.	It is recommended that, there should be a review of the layout, design and storage areas of the unit for maximum space utilisation. As part of any refurbishment/new build planning, core clinical space recommendations should be complied with. The placement of clinical hand wash basins should be reviewed to comply with current guidance.	General Manager Lead Nurse	Plans being prepared to re-design the Clean and Dirty Utility areas to maximize space. Capital funding to be released to support the completion of re-design of dirty and clean utility The area has been reviewed previously and there is currently no space within the Unit to redesign the 6 bedded area in line with current guidance. There is no current plan for a new build. This is logged as a risk on the Trust Risk register and will be discussed at Capital Development meetings.	June 2016 By March 2017 Ongoing	The unit had an extensive refurbishment programme completed November 2017. The layout of the unit was redesigned to maximise storage and create a segregate clean and dirty utility. There is no space within the current footprint to change the existing bed spaces to comply with current guidance. This is logged as a risk on the Trust Risk register however as part of the Trust's 10

Improvement Plan – Year 2 (2015/16)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
					year capital plan a SOC for a new build ICU is currently being progressed.
4.	It is recommended that a protocol/ policy should be developed that identifies individual staff roles and responsibilities in relation to the reporting of laboratory results to receiving or transferring units.	ICU	A protocol has been developed which identifies individual staff roles and responsibilities in relation to the reporting of laboratory results to receiving or transferring units.	9/3/16	Completed 9/3/16. Best Practice ongoing.
5.	It is recommended that patients identified with alert organisms are isolated to reduce the risk of transmission.	ICU	The guidance that: 'patients' identified with alert organisms are isolated to reduce the risk of transmission' has been re-enforced with all staff.	Immediate	Completed February 2016. Best Practice ongoing.
6.	It is recommended that mechanisms are in place to ensure that all staff complies with the Trust hand hygiene policy.	IPCT ICU General Manager	At time of audit, it was addressed with both staff members not in compliance with hand hygiene. All staff encouraged to challenge poor IPC practice within the Unit	Immediate	Completed 25.3.16. Best Practice ongoing includes weekly Hand Hygiene Audits - any

Improvement Plan – Year 2 (2015/16)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
					deviation from the standard is immediately addressed.
7.	It is recommended that mechanisms are in place to ensure that equipment that is shared between departments is decontaminated prior to use.	IPCT/ Radiography Dept.	All equipment that is shared between departments is decontaminated both prior to and after use in line with Trust IPC policy and per manufactures instructions		IPCN actioned on 19.5.17 with radiology staff. Best Practice ongoing.

Year 1 (2014/15)
Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool

Improvement Plan – Year 1 (2014/15)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
The Regional Infection Prevention and Control Clinical Practices Audit Tool					
1.	It is recommended that the clinical decision taken for an invasive device to remain in situ longer than that is advised within best practice guidance, should be clearly documented within patient records.	Medical Staff	The clinical decision taken for an invasive device to remain insitu longer than that advised within best practice guidance, should be clearly documented within patient records by Medical Staff. This action will be discussed with all Medical staff at the next Anaesthetic meeting and a memo issued from the Clinical Director.	10/06/14	Completed 10.6.14. Best Practice ongoing.
2.	It is recommended that blood cultures are documented within patient records and include the date, time ,site and clinical indication for	Medical Staff	Blood cultures are now documented within patient records to include the date, time, site and the clinical indication for	10/06/14	Completed 10.6.14. Best Practice ongoing.

Improvement Plan – Year 1 (2014/15)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
	taking		taking samples by Medical staff.		
3.	It is recommended that systems are implemented to routinely monitor compliance with best practice when taking blood cultures	ICU Nursing and Medical Staff	Audit tool being developed.	30/09/14	Completed 30.9.14 Best Practice ongoing..
4.	It is recommended that the links between the unit pharmacist and the antimicrobial pharmacist are strengthened to ensure a collaborative approach to care	Pharmacy	Links have been established and the information from the visit in relation to pharmacy discussed to ensure a collaborative approach to care.	31/07/14	Scheduled initial meeting between Unit Pharmacist and Trust antimicrobial pharmacist; there will then be a regional collaborative meeting on 25.1.19 to scope current practice in each of the ICU units regionally and to plan a way forward. Agenda items will include 'audit sepsis management and antimicrobial stewardship,' 'frequency of audits and the most beneficial data to collect' and ' what is common to most units with respect to direct microbiology input to patient care.'

Improvement Plan – Year 1 (2014/15)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
5.	It is recommended that antimicrobial usage should be audited in line with current antimicrobial prescribing guidance.	Pharmacy Microbiology	A user account has been set up for the unit pharmacist and they are now auditing compliance with the antimicrobial policy. The results of this audit will be fed back to the consultants, ward manager and pharmacy staff within the unit to facilitate learning. This information is also reported to the trust Antimicrobial Management Team and the Infection prevention control and environmental health committee.	31/07/14	As above.
6.	It is recommended that the completion of the CDI care pathway is audited as applicable.	IPCT	CDI management is already audited 48 hours after result is issued, this includes use of the pathway.	Ongoing Oct 14	Care Bundle is now in use and the auditing process continues with the IPCN's. Any deviations identified are immediately addressed.

Improvement Plan – Year 1 (2014/15)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
			The pathway is currently under review and will be replaced with a care bundle.		IPCN visits ICU daily and review the pathway when applicable.
7.	It is recommended that staff adhere to best practice guidance in the management of an enteral feeding system.	ICU Antrim Hospital	Nursing staff now record 0 aspirate when none obtained. Dispose of single use items, water and syringes immediately after single use.	10/06/14	Completed 10.6.14. Best Practice ongoing.
8.	It is recommended that adherence to the MRSA screening and treatment policy is audited and actions plans developed where issues are identified.	IPCT	MRSA screening/management/treatment is audited and evidence of this was provided to RQIA at time of audit. ICU staff with the support of IPCT will audit screening within the unit monthly using an addendum tool to the HII returns.	Already in place	This Best Practice has been consistent and compliance is very high when audited.

Improvement Plan – Year 1 (2014/15)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
9.	It is recommended that the trust continue to develop and implement the new MRSA bundle of care; completion of the bundle should be audited by the IPC team.	IPCT	MRSA Care Bundle is now in place Trust wide	completed	Care Bundle is in use and the auditing process continues with the IPCN's. Any deviations are immediately addressed. However due to physical infrastructure constraints there are occasions when we are unable to isolate patients with MRSA. When that is the case (and indeed in on all occasions) decisions regarding patients are made on a case by case basis and include specific measures e.g. patient placement, use of suppression therapy and immediate contact precautions to reduce the microbial load shed into the environment.
Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool					
Standard 2: Environment					

Improvement Plan – Year 1 (2014/15)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
10.	It is recommended that staff ensure all surfaces including furniture, fixtures and fittings are clean and in a good state of repair. A maintenance programme should be in place to ensure all building repairs are carried out.	Estates Department Ward Manager	Senior staff ensure that all surfaces including furniture, fixtures and fittings are clean and in a good state of repair. All repairs are reported immediately through the Trust Action Desk.	28/07/14	Completed 28.7.14. A local Inspection rolling programme is facilitated by the Domestic Services Manager using the Regional Health Care Hygiene and Cleanliness Audit Tool. The last inspection was on the 24.4.18. In addition the Domestic Supervisor carries out an environmental inspection monthly, with the Ward manager who is responsible for ensuring any actions are carried out. There is also an online 'Webtraq' facility on the hospital intranet to log desired repairs.
11.	It is recommended that drugs fridge temperature checks are carried out and recorded on the trust record	ICU Nursing Staff	Daily fridge temperature checks completed and any variations in temperature reported	10/06/14	Daily fridge temperature checks completed and any variations in temperature reported

Improvement Plan – Year 1 (2014/15)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
	sheet. Variations in temperature and actions taken to address these should be recorded.		Drug fridge temperature also monitored by Pharmacy.		Drug fridge temperature also monitored by Pharmacy. Additional process, reminder implemented in September 2017. The Ward Manager regularly monitors compliance. Records are kept for auditing purposes.
12.	Nursing cleaning schedules should detail available equipment and outline staff responsibilities.	ICU Nursing Staff	More detail to include available equipment to be added to cleaning schedule for each bed space.	30/09/14	Further work undertaken for simplification and efficiency in 2016-2017. This included adding the recording of adherence to cleaning schedules onto the Clinical Information System for occupied bed spaces. Unoccupied bed spaces recorded as before.
Standard 4: Waste and Sharps					
13.	It is recommended that appropriate waste bins are	ICU Antrim Hospital	Appropriate bins now available	10/06/14	Completed 10.6.14. Best practice ongoing.

Improvement Plan – Year 1 (2014/15)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
	available for staff use.				
Standard 5: Patient Equipment					
14.	It is recommended that general patient equipment must be clean, stored correctly and in a good state of repair. Trigger tape should be used consistently to identify items of equipment that have been cleaned and all staff should be aware of the symbol designating equipment as single use.	ICU Antrim Hospital	Consistent labeling of all cleaned equipment after cleaning. All staff made aware of the symbol for single use equipment. New Difficult Airway trolley introduced	24/06/14	Completed 10.6.14-24.6.14, respectfully. Best practice ongoing.
Standard 7: Hygiene Practice					
15.	All staff should comply with the WHO five moments for hand hygiene and hand washing should be supplemented with the use of antimicrobial hand rub.	ICU Antrim Hospital	Updated weekly hand hygiene audit tool implemented which includes the use of antimicrobial hand rub.	13/07/14	Completed 13.7.14. Best practice ongoing.
16.	It is recommended that all staff adhere to the trust	ICU Antrim Hospital	Strict adherence to dress code policy.	10/06/14	Actioned 10.6.14. Best practice ongoing

Improvement Plan – Year 1 (2014/15)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
	dress code policy.		Constantly audited by the Nurse in Charge		
17.	It is recommended that COSHH data sheets are available for nursing staff.	ICU Antrim Health and Safety Advisor	COSHH data sheets will be available for nursing staff.	30/09/14	Completed 30.9.14. Updated 2017.

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