The Regulation and Quality Improvement Authority

Unannounced Augmented Care Inspection

Antrim Area Hospital
Neonatal Unit
Year 3 Inspection

15 August 2017

Contents

1.0 Profile of Service

The three year improvement programme of unannounced inspections to augmented care areas commenced in Antrim Area Hospital Neonatal unit on 6 August 2013.

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

Service Details

Responsible Person: **Dr. T. 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 neonatal units were initially assessed against the following regionally agreed standards and audit tools:

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

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

2.0 Inspection Summary

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

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

In this neonatal unit (Antrim Area Hospital), the overall year three compliance target of 95 per cent had already been achieved in relation to two of the three regional audit tools (the regional neonatal infection prevention and control audit tool and the regional healthcare hygiene and cleanliness standards and audit tool) during the unit's unannounced inspection in 2013/14 and 2015/16 (year one and two of the inspection cycle). Therefore the standards and areas assessed by these tools were not in the unit's year three inspection.

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

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

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

https://www.rqia.org.uk/inspections/view-inspections-as/map/antrim-area-hospital/

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

We found improvements in the clinical practices of aseptic non-touch technique (ANTT), the management of invasive devices, the taking of blood cultures, antimicrobial prescribing and enteral feeding within the unit.

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

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

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

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

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

3.0 Inspection findings

The Regional Infection Prevention and Control Clinical Practices Audit Tool

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

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

	Year 1	Year 2	Year 3
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 overall year three compliance target of 95 per cent had already been achieved in relation to two of the three regional audit tools (the regional neonatal infection prevention and control audit tool and the regional healthcare hygiene and cleanliness standards and audit tool) during the unit's unannounced inspection in 2013/14 and 2015/16 (year one and two of the inspection cycle). Therefore the standards and areas assessed by these tools were not in the unit's year three inspection. Only those standards that had been identified in previous inspections as requiring improvement (in order to achieve year three compliance) were assessed.

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

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

Table 1: Clinical Practices Compliance Level

Area inspected	Year 2	Year 3
Aseptic non touch technique (ANTT)	88	94
Invasive Devices	86	97
Taking Blood Cultures	78	100
Antimicrobial prescribing	94	94
Enteral Feeding or tube feeding	90	93

Aseptic non touch technique (ANTT) within the unit continues to be an integral part of the safe management of invasive devices and susceptible body sites. We were advised that staff ANTT competency assessments and ongoing monitoring of ANTT practice had recommenced since the previous inspection. Implementation of these processes has helped to enable a consistent and standardised approach by staff in the application of ANTT principles. We observed improvements in documentation in management of invasive devices; of note was the inclusion of a section to record the device batch number. This practice supports effective traceability of devices, to enable follow up actions as required to reduce safety risks to patients and staff.

Previous inspections of this neonatal unit had highlighted the ineffective surveillance of positive blood culture contamination rates. During this inspection we identified improvements in staff training and in assessment and analysis of blood culture rates. A new bespoke blood culture policy and recording labels have been developed. These improvements have contributed to the unit achieving and sustaining a low blood culture contamination rate. Figures provided evidenced that contamination rates have reduced from over four percent in 2016 to zero percent thus far in 2017.

The trust Microbiology Team and Antimicrobial Pharmacist provide good support and advice in relation to antimicrobial prescribing within the unit. Antimicrobial usage audits have continued to support good antimicrobial stewardship activity.

A process to monitor staff compliance with infection prevention and control standards relating to management of enteral tube feeding has been introduced, with assistance from the trust infection prevention and control team. This helps to ensure that a consistent and standardised approach is taken in these practices.

We observed that a number of policy documents relating to invasive procedures had passed their revision date. We were provided with evidence that these documents had been reviewed and updated and are awaiting review by the trust policy standards group, before they are published on the trust intranet site.

We observed evidence that staff were implementing the content of these updated documents.

Quality Improvement Initiatives

Since our previous inspection on 4 and 5 August 2015, the neonatal unit had focused on a number of quality improvement initiatives.

Staff within the unit identified that the survival of neonatal infants (less than 1000grams) continues to improve, although many infants continue to have high rates of the developmental morbidity. Problems were identified with the follow up care of these infants after discharge. To address the identified issues at follow-up a multidisciplinary team of unit staff established a structured neonatal neurodevelopmental follow-up clinic. The advantages of this initiative included ensuring consistent evidence based approach to follow-up, improved support for parents of high risk infants and improved equity of access to services. Feedback from parents in relation to this initiative has been extremely positive and staff highlighted that it has been an invaluable addition to neonatal services. In recognition of the success of this quality improvement initiative, the development group achieved first place in the partnership category of the trust chairman's awards (Picture 1).

Picture 1: Award Certificate.

Over the past 2 years, the neonatal unit has been extended and refurbished. This has provided staff with additional space to deliver care, improved parent and family experience and enhanced infection prevention and control precautionary measures. This refurbishment work lasted longer than was anticipated and required neonates to be moved to other facilities within Antrim Area hospital. In light of these challenges staff reported that patient safety was not compromised and no concerns were reported by parents.

The trust's neonatal team has continued with their programme of random safety audits. This local initiative includes the assessment of fourteen standards, seven infection prevention and control and seven care standards. Reported outcomes highlighted that these audits have been integral to maintaining standards of care and also provide a forum for good team work and practice development.

Since the previous inspection, one full time Band 7 Clinical Educator and one full time Band 7 Neonatal Infant Feeding Lead have been employed within the unit. The role of Clinical Educator is essential for the ongoing education and development of the unit's nursing team. The Neonatal Infant Feeding Lead is currently supporting implementation of best practice for breastfeeding in line with the United Nations International Children's Emergency Fund (UNICEF) UK Baby Friendly Initiative Neonatal Standards

Our inspection team observed that staff within the neonatal unit are engaged and committed to quality initiatives and are working collaboratively to drive 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

Trust Representative Attending local Feedback Session

The key findings of this inspection were discussed with the following trust representative:

Ms E McEneaney	Executive Director of Nursing/ Chair of the Neonatal Network
Ms C Keown	Interim Head of Midwifery and Gynae
Ms J Duncan	Paediatric Lead Nurse
Ms J Lambrechts	Ward Manager
Ms J Gilmour	Infection Prevention and Control Nurse

5.0 Improvement Plan – Year 3 (2017/18) (position as at 5th December 2017

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

Improvement Plan – Year 3 (2017/18)				
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**
Regional Augmented Care Infection Prevention and Control Audit Tool.				
None Required				
Regional Infection Prevention and Control Clinical Practices Audit Tool				
None Required				
Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool				
None Required				

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

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

Year 2 (2015/16)
The Regional Neonatal Care Audit Tool
The Regional Clinical Practices Audit Tool

Improvement Plan – Year 2 (2015/16)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion / timescale**	**Update by Trust 2017**
Regional Neonatal Care Infection Prevention and Control Audit Tool.					
1.	It is recommended that senior nursing staff are supported and given protected time to ensure the monitoring of compliance with best practice and validation audits.	Nursing	Timetable has been designed to indicate allocation of staff to ensure the monitoring of compliance with best practice (infection control link nurses). All on going infection control audits discussed at staff meetings. Neonatal team will be represented on directorate infection control team meetings.	Sept 15 Sept 15	Forms composite part of weekly duties. Completed as evidenced in minutes of staff meetings and monthly newsletter in NNU. Attendance by IPC Link Nurses documented at

Improvement Plan – Year 2 (2015/16)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion / timescale**	**Update by Trust 2017**
					Augmented IPCT meetings. Augmented Care Group meetings attended by Shirley Montgomery (Lead Nurse). Divisional IPC – Grace Edge (Head of Service) Chairs. Grace Edge represents all Neo Natal Staff at Divisional IPC. Water Safety Group – Quarterly. Represented by Lead Nurse.

Improvement Plan – Year 2 (2015/16)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion / timescale**	**Update by Trust 2017**
2.	It is recommended that the trust reviews the role of clinical educator within the NNU and the provision of competency based training for long term staff.	Nursing	Discussions regarding Clinical Educator have commenced within service and to be escalated. There currently is not a dedicated funding stream for a clinical educator. Current education within the facility is within the role of senior nurses through, preceptorship/mentoring and ongoing continuous professional development. The one year competency programme for new starts has recently become protracted due to significant staffing pressures. Clinical educator arrangements will be revised in the coming months.	On going	In place since April 2017. On Maternity Leave at present. To commence when staff member returns from Maternity Leave (ie May 2018)
3.	It is recommended that all trust policies/guidance, including the patient information booklet, are reviewed and updated and available for staff.	Nursing/IPC team	Patient information booklet reviewed, completed and available for staff. ANTT policy review	Aug 15 Nov 2015	Revised, updated and in process of being printed. A number of policies have been reviewed via the Infection

Improvement Plan – Year 2 (2015/16)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion / timescale**	**Update by Trust 2017**
					Control Team and are awaiting approval by Policy/Standards Committee.
4.	It is recommended that the flowchart outlining staff roles and responsibilities on the receipt of positive laboratory results is reviewed. Staff responsibility for reporting to the sending unit when admission screens are positive should be clearly identified.	Nursing	Completed	Aug 15	August 2015
5.	It is recommended that risk assessments should be undertaken in relation to existing procedural arrangements for the collection and storage of breast milk and for the preparation and storage of specialised infant formula.	Nursing	Draft Policy in place, to be finalised and progressed through Policy standards group. Validation audits in draft format.	March 16	Completed Policies held in the Neo Natal Unit with Lead Nurse holding final drafts for preparation, storage and for proceeding through Policy Standards.

Improvement Plan – Year 2 (2015/16)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion / timescale**	**Update by Trust 2017**
					Draft Policies have been shared with RQIA Inspectors.
6.	It is recommended that action plans to address issues in relation to critical control points to recommendation 5 should be available e.g. temperature.	Nursing	Policy in draft format at present and being used within unit as draft. To be finalised and progressed through Policy standards group.	March 2016	Completed Updated and commenced March 2016.
Regional Infection Prevention and Control Clinical Practices Audit Tool					
7.	It is recommended that yearly ANTT staff assessment, by a nominated person, is commenced in line with trust policy and action plans developed where issues are identified.	Nursing	Validation audit in draft. ANNP and Infection Control team act as validators.	August 15	Completed Continues for all staff – Annually.
8.	The Trust needs to ensure all trust policies in use for neonates include specific paediatric/neonatal advice, reflect current staff practice and the replacement and ongoing management of any invasive device.	Medical/ Nursing /IPC team	Adult policies for these devices will be reviewed and adapted for neonates/paediatrics • Peripheral cannula • Umbilical/arterial and venous catheter	December 2015	A number of policies have been reviewed and these have been shared and reviewed with RQIA.

Improvement Plan – Year 2 (2015/16)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion / timescale**	**Update by Trust 2017**
9.	It is recommended that all invasive device documentation is reviewed to ensure recording of the device batch number.	Medical	As above, batch number now being recorded.	Sept 15	Completed September 2015 and ongoing.
10.	It is recommended that blood culture analysis and results are discussed as a standing item on the MDT meeting agenda.	Medical/ Nursing	Dr S Bali to action by including in Multidisciplinary Team meetings.	Sept 15	Completed Monthly and discussed at MDT meeting.
11.	It is recommended that systems are implemented to routinely monitor compliance with best practice when taking blood cultures, when carrying out enteral feeding and the cleaning of specialised equipment. Action plans should be developed and independent verification carried out where issues are identified.	Medical	Best practice guidelines all in draft and being progressed. Adult policy with competency framework already in place and will be adapted.	Dec 15	Audited and staff revalidated annually.
12.	Electronic /computer aided tools should be available to assist with antimicrobial prescribing.	Medical	Awaiting Regional Steer regarding this point. We are currently looking at the potential for an APP to assist medical staff.	Ongoing	Awaiting Regional direction

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

Improvement Plan – Year 1 (2013/14)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion / timescale**	**Update by Trust 2017**
Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool					
Standard 2: Environment					
1.	A maintenance programme should be in place to ensure the general environment, furniture, fixtures and fittings are in a good state of repair.	Estates	A maintenance programme is in place ensuring general environment is in good state of repair. Furniture, fixtures and fittings are assessed by Nursing staff and where repair is required Estates are contacted via Help Desk system and minor capital works are requested. Record and follow up is maintained at ward level and with Estates	Completed	Completed and Ongoing since 2013/l4 visit.
2.	Cleaning schedules should outline staff roles/responsibilities for all equipment within the unit.	Nursing, Domestic Services	Cleaning schedules are available for domestics for general environment. More specific cleaning of equipment is available for Nursing/auxiliary staff as weekly cleaning. Daily cleaning of individual infant's	Completed	Completed and Ongoing since visit.

Improvement Plan – Year 1 (2013/14)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion / timescale**	**Update by Trust 2017**
			area is completed and documented.		
3.	Hand washing sinks should be available in the domestic store and the kitchen.	Estates	Hand washing sinks will be available in the domestic store and kitchen as part of the refurbishment project.	Due to be completed August 2014	Completed 2016.
Standard 4: Waste and Sharps					
4.	All staff should ensure the correct segregation of waste.	Nursing	Signage is available for the segregation of waste on top of each waste bin in Neonatal Unit. Staff informs parents of the correct usage.	Completed	Completed Ongoing since 2013/2014 visit.
5.	Staff should ensure that the temporary closure mechanism is deployed when the sharps bin is not in use.	Nursing	All staff have been provided with the Disposal of sharps policy and reminded of the need to ensure temporary closure is deployed when sharp box not in use.	Completed	Completed & Ongoing
Standard 5: Patient Equipment					
6.	Sterile or single use equipment should not be removed from its packaging prior to use.	Nursing	Sterile or single use equipment is maintained in its packaging prior to use. This was addressed with all staff at time of RQIA audit and was raised again at the	Completed	Completed Staff Awareness ongoing and incorporated in staff training.

Improvement Plan – Year 1 (2013/14)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion / timescale**	**Update by Trust 2017**
			Ward meeting in September 2013. Minutes of the meeting were provided to all staff.		
Standard 6: Hygiene Factors					
7.	All chemicals should be stored in a locked, inaccessible area in accordance with COSHH regulations.	Nursing, Domestics	All staff will be provided with COSHH awareness training and chemicals are stored in a locked, inaccessible area.	Partially completed as training is ongoing	Completed COSHH training records. COSHH cupboard in place.
Standard 7: Hygiene Practices					
8.	All staff should comply with the WHO five moments for hand hygiene.	All staff and parents.	All staff must have training in hand hygiene. Parents are shown how to do hand hygiene by nursing staff. The Neonatal Unit has weekly auditing of hand hygiene. All staff have had training in hand hygiene through their mandatory infection control annual training.	Completed	Completed Staff Training and induction and Hand Hygiene Audits.
9.	NPSA colour coding guidelines should be displayed for nursing staff.	Nursing	NPSA colour coding guidelines are displayed in the dirty utility	Completed	Completed & Ongoing

Improvement Plan – Year 1 (2013/14)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion / timescale**	**Update by Trust 2017**
	Nursing staff should be updated on the NPSA colour coding for the cleaning of equipment.		room for nursing staff. Nursing staff are updated on the NPSA colour coding for the cleaning of equipment using the NHSCT decontamination policy.		
10.	All staff should adhere to the trust dress code policy.	All staff	All staff must adhere to the NHSCT dress code policy. Staffs who are in breach of the policy will be managed under disciplinary process.	Completed	Completed Staff Awareness and highlighted in Newsletter.

The **Regulation** and
Quality Improvement
Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews