The Regulation and Quality Improvement Authority

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Unannounced Infection Prevention/Hygiene Augmented Care Inspection

Year 2 Inspection

Antrim Area Hospital Critical Care Unit

21 January 2016

informing and improving health and social care
www.rqia.org.uk

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care (HSC) services in Northern Ireland.

RQIA's reviews and inspections are designed to identify best practice, to highlight gaps or shortfalls in services requiring improvement and to protect the public interest.

Our Hygiene and Infection Prevention and Control inspections are carried out by a dedicated team of inspectors, supported by peer reviewers from all trusts who have the relevant experience and knowledge. Our reports are available on the RQIA website at www.rqia.org.uk.

Inspection Programme

The CMO's letter (HSS MD 5/2013) endorsed the use of the Regional Infection Prevention and Control Audit Tools for Augmented Care Settings by all Trusts in Northern Ireland in the relevant clinical areas www.rqia.org.uk.

- Governance Assessment Tool;
- Infection Prevention and Control Clinical Practices Audit Tool;
- Neonatal Infection Prevention and Control Audit Tool;
- Critical Care Infection Prevention and Control Audit Tool;
- Augmented Care Infection Prevention and Control Audit Tool

The introduction of this suite of audit tools is follow-on from development of the existing regional healthcare hygiene and cleanliness standards and audit tool, developed and disseminated in 2011. Both sets of tools should be used in conjunction with each other. A 'Guidance and Procedural Paper for Inspections in Augmented Care Areas' has been developed which outlines the inspection process www.rqia.org.uk.

The inspection programme for augmented care covers a range of specialist facilities and a rolling programme of unannounced inspections has been developed by RQIA to assess compliance with both of these sets of audit tools.

RQIA also carries out announced inspections. These examine the governance arrangements and systems in place to ensure that infection prevention and control and environmental cleanliness policies and procedures are working in practice.

Contents

1.0 Inspection Summary

The three year improvement programme of unannounced inspections to augmented care areas commenced in Antrim Area Hospital Critical Care Unit (CCU) on 9 and 10 June 2014.

RQIA use audit tools as an assessment framework to build progressive improvement over the three-year inspection cycle. Compliance scores for the first inspection are 85 per cent, rising to 95 per cent by the end of the third inspection.

The findings of the inspection indicated that the unit achieved year two compliance rate of over 90 per cent in:

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

As a result, these tools were not included as part of the year two inspection programme.

The CCU did not achieve the set compliance level in the Regional Critical Care Infection Prevention and Control Audit Tool for year one. An unannounced inspection was undertaken to the CCU on 21 January 2016 as part of the three-year improvement programme. The inspection team comprised of two RQIA inspectors. Details of the inspection team and trust representatives who received feedback can be found in section 6.

The report highlights strengths as well as areas for further improvement, and includes recommendations and a quality improvement action plan. This can be read in conjunction with year one inspection report www.rqia.org.uk.

Overall the inspection team found evidence that the CCU at Antrim Area Hospital was working to comply with the regional audit tool inspected.

Inspectors observed:

- The unit achieved year two compliance with the Regional Critical Care Infection Prevention and Control Audit Tool

Inspectors found that the key areas for further improvement were:

- Layout, design and storage capacity within the unit

Inspectors observed the following areas of good practice:

- the role of clinical educator continues to be pivotal to the ongoing education and development of unit staff
- the development of a pocket infection prevention and control (IPC) guide for staff
- the development of the new trust Antibiotic Guidelines which can be accessed via an app on a smart phone

The inspection resulted in **7** recommendations for improvement listed in Section 5.

The inspection in **2014** resulted in **nine** recommendations, related to the Regional Critical Care Infection Prevention and Control Audit Tool**. Six** recommendations have been addressed, **three** have been repeated and there are **four** new recommendations.

The final report and quality improvement action plan will be available on RQIA's website. Where required, reports and action plans will be subject to performance management by the Health and Social Care Board and the Public Health Agency (PHA).

RQIA's inspection team would like to thank the Northern Health and Social Care Trust (NHSCT), and in particular all staff at the Antrim Area Hospital CCU for their assistance during the inspection.

2.0 Overall Compliance Rates

The Regional Critical Care and Clinical Practices Infection Prevention and Control Audit Tools

RQIA uses these tools as an assessment framework to build progressive improvement over a three-year inspection cycle. Compliance scores for the first inspection are 85 per cent, rising to 95 per cent by the end of the third inspection.

Compliance rates are based on the scores achieved in the various sections.

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

Areas inspected	9 & 10 June 2014	21 Jan 2016
Local Governance Systems and Processes	96	98
General Environment – Layout and Design	57	68
General Environment – Environmental Cleaning	100	100
General Environment – Water Safety	95	100
Clinical and Care Practice	87	87
Patient Equipment	98	97
Average Score	**89**	**92**

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

Where an inspection identifies issues that are considered to be of high risk, trusts will be asked to take immediate action.

3.0 Inspection Findings: Regional Critical Care Infection Prevention and Control Audit Tool

The Regional Critical 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 critical care. This will assist in the prevention and control of healthcare associated infections.

Regional Critical Care Infection Prevention and Control Audit Tool Compliance Levels

Areas inspected	9 & 10 June 2014	21 Jan 2016
Local Governance Systems and Processes	96	98
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Clinical and Care Practice	87	87
Patient Equipment	98	97
Average Score	**89**	**92**

The findings indicate that whilst overall compliance was achieved in relation to the Regional Critical Care Infection Prevention and Control Audit Tool, inspectors identified that the layout and design of the unit continues to be of specific concern.

3.1 Local Governance Systems and Processes

For organisations to comply with this section, good governance should be displayed through management that displays effective decision-making and leadership. Systems and processes should be robust, and staff should be aware of their roles and responsibilities. Appropriate policies and procedures should be available. Good compliance was achieved with this section.

The eight bed critical care unit, based at Antrim Area Hospital site, is part of the NHSCT and provides adult general intensive care and high dependency services. It is commissioned for six intensive care (level 3) and two high dependency (level 2) care beds.

The unit provides intensive care services to patients with life threatening illness, following major and complex surgery and serious accidents. Patients in high dependency care are generally less ill than those in critical care but still require organ support which cannot be provided in an ordinary ward.

Leadership and Management

The clinical educator/ sister, continues to display good leadership, management and knowledge on IPC and can avail of protected time for appropriate training opportunities. Unit staff continue to display good awareness of IPC measures and precautions.

The unit has a dedicated trust IPC nurse for advice and support. Inspectors were informed that IPC staff visit the unit daily during the core working week and provide a written report on identified or observed IPC issues. Visits by IPC staff can be increased for outbreak management.

IPC link meetings continue to be facilitated within the unit and are attended by a member of the IPC team and domestic services. These link meetings were held every three months and provide the opportunity for staff to discuss IPC issues specific to the unit.

The unit had nine dedicated IPC link nursing staff that collaborate and communicate with members of the IPC team. Link staff cascade information to other unit staff for learning via staff meetings and safety briefs. IPC remains a significant focus of the CCU meetings. The most recent meeting evidenced staff updates with an internal validation audit of Methicillin-resistant Staphylococcus aureus (MRSA) management, performance with high impact interventions, environmental cleanliness audits, and device associated infection surveillance.

Inspectors were informed, when patients with infections are identified, staffing levels can be increased to assist in the delivery of care and ensure adherence to good IPC practices. Bank staff can be used to supplement unit staffing levels.

Review of Documentation

The IPC & Environmental Hygiene Committee, meet bimonthly. The meeting is chaired by the Director of Nursing and User Experience. The trust performance with Healthcare Associated Infection targets, surveillance activity, IPC validation audits and antimicrobial stewardship are core components for discussion.

A review of documentation evidenced that incidents relating to IPC were appropriately reported and acted on. Post infection review meetings (previously root cause analysis) are carried out for MRSA/MSSA bacteraemia and Clostridium *difficile* infections (CDI). Post infection review meetings are hosted by the trust Chief Executive and the Director of Nursing and IPC. Documentation from these meetings evidenced that a multidisciplinary approach was taken to this process and minutes from staff meetings highlight that staff receive timely feedback from such incidents.

Accessing IPC policies and the ability to demonstrate knowledge of these policies is included as part of the IPC competency tool for staff in acute care

settings. All staff questioned, had a good knowledge of IPC policies and procedures, and were able to access the relevant documents on the staff intranet site.

Inspectors again have observed that a number of policy documents for invasive procedures had passed their revision date. Inspectors also noted that a number of policies had no revision date appended to the approval date of the policy.

We were informed that the IPC team are reviewing and updating all IPC policies that are due for review. Policies had been allocated to senior IPC nurses with a plan to have these all reviewed and completed by end of March 2016 subject to review at Policy Standards Group. Two policies that have recently been completed and reviewed to be tabled at the Policy Standards Group in March 2016 are MRSA and Post Infection Review.

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. (Repeated)**

Advice for staff is also supplemented by the use of a 'Pocket Guide to IPC'. Contents include advice in relation to control measures that break the chain of infection, i.e. the use of personal protective equipment, isolation, and hand hygiene.

Staff members questioned, were knowledgeable on the appropriate action to take in the event that they develop an infection. We note however that an overarching occupational health/infection prevention and control policy was not available. We were provided with a draft document that outlined guidance on screening, immunisation and the management of infection to negate the risk and transmission of infection to patients. We were informed that this guidance document is currently being reviewed and once completed will be made available for staff on the trust intranet site.

2. **It is recommended that an occupational health policy to negate the risk of the transmission of infection is developed for staff guidance. (New)**

A system was in place for unit staff to identify and report maintenance and repair issues. The computerised recording system (Webtrack) in the estates department captures this information.

Audit

Local and regional audits were undertaken to improve IPC practices. Recent invasive device HIIs, environmental cleanliness and hand hygiene audits evidenced good compliance with best practices.

Inspectors evidenced that the IPC team independently validate practices within the unit. Recent validation audits included: management of urinary catheters, CDI and MRSA management and hand hygiene practices. In June 2015, the IPC team also carried out an audit of clinical practices within the unit using the Regional Infection Prevention and Control Clinical Practices Audit Tool. When audits identified deficits in practice, action plans were developed to address poor practices. Key performance data from audits was displayed publicly within the unit and reported to unit staff at staff briefings and team meetings.

The audit tool used to assess the practice of hand hygiene had been updated since the last inspection. The tool now assesses that alcohol hand rub is used following a seven step hand hygiene procedure with soap and water.

Surveillance

Surveillance, the continuous monitoring of healthcare associated infection (HCAI) is key to the control of infection. A surveillance programme can be used to implement improvement initiatives, assess effectiveness of clinical interventions and can quickly identify outbreaks if infection.

Inspectors noted that mandatory and non-mandatory surveillance programmes were in place. Surveillance data is analysed by the microbiology and the IPC teams and presented at the IPC & Environmental Hygiene Committee meetings. The lead nurse for the CCU attends this meeting bi-monthly. This forum reviews the current trust incidence of CDI, MRSA and MSSA bacteraemia in line with set Public Health Agency (PHA) targets and discusses the emerging themes from post infection reviews.

Surveillance continues with Caesarean Section SSI wound infection rates. Meeting minutes identified that recent validation audits of all positive SSI's reported, demonstrated that completion of documentation had improved.

The trust continues to use the software-based, Live Automated Microbiology Pharmacy Surveillance (LAMPS) system. We were informed that this software gives access to patients' full archived history of microbiology laboratory data and that outbreak and anti-microbial resistance detection algorithms send alerts, in real-time, to the IPC team.

Training and Development

Staff IPC knowledge and up-to-date practical skills are a prerequisite for clinical staff to carry out their role in an effective manner.

Training records available highlighted that all unit staff had participated in the trust's induction programme and have attended or are booked to attend mandatory IPC training. All new nursing staff must progress through a set of IPC 'Step 1' competencies outlined within the CCaNNI (Critical Care Network in Northern Ireland) competency framework for registered nurses in adult critical care.

All staff are expected to attend face to face IPC training every three years. In between, training is supplemented by a DVD on the principles of IPC and staff members complete an IPC competency assessment. The ward manager is responsible for marking the competency assessment of each staff member. If a score of less than 90 per cent is achieved, the staff member must attend face to face IPC training.

Information and Communication

Information on infection prevention and control, and the effective communication of this information, is vital to ensure adherence to good practice.

A range of resources was available to advise patients and visitors of IPC precautions. Leaflets and booklets were provided for relatives on hand hygiene, visiting times and advice in relation to bringing food into hospital. In collaboration with CCaNNI, a new visitor's booklet has been developed that provides guidance in the appropriate use of clinical hand wash sinks. We were informed that advice for visitors to the unit on the concept of being 'bare below the elbow' and the bringing of outside coats into the unit was guided by advice from the IPC team.

3.2 General Environment

3.2.1 Layout and Design

For organisations to comply with this section of the audit tool they must ensure adequate facilities are available for the delivery of care. This includes the space available to carry out care, decontaminate equipment and to ensure effective isolation. The unit has achieved minimal compliance in the layout and design of the environment.

The CCU consists of eight beds, incorporating two side rooms.
As no bed reconfiguration changes have been made to the unit since the first inspection the allocation of space in the clinical areas of the unit continues to be viewed as inadequate.

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 DHSSPSNI. The limitations in clinical space continue to affect staff members' ability to manoeuvre patients and equipment.

Although the core clinical space did not meet current recommended requirements, staff were working within these limitations to deliver safe and effective care. Inspectors observed that bed spaces were free from clutter during the inspection.

There were two single rooms available within the unit. These rooms were used for the isolation of patients to control the spread of infection or for the

protection of immunosuppressed patients. This is not in line with numbers recommended by the DHSSPS and outlined in the audit tool; a minimum of four single rooms per eight beds. Inspectors were informed, that due to the lack of single rooms, patients either colonised or infected with alert organisms could be nursed in the multi bedded area with other susceptible patients. This was observed for one specific case during the inspection.

Inspectors observed that clinical hand wash sinks were located in close proximity to bed spaces two and seven. The positions of these sinks continue to present a splash risk to the patient, the bed and the equipment at the bed space.

There were no dedicated areas for equipment cleaning and near patient testing equipment. Inspectors observed that there was no clear separation of clean and dirty storage areas. Inspectors were informed that plans are in place for the reconfiguration of the dirty utility room, clinical room and the removal of the infrequently used shower room. The purpose is to provide segregated clean and dirty designated work areas and improve on storage facilities.

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. (Repeated)**

Inspectors evidenced that ventilation systems are routinely monitored, serviced and cleaned by estates department

3.2.2 Environmental Cleaning

For organisations to comply with this section they must ensure cleaning staff display knowledge of cleaning policies and procedures, and are competent in cleaning hand washing sinks. Environmental cleaning audits should be carried out, and the infection prevention and control team should be consulted when infection has been identified.

Good practice was observed and the unit was fully compliant in this section on environmental cleaning. Environmental cleaning; guidelines, audit and staff competency based training were in place and reviewed. On questioning, staff displayed good knowledge on appropriate cleaning procedures. There was a regular programme of de-cluttering in place.

3.2.3 Water Safety

For organisations to comply with this section they must ensure that an overarching water safety plan and individual area risk assessment plan is in place. Water sampling, testing, flushing and maintenance are carried out correctly, and there is a mechanism in place to report water analysis results.

The unit was fully compliant in relation to water safety. An overarching trust water safety plan and individual unit risk assessment plan were in place. Collection of tap water samples to facilitate microbiological organism testing and analysis was carried out. The trust carries out a quarterly schedule of water sampling for legionella and six monthly sampling for Pseudomonas *aeruginosa* from all outlets in augmented care areas.

All results of water analysis are reported to the trust water safety group. The group is inclusive of staff from IPC, estates and clinical representatives. Water safety data is presented by the water safety group to the trust IPC & Environmental Hygiene Committee.

We were informed that all water outlets within the unit, used for direct or indirect clinical care are flushed twice daily for two - three minutes. This ensures that water does not stagnate within the water system and is in line with best practice guidelines. We observed that all flushing records were available and satisfactorily completed.

Hand washing sinks were used correctly - only for hand washing. We did not observe bodily fluids and cleaning solutions being disposed of down hand washing sinks. Patient equipment was not stored or washed in hand washing sinks. A system was in place to address any issues raised with the maintenance of hand washing sinks and taps.

3.3 Critical Care Clinical and Care Practice

For organisations to comply with this section they must ensure that the delivery of care is provided in a way that negates the risk of transmission of infection. This is provided through adequate staffing, monitoring of neonate movement, infection control screening policies and adherence to DHSSPS and local guidance on cleansing the critical care.

Partial compliance was achieved in this section of the audit tool. During the inspection, staff allocation ensured optimal IPC practices. A 'live' and retrospective patient placement tracking system to identify which bed and bed space the patient was in during their stay was available on the 'ward watcher' computer system and ICIPs (Intellivue Clinical Information Portfolio) software package.

To facilitate the continuity of care following the transfer of a patient to another unit, staff members completed a handover summary which outlined the patient's infection status. Nursing staff also completed the CCaNNI transfer form, which would accompany the patient. Screening policies and procedures were in place and known to staff. All patients were routinely screened on admission for MRSA and weekly thereafter.

Evidence was available that if patients' critical care admission screens were positive or if their results following discharge or transfer to another ward were positive the receiving or transferring wards were routinely informed. The

protocol to guide staff however should be reviewed. It outlines that following transfer of a patient to another unit; the receiving unit must be explicitly informed of any pending/ positive results. It however does not guide staff that the sending unit should be explicitly informed of positive admission screens to the CCU. It also does not specifically outline which staff members will be allocated these responsibilities.

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. (Repeated)**

During the inspection, a patient in the unit had been identified as colonised with an alert organism. The patient's care bundle for the management of this organism had been completed appropriately. We observed however that the patient had not been isolated into a side room, even though a side room was available. The patient was being nursed in the multi-bedded area of the unit.

5. **It is recommended that patients identified with alert organisms are isolated to reduce the risk of transmission. (New)**

Staff washed patients in water from a source of known quality and used alcohol rub after hand washing when caring for patients. Staff were aware of risk factors that cause skin injury, patient's skin condition was recorded in care records.

Staff compliance with the trust hand hygiene policy throughout the inspection was generally good however we did observe breaches to the policy from some visiting staff. Some visiting medical staff were observed not bare below the elbow. One failed to perform hand hygiene in line with the WHO five moments while in the patient's immediate clinical environment and another member of staff lifted the lid of the waste bin with their hand following hand decontamination.

6. **It is recommended that mechanisms are in place to ensure that all staff complies with the Trust hand hygiene policy. (New)**

3.4 Critical Care Patient Equipment

For organisations to comply with this section they must ensure specialised equipment is effectively cleaned and maintained. Audits of equipment cleaning and education on the use of equipment should be available.

The unit achieved compliance in this section of the audit tool. 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.

We observed that a portable x-ray machine being used during the inspection was dusty.

7. **It is recommended that mechanisms are in place to ensure that equipment that is shared between departments is decontaminated prior to use. (New)**

4.0 Summary of Recommendations

The Regional Critical Care 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. **(Repeated)**

2. It is recommended that an occupational health policy to negate the risk of the transmission of infection is developed for staff guidance. **(New)**

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. **(Repeated)**

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. **(Repeated)**

5. It is recommended that patients identified with alert organisms are isolated to reduce the risk of transmission. **(New)**

6. It is recommended that mechanisms are in place to ensure that all staff complies with the Trust hand hygiene policy. **(New)**

7. It is recommended that mechanisms are in place to ensure that equipment that is shared between departments is decontaminated prior to use. **(New)**

5.0 Key Personnel and Information

Members of RQIA's Inspection Team

Thomas Hughes	Inspector Infection Prevention/Hygiene Team
Margaret Keating	Inspector Infection Prevention/Hygiene Team

Trust Representatives attending the Feedback Session

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

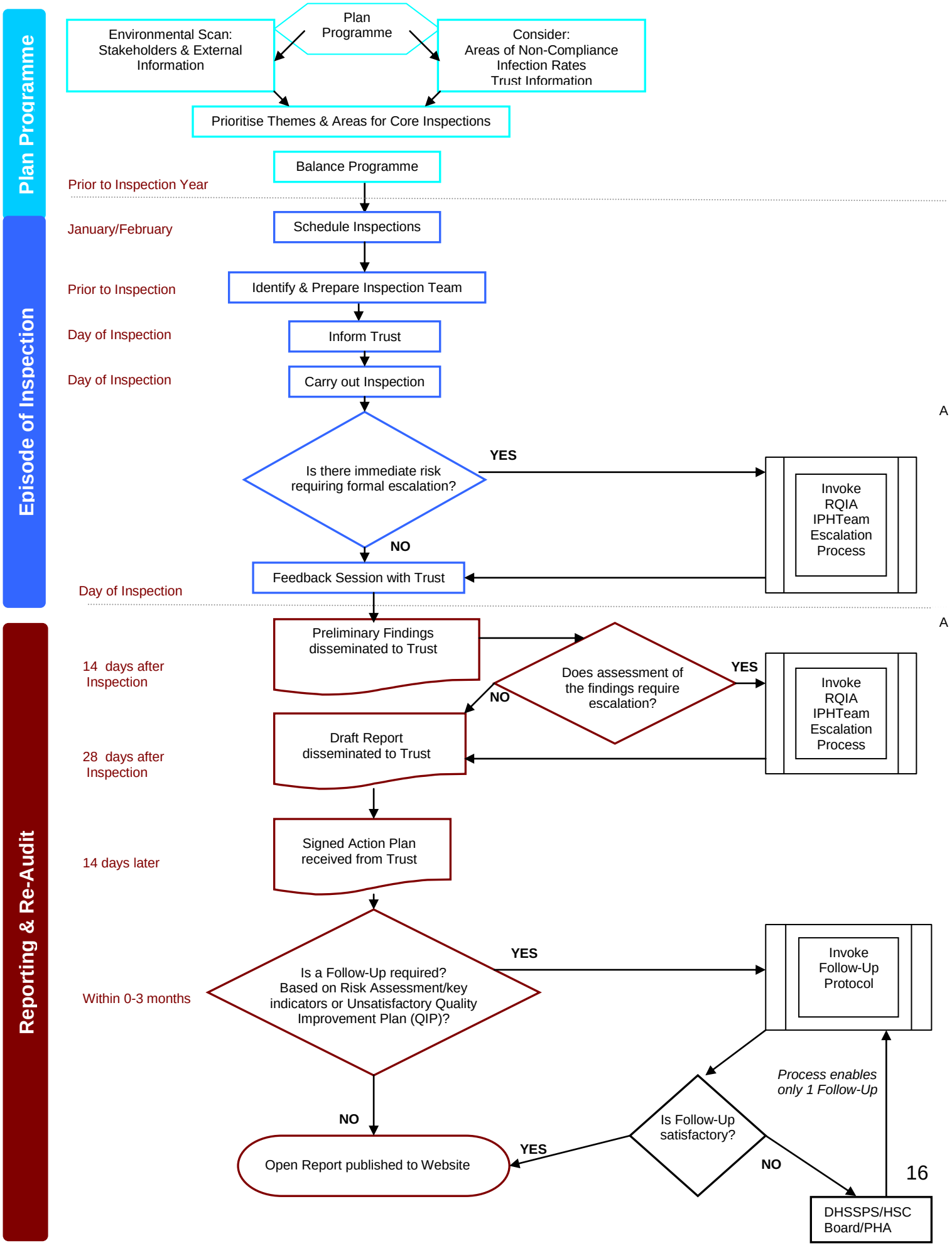
Sheila Kinoulty	Clinical Educator
Kathleen O'Rawe	Sister ICU
David Farren	Infection Prevention and Control Doctor
Pauline McGaw	General Manager ATICS
Lorraine Crymble	Senior Infection Prevention and Control Nurse
Alan Doole	Healthcare Assistant

6.0 Augmented Care Areas

Based on DHSSPS guidance, the augmented care areas currently identified for inclusion in inspections are:

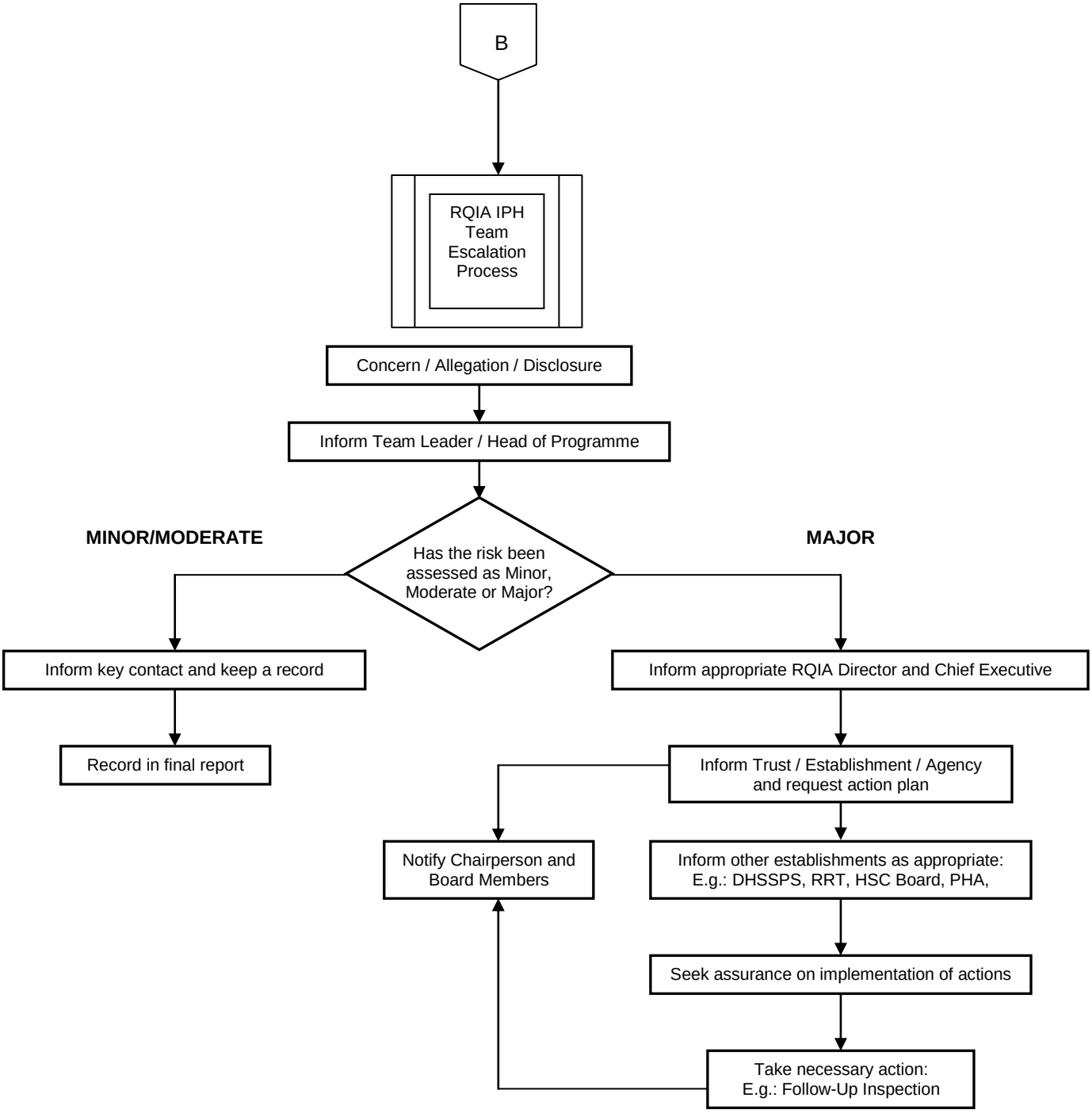
- neonatal and special care baby units
- paediatric intensive care
- all adult intensive care which includes cardiac intensive care
- burns units
- renal (dialysis) units
- renal transplant unit
- high dependency units (HDU)
- haematology
- oncology

7.0 Unannounced Inspection Flowchart



8.0 Escalation Process

RQIA Hygiene Team: Escalation Process



9.0 Quality Improvement Plan

Reference number	Recommendations	Designated department	Action required	Date for completion/ timescale
The Regional Critical Care 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. (**Repeated**)	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
2	It is recommended that an occupational health policy to negate the risk of the transmission of infection is developed for staff guidance. (**New**)	OH	ICU Lead Nurse has shared copy of OH Guidelines with all staff. Policy has been available for staff guidance since February 2016.	12 February 2016
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. (**Repeated**)	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	June 2016 By March 2017 Ongoing

			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.	
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. (**Repeated**)	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
5	It is recommended that patients identified with alert organisms are isolated to reduce the risk of transmission. (**New**)	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
6	It is recommended that mechanisms are in place to ensure that all staff complies with the Trust hand hygiene policy. (**New**)	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
7	It is recommended that mechanisms are in place to ensure that equipment that is shared between departments is decontaminated prior to use. (**New**)	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	

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