The Regulation and Quality Improvement Authority

Unannounced Augmented Care Inspection

Ward C7
Antrim Area Hospital

14-15 November 2016

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

Contents

1.0 Profile of Service

The three year improvement programme of unannounced inspections to augmented care areas commenced in Ward C7 of Antrim Area Hospital on 14 and 15 November 2016.

Ward C7 is a modern facility which opened in 2013. The ward comprises of 24 beds and manages the care of patients admitted with various haematology, renal, oncology, rheumatology, gastrointestinal and other medical conditions. Sixteen of the 24 beds are designated as augmented care beds.

Service Details

Responsible Person: **Dr Tony Stevens**	Position: **Chief Executive Officer Northern HSC Trust**

What We Look for

Inspection Audit Tools

This augmented care ward was assessed against the following regionally agreed standards and audit tools:

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

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

2.0 Inspection Summary

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

Year 1

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

Inspection Tools	Year 1 Compliance Level
Regional Augmented Care Infection Prevention and Control Audit Tool.	**95**
Regional Infection Prevention and Control Clinical Practices Audit Tool.	**91**
Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool.	**98**

Through discussion and examination of documentation we found that infection prevention and control (IPC) governance arrangements were good. Ward staff had a good knowledge and awareness of how to manage infections. We were informed that the trust IPC team provided good support and advice for ward staff. Staff attendance at IPC mandatory training should be improved.

The ward consists entirely of single patient ensuite rooms. An advantage of having single patient rooms is that it assists in reducing the risk of the transmission of infection. The core clinical space around patients' beds for the delivery of care exceeded the minimum dimensions recommended for new builds.

Eradication of Pseudomonas aeruginosa from the ward water system has been an ongoing challenge. The trust has implemented a number of actions to minimise the risk of transmission of water borne pathogens. Local screening policies/procedures are in place which inform clinical and IPC practice.

Nursing staff demonstrated good aseptic non touch technique (ANTT) knowledge and practice in the management of invasive devices. Quality improvement tools were in place to monitor ANTT compliance with invasive devices. Policies for the insertion and on-going management of invasive devices were available however a number had passed their review date.

Improvement is required in staff members recording and management of inserted peripheral venous cannula.

Staff who obtain blood cultures were knowledgeable in the correct technique. Compliance with best practice in obtaining a blood culture was being monitored. The low contamination rate of blood cultures within the ward suggests that blood cultures were being collected with proper attention to aseptic technique. Improvement is required in documentation when blood cultures are taken and a system should be put in place to compare the rate of positive cultures with other trust wards/ departments.

Up to date antimicrobial guidelines were in place. We were informed that these guidelines are cascaded to medical staff as part of their trust induction. Antimicrobial usage is audited is in line with antimicrobial prescribing guidance.

Up to date guidance and care bundles on the management of CDI and MRSA were available and known to staff. The IPC team audit staff compliance with these alert organisms as part of six monthly validation audits. The monitoring of patients with CDI and MRSA and completion of associated care bundles, should also be carried out by ward staff when identified.

Nursing staff had good knowledge on the management of an enteral feeding system; administration, set up and care. A system should be put in place to assess staff competence and monitor compliance with enteral feeding protocol and guidance.

The ward was bright, spacious, in excellent decorative order and environmental cleanliness was of a high standard. Patient equipment was clean and in a good state of repair. Staff demonstrated good practice in the management of linen, sharps and the disposal of waste.

We observed good practice in the use of personal protective equipment and hand hygiene. Hand hygiene was performed at the correct moments, and at the correct location, within the flow of care delivery.

The findings of the inspection were discussed with trust representatives, as part of the inspection process and can be found in the main body of the report. Escalation procedures were not required for this inspection. The escalation policies and procedures are available on the RQIA website.

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

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

3.0 Inspection findings: Regional Augmented Care Infection Prevention and Control Audit Tool

The Regional Augmented Care Infection Prevention and Control Audit Tool contains six sections. Each section aims to consolidate existing guidance in order to improve and maintain a high standard in the quality and delivery of care and practice in augmented care. This will assist in the prevention and control of healthcare associated infections.

Regional Augmented Care Infection Prevention and Control Audit Tool Compliance Levels

Areas Inspected	
Local Governance Systems and Processes	95
General Environment – Layout and Design	94
General Environment – Environmental Cleaning	100
General Environment – Water Safety	92
Clinical and Care Practice	90
Patient Equipment	100
Average Score	**95**

Local Governance Systems and Processes

Areas of good practice

- During the inspection, both the ward sister and deputy sister displayed good clinical leadership and knowledge of infection prevention and control (IPC).
- We were informed that when patients with infections are identified, staffing levels can be increased to assist in the delivery of care and ensure adherence to good IPC practices.
- We were informed that the IPC team provides good support for ward staff.
- We observed evidence that incidents relating to IPC were appropriately reported and acted on. A multidisciplinary approach was taken to these incidents and minutes from staff meetings highlight that staff receive timely feedback from such incidents.
- Mandatory and non-mandatory surveillance programmes were in place.
- Local and regional audits and the implementation of high impact interventions were undertaken to improve IPC practices and environmental cleanliness. Audit results were displayed for visitors to the ward.

- We were provided with evidence of a number of leadership walkrounds to ward C7. These walkrounds provide an opportunity for staff to connect with senior trust leadership and identify and increase awareness of IPC safety issues.

Areas for improvement

- Ward staff attendance at IPC mandatory training needs to be improved. We were informed that approximately 65% of staff had attended.
- The ward information leaflet should be updated to advise patients, families and visitors that clinical hand wash sinks should only be used for the purposes of hand hygiene.
- The occupational health document that provides staff guidance on common infectious conditions remains in draft. We were informed that the planned review of this document has been delayed however it had been circulated to all ward and department areas for staff guidance. During the inspection a number of staff were unaware of the availability of this document.
- We were informed that not all ward staff had email access. Email access for all ward staff would be an additional mechanism for the dissemination of IPC information.

General Environment - Layout and Design

Areas of good practice

- The ward consists entirely of single patient ensuite rooms (Picture 1). An advantage of having single patient rooms is that it assists in reducing the risk of the transmission of infection causing organisms.

Picture 1: Corridor access to patient side rooms

- We were provided with information that highlighted that the core clinical space around patients' beds for the delivery of care exceeded the minimum dimensions recommended for new builds.
- Clinical hand wash sinks were positioned appropriately to prevent splashing of patients, beds and equipment.
- The layout of the unit promoted minimal footfall and a clean to dirty workflow.
- To prevent the spread of transmitted pathogens by airborne route the ward contains a purpose built negative pressure room.
- Clinical support spaces throughout the ward were available and used effectively to ensure a clutter free environment.

Areas for improvement

- We observed that the number of bed spaces did exceed the number of commissioned spaces. The ward procedure room was used during the inspection to accommodate an additional patient.

General Environment - Environmental Cleaning

Areas of good practice

- Environmental cleaning; guidelines, audit and staff competency based training were in place and reviewed.
- On questioning, staff had good knowledge on appropriate cleaning procedures. There was a regular programme of de-cluttering in place.
- We were informed that the trust has a set 6 month deep clean programme.

General Environment - Water Safety

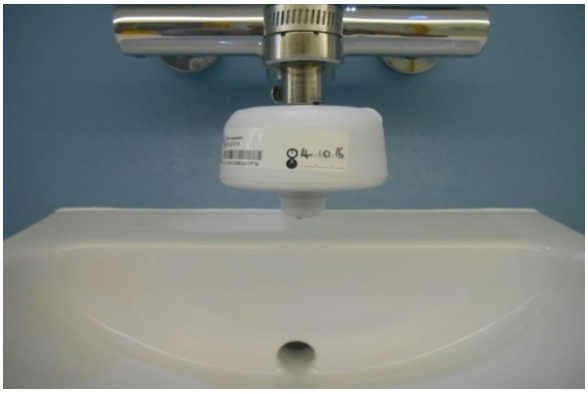
Areas of good practice

- An up to date overarching trust water safety plan and individual risk assessment were in place.
- We were informed that the trust carries out a quarterly schedule of water sampling for legionella and six monthly sampling for Pseudomonas *aeruginosa* from all water outlets in augmented care areas.
- Evidence was available that results from water analysis are reported to the trust water safety group and presented to the IPC and Environmental Hygiene Committee.

- All water outlet flushing records were available and completed appropriately.
- Throughout the inspection we observed that hand washing sinks were used correctly - only for hand washing.

Areas for improvement

- Eradication of Pseudomonas Aeruginosa from the ward water supply has been an ongoing challenge. Point of use (POU) filters had been placed on some taps where water testing had identified this organism. We observed that when POU filters were used, they did not have a removal/ change date documented on its surface label (Picture 2). This made it challenging to determine when POU filters should be changed.



Picture 2: Point of use filter with missing removal date

Clinical and Care Practice

Areas of good practice

- We observed that the ward maintains records of patient placement and movement within the ward.
- Local screening policies/procedures are in place which inform clinical and IPC practice. Screening records were reflective of local policy.
- We observed protocols in place to ensure patients are washed appropriately to negate the risk of transmission of infection.
- We were informed that the occupational health department had trained a number of ward nurses to be respiratory mask fit testers.
- Ward staff have received preparedness training for patients infected with Ebola virus.

Areas for improvement

- A communication protocol was in place to ensure that when patients are admitted or transferred to or from the ward, the sending or receiving units are explicitly made aware of positive screening/ sample results. However, some staff when questioned were unaware of this communication protocol and were uncertain as to their responsibilities in managing this information.

Patient Equipment

Areas of good practice

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

4.0 Inspection Findings: Regional Infection Prevention and Control Clinical Practices Audit Tool

The Regional Infection Prevention and Control Clinical Practices Audit Tool contain nine sections. The observations of key clinical procedures have shown to reduce the risk of infection if performed correctly. Each section aims to consolidate and build on existing guidance in order to improve and maintain a high standard in the quality and delivery of care and practice in augmented care. This will assist in the prevention and control of healthcare associated infections.

Regional Infection Prevention and Control Clinical Practices Audit Tool Compliance Levels

Areas Inspected	
Aseptic non touch technique (ANTT)	93
Invasive devices	88
Taking Blood Cultures	84*
Antimicrobial prescribing	89
Clostridium *difficile* infection (CDI)	97
Surgical site infection	N/A
Ventilated (or tracheostomy) care	N/A
Enteral Feeding or tube feeding	92*
Screening for MRSA colonisation and decolonisation	97
Average Score	**91**

* 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

- A draft ANTT policy and guidance was in place and accessible for all staff. Staff have received training on ANTT and can demonstrate when procedures are applied.
- All nursing staff had ANTT competency assessments and we observed evidence that ANTT audits of staff practice were undertaken.
- In the records of a patient with a self-retaining catheter, we observed a comprehensively detailed care plan.

Areas for improvement

- The ANTT policy had passed its revision date without being reviewed.

Invasive Devices

Areas of good practice

- Quality improvement tools were in place to monitor compliance with invasive devices best practice guidance.
- Staff displayed good knowledge in the management of invasive devices. We observed that ANTT principles were used when accessing invasive devices.
- A laminate poster was displayed to advise staff of the timely removal of invasive devices (Picture 3).

Picture 3: Invasive device poster

Areas for improvement

- Policies/ procedures for the insertion and on-going management of invasive devices were in place however a number had passed their revision date without being reviewed.
- We were informed that for longer term staff there had been no update/ refresher training in invasive device procedures.
- We reviewed the visual infusion phlebitis (VIP) charts of five patients that had an inserted peripheral venous cannula (PVC). In all five charts the batch number of the PVC had not been recorded and in two charts the reason for insertion had not been recorded. In three charts where the PVC was inserted longer than 72 hours, four hourly observation checks were not being carried out.

Taking Blood Cultures

Areas of good practice

- Although there was no opportunity to observe blood cultures being obtained, staff who undertake the procedure were aware of the correct technique.
- We observed that the blood culture incidence of contamination within the ward was 0 per cent which suggests that blood cultures were being collected with proper attention to aseptic technique.
- At present medical staff are responsible for obtaining blood cultures. We were informed that plans are in place to implement blood culture competency training for nursing staff and train senior registered nurses as their assessors.
- Compliance with best practice in obtaining a blood culture was being monitored.

Areas for improvement

- The trust blood culture policy had passed its review date.
- Within the medical notes of three patients that had a blood culture obtained, medical staff did not document the site where the culture was taken.
- There was no system in place to compare the rate of positive cultures with other trust wards/ departments.

Antimicrobial Prescribing

Areas of good practice

- Up to date antimicrobial guidelines were in place and we were informed that they are cascaded to medical staff as part of their trust induction.
- A trust wide antimicrobial steering committee was in place. This team centrally reviews audit results, anti-microbial usage and incidents.
- A ward based pharmacist is in place.
- Relevant documentation for prescribed antimicrobials was available and appropriately completed.
- We observed evidence that antimicrobial usage is audited is in line with antimicrobial prescribing guidance.

Areas for improvement

- Electronic aided prescribing tools were unavailable to aid antibiotic prescribing within the ward.
- An audit to include the assessment of multidisciplinary information provided to patients on antimicrobial usage was not in place.

Clostridium *Difficile* Infection (CDI)

Areas of good practice

- Up to date guidance and a care bundle on the management of CDI was available and known to staff.
- Staff were knowledgeable in the IPC management of patients with CDI.
- An antibiotic policy was in place for patients who have or are suspected to have CDI.
- IPC staff monitor adherence with policy if a patient is identified with CDI

Areas for improvement

- We observed that a CDI care bundle in place for a patient was not fully completed. The completion of the CDI care bundle should be included as part of the audit process.

Surgical Site Infection (SSI)

Not applicable for this ward.

Ventilated (or Tracheostomy) Care

Not applicable for this ward.

Enteral Feeding or Tube Feeding

Areas of good practice

- Although there were no patients identified as requiring enteral feeds during the inspection, staff had good knowledge on the management of an enteral feeding system; administration, set up and care.
- We were informed that an enteral feeding care bundle is in the process of being introduced throughout the trust.

Areas for improvement

- The trust enteral feeding policy had passed its review date.
- We observed that there are currently no systems in place to assess competence and monitor compliance with enteral feeding protocol and guidance.

Screening for MRSA Colonisation and Decolonisation

Areas of good practice

- A Meticillin-resistant *Staphylococcus aureus* (MRSA) screening and treatment policy and care bundle was in place.
- When questioned, staff were knowledgeable in what precautions to take in managing a patient identified with MRSA.
- The IPC team carry out six monthly snap shot audits of the MRSA care bundle as part of independent validation.

Areas for improvement

- The management of patients with MRSA including the completion of the MRSA care bundle should be monitored by ward staff.

5.0 The Regional Healthcare Hygiene and Cleanliness Audit Tool

The Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool provide a common set of overarching standards for all hospitals and other healthcare facilities in Northern Ireland. Inspections using the audit tool gather information from observations in functional areas including, direct questioning and observation of clinical practice and, where appropriate, review of relevant documentation.

The Regional Healthcare Hygiene and Cleanliness Audit Tool

Compliance Levels

Areas Inspected	
General environment	99
Patient linen	100
Waste	100
Sharps	95
Equipment	96
Hygiene factors	100
Hygiene practices	98
Average Score	**98**

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

General Environment

Areas of good practice

- The ward is a modern facility specifically designed to enhance the patient experience and provide improved patient privacy. The ward was bright, spacious, in excellent decorative order and environmental cleanliness was of a high standard. The ward was tidy and well organised which ensures effective cleaning can be undertaken.
- Domestic staff followed agreed protocols and had access to adequate resources and cleaning equipment.

Patient Linen

Areas of good practice

- We observed that patient linen was visibly clean, free of damage and stored in a clean and tidy environment.
- Staff managed linen safely to prevent the spread of microorganisms to those receiving care.

Waste and Sharps

Areas of good practice

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

Equipment

Areas of good practice

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

Hygiene Factors

Areas of good practice

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

Hygiene Practices

Areas of good practice

- We observed good practice in the use of personal protective equipment and hand hygiene.
- Hand hygiene was performed at the correct moments, and at the correct location, within the flow of care delivery.

6.0 Level of Compliance Tables

Standard 2: General Environment

For organisations to comply with this standard they must provide an environment which is well maintained, visibly clean, free from dust and soilage.

General Environment	
Reception	N/A
Corridors, stairs lift	N/A
Public toilets	N/A
Ward/department - general (communal)	100
Patient bed area	N/A
Bathroom/washroom	N/A
Toilet	100
Clinical room/treatment room	N/A
Clean utility room	95
Dirty utility room	98
Domestic store	100
Kitchen	100
Equipment store	100
Isolation	100
General information	100
Average Score	**99**

Standard 3: Patient Linen

For organisations to comply with this standard, patient linen should be clean, free of damage, handled safely and stored in a clean and tidy environment.

Patient Linen	
Storage of clean linen	100
Storage of used linen	100
Laundry facilities	N/A
Average Score	**100**

Standard 4: Waste and Sharps

For organisations to comply with this standard they must ensure that waste is managed in accordance with HTM07-01and Hazardous Waste (Northern Ireland) Regulations (2005).

Waste and Sharps	
Handling, segregation, storage, waste	100
Availability, use, storage of sharps	95

Standard 5: Patient Equipment

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

Patient Equipment	
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	
Availability and cleanliness of wash hand basin and consumables	100
Availability of alcohol rub	100
Availability of PPE	100
Materials and equipment for cleaning	100
Average Score	**100**

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	100
Safe handling and disposal of sharps	100
Effective use of PPE	100
Correct use of isolation	89
Effective cleaning of ward	100
Staff uniform and work wear	100
Average Score	**98**

7.0 Key Personnel and Information

Members of the RQIA inspection team

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

Trust representatives attending the feedback session

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

Ms E McEneaney	-	Executive Director of Nursing and User Experience
Ms M Bermingham	-	Assistant Director Corporate Support Services
Ms A McErlane	-	Clinical Service Manager
Ms C McGuckin	-	Ward Manager Ward C7
Ms A McWhirter	-	Deputy Ward Manager Ward C7
Ms V Davidson	-	General Manager Catering and Domestic Services
Ms J Carroll	-	Assistant Domestic Manager
Ms E Dargan	-	Consultant Microbiologist
Ms L Crymble	-	Interim Lead Nurse, Infection Prevention & Control
Mr D Loughlin	-	Infection Prevention & Control Nurse
Ms L Surgenor	-	Infection Prevention & Control Nurse
Ms C Colgan	-	Nursing Student

Apologies

Mr D Farren	-	Infection Prevention & Control Doctor

8.0 Provider Compliance Plan

The provider compliance plan should be completed detailing the actions taken and returned to cscg.team@rqia.org.uk for assessment by the inspector. The responsible person should note that failure to comply with the findings of this inspection may lead to escalation action being taken. The responsible person identified should ensure that all recommended actions are taken within the specified timescales.

Reference number	Recommended Actions	Responsible Person	Action/ Required	Date for completion/ timescale
Regional Augmented Care Infection Prevention and Control Audit Tool.				
1.	The occupational health document which provides guidance on common infectious conditions that staff may experience, should be made available for all staff.	Angela Higgins (Occupational Health)	Occupational Health have advised that guidance on common infectious conditions will be uploaded and made available on the Trust Intranet (Staffnet).	31st March 2017
2.	All ward staff should be aware of their responsibilities in relation to the communication protocol that ensures any sending or receiving units is explicitly made aware of positive screening/ sample results.	Christine McGuckin (Ward Sister C7)	A communication logbook for recording positive screening/sample results has been developed within ward C7. Awareness has been raised with all staff of the protocol to be followed when sending samples & receiving positive results. This includes the actions & recordings required if a patient has been discharged.	Completed / In place 9th January 2017

Reference number	Recommended Actions	Responsible Person	Action/ Required	Date for completion/ timescale
3.	Ward staff attendance at IPC mandatory training should be improved.	Christine McGuckin (Ward Sister C7)	All staff who have not recently attended the NHSCT three year mandatory training (which includes IPC) have been booked onto the course and will be completed by June 2017. The ward sister has nominated a deputy ward sister to be responsible for the management of training within the ward.	30th June 2017
4.	When sink tap point of use filters are used, staff should ensure that the removal/ change date is clearly recorded.	Caitriona Mc Eldowney Water Safety Manager NHSCT	Recording of the removal date on the point of use filters will be discussed and agreed at the next Trust Water Safety Group meeting.	31th January 2017
Regional Infection Prevention and Control Clinical Practices Audit Tool				
5.	The trust should ensure that all trust policies are timely reviewed and updated as appropriate. (Specific policies relating to IPC include ANTT, blood culture, invasive devices and enteral feeding)	L Crymble (Infection Control Lead Nurse)	All policies are reviewed; a number of these have been updated but are still in DRAFT format.	30th June 2017
6.	Ward staff should ensure that all relevant information is recorded in relation to the insertion and ongoing management of invasive devices, blood cultures and in the management of patients identified with MRSA and CDI.	Christine McGuckin (Ward Sister)	The ward sister and deputies have scheduled monthly compliance audits for the insertion and ongoing management of invasive devices, blood cultures and in the management of patients identified with MRSA and CDI. Audits to commence	Completed / In place 9th January 2017

Reference number	Recommended Actions	Responsible Person	Action/ Required	Date for completion/ timescale
			in January 2017. The ward sister will collaborate with the IPC team regarding the ongoing review of 6 monthly independent validation audits.	
7.	A system should be introduced to compare the rate of positive blood cultures and the incidence of contaminated blood cultures with other trust wards/ departments.	Christine McGuckin (Ward Sister C7)	The ward sister will inform staff on a monthly basis of the blood culture contamination rate and ensure that results are also discussed and noted at the Haematology & Renal Governance meetings. Rates will be compared and actions discussed at the Trust Augmented Care Group meetings.	Completed / In place 9th January 2017
8.	The trust should work towards implementing electronic aided prescribing tools to aid antibiotic prescribing within the ward and the auditing of the multidisciplinary information provided to patients on antimicrobial usage.	NHSCT Pharmacy Department/IPC	NHSCT have made significant progress in launching a web and mobile prescribing App. There is still work to be done in progressing to an electronic prescribing system such as ICIP. This system is already in use in NHSCT ICU and it would be beneficial to replicate this in other augmented care areas. This proposal will be taken forward with the Trust Antimicrobial Team. The ward sister in collaboration with the ward pharmacist will undertake an audit	February 2018

Reference number	Recommended Actions	Responsible Person	Action/ Required	Date for completion/ timescale
			of the multidisciplinary information provided to patients on antimicrobial usage.	
9.	All ward clinical staff should have training and competency assessment in the management of enteral feeds.	Christine MCGuckin (Ward Sister C7)	A record of staff training in enteral feeding is available on the ward. The ward sister has nominated a deputy ward sister to be responsible for the management of training and competency assessment within the ward.	31st January 2017
10.	All ward clinical staff should have ongoing update/ refresher skills training in the insertion and management of invasive devices.	Christine McGuckin (Ward Sister C7)	The C7 deputy ward sister responsible for training and education, will ensure that all C7 nurses are up to date in relation to the insertion and management of invasive devices. A process for on-going refresher training will be put in place.	All updates will be completed by 30th June 2017
11.	Ward staff should ensure that compliance with best practice is monitored in the management of a patient receiving enteral feeds and the management of those patients identified with MRSA and CDI.	Christine McGuckin (Ward Sister C7)	The ward sister will work in collaboration with the dietician to monitor compliance of best practice with enteral feeding. The ward sister will raise awareness with staff at safety briefing and ward meetings on the compliance with MRSA and CDI best practice.	31st January 2017

Reference number	Recommended Actions	Responsible Person	Action/ Required	Date for completion/ timescale
Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool				
No Recommendations				

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