Unannounced Inspection Report
26 September 2019

Emergency Department and Neely Ward
Ulster Hospital

South Eastern Health and Social Care Trust

Address: Upper Newtownards Rd, Dundonald, Belfast, BT16 1RH
Inspectors: Wendy McGregor, Sheelagh O'Connor,
Thomas Hughes, Jean Gilmour and Lorraine O'Donnell

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 from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

The Ulster Hospital is the major acute hospital in the South Eastern Health and Social Care Trust and delivers the full range of acute services for the population. The hospital includes an Emergency Department which is open 24/7 with over 90,000 people attending the department each year. The hospital also provides a comprehensive range of Diagnostic Services, a full range of Outpatient, Inpatient and Day-case Medical and Surgical Services, Cancer Care, Coronary Care, Obstetrics and Paediatric Services.

3.0 Service details

Responsible person:	**Position:**
Mr. Seamus McGoran South Eastern Health and Social Care Trust (SEHSCT)	Chief Executive Officer

4.0 Inspection summary

An unannounced inspection took place on 26 September 2019.

This inspection was undertaken by a team of inspectors from the Hospitals Programme Team.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Mental Health (Northern Ireland) Order 1986, The Quality Standards for Health and Social Care DHSSPSNI (March 2006) and The Regional Healthcare Hygiene and Cleanliness Standards.

This inspection was undertaken following receipt of a number of concerns from members of the public who contacted RQIA. The concerns shared with RQIA related to:

- the management of risks to patients with mental health needs who present at the Emergency Department;
- the arrangements for infection prevention and control in Neely Ward; and
- thermal comfort within an Outpatients Department.

While RQIA does not have formal powers to investigate complaints about health and social care services we take all concerns brought to our attention seriously.

The following areas were examined during this inspection:

- the specific arrangements for the management of risks to patients with mental health needs in the Emergency Department;
- the Emergency Department and Neely Ward's adherence to the Regional Healthcare and Hygiene Standards; and
- how the trust are managing thermal comfort within one of the Outpatient Departments, following receipt of a complaint.

Previous infection prevention and hygiene inspection reports of the Ulster Hospital are available on the RQIA website www.rqia.org.uk.

Inspectors visited the relevant departments and reviewed the care and treatment processes. Inspectors evidenced the following outcomes:

Infection prevention and control

Neely Ward

The inspection team evidenced good practice with respect to the standard of cleaning within patient bed areas; the management of patient linen and the use of PPE. More attention to detail is required in respect of compliance with hand hygiene procedures, the decontamination and storage of patient equipment and the management of sharps.

Emergency Department

The inspection team observed good practice in the use of personal protective equipment. There was good compliance with hand hygiene procedures for example it was performed at the correct moments, and at the correct location, within the flow of care delivery. More attention to detail is required in respect to cleanliness within the department, the decontamination of domestic cleaning equipment, completion of mattress audits and the management of sharps.

The management of risks to patients with mental health needs who present at the Emergency Department

The inspection team observed good practice in the use of a care pathway for patients who present with a mental health issue in the Emergency Department. A protocol was also available for staff to follow in the event that a patient who presents at risk of harm leaves the department before they have been medically assessed. Staff advised inspectors as a result of significant delays in the department there is a risk of patients leaving the emergency department before their medical assessment is completed. Staff told us that when they contacted the trust Mental Health Service, they were not always available to attend the department in a timely manner. The inspection team were concerned that this was causing a delay in patients receiving a mental health assessment. Staff confirmed that this delay often resulted in nursing staff having to provide close supervision to patients due to risks to their safety. This often proved difficult due to the competing priorities in the emergency department.

Management of thermal comfort within one of the Outpatients Departments

The deputy manager was aware of the thermal comfort issues within the department and outlined the ongoing actions which had been taken to address the issue including that the estates department participate in the ongoing assessment and management of the temperature control in the department. In order to make patients aware of the ongoing issues with thermal comfort in the outpatients department the deputy manager confirmed that they will update the patient information to encourage patients to raise their concerns about the thermal comfort. This will ensure that staff can take prompt action to address these concerns. The deputy manager confirmed, that access to refreshments, such as cold drinks will be reviewed and confirmed that they will respond directly to the complainant.

Total number of areas for improvement	11

4.1 Inspection outcome

There are ten areas for improvement arising from this inspection. These are detailed in the Quality Improvement Plan (QIP).

Details of the QIP were discussed with the trust management team as part of the inspection process. The timescales for implementation of these improvements commence from the date of this inspection.

In line with our inspection guidance we will carry out a further unannounced follow-up inspection of Neely Ward and the Emergency Department to assess progress with the actions outlined in the QIP.

This inspection did not result in enforcement action.

5.0 How we inspect

Prior to this inspection a range of information relevant to the service was reviewed, including the following records:

- Previous inspection reports
- Serious Adverse Incident notifications
- Information on Concerns
- Information on Complaints
- Other relevant intelligence received by RQIA

Each ward is assessed using an inspection framework. The methodology underpinning our inspections include; discussion with patients and relatives, observation of practice; discussions with staff and review of documentation. Records examined during the inspection include: nursing records, medical records, minutes of meetings, duty rotas and training records.

Findings of this inspection were shared with the South Eastern Health and Social Care Trust representatives at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from previous inspections

Neely Ward has not previously been inspected by RQIA. The previous inspection of the Emergency Department was an unannounced Infection Prevention/Hygiene inspection undertaken on 28 May 2015. The overall compliance levels in respect of the Regional Healthcare Hygiene and Cleanliness Standards in the Emergency Department were achieved. A review of previous Infection Prevention/Hygiene inspections of wards and departments in the Ulster Hospital has highlighted a number of recurring issues which include:

- the standard of cleaning of the general environment;
- the standard of cleaning of patient equipment;
- the handling and disposal of sharps;
- hand hygiene practices; and
- the completion of audits.

The South Eastern Health and Social Care Trust should ensure that sustained efforts are made to address recurring issues, and ensure that learning from inspections is shared with staff. Appropriate audits should be undertaken to support that standards are being maintained and where necessary improved.

Previous infection prevention and hygiene inspection reports of the Ulster Hospital are available on the RQIA website www.rqia.org.uk.

6.2 Inspection findings

Infection prevention and control

Our inspection standards are intended to assess healthcare hygiene, general cleanliness and state of repair of the fabric of the areas, the fixtures and fitting and aspects of infection prevention and control for all hospitals and other healthcare facilities in Northern Ireland.

Our audit tool is comprised of the following sections:

- general environment;
- patient linen;
- waste and sharps;
- patient equipment;
- hygiene factors/cleaning practices; and
- hygiene practices/staff questions.

Guided by our audit tool our inspectors gather information from observations in functional areas (including direct questioning and observation of clinical practice) and, where appropriate, review of relevant documentation. The areas were also assessed against the Regional Healthcare and Cleanliness Standards.

Public areas (entrance, reception, public toilets, corridors, stairs and lift)

The entrance to the hospital is clean, tidy and uncluttered. Large windows provide a good source of natural lighting to the internal facilities. These facilities include a small shop, a reception area and a waiting area with comfortable seating. The reception area was visibly clean and free from clutter. Public toilets were clean and well maintained. (Picture 1)

Picture 1: Main Hospital Entrance

Neely Ward

General environment - maintenance and cleanliness

The standard of cleaning of patient bay areas, side rooms and sanitary areas throughout the ward was excellent. The ward is located within the old hospital building, many of its surfaces, fixtures and fittings are old and worn. Maintenance issues were observed throughout the ward however most notable in the kitchen, dirty utility room and equipment and domestic stores. Paintwork was tired, there was damage to wall plaster and fixtures and fittings such as cupboards, units, shelves and door frames were worn making it difficult to effectively clean these areas.

There was insufficient storage for equipment and supplies. Many items of equipment were stored on units throughout the main ward thoroughfare, giving the appearance that the ward is untidy and cluttered. Additionally, the equipment store was disorganised with no definite pre-arranged order, a number of items were stored on the floor. We observed a build-up of dust and stains on many high and low surfaces, particularly in areas of the room which were difficult to access due to equipment storage.

Patient linen

We observed patient linen that was visibly clean and free from damage. Staff were observed to handle clean linen safely to prevent the spread of microorganisms to those receiving care. Staff wore appropriate PPE when handling soiled/contaminated linen and placed it into the correct linen bag at the point of use.

The linen store was untidy and was used to store a number of non-linen items. High and low horizontal surfaces of this room were dusty. The poor standard of cleanliness of this room presents a risk of contamination to clean linen (Picture 2).

Picture 2: Debris on the floor of the linen store

Waste and sharps

Effective arrangements for the handling, segregation and storage of waste on the ward were in place. Throughout the ward we observed that many sharps boxes were not signed and dated on assembly and their temporary closure mechanisms deployed when they were not in use.

Equipment

There was evidence of good stock rotation and single use equipment was within its use by date. There was a lack of attention to detail in the decontamination of patient equipment. We observed a number of items of equipment that were blood stained including the infusion pump, blood glucose monitor, top surface of the resuscitation trolley, front surface of the phlebotomy trolley and the surface of an integrated sharps tray. We observed a build-up of dust on stored items of equipment.

Hygiene factors/cleaning practices

We observed that hand washing facilities and a range of consumables were available to enable hygiene practices to be carried out effectively. PPE was readily available and we observed that it was used appropriately by staff.

Clinical hand wash sinks were used for hand hygiene purposes only. Additionally, alcohol hand sanitiser was available for use at the point of care. A range of personal protective equipment (PPE) was available and accessible to staff.

Attention to detail is required in the cleaning of items of cleaning equipment (cleaning trolley, floor polisher) to ensure effective cleaning within the ward.

Hygiene practices/staff questions

We observed good compliance with trust uniform policy. All staff when questioned had a satisfactory knowledge of both standard and enhanced IPC precautions which included hand hygiene, cleaning and decontamination of equipment.

We observed poor compliance with the fundamental practice of hand hygiene. A number of nursing staff did not carry out hand hygiene practices effectively when using alcohol hand sanitiser.

Emergency Department

General environment - maintenance and cleanliness

Staff when questioned, were aware of the importance of their role and responsibilities in maintaining a clean environment. Patient bay areas in majors and minors were clean and well maintained and uncluttered. Patients' personal belongings were stored appropriately.

The fixtures and fittings of the ward were old and in poor repair. Wall and door paint work was damaged throughout the ward. An area of flooring was worn and in disrepair, presenting a risk of trips. The fixtures and fabric of the domestic store were worn. Maintenance of this ward should be kept to a high standard to allow for effective cleaning practices and promote a safer patient environment.

The equipment storage area was small and untidy. Many items of equipment were stored in no defined order, with some items stored on the floor. (Picture 3)

Picture 3: Cluttered equipment area

Improvement is required to the cleaning of high and low horizontal surfaces throughout the department. We observed a build-up of debris in floor corners, behind appliances and under shelving.

The door into the dirty utility room was ajar and had the potential for unauthorised access to cleaning chemicals stored in an unlocked Control of Substances Hazardous to Health (COSHH) cupboard. Cleaning and decontamination products must be stored securely when not in use.

There was poor accessibility to information leaflets to guide visitors on infection prevention and control (IPC) practices.

Patient linen

We observed that patient linen was visibly clean, and free from damage. Staff wore appropriate PPE when handling soiled/contaminated linen and placed it into the correct colour coded bag at the point of use.

We observed clean linen bags stored on the floor of the clean linen store making it difficult for domestic staff to effectively clean the area. Patient linen was also stored exposed on an open cage in the department.

Waste and sharps

We observed the safe handling and transport of waste and sharps. The aperture of some sharps boxes was not always deployed when the sharps box was not in use. This practice increases the risk of a needle stick injury to staff in the event that the sharps box is not properly secured. A blood stain was present on the lid of one sharps box putting users at risk of exposure to potentially harmful microorganisms. (Picture 4) Improvement is required in the segregation of waste. We observed the inappropriate disposal of household waste into both sharp and clinical waste bins.

Picture 4: Blood stained sharps box aperture

Equipment

Equipment that was in use on the ward was clean, in a good state of repair and managed appropriately to limit the risk of contamination with microorganisms. There was evidence of good stock rotation; single use equipment was within its use by date. The standard of cleanliness of commodes throughout the department was good.

Mattresses examined in the department were noted to be bloodstained and the foam interior appeared stained. Auditing of all mattresses to check their efficiency (in good condition, impermeable to moisture) had not been completed.

We observed boxes stored on the floor causing problems for effective cleaning of the store and moving and handling issues for staff trying to access difficult to reach stock.

Domestic cleaning equipment stored inverted and ready for use contained a build-up of dirt and debris.

Hygiene factors/cleaning practices

We observed that clinical hand washing facilities and a range of consumables were available to enable hygiene practices to be carried out effectively. Clinical hand wash sinks were used for hand hygiene purposes only. Additionally, alcohol hand sanitiser was available for use at the point of care.

Information on key performance indicators including hand hygiene and commode cleaning audits were clearly displayed in the ward to promote public assurance of the ward's adherence to IPC standards. However, the environmental cleaning audit and mattress audit scores were not displayed.

Posters and alcohol hand sanitiser was not clearly visible in the reception. There was a lack of information available reinforcing the correct hand hygiene technique and general IPC precautions and correct hand hygiene technique.

Aprons were not consistently stored appropriately; we observed aprons hanging out of dispensers exposing them to potential contamination from harmful microorganisms prior to use.

Hygiene practices/staff questions

All staff when questioned had good knowledge of both the standard and enhanced IPC precautions which included hand hygiene, cleaning and decontamination of equipment, use of PPE and the management of sharps and waste. Hand hygiene was performed at the correct moments, at the correct location within the flow of patient care delivery.

We observed that several members of staff were not compliant with bare below the elbow practices when in the clinical area.

Level of compliance

The table below summarises the overall compliance levels achieved in each standard/section. Scores are allocated a level of compliance using the categories described below.

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

Standard: General environment

To comply with this standard, organisations must provide an environment which is well maintained, visibly clean, and free from dust and debris.

General environment standards public shared areas	
Reception	98
Public toilets	88
Corridors, stairs lift	96

General environment standards wards or departments	Neely Ward	Emergency Department
Ward/department - general (communal)	72	66
Patient bed area	95	85
Bathroom/washroom	79	78
Toilet	91	79
Clinical room/treatment room	90	86
Dirty utility room	84	82
Domestic store	77	72
Kitchen	74	N/A
Equipment store	64	44
Isolation	86	96
General information	93	93
Average score	**82**	**79**

Standard: 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	Neely Ward	Emergency Department
Storage of clean linen	59	84
Storage of used linen	100	93
Laundry facilities	N/A	N/A
Average score	**80**	**89**

Standard: Waste and sharps

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

Waste and sharps	Neely Ward	Emergency Department
Handling, segregation, storage, waste	96	94
Availability, use, storage of sharps	72	83

Standard: Patient equipment

To comply with this standard, organisations must ensure that patient equipment is appropriately decontaminated.

Patient equipment	Neely Ward	Emergency Department
Patient equipment	82	87

Standard: Hygiene factors/cleaning practices

To comply with this standard, organisations must ensure that a range of fixtures, fittings and equipment is available so that hygiene practices can be carried out effectively.

Hygiene factors	Neely Ward	Emergency Department
Availability and cleanliness of wash hand basin and consumables	99	96
Availability of alcohol rub	97	97
Availability of PPE	100	94
Materials and equipment for cleaning	93	89
Average score	**97**	**94**

Standard: Hygiene practices/staff questions

To comply with this standard, organisations must ensure that appropriate healthcare hygiene practices are embedded into the delivery of care and related services.

Hygiene practices	Neely Ward	Emergency Department
Effective hand hygiene procedures	67	95
Safe handling and disposal of sharps	100	92
Effective use of PPE	92	94
Correct use of isolation	100	96
Effective cleaning of ward	76	90
Staff uniform and work wear	100	94
Average score	**89**	**94**

Further inspection findings

The management of risks to patients with mental health needs who present at the Emergency Department

Following receipt of concerns from a member of the public who had observed a patient outside the hospital grounds presenting as distressed following attendance at the emergency department, we reviewed the arrangements in place for the management of risks to patients with mental health needs who present at the emergency department.

An integrated care pathway was in place for patients with mental health issues. A mental health liaison nurse was also available. There was good interface between the department staff and mental health services staff. There was a protocol in place to guide staff when a patient leaves the department contrary to medical advice and an environmental ligature risk assessment and management plan was in place.

Staff confirmed that there can be a delay in patients receiving an assessment of their mental health, and this has caused patients to leave the department contrary to medical advice. The aligned out of hours mental health service is not always available at night, however, staff can access an 'out of hours' psychiatrist for the trust; it was unclear why staff were not using this 'out of hours' service.

Staff informed us that at any given time there are a high number of patients who present to the department with a mental need and who may require a level of supervision due to risks to their safety. This has an impact on the availability of nursing staff and the delivery of care to all patients in the department. Staff said there could be up to 10 patients attending each day with suicidal intentions.

Patients who are assessed as a high risk of self-harm/suicide do not see a doctor within 10 minutes in accordance with the trust's Emergency Department policy.

Governance mechanisms were not in place to oversee, the assessment, care and treatment of patients with mental health needs who present to the department, including the management of risks. There was no evidence that trend/data analysis in relation to incidents involving patients with mental health needs was produced and reviewed regularly. Therefore there was no formal mechanism in place for learning from incidents involving this group of patients.

A "secure" room was available in the department; this room can be used for patients who cannot be supported in the department's main area due to risks to their safety and that of others. The room is monitored by CCTV. On the day of the inspection, a patient using the room was being monitored by this means even though they did not require it. This was brought to the attention of staff who promptly switched the CCTV of. There is no specific policy or protocol available in relation to the use of CCTV in the "secure" room. An area for improvement has been made.

Staff training

Following an environment ligature risk assessment the department was furnished with ligature-cutting equipment in three areas of the department. We were informed that none of the required staff had been trained in the use of this equipment. An area for improvement has been made.

At times staff have to seek assistance from the hospital security staff, to support them with the management of patients who are presenting with behaviours that are challenging. Security staff can only provide that support within the perimeter of the hospital. We received confirmation that security staff are trained in Management of Actual or Potential Aggression (MAPA). We also received confirmation that 10 out of 18 security staff had attended Suicide Awareness training and 8 had attended Safe Talk Training. Security staff have not attended mental health or learning disability awareness training. An area for improvement has been made.

Thermal comfort within an area of the Outpatients Department (OPD).

As part of this inspection we visited one of the hospital Outpatient Departments. This visit was undertaken following receipt of concerns from a member of the public, who had informed RQIA that during attendance at a number of outpatients' appointments the heat within the OPD was uncomfortable and caused them to feel unwell. The member of the public has also raised their concern directly with the trust's complaints department. The deputy manager has confirmed they will be responding directly to the individual in line with trust policy, to inform them of actions taken to address their concerns.

We visited the relevant OPD and discussed the concerns with the deputy manager. The department has air conditioning units within consultation rooms. However, the air conditioning units are noisy and can be turned off during consultation to enable effective staff/patient communication. There is no air conditioning unit in the main waiting area. The deputy manager was aware of the thermal comfort issues within the department and outlined the ongoing actions which had been taken to address the issue including that the estates department participate in the ongoing assessment and management of the temperature control in the department. In order to make patients aware of the ongoing issues with thermal comfort in the outpatients department the deputy manager confirmed that they will update the patient information to encourage patients to raise their concerns about the thermal comfort. This will ensure that staff can take prompt action to address these concerns. The deputy manager confirmed, that access to refreshments, such as cold drinks will be reviewed and confirmed that they will respond directly to the complainant.

Total number of actions for improvement	11

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with the trust representatives as outlined below, as part of the inspection process. The timescales for implementation of these improvements commence from the date of this inspection.

Mr D Robinson		Interim Director, Hospital Services.
Mr K Quinn		Interim Assistant Director, Women and Child Health
Ms J Nicholson		Interim Lead Nurse Emergency Department
Mr C Campbell		Governance Senior Manager
Ms G Smyth		Quality Performance Training Manager, Patient Experience
Mr R Knight		Service Lead, Patient Experience
Ms M Hamilton		Emergency Department Sister
Ms F Rice		Deputy Sister, Neely Ward
Ms N Magee		Senior Infection Control Nurse
Ms A Bradley		Senior Infection Control Nurse

The trust should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further action. It is the responsibility of the trust to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

7.1 Areas for improvement

Areas for improvement have been identified and action is required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to meet the areas for improvement identified. The trust should confirm that these actions have been completed and return the completed QIP to BSU.Admin@rqia.org.uk for assessment by the inspector by **29 January 2020.**

Quality Improvement Plan	
The trust must ensure the following findings are addressed:	
Area for Improvement 1 **Ref**: 5.3.1(f) **Stated:** First **To be completed by:** 28 December 2019	The standard of environmental cleaning in the equipment storage areas and linen store within **Neely Ward** and the **Emergency Department** reception and equipment storage area should be improved. Robust monitoring should be in place to provide continued assurance.
	Response by the trust detailing the actions taken: Neely In the equipment and linen store areas within Neely Ward: -decluttered and reorganised has facilitated daily and weekly environmental cleaning - monitored daily by the nurse in charge - recorded weekly in the cleaning schedule which is kept at the nurses station - reintroduced twice daily Nursing Assistant recorded handover of each area, this handover document is kept at the nurses station -the monthly audit continues ED There has been a concerted effort between the ED and senior patient experience staff to improve the environmental cleaning in the equipment storage areas. This has involved a focus group looking at the areas to improve and focusing staff on ensuring these areas are cleaning and monitored regularly. This has been followed up with MDT inspections and issues addressed at the time. Trust - Patient Experience Daily Observational audits are completed on the Ward each day by a Supervisor and countersigned by a member of Ward staff. Minimum of a weekly (progress) audit completed by Assistant Operational Manager until sustained improvement. QPT audit the area once per month accompanied by Assistant Operational Manager/Operational Manager.

	A weekly update sent to Service Lead and Senior Manager of all actions that have been taken during the week to improve the environment. Senior Management (Service Lead or Senior Manager) visiting the area at least once per month. Review of all work schedules has taken place to ensure they have personal accountability and the flow is correct. Review working hours for the Ward/Department has taken place. Review of equipment needs has been completed. Review of staff training needs (both Service Assistants and Supervisor) has been completed.
Area for Improvement 2 **Ref**: 5.3.1(f) **Stated:** First **To be completed by:** 28 March 2020	Improvement is required to the fabric, fixtures and fittings of the **Neely Ward** and the **Emergency Department**. Remedial work should be undertaken to maximise the therapeutic environment for patients and clients.
	Response by the trust detailing the actions taken: ED Following the review a list of fabric, fixture and fittings of the Emergency Department in need of repair has been collated. While some of these has been actioned, the pressure within the ED over the last months has made the completion of all of this work very difficult. The Clinical Manager is meeting with the estates team this week to go over progress and draw up a realistic timescale. Neely The fabric, fixtures and fittings of Neely Ward: -the shower room has been completely refurbished , completed December 2019 - the ensuite of side room 4 is due to be completely refurbished on 3rd February , expected completion date 10th February -there is planned redecoration throughout the ward , due to commence early February
Area for Improvement 3 **Ref**: 5.3.1(f) **Stated:** First **To be completed by:** 28 March 2020	A programme of decluttering and reorganisation of the **Emergency Department** storage areas should commence. Robust monitoring should be in place to provide continued assurance.
	Response by the trust detailing the actions taken: ED There has been a decluttering process and reorganisation process started within the Emergency Department storage areas and monitoring has been put in place by senior staff to provide continued assurance

Area for Improvement 4 **Ref**: 5.3.1(f) **Stated:** First **To be completed by:** 28 December 2019	The standard of cleaning and decontamination of patient equipment throughout **Neely Ward** should be improved. Robust monitoring should be in place to provide continued assurance.
	Response by the trust detailing the actions taken: Neely Cleaning and decontamination of patient equipment throughout Neely Ward: -designated staff champions -sharps box audit has been introduced, monitored and recorded twice weekly (spot checks) which is kept at the nurses station -reintroduced twice daily Nursing Assistant recorded handover of each area, this handover document is kept at the nurses station -the monthly audit continues
Area for Improvement 5 **Ref**: 5.3.1(f) **Stated:** First **To be completed by:** 28 December 2019	Action must be taken to improve **Neely Ward** staff adherence to trust standards on hand hygiene.
	Response by the trust detailing the actions taken: Staff adherence to trust standards on hand hygiene on Neely Ward: -audit completed weekly (spot checks) -Infection Prevention Control team have provided extra support and training , this is ongoing with 50% of staff completed
Area for Improvement 6 **Ref**: 5.3.1(f) **Stated:** First **To be completed by:** 28 December 2019	Action must be taken to improve **Emergency Department** staff adherence to trust standards on the management of sharps. Robust monitoring should be in place to provide continued assurance.
	Response by the trust detailing the actions taken: ED Staff have been reminded on a daily basis at nursing huddles and MDT safety briefs about the need to adhere to Trust standards on the management of sharps. This has been in conjunction with senior staff carrying out spot checks and challenging staff on poor practice.
Area for improvement 7 **Ref**: Standard 4.3 (i) **Stated:** First **To be completed by:** 28 March 2020	A governance mechanism must be put in place for the oversight and monitoring of the assessment, care and treatment of patients with mental health needs who present at the Emergency Department. This mechanism must take account of the management of risk and learning from any incidents.
	Response by the trust detailing the actions taken: ED Learning from incidents is shared to staff through learning points and discussed at Senior staff meetings. – may need more from risk here

Area for improvement 8 **Ref**: Standard 5.3.1(c) **Stated:** First **To be completed by:** 28 March 2020	The trust must ensure there is a policy and procedure in place for the use of CCTV in the 'secure room' in the emergency department. The trust must implement assurance mechanisms to ensure CCTV is being used in line with the policy.
	Response by the trust detailing the actions taken: ED A local policy has been drawn up for the use of CCTV in the 'secure room' – this has been shared among senior staff for approval. The use of the camera has been discussed at morning safety briefs and staff are aware that it should not be in use unless required.
Area for Improvement 9 **Ref**: Standard 5.3.1 (f) **Stated:** First **To be completed by:** 28 January 2020	The trust must ensure that all appropriate staff are trained in the use of ligature cutting equipment.
	Response by the trust detailing the actions taken: ED Training has been sought for all staff on the use of ligature cutting equipment and there is training in place for the next few months. The ED plan to initially train the senior staff (band 7 and 6) ensuring that someone with training will always be on duty and then train all other staff
Area for Improvement 10 **Ref**: Standard 5.3.1(f) **Stated:** First **To be completed by:** 28 March 2020	The trust must ensure that all security staff working in the hospital attends awareness training in relation to mental health and learning disability.
	Response by the trust detailing the actions taken: The Trust advised RQIA that as a result of the recommendation they would meet Adult Mental Health to discuss if there were any identified gaps in security MH awareness training – A meeting is being arranged to tease out what this training could look like and ascertain exactly what content is required/if any. The initial meeting is due to take place in April.

Area for Improvement 11 **Ref**: Standard 5.3.3(h) **Stated:** First **To be completed by:** 28 March 2020	The trust must ensure it has systems in place to prioritise, conduct and act upon the findings of clinical and social care audit and to disseminate learning across the organisation and the HPSS, as appropriate.
	Response by the trust detailing the actions taken: Trust The Trust prioritises clinical and social care guidelines through its dedicated function within Safe and Effective Care Department. A programme of audit is in operation with appropriate reporting and accountability mechanisms to support reliable response to audit findings. Action plans are initiated per audit to respond to findings accordingly. Learning is disseminated through audit meetings, newsletter and Lessons Learnt Sub Committee.

Please ensure this document is completed in full and returned to** BSU.Admin@rqia.org.uk **from the authorised email address

The Regulation and Quality Improvement Authority

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