The Regulation and Quality Improvement Authority

Unannounced Augmented Care Inspection

Ulster Hospital
Ward 4

23-24 October 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 the Ulster hospital on 23-24 November 2016

Ward 4 comprises of 12 single rooms and manages the care of patients with various hematology conditions. This ward will be transferring to the new inpatient ward block early next year.

Service Details

Responsible Person: **Mr. Hugh McCaughey**	Position: **Chief Executive Officer** **South Eastern 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.	**85**
Regional Infection Prevention and Control Clinical Practices Audit Tool.	**89**
Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool.	**92**

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, however due to continued staff shortages the ward sister has little protected time to carry out her managerial role.

We were informed that the trust IPC team provided good support and advice for ward staff.

The ward consists of twelve single patient en-suite 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 does not meet current department of health (DoH) guidance. The assessment of the ward reflects what we observed on the day of inspection. We have been informed by the trust that this ward is to be relocated to the new in patient ward block in late spring. The new environment will meet the recommended specification for a new build.

A water management plan and risk assessment was in place. We observed records of patient placement and movements within the ward. Local screening policies were in place and patients were isolated when appropriate to negate the risk of transmission of infection.

Nursing staff demonstrated a good knowledge and practice in relation to clinical practices and policies. Newly appointed staff have received competency training with a range of invasive devices and a programme of update/refresher training was in place for longer term staff. Competency or formal training had not taken place for taking blood cultures or in relation to enteral feeding.

Antimicrobial guidelines were in place and disseminated at staff induction. Weekly antimicrobial ward rounds are undertaken and there was a ward based pharmacist.

We observed the ward was clean bright and in good repair, with some localised damage to rooms such as the medicine management room, equipment and domestic store.

Patient equipment was clean and in a good state of repair. Staff demonstrated good practice in the management of linen and waste. Staff should ensure they follow the trust policy on the management of sharps.

We observed good practice in the use of personal protective equipment and hand washing. However we observed staff did not carry out the additional step of using alcohol gel following hand washing.

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 South Eastern Health and Social Care Trust and in particular all staff at the Ulster 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	84
General Environment – Layout and Design	81
General Environment – Environmental Cleaning	81
General Environment – Water Safety	95
Clinical and Care Practice	82
Patient Equipment	N/A
Average Score	**85**

Local Governance Systems and Processes

Areas of Good Practice

- The medical directorate produces a quarterly newsletter. We were informed that the IPC team and directorate governance lead, regularly input IPC information into the newsletter e.g. learning from root cause analysis (RCA).
- Staff when questioned informed us that they receive good support from IPC team.
- We were provided with evidence to show that there was good attendance at staff mandatory training which was in line with the trust guidance.
- Key Performance Indicators (KPI) monthly reports are made available for all staff to read and action.
- Whiteboards muliti disciplinary meetings are held each morning.

Areas for Improvement

- The ward sister is aware of their role and responsibilities in relation to infection prevention and control, however due to continued staff shortages she has little protected time to carry out her managerial role.
- We were informed that there is a heavy reliance on bank and agency staff. We were also informed the when some bank and agency staff were used they did not have sufficient competency training in the management of certain invasive devices. This work then falls on to the permanent member of staff.
- There was no documented evidence to show staff receive feedback from RCAs or serious incidents. Staff meetings have not taken place since January 2016.
- There was no documented evidence to show audit frequencies were increased if compliance audit scores were minimal, we were told that that ad hoc spot checks were carried but not documented.
- There was no occupational health/infection prevention and control policy available to provide explicit staff guidance on common infectious conditions.
- There was no specific relatives or visitors information leaflet or guidance on hand hygiene, use of alcohol gel, appropriate use of hand wash sinks or advice on when not to visit, for example, when unwell.

Additional Issue

- We were informed that the ward takes responsibility for the McDermott Unit's out of hour's telephone help line calls. This is a non-funded role with no additional staffing. Night staff have particular concerns as calls can take staff away from ward duties. We were told not all bank and agency staff have the appropriate knowledge to take the helpline phone calls.

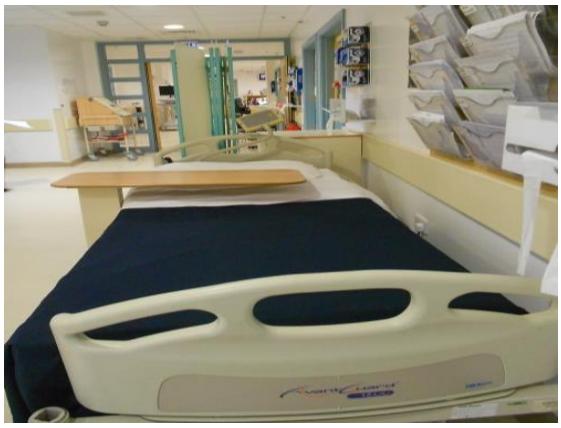
General Environment - Layout and Design

Areas of Good Practice

- The ward is all single patient rooms, the layout and design of the unit minimises the risk of transmission of infection.

Areas for Improvement

- The number of beds spaces can exceed the number of commissioned beds. We observed an escalation bed positioned in the corridor; we were told the bed had been used in the past week.



Picture 1: Escalation bed in corridor

- Patient rooms did not met the core clinical space requirements for the delivery of care or within 80 per cent of the minimum dimensions currently recommended for existing units by the DoH.
- There are no dedicated visitor areas or overnight accommodation.

General Environment - Environmental Cleaning

Areas of Good Practice

- Environmental cleaning: guidelines and audits were in place and reviewed.

Areas for Improvement

- Patient experience staff were unsure of the surface contact time for the disinfectant in use.
- A review of training records demonstrated that staff required update competency training for the cleaning of hand washing sinks.
- Two members of domestic staff did not follow trust protocol on the four cloth cleaning procedure of the hand washing area.

General Environment - Water Safety

Areas of Good Practice

- We were informed that the trust carries out a quarterly schedule of water 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 and user group and the Augmented Care IPC network for review.
- Throughout the inspection we observed that hand washing sinks were used correctly - only for hand washing.

Areas for Improvement

- The water safety plan and written control scheme is in draft format, May 2016

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 infection prevention and control practice. Screening records were reflective of local policy.
- We observed that patients were isolated when appropriate to minimise the risk of transmission of infection.
- We observed protocols in place to ensure patients are washed appropriately to negate the risk of transmission of infection.
- The ward has a link tissue viability nurse.

Areas for Improvement

- We observed an escalation bed in the corridor; staff informed us that it had been used the previous week. We were informed that staffing levels are not increased when an escalation bed is in use.
- When an escalation bed is used the number of beds exceed the commissioned numbers.
- A communication protocol was not 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.
- Staff were not consistent in using alcohol gel after hand washing.

Patient Equipment

There was no specialist equipment on this ward.

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)	92
Invasive devices	84
Taking Blood Cultures	86
Antimicrobial prescribing	81
Clostridium *difficile* infection (CDI)	92
Surgical site infection	N/A
Ventilated (or tracheostomy) care	N/A
Enteral Feeding or tube feeding	91
Screening for MRSA colonisation and decolonisation	94
Average Score	**89**

* 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

- Staff have received ANTT training, a training DVD is available on the trust intranet site.
- Staff were able to demonstrate when ANTT practices should be applied.

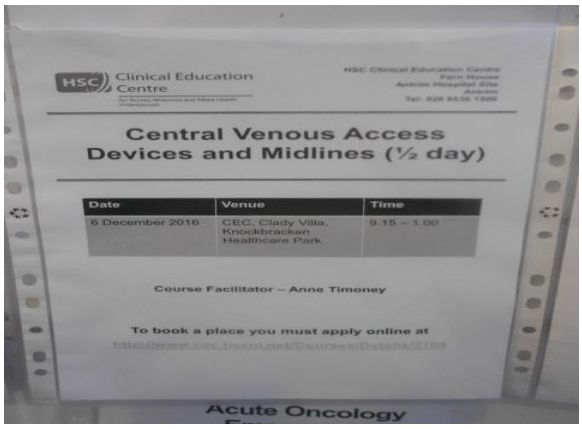
Areas for Improvement

- An ANTT policy was in place and accessible however it needs to be reviewed to include guidance for staff; in the actions to take in the event of a failure of an ANTT assessment of practice and also to include guidance on the re-assessment cycle.

Invasive Devices

Areas of Good Practice

- A policy was in place for the insertion of Central Venous Catheters (CVC). The policy detailed instructions on insertion, duration, replacement and ongoing maintenance. We were shown evidence of staff training on the insertion and ongoing management of invasive devices. Training includes competency based practice. Update training is delivered through the Knockbracken education centre.



Picture 2: Poster for Central Venous training

- High impact intervention care bundles were in place. Audits were carried out to identify poor practice.
- Staff displayed good knowledge in the management of invasive devices. We observed that ANTT principles were used when accessing invasive devices.
- We were informed that throughout the hospital there have been no cases of device associated MRSA bacteraemia this year.
- We were informed that there is a project to review the peripheral cannula documentation with the aim of minimising cannulation and improving documentation.

Areas for Improvement

- Improvement is required in the ANTT practices relating to invasive devices in particular the management of PPE, sharps and placement of aseptic fields.
- We observed the poor recording of invasive device information relating to peripherally inserted central catheter (PICC) lines, Peripheral Venous Catheter (PVC) and urinary catheters.
- We observed that many staff did not use alcohol hand rub after hand washing.

Taking Blood Cultures

Areas of Good Practice

- A policy was available and staff could access it readily. Although there was no opportunity to observe blood cultures being obtained we spoke with staff who undertake the procedure. They were aware of when blood cultures should be taken and the correct technique.
- Blood cultures were documented appropriately in patients' notes.
- The incidence of blood culture contamination was less than 3% which indicated that blood cultures were obtained with proper asepsis.

Areas for Improvement

- Ward nursing staff that collect blood cultures have had no formal competency training. All staff with this responsibility should progress through the blood culture e-learning training programme which is available on the trust intranet site.
- Compliance with best practice in obtaining blood cultures was not being monitored.

Antimicrobial Prescribing

Areas of Good Practice

- Up to date antimicrobial guidelines were in place and we were informed that they were cascaded to medical staff as part of their trust induction. The guidelines were available on the trust intranet site.
- A ward based pharmacist was in place and they attend ward rounds to ensure that antimicrobial prescribing is controlled.
- A trust wide antimicrobial steering committee was in place. This team centrally reviews audit results, anti-microbial usage and incidents.
- Relevant documentation for prescribed antimicrobials was available and appropriately completed.

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.
- Antimicrobial usage is not routinely audited within the unit in line with antimicrobial prescribing guidance.

Clostridium *difficile* infection (CDI)

Areas of Good Practice

- Up to date guidance and a care pathway on the management of CDI was available and known to staff. Although there were no patients identified with CDI on the ward during the inspection, staff were knowledgeable in the IPC management of these patients.
- An antibiotic policy was in place for patients who have or are suspected to have CDI.
- We were informed that Trust wide CDI cases are on target and there are 14 fewer cases than at the same time last year.
- From April 2016, all CDI patients identified in hospital have a Clostridium *difficile* -Consultant Microbiology letter sent to their GP and given to them. This advises on the patient's Clostridium *difficile* diagnosis, important factors to be considered in any subsequent prescribing and advises the patient that they need to seek the advice of their GP if their symptoms return.

Areas for Improvement

- Adherence to the antibiotic protocol for the treatment of patients with CDI is not currently audited.

(We were informed that patients identified with CDI on the ward are an infrequent occurrence. Ward staff should take the opportunity to audit the management of patients with CDI, if and when appropriate).

Surgical site infection (SSI)

This section is not applicable for this ward.

Ventilated (or tracheostomy) care

This section is not applicable for this ward.

Enteral Feeding or tube feeding

Areas of Good Practice

- Enteral feed was stored and disposed of in line with best practice. Staff had good knowledge on the management of an enteral feeding system; insertion, administration, set up and care.

Areas for Improvement

- Competence based training in the management of enteral feeds had not been provided for nursing staff.

- There are currently no systems in place to monitor compliance with enteral feeding protocol and guidance.

Screening for MRSA colonisation and decolonisation

Areas of Good Practice

- An MRSA screening, treatment policy and care pathway were in place.
- When questioned staff were knowledgeable on the precautions to take in managing a patient identified with MRSA.
- We observed evidence of auditing of compliance with best practice in the management of MRSA including the completion of the care pathway.

Areas for Improvement

- The MRSA policy had passed its review date without review.
- Adherence to the MRSA policy and completion of the screening and decolonisation protocol 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	88
Patient linen	98
Waste	94
Sharps	85
Equipment	94
Hygiene factors	98
Hygiene practices	90
Average Score	**92**

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

General Environment

Areas of Good Practice

- Overall the ward was clean, bright and in good repair.

Areas for Improvement

The medicine management room, equipment store and domestic store were cluttered; there was insufficient storage and some damage to fixtures and fittings.

Picture 3: Cluttered store room

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

- Bins were clean, in good repair and appropriately placed.

Areas for Improvement

- We observed inappropriate waste in clinical waste bins and sharps boxes, not all sharps boxes were labelled or replaced in line with trust guidance.

Equipment

Areas of Good Practice

- We observed that patient equipment was clean and in a good state of repair.

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.

Areas for Improvement

- We observed staff did not carry out the additional augmented care hand hygiene step of using alcohol gel after washing their hands with soap and water.
- Not all staff were knowledgeable on the seven steps for hand hygiene.

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)	92
Patient bed area	N/A
Bathroom/washroom	89
Toilet	N/A
Clinical room/treatment room	82
Clean utility room	89
Dirty utility room	95
Domestic store	84
Kitchen	96
Equipment store	67
Isolation	91
General information	96
Average Score	**88**

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	96
Storage of used linen	100
Laundry facilities	N/A
Average Score	**98**

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	94

Availability, use, storage of sharps	85

Standard 5: Patient Equipment

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

Patient equipment	
Patient equipment	94

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	99
Availability of alcohol rub	97
Availability of PPE	100
Materials and equipment for cleaning	96
Average Score	**98**

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	79
Safe handling and disposal of sharps	100
Effective use of PPE	86
Correct use of isolation	94
Effective cleaning of ward	85
Staff uniform and work wear	97
Average Score	**90**

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:

L Kelly	-	Assistant Director of Nursing, Safe and effective Care
L Lowery	-	Clinical Co-ordinator, Medicine
P Hamill	-	Senior Manager Patient Experience
M Merrion	-	Infection Prevention and Control, Lead
J Reid	-	Infection Prevention and Control
L Elias	-	Clinical Manager, Medical Specialities
L Maxwell	-	Ward 4, Sister
J MaCartney	-	Ward 4, Deputy Sister
G Moore	-	Patient Experience Manager
S Dineley	-	Patient Experience, Quality and Training Office
G Rooney	-	Patient Experience
C Campbell	-	Safe and Effective Care Manager

Apologies:

None

8.0 Provider Compliance Improvement Plan

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

Area: Ward 4

Reference number	Recommended Actions	Responsible Person	Action/ Required	Date for completion/ timescale
Regional Augmented Care Infection Prevention and Control Audit Tool.				
1.	The trust should ensure the ward sister has protected time to carry out their managerial role.	Nursing	Staffing issues escalated to management and HR are working to fill vacancies. Since the RQIA inspection 1 fulltime SN post has been filled and another candidate has accepted a fulltime post awaiting Police checks.	progressive to September 2017
2.	The trust should ensure nursing staff have received training commensurate to their roles.	Nursing	Training programme reviewed and planned. There are planned IPC training dates; planned Enteral Feeding training, and staff to complete blood culture e-learning module	progressive to September 2017
3.	Staff meetings should be re-established to ensure staff are kept informed.	Nursing	A ward meeting has taken place January 2017and a further date planned. Communication also continues through the channels of verbal handovers,	Completed January 2017

Reference number	Recommended Actions	Responsible Person	Action/ Required	Date for completion/ timescale
			communication book, Safety Briefs, and information displayed in staff room. Further meetings are scheduled.	
4.	Audits should be documented and results shared with staff, patients and the public.	Nursing Patient Experience	Audits are documented and the results shared. The Hand Hygiene; Safety Cross, Walking Stick and Maximiser Cleaning results were already displayed for the staff and public to see. The other KPI audits including peripheral cannula, central venous device, NEW's, MUST, commode audit, omitted medications and Skin Bundles were and continue to be displayed for staff reference in the Resource Room and are on agenda for staff meetings as well as being recorded in the Communication Book All environmental cleanliness audits are documented and shared . Plans are in place to ensure that audit results are displayed in each ward as part of the overall dashboard to enable staff, patients and the public to view. As part of continuing development discussions have taken place and plans are being developed to incorporate	Immediate and completed

Reference number	Recommended Actions	Responsible Person	Action/ Required	Date for completion/ timescale
			Environmental Cleanliness Audit scores into the Infection Control dashboard.	
5.	The occupational health document which provides guidance on common infectious conditions that staff may experience, should be made available for all staff.	Nursing IPC	This matter has been raised and discussed with the Trust's HCAI Steering group and a draft document in place which will be tabled at the next infection Control Committee meeting in Mar 2017	May 2017
6.	The trust augmented care information leaflet for visitors should be available on the ward.	Nursing IPC	There is a Ward 4 Leaflet with advice to avoid infection when immunity is reduced as approved by IPC. There is a Hand Hygiene leaflet for Patients and Visitors issued by the Public Health Agency and readily available on the ward leaflet rack. These will be collectively reviewed at the Trusts Augmented Care IPC network meeting April 2017. This work is underway and harmonised with other augmented care areas.	June 2017
7.	Patient experience staff require update training in relation to the four cloth cleaning procedure and the use of disinfectants	PE	Patient Experience Manager has ensured that staff on the ward have been trained and are now familiar with the four cloth protocol. Competency checks will be undertaken by monitoring team and reported All Patient Experience staff working in	May 2017

Reference number	Recommended Actions	Responsible Person	Action/ Required	Date for completion/ timescale
			augmented care areas will receive refresher training in the four cloth cleaning procedure. Four cloth audit checklist has now been implemented and plans are in place to have prompt cards on service assistants trollies to remind them of the correct procedure to follow. All Patient Experience staff will receive update training in the use of disinfectants as part of their annual Control of Infection training.	
8.	The water safety plan needs to be finalised.		The current Draft version of the Water Safety Plan was discussed at the Jan'17 Water Safety Group Meeting and final consultation is in progress. This is currently a working document and all actions in place.	July 2017
9.	Ward staff should ensure that sending or receiving wards are explicitly informed of any positive screening results.		. At present the nurse/doctor receiving positive results informs the receiving unit in a Transfer form and by phone call. There is an IPC Admission Risk assessment /transfer form regionally accepted which will be implemented for	Immediate

Reference number	Recommended Actions	Responsible Person	Action/ Required	Date for completion/ timescale
			this process –roll-out to commence April 2017. Local admission /transfer policies will be updated. Ref TH comment In our Transfer policy there is reference to communication of any diagnostic test results and an updated signed copy of the IPC risk assessment is to be included with the Patient Transfer Form which thus covers these requirements. This is already built into practice through IPC risk assessment and Trust transfer form. The enteral feeding policy is currently in a draft format that has not been issued. It needs to be reformatted before it can be approved and placed on Iconnect. There is not an ICU enteral feeding assessment form in it. This has been discussed this with the ICU dietitian who is not aware of such a form especially as all documentation is done on the electronic ICIP system. Checks on this with ICU nursing staff are being carried out. Feeding practices may be somewhat different on ICU however and if such a form does exist it may not be appropriate to the general wards. In February 2017, an agreement was made between the ward manager and	

Reference number	Recommended Actions	Responsible Person	Action/ Required	Date for completion/ timescale
			dietetics re: provision of enteral feeding training for nursing staff. This includes indications for enteral tube feeding, assessment for tube feeding, types of enteral feeding tubes , feeding regimens, complications, monitoring and types of feed commonly used. It does not cover care and management of feeding tubes – a nursing role. NICE clinical guideline 32 which was deemed applicable to NI last year states that Trusts should employ a Nutrition Specialist Nurse who can lead on education around care of tubes and lines. SEHSCT is currently addressing the business case for this role. The document referred to as" RQIA on their assessment recommended adopting the assessment form currently utilised by ICU" is actually this Trust policy: Insertion and Ongoing Confirmation of the Position of Nasogastric and Orogastric Feeding Tubes in Adults (includes procedure for insertion of NG tube with an introducer), which just refers to placing NG tubes and confirming their position. A copy of this will be included in the Trust enteral feeding policy which is currently in draft.	

Reference number	Recommended Actions	Responsible Person	Action/ Required	Date for completion/ timescale
Regional Infection Prevention and Control Clinical Practices Audit Tool				
1.	The ANTT policy should be reviewed to include guidance in the event of a failed assessment and on the reassessment cycle.	Nursing IPC	ANTT guidelines are now published on the Regional IPC Manual Website. The staff are deemed competent locally in venepuncture and cannulation. Plan to develop peer review and competency of practice across all augmented care areas to be taken forward at next IPC Augmented Care network meeting. This is a regional policy and the recommendation for review has been made to the PHA and will be taken forward regionally. SET has sought to have a review of the regional policy via PHA and plan to include some regional guidance about monitoring practice. Currently in any staff members deviation /noncompliance with policy the ward manager will take the steps of correction though an escalation	June 2017

Reference number	Recommended Actions	Responsible Person	Action/ Required	Date for completion/ timescale
			to manage such a situation. This will range from discussion and raising awareness of the issue to considering supervision or retaining and this approach cannot be itemised in each policy but is more considered part of the compliance with practice overall. This is one of the major roles of a manager. This just cannot be detailed into very policy. This matter has already been included in the agenda of our IPC Augmented care network meeting which is planned for 1st week in April	
2.	Staff should ensure that when carrying out a clinical practice a suitable clinical work station is brought to the patient or bedside.	Nursing	All staff advised of requirement to use a trolley at the patient's bedside for clinical practices.	January 2017
3.	Staff should ensure all documentation in relation to the insertion and ongoing management of invasive devices is completed.	N	The importance of documenting care management of devices has been brought to the attention of staff. Routine audits being establish to review this in practice lead by ward Band 6.	May 2017
4.	Nursing staff should receive formal training on taking blood cultures and compliance with best practice should be monitored.	N	All staff receive face to face training on taking blood cultures and undertake peer review of ANTT in practice. All staff to complete the available e-learning module	June 2017

Reference number	Recommended Actions	Responsible Person	Action/ Required	Date for completion/ timescale
			in the next 3 months. This will again be considered as any manager will respond to someone's deviation from policy and the approach depends on the deviation and the number of occasions or why this has occurred.	
5.	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.	PH	Trust Antibiotic Guidelines are available on i-Connect and the Microguide Smartphone 'App'. In addition the Regional NICAN Guidelines are also available via the same 'App'. These provide detailed instructions regarding the diagnosis and treatment of Neutropenic Sepsis. An audit of multidisciplinary information provided to patients on antimicrobial usage would require a patient user survey to determine what information each patient received regarding their antibiotics and from which profession. As a baseline all patients discharged on antibiotics will receive a Patient Information Leaflet giving information on antibiotics such as side effects and instructions on the duration of course.	Sept 2017

Reference number	Recommended Actions	Responsible Person	Action/ Required	Date for completion/ timescale
			Antimicrobial usage is now reported monthly on the ward. Also plan to establish regular audit on antimicrobial compliance with Trust Guidelines. An antimicrobial audit bundle is currently available on the HCAI Dashboard and Antimicrobial pharmacist aims to establish audit programme with medical staff.	
6.	Staff should receive competence based training in the management of enteral feeding and compliance should be monitored.	N	Staff receive this training as part of their RGN training. RQIA on their assessment recommended adopting the assessment form currently utilised by ICU (which is available as part of the Trust Enteral Feeding Policy and which staff have been advised to use.) Further staff training is being arranged with the Dietetic Department and a Dietetic Resource File is readily available to staff.	June 2017
7.	The trust policy on MRSA required review.	Nursing IPC	The MRSA screening guidelines remain the active guideline for practice. The policy review is underway and awaits agreed outcomes from recent regional and SET audits of MRSA and will be incorporated into update of the policy	August 2017

Reference number	Recommended Actions	Responsible Person	Action/ Required	Date for completion/ timescale
			This policy review is currently underway and work has been undertaken both, locally and regional to inform the update of the policy	
8.	Adherence to the MRSA policy and completion of the screening and decolonisation protocol should be monitored by ward staff.	Nursing IPC	This is currently undertaken by the IPC who provide feedback to the ward sister, but an Augmented Care MRSA Screening and Decolonisation Audit tool has been provided to sister to establish local audits. An audit was undertaken in 2016 to review this policy and its application in ward 4. This is already an on-going process within the Trust.	Complete April 2017

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