The Regulation and Quality Improvement Authority

Unannounced Augmented Care Inspection

Mandeville Unit
Craigavon Hospital

2-3 February 2017

Contents

1.0 Profile of Service

The three year improvement programme of unannounced inspections to augmented care areas commenced in the Mandeville Unit, Craigavon Hospital on 2 and 3 February 2017.

The Macmillan Building at Craigavon is the designated Cancer Unit for the Southern Area, providing Oncology and Haematology outpatient clinics and day procedures. The hospital also offers a wide range of diagnostic and therapy services. The Mandeville Unit is located in the Macmillan building (Picture 1). There are four consulting rooms, a treatment area with eight spaces and a side room. The adjacent sun room can accommodate seven more spaces for diagnostic and therapy services.

Picture 1: Entrance to Macmillan building

Service Details

Responsible Person: Mr. Stephen McNally	Position: **Interim Chief Executive Officer Southern 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.	**92**
Regional Infection Prevention and Control Clinical Practices Audit Tool.	**84**
Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool.	**92**

Ward staff had a good knowledge and awareness of how to manage infections. The trust IPC team were available to provide support and advice. However through discussion and examination of documentation, we found that infection prevention and control (IPC) governance arrangements and staff attendance at mandatory training need improved. We were told that protected time for the interim ward sister to undertake appropriate educational level training opportunities had been a challenge.

The Unit has been in a transition period of variable staffing levels and movement in staff management. The trust has worked to resolve these issues and address staff deficits. The newly appointed ward manager will require support from senior staff and unit nursing staff and protected time for educational training opportunities to undertake the responsibilities involved in the role. There was minimum evidence of multi professional working relating to infection prevention and control; there was no documented evidence of multidisciplinary meetings held in the unit to interpret surveillance data collected and identify trends.

The Unit is an outpatient facility and incorporates consulting rooms, two large treatment areas and one single room.

An advantage of having this room is that it can be used for specific treatments and also assists in reducing the risk of the transmission of infection.

We observed that the core clinical space around patients' beds was within the current recommended specification. There was no bed/ couch/space tracking system in place.

A water management plan and risk assessment was in place. Local screening policies were in place and we were told that patients can be isolated when appropriate to negate the risk of transmission of infection.

As this is an outpatient's facility, some sections of the Regional Infection Prevention and Control Clinical Practices Audit Tool are not applicable.

A number of policies/procedures/guidelines had exceeded their review dates. ANTT competency training needs for all clinical staff and update training on invasive devices needs addressed to improve compliance.

Staff who obtain blood cultures were knowledgeable in the correct technique however when questioned were not aware of the unit's rate of positive blood cultures or the consistently low blood culture contamination rate. Compliance with best practice in obtaining a blood culture was not being monitored.

The prescribing of antimicrobials in the unit is an infrequent occurrence however pharmacy support within the unit was available when required.

We observed that the unit had a high standard of environmental cleanliness and was bright, spacious and in good decorative order. 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.

Hand hygiene was performed at the correct moments and at the correct location, within the flow of care delivery. An improvement is required on the correct wearing of single use gowns, staff knowledge on the correct disinfectant dilution rates for decontaminating blood or body fluids and the National Patient Safety Agency (NPSA) guidance for colour coding of cleaning equipment.

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 Southern Health and Social Care Trust and in particular all staff at the Mandeville Unit, Craigavon 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	15/16 Sept 2016
Local Governance Systems and Processes	81
General Environment – Layout and Design	93
General Environment – Environmental Cleaning	100
General Environment – Water Safety	95
Clinical and Care Practice	93
Patient Equipment	N/A
Average Score	**92**

Local Governance Systems and Processes

Areas of Good Practice

- Four registered nurses have been trained to assist the medical staff in carrying out Intrathecal therapy in the unit. This is beneficial to patients and families who live locally.
- There was a good variety of information leaflets for patients and families.
- We were informed that the IPC team provides good support for ward staff.
- To facilitate communication with the nursing team, the acting sister holds a whiteboard meeting at least weekly. This practice informs staff of relevant information such as training updates, staffing levels, IPC and environmental cleanliness audits, equipment, complaints and incidents.
- There are IPC policies in place for staff to reference when dealing with an infection.
- The unit regularly carries out Malnutrition Screening Tool (MST) and Toxicity audits. This can be identified as a quality indicator for the unit.

Areas for Improvement

- The acting (interim) sister has stepped into being the lead person for IPC but does not have protected time for appropriate educational training opportunities.
- There was minimum evidence of multi professional working relating to infection prevention and control.
- There was no documented evidence of multidisciplinary meetings held in the unit to interpret surveillance data collected and identify trends.
- Up to date audit results were not displayed in the unit.
- The system to record estates issues does not identify when the required action has been completed.
- We were informed that IPC nursing staff while supportive, do not visit the unit on a daily basis, however they will quickly respond to requests for a visit.
- An occupational health policy, to inform staff and negate the risk of potential risk of transmission of infection was not available.

General Environment - Layout and Design

Areas of Good Practice

- The number of bed spaces does not exceed the number of commissioned spaces.
- We were advised by the Southern Trust estates department that the core clinical space around patients' beds for the delivery of care exceeded the minimum dimensions recommended for existing units.
- In the treatment areas, the dimensions between bed head centres exceeded that what is currently recommended for existing units by the DoH.

Areas for Improvement

- In the treatment area and sun room, clinical hand wash sinks are in close proximity to patient beds. The positions of these sinks present a splash risk to the patient, the bed and the equipment at the bedside.
- In the sun room we identified the number of clinical hand wash sinks did not comply with local and national policy. At the feedback we were informed that an additional clinical hand wash sink is to be installed.

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.

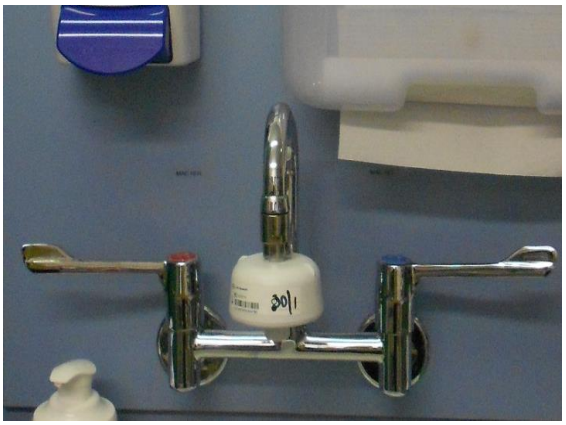
General Environment - Water Safety

Areas of Good Practice

- An up to date overarching trust water safety plan and unit risk assessment were in place.
- We were informed that the trust carries out a bi-annual schedule of water sampling for Pseudomonas *aeruginosa* and quarterly checks for *Legionella* from all water outlets in augmented care areas.
- We were informed that the PHA (England) had conducted an external review of the unit in December 2016/ January 2017. The trust was waiting on the ensuing report however immediate feedback had highlighted replacing clinical wash hand basins. This is to accommodate appropriate hand washing due to the installation of point of use filters on taps.
- 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 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 their surface label (Picture 2). This made it challenging to determine when POU filters should be changed.



Picture 2: Point of Use filter with no removal date

Clinical and Care Practice

Areas of Good Practice

- 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 can be 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.

Areas for Improvement

- There was no bed/ couch/space tracking system in place.

Patient Equipment

This section is not applicable. Patient equipment has been audited in the Regional Healthcare Hygiene and Cleanliness Audit Tool.

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	2/3 Feb 17
Aseptic non touch technique (ANTT)	79
Invasive devices	78
Taking Blood Cultures	78
Antimicrobial prescribing	100
Clostridium *difficile* infection (CDI)	N/A
Surgical site infection	N/A
Ventilated (or tracheostomy) care	N/A
Enteral Feeding or tube feeding	N/A
Screening for MRSA colonisation and decolonisation	N/A
Average Score	**84**

* 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

- An ANTT policy and guidance was in place and accessible for all staff.

Areas for Improvement

- The ANTT policy had passed its revision date without being reviewed.
- Only one third of nursing staff had been signed off as ANTT competent within the unit.
- Senior unit medical staff had not completed a programme of ANTT training and competency assessment.

Invasive Devices

Areas of Good Practice

- There were no reports of healthcare associated infections relating to invasive devices in the unit.
- Staff displayed good knowledge in the management of invasive devices.

Areas for Improvement

- Visual infusion phlebitis (VIP) charts were available but not routinely used by staff in the unit.
- A number of policies/procedures/guidelines had exceeded their review dates.
- We were informed that for longer term staff there had been no update/ refresher training in invasive device procedures.
- We observed inconsistent compliance in the application of ANTT for the management of invasive devices.

Taking Blood Cultures

Areas of Good Practice

- Guidelines on blood culture taking were available, up to date and easily accessible for staff.
- There was one opportunity to observe blood cultures being obtained. The clinical indication for obtaining the blood cultures was identified and the correct ANTT technique was implemented.
- 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

- There was no system in place to compare the rate of positive cultures with other trust wards/ departments.
- Compliance with best practice in obtaining a blood culture was not being monitored.

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.
- We were informed that the prescribing of antimicrobials within the unit is an infrequent occurrence however pharmacy support is available when required.

Clostridium *Difficile* Infection (CDI)

Not applicable for this unit.

Surgical Site Infection (SSI)

Not applicable for this unit.

Ventilated (or Tracheostomy) Care

Not applicable for this unit.

Enteral Feeding or Tube Feeding

Not applicable for this unit.

Screening for MRSA Colonisation and Decolonisation

Not applicable for this unit.

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	97
Patient linen	100
Waste	95
Sharps	90
Equipment	97
Hygiene factors	98
Hygiene practices	90
Average Score	**95**

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

General Environment

Areas of Good Practice

We observed that the ward was in good decorative order and environmental cleanliness was of a high standard. The unit was tidy and well organised. This ensures effective cleaning can be undertaken. Cleaning 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.

Waste and Sharps

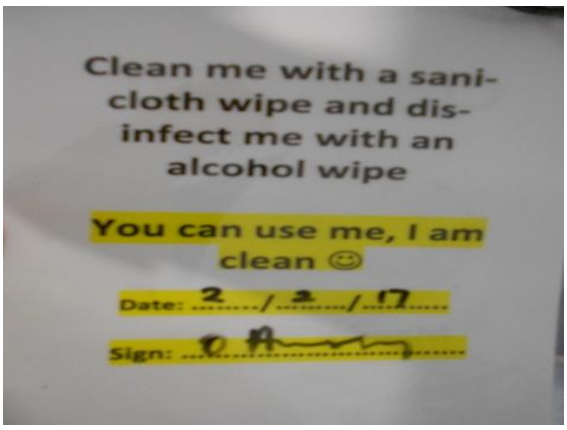
Areas of Good Practice

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 (Picture 3).



Picture 3: Example of a sticker to identify cleaned equipment

Hygiene Factors

Areas of Good Practice

We observed facilities and that a range of consumables 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.

Areas for Improvement

- The sun room has only one clinical hand wash sink, the sink is beside the designated area for patients with an infection, therefore access to the sink would be limited.

Hygiene Practices

Areas of Good Practice

Hand hygiene was performed at the correct moments and at the correct location, within the flow of care delivery.

Areas for Improvement

- We observed staff wearing single use gowns for more than one procedure
- On day 1 staff were observed not wearing eye/face protection where there was a risk of exposure from splashing of hazardous drugs.
- When questioned, staff were unsure of the correct dilution rates for decontaminating blood or body fluid spills and the National Patient Safety Agency (NPSA) guidance for colour coding of cleaning equipment.

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	100
Corridors, stairs lift	N/A
Public toilets	92
Ward/department - general (communal)	98
Patient bed area	98
Bathroom/washroom	N/A
Toilet	100
Clinical room/treatment room	91
Clean utility room	N/A
Dirty utility room	100
Domestic store	95
Kitchen	98
Equipment store	N/A
Isolation	97
General information	86
Average Score	**97**

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	95
Availability, use, storage of sharps	90

Standard 5: Patient Equipment

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

Patient Equipment	
Patient equipment	97

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	100
Availability of PPE	93
Materials and equipment for cleaning	100
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	100
Safe handling and disposal of sharps	100
Effective use of PPE	74
Correct use of isolation	N/A
Effective cleaning of ward	76
Staff uniform and work wear	100
Average Score	**90**

7.0 Key Personnel and Information

Members of the RQIA inspection team

Ms L Gawley - Inspector, Healthcare Team

Ms S O'Connor - Senior Inspector, Healthcare Team
Ms M Keating - Inspector, Healthcare Team
Ms J Gilmour - Inspector, Healthcare Team

Trust representatives attending the feedback session

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

Ms H Trouton - Assistant Director, IMWIH and C &CS
Ms F Reddich - Head of Cancer Services
Ms M Novak - Acting Ward Manager
Ms M Johnston - Senior Domestic Services Manager
Mr G White - Domestic Services Manager

Apologies: None

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 trust should ensure the unit sister has protected time to carry out their managerial role.	Nurse in Charge	Clair has allocated time to carry out her managerial role	Ongoing
2.	The trust should ensure nursing staff have received training commensurate to their roles.	Nurse in Charge	Staff training is ongoing and is a requirement of their post	Ongoing
3.	Unit staff should be facilitated to attend multidisciplinary team meetings. Minutes of meetings should be forwarded to the unit and cascaded to staff.	Nurse in Charge	Multi- disciplinary meetings are encouraged and a copy of these should be maintained and shared with staff	Ongoing
4.	Staff meetings should be re-established to ensure staff are kept informed.	Staff meetings have always	Daily whiteboard meetings take place and first formal staff meeting is scheduled	Ongoing

Reference number	Recommended Actions	Responsible Person	Action/ Required	Date for completion/ timescale
		been encouraged and are now re-established	for 3rd April, 2017	
5.	Audits should be documented and results shared with staff, patients and the public.	Nurse in Charge	There are a number of audits currently been undertaken and results of these will be shared with staff, patients and the public	Ongoing
6.	The trust should provide an occupational health document which provides guidance on common infectious conditions that staff may experience.	Infection Control Team	The Trust has written Guidelines recently and these should be finally approved next week.	2 weeks
7.	A bed/couch/ space tracking system should be in place.	Nurse in Charge	Staff are currently documenting this in the patient records	Ongoing
8.	The removal date should be written on POU filters.	Estates	We are in the process of moving to a data logging system where the data for the filter changes is captured on a server which can be used as an audit tool. We will continue to have the removal date added to the filter in parallel with this process.	Ongoing

Reference number	Recommended Actions	Responsible Person	Action/ Required	Date for completion/ timescale
Regional Infection Prevention and Control Clinical Practices Audit Tool				
9.	The trust should ensure that policies to guide staff in the management of invasive devices are timely reviewed and updated as appropriate.	Nurse in Charge	The Trust endorse Guidelines provided by NICaN SACT group	Ongoing
10.	All clinical staff should receive ongoing competency assessment of ANTT practice in line with trust policy.	Nurse in Charge	Nursing staff receive ongoing competency assessment of ANTT. The unit is currently working with medical staff to ensure they comply with ANTT practice in line with Trust policy.	Ongoing
11.	Staff should ensure all documentation in relation to the insertion and ongoing management of invasive devices is completed. Clinical staff should use VIP charts to promote compliance and standardisation in the application of ANTT practices and identify early signs of phlebitis.	Nurse in Charge	VIP charts have been implemented within Mandeville unit and staff are recording these.	Ongoing
12.	The trust should ensure that there is a formal programme of training including update/ refresher skills training for staff in the insertion and management of invasive devices.	Nurse in Charge	There is an annual competency programme to assess staff.	Ongoing

Reference number	Recommended Actions	Responsible Person	Action/ Required	Date for completion/ timescale
13.	Compliance with invasive device high impact intervention and/or care bundles should be monitored.	Nurse in Charge	This is being rolled out by the Infection Control link nurses within Mandeville unit week commencing 3/4/2017	Ongoing
14.	All ward clinical staff should be explicitly informed of the unit's rate of positive blood cultures and the incidence of culture contamination.	Nurse in Charge	These will be circulated to all staff within the unit week commencing 03/04/2017	Ongoing
15.	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.	Nurse in Charge	This is circulated to staff within the unit	Ongoing
Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool				
16.	Robust systems should be in place to ensure staff wear personal protective equipment correctly.	Nurse in Charge	Staff are aware and ongoing monitoring of this is undertaken and staff are challenged when non -compliance has been detected.	Ongoing
17.	All clinical staff should ensure that they are knowledgeable in the correct dilution rates for disinfectants used and NPSA guidance for colour coding of cleaning equipment.	Nurse in Charge	Staff are aware and this is displayed within the department	Ongoing

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