The Regulation and Quality Improvement Authority

Unannounced Critical Care Inspection

Craigavon Area Hospital Critical Care Unit
Year 3 Inspection

21 August 2018

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Assurance, Challenge and Improvement in Health and Social Care

Contents

1.0	Profile of Service	3
2.0	Inspection Summary	4
3.0	Inspection Findings and Quality Improvement Initiatives	6
4.0	Key Personnel and Information	11
5.0	Improvement Plan – Year 3	12
6.0	Improvement Plan – Year 1 Updated by Trust	14

1.0 Profile of Service

The RQIA three year improvement programme of unannounced inspections to critical care areas commenced in Craigavon Area Hospital Critical Care Unit, Southern Health and Social Care Trust (Southern Trust) on 27 November 2014.

The unit provides intensive care services to patients with life threatening illness, following major, complex surgery and following serious accidents.

Service Details

Responsible Person: **Mr. Shane Devlin**	Position: **Chief Executive of the Southern Health and Social Care Trust**

What We Look for

Inspection Audit Tools

During a three year cycle all critical care units were initially assessed against the following regionally agreed standards and audit tools:

- Regional Critical 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 is the second inspection of a three year inspection cycle undertaken within critical care units. Initially, in year one of this inspection cycle all critical care units were assessed against all three audit tools: the regional critical care infection prevention and control audit tool, the regional infection prevention and control clinical practices audit tool and the regional healthcare hygiene and cleanliness standards and audit tool. Compliance was assessed in each separate area by taking an average score of all elements of each tool. The Department of Health (DoH) agreed overall compliance target scores were 85 per cent in the first year, rising to 90 per cent in the second year and 95 per cent in year three. The table below sets out agreed compliance targets.

	Year 1	Year 2	Year 3
Compliant	85% or above	90% or above	95% or above
Partial Compliance	76% to 84%	81 to 89%	86 to 94%
Minimal Compliance	75% or below	80% or below	85% or below

The focus of this unannounced inspection was to assess practice against standards contained within two inspection tools. Only those standards that had been identified in previous inspections as requiring improvement (in order to achieve year three compliance) were assessed. During this inspection we also reviewed the critical care unit's improvement plans (current and/or previous) and discussed any quality improvement initiatives established and in place since the unit's last inspection visit.

This report can be read in conjunction with year one and two inspection reports which are available at www.rqia.org.uk.

This inspection team found evidence that the Critical Care Unit (CCU) in Craigavon Area Hospital has continued to improve and implement regionally agreed standards.

We observed a unit that was bright, tidy and in excellent decorative order. Since the initial inspection in 2014, the CCU has been refurbished. An additional equipment decontamination room has been added, clinical hand wash sinks have been replaced and fixtures and fittings upgraded throughout. Cleaning by support service and nursing staff, was of a very high standard.

Inspectors note that although the core clinical space does not meet current recommended requirements; staff were working within these limitations to deliver safe and effective care.

We found ongoing improvements in all clinical practice standards assessed, with antimicrobial prescribing and screening for *Meticillin*-resistant *Staphylococcus aureus* (MRSA) achieving full compliance. Further improvement is however required in the management of blood cultures.

After reviewing improvement plans with the unit sister, we were satisfied that all necessary actions had and continue to be progressed. Details of these can be found in section 6.

We were informed of some positive improvement initiatives within the unit that have been included within the body of this report.

Escalation procedures were not required for this inspection. Our 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 Craigavon Area Hospital Critical Care Unit for their assistance during the inspection.

Please note: 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 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 all relevant legislation, standards and best practice.

3.0 Inspection Findings and Quality Improvement Initiatives

The regional critical care infection prevention and control audit tool, the regional infection prevention and control clinical practices audit tool, and the regional healthcare hygiene and cleanliness audit tool provide a common set of overarching standards for all hospitals and other healthcare facilities in Northern Ireland. The audit tools cover a number of areas which are assessed individually using a number of standards.

Compliance targets in each individual area are the same as those set out earlier in relation to overall compliance scores.

	Year 1	Year 2	Year 3
Compliant	85% or above	90% or above	95% or above
Partial Compliance	76% to 84%	81 to 89%	86 to 94%
Minimal Compliance	75% or below	80% or below	85% or below

Only those standards that had been identified in previous inspections as requiring improvement (in order to achieve year three compliance) were assessed.

As the full audit tool was not required for this inspection an overall score is not available. Only those individual areas which contributed to a compliance target of 95 per cent not previously being achieved were assessed.

The Regional Critical Care Infection Prevention and Control Audit Tool

The table below includes the areas of the audit tool that were assessed during this inspection and also gives the compliance rates in these areas in both year one (2014/15) and this year three (2018/19) inspection.

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

Areas Inspected	Year 1	Year 3
Local governance systems and processes	93	100
General environment – layout and design	71	81

Senior nursing staff continued to display good clinical leadership and knowledge in the management of infection prevention and control (IPC). We observed evidence of multi-professional working between unit staff and the IPC team who visit the unit regularly to provide support and advice.

Audits which include hand hygiene and environmental cleanliness are ongoing to improve staff practices. Hand hygiene audits are carried out by independent assessors which provide additional assurance of staff practice.
Unit staff attendance at IPC mandatory training was 97 per cent. We observed evidence that mandatory and non-mandatory surveillance programmes for the detection of healthcare associated infections continue to work effectively to enable treatment and IPC precautions to be initiated when required.

Incidents relating to IPC were appropriately reported and acted on. Staff use the mechanism of root cause analysis (RCA) to investigate incidences of MRSA and *Meticillin*-sensitive *Staphylococcus aureus* (MSSA) blood stream infections and Clostridium *difficile* infections (CDI).

Throughout the unit there is a range of information which is clearly displayed to inform relatives and visitors of the importance of key IPC practices for example hand hygiene posters.

The unit was bright, tidy and in excellent decorative order. Following the initial inspection in 2014, considerable refurbishment work has been carried out within the unit. An additional equipment decontamination room has been added (Picture 1), clinical hand wash sinks have been replaced and fixtures and fittings renewed throughout. We were also informed that plans are in place to refurbish the visitor's overnight room to improve comfort and offer a greater range of facilities for families.

Picture 1: New equipment Decontamination Room

Cleaning throughout the unit by support service and nursing staff, was of a very high standard.

As no changes have been made to bed space configuration/space within the unit since the initial inspection, the core clinical space and linear distance at the patient bed area remains unchanged. Spacing therefore does not comply with 80 per cent of the minimum dimensions recommended by the Department of Health (DoH) and outlined in the audit tool. The unit continues to have only three side rooms for the isolation of patients which is not in line with numbers recommended by the DoH and outlined in the audit tool.

We were informed of future plans for a new build critical care unit on the Craigavon Area hospital site. The start and completion date of this work is still to be determined.

Additional Issues

During the inspection we observed that some medicine cupboards in the CCU remained unlocked (Picture 2).

Area for Improvement

1. **Staff should ensure that medicines are stored safely to prevent unauthorised access and comply with all legislative requirements, professional standards and good practice.**

Picture 2: Unlocked Medicine Cupboards

- The call system to request security staff within the unit was not working. We were informed that there has been a considerable delay in the repairing this system.

Area for Improvement

2. **The trust should ensure that maintenance to the security staff call system within the unit is carried out in a in a timely manner.**

The Regional Infection Prevention and Control Clinical Practices Audit Tool

The table below includes the areas of this audit tool that were assessed during this inspection and also gives the compliance rates in these areas in both year one (2014/15) and this year three (2018/19) inspection.

Table 2: Clinical Practices Compliance Level

Area inspected	Year 1	Year 3
Invasive Devices	94	97
Taking Blood Cultures	59	86
Antimicrobial Prescribing	88	100
Screening for MRSA colonisation and decolonisation	88	100

* Staff practice was not observed during the inspection.
Information was gained through staff questioning and review of unit audits.

Overall we were assured that systems and processes were in place to ensure a standardised approach to the insertion and ongoing maintenance of invasive devices. We observed that invasive lines were appropriately labelled to prevent wrong route administration, in line with the regional line labelling policy.

There was no system in place to review the competency assessment of staff practices such as the insertion of invasive devices e.g. peripheral venous cannulas (PVC). We were told that plans were in place to recruit a Clinical Educator who could support staff in competency assessment of clinical practices.

We observed ongoing improvement in the management of blood cultures. Staff demonstrated good knowledge on how and why to take a sample of blood for blood culture processing. The new IntelliVue Clinical Information Portfolio (ICIP) system provides a standardised approach to clinical documentation but could be further adapted to allow staff to record the batch numbers of invasive devices and site from which the blood culture sample was obtained. An audit tool to monitor the clinical procedure for taking blood cultures samples is in use and results are fed back to Medical staff.

Despite these quality improvements, the incidence of blood culture contaminants had risen above 3 per cent. This may suggest that blood cultures samples were not always being collected with proper attention to aseptic technique. We were not provided with evidence that the rate of positive blood cultures and incidences of contaminants is discussed at multidisciplinary meetings.

Area for Improvement

3. **Unit staff should ensure that blood culture contamination rates are routinely discussed at multidisciplinary team meetings and actions clearly evidenced when levels are increased.**

Antimicrobial/microbiology rounds occur every week day. Staff report that they have good support from Microbiology and the Infection Prevention and Control Team (IPCT). A ward based pharmacist is in place. Compliance against antimicrobial guidance is audited in line with antimicrobial prescribing guidance/local targets and feedback is given to medical staff on the findings. An online internal monitoring procedure is in place to monitor the use of restricted antibiotics in the unit.

Additional quality improvements initiatives introduced since the last inspection include a care bundle to guide all staff in the correct management of patients in relation to screening, isolation and decolonisation for MRSA. There were no patients in the unit known or suspected to have MRSA at the time of the inspection. The unit manager carries out snap shot audits of practice in relation to IPC, results are shared with staff and action plans devised where improvement in clinical practice is identified.

Overall, hand hygiene practices within the unit adhered to best practice guidance; staff were advised to continue to be vigilant, monitoring staff adherence in line with trust policy.

Quality Improvement Initiatives

The new IntelliVue Clinical Information Portfolio (ICIP) computer software system was introduced within the critical care unit in March 2018. The system contains applications that combine patient clinical information from a number of sources to support care management. Inspectors observed the benefits of this system during the inspection by evidencing improvement in the recording of patient clinical information onto this system. This system also contains an electronic prescribing module which can assist in helping to reduce medication prescribing errors.

An initiative to ensure the safe use and storage of insulin for diabetic patients has been introduced within the unit and throughout other inpatient areas of the Southern Trust. Inspectors observed an insulin dashboard that displayed key advice for staff in the management of patients with diabetes including best practice in the administration and storage of insulin within the unit.

Staff recently commenced an improvement project aimed at improving patients' sleep experience when in the unit. Sleep deprivation is a major precipitating factor for the development of delirium amongst patients which can have a negative impact on a patient's recovery from ill health. Staff employed a number of strategies to promote sleep for patients whilst in the unit, including the development of a 'clustering of care' strategy and review of the time of night medication was administered. This reduced the frequency of potential interruptions to a patient's sleep experience.

The inspection team observed that staff within the Craigavon Area Hospital Critical Care Unit were engaged and committed to quality initiatives and collaborative working in order to drive forward improvement in the delivery of care.

4.0 Key Personnel and Information

Members of the RQIA Inspection Team

Mr T Hughes	Inspector, Healthcare Team
Mrs E Gilmour	Inspector, Healthcare Team
Ms J Stevenson	Observer, Critical Care IPC Nurse BHSCT

Trust Representative Attending local Feedback Session

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

Mr C Carroll	Assistant Director
Ms Emma-Jane Kearney	Lead Nurse, ATICS
Ms R McParland	ICU Sister
Mr C Clarke	Consultant Anaesthetics & Clinical Director Critical Care
Mr S McEntee	Band 6 ICU Nurse
Mr C Clarke	Lead Infection Prevention & Control Nurse
Ms A O'Hare	Infection Prevention & Control Nurse

5.0 Improvement Plan – Year 3 (2018/19)

This improvement plan should be completed detailing the actions planned and returned to RQIA's Healthcare Team via the web portal for assessment by the inspector. The responsible person should note that failure to comply with the findings of this inspection may lead to further action. The responsible person should ensure that all actions for improvement are progressed within the specified timescales.

Please do not identify staff by name on the improvement plan.

Improvement Plan – Year 3 (2018/19)				
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**
Regional Critical Care Infection Prevention and Control Audit Tool				
Additional Actions for Improvement				
1.	**Staff should ensure that medicines are stored safely to prevent unauthorised access and comply with all legislative requirements, professional standards and good practice.**	ICU Ward Sister	Locked drug cupboards start week commencing 3rd December 2018	Completed
2.	**The trust should ensure that maintenance to the security staff call system within the unit is carried out in a in a timely manner.**	ICU Ward Sister	This work is in progress and should be completed end of December 2018 **30.11.18 – Call system fully functional & commencing checking procedure from 03/12/18 – to be added to weekly checklist**	Completed

Regional Infection Prevention and Control Clinical Practices Audit Tool				
3.	**Unit staff should ensure that blood culture contamination rates are routinely discussed at multidisciplinary team meetings and actions clearly evidenced when levels are increased.**	ICU Ward Sister	Blood Contamination rates will now be a standing agenda item at the ICU Team Meetings **Daily Information Board updated. At morning handover – all infections are discussed with the Nursing staff at Handover. 4pm Microbiology ward round – MDT attendance.**	Completed

6.0 Improvement Plan – Year 1 (Updated by the Trust)

This improvement plan should be completed detailing the actions planned and returned to RQIA's Healthcare Team via the web portal for assessment by the inspector. The responsible person should note that failure to comply with the findings of this inspection may lead to further action. The responsible person should ensure that all actions for improvement are progressed within the specified timescales.

Year 1 (2014/15)

Regional Critical 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

Improvement Plan – Year 1 (2014/15)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
Regional Critical Care Infection Prevention and Control Audit Tool					
1.	It is recommended that infection prevention and control staffing levels are reviewed to facilitate daily visits to the unit.	Lead Nurse IPC	Consultant microbiologist present on daily ward rounds therefore opportunity exists for IPC issues to be discussed in a timely fashion. ICU staff can and do contact IPCN when required Mon-Fri 8.30-5pm. Also IPCN allocated regarding augmented care area for support/advice and guidance on a regular basis.	Completed	Complete
2.	It is recommended that the trust ensure IPC mandatory training is up to date.	Ward Sister, Lead Nurse, Head of Service and Assistant Director	Staff attendance at mandatory IPC sessions is monitored and monthly staff attendance levels are collated and sent to the Lead Nurse, Head of Service and Assistant Director. These records	Ongoing monitoring	Ongoing monitoring & Matrix updated live

Improvement Plan – Year 1 (2014/15)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
			indicate the overall percentage of staff who have attended from the unit.		
3.	It is recommended that visitors/ relatives are educated on the correct hand washing technique.	ICU Nursing Team	The ICU Relatives Book will be reviewed and updated to include information advising relatives on the correct technique Above each of the washing facilities and in the relatives' waiting room there is laminated pictorial information on the correct technique. Visitors' attention will be/are drawn to these. Where appropriate e.g. a patient is known to have an infection requiring isolation, the relatives of that patient will be shown/instructed in the correct hand washing technique.	March 2015	COMPLETED - Relatives are fully informed on admission of the handwashing procedure. Posters, leaflets & updates by staff remind relatives of the importance of handwashing technique.
4.	It is recommended that the trust reviews the storage of IV medication in CCU to ensure medication is held in line with medicines management guidance.	ICU Nursing Team	The Trust has completed a Risk Assessment to address this recommendation and will be compliant by March / April 2015.	March / April 2015.	Completed
5.	It is recommended that, there should be a review of the layout, design and storage areas of the	ICU Team, Lead Nurse, Estates Dept.,	The staff are working within an environment which is challenging however a review of existing	March 2015	ICU remains in the same environment

Improvement Plan – Year 1 (2014/15)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
	unit for maximum space utilisation. As part of any refurbishment/new build planning, core clinical space recommendations should be complied with.	IPC.	storage will be undertaken to maximise all available space. Moving forward The Trust has a strategic Development Plan for Craigavon Area Hospital, of which ICU is Phase One. –		however storage has been optimised as far as possible.
6.	It is recommended that an IPC nursing care plan is in place for patients with a known infection. Nursing care plans should be present, reviewed and reflected in the daily evaluation of care.	ICU Nursing Team	Within the Unit there is an existing care plans detailing the care of patients with MRSA, C DIFFICILE and ESBL. The nursing intervention includes compliance with all IPC recommendations for the above. This care plan will be updated to include specific Nursing Care/interventions required when dealing with new and emerging infections.	31st March 2015	Completed
Regional Infection Prevention and Control Clinical Practices Audit Tool					
7.	It is recommended that policies for invasive devices are developed that take into account the principles and protocols of the specific device.	ICU Team	The Trust will develop an overarching policy to cover all invasive devices to include such elements as ANTT, Training & Assessment, Roles & Responsibilities and revision dates.	End of March 2015.	ICU Have in association with CCaNNI guidelines for insertion and maintenance of central venous catheters. Available on the Intranet & all

Improvement Plan – Year 1 (2014/15)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
					staff must complete Elearning .IPC link nurses are a fundamental part within the core staffing.
8.	It is recommended that that all relevant information is recorded in relation to the insertion and ongoing management of invasive devices.	ICU Team	Moving forward it would be best practice to have the batch numbers for all invasive devices recorded. The recording of this number can be captured in the patient's Nursing / Medical / Care bundles for example through the use of a Traceability sheet. With specific reference to the recording of the Arterial Line insertion, this had been taken forward by one of the CCU Consultants in collaboration with the Nursing staff, however this requirement to have a recording tool for ongoing management has been taken forward by CCaNNI, Standards, Audit & Guidelines Group.	Estimated May 2015.	January 2019
9.	It is recommended that trust guidance on best practice on taking blood cultures be formalised into a policy that	IPC Team	This guidance is in Draft at present and out for consultation within the IPCT.	March 2015	On the Intranet in standards & guidelines -

Improvement Plan – Year 1 (2014/15)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
	takes into account the principles and protocols of the procedure.				SOPS
10.	It is recommended that following the collection of blood cultures all relevant information is recorded within the patient's records.	ICU Medical Team/IPC Team	This will be highlighted at the ICU Consultants meeting and all ICU Trainees will be reminded of the need to record this information in the patients' notes. This requirement will also be included in the induction for new ICU Trainees	March 2015	Completed
11.	It is recommended that a system is developed to allow the review of positive blood cultures between units and to capture the blood culture contamination rates of the unit. Unit staff should be routinely provided with this information.	IPC Team	This has been addressed and developed. Communication strategy being developed and blood culture contamination rates will be given from the microbiology laboratory to the ward sister and lead clinician of each augmented care area on a quarterly basis.	March 2015	Completed
12.	It is recommended that where audit scores identify poor practice further update competency based training is undertaken and compliance with best practice is independently verified.	ICU Medical Team/IPC Team	Further update competency based training provided by the IPC Team will be undertaken where audit scores identify poor practice. This will be independently verified.	Ongoing	Completed
13.	It is recommended that the trust review the provision of pharmacy cover to meet the	Director of Pharmacy	The staffing standard is 0.1wte pharmacist per ICU bed and currently CAH ICU has 0.3 wte	Resource dependant	March 2019

Improvement Plan – Year 1 (2014/15)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
	needs of the unit.		pharmacist input. Increasing this to the agreed level will require additional funding.		
14.	It is recommended that the trust further support antimicrobial prescribing with the assistance of contemporary computer aided prescribing tools.	ICU Consultant and Director of Pharmacy	The Trust will investigate the feasibility of introducing a computer aided prescribing tool and the availability of funding for same.	April 2015	Completed
15.	It is recommended that a care pathway is developed to guide staff in the anticipated care for a patient that develops a CDI.	IPC Team	A multidisciplinary Care Pathway will be developed by IPCT.	September 2015	Completed
16.	It is recommended that staff record all relevant information in relation to the insertion and management of enteral feeding systems.	ICU Nursing Team	This recommendation has already been addressed by Sisters in the Department through compliance with the NMC Standards for Record keeping and audited through the use of Nursing Quality Indicators.	Complete Ongoing Monitoring	Completed
17.	It is recommended that staff adherence to the trust MRSA guidelines are audited; inclusive of achievement of isolation. Unit staff should be routinely provided with audit results.	ICU Team IPC Team	An audit process/mechanism to this regard to be agreed between IPCT & ICU.	March 2015	Completed

Improvement Plan – Year 1 (2014/15)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
18.	It is recommended that a care pathway is developed to guide staff in the anticipated care for a patient colonised or infected with MRSA; completion of this documentation should be monitored. Unit staff should be routinely provided with audit results.	IPC Team	A multidisciplinary Care Pathway will be developed by IPCT	September 2015	Completed
19.	It is recommended that suppression therapy should be commenced on admission of patients to the unit and discontinued on receipt of the screening results.		This is not supported by Consultant Microbiologists in Southern Trust. Therefore this recommendation at present will not be implemented. Outcomes from Regional MRSA Short Study may change opinion on this and we await the Final report with its recommendations.	Continue to keep under review.	Continue to keep under review
The Regional Healthcare Hygiene Cleanliness Standards and Audit Tool Standard 2: Environment					
20.	It is recommended that staff ensure all surfaces including furniture, fixtures and fittings are clean and in a good state of repair. A maintenance programme should be in place to ensure all building repairs are carried out.	ICU Nursing Team, Hotel Services and Estates Dept	Within ICU there is currently a cleaning programme for Hotel Services staff and a daily work surface cleaning SOP for the Nursing staff. A bi-weekly environmental audit is carried out which examines Nursing, Estates and Hotel Services aspects of the environment. The results of these	Ongoing	All processes ongoing & embedded.

Improvement Plan – Year 1 (2014/15)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
			are shared with all relevant Managers,		
21.	It is recommended that the drugs fridges are locked in line with medicine management guidance.	ICU Nursing Team	This recommendation has been actioned and completed.	Complete	Complete
Standard 3: Patient Linen					
22.	Refer to Recommendation 20		As per Recommendation 20		COMPLETE
Standard 4: Waste and Sharps					
23.	It is recommended that all staff ensure the correct segregation of waste and that waste receptacles are not overfilled.	ICU Team	Staff have been reminded of the importance of adhering to the correct segregation of all waste. This is noted in the communication book for staff's immediate attention and action This is a standing item on the Agenda of the Sisters ICU/Consultants and all, Staff meetings Inspections and observations of practice both formal and informal are undertaken and if required action will be taken at the time.-	Ongoing Monitoring	Ongoing Monitoring
Standard 5: Patient Equipment					

Reference number	Actions for Improvement	Responsible Person	Action/ Required	Date for completion/ timescale	Updated by Trust 2018
	Improvement Plan – Year 1 (2014/15)				
24.	It is recommended that general patient equipment must be clean, in a good state of repair, used and stored correctly. Stored patient equipment should have trigger tape insitu to identify that it has been cleaned.	ICU Team	This recommendation will be taken forward through the following avenues. Staff being reminded of the need to comply with the policy. Standing item on all CCU meetings and where appropriate the purchase of new equipment. With specific regard to the use to trigger tape this is accepted and will be progressed internally.	March 2015	Ongoing Monitoring
Standard 6: Hygiene Factors					
25.	It is recommended that the number of clinical hand wash sinks within the unit is reviewed to meet national guidance.	IPC and Estates	With regard to this recommendation the Trust will work with Estates and Infection Control Team to progress.	March 2015	Complete
26.	It is recommended that all chemicals are stored in a locked, inaccessible area in accordance with COSHH regulations.	ICU Nursing team and Hotel Services Staff	This action is now complete.	Complete	COMPLETE
Standard 7: Hygiene Practices					
27.	It is recommended that all staff comply with the WHO five moments for hand hygiene and trust guidance on the use of	ICU team	This recommendation will be taken forward by several means and will be placed on the Sisters ICU Agenda with Consultants,	Ongoing Monitoring	Complete

Improvement Plan – Year 1 (2014/15)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
	PPE.		Staff meetings, Inspections both formal and informal.		
28.	It is recommended that COSHH data sheets are available for nursing staff.	ICU Nursing team	With regard to this recommendation there is a CCU COSHH folder which will be updated contemporaneously as new updates become available and for all new products.	March 2015 with Ongoing updating	Complete

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