The Regulation and Quality Improvement Authority

Unannounced Critical Care Inspection

Altnagelvin Area Hospital
Critical Care Unit Inspection
Year 3
27 September 2018

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

Contents

1.0 Profile of Service

The RQIA three year improvement programme of unannounced inspections to critical care areas commenced in the Altnagelvin Hospital Critical Care Unit (CCU), Western Health and Social Care Trust (WHSCT) on 4 September 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: Dr Anne Kilgallen	**Position:** Chief Executive of the Western 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 third year inspection of a three year inspection cycle undertaken within critical care units. A Year 2 inspection was not required as the Critical Care Unit (CCU) achieved Year 2 compliance in Year 1.

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

In Altnagelvin Hospital CCU, the overall year three compliance target of 95 per cent had already been achieved in relation to one of the audit tools (the regional healthcare hygiene and cleanliness audit tool) during the unit's unannounced inspection in 2013/14 (year one of the inspection cycle). Therefore, the standards and areas assessed by this tool were not included in the unit's year three inspection.

The focus of this year three 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 inspection report which is available at www.rqia.org.uk.

This inspection team found evidence that the Altnagelvin Hospital CCU has continued to improve and implement regionally agreed standards.

Inspection Summary

The 10 bed CCU consists of an Intensive Care Unit (ICU) and a high dependency unit (HDU); environmental cleanliness was of a high standard and the unit was undergoing a repaint. New furniture and art work has been purchased for the relatives' area and corridor leading to the unit.
Inspectors noted that the core clinical space of the unit did not meet current recommended requirements. We however observed staff that were endeavoring to deliver safe and effective care, in spite of clearly evident space constraints. We found ongoing improvement to staff information, communications and training in relation to clinical and infection prevention and control (IPC) practice. . "A Study week which included infection prevention sessions for all staff had been held earlier in the year" - this should be changed to "A Rolling Education Programme which included infection prevention sessions for all staff had been held earlier in the year". Action plans were in place following increased incidences of infections.

Overall there has been improvement in clinical practices; the section on Aseptic Non Touch Technique (ANTT) achieved 100 per cent. However, issues identified during the 2014 inspection in relation to the taking of blood cultures and the auditing of antimicrobial prescribing have not progressed and were still under discussion at critical care team meetings.

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 Western Health and Social Care Trust and in particular all staff at Altnagelvin 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

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	98
General environment – layout and design	76	76
Clinical and Care Practice	91	100

Unit managers were visible, showed good leadership and had excellent knowledge in relation to infection prevention and control (IPC). Staff maintained

a folder of actions identified for improvement during year one inspection in relation to local governance systems and processes which continue to be reviewed.

We were told that there had been issues with staffing turnover due to staff leaving and maternity leave. New staff have been recruited but we were told of the challenges in relation to ensuring the correct staff skill mix per shift. The practice educator has been proactive and has a rolling programme to ensure all staff have their training needs identified and met. An IPC Study week was held earlier in the year" – this should be changed to "This included an excellent IP&C workshop which focused on patient placement in the unit".

Staff communication has been improved, through email, staff meetings, safety briefing and a monthly alerts and information sheets. A relative information booklet is now available; information is also displayed on a monitor in both waiting areas.

We reviewed action plans that were implemented following an increased incidence of Glycopeptide Resistant *Enterococci* (GRE**)** and Vancomycin Resistant *Enterococci* (VRE) to ensure IPC measures were adhered to by all staff. Patient histories along with bed placements and locations of bedside work stations were reviewed to determine any contributing factors. Enhanced hand hygiene, environment, and patient equipment cleaning audits have been carried out to provide assurance.

There has been no change in relation to the layout and design of the unit. The core clinical space and linear distance at the patient bed area, for the delivery of care, was not within 80 per cent of the minimum dimensions recommended by the Department of Health (DoH) and outlined in the audit tool.

We were pleased to hear plans are in place for a new purpose built unit and due for completion in five years. The new unit will be double the existing space and will be in line with departmental guidance.

A retrospective patient placement tracking system to identify which bed space the patient was in during their stay was available. Local screening policies/procedures are in place and known to staff which inform clinical and IPC practice.

Inspectors observed evidence that if a patient's critical care admission screens or if their results following discharge or transfer to another ward were positive, the receiving or transferring wards were routinely informed. Inspectors however note that there was no clear protocol to guide staff, which outlines nominated staff responsibilities and set timeframes for completion.

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.

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
Aseptic Non Touch Technique (ANTT)	83	100
Invasive Devices	86	94
Taking Blood Cultures	*71	*72
Antimicrobial Prescribing	88	94
*Clostridium *difficile* infection (CDI)	94	97
Enteral Feeding or tube feeding	94	97

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

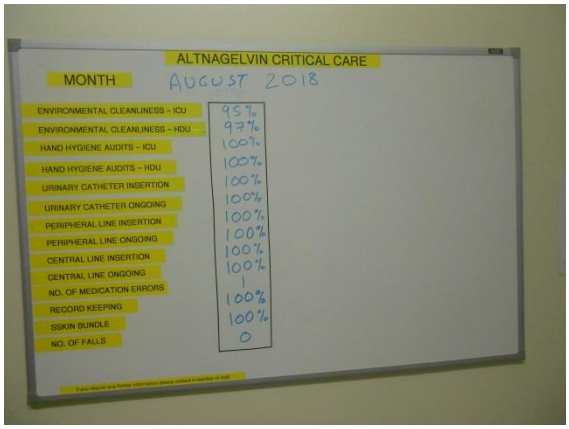
An ANTT policy and guidance was in place and accessible for all staff. ANTT pictorial guidelines were displayed throughout the unit. Staff displayed good knowledge on the principles of ANTT and were able to demonstrate when ANTT procedures should be applied.

We observed evidence of ANTT competency assessment and audits of staff practice. Staff ANTT competency and practice is assessed on a range of interventions including administration of intravenous antibiotics, enteral feeding, peripheral venous cannulation and the obtaining of blood cultures.

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. Quality improvement tools were in place to monitor compliance with invasive devices. We observed a programme of update/refresher training with the management of arterial lines and central venous lines for all nursing staff.

Staff generally displayed good practices in the management of invasive devices. Invasive devices were observed labelled to prevent wrong route administration, in line with the regional line labelling policy. Audit results displayed for August 2018 evidenced 100 percent compliance with peripheral

line, central line and urinary catheter care bundles (Picture 1) Validation audits of staff practice are carried out by the IPC team.



Picture 1: Altnagelvin Critical Care Performance Indicators

Policies/procedures for the insertion and on-going management of invasive devices were in place however a number had passed their revision date without being reviewed. Policies for review included, urinary catheter care and enteral feeding.

Invasive device documentation was generally well completed on the IntelliVue Clinical Information Portfolio (ICIP) computer software system. Staff should however ensure that the section to record the device batch number is completed to enable effective traceability.

Improvement is required in the management of blood cultures. Medical staff are responsible for obtaining blood cultures within the unit. Throughout 2017/18 the blood culture contamination rate has been regularly above three per cent. Contamination of blood culture specimens or poor aseptic technique may lead to delay in optimum clinical decisions.

During the initial inspection of the unit in 2014, inspectors recommended a number of actions to improve the overall management of blood cultures. These actions included, update training for all relevant staff involved in the collection of blood cultures and routine monitoring of staff compliance when obtaining blood cultures. It is disappointing that inspectors found little progress in implementing these recommended improvements. Refer to the previous action plan on for 2014 inspection.

We were informed that the trust Microbiology Team continue to provide good support in relation to antimicrobial prescribing, with daily visits to the unit. In patient records we observed evidence of relevant prescribed antimicrobial information. We were told that the implementation of a critical care based pharmacist has been a great addition to the unit. During the year 1 inspection of the unit, we identified that antimicrobial usage should be audited in line with current prescribing guidance. On this inspection we were provided with

evidence of a number of antimicrobial audits being carried out in CCU; however, we did not see evidence of action plans being implemented where learning or improvement to practice was required.

This is an area of improvement that still needs to be progressed.

In 2017, the critical care unit participated within the Regional Point Prevalence Survey (PPS) 2017. Results of the survey have been disseminated by the Public Health Agency (PHA). This survey provides important information for unit staff on antimicrobial usage and stewardship.

When questioned, staff displayed good knowledge on the ongoing care and management of patients with Clostridium *difficile* infection. A retrospective search of completed documentation on the management of such incidences provided inspectors with assurance that patients with an infection risk were managed appropriately and routinely reviewed to promote recovery and reduce the risk of transmission of infection to other patients.

Compliance with enteral feeding guidance/protocol continues to be audited to ensure a consistent and standardised approach to this procedure. We observed that oral feeding tubes were labelled and the majority of nursing care records clearly detailed relevant information. When we questioned staff, they demonstrated a good knowledge of the procedure and in line with the policy.

Quality Improvement Initiatives

- Cleaning practices have been enhanced; nursing staff carry out a six hourly bedside clean and support services staff carry out a four hourly frequently touched cleans. Cleaning schedules had been reviewed and updated.
- A section on zero tolerance to health care associated infections and infection prevention and control had been added to the staff appraisal process.
- The lead person for the technologist support has introduced a mattress cleaning service. Mattresses are dismantled and go through a laundry process. Each new patient's bed has a freshly laundered mattress on admission.
- Mental health first aid awareness training has been provided for staff.
- Staff have introduced a memory box for bereaved families.

Additional Issue

Staff told us of concerns regarding the lack of middle grade medical staff dedicated to ICU and HDU during the evening and night. They told us that in addition to covering core areas of Theatres, Critical Care and Labour Ward; the service is required to provide cover to multiple other areas. Staff feel with current gaps in ICU resident tier cover, the unit does not meet National Standards for Intensive care units or for Obstetric Anaesthetic Services. This risk has now been added the trust's risk register.

4.0 Key Personnel and Information

Members of the RQIA Inspection Team

Mrs M Keating	Inspector, Healthcare Team
Mr T Hughes	Inspector, Healthcare Team
Mrs E Gilmour	Inspector, Healthcare Team
Mrs L O'Donnell	Inspector, Healthcare Team

Trust Representative Attending local Feedback Session

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

B McFetridge	Assistant Director, Nursing (Altnagelvin)
H McDonald	Lead Nurse, Critical Care
R Reid	ICU/HDU Sister
G Quigley	Practice Educator, Critical Care
R Varghese	Nurse, Critical Care
N McAlister	Principle Critical Care Technologist
B Fleming	Team Lead, SSA
M McGinley	Critical Care Audit Officer
N McKenny	Infection Prevention and Control Nurse
C Gormley	Lead Antimicrobial Pharmacist

5.0 Improvement Plan – Year 3 (2018/19)

These improvement plans should be completed detailing the actions planned/progressed 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				
1	**It is recommended that the Trust put measures in place to mitigate against any risk identified related to the lack of middle grade medical staff dedicated to ICU and HDU during the evening and at night.**	**Clinical Lead & Lead Nurse for Critical Care**	Clinical Lead and Lead Nurse to meet with Business Services Manager for Acute early January 2019 to address the gap in the dedicated middle anaesthetic tier for Critical Care. Date to be arranged when all back from leave.	**30th June 2019**
Regional Infection Prevention and Control Clinical Practices Audit Tool				
1	**It is recommended that update training should be provided for all relevant staff involved in the collection blood cultures.**	**Clinical Lead & Lead Nurse for Critical Care**	Senior IPC Nurse for Critical Care has agreed to provide updated training on collection of Blood Cultures. Consultant Anaesthetist responsible for Training has agreed to facilitate the training on one of the Audit days. Lead Nurse to liaise with both and agree a date.	**31st March 2019**

2	**It is recommended that a system should be initiated to routinely monitor compliance with best practice when collecting blood cultures.**	**Clinical Lead & Lead Nurse for Critical Care**	Blood Culture Audit Tool now on the Patient Clinical Information System. A Speciality Doctor has been identified to monitor compliance with best practice. The Lead Nurse, Practice Educator and Project Lead Nurse for ICIP will assist with same.	**31st March 2019**

6.0 Improvement Plan – year 2 and Year 1 (Updated by the Trust)

These improvement plans should be completed detailing the actions planned/progressed 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 further action. The responsible person should ensure that all actions for improvement are progressed within the specified timescales.

Year 1 (2014/15)

Regional Infection Prevention and Control Clinical Practices Audit Tool
Regional Critical Care Infection Prevention and Control 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 and a dedicated IPC nurse is nominated for the unit.	IP&C	In order to comply with this requirement further staffing is required. Initial requests for funding included sufficient staff to allow this to happen, the request was rejected by the commissioners. There is an IPCN already designated for acute	Unlikely to be achieved in the current financial climate.	Work is being undertaken in the further development of business cases which would also include support to

Improvement Plan – Year 1 (2014/15)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
			services, the current staff levels do not allow for a dedicated IPCN. The Trust will submit a new business case.		augmented care areas. Current Infection Prevention and Control Nursing support continues to be provided within existing work plans and resources. There is a named Senior IPCN for Critical Care and as such provides IPC ward based enhanced support to the clinical team. This is also supported by IPCN advice/support available on a daily basis when required.

Improvement Plan – Year 1 (2014/15)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
2.	It is recommended that visitors/ relatives are educated on the correct hand washing technique.	IP&C / Ward Manager	Advice on hand washing and the use of alcohol gel is included in the relatives information leaflet. Staff will reinforce to relatives when they visit. An information video display in the relatives room is commencing November 2014 Feedback from relatives in relation to hand hygiene is requested in the relatives' satisfaction survey.	Ongoing November 2014 Ongoing	Completed In addition, large red adhesive labels applied to both ICU & HDU doors. New large screen installed 2016 and smaller screen to small relatives room.
3.	It is recommended that, there should be a review of the layout, design and storage areas of the unit for maximum space utilisation. As part of any refurbishment/new build planning, core clinical space recommendations should be complied with.	Estates / Ward Manager	A Health and Safety risk assessment has been carried out. Lack of space and associated difficulties has been included in the Divisional risk register. The critical care management team are in discussions with estate department colleagues on any potential to refit the Unit.	Completed Ongoing	Refit cancelled. Business case 5.2 progressing with new build for critical care.

Improvement Plan – Year 1 (2014/15)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
					However, this may not be available for 5-7 years. Further discussions taking place regarding maintenance & updating of equipment & services .
4.	It is recommended that the trust water safety plan is reviewed and updated to include current best practice guidance in relation to flushing of infrequently used water taps in augmented care units. Staff should ensure that all flushing records are robustly completed.	IP&C / Estates / Ward Manager	Ward Manager will liaise with nursing auxiliary staff regarding the importance of accurate flushing records. Ward Manager will continue to monitor practice. The current water flushing schedule form will be amended to include reason for not flushing. Review Water Safety Plan	November 2014 March 2015	Completed. Compliance improved. Updated Water Safety Plan January 2017.

Improvement Plan – Year 1 (2014/15)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
5.	It is recommended that a protocol/ policy should be developed that identifies individual staff roles and responsibilities in relation to the reporting of laboratory results to receiving or transferring units. These discussions should be robustly recorded.	Corporate Nursing	This has been tabled at the Trust Nursing and Midwifery Governance Meeting in October 2014. A scoping exercise has been commenced following which a guidance document will be developed.	February 2015	Sisters in Critical Care currently follow up on all lab results to receiving or transferring units. These are robustly recorded. Yellow Ward IP&C folder updated to include patients to be transferred in from other hospitals. A protocol is to be developed by Lead Nurse that identifies individual staff roles and responsibilities in relation to the reporting of laboratory results to

Improvement Plan – Year 1 (2014/15)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
					receiving or transferring units. This will also include set timeframes for completion.

Regional Infection Prevention and Control Clinical Practices Audit Tool					
6.	It is recommended that the ANTT policy is circulated to all relevant staff when finalised.	IP&C	Awaiting approval by Chief Exec HCAI accountability forum.	February 2015	Completed
7.	It is recommended that all trust policies/ guidelines are reviewed and updated as required to ensure continued accuracy of guidance for staff.	Corporate	This will be raised at the Trust Quality and Safety Committee and a review of existing processes carried out with a recommendation / guidance for staff to follow.	March 2015	WHSCT Enteral Feeding Guidelines Jan 2018 now available. Guidelines for the Prevention and Control of Infection Related to Urinary Catheters May 2015 is available. This is currently being updated.
8.	It is recommended that longer term staff receive update training and ongoing competency assessment in the management of invasive devices.	Ward Manager	Update training continues through the rolling training programme. A process for peer review and assessment is being discussed.	March 2015	Completed peer review audit of ANTT practice. Annual Rolling Programme undertaken to update senior and also junior staff.

9.	It is recommended that all relevant information is recorded in relation to the insertion and ongoing management of invasive devices.	Ward Manager / Consultant / Nurse	This is being reinforced with staff following monthly audits and is highlighted at staff meetings.	Ongoing	All invasive devices must have device batch number recorded on ICIP. ICIP has been updated to facilitate same.
10.	It is recommended that update training should be provided for all relevant staff involved in the collection blood cultures.	IP&C / Clinical Lead Critical Care	Staffing challenges in IPC Team mean this cannot be actioned until the new year.	March 2015	Please see No. 1 of Year 3 Improvement Plan for 2018 – 2019 (Please see page 12).
11.	It is recommended that a system should be initiated to routinely monitor compliance with best practice when collecting blood cultures.	IP&C	The Trust currently has insufficient numbers of IPC staff to be able to routinely monitor blood culture compliance. The IPC team will agree a system of internal audit with clinical staff and will include blood culture monitoring in the suite of tools used when completing planned independent audits.	March 2015	Please see no. 2 Year 3 Improvement Plan 2018 – 2019 (page 13).
12.	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	Clinical Lead Critical Care	Blood culture results are currently fed back to the Lead Nurse and Anaesthetic staff. A more structured discussion is required when these results are available.	March 2015	Critical Care is provided with blood culture contamination rates every month. These were

	this information.				discussed at the MDT Critical Care Meeting on 18th December 2018. Lead Nurse to explore the possibility of reviewing positive blood cultures contaminants with other augmented care areas Leads. Lead Nurse to identify and follow up on any learning by 30th March 2019.
13.	It is recommended that antimicrobial usage should be routinely audited in line with current antimicrobial prescribing guidance.	Clinical Lead / Microbiology /Pharmacy	A rolling audit programme is in place to monitor antimicrobial prescribing.	On-going	Following audits, when learning or improvement to practice is required then an action plan will be developed and implemented.

					Compliance with same will also be monitored. Please note 'off guidance antimicrobial prescribing' is largely in line with Microbiology advice.
14.	It is recommended that the trust introduce computer aided prescribing tools where appropriate.	Pharmacy	The prescribing module of ICIP will be used to assist in the prescribing of antimicrobials following its introduction to the Unit.	December 2015	ICIP is updated when and as required. The plan is to benchmark against best practice in other critical care units and update ICIP accordingly.
15.	It is recommended that in the event of a CDI occurring within the unit, formal auditing of the completion of the CDI care pathway should be undertaken.	Ward Manager	CDI bundle audit form has been developed and is in practice.	Ongoing	A new C. Diff Audit Form has been devised by our IP&C Nurse and is on ICIP. IP&C undertake regular validation audits. Any

					issues are identified and acted upon.
16.	It is recommended that antibiotic prescribing is audited in line with CDI prescribing policy.	Pharmacy / Ward Manager	This recommendation has been incorporated in the CDI bundle audit form.	Commenced Ongoing	completed
17.	It is recommended that compliance with ventilated care protocol is independently verified if infection rates and audit scores identify poor practice and if self-scoring or validation scores are poor.	Ward Manager	The Critical Care management team will arrange for independent audit if infection rates and audit scores identify poor practice and if self-scoring or validation scores are poor .	Will occur if required	Will occur if required.
18.	It is recommended that staff record all relevant information in relation to the insertion and management of enteral feeding systems.	Ward Manager	The recording of all relevant information in relation to the insertion and management of enteral feeding systems on the enteral feeding adhesive label will be reinforced to staff. This practice will be monitored.	Ongoing	This information is now captured on the Clinical Information System. It is audited against the Enteral Feeding Bundle.
19.	It is recommended that compliance with enteral feeding protocol is independently verified if infection rates and audit scores identify poor practice and if self-scoring or validation scores are poor.	Lead Nurse	The Critical Care management team will arrange for independent audit of compliance with enteral feeding protocol if infection rates and audit scores identify poor practice and if self-scoring or validation scores are poor.	Will occur if required	This will occur if required.

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.	Ward Manager/ Estates	Environmental audits are ongoing and results monitored. Any actions are identified and resolutions planned/carried out.	Ongoing	Environmental Cleanliness Audits are undertaken twice per month in each unit. All failures are reported and addressed.
21.	It is recommended that nursing equipment cleaning schedules detail all available equipment.	Ward Manager	The bed space cleaning schedule will be amended to include itemised equipment. It is planned to incorporate this into ICIP	November 2014 December 2015	Equipment at the bed space is cleaned 12 hourly by Nursing Assistant. Each bed space is then recorded on a cleaning schedule. In addition the nurse undertakes 6 hourly clean of frequently touched areas. This is recorded on the ICIP system.

Standard 3: Patient Linen					
	No recommendations				
Standard 4: Waste and Sharps					
22.	It is recommended that waste is disposed of into the correct waste stream in accordance with trust policy. Sharps boxes should be cleaned and changed as per local policy.	Ward Manager	This will be discussed at staff meetings. Monthly Crash Trolley audits in place. Crash trolley checks carried out monthly or after use.	November 2014	Achieved.

Standard 5: Patient Equipment					
23.	It is recommended that general patient equipment must remain clean and all staff should be aware of the symbol designating equipment as single use.	Ward Manager	The blood glucose machine has been added to schedule for decontamination of equipment. The symbol designating equipment as single use will be highlighted to staff through staff meetings and information brochure.	November 2014	Achieved
Standard 6: Hygiene Factors					
24.	It is recommended that the number of clinical hand wash sinks within the unit is reviewed to meet national guidance.	IP&C / Estates	ICU complies with national guidance. HDU requires 1 additional sink to comply with national guidance; this will be addressed through any department refit.		This will be addressed in the New Build.
25.	It is recommended that all chemicals are stored in a locked, inaccessible area in accordance with COSHH regulations and PPE should be stored in an area away from a risk of contamination.	Ward Manager	All chemicals will be stored in locked cupboards in accordance with COSHH regulations. Apron holder will be relocated away from bedpan washer & sluice.	Immediate	Achieved.

Standard 7: Hygiene Practices					
26.	It is recommended that all staff adhere to the trust dress code policy.	General Manager	The dress code policy was highlighted to all staff immediately following the RQIA visit. Unit Sisters will monitor its implementation.	Ongoing	Achieved.

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