The Regulation and Quality Improvement Authority

Unannounced Augmented Care Inspection

Daisy Hill Hospital
Special Care Baby Unit
Year 3 Inspection

18 January 2018

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	10
5.0	Improvement Plan – Year 3	11
6.0	Improvement Plan – Year 2 and 1 Updated by Trust	12

1.0 Profile of Service

The three year improvement programme of unannounced inspections to augmented care areas commenced in Daisy Hill Hospital Special Care Baby Unit (SCBU) on 10 September 2013.

The unit cares for premature and sick babies, any baby requiring special care and those babies who may need special attention during the first days of life.

Service Details

Responsible Person: **Mr. Shane Devlin**	Position: **Chief Executive Officer**

What We Look for

Inspection Audit Tools

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

- Regional Neonatal 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 inspection of a three year inspection cycle undertaken within neonatal care units. Initially, in year one of this inspection cycle all neonatal units were assessed against all three audit tools: the regional neonatal 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 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 this special care baby unit (Daisy Hill Hospital), 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 was not in the unit's year three inspection.

The focus of this year three unannounced inspection was to assess practice only against standards contained within the regional infection prevention and control clinical practices audit tool and the regional neonatal infection prevention and control audit tool. 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 neonatal 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 www.rqia.org.uk.

https://www.rqia.org.uk/inspections/view-inspections-as/map/craigavon-area-hospital/

This inspection team found evidence that the special care bay unit in Daisy Hill Hospital has continued to improve and implement regionally agreed standards.

We found improvements in the clinical practices of the management of invasive devices, the taking of blood cultures and antimicrobial prescribing. With the Regional Neonatal Infection Prevention and Control Audit Tool, we found improvements in local governance systems and processes, and in the management of neonatal patient equipment. There have been some small improvements made to the unit physical environment since previous

inspections. However, to achieve compliance with the requirements outlined within the inspection tool, significant investment would be required to enhance the layout and design of the unit.

After reviewing improvement plans with the unit deputy 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 the Daisy Hill Hospital, 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 Infection Prevention and Control Clinical Practices Audit Tool

The regional infection prevention and control clinical practices audit tool and 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 tool covers 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

The overall year three compliance target of 95 per cent had already been achieved in relation to one of the three regional 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 assessed in the unit's year three inspection. 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 been achieved were assessed.

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 two (2015/16) and this year three (2017/18) inspection.

Table 1: Clinical Practices Compliance Level

Area inspected	Year 2	Year 3
Invasive Devices	93	96
Taking Blood Cultures	79	94
Antimicrobial Prescribing	88	94

Aseptic non touch technique (ANTT) within the unit continues to be integral in the safe management of invasive devices. Staff knowledge in the ongoing management of invasive devices was in line with trust guidelines. Invasive device documentation reviewed retrospectively was well completed. Staff reported that invasive devices are labelled to prevent wrong route administration, in line with the regional line labelling policy.

During this inspection we identified improvements in staff training, assessment and analysis of blood cultures. Whilst there was no opportunity to observe medical staff taking blood cultures, one doctor demonstrated a good level of knowledge on the ANTT technique used to obtain blood cultures and prevent contamination. It was reported that the trust blood culture guidelines are in the process of being reviewed. New blood culture recording labels have been introduced to ensure consistency of practice.

Up to date antimicrobial guidelines were in place. Medical and nursing staff questioned confirmed that they are aware of the guidelines and how to access them. We observed evidence that antimicrobial usage is audited in line with antimicrobial prescribing guidance. Staff reported that they had good access to trust pharmaceutical support when required.

The Regional Neonatal Infection Prevention and Control Audit Tool.

Table 2: Regional Neonatal Infection Prevention and Control Audit Tool Compliance Levels

Areas Inspected	Year 1	Year 3
Local governance systems and processes	92	95
General environment – layout and design	63	68
Neonatal patient equipment	91	100

During the inspection, the deputy sister displayed good clinical leadership and knowledge of infection prevention and control (IPC). We were informed that the IPC team continues to provide good support for unit staff. Since the initial inspection in 2013, an occupational health document that provides staff guidance on common infectious conditions has been introduced.

Staff reported that mandatory and non-mandatory surveillance programmes for the detection of healthcare associated infections continue to work effectively.

We were informed that local and regional audits are ongoing to improve IPC practices and environmental cleanliness. However, up to date performance scores were not displayed or evidenced within available records. The unit had been without a dedicated unit sister for a number of months. We were informed that the trust has been proactive in recruiting for this post

The unit was bright, tidy and in good decorative order. Environmental cleanliness was of a high standard. There has been little change in the layout and design of the unit since the initial inspection in 2013. Therefore, minimal

compliance continues to be achieved for this section. Cot/incubator space within the unit is not within 80 per cent of the minimum dimensions recommended by the Department of Health (DoH) and outlined within the inspection tools. Clinical support spaces such as a milk expression room and a near patient testing room were unavailable. To achieve compliance with the requirements outlined within the inspection tool, significant investment would be required.

Clinical hand wash sinks were clean, well maintained and located near to the point of care. Since the initial inspection a clinical hand wash sink has been removed from the main cot area to prevent the potential risk of splashing on incubators cots (Picture 1). We observed good hand hygiene practice and ongoing auditing to provide assurance of adherence to best practice.

Picture 1: Area of wall where the clinical hand wash sink was removed

Neonatal equipment inspected was clean and in a good state of repair. Staff displayed good knowledge of single use equipment. There was guidance and routine auditing of the cleaning, storage and replacement of specialised neonatal equipment e.g. incubators. Competency based training on decontamination of specialised neonatal equipment continues to be provided for designated staff.

Quality Improvement Initiatives

Since the previous inspection, the neonatal unit had focused on a number of quality improvement initiatives

In response to increased levels of blood culture contamination rates in 2016, actions for improvement were identified in staff training, practices and assessment. Improvement with these factors was critical in a reduction of blood culture contamination rates within the unit. The most recent figures highlight a zero per cent blood culture contamination rate within the unit from January to March 2017.

The reciprocal exchange of nursing staff between the SCBU at Daisy Hill Hospital and the neonatal unit at Craigavon Area Hospital is an ongoing improvement initiative. The aim of this initiative was to facilitate continuity and standardisation of practices and policies between both units. Staff reported that rotating between units has helped them improve their knowledge and skills, provided development opportunities and improved networking within the trust.

A number of healthcare support workers (HCSW) within the unit have gained enhanced skills in supporting new born babies through an accredited training course. Following competency assessment from trained practitioners, HCSWs can carry out specific care tasks such as tube feeding while allowing registered staff to focus on more complex cases.

Unit staff were engaged in initiatives to improve the percentage of mothers' breastfeeding. Neonatal staff spoke positively in relation to attending a recent breast feeding course facilitated by UNICEF UK. The course was designed to enhance staff members' knowledge of breastfeeding in order to empower mothers to breastfeed successfully. Staff were keen to implement new strategies highlighting the important role in how breastfeeding helps support and develop a baby's immune system to prevent infection.

Babies within the Craigavon Area Hospital neonatal unit have direct access to specialist neonatal physiotherapy, speech and language and occupational therapy. It is anticipated that this multidisciplinary developmental team will also input into the Daisy Hill SCBU.

The inspection team observed that staff within the SCBU 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

Trust Representative Attending local Feedback Session

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

Mrs T Elmore	Band 6 Sister SCBU

5.0 Improvement Plan – Year 3 (2017/18)

This improvement plan should be completed detailing the actions planned 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.

Improvement Plan – Year 3 (2017/18)				
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**
Regional Neonatal Infection Prevention and Control Audit Tool				
No additional recommendations required				
Regional Infection Prevention and Control Clinical Practices Audit Tool				
No additional recommendations required				
Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool				
No additional recommendations required				

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 2 (2015/16)
The Regional Clinical Practices Audit Tool

Improvement Plan – Year 2 (2015/16)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
1.	It is recommended that the trust provides relevant and appropriate refresher training for staff.	IPC and SCBU Ward staff	Assess staff refresher training needs at annual appraisal and implement action plan to achieve training needs. This will be based on the development of a NI regional career, education and competency framework document for nursing staff based on level of training required for the new registrant/novice, the competent neonatal nurse, the proficient neonatal nurse, and the expert neonatal nurse. This work has commenced regionally in May 2015. Staff will access any face to face	Ongoing as part of annual appraisal and KSF process.	Refresher training remains an ongoing process which is increased when new staff join the workforce.

Improvement Plan – Year 2 (2015/16)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
			at Clinical Education centre or e-learning training in house as required.		
2.	It is recommended that staff document all elements of the care bundle for the insertion of invasive devices.	SCBU Staff	Medical and nursing staff in SCBU to focus on completion of all care bundle documentation. At hand over nursing staff on a daily basis to check all care bundle information in relation to invasive device in use is in place and updated as required during the shift. Ward manager to raise awareness of this requirement in next "snap shot Data session" with MDT.	Ongoing on a daily basis.	Ongoing process with nominated Paediatrician who focuses on the medical staff for training and skills. This practice is audited bi-monthly. Competencies are audited as part of appraisal and KSF.
3.	The blood culture policy should be reviewed and amended to reflect neonatal care.	IPCT	Draft Blood culture policy for Adults with an appendix for neonates is currently going through approval process. It has been raised at SHSCT HCAI meeting, and will be presented at next strategic forum meeting in July before final approval and dissemination to clinical staff.	July 2015	Blood culture Guidelines issued in 2015 include relevant references to neonatal and augmented care areas.
4.	It is recommended that the trust reviews and provides training for nursing staff on blood cultures, which is relevant to	SCBU	There is an e-learning module for medical staff on the Trust homepage - Doctors in Training - on Best Practice in relation to	Nursing staff to complete Doctors in Training –	All Medical staff up to date with Training

Improvement Plan – Year 2 (2015/16)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
	neonates.		taking blood cultures. This module is adult based and the best practice principles will be used alongside the neonatal blood culture written guidance which is currently going through the approval process. All nursing staff in SCBU DHH will undertake this module re Key Principles and Best Practice. The clinical procedure of taking blood cultures in SCBU DHH is predominantly the role of medical staff, or nursing staff who have undertaken the Enhanced Practice course at QUB, and have an extended scope of practice and who may be involved in the clinical procedure of venepuncture/taking blood cultures. Consideration will be given to medical staff training these key nursing staff in SCBU.	e-learning module within one month. Practical training will roll out following approval of Neonatal Written Guidance on "Taking Blood Cultures" – anticipated approval early July 2015.	Nursing staff do not routinely take blood cultures within the unit. All current SCBU staff have their ANNT training which covers blood culture collection.
5.	It is recommended that the trust reviews and updates the antimicrobial prescribing and management guidelines, and ensures the timely forwarding of the rates of positive blood cultures and incidence of		The Neonatal Network group have produced EONS guidance (Early onset neonatal sepsis) which has been issued regionally and is being implemented across N Ireland.	Autumn 2015	Guidance on antimicrobial prescribing was released by the neonatal network in January 2017:

Improvement Plan – Year 2 (2015/16)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
	contaminated and false positives to the SCBU.		In addition the Regional Neonatal Network group have established a Task and Finish group to review antimicrobial use in neonates, and to produce guidelines to support consistency in care. The group was established January 2015 and anticipated completion date Autumn 2015. The generation of reports to identify contamination rates in blood culture samples is now an on-going action within the microbiology department. The reports will be shared with the Lead Clinician and the Unit Sister/Lead Nurse and actions developed as and when required.		Blood culture reports and antimicrobial prescribing are reviewed quarterly within the Trust.
6.	It is recommended that the trust reviews the availability of electronic/computer aided prescribing tools to assist with auditing current antimicrobial guidelines.	Trust Pharmacy IPCT and Antimicrobial Stewardship team	The regional 'Northern Ireland Electronic Prescribing and Administration Project' is working to implement total e-prescribing and administration recording across hospitals in NI. At the moment the planned implementation date is not until 2017 - this programme will be able to produce audit data.	2017	Regional work outstanding.

Year 1 (2013/14)
The Regional Neonatal Care Audit Tool
Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool

Improvement Plan – Year 1 (2013/14)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
Regional Neonatal Care Audit Tool					
7.	The Trust should work on the development of an occupational health/infection prevention and control policy.	IPCT OH	This is currently under review by the IPCT and Occupational Health teams.	Within 6 months	Achieved
8.	A surveillance data analysis system should be developed to assess results and identify trends in infection.	IPCT LABS	This is currently being explored by IPCT and laboratory teams.	Within 12 months	Achieved
9.	The layout and design of the unit should be reviewed for maximum space utilisation and a clean to dirty work flow. Adherence to core clinical space recommendations and an improvement in the facilities available within the unit should be reviewed as part of any refurbishment/new builds.	Estates IPCT	The SHSCT will actively address this issue as part of any refurbishment/new builds.	Ongoing	Ongoing
10.	The Trust should continue to implement the Trust water safety plan.	Estates IPCT	Implementation of Trust water safety plan is on going	Ongoing	Ongoing
11.	A review of the Regional Incubator Transfer form should be carried out to ensure all infection control information can	NI Neonatal Network Board and Task and finish group	The first meeting of the NI Neonatal Network took place in October 2013.	First meeting 4th December 2013—ongoing review.	Neonate notification of Alert Organism

Improvement Plan – Year 1 (2013/14)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
	be recorded.	members	The NINN Board has recommended the establishment of a task and finish group to develop and implement a communication protocol in relation to unit and network responsibility and action regarding Infection Control issues (e.g. moving of IC patients, potential and actual outbreaks). The SH&SCT lead Neonatal Nurse and IPC lead Nurse are members of this with the first meeting taking place December 2013. It is envisaged that a review of the Regional Incubator transfer form will be on this agenda.		Status transfer form "now operational from April 2013".
12.	The Trust should ensure guidance on staff roles and responsibilities is available for staff to follow when forwarding transfer results and admission screens to staff in the receiving or transferring units during out of hours.	NI Neonatal Network Board and Task and finish group members	As above	As above	In operation Flow chart for communication of positive isolates.
13.	Adherence to the specialist equipment cleaning policy should be routinely audited by senior nursing staff.	Neonatal / SCBU ward staff	A monthly audit of adherence to the specialist equipment cleaning policy for high risk equipment for example incubators, CPAP or	Ongoing	Ongoing

Improvement Plan – Year 1 (2013/14)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
			ventilators will be carried out by Senior nursing staff in the unit (Band 6 and above).		
14.	Mattress audits should be routinely carried out.	Neonatal / SCBU ward staff	A monthly audit of all mattresses will take place.	Ongoing	Ongoing
15.	A system should be in place to identify that donor expressed breast milk is expressed no longer than six months prior to use.	Milk Bank Neonatal staff	The Milk Bank has been contacted and have given an assurance that a hard copy label retained in the milk bank corresponding with the Donor EBM track back label at ward level has the date of expression recorded. The Milk Bank confirm they are currently reviewing the detail on the track back labels as a result of feedback received from all the Neonatal Units in the Province following recent RQIA inspections. Feedback from the Milk Bank is anticipated mid-November.	Preliminary advice due mid November 2013 from Milk Bank Enniskillen.	Ongoing

Improvement Plan – Year 1 (2013/14)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool					
Standard 2: Environment					
16.	Staff should ensure all surfaces are clean and free from dust and dirt.	Domestic services	All surfaces have been cleaned and are included in departmental audits	Complete	Cleaning and Audit schedules in place
17.	A maintenance programme should be in place to ensure minor repairs are carried out to walls and doors.	Estates Facilities ward staff	Weekly ward managerial environmental cleanliness audits will continue, and minor areas for repair will be reported and actioned.	Ongoing	Ongoing
18.	Nursing cleaning schedules should include all general patient equipment.	Ward staff	A modified version of the cleaning schedule has been implemented which details a complete cot-side clean on a daily basis. Records will be retained.	Ongoing on daily basis	Ongoing

Improvement Plan – Year 1 (2013/14)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
19.	NPSA colour coding guidelines should be displayed for nursing staff.	Facilities	Laminated poster of NPSA guidelines now available and on display.	Completed	Achieved
Standard 4: Waste and Sharps					
20.	All staff should ensure sharps boxes are labelled on assembly.	Ward Nursing staff	Re enforcement of Staff awareness on appropriate assembly, use and disposal of Sharps containers carried out.	Completed and re-enforced as required.	Achieved and reinforced as required
Standard 7: Hygiene Practice					
21.	The Trust should ensure that patient equipment is in a good state of repair, stored correctly when not in use, and a risk assessment/review carried out on the practice of attaching sterile equipment to specialist machinery when not in use.	Ward staff and Medical technical team	Draft risk assessment being progressed for consultation.	December 2013	Ongoing

The **Regulation** and
Quality Improvement
Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews