The Regulation and Quality Improvement Authority

Inspection Report

22 July 2021

SOUTHERN HEALTH AND SOCIAL CARE TRUST

Special Care Baby Unit
Daisy Hill Hospital
Hospital Road
Newry
BT35 8DR
Telephone number: 028 3083 5000

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Southern Health and Social Care Trust	**Responsible Individual:** Mr. Shane Devlin, Chief Executive Officer, Southern Health and Social Care Trust (SHSCT)
Person in charge at the time of inspection: Ms. Ann Brogan, Ward Manager	**Number of commissioned cots:** 6
Categories of care: Augmented care	**Number of cots accommodated in the** Special Care Baby Unit on the day of this inspection: 0
Brief description of the accommodation/how the service operates: The Special Care Baby unit (SCBU) at Daisy Hill Hospital is a six bedded level 3 facility. Those neonates requiring a higher level of care such as level 1, intensive care or level 2, high dependency, are normally stabilised and transferred to an appropriate neonatal intensive care facility.	

2.0 Inspection summary

The Chief Medical Officer endorsed the use of the Regional Infection Prevention and Control Audit Tools for Augmented Care Settings by all health and social care (HSC) Trusts in Northern Ireland in the relevant clinical areas in 2013. An improvement programme of unannounced inspections to augmented care areas commenced on 28 May 2013 and continued until 2018. Within the programme there was an expectation that compliance levels would improve year on year until all HSC Trust areas had achieved a compliance rate of 95%. A compliance level of 95% is now the expected standard.

Following on from this in 2018 the future approach to assurance of infection prevention and control practices within neonatal intensive care wards and special care baby units moved from compliance dominant to a collaboration-based model in assuring good practice.

This approach required HSC Trusts to undertake regular self-assessment of the care delivered in their augmented care settings with the agreed overall compliance target scores of 95%. The Neonatal Network Northern Ireland (NNNI) works with HSC Trusts to provide a platform for regional sharing of good practice and learning. RQIA have worked collaboratively with the NNNI and agreed the protocol for the return of twice yearly submission of HSC Trust self-assessments and updated action plans from the NNNI to RQIA.

Inspection visits to a selection of neonatal units are undertaken by RQIA to randomly sample aspects of the Regional Infection Prevention and Control Audit Tools for Augmented Care Settings to maintain a watching brief on systems and processes of care, while reserving the right to independently assess/inspect any neonatal unit at any stage should a particular circumstance require this.

An unannounced inspection of the SCBU at the Daisy Hill Hospital commenced on 22 July 2021, at 09.30 and concluded at 16:30 with feedback to the ward manager.

The inspection was carried out by two care inspectors from the Hospital Programme Team.

The purpose of this inspection was to validate the findings and actions taken by the SHSCT (the Trust) following their self-assessment with the three regionally agreed inspection tools for augmented care areas. (Regional Infection Prevention and Control Audit Tool for Augmented Care Settings in Northern Ireland, (HSS MD 5/2013), Regional Infection Prevention and Control Clinical Practices Audit Tool for Augmented Care Areas and the DHSSPS Regional Healthcare Hygiene and Cleanliness Audit Tool). Table 1 below sets out agreed regional compliance targets and table 2 sets out the Trust's self-assessment compliance levels.

Table 1: Regional Level of Compliance

Compliant	95% or above
Partial Compliance	86 to 94%
Minimal Compliance	85% or below

Table 2: Self-assessment of Level of Compliance July 2020

Inspection Tools	**Self-assessment**
Regional Augmented Care Infection Prevention and Control Audit Tool.	**97%**
Regional Infection Prevention and Control Clinical Practices Audit Tool.	**97%**
Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool.	**96%**

This inspection focused on four key themes: the unit's layout and design; environmental safety and Infection Prevention and Control (IPC) and; anti-microbial prescribing; and quality improvement initiatives.

The SCBU was in good decorative order creating a friendly and welcoming environment for patients, visitors and staff. Environmental cleanliness was of a high standard. There were no occupied cots at the time of the inspection.

Staff demonstrated good knowledge in the management of sharps and the disposal of waste. Patient equipment was clean and in a good state of repair. Overall, staff had good knowledge and awareness of how to manage infections.

Local IPC screening policies were in place and staff told us that patients can be isolated when appropriate to reduce the risk of the transmission of infection. The Trust IPC team were available to provide support and advice as required.

This inspection identified deficits in the completion of mattress audits, IPC training and ensuring a fire exit is free from obstructions. The ward manager ensured that the equipment in front of the fire exit door was removed immediately and confirmed they would contact the estates department to address another matter. Three areas for improvement were identified, one in relation to mandatory training, the second in relation to the completion of audits and the third in relation to ensuring fire exits are free from obstructions.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. To do this, we review the information we hold about the service, examine a variety of relevant records, speak with visitors, staff and management and observe staff practices throughout the inspection.

The information obtained is then considered before a determination is made on whether the service is operating in accordance with the relevant legislation and quality standards.

This report reflects how the service was performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the Trust to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

4.0 What people told us about the service

There were no patients in the unit; therefore we were unable to speak with parents at the time of the inspection.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

The last inspection to SCBU was undertaken on 18 January 2018 by care inspectors; no areas for improvement were identified. The overall year three compliance target of 95 % had been achieved.

5.2 Inspection findings

This inspection focused on four key themes. Each theme was assessed by inspectors to validate the findings and actions taken by the Trust following their self-assessment with the three regionally agreed inspection tools for augmented care areas.

- Layout and design;
- Anti-microbial prescribing;
- Environmental safety and Infection Prevention and Control (IPC); and
- Quality improvement initiatives.

5.2.1 Layout and Design

The available space and storage facility within the unit continues to be limited with little change in the layout and design of the unit noted since the initial inspection in 2013. Core clinical space around the incubator/cot area for the delivery of care, was not within 80 per cent of the minimum dimensions recommended by the Department of Health, therefore minimal compliance continued to be achieved in this section of the assessment tool.

Whilst it is acknowledged that significant investment and redevelopment would be required to achieve compliance in this area, staff told us they monitor and review the positioning of equipment to ensure the available space is used as effectively and safely as possible. Staff told us they are considering the purchase of new chairs for each cot space which will require less floor space and provide a higher standard of comfort for parents.

There were limited storage facilities in the unit and a number of rooms continue to have dual functions. A room was available which allows for the isolation of patients identified with an infection control risk, although, when not in use this room is used for storage of equipment. Staff told us they have reviewed and considered all options to maximise the use of all storage areas including implementing stock rotation of necessary equipment. It was observed new storage systems had been installed in the unit and staff reported this had assisted with improved access to equipment and other resources and facilitated effective cleaning of these areas.

There continues to be no dedicated room available for breast milk expression. The ward manager outlined the use and purpose of all rooms within the unit and explained that all options had been explored to maximise the use of storage space and specifically to review the potential to facilitate a dedicated breast milk expression room. The ward manager told us attempts to source a suitable additional storage area within the Daisy Hill Hospital site had been unsuccessful, although, this would be re-escalated to the senior management team following the inspection.

5.2.2 Antimicrobial Prescribing

Antibiotic prescribing should be carried out in line with evidence-based antimicrobial guidelines. This should improve and reduce the progression of antibiotic resistance and optimise patient outcomes.

For organisations to comply with this section they must ensure that there are systems and process in place to ensure a standardised and consistent approach by staff to prescribing. Prescribing should be monitored and reviewed.

The ward manager told us that antimicrobial usage within the unit is minimal and there is not the same requirement as in a neonatal intensive care for routine anti-microbial ward rounds. It was established that there is no ward based pharmacist currently in place within the unit but pharmacy and microbiology support was available and easily accessible when required. There are monthly Clinical Forum meetings attended by unit staff, pharmacists and IPC staff during which antibiotic usage is discussed and learning is shared.

An antimicrobial stewardship audit is carried out once per month by a designated pharmacist. Any patients who are currently on antibiotics or have completed a recent course are included in the audit. There was evidence that antimicrobial prevalence audit results were shared with staff. There is a Trust wide multidisciplinary antimicrobial stewardship team who review audits and analyse data to identify risk factors in prescribing and antimicrobial resistance.

Antimicrobial usage was monitored at the unit, however, electronic, computer aided prescribing tools were not available to assist with this. The Trust requires the completion of regional work in order to facilitate an electronic system to monitor antimicrobial usage. Regional work is currently in progress to develop an electronic prescribing and administration record system as part of the Encompass project.

Regional neonatal prescribing guidance was available for staff to access on the Trust intranet and digital applications which staff can access on their mobile phones. This guidance is reviewed by the NNNI. The pharmacist stated they provide information to medical staff during their induction advising them on the location of and how to access relevant antibiotic prescribing policies.

5.2.3 Environmental Safety and Infection Prevention and Control

The unit was in good decorative order. Hand decontamination stations and a good supply of personal protective equipment (PPE) were available for staff and visitors throughout the unit. Clinical hand wash sinks were clean and located near the point of care.

There was a dedicated IPC nurse available to advise staff on the management of infection control issues and complete IPC validation audits. Staff confirmed there was good communication between the unit and the IPC team. A range of IPC audit scores were displayed for staff and visitors to provide assurance of good cleaning and IPC practices.

Environmental cleanliness was of a high standard and there was a regular programme of environmental auditing and equipment cleaning schedules were in place. Neonatal equipment inspected, including mattresses were clean and in a good state of repair. Monthly mattress audits were not available. An area for improvement has been made in relation to the completion of mattress audits

Staff were observed to be compliant with the Trust's dress code policy and they were knowledgeable about IPC practices. Good compliance with IPC practices was observed in relation to hand hygiene, equipment cleaning, and use of personal protective equipment. The management of waste and sharps was in line with Trust policy.

IPC training was not up to date for all staff. We were informed by the ward manager the availability of this training had been impacted on by restrictions placed on face to face training due to Covid-19. The IPC nurse confirmed a suite of videos to deliver the required training were awaiting approval for use. An area for improvement has been made in relation to the completion of IPC mandatory training.

Whilst it was noted that some improvements had been made since the last inspection, we found a storage area tightly packed with equipment and items blocking one of the unit's fire exits. This was addressed during the inspection. It was also noted there were blinds covering this door and therefore may impact on the ability to freely access this exit. The ward manager agreed to contact the estates department and have these removed promptly. An area for improvement has been made in relation to ensuring clear unobstructed access to fire exits.

5.2.4 Quality Improvement Initiatives

Since our previous inspection the neonatal unit had focused on a number of quality improvement (QI) initiatives.

Following the review of staff debriefs from emergency situations a bleep system is now in place within the unit to alert a member of staff to attend emergency situations in delivery suite, theatres, or the post-natal ward. The ward manager told us this has enhanced continuity of care, enhanced communication, provided a valuable learning environment for the SCBU nursing staff and provided reassurance to the multidisciplinary team when managing emergency situations.

The development of the, 'emergency equipment bag', has been implemented following the review of incident reporting where insufficient storage of equipment to manage emergency situations outside the SCBU had been identified. The initiative has been a success and ensured the correct equipment is available for staff while responding to and assisting with emergency situations.

6.0 Conclusion

We found the self-assessments were generally well completed and in the main action plans had been developed to address any issues identified by the Trust. Some minor discrepancies were identified and these were discussed with staff. The ward manager commented that completion of the self-assessment tools was time consuming for them as they acted as the coordinator arranging for other teams such as estates to participate in the completion of the tools.

We identified three areas for improvement that will further support the Trust to deliver improved outcomes for patients and staff.

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

	Standards
Total number of Areas for Improvement	3

Areas for improvement and details of the Quality Improvement Plan were discussed with the ward manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

Area for improvement 1 **Ref:** Standard 5.1 Criteria: 5.3.1 **Stated:** First time **To be completed by:** 22 August 2021	The Trust should ensure that mattress audits are routinely completed and action plans are developed to address issues identified as part of the audit process. Ref: 5.2.3
	Response by registered person detailing the actions taken: The Trust can confirm that the SCBU are now compliant with this area of quality improvement. SCBU have created a monthly mattress audit in keeping with the quality impovement plan as per RQIA recommendations. This is in tandem with SCBU's normal practice of mattress maintenance audit.
Area for improvement 2 **Ref:** Standard 5.1 Criteria 5.3.1 **Stated:** First time **To be completed by:** 22 September 2021	The Trust should ensure all SCBU staff complete mandatory IPC training in line with Trust policy. Ref: 5.2.3
	Response by registered person detailing the actions taken: All SCBU staff have completed the Trust mandatory e-learning IPC training and this can be evidenced through staff training matrix. In place of face to face IPC training being available to SCBU staff due to covid 19 restrictions, SCBU staff have completed the 2 online training vidoes, Red and Amber PPE, and ANTT. SCBU staff are in the process of revewing these on-line videos again to evidence compliance. In addition IPC have meetings which all augmented care areas attend.

Area for improvement 3 **Ref:** Standard 5.1 Criteria 5.3.1 **Stated:** First time **To be completed by:** Immediate from the date of inspection.	The Trust must ensure the fire exit in the storage area is kept free from obstructions at all times. Ref: 5.2.3
	Response by registered person detailing the actions taken: The Trust can confirm that SCBU are now compliant with this area of quality improvement. All escape routes/fire exits are free from obstruction and this is monitored twice daily with a formal check during nursing handover, completed by the Nurse in Charge and filed accordingly.

Please ensure this document is completed in full and returned via the Web Portal

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