Unannounced Critical Care Inspection

Mater Hospital Critical Care Unit
Year 3 Inspection

9 and 10 May 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 Mater Hospital Critical Care Unit, Belfast Health and Social Care Trust (Belfast Trust) on 29 April 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. Martin Dillon**	Position: **Chief Executive of the Belfast 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 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 year three unannounced inspection was to assess practice against standards contained within the three 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 in the Mater Hospital has continued to improve and implement regionally agreed standards.

The unit was bright, tidy and in excellent decorative order. Additional facilities had been added to the unit, for example a patient toilet, a utility area for cleaning patient equipment, a visitor waiting room and a relative's overnight room. Cleaning by patient client support services and nursing staff, was of a very high standard.

We found improvements in local governance systems and processes. Inspectors noted that although the core clinical space does not meet current recommended requirements; staff are working within these limitations to deliver safe and effective care. Planning meetings have taken place to identify a suitable location within the unit for the creation of an additional patient side room.

We found improvements in clinical practice standards, particularly in the management of invasive devices and enteral feeding.

Further improvement however is required in antimicrobial prescribing and more specifically in the management of blood cultures.

After reviewing improvement plans with the unit coordinator, 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 Belfast Health and Social Care Trust and in particular all staff at the Mater 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 two (2015/16) and this year three (2018/19) inspection.

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

Areas Inspected	Year 2	Year 3
Local governance systems and processes	89	100
General environment – layout and design	76	79
Clinical and Care Practice	91	95

The unit sister displayed good clinical leadership and knowledge of infection prevention and control (IPC). Staff reported that that the IPC team continues to provide good advice and support by telephone and with regular visits to the unit.

We observed a variety of mechanisms in place to assure the dissemination of information to staff throughout the critical care service. Policies to guide staff specifically related to critical care were located within the document management system 'SharePoint' for ease of access.

Staff reported that mandatory and non-mandatory surveillance programmes for the detection of healthcare associated infections continue to work effectively. We were informed that audits in relation to hand hygiene and environmental cleanliness are ongoing to improve IPC practices and environmental cleanliness. Hand hygiene audits were independently validated by the trust IPC team.

We observed that incidents relating to IPC were appropriately reported and acted on. Staff use the mechanism of root cause analysis to investigate incidences of Meticillin-resistant *Staphylococcus aureus* (MRSA) blood stream infections and Clostridium *difficile* infections (CDI). It was reported that it has been over two years since an incidence of either had occurred.

A 'live' and retrospective patient placement tracking system to identify which bed space the patient was in during their stay was available on the 'ward watcher' computer system. Staff should also ensure that the bed ID number is recorded within each patient's notes.

Local screening policies/procedures are in place and known to staff which inform clinical and IPC practice. Screening records were reflective of the local policy. All patients were routinely screened on admission for MRSA and thereafter weekly for Carbapenemase producing Organisms (CPO).

A new IPC booklet has been developed for visitors which provides clear guidance in relation to IPC practices.

The unit was bright, tidy and in excellent decorative order. Environmental cleanliness was of a 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 one side room for the isolation of patients which is not in line with numbers recommended by the DoH and outlined in the audit tool. The single room is not fit for purpose; staff advised that due to space restrictions it was not always possible to isolate a patient who requires a number of large pieces of equipment in this room. We were informed that planning meetings have taken place to identify a suitable location within the unit for the creation of an additional patient side room.

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 two (2015/16) and this year three (2018/19) inspection.

Table 2: Clinical Practices Compliance Level

Area inspected	Year 2	Year 3
Aseptic Non Touch Technique (ANTT)	94	94
Invasive Devices	91	93
Taking Blood Cultures	67*	76*
Antimicrobial Prescribing	88	88
Enteral Feeding or tube feeding	93	100

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

An Aseptic Non Touch Technique (ANTT) policy was in place and up to date. The policy identifies competency training and assessment as key principles in ensuring adherence to best practice.

All nursing staff receive mandatory training by means of on line presentation or face to face training sessions. Assessment of staff ANTT practices is carried out annually. Staff displayed good knowledge and practical skills on the principles of ANTT. Personal protective equipment (PPE) including disposable gloves and aprons were worn appropriately. All medical staff have been trained and competency assessed on ANTT by the unit medical assessor.

Blood culture packs are in use in the critical care unit; the use of these packs enables the standardisation of clinical practice. Staff demonstrated good knowledge in the collection of blood for blood culture processing. The use of the blood culture label in the medical notes to record when and who takes a blood culture is considered good practice; this could be further adapted to record the time and also the site from which the blood culture was taken.

Despite these quality improvements, the incidence of blood culture contaminants had risen above 3 per cent, which suggests that blood cultures were not always being collected with proper attention to aseptic technique. We observed evidence that the rate of positive blood cultures and incidence of contamination and false positives is discussed at multidisciplinary meetings. We were informed that retrospective blood culture data is being analysed and systems established to address the increased incidence. An audit tool to monitor clinical procedures for collecting blood for culture has been developed, however is not yet in use.

We observed improvement in the completion of invasive device documentation in relation to the management of peripheral venous cannula, central venous catheters, blood cultures and enteral feeding. It is essential that accurate records for the insertion of invasive devices are maintained. We observed that invasive lines were appropriately labelled to prevent wrong route administration, in line with the regional line labelling policy. A number of policies for the insertion and management commonly used invasive devices are in the process of being reviewed and updated.

Antimicrobial/microbiology rounds occur every Tuesday and Thursday. A ward based pharmacist is not in place. Medical staff reported that a dedicated critical care pharmacist would improve efficiency and patient safety. 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. The regional Point Prevalence Survey (PPS) 2017 was recently completed, the results of which will be available from the Public Health Agency (PHA) in due course.

Whilst electronic/computer aided prescribing tools are not currently available, plans are in place to configure an electronic prescribing module as part of the new IntelliVue Clinical Information Portfolio (ICIP) computer software system. This is scheduled to be introduced within the unit on 18 June 2018. The system contains applications that combine patient clinical information from a number of sources to support care management.

Staff receive a yearly competency based assessment associated with the management of enteral nutrition. Compliance with enteral feeding guidance/protocol is audited to ensure a consistent and standardised approach to this procedure. We observed that oral feeding tubes were labelled and nursing care records clearly detailed information on: who inserted tube, route of administration, PH and amount of aspirate, time and volume of feed, type of feed.

The Regional Healthcare Hygiene and Cleanliness 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. This audit tool was not assessed as part of year two inspection as year two compliance was achieved in year one.

Table 3: Hygiene and Cleanliness Standards Compliance Level

Areas inspected	Year 1	Year 3
General environment	93	99
Waste	94	97
Sharps	90	93
Equipment	87	95
Hygiene practices	94	100
Average Score	**92**	**97**

The fabric of the unit was well maintained. We found a programme for continuous improvement in relation to the environment. Additional facilities had been added to the unit, for example a patient toilet, a utility area for cleaning patient equipment, a visitor's waiting room and a relative's overnight waiting room (Picture 1).

Picture 1: New Relatives Overnight Waiting Room

Cleaning by patient client support services and nursing staff, was of a very high standard; there was good documentation and audits to support environmental and patient equipment cleaning.

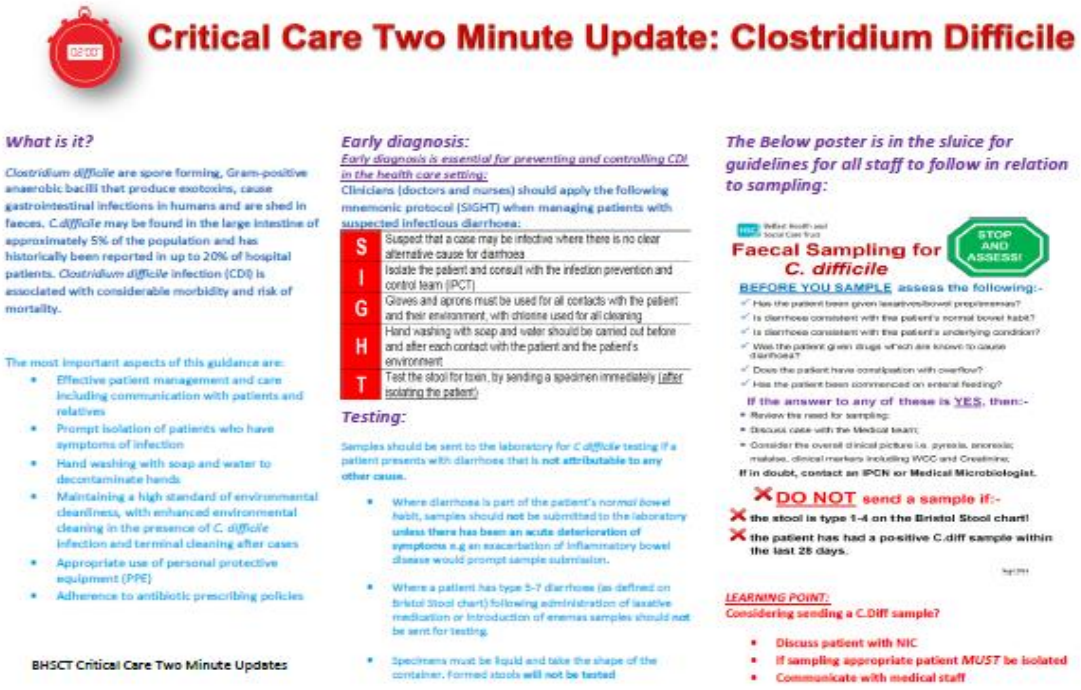
Clinical hand wash sinks were clean, well maintained and located near to the point of care. We observed good practice in relation to hand hygiene and the wearing of PPE.

Quality Improvement Initiatives

Critically ill patients are at increased risk of acquiring an infection compared to other hospitalised patients. To assist in reducing this risk, the trust has put in place a dedicated band 7 critical care IPC nurse, working across the three sites of the Trust adult critical care service. The key priorities of the post include education, surveillance, audit and investigation within critical care.

A focus of the new critical care IPC nurse is to implement initiatives to help reduce the incidence of CDI across the Belfast Trust critical care service.

Areas for improvement were identified in the timely isolation and appropriate sampling of patients with suspected CDI and improving communications between staff on implementing IPC precautions. We were informed that improvement interventions such as: feedback and reflection for staff regarding isolation of patients, advice of when to take samples, shared learning via a newsletter, a two minute CDI update bulletin (Picture 2) and safety briefs helped reduce the incidence of CDI across the service throughout 2017.



Critical Care Two Minute Update: Clostridium Difficile

What is it?

Clostridium difficile are spore forming, Gram-positive anaerobic bacilli that produce exotoxins, cause gastrointestinal infections in humans and are shed in faeces. *C.difficile* may be found in the large intestine of approximately 5% of the population and has historically been reported in up to 20% of hospital patients. *Clostridium difficile* infection (CDI) is associated with considerable morbidity and risk of mortality.

The most important aspects of this guidance are:

- Effective patient management and care including communication with patients and relatives
- Prompt isolation of patients who have symptoms of infection
- Hand washing with soap and water to decontaminate hands
- Maintaining a high standard of environmental cleanliness, with enhanced environmental cleaning in the presence of *C. difficile* infection and terminal cleaning after cases
- Appropriate use of personal protective equipment (PPE)
- Adherence to antibiotic prescribing policies

BHSCT Critical Care Two Minute Updates

Early diagnosis:

Early diagnosis is essential for preventing and controlling CDI in the health care setting:

Clinicians (doctors and nurses) should apply the following mnemonic protocol (SIGHT) when managing patients with suspected infectious diarrhoea:

S	Suspect that a case may be infective where there is no clear alternative cause for diarrhoea
I	Isolate the patient and consult with the infection prevention and control team (IPCT)
G	Gloves and aprons must be used for all contacts with the patient and their environment, with chlorine used for all cleaning
H	Hand washing with soap and water should be carried out before and after each contact with the patient and the patient's environment
T	Test the stool for toxin, by sending a specimen immediately (after isolating the patient)

Testing:

Samples should be sent to the laboratory for *C.difficile* testing if a patient presents with diarrhoea that is **not attributable to any other cause.**

- Where diarrhoea is part of the patient's *normal* bowel habit, samples should **not** be submitted to the laboratory **unless there has been an acute deterioration of symptoms** e.g an exacerbation of inflammatory bowel disease would prompt sample submission.
- Where a patient has type 5-7 diarrhoea (as defined on Bristol Stool chart) following administration of laxative medication or introduction of enemas samples should **not** be sent for testing.
- Specimens must be liquid and take the shape of the container. Formed stools **will not be tested**

The Below poster is in the sluice for guidelines for all staff to follow in relation to sampling:

Faecal Sampling for *C. difficile*

STOP AND ASSESS!

BEFORE YOU SAMPLE assess the following:-

- ✓ Has the patient been given laxatives/bowel preparations?
- ✓ Is diarrhoea consistent with the patient's normal bowel habit?
- ✓ Is diarrhoea consistent with the patient's underlying condition?
- ✓ Was the patient given drugs which are known to cause diarrhoea?
- ✓ Does the patient have constipation with overflow?
- ✓ Has the patient been commenced on enteral feeding?

If the answer to any of these is YES, then:-

- Review the need for sampling;
- Discuss case with the Medical team;
- Consider the overall clinical picture i.e. pyrexia, anorexia; malaise, clinical markers including WCC and Creatinine;

If in doubt, contact an IPCN or Medical Microbiologist.

✗ **DO NOT send a sample if:-**

✗ **the stool is type 1-4 on the Bristol Stool chart!**

✗ **the patient has had a positive C.diff sample within the last 28 days.**

LEARNING POINT:

Considering sending a C.Diff sample?

- **Discuss patient with NIC**
- **If sampling appropriate patient *MUST* be isolated**
- **Communicate with medical staff**

Picture 2: Clostridium Difficile Two Minute Update Bulletin

A trust safety and quality visit was carried out to the Mater Critical Care unit on 27 April 2018. The visit was carried out by senior managers with the purpose of listening to staff in how they embed quality improvement within their jobs. During this visit, staff were given the opportunity to speak freely about safety and quality and discuss any challenges in implementing new initiatives. Some of the actions agreed following the visit included the introduction of a 'celebration board', where staff acknowledge and celebrate the care they provide and how they keep their unit safe for patients. Another action is to support the unit staff through education and training in managing patients with mental health addictions

In 2017, a quality improvement initiative was carried out across the Trust's adult critical care service in relation to a new technique for obtaining arterial line blood samples. This has resulted in the development of a standardised procedure for sampling and a reduction in blood phlebotomy for all patients due to the size of the blood sample taken.

The inspection team observed that staff within the Mater 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
Mrs M Keating	Inspector, Healthcare Team

Trust Representative Attending local Feedback Session

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

Tracie Young	Critical Care Unit Manager
Jane Sheridan	Clinical Co-ordinator Critical Care
Paul Glover	Clinical Director, Critical Care
Martin Duffy	ICU Consultant
Jillian Stevenson	Critical Care Infection Prevention and Control Nurse
Jennifer Gibb	Deputy Sister, Education Critical Care
Justine Boyle	Infection Prevention and Control Nurse
Paul Quinn	Assistant Support Services Manager
Brenda Waring	PCSS Supervisor

5.0 Improvement Plan – Year 3 (2018/19)

This improvement plan should be completed detailing the actions planned and returned to Healthcare.Team@rqia.org.uk for - portal 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 Infection Prevention and Control Clinical Practices Audit Tool				
No additional actions for improvement				
Regional Critical Care Infection Prevention and Control Audit Tool				
No additional actions for improvement				
Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool				
No additional actions for improvement				

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)

Regional Infection Prevention and Control Clinical Practices Audit Tool
Regional Critical Care Infection Prevention and Control 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**
Regional Infection Prevention and Control Clinical Practices Audit Tool					
1.	It is recommended that longer term staff receive update training and competency assessment on the insertion and care of invasive devices.	Senior Sisters and education team critical care.	Learning and Development team and Clinical Educator leading. To update staff, audit and ensure competency.	March 2016	ANTT audits assess staff competence of care of invasive devices – ongoing April 2018.
2.	It is recommended that an audit of staff competence and adherence to guidance on blood culture technique is carried out. Staff should be regularly updated on the results of blood culture analysis.	Senior Sisters and education team critical care. IPCN ICU. MIH Improvement Lead.	Learning and Development team to take forward to develop a plan for training on a rotational basis for the three sites. IP&C team to provide an updated Blood Culture Policy with advice on audit and evidence compliance. Have an agreed Tool	April 2016	Ongoing. blood culture policy in place. blood culture audit tool in process of being Implemented- Feb 2019.

Improvement Plan – Year 2 (2015/16)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
			and explore Audit findings. To be discussed at CCMT meeting.		
3.	It is recommended that a unit based pharmacist is in place.	Senior management team.	A business case is being produced for 0.5 WTE pharmacist for Critical Care.	July 2016	Ongoing. Business case submitted Jan 2019.
4.	It is recommended that compliance with the enteral feeding protocol and guidance is audited and actions plans developed were issues are identified.	Senior Sisters and Senior management team.	Enteral feeding to be audited. Trust Policy needs updated. To be reviewed at Senior Sisters meeting. To be discussed at CCMT for standardisation throughout the three Critical Care units.	April 2016	Ongoing. Enteral feeding audited monthly.
Regional Critical Care Infection Prevention and Control Audit Tool					
5.	It is recommended that infection prevention and control staffing levels are reviewed to facilitate daily visits to the unit.	Senior sisters Critical care Belfast Trust	IP&C team are available via telephone for advice. Belfast Trust Critical Care Service are in the process of recruiting 1.0 WTE Infection Control nurse.	March 2016	Complete. Critical Care IPCN 1.0 WTE in post.
6.	It is recommended that audits and incidents should become a standard item on local staff meeting agenda.	Senior nurses Critical Care Belfast Trust CCMT/MIH Improvement Lead.	Audits and incidents are presented and discussed at the Medical Audit and at Governance meetings. Nursing staff review at monthly senior sister and monthly staff meetings.	March 2016	Complete as of December 2018.

Improvement Plan – Year 2 (2015/16)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
			Audits and incidents are included in both agenda and minutes of staff meetings, and are also discussed at daily safety briefings. Discussed at monthly Critical Care Management Team meetings.		
7.	It is recommended that the intranet Unscheduled Care/Emergency Care HUB should be updated to contain all policies relevant to critical care. All IPC policies that have past their review date should be updated. All staff should be aware of how to access these policies.	Senior sisters and CCMT (Critical Care Management Team) CCaNNI	Work in progress. All policies to be included in the Critical Care aspect of the Hub. To be discussed at CCMT meeting (Critical Care Management Team) and with CCaNNI (Critical Care Network at Northern Ireland) to discuss policies most relevant to Critical Care.	July 2016	Complete as of December 2018.
8.	It is recommended that information leaflets for relatives and visitors should be updated and developed. Leaflets should detail the concept of care below the elbow and adherence to the dress code policy were appropriate.	Senior nursing team.	Leaflets are currently in draft form with expected completion within three months. Leaflets will detail the concept of care below the elbow and adherence to the dress code policy were appropriate.	April 2016	Complete as of December 2018.

Improvement Plan – Year 2 (2015/16)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
9.	It is recommended that the upgrading of single room facilities should continue. As part of any refurbishment/new build planning, adherence to core clinical space recommendations and an improvement in the facilities available should be reviewed. There should be on-going review of the layout and design of the unit for maximum space utilisation.	Senior management team.	On Capital Bid's list and Risk Register. Allocation dependent upon available Trust Capital.	January 2017	Ongoing.
10.	It is recommended Carevue is implemented within the unit. All staff should be updated on the trust communication flow chart on the management of multi resistant organisms.	Senior management team.	Carevue is on the Capital Bid's list. Communication flow chart to be on Team meeting Agenda's and also included in daily safety briefs.	March 2017	Complete as of December 2018.
11.	It is recommended that an IPC nursing care plan is in place for patients with a known infection.	Senior nurses Critical Care Belfast Trust	Create awareness through team meetings and safety briefs.	April 2016	Complete as of December 2018.

Year 1 (2014/15)
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 Healthcare Hygiene and Cleanliness Standards and Audit Tool					
Standard 2: Environment					
1.	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. Storage facilities within the unit should be reviewed and improved.	Senior sister, CCMT, Estates	Senior sister to identify a programme for replacement and repair of furniture, fixtures and fittings. This will be escalated to the CCO and Service Manager for replacement as required through the capital bids and procurement process. Follow up to the weekly environmental audits will be carried out to ensure issues of maintenance to the building are escalated appropriately to Estates A working group with Estates will be convened	Ongoing Complete and ongoing as necessary Ongoing	Complete as of December 2018.

Improvement Plan – Year 1 (2014/15)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
			to review and action issues identified within this report.		
2.	It is recommended that drugs fridge temperature checks are carried out and recorded on the trust record sheet. Variations in temperature and actions taken to address these should be recorded.	Senior sister	Nursing auxiliaries within the unit are recording the fridge temperatures on a daily basis and this is audited by the senior sister in the unit.	Complete	Complete
3.	It is recommended that a hand washing sink is available in the clinical room.	Senior sister, Estates	A working group with Estates will be convened to review and action issues identified within this report.	Ongoing	Complete
Standard 3: Patient Linen					
4.	It is recommended that the linen store is clutter free and linen bags stored correctly.	Senior sister	Staff have been reminded of the importance of a clutter free environment and this forms part of the cleaning rota within the unit. The nurse in charge checks this on a daily basis.	Complete	Complete

Improvement Plan – Year 1 (2014/15)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
Standard 4: Waste and Sharps					
5.	It is recommended that all staff ensure the correct segregation of waste. Waste receptacles should be clean, not overflowing and in a good state of repair. The waste storage area should be clean and uncluttered.	Senior sister	Staff have been reminded of importance of implementing this recommendation in relation to waste and sharps. The nurse in charge checks this on a daily basis. The senior sister is currently reviewing the staff training on waste management.	Complete Complete by end Dec 2014	Complete -2018
6.	It is recommended that all sharps box temporary closure mechanisms are in place when sharps boxes are not in use. Sharps boxes should be changed when full.	Senior sister	Staff have been reminded of importance of implementing this recommendation in relation to temporary closure mechanisms. The nurse in charge checks this on a daily basis.	Complete	Complete
Standard 5: Patient Equipment					
7.	General patient equipment must be clean, stored	Senior sister Critical Care	Critical Care are using the Belfast Trust	Complete	Complete as of December 2018.

Improvement Plan – Year 1 (2014/15)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
	correctly and in a good state of repair. Stored patient equipment should have cleaning guidelines in place and trigger tape in situ to identify that it has been cleaned.	Scientist	equipment cleaning schedule to ensure that equipment is cleaned and stored appropriately. Trigger tape is now in use to identify that equipment has been cleaned.		
Standard 6: Hygiene Factors					
8.	It is recommended that consumables and dispensers are available and in working order. The domestic trolley should be kept clean at all times.	Critical Care Management Team (CCMT), Senior Nurses and PCSS Management Team	CCMT to set up a working group with PCSS Management to take forward this recommendation Dispensers in the unit have been reviewed and actions regarding repair have been taken.	Working group To be set up by end Sept 2014 Complete	Complete as of December 2018.
9.	It is recommended that all chemicals are stored in a locked, inaccessible area in accordance with COSHH regulations.	Critical Care Management Team (CCMT), Senior Nurses and PCSS Management Team	CCMT to set up a working group with PCSS Management to take forward this recommendation All staff are aware of their responsibilities for	Working group To be set up by end Sept 2014 Complete	Complete as of December 2018.

Improvement Plan – Year 1 (2014/15)					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
			keeping COSHH cupboard locked. All staff have completed their COSHH mandatory training.		
10.	It is recommended that staff review the number of PPE stations with a view to increasing the number available.	Critical Care CCO and Senior Sister	Senior sister with Critical Care CCO to look at increasing the number of PPE stations from 2, this will be dependent on available space within the unit.	End August 2014	Complete as of December 2018.
Standard 7: Hygiene Practice					
11.	It is recommended that a Difficil - S dilution chart and COSHH data sheets are available.	Senior sister	Senior sister is taking this forward	End August 2014	Complete as of December 2018.
12.	It is recommended that all staff adhere to the trust dress code policy.	CCMT, Clinical Lead	A reminder regarding the staff dress code policy will be distributed to all staff (including AHP and support services)	End August 2014	Complete as of December 2018.

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