The Regulation and Quality Improvement Authority

Unannounced Augmented Care Inspection

South West Acute Hospital
Special Care Baby Unit

Year 3 Inspection
30 January 2018

Contents

1.0 Profile of Service

The three year improvement programme of unannounced inspections to augmented care areas commenced in South West Acute Hospital Special Care Baby Unit (SCBU) on 28 August 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: Dr Anne Kilgallen	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 (South West Acute 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 were not assessed 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 inspection report which is available www.rqia.org.uk.

https://www.rqia.org.uk/inspections/view-inspections-as/map/south-west-acute-hospital/

Summary Paragraph

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

Within the Regional Neonatal Infection Prevention and Control Audit Tool, in relation to general environment and the preparation, storage and use of breast

milk and specialised powdered infant formula we found both these areas to be compliant.

We found improvements in the clinical practices of the management of invasive devices, the taking of blood cultures and enteral feeding.

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

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 neonatal infection prevention and control 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, year three compliance was achieved.

Table 1 Regional Neonatal Infection Prevention and Control Audit Tool Compliance Levels

Areas inspected	Year 1	Year 3
General Environment – Environmental Cleaning	88	100
Preparation, storage and use of Breast Milk and Specialised Powdered Infant Formula	77	98

We observed the environment to be clean, tidy and in good repair. On speaking to cleaning staff they were knowledgeable regarding the additional cleaning required in augmented care areas. Environmental cleaning audits are

carried out regularly and terminal cleans are assured and signed off by either the domestic supervisor or unit nursing staff. Audit results were displayed for the public on a notice board in the unit. Picture 1

Picture 1 displayed audit scores

Staff were aware of the policy and procedures in relation to the storage and use of breast milk. Both fresh and frozen breast milk was correctly labeled and stored appropriately. However we could not find any evidence that the temperature is taken and recorded when frozen breast milk is received from the donor milk bank. We were told the regional donor breast milk unit is to be relocated to South West Acute hospital.

Action for improvement

1. **Staff should ensure that temperature checks are carried out on receipt of the frozen donor milk to identify any failures in the cold chain.**

Table 2: Regional Infection Prevention and Clinical Practices Compliance Level

Area inspected	Year 2	Year 3
Invasive Devices	93	98
Taking Blood Cultures	82*	95
Antimicrobial Prescribing	86	85
Enteral Feeding	90	100

We observed that Aseptic Non Touch Technique (ANTT) was followed during the insertion, management and removal of invasive devices. Staff knowledge in the ongoing management of invasive devices was in line with trust guidelines.

Invasive device documentation reviewed was generally well completed; staff should however ensure that the section to record the device batch number is completed to enable effective traceability. Invasive devices were observed 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. These improvements have contributed to the unit sustaining a low blood culture contamination rate. Staff knowledge in carrying out the procedure was in line with trust guidance. A system was in place to monitor the incidence of positive and contaminated blood cultures within the unit. Staff should ensure that the clinical indications for obtaining a blood culture are documented within the patient records.

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. Staff reported that they had good access to trust pharmaceutical and microbiology support when required. We however found no evidence that antimicrobial usage is routinely audited in line with antimicrobial prescribing guidance.

Action for improvement

2. **Antimicrobial usage within the unit should be routinely audited in line with antimicrobial prescribing guidance.**

Nursing staff had good knowledge on the management of enteral or tube feeding systems; administration, set up and care. A system was in place to assess staff competence and monitor compliance with enteral feeding protocol and guidance.

To facilitate continuity and standardisation of practices and policies between the SCBU at South West Acute Hospital and the neonatal unit at Altnagelvin hospital, we would encourage the reciprocal exchange of nursing staff. Rotating nursing staff between units can help to improve staff knowledge and skills and provide development opportunities.

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 J Gilmour	Inspector, Healthcare Team

Trust Representative Attending local Feedback Session

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

Dr B Browne	Director of Nursing and Primary Care and Older People
Ms N Colton	Neonatal Manager
Ms J Maguire	Staff Nurse

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				
1.	Staff should ensure that temperature checks are carried out on receipt of the frozen donor milk to identify any failures in the cold chain.		Staff reminded to record temperature on arrival of donor milk. Added to safety briefings	Completed
Regional Infection Prevention and Control Clinical Practices Audit Tool				
2.	Antimicrobial usage within the unit should be routinely audited in line with antimicrobial prescribing guidance.		Medical staff continue to undertake an audit in respect of antimicrobial prescribing practise and the last audit was carried out in October 2017. A further audit will be carried out in 6months -1 year.	Ongoing.Achieved

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 longer-term staff receive update training and ongoing competency assessment in the management of invasive devices.	NNU	A programme needs to be developed to ensure that staff are updated and undergo annual competency assessment in the management of invasive devices. A database set up to monitor compliance Competencies will be reviewed at appraisal	March 2016	Competency assessments are now completed every 3 years. Records are retained by Unit Sister
2.	It is recommended that the trust medical devices group review the peripheral safety cannula used in NICU.	NNU	Further training and an opportunity for evaluation of these devices needs to be made available locally	August 2016 (in line with new Drs starting)	Safety cannulas were introduced to the unit in August 2016

Improvement Plan – Year 2 (2015/16					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
3.	It is recommended that a trust wide system is developed to monitor the rate of blood culture contamination. This should be discussed at the trust HCAI Group and local MDT meetings. Results or actions taken should be fed back to clinical, nursing and IPC staff. (Repeated)	NNU	Database to be set up Trustwide and made available on SharePoint MDT Unit meetings to continue with IPC presence. Standard agenda item to discuss all reported positive blood cultures. Blood culture audits continued and reviewed at local level. Positive HCAI reviewed and RCA completed and shared at Trust HCAI group and locally. Reports stored electronically on SharePoint and disseminated with all MDT staff.	March 16	Blood culture result database maintained by Microbiology and results shared with Lead Consultant and Nurse. Local database maintained on Sharepoint. Positive results discussed at local level.

Improvement Plan – Year 2 (2015/16					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
4.	It is recommended that trust blood culture (positive, false positive,) results are reviewed and discussed at senior trust meetings. A system should be in place to compare the rate of positive blood cultures between units within the trust. Results or actions taken should be fed back to clinical, nursing and IPC staff.	NNU	As above	March 2016	Completed
5.	It is recommended that an overall compliance rate is correlated for adherence to best practice when taking blood cultures. This information should be fed back to staff, with action plans developed and independent verification carried out if issues are identified.	NNU	As above. Independent audits to be carried out.	March 2016	Independent audits carried out and Action plans completed IPCN nurses to carry out ANTT training to new Doctors Senior NNU Nurses visited Altnagelvin NICU to observe practices to ensure consistency, and to take a lead in overseeing audits in SWAH.

6.	It is recommended that an overall compliance rate is correlated for adherence to best practice when taking blood cultures. This information should be fed back to staff, with action plans developed and independent verification carried out if issues are identified.	NNU	As above. Independent audits to be carried out.	March 2016	
Improvement Plan – Year 2 (2015/16					
Reference number	**Actions for Improvement**	**Responsible Person**	**Action/ Required**	**Date for completion/ timescale**	**Updated by Trust 2018**
7.	It is recommended that electronic/computer aided prescribing tools should be available to assist with antimicrobial prescribing. **(Repeated)**	NNU	This remains unachievable unless finance is made available.	Without investment this is not achievable.	Without investment this is not achievable.
8.	It is recommended that the 'Guidance on the Insertion of Naso/Orogastric Enteral Feeding Tube in NICU and Staff Competency' is reviewed and updated to include time interval for the replacement of enteral feeding tubes and labelling of enteral feeding lines.	NNU	Guideline to be updated to reflect best practice Labels sourced and utilised	September 2015	Completed

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					
1.	Staff should continue to review and update policies, procedures and documentation in relation to neonatal care.	Neonatal and IP&C staff	Systems are in place to ensure that policies, procedures and guidelines pertaining to neonatal care are reviewed and amended accordingly.	Ongoing.	Completed. Guidelines on Sharepoint and updated when required
2.	The trust should ensure where possible, IPC link staff have protected time to attend link meetings.	Neonatal	Time will be factored into duty roster to accommodate this.	Achieved	Achieved
3.	Staff should ensure an information leaflet is available for parents.	Neonatal	The Altnagelvin amended Information booklet for parents is being customised for the SWAH NNU.	December 2013	Achieved
4.	A surveillance data analysis system should be developed/implemented to assess results and identify trends in infection.	NNU Labs	The Lab will give an electronic download (spreadsheet) of results to neonatal each month to analyse.	Aiming For December to be established.	Achieved
5.	Staff in the unit in with conjunction with IPC and estates should review the use of the incubator/cot space	Neonatal / Estates	A review has been carried out and the identified sink is to be removed. This is currently being progressed and a small works	Pending	Completed

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					
	located by the hand wash sink.		request has been initiated and marked as a priority.		
6.	A system of random vaildation audits for terminal cleans should be scheduled by Domestic Services.	Support services	A system of monitoring terminal cleaning is now in place to randomly check the standard of terminal cleaning.	Achieved	Achieved
7.	Water flushing checks should be carried out consistently.	Neonatal	The ward manger will monitor this within her plan to do spot checks on a number of areas.	Achieved	Achieved
8.	A review of the Regional Incubator Transfer form should be carried out to ensure all infection control information can be recorded.	Regional Neonatal Network	This needs discussed and actioned by the neonatal network	For neonatal network to complete	Completed. A regional form developed and in use.
9.	Guidance for nursing staff on the cleaning of Neonatal Patient Equipment requires more detail, and validation audits should be carried out to ensure effective cleaning, this should include clarification on the cleaning of soothers.	Neonatal	>Guidelines for cleaning of specialised equipment are developed as identified. >A guideline for the decontamination of soothers is being developed. >Validation audits will be carried out by senior staff and reported to lead nurse	Ongoing November 2013 November 2013	Completed.

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					
10.	Staff should not remove equipment from packaging prior to use.	Neonatal	Message has been communicated to all staff following the RQIA visit.	Achieved	Achieved
11.	Staff should document matress audits.	Neonatal	Mattresses of incubators and cots are inspected as part of the decontamination of the incubator/cot and documented. Spot checks will also take place of mattresses.	Achieved	Achieved
12.	The current process of receiving frozen breast milk should be reviewed.	Neonatal	Donor Milk is transported in a cool box at -40C from the milk bank. A data recorder is present in the cool box which monitors the temperature continuously. Milk Bank delivery staff record the temperature from the data recorder when the donor milk is delivered before they put the milk in the freezer. A print out is available of the temperature range while the milk is in transit until the time of delivery. A copy of this print out is now available in the neonatal unit.	Achieved	Achieved

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					
13.	A system should be in place to identify that donor expressed breast milk is expressed no longer than six months prior to use.	Neonatal	The Human milk bank are compliant with the NICE Guidance CG93 'Donor milk banks: the operation of donor milk bank services' Donor milk expression dates are logged by the milk bank and bottles are dated 6 months after the earliest date of expression for that batch. Each bottle has a tracking label which allows all stock to be monitored (Trackback label record the date of pasteurizing. Too many units read this date as the expiry date and discarded the milk). NICE does recommend expression dates to be on the label.	Achieved	Achieved
The Regional Clinical Practices Audit Tools					
14.	The new trust ANTT policy must be disseminated to staff on completion.	IP&C	This policy is to be tabled for approval at the IP&C committee meeting in November.	December for draft to be on sharepoint	Completed

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					
15.	The blood culture policy should be reviewed and amended to reflect neonatal care.	Neonatal IP&C	A blood culture policy to reflect neonatal care is being developed for consultation. Stickers have been developed for staff to complete and put into the lab recording book when they take verbal results of blood cultures by telephone.	Consultation to be completed by Jan 2013 and then to go through approval process	completed
16.	The rate of blood culture contamination should be monitored and results fed back to clinical, nursing and IPC staff.	Microbiology Neonatal IP&C	The lab now provide a monthly report of blood culture results to the neonatologist and lead nurse for neonatal services. This report details the number of positive results out of the total for that period.	Achieved	Achieved
17.	Systems should be implemented to monitor compliance with best practice when taking blood cultures and enteral feeding.	Neonatal IPC	>A pro-forma for assessing staff performance in taking blood cultures has been developed. >An audit tool is running alongside the Enteral feeding HII to monitor compliance.	November November to be established	Achieved
18.	Electronic/ computer aided tools should be available to assist with antimicrobial prescribing.	Paediatricians/ Pharmacy	This is not currently achievable. A business case is required to purchase an electronic	Without investment this is not achievable**.**	Without investment this is not achievable.

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					
			prescribing tool. Antimicrobial prescribing guidance and the BNF for children are available on the intranet. A neonatal formulary was approved by Drugs and Therapeutic earlier this year and is also available on the intranet.		
19.	Antimicrobial usage should be audited in line with current antimicrobial prescribing guidance.	Paediatricians/ Pharmacy	Pharmacist will train staff grade doctors to carry out self audit to monitor compliance	February 2013 for 1st audit and every 3-6 months thereafter**.**	This has not been carried out every 3-6 months. However medical staff have recently conducted an audit with the antimicrobial pharmacist.
20.	Systems should be implemented to monitor adherence with MRSA policy and care pathway as appropriate.	IPC/Neonatal lead nurse and ward manager	An MRSA pathway will be developed to reflect neonates.	March 2014	Completed
21.	Infection control audits should be carried out for achievement of isolation.	IPC	In order to set up a plan for infection control staff to do these audits, further staff would be required. IPC are developing an IPT highlighting investment required to achieve this recommendation.	Outstanding	Achieved

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