The Regulation and Quality Improvement Authority

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Unannounced Infection Prevention/Hygiene Augmented Care Inspection

South West Acute Hospital Critical Care Unit

3 and 4 December 2014

Assurance, Challenge and Improvement in Health and Social Care

www.rqia.org.uk

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care (HSC) services in Northern Ireland.

RQIA's reviews and inspections are designed to identify best practice, to highlight gaps or shortfalls in services requiring improvement and to protect the public interest.

Our Hygiene and Infection Prevention and Control inspections are carried out by a dedicated team of inspectors, supported by peer reviewers from all trusts who have the relevant experience and knowledge. Our reports are available on the RQIA website at www.rqia.org.uk.

Inspection Programme

The CMO's letter (HSS MD 5/2013) endorsed the use of the Regional Infection Prevention and Control Audit Tools for Augmented Care Settings by all Trusts in Northern Ireland in the relevant clinical areas www.rqia.org.uk.

- Governance Assessment Tool;
- Infection Prevention and Control Clinical Practices Audit Tool;
- Neonatal Infection Prevention and Control Audit Tool;
- Critical Care Infection Prevention and Control Audit Tool;
- Augmented Care Infection Prevention and Control Audit Tool

The introduction of this suite of audit tools is follow-on from development of the existing regional healthcare hygiene and cleanliness standards and audit tool, developed and disseminated in 2011. Both sets of tools should be used in conjunction with each other. A 'Guidance and Procedural Paper for Inspections in Augmented Care Areas' has been developed which outlines the inspection process www.rqia.org.uk.

The inspection programme for augmented care covers a range of specialist facilities and a rolling programme of unannounced inspections has been developed by RQIA to assess compliance with both of these sets of audit tools.

RQIA also carries out announced inspections. These examine the governance arrangements and systems in place to ensure that infection prevention and control and environmental cleanliness policies and procedures are working in practice.

Contents

1.0 Inspection Summary

An unannounced inspection was undertaken to the South West Acute Hospital Critical Care Unit (CCU), on 3 and 4 December 2014. The inspection team comprised of four RQIA inspectors. Details of the inspection team and trust representatives attending the feedback session can be found in Section 7.

Picture 1: Typical bed space

The 10 bed critical care unit, based at the South West Acute Hospital is part of the Western Health and Social Care Trust (Picture 1). The unit was opened in June 2012 as part of the new South West Acute Hospital build. The unit is commissioned for only six beds, two intensive care and four high dependency care beds. The remaining beds are used by renal services, to facilitate patient movement and for storage.

The unit provides intensive care services to patients with life threatening illness, following major, complex surgery and following serious accidents. Patients in high dependency care are generally less ill than those in critical care but still require organ support e.g. to help maintain blood pressure, which cannot be provided in an ordinary ward.

The critical care unit was 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

This inspection is the first of a three year cycle of inspection carried out within this area.

The report highlights strengths as well as areas for further improvement, and includes recommendations and a quality improvement action plan.

Overall the inspection team found evidence that the critical care unit at South West Acute was working to comply with the regional standards and audit tools.

Inspectors observed:

- the unit was compliant in all seven of the Regional Healthcare Hygiene and Cleanliness Standards

Inspectors found that the key areas for further improvement were:

- taking blood cultures
- review of policies and audit of practice

Inspectors observed the following areas of good practice:

- the unit was one of 20 units within the UK to participate in the Intensive Care National Audit Research Centre (ICNARC) 2013/14 survey for relatives on their experience in critical care units.
- technical staff have developed equipment standard operational procedures which have been illustrated with pictures. Training sessions are held for staff to update their skills on using equipment.
- computer aided antimicrobial prescribing tool
- enhanced support when required from the infection prevention and control team

The inspection resulted in 20 recommendations for improvement listed in Section 6.

Detailed lists of the findings are available on request from RQIA Infection Prevention and Hygiene Team.

The final report and quality improvement action plan will be available on RQIA's website. Where required, reports and action plans will be subject to performance management by the Health and Social Care Board and the Public Health Agency (PHA).

RQIA's inspection team thanks the Western HSC Trust (WHSCT), and in particular all staff at South West Acute Hospital Critical Care Unit for their assistance during the inspection.

2.0 Overall Compliance Rates

The Regional Critical Care and Clinical Practices Infection Prevention and Control Audit Tools

RQIA uses these tools as an assessment framework to build progressive improvement over a three-year inspection cycle. Compliance scores for the first inspection are 85 per cent, rising to 95 per cent by the end of the third inspection.

Compliance rates are based on the scores achieved in the various sections.

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

Areas inspected	Compliance Level
Local governance systems and processes	89
General environment - layout and design	95
General environment - environmental cleaning	100
General environment - water safety	90
Critical Care clinical and care practice	90
Critical Care patient equipment	100
Average Score	**94**

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

Areas inspected	Compliance Level
Aseptic non touch technique (ANTT)	88
Invasive devices	94
Taking blood cultures	*61
Antimicrobial prescribing	93
Clostridium *difficile* infection (CDI)	*100
Surgical site infection	100
Ventilated (or tracheostomy) care	100
Enteral feeding or tube feeding	88
Screening for meticillin resistant staphylococcus aureus (MRSA) colonisation and decolonisation	*100
Average Score	**92**

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

Compliant: 85% or above
Partial Compliance: 76% to 84%
Minimal Compliance: 75% or below

The Regional Healthcare Hygiene and Cleanliness Audit Tool

Compliance rates are based on the scores achieved in each section of the Regional Healthcare Hygiene and Cleanliness Audit Tool. Percentage scores can be allocated a level of compliance using standard compliance categories below.

Table 3: The Regional Healthcare Hygiene and Cleanliness Audit Tool Compliance Levels

Critical Care Unit	Compliance Level
Environment	99
Patient linen	98
Waste	96
Sharps	94
Equipment	99
Hygiene factors	100
Hygiene practices	94
Average Score	**97**

Compliant: 85% or above
Partial Compliance: 76% to 84%
Minimal Compliance: 75% or below

Where an inspection identifies issues that are considered to be of high risk, trusts will be asked to take immediate action.

3.0 Inspection Findings: Regional Critical Care Infection Prevention and Control Audit Tool

The Regional Critical Care Infection Prevention and Control Audit Tool contains seven sections. Each section aims to consolidate existing guidance in order to improve and maintain a high standard in the quality and delivery of care and practice in critical care. This will assist in the prevention and control of healthcare associated infections.

Regional Critical Care Infection Prevention and Control Audit Tool Compliance Levels

Areas inspected	**Compliance Levels**
Local governance systems and processes	89
General environment - layout and design	95
General environment - environmental cleaning	100
General environment - water safety	90
Critical Care clinical and care practice	90
Critical Care patient equipment	100
Average Score	**94**

The findings indicate that overall compliance was achieved in relation to the Regional Critical Care Infection Prevention and Control Audit Tool. Compliance was achieved in all sections; however inspectors identified some areas for improvement.

3.1 Local Governance Systems and Processes

For organisations to comply with this section, good governance should be displayed through management that displays effective decision-making and leadership. Systems and processes should be robust, and staff should be aware of their roles and responsibilities. Appropriate policies and procedures should be available. The unit achieved compliance in this section of the audit tool.

Leadership and Management

The unit manager displayed good leadership, management and knowledge on infection prevention and control. Unit staff displayed good awareness in this area.

The manager takes the lead in attending senior operational meetings relating to infection prevention and control (IPC). The unit has a dedicated IPC link nurse who has protected time to attend infection prevention and control meetings and to carry out a proactive link nurse role e.g. staff hand hygiene training. This is good practice as the DHSSPS document 'Changing the Culture' 2006 identifies that link staff need to have dedicated protected time

for their infection prevention and control activities. The unit manager advised that two further unit staff are to be developed in the IPC link nurse role.

The unit has a dedicated trust IPC nurse for advice on the management of infection control issues. All site based IPC nurses can however be contacted for advice if required. Inspectors were advised that an IPC nurse will either visit or contact the unit by phone each day; daily visits are not carried out. An increase in visits does occur for example, outbreak management. Unit staff advised that there is a good working relationship between the unit and the IPC team. Documentation viewed evidenced local monthly IPC and critical care meetings, attended by the unit manager, link nurse and IPC team. These meetings had been on hold to facilitate trust Ebola training, however are to be recommenced.

1. **It is recommended that infection prevention and control staffing levels are reviewed to facilitate daily visits to the unit.**

IPC information is cascaded down to staff for learning via staff meetings, communication book, safety briefings and email. The IPC link nurse provides written feedback to the manager on link nurse meetings. This feedback, minutes of staff meetings and the trusts 'Safety Lesson of the Week' are emailed to all staff for information. Inspectors were advised that the unit plans to develop a staff newsletter and further engage with staff by encouraging them to take the lead in setting the agenda for staff meetings.

Inspectors were informed that the ratio of nursing staff to patient is reviewed and increased as appropriate. Due to present and planned sick leave the trust has reviewed nursing staffing levels within the unit; this review is due again at the end of January 2015. Some part-time unit staff have increased their hours to fill outstanding shifts. Trust bank nurse staff can be used to supplement unit staffing levels. A recruitment programme is underway for one new staff member. Staffing levels within the unit should continually be reviewed and actioned to ensure infection prevention and control practices are not compromised.

2. **It is recommended that critical care nursing staff levels and the recruitment programme should continue to be reviewed and actioned.**

The ratio of domestic staff is reviewed and increased when required, for example, during an outbreak.

Unit staffing levels are maintained therefore beds are not closed due to staff shortage.

Review of Documentation

A review of documentation evidence a range of critical care meetings, from management level to frontline staff, which feed into each other e.g. trust critical care delivery group, critical care network NI (CCaNNI), organ donation committee, local directorate sisters meeting, unit staff meeting. These were attended by senior management, nursing and medical staff where appropriate and discuss core components of patients care within critical care. Inspectors were advised that site specific critical care meetings had been in place but had not been held for a period of time. These meetings were attended by the lead nurse and clinician and seen as beneficial as they were used as a way to consolidate and implement improvement.

3. **It is recommended that regular site specific critical care meetings are reintroduced within the unit.**

A process for root cause analysis (RCA), follow up and learning was in place for the management of serious adverse incidents. All incidents are logged onto Datix, reported and investigated through the line management structure. Incident reporting and learning are discussed as a standard agenda item at local staff meetings. When an MRSA blood culture was identified, documentation reviewed evidenced a multidisciplinary RCA approach to incident investigation and discussion throughout the governance structure.

Inspectors were advised that unit based weekly multidisciplinary patient care meetings have been commenced, the development of this process is in its infancy.

Accessing IPC policies and the ability to demonstrate a basic knowledge of these policies is included as part of nursing staff critical care preceptorship period. IPC policies were available in hard copy and on the trust intranet site. All new policies are emailed to staff for information. Inspectors were advised and observed that the intranet site can be difficult to navigate, with key policy word searches not always recognised.

4. **It is recommended that access to trust intranet site policies are reviewed to facilitate easy staff use.**

An overarching trust occupational health/infection prevention and control policy was in place to identify when staff screening and vaccination is required. Staff questioned were aware of action to take if they develop an infection, thus preventing the transmission of infection.

A system was in place for unit staff to identify and report maintenance and repair issues either to the local estates department or Interserve facilities management. Requests for maintenance are given a reference log number to identify and track progress.

Audit

Local and regional audits and the implementation of high impact interventions were undertaken to improve IPC practices and environmental cleanliness. Evidence was available to show that audit results were reported to unit staff and discussed at local and managerial meetings.

The IPC team conducts independent audits where infection prevention and control issues are identified and audit scores are low. From 1st – 31st January 2014, the unit was selected to receive Enhanced Support from the IPC team due to an increase in MRSA colonisation following admission to the unit. IPC baseline audit results identified aspects of practice, relating to hand hygiene and on-going peripheral catheter care, which required improvement. Audit frequency was increased and at the end of January 2014, all baseline audits achieved 100 per cent.

Inspectors observed that a central venous catheter insertion quality indicator compliance rate was 70 per cent in July 2014. This was reported as part of the units monthly quality indicator reporting and actioned to improve practice, all subsequent monthly compliance rates achieved 100 per cent.

During 2014, a range of IPC quality indicators have been independently validated; hand hygiene, ongoing peripheral line and catheter care.

Picture 2: Performance data displayed

Audit information on hand hygiene and environmental cleanliness is displayed on a notice board at the entrance to the unit. Information on care bundle scores and quality indicators are displayed at the central nurses station (Picture 2).

Surveillance

Surveillance, the continuous monitoring of healthcare associated infection (HCAI) is key to the control of infection. A surveillance programme can be used to implement improvement initiatives, assess effectiveness of clinical interventions and can quickly identify outbreaks if infection.

Inspectors noted that IPC audit and microorganism local surveillance programmes were in place. These monitor and promote improvement in infection prevention and control practices and infection rates. As part of the unit practice, the nurse in charge, twice per shift, reviews each patient's infection status, a hard copy is kept of this information. A daily medical review, complemented by a twice weekly microbiology and IPC ward round is also in place to review this data.

Evidence was available to show that where surveillance identified an increase in MRSA colonisation rates, systems were put into to improve practice as outlined in this report.

Surveillance data is reviewed at the trust surveillance meetings, attended by the Head of Infection Prevention and Control and the directorate lead nurse. This information is fed upwards through the governance structure and outcomes and actions discussed at the trust healthcare associated infection (HCAI) accountability meeting.

Training and Development

Staff infection prevention and control knowledge and up-to-date practical skills are a prerequisite for clinical staff to carry out their role in an effective manner.

All unit staff have participated in the trust induction day, all new staff also receive a dedicated unit induction and a second IPC update in their first year. Documentation evidenced that the majority of staff have completed their two yearly mandatory IPC update.

A healthcare assistant (HCA) critical care IPC induction programme is being developed, two unit HCAs have received this training.

Unit staff have the opportunity to attend trust critical care and CCaNNI conferences. Staff have received training on the key principles of nursing practice to support and emphasise their role and patient expectations in the delivery of care. A document was developed for staff to prepare them for the RQIA inspection process.

Inspectors were advised that the manager and two staff have attended training on Ebola and the use of PPE, allowing them to cascade train other unit staff. An Ebola presentation is available for staff on computer, an information folder on how to don and remove PPE is also available for staff to reference

Information and Communication

Information on infection prevention and control, and the effective communication of this information, is vital to ensure adherence to good practice.

A range of information leaflets were in place to advise relatives or visitors of infection prevention and control precautions; hand hygiene, general visitor information, not to bring food into the unit, HCAIs.

Relatives and visitors receive information on hand hygiene however this does not explicitly detail the concept of bare below the elbow and where, if appropriate, they should to adhere to it; not to wear false nails, jewellery; stoned rings, watches and bracelets.

Inspectors were informed that staff routinely advise all visitors on the need to carry out hand hygiene. Patients' next of kin are given 1:1 advice on the important of hand hygiene, this was not evidenced by staff on the computer information system (CIS).

5. **It is recommended that computer information records are completed following hand hygiene education.**

An electronic information system is available in the relative waiting area; this has been used to relay information to visitors e.g. visiting times. CCaNNI has developed a generic patient information leaflet template, 'Critical Care Relatives Information Booklet'. This template can be adapted with details on each critical care unit. The template gives information on visiting times however does not include information on not to bring outside coats into the unit.

6. **It is recommended that patient and relative information leaflets are updated to include; the concept of bare below the elbow and not to bring outside coats into the unit.**

The unit was one of 20 units within the UK to participate in the Intensive Care National Audit Research Centre (ICNARC) 2013/14 survey for relatives on their experience in critical care units. While results from this survey are not yet published the unit is continuing to proactively engage with relatives for feedback on their experience in the unit.

3.2 General Environment

3.2.1 Layout and Design

For organisations to comply with this section of the audit tool they must ensure adequate facilities are available for the delivery of care. This includes the space available to carry out care on the critical care, decontaminate equipment and to ensure effective isolation.

The unit was compliant in the layout and design of the environment.

The critical care unit, opened in June 2012, consists of 10 single bed spaces, four curtained spaces, six single doored rooms. Of these rooms three have ensuite, two of which are lobbied and fully ventilated. The unit is commissioned for only six beds, two intensive care and four high dependency

care beds. This number of commissioned beds is never exceeded. At present the trusts renal services use the two designated ensuite lobbied rooms for patients requiring renal dialysis. The remaining two rooms are used to facilitate patient movement and for storage.

The critical care core clinical space around the patient bed area, for the delivery of care, was within 80 per cent of the minimum dimensions recommended by the DHSSPS and outlined in the audit tool. The minimum core space should be 26 sqm, with 20.8 sqm deemed acceptable. Inspectors were advised by Interserve that the core clinical space for the bed area was 25 sqm.

Bed spaces were free from clutter and easily accessible for staff to deliver safe and effective care. The installation of pedestals at each bed space allows staff to have 360° access to the patient. Dedicated patient equipment areas reduce clutter at the bedside

All 10 single bed spaces can facilitate isolation. Of the six spaces in use by the unit, rooms are available with closing doors. If fully ventilated isolation rooms are required, renal patients can be relocated within the unit.

Facilities as outlined in the audit tool were available for visitors, relatives and staff. There was a dedicated visitors' toilet, beverage point, overnight accommodation and a relative's room. A staff changing area and staff room were available.

There is a dedicated technician's room for equipment. The room has a clean and dirty section divided by a wall; each section has its own entrance/exit door. Equipment is cleaned at the bedside and then left in the 'dirty' side of the room for further cleaning. Once cleaned it is moved to the 'clean' side ready for use.

If a piece of equipment is faulty unit staff complete a faults book – this is actioned by the technician, who has an area in the room dedicated for fixing equipment. There is no dedicated area for the storage of equipment for external repair. Equipment for further repair is stored and serviced in the estates department.

A dedicated equipment store is available however inspectors noted that one side room was also used as a store. This should be reviewed as there is the potential for future issues to arise with the utilisation of space and clutter if the room was required for patient care, for example emergency situation, Ebola.

Documentation was provided to evidence a yearly external regime of ventilation/air pressure testing. Monthly cleans are carried out on extract supply grills, diffusers, ledges and pendants.

7. **It is recommended that as part of any refurbishment, adherence to core clinical space recommendations should be considered. The use of a room for storage facilities should be reviewed.**

3.2.2 Environmental Cleaning

For organisations to comply with this section they must ensure cleaning staff display knowledge of cleaning policies and procedures, and are competent in cleaning hand washing sinks. Environmental cleaning audits should be carried out, and the infection prevention and control team should be consulted when infection has been identified.

Good practice was observed and the unit was fully compliant in the section on environmental cleaning. Environmental cleaning; guidelines, audit and staff competency based training were in place and reviewed. Terminal cleans were signed off and randomly validated.

On questioning, staff displayed good knowledge on cleaning procedures, guidelines and the four cloth tap and sink cleaning technique.

3.2.3 Water Safety

For organisations to comply with this section they must ensure that an overarching water safety plan and individual area risk assessment plan is in place. Water sampling, testing, flushing and maintenance are carried out correctly, and there is a mechanism in place to report water analysis results.

The unit was compliant in relation to water safety. The overarching trust Water Safety Plan March 2013, available on the intranet, is under review for completion by March 2015. The South West Acute Water Safety Plan, with individual unit risk assessment plan, was updated in November 2014, to take account of Water Systems: Health Technical Memorandum 04-01: Addendum – *Pseudomonas aeruginosa* – Advice for Augmented Care Units. This has been sent to the trust water safety group for final approval at its next meeting.

Documentation reviewed evidenced the collection of tap water samples to facilitate microbiological organism testing and analysis. Evidence was provided of an yearly external Risk Assessment and Water Hygiene Survey Report carried out 8 January 14. A programme for routine maintenance work carried out on weekly, monthly, quarterly, annual basis was also available. This includes TMV disinfection and the overall functioning of TMV, 'fail safe' test, every six months.

Inspectors observed nursing daily flushing records for taps and infrequently used outlets. This is not reflected in the trust overarching and South West Acute Water Safety Plans.

8. **The overarching trust and South West Acute Water Safety Plans should be reviewed to reflect current practice. Once completed and ratified, plans should be made available to all staff.**

All results of water analysis are reported to the trust water safety group. This includes staff from infection prevention and control, microbiology, Interserve, estates, governance and the unit manager.

Interserve advised that in line with Health Estates guidance they plan to remove flexible connections to the water system. A site survey has been carried out and work started to remove all plastic pipework as per HTM 04 – 01. Proactive descaling tap outlets every six months is also carried out. It is planned to introduce the 'Zeta Safe' water sampling and tracking system to mirror Altnagelvin to assist with water safety management.

Hand washing sinks were used correctly - only for hand washing. Bodily fluids and cleaning solutions were not disposed of down hand washing sinks. Patient equipment was not stored or washed in hand washing sinks. A system is in place to address any issues raised with the maintenance of hand washing sinks and taps.

3.3 Critical Care Clinical and Care Practice

For organisations to comply with this section they must ensure that the delivery of care is provided in a way that negates the risk of transmission of infection. This is provided through adequate staffing, monitoring of patient movement, infection control screening policies and adherence to DHSSPS and local guidance on cleansing the patient.

The unit achieved compliance in this section of the audit tool. During the inspection, staff allocation ensured optimal infection prevention and control practices.

A manual patient placement system to identify which bed the patient is in during their stay in critical care. The nurse in charge, twice per shift, records on a tracking sheet patient placement. This is filed and can be used to retrospectively identify patient placement. Details on patient placement are recorded on the computer information system.

The unit has introduced the computer information system. At present work is being carried out to ensure the same information captured on the Altnagelvin critical care unit system, Intellivue Clinical Information Portfolio 'ICIP' is mirrored. At present staff are working to ensure this is carried out. At the same time all manual recording documentation is being transferred onto the computer system. Refining and loading documentation onto the system is ongoing.

The unit has developed a patient discharge summary based on the CCaNNI transfer/handover form and on trust guidance. The CCaNNI form, along with a printed copy of the discharge summary and patient test results, accompanies the patient on leaving the unit.

Screening policies and procedures are in place and known to staff. All patients admitted to the unit are routinely screened for MRSA and weekly thereafter. If a patient has a wound this will be swabbed. Staff refer to the Regional Infection Prevention and Control Manual for guidance on isolation. Alert organisms will be identified on the computer information system.

Inspectors were advised that if a patients critical care admission screens are positive or if their results following discharge or transfer to another ward are positive the receiving or transferring wards are informed. This will be done via a telephone call from either a unit nurse, doctor or IPC nurse and should, but is not always recorded in the ward diary. There is no policy or protocol in place for this practice to identify staff role and responsibilities and a system to ensure robust documentation.

9. **It is recommended that a policy or protocol should be developed to outline roles, responsibilities and the documentation to be completed when reporting of laboratory results.**

Staff washed patients in water from a source of known quality and used alcohol rub after hand washing when caring for patients. Staff were aware of risk factors that cause skin injury, patients skin condition was recorded in care records.

3.4 Critical Care Patient Equipment

For organisations to comply with this section they must ensure specialised critical care equipment is effectively cleaned and maintained. Audits of equipment cleaning and education on the use of equipment should be available.

Picture 3: Equipment in technician's room

The unit achieved full compliance in this section of the audit tool; staff are commended for this achievement. Specialist equipment inspected was clean and in a good state of repair (Picture 3). Staff displayed good knowledge of single use equipment. There was guidance for the cleaning, storage and replacement of specialised patient equipment, including when a patient is in isolation or during an outbreak. Specialist equipment was routinely audited by senior staff.
Technical staff have developed equipment standard operational procedures which have been illustrated with pictures. Training sessions are held for staff to update their skills on using equipment.

4.0 Inspection Findings: Regional Infection Prevention and Control Clinical Practices Audit Tool

The Regional Infection Prevention and Control Clinical Practices Audit Tool contains nine sections. The observations of key clinical procedures has shown to reduce the risk of infection if performed correctly. Each section aims to consolidate and build on existing guidance in order to improve and maintain a high standard in the quality and delivery of care and practice in critical care. This will assist in the prevention and control of healthcare associated infections.

Regional Infection Prevention and Control Clinical Practices Audit Tool Compliance Levels

Areas inspected	**Compliance Levels**
Aseptic non touch technique (ANTT)	88
Invasive devices	94
Taking blood cultures	*61
Antimicrobial prescribing	93
Clostridium *difficile* infection (CDI)	*100
Surgical site infection	100
Ventilated (or tracheostomy) care	100
Enteral feeding or tube feeding	88
Screening for MRSA colonisation and decolonisation	*100
Average Score	**92**

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

The findings indicate that overall compliance was achieved, four sections achieved full compliance. Inspectors identified some areas for improvement, especially in the taking of blood cultures, where minimal compliance was achieved.

During the inspection clinical practice was observed in the majority of areas. Staff were questioned on all aspects of the clinical practices audit tool and displayed good knowledge on the practical application of clinical procedures.

4.1 Aseptic Non Touch Technique (ANTT)

ANTT is a standardised, best practice and safe aseptic technique used for care the overall management of invasive clinical practices and preparation of medication. For organisations to comply with this section they must have a policy in place; staff should display knowledge and practical skills on the key principles, and audit of staff competency is carried out.

The unit achieved compliance in this section of the audit tool. An ANTT policy was not in place and available for staff to reference. Inspectors were informed that the ANTT policy/ guidance document will shortly be ratified at the HCAI accountability meeting. Staff continue to use the Assessment of Safe Practice, the ANTT Theory and Practice Framework as guidance in the interim period. There is a range of step by step pictorial posters on ANTT at each bed space and within the clinical room for staff to reference. A resource file is available at each bed space and a video link and power point presentation on the computer desk top for staff to watch.

10. **It is recommended that the ANTT policy is ratified and disseminated to staff.**

The practices of ANTT are embedded within the unit; staff can demonstrate when ANTT procedures are to be applied. This included a student nurse on their first day of placement.

Inspectors observed excellent application of the key elements of ANTT in a number of practice interventions; accessing arterial lines, central lines.

The IPC team hold stand-alone face to face ANTT training four times a year; utilising clinical work stations to reinforce ANTT skills in relation to blood culture collection, urinary catheters, wound care and peripheral line administrating of intravenous antibiotics. These sessions are offered to nursing and medical staff. It was planned all staff will attend one - two yearly updates of this training. ANTT is also a component of IPC mandatory training sets.

The IPC team hold bi-annual ANTT training sessions exclusively for medical staff new to the trust.

A number of staff within the unit had been trained as ANTT competency assessors. However, the IPC link nurse has the main responsibility for carrying out assessment and cascade training. Inspectors were informed that the link nurse has been allocated protected time to carry this out this role.

Inspectors were informed that all nursing and medical staff within the unit have had ANTT training and assessments of practice. Records were available on ANTT ongoing staff assessments in relation to peripheral cannulation, peripheral/ central line IV therapy, blood culture collection, venepuncture, wound care, indwelling urinary catheters and enteral feeding. Evidence was also available for impromptu assessments of staff practice in relation to these procedures.

4.2 Invasive Devices

Invasive devices are medical devices which in whole or in part, penetrate the body, either through a body orifice or through the surface of the body. 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 in the insertion and ongoing maintenance of invasive devices.

The unit achieved compliance in this section of the audit tool.

Evidence of practice was obtained through observation, review of documentation and speaking with staff. Policies and procedures for the insertion and on-going management of invasive devices were in place. However some of these policies had passed their review date. Policies identified for review were; urinary catheter (Nov 2013), peripheral vascular catheter (Nov 2013). There was no central venous catheter policy in place; the unit was using the CCaNNI guidelines for insertion and maintenance of central lines. Inspectors are aware that the trust is currently reviewing existing processes.

11. **It is recommended that all trust policies/guidelines are reviewed and updated as required to ensure continued accuracy of guidance for staff.**

Competency in the management of a range of invasive access devices is assessed as an aspect of Step 1 of the new national competency framework for critical care nurses. As part of this framework all new staff are competency assessed during their preceptorship period, by their allocated mentor, in the management of; vascular, urinary, respiratory and enteral feeding devices. Evidence was available that new staff also attend the Clinical Education Centre for further competency training on a number of invasive devices.

As previous discussed staff attend IPC training in relation to the principles of asepsis and invasive devices and have ongoing training and assessment in relation to ANTT and invasive devices/procedures.

For long term staff there was little evidence to support update training assessment of competence when using invasive devices. Inspectors were informed that generally, staff competence is gained through mentorship.

12. **It is recommended that longer term staff receive update training and ongoing competency assessment in the management of invasive devices.**

Staff displayed good knowledge and practice in the insertion and management of invasive devices during the inspection. Audit results for November 2014 evidenced compliance with 100 per cent high impact interventions standards.

As already discussed, in July 2014, 70 per cent was achieved for central venous catheter insertion compliance rate. The issue identified was medical staff not wearing of a mask during the procedure. Evidence of action points and subsequent scores of 100 per cent compliance were available.

Reviewing patient electronic records evidenced that all information on the insertion and ongoing maintenance of peripheral and central lines was available.

The Public Health Agency (PHA) 'Device associated Infection Surveillance in Critical Care Units HCAI Monthly Report', November 2013 – October 2014 details South West Acute hospital critical care unit infection rates. This report identifies that the critical care unit has had:

- **zero** VAP (ventilated associated pneumonia)
- **zero** CAUTI (catheter associated infection)
- **zero** CLABSI (central line associated blood stream infection)
- **zero** CR-BSI (central venous catheter- related bloodstream infection)

The unit is commended for results in compliance with best practice for care bundle scores and the device associated infection surveillance.

4.3 Taking Blood Cultures

A blood culture is a microbiological culture of blood. It is employed to detect infections that are spreading through the bloodstream. For organisations to comply with this section they must ensure that a policy is in place, staff display knowledge and practical skills on the key principles and monitoring of the rate of blood cultures is carried out.

The unit achieved non-compliance in this section of the audit tool. Immediate attention is required to improve scoring in this section.

Inspectors were unable to observe practice at the time of the inspection. Evidence of practice was obtained through a review of documentation and speaking with staff.

A trust blood culture policy is available. This is incorporated into the Guidelines on the Collection of Clinical Specimens for Laboratory Examination. A video link on the procedure for collecting blood cultures is on all computer desk tops for staff to watch and reference. Nursing staff within the unit have primary responsibility for blood culture collection. Staff demonstrated good knowledge on the key components of this procedure.

Inspectors reviewed the electronic records of a number of patients who had a blood culture taken. There was inconsistent recording of information; with the time of obtaining the blood culture consistently not recorded.

13. **It is recommended that all information on the collection of blood cultures is consistently recorded.**

The laboratory regularly informs clinical, nursing and IPC staff of positive blood cultures within the unit. The rate of positive blood cultures and the incidence of contaminated cultures are currently not monitored. Therefore inspectors were not able to evidence if the incidence of contamination is less than 3% and comparisons of positive blood cultures are not able to be made between clinical units within the trust.

14. **It is recommended that a system is developed to allow the review of positive blood cultures between units and to capture the blood culture contamination rates in the unit. Unit staff should routinely be provided with this information.**

At present there is no system in place to monitor compliance with best practice when taking blood cultures. Inspectors were informed that blood culture assessments with ANTT have been added to the units ANTT training programme; assessment has not yet commenced but will be undertaken by the units IPC link nurse.

15. **It is recommended that a system should be initiated to routinely monitor compliance with best practice when collecting blood cultures.**

4.4 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.

Compliance was achieved in this section of the audit tool. Inspectors observed that antimicrobial guidelines were in place and cascaded to staff as part of induction, ensuring continuity of prescribing within the unit. These guidelines are due for review in December 2014; inspectors were informed that these guidelines are being reviewed and updated at present. These guidelines were observed on a wall at the central work station and are available on the trust intranet site for staff to reference.

Computer aided prescribing tools were available to aid antibiotic prescribing. The prescribing module and how it is used to assist prescribing was demonstrated to inspectors.

A unit based pharmacist has recently taken up the post within the last number of months (October 1st 2014). The pharmacist has an allocated 3.75 hours per day in the unit, Monday - Friday. Due to their previous role as a trust

antimicrobial pharmacist, an excellent knowledge base on trust antimicrobial policy and practices was evident.

In October 2014, the pharmacist provided an update training session for all unit nursing staff on antimicrobial prescribing. It is planned to provide a similar session for unit medical staff in the future. New unit medical staff have a 1:1 teaching session with the pharmacist on prescribing guidelines within the unit.

A trust wide anti-microbial management team meets quarterly and was chaired by the medical director. Representatives from IPC, microbiology, pharmacy and general practitioners attend these meetings. This team centrally reviews audit results, anti-microbial usage and incidents.

An antimicrobial ward round, attended by the microbiologist, unit physicians and anti-microbial pharmacist, takes place Monday and Friday. As part of this round the pharmacist reviews each patient's antimicrobial prescription.

As part of a Point Prevalence Survey, antimicrobial usage was reviewed in June 2012. There had been no patients prescribed antimicrobials within the unit during the survey; no issues were identified.

Antimicrobial usage is currently not audited in line with antimicrobial prescribing guidance. An audit tool has been devised and plans are in place to commence this audit in the next number of months. The unit based pharmacist carries out informal auditing of antimicrobial prescribing on a daily basis.

16. It is recommended that antimicrobial usages should be routinely audited in line with current antimicrobial prescribing guidance.

4.5 Clostridium *difficile* infection (CDI) Recommendations

The detection and treatment of CDI should be carried out in line with best practice guidance. For organisations to comply with this section they must ensure that guidance on care is in place, staff display knowledge and implement the guidance and adherence to best practice is monitored.

The unit achieved full compliance in this section of the audit tool. Inspectors were unable to observe practice at the time of the inspection. Evidence of practice was obtained through review of documentation and speaking with staff.

An up to date guide and care pathway on the management of CDI is available and known to staff.

Inspectors were informed that the unit has never had a patient with CDI. Audit tools have been developed to monitor adherence to the CDI bundle as appropriate. When a patient, suspected to have CDI was admitted to the unit, the manager had commenced auditing of staff practice in adhering to policy

and completion of the care pathway. Completion of the CDI care pathway for patients identified in the future should continue to be audited. The IPC team carry out audits on the achievement of isolation as part of the RCA process.

An antibiotic policy is in place for patients who have or are suspected with CDI. If necessary the daily ward round and antimicrobial ward round can discuss and review antibiotic usage in conjunction with the microbiologist. The IPC team will review antimicrobial prescribing as part of the CDI care bundle.

4.6 Surgical site infection (SSI)

Surgical site infection (SSI) is a type of healthcare associated infection, in which a wound infection occurs after an invasive (surgical) procedure. The majority of surgical site infections are preventable. For organisations to comply with this section they must ensure that systems and processes are in place throughout perioperative (pre, intra and post-operative) care to reduce the risk of infection. A programme of surgical site infection surveillance should be in line with DHSSPS guidance.

A review of the trust and unit in the management of SSI identified full compliance in this section of the audit tool. Information was obtained from discussion with unit and infection prevention and control staff and a review of a patient's emergency surgery notes. There were no elective surgery patient notes present to be reviewed as part of the perioperative assessment.

Inspectors observed that perioperative guidance on the prevention of SSI was available. Staff within the unit displayed knowledge of the postoperative SSI care bundle for patients within critical care.

The trust undertakes mandatory reporting of SSI surveillance to the Public Health Agency on orthopaedic surgery and caesarean section delivery. Results of audit and surveillance are reviewed by the HCAI surveillance group.

In quarter 1 of 2014 the trust had 2 orthopaedic SSI. Evidence was available to show discussion and actions taken to address issues identified.

The SSI rate for South West Acute in quarter 1 of 2014 is below NI average. In 2012/13 changes to the choice of wound dressings have helped reduce SSI rates.

4.7 Ventilated (or tracheostomy) care

Ventilator-associated pneumonia (VAP) is pneumonia that develops 48 hours or longer after mechanical ventilation is given by means of an endotracheal tube or tracheostomy. For organisations to comply with this section they must ensure that guidance on the prevention and care of a patient with VAP is in place and monitored.

Full compliance was achieved in this section of the audit tool. A care bundle for ventilation ongoing care was in place and validated by senior staff (Picture 4). A monthly compliance score of 100 per cent has been achieved in January – November 2014.

Picture 4: Care bundle component – 30° bed tilt

Staff have received training on VAP and were knowledgeable on the prevention and care of a VAP.

Regional VAP surveillance is carried out and forwarded to the PHA and directorate lead on a monthly basis. The last VAP recorded in the unit, as per PHA figures, was on 2 August 2011. Results of audit and surveillance is reviewed and discussed at the HCAI accountability meeting and at trust critical care and staff meetings.

4.8 Enteral feeding or tube feeding

Enteral feeding or tube feeding is defined as a mode of feeding that delivers nutrients directly into the stomach, duodenum or jejunum (gastrostomy, jejunostomy, naso/orogastric tubes). For organisations to comply with this section staff should display awareness of guidelines for the management management of an enteral feeding system; insertion, set up and care. Adherence to best practice should be monitored.

Compliance was achieved in this section of the audit tool. Evidence of practice was obtained through observation, review of documentation and speaking with staff.

AN enteral feeding policy/guidance was available (September 2013). Staff also follow and take guidance from the Out of Hours Feeding Protocol (November 2013) and Reducing the Harm caused by Misplaced Nasogastric and Orogastric Feeding tubes Policy (due review December 2014).

Enteral feed is stored, administered and disposed of as per trust policy and in line with best practice. Nursing staff displayed good knowledge on the management of an enteral feeding system; set up and care. When

necessary, staff adhere to guidance on the care of a stoma site from the hospital stoma nurse.

Preparation, decanting, reconstituting or diluting of feeds is not done within the unit.

Within the unit, only medical staff insert nasogastric tubes. Observation identified nasogastric lines were not labelled, dated or signed as outlined in the enteral feeding care bundle. A review of documentation evidenced that there was no documentation of the pH (acidic or alkaline levels) and amount of aspirate when a nasogastric tube was initially inserted. Documentation evidenced that an x-ray was taken after insertion and before feeding commenced. At the feedback session, the clinical lead advised that aspirate is not taken as the fine bore tubing used did not allow for this practice. Trust policy does not reflect this practice and also states that 'if unable to obtain aspirate refer to relevant policy flowchart for advice', this flow chart was no present in the policy.

17. **It is recommended that following a review and update of relevant policy/guidance, staff adhere to practice guidelines. Adherence to best practice should be audited and actioned were issues are identified.**

Compliance in relation to management of a nasogastric tube, through the ANTT enteral feeding care bundle has commenced. No issues have been identified up to present time.

4.9 Screening for Meticillin Resistant Staphylococcus Aureus (MRSA) colonisation and decolonisation

The detection and treatment of MRSA should be carried out in line with DHSSPS Best Practice on Screening for MRSA Colonisation (HSS MD 12/2008). For organisations to comply with this section they must ensure that a screening and treatment policy is in place, staff display knowledge of the policy and adherence to best practice is monitored.

The unit achieved full compliance in this section of the audit tool. Inspectors were unable to observe practice at the time of the inspection. Evidence of practice was obtained through review of documentation and speaking with staff.

An up to date MRSA screening and treatment policy, implemented in September 2014, was known to staff. Routine screening is carried out in line with DHSSPS Best Practice on Screening for MRSA colonisation.

An MRSA care pathway was available and known by staff. The inspection team was informed by the IPC nurse that newly isolated MRSA colonised patients have been nursed within the unit. As already discussed, from 1st – 31st January 2014, the unit was selected to receive Enhanced Support from the IPC team due to an increase in MRSA colonisation following admission to

the unit. IPC baseline audit results identified aspects of practice, relating to hand hygiene and on-going peripheral catheter care, which required improvement.

Enhanced support from the IPC team included audits of hand hygiene, isolation, cleaning commodes, ANTT and peripheral and urinary catheter care. The unit commenced daily audits, until a compliance level of 95 percent and above was achieved, the unit manager reviewed and audited MRSA swabbing practice and staff were updated on MRSA guidelines. Additional environmental and equipment cleaning was carried out and procedures reviewed and updated. Patient placement within the unit was also reviewed. Update IPC training was available for all unit staff.

At the end of January 2014, all baseline audits achieved 100 per cent. MRSA audits are discussed as part in HCAI surveillance group meetings. RCAs are carried out on all MRSA bacteraemias.

An MRSA clinical risk assessment and policy audit tool is in place. There were no MRSA cases in the unit at the time of inspection. For future MRSA cases the unit manager and IPC will commence audits on compliance with care pathway.

5.0 Inspection Findings: Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool

The Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool provide a common set of overarching standards for all hospitals and other healthcare facilities in Northern Ireland. Inspections using the audit tool gather information from observations in functional areas including, direct questioning and observation of clinical practice and, where appropriate, review of relevant documentation.

The audit tool is comprised of the following sections:

- organisational systems and governance
- general environment
- patient linen
- waste and sharps
- patient equipment
- hygiene factors
- hygiene practices

The section on organisational systems and governance was not reviewed during this unannounced inspection.

Standard 2: General Environment

For organisations to comply with this standard they must provide an environment which is well maintained, visibly clean, free from dust and soilage. A clean, tidy and well maintained environment is an important foundation to promote patient, visitor and staff confidence and support other infection prevention and control measures.

The Regional Healthcare Hygiene and Cleanliness Audit Tool Compliance Levels

General environment	**Compliance levels**
Reception	93
Corridors, stairs lift	100
Public toilets (main reception)	98
Unit/department - general (communal)	100
Patient bed area	96
Bathroom/washroom	100
Toilet	N/A
Clinical room/treatment room	100
Clean utility room	100
Dirty utility room	100
Domestic store	98
Kitchen	100
Equipment store	100
Isolation	99
General information	96
Average Score	**99**

The findings in the table above indicate that the general environment and cleaning in the Critical Care Unit was of an excellent standard, with eight sections achieving full compliance.

Picture 5: Well maintained sanitary area

A high standard of cleaning and well maintained public areas such as the reception, corridors and public toilets promote public confidence in the standards set by the hospital (Picture 5).

The key findings in respect of the general environment for the unit are detailed in the following section.

Critical Care Unit

Within the environment section of the audit tool inspectors found excellent compliance with the standard of cleaning. Inspectors identified only minor issues for improvement in this section of the audit tool:

- dust, debris or smudge marks on some surfaces
- some wall and surfaces damage
- the lock on the domestic store chemical cupboard was broken
- a member of nursing staff was not aware of the NPSA colour coding, a poster not displayed for nursing staff to reference

18. **It is recommended that staff ensure all surfaces including furniture, fixtures and fittings are clean and in a good state of repair. Information posters should be readily available for staff to reference.**

Standard 3: Patient Linen

For organisations to comply with this standard, patient linen should be clean, free of damage, handled safely and stored in a clean and tidy environment. The provision of an adequate laundry service is a fundamental requirement of direct patient care. Linen should be managed in accordance with HSG 95(18) and once published the final DHSSPS Policy for Provision of Health and Social Care Laundry and Linen Services.

Compliance of Patient Linen

Patient linen	**Compliance levels**
Storage of clean linen	96
Storage of used linen	100
Laundry facilities	N/A
Average Score	**98**

The above table indicates that the unit achieved good overall compliance in the management of patient linen.

Linen was clean, free from damage and stored appropriately in the designated store. Staff demonstrated good knowledge on the handling of clean and used linen.

The issue identified for improvement in this section of the audit tool was:

- debris in the light fitting

Refer to Previous Recommendation

Standard 4: Waste and Sharps

For organisations to comply with this standard they must ensure that waste is managed in accordance with HTM07-01 and Hazardous Waste (Northern Ireland) Regulations (2005). The safe segregation, handling, transport and disposal of waste and sharps can, if not properly managed, present risks to the health and safety of staff, patients, the public and the environment.

Waste bins in all clinical areas should be labelled, foot operated and encased. This promotes appropriate segregation, and prevents contamination of hands from handling the waste bin lids. Inappropriate waste segregation can be a potential hazard and can increase the cost of waste disposal.

Sharps boxes must be labelled and signed on assembly and disposal. Identification of the origin of sharps waste in the event of spillage or injury to staff is essential. This assists in the immediate risk assessment process following a sharps injury.

Compliance of Waste and Sharps

Waste and sharps	Compliance levels
Handling, segregation, storage, waste	96
Availability, use, storage of sharps	94

4.1 Management of Waste

The above table indicates that the unit achieved good overall compliance in the handling and storage of waste. The issue identified for improvement in this section of the audit tool was:

- household waste bins were not available in the dirty utility or blood testing room

4.2 Management of Sharps

The above table indicates that the unit achieved good overall compliance in this standard. The issues identified for improvement in this section of the audit tool were:

- the sharps box on the paediatric resuscitation trolley was not signed or dated
- the sharps box on the resuscitation trolley had contents insitu and was not changed according to local policy

19. **It is recommended that household waste bins are available in the dirty utility and blood testing room. All sharps boxes are signed, dated and changed in accordance with local policy**

Standard 5: Patient Equipment

For organisations to comply with this standard they must ensure that patient equipment is appropriately decontaminated. The Northern Ireland Regional Infection Prevention and Control Manual, states that all staff that have specific responsibilities for cleaning of equipment must be familiar with the agents to be used and the procedures involved. COSHH regulations must be adhered to when using chemical disinfectants.

Any unit, department or facility which has an item of equipment should produce a decontamination protocol for that item. This should be in keeping with the principles of disinfection and the manufacturer's instructions.

Compliance of Patient Equipment

Patient equipment	**Compliance levels**
Patient equipment	99

The above table indicates that the unit achieved good overall compliance in this standard. Equipment was clean and in a good state of repair. Staff displayed good knowledge on their roles and responsibly and are commended for this achievement.

The only issue identified for improvement in this section of the audit tool was:

- The case of the blood gas machine was damaged

Standard 6: Hygiene Factors

For organisations to comply with this standard they must ensure that a range of fixtures, fittings and equipment is available so that hygiene practices can be carried out effectively.

Compliance of Hygiene Factors

Hygiene factors	Compliance levels
Availability and cleanliness of wash hand basin and consumables	100
Availability of alcohol rub	100
Availability of PPE	100
Materials and equipment for cleaning	100
Average Score	**100**

The above table indicates that the unit achieved full overall compliance in this standard. Staff are commended for this score.

Picture 6: Typical hand washing sink.

Hand washing sinks were easily accessible, in a good state of repair and used correctly; only for hand hygiene (Picture 6). Alcohol rub and hand washing consumables were readily available and adequately stocked. PPE was positioned throughout the unit for staff to use. Domestic cleaning equipment was clean, used and stored correctly in a designated store.

Standard 7: Hygiene Practices

For organisations to comply with this standard they must ensure that healthcare hygiene practices are embedded into the delivery of care and related services.

Compliance of Hygiene Practices

Hygiene practices	**Compliance levels**
Effective hand hygiene procedures	94
Safe handling and disposal of sharps	92
Effective use of PPE	94
Correct use of isolation	N/A
Effective cleaning of unit	100
Staff uniform and work wear	88
Average Score	**94**

The above table indicates that the unit achieved good overall compliance in this standard. Full compliance was achieved in effective cleaning of the unit.

The issues identified for improvement in this section of the audit tool were:

- two medical staff did not perform hand hygiene before entering a patients bed room

Picture 7: Re-sheathed needle

- there was a re-sheathed needle in a sharps box in bed space 3 (Picture 7)
- the HCA removed her gloves, touched the lid of the bin and did not wash their hands
- some staff had unsecured long hair
- some staff wore stoned jewellery

20. **It is recommended that all staff adhere to trust policies; hand hygiene, sharps management, use of PPE and dress code.**

6.0 Summary of Recommendations

The Regional Critical Care Audit Tool

1. It is recommended that infection prevention and control staffing levels are reviewed to facilitate daily visits to the unit.

2. It is recommended that critical care nursing staff levels and the recruitment programme should continue to be reviewed and actioned.

3. It is recommended that regular site specific critical care meetings are reintroduced within the unit.

4. It is recommended that access to trust intranet site policies are reviewed to facilitate easy staff use.

5. It is recommended that computer information records are completed following hand hygiene education.

6. It is recommended that patient and relative information leaflets are updated to include; the concept of bare below the elbow and not to bring outside coats into the unit.

7. It is recommended that as part of any refurbishment, adherence to core clinical space recommendations should be considered. The use of a room for storage facilities should be reviewed.

8. The overarching trust and South West Acute Water Safety Plans should be reviewed to reflect current practice. Once completed and ratified, plans should be made available to all staff.

9. It is recommended that a policy or protocol should be developed to outline roles, responsibilities and the documentation to be completed when reporting of laboratory results.

The Regional Clinical Practices Audit Tools

10. It is recommended that the ANTT policy is ratified and disseminated to staff.

11. It is recommended that all trust policies/guidelines are reviewed and updated as required to ensure continued accuracy of guidance for staff.

12. It is recommended that longer term staff receive update training and ongoing competency assessment in the management of invasive devices.

13. It is recommended that all information on the collection of blood cultures is consistently recorded.

14. It is recommended that a system is developed to allow the review of positive blood cultures between units and to capture the blood culture contamination rates in the unit. Unit staff should routinely be provided with this information.

15. It is recommended that a system should be initiated to routinely monitor compliance with best practice when collecting blood cultures.

16. It is recommended that antimicrobial usages should be routinely audited in line with current antimicrobial prescribing guidance.

17. It is recommended that following a review and update of relevant policy/guidance, staff adhere to practice guidelines. Adherence to best practice should be audited and actioned were issues are identified.

Regional Healthcare Hygiene Cleanliness Standards and Audit Tool
Standard 2: Environment

18. It is recommended that staff ensure all surfaces including furniture, fixtures and fittings are clean and in a good state of repair. Information posters should be readily available for staff to reference.

19. It is recommended that household waste bins are available in the dirty utility and blood testing room. All sharps boxes are signed, dated and changed in accordance with local policy

Standard 3: Patient Linen

Refer to Previous Recommendation

Standard 4: Waste and Sharps

Standard 5: Patient Equipment

None

Standard 6: Hygiene Factors

None

Standard 7: Hygiene Practices

20. It is recommended that all staff adhere to trust policies; hand hygiene, sharps management, use of PPE and dress code.

7.0 Key Personnel and Information

Members of RQIA's Inspection Team

Lyn Gawley	Inspector Infection Prevention/Hygiene Team
Sheelagh O'Connor	Inspector Infection Prevention/Hygiene Team
Margaret Keating	Inspector Infection Prevention/Hygiene Team
Thomas Hughes	Inspector Infection Prevention/Hygiene Team

Trust Representatives attending the Feedback Session

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

Mary Melley	Ass. Nursing Services Manager
Francis Smyth	Ward Sister
Dymphna Lynch	Infection Prevention & Control Nurse
Ronan O'Hare	Lead Clinician
Karen Martin	Infection Prevention & Control Nurse
Martin Ferguson	IFM
Mary McGoldrick	Support Services
Anita McConnell	Contracts Lead
Lewis Quinn	CCCS

Apologies

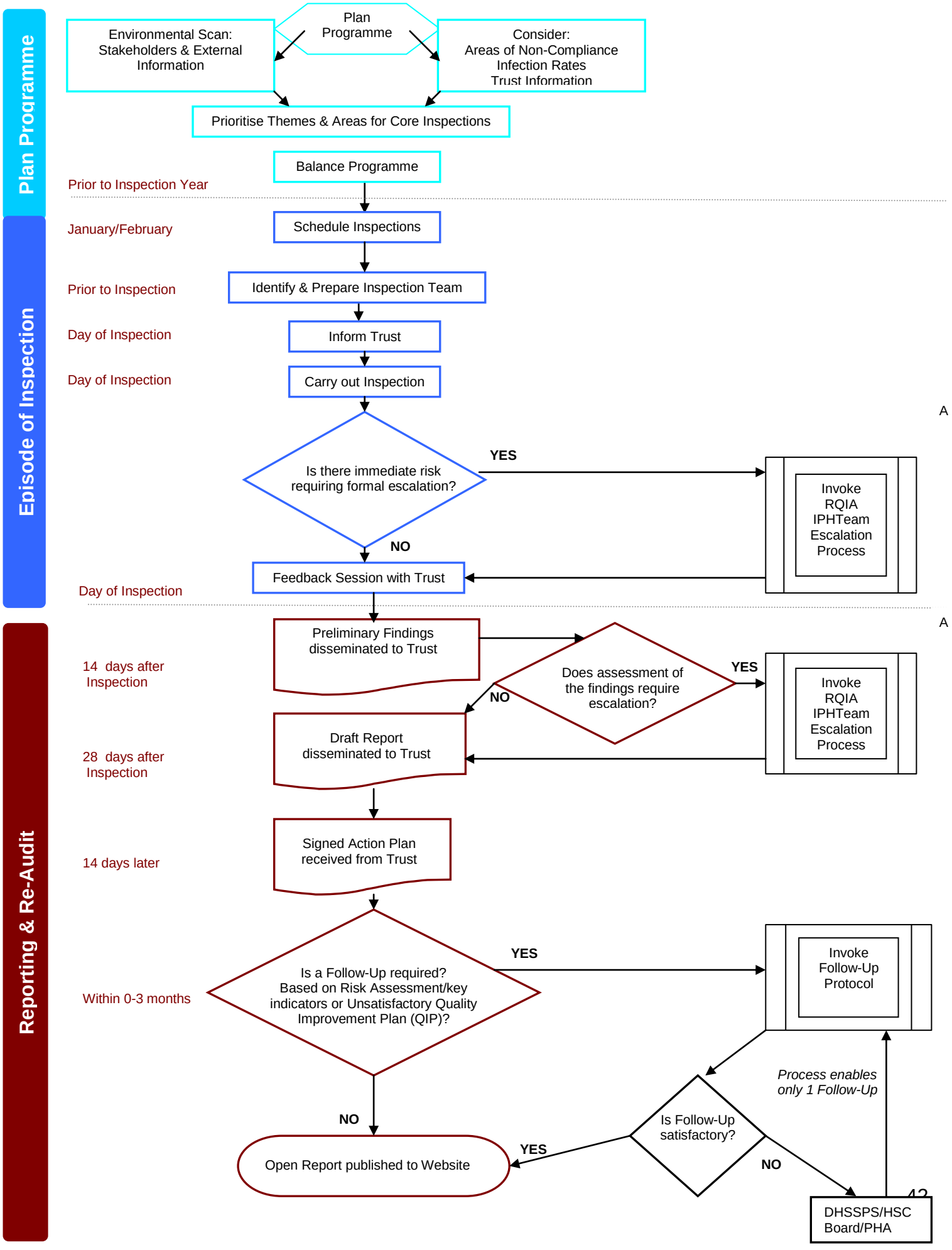
Kathleen Crossan	Ass. Director, Surgery & Anaesthetics
Jackie McGrellis	General Manager, Theatres & Anaesthetics
Brian McFetridge	Critical Care, Nurse Consultant
Shireen McGlone	Infection Prevention & Control Nurse

8.0 Augmented Care Areas

Based on DHSSPS guidance, the augmented care areas currently identified for inclusion in inspections are:

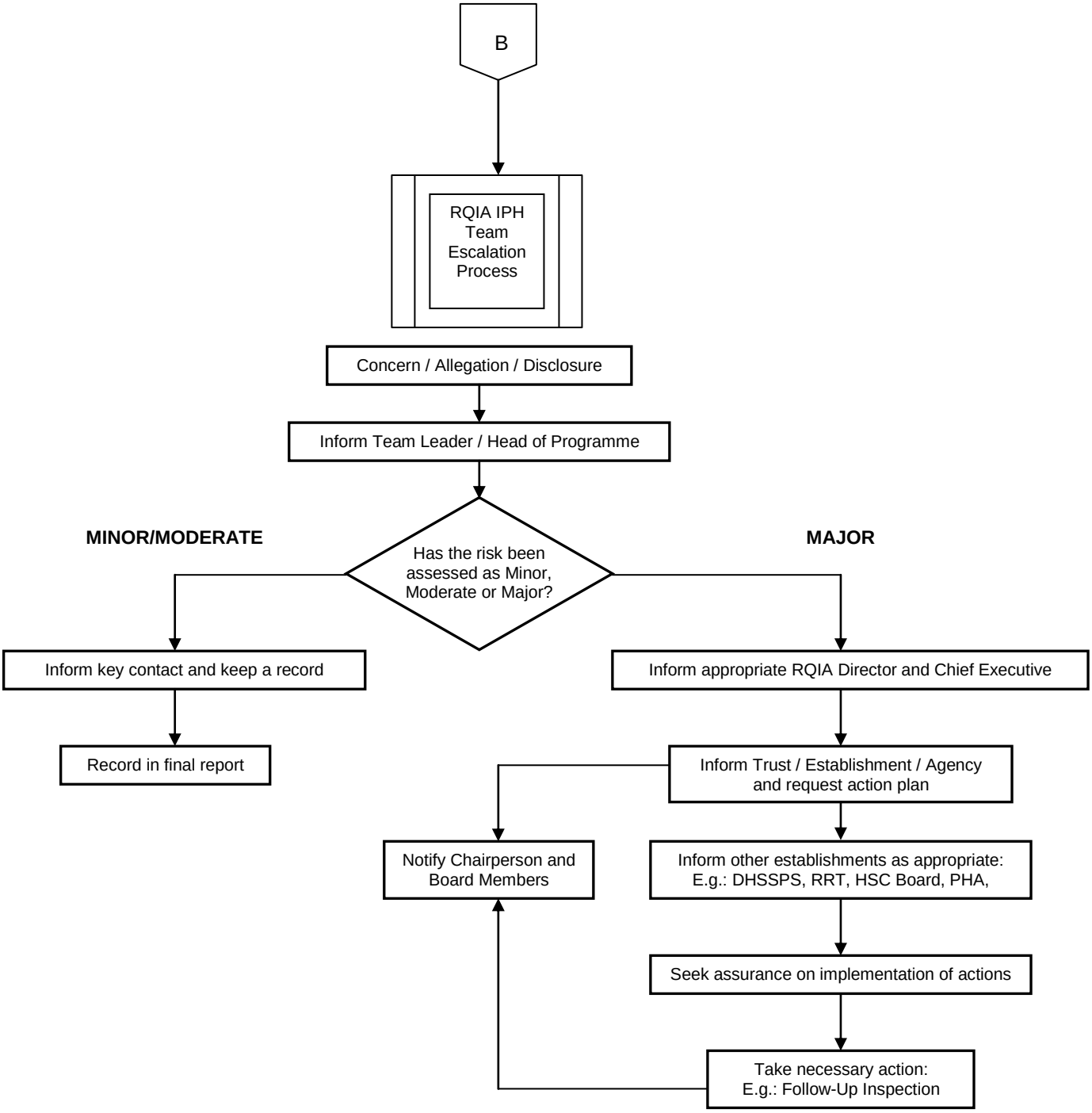
- neonatal and special care baby units
- paediatric intensive care
- all adult intensive care which includes cardiac intensive care
- burns units
- renal (dialysis) units
- renal transplant unit
- high dependency units (HDU)
- haematology
- oncology

9.0 Unannounced Inspection Flowchart



10.0 Escalation Process

RQIA Hygiene Team: Escalation Process



11.0 Quality Improvement Plan

Reference number	Recommendations	Designated Department	Action required	Date for completion / timescale
The Regional Critical Care Audit Tool				
1.	It is recommended that infection prevention and control staffing levels are reviewed to facilitate daily visits to the unit.	IP&C	A business case is being prepared and will be submitted to Medical Directorate Senior Management Team outlining the staffing requirements to achieve this standard.	25th March 2015
2.	It is recommended that critical care nursing staff levels and the recruitment programme should continue to be reviewed and actioned.	Lead Nurse/ Ward Sister	Staffing are continually monitored by the ward Manager and Lead Nurse and appropriate actions taken to ensure safe and appropriate staffing within the Unit. Intention to recruit process has been commenced to address long term unplanned absence.	Ongoing
3.	It is recommended that regular site specific critical care meetings are reintroduced within the unit.	Lead Nurse	Lead Nurse, Ward Sister and Lead Anaesthetist to have an initial meeting to agree implementation of same and frequency of meeting.	February 2015
4.	It is recommended that access to trust intranet site policies are reviewed to facilitate easy staff use.	Ward Sister	Currently all of IPC policies, procedures and guidelines are on intranet. Electronic Clinical Information System (CIS) Nurse and Nurse Consultant will explore direct links from	May 2015

			sections of CIS to relevant documentation.	
5.	It is recommended that computer information records are completed following hand hygiene education.	Ward Sister	The facility to capture this information is on CIS. Communication with the staff regarding the importance of recording relative's education of hand hygiene on CIS has been commended – this is through email and staff safety brief and Unit meetings an audit is to be commenced and completed.	Commenced and ongoing Audit by March 2015
6.	It is recommended that patient and relative information leaflets are updated to include; the concept of bare below the elbow and not to bring outside coats into the unit.	Lead Nurse/ Ward Sister/ Consultant Nurse	A suitable & safe area for visitors to hang their coats has been identified.	January 2015
7.	It is recommended that as part of any refurbishment, adherence to core clinical space recommendations should be considered. The use of a room for storage facilities should be reviewed.	Estates	The side room which is currently being used as a temporary store does not impede our ability to facilitate additional patients into the Unit if this is required. If We will review other ways of facilitating this storage and implement same.	Ongoing
8.	The overarching trust and South West Acute Water Safety Plans should be reviewed to reflect current practice. Once completed and ratified, plans should be made available to all staff.	IP&C	Water Plans are undergoing ratification and will be available under IP & C guidelines on the Trust Intranet by February 2015	16th February 2015

9.	It is recommended that a policy or protocol should be developed to outline roles, responsibilities and the documentation to be completed when reporting of laboratory results.	Consultant Nurse	The Nurse Consultant has raised this issue at the regional Critical Care Network [CCaNNI] with a view to propose a regional standard operational procedure (SOP) and in the interim the Unit is reviewing internal processes.	Commenced & ongoing
The Regional Clinical Practices Audit Tools				
10.	It is recommended that the ANTT policy is ratified and disseminated to staff.	IP&C	Completed and ongoing	27th January 2015
11.	It is recommended that all trust policies/guidelines are reviewed and updated as required to ensure continued accuracy of guidance for staff.	IP&C	A programme of work is ongoing in relation to IP&C policy updates for example the peripheral line policy was uploaded 13th October 2014 (prior to this inspection. Urinary Catheter Care has recently been ratified and will be uploaded by 2nd February 2015. Central Line policy due for ratification early March 2015 and will be uploaded by 31st March 2015.	Commenced and on-going 31st March 2015
12.	It is recommended that longer term staff receive update training and ongoing competency assessment in the management of invasive devices.	IP&C/ Ward Sister	• Experience Critical Care staff attended an update by lead assessors in adult critical care held on 9th & 12th May 2014 who currently support staff undertaking the critical care short course programme. This will now include longer term staff using the national	November 15

			competency framework for adult critical care nurses. • The Units IPC Link Nurse will provide updates in the management of invasive devices for longer term Staff and this will be rolled out between now and September. • Competency assessment of these updates will be linked with staff appraisals and identifying learning needs analysis.	
13.	It is recommended that all information on the collection of blood cultures is consistently recorded.	Ward Sister	• Communication has been sent by email and will be a standing item on safety briefs and unit based meetings to ensure all blood cultures taken are recorded in the CIS taken under ANTT with date and time recorded electronically by the person who obtained the blood culture. • Audit of all blood cultures taken within the unit has commenced from December 2014 within the Critical Care Unit and will continue on a monthly basis. • The lab will commence a monthly audit of all blood cultures taken within the unit from January 2015.	Actions are commenced will be on-going

			• The results of all audits will be communicated to unit staff via email / safety briefs and unit based meetings.	
14.	It is recommended that a system is developed to allow the review of positive blood cultures between units and to capture the blood culture contamination rates in the unit. Unit staff should routinely be provided with this information.	Laboratory Critical Care Medical Staff	• Results from the blood culture diary for December 2014 were audited by Critical Care staff in Jan 2015. • Laboratory contacted to commence audits of all blood cultures sent from Critical Care from January 2015 onwards and report on a monthly basis. • The Trust surveillance sub group have requested a paper be presented at the next surveillance meeting 18th Feb.	January 2015
15.	It is recommended that a system should be initiated to routinely monitor compliance with best practice when collecting blood cultures.	Consultant Nurse	Consultant nurse and ANTT link nurse are to commence work on this and will devise a process for monitoring compliance in line with best practice.	September 2015
16.	It is recommended that antimicrobial usages should be routinely audited in line with current antimicrobial prescribing guidance.	Lead Consultant	Plans to audit antimicrobial usage have been agreed and will be implement by the unit pharmacist/medical team	September 2015

17.	It is recommended that following a review and update of relevant policy/guidance, staff adhere to practice guidelines. Adherence to best practice should be audited and actioned were issues are identified.	Lead Nurse	• Ward Manager / Consultant Nurse will review current practice relating to naso-gastric tubes and naso-gastric feeding. • Reducing the Harm Caused by Misplaced Nasogastric & Orogastric Feeding Tubes Policy has been emailed to all staff and included on safety brief. • Policy Flowchart will be laminated and available at each bed space to ensure the best practice recommendations and Trust policy is adhered to.	Commenced and on-going Jan 2015
Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool Standard 2: Environment				
18.	It is recommended that staff ensure all surfaces including furniture, fixtures and fittings are clean and in a good state of repair. Information posters should be readily available for staff to reference.	Support Services	NSPA posters made available for display for nursing staff to reference. Support Services Quality control checks and Environmental Cleanliness Audits to review and report any damaged furniture, fixtures or fittings to the relevant department for action.	January 2015
19.	It is recommended that household waste bins are available in the dirty utility and blood testing room. All sharps boxes are signed dated and changed in accordance with local policy.	Support Services/ Ward Sister	• Ward manager ordered household waste bin for dirty utility. • Reissue sharps policy to all staff.	Commenced and on-going January 2015

			• All emergency trolleys when checked post use, ensure used sharps box sealed, removed, signed, dated and changed.	
20.	It is recommended that all staff adhere to trust policies; hand hygiene, sharps management, use of PPE and dress code.	Lead Nurse/ Ward Sister	• Policies reissued to staff and asked to ensure they adhere to these • Hand hygiene assessments will be undertaken during doctor's rounds. • Increased awareness and effort to ensure all hand hygiene's audits are multi-disciplinary within the unit to ensure high standards.	Commenced and on-going January 2015

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