Inspection Report

5 and 6 September 2022

Belfast Health and Social Care Trust

Neonatal Unit
Royal Jubilee Maternity Services
274 Grosvenor Road,
Belfast,
BT12 6BA

Telephone number: 028 90240503

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

1.0 Service information

Organisation/Registered Provider: Belfast Health and Social Care Trust (BHSCT)	**Responsible person:** Dr Cathy Jack Chief Executive
Person in charge at the time of inspection: Ms. Lisa Darrah, Interim Lead Midwife.	**Number of commissioned beds:** 29
Categories of care: Augmented Care	**Number of beds occupied in the ward on the day of this inspection:** 24
Brief description of the accommodation/how the service operates: The unit cares for premature babies, sick babies, any baby requiring special care and those babies who may need special attention during the first days of life. There are three areas in the Neonatal Unit: • Neonatal Intensive Care Unit (NICU); • High Dependency Unit (HDU); and • Special Care Baby Unit (SCBU).	

2.0 Inspection summary

An unannounced inspection of the Neonatal Unit (NNU) at Royal Jubilee Maternity Services took place on 5 and 6 September 2022, between 9am and 5pm by care Inspectors, and concluded with feedback to Ms Lisa Darrah, Interim Lead Midwife and members of the senior management team (SMT) on 10 October 2022.

The neonatal unit was assessed against a set of Regional Infection Prevention and Control Audit Tools for Augmented Care Settings and compliance was assessed in each separate area by taking an average score of all elements of each tool. A 'Guidance and Procedural Paper for Inspections in Augmented Care Areas' has been developed which outlines the inspection process www.rqia.org.uk.

Background to the Augmented Care Inspection Programme

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

Following on from this in 2018 the future approach to assurance of infection prevention and control practices within NNU moved from compliance dominant to a collaboration-based model in assuring good practice.

This approach required HSC Trusts to undertake regular self-assessment of the care delivered in their augmented care settings with the agreed overall compliance target scores of 95%. The Neonatal Network Northern Ireland (NNNI) works with HSC Trusts to provide a platform for regional sharing of good practice and learning. RQIA have worked collaboratively with the NNNI and agreed the protocol for the return of twice yearly submission of HSC Trust self – assessments and updated action plans from the NNNI to RQIA. Inspection visits to intensive care units are undertaken by RQIA to randomly sample aspects of the Regional Infection Prevention and Control Audit Tools for Augmented Care Settings to spot check the systems and processes of care, while reserving the right to independently assess/inspect any intensive care unit at any stage should a particular circumstance require this.

The purpose of this inspection was to validate the findings and actions taken by the BHSCT following their self-assessment using the three regionally agreed inspection tools for augmented care areas (Regional Neonatal Infection Prevention and Control Audit Tool, Regional Infection Prevention and Control Clinical Practices Audit Tool for Augmented Care Areas and the DHSSPS Regional Healthcare Hygiene and Cleanliness Audit Tool). Table 1 sets out agreed regional compliance targets and table 2 sets out the Trust's self – assessment compliance levels and the validation inspection compliance levels.

Table 1: Regional Level of Compliance

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

Table 2: Self – assessment Level of Compliance October 2021 and inspection scores.

Inspection Tools	Self- assessment	Validation Inspection
Regional Neonatal Infection Prevention and Control Audit Tool	**95.9%**	**96**
Regional Infection Prevention and Control Clinical Practices Audit Tool	**98.5%**	**97**
Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool	**92.8%**	**94**

The unit was generally in good decorative order with environmental cleanliness maintained to a high standard. Staff had good knowledge of enteral feeding systems. Aseptic non- touch technique (ANTT) practices were observed to be in line with policy and good practice. ANTT is a standardised practice used to prevent infections in healthcare settings and support staff to practice safely. There was evidence of an auditing process of compliance with ANTT practices in the taking of blood cultures by staff, which provide assurances to management.

There were good antimicrobial stewardship mechanisms in place which is a healthcare wide approach to the appropriate use of antibiotics and monitoring their effectiveness, thus improving patient outcomes and helping to reduce antibiotic resistance.

A system was in place to mitigate risks associated with bacterial contamination of water distribution and supply systems and associated equipment. The Trust had a robust system in place to address any issues raised with the maintenance of hand washing sinks and taps.

An example of good practice related to the nurse cleaning records which were incorporated into the patient's clinical record. Completion of checks and cleaning of cot side equipment was embedded as part of the named nurses' duties.

Three areas for improvement (AFIs) were identified relating to mandatory training compliance and completion of ANTT and enteral feeding competency assessments, the use and storage of disinfectants and the mechanisms in place to provide assurance of effective cleaning.

3.0 How we inspect

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

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

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

4.0 What people told us about the service

We spoke to a range of staff including the interim lead midwife, clinical sister, infection prevention and control (IPC) team nurse, staff nurses, medical staff, Clinical Education Facilitator (CEF), Patient and Client Support Services (PCSS) staff and clinical technicians. There was no opportunity to speak with patients or relatives during the inspection. There were no completed questionnaires returned post inspection from staff, patients or relatives.

5.0 The inspection

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

The last inspection to the NNU was undertaken on 23 August 2017 by care inspectors; no areas for improvement were identified.

5.2 Inspection Findings

5.2.1 Local Governance systems and processes

The interim lead midwife was supported in their role by the CEF and several ward managers. There are arrangements in place to book Trust bank staff to supplement unit staffing, and substantive staff work additional hours to back fill vacant shifts. A recruitment programme has been successful with thirty new nursing staff recently employed. Staff told us that the ratio of nursing and PCSS staff is reviewed and increased when required, for example, during an infection outbreak. Staff told us staff shortages have resulted in the closure of neonatal beds and this was confirmed by the interim lead midwife.

IPC staff visit the unit and are available for advice by telephone, and increase visits when appropriate, for example, during an infection outbreak and with the management. Within the unit a multi-professional project group, led by a consultant neonatologist, with a focus on clearing serious infections (CSI) meets regularly.

A range of audits including environmental, hand hygiene and compliance with PPE usage was evidenced with actions in place for any non-compliance and oversight by the ward manager. The IPC team had oversight of hand hygiene, clinical practices, environmental and equipment cleanliness and completed validation audits. The frequency of these audits was increased in response to poor compliance scores.

It was 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. A weekly microbiologist ward round review this data; identify trends and action plans are developed to address appropriately.

IPC incidents are reported via datix, the Trust's incident reporting system, and of serious adverse incident (SAI) investigations and ongoing outbreak management. Staff are informed of IPC issues at safety brief, multi-disciplinary team (MDT) meetings and staff meetings, however staff meetings were infrequent. Infection prevention and control information was also shared with staff by e-mail.

There was evidence of mechanisms in place to provide oversight of staff compliance with mandatory training and competency assessments. However, it was noted mandatory training and completion of ANTT competency assessments were not up to date for all staff. This was identified as an area for improvement (AFI).

5.2.2 Layout and Design, Environment and Environmental cleaning.

The Department of Health (DoH) set minimum dimensions in terms of a safe space between patient beds to uphold IPC practices and permits space for use of equipment and staff movement to care for patients safely. Spacing on this ward does not comply with 80% of the minimum dimensions. There were isolation facilities available within the unit however there were no clinical handwashing sinks outside two of these rooms.

Staff told us issues relating to nursing patients in line with the DOH dimensions have been addressed in the design of the new maternity hospital, although no definitive date for the planned move has been decided it is anticipated to happen early 2023.

The unit was in most areas in good decorative order. Alcohol gel and a supply of personal protective equipment (PPE) were available for visitors on entry to the unit. There was clear signage which provided guidance on the use of PPE. A range of IPC audit scores were displayed for visitors to provide assurance of good cleaning and IPC practices. Information about hand hygiene practices for visitors was also on display throughout the unit.

Environmental cleanliness was of a high standard and equipment cleaning schedules were in place. Each baby's space and surrounding surfaces, fixtures and fittings was cleaned twice daily and recorded. However, some dust was noted on the surface of the unit containing the connections for the wall mounted suction and oxygen.

PCSS supervisors randomly select and check, the areas cleaned on a daily basis and maintain records to evidence their findings which document remedial action taken to address any areas found lacking. PCSS staff demonstrated good knowledge of correct cleaning techniques and told us they receive training in relation to water safety. However, not all staff were familiar with the dilution rates for disinfectants used in the unit and this was brought to the attention of the team leader during inspection who agreed to ensure this knowledge was shared with the relevant staff. PCSS staff identified an issue relating to the introduction of a new cleaning product which was inadvertently used incorrectly on taps, causing erosion. Procedures are in place to ensure staff are informed of new products and their correct usage. Some nursing staff's knowledge regarding decontamination of blood spillage and colour coding of equipment for cleaning requires improvement.

It was noted the Control of Substances Hazardous to Health (COSHH) safety data folder for clinical staff was out of date and did not contain safety information on all the chemicals used in NNU. Up to date COSHH safety data sheets to include all chemicals used in NNU must be made available to staff and they should know how to access them. Staff told us that a folder was currently being developed online and will be available to them in due course.

It was noted a number of disinfectant chemicals were freely accessible and not stored appropriately in accordance with COSHH Regulations. In addition to this, there was no assurance that the disinfectant chemical (Perasafe), used to decontaminate clinical equipment, was reconstituted in a safe manner by staff or stored and used in accordance with manufacturer's instructions. Staff told us they carried out the practice for making up, using and storing Perasafe in line with a standard operating procedure, a copy of which was requested from the Trust, and subsequently provided, this guidance requires further work with input from the IPC team. COSHH safety data for Perasafe was not available in the unit. The COSHH safety data for Perasafe stated this substance was an irritant to eyes. The eye bath located in the decontamination room, was noted to contain out of date solutions for the first aid of splashes to the eyes.

There were limited storage facilities in the unit which will only be addressed when they move to the new maternity building. Some storage areas were found to be disorganised and tightly packed with equipment. Some dust was observed on equipment not in use, and due to limited storage, items were being stored on the floor making access to cleaning difficult.

5.2.3 Water safety

Water safety systems are required to manage and monitor the prevention and control of infection risks posed by water systems on premises. Organisations must ensure that an overarching water safety plan and individual areas have risk assessment plans in place. These plans mitigate risks associated with bacterial contamination of water distribution, supply systems and associated equipment.

Water sampling, testing, flushing and maintenance are carried out correctly, and there was a mechanism in place to report water analysis results.

An overarching Trust water safety plan and individual unit risk assessment plan were in place. Collection of tap water samples to facilitate microbiological organism testing and analysis was carried out. All taps flush automatically every twelve hours to ensure water was not pooling in the system. Hand washing sinks were used correctly. A system was in place to address any issues raised with the maintenance of hand washing sinks and taps.

It was noted all results of water analysis are reported to the Trust water safety and usage group. This includes staff from the IPC team, microbiology, estates and governance. This group provides reports on the Trust water quality to the governance steering committee and ultimately the Trust board.

5.2.4 Infection Prevention and Control (IPC)

All policies relating to clinical practices were reviewed and noted to be in date with version history and review dates clearly recorded. Staff knew how to access the policies and demonstrated a good understanding of their application to clinical practice. The unit has an infection prevention and control link nurse, however due to pressures on unit staffing it has been difficult to ensure protected time to fulfil this role.

The majority of staff were compliant with the dress code/uniform policy being bare below the elbow in the clinical area and free from nail polish/gel nails. Two observations of non-compliance were observed in the clinical area and these were brought to the attention of senior nursing staff in the unit and were addressed immediately.

Hand hygiene practices throughout were observed to be of a high standard with staff adhering to effective hand hygiene with the application of alcohol hand sanitiser following hand wash/drying, in line with current best practice guidance.

Waste and sharps management was generally good. Sharps boxes were assembled correctly; and each were dated and signed by staff in accordance with Trust policy. However, not all bins had temporary closures deployed and we noted a few items of inappropriate waste in some bins. A few blood droplets were evident on the lids of two sharps boxes; this was brought to the attention of staff and replaced immediately.

Surveillance, the continuous monitoring of healthcare associated infection (HCAI) is key to controlling an infection. A surveillance programme can be used to implement improvement initiatives, assess effectiveness of clinical interventions and can quickly identify outbreaks of infection. Staff have access to policies and procedures on the Trust intranet to guide staff in relation to IPC and surveillance programmes.

Staff told us there was no standardised surgical site care bundle in place; this was brought to the attention of the senior management team in order for this work to be progressed. Staff demonstrated a good awareness of the measures to be taken to prevent surgical site infections.

An incubator/cot tracking system was in place to record the movement of neonates within and outside the unit. Patient movement was recorded in the neonates' notes. This can be used by staff to identify neonate placement and movement, particularly in the event of an outbreak of infection.

It was noted assessment of need in relation to isolation was made in accordance with recommendations from the outbreak control group and the clinician responsible for the patient's care. Staff adhered to infection prevention and control measures including effective hand hygiene practices, management of equipment, safe handling of infected laundry/waste and environmental cleaning. It was evidenced that good infection control practices were in place for the management of patients isolated with known/suspected infection risk.

It was noted admission packs for parents contained information on IPC and leaflets were available when needed. Staff were observed providing parents with appropriate hand hygiene advice and regularly observed parents washing their hands. This is good practice.

5.2.5 Patient Equipment

Generally equipment in use was observed to be clean, with trigger tape to indicate when the piece of equipment was last cleaned and ready for use. The majority of stored patient equipment was covered to reduce environmental contamination of clean equipment.

A range of clinical equipment was checked including incubators, intravenous (IV) drip stands and pumps, blood gas machine, breast pumps, respiratory and cardiac monitoring equipment to confirm that the equipment was cleaned between patient use and stored appropriately when not in use. Overall the equipment appeared clean and fit for purpose. Some attention to more detailed cleaning is required for some items of equipment. This detail was provided to the interim lead midwife during the inspection.

The BHSCT Cleaning Manual available to staff was last reviewed in 2013, this document should be reviewed to ensure it includes most up to date guidance for staff.

Whilst a cleaning schedule was in place which included the cleaning of breast pumps, there was a number of gaps in the cleaning record and no assurance of oversight that this had been addressed. Shared pieces of equipment can be a source of transmission of harmful microorganisms if not cleaned effectively between patient uses; it is recommended that robust action be taken to confirm that breast pumps are cleaned between each patient use.

The occurrence of terminal cleaning for incubators was unclear, and on questioning staff, there was a variance between the frequencies of these cleans with a number of staff stating it was carried out every week and other staff stating every two weeks. There should be a standardised approach in line with recent incubator cleaning guidance,(Good IPC practice for cleaning and handling of incubators and other equipment in neonatal units Oct 2022)[1], which recommends that in use incubators receive a terminal clean every seven days.

Clinical trolleys appeared clean and were free from excess items to promote effective cleaning, however, the frame of the bloods trolley was noted to have paint chipped which prevents

[1] https://www.gov.uk/government/publications/infection-prevention-and-control-incubators-on-neonatal-units/good-ipc-practice-for-the-cleaning-and-handling-of-incubators-and-other-equipment-in-neonatal-units

effective cleaning and could be a potential reservoir for harmful microorganisms. It was noted items on the resuscitation trolley were visibly clean and free from dust and body fluids.

One of the emergency equipment bags in the Special Care Baby Unit (SCBU) was extremely dusty and held many out of date contents. This bag was removed from the clinical environment and given to the nurse in charge for immediate attention. It was recommended that this bag is included in the equipment checking and cleaning schedules. There were gaps in the records completed by staff to indicate when equipment on the resuscitation trolley at SCBU had been checked. It is recommended that this resuscitation trolley be checked alongside the other resuscitation trolleys and neonatal equipment in the neonatal unit (NNU) in line with the Trust policy.

An AFI was identified in relation to the completion and oversight of checking and cleaning schedules by clinical staff.

5.2.6 Preparation, Use and Storage of breast milk and specialised powdered infant formula.

There were a range of policies and procedures available to advise staff on the collection, storage, use and disposal of breast milk including donor breast milk. Staff were aware of these policies and how to access them. Both fresh and frozen breast milk was correctly labelled and stored appropriately. It was noted that staff record the temperature of frozen donor breast milk when it was delivered to the unit in line with Trust policy.

5.2.7 ANTT and Invasive Devices

ANTT is a standardised practice used to prevent infections in healthcare settings and support staff to practice safely.

Staff had received ANTT refresher training and training updates were provided. Good practice was observed in regards to ANTT and nursing staff were knowledgeable in the process.

Review of documentation evidenced that audits of staff practice were carried out, and compliance was independently verified if infection rates and audit scores identify poor practice. Staff told us an incident report form was completed by staff for any breach in ANTT practices.

Systems and processes were in place to ensure a standardised and consistent approach in the insertion and ongoing maintenance of invasive devices, which are medical devices which in whole or in part, penetrate the body, either through a body orifice or through the surface of the body.

Documentation reviewed confirmed good oversight and management of invasive devices. It was noted an ANTT care bundle, cannula insertion and ongoing care were recorded for each patient.

A process was in place to assess staff ANTT competency, however these assessments were not up to date for a significant number of staff. As previously stated in section 5.2.1, this was identified as an AFI.

5.2.8 Enteral Feeding

Enteral tube feeding is a way of delivering nutrition directly to your stomach or small intestine through a tube. Trusts must ensure guidance is available to inform practice and to assist in the prevention of infection associated with enteral nutrition. Enteral feed must be stored, used and disposed of in accordance with Trust policy and the administration and maintenance of the enteral feeding system should be carried out in accordance with evidence based practice.

Enteral feed was stored, administered and disposed of as per trust policy and in line with best practice. Staff demonstrated good knowledge on the management of an enteral feeding system; insertion, set up and care.

Patient care records relating to enteral feeding were reviewed and the required documentation was completed and reviewed daily. Staff demonstrated good knowledge in relation to the appropriate checks required, such as positioning, and aspiration.

A process was in place to assess enteral feeding competency, however these assessments were not up to date for a significant number of staff. As previously stated in section 5.2.1, this was identified as an AFI.

5.2.9 Taking Blood Cultures

Blood contamination may occur during the process of collecting blood for culture while preparing the site or insertion of the needle. The laboratory monitors and collects data which they share with the IPCT in regards to blood contamination rates.

The rates of positive blood cultures are reviewed and discussed with the clinical team and at governance meetings held every two weeks. Results are fed back to staff at safety briefs and discussed at the CSI meetings which are held quarterly. Independent validation audits were completed and action plans devised where improvement in clinical practice identified.

Staff had good knowledge of the clinical indications for taking blood cultures and demonstrated good awareness of the correct technique for taking blood cultures. It was noted staff had received online and practical training on the procedure for taking blood cultures and training updates had been provided where an increase in the number of positive blood cultures was identified.

5.2.10 Antimicrobial stewardship

Antimicrobial stewardship is the process in which antibiotics are prescribed, monitored and evaluated in an effort to preserve their future effectiveness and in line with evidence-based antimicrobial guidelines. This should improve and reduce the progression of antibiotic resistance and optimise patient outcomes. For Trust's to comply with this area of practice 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.

Antimicrobial/microbiology ward rounds occur every week day with input from the microbiologist, pharmacist, lead clinician, nurse in charge, and IPC nurse. Outcomes are documented within patient records.
Clear guidelines on the use of antimicrobials to be used in the neonatal unit were available for staff on induction and as part of their training and these were accessible on the Trust intranet.

Governance arrangements are in place to comply with six monthly auditing of antimicrobial prescribing. Anti-microbic usage was monitored at unit level, however, electronic, computer aided prescribing tools were not available to assist with this. Regional work is underway to develop an electronic prescribing and administration record system as part of the Encompass project. Encompass is a Health and Social Care Northern Ireland (HSCNI) wide initiative that will introduce a digital integrated care record to Northern Ireland. It is where medical notes will be made, medicines prescribed, tests ordered and referrals made and received. Providing real time up to date information. The Trust requires the completion of the regional work in order to facilitate an electronic system to monitor anti-microbic usage.

It was noted relevant documentation for prescribing antimicrobials was available in the medical notes and kardex reviewed.

6.0 Quality Improvement Plan/Areas for Improvement

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

	Standards
Total number of Areas for Improvement	3

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

Quality Improvement Plan	
Action required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006)	
Area for improvement 1 **Ref:** Standard 5 Criteria: 5.3.1 **Stated:** First time **To be completed by:** 6 November 2022	The Trust must ensure that staff have up to date competency assessments completed in relation to ANTT and enteral feeding. **Ref: 5.2.1**
	Response by registered person detailing the actions taken: Due to COVID pressures the number of staff trained fell below the expected standards. Within the NNU all staff including newly appointed staff and students receive training and competecy assessments which includes hand hygiene, ANTT and Enteral feeding. The NNU undertake regular weekly audits.

	Staff are indentified on each shift to perform ANTT compentency assessments. 10 new ANTT assessors have been indenfied and trained to deliver training and competency assessment within the NNU. Current competency assessment compliance is: hand hygiene 69%, ANTT 62% and enteral feeding 57%. Projected completion of 100% by end of 31/01/2023.
Area for improvement 2 **Ref:** Standard 5 Criteria: 5.3.1 **Stated:** First time **To be completed by:** 6 November 2022	The Trust must ensure COSHH data and product guidance is available for all disinfectants used within the unit and available to staff. They must ensure all products are stored and used correctly in accordance with COSHH Regulations; this should include the appropriate use of PPE and ensure the emergency eye splash kit is in date. **Ref: 5.2.2**
	Response by registered person detailing the actions taken: COSHH data is currently being transfered to an electronic system to ensure all staff have access to the most up to date and relevant information for all disinfectants used within the unit. This information is also available on The Loop. An in date eye kit is available in the unit and the NNICU housekeeper has been assigned to ensure these remain available and within date. This equipment is checked on a monthly basis and the Lead Midwife has oversight of compliance data. All products including PPE is stored and used in line with COSHH regulations. PCSS and nursing staff in NNICU undertake weekly audits to ensure appropriate storage and use of products including PPE and the results are forwarded to IPCN colleagues for reporting to the Divisional Midwife and the Exec Director of Nursing. Additonal cleaning schedules have been added to the areas to ensure high level dusting is peformed on a weekly basis. The health care assistances within the unit have responsibility for daily cleaning schedules and for additional assurance now report to a named Charge nurse. The cleaning schedules are monitored with outcomes reported to the Lead Midwife. Further training has been added to the induction programme and refresher training for staff in relation to appropriate management of blood spillage and colour coded equipment. Clinical scientists who work within the area adhere to the current

	Standard Operating Procedure in relation to Perisafe. They are currently developing a comprehensive document with increased focus on preparation, storage, assurance of sterility and disposal. COSHH safety data is now available within the unit.
Area for improvement 3 **Ref:** Standard 5 Criteria: 5.3.1 **Stated:** First time **To be completed by:** Immediate from date of inspection	The Trust must ensure there are robust assurance and oversight mechanisms in place to ensure equipment is checked and cleaned effectively and records of same are completed. **Ref: 5.2.5**
	Response by registered person detailing the actions taken: Breastpumps will have a unique identifier. Pumps will be cleaned daily by a member of staff. Daily records will be kept of the cleans of breast pumps. Breast packs for expression of milk are given to mothers who sterilise these between use. Incubators now receive a terminal clean every 7 days and the importance of this is reiterated to staff via the safety brief each morning and evening. PCSS have also been informed. PCSS staff receive robust training for disassembling, reassembling and cleaning the incubators. Training is ongoing and regular audits are completed by PCSS staff. A new venepuncture trolley has been ordered and is due for delivery early January 2023. All resuscitation trolleys and the emergency equipment bag are checked twice daily, cleaned weekly with the results reported to the Lead Midwife.

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

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