Unannounced Inspection Augmented Care Settings

7 - 8 and 16 July 2026



Ward 6 North, Belfast City Hospital
Belfast Health & Social Care Trust

Type of service: Acute Hospital

Address: Lisburn Road, Belfast, BT9 7AB

Telephone number: 028 9032 9241

1.0 Service Information

2.0 Background

Chief Executive – Ms. Jennifer Welsh	
Person in charge at time of inspection: Ms. Carol Waddell	Position: Ward Manager
Brief description of how the service operates: Ward 6 North (temporarily relocated to ward 7 North) is one of two in-patient haematology wards located at the Belfast City Hospital in the Belfast Health and Social Care Trust. The ward provides specialist haematology treatment for adults living in Northern Ireland. Patients are generally accepted to the ward following an assessment at the onsite Acute Oncology and Haematology Unit (AOHU).	

Inspections of augmented care wards and departments assess whether local governance systems supporting infection prevention and control, patient safety, clinical leadership and quality improvement are operating effectively. Using inspection tools endorsed by the Chief Medical Officer, they provide independent assurance on care standards in higher-risk settings, including neonatal units, critical care units, haematology and oncology services.

The ward was assessed using the three regionally agreed standards and inspection tools for augmented care areas:

- Regional Augmented 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

The RQIA inspection team would like to thank the Belfast Health and Social Care Trust and in particular, all staff working in the ward for their assistance during the inspection.

3.0 Inspection Summary

An unannounced inspection of ward 6 North (ward 6N) at Belfast City Hospital (BCH) took place on 7, 8 and 16 July 2026. An online meeting was also held with the lead antimicrobial pharmacist and microbiologist on 22 July 2026.

At the beginning of the inspection, inspectors confirmed that ward 6N had temporarily relocated to ward 7 North (ward 7N) while estates work was completed in ward 6N.

The inspection therefore assessed clinical and support areas in ward 7N, recognising that this was a temporary location and that the ward was due to return to ward 6N. For this report, the location is referred to as ward 7N.

The inspection was carried out by Care Inspectors from the RQIA HSC Hospitals Team and concluded on 10 August 2026 when feedback was provided to senior Trust staff.
The purpose of the inspection was to assess infection prevention and control (IPC) practices on ward 7N and confirm that current governance arrangements are in place to protect patients from exposure to harmful microorganisms.

The inspection team reviewed local governance systems and processes, including layout and design, environmental cleaning, water safety, augmented care clinical and care practice, and patient equipment.

Clinical practice was assessed in relation to Aseptic Non-Touch Technique (ANTT), invasive devices, blood culture taking, antimicrobial prescribing and stewardship, *Clostridioides difficile* infection (CDI), and Meticillin-resistant *Staphylococcus aureus* (MRSA) screening, colonisation and decolonisation.

Governance processes regarding audit and independent assurance of compliance with best practice were reviewed; and how this information is communicated with staff.

The general environment was inspected taking into consideration the patient's journey from the hospital entrance to ward 7N.

Inspection scores confirmed compliance across all three tools. Staff are commended for the high standards achieved.

Inspection Tools	Compliance Level
Regional Augmented Care Infection Prevention and Control Audit Tool.	**95%**
Regional Infection Prevention and Control Clinical Practices Audit Tool.	**94%**
Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool.	**96%**

Table 1: Ward 7N overall compliance scores against the regional audit tools

The ward was busy during the inspection; however, staff were observed working in a calm and organised way whilst promoting an effective and efficient service.

Ward 7N was in good decorative order creating a friendly and welcoming environment for patients, visitors and staff. Environmental cleanliness was of a high standard throughout, with evidence of best use being made of the limited storage facilities.

Staff demonstrated good adherence to hand hygiene practices including the application of hand sanitiser following physical hand washing, to reduce the risk of the spread of harmful microorganisms; and were knowledgeable in the management of sharps and the disposal of waste. Patient equipment was clean and in a good state of repair. Overall, staff had a good knowledge and awareness of how to manage infections.

Local infection prevention control (IPC) screening policies were in place and staff reported that patients can be isolated when appropriate to reduce the risk of the transmission of infection.

The Trust Infection Prevention Control Team (IPCT) were available to provide support and advice as required.

A small number of patient safety issues were identified and escalated on day one. The ward shared an action plan with inspectors on day two, and the issues were promptly addressed or actions taken to address them.

A number of policies, procedures, or guidelines had exceeded their review dates with some being progressed regionally and others such as the Blood Culture Policy awaiting review following updating of the Blood Transfusion Policy. These matters are addressed later in the report. Overall, this was a positive inspection. No areas for improvement were recommended. Several noteworthy and practical considerations were highlighted to Trust representatives and, if progressed, will further strengthen governance arrangements.

The inspection team appreciated the co-operation of the ward manager, clinical educator, domestic supervisor and catering manager, and noted that Trust staff listened to concerns and acted promptly.

4.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of Health and Social Care services in Northern Ireland. RQIA inspection reports reflect how services were performing at the time of the inspections, highlighting both good practices 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 RQIA inspections.

This inspection was underpinned by the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003; and care provision was measured against the DHSSPSNI Quality Standards for Health and Social Care (March 2006); and the regionally agreed standards and inspection tools for augmented care.

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.

During the inspection, the inspection team spoke with a range of staff and a number of patients and gave patients, relatives and staff the opportunity to complete an online or postal survey.

5.0 The Inspection

5.1 Regional Augmented Care Infection Prevention and Control Audit Tool

The Regional Augmented Care Infection Prevention and Control (IPC) Audit Tool contains six sections and consolidates existing guidance to improve care and practice in augmented care settings, supporting the prevention and control of healthcare-associated infections.

Areas Inspected	7, 8 and 16 July 2026
Local Governance Systems and Processes	93%
General Environment – Layout and Design	82%
General Environment – Environmental Cleaning	100%
General Environment – Water Safety	100%
Clinical and Care Practice	100%
Patient Equipment	92%
Average Score	**95%**

Table 2: Regional Augmented Care Infection Prevention and Control Audit Tool Compliance Levels

5.1.1 Local Governance Systems & Processes

Healthcare-Associated Infections (HCAIs) present significant risks to patients, staff and visitors and can create substantial NHS costs. Reducing HCAIs is a key priority. Trust leaders support this through clear structures, roles and responsibilities, staff compliance with effective IPC practice and a culture of continuous improvement.

Local governance systems and processes were reviewed in ward 7N to confirm if the ward was adhering to best practice guidance.

The ward sister was on leave on day one, but staff worked effectively in her absence and delivered a high standard of care. The clinical educator and three deputy ward sisters/charge nurses provided good leadership. On return, the ward manager was visible, understood IPC responsibilities and demonstrated strong IPC leadership and knowledge.

Staff are supported to develop their haematology knowledge and skills. The haematology clinical educator provides weekday support for education, practice development and competency assessment, including mandatory training, haematology and oncology procedures, ANTT, blood culture training and patient education. The role also supports research, guideline development and dissemination of best practice.

There are three IPC link nurses who provide ward level support. They attend quarterly IPCT link nurse meetings for education updates, which are then shared with ward staff.

The IPCT provides good telephone support and specialist IPC advice. Ward staff could not confirm visit frequency, but felt on-site visits should be more regular.

The IPCT confirmed monthly ward visits, with enhanced visits during outbreaks. This is not in line with extant guidance recommending sufficient IPC nurses to provide daily visits. The Trust has introduced a three-monthly rotational programme for dedicated IPC nurses across sites, but practice should be reviewed to increase on-site support. IPCT visit records are held on a spreadsheet; inspectors noted that records capture issues but not consistently whether actions were taken, particularly for recurring issues. This was discussed with IPC staff and escalated for managerial consideration.

On review of data it was evidenced that incidents relating to IPC were reported and actioned appropriately. The ward sister confirmed that there had been no serious adverse incidents reported by the ward during the past year.

There was evidence of senior leadership walkabouts being undertaken at ward level, providing an opportunity for staff to connect with senior leadership and discuss any IPC related issues.

Hand hygiene and environmental audits were undertaken routinely. The Nurse Development Lead completed monthly audits and the IPCT independently validated hand hygiene and environmental practice during visits. Audit activity increased when IPC issues emerged, as evidenced in Post Incident Review meetings (PIR) minutes.

Audit results showed good compliance with IPC Key Performance Indicators (KPIs). However, up-to-date results were not displayed for visitors, patients and the public. This was reported to the nurse in charge, as visible KPI reporting supports public confidence and accountability.

IPC communication takes place through safety briefs, handovers, emails and staff meetings. Meeting minutes confirmed IPC as a standing agenda item and showed multidisciplinary working. Although audit results were shared in meetings and by email, some staff could not recall receiving them; the ward manager agreed to review how IPC audit feedback is communicated.

PIR minutes showed that harmful microorganism isolates prompted multidisciplinary review meetings, including Public Health Agency (PHA) representation where required. Staff said feedback was shared through safety briefs and email.

Staff receive mandatory IPC refresher training every two years. Training figures confirmed that 92% of staff have received mandatory IPC training to date with plans in place to progress any remaining staff training required.

IPC policies and procedures were available on the Trust intranet and staff knew how to access them. Some policies had passed review dates but were marked as under review. The Blood Culture Policy, overdue since May 2023, remains extant pending Blood Transfusion Policy updates. Trust representatives were aware of overdue IPC policies and RQIA advised that this work should progress at pace.

Trust surveillance programmes support detection and prevention. Routine screening for MRSA, Pneumocystis jirovecii pneumonia (PJP) and Covid-19 is in place. Patients are not routinely screened for Pseudomonas or other gram-negative organisms unless directed during outbreaks. Screening is usually completed in AOHU before transfer; direct ward admissions are screened on admission in line with policy.
Clinical, microbiology and pharmacy staff reported close working relationships when reviewing treatment pending and following clinical test results. PIR is used to investigate, action and report IPC safety incidents, which was verified through meeting minutes.

An admission pack issued to all patients and/or relatives provides specific IPC related information regarding hand hygiene and actions to minimise the risk of infection for example, advice on bringing food into hospital.

Quality improvement is embedded in ward 7N. Eleven projects aim to improve patient experience and outcomes through symptom prevention, treatment safety, focus groups, patient support, education and policy or standard operating procedures (SOP) development. One respiratory project has an IPC focus, auditing tests for respiratory symptoms in immunocompromised haematology patients. Project managers have worked with staff and developed an information sheet to support correct virology testing across ward 7N, ward 10N and AOHU.

There were effective management and governance systems in place in the ward to ensure the overall quality and safety of the services provided.

5.1.2 General Environment - Layout and design

Ward 7N accommodates 22 patients across four bays and six side rooms, with space for two additional patients or one patient requiring effective isolation. Ward 6N will have a similar layout, with two additional side rooms and a renovated patient kitchen.

Whilst dated and in need of refurbishing, the environment in ward 7N was clean, organised and created a welcoming atmosphere for patients, visitors and staff.
Core clinical space should allow safe and effective care. Floor plans indicated that ward 7N bed spaces do not meet 80% of the minimum Department of Health (DoH) dimensions in the inspection tool; however, the building opened in 1986, before current best practice guidance. The limited space can affect care delivery by causing staff to encroach on adjacent bed areas. Staff advised that ward 6N will have similar constraints after return. During inspection, bed spaces were kept free from excess items and contained only essential equipment, which supports safe care.

A maintenance programme is in place for the ward ventilation systems which are cleaned by Estates staff once a month and routinely serviced. There are separate clean and dirty utility rooms and clean storage areas allowing for clean to dirty workflow. The layout and design facilitate effective storage of clean linen and consumables separate from dirty linen and decontamination of equipment.

The DoH sets minimum dimensions in terms of a safe space between patient beds to uphold IPC practices and permit space for the use of equipment and staff movement to care for patients safely. Whilst the core clinical space does not meet current DoH health build note standards, continuing to keep patient bed areas free from excess clutter will support staff in delivering safe and effective care.

5.1.3 General Environment - Environmental Cleaning

Governance systems and processes in relation to environmental cleaning were reviewed. Environmental cleaning guidelines were available in the ward and included the relevant information required by cleaning staff. Environmental cleaning records were maintained and validated by the domestic supervisor.
Although ward 7N is an older, temporary environment, it was well maintained, bright, welcoming and visibly clean. Recent environmental cleaning audits showed excellent scores of 98.9% and 100%.

Staff understood cleaning policies and procedures, including the four-cloth technique for clinical wash-hand stations to reduce cross-contamination. Staff also described proactive escalation of patient safety risks.

Staff reported that routine, enhanced and terminal environmental cleaning is undertaken in line with Trust policy, with a programme of intensive/deep cleaning carried out when required in consultation with the IPCT.

Dilution rates for products no longer used were displayed in the domestic storeroom. Inspectors recommended their removal to avoid confusion and reported this at feedback. Further detail on the ward environment will be reported within the Regional Healthcare Hygiene and Cleanliness Audit Tool section.

5.1.4 General Environment – Water Safety

Water management governance in ward 7N was reviewed to confirm if it is managed in line with regional guidelines for water sources in augmented care areas. The Trust water safety plan was up to date. Yearly Pseudomonas aeruginosa risk assessments are completed in augmented care areas, but one was not completed for ward 7N when it became a temporary augmented care area. The IPCT worked with estates and senior ward staff, and patients were not transferred until water sampling confirmed safety. Trust representatives acknowledged learning from the move and confirmed that a ward 7N risk assessment was due in August 2026.

Staff reported that the Trust manages its augmented care areas in two levels - Level 1 or Level 2. Water testing in Level 1 areas is undertaken every quarter, whereas in augmented care areas designated as Level 2, water testing is only carried out on the receipt of positive isolates.

Ward 7N is currently considered a “Level 1” augmented care area therefore water sampling for the presence of pseudomonas aeruginosa bacteria in the ward is carried out quarterly in line with current guidance. Of note water sampling for the presence of Legionella is undertaken monthly in line with current guidance.

A strict water-sampling protocol reduces contamination and false positives. Positive results trigger source isolation, remedial works and three consecutive days of sampling; if clear, the outlet is reinstated and sampling moves to weekly, then monthly, before returning to quarterly testing.

Water flushing of all taps takes place automatically at intervals throughout the day and night. Inspectors observed hand-washing sinks being used correctly for hand hygiene only. A clearly designated safe source sink was available in-patient bays for other water use.



Image 1: Safe Source Sink

Estates staff from the water safety team routinely visit the ward to provide support to staff and identify any emerging water related issues or concerns.

There was good assurance of Trust water safety oversight, supported by multidisciplinary working. Trust representatives confirmed that learning from the ward 6N to ward 7N move would be taken forward.

5.1.5 Clinical and Care Practice

Ward 7N is led by an experienced manager and senior team with specialist expertise. Staffing is at full complement and can be adjusted for infection risks, including assigning an additional HCA if required. Low staff turnover supports consistency in IPC practice and safety culture.

Ward 7N has an adequate level of domestic staff. There is a contingency plan in place should additional cleaning be required to reduce the risk of transmission of infection. Although electronic bed tracking is unavailable, patient placement and movement can be tracked to reduce infection transmission risk and support contact tracing. Isolation needs are discussed at safety briefs.

Staff knew local screening policies and how to take clinical swabs, including MRSA sites such as nose, axilla, wounds and indwelling devices. They also understood suppression and decolonisation treatment in line with policy. Patients were observed to be isolated when appropriate with specific information displayed to advise of the isolation precautions required.

Staff demonstrated good adherence to standard and transmission-based precautions, including effective hand hygiene practices and appropriate use of Personal Protective Equipment (PPE) where patients required isolation precautions. There was assurance of effective infection prevention and control measures in place to minimise the risk of the transmission of infection.

5.1.6 Patient Equipment

Equipment cleaning schedules were in place and equipment reviewed during the inspection appeared to be clean and was stored appropriately. Mandatory training theory and competency assessments in the use of specialist patient equipment is undertaken as required, and further refresher education and modelling can be delivered by the clinical educator.

Wall-mounted suction equipment was secured in plastic coverings, limiting emergency availability. This was raised as a patient safety concern at the outset and addressed immediately. Resuscitation trolley documentation was unclear about what should be checked and how often; gaps were also noted. Staff received clarification on daily, weekly, monthly and post-use checks.

- Daily check: top of trolley, sharps bin, ensure it is tidy and free from clutter
- Weekly check: entire trolley and defibrillator check.
- Monthly check: entire trolley check and defibrillator, including expiry dates.
- The trolley should also be checked thoroughly after any use.

Following RQIA feedback, the ward revised documentation to clarify the checking and recording process. Ongoing governance is needed to oversee and monitor these records. Further detail is in section 5.3.4.

5.2 Regional Infection Prevention and Control Clinical Practices Audit Tool

The Regional Infection Prevention and Control Clinical Practices Audit Tool contains nine sections covering key clinical procedures that reduce infection risk when performed correctly. It consolidates guidance to improve care and practice in augmented care settings. Information was gained through staff questioning and review of documentation. Observation of staff practice was not conducted during the inspection.

Areas Inspected	7, 8 and 16 July 2026
Aseptic non-touch technique (ANTT)	94
Invasive devices	94
Taking Blood Cultures	86
Antimicrobial prescribing	88
Clostridioides difficile infection (CDI)	100
Surgical site infection	N/A
Ventilated (or tracheostomy) care	N/A
Enteral Feeding or tube feeding	N/A
Screening for MRSA colonisation and decolonisation	100
Average Score	**94**

Table 3: Regional Infection Prevention and Control Clinical Practices Audit Tool Compliance Levels.

5.2.1 Aseptic Non-Touch Technique (ANTT)

ANTT is a standardised aseptic technique for managing invasive clinical practice and medication preparation. Compliance requires an accessible policy, staff knowledge and skills, and competency audit.

An up-to-date ANTT Trust policy is available, with review due in 2027. Three ANTT assessors support the ward.

Staff reported annual competency assessment and updates when guidance changes or infection issues arise. Staff demonstrated a good understanding of the process of ANTT and examples of when it would be applied in practice which was in line with ANTT policy.

ANTT practice is audited by the ward sister or deputy sisters/charge nurses. Feedback is shared by email, handovers, safety briefs and meetings, although staff recall varied. The ward manager agreed to review agenda and minute templates to make this clearer. Although ANTT assessments are completed, compliance is not independently verified and action plans are not developed where poor practice is identified through infection rates or audit scores. This also applied to invasive device management and blood culture taking. Senior staff acknowledged the issue and had scheduled a meeting to address it.

Overall, there was good governance, oversight and assurance mechanisms in place for some patient audits, however, independent verification would provide robust assurance of compliance with practice.

5.2.2 Invasive devices

An invasive medical device is any device that penetrates the body through the surface of the skin or a body orifice. The insertion of a device can provide an entry point for microorganisms, such as bacteria, to enter the body and is a potential source of infection. Clinical areas must demonstrate that there are systems and processes in place to ensure a standardised and consistent approach by staff of the insertion and ongoing maintenance of invasive devices.
Nursing staff demonstrated good knowledge and practice in managing invasive devices. Training and competency assessment are included in mandatory training, and relevant policies and procedures are accessible.

Insertion and ongoing management of invasive devices are documented on encompass flowsheets. The intravenous cannula flowsheet has no specific field for batch number; staff can add this as free text, but use was inconsistent. Trust representatives agreed to address this to support traceability and patient safety.

Adherence to the management of insertion and on-going maintenance of invasive devices, and the associated documentation, was monitoring at ward level and via the HCAI Leadership walk around tool. However, during the inspection there was no evidence provided of additional independent verification of compliance. This was raised at feedback with Trust representatives, who agreed to take this forward, as stated in 5.2.1 above.

5.2.3 Taking Blood Cultures

A blood culture is a laboratory test that checks for the presence of micro-organisms such as bacteria or yeast that may cause infection, in the bloodstream. Trusts must ensure that a blood culture policy is in place and accessible to staff. The clinical staff who obtain blood cultures undertake training and demonstrate practical skills on the key principles of taking blood cultures. The rate of positive blood cultures, false positives and contamination incidents should be monitored and action plans devised to improve practice if required. These should be independently verified and results fed back to the relevant staff.

As noted in section 5.1.1, the Blood Culture Policy requires update but remains extant and available to staff. Staff reported that it is the nursing staff on ward 7N who have been trained and competency assessed to obtain blood cultures. Inspectors were unable to observe the procedure for taking blood cultures during the inspection, however, on speaking to nursing staff they demonstrated a good understanding of the correct procedure for taking blood cultures. They were also able to provide details of the clinical indicators/ reasons for obtaining blood cultures.

Auditing of compliance of practice is carried out by the ward sister/deputy sisters/charge nurse, however it is unclear if results are fed back to staff. As previously reported, there is also no independent verification carried out. Staff reported that there is good communication between laboratories and nursing/medical staff with any positive blood culture results reported promptly so that clinical interventions can start in a timely manner. Staff demonstrated within encompass and the staff handover where this information is documented, to ensure continuity of care.

Contamination rates indicate whether blood cultures are being collected with proper attention to aseptic technique. Incidents of contamination rates should be less than three per cent. Upon review of blood culture contamination/false positive results reported from the ward, it was noted that over the past five quarters from January 2025 the ward reported blood culture contamination rates below three percent for four out of five of those quarters.

Both the ward manager and the clinical educator confirmed that where an issue arose regarding blood culture taking in the ward results are reviewed and a multidisciplinary meeting is held with (medical/microbiology/IPC) staff to review the case and if required, staff would undertake refresher training and competency assessment in relation to blood culture taking.

Evidence was reviewed which confirmed that systems are in place to compare the rate of positive cultures between clinical units within the Trust. Although staff spoken with were unsure regarding contamination rates or any action plans the ward sister was able to confirm that the ward contamination rate is less than three per cent.

Nursing staff displayed a good understanding of the procedure for taking blood cultures, including how, why and when they should be taken. With the understanding that it is nursing staff who routinely take blood cultures the sharing of information such as blood culture contamination results will promote collective leadership and accountability of the importance of taking blood cultures in line with policy and procedure. Independent verification audits will provide an additional layer of assurance.

5.2.4 Antimicrobial prescribing and stewardship

Antimicrobial stewardship (AMS) 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. The overarching aim is to 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 processes in place to ensure a standardised and consistent approach by staff to prescribing. Prescribing should be monitored and reviewed.

Electronic prescribing and management guidelines are available to staff. These tools support AMS and benefit patients by improving safety, accuracy and the quality of antibiotic use. Trust antimicrobial guidelines are available on EOLAS, which is a knowledge management and antimicrobial system designed to support clinical teams in sourcing evidence-based practice, ensure compliance and reduce the risk of inappropriate broad-spectrum antibiotic use. Staff reported that guidelines are monitored and updated regularly with any changes being reviewed by the Therapeutic Drugs Committee for approval.

In addition to EOLAS the Antimicrobial Review Kit (ARK) is built into prescribing within encompass and it prompts clinicians to review medication, preventing patients from exposure to antibiotic over use. EOLAS appears in tandem on the screen. AMS tools for pharmacists display blood results, timelines, therapeutic drug monitoring results and dates. These systems are available to all clinical staff including ward pharmacists.

Northern Ireland Cancer Network (NICaN) protocols are also followed regarding use of antibiotics and anti-viral drugs for those patients receiving chemotherapy. There are significant staffing challenges within the AMS pharmacy and microbiology teams, and these have impacted the ability for ward based antimicrobial ward rounds to take place. Despite these challenges, the AMS pharmacy team have remote oversight and review all patients on a daily basis. The team are also available to clinicians for specialist advice. Ward staff confirmed there is good communication between the microbiology team and clinical staff regarding antibiotic usage and medical review.

Antimicrobial stewardship audits are carried out quarterly using the Hospital Antimicrobial Prudent Prescribing Indicators (HAPPI) audit proforma. HAPPI audits are usually completed by pharmacy staff in Q1 and Q3 and junior medical staff in Q2 and Q4. Data is uploaded to FORMIC, which supports clinical audit, patient experience and quality improvement. AMS pharmacists can access FORMIC, but ward staff cannot access results once uploaded.

Senior ward staff were unclear who completes HAPPI audits or how to obtain results. AMS pharmacy can provide results on request but cannot do so routinely for every ward. If quarterly results are not communicated to the nurse in charge, poor results may not drive action and good practice may not be shared. There is also a risk that audit results may not be uploaded to FORMIC. Automated ward access to results was suggested as a possible solution.

As with all audit programmes, robust feedback mechanisms are needed to confirm care meets standards. Where required, action plans should improve care and outcomes, with progress monitored and feedback shared with relevant staff. The AMS pharmacy team also reported that meaningful antimicrobial usage data cannot be extracted from encompass, limiting the Trust's ability to report against its antibiotic reduction KPI. The PHA is aware, and this is being progressed regionally with stakeholders.

Overall, antimicrobial use was well overseen at ward level, with good collaboration between clinical staff, AMS pharmacy and microbiology. Reintroducing antimicrobial ward rounds would strengthen this.

5.2.5 *Clostridioides difficile* Infection (CDI)

CDI is a highly contagious bacterium that causes clinical symptoms ranging from mild to life threatening. Healthcare organisations must ensure best practice guidance on detection and treatment of CDI are in place and staff should have knowledge of this guidance. The organisation should also ensure the implementation and adherence to the guidance is monitored.

There were no patients with confirmed CDI present in the ward during the inspection. However, where a patient was suspected of having infective diarrhoea staff demonstrated a holistic approach to the risk assessment of the patient's needs including prompt isolation and follow up environmental cleaning to ensure any risks to other patients and staff were minimised.

On questioning staff they were knowledgeable in how they would manage a patient with CDI ensuring compliance with the CDI care pathway, including isolation / prudent antimicrobial prescribing / hand hygiene / appropriate use of PPE / environmental and equipment cleaning etc. Staff confirmed that compliance with CDI care bundles is monitored and independently verified by IPCT.

During the inspection staff knowledge and practice demonstrated that there was assurance of good oversight and management of patients with infective diarrhoea.

5.2.6 Surgical site infection

Not applicable for this ward.

5.2.7 Ventilated (or tracheostomy) care

Not applicable for this ward.

5.2.8 Enteral Feeding or tube feeding

Enteral tube feeding is a way of delivering nutrition directly into the stomach or small intestine through a tube. 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. At the time of the inspection there were no patients requiring enteral feeding and staff advised this would be uncommon.

A stock cupboard containing build up drinks and bottles for enteral feeding was inspected and noted to contain a number of items which were close to or had exceeded their expiry dates. This was immediately reported to the nurse in charge for escalation to the team responsible for replenishing and monitoring the stock rotation. An action plan indicating that prompt action was taken to resolve the issue was shared with inspectors on day two of the inspection.

To reduce the risk of this problem reoccurring it is important that regular stock rotation checks are in place for the management of nutritional supplements and that any issues identified are reported to the nurse in charge. This was reinforced at feedback with senior Trust representatives who agreed to take forward.

5.2.9 Screening for MRSA colonisation and decolonisation

MRSA is a bacteria that can cause serious infection and is highly resistant to many common antibiotics. Healthcare organisations must ensure that MRSA screening and management of colonisation policies are in place and staff exhibit knowledge of these policies. The organisation must also ensure adherence to best practice is monitored. An up to date MRSA screening and treatment policy is available to guide staff in the appropriate management of patients known or suspected to have MRSA.

At the time of inspection there were no patients present in the ward who were known or suspected to have MRSA, however, on questioning staff they demonstrated a good understanding of the MRSA screening and treatment policies and protocols in place; and were aware of the relevant care pathways, including the admission screening protocol and documentation required to manage patients safely.

Staff were familiar with the MRSA decolonisation protocol to be followed for suitable patients and where suppression therapy may be required to reduce the risk to the patient and minimise the shedding of harmful skin scales into the immediate patient environment. Staff informed us that adherence to best practice protocols and documentation was audited and independently verified by the IPCT during their monthly visits to the ward. We were informed that the results are shared with staff. There were no concerns regarding staff knowledge and the management of patients with MRSA.

5.3 The Regional Healthcare Hygiene and Cleanliness Audit Tool

The Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool provides 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 Regional Healthcare Hygiene and Cleanliness Audit Tool - Compliance Levels

Areas Inspected	7,8 and 16 July 2026
General environment	95
Patient linen	92
Waste	92
Sharps	92
Equipment	100
Hygiene factors	98
Hygiene practices	100
Average Score	**96**

Table 4: A more detailed breakdown of each table can be found in Section 7.0.

5.3.1 General Environment

The patient's journey to ward 7N begins at the main entrance to the hospital, therefore the general hospital environment was also considered as part of this inspection. A high standard of environmental cleanliness was evident throughout; the spacious public areas were in good decorative order, clutter free and freshly cleaned with slip hazard signs appropriately placed. The displayed artwork and shrubbery in the atrium contributed to the calm and supportive atmosphere.

The environment in ward 7N made a very good first impression. The ward had just been cleaned, the air smelled fresh and well ventilated and the temperature was comfortable. As noted earlier, ward 7N is a temporary location, however it was in good decorative order, tidy and well organised and best use was made of the storage facilities. Patient bed areas were free from excess clutter and their bathroom facilities were hygienic.

The clinical room was spacious, organised and suitable for treatment preparation. However, oxygen cylinder storage did not meet best practice: no door signage identified oxygen, the door was open, excess cylinders were unsecured on the floor, and fridge temperature records were incomplete. The ward manager initiated remedial action and included these issues in the action plan.
Ceiling tiles were noted to be missing in a number of support areas of the ward including, but not limited to the housekeeper's store, the ward manager's office and the linen store. This was raised during the inspection and featured within the action plan. Domestic staff followed cleaning protocols and had adequate resources. On day one, the domestic store floor was cluttered, inappropriate items were stored, the sink was dirty, some horizontal surfaces were damaged and the cleaning log was incomplete. These issues were reported and had visibly improved by day three.

Gaps were noted in a number of records maintained at ward level, including the following: Temperature check records for the fridge in the clinical room (mentioned previously in this section); Temperature records for the automated bedpan washer disinfector machines in the dirty utility room; Domestic cleaning log (as mentioned in this section); Nursing cleaning log; and In the kitchen – temperature checks for the patient fridge and dish washer.

It was noted that the manager had documented actions taken as a result of gaps in the records, however, there was no evidence that corrective action was taken when the dishwasher temperature was recorded as being outside the normal temperature range. We highlighted the issues identified in the kitchen with the Catering Manager. The kitchen was clean and tidy, but units had damaged or missing edging and exposed wood, with some wall damage above skirting. The hand-washing sink was out of order but repaired promptly. A budget has been approved to improve all BCH ward kitchens, and the kitchen upgrade is planned before the return to ward 6N.

Upon review of the Leadership Walkabout report from March 2026 it was noted that gaps in records held for the nurses cleaning log and the automated bedpan washer disinfector machines were highlighted as issues with action to be taken as a result. Whilst it is reassuring to report that the Trust's own assurance mechanisms are highlighting similar issues and addressing, it is important that any identified improvement is sustained. This was raised at feedback with Trust representatives. Overall, despite the practical issues identified, the ward environment, particularly clinical and patient bed areas, was clean, tidy and well maintained. Trust environmental audits consistently showed high standards. The ward achieved 95% for the general environment element of healthcare hygiene and cleanliness.

5.3.2 Patients Linen

The storage and handling of clean and used patient linen was reviewed. Clean linen was visibly clean, undamaged and stored in clear wrapping on shelving.

Used linen was noted to be placed into the appropriate colour coded bag and stored in the dirty utility room. Used linen bags were noted to be less than 2/3 full. Water soluble bags were available for use with heavily soiled or infected linen. Linen skips were in a good state of repair and appeared clean. Staff were observed wearing appropriate PPE when handling soiled or contaminated linen. Effective arrangements were in place for the storage and handling of clean and used patient linen.

5.3.3 Waste and Sharps

The effectiveness of arrangements for handling, segregation, storage and disposal of waste and sharps was reviewed. Clinical waste bins were adequate, visibly clean, undamaged, functional and less than two-thirds full. Household waste bins were absent in clinical and patient bed areas, reducing appropriate paper-waste segregation. This was raised immediately and the nurse in charge confirmed household waste bins had been ordered for appropriate ward areas. Waste bags were securely tied and stored appropriately prior to collection from the ward. Pharmaceutical and burns bins were available for use in clinical areas and their contents appeared appropriate.

Sharps containers were labelled, dated and signed in line with policy. They had no protruding sharps, were below the fill line, clean, and had temporary closures in place when not in use. Sharps trays were available and mostly clean; one stained tray and a used emergency trolley sharps box were escalated during the inspection.
Overall, there was good assurance around the handling, segregation, storage and disposal of waste and sharps.

5.3.4 Patient Equipment

In use and stored patient equipment was examined to confirm that it was clean and in a good state of repair. In use patient equipment was observed to be visibly clean and in a good state of repair. Clean equipment was stored appropriately in an equipment store with evidence of trigger tape displayed to confirm reusable stored equipment is cleaned between each patient use.

Equipment aids for moving and handling of patients were clean and in good state of repair. A range of sizes of single use hoist slings and sliding sheets were available to staff.

Good practice was noted in the use of patient wash basins with the use of disposable liners. Ward 7N has two bedpan washer disinfectors. Bedpans were stored appropriately to minimise contamination. Commodes were noted to be clean, in a good state of repair and displayed trigger tape ready for use. Sterile single use items were stored correctly and retained in their packaging prior to use. A number of single use and single patient use equipment items were reviewed which confirmed they were within their expiry date and evidenced good oversight of stock rotation. Patient equipment is not routinely shared between wards, further protecting patients from HCAIs. Damaged equipment was observed to be taken out of use and reported for repair.

Some boxes were stored on the equipment store floor, which can hinder cleaning. As ward 6N will have a similar layout, the Trust should consider whether this reflects overstocking or a need for additional shelving. Bedpan washer disinfectant containers were also stored inappropriately and should be secured in a Control of Substances Hazardous to Health (COSHH) cupboard or locked storeroom. These matters were escalated to the ward manager.

Staff knowledge regarding the use and management of patient equipment confirmed that they are aware of the single use symbol, were able to identify appropriate single use equipment used on the ward and were familiar with the appropriate decontamination of reusable equipment after patient use. Auditing and monitoring processes were in place to ensure equipment was clean and safe for use. The monthly mattress audit had just been completed and staff reported that any issues identified during the mattress audit were quickly addressed. Inspectors carried out a random external and internal check of one patient mattress which confirmed that the outer cover was intact with no evidence of tears or rips, the zipper was opened and visible inspection of the internal foam verified that it was free from staining and not damaged.

5.3.5 Hygiene Factors

Hygiene factors including the availability and cleanliness of hand wash sinks was good. Wash-hand sinks were in excellent condition, with elbow-operated or sensor taps and good consumable availability. Soap dispensers displayed the seven-step hand-hygiene technique; paper towels, hand sanitiser and moisturiser were available. Safe source sinks in patient bays were a positive addition, helping protect hand-wash-only sinks from contamination. Personal Protective Equipment (PPE) was readily available, accessible at the point of use and observed to be used appropriately by staff. There was adequate PPE which was stored appropriately.

Cleaning materials and chemicals were available and stored in the COSHH cupboard when not in use. Dilution charts supported correct solution preparation, but charts for discontinued products, including Difficil-S, remained displayed in the domestic store. Cleaning equipment was available but it was noted that the domestic cleaning trolley had a build-up of sticky tape present on the handles and not all equipment used for ward cleaning was cleaned after use and prior to storing.

This was also noted to be an issue in the patient kitchen. It is important that staff have the correct information for safe cleaning practice and that cleaning equipment is stored clean after use. The issues were raised with managers during inspection and at Trust feedback; Trust representatives acknowledged the concerns and planned to address them at a forthcoming meeting.

5.3.6 Hygiene Practices

All staff when questioned had good knowledge of both the standard and enhanced IPC precautions, including hand hygiene, which was performed at the correct moments and at the correct location within the flow of care delivery; environmental cleaning; decontamination of equipment; appropriate use of PPE and the management of waste and sharps. Staff demonstrated good awareness of the correct dilution rates for reconstitution of cleaning agents. A COSHH safety folder was present in the ward and contained the necessary safety data information required for staff.

6.0 What people told us about the service

6.1 Patient and Relative Engagement

Feedback was received from four patients: three spoke with inspectors and one responded by post. All indicated they were extremely satisfied with care, felt safe, described compassionate staff and considered the ward well managed.

In addition, a review of a selection of ward meeting minutes consistently reported 100% patient satisfaction survey results, and that the occasional patient complaints are managed satisfactorily at ward level. Student nurses spoke highly of their clinical placement in the ward stating they felt well supported during their placement. This positive feedback is commendable and important feedback for the staff to hear.

6.2 Care Opinion

Care Opinion is a platform used by Trusts to capture patient and service-user feedback. RQIA reviewed stories in relation to the ward. Four results were published between 2024 and June 2026. It was noted that service user feedback in relation to this ward was overall very encouraging.

Care Opinion feedback was consistently positive. Patients described doctors, nurses and domestic staff as compassionate, helpful and reassuring. Care was described as “excellent”, “outstanding” and “most wonderful”. Patients also valued the 24-hour helpline and exercise programme, which supported recovery physically and psychologically.

6.3 Online Survey for staff and patients

At the start of the inspection, posters linking to anonymous patient and relative surveys were displayed at the ward entrance and outside the ward manager’s office. The survey sought views on whether care was safe, effective, compassionate and well managed. These posters were accessible for two weeks from the commencement of the inspection on 7 July 2026. Despite the closing date being extended by a further week, no online feedback was received.

7.0 Levels of compliance tables

7.1 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 well-maintained environment is an important foundation to promote patient, visitor and staff confidence and support other infection prevention and control measures.

General Environment	7,8 and 16 July 2026
Reception	100
Corridors, stairs lift	100
Public toilets	100
Ward/department - general (communal)	100
Patient bed area	100
Bathroom/washroom	98
Toilet	N/A
Clinical room/treatment room	95
Clean utility room	N/A
Dirty utility room	98
Domestic store	86
Kitchen	85
Equipment store	96
Isolation	98
General information	79
Average Score	**95**

7.2 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.

Patient Linen	7,8 and 16 July 2026
Storage of clean linen	88
Storage of used linen	100
Laundry facilities	N/A
Average Score	**92**

7.3 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).

Waste and Sharps	7,8 and 16 July 2026
Handling, segregation, storage, waste	91
Availability, use, storage of sharps	92
Average Score	**92**

7.4 Standard 5: Patient Equipment

For organisations to comply with this standard they must ensure that patient equipment is appropriately decontaminated.

Patient Equipment	7,8 and 16 July 2026
Patient equipment	100

7.5 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.

Hygiene Factors	7,8 and 16 July 2026
Availability and cleanliness of wash hand basin and consumables	100
Availability of alcohol rub	100
Availability of PPE	100
Materials and equipment for cleaning	93
Average Score	**98**

7.6 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.

Hygiene Practices	7,8 and 16 July 2026
Effective hand hygiene procedures	100
Safe handling and disposal of sharps	100
Effective use of PPE	100
Correct use of isolation	100
Effective cleaning of ward	100
Staff uniform and work wear	100
Average Score	**100**

8.0 Quality Improvement Plan/Areas for Improvement

This was a very positive inspection, highlighting effective management and IPC arrangements to ensure safe, high-quality care. Patient and student nurse feedback was exemplary. Staff are commended for the high standards of care delivered in the ward especially given the vulnerability of the patient cohort present.

Several noteworthy and practical points are highlighted in the report. If implemented, they will further strengthen governance arrangements for augmented care practice on ward 7N. There are no areas for improvement identified where action is required to ensure compliance with The Quality Standards for Health and Social Care 2006 DHSSPSNI (March 2006).

	Standards
Total number of Areas for Improvement	**0**



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