The Regulation and Quality Improvement Authority

Guidance and Procedural Paper for RQIA Inspections in Augmented Care Areas

informing and improving health and social care
www.rqia.org.uk

Contents

1.0 Background and Context for the Development of the Audit Tools

On 30 January 2012, the Minister for Health, Social Services and Public Safety asked the Regulation and Quality Improvement Authority (RQIA) to facilitate the development of a range of specialised audit tools with expert public health input from the Public Health Agency. The Minister in his statement outlined that these tools should provide an assurance of the standards of infection prevention and control within neonatal units and other augmented care settings. Based on DHSSPS NI guidance the augmented care areas currently identified for inclusion in inspections are as follows:

- 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

Inspections undertaken by RQIA indicate that processes have been developed to provide a message to staff that tackling health care associated infections and ensuring cleanliness is "everybody's business". This is being taken forward in a "Board to Ward" approach. However inspections found that in some instances there was a need to further embed these approaches at ward level. Reference (Overview Report of RQIA Infection Prevention and Hygiene Inspections 1 January 2011 – 31 March 2012) www.rqia.org.uk

"Changing the Culture 2010", the strategic regional action plan for the prevention and control of healthcare-associated infections in Northern Ireland, outlined a core aim which is supported by five inter-related objectives. The core aim is to "*Eliminate the occurrence of preventable healthcare-associated infections in all health and social care settings, and promote, strengthen and maintain public confidence and understanding*. "

The five inter-related objectives are:

1. Ensure that all health and social care settings provide a safe environment.

2. Ensure that effective HCAI surveillance programmes and systems to investigate clusters and adverse incidents and to share learning are in place.

3. Renew the focus on antimicrobial resistance and antibiotic prescribing.

4. Promote public knowledge, engagement and feedback; strengthen accountability to the public.

5. Use and undertake rigorous research to inform improvements in infection prevention and control.

The introduction of this suite of audit tools is designed to support these objectives and is a natural progression/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.

2.0 Will the Audit Tools Make a Difference?

Since the introduction of the unannounced inspection programme in 2008/09 and Regional Healthcare Hygiene and Cleanliness Standards in 2011 there has been a steady improvement in the standard of cleaning, the physical environment and hygiene practices across HSC facilities in Northern Ireland.

These inspections have promoted and strengthened accountability arrangements of the importance of creating a safe healthcare environment for patients, visitors and staff. It is also recognised that whilst managers have found the inspection process challenging in the current financial climate, they also recognise that the inspections have raised awareness of accountability and there has been more focused activity directed towards continuous improvement.

The introductions of these new audit tools will help further implement existing standards and guidance including delivery of the regional strategy. They will also help target areas for improvement and inform and shape the development of local and regional initiatives.

There is a need for monitoring, oversight and continued scrutiny in the fight to prevent HCAI's. The work already carried out across Northern Ireland to improve hospital infections has had a significant impact; this focus on improvement must continue. These tools will assist in this focus in high risk augmented care areas where patients are more susceptible to infection as a result of their illnesses.

3.0 Development of the Tools

A working group was set up and included representatives from RQIA, the Public Health Agency, Northern Ireland (NI) Infection Prevention Society Nurses Regional Group, HSC Trusts, Regional Support Services Steering Group, Association of Healthcare Cleaning Professionals and DHSSPS. (Appendix 1 Members of the working group).

The work was informed by existing documents such as:

- the Regional Infection Prevention and Control Manual for Northern Ireland
- the Regional Healthcare Hygiene and Cleanliness Standards and Regional Healthcare Hygiene and Cleanliness Audit Tool
- "*Changing the Culture*" 2006 action plan, updated in 2010
- the RCN guide "*Wipe it out*" Essential practice for infection prevention and control Guidance for nursing staff, Jan 2012

In addition, a range of local knowledge and expertise was drawn from the managers and staff of augmented care facilities including:

- Clinical leads and staff within all neonatal units in Northern Ireland
- Critical Care Network Northern Ireland (CCaNNI)
- Northern Ireland Cancer Network (NICaN)
- Clinical leads for other augmented care areas, renal, burns, and haematology

Visits were undertaken to Neonatal Intensive Care Units and Critical Care Units to discuss and determine the effectiveness, validity and reliability of the audit tools. The relevant staff within HSC Trusts were given the opportunity to provide comments on drafts of the tools on two separate occasions.

4.0 Audit Tools

The tools are designed to be used in conjunction with the **Regional Healthcare Hygiene and Cleanliness Audit Tool.**

4.1 Regional Infection Prevention and Control Governance Assessment Tool

This tool is applicable to all Augmented Care Areas

This audit tool is based on the National Institute for Health and Clinical Excellence, Quality Improvement Guide, Prevention and Control of Healthcare Associated Infections. The tool contains 11 criteria statements and can be used by HSC Trusts, as well as those working in private, voluntary and community sectors.

The criteria statements aim to help build on previous guidance to improve the quality of care and practice over and above current standards. The quality improvement statements contained in the guidance describe excellence in care and practice to prevent and control healthcare associated infections.

4.2 Clinical Practices Audit Tool

This tool is applicable to all Augmented Care Areas

This tool helps provide assurance on the robustness of the systems and processes in place which are designed to ensure a consistent approach to clinical interventions, thereby reducing the risk of infection to patients, visitors and staff and to ensure that standard infection prevention and control precautions are applied by all healthcare practitioners in the delivery of care to all patients.

The report from the Independent Review of Incidents of *Pseudomonas aeruginosa* Infection in Neonatal Units in Northern Ireland indicated that various initiatives aimed at reducing the risk of healthcare associated infection had been introduced. These include the introduction of high impact interventions (HII) or care bundles, which are evidence based care processes, related to key clinical procedures that have been shown to reduce the risk of infection if performed appropriately. However, the investigation noted variation in the mechanism for implementation and practice which resulted in the review team recommending that there was a requirement for standardisation in clinical practice and robust systems and processes for clinical interventions.

The questions posed in the various subsections of the tool are based on best practice guidance and high impact interventions (HII) or care bundles. The tool contains nine interventions and has been devised for use in various clinical settings.

4.3 Neonatal Audit Tool

This tool is applicable to all Neonatal Intensive care and special care baby units

The Neonatal audit tool is based on existing documents, from the DHSSPS, DH England, The British Association of Perinatal Medicine and a range of recognised research sources.

The 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 neonatal care to assist in the prevention and control of healthcare associated infections.

4.4 Critical Care Audit Tool

This tool is applicable to all Adult and Paediatric Intensive Care (which includes Cardiac Intensive Care and High Dependency Units)

The Critical Care Audit Tool is based on existing documents, from the DHSSPS, DH England, Infection Prevention Society, Quality Improvement Tools, www.ips.uk.net, Critical Care Network Northern Ireland, Royal College of Nursing and a range of other recognised research sources.

The tool contains six sections. 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 and to assist in the prevention and control of healthcare associated infections.

4.5 Augmented Care Audit Tool

This tool is applicable to the following Augmented Care Units (which includes Renal (Dialysis) Units, Renal Transplant Unit, Oncology, Haematology, and Burns)

The Augmented Care Audit Tool is based on existing documents, from the DHSSPS, DH England, Infection Prevention Society, Quality Improvement Tools, www.ips.uk.net , Cancer Care Network Northern Ireland, Renal Network, Royal College of Nursing and a range of other recognised research sources.

The tool contains six sections. 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 augmented care settings to assist in the prevention and control of healthcare associated infections.

5.0 Who Are the Tools Designed For

The tools will be applicable across all augmented care areas in HSC trusts and the independent sector hospitals within Northern Ireland. As outlined, the governance assessment tool can be used by HSC trusts, as well as those working in private, voluntary and community sectors. The clinical practices tool is designed in such a way that the principles can be adapted and applied to all settings. The range of tools will relate to staff in specific areas of augmented care. Where there is augmented care patients cared for in a general ward, trusts should assess the risk and use these tools as appropriate.

Exclusions

Cystic fibrosis units and Maternity Delivery suites have not been included at present, but will be considered as part of additional work in the future.

6.0 How will the tools be used

The tools should be viewed as a means to standardise and consolidate practice, and to assist with processes already in place to support and promote continuous improvement.

The Governance Assessment Tool will not be subject to a scoring system. It is envisaged that organisations will use this tool as a self-assessment. RQIA will incorporate this tool into the announced inspection process. It is envisaged that all criteria will be reviewed within the three year cycle of improvement. In the first year criteria chosen for inspection will be developed using a methodology, which ensures that the criteria chosen will be comprehensively sourced, prioritised and appropriately balanced, will initially be based on the same methodology as used to identify reviews.(RQIA Three Year Review Programme 2012-2015) www.rqia.org.uk

The Clinical Practices and other Augmented Care Audit Tools will be scored using the scoring system set out in the introduction section of the tools.

It is proposed that RQIA will use these tools, as an assessment framework for improvement over a three year inspection cycle. The working group has suggested that in order to build progressive improvement over the three year cycle, compliance scores should be set at 85 per cent in year one, rising to 95 per cent by the end of year three. This will allow facilities time to fully introduce any necessary improvements.

However, if RQIA inspections identify issues that are considered to be of high risk, trusts will be asked to take immediate action. RQIA propose to commence the inspection programme for augmented care areas in April 2013. From this date RQIA will commence a three year cycle of inspections of facilities; the first year programme will commence with Neonatal Intensive Care and Critical Care units.

7.0 Inspections

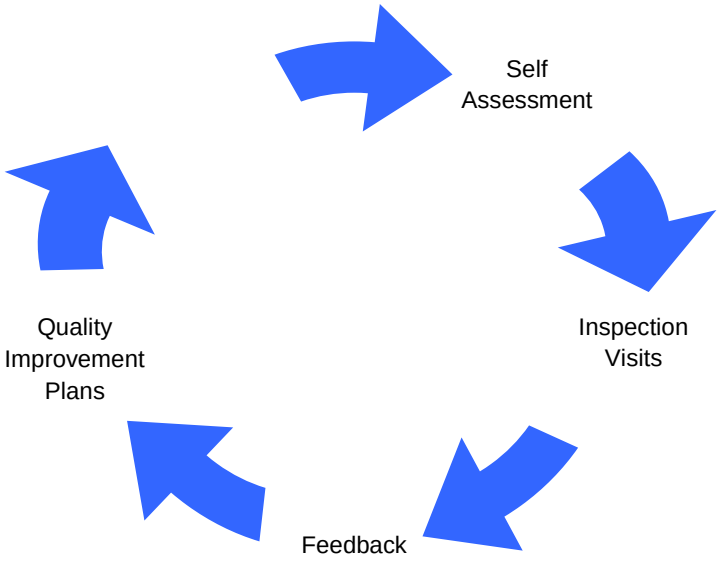
RQIA inspections will include those specialities outlined in section 1.0. The infection prevention/ hygiene team will carry out an announced inspection of each trust each year to review a number of the criteria of the governance assessment tool to ensure that hygiene and infection prevention and control policies and procedures are working in practice.

The clinical practices and other augmented audit tools will mainly be assessed using unannounced inspections. The inspections will also include the use of the DHSSPS Regional Healthcare Hygiene and Cleanliness audit tool.

In the first instance it is anticipated that the unannounced inspections will take two days to complete. The first day of the inspection will be unannounced; the second day will facilitate discussion with the appropriate senior personnel at ward/unit level. As the process rolls out these timelines may be reviewed.

Follow up inspections will be undertaken as required if any of the key indicators are triggered or if issues of public concern arise.

7.1 The methodology/process of announced inspections includes:



7.2 Self-assessment

7.2.1 The announced inspection will use an electronic self-assessment to gather information regarding a number of the criteria within the governance assessment tool, in addition mandatory surveillance data (not limited to CDI and MRSA)obtained from the PHA/HSCB may be used to risk assess and inform the inspection process. The information collected will be reviewed and validated on inspections. To provide a

risk based proportionate approach to the programme, quantitative and qualitative data will be reviewed to help indicate areas of high risk.

7.3 Announced inspections (Flowchart Appendix 2)

7.3.1 Organisations will receive a minimum of six weeks' notice which is in line with the regulatory inspection processes within RQIA (they will not receive any notice of areas to be inspected). The self-assessment issued at this time should be returned three weeks prior to the inspection. The organisation will be issued with a draft on-site programme at this time to allow for identification of representatives who may wish to accompany inspection teams and to provide a contact affiliate for the inspection.

7.3.2 Announced inspections will generally be within working hours including evenings. Weekend and out of hours night time inspections will be carried out if required.

7.3.4 Inspections may take place over one to three days dependent upon the criteria to be inspected and will include feedback on outcomes or learning. Announced inspections will not include an inspection of the environment or practice within wards/units.

7.3.5 Announced inspections will usually be carried out by the RQIA infection prevention/hygiene team; if required this team will be supplemented by peer reviewers who have received the appropriate training.

7.3.6 Inspectors/ peer reviewers will follow the "Infection prevention/hygiene team inspection protocol" which is available on the RQIA website.

7.3.7 The inspection will conclude with a feedback session to outline key findings and the process for the report and action plan development.

7.4 Unannounced inspections (Flowchart Appendix 3)

7.4.1 Organisations will normally receive an email and telephone call by a nominated person from RQIA 30 minutes prior to the team arriving on site. However, at weekends or outside normal working hours this may not be possible. At these times inspectors will ask staff at reception to contact the site manager.

7.4.2 Unannounced inspections will generally be within working hours including evenings. Weekend and out of hours night time inspections may be carried out.

7.4.3 It is anticipated that unannounced inspections will take two days to complete. The first day of the inspection will be unannounced and will include inspection or area/ facility; the second day will facilitate

discussion with the appropriate senior personnel at ward/unit level. As the process rolls out these timelines may be reviewed.

7.4.4 On arrival the inspection team should, if possible be met by a trust representative to identify a senior representative to contact the inspection team or to arrange any special requirements. If this is not possible the inspection team will leave details of the areas to be inspected at the reception desk.

7.4.5 The unannounced inspection will be undertaken using the following audit tools:

- Clinical practices audit tool
- Relevant augmented care audit tool
- DHSSPS Regional Healthcare Hygiene and Cleanliness audit tool.

7.4.6 RQIA may use questions devised from the audit tool to obtain information from staff and patients.

7.4.7 During inspections the team will require access within areas inspected, to the list of documentation outlined in the clinical practice and relevant augmented care audit tool.

7.4.8 The inspection will, where necessary, include taking digital photographs of the environment and equipment for reporting purposes and primarily as evidence of assessments made. No photographs of staff, patients or visitors will be taken in line with the RQIA policy on the" Use and Storage of Digital Images".

7.4.9 The inspections will be carried out by the RQIA infection prevention/ hygiene team and supplemented when required by peer reviewers from a range of disciplines/specialities who have received the appropriate training. Inspectors/ peer reviewers will follow the "Infection prevention/ hygiene team inspection protocol" which is available on the RQIA website.

7.4.10 The inspection will usually conclude with a feedback session to outline key findings and the process for the report and action plan development.

7.5 Reports

7.5.1 Reports will include an overview of the findings from all audit tools used during the inspection.

7.5.2 The organisation will receive the preliminary findings within 14 days of the inspection visit and the draft report within 28 days in line with RQIA regulatory processes.

7.5.3 The detailed list of preliminary findings should be used by organisations to develop their own improvement plan this does not require to be returned with the draft report. The Quality Improvement Plan attached to the report will highlight recommendations and requirements (the detailed list of preliminary findings will be available on request)

The definitions of recommendations are as follows:

- The action required to comply with
  - Clinical practices audit tool
  - Relevant augmented care audit tool
  - DHSSPS Regional Healthcare Hygiene and Cleanliness audit tool

- Other issues which may impact on patient care which relate to regional/ national guidance and recognised best practice

The definition of requirement is as follows:

- Any action falling within the regulatory framework (regulated facilities only)

7.5.4 The organisation will agree the factual accuracy of the draft report and return the signed Quality Improvement Plan to the RQIA within 14 days of receiving the draft report.

7.5.5 The inspection team will work with organisations to discuss and correct any agreed errors of accuracy/fact in preparation of the final report. In the event that agreement cannot be reached, RQIA will append the communication, outlining any outstanding issues that have not been agreed.

7.5.6 The final open inspection report will be made available on the RQIA website.

7.5.7 If serious concerns regarding patient/client care are identified, which require a follow up inspection within 4 weeks of the initial inspection,

the report will not become open until the follow up inspection has taken place. The final report will then include details of the follow up inspection and will be published on the RQIA website. These reports and Quality Improvement Plans for inspections in HSC Trusts will be forwarded as required to the HSC Board and PHA for onward performance management.

7.5.8 Organisations should commence work on the findings of the inspection as soon as the inspectors have given the initial feedback at the end of the inspection and formalised on receipt of the inspection report.

7.5.9 In line with the RQIA core activity of influencing policy, RQIA may formally advise the DHSSPS, HSC Board and the Public Health Agency of a requirement to take account of emerging evidence which may have implications for best practice.

7.6 Follow up

7.6.1 The inspection team will initially follow up progress with the implementation of the Quality Improvement Plan (QIP). This will take place within three months of the inspection. The type of follow up will be dependent upon the severity of the issues identified at the inspection and subsequent action taken by the organisation. Were issues have reached the threshold of the RQIA Escalation policy these will be reported to the DHSSPS, HSC Board and the Public Health Agency.

7.6.2 The follow up may involve:

- Communication with the organisation either in writing or verbally
- Meeting with organisational representatives
- Announced inspection
- Unannounced inspection
- Evoking the RQIA escalation policy

7.6.3 If a follow up visit is undertaken (within three months of the initial inspection), a short report will be produced on the areas that did not reach the required compliance level on the initial inspection. A full inspection will not be undertaken, however if inspectors observe a fall in the compliance levels achieved on the first inspection this information will also be included in the report.

7.6.4 Follow up Indicators

The QIP is not produced within the agreed timescale

Action: A member of the infection prevention/ hygiene team will contact the organisation and determine the reason for the delay; if a valid reason is given, the timescale will be reset. If no valid reason is given, this should be escalated to the RQIA Director of Reviews and a letter sent to the Chief Executive/Registered Person of the organisation requesting the QIP to be completed and returned to RQIA.

If after an agreed period, the QIP is still not produced a formal letter will be sent by the Chief Executive of the RQIA to the Registered Person/ Chief Executive of the trust indicating the timescale for resolution. For HSC Trusts this will be copied to the HSC Board and PHA for onward performance management.

7.6.5 The QIP is inadequate or not fully completed

Initial Action: The QIP is returned to the organisation for clarification or amendment for a maximum of two times. This may also be accompanied by a phone call.

7.6.6 The QIP is still inadequate or not fully completed

Action: A formal letter will be sent by the Chief Executive of RQIA to the Registered Person/Chief Executive of the organisation indicating a timescale for resolution and the procedure for escalation. If the QIP still remains inadequate or is not fully completed in regulated facilities the RQIA enforcement procedure will be followed. For HSC Trusts this will then be escalated by the Chief Executive of RQIA to the HSC Board and PHA.

7.6.7 If significant patient/client safety concerns are identified during the inspection

Action: These will be highlighted if possible at the formal feedback session or as soon as possible after the findings have been completed. A letter will be sent by the Chief Executive of RQIA to the relevant organisation and copied to the HSC Board and PHA.

Further Action: A follow up visit within four weeks or within three months may be undertaken dependent upon the severity of the findings and based on risk assessment and professional judgement. Onward communication on action taken will be communicated as outlined in the escalation policy.

7.6.8 Follow up inspections

There are a number of key indicators that would prompt a follow up inspection listed below

- If an overall minimally compliant score is achieved in any of the Regional Infection Prevention and Control Audit Tools.
- If one section within the Regional Infection Prevention and Control Clinical Practices Audit Tool is not compliant a letter will be sent to the Chief Executive to ensure improvement in practice.
- If two sections within the Regional Infection Prevention and Control Clinical Practices Audit Tool are not compliant.
- If two sections within any of the Regional Infection Prevention and Control Audit Tools are minimally compliant(Neonatal, Critical Care and Augmented Care).

A follow up inspection may also be undertaken based on professional judgement, or assessment of risk, even though a compliant or partially compliant score has been achieved. During inspections if a serious issue which is not included in the audit tool is identified this may require some level of follow up, the type of follow up will be dependent on the level of risk identified.

A follow up inspection may also be undertaken if:

- A complaint received by the RQIA indicates that an inspection is required
- A request has been made by the DHSSPS, HSC Board or PHA
- Media attention

7.7 Escalation

7.7.1 During inspection it may be necessary for RQIA to implement the infection prevention/ hygiene team escalation policy. The process is outlined in the escalation flowchart (Appendix 4) and detailed in the escalation policy.

7.7.2 This includes communication to the DHSSPS, HSC Board and the Public Health Agency.

Appendix 1 Members of the Working Group

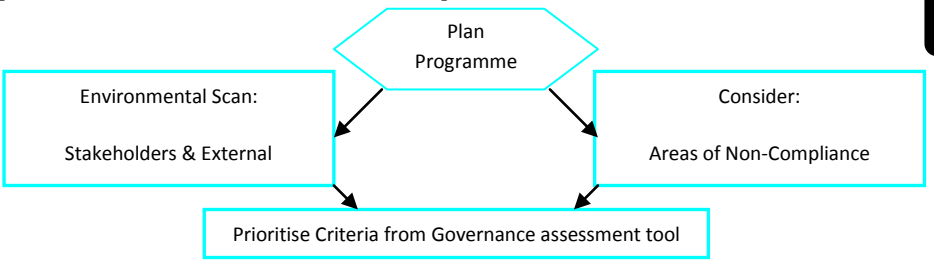
Phelim Quinn	Chair/Director of Regulation and Nursing, RQIA
Elizabeth Colgan	Head of Infection Prevention and Hygiene, RQIA
Sheelagh O'Connor	Infection Prevention and Hygiene Team, RQIA
Mary McClean	Project Manager ,RQIA
Dr Brian Smyth	Consultant in Health Protection, Public Health Agency
Dr Lourda Geoghegan	Health Protection Consultant, Public Health Agency
Caroline McGeary	Senior Infection Prevention & Control Nurse, Public Health Agency
Mary Maguire	Head of Health Care Facility Planning, DHSSPS
Fiona Hughes	Infection Prevention Society NI Regional Group
Nancy Scott	Senior Manager, Patient & Client Support (BHSCT)
Anne Hamilton	Association of Healthcare Cleaning Professionals General Manager for Domestic Services (NHSCT)
Lorraine Clegg	Patient Environment Branch, Health Estates, DHSSPS
Mary Curran	Patient Environment Branch, Health Estates, DHSSPS
Dr. Liz Reaney	Senior Medical Officer (Communicable Disease), DHSSPS

Appendix 2 Announced Inspection Process

RQIA Infection Prevention /Hygiene Team

Plan Programme

Notification of Inspection



Prior to Inspection Year

Balance Programme

Schedule Inspections

Identify Inspection Team

6 weeks prior to inspection

Notify organisation of inspection date send self-assessment

Make request for supplementary information from organisation if required

Organisation advises of affiliate for inspection

3 weeks prior to inspection

Organisation returns self assessment and any supplementary information

Is all information returned?

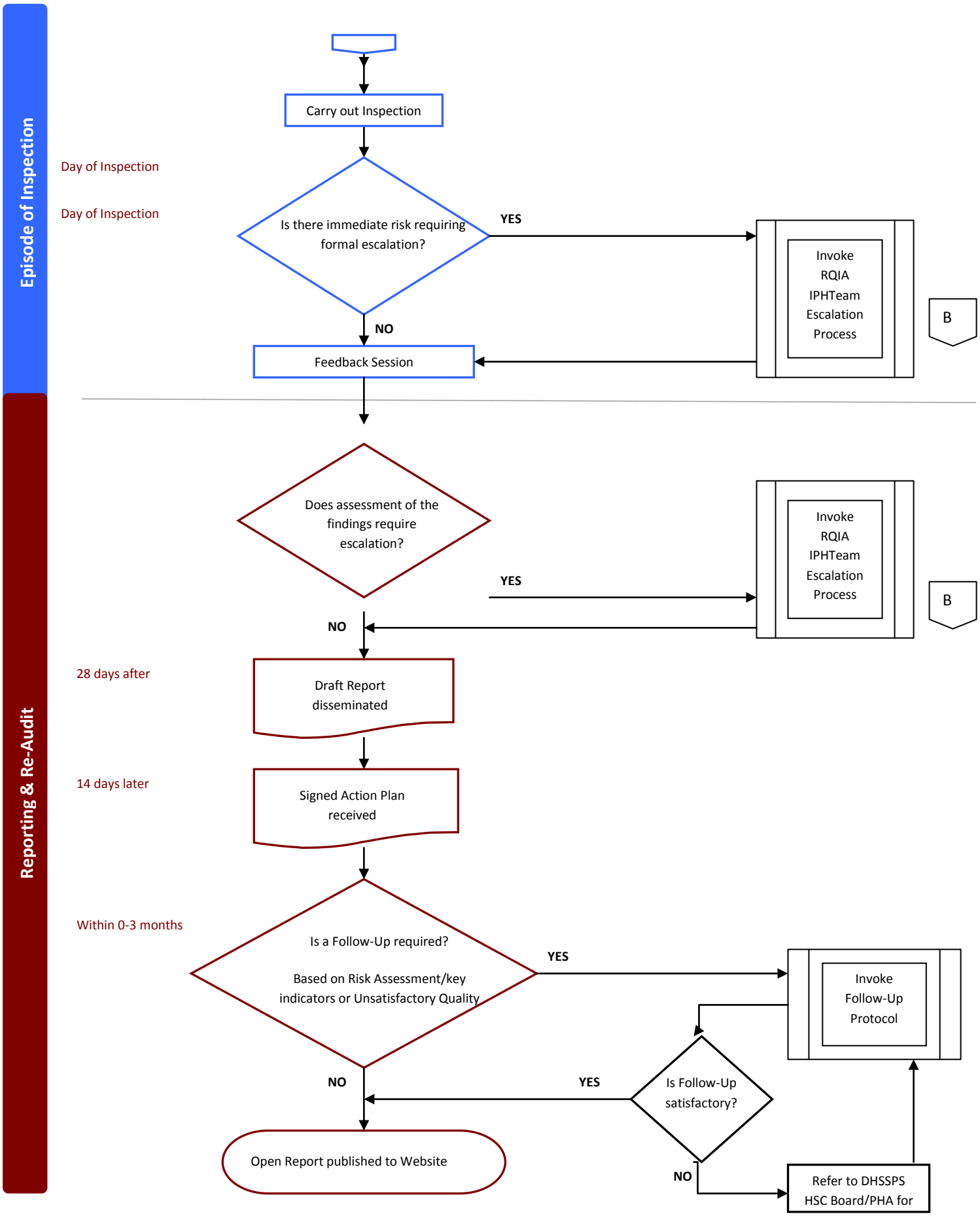
NO

YES

1 week prior to inspection

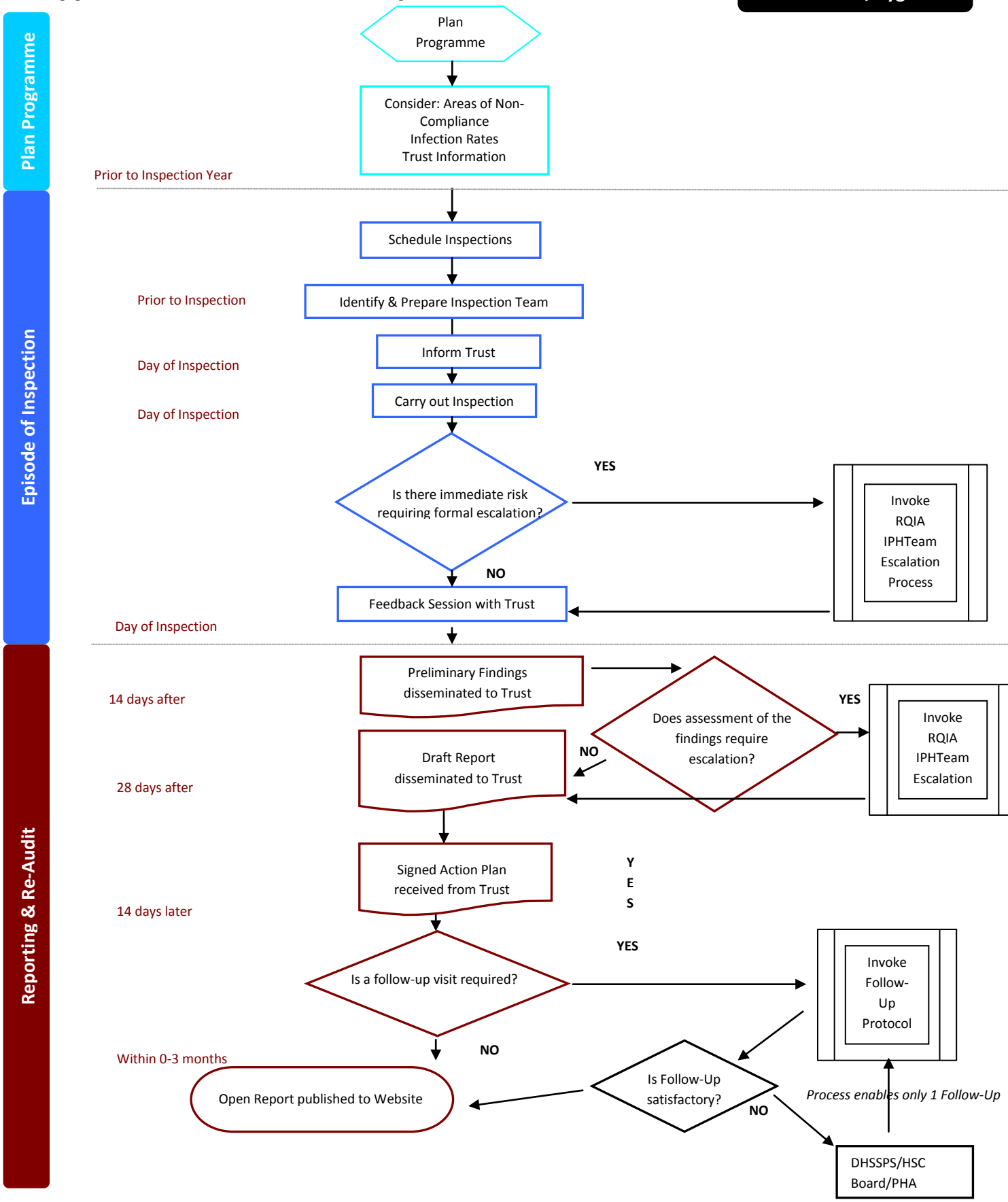
IPHTeam analyse returned information

IPHTeam identify areas for clarification at the time of inspection

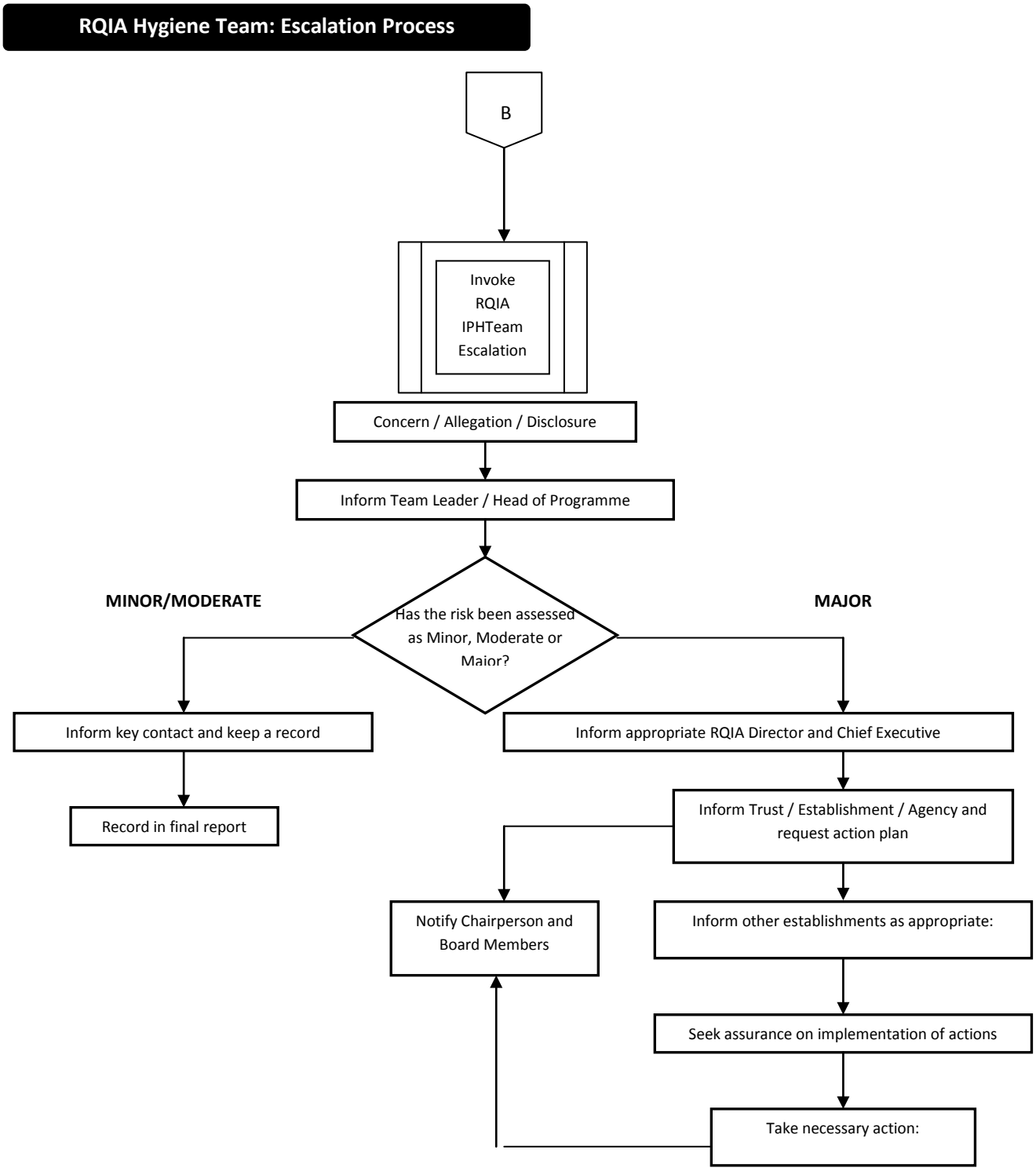

Episode of Inspection
Reporting & Re-Audit
Carry out Inspection
Day of Inspection
Day of Inspection
Is there immediate risk requiring formal escalation?
YES
NO
Invoke RQIA IPHTeam Escalation Process
B
Feedback Session
Does assessment of the findings require escalation?
YES
NO
Invoke RQIA IPHTeam Escalation Process
B
28 days after
Draft Report disseminated
14 days later
Signed Action Plan received
Within 0-3 months
Is a Follow-Up required?
Based on Risk Assessment/key indicators or Unsatisfactory Quality
YES
NO
Invoke Follow-Up Protocol
Is Follow-Up satisfactory?
YES
NO
Open Report published to Website
Refer to DHSSPS HSC Board/PHA for

Appendix 3 Unannounced Inspection Process

RQIA Infection Prevention /Hygiene



Appendix 4 RQIA Hygiene Team: Escalation Process



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