Regional Augmented Care Infection Prevention and Control Audit Tool

Organisation Name:

Area Inspected/Speciality:

Auditors:

Date:

Contents

Augmented Care Audit Tool - Guidance

This audit tool is designed to be used in conjunction with the Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool

This audit tool is based on the following documents:

Regulation and Quality Improvement Authority

The Interim Report of the Independent Review of Incidents of *Pseudomonas aeruginosa* Infection in Neonatal Units in Northern Ireland, 4 April 2012

Independent Review of Incidents of *Pseudomonas aeruginosa* Infection in Neonatal Units in Northern Ireland, 31 May 2012

DHSSPSNI

Water sources and potential *Pseudomonas aeruginosa* contamination of taps and water systems – Advice for augmented care units (*including neonatal units caring for babies at levels 1, 2 and 3*), and relating documentation, 30 April 2012.

Guidance on Cleanliness Procedures in relation to Cleaning of Sinks in Clinical Settings – including Augmented Care Settings/Neonatal Units, 31 May 2012

The Department of Health England

Facilities for Cancer Services, HBN 54, DOH 2006

Facilities for Main Renal Unit, HBN 07-02, DOH 2008

Miscellanous

Infection Prevention Society, Quality Improvement Tools, www.ips.uk.net

During the development of this tool a review of various articles and research papers was undertaken. A list of these can be provided on request in the final document.

This tool contains five 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 and to assist in the prevention and control of Healthcare Associated Infections.

The audit tool is formatted as follows:

Section 3 Regional Augmented Care Infection Prevention and Control Audit Tool

Section 3.1 – Local Governance Systems and Processes – Ward/Unit
Section 3.2 - General Environment
- 3.2.1 - Layout and Design format
- 3.2.2 - Environmental Cleaning
- 3.2.3 -Water Safety

Section 3.3 – Augmented Care Clinical and Care Practice
Section 3.4 – Augmented Care Patient Equipment
Documentation for the Regional Augmented Care Infection Prevention and Control Audit Tool

Scoring

All criteria should be marked either yes/ no or non-applicable.

It is not acceptable to enter a non-applicable response where an improvement may be achieved. For example where a regional/ national standard is not being met, a non-applicable must not be used:

Section						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
1. IPC policies and procedures are available and accessible to staff	Ask staff, review documentation or intranet access					
	remove					

*** R= Designates area of responsibility i.e. Nursing, Estates and Cleaning**

In the example above it is not appropriate to mark non-applicable where IPC policies and procedures are not available as the regional standard is to have them. Therefore if they are not available a no score must be allocated. The action plan will then reflect the change in practice required.

If a question is not achievable because a facility is absent or a practice is not observed, the use of non-applicable is acceptable.
For example if syringe drivers are not in use.

Section 2.2 Invasive Devices						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
1. Syringe drivers are clean and in a good state of repair	1. Visibly clean			***X***		
	2. No visible damage, adhesive tape			***X***		

Comments should be written on the form for each of the criteria at the time of the audit clearly identifying any issues of concern and areas of good practice. These comments can then be incorporated into the final report.

Manual scoring can be carried out as follows:

Add the total number of yes answers and divide by the total number of questions answered (including all yes and no answers) excluding the non-applicable; multiply by 100 to get the percentage.

Formula

$$\frac{\text{Total number of yes answers}}{\text{Total number of yes and no responses}} \times 100 = \%$$

Section						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
1. Hand washing sinks are used appropriately	1. Hand washing is only carried out at hand washing sinks	✓				
	2. Bodily fluids/cleaning solutions are not disposed of at hand washing sinks	✓				
	3. Patient equipment is not washed at hand washing sinks		✓			
	4. Patient equipment is not stored awaiting cleaning in the hand washing sink		✓			

The score for the above table would be calculated as follows:

2/4 X 100 = 50%

Level of Compliance

Percentage scores can be allocated a level of compliance using the compliance categories below.

Compliance levels should increase yearly to promote continuous improvement.

Year 1

Compliant	**85% or above**
Partial compliance	**76 to 84%**
Minimal compliance	**75% or below**

Year 2

Compliant	**90% or above**
Partial compliance	**81 to 89%**
Minimal compliance	**80% or below**

Year 3

Compliant	**95% or above**
Partial compliance	**86 to 94%**
Minimal compliance	**85% or below**

Each section within the audit tool will receive an overall score. This will identify any specific areas of partial or minimal compliance and will assist in the identification of areas were improvement is most required to ensure that the appropriate action is taken.

Weighting Criteria

Millward et al (1993) reported that weighting of the criteria did not significantly influence overall scores. Therefore weighting of criteria has not been attempted.

Auditing

The audits obtain information from observations in functional areas including, direct questioning of staff, patients, carers, observation of clinical practice and review of relevant documentation where appropriate.

If any serious concerns are identified during the audit, these should be brought to the attention of the person in charge before the auditors leave the premises and where necessary escalated to Senior Management.

Feedback

Verbal feedback of key findings should be given to the person in charge of the area prior to leaving or as soon as possible. A written copy of the findings and actions required should be made available to all relevant personnel within locally agreed timescales.

A re-audit of a functional area may be undertaken if there are concerns or a minimal compliance rating is observed to ensure action has been taken.

Section 3 Regional Augmented Care Infection Prevention and Control Audit Tool

Section 3.1 – Local Governance Systems and Processes – Ward/Unit						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
1. The ward sister/charge nurse/team leader is aware of their role and responsibility in relation to infection prevention and control (this would include the person in charge at the time of the audit)	The audit tool should evidence most aspects of this question. Areas that have not been evidenced should be discussed with the ward sister/charge nurse/team leader. Discussion will allow the ward sister/charge nurse to discuss challenges etc Areas to be evidenced on discussion are listed at the end of the tool under roles/responsibility.					
2. The ward/unit has a lead person responsible for infection prevention and control	1. A lead person has been identified					
	2. Staff can name the lead person for IPC at ward level (this may be a link member of staff)					
	3. The named lead at ward/team level should have protected time for appropriate educational training opportunities to undertake the responsibilities involved in the role					
3. There is evidence of ward/unit based multiprofessional working relating to infection prevention and control	Review documentation e.g: Minutes of meetings Improvement Groups Joint audit					
4. Incidents related to infection prevention and control are reported and actioned appropriately	1. SAIs, incidents and near misses are appropriately reported and acted on (check copies of reports, IPCT informed, multidisciplinary meetings, action plan developed)					
	2. A multi disciplinary approach is taken to root cause analysis as per local policy (check policy/ask staff)					
	3. Staff receive feedback from root cause analysis/ serious incidents (check documentation/minutes of staff meetings/ask staff)					

Section 3 Regional Augmented Care Infection Prevention and Control Audit Tool

Section 3.1 – Local Governance Systems and Processes – Ward/Unit						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
5. IPC policies and procedures are available and accessible to staff	1. Ask staff, review documentation or intranet access					
6. There is evidence that audits have been undertaken and practice changed to improve infection prevention and control and environmental cleanliness	1. Regular audits are undertaken - ask staff about department audits carried out /check recent audits e.g: - Hand hygiene(including facilities) - HII/dash boards/score cards - Environmental cleanliness - Patient equipment - Regional healthcare hygiene and cleanliness audit tool					
	2. Action plans have been developed and implemented if required (check recent action plans)					
	3. Audit frequency has increased if compliance minimal					
	4. Audits are independently validated and carried out more frequently if self-scoring or validation compliance is minimal (review documentation)					
	5. Up to date results are displayed (Ref Changing the Culture 2010)					
	6. Staff receive up to date feedback on the audit results (displayed/discuss at staff meetings)					
7. Surveillance programmes are in place which allow detection and implementation of preventive strategies for HCAI	1. Ward staff are aware of mandatory surveillance in place i.e. Staphylococcus aureus bacteraemia's					
	2. Ward staff are aware of non-mandatory surveillance of nosocomial infections are in place e.g. Pseudomonas, Enterobacter, Klebsiella					
	3. Screening policies/protocols that are in place should be determined by microbial burden in the augmented care unit and inform clinical and infection prevention					

Section 3 Regional Augmented Care Infection Prevention and Control Audit Tool

Section 3.1 – Local Governance Systems and Processes – Ward/Unit						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
	and control actions for future surveillance					
8. Surveillance data is collected, analysed, interpreted, shared and used to inform changes as required	1. Data collection processes are in place of organisms identified in the unit					
	2. There is documented evidence of multidisciplinary meetings to interpret data collected, identify trends and discuss actions e.g. Surveillance Committee					
	3. Data collected is shared with all members of the clinical team in a timely and appropriate manner (ask staff/displayed for staff)					
	4. Data collected is used by clinicians to inform practice (check available documentation)					
9. Estates issues are managed appropriately	1. A record is available for identified estates issues i.e. log/maintenance book/computer record					
	2. The ward sister/charge nurse and IPCT are involved in estates monitoring within the ward and are informed of any planned works					
	3. A system is in place to record and action estates issues identified from relevant audit activity					
10. Staffing does not compromise infection prevention and control	1. The ratio of nursing staff to patient is reviewed and increased as appropriate and when isolation is required					
	2. The ratio of cleaning staff is reviewed and increased as appropriate and when isolation is required					
	3. The unit does not have a heavy reliance on bank and agency staff					
	4. Are beds closed due to staff shortages					
11. The IPCT team undertake daily and enhanced visits to augmented care areas	1. There are sufficient IPCT nurses to provide daily visits to the area and increased visits when appropriate e.g. outbreak management					

Section 3 Regional Augmented Care Infection Prevention and Control Audit Tool

Section 3.1 – Local Governance Systems and Processes – Ward/Unit						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
	2. There is a IPC nurse with dedicated responsibility for augmented care areas (ask staff)					
12. All staff have received mandatory training in line with trust policy	1. Ask staff/check records (clinical staff every two years)					
	2. Infection prevention and control is included in all staff induction programmes					
	3. A process is in place to ensure non attendees are followed up					
13. An Occupational Health policy, known to ward staff, is in place to negate the potential risk of transmission of infection	1. Check policy is available					
	2. Staff are offered the appropriate immunisation					
	3. OHD/IPCT contacted by manager for staff with potential infection or when a trend in staff illness is identified e.g. vomiting/diarrhoea/ communicable disease					
	4. Check if the staff know about remaining off work for 48/72 hours dependant on trust policy, after resolution of illnesses such as diarrhoea/vomiting/Group A Streptococcal infection/ Herpes Simplex					
	5. There is a process in place, as part of policy, to screen staff if an increased incidence of infection is identified e.g. MRSA/vomiting and diarrhoea					
	6. Staff are aware of the need to report the development of conditions e.g. skin conditions					
14. There is a range of information sources to inform patients and relatives about infection prevention and control	1. Education sources are available e.g. leaflets, DVDs					
	2. Information leaflet/s (include when not to visit for example when feeling unwell or any illness, visiting arrangements/times/bringing food into the unit)					

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Section 3.1 – Local Governance Systems and Processes – Ward/Unit						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
15. Relatives /visitors are educated on the correct hand washing technique	1. Relatives / visitors received guidance on how, where and when to wash their hands (use alcohol gel after hand washing as per regional policy Ref HSS (MD)(16/2012))					
	2. Relatives/visitors use hand wash basins appropriately					
	3. Relatives/visitors have received a one to one session in hand hygiene if appropriate					
	4. Relatives/visitors have been informed, if appropriate, why the concept of bare below the elbow as defined in local policy (e.g. no stoned rings, watches, bracelets, false nails) is important for them to adhere to					
16. Other aspects of the area observed during the inspection	Record here any other areas not mentioned above					

Scores	**Yes**	**No**	**N/A**
Percentage achieved			

Section 3 Regional Augmented Care Infection Prevention and Control Audit Tool

Section 3.2 - General Environment 3.2.1 Layout and Design						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
1. The layout, design and use of the unit is in line with local and national policy	1. The number of bed spaces in use does not routinely exceed the number of commissioned spaces					
	2. Cancer/Renal – minimum of 16 sqm per core clinical space with access space in new builds/refurbished areas (this relates to bays and single rooms) (80% recommended area acceptable in existing units built before HBN 57 2003)					
	3. In existing facilities 3.5 sqm is required between bed head centres					
	4. Day procedures and treatment areas – minimum 10 sqm core space with clinical access in new builds/refurbished areas (80% recommended area acceptable in existing units built before HBN 57 2003)					
	5. Dedicated visitors areas are available and used appropriately (dedicated toilet/beverage provision/seating area/overnight accommodation/interview room)					
	6. Dedicated staff area – changing facility/rest room					
2. The design and layout of the unit minimises the risk of transmission of infection	1. A minimum of four single rooms per eight beds are available (one equipped to ICU level with fully ventilated lobby for isolation purposes) for isolation/cohort nursing					
	2. Clinical hand wash sinks are positioned to prevent splashing on patients/beds/equipment/staff					

Section 3 Regional Augmented Care Infection Prevention and Control Audit Tool

Section 3.2 - General Environment 3.2.1 Layout and Design						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
	3. Clinical hand washing sinks are logically placed to allow optimal workflow i.e. clean to patient to dirty					
	4. Space is allowed for waste bins					
	5. The design of the unit promotes minimal footfall/ movement through the unit (separate clinical route to public entrance)					
	6. There are separate dirty utility , and clean storage areas					
	7. The layout of the unit promotes a clean to dirty work flow					
	8. Core clinical spaces are easily accessible, free from clutter, contain only essential equipment					
	9. Dedicated equipment store is available					
	10. Dedicated equipment cleaning room					
	11. Dedicated area for storage of equipment for repair area					
	12. Dedicated clean utility/drug storage room					
	13. Dedicated area for near patient testing equipment e.g. blood gas machine					
	14. Dedicated consumable store					
3. Ventilation systems are maintained appropriately	1. Ventilation systems are routinely serviced cleaned by Estates includes cleaning and monitoring of air quality/flow(check records)					
4. Other aspects of the area observed during the inspection	Record here any other areas not mentioned above					

Scores	**Yes**	**No**	**N/A**
Percentage achieved			

Section 3 Regional Augmented Care Infection Prevention and Control Audit Tool

Section 3.2 - General Environment 3.2.2 – Environmental Cleaning						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
1. Domestic cleaning guidelines are available for critical care units	1. Guidelines are available and staff display an awareness of same (outline role/responsibility/rooms/areas)					
	2. Includes guidance on: - Routine cleaning - Enhanced cleaning - Terminal cleaning					
2. Environmental cleaning is carried out at the appropriate intervals	1. Routine cleaning is carried out daily and includes frequently touched surfaces (am/pm cleaning)					
	2. During an outbreak/increased incidence of particular organism enhanced cleaning is carried out that reflectsregional/IPC team guidance. Includes frequently touched surfaces					
	3. Terminal cleaning – following an outbreak/increased incidence of infection/discharge/transfer/death of individual patients who have had a known infection					
3. Environmental cleaning processes and outcomes are regularly audited	1. An audit programme is in place for routine environmental cleaning. Check audit records and action plans if non-compliant					
	2. Terminal cleans are signed off by domestic staff or nurse in charge when cleaned (check documentation)					
	3. Terminal cleans are randomly validated by supervisors (as per local targets, check documentation with domestic staff or nurse in charge)					
4. A programme of intensive/ deep cleaning in addition to the general cleaning schedule is in place	1. A programme of intensive/deep cleaning is carried out when required in consultation with the IPC team					
5. A programme of de-cluttering is in place	1. Regular de-cluttering is in place					
6. Disinfectants and cleaning products in use are	1. For example, Hypochlorite solution, Chlorine dioxide detergent wipes					

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Section 3.2 - General Environment 3.2.2 – Environmental Cleaning						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
appropriate to the area	2. Surface contact time maintained if appropriate					
7. A protocol is in place for cleaning hand washing sinks	1. Protocol is in place/on display and domestic staff are an aware of same					
	2. Protocol outlines four cloth clean of the hand washing area (includes thorough drying or air drying as appropriate)					
	3. Competency based training is carried out (check records with domestic staff)					
8. The correct tap and sink cleaning technique is in use	Ask/Observe domestic staff Ref : Cloth 1 – Clean soap/towel dispenser Cloth 2 – Hand wash basin surround Cloth 3 – Clean tap (base to outlet) Cloth 4 – Clean hand wash basin (overflow/waste outlet last)					
9. Taps fitted with point of use filters are cleaned correctly	1. Point of use filters are removed, cleaned and replaced as per manufacturers instruction/local policy (ask/check documentation)					
10. Other aspects of the area observed during the inspection	Record here any other areas not mentioned above					

Scores	**Yes**	**No**	**N/A**
Percentage achieved			

Section 3 Regional Augmented Care Infection Prevention and Control Audit Tool

Section 3.2 - General Environment 3.2.3 - Water Safety						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
1. Water management in augmented care is carried out as per regional guidelines for water sources and potential Pseudomonas contamination of taps and water systems	1. Overarching written guidance for water safety is available and known to the ward sister/charge nurse (includes guidance on risk assessment, water safety plan, sampling, infection control) (HSS (MD) 16/2012)					
2. A water safety plan in place and is up to date	1. A water safety plan is in place as per HSS (MD) 23/2012 and known to ward sister/charge nurse					
	2. The water safety plan identifies links to clinical surveillance (early warning regarding microbiological safety)					
	3. An initial risk assessment and follow up review as per trust policy is carried out (to determine risks that the environment and other patients may pose has been undertaken (check assessment contains advice from regional guidance) e.g. sampling, monitoring and surveillance					
	4. Water used to clean equipment is of a satisfactory standard (sterile, filtered or a source shown to be free of *Pseudomonas aeruginosa*)					
	5. Identified actions have been implemented, reviewed and adhered to (ask ward sister/charge nurse /review documentation)					

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Section 3.2 - General Environment 3.2.3 - Water Safety						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
3. Tap water is sampled and tested as per regional guidelines	1. Random tap water sampling and microbiological testing is carried out (check ward records) as per risk assessment					
	2. Results of any water testing regime undertaken are reviewed with ward sister/charge nurse , estates, IPC					
	3. Water sampling is carried out correctly for installation of new taps or after remedial work as per regional guidance					
4. All manual or automatic taps are flushed regularly	1. All infrequently used taps are removed or flushed regularly (at least daily in morning) – records/ask staff					
	2. All clinical hand washing sinks are used regularly (at least daily)					
5. Hand washing sinks are used appropriately	1. Hand washing is only carried out at hand washing sinks					
	2. Bodily fluids/cleaning solutions are not disposed of at hand washing sinks					
	3. Patient equipment is not washed at hand washing sinks					
	4. Patient equipment is not stored awaiting cleaning in the hand washing sink					
6. Taps comply with local guidelines	1. The use of rose diffusers/rosettes are under review					
	2. Taps can accommodate point of use (POU) filters if required in an emergency					
	3. The use of thermostatic mixer valves (TMV) in use are under review (acceptable in areas where there is					

Section 3 Regional Augmented Care Infection Prevention and Control Audit Tool

Section 3.2 - General Environment 3.2.3 - Water Safety						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
	a risk of scalding)					
	4. Where thermostatically mixer valves are not present 'Hot Water' signage is present					
7. Issues identified with safety, maintenance and cleanliness of hand washing sinks/taps are actioned	1. Report to estates, IPC, domestic services – ask staff/written record					
	2. Unresolved issues are escalated to the appropriate committee – see records					
8. Other aspects of the area observed during the inspection	Record here any other areas not mentioned above					

Scores	**Yes**	**No**	**N/A**
Percentage achieved			

Section 3 Regional Augmented Care Infection Prevention and Control Audit Tool

Section 3.3 – Augmented Care Practice						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
1. Staffing levels are reviewed if admission rates exceed the number of commissioned beds to ensure optimal IPC practices are maintained	1. Staff allocation reflects the need to manage patients within the unit who have suspected or confirmed infections					
2. A record is maintained of patient placement and movements within the unit	1. Check record or randomly select notes to check: 2. Placement plan available					
	3. There is a bed tracking system in place (dedicated ID number which is recorded in patient notes)					
3. A record is maintained of patient movement outside the unit	4. A transfer information form is completed on transfer of the patient (check copy is kept in notes)					
4. Local screening policies/procedures are in place which inform clinical and infection prevention and control actions for present/future surveillance	1. Screening policies/protocols are in place					
	2. Staff are aware of screening policy					
	3. Outlines process for swabbing					
	4. Outlines process of decolonisation/treatment as applicable (under the supervision of the clinician)					
5. Screening, reflective of local policy, is carried out to negate the potential transmission of infection	1. Screening is carried out on admission to the unit, including transfers between hospitals in the same trust					
	2. Prior to transfer from one hospital to another staff are required to record the most recent screening results in the transfer notes (to include blood cultures)					
	3. If admission screens are positive the sending unit must be explicitly informed					
	4. If colonised/infected results there is a system in place to ensure the receiving unit is explicitly informed					

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Section 3.3 – Augmented Care Practice						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
	5. Screening is carried out weekly/twice weekly during time in the unit in line with extant guidance					
6. Patients are isolated when appropriate to negate the risk of transmission of infection	1. Specific guidelines are in place for isolation precautions					
	2. Contact precautions are initiated until the results of swabs are obtained and continued if results are positive					
	3. Standard precautions are in place if screening results are negative					
7. Patients are washed appropriately to negate the risk of transmission of infection	1. Patients are washed with water of a known satisfactory quality (sterile/filtered or source shown to be free from *P. aeruginosa*)					
	2. Body cleansing wipes are single use					
	3. Staff wear gloves/aprons as per local policy when washing patients					
	4. Waste (including water) is disposed of as per local policy (not into hand washing sink)					
	5. Where infection has been identified any risks associated with the delivery of personal care is included in the care plan (check records)					
8. Hand washing is carried out in line with HSS (MD)(16/2012)	1. Staff use alcohol gel after hand washing when caring for the patient					
9. Risk factors that cause skin injury are identified	1. Guidance is available for staff e.g. excessive manipulation or drying, trauma caused by use of adhesive tape					
10. Other aspects of the area observed during the inspection	1. Record here any other areas not mentioned above					

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Scores	Yes	No	N/A
Percentage achieved			

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Section 3.4 – Augmented Care Patient Equipment						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
1. Guidelines are in place for cleaning, storage and replacement of all specialised patient equipment	1. Guidance is in place for cleaning, storage and replacement of all specialised patient equipment					
	2. Guidance includes cleaning during an outbreak of infection or patient isolation					
	3. Policy known to staff (ask staff)					
	4. Adherence to policy is audited by senior nursing staff					
2. Haemoddialysis machines are in a good state of repair, and maintained as per manufacturer's instructions/ local policy	1. Visibly clean					
	2. No sign of damage, adhesive tape					
	3. Single use attachments are changed after every use					
	4. Pre planned maintenance programme in place – this includes changing the filter and tubing					
3. Peritoneal dialysis cycler machines are in a good state of repair, and maintained as per manufacturer's instructions/ local policy	1. Visibly clean					
	2. No sign of damage, adhesive tape					
	3. Pre-planned maintenance programme in place					
4. Plasma exchange machines are in a good state of repair, and maintained as per manufacturer's instructions/ local policy	1. Visibly clean					
	2. No sign of damage, adhesive tape					
	3. Pre-planned maintenance programme in place					
	4. Single use attachments are changed after every use					
5. Photopheresis machines are in a good state of repair, and maintained as per manufacturer's instructions/ local policy	1. Visibly clean					
	2. No sign of damage, adhesive tape					
	3. Pre-planned maintenance programme in place					
	4. Single use attachments are changed after every use					
6. CPAP respiratory support equipment is in a good state	1. Visibly clean					
	2. No sign of damage, adhesive tape					

Section 3.4 – Augmented Care Patient Equipment						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
of repair, and maintained as per manufacturer's instructions/ local policy	3. Equipment is single use (tubing/dome)					
	4. Tubing is changed weekly or as per local policy					
	5. Sterile water is used in the water reservoir/dome					
	6. Pre planned maintenance programme in place					
7. Bedside resuscitation equipment is in a good state of repair, and maintained as per manufacturer's instructions/ local policy	1. Visibly clean					
	2. No sign of damage, adhesive tape					
	3. Tubing and face mask are single use					
	4. Tubing is changed after use as per local policy					
	5. Pre planned maintenance programme in place					
8. Syringe drivers are clean and in a good state or repair	1. Visibly clean					
	2. No visible damage, adhesive tape					
9. Oroscopes are clean and in a good state or repair	1. Visibly clean					
	2. No visible damage, adhesive tape					
10. Urine testing machine is clean and in a good state or repair	1. Visibly clean, no body substances					
	2. No visible damage, adhesive tape					
11. Cooling/warming blankets are clean and in a good state or repair	1. Visibly clean					
	2. No sign of damage, adhesive tape					
	3. Rectal lead is single use					
	4. Guidelines are in place for the cleaning and changing of collection units if single patient use					
	5. Stored clean and dry					
12. Armbands are visibly clean and in a good state of repair	1. Visibly clean					
	2. No visible sign of damage (ripped or torn), adhesive tape					
	3. Changed when visibly soiled/as per local policy					
13. X-ray vests are visibly clean and in a good state of repair	1. Visibly clean					
	2. No visible sign of damage, adhesive tape					
	3. Easily cleaned					
	4. Cleaned between use as per local policy					

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Section 3.4 – Augmented Care Patient Equipment						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
14. Portable X-ray machine is visibly clean and in a good state of repair	1. Visibly clean 2. No visible sign of damage, adhesive tape					
15. Other aspects of the area observed during the inspection	Record here any other areas not mentioned above					

Scores	Yes	No	N/A
Percentage achieved			

Documentation for Augmented Care Infection Prevention and Control Audit Tool

The following policies/procedures/audits and related documentation are associated with the Augmented Care Quality Improvement Tool and are required:

Roles/Responsibility

- Staffing and training,
- Access to the Regional IPC Manual,
- Monitoring and audit,
- Introduction of HII, Safer Patient Initiative,
- Knowledge of Infection rates relevant to the ward,
- Root Cause Analysis,
- Outbreak Management,
- Involvement in improvement groups,
- Policy development, Communication of and Implementation of DHSSPS guidance CMO/CNO circulars applicable to the department

Policy/Procedures/Guidelines

- Local policy on Root Cause Analysis for untoward incidents related to IPC
- Domestic cleaning guidelines and schedule
- Nursing/patient equipment cleaning guidelines and schedule
- Water management guidelines and a water safety plan
- A protocol for cleaning clinical hand washing sinks
- Local guidelines for use and cleaning of point of use filters, rose diffusers and thermostatic mixer valves
- Local screening policy
- Isolation guidelines
- A policy for cleaning, storage and replacement of all specialised equipment to include audit of adherence to policy
- Occupational Health policy on staff illness – to include advice if staff present with vomiting/diarrhoea/skin conditions

Audits

- Recent audit programme/audits and action plans/re-audits/including independent validation e.g.
  - Hand hygiene
  - HII/dash boards/score cards
  - Environmental cleanliness
  - Patient equipment
  - Regional healthcare hygiene and cleanliness audit tool
- Recent audit programme/audits and action plans/re-audits on domestic environmental cleaning procedures
- Recent audit programme/audits and action plans/re-audits on nursing/patient cleaning procedures
- Signed off terminal cleans/audit of terminal cleans
- Multi- professional audits e.g. service improvement areas
- Mattress audits/replacement programme
- Specilaist equipment e.g. renal dialysis machine service records

Associated Documentation

- Copies of untoward incident reports relating to IPC
- Range of information sources to inform relatives about infection prevention and control/hand hygiene– documented evidence of advice and demonstration of practice
- Risk assessments on the management of water systems/action plans
- Evidence that tap water is tested as per regional guidelines for installation of new taps or after remedial work
- Water safety issues – records of reports to estates/IPC/domestic/escalation process to water management group/committee
- Tap flushing records
- Surveillance programmes
- Estates maintenance records/actions/audits
- Bedspace specification – available space
- Bed tracking system/placement plan
- Transfer documentation

Meetings

- Minutes of staff meetings to include feedback re RCA/audits
- Multi-professional meetings and relevant action plans relation to IPC e.g. improvement group
- Surveillance - team meetings to interpret/discuss data - dissemination of results

Training

- Staff IPC training records/process to follow up non attendees
- Competency based training records for cleaning clinical hand washing sinks