Regional Neonatal Infection Prevention and Control Audit Tool

Organisation Name:

Area Inspected/ Speciality:

Auditors:

Date:

Contents

Neonatal 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.

Guiding Principles for the Development of Decontamination Procedures for Infant Incubators and other Specialist Equipment for Neonatal Care, 15 May 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

Neonatal units: Planning and design manual, 2011

Guide to bottle feeding, 2011

Guidance for Health Professionals on safe preparation, storage and handling of powdered infant formula, 2011

HM Government: Guidelines for making up special feeds for infants and children in hospital, 2007

The British Association of Perinatal Medicine, Service Standards for Hospitals Providing Neonatal Care, 2010

Designing a Neonatal Unit; Report for the British Association of Perinatal Medicine, 2004

Infection Prevention Society

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 Neonatal Care and to assist in the prevention and control of Healthcare Associated Infections.

The quality improvement tool is formatted as follows:

Section 3 Regional Neonatal 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
- 3.2.2 - Environmental Cleaning
- 3.2.3 -Water Safety

Section 3.3 - Neonatal Clinical and Care Practice
Section 3.4 - Neonatal Patient Equipment
Section 3.5 - Preparation, Storage and Use of Breast Milk and Specialised Powdered Infant Formula
Documentation for the Regional Neonatal 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	1. Ask staff, review documentation or intranet access					

***R = Designated 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 Neonatal 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 unit/ward 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 multi-professional 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 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 and carried out 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)					

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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	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 neonatal unit and inform clinical and infection prevention and control actions for future surveillance					
8. Surveillance data is collected,	1. There is documented evidence of multidisciplinary meetings to interpret data collected, identify trends					

Section 3 Regional Neonatal Infection Prevention and Control Audit Tool

Section 3.1 – Local Governance Systems and Processes – Ward/Unit						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
analysed, interpreted, shared and used to inform changes as required	and discuss actions e.g. Surveillance Committee					
	2. Data collected is shared with all members of the clinical team in a timely and appropriate manner (ask staff/displayed for staff)					
	3. 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 add line below					
	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					
	2. There is a IPC nurse with dedicated/rotational 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,	1. Check policy is available					
	2. Staff are offered the appropriate immunisation					

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Section 3.1 – Local Governance Systems and Processes – Ward/Unit						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
is in place to negate the potential risk of transmission of infection	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 parents 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)					
15. Parents/visitors are educated on the correct hand washing technique	1. Parents/visitors spoken with have received the appropriate guidance and have been informed of how, where and when to wash their hands (use alcohol gel after hand washing (Ref HSS (MD)(16/2012))					
	2. Parents/visitors use hand wash basins appropriately					
	3. Parents/visitors have received a one to one session in hand hygiene					
	4. Parents/visitors have been informed of 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					
	5. Outside coats should not be brought 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**
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 Neonatal 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 incubators/cots in use does not exceed the number of commissioned spaces					
	2. Bays are designed for four or six spaces to support maximum use of staff: neonate ratios					
	3. NICU/HICU – minimum of 13.5 sqm per core clinical space(in bays) and up to 17sqm (single rooms) with access space in new builds/refurbished areas (80 per cent recommended area acceptable in existing units)					
	4. SCBU – minimum of 9sqm - 11.5sqm to include core space and access space (80 per cent recommended area acceptable in existing units)					
	5. Dedicated parent areas are available and used appropriately (dedicated toilet/beverage provision/overnight room with ensuite, double bed to facilitate couple/interview room/bereavement 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 one single and a two cot nursery is available (equipped to NICU level) for isolation/cohort nursing (fully ventilated lobby not required)					
	2. Clinical hand wash sinks are positioned to prevent splashing on incubators/cots/equipment/staff					
	3. Clinical hand washing sinks are logically placed to allow optimal workflow i.e. clean to baby 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 maternity/separate public entrance)					
	6. There are separate dirty utility , and clean storage areas					
	7. The layout of the unit promotes a clean to dirty work					

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Section 3.2 - General Environment 3.2.1 Layout and Design						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
	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 e.g. for incubator					
	11. Dedicated are for storage of equipment for repair area					
	12. Dedicated milk room – preparation/storage					
	13. Dedicated breast milk expression room					
	14. Dedicated clean utility/drug storage room					
	15. Dedicated area for near patient testing equipment e.g. blood gas machine					
	16. Dedicated consumable store					
3. Baby clothing is laundered within the unit in line with regional guidelines	1. Laundering of baby clothing is carried out with agreement from the IPCT					
	2. There is a designated area for laundering baby clothing					
	3. Laundering of baby clothing is audited in line with the Regional Healthcare Hygiene and Cleanliness Audit Tool standard for linen					
4. Ventilation systems are maintained appropriately	1. Ventilation systems are routinely serviced cleaned by estates includes cleaning and monitoring of air quality/flow(check records)					
5. 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 Neonatal 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 neonatal 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 twice daily and includes frequently touched surfaces (am/pm cleaning)					
	2. During an outbreak/increased incidence of particular organism enhanced cleaning is carried out that reflects regional/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 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 appropriate to the area	1. For example, Hypochlorite solution, Chlorine dioxide detergent wipes					
	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 aware of same					

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Section 3.2 - General Environment 3.2.2 – Environmental Cleaning						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
	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			

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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 for neonatal care is in place and up to date	1. A water safety plan is in place as per HSS (MD) 23/2012 and known to ward sister 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)					
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					

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Section 3.2 - General Environment 3.2.3 - Water Safety						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
	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 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					

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Section 3.2 - General Environment 3.2.3 - Water Safety						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
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 Neonatal Infection Prevention and Control Audit Tool

Section 3.3 - Neonatal Clinical and Care Practice						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
1. Staffing levels are reviewed if admission rates exceed the number of commissioned cots to ensure optimal IPC practices are maintained	Staffing levels are reviewed if admission rates exceed commissioned spaces (ask staff) Ref (BAPM)					
	1. Level 1/NICU – 1nurse:1 neonate					
	2. Level 2/NHDU – 1nurse:2 neonates					
	3. Level 3/SCBU – 1nurse:4 neonates					
2. A record is maintained of neonate placement and movements within the unit	Check record or randomly select notes to check: 1.Placement plan available					
	2.There is an incubator tracking system in place (dedicated ID number which is recorded in neonate notes)					
3. A record is maintained of neonate movement outside the unit	1. A transfer information form (CONNECCT transfer form or similar) is completed on transfer of the neonate (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 paediatrician)					
5. Neonatal 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. Screening is carried out on transfer from the delivery suite in birth hospital					
	3. 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)					
	4. If admission screens are positive the sending unit must be explicitly informed					
	5. 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 - Neonatal Clinical and Care Practice						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
	6. Screening is carried out weekly/twice weekly during time in NICU in line with extant guidance					
6. Neonates 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. Neonates are washed appropriately to negate the risk of transmission of infection	1. A protocol is available for whole body bathing and eye cleansing (Ask staff re protocol)					
	2. Neonates are washed with sterile water (Levels 1-3) (This may be reviewed as new evidence emerges)					
	3. There is no direct contact between tap water and neonates					
	4. Eye care is carried out as per local protocol					
	5. Cleaning of the napkin area and other soiled areas is carried out in accordance with local protocol					
	6. Cleaning of the umbilical area is carried out in accordance with local protocol					
	7. Single use and sterile equipment is used in accordance with local protocol (gauze and/or receiver)					
	8. Single use ampoules of water are used					
	9. Bottles of water are not contaminated during use and used within 24hrs of opening (dedicated neonate/labelled and dated)					
	10. Staff wear gloves/aprons as per local policy when washing the neonate					
	11. Waste (including water) is disposed of as per local policy (not into hand washing sink)					
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 neonate					

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Section 3.3 - Neonatal Clinical and Care Practice						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
9. Risk factors that cause skin injury are identified	Guidance is available for staff and parents e.g. excessive manipulation or drying, trauma caused by use of adhesive tape					
10. Maternal blood and secretions are removed after birth as appropriate	1. Staff are aware of when to remove maternal blood and secretions (when neonate clinically stable)					
	2. Staff wear gloves/aprons when handling the neonate until maternal blood and secretions are removed due to the risk of infection with blood-borne pathogens (observe/ask staff)					
11. Other aspects of the area observed during the inspection	Record here any other areas not mentioned above					

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

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Section 3.4 - Neonatal 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. The incubator/transport incubator is cleaned in a designated area that allows for effective cleaning	1. The incubator/transport incubator is dismantled and cleaned in a designated area					
	2. The incubator/transport incubator is stored in a designated area after cleaning to maintain the clean status					
	3. Appropriate PPE used when cleaning					
3. Incubators are visibly clean, in a good state of repair, and maintained as per manufacturer's instructions/ local policy and regional guidance	1. Visibly clean					
	2. No visible sign of damage, adhesive tape					
	3. Guidance is in place for dismantling and cleaning incubator after neonate has been discharged (this includes the transport incubator) ask staff, check guidance					
	4. Guidance is in place for the cleaning of incubator whilst in use (daily, visibly soiled, infection)					
	5. Guidance includes how often incubators are changed when in use (e.g. weekly with terminal clean)					
	6. Single use detergent wipes are used for cleaning incubators					
	7. Disinfectants are not used to clean and incubator while occupied					
	8. Disinfectants are used in line with manufacturer's instructions (do not cause damage to material of the incubator) Ref HSS (MD) (16/2012)					
	9. Dedicated staff are assigned to dismantle and clean incubator as per manufacturer's instructions					
	10. Dedicated staff have received competency based training and assessment on dismantling and cleaning					

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Section 3.4 - Neonatal Patient Equipment						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
	the incubator as per manufacturer's instructions					
	11. Equipment is opened only immediately prior to use (sterile single use)					
	12. Cleaning fluids are not disposed of in the clinical hand washing sink (disposed of as per local waste policy)					
	13. Pre planned maintenance programme in place					
	14. Mattresses are regularly checked (audit/internal and external cover					
	15. Trigger tape and visual inspection is used to identify when incubators are cleaned and stored ready for use					
	16. Pre-planned maintenance programme is in place					
4. The incubator water reservoir/humidity drawer is visibly clean, in a good state of repair, and maintained as per manufacturer's instructions/local policy	1. Visibly clean					
	2. No visible sign of damage, adhesive tape					
	3. Sterile water is used in the reservoir/drawer					
	4. Sterile water and reservoir/drawer are changed daily or as per manufacturers instruction					
	5. Reservoir/drawer is sent to CSSD for sterilisation when changed					
	6. Filters on humidified incubators are changed as per manufacturers instruction (inspected after every use and changed routinely as part of servicing)					
5. Cots are visibly clean, in a good state of repair, and maintained as per manufacturer's instructions/ local policy	1. Visibly clean					
	2. No visible sign of damage, adhesive tape					
	3. Cot mattresses are regularly checked (audit/internal and external cover)					
	4. Linen is placed on the cot only immediately prior to use					
6. Ventilator 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. Equipment is single use (tubing/dome)					
	4. Tubing and humidification dome are changed weekly or as per local policy					

Section 3 Regional Neonatal Infection Prevention and Control Audit Tool

Section 3.4 - Neonatal Patient Equipment						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
	5. Sterile water is used in the water reservoir/dome					
	6. Pre planned maintenance programme in place					
	7. Expiratory bacterial filter - single use, changed daily					
	8. Inspiratory gas bacterial filter - changed on completion of ventilator use, sterilised in CSSD, tracked by CSSD and disposed of after 25 uses					
7. High frequency oscillatory ventilator 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. Equipment is single use (tubing/dome)					
	4. Tubing and humidification dome are 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. Expiratory bacterial filter - single use, changed daily					
	8. Inspiratory gas bacterial filter - changed on completion of ventilator use, sterilised in CSSD, tracked by CSSD and disposed of after 25 uses					
8. CPAP respiratory support 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. 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					
9. Bedside resuscitation equipment (Neo puff) 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					
10. Pulmonary Function testing equipment	1. Visibly clean					
	2. No sign of damage, adhesive tape					
	3. Single use face mask					
	4. Filter is insitu and changed as per manufacturer's guidance					

Section 3 Regional Neonatal Infection Prevention and Control Audit Tool

Section 3.4 - Neonatal Patient Equipment						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
11. Syringe drivers are clean and in a good state or repair	1. Visibly clean					
	2. No visible damage, adhesive tape					
12. Cord clamp cutters are clean and in a good state or repair	1. Single use					
	2. Reusable cutters are sent to CSSD and retained in packaging until required					
13. Oroscopes are clean and in a good state or repair	1. Visibly clean					
	2. No visible damage, adhesive tape					
14. Urine testing machine is clean and in a good state or repair	1. Visibly clean, no body substances					
	2. No visible damage, adhesive tape					
15. Measuring tapes are clean and in a good state or repair	1. Visibly clean					
	2. No visible damage, adhesive tape					
	3. Single use disposable or wipe able and single patient use					
16. Cerebral function monitor is clean and in a good state or repair	1. Visibly clean					
	2. No sign of damage, adhesive tape					
	3. Electrodes are single use					
17. Transcutaneous bilirubinometer is visibly clean and in a good state of repair	1. Visibly clean					
	2. No sign of damage, adhesive tape					
18. Cooling 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/re-usable sent to CSSD					
19. Baby warmers are visibly clean and in a good state of repair	1. Visibly clean					
	2. No visible damage, adhesive tape					
	3. Cover changed if soiled/pt discharge/infection					
	4. Cover laundered as per local guidelines					
20. Baby baths are visibly clean, in a good state of repair and maintained as per manufacturer's instructions/local policy	1. Visibly clean					
	2. No visible sign of damage, adhesive tape					
	3. Stored, dry and inverted					

Section 3 Regional Neonatal Infection Prevention and Control Audit Tool

Section 3.4 - Neonatal Patient Equipment						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
21. Baby soothers are visibly clean and in a good state of repair	1. Visibly clean					
	2. No sign of damage, adhesive tape					
	3. Single patient use soothers are cleaned with sterile water after each use and stored in a sterile clean dry container					
	4. Reusable soothers are returned to CSSD for sterilisation prior to re-use					
	5. Soothers are replaced as per local policy					
22. Breast pumps/collection units are visibly clean, in a good state of repair, and maintained as per manufacturer's instructions/ local policy/guidelines	1. Visibly clean					
	2. No visible sign of damage, adhesive tape					
	3. Breast milk collection units are single use/single patient use					
	4. Breast pumps used by more than one mother are cleaned between use					
	5. Mothers with infection are provided with a dedicated breast pump					
	6. Guidelines are in place for the cleaning of breast pumps					
	7. Guidelines are in place for the cleaning and changing of collection units if single patient use					
	8. Staff and parents are aware of local guidelines and where to access cleaning products as necessary					
	9. Parents are provided with training on cleaning breast pumps and cleaning/changing collection units before/after each use					
23. Sterilisers are visibly clean, in a good state of repair, and maintained as per manufacturer's instructions/local policy	1. Visibly clean					
	2. No visible sign of damage, adhesive tape					
	3. Guidelines are in place for emptying and cleaning sterilisers (includes cleaning after each use and daily by staff)					
	4. Staff and parents are aware of local policy/guidelines					
	5. Parents have received training on cleaning steriliser					

Section 3 Regional Neonatal Infection Prevention and Control Audit Tool

Section 3.4 - Neonatal Patient Equipment						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
	after each use					
	6. Sterile water is used in the steriliser and changed as per manufacturers guidance					
	7. Equipment is sterilised for at least 30 minutes (or as per manufacturers guidance, dependant on type of steriliser)					
24. Microwave sterilising bags are visibly clean, in a good state of repair, and maintained as per manufacturer's instructions/local policy	1. Visibly clean					
	2. Stored dry in a closed container/bag					
	3. Bags are reused as per manufacturers guidelines (ask staff)					
	4. The length of time bags are heated for is in line with manufacturers guidance and the microwave wattage (ask staff)					
	5. Staff and parents are aware of local policy/guidelines					
	6. Parents have received training on use of the microwave bag (check records)					
25. Bottle warmers/milk warmers are visibly clean and in a good state of repair	1. Visibly clean					
	2. No visible sign of damage, adhesive tape					
	3. Maintenance programme in place and records available					
26. Water warming units for baby bath water are visibly clean, in a good state of repair, and maintained as per manufacturer's instructions/local policy	1. Visibly clean					
	2. No visible sign of damage, adhesive tape					
	3. Temperature checks are carried out on a daily basis (as per local guidance)					
	4. Variation outside temperature ranges are actioned					
	5. No visible sign of damage, cracks, flaking paint					
	6. Maintenance programme in place and records available					
27. Bottle brushes are visibly clean and in a good state of repair	1. Visibly clean					
	2. Replaced if damaged					
	3. Single patient use/or single use					
	4. Cleaned between each use as per local policy					
	5. Stored clean and dry					
28. Bottle teats standard/	1. Single use/single neonate use					

Section 3 Regional Neonatal Infection Prevention and Control Audit Tool

Section 3.4 - Neonatal Patient Equipment						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
specially adapted e.g. cleft palate	2. Replaced if damaged					
	3. Clean between use as per local policy					
	4. Stored clean and dry					
29. Baby scales are washable, visibly clean and in a good state of repair	1. Visibly clean					
	2. No visible sign of damage, adhesive tape					
	3. Easily cleaned					
	4. Stored clean and dry					
30. Phototherapy units (including pad) are visibly clean and in a good state of repair	1. Visibly clean					
	2. No visible damage, adhesive tape					
	3. Pre planned maintenance programme in place					
	4. Cleaned between use as per local guidelines					
	5. Disposable single patient use cover (Billy Blanket) is used on the pad underneath the neonate					
31 Nipple protectors if provided are visibly clean and in a good state of repair	1. Visibly clean					
	2. Single use/single patient use					
	3. No visible sign of damage					
	4. Clean between use as per local policy					
	5. Stored clean and dry					
32. Cups for babies lapping breast milk are visibly clean and in a good state of repair	1. Visibly clean					
	2. Single use/single neonate use					
	3. No visible sign of damage, adhesive tape					
	4. Clean between use as per local policy					
	5. Stored clean and dry					
33 Feeding syringes (purple) are single use disposable	1. Single use syringes are used for infants <12 months or who are immunocompromised					
34. Feeding spoons are visibly clean and in a good state of repair	1. Single use/single neonate use					
	2. No visible sign of damage, adhesive tape					
	3. Stored clean and dry					
	4. Advice is available for parents wishing to bring neonates own spoon into unit (cleaning/drying/ transporting)					
35. Armbands/anklets are visibly clean and in a good state of	1. Visibly clean					
	2. No visible sign of damage (ripped or torn), adhesive					

Section 3 Regional Neonatal Infection Prevention and Control Audit Tool

Section 3.4 - Neonatal Patient Equipment						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
repair	tape					
	3. Changed when visibly soiled/as per local policy					
36. Baby clothes, toys and snuggles are clean and in a good state of repair	1. Visibly clean					
	2. No visible sign of damage (ripped or torn), adhesive tape					
	3. Policy in place for cleaning/laundering after use and for replacement when required					
	4. Policy known to staff					
	5. Advice is available for parents wishing to bring neonates own linen/toys into unit					
37. 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					
38. 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					
39. 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 Neonatal Infection Prevention and Control Audit Tool

Section 3.5 - Preparation, Storage and Use of Breast Milk and Specialised Powdered Infant Formula						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
1. A protocol/guidance is available for the collection storage and use of Breast Milk in Neonatal/SCBU	1. Available, easily accessible and known to staff (ask staff)					
2. A risk assessment has been carried out in relation to existing procedural arrangements for the collection and storage of Breast milk in Neonatal units	1. Risk assessment available					
	2. An action plan has been developed to address identified issues in relation to critical control points if required					
3. Breast milk is collected, stored, defrosted and disposed of as per trust policy	1. Information is available for parents on the collection/ use/labelling and transportation of breast milk expressed at home (verbal/written)					
	2. Breast milk is administered as per local policy (single/double checking system)					
	3. Breast milk is stored of as per trust policy (48 hours fridge/three months freezer – randomly check expiry date)					
	4. Breast milk is labelled correctly – name/date of birth/ date and time of collection/use by date					
	5. Breast milk is defrosted with sterile water or in the fridge (microwave not used)					
	6. Breast milk is used within 24hrs of commencing the defrosting process (check labelling)					
	7. Unused breast milk is disposed of as per local waste policy (not in clinical hand washing sink)					
4. Donor Milk is stored, used and disposed of as per trust policy	1. A trust policy is available on the storage, use, administration and disposal of donor milk					
	2. Donor milk is transported to the unit under refrigerated conditions and labelled correctly (ID number, milk pasteurised, instructions for use, a check list is completed and returned to the milk bank)					
	3. Temperature checks are carried out on receipt of the donor milk (to identify failures in cold chain)					

Section 3 Regional Neonatal Infection Prevention and Control Audit Tool

Section 3.5 - Preparation, Storage and Use of Breast Milk and Specialised Powdered Infant Formula						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
	4. Variations outside temperature ranges for transported donor milk are actioned					
	5. A tracking label and batch number is present on donor milk and is recorded in the neonates notes					
	6. Donor milk that has spoiled or not transported at the correct temperature is returned to the milk bank					
	7. Donor milk has an expiry date no later than six months from expression					
	8. Donor milk is administered as per local policy (single/double checking system)					
5. A protocol/guidance is available for the preparation and storage of Specialised Powdered Infant Formula in Neonatal/SCBU	1. Available, easily accessible and known to staff (ask staff)					
6. A risk assessment has been carried out in relation to existing procedural arrangements for the preparation and storage of specialised powdered infant formula in the Neonatal unit	1. Risk assessment available					
	2. An action plan has been developed to address identified issues in relation to critical control points if required					
7. Formula milk is prepared and transported as per trust policy	1. Powdered formula or pre-prepared milk bottles are within expiry date					
	2. Prepared milk bottles – tamper proof, intact lids					
	3. Formula milk is made up as per trust policy/ manufacturer's instructions (cooled boiled sterile water or freshly cooled boiled tap water to 70°C from a tap known to be of satisfactory quality)					
	4. Sterile water bottles used to prepare feed are in date/labelled/seal intact/used within 24 hours					
	5. Standard precautions are used to prepare formula milk – gloves/aprons/hand hygiene					
	6. Sterilised bottles are used for formula milk					

Section 3 Regional Neonatal Infection Prevention and Control Audit Tool

Section 3.5 - Preparation, Storage and Use of Breast Milk and Specialised Powdered Infant Formula						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
	7. Parents and staff are educated on how to prepare formula milk					
	8. Powdered formula feeds are prepared just prior to use					
	9. Formula milk prepared in a central milk kitchen is transported to the milk fridge under refrigerated conditions (must be in fridge for at least one hour prior to transporting) (transfer should take no than four hours)					
	10. Formula milk is cooled by placing in a container of sterile cold water prior to storage in the fridge					
	11. Formula milk is labelled correctly – name/date of birth/type of formula/date and time of preparation/use by date					
	12. Bottles of sterile water used for thirst quenching are in date/labelled/seal intact/single use					
8. Formula milk is stored, used and disposed of as per trust policy	1. Formula milk is stored of as per manufacturer's instructions (fridge or room temperature)					
	2. Formula milk is used within the expiry date (powdered formula can be stored for 24 hours under refrigerated conditions once reconstituted/two hours at room temperature however not considered ideal especially for neonates)					
	3. Formula milk is re-warmed using a bottle warmer or by placing in a container of warm sterile water (microwaves not to be used/never leave in warm water for more than 15 minutes)					
	4. Unused formula milk is disposed of as per local waste policy (not in hand washing sink)					
9. Milk is administered safely as per trust policy	1. Any feed left in the bottle after one hour of starting the feed must be discarded					
	2. Continuous breast feed via tube is hung for no more than four hours					

Section 3 Regional Neonatal Infection Prevention and Control Audit Tool

Section 3.5 - Preparation, Storage and Use of Breast Milk and Specialised Powdered Infant Formula						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
	3. Container used to administer feed is changed every four hours or after every feed					
	4. Continuous modular feed via tube – hung for no more than four hours.					
	5. Tube feed giving sets should be changed on a 24 hourly basis except when high risk change four hourly					
	6. Bolus (single dose) feed – drawn up immediately prior to use, only amount required, discarded if not used (approx. 10mins for administration)					
10. The milk fridge is visibly clean, free from inappropriate items, in a good state of repair and serviced regularly	1. Visibly clean					
	2. Only used to store milk, no specimens, food etc					
	3. Signage is in place for staff/parents to easily identify the designated milk fridge					
	4. Temperature checks are carried out on a daily basis (to identify failures in cold chain) (2-5°Cfridge) (-18 to -21°C freezer)					
	5. Variation outside temperature ranges are actioned					
	6. No visible sign of damage, cracks, flaking paint					
	7. Maintenance programme in place and records available					
	8. Evidence of cleaning schedules for milk fridge					
	9. Commercial fridge is used to store milk					
	10. Milk is not stored in the door of the fridge					
	11. Freezer compartment is free from ice					
11. If in use the kettle for heating water to prepare milk feeds 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. Descaled on a regular basis					
	4. Pre-planned maintenance programme in place					
	5. Designated for use only in the preparation of milk feeds					

Section 3 Regional Neonatal Infection Prevention and Control Audit Tool

Section 3.5 - Preparation, Storage and Use of Breast Milk and Specialised Powdered Infant Formula						
Question	**Guidance**	**Yes**	**No**	**N/A**	**R**	**Comments**
12. 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 the Regional Neonatal Infection Prevention and Control Audit Tool

The following policies/procedures/audits and related documentation is associated with the Neonatal Audit 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 neonatal screening policy
- Neonatal isolation guidelines
- A protocol for whole body bathing/eye cleansing/nappy area/umbilical area/removal maternal blood
- A policy for cleaning, storage and replacement of all specialised equipment to include audit of adherence to policy
- Policy in place for dismantling and cleaning incubator after neonate has been discharged (this includes the transport incubator)
- Policy in place for cleaning of incubator whilst in use (daily/weekly, visibly soiled, infection)
- Guidelines for the cleaning of breast pumps and sterilisers
- A protocol/guidance for the preparation and storage of Specialised Powdered Infant Formula in Neonatal/SCBU/Breast Milk in Neonatal/SCBU (to include donor milk) and related risk assessment
- 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
- Cot and incubator mattress audits/replacement programme
- Ventilation service records

Associated Documentation

- Copies of untoward incident reports relating to IPC
- Range of information sources to inform parents about infection prevention and control/hand hygiene/care of neonate – 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
- Evidence of education of parents on the preparation of formula milk
- Parent information on the collection, storage and use of Breast Milk
- Surveillance programmes
- Estates maintenance records/actions/audits
- Bedspace specification – available space in NICU/HICU/SCBU
- Incubator tracking system/placement plan
- Neonatal 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
- Competency based training records on dismantling and cleaning the incubator