MERLIN PARK UNIVERSITY HOSPITAL QUALITY IMPROVEMENT PLAN

HIQA Report of the Unannounced Monitoring Assessment at Merlin Park University Hospital Galway - 9th July 2013

Areas Assessed: **Orthopaedic Ward (Elective) & Ward 4 (Rehabilitation)**

	Report Findings	Action Identified	Responsible Person	Time Frame	Status
	Environment & Facilities Management				
1.1	Some part of the floor covering in Unit 4 Ward was cracked and torn. Paint was also chipped and cracked on some areas of the walls, skirting boards, radiators and window ledges hindering effective cleaning. Surface paint was missing from some areas of a radiator in a patient area in the Orthopaedic Ward.	Remedial painting has been carried out in Unit 4 and further painting is scheduled to commence 4th October, 2013. Repairs to damaged floor covering is planned. Radiator identified in patient area as missing paint has been re-painted.	Buildings& Maintenance Manager	Aug-13	Completion is cost dependent
1.2	The impermeable material surface on a patient chair was cracked exposing the interior filling. This hindered effective cleaning and posed a risk of spread of HCAIs to patients	All patient chairs in Unit 4 and Hospital 2 have been reviewed and replaced or reupholstered as required.	CNM11 & Equipping Officer	Aug-13	Complete
1.3	There was a pool of yellow fluid on the floor of one toilet assessed and spillage on another toilet floor in Unit 4 Ward. Although an up to date ensuite checklist with three hourly confirmatory signatures was in place in the "Day Hall" area of the Orthopaedic Ward, staining was observed on the floor around the base of the toilet bowl. The area around a sink water outlet grid and a stainless steel panel located a the back of a shower in an ensuite facility were unclean. A bottle of solution in use for pre surgical preparation purposes did not have a dispenser fitted to facilitate communal use. The areas over the wheels of a shower chair were stained.	Hospital wide audit carried out on regularity of toilet checks and 3 hourly checks confirmed as sufficient. Water outlet grid and stainless steel panel on shower en- suite in Hospital 2 reviewed and excess silicone removed thus facilitating a thorough clean. All bottled solutions (pre surgical preparation) removed and replaced with single use containers. New shower chairs have been ordered.	Domestic supervisor/ CNM 11 / Maintenance	Jul- 13 & Aug 13	Complete- awaiting delivery of shower chairs

	Report Findings	Action Identified	Responsible Person	Time Frame	Status
1.4	The doors to two patient clinical equipment storerooms were unlocked on the Orthopaedic Ward; while one door was closed, the other was wide open. There was a potential risk of access by unauthorised persons to syringes, needles and intravenous fluids. The Authority brought this to the attention of the Ward Manager and Hospital Management. A floor polisher, the surface of which was dusty, was inappropriately stored in a smaller clinical equipment storeroom. A sharps waste disposal container attached to a phlebotomy trolley stored in the large clinical storeroom was overfilled with hazardous waste producing over the top.	Education/awareness created by ward managers on the importance of keeping clinical equipment store rooms locked when not in use. Re-enforcement through daily checks by CNM. Check-list in place. Floor polisher removed and viewed as an isolated incident. Reinforced message to relevant staff. Programme of waste management education and training provided to phlebotomy staff by Environmental &Waste Management Co-ordinator.	CNM11/ Env &Waste Co-ordinator/ Phlebotomy Manager	Immediate and ongoing	Complete-On-going monitoring
1.5	The door to the clean utility room on Unit 4 Ward had a key code pad fitted but was unlocked. There was a potential risk of access by unauthorised persons to syringes, needles and intravenous fluids. The Authority brought this to the attention of the Ward Manager and Hospital Management. A light layer of dust was found on two injection trays, draws of blood collection trolley, shelving and two blood glucose analysis units used for near patient testing. The area around the wheels of dressing trolleys were found to be heavily soiled. There was grit and debris found on the floor.	Installation of door closures and changing of locks so that door automatically closes and locks. Reinforcement to ward staff the requirement to keep door to clean utility locked with not in use. Daily checks carried out by CNM and checklist in place. Immediate cleaning undertaken of areas identified. Trolleys cleaned and checked on a regular basis.	CNM 11/ Infection control nurse/ Domestic Supervisor	Aug- 13 & Sept-13	Complete-On-going monitoring
1.6	Not all paper based signage was laminated in the Orthopaedic Ward to facilitate effective surface cleaning.	All paper based signage is now laminated.	CNM11	Jul-13	Complete-On-going monitoring
1.7	There were six boxes of cleaning wipes stored on the floor in the clean utility room on the Orthopaedic Ward	A once off incident. Signage now in place . Re-enforcement by ward manager with staff.	CNM11	Jul-13	Complete-On-going monitoring
1.8	Key code locks were fitted to the 'dirty' utility room doors but were not engaged in either area assessed. There was a potential risk of access by unauthorised persons to hazardous cleaning solutions, chemicals and waste material. The Authority brought this to the attention of respective Ward Managers and Hospital Management.	Installation of door closures and changing of locks so that door automatically closes and locks. Reinforcement to ward staff the requirement to keep door to clean utility locked with not in use. Daily checks carried out by CNM and checklist in place.	CNM11	Aug-13	Complete-On-going monitoring

	Report Findings	Action Identified	Responsible Person	Time Frame	Status
1.9	The seat of a commode assessed in Unit 4 Ward was stained with a brown coloured substance. The wheels on two commodes were also soiled. Bed urinals were not stored inverted following decontamination.	New commodes have been ordered. Awaiting delivery. Rack for storing urinals in an inverted position has been ordered. Awaiting delivery.	CNM11	Sep-13	Awaiting delivery
2..0	Access to the hand wash sink in the 'dirty' utility room on the Orthopaedic Ward was hindered by the placement of a non clinical waste disposal bin. A separate sink was not available for cleaning of patient equipment.	Bins have bee re-arranged in the dirty utility and access to hand wash sink no longer hindered. Review process currently used for cleaning of patient equipment and identify options for improvement.	CNM11/ Infection Control Nurse/ Env&Waste Coordinator	Jul-13	Oct-13
2.1	There was staining on the floor area under the sluice hopper and dust in the corners in the 'dirty' utility room on the Orthopaedic Ward. In addition, the surface area over commode wheels assessed was stained.	Additional cleaning resource directed to the area at the time and on-going monitoring. Audit system in place to check commodes. New commodes have been ordered.	Domestic supervisor/ CNM 11	Jul-13	Complete-On-going monitoring
	Cleaning Equipment				
1.1	Cleaning products used in Unit 4 Ward were stored in the 'dirty' utility but not securely, which presented a Health & Safety Risk if accessed by unauthorised persons.	Education and re-enforcement to staff on appropriate and safe storage of cleaning products. Daily checks carried out by CNM and check list is in place.	CNM 11	Jul-13	Complete-On-going monitoring
1.2	Cleaning products were stored on open shelves in the cleaners' room on the Orthopaedic Ward; the door was lockable with a key but was fund unlocked at the time of assessment. Cleaning staff reported that the door is always locked as standard. Two canvas bags of mop supplies and packs of hand towels were inappropriately stored on a window ledge in this room.	Education and re-enforcement to staff on appropriate and safe storage of cleaning products. Daily checks carried out by CNM and check list is in place.	CNM11	Jul-13	Complete-On-going monitoring

	Report Findings	Action Identified	Responsible Person	Time Frame	Status
1.3	The Authority were informed that cleaning staff undertook both cleaning and catering duties in the same shift of work on Unit 4 Ward which presented HCAI risk to patients.	Cleaning and catering duties are not segregated-staff undertake both duties in seperate time slots. HCAI risk to patients eliminated through a programme of PPE, education and audit. Catering staff are trained on HACCP policies. All staff working in the kitchen wear hair nets, blue vinyl gloves and blue apron. Staff are trained by the catering manager/infection control nurse on hand hygiene and the policy of removing kitchen ppe when going onto the wards to undertake cleaning duties. Policy is audited by the domestic supervisor and through monthly internal HACCP audits.	Domestic supervisor/ Infection control nurse	On-going monitoring	On-going monitoring
1.4	The Authority was informed that training was provided for cleaning staff on correct dilution procedures for cleaning products; however no written guide was available for reference.	New chemicals installed in all areas through-out the hospital as part of the implementation of the national contract . All staff have been trained by the company on safe use and storage of the chemicals and records are in place. Laminated coloured instructions on the use of these chemicals are in place in all cleaning store rooms.	Domestic supervisor/ CNM 11	Jul-13	Complete-On-going monitoring
	Isolation				
1.1	Doors to isolation rooms were open as Standard on Unit 4 Ward throughout the monitoring assessment. This finding was not in line with the National Standards for the Prevention and Control of Healthcare Associated Infections and posed a risk of spread of HCAIs to other patients in the Ward.	It was an unseasonally hot day at the time of the unannounced HIQA inspection. The standard is that doors to isolation rooms are kept closed. However from an infection control viewpoint patients are reviewed on a case by case basis and when appropriate are encouraged to leave the bedside to participate in therapy and practise mobility under supervision.	Infection control nurse/ CNM11	On-going monitoring	On-going monitoring
1.2	There was no clinical waste disposal bin available in the isolation room in line with best practice hazardous waste management.	Clinical waste from an isolated room is disposed of in the clinical waste disposal bin in the sluice room. In certain cases as directed by the infection control nurse a yellow bag maybe placed in the room. The procedure was agreed by the infection control committee with input from the Environmental and Waste Management Co-ordinator and the Dangerous Goods Safety Adviser.	Infection control nurse/ CNM11/ Env&Waste Coordinator	On-going monitoring	On-going monitoring

	Report Findings	Action Identified	Responsible Person	Time Frame	Status
1.3	Isolation procedures were not fully controlled as visitors to isolated patients did not remove personal protective equipment on exiting the isolation rooms and were observed to continue wearing contaminated apron and gloves outside the isolation room for the duration of their visits. Isolated patients with confirmed communicable infections were observed by the Authority to leave the isolation facilities to use a communal bathroom and to sit outdoors	Isolated patients that are mobile are given a designated bathroom. Clear signage in place to direct and re-enforce to staff the correct process for cleaning this bathroom. Signage displayed in isolated rooms to direct visitors as to correct protocol with regard to isolated patient.	Infection control nurse/ CNM11	On-going monitoring	On-going monitoring
	Waste Segregation				
1.1	Management of used blood product packaging was not in line with best practice in the Orthopaedic Ward. Two rigid yellow waste containers, one small in size was stored on a window ledge and a larger container was stored on the floor adjacent to the designated hand was sink. Both rigid containers had a number of small tied yellow bags containing waste blood product bags placed in them. Neither bin was secured to prevent unauthorised access.	Multi-disciplinary group with input from haemovigilance, labs, infection control and environmental &waste management co-ordinator set up to review process for storing blood product packaging across GUHs. Alternative container with secure lid has now been sourced for the safe storage of blood product packaging. Currently on trial in Hospital 2 with a view to extending across the site.	CNM11/ Multi-disciplinary Group	Sep-13	Oct-13
1.2	It was reported to the Authority by staff that hazardous clinical waste bags were temporarily stored in an open unattended cage trolley near the entrance to Unit 4 Ward which was intermittently collected by a Porter. This practice presented health and safety risks to patients and visitors and was notified by the Authority to the Ward Manager and Hospital Management.	Once off occurrence. Clinical waste is taken directly from point of generation to a designated clinical waste wheelie bin stored in a locked compound pending collection by transport staff. Education, awareness & training provided to staff to reinforce correct protocol by environmental & waste management co-ordinator. Spot audits have been undertaken.	CNM11/ Domestic Supervisor/ Env &Waste Coordinator	Jul-13	On-going monitoring
	Water Outlet Flushing				
1.1	While records demonstrated a weekly flushing regimen of all outlets, there was no risk assessment process in place identifying infrequently used water outlets requiring scheduled flushing.	As part of the water monitoring programme in the hospital regular random water samples are taken every two weeks and reported the the Environmental Monitoring Group. A risk assessment will be carried out by Maintenance and the CNM identifying any infrequently used water outlets for monitoring .	Maintenance/CNM 11	Oct-13	On-going monitoring

	Report Findings	Action Identified	Responsible Person	Time Frame	Status
	Hand Hygiene				
1.1	While there were designated hand wash sinks in the clinical areas, they did not comply with the Health Service Executive's (HSE's) Health Protection Surveillance Centre's Guidelines for Hand Hygiene (2005)	When sinks have to be replaced they will be replaced with sinks that are in line with the HSE Guidelines for Hand Hygiene	Maintenance	As required	As arising
1.2	Not all hand hygiene sinks had hand hygiene advisory posters displayed by them; there was also no advisory signage displayed to inform appropriate use of surgical hand wash soap when non-surgical hand was soap was also available.	Signage now in place.	Infection Control Nurse	Jul-13	Complete-On-going monitoring
1.3	Medication trolleys not secured to wall when not in use	Mechanisms installed to ensure trolleys are secure to wall when not in use. Monitoring on a daily basis completed by CNM11 on the ward.	CNM11/ Maintenance	Aug-13	Complete-On-going monitoring
1.4	Designated fire escape route on the first floor partially blocked with equipment and furniture.	Monitoring to be completed daily by maintenance staff. Check list in place.	Maintenance	Aug-13	On-going monitoring