Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

QUALITY ASSURANCE AND VERIFICATION DIVISION

Tús Áite do Shábháilteacht Othar
Patient Safety First

HEALTHCARE AUDIT

SUMMARY REPORT

Title	**Audit of National Ambulance Service Compliance with the National Standards for the Prevention and Control of Healthcare Associated Infections.**	
Number	QAV007/2015	
Timeframe	July 2015 – September 2015	
Team Members	Mr. Alfie Bradley, Healthcare Auditor (Lead), Quality Assurance and Verification Division	
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Approved by	Dr. Edwina Dunne, Assistant National Director, Quality Assurance and Verification Division	
Audit Liaison	Dr. Cathal O'Donnell, Medical Director, National Ambulance Service	
Source of Evidence	**Type**	**Date**
	Site Visits: NAS South, Kilkenny NAS North Leinster, Dublin NAS West, Galway	 21 and 22 July 2015 23 and 24 July 2015 19 and 20 August 2015

Report Distribution	
Date: 25 September 2015	
Name	**Title**
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1. BACKGROUND / RATIONALE

The National Standards for the Prevention and Control of Healthcare Associated Infections was published by the Health Information and Quality Authority in 2009 (herein referred to as the National Standards). This provides a framework for health and social care providers to prevent or minimise the occurrence of healthcare associated infections (HCAI) in order to maximise the safety and quality of care delivered to all service users.

This audit was requested by the National Director, Quality Assurance and Verification Division, who required assurance that the National Ambulance Service (NAS) complied with these standards.

2. AIM AND OBJECTIVES

The aim of this audit was to provide assurance that the NAS was compliant with the National Standards and the objective was to determine the level of compliance with Standards 1 and 5.

3. KEY FINDINGS

Standard 1: The prevention and control of HCAI is effectively and efficiently governed and managed

- The prevention and control of HCAI is not effectively governed and managed. The NAS Operational Plan 2015 lists HCAI as a system wide priority, however this was not covered in any detail within the document. Similarly, the Balance Scorecard for measuring performance does not include HCAI management as a measure of quality and safety. Furthermore, the NAS Education Assurance and Competency Plan 2015 – 2016 noted ten goals across eighteen key areas in which seven objectives were identified, none of which referenced HCAI.

- For all three regions, there was minimal evidence of proactive HCAI management. HCAI issues did not appear as standing items on management agendas and were addressed reactively as they occurred under the heading of 'risk' or 'any other business'. However, the Quality Safety and Risk Manager (QSRM) job description ascribed specific duties with regard to HCAI management. Incidents when reported, were managed appropriately, however, a culture of non-reporting of near miss incidents was evident across all three regions.

- Two regions had established committees to deal with quality assurance, safety and risk and although HCAI issues were discussed when they arose, they were not a standing item on the agendas. In one of these regions, good practice was noted around the methodology utilised to deal with issues that arose. The other region was in the process of establishing such a group but TOR for this committee made no reference to HCAI management. Each region had a health and safety committee that also dealt with HCAI issues as they arose.

- One region provided a regional risk register, however, of the 20 regional risks identified, none related to HCAI issues. Two regions provided evidence of up to date HCAI risk assessments and one region provided risk assessments which were dated 2011.
- Frontline staff in all regions expressed pride in their work and described a process of self regulation with regard to vehicle cleanliness. The NAS utilises disposable blankets, pillowcases and stretcher covers which is considered good practice. Managers interviewed stated they check vehicle cleanliness on an ad hoc basis but do not keep formal records.
- The audit team found no evidence of a structured audit programme for HCAI.
- All three regions employed external contractors on an ad hoc basis to deep clean ambulances. Vehicles were cleaned after an incident had occurred. There was no evidence of monitoring the performance of the cleaning company. An external operator was employed on a routine basis in one area of one region and this was noted as good practice.

- It was stated that some sluice facilities were not fit for purpose. One region adopted NHS guidelines for the provision of sluice facilities whilst in two regions, there was no evidence of a standardised approach to the provision of sluice facilities.

Standard 5: A communication strategy is in place which ensures information relating to HCAI is communicated and responded to in an efficient, timely, effective and accurate manner.

- A framework for communication was in operation in all three regions, however, there was minimal evidence of HCAI information being disseminated. Two regions reported that all staff had individual email accounts and policies, protocols, procedures and guidelines (PPPG) were disseminated via group emails. One region notified staff of PPPG updates via text messages. Hard copies of circulated information were placed on notice boards in the station rest rooms of all three regions. Two regions provided evidence of staff sign off records to verify receipt.
- Frontline staff in all regions documented care in the patient care record but interviewees stated that they were often misinformed of patients' diagnoses in relation to HCAI and were unsure of the appropriate management of some infections due to the variance in treatment between different healthcare facilities. Being misinformed or the omission of relevant data was considered a near miss incident and necessitated the completion of a near miss form and appropriate follow up. However, there was no evidence that the near miss procedure was followed and when asked, interviewees cited a lack of time and a belief that nothing would change the situation as reasons for not reporting.
- Good practice was noted in one region in that an NAS representative attended operational meetings with acute hospitals, although HCAI issues were not discussed in the two sets of minutes reviewed.
- All three regions reported that HCAI training was delivered during national recruitment and advanced paramedic training. HCAI training did not take place as part of the up-skilling programmes delivered in two regions. Good practice was noted in the third region, in that the training and up-skilling delivered in relation to HCAI addressed the practicalities of the daily working environment and was considered adequate by the frontline staff interviewed.
- In all three regions, there was no evidence of seeking service user feedback with regard to HCAI issues.

4. CONCLUSION

Based on the evidence reviewed, the audit team found significant issues of non-compliance and therefore it is not possible to provide assurance that the NAS is compliant with Standard 1 and 5 of the National Standards.

The NAS Operational Plan 2015 recognised HCAI as a priority but failed to address the issue any further. There was minimal evidence of proactive HCAI management in each region. HCAI issues did not appear as standing items on management agendas and were addressed reactively as they occurred. HCAI risks were only evident in one regional risk register and a deep cleaning service for vehicles was, in the majority of cases, only provided on an ad hoc basis. There was no definition for what was acceptably clean for an ambulance and no evidence of a standardised approach to the provision of sluice facilities in two regions. HCAI training did not feature in the up-skilling programme of two regions, a culture of non-reporting of incidents by staff was evident across all three regions and there was no evidence of a structured audit plan for HCAI.

Good practice included appropriate governance in relation to the management of reported HCAI issues, feedback to those involved and engagement in risk assessment.

5. RECOMMENDATIONS

Audit reports containing specific findings and recommendations were issued to the three regions (see Appendix A for list of recommendations issued).

The National Director for the NAS must implement the following recommendations to ensure compliance with national standards:

1. Implement HCAI as a system wide priority.
2. Ensure that HCAI issues are proactively managed.
3. Ensure HCAI risks are managed in accordance with best practice guidelines outlined in the HSE integrated risk management framework.
4. Define what is acceptably clean for an ambulance and introduce a routine deep cleaning roster that will capture every vehicle on a scheduled basis.
5. Develop and implement a structured approach to inspecting vehicle cleanliness.
6. Define standards for the provision of sluice facilities.
7. Ensure that HCAI training is a priority within the Education Assurance and Competency Plan.
8. Seek service user feedback with regard to HCAI issues.

Acknowledgements:

The audit team wish to acknowledge the co-operation and goodwill afforded to them by the management and staff of the National Ambulance Service.

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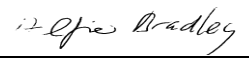
Signature	
Date	**25/09/2015**
Assistant National Director QAVD	**Dr. Edwina Dunne**
Signature	
Date	**25/09/ 2015**

Appendix A: Recommendations Issued to the Regions

The senior most accountable person in NAS North Leinster must ensure that:

1. Ensure that infection control is a standing item on the agenda of all management meetings.
2. Ensure that all near miss incidents in relation to HCAI issues are reported and managed appropriately according to local policy.
3. Develop an annual audit schedule for hygiene and infection control with appropriate audit tools, reporting and action plans when deficits are found.
4. Regular HCAI training must be undertaken.
5. Ensure that PPPG updates are disseminated to all staff with appropriate sign off to verify receipt.
6. Introduce patient satisfaction surveys and use feedback to inform HCAI management.
7. Introduce a routine deep cleaning roster which will capture every vehicle on a scheduled basis.

The senior most accountable person in NAS South must ensure that:

1. Ensure that infection control is a standing item on the agenda of all management meetings.
2. Develop an annual audit schedule for hygiene and infection control with appropriate audit tools, reporting and action plans when deficits are found.
3. Ensure that all near miss incidents in relation to HCAI issues are reported and managed appropriately according to local policy.
4. Introduce patient satisfaction surveys and use feedback to inform HCAI management.
5. Regular HCAI training must be undertaken.
6. Introduce a routine deep cleaning roster which will capture every vehicle on a scheduled basis.

The senior most accountable person in NAS West must ensure that:

1. Ensure that infection control is a standing item on the agenda of management meetings.
2. Develop terms of reference for NAS West committees dealing with HCAI to include specific mention of HCAI management.
3. Ensure that all PPPGs are signed off as having been received and understood by staff.
4. Develop an annual audit schedule for hygiene and infection control with appropriate audit tools, and action plans when deficits are found.
5. Regular HCAI training must be undertaken.
6. All near miss incidents in relation to HCAI issues must be reported and managed appropriately according to local policy.
7. Introduce patient satisfaction surveys and use feedback to inform HCAI management.
8. Introduce a routine deep cleaning roster which will capture every vehicle on a scheduled basis