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**National Standards for the Prevention and Control of Healthcare Associated Infections (NSPCHCAI) Monitoring Programme**

**QUALITY IMPROVEMENT ACTION PLAN.**

**Report of the unannounced inspection at Letterkenny University Hospital, Co Donegal:**

**28th June 2016 = Medical 3 Ward & Renal Dialysis Unit + Revisits to Medical 2 Ward and the Orthopaedic Ward**

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| **Number** | **Findings** | **Action** | **Person(s) Responsible** | **Completion Date** | **Review Date/ Outcome Measures** |
| **1** | **Patient Equipment** |  |  |  |  |
| **1.1** | Overall, patient equipment in the **Renal Dialysis Unit** was generally clean. There was a red stain, sticker residue and surface damage on one dialysis bed and there was light dust on the under surface of one dialysis chair. The core of one mattress was stained, indicating that the cover was no longer moisture proof. | 1. SOP’s -Definitive roles & responsibilities for patient equipment is in development 2. All developed SOP’s will be ratified through the MDTPPG Committee and will then be available on Q-Pulse 3. Reiterate the Policy for the Management and Replacement of Hospital Mattresses” to staff | Facilities Manager, ADON/SM, CNM3.  CNM/CMM’s. | Dec 2016 | Environmental Hygiene Audit results reviewed by Hygiene Services Action Group (HSAG) |
| **1.2** | Patient equipment was generally clean in **Med 3**. Brown staining was present on the under surface of three patient armchairs and organic matter was noticed under one of these chairs. Light dust was observed on the base of a drip stand and on the undercarriage of two beds. In addition, staining was visible on two electronic thermometer holders. It was observed that patient equipment checklists had not been consistently signed off to indicate that cleaning had been performed. | 1. Ward Managers to carry out equipment cleanliness check using visual observation and ensuring compliance with the existing tagging system 2. Checklists will be signed off and records maintained. | CNM/CMM’S  Domestic Supervisor  Staff Nurses/Midwives.  HCA’s  Domestic Staff  Heads of Departments | On-Going | Environmental Hygiene Audits reviewed by HSAG |
| **2** | **Environmental Hygiene** |  |  |  |  |
| **2.1** | **Workstation Cleaning.**  Light dust was present on surfaces including computer keyboards on the staff workstation in the main Dialysis unit. In Med 3 Light dust was visible on the staff workstation and heavy dust was present on healthcare record trolleys. Cleaning of ward workstations and medical storage trolleys should be included in local cleaning specifications. Roles and responsibilities in this regard should be clearly defined. | 1. Working Group established inclusive of all stakeholders to develop a SOP to outline  * Definitive role and responsibilities * To include equipment on Corridor spaces with sub sections outlining responsibilities for each discipline.  1. To be included in SOP for ward cleaning schedule 2. Public service agreement was discussed with Union | Working group-Facilities Manager, IPCT Manager, Consultant Microbiologist, Domestic Supervisor, CNM2, HCA, and Ward Receptionist.  Everyone’s responsibility  Clerical Staff – Public Service Agreement. As per talks with IMPACT union – all ward clerks are responsible for their own working environment. | Dec 2016  On Going | Environmental Hygiene Audits reviewed by HSAG. |  |
| **3** | **Renal Dialysis Unit Infrastructure** |  |  |  |  |
| **3.1** | The infrastructure of the Renal Dialysis Unit was not in line with desirable modern standards for such facilities and as such did not facilitate effective infection prevention and control. There should be sufficient isolation facilities to facilitate compliance with hospital IPC guidelines. | 1. Business Case submitted. Awaiting Capital approval and awaiting revenue approval. 2. Added to Risk Register 3. Isolation room doors should be kept closed 4. The practice of Patients using clinical hand wash sinks in the open dialysis unit to cleanse the skin over the arteriovenous fistula prior to dialysis has stopped. | SAOLTA Management  GM, Facilities Manager, DON, ADON/SM, Finance Manager.  CNM’s/ Staff Nurses, HCA’s | DEC 2017. Funding dependent | 2017 |
| **4** | **Renal Dialysis Unit Facilities** |  |  |  |  |
| **4.1** | **Operational**: There were two dialysis machines running in each of three occupied dialysis stations. The operational norm in most dialysis units is that dialysis machines can be heated up for patients in a designated area other than an occupied dialysis station. It is recommended that this practice is reviewed due to risk of dialysis machine contamination. | 1. Practice was reviewed immediately and only equipment needed for the individual dialysis cycle is now brought into the dialysis station. | CNM’s, Staff nurses, HCA’s.  IPCT | Completed July 2016 | Environmental Hygiene Audit results reviewed by HSAG |
| **4.2** | **Storage facilities:** Theseare insufficient. Patient equipment including multiple dialysis machines, extra dialysis chairs and boxes of clean supplies were stored along corridors. Items including a moving and handling hoist, an electrocardiograph machine and hoist slings were stored in a stairwell landing. A wooden pallet stacked with drums of dialysis fluid was located at the main entrance to this unit and a trolley for transporting supplies and a pallet jack were stored along the main unit corridor. | 1. Storage Solution is in approving the Business case. 2. In the interim, maximising all available space and keeping corridors free. | Facilities Manager, DON  ADON/SM  CNM’s/Staff Nurses/HCA’s | On Going | Environmental Hygiene Audit reviewed by HSAG. |
| **4.3** | **Waiting Times for Patients**  It was reported that there were significant waiting times for patients requiring surgery to form an arteriovenous fistula to provide vascular access for dialysis. It is recommended that the hospital accurately quantify the extent of any delays and associated risks. Risks identified should be managed and mitigated within the HSE risk management process. | 1. Pathway: All patients are referred to Altnagelvin Hospital, Derry. Delays occur when Altnagelvin are unable to insert due to complexity of individual cases. 2. Complicated cases referred to Galway-delays of up to 1 year. 3. Incidents recorded on Q-Pulse, data collated and associated risks are being identified and managed. 4. Exploring alternative patient pathway via Sligo University Hospital. | Consultant Physician, Associate CD, ADON/SM, GM, DON. | On Going -external capacity issue. | July 2017 |
| **5** | **Preventative Measures to Control Nosocomial Aspergillus** |  |  |  |  |
| **5.1** | Preventative measures to protect at-risk patients from possible infection due to fungal spores generated during building works had not been fully implemented on the day of inspection. Several windows in the hospital facing an area where soil had been excavated were open despite the finding that keeping adjacent windows closed was a locally determined control measure and signage was in place indicating that windows should remain closed. Preventative measures to control nosocomial aspergillosis should be monitored regularly. | 1.The Infection Prevention and Control reporting document (ORG-IC-0023) has been revised 30/06/2016 based on the *“National Guidelines for the Prevention of Nosocomial Invasive Aspergillosis during Construction/Renovation Activities”*   1. Directive was issued from GM following the unannounced inspection in June instructing staff re their responsibilities in relation to preventative control measures. 2. Monitoring, Surveillance & compliance 3. Dust Control measures: Dust Monitor results are received on a weekly basis from the Contractor and reviewed at the monthly site meetings, Note - Dust Control is also discussed at the site meetings and any improvements required 4. Convene Major Building Working Action Group to engage staff in the planning of future Construction and renovation projects to increase compliance with preventative measures to control nosocomial aspergillosis | GM, Facilities Manager, DON, DOM, ADON/SM’s, IPCT, Heads of Departments, CN/MM’S, Staff Nurses/ Midwives. Domestic Staff, Support Staff, Clerical Staff  Project Manager HSE Estates  Facilities Manager. GM. IPC Manager. Consultant Microbiologist  Action group inclusive of Industrial Relations bodies. | On Going due to extensive rebuild programme. | Senior Management safety walks to monitor compliance. |
| **6** | **General Hospital Maintenance** |  |  |  |  |
| **6.1** | Opportunities for improvement were identified in relation to the maintenance of the main hospital entrance lobby and public toilet facilities. Paintwork on walls and skirting in the main lobby was damaged and worn, particularly on surfaces near alcohol gel dispensers. Surfaces, finishes and sanitary fixtures in the public toilets in the main entrance lobby were dated and did not facilitate effective cleaning. | 1. Is being addressed in the hospital maintenance and refurbishment programme. | Maintenance Manager  Facilities Manager  General Manager  DON, DOM  ADON/SM’s  Finance Manager | Dec 2016 | Dec 2016 |  |
| **7** | **Legionella Control** |  |  |  |  |
| **7.1** | Evidence viewed at the time of inspection indicated that a risk assessment for the prevention and control of legionella was last carried out at Letterkenny University Hospital in 2014 by an external contractor. It is recommended that legionella control risk assessments are reviewed in accordance with national recommendations.  Water outlet flushing records were not consistently completed in the Renal Dialysis Unit. Water flushing records should be checked regularly by supervisory staff to ensure that hospital policy in this regard is implemented. | 1. “National Guidelines for the control of Legionellosis in Ireland, 2009” 2. Risk Assessment to include all water systems where a reasonably foreseeable risk of exposure to legionella bacteria may exist. 3. The risk assessment will identify all potential risks and will outline a site specific control programme which will be put in place to prevent exposure or to control the risk from exposure to Legionella bacteria. 4. Implement the maintenance programme which will outline all weekly, monthly, quarterly, 6 monthly and annual actions. 5. Check water flushing and maintain records as per policy. | GM, Facilities Manager, Maintenance Manager, Maintenance Foreman.  IPCT.  Domestic Supervisors | Nov 2016  On going | Audit as outlined in the maintenance Programme  Weekly Checklist |
| **8** | **Transmission- Based Precautions** |  |  |  |  |
| **8.1** | Transmission-based precautions were not fully implemented at the time of this inspection on **Medical 3** Ward. Some staff did not put on plastic aprons before entering isolation rooms to remove meal trays which is not in line with hospital isolation policy. A door to an occupied isolation room in the **Renal Dialysis Unit** was ajar at the time of inspection. | 1. Increase awareness on Guideline for Correct Use of Personal Protective Equipment during Clinical Work Practices. Available on Q Pulse. 2. IPC Link Liaison nurse on each ward/department 3. Adherence to IPC Policies 4. Review communication process in relation to isolation cleaning requirements 5. Isolation room doors must be closed as per patient risk assessment | IPC Link Nurse Group  CN/MM’s  Staff Nurses/Midwives,  HCA’s  Domestic Services  Catering Staff.  Support Staff  All LUH staff | On going | Environmental Hygiene Audits reviewed by HSAG |
| **9** | **Hand Hygiene** |  |  |  |  |
| **9.1** | **Hand Hygiene Sinks**  Clinical hand wash sinks in the Renal Dialysis Unit were not compliant with Health Building Note (HBN) 00-10 Part C: Sanitary Assemblies standards. There was exposed pipe work beneath these sinks and tiled splash backs which did not facilitate effective cleaning. Sealant between sinks and splash backs was not intact.  There was poor water pressure and inconsistent water temperature at clinical hand wash sinks in Medical 2 Ward and Medical 3 Ward. These sinks did not comply with the most recent Health Building Note 00-10 Part C: Sanitary Assemblies, published in 2013.Technical problems that create potential barriers to effective hand hygiene should be addressed. | 1. Clinical hand wash sinks in higher risk clinical areas will be prioritized for replacement as per refurbishment plan -RDU | Project Manager HSE Estates Facilities Manager, Maintenance Manager,  GM  IPCT | On going | As per refurbishment plans.  HIQA Audits |
| **9.2** | **Training and Education**  92% of relevant staff in the hospital were up to date with HSE mandatory hand hygiene training requirements. Hand hygiene training uptake was lowest among medical staff in that only 44% of locum consultant medical staff and 76% of consultants had completed hand hygiene training. Uptake of hand hygiene training among medical staff requires improvement.  Use of disposable gloves by some staff on **Medical 3** Ward was not in line with best practice guidelines. Training in relation to hand hygiene and standard precautions should include information regarding appropriate indications for glove usage. | 1. Hand hygiene compliance rates to be compliant with national KPI 2. Additional training to be targeted at Consultants, Locum Consultants and NCHD’s. 3. Checklist for mandatory requirements will be issued to staff at appointment from Medical Manpower Manager 4. Encourage use of HSE land to allow staff a choice of training 5. Monthly training schedule 6. Education strategy entitled ‘In the Spotlight’ -plan to hold monthly workshops to raise awareness regarding infection prevention and control. 7. Targeted training in relation to observed non compliances | General Manager  Clinical & Associate Clinical Directors, HR Manager, Medical Manpower Manager,  Infection Control Team  DON, DOM  ADON/SM’s  CNM’s/MM’s  Heads of Departments  All LUH staff.  IPCT | On going  NCHD Induction Programmes. | Monthly Data collated : KPI’s  National KPI’s disseminated Q&S Advisory Committee, HEB, and HIPPC. |
| **10** | **Sterile Supplies**  Inspectors observed that sterile items were stored in open trolleys on corridors in **Medical 3** Ward**.** Storage of Sterile Supplies should be reviewed across the Hospital. | 1. Practice was addressed immediately, sterile supplies are not stored on point of care trolleys | CN/MM’s, Staff Nurses/Midwives, HCA’s | Complete June 2016 | Monitor Environmental Hygiene Audits |