University Hospital Waterford (UHW) Quality Improvement Plan – HIQA Report of the Unannounced Monitoring Assessment on 16th December 2015

QIP dated 24th November 2016

Standard 6: Hand Hygiene practices that prevent and control the risk of healthcare associated infections are in place

RECOMMENDATION

(1) Continue to demonstrate consistently high compliance with national hand hygiene audits (2) progress internal hand hygiene audits in all clinical areas

AIM	ACTIONS REQUIRED	MEASUREMENT/EVIDENCE OF COMPLIANCE	RESPONSIBLE PERSON/COMMITTEE	TARGET COMPLETION DATE	PROGRESS
1. Continue to embed a Culture of Hand Hygiene Compliance across all services.	**1.1 Governance & Management:**				
	"The hospital demonstrated a consistently high compliance in national hand hygiene audits which is commendable" (HIQA UHW Report 2015) UHW compliance rate was 96.7% in Period 12 (October 2016) of the national Hand Hygiene audits. HSE current compliance target is 90%. UHW compliance rate was 93.3% in Period 11 (May 2016) of the national Hand Hygiene audits. UHW compliance rate was 96.2% in Period 10 (October 2015).	Meeting and exceeding the HSE target compliance rate of 90%	Hospital Executive Management Board (EMB)	As per the *HPSC defined schedule for conducting national hand hygiene audits * Health Protection Surveillance Centre	Ongoing
	UHW IPC Work Programme & Hand Hygiene Strategy in place for 2016.	IPCT Work Programme 2016	Infection Prevention & Control Team Infection Prevention & Control Committee	Ongoing	Completed

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1. Continue to embed a Culture of Hand Hygiene Compliance across all services	Targeted programme of Front Line Ownership (FLO) at individual ward level to focus and support staff on implementation of HIQA QIP and National Standards for the Prevention & Control of Healthcare Associated Infections (HCAIs).	Individual ward plan developed and regular review meetings with the Directorate ADON	Directorate ADON DONM ADON IPC	Ongoing	Ongoing
	Each Head of Department /Ward Manager to raise staff awareness at staff team meetings to ensure full compliance with hand hygiene. Infection Prevention Control (IPC) including Hand Hygiene & Patient Safety to be standing agenda items.	Departmental/Ward Team meeting agenda and minutes.	All Heads of Department /Ward Managers	Ongoing	Ongoing
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1. Continue to embed a Culture of Hand Hygiene Compliance across all services.	**1.2 Education & Training:**				
	The Hand Hygiene Policy is available and accessible to all staff.	Revision dates maintained and policy in date. Policy Q-Pulse document management system.	Infection Prevention & Control Team	Completed	Completed
	Retrain /Train all hospital staff on hand Hygiene (HH). 2 yearly mandatory training.	HH Training records now provide the percentage of staff trained per staff group. Individual staff training record available.	Hospital Manager & Clinical Directors DONM	In Progress and ongoing	Ongoing
	The Health & Safety (H&S) Training Database includes all staff that has had hand hygiene training. This database will be kept maintained and updated.	H&S Training Database maintained to include Hand Hygiene training records.	Deputy Hospital Manager HR Manager	Ongoing	This database is updated after each education session

1. Continue to embed a Culture of Hand Hygiene Compliance across all services.	**1.2 Education & Training:**				
	The Infection Prevention Control Team (IPCT) provides bi-monthly education sessions. In addition, an intensive training programme on hand hygiene is in place to train all staff. Monthly Clinical Safety Update Programme incorporates session on IPC/Hand Hygiene - open to all staff including NCHD induction.	Schedule in place. Monitor staff attendance	IPCT Directorate ADON/Head of Clinical discipline / Head of Dept.	Dec 2016 Ongoing	Ongoing
	All Heads Of Departments (HODs) to review their departmental staff training records to ensure all staff are trained. Establish a schedule of staff attendance at IPC Hand hygiene training sessions and have available for inspection at ward level.	HODs to maintain up to date Hand Hygiene training records. Review records and track training versus audit compliance results.	All Heads of Department / Ward Managers	Ongoing	Ongoing
	Ensure all new staff and contract staff receives induction training on hand hygiene on commencement of work. Contract Cleaning training programme reviewed by UHW IPC to assure training is consistent with HSE training (April 2016).	Induction process includes Hand Hygiene training.	All Heads of Department IPC/Cleaning & Waste Coordinator	Ongoing April 2016	Ongoing Completed
	Infection Prevention Control (IPC) Link Practitioners to focus on hand hygiene and act as clinical champions for infection, prevention and control in their clinical areas. Meetings held quarterly. Focus of education is on Hand Hygiene and competency assessments	Meetings schedule adhered to (quarterly meetings): • February • May • August • Nov	Infection Prevention Control Team CNM2/CNM3/ADON	Q 4 session (Nov '16) Q 3 session (Aug '16) Q 2 session (May '16) Q1 2016 meeting completed on 24th Feb '16	Completed Completed Completed Completed

AIM	ACTIONS REQUIRED	MEASUREMENT/EVIDENCE OF COMPLIANCE	RESPONSIBLE PERSON/COMMITTEE	TARGET COMPLETION DATE	PROGRESS
1. Continue to embed a Culture of Hand Hygiene Compliance across all services.	Hold Hand Hygiene and IPC Awareness Campaigns in 2016 (annual) with a specific focus on hand hygiene. National IPC Awareness – 2 days held 17 and 18th October in Main Foyer at UHW.	Hand Hygiene Awareness Day held at UHW in accordance with national date and to coincide with the World Health Organisation (WHO) – 5th May 2016. October 2016	Infection Prevention Control Team	National and WHO Hand Hygiene Awareness Day 5th May 2016. Campaign in UHW-03/05/16	Completed Completed
	1.3 Audit				
	National Hand Hygiene Audit Programme to measure overall compliance across hospital and individual staff group compliance rates. The IPCT will also undertake a more detailed glove use audit during hand hygiene – Glove audits commenced June 2016.	Review of compliance rates against HSE Target rate. *UHW Compliance rate for National Hand Hygiene Audits have met HSE target.* National Hand hygiene audit results to be reported to IPCC, H&S Committee, EMB and National audits to HPSC.	IPC Team Hospital Infection Prevention Control Committee	Last national audit completed in October 2016 (Period 12)	Ongoing
	Local Hand Hygiene Audit Programme-all clinical areas will be audited once a year at a minimum and any areas that are below the HSE target of 90% will be re-audited. Verbal and written audit feedback provided to staff. The implementation of internal hand hygiene audits in all clinical areas should be progressed to ensure sustainable compliance Ward/Dept audit reports must be available for inspection.	Annual audit of all clinical areas. Local Hand hygiene audit results to be reported to IPCC & H&S Committee. Feedback on Hand Hygiene compliance rates from Infection Prevention Control Committee (IPCC) to the EMB at quarterly intervals.	IPC Team IPC Team Hospital Infection Prevention Control Committee	Ongoing Ongoing	Ongoing Ongoing

	Feedback on Hand Hygiene compliance rates from Infection Prevention Control Committee (IPCC) to the EMB at quarterly intervals.	Ward/Dept audit reports available at inspection. EMB Minutes.	Ward/Dept Managers IPCT/EMB		
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1. Continue to embed a Culture of Hand Hygiene Compliance across all services.	**1.3 Audit**				
	Ensure alcohol gel dispensers are labelled.	Alcohol gel dispensers are labelled.	Clinical Nurse Manager Audits & Hygiene Services Team audits	Hospital wide review undertaken in February 2016	Completed
	Regular hospital wide review of hand hygiene facilities (alcohol gel and liquid dispensers and posters.	Include as part of hygiene audits.			
	Review of soap dispensers focusing on signage and hand wash technique guidelines undertaken in April 2016.	Signage in place.	IPC/Cleaning & Waste Coordinator	April 2016	Completed.
1. Continue to embed a Culture of Hand Hygiene Compliance across all services.	**1.4 Patient Empowerment**				
	Embed a culture of empowering patients on hand hygiene compliance and asking health care workers if they have washed their hands. In 2015 the UHW Patient Partnership Forum held two awareness days: • 11th February • 29th September Two Awareness days scheduled for 2016.	Hold hand hygiene awareness days in Main Hospital Foyer on a 6- monthly basis and include members of UHW Patient Partnership Forum. A/ADON IP&C attends Patient Partnership Forum (PPF).	Deputy Hospital Manager/Patient Partnership forum	23rd February 2016 20th Sept 2016	Completed Completed
	1.5 Environmental				
	Erect additional framed Hand Hygiene Posters	Additional hand hygiene posters in place	ADON/ IPC Technical Services Manager	February 2016	Completed
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1. Continue to embed a Culture of Hand Hygiene Compliance across all services.	**ICU and Ardkeen Wards** Install clinical hand wash sinks compliant with Health Building Note 00-10 Part C: Sanitary assemblies. Install an additional dedicated hand wash sinks in the Dirty Utility room. Incremental programme of replacement.	Installation of the hand wash sinks as mandated.	Technical Services Manager	ICU by August '16	
	All new builds and refurbished wards to have the appropriate number and design of hand hygiene facilities. This policy has been adhered to:- Refurbished Units: • AMU Ward (Q3 2015) • Ante natal/Gynae Ward (Q4 2015) 2016 • CF Gym /Paeds Day Ward General – completed 24th February 2016 • Interventional Radiology Unit works – *commenced 21st November* 2016 • Central decontamination Unit – *commenced 1st November 2016* • New Mortuary –*project date moved to 2020* Proposed new 5 storey block incorporating 2 floors for Palliative Care and 3 ward floors – *currently out to tender.*	HIQA QIP Progress Reports. Minutes of meetings.	Technical Services/ Estates Project Services/ IPCT	Ongoing	Completed Completed
	General Storage area for Cleaning Company's clean consumables Remodel existing area to ensure the storage for clean consumable is within a self-contained area. At present area decluttered and better structured.	Remodelling completed.	Deputy General Manager/ Cleaning & Waste Coordinator/Technical Services Manager	July 2016	

RECOMMENDATION

Standard 3: The physical environment, facilities and resources are developed and managed to minimise the risk of service users, staff and visitors acquiring a healthcare associated infection.

AIM	ACTIONS REQUIRED	MEASUREMENT/EVIDENCE OF COMPLIANCE	RESPONSIBLE PERSON/COMMITTEE	TARGET COMPLETION DATE	PROGRESS
2. A clean and maintained hospital environment and patient equipment to maximise service user safety.	**2.1 Governance & Management:**				
	Intensive Care Unit (ICU) & Ardkeen Ward: The auditors acknowledged that overall the environmental hygiene in the ICU and Ardkeen Ward was generally clean. Times of cleaning changed as per request from clinical service for the cleaning to occur later in the day.	Ongoing monitoring and vigilance of cleaning standards and evidence at audit of the continued and effective Front Line Ownership (FLO) for environmental hygiene at local level.	Ward Manager Directorate - ADON/CNM 3 - Hygiene Services Team	Ongoing May 2016	Completed
	Infrastructure Infrastructural deficiencies noted in ICU. The hospital to strive to maintain and improve the critical care infrastructure. A business plan proposing an interim solution (until a permanent solution is finalised) to address as a priority the infrastructural deficiencies has been submitted to the SSWHG Leadership for funding. Critical care infrastructure to meet capacity is risk rated at 25 on the hospital Risk Register. Project status as per SSWHG Capital Project Status Report: Project in Discussion.	Securing of funding approval for the submitted plan to address the infrastructural deficiencies	Hospital Manager/ CEO SSWGH	Q4 2016	
	Funding source to be identified for the equipment and maintenance programme requirements. Clinical Directorates to compile an updated; prioritised and ranked inventory of replacement near patient equipment. Some urgent equipment replacement completed throughout the year.	Adequate funding securing for a phased programme.	Hospital Manager/EMB/ SSWHG	Q 2 2016	Completed

AIM	ACTIONS REQUIRED	MEASUREMENT/EVIDENCE OF COMPLIANCE	RESPONSIBLE PERSON/COMMITTEE	TARGET COMPLETION DATE	PROGRESS
2. A clean and maintained hospital environment and patient equipment to maximise service user safety.	Update the prioritisation of equipment replacement and refurbishment programme in each Clinical Directorate.	The actions completed off the Summary Report and priority needs assessment list.	DGM/ Hygiene Services Team	Q 3 2016	Completed
	Senior Hospital Management meetings with Senior Contract Cleaning Managers on a 6 weekly basis.	Adherence to Meeting schedule.	Deputy Hospital Manager & Director of Nursing	In place & Ongoing	
	2.2 Cleaning				
	Scheduled hygiene audits of all clinical areas using the UHW Hygiene Observation Tool to review cleaning standards. Hygiene Team meetings and bi-monthly at Nurse Management Meetings.	Individual reports for each clinical area and summary report. Compliance rates to be monitored at fortnightly.	Hygiene Services Team, Cleaning and Waste Co-ordinator & ADON HIQA QIP	Ongoing	
	Contract Cleaning Company Laundry Facility Onsite facility used by Contract Cleaning Company for the laundering of the reusable cleaning materials requires to be revised as a priority. Remodelling of the Laundering area to a self-contained area and include the segregation of clean and dirty areas, processes and washing temperatures has been undertaken. The remodelling plan will require significant funding. Design /tender specification phase stage and tender process completed Awaiting funding allocation. Ranked priority No 1 on UHW 2017 Minor capital list as submitted to SSWHG. Listed on hospital Risk register.	Alternative facility in place and in use. Funding approval secured.	Deputy General Manager/Technical Services Manager/ Contract Cleaning Management General Manager	July 2016 April 2016 August 2016 November 2016	

AIM	ACTIONS REQUIRED	MEASUREMENT/EVIDENCE OF COMPLIANCE	RESPONSIBLE PERSON/COMMITTEE	TARGET COMPLETION DATE	PROGRESS
2. A clean and maintained hospital environment and patient equipment to maximise service user safety.	**Personal Protective Clothing (PPE)** Contract staff engaged in the process of handling and laundering contaminated reusable laundry (mop heads/ cloths) must wear the correct PPE. Contract Cleaning company have sourced an appropriate glove which extends further up the arm. ISS management/supervisors monitor strict adherence to colour coded trollies for segregation.	Re-training of contract staff and audit to assure compliance.	Contract Cleaning On-Site Supervisor for cleaning & Waste UHW Cleaning & Waste Coordinator	Dec 2015	Completed
	2.2 Cleaning				
	Implement and monitor lean management principles for storage and decluttering of clinical environment to optimise cleaning. An additional hospital wide 6 monthly declutter week to supplement collection schedule of obsolete/unwanted items from ward areas.	Individual QIP plans for clinical areas Audit.	Directorate ADON /CNM3; CNM 2/ Link Practitioners ADON IPC Portering Services Manager	In place & Ongoing Next Declutter Week is 12th December 2016 Declutter Week 4th April 2016	Completed
	Heads of Department continue to monitor and audit clinical areas to ensure the maintenance of a decluttered environment. TPOT (Productive Theatre) – particular focus on decluttering.	Use of Hygiene Observation Tool-evidence that environment is decluttered and clean.	CNM2/CNM3/ADONs/ Heads of Department Perioperative Clinical Directorate	Ongoing Q1 to Q3 2016	Completed

	Contract Clearing company Operatives cleaning trolley upgrade near completion – segregation of compartments, secure storage with lockable trolley. Clinical waste bins replaced where required.	100% of trolleys upgraded.	DGM/ Cleaning & Waste Coordinator DGM/ Cleaning & Waste Coordinator	October 2016	Completed
AIM	**ACTIONS REQUIRED**	**MEASUREMENT/EVIDENCE OF COMPLIANCE**	**RESPONSIBLE PERSON/COMMITTEE**	**TARGET COMPLETION DATE**	**PROGRESS**
2. A clean and maintained hospital environment and patient equipment to maximise service user safety.	**2.3 Patient Equipment**				
	Patient equipment management requires improvement including storage and disposal of equipment. Cleaning logs to be maintained and updated as per defined schedule. Improved storage in a number of areas.	Ward documentation logs on cleaning of patient equipment maintained and updated. Audit of patient equipment cleaning logs during hygiene audits. Monitor remedial action compliance.	Ward Mangers /Heads of Departments ADON/CNM 3 for Service Area Hygiene Services Team	Ongoing	
	Inventory of patient equipment requiring replacement and associated costs has been developed. Update inventory as required. Some near patient equipment replaced where required.	Patient equipment Inventory database. Items replaced are updated on a database. November 2016	DGM Office DGM/ Clinical Directorates	Ongoing programme	
2. A clean and maintained hospital environment and patient equipment to maximise service user safety.	**2.3 Patient Equipment**				
	Monitoring and auditing system for mattress and bed bases to be fully implemented. The Hygiene Audit Tool contains key questions on mattresses and bed bases – audit tool revised and 4 additional questions as required by Tissue Viability CNS and following consultation process.	Audit system in place.	Ward Mangers /Heads of Departments ADON/CNM 3 for Service Area	Ongoing	Completed

	Hospital Cleaning Specification Hospital cleaning specification revision finalised Includes the necessary cleaning specifications and documentation required for the cleaning of each functional area in line with best practice. Progress signed off cleaning specification to tender phase.	Completion and sign off of the Hospital Cleaning Specification. Progress tender Q1 2017	Deputy Hospital Manager/ Cleaning & Waste Coordinator /ADON IPC Hospital Manager /Deputy Hospital Manager	Q 3 2016 Q1 2017	
AIM	**ACTIONS REQUIRED**	**MEASUREMENT/EVIDENCE OF COMPLIANCE**	**RESPONSIBLE PERSON/COMMITTEE**	**TARGET COMPLETION DATE**	**PROGRESS**
2. A clean and maintained hospital environment and patient equipment to maximise service user safety.	Sodium Hypochlorite 1,000ppm Wipes to be sourced to facilitate decontamination of small devices	Ward documentation and audit of patient equipment cleaning logs during hygiene audits.	Ward Mangers /Heads of Departments	Approved by Hospital IPCC on 2nd March 2016	Completed
	The Arterial Blood Gas Analyser (ABG) washer and disinfector will be moved from the Clean Utility Room to an identified alternative location within ICU.	Completion of the task. Hygiene Audits	Technical Service CNMs 1 & 2 IPCT ADON/CNM 3	June 2016	
	2.4 Maintenance				
	Following HIQA Reports a prioritised maintenance/refurbishment programme to address infrastructural deficits identified is costed at €3.3m. Escalation of this significant cost requirement to CEO SSWHG and Estates Management to seek an appropriate level of an ongoing maintenance budget in the acute hospitals. Progress is based on the funding available. 2016 minor capital: no funding allocation for ward refurbishment works.	A prioritised maintenance/refurbishment programme has been identified. Monitor progress	Hospital Manager Deputy Hospital Manager	Incremental phased improvement plan - as per funding allocation received.	Completed
2. A clean and maintained hospital environment and patient equipment to maximise service	Maintenance/Refurbishment plan will be a standing agenda item at the Hygiene Services Team meetings / Clinical Directorates /Management Team meetings. An update provided to the Hospital Infection Prevention & Control Committee.	Monitor progress and areas of risk and close out non-conformances.	Hygiene Services Team Meetings	Ongoing	Completed

user safety.	**2.5 Waste Management (Criterion 3.7)**				
	Waste Compound Improve security of the potential for unauthorised pedestrian access to the external waste compound in accordance with national guidelines. Designated entrance identified for Contractor and Technical Services dept. staff to avoid access via waste compound. Increased storage space created by removing old storage containers. Installed a high pressure washer.	Ongoing monitoring of the area to ensure no unauthorised access.	Technical Services Manager / Cleaning & Waste Co-ordinator Cleaning & Waste Coordinator	Q 2 2016	Ongoing monitoring
AIM	**ACTIONS REQUIRED**	**MEASUREMENT/EVIDENCE OF COMPLIANCE**	**RESPONSIBLE PERSON/COMMITTEE**	**TARGET COMPLETION DATE**	**PROGRESS**
2. A clean and maintained hospital environment and patient equipment to maximise service user safety.	**Healthcare Waste Bins** Secure all healthcare waste bins when located in the Waste Compound – a number of bins were not locked at time of audit.	Audit compliance. Maintain record of audit findings.	Contract Cleaning On-Site Supervisor for cleaning & Waste/ UHW Cleaning & Waste Coordinator	December 2015	Completed & ongoing monitoring
2. A clean and maintained hospital environment and patient equipment to maximise service user safety.	**Sharps Bins (ICU)** A sharps bin and stand should be positioned at each bed space in ICU.	Completion of the task.	Contract Cleaning On-Site Supervisor	29th March 2016	Completed
	2.6 Storage and labelling of cleaning solutions and chemicals				
	All reusable spray bottles containing detergent for general purpose cleaning must be correctly labelled and dated. Contract Cleaning have implemented pre-printed	Audit	Cleaning & Waste Coordinator	Jan 2016	Completed Completed

	spray bottles stating contents of chemical for all its cleaning products. All Cleaning Operatives instructed on the importance of emptying and the washing of spray bottles after each shift.				
	Improve assurance regarding the appropriate emptying, washing via dishwasher and drying of reusable bottles after each day's cleaning.	Audit	Cleaning & Waste Coordinator / Contract Cleaning Supervisor	Jan 2016	Completed
	2.7 Transmission based Precautions-Isolation of patients				
	Hand washing sinks are required in the majority of the side rooms used for isolation purposes.	A prioritised maintenance/refurbishment programme has been identified. All new builds have hand washing sinks in single rooms.	Hospital Manager Technical Services Manager	Ongoing as new builds / refurbishments progress.	

RECOMMENDATION

Standard 8:- Invasive medical device related infections are prevented or reduced.

AIM	ACTIONS REQUIRED	MEASUREMENT/EVIDENCE OF COMPLIANCE	RESPONSIBLE PERSON/COMMITTEE	TARGET COMPLETION DATE	PROGRESS
3. Care Bundles are in place to reduce the risk of infection	**3.1 Care Bundles: a structured collection of evidence-based measures can reduce the chances of infection occurring from a number of healthcare interventions when used reliably and consistently.**				
	Peripheral Vascular Catheter (PVC) Care Bundles *"Overall peripheral vascular catheter care bundles have been well advanced and embedded in the hospital which is commendable" (HIQA UHW Report 2015)* Complete daily documentation on care of each patient with a PVC. Undertake weekly audit on PVC care bundles. Record results and put a plan in place if compliance is less than **100%.** Complete Monthly Quality, Safety and Risk (QSR) reports for discussion at Senior Nurse Management Meetings.	Individual patient documentation records Audit records Monthly QSR reports	CNM1 & CNM2 Ward Managers CNMs 1 & 2 & Directorate CNM3 & ADON	Ongoing	Ongoing
	Ventilator Associated Pneumonia (VAP) care bundles Ventilator Associated Pneumonia (VAP) care bundles and CVC Care bundles are in place in ICU. This data is collected but not analysed due to competing demands. As the analysis aspect of VAP is a staff resource issue therefore progress is dependent on securing the staff resource.	Individual patient documentation records	General Manager / DONM SSWHG	Unknown	

AIM	ACTIONS REQUIRED	MEASUREMENT/EVIDENCE OF COMPLIANCE	RESPONSIBLE PERSON/COMMITTEE	TARGET COMPLETION DATE	PROGRESS
3. Care Bundles are in place to reduce the risk of infection	**Central Venous Catheter (CVC) Care Bundles** *"There are quality improvement measures in place in ICU to reduce the risk of central venous access device related infection' (HIQA UHW Report 2015)* A Hospital CVC working group has been developed to ensure CVC policies, care plans, care bundles, documentation and stickers are available and used appropriately for Invasive Medical Devices such Tunnelled and Non-Tunnelled CVC's as to prevent healthcare Associated Infections. Complete daily documentation on care of patient with a CVC. Record results and put a plan in place if compliance is less than **100%.** Complete Monthly Quality, Safety and Risk (QSR) reports for discussion at Senior Nurse Management Meetings .	Documentation available on Q-Pulse and on wards. Individual patient documentation records Audit records & Monthly QSR reports	Infection Prevention and Contro, Nurse Practice Development Coordinator, Co-Ordinator, Oncology CNS	March 2017	
	Urinary Catheter (UC) Care Bundles *"Care bundles for urinary catheters were not implemented; however a patient specific urinary catheter care plan was in place".* As part of UHW strategy for the incremental implementation of Care Bundles, the brief of the existing Working Group will be expanded to include Urinary Catheter Care Bundle.	Individual patient documentation records Audit records & Monthly QSR reports	Nurse Practice Development Coordinator (NPDC) /Infection Prevention and Control (IPC)	Unable to progress due to lack of IPCT staff Resources	

RECOMMENDATION

Medication Management-Safe Preparation, Storing and Labelling of Intravenous Medication in ICU

AIM	ACTIONS REQUIRED	MEASUREMENT/EVIDENCE OF COMPLIANCE	RESPONSIBLE PERSON/COMMITTEE	TARGET COMPLETION DATE	PROGRESS
4. Safe Medication Practices to be in place in ICU.	*Anaesthetic medication in ICU to be prepared and stored safely.* Unit to comply with safe injection practices including labelling and storing.	Compliance with safe injection practices. Medication audits.	Anaesthetic Clinical Lead /ADON/CNM 3 / ICU Ward Manager	Dec 2016	
	A dedicated clean surface is to be available for the preparation of intravenous medications in ICU. The dedicated work surface will be in place once ABG analyser, washer and disinfector and are relocated to another area in ICU *(cross ref 2.3).*		Ward Manager Directorate - ADON/CNM 3 Technical Services Manager	31st Jan 2017	
	Medication fridges must have temperature display and lockable for safe storage of refrigerated medications. Two new medication fridges purchased - both have digital temperature display and are lockable.	New medication fridges in place in ICU.	Ward Manager/ / Deputy General Manager	Completed 27.01.16	