



The **Regulation** and  
**Quality Improvement**  
Authority

**RQIA**  
**Infection Prevention/Hygiene**  
**Augmented Care Unannounced**  
**Inspection**  
**Northern Health and Social Care Trust**  
**Antrim Area Hospital Neonatal Unit**

**6 August and 20 August 2013**

## **The Regulation and Quality Improvement Authority**

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care (HSC) services in Northern Ireland.

RQIA's reviews and inspections are designed to identify best practice, to highlight gaps or shortfalls in services requiring improvement and to protect the public interest.

Our Hygiene and Infection Prevention and Control inspections are carried out by a dedicated team of inspectors, supported by peer reviewers from all trusts who have the relevant experience and knowledge. Our reports are available on the RQIA website at [www.rqia.org.uk](http://www.rqia.org.uk).

### **Inspection Programme**

The CMO's letter (HSS MD 5/2013) endorsed the use of the Regional Infection Prevention and Control Audit Tools for Augmented Care Settings by all Trusts in Northern Ireland in the relevant clinical areas [www.rqia.org.uk](http://www.rqia.org.uk).

- Governance Assessment Tool;
- Infection Prevention and Control Clinical Practices Audit Tool;
- Neonatal Infection Prevention and Control Audit Tool;
- Critical Care Infection Prevention and Control Audit Tool;
- Augmented Care Infection Prevention and Control Audit Tool

The introduction of this suite of audit tools is follow-on from development of the existing regional healthcare hygiene and cleanliness standards and audit tool, developed and disseminated in 2011. Both sets of tools should be used in conjunction with each other. A 'Guidance and Procedural Paper for Inspections in Augmented Care Areas' has been developed which outlines the inspection process [www.rqia.org.uk](http://www.rqia.org.uk).

The inspection programme for augmented care covers a range of specialist facilities and a rolling programme of unannounced inspections has been developed by RQIA to assess compliance with both of these sets of audit tools.

RQIA also carries out announced inspections. These examine the governance arrangements and systems in place to ensure that infection prevention and control and environmental cleanliness policies and procedures are working in practice.

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## 1.0 Inspection Summary

An unannounced inspection was undertaken to the Antrim Area Hospital Neonatal Unit on the 8 August and 20 August 2013. The inspection team was made up of four RQIA inspectors and a peer reviewer. Details of the inspection team and trust representatives attending the feedback session can be found in Appendix 7.

The Neonatal unit cares for premature babies, sick babies and any baby requiring special care and those babies who may need special attention during the first days of life. The Neonatal Unit is located on the second floor of Antrim Area Hospital, beside the Maternity Unit. The unit was officially opened in March 1994 and presently work has commenced on the refurbishment of the unit and the building of a new extension.

The neonatal intensive care unit was assessed against the following regionally agreed standards and audit tools:

- Regional Neonatal Infection Prevention and Control Audit Tool
- Regional Infection Prevention and Control Clinical Practices Audit Tool
- Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool

This inspection is the first of a three year cycle of inspection carried out within this area.

The report highlights areas of strengths as well as areas for further improvement, including recommendations.

Overall the inspection team found evidence that the neonatal intensive care unit at the Antrim Area Hospital was working to comply with the above standards and audit tools.

### **Inspectors observed:**

- The unit was compliant in all of the Regional Healthcare Hygiene and Cleanliness Standards

### **Inspectors found that the key areas for further improvement were:**

- The Layout and Design of the environment.
- Adherence to the principles of Aseptic Non-Touch Technique (ANTT).
- Guidance for nursing staff on the cleaning of neonatal equipment
- Equipment cleaning requires more detail and validation audits should be carried out to ensure cleaning is effective
- The collection and storage of breast milk
- Systems to monitor compliance with best practice when taking blood cultures, enteral feeding and MRSA

- The auditing of antimicrobial usage in line with prescribing guidance

**Inspectors observed the following areas of good practice:**

- The neonatal unit conducts weekly random safety audits. These audits randomly assess staff compliance with the trusts hand hygiene and dress code policies
- The procurement of a trust wide software-based Live Automated Microbiology Pharmacy Surveillance (LAMPS) System. This system was designed to improve the Trust's management of healthcare associated infections (HCAIs)
- Each new staff nurse appointed to the neonatal unit undertakes the 'Foundation in Neonatal Nursing Work Based Learning Programme'. This is a program designed to equip each learner with the skills and neonatal knowledge to provide safe, effective competent care for the neonate
- The unit has revised the regional CONNECCT form, which now makes reference to the *Pseudomonas* status of the neonate
- The neonatal unit conducts parent satisfaction surveys. The most recent survey report published in January 2013 highlighted a 99 per cent satisfaction rate with the service provided within the unit.

The inspection resulted in 28 recommendations listed in Section 6.

A detailed list of the findings is forwarded to the trust within 14 days of the inspection. This enables early action on all areas within the audit which require improvement. (There will no longer be a need to return this as an action plan). The findings are available on request from RQIA Infection Prevention and Hygiene Team.

The final report and Quality Improvement Action Plan will be available on the RQIA website. When required reports and action plans will be subject to performance management by the Health and Social Care Board and the Public Health Agency.

The RQIA inspection team would like to thank the Northern Health and Social Care Trust (NHSCT) and in particular all staff at Antrim Area Hospital for their assistance during the inspection.

## 2.0 Overall compliance rates

### The Regional Neonatal Care and Clinical Practices Infection Prevention and Control Audit Tools

RQIA will use these tools, as an assessment framework for improvement to build progressive improvement over a three year inspection cycle; compliance scores for the first inspection are 85 per cent, rising to 95 per cent by the end of the third inspection.

Compliance rates are based on the scores achieved in the various sections.

**Table 1: Regional Neonatal Infection Prevention and Control Audit Tool Compliance Levels**

Areas inspected	Compliance Level
Local Governance Systems and Processes	96
General Environment - Layout and Design	69
General Environment - Environmental Cleaning	89
General Environment - Water Safety	100
Neonatal Clinical and Care Practice	95
Neonatal Patient Equipment	90
Preparation, storage and use of Breast Milk and Specialised Powdered Infant Formula	80
<b>Average Score</b>	<b>88</b>

**Compliant:** 85% or above

**Partial Compliance:** 76% to 84%

**Minimal Compliance:** 75% or below

**Table 2: Regional Infection Prevention and Control Clinical Practices Audit Tool Compliance Levels**

Areas inspected	Compliance Level
Aseptic non touch technique (ANTT)	100
Invasive devices	87
Taking Blood Cultures	74*
Antimicrobial prescribing	76
Clostridium <i>difficile</i> infection (CDI)	N/A
Surgical site infection	N/A
Ventilated (or tracheostomy) care	N/A
Enteral Feeding or tube feeding	88
Screening for meticillin resistant staphylococcus aureus (MRSA) colonisation and decolonisation	95*
<b>Average Score</b>	<b>87</b>

\*Staff practice was not observed during the inspection. Information was gained through staff questioning and review of unit audits.

**Compliant:** 85% or above  
**Partial Compliance:** 76% to 84%  
**Minimal Compliance:** 75% or below

### **The Regional Healthcare Hygiene and Cleanliness Audit Tool**

Compliance rates are based on the scores achieved in the various sections of the Regional Healthcare Hygiene and Cleanliness Audit Tool. Percentage scores can be allocated a level of compliance using standard compliance categories below.

**Table 3: The Regional Healthcare Hygiene and Cleanliness Audit Tool Compliance Levels**

<b>Areas inspected</b>	<b>Compliance Levels</b>
General environment	94
Patient linen	100
Waste	95
Sharps	97
Equipment	95
Hygiene factors	96
Hygiene practices	93
<b>Average Score</b>	<b>96</b>

**Compliant:** 85% or above  
**Partial Compliance:** 76% to 84%  
**Minimal Compliance:** 75% or below

Where an inspection identifies issues that are considered to be of high risk, trusts will be asked to take immediate action.

### 3.0 Inspection Findings: Regional Neonatal Infection Prevention and Control Audit Tool

The Regional Neonatal Infection Prevention and Control Audit Tool contains seven sections. Each section aims to consolidate existing guidance in order to improve and maintain a high standard in the quality and delivery of care and practice in neonatal care. This will assist in the prevention and control of healthcare associated infections.

#### Regional Neonatal Infection Prevention and Control Audit Tool Compliance Levels

Areas inspected	Compliance Levels
Local Governance Systems and Processes	96
General Environment – Layout and Design	69
General Environment – Environmental Cleaning	89
General Environment – Water Safety	100
Clinical and Care Practice	95
Patient Equipment	90
Preparation, storage and use of Breast Milk and Specialised Powdered Infant Formula	80
<b>Average Score</b>	<b>88</b>

The findings indicate that whilst overall compliance was achieved in relation to the Regional Neonatal Infection Prevention and Control Audit Tool, inspectors identified areas for improvement; the layout and design of the unit and the preparation, storage and use of breast milk.

#### 3.1 Local Governance Systems and Processes

For organisations to comply with this section, good governance should be displayed through management that displays effective decision-making and leadership. Systems and processes should be robust, and staff should be aware of their roles and responsibilities. Appropriate policies and procedures should be available. The unit achieved compliance in this section of the audit tool.

##### Leadership and Management

The unit manager is presently on extended leave. Management of the unit is currently overseen by unit sisters who take charge on a three monthly rotational basis. The ward sister on the day of the inspection displayed good leadership, management and knowledge on infection prevention and control process.

The unit has a dedicated infection prevention and control (IPC) nurse to advise on the management of infection control issues. IPC nursing staff visit the unit on a daily basis and they provide a written report on IPC issues for unit staff. The IPC team is also available for advice by phone.

The unit has six nominated IPC link nurses; their names were clearly displayed on the notice board. Evidence was available of link nurses attendance at link meetings and there was clear feedback of learning at the neonatal unit staff meetings. Multi-professional working with the IPC team was demonstrated in the minutes of meetings and joint audit reports.

Inspectors were informed that the ratio of nursing and domestic staff are reviewed and increased when isolation is required. Trust bank staff can be used to supplement unit staffing levels.

### **Review of Documentation**

A review of documentation evidenced that incidents relating to IPC were appropriately reported and acted on. The NHSCT conduct a Root Cause Analysis (RCA) on MRSA/ MSSA bacteraemia and *Clostridium difficile* infections. Root cause analysis is a well-recognised way of identifying what, how and why patient safety incidents have occurred. Analysis can then be used to identify areas for change and look for effective solutions to improve the patient experience and reduce avoidable infections. Documentation from recent RCAs conducted within the unit confirmed that a multidisciplinary approach was taken to this process and minutes from staff meetings highlight that staff receive timely feedback from such incidents.

A system was in place for unit staff to identify and report maintenance and repair issues. The computerised recording system in the estates department captures this information.

### **Audit**

Local and regional audits were undertaken to improve IPC practices and environmental cleanliness within the unit. Audits include: environmental cleanliness, hand hygiene and high impact interventions (peripheral venous cannulation insertion and on-going care and central line insertion and on-going care). The neonatal unit also conducts weekly random safety audits. These audits randomly assess staff compliance with the trusts hand hygiene and dress code policies.

Key performance data from audits was displayed publicly within the unit and it was also reported to staff during meetings. When audits identified deficits in practice, action plans were devised to address the issues identified.

The inspection team was provided with evidence that the IPC team independently validate practice within the unit. In April 2013 the IPC team

conducted a joint audit using the neonatal augmented care tools with a senior member of nursing staff.

## **Surveillance**

Surveillance, the continuous monitoring of Healthcare Associated Infection (HCAI) is key to the control of infection. A surveillance programme can be used to implement improvement initiatives, assess effectiveness of clinical interventions and can quickly identify outbreaks of infection.

The trust has procured a software-based Live Automated Microbiology Pharmacy Surveillance (LAMPS) System, designed to improve the management of Healthcare Associated Infections (HCAIs). This software gives access to the full archived history of microbiology laboratory data which can be analysed both in real time and retrospectively to detect changing trends in microorganisms and sensitivities.

This software assisted in the detection of an increased incidence of *Pseudomonas aeruginosa* skin colonisation which had occurred around the time of the inspection. The organisms detected were of the same strain of *Pseudomonas aeruginosa*. The inspection team were informed that and there was a probability that transmission had occurred and that the vehicle of transmission was either through direct or indirect means e.g. hands of staff or contaminated equipment. The findings of the inspection identified individual issues with compliance in hand hygiene practices and the decontamination of equipment, both of which can be vehicles for the transmission of infectious organisms.

The inspection team were informed of the arrangements which had been put in place to manage the increased incidence of cases. Incident team meetings were implemented to review cases and outline actions, staffing levels were increased to assist in the delivery of care and ensure adherence to good infection prevention and control practices and tap water samples to facilitate microbiological organism testing and analyses had been carried out pre and post this incident. All samples produced negative results.

The Neonatal Unit at the Antrim Area Hospital is a member of Vermont Oxford Network (VON). The Network maintains databases which includes information about the care and outcomes of high-risk newborn infants. The primary goal of the database is to assist the unit in understanding their performance for purposes of quality improvement. Sepsis data from the unit can be compared with other units both regionally and worldwide.

## **Training and Development**

Staff, infection prevention and control knowledge and up-to-date practical skills are a prerequisite for clinical staff to carry out their role in an effective manner.

Records were available that all unit staff have participated in the trust's induction programme on IPC. Each new staff nurse appointed to the neonatal unit undertakes the 'Foundation in Neonatal Nursing Work Based Learning Programme'. It is a program designed to equip each learner with the skills and neonatal knowledge to provide safe, effective competent care for the neonate. Infection prevention and control pervades many of the competencies within this programme, examples include: skin care, mouth care, eye care, nutritional needs, cleaning of equipment and effective communication for safe transfer.

An innovative competency based programme has been introduced within the neonatal unit. Six staff nurses have undertaken an enhanced neonatal practice course. The programme aims to develop enhanced nursing skills and knowledge. Many of these enhanced skills involve the management of invasive devices which would have been previously undertaken by medical staff. The enhanced neonatal nurse practitioners (ENNP) will continue to have on-going assessment of competence by the advanced neonatal nurse practitioner (ANNP).

Evidence was available that all staff have received mandatory infection control training in line with trust policy. An email alert system notifies the ward manager in the event that a staff member does not attend training.

Staff receive in-house training on the principles of aseptic non touch technique (ANTT) and IV cannulation insertion and on-going care. A number of unit staff have further improved their clinical practices by undertaking neonatal modules at the Queens University Belfast.

Medical staff provided evidence of competency in undertaking invasive procedures through direct Observation of Procedural Skills (DOPS) assessments.

An overarching Occupational Health (OH) policy was not available. At present the OH department is gathering all protocols together in order to draw up a policy. Staff knowledge was consistent with protocols viewed in the actions to take in the event of the development of an infection.

## **Information and Communication**

Information on infection prevention and control and the effective communication of this information is vital to ensure adherence to good practice.

A range of educational sources were available to advise parents and visitors of infection prevention and control precautions. Hand hygiene is an integral aspect of this and staff informed the inspection team that parents receive appropriate guidance and a one to one session on hand hygiene. The neonatal admission checklist, signed by staff, provides confirmation this has been undertaken.

Parents are provided with an information booklet on the admission of their baby to the neonatal unit. This booklet provides comprehensive infection prevention and control information for parents. It instructs parents in how to minimize the risk of the transfer of infectious organisms, examples include: the removal of watches and wrist jewellery, not bringing food or drink into the unit and not visiting the unit with symptoms of vomiting, diarrhoea or flu like symptoms.

During the inspection it was observed that a parent had disposed of neonatal wash water into a clinical hand wash sink. Staff informed the inspection team that parents are advised against this activity during the neonatal admission process. It is recommended that advice regarding disposal of wash water is included within the parent's information booklet.

## **3.2 General Environment**

### **3.2.1 Layout and Design**

For organisations to comply with this section of the audit tool they must ensure adequate facilities are available for the delivery of care. This includes the space available to carry out care on the neonate, decontaminate equipment and to ensure effective isolation.

The Neonatal Unit is located on the second floor of Antrim Area Hospital, beside the Maternity Unit. The unit was officially opened in March 1994. The unit cares for premature babies, sick babies, any baby requiring special care and those babies who may need special attention during the first days of life.

The unit has achieved minimal compliance in the layout and design of the environment however work has commenced on refurbishment of the unit and the building of a new extension. This extension will provide increased accessibility for parents and an improved parent and family experience. There are no plans to increase the number of commissioned incubator/cot spaces within the unit which will remain at 16. The new extension (Picture 1) will increase core clinical space, provide much needed storage space for specialised equipment and allow for dedicated rooms for decontamination of equipment and an area for near patient testing of equipment.



Picture 1: Proposed view of Antrim Area Hospital Neonatal Extension

At present, the core clinical space around the incubator/cot area for the delivery of care was not within 80 per cent of the minimum dimensions currently recommended for existing units by the DHSSPSNI. After completion of the new extension, the inspection team were informed that the core clinical space will be in line with this recommendation.

Neonatal staffing levels within the unit are based on the British Association of Perinatal Medicine (BAPM) nurse to neonate ratio e.g. 1:1/1:2/1:4. Bays are designed for four or six spaces which supports maximum use of staff.

There were two single isolation rooms equipped to intensive care level available but a two cot nursery equipped to intensive care level was not available.

The unit does not have a dedicated equipment cleaning room. Equipment including incubators is routinely cleaned in the dirty utility room and there is no dedicated area for near patient testing of equipment. Inspectors observed that blood gas monitoring equipment was located in the dirty utility room (Picture 2).



Picture 2: Cluttered Dirty Utility Room

### 3.2.2 Environmental Cleaning

For organisations to comply with this section they must ensure cleaning staff display knowledge of cleaning policies and procedures and are competent in cleaning hand washing sinks. Environmental cleaning audits should be carried out and the infection prevention and control team should be consulted when infection has been identified.

Good practice was observed and the unit achieved compliance in the section on environmental cleaning. Environmental cleaning; guidelines, audit and staff competency based training were reviewed. These evidenced good practice in adhering to current guidelines and there was evidence of competency based training in relation to the cleaning of clinical hand wash sinks. On questioning, staff displayed good knowledge on cleaning procedures. There was a regular programme of de-cluttering in place.

An issue identified in this section was that terminal cleans are not randomly validated by domestic supervisors.

### **3.2.3 Water Safety**

For organisations to comply with this section they must ensure that an overarching water safety plan and individual area risk assessment plan is in place. Water sampling, testing, flushing and maintenance are carried out correctly and there is a mechanism in place to report water analysis results.

The unit was fully compliant in relation to water safety. An overarching trust water safety plan and individual unit risk assessment plan were in place. Collection of tap water samples to facilitate microbiological organism testing and analysis is carried out. All taps are flushed daily to ensure water is not pooling in the system. With the exception of the occasion previously discussed, hand washing sinks were used correctly - only for hand washing. Patient equipment was not stored or washed in hand washing sinks. A system was in place to address any issues raised with the maintenance of hand washing sinks and taps.

### **3.3 Neonatal Clinical and Care Practice**

For organisations to comply with this section they must ensure that the delivery of care is provided in a way that negates the risk of transmission of infection. This is provided through adequate staffing, monitoring of neonate movement, infection control screening policies and adherence to DHSSPSNI and local guidance on cleansing the neonate.

The unit achieved compliance in this section of the audit tool. On the day of the inspection, staffing levels were in line with the number of incubator/cot spaces to ensure optimal infection prevention and control practices.

An incubator/cot tracking system was in place, movement of babies within the unit was recorded using an incubator/cot mapping system. This can be used by staff to identify baby placement and movement and provides staff with the ability to carry out a retrospective placement tracing exercise if necessary.

A local screening policy was in place, all patients are routinely screened on admission for MRSA and *P.aeruginosa* and weekly thereafter. All neonatal patients transferred from the Regional Neonatal unit at the Royal Jubilee Maternity Hospital are screened for enterobacter. On questioning, this protocol was known to staff and a protocol for the decolonisation/treatment of the neonate was in place.

A protocol for personal care of the neonate was in place and known by staff however this guidance needs updated to include the correct disposal of waste.

Staff used alcohol rub after hand washing when caring for the neonate. Risk factors that cause skin injury were recorded in the neonatal care plan and staff

are competency assessed at induction on maintaining a high standard of skin care. Staff were aware of the safe handling and removal of maternal secretions from the neonate.

Inspectors were informed that on transfer and admission of the neonate to the unit, it is the responsibility of the IPC team to ensure that all positive transfer results and admission screens are reported to staff in the receiving or transferring units. There was no documented protocol available to highlight individual responsibilities for reporting of this information.

The modes of reporting information to receiving or transferring units include: contact by phone and the regional transfer information form 'CONNNECT'. The Unit has revised the regional CONNNECT form, making reference to the Pseudomonas status of the neonate.

### 3.4 Neonatal Patient Equipment

For organisations to comply with this section they must ensure specialised neonatal equipment is effectively cleaned and maintained. Audits of equipment cleaning and education on the use of equipment should be available.

The unit achieved compliance in this section of the audit tool however there are a number of issues identified for improvement.

The transport incubator was being cleaned in the dirty utility room as a designated area was not available; following cleaning it was being stored in the corridor. Trigger tape had been used on another incubator to inform staff that it had been cleaned, however on close inspection it was observed that there were blood spots on the control panel and debris on the reservoir handle (Picture 3). Staff used Dificile S disinfectant to clean incubators. It was observed, during the cleaning of incubators, staff were decanting cleaning solution into a bucket and double dipping cloths into the disinfectant, therefore contaminating clean cloths. Parts of the incubator were also steeped in the bucket containing the disinfectant solution. Competency training for the dismantling and cleaning of incubators, although carried out, needs to be more robustly monitored.



Picture 3: Spots of blood on incubator control panel

Guidance for cleaning the transport incubator, microwave steriliser and breast pumps was not available. The cleaning of specialised equipment was not audited by senior nursing staff.

### **3.5 Preparation, Storage and Use of Breast Milk and Specialised Powdered Infant Formula**

For organisation to comply with this section they must ensure that preparation, storage and use of breast milk and specialised powdered infant formula is carried out correctly. Policies and procedures should be in place, known and implemented by staff. The unit achieved partial compliance in this section of the audit tool.

A risk assessment for the collection and storage of breast milk was not made available at the time of the inspection and the policy on the collection and storage of breast milk did not reflect current staff practice. Staff were not using the detailed breast milk labels which included name/date of birth/date and time of collection/use by date. The donor milk tracking label which contains the batch number was not securely recorded in the notes at the time of the feed, it was placed loosely in a pouch at the back of the neonatal notes. There was no date on the donor expressed breast to identify when the milk had been expressed. Inspectors were unable to confirm that the expiry date on the expressed breast milk was no later than six months from expression.

A commercial fridge and freezer were not in use to store milk. Temperature checks for the freezers were inconsistently recorded and variations outside temperature were not actioned.

## 4.0 Inspection Findings: Regional Infection Prevention and Control Clinical Practices Audit Tool

The Regional Infection Prevention and Control Clinical Practices Audit Tool contains nine sections. The observations of key clinical procedures have shown to reduce the risk of infection if performed correctly. 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. This will assist in the prevention and control of healthcare associated infections.

### Regional Neonatal Infection Prevention and Control Audit Tool Compliance Levels

Areas inspected	Compliance Levels
Aseptic non touch technique (ANTT)	100
Invasive devices	87
Taking Blood Cultures	*74
Antimicrobial prescribing	76
Clostridium <i>difficile</i> infection (CDI)	N/A
Surgical site infection	N/A
Ventilated (or tracheostomy) care	N/A
Enteral Feeding or tube feeding	88
Screening for MRSA colonisation and decolonisation	*95
<b>Average Score</b>	<b>87</b>

\* Staff practice was not observed during the inspection.

The findings indicate that overall compliance was achieved. Inspectors identified that improvement was required in taking of blood cultures and antimicrobial prescribing.

On both days of the inspection, inspectors were able to observe staff practice for a number of clinical procedures. Staff questioned on all aspects of the clinical practices audit tool displayed good knowledge on the practical application of clinical procedures.

#### 4.1 Aseptic non touch technique (ANTT)

ANTT is a standardised, best practice and safe aseptic technique used for care the overall management of invasive clinical practices and preparation of medication. For organisations to comply with this section they must have a policy in place, staff should display knowledge and practical skills on the key principles and audit of staff competency is carried out.

The unit achieved full compliance in this section of the audit tool.

Staff displayed good knowledge on the principles of ANTT and were able to demonstrate when ANTT procedures should be applied. Records were available on ANTT staff assessments and on-going audits; these were independently verified by the IPC team. In order to maintain staff competency through annual re-assessment of ANTT practice the trust aims to develop an e-learning program. The audit results viewed, evidenced good compliance, however deficits in adherence to the key principles of ANTT were observed during access of a peripheral venous cannula. This will be discussed in more detail in the following section on the management of invasive devices.

## **4.2 Invasive devices**

Invasive devices are medical devices which in whole or in part, penetrate the body, either through a body orifice or through the surface of the body. For organisations to comply with this section they must ensure that there are systems and process in place to ensure a standardised and consistent approach by staff in the insertion and on-going maintenance of invasive devices.

The unit achieved compliance in this section of the audit tool. Policies/ procedures for the insertion and on-going management of invasive devices were in place. Bundles of care include the management of peripheral venous catheters and central venous catheters (umbilical arterial catheters, umbilical venous catheters).

Staff receive in house training for IV cannulation insertion and on-going care; and are competency assessed within the unit as opportunities arise.

Audit results, viewed by inspectors, showed evidence of unit compliance with care bundles and this was supported by good staff knowledge. Documentation was available in neonate notes on the management of the relevant invasive devices.

During the observation of staff practice, members of nursing staff were observed accessing a peripheral venous catheter. Practice carried out did not adhere to the principles of asepsis. Issues included: not cleaning the port tip for the recommended period of time, not allowing the port tip to dry for the recommended period of time before connecting the syringe and not taking opportunities for hand hygiene and glove changes. Nursing staff were using silver disposable trays as an aseptic field for ANTT practices, these trays cannot be effectively decontaminated prior to use.

## **4.3 Taking Blood Cultures**

A blood culture is a microbiological culture of blood. It is employed to detect infections that are spreading through the bloodstream. For organisations to comply with this section they must ensure that a policy is in place, staff displays knowledge and practical skills on the key principles and monitoring of the rate of blood cultures is carried out.

The unit achieved partial compliance in this section of the audit tool.

The inspection team were informed that the current trust policy for taking blood cultures did not meet the needs of the neonatal unit; the policy is to be further developed to reflect the requirements of neonatal care.

Although this practice was not observed, staff knowledge was good in the obtaining of blood cultures with adherence to the principles of asepsis. Clinical reasons for taking blood cultures and date, time and site of where the culture was taken were documented within the neonate's notes.

Evidence was available that the laboratory regularly inform the clinical staff on the rate of positive blood cultures however systems were not in place to monitor the incidence of blood culture contamination. This information should be routinely fed back to clinical, nursing and IPC staff.

Currently there is no system in place to assess compliance with best practice when taking blood cultures.

The Enhanced Neonatal Nurse Practitioners are primarily responsible for obtaining of blood cultures within the unit. Competency in carrying out this procedure will be assessed as an aspect of the enhanced neonatal nursing programme.

#### **4.4 Antimicrobial Prescribing**

Antimicrobial prescribing should be carried out in line with evidence-based antimicrobial guidelines. This should improve and reduce the progression of antibiotic resistance and optimise patient outcomes. For organisations to comply with this section they must ensure that there are systems and process in place to ensure a standardised and consistent approach by staff to prescribing. Prescribing should be monitored and reviewed.

Partial compliance was achieved in this section of the audit tool. A number of issues have been identified for improvement. Antimicrobial prescribing guidelines for the neonatal unit are available however there have been no antimicrobial usage audits against this guidance. A trust wide antimicrobial stewardship team is in place and centrally reviews audit results, antimicrobial incidents and usage. The team meets on a quarterly basis and is attended by members of the IPC team. A department based antimicrobial pharmacist is available. Electronic/computer aided prescribing tools were not currently available however the LAMPS software system has the potential to be used to aid prescribing. The lead IPC doctor informed the inspection team of possible future plans to implement a smartphone application to help with antimicrobial prescribing. There are routine antimicrobial ward rounds carried out in the unit.

As part of good practice, antimicrobial prevalence audits have been carried out in the unit over the last number of years. Most notably, the 'Antibiotic

Resistance and Prescribing in European Children (ARPEC) survey was carried out in autumn 2012. Survey results highlighted that the neonatal unit adhered to antibiotic prescribing guidelines.

Documentation from neonate notes and medicine Kardexes evidenced the indication for prescribed antimicrobials, the drug prescribed, dose, frequency, route, planned duration and previous antimicrobial history. Baseline investigations were documented, microbiological samples obtained and results reviewed in line with prescribing, therapy was de-escalated as appropriate.

#### **4.5 Enteral Feeding or Tube Feeding**

Enteral Feeding or tube feeding is defined as a mode of feeding that delivers nutrients directly into the stomach, duodenum or jejunum (Gastrostomy, Jejunostomy, Naso /orogastric tubes). For organisations to comply with this section staff should display awareness of guidelines for the management of an enteral feeding system; insertion, set up and care. Adherence to best practice should be monitored.

Compliance was achieved in this section of the audit tool. Evidence of practice was obtained through review of documentation, observation and speaking with staff.

A policy/guidance was available and staff have received competency training on enteral feeding. Enteral feed were stored, administered and disposed of as per trust policy and in line with best practice. Staff displayed good knowledge on the management of an enteral feeding system; insertion, set up and care. When required staff adhere to guidance on the care of a stoma site and would liaise with the trust stoma care nurse for specialist advice.

Currently there is no system in place to assess compliance with enteral feeding policy/guidance.

#### **4.6 Screening for Meticillin Resistant Staphylococcus Aureus (MRSA) colonisation and decolonisation**

The detection and treatment of MRSA should be carried out in line with DHSSPS Best Practice on Screening for MRSA Colonisation (HSS MD 12/2008). For organisations to comply with this section they must ensure that a screening and treatment policy is in place, staff display knowledge of the policy and adherence to best practice is monitored.

The unit achieved compliance in this section of the audit tool.

A new amended MRSA policy with reference to neonatal care has been devised and is currently in draft form awaiting trust approval. Screening is carried out in line with DHSSPS 'Best Practice on Screening for MRSA colonisation'.

Inspectors were unable to observe practice at the time of the inspection as there was currently no neonates either colonised or infected with MRSA. Evidence of practice was obtained through a review of documentation and speaking with staff.

The inspection team was informed that there has been limited opportunity to audit compliance with MRSA policy and relevant MRSA documentation. It is recommended that systems are put in place to audit compliance whenever appropriate. In light of limited opportunities to care for a neonate affected with MRSA, staff were very knowledgeable in the appropriate management.

The IPC nurses on daily visits to the unit audit compliance with isolation in line with local guidance.

## **5.0 Inspection Findings: Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool**

The Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool provide a common set of overarching standards for all hospitals and other healthcare facilities in Northern Ireland. Inspections using the audit tool gather information from observations in functional areas including, direct questioning and observation of clinical practice and, where appropriate, review of relevant documentation.

The audit tool comprises the following sections:

- organisational systems and governance
- general environment
- patient linen
- waste and sharps
- patient equipment
- hygiene factors
- hygiene practices

The section on organisational systems and governance was not reviewed during this unannounced inspection.

## Standard 2: General Environment

For organisations to comply with this standard they must provide an environment which is well maintained, visibly clean, free from dust and soilage. A clean, tidy and well maintained environment is an important foundation to promote patient, visitor and staff confidence and support other infection prevention and control measures.

### The Regional Healthcare Hygiene and Cleanliness Audit Tool Compliance Levels

General environment	Compliance Levels
Reception	95
Corridors, stairs lift	86
Public toilets	95
Ward/department - general (communal)	100
Patient bed area	100
Bathroom/washroom	N/A
Toilet	N/A
Clinical room/treatment room	100
Clean utility room	94
Dirty utility room	84
Domestic store	90
Kitchen	90
Equipment store	97
Isolation	98
General information	92
<b>Average Score</b>	<b>94</b>

The findings in the table above indicate that the general environment and cleaning in the Neonatal Unit was of a good standard.

The reception area at the main entrance to Antrim Area Hospital was clean and in good decorative order. In contrast to the reception area a number of maintenance issues have been identified in the corridors and stairs leading to the neonatal unit. These include: the vinyl flooring at the doors to the stairs was worn through to the concrete and the paint finish on the doors and hand rails was chipped and worn.

A clearly displayed hand sanitising station (Picture 4) can be viewed in the hospital reception for use by visitors and staff.



Picture 4: Hand sanitising zone at entrance to Antrim Area Hospital

The key findings in respect of the general environment for the unit are detailed in the following section.

### **Neonatal Unit**

Within the environment section of the audit tool, inspectors found good compliance with the standard of cleaning. The key issues identified for improvement in this section of the audit tool were:

- minor damage to the wooden finish of the equipment store and kitchen doors
- there were no dedicated hand washing sinks in the domestic store and the kitchen. The equipment sink in the kitchen was old and tarnished and there was lime scale noted on the hot tap of the equipment sink in the dirty utility room
- the dirty utility room was small with minimal work space. It was used for multiple purposes which include: the cleaning of incubators, storage of the blood gas testing machine, cleaned baby baths and sharps boxes which were stored on the floor. The inspection team were informed that these issues will be addressed as a result of the renovation work to the unit
- the domestic room was small and there was insufficient space for equipment and supplies. Supplies of mops and equipment were stored on the floor
- cleaning schedules and the method used to record cleaning carried out did not outline staff roles/responsibilities for all equipment within the unit

### Standard 3: Patient Linen

For organisations to comply with this standard, patient linen should be clean, free of damage, handled safely and stored in a clean and tidy environment. The provision of an adequate laundry service is a fundamental requirement of direct patient care. Linen should be managed in accordance with HSG 95(18).

#### Compliance of Patient Linen

Patient linen	Compliance Levels
Storage of clean linen	100
Storage of used linen	100
Laundry facilities	N/A
<b>Average Score</b>	<b>100</b>

The above table indicates that the unit achieved full compliance in the management of patient linen. Linen was clean, free from damage and stored appropriately in the designated store. Staff demonstrated good knowledge on the handling of clean and used linen.

## Standard 4: Waste and Sharps

For organisations to comply with this standard they must ensure that waste is managed in accordance with HTM07-01 and Hazardous Waste (Northern Ireland) Regulations (2005). The safe segregation, handling, transport and disposal of waste and sharps can, if not properly managed, present risks to the health and safety of staff, patients, the public and the environment.

Waste bins in all clinical areas should be labelled, foot operated and encased. This promotes appropriate segregation, and prevents contamination of hands from handling the waste bin lids. Inappropriate waste segregation can be a potential hazard and can increase the cost of waste disposal.

Sharps boxes must be labelled and signed on assembly and disposal. Identification of the origin of sharps waste in the event of spillage or injury to staff is essential. This assists in the immediate risk assessment process following a sharps injury.

### Compliance of Waste and Sharps

Waste and sharps	Compliance Levels
Handling, segregation, storage, waste	95
Availability, use, storage of sharps	97
<b>Average Score</b>	<b>96</b>

#### 4.1 Management of Waste

The above table indicates that the unit achieved good overall compliance in the handling and storage of waste. Issues identified for improvement in this section of the audit tool were:

- a household waste bin was not available in the dirty utility room and household waste was disposed of into clinical waste

#### 4.2 Management of Sharps

The above table indicates that the unit achieved good overall compliance with this standard. The issue identified for improvement in this section of the audit tool was:

- the sharps box on the blood trolley, located at sister's office, did not have its temporary closure mechanism deployed when it was not in use

## Standard 5: Patient Equipment

For organisations to comply with this standard they must ensure that patient equipment is appropriately decontaminated. The Northern Ireland Regional Infection Prevention and Control Manual states: 'that all staff that have specific responsibilities for cleaning of equipment must be familiar with the agents to be used and the procedures involved'. COSHH regulations must be adhered to when using chemical disinfectants.

### Compliance of Patient Equipment

Patient equipment	Compliance Levels
Patient equipment	95

The above table indicates that the unit achieved good compliance in this standard.

The issues identified for improvement in this section of the audit tool include:

- sterile and single use equipment had been removed from its original packaging
- ANTT trays were not in use, staff were using silver disposable trays which cannot be effectively decontaminated.

## Standard 6: Hygiene Factors

For organisations to comply with this standard they must ensure that a range of fixtures, fittings and equipment is available so that hygiene practices can be carried out effectively.

### Compliance of Hygiene Factors

Hygiene factors	Compliance Levels
Availability and cleanliness of wash hand basin and consumables	100
Availability of alcohol rub	100
Availability of PPE	100
Materials and equipment for cleaning	94
<b>Average Score</b>	<b>96</b>

The above table indicates that the unit achieved good compliance in this standard. Clinical hand washing sinks were in line with HBN 04-01, the sinks, consumables and alcohol hand rub containers were clean and in good repair. A full range of personal protective equipment (PPE) was available. Cleaning products were available for all staff and were clean and in good repair.

The issue identified for improvement in this section of the audit tool was:

- disinfectant products stored in the domestic store and the dirty utility room were not stored in accordance with COSHH guidance

## Standard 7: Hygiene Practices

For organisations to comply with this standard they must ensure that healthcare hygiene practices are embedded into the delivery of care and related services.

### Compliance of Hygiene Practices

Hygiene practices	Compliance Levels
Effective hand hygiene procedures	93
Safe handling and disposal of sharps	100
Effective use of PPE	93
Correct use of isolation	89
Effective cleaning of ward	85
Staff uniform and work wear	97
<b>Average Score</b>	<b>93</b>

The above table indicates that the unit achieved compliance within this standard. Issues identified for improvement include:

- a member of the nursing staff reviewed a set of patient's notes whilst wearing a pair of gloves. The staff member proceeded to carry out patient care without removing the gloves and carrying out hand hygiene
- an NPSA colour coded poster for domestic cleaning equipment was not displayed for nursing staff. Nursing staff questioned, were unsure of the NPSA colour coding
- on the first day of the inspection a member of support service staff had long hair not tied up; during the second day of the inspection the staff members hair was secured above the collar

## 6.0 Summary of Recommendations

### The Regional Neonatal Care Audit Tool

1. In order to prevent the transmission of microorganisms and ultimately prevent the chain of infection it is recommended that all staff within the unit strictly adhere to infection prevention and control best practices in line with trust policy and that practices are robustly audited with special reference to hand hygiene and the decontamination of equipment.
2. The parent's guidance booklet should be reviewed to include advice regarding disposal of neonates wash water.
3. Terminal cleans should be randomly validated by domestic supervisors.
4. The trust should continue with their programme of refurbishment of the neonatal unit to meet the standards within Health Building Note 09-03: Neonatal Units.
5. A protocol that identifies individual staff roles and responsibilities in relation to the reporting of laboratory results to receiving or transferring units should be developed.
6. Staff should ensure that manufacturers guidelines are available for the cleaning of specialist neonatal equipment and the cleaning of specialised neonatal equipment should be routinely audited.
7. The dismantling and cleaning of incubators should be robustly assessed in line with best practice.
8. A risk assessment should be undertaken in relation to existing procedural arrangements for the collection and storage of breast milk in the neonatal unit.
9. The policy on the collection and storage of breast milk should be reviewed to reflect current staff practice.
10. A commercial fridge should be used to store milk. Fridge and freezer temperature checks must be recorded on a daily basis. Deviations from the recommended temperature ranges should be actioned immediately and details recorded.

### The Regional Clinical Practices Audit Tools

11. Staff must comply with the principles of ANTT when accessing invasive devices. Compliance with these principles must be robustly assessed.
12. The blood culture policy should be reviewed and amended to reflect neonatal care.

13. The rate of blood culture contamination should be monitored and results fed back to clinical, nursing and IPC staff.
14. Systems should be implemented to monitor compliance with best practice when taking blood cultures and enteral feeding
15. The updated MRSA policy should be disseminated to staff on completion.
16. Systems should be implemented to monitor adherence with MRSA policy and care pathway as appropriate.
17. Electronic/ computer aided tools should be available to assist with antimicrobial prescribing.
18. Antimicrobial usage should be audited in line with current antimicrobial prescribing guidance.

## **Regional Healthcare Hygiene and Cleanliness Standards and audit tool**

### **Standard 2: Environment**

19. A maintenance programme should be in place to ensure the general environment, furniture, fixtures and fittings are in a good state of repair.
20. Cleaning schedules should outline staff roles/responsibilities for all equipment within the unit.
21. Hand washing sinks should be available in the domestic store and the kitchen.

### **Standard 4: Waste and Sharps**

22. All staff should ensure the correct segregation of waste.
23. Staff should ensure that the temporary closure mechanism is deployed when the sharps bin is not in use.

### **Standard 5: Patient Equipment**

24. Sterile or single use equipment should not be removed from its packaging prior to use.

### **Standard 6: Hygiene Factors**

25. All chemicals should be stored in a locked, inaccessible area in accordance with COSHH regulations.

## **Standard 7: Hygiene Practices**

26. All staff should comply with the WHO five moments for hand hygiene.
27. NPSA colour coding guidelines should be displayed for nursing staff.  
Nursing staff should be updated on the NPSA colour coding for the cleaning of equipment.
28. All staff should adhere to the trust dress code policy.

## 7.0 Key Personnel and Information

### Members of RQIA's Inspection Team

Mr T Hughes	- Inspector Infection Prevention/Hygiene Team
Mrs L Gawley	- Inspector Infection Prevention/Hygiene Team
Mrs S O'Connor	- Inspector Infection Prevention/Hygiene Team
Mrs M Keating	- Inspector Infection Prevention/Hygiene Team
Ms S Baird	- Peer Reviewer

### Trust Representatives attending the Feedback Session

The key findings of the inspection were outlined to the following trust representatives:

Ms A Ennis	- Acting Ward Manager NNICU
Ms F McCloskey	- Lead Nurse NNICU
Ms M Bermingham	- Assistant Director Corporate Support Services
Ms J Carroll	- Assistant Domestic Services Manager
Mr D Farren	- IPC Doctor
Ms N Baldwin	- Infection Prevention and Control Lead (NHSCT)
Ms L Crymble	- Senior Infection Prevention and Control Lead (AAH)
Ms F Gallagher	- Antimicrobial Pharmacist
Ms F Brown	- Head of Children's Nursing
Mr C Kelly	- Senior Engineer - Estates

### Apologies

Ms O MacLeod	- Director of Nursing and User Experience
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## 8.0 Augmented Care Areas

Based on DHSSPS guidance, the augmented care areas currently identified for inclusion in inspections are:

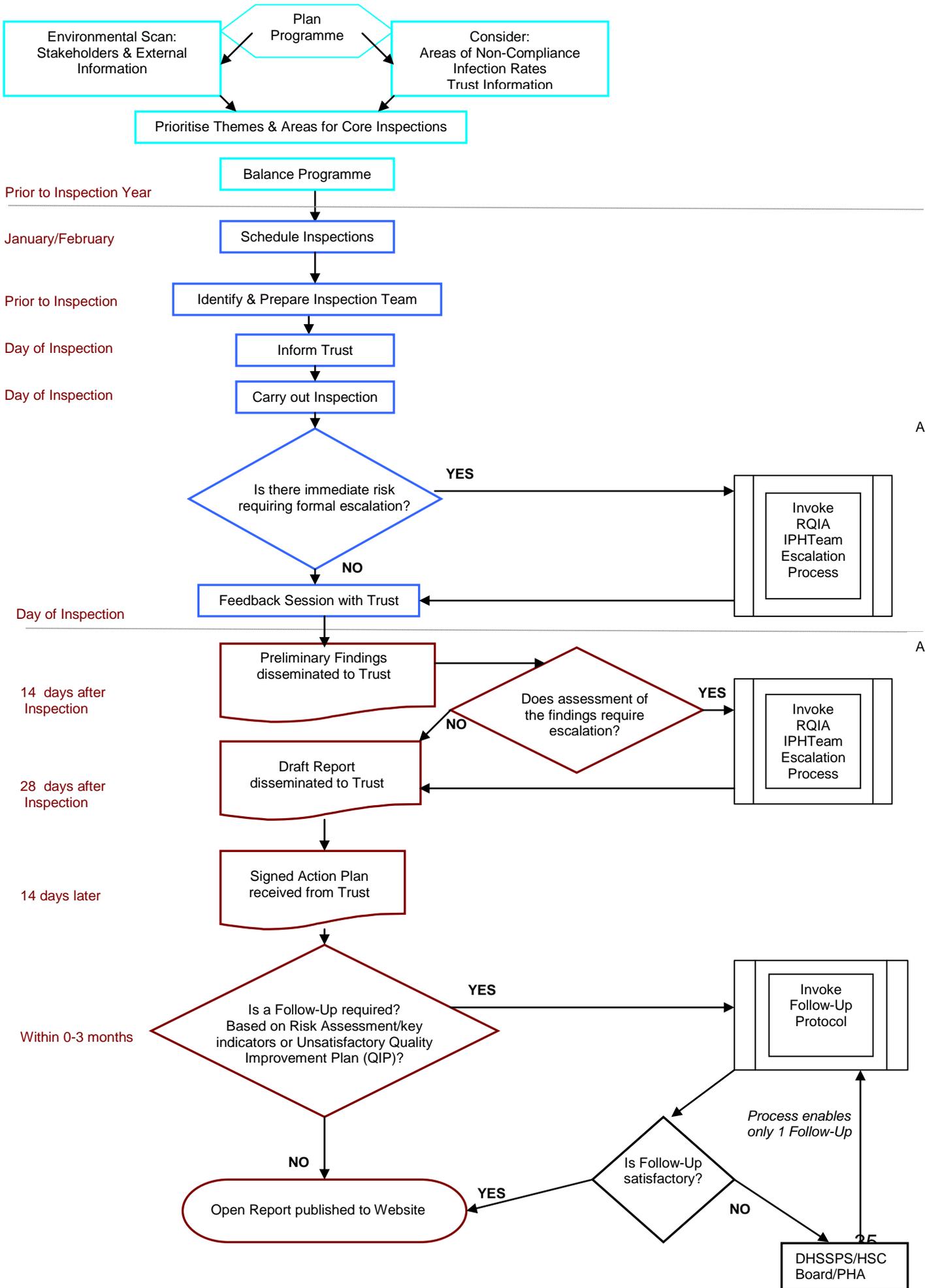
- neonatal and special care baby units
- paediatric intensive care
- all adult intensive care which includes cardiac intensive care
- burns units
- renal (dialysis) units
- renal transplant unit
- high dependency units (HDU)
- haematology
- oncology

# 9.0 Unannounced Inspection Flowchart

Plan Programme

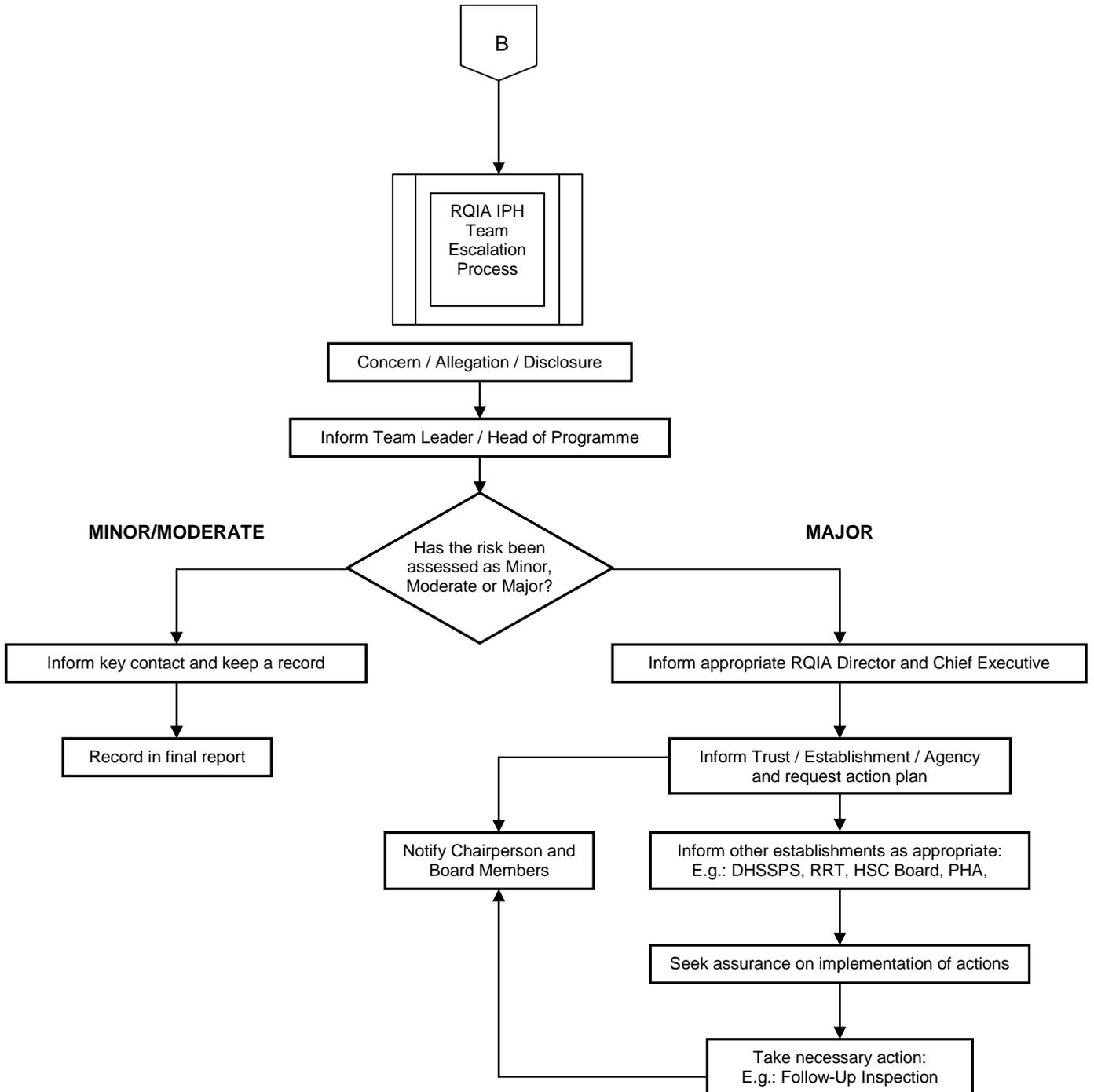
Episode of Inspection

Reporting & Re-Audit



## 10.0 Escalation Process

### RQIA Hygiene Team: Escalation Process



## 11.0 Quality Improvement Plan

Reference number	Recommendations	Designated department	Action required	Date for completion/ timescale
<b>The Regional Neonatal Care Audit Tool</b>				
1	In order to prevent the transmission of microorganisms and ultimately prevent the chain of infection, it is recommended that all staff strictly adhere to infection prevention and control best practices in line with trust policy and that practices are robustly audited with special reference to hand hygiene and the decontamination of equipment.	All staff working within NHSCT	Bi annually IPC independent audits are carried out and all actions identified must be completed within agreed timescales. All staff receives mandatory Infection Control training based on best practice and regional and local policy. Weekly hand hygiene audits are on-going with results displayed at ward level. Where hand hygiene results are reduced the audit is increased to daily until practice has improved.	Completed
2	The parent's guidance booklet should be reviewed to include advice regarding disposal of neonates wash water.	Nursing	Parent information booklet is being reviewed to include recommendation.	January 2014
3	Terminal cleans should be randomly validated by domestic supervisors.	Domestic Services and Infection Control Team	Terminal cleans are randomly validated by Infection Control Team and domestic supervisors	Completed

Reference number	Recommendations	Designated department	Action required	Date for completion/ timescale
4	The trust should continue with their programme of refurbishment of the neonatal unit to meet the standards within Health Building Note 09-03: Neonatal Units.	NNU team Estates Architects Health estates	The building note is currently being considered as part of the refurbishment	
5	A protocol that identifies individual staff roles and responsibilities in relation to the reporting of laboratory results to receiving or transferring units should be developed.	Medical, Nursing and Infection Control	A communication flow chart has been agreed and is now in use for the reporting positive laboratory results to receiving or transferring units.	Completed
6	Staff should ensure that manufacturers guidelines are available for the cleaning of specialist neonatal equipment and the cleaning of specialised neonatal equipment should be routinely audited	Nursing	Manufactures guidelines are available at ward level for all items of equipment. Decontamination of equipment is audited at ward level through random weekly audit programme and as part of the biannually Infection Control Audit.	Completed
7	The dismantling and cleaning of incubators should be robustly assessed in line with best practice	Nursing	Guidance on the dismantling and cleaning of incubators is available at ward level in line with best practice. This will be audited as part of the independent clinical and environmental 3 monthly auditing which is undertaken by Senior management of the NHSCT.	Completed

Reference number	Recommendations	Designated department	Action required	Date for completion/ timescale
8	A risk assessment should be undertaken in relation to existing procedural arrangements for the collection and storage of breast milk in the neonatal unit.	Nursing	A risk assessment has been undertaken in relation to existing procedural arrangements and a policy has been developed in line with best practice	Completed
9	The policy on the collection and storage of breast milk should be reviewed to reflect current staff practice.	Nursing	The policy on the collection and storage of breast milk has been reviewed to reflect practice	Completed
10	A commercial fridge should be used to store milk. Fridge and freezer temperature checks must be recorded on a daily basis. Deviations from the recommended temperature ranges should be actioned immediately and details recorded.	Nursing	A commercial fridge has been ordered. Deviations in temperature are reported immediately to the Nurse in charge and action required taken. Temperature recorded twice daily and any actions taken at time of deviations.	Awaiting delivery. Partially completed
<b>The Regional Clinical Practices Audit Tools</b>				
11	Staff must comply with the principles of ANTT when accessing invasive devices. Compliance with these principles must be robustly assessed.	Medical, Nursing	All staff have received update training in ANTT. This will be provided annually and is mandatory. Random audits and reporting of High impact interventions are in place. Biannually Infection Control Audits will also include ANTT practice.	Completed
12	The blood culture policy should be reviewed and amended to reflect neonatal care.	Medical, Nursing	Blood Culture Policy is being developed	March 2014

Reference number	Recommendations	Designated department	Action required	Date for completion/ timescale
13	The rate of blood culture contamination should be monitored and results fed back to clinical, nursing and IPC staff.	Medical, Microbiology	System will be developed for discussion between microbiology team and Neonatal Medical team to clarify significance of blood culture results.	March 2014
14	Systems should be implemented to monitor compliance with best practice when taking blood cultures and enteral feeding.	Medical, Nursing	Blood Culture Policy and Enteral Feeding Policy will be completed by January 2014. Following there completion audits will be carried out based on the policies. This will be initially as part of random audits and will then be part of the biannually IPC audits.	March 2014
15	The updated MRSA policy should be disseminated to staff on completion	Management Structure	MRSA policy will be disseminated to all staff via the NHSCT policy dissemination process	Completed
16	Systems should be implemented to monitor adherence with MRSA policy as appropriate.	Nursing	Ward level random audits and root cause analysis.	Completed
17.	Electronic/ computer aided tools should be available to assist with antimicrobial prescribing.	Medical, Pharmacy, IT	The NHSCT feels this should be a regional process/system and item will be posted onto the Neonatal Network NI agenda by Dr S Bali.	

Reference number	Recommendations	Designated department	Action required	Date for completion/ timescale
18.	Antimicrobial usage should be audited in line with current antimicrobial prescribing guidance.	Medical, Microbiology	This has been looked at. Current up to date guidance underpins new NHSCT antibiotic guidance being progressed. Once finalised an audit programme will be agreed by Medical team.	January 2014
<b>Regional Healthcare Hygiene and Cleanliness Standards and Audit Tool</b>				
<b>Standard 2: Environment</b>				
19	A maintenance programme should be in place to ensure the general environment, furniture, fixtures and fittings are in a good state of repair.	Estates	A maintenance programme is in place ensuring general environment is in good state of repair. Furniture, fixtures and fittings are assessed by Nursing staff and where repair is required Estates are contacted via Help Desk system and minor capital works are requested. Record and follow up is maintained at ward level and with Estates	Completed
20	Cleaning schedules should outline staff roles/responsibilities for all equipment within the unit.	Nursing, Domestic Services	Cleaning schedules are available for domestics for general environment. More specific cleaning of equipment is available for Nursing/auxiliary staff as weekly cleaning. Daily cleaning of individual infant's area is completed and documented.	Completed

Reference number	Recommendations	Designated department	Action required	Date for completion/ timescale
21	Hand washing sinks should be available in the domestic store and the kitchen.	Estates	Hand washing sinks will be available in the domestic store and kitchen as part of the refurbishment project.	Due to be completed August 2014
<b>Standard 4: Waste and Sharps</b>				
22	All staff should ensure the correct segregation of waste.	Nursing	Signage is available for the segregation of waste on top of each waste bin in Neonatal Unit. Staff informs parents of the correct usage.	Completed
23	Staff should ensure that the temporary closure mechanism is deployed when the sharps bin is not in use.	Nursing	All staff have been provided with the Disposal of sharps policy and reminded of the need to ensure temporary closure is deployed when sharp box not in use.	Completed
<b>Standard 5: Patient Equipment</b>				
24	Sterile or single use equipment should not be removed from its packaging prior to use.	Nursing	Sterile or single use equipment is maintained in its packaging prior to use. This was addressed with all staff at time of RQIA audit and was raised again at the Ward meeting in September 2013. Minutes of the meeting were provided to all staff.	Completed

Reference number	Recommendations	Designated department	Action required	Date for completion/ timescale
<b>Standard 6: Hygiene Factors</b>				
25	All chemicals should be stored in a locked, inaccessible area in accordance with COSHH regulations.	Nursing, Domestic	All staff will be provided with COSHH awareness training and chemicals are stored in a locked, inaccessible area.	Partially completed as training is ongoing
<b>Standard 7: Hygiene Practices</b>				
26	All staff should comply with the WHO five moments for hand hygiene.	All staff and parents.	All staff must have training in hand hygiene. Parents are shown how to do hand hygiene by nursing staff. The Neonatal Unit has weekly auditing of hand hygiene. All staff have had training in hand hygiene through their mandatory infection control annual training.	Completed
27	NPSA colour coding guidelines should be displayed for nursing staff. Nursing staff should be updated on the NPSA colour coding for the cleaning of equipment.	Nursing	NPSA colour coding guidelines are displayed in the dirty utility room for nursing staff. Nursing staff are updated on the NPSA colour coding for the cleaning of equipment using the NHSCT decontamination policy.	Completed
28	All staff should adhere to the trust dress code policy.	All staff	All staff must adhere to the NHSCT dress code policy. Staff who are in breach of the policy will be managed under disciplinary process.	Completed



The **Regulation** and  
**Quality Improvement**  
Authority

The Regulation and Quality Improvement Authority  
9th Floor  
Riverside Tower  
5 Lanyon Place  
BELFAST  
BT1 3BT

Tel: (028) 9051 7500  
Fax: (028) 9051 7501  
Email: [info@rqia.org.uk](mailto:info@rqia.org.uk)  
Web: [www.rqia.org.uk](http://www.rqia.org.uk)