MERCY UNIVERSITY HOSPITAL HYGIENE QUALITY IMPROVEMENT PLAN 2016/17

STANDARD AREA	ITEM	IMPROVEMENT PROCESSES	RESP. FOR COMPLETION	PROGRESS	ProgressRAG	COMPLETION TIMESCALE
1 GENERAL MONITORING SYSTEM	1 The hospital must have an effective and comprehensive process in place to identify, understand, monitor and address current and future risks in a timely manner.	The Board of Governors and Executive Management Board must establish a clear protocol for action to address long standing high priority risk items on the hospital risk register	CEO/RM	Process is underway and clear priorities have been drawn up and submitted to HSE/DoH		31/03/17
	2 The current lack of clinical audit prevents the hospital from effectively assuring itself that the service provided is in line with best practice and does not pose risks to patients.	The expansion of existing clinical audit mechanisms will be undertaken to ensure measurable KPIs are achieved	CD/RM			
	3 The development of a track and trace auditing structure was in progress at the time of the re- inspection, a timeframe was not clearly defined.	The track and trace system is to be incoporated in the outsourcing project	CFA/Theatre Manager	Completed		Completed
	4 At the time of re—inspection while a number of staff had completed HSE online training course, no staff member had undertaken formal training in decontamination of reusable invasive medical devices. Inspectors were informed that three staff members were to undertake an academic program in the near future.	A system to ensure all relevant staff are trained routinely will be developed.	DoN/Theatre Manager	Training in progress		31/12/16
	5 There is significant scope for improvement in clinical governance structures and effective assurance mechanisms relating to decontamination processes.	1. The Decontamination Committee will be reformed on a permanent basis as part of the hospital\s governance procedures. 2 A surgical site infection surveillance programme will be instituted 3. A full time Decontamination Officer will be appointed on a nursing grade.	1.DCEO 2. Consultant Microbiologist and Theatre Manager 3 Don/HRM	The Decontamination Committee has been reformed. A surgical site surveillance programme requires action at Group level. A Decontamination Officer Post is under preparation.		by 31/03/2017
2 PATIENT EQUIPMENT CLEANING	1 The arrangements for surgical instrument decontamination within the TheatreDepartment did not comply with the Health Service Executive Code of Practice for Decontamination of Reusable Invasive Medical Devices7, and were not in compliancewith the National Standards for the Prevention and Control o fHealthcare AssociatedInfection}	1 The hospital will address the totality of the decontamination issues through the outsourcing of its decontamination processes and the development of a three phase plan to upgrade and/or reprovide its theatre complex.	DCEO/EMB	Outsourcing has commenced		28/02/17
				Phase 2 Programme finalised for implementation in Spring 2017		Completed
				3. Phase 2 Theatre Programme to address theatre layout and provision of compliant scrubs/sluices/clean and dirty areas/effective circulation process		31/05/17
				Planning process will commence in late 2017		Post 2018
	2 Decontamination of reusable surgical instruments was performed within the Theatre Department by theatre staff rather than in a separate central sterile supply department.	See 2.1.1 above		Outsourcing has commenced for completion in February 2017		28/02/17
	3 There was no decontamination lead within the hospital.	See 1.5.3 above		See 1.5.3 above		by 31/03/2017
	4 HIQA was informed that the hospital decontamination committee had not met in a number of years.	See 1.5.1.above		See 1.5.1.above		by 31/03/2017
	5 Assurance was not provided at the time of the initial inspection that effective governance and management arrangements in place were sufficient to fully ensure the provision of a high quality and safe decontamination of reusable invasive medica ldevices service within the hospital.	See 1.5.1.above		See 1.5.1.above		by 31/03/2017
	6 The configuration and location of the decontamination facilities was not fit—for purpose and did not facilitate the implementation of effective infection prevention and control measures. Decontamination of reusable invasive medical devices such as surgical instruments and endoscopes were carried out in three different locations throughout the Theatre Department. The main area used for the decontamination of surgical instruments was located between two operating	See 2.1.1 above		See 2.1.1 above		14/11/16
	7 Dedicated gowning rooms with hand hygiene facilities were not available at the entrance to the clean room, inspection, assembly and packing room.	See 2.1.1 above		See 2.1.1 above		14/11/16
	8 Access to the wash room was through an operating theatre. Inspectors observed that movement of staff in the operating theatre was not restricted. Inspectors observed staff walking through an operating theatre to access the decontamination facilities while a procedure was in progress. Access from the inspection and packing room to the corridor was via a scrub room shared between the two theatres or via the operating theatre. The width of the scrub room was very narrow which posed logistical challenges when transporting surgical equipment from the decontamination unit.	See 2.1.1 above		See 2.1.1 above		14/11/16

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	9 An autoclave machine used to sterilize surgical instruments was inappropriately located within a separate store room. The store room was cluttered, overstocked with little space to manoeuvre due to the storage of equipment on the available floor space. In addition, the room was poorly maintained with visible damage to wall surfaces and ceiling tiles. There were no hand hygiene facilities in this room.	This room will be converted to storage and the autoclave will be removed as part of 2.1.1.2above	PE/Theatre Manager	Room converted autoclave will be removed in Febriary 2017		31/05/17
	10 Reprocessing of endoscopes took place in a third room which also served as a store room for equipment and surgical supplies. It was reported that the washer-disinfector in use at the time of the inspection was approaching its end of life and as a consequence could no longer be validated. This washer-disinfector was located in an inappropriate area that did not support the separation of clean and dirty processes and had the potential to impact on the sterile supplies also stored in the room. The facilities for endoscope reprocessing did not comply with the Health Service Executive Code of Practice for Decontamination of Reusable Invasive Medical Devices.	1 The reprocessing of endoscopes will be transferred to the Endoscopy Decontamination department and/or the outsourced contractor	Theatre Manager	Completed Completed		COMPLETED COMPLETED
	11 In St Therese's ward A fan which was dusty was in use in a clinical room, which is not in line with best practice.	1 Cleaning schedules to be reinforced	HM	Completed		COMPLETED
	12 In St Therese's ward pinprick holes and staining were observed on the inside cover of a mattress. This posed a risk to patients and staff of transmissible infective microorganisms as the integrity of the cover was compromised and thus no longer impermeable to body fluids. Inspectors were informed that mattress inspections had been introduced on an ad hoc basis. It is recommended that a regular more frequent scheduled system of mattress inspection is implemented.	2 More routine mattress inspection system to be instituted	DoN	Completed		COMPLETED
3 INFRASTRUCTURAL CLEANING	1 Infection prevention environmental controls in operating theatres one and two could not be assured at the time of the inspection and was a particular concern. There was unrestricted access into the operating theatres from the corridor. Inspectors observed that the operating theatre was a thoroughfare for staff en route to the decontamination facilities during procedures and during the preparation of surgical instruments at the time of the inspection.	See 2.1.1.3 above		See 2.1.1.3 above		31/05/17
	2 Scrub room facilities for operating theatres one and two did not comply with current standards." There was no door between the shared scrub room and the corridor and from the scrub room into the operating theatres. Open access between the corridor and the operating theatre may compromise the pressure gradients within and between the two operating theatres, with possible adverse consequences for infection contro|.8 In addition, the privacy and dignity of patients could not be protected.	See 2.1.1.3 above		Temporary solution implemented prior to Phase 2		COMPLETED
	3 There was no waste sub collection facility resulting in the build up of clinical risk waste in the operating theatre and in the service lift to the rear of the department. The build up of waste observed at the time of the first inspection presented an infection prevention and control risk. Waste had to regularly be transported through the operating theatres as there was no separate exit.	See 2.1.1.3 above		See 2.1.1.3 above		31/05/17
	4 The design of the Theatre Department did not facilitate patient flow and workflow processes. The two 'dirty' utility rooms serving the Theatre Department were only accessible via operating theatres one and two. This did not facilitate appropriate workflow and posed a risk of cross contamination. Units should be designed so that the flow of waste materials including body fluids is such that cross—contamination between contaminated and clean items is minimised.	See 2.1.1.3 above		Temporary solution implemented prior to Phase 2		COMPLETED
	5 The entrance to the Theatre Department was not secure and therefore unauthorized access could not be prevented	Security arrangements to be applied especially swipe locks	DCEO	Completed		COMPLETED
	6 Operating theatres and adjoining ancillary rooms were cluttered and cramped. Lack of storage meant that sterile supplies were stored in various ancillary rooms throughout the department, many of which were inappropriate and poorly maintained in some cases.	See2.1.1.2 above		Completed		COMPLETED
	7 Many of the wall and ceiling vents viewed were dusty at the time of the inspection. It was reported to HIQA that vents should be cleaned on a six monthly basis, however compliance with this regime was poor which was symptomatic of the dustlevels seen	See 2.1.1.3 above		Completed		COMPLETED

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	8 Floor mats were present on the floors of scrub rooms. It was reported that these mats were in place to prevent slips, trips and falls caused by wet slippery floors. These mats were replaced each week and cleaned. Alternative solutions to this issue should be considered in light of the infection prevention control risk associated with damp floor mats left in situ each day for up to a week. Floor mats in a theatre setting are not recommended	See2.1.1.2 above		Completed		COMPLETED
	9 It was reported during the re—inspection that the audit tool was under review. Identified maintenance issues should be prioritised and addressed to facilitate effective infection prevention and control practices.	Monitoring process to be reviewed and reformed	DCEO/CNM3	Completed		COMPLETED
	10 Hospitals should ensure that the acquisition process in place ensures all equipment purchased including reusable medical devices is safe for its intended use. Therefore, infection prevention and control teams and key individuals should be involved in the procurement of equipment prior to purchase to ensure that the required level of safety, quality and performance is met. Sufficient resources must be allocated to ensure a seamless transition of the current decontamination services to an external contractor and to ensure the sustainability of the surgical and decontamination services in the short and long term.	To be included in Board estates review reforms	DCEO	Completed		COMPLETED
4 HYGIENIC DESIGN ISSUES	1 The lack of storage space in the Theatre Department also resulted in unnecessary overstocking within the operating rooms and sterile consumables being stored inappropriately on open shelves and in a number of mobile cabinets in the operating theatres. To prevent inadvertent contamination, sterile and clean supplies in operating theatres should be kept to a minimum and should be stored in fully enclosed storage units.	See 2.1.1.3 above		Completed		COMPLETED
	2 There was no designated linen facility. Linen was stored inappropriately on patient equipment in the Recovery Bay and on stored sterile supplies in the Anaesthetic Room.	See 2.1.1.3 above		Completed		COMPLETED
	3 The Theatre Department did not have a dedicated room for the storage of cleaning equipment and supplies. Cleaning equipment was inappropriately stored in the room used for endoscope decontamination.	See 2.1.1.3 above		See 2.1.1.3 above		31/05/17
	4 The recovery room accommodates up to five patients however the space allocated to each trolley bay and between trolleys was very limited. In addition, floor covering was not intact in the recovery room. There was only one designated patient toilet within the Theatre Department which was located in the patient reception. There were no appropriate patient toilet facilities in the recovery bay. Facilities in place were not sufficient enough to comfortably meet patients' needs and posed challenges in the management of bodily fluids. There was no segregated area for children within the recovery room.	See 2.1.1.4		Toilets will be addressed in 2.1.1.3 above reminder will be addressed in 2.1.1.4 above		31/05/17
	5 Flooring, ceilings, walls and exposed pipe work were poorly maintained.	See 2.1.1.3 above		Toilets will be addressed in 2.1.1.3 above reminder will be addressed in 2.1.1.4 above		31/05/17
	6 While some improvements were made relating to maintenance of and storage within the Intensive Care Unit, substantive issues and risks identified in the 2015 HIQA report relating to the infrastructural deficiencies and the isolation facilities remain outstanding. Inspectors were informed that a funding application has been submitted to the HSE for reconfiguration of the Intensive Care Unit. However, on the day of the inspection there were as yet, no funded plans or agreed timelines in place to address the issues which have been identified.	The hospital will expedite the initial proposal submitted to Hse on 2015	DCEO/Proj Asst	Plans submitted		31/03/18
	7 The facilities for the processing of clean and dirty cleaning textiles remained unchanged. Inspectors were informed that alternatives are being explored to fully address this issue.	The hospital will resolve this issue either by outsourcing or reprovision of laundry facilities				31/03/17

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5 HAND HYGIENE	1 in theTheatre Department where the majority of sinks viewed did not comply with current recommended specifications. It is recommended that sink replacement programmes should be prioritized towards high risk functional areas such as Theatre Departments and be included as a component of the planned works.	See 2.1.1.3 & 2.1.1.4 above		See 2.1.1.3 & 2.1.1.4 above		31/05/17
	2 Placement of alcohol hand gels and moisturiser at some clinical hand wash sinks in St Therese's Ward should be reviewed to ensure that it is not mistaken for liquid soap.	This will be reviewed	COI Dept	Completed		COMPLETED
	3 There was inadequate provision of hand hygiene sinks in the decontamination facilities within the Theatre Department.	See 2.1.1.3 above		See 2.1.1.3 above		31/05/17
	4 A breakdown of hand hygiene training compliance for each staff group showed that only 16% of Medical Consultants were up-to-date with hand hygiene training. This figure is considerably lower than other staff groups. As variation in performance among disciplines affects overall hospital hand hygiene compliance scores, it is recommended that targeted education and audit is performed in order to drive improvement in hand hygiene compliance.	A new policy to link hand hygiene to clinical access will be considered	EMB	Completed		COMPLETED
	5 In general the hospital's compliance rate has exceeded the HSE's national 90% target." However, the latest results for October/November 2015 show a decrease to 87.6%. The Hospital needs to continue to improve hand hygiene compliance in order to again meet and maintain the HSE's national hand hygien	Departmental training and monitoring to be strengthened by extension of train the trainer and digital audit tool		Completed		COMPLETED
5 CLINICAL PRACTICE	1 In St Therese's ward nine intravenous infusion giving sets were primed with intravenous fluids and stored in an intravenous tray in preparation for patients attending the morning session in the Day Ward. This practice of preparing solutions for intravenous use in advance of anticipated administration time should be reviewed to ensure that the risk of contamination of either the medication or the equipment used to administer medication is prevented. Intravenous solutions should, where possible, be prepared as close as possible to the time of administration in a clean environment using an aseptic non—touch technique	To be reviewed and changes identified and implemented	DoN	Completed		COMPLETED
	2 Open multiple dose vials of insulin and other medicine which was not designated tosingle patient use in line with best practice guidelines were observed in the medicinefridge located in the anaesthesia room. Inappropriate use of mu|ti—dose vials hasbeen linked to outbreaks of infection. It is recommended that mu|ti—dose vials are designated single patient use where possible. Such vials should be labelled with thedate of opening and discarded within the recommended timeframe specified by themanufacturer. Both the Theatre Manager and Senior Management were informedof these findings at the time of the inspection for immediate mitigation.	Instructions given for this change in June 2016	DCEO/DoN	Completed		COMPLETED
	3 it is recommended that the hospital further explores the potential for the establishment of surveillance of device related infection rates over time to ensure full compliance with best practice standards and guidelines.	See 1.5.2 above				by 31/03/2017