MERCY UNIVERSITY HOSPITAL HYGIENE QUALITY IMPROVEMENT PLAN 2016/18 updated 25/4/2018

STANDARD AREA	ITEM	IMPROVEMENT PROCESSES	RESP. FOR COMPLETION	PROGRESS	ProgressRAG	COMPLETION TIMESCALE
1 GENERAL MONITORING SYSTEM	(1.1) 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.	(1.1.1) Clear processes in place for registering and highlight risks to HSE/ Board.	CEO/RM	(1.1.1.1) Ongoing submissions to HSE to address high risk items		31/07/2017 COMPLETED
	(1.2) 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.	(1.2.1) The expansion of existing clinical audit mechanisms will be undertaken to ensure measurable KPIs are achieved	CD/RM	(1.2.1.1) Expansion of clinical audit mechanisms has not taken place. Need a dedicated nurse resource to do this.		
	(1.3) 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.	(1.3.1) The track and trace system is to be incoporated in the outsourcing project	CFA/Theatre Manager	(1.3.1.1) Electronic tracking on despatching and return of instruments to MUH in place. Manual tracking to Theatres in place		31/12/2017 COMPLETED
	(1.4) 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.	(1.4.1) A system to ensure all relevant staff are trained routinely will be developed.	DoN/Theatre Manager	(1.4.1.1) 2 Persons trained in Endoscopy. No requirement in theatre post outsourcing. Improvement process to be that theatre staff perform HSE on-line training on Decontamination.		
	(1.5) There is significant scope for improvement in clinical governance structures and effective assurance mechanisms relating to decontamination processes.	(1.5.1) The Decontamination Committee will be reformed on a permanent basis as part of the hospital's governance procedures. (1.5.2) A surgical site infection surveillance programme will be instituted (1.5.3) A full time Decontamination Officer will be appointed on a nursing grade	1.DCEO 2. Consultant Microbiologist and Theatre Manager 3 Don/HRM	(1.5.1.1) The Decontamination Committee has been reformed. (1.5.2.1) A surgical site surveillance programme requires action at Group level. (1.5.3.1) A Decontamination Officer Post not in place to date.	1.5.2 & 1.5.3	1.5.1 COMPLETED
	(2.1) The arrangements for surgical instrument decontamination within the Theatre Department 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 of Healthcare Associated Infection}	(2.1.1) The hospital will address the totality of its Theatre Instrument decontamination issues through the outsourcing of OT decontamination processes and the development of a three phase plan to upgrade and/or reprovide its theatre complex.	DCEO/EMB	(2.1.1.1) 95% RIMD outsourced. Remaining dependant on instrument purchasing reviews. Remaining 5% carried out in one location only. Plan to decommission second autoclave by end September 2018.		31/07/2017
				(2.1.1.2) Phase 1 Programme finalised for implementation in Spring 2017		COMPLETED
				(2.1.1.3) Phase 1 Theatre Programme to address theatre layout and provision of compliant scrubs/sluices/clean and dirty areas/effective circulation process		COMPLETED
				(2.1.1.4) Phase 2 Planning process will commence in late 2017		Post 2018 COMPLETED
	(2.2) Decontamination of reusable surgical instruments was performed within the Theatre Department by theatre staff rather than in a separate central sterile supply department.	(2.2.1) See 2.1.1 above		(2.2.1.5) Outsourcing has commenced for completion in July 2017. 95% RIMD now outsourced. Remaining 5% carried out in one location only. Plan to decommission second autoclave by end September 2018.		31/07/2017
	(2.3) There was no decontamination lead within the hospital.	(2.3.1) See 1.5.3 above		(2.3.1.1) See 1.5.3 above		by 31/03/2017
	(2.4) HIQA was informed that the hospital decontamination committee had not met in a number of years.	(2.4.1) Decontamination Committee to hold regular schedulred meetings from now on		(2.4.1.1) Decontamination Committee to hold regular schedulred meetings from now on		
	(2.5) 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 medical devices service within the hospital.	(2.5.1) See 1.5.1, 1.5.2 & 1.5.3 above		(2.5.1.1) See 1.5.1.1, 1.5.2.1, 1.5.3.1 above		

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STANDARD AREA	ITEM	IMPROVEMENT PROCESSES	RESP. FOR COMPLETION	PROGRESS	ProgressRAG	COMPLETION TIMESCALE
2 PATIENT EQUIPMENT CLEANING	(2.6) 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 rooms. The allocated space was inadequate, cramped and dated in design.	(2.6.1) See 2.1.1 above		(2.6.1.1) 95% of RIMDs decontaminated off site now. Remaining 5% carried out in one location only. Plan to decommission second autoclave by end September 2018.		01/09/2018
	(2.7) Dedicated gowning rooms with hand hygiene facilities were not available at the entrance to the clean room, inspection, assembly and packing room.	(2.7.1) See 2.1.1 above		(2.7.1.1) These areas have been closed		2017/18 COMPLETED
	(2.8) 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	(2.8.1) See 2.1.1 above		(2.8.1.1) Access revised on an interim basis pending full capital scheme in 2017/18		COMPLETED
	(2.9) 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.	(2.9.1) This room will be converted to storage and the autoclave will be removed as part of 2.1.1. above	PE/Theatre Manager	(2.9.1.1) Room refurbished. Autoclave decommissioned. For removal in June 2017		COMPLETED
	(2.10) 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-	(2.10.1) The reprocessing of endoscopes will be transferred to the	Theatre Manager	(2.10.1.1) Completed		COMPLETED
				(2.10.1.2) Completed		COMPLETED
	(2.11) 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.	(2.11.1) Cleaning schedules to be reinforced	HM	(2.11.1.1) Completed		COMPLETED
	(2.12) 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.	(2.12.1) More routine mattress inspection system to be instituted	DoN	(2.12.1.1) Completed		COMPLETED
	(3.1) Infection prevention environmental controls in operating theatres 1 and 2 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 enroute to the decontamination facilities during procedures and during the preparation of surgical instruments at the time of the inspection.	(3.1.1) See 2.1.1 above		(3.1.1.1) See 2.1.1.3 above. Two separate scrub areas created and separate route to CSSD.		COMPLETED
	(3.2) 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	(3.2.1) See 2.1.1. above		(3.2.1.1) Scrub issues resolved on an interim basis prior to capital scheme completion.		COMPLETED

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STANDARD AREA	ITEM	IMPROVEMENT PROCESSES	RESP. FOR COMPLETION	PROGRESS	ProgressRAG	COMPLETION TIMESCALE
3 INFRASTRUCTURAL CLEANING	(3.3) 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.	(3.3.1) See 2.1.1. above		(3.3.1.1) Revisions to waste control system undertaken in June 2016. Additional waste collections be included & a bin lift m/c ordered in 2017. Final resolution dependant on capital scheme. There are 5 number collections Monday to Saturday inclusive with 4 carried out on a Sunday by the in-house staff (the last of which is at approx 5pm). Further to this there is an additional collection carried out by Noonan's staff at approximately 6.30pm in the evening daily. Noreen and the theatre staff are happy with this arrangement, given that they can call the helpdesk and request additional collections if need be.		COMPLETED
	(3.4) 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.	(3.4.1) See 2.1.1. above		(3.4.1.1) Temporary solution implemented prior to Phase 2		COMPLETED
	(3.5) The entrance to the Theatre Department was not secure and therefore unauthorized access could not be prevented	(3.5.1) Security arrangements to be applied especially swipe locks	DCEO	(3.5.1.1) Completed		COMPLETED
	(3.6) 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.	(3.6.1) See2.1.1.2 above		(3.6.1.1) Completed		COMPLETED
	(3.7) 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.	(3.7.1) Planned maintenance regieme in place for quarterly cleaning of these grilles.		(3.7.1.1) Completed		COMPLETED
	(3.8) 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	(3.8.1) See2.1.1.2 above		(3.8.1.1)Completed		COMPLETED
	(3.9) 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.	(3.9.1) Monitoring process to be reviewed and reformed	DCEO/CNM3	(3.9.1.1) Completed		COMPLETED
	(3.10) 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.	(3.10.1) The norm is for the Hospital (via Procurement) to engage with its staff as expert end users when procurring equipment	DCEO	(3.10.1.1) Completed		COMPLETED

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4 HYGIENIC DESIGN ISSUES	(4.1) 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.	(4.1.1) See 2.1.1.3 above		(4.1.1.1) Specific room for sterlie RIMDs in place. Kanban rooms introduced to theatre to control stock levels. Daily replenishmet processes for all stock items		COMPLETED
	(4.2) 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.	(4.2.1) Lockable linen press ordered		(4.2.1.1) Complete		COMPLETED
	(4.3) 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.	(4.3.1) When decontam outsourcing is completed, the removal of remaining autoclave will provide space for cleaning stores for OT's 1 and 2. OT's 4 and 5 have their own sluice rooms which can be used to store cleaners equipment (in-line with HTM standards)		(4.3.1.1) dependant on removal of second autoclave		31/07/2017
	(4.4) 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	(4.4.1) See 2.1.1.4 above		(4.4.1.1) Toilets will be addressed in 2.1.1.3 in the capital scheme. No short term option at present.		2017/18
	(4.5) Flooring, ceilings, walls and exposed pipe work were poorly maintained.	(4.5.1) See 2.1.1.3 above		(4.5.1.1) Completed		Completed
	(4.6) 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.	(4.6.1) The hospital will expedite the initial proposal submitted to Hse on 2015	DCEO/Proj Asst	(4.6.1.1) Plans submitted		31/03/2018
	(4.7) 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.	(4.7.1) The hospital will resolve this issue either by outsourcing or reprovision of laundry facilities		(4.7.1.1) A site has been identified at St Mary's site as part of a refurbishment project		31/12/2017
	(5.1) 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.	(5.1.1) See 2.1.1.3 & 2.1.1.4 above		(5.1.1.1) See 2.1.1.3 & 2.1.1.4 above At present there are a total of 4 designated wash hand basins in the theatre department and the recovery area (excluding the scrub troughs located in each of the four theatres). Out of the 4 there are 3 fully compliant sinks. The one exception is a stainless steel wash hand basin beside the washers in the sluiceroom at the back of the theatre department (Th 1 & 2). (4/2018)		2017/18
	(5.2) 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.	(5.2.1) This will be reviewed	COI Dept	(5.2.1.1) Completed		COMPLETED

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5 HAND HYGIENE	(5.3) There was inadequate provision of hand hygiene sinks in the decontamination facilities within the Theatre Department.	(5.3.1) See 2.1.1.3 above		(5.3.1.1) See 2.1.1.3 above		2017/18
	(5.4) 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.	(5.4.1) A new policy to link hand hygiene to clinical access will be considered	EMB	(5.4.1.1) Work in progress. Monitoring to revert back to Infection Control Nurse with effect from February 2018		01/02/2018
	(5.5) 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 hygiene.	(5.5.1) Departmental training and monitoring to be strengthened		(5.5.1.1) Work in progress. Monitoring to revert back to Infection Control Nurse with effect from February 2018		01/02/2018
(6) CLINICAL PRACTICE	(6.1) 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.	(6.1.1) To be reviewed and changes identified and implemented	DoN	(6.1.1.1) Completed		COMPLETED
	(6.2) 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.	(6.2.1) Instructions given for this change in June 2016	DCEO/DoN	(6.2.1.1) Completed		COMPLETED
	(6.3) 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.	(6.3.1) See 1.5.2 above		(6.3.1.1)		by 31/07/2017

Clear processes in place for registering and highlight risks to HSE/ Board.