# MERCY UNIVERSITY HOSPITAL HYGIENE QUALITY IMPROVEMENT PLAN 2020 (DRAFT December 2020)

| Departments | No | ITEM | IMPROVEMENT PROCESSES | PERSON RESPONSIBLE | PROGRESS | COMPLETION TIMESCALE & RAG |
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| **HIQA Visit November 2018**<br><br>**<u>Main Decontamination Areas</u>**<br>**1) Theatre**<br>**2) Endoscopy**<br>**3) Radiology**<br>**4) Cardiology**<br>**5) Clinical Measurement Lab**<br>**6) St John's**<br><br>**(Pain and Physio no longer relevant as moving to disposable)** | **1.00** | Decontamination of critical items and semi-critical items are performed in a designated decontamination area, inline with best practice guidelines. | All satellite decontamination areas require<br>1) review<br>2) risk assessments<br>3) statement of needs<br>4) possibly upgrading in order to comply | ADON / HOD | 1) A review was carried out in October 2018 and October 2020 by an external Authorised Engineer in Decontamination and a statement of "high level of safety" was issued.<br>2) Internal Risk Assessments have been carried out<br>3) Statement of needs have been created<br>**4) Relevant department upgrade works are awaiting actioning** | No 4 - Q1 2021<br>No 1, 2 & 3 Complete |
| | **1.01** | **SOP:**<br>The hospital has up to date policies and procedures for the reprocessing of all reusable invasive medical devices used in and by the facility inline with relevant national guidelines. | SOPs are required for all satellite decontamination areas | ADON / HOD | SOPS are currently being drafted for approval by Policies Approval Committee (PAC)<br>**1) Radiology - to be submitted to PAC**<br>**2) Cardiology - to be submitted to PAC**<br>3) Clinical Measurement Lab (complete)<br>4) St Johns (complete) | No 1 & 2 - Q1 2021<br>No 3 & 4 - complete |
| | **1.02** | **Training:**<br>The hospital has a competency-based training program for reprocessing of critical and semi-critical devices. | Establish training programme and include in all SOPS for all satellite decontamination areas. | ADON / HOD | 1) Education and Training tool created by AED, to be individually adopted by each department<br>2) Departments hold training records<br>3) External AED can provide training<br>4) Inclusion in SOPs In progress by each department, SOP awaiting approval. | No 4 - Q1 2021<br>No 1, 2 & 3 - Complete |
| | **1.03** | **Training:**<br>There is a continuing programme of training and education for personnel involved in device decontamination. | Establish training programme and include in all SOPS for all satellite decontamination areas. | ADON / HOD | *Reference 1.02* ***Training:*** *The hospital has a competency-based training program for reprocessing of critical and semi-critical devices.* | |
| | **1.04** | **Audits:**<br>The hospital regularly audits (monitors and documents) adherence to reprocessing procedures for critical and semi-critical devices. | 1) Establish audit requirements and audit template.<br>2) Include in all SOPS for all satellite decontamination areas. | ADON / HOD | 1) Decontamination Audit schedule now in place<br>2) External AED to sign off on audits throughout the year<br>3) Inclusion in SOPs in progress by each department, SOP awaiting approval. | No 3 - Q1 2021<br>No 1 & 2 - Complete |
| | **1.05** | **Audits:**<br>The hospital provides feedback from audits to relevant personnel and hospital management regarding adherence to reprocessing procedures for critical and semi-critical devices. | Include in all SOPS | ADON / HOD | 1) Outsourcing Zehnacker monthly reports are submitted to Theatre and DCEO<br>2) Audit Schedule issued and results to be given to External AED and Decontamination Committee for sign off<br>3) Inclusion in SOPs In progress by each department, SOP awaiting approval. | No 3 - Q1 2021<br>No 1 & 2 - Complete |
| | **1.06** | **SOP:**<br>Each step of the decontamination cycle is recorded, including the identity of the person undertaking each step. | Theatre, Endoscopy and St John's comply.<br>All satellite areas are to ensure this process is followed also. | ADON / HOD | 1) Theatre, Endoscopy and St John's comply<br>2) Process expanded to include satellite areas and included in SOPs | No 1 - Complete<br>No 2 - Q1 2021 |
| | **1.07** | **SOP:**<br>All reusable invasive medical device sets (e.g. surgical instrument sets) and endoscopes can be traced through the decontamination process to the patient. | Endoscopy and Theatre comply.<br>All satellite areas are to ensure this process is followed also. | Decontamination Committee | 1) Endoscopy and Theatre comply manually.<br>2) Process expand to include satellite areas<br>3) To be included in SOPs | No 1 & 2 - Complete<br>No 3 - Q1 2021 |

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| | **1.08** | The hospital has a named decontamination co-ordinator with responsibility for reusable invasive medical device reprocessing. | A Decontamination lead was also raised at the Theatre Visit | DON | A business case for the Decontamination Lead was resubmitted to SSWHG and has been approved. MUH to advertise post | Q1 2021 |
| **HAND HYGIENE (HIQA visit 2016)** | **2.00** | **THEATRE:**<br>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. | 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 sluice room at the back of the theatre department (Th 1 & 2). (4/2018) | TSD Project Team | The stainless sink is not replaced and is part of the refurbishment plan. | 2021/2022 |
| | **2.01** | **Hand hygiene:**<br>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. | Infection Control | As of 09/12/20 Consultants were at 64% and NCHDs at 99%.<br>Work in progress, Clinical Director is continuing to follow up with consultants.<br>A new policy is being drafted and will include CJD reference | Q1 2021 |
| **GENERAL MONITORNG SYSTEM (HIQA visit 2016)** | **3.00** | 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 | DON | Expansion of clinical audit mechanisms has not taken place. Need a dedicated nurse resource to do this. | 2020 |
| | **3.01** | **Clinical governance structures:**<br>There is significant scope for improvement in clinical governance structures and effective assurance mechanisms relating to decontamination processes. | | DON | 1) The Decontamination Committee has been reformed.<br>2) A surgical site surveillance programme requires action at SSWHG Group level.<br>3) A business case for the Decontamination Lead was resubmitted to SSWHG and has been approved. It is currently with HR for the advertising of the post.<br>4) 95% of MUH decontamination activity is outsourced to Zehnacker.<br>5) Currently leading by committee with the assistance of an external Authorised Engineer Decontamination. | No 2 - 2020<br>No 3 - Q1 2021 |
| | **3.02** | **Track and Trace:**<br>The development of a Theatre track and trace auditing structure was in progress at the time of the re-inspection, a timeframe was not clearly defined. | The Theatre track and trace system is to be incorporated in the outsourcing project | DON | Manual tracking within Theatre is in place. However this should move to electronic Fingerprint tracking awaiting HSE project development.<br><br>Electronic tracking between MUH and Zehnacker is in place. | 2020/2021 |
| **PATIENT EQUIPMENT CLEANING (HIQA visit 2016)** | **4.00** | **Decontamination:**<br>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. | | DON | 1) The Decontamination Committee has been reformed.<br>2) A surgical site surveillance programme requires action at SSWHG Group level.<br>3) A business case for the Decontamination Lead was resubmitted to SSWHG and has been approved. It is currently with HR for the advertising of the post.<br>4) 95% of MUH decontamination activity is outsourced to Zehnacker.<br>5) Currently leading by committee with the assistance of an external Authorised Engineer Decontamination. | No 2 - 2020<br>No 3 - Q1 2021 |

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| **HYGIENIC DESIGN ISSUES (HIQA visit 2016)** | **5.00** | **THEATRE:** 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. | When decontamination 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) | DON | The removal of second autoclave is currently being costed for.<br>If this is not successful, a location is to be sourced post Theatre upgrade. | 2020 |
| | **5.01** | **THEATRE:** 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.<br>1) There was only one designated patient toilet within the Theatre Department which was located in the patient reception.<br>2) 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.<br>3) There was no segregated area for children within the recovery room. | To be addressed in the Theatre Project, no short term option at present. | DON | There is no space currently available under current infrastructure, however a potential WC has been identified in future Theatre fit outs. | 2021/2022 |
| | **5.02** | **ICU:** 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.<br><br>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 | DON | Plans submitted and scope of works complete. To be submitted to HSE Q1 2021. | Q1 2021 |
| | **5.03** | **Laundry facility in the backyard** The facilities for the processing of clean and dirty cleaning textiles remained unchanged. Inspectors were informed that alternatives are being explored to address this issue. | The hospital will resolve this issue either by outsourcing or provision of laundry facilities | DON | This is to be outsourced to Noonan's and will be completed by the end of February 2021. | 28/02/2021 |
| **CLINICAL PRACTICE (HIQA visit 2016)** | **6.00** | **Surgical site surveillance:**<br>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. | On-going monitoring of care bundles. | DON | A surgical site surveillance programme requires action at SSWHG Group level. Seeking funding since 2017. | 2017 |

# MERCY UNIVERSITY HOSPITAL HYGIENE QUALITY IMPROVEMENT PLAN DECEMBER 2020
# OUTSTANDING ITEMS

| Departments | No | ITEM | IMPROVEMENT PROCESSES | PERSON RESPONSBILE | PROGRESS | COMPLETION TIMESCALE & RAG |
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| **HIQA Visit November 2018**<br><br>**Main Decontamination Areas**<br>**1) Theatre**<br>**2) Endoscopy**<br>**3) Radiology**<br>**4) Cardiology**<br>**5) Clinical Measurement Lab**<br>**6) St John's**<br><br>**(Pain and Physio no longer relevant as moving to** | **1.00** | The hospital has an inventory of all critical and semi-critical devices used in the facility that identifies areas in the hospital and services provided by the hospital where such devices are used. | An inventory was available but not aged. | Procurement | List issued to Procurement for aging. Now complete and merged with RiMD inventory | COMPLETE |
| | **1.01** | Decontamination Committee Terms of Reference | TOR's of Decontamination Committee to be reviewed to include monthly review of performance of 3rd party provider | Decontamination Committee | Complete | COMPLETE |
| | **1.02** | The hospital has up to date policies and procedures to minimise the exposure of patients and employees to transmissible spongiform encephalopathies. | MUH policy to be drafted | Infection Control | SOP been approved by Policies Approval Committee (PAC) | COMPLETE |
| | **1.03** | The hospital has a standard operating procedure in place based on national guidelines if devices are loaned, borrowed or trialled to minimise the risk of infection to patients, personnel and others. | Theatre, Endoscopy and St John's comply.<br>All satellite areas are to be included | ADON / HOD | Theatre and Endoscopy SOPs are complete.<br>Satellite areas do not loan instruments | COMPLETE |
| **HAND HYGIENE (HIQA visit 2016)** | **2.00** | ST THERESES: 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 | Complete | COMPLETE |
| | **2.01** | 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. | Departmental training and monitoring to be strengthened | Infection Control | Period 17 National hand hygiene audit June 2019 results achieved an overall result of 92.4%. Hand Hygiene Figures at August 2019 were 90% | COMPLETE |
| | **2.02** | There was inadequate provision of hand hygiene sinks in the decontamination facilities within the Theatre Department. | Will be addressed in the capital scheme. No short term option at present. | DCEO/ Project Team | As part of the Theatre Upgrade Project, the decontamination processes will be relocated to a purpose-built facility. This is no longer required due to the outsourcing of decontamination | COMPLETE |
| **GENERAL MONITORNG SYSTEM (HIQA visit 2016)** | **3.00** | 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. | ADON / Theatre | No requirement in Theatre post outsourcing. Improvement process to be that theatre staff perform HSE on-line training on Decontamination. All Theatre staff completed the HSELand training. Key staff members are booked to attend decontamination course in Dublin 2019. | COMPLETE |
| | **3.01** | 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. | Clear processes in place for registering and highlight risks to HSE/ Board. | QRMD | Ongoing submissions to HSE to address high risk items | COMPLETE |
| | **4.00** | 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 | The hospital will address Theatre Instrument decontamination issues through the outsourcing of | DCEO/EMB | 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. Use of autoclaves has ceased and 100% of Theatre instruments are now outsourced for decontamination. | COMPLETE |
| | **4.01** | | | DCEO/EMB | Phase 1 Programme finalised for implementation in Spring 2017 | COMPLETE |

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| | **4.02** | for Decontamination of Reusable Invasive Medical Devices7, and were not in compliance with the National Standards for the Prevention and Control of Healthcare Associated Infection} | decontamination and the development of a three phase plan to upgrade and/or reprovide its theatre complex. | DCEO/EMB | Phase 1 Theatre Programme to address theatre layout and provision of compliant scrubs/sluices/clean and dirty areas/effective circulation process | COMPLETE |
| | **4.03** | | | DCEO/EMB | The removal of second autoclave is currently being costed for. If this is not successful a site will be identified as part of the refurbishment project. No longer relevant due to the outsourcing of Decontamination for Theatre. | COMPLETE |
| | **4.04** | Decontamination of reusable surgical instruments was performed within the Theatre Department by theatre staff rather than in a separate central sterile supply department. | | DCEO | Outsourcing has commenced for completion in July 2017. Of off Q2 all Theatre Instruments are now outsourced for decontamination. 100% of Theatre instruments are now outsourced for decontamination. | COMPLETE |
| | **4.05** | HIQA was informed that the hospital decontamination committee had not met in a number of years. | Decontamination Committee to hold regular scheduled meetings from now on | DCEO | Decontamination Committee to hold regular scheduled meetings from now on | COMPLETE |
| | **4.06** | 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. | 99% of RIMDs decontaminated off site now. Remaining 1% carried out in one location only. Plan to decommission second autoclave by end March 2019. | DCEO | 100% of Theatre instruments are now outsourced for decontamination. | COMPLETE |
| | **4.07** | Dedicated gowning rooms with hand hygiene facilities were not available at the entrance to the clean room, inspection, assembly and packing room. | These areas have been closed | DCEO/EMB | These areas have been closed | COMPLETE |
| **PATIENT EQUIPMENT CLEANING (HIQA visit 2016)** | **4.08** | 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. | Access revised on an interim basis pending full capital scheme in 2017/18 | DCEO/EMB | Access revised on an interim basis pending full capital scheme in 2017/18 | COMPLETE |
| | **4.09** | 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. | Theatre Manager/TSD | Room refurbished. Autoclave decommissioned. For removal in June 2017 | COMPLETE |

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| | **4.10** | 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. | The reprocessing of endoscopes will be transferred to the Endoscopy Decontamination department and/or the outsourced contractor | Theatre Manager | Complete | COMPLETE |
| | **4.11** | 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. | Cleaning schedules to be reinforced | CNM | Complete | COMPLETE |
| | **4.12** | 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. | More routine mattress inspection system to be instituted | DON | Complete | COMPLETE |
| | **5.00** | 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. | | | Two separate scrub areas created and separate route to CSSD. | COMPLETE |
| | **5.01** | 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. | Scrub issues resolved on an interim basis prior to capital scheme completion. | | Complete | COMPLETE |

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| **INFRASTRUCTURAL CLEANING (HIQA visit 2016)** | **5.02** | 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. | 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. | | Complete | COMPLETE |
| | **5.03** | 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. | Temporary solution implemented prior to Phase 2 | | Temporary solution implemented prior to Phase 2 | COMPLETE |
| | **5.04** | 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 | Complete | COMPLETE |
| | **5.05** | 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. | | | Complete | COMPLETE |
| | **5.06** | 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 dust levels seen. | Planned maintenance regime in place for quarterly cleaning of these grilles. | | Complete | COMPLETE |
| | **5.07** | 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 | | | Complete | COMPLETE |
| | **5.08** | (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. | Monitoring process to be reviewed and reformed | DCEO/CNM3 | Complete | COMPLETE |

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| | **5.09** | 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. | The norm is for the Hospital (via Procurement) to engage with its staff as expert end users when procuring equipment | DCEO | Complete | COMPLETE |
| **HYGIENIC DESIGN ISSUES (HIQA visit 2016)** | **6.00** | THEATRE: 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. | Specific room for sterile RIMDs in place. Kanban rooms introduced to theatre to control stock levels. Daily replenishment processes for all stock items | | Complete | COMPLETE |
| | **6.01** | 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. | Lockable linen press ordered | | Complete | COMPLETE |
| | **6.02** | Flooring, ceilings, walls and exposed pipe work were poorly maintained. | | | Complete | COMPLETE |
| **CLINICAL PRACTICE (HIQA visit 2016)** | **7.00** | 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 | Complete | COMPLETE |
| | **7.01** | Open multiple dose vials of insulin and other medicine which was not designated to single patient use in line with best practice guidelines were observed in the medicine fridge located in the anaesthesia room. Inappropriate use of multi—dose vials has been linked to outbreaks of infection. It is recommended that multi—dose vials are designated single patient use where possible. Such vials should be labelled with the date of opening and discarded within the recommended timeframe specified by the manufacturer. Both the Theatre Manager and Senior Management were informed of these findings at the time of the inspection for immediate mitigation. | Instructions given for this change in June 2016 | DON | Complete | COMPLETE |