South Infirmary –Victoria University Hospital

PCHAI Inspection

Quality Improvement Plan

2016

Introduction

On the 6th April 2016 the South Infirmary Victoria University Hospital (SIVUH), was inspected by the Health Information Quality Authority (HIQA).against the National Standards for the Prevention and Control of Healthcare Associated Infections (PCHAI)

Two new areas were inspected Surgical Day Care Unit (SDCU) and Ground Floor South 1 (GFS1)

The areas which were audited in 2015 were also revisited these included Ground floor Victoria (GFV), the General Theatre and the Oncology Day Unit.

The SIVUH aims to provide a safe and positive experience to all our patients and using the inspection report we have developed the following quality improvement plan (QIP), in order to ensure that we achieve this.

Issue- Environment/infrastructure	Action Required	Responsible Person	Due Date	QIP status
Area: General Theatre				
The design and structure of four of the seven theatres located in the General theatre department are below standards and risks identified in 2015 remain.	Risks identified and are on the risk register and escalated to hospital group. Capital funding sought from HSE estates via hospital group	CEO		Feasibility study has been conducted by the hospital and reported to the SSWHG.
Area: Ground Floor South 1				
The design and infrastructure of GFS1 which is a multi occupancy nightingale style ward, does not comply with National Standards and hospital building guidelines	Feasibility study to be carried out on the nightingale wards and a refurbishment plan put in place	CEO Maintenance Manager CNM3 IPC CNM2 GFS2	November 2016	Conduction of the feasibility study is subject to funding. Request for funding for same has been submitted to the SSHWG
Patient's belongings were stored on floor which impeding cleaning.	All patients to be advised of the importance of keeping all surface clutter free to aid cleaning of the environment.	CNM2 GFS1 CNM3 IPC	Sept 2016	
Space in the clean utility room was limited and did not facilitate infection prevention and control measures.	Area to be reviewed and refurbishment plan put in place.	CNM2 GFS1 Maintenance manager CNM3 IPC	Jan 2017	
Space in the dirty utility, was cluttered and consumables are stored incorrectly.	Storage of consumables to be reviewed in line with best practice for the prevention and control of HAI.	CNM2 GFS1 Maintenance manager	August 2016	
Inappropriate storage of staff personal items in utility rooms.	No staff items are to be stored in a clean or dirty utility room.	CNM2 GFS1 Hygiene Co-ordinator CNM3 IPC	April 2016	Completed
Area: Surgical Day Care Unit				
There is limited Spatial separation between trolleys which does not allow for ease of movement of staff or mobilization of patients.	Control measures in regards to Patient placement must be carefully considered. SSI Surveillance required.	CNM2 SDCU CNM3 IPC		Business case submitted to SSWHG for resources for SSI surveillance.

Wood fishes on the doors to the theatres were damaged	All wooded doors to be repaired and reinforced to protect form further damage	Maintenance manager	August 2016	
There is open shelving in the dirty utility room which was of concern.	All consumables should be in stored in enclosed units.	CNM2 SDCU Maintenance manager	August 2016	
Patient Equipment	**Action Required**	**Responsible Person**	**Due Date**	**QIP status**
Area Surgical Day Care Unit				
Three patient chairs were torn.	All torn chairs to be re-upholstered or replaced.	CNM2 SDCU	August 2016	
Area Ground floor South 1				
Frequently used equipment was unclean.	All equipment to be on a schedule and audit of same to be carried out on a monthly basis.	CNM2 GFS1	April 2016	
The internal fabric cover of mattresses were stained	Mattress to be removed and replaced. Audit of same to carried out annually as per SOP.	CNM2 GFS1 Hygiene Co-ordinator	April 2016	Removed and replaced.SOP signed off at clinical governance in May 2016
Organic matter on chairs	All equipment to be cleaned daily and schedule of same to be kept on ward area to be audited to ensure compliance.	CNM2	April 2016	
Reprocessing of cleaning equipment	**Action Required**	**Responsible Person**	**Due Date**	**QIP status**
The laundering area for reusable cleaning textiles such as mop heads and cloths was located in multi-functional room and was inappropriate.	Laundering of the mop heads should be managed in line with best practice guidelines in infection prevention and control. Separate clean and dirty areas should be maintained.	Hygiene Co-ordinator CNM3 IPC	Nov 2016	
Legionella Control	**Action Required**	**Responsible Person**	**Due Date**	**QIP status**
A risk assessment review was not carried out annually as per National Recommendations	Legionella risk assessment review to be carried out annually, and risk assessment completed by an independent body every two years.	Maintenance manager IPC CNM3 DON	Nov2016	

Issue- Hand Hygiene	Action Required	Responsible Person	Due Date	QIP status
The design of the clinical hand wash sinks on Surgical Day ward did not conform to HBN 00-10 Sanitary assemblies.	All sinks are to be changed over to conform to HBN 00-10 these are to be identified and reported to maintenance	CEO Maintenance manager. IPCNM3		In progress. Waiting funding from SSWHG to continue with planned works.
Access to sinks in GFS1 was restricted due to, curtain placement, the storage of equipment and space limitations in GFS1	All sinks should be easily accessible areas around sinks top be reviewed and storage facilities to be reviewed.	CNM 2 CNM3 IPC Maintenance manager	Nov 2017	
Non clinical risks bins were not stored by all sinks	All sinks to have a non clinical waste bin next to it.	CNM 2	April 2016	Completed
Percentage of Medical staff who have attended hand hygiene training is poor.	Hand hygiene sessions to be carried out until medical staff have reached 90% UCC representative to be contacted in regards to Interns attendance there.	IPCNM3 Medical Manpower. Human Resources Manager.	August 2017	
Hand hygiene posters were not consistently displayed throughout the department.	Hand hygiene posters to be developed and ordered.	IPC CNM3.	August 2016	
Inappropriate use of gloves by healthcare workers.	All staff to be advised of the appropriate use of PPE.	Health and Safety Officer	August 2016	SOP updated awaiting sign off at clinical governance.
Hand hygiene posters in SDCU were observed at hand hygiene sinks but not at alcohol gel dispensers.	Hand hygiene technique signs, to be put on the alcohol gel units.	CNM3 IPC CNM2 SDCU/GFS1	July 2016	

Standard [illegible]

Medication Management	**Action Required**	**Responsible Person**	**Due Date**	**QIP status**
The process for safe medication practices have improved but more progress is needed in regards to labeling of IV medications.	Medication management in Theatres to be monitored and policy adhered to.	CNM3 theatres	August 2016	
Safe Injection Practices	**Action Required**	**Responsible Person**	**Due Date**	**QIP status**
An open multi vial of insulin was observed in Ground Floor South 1 The date on the vial indicated that it had been opened on 1st March and not discarded within 28 days of opening.	All vials should be dated at time of opening, and the use of multi dose vials should be dedicated as single patient use, and discarded within recommended time frame	CNM2 GFS1	April 2016	
Inspectors observed a staff member carrying a used sharp to the clean utility to dispose of the sharp.	All staff to be reminded of the Sharps policy and the safe disposal of sharps at the point of care	CNM2 GFS1	July 2016	
Blood glucose monitors were brought in their holders to the patients bedside in both wards	All staff to be reminded of the SOP on blood glucose, and the importance of decanting the machine and items to a sharps tray and disposal of all at the patients bedside and the importance of cleaning all equipment after each use.	CNM2 GFS1 CNM2 SDCU CNM3 IPC	July 2016	
Needles with safety devices are not currently in use within sivuh	The SIVUH complies with the EN regulations 2014 in relation to needles and their safety devices.	Sharps committee	July 2016	
Legionella Control	**Action Required**	**Responsible Person**	**Due Date**	**QIP status**
Risk assessment review was not carried out annually as per National Recommendations	Legionella risk assessment review to be carried out annually, and risk assessment review by an independent body every two years.	Maintenance manager IPC CNM3 DON	Nov2016	

Care bundles	Action Required	Responsible Person	Due Date	QIP status
Auditing compliance with care bundles is required	Quarterly audits to be submitted and results fed back to IPCC	ADON Practice development. CNM3 IPC	Nov 2016	
Patient education leaflets is required on all invasive devices	Leaflets to be devised on PIVC and distributed to the patients as required.	CNM3 IPC	Nov 2016	

Written by:

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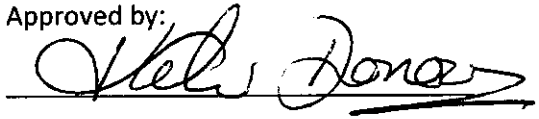

Helen Donovan Interim CEO

On behalf of the Infection Prevention and Control Committee