Wexford General Hospital – Quality Improvement Plan for the Prevention & Control of Infection, November 2016

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Wexford General Hospital QIP – relating to recommendations within HIQA Report of unannounced inspection at WGH (July 6th 2016) and National Standards PCHCAI

TODAY'S DATE: November 21st 2016

QIPs STATUS
Completed
Not yet due
Late

Note: Please ensure you enter the 'Entry Date' (i.e. date that QIP is entered into the log), 'Due Date' (i.e. date that the QIP is due for completion), and, when appropriate, the 'Completed Date' (i.e. date that QIP has been fully implemented).

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No.	Entry Date	Standard / Theme	HIQA Recommendations	Description of Quality Improvement Plan (QIP)	Responsible Group	Due Date	Completed Date	QIP Status	Comments
1		**Standard 1 Governance and Management** **Standard 2 Structures, Systems and Processes;** **Standard 6 Hand Hygiene Practices;** **Standard 11 Monitoring and Audit.**	**The Authority recommends -** **The hospital needs to continue to improve hand hygiene compliance in order to achieve the Health Service Executive target of 90% (P 11).**	A robust improvement strategy is being implemented in recent years at WGH with regard to Hand Hygiene (HH) practices and Hand Hygiene Training. See elements below: <u>Hand Hygiene Training:</u> 91% of staff members are currently in date with mandatory HH training (the HSE Key performance indicator is that all staff attend every two years). This is monitored carefully and reported at Hygiene and IPCC committee meetings. <u>Local HH Audit:</u> Monthly local compliance audits on HH practice (five moments of HH) are required to be carried out by Hand Hygiene Leaders in all ward areas. <u>National HH Audits</u> (Nov 2016) are currently underway at WGH – so far findings are good and indications are that the 90% target will be reached.	IPCC; Hospital Management				Await publication of national audit results.
			Hand Hygiene compliance had not been audited in the Oncology Day Ward in 2016. (p10)	**<u>Improvement:</u> a Hand Hygiene Leader has been identified for the Oncology Day Ward – training will be provided by the IPC CNSs. The HH leader will carry out monthly compliance audits.**	IPC CNSs / Oncology CNM	Jan 31st 2017		Not yet due	

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2		Standard 2 Structures, Systems and Processes; Standard 6 Hand Hygiene Practices; Standard 11 Monitoring and Audit.	**The Authority Recommendations in respect of Oncology Day Ward:** **Toilets to be cleaned and checked more frequently than once daily.**	A system has been put in place whereby toilets are now cleaned and checked on a twice daily basis AND as needed throughout the hospital.	Housekeeping	31st July 2016	31st July 2016	completed	
			Establish a 'defined clean work space in the clean utility room for preparing intravenous medications and infusions'. (P 5)	This is being progressed – in association with the implementation of the Aseptic Non-Touch Technique (ANTT) Policy, the IPC Nurses overseeing the introduction of designated clean work space areas for the preparation of Intravenous Medications in all clinical areas.	IPCNs; Clinical Ward Management	28th February 2017		Not yet due	
			Sterile supplies are to be stored in fully enclosed drawers or cupboards (P 5)	There is a service level agreement in place between Surgical Stores and all Clinical ward managers with regard to stock management. Top ups are carried out twice weekly. **Improvement: a system has been put in place to ensure all sterile supplies are stored appropriately or sent back to Stores.**	Oncology CNM	31st August 2016	31st August 2016	completed	

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3.		Standard 1 Governance & Management Standard 9 Microbiological Services	**The Authority (previous Report):** **1.0 WTE Consultant Microbiologist sought in 2014, not yet in place.**	Current provision of this post is 0.1 WTE (Whole Time Equivalent) which is insufficient – this is reflected on the WGH Risk Register A Business case for 1.0 WTE was submitted on 31.07.2014. This Post was not approved in the HSE Service Plan, 2015. **Update November 2016:** The General Manager and Board of Management (BOM) is continuing to pursue this.	General Manager / BOM	31.12.2014		**late**	Microbiology Resource continues to be provided as heretofore from University Hospital Waterford.
4.		Standard 2 Structures, Systems and Processes;	**The Authority Recommendations in respect of Waste Management (P4)** The Waste Management Policy requires updating.	WGH Waste Management Policy is currently being revised and Waste training is being organised.	Hygiene Committee	31st January 2017		Not yet due	

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5.		Standard 3 Physical Environment	**The Authority Recommendations / findings in respect of Day Care Unit (DCU)** **(P 11) Opportunities for improvement were identified in relation to environmental hygiene in the Day Care Unit. The infrastructure of accommodation for surgical day patients was not in line with desirable modern standards for such facilities and this requires improvement.**	WGH acknowledges that part of the DCU has an 'older' infrastructure of accommodation which is not in line with modern standards. Following HIQA inspection on July 6th 2016, a deep clean of the Day Care Unit was carried out by the Housekeeping Department – this included removing all sticky residue from surfaces. Ceiling tiles were replaced. Housekeeping Supervisor communicated with all relevant staff re cleaning processes post HIQA visit. **Improvement: the 'older' part of DCU is given a scheduled Deep Clean on a bimonthly basis.**	House-keeping Dept.	31st July 2016 31st January 2017	31st July 2016	Completed Not yet due	Deep Cleans occurring on a bimonthly basis of 'older' DCU.
			Rusted Oxygen Cylinders were noted on the bottom of some DCU trolleys.	Rust: A solution is being sought currently - Hygiene Committee are contacting the company that supplies the cylinders.	Hygiene Committee	31st July 2016	31st July 2016	Completed	
			Environmental hygiene audit processes should be reviewed and training provided for staff as necessary – there should be	Assistant Director of Nursing provided educational input on carrying out the Environmental Hygiene Audit Process with nurse management of DCU; and	ADON; CNMs, DCU; Hygiene Committee.	31st July 2016	31st July 2016	Completed	

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			sufficient resources in place to facilitate effective cleaning and supervision of cleaning (P 6) **Storage of Sterile supplies - inappropriately stored – (P 7)**	this was also flagged up at Hygiene and CNM meetings. There is a service level agreement in place between Surgical Stores and all Clinical ward managers with regard to stock management. Top ups are carried out twice weekly. **Improvement: a system has been put in place to ensure all sterile supplies are stored appropriately or sent back to Stores.**	CNM, DCU Surgical Stores	August 31st 2016	August 31st 2016	Completed	

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6.		Standard 1 Governance and Management	**Surgical Site Infection Surveillance Programme (P 7 & P 8) It is recommended that SSIS resource requirements are reviewed.**	This programme is paused at the moment at WGH due to lack of staff resources. The SSIS Resource Requirements will be reviewed in January 2017.	Board Of Management	31st January 2017		Not yet due.	

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7.		Standard 2 - Structures, Systems and Processes.	**The Authority recommends in respect of Care Bundles: Wexford General Hospital needs to continue to build on the progress to date to fully implement and audit peripheral vascular care bundles and urinary catheter infection prevention care bundles.**	The elements of both the peripheral vascular care (pvc) bundle and the urinary catheter infection prevention care (UCIPC) bundle already form part of WGH clinical documentation. **Improvement:** In respect of the audit component, a baseline audit has been carried out on compliance with the pvc elements; and it is now planned that the CNMs will carry out monthly audits of the pvc elements. Once the pvc bundle is fully embedded, the focus will turn to the UCIPC Bundle.	CNMs; Nursing Management IPCNs	31st March 2017 31st Dec 2017		Not yet due Not yet due	

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8.		Standard 1 Governance and Management Standard 3 Physical Environment Standard 11 Monitoring, Audit	**The Authority recommends to continue Hygiene Spot Checks of patient areas and to ensure robust governance for same.**	This system is already well established – a schedule of Hygiene Spot Checks is developed each year; the aim is to carry out 2 Spot Checks each month – all unannounced. Spot Check Team are known as the Hygiene Operational Team (HOT) and meetings occur every two months, with the Hygiene Meeting occurring every other month. Reminders in relation to carrying out spot checks are sent by Quality and Safety Manager, who chairs Hygiene Committee. Copies of Completed Spot Checks are sent to head of department, General Manager and Q&S Dept.	Spot Check Team; Chair of Hygiene Committee.				This is already established and is ongoing.

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9.		Standard 2 - Structures, Systems and Processes. Standard 11 Monitoring, Audit	**HIQA finding: Reprocessing of reusable vaginal ultrasound transducer probes was not in line with best practice guidelines and requires review and improvement (P 11) .**	Process was revised and put in place by July 7th (the day after HIQA inspection). Training has been provided for all relevant staff in relation to the revised process; A Decontamination Record is in place – each validation is being recorded and signed off. Audit process is being put in place. **Improvement:** WGH are looking at the viability of new automated technologies for reprocessing / decontamination of Reusable medical devices/probes outside of designated decontamination units.	IPCNs; EPAU staff; Nurse / Midwifery Management; IPCNs; Nurse / Midwifery Management; Hospital Management	31st July 2016 31st January 2017 31st Dec 2017	7th July 2016	completed Not yet due not yet due	

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No.	Entry Date	Theme	HIQA Recommendations	Description of Quality Improvement Plan (QIP)	Responsible Group	Due Date	Completed Date	QIP Status	Comments
10.		Standard 1 Governance and Management	**The Authority recommend…** The hospital needs to perform a Legionella site risk assessment and to manage legionella control measures in line with current national guidelines **(P 11)**.	**Improvement:** A contractor has been selected to carry out the risk assessment - Purchase order has been requested and then work may be scheduled.	Hospital Management	31st January 2017		Not yet due	