Portiuncula Hospital Quality Improvement Plan 8th September 2015 in respect of National Standards for the Prevention and Control of Healthcare Associated Infections

Std. 3.	**Environment and facilities Management: CLEANLINESS OF PATIENT ENVIRONMENT** **The physical environment, facilities and resources are developed and managed to minimise the risk of service users, staff, and visitors acquiring a Healthcare associated infection.**				
REF.	**IDENTIFIED IMPROVEMENT REQUIRED**	**QUALITY IMPROVEMENT ACTIONS REQUIRED**	**RESPONSIBLE PERSON(S)**	**TARGET TIME FRAME**	**STATUS**
3.6	Increase awareness and embed a culture of ownership and accountability for Hygiene services across all services and Departments.	Develop and implement Portiuncula Hygiene Services Monitoring and Management guideline and provide appropriate education and training.	*Chairperson Hygiene Services*	September 2015	
		Amended cleaning schedules to be implemented in all departments in PHB.	*Hygiene Services Co-ordinator/ Household Services Manager/ Contract Cleaning Manager*	October 2015	
3.8	Monitor and evaluate the standard and quality of services delivered.	Devise audit schedule to include Dept. Managers in respect of monthly Department Hygiene Audits. Develop and action department QIP's based on audit findings	*Chair of IPC Hygiene Services group Divisional/Department Managers*	October 2015	

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Std. 3.	**Environment and facilities Management: CLEANLINESS AND MAINTENANCE OF PATIENT EQUIPMENT** **The physical environment, facilities and resources are developed and managed to minimise the risk of service users, staff, and visitors acquiring a Healthcare associated infection.**				
REF.	**IDENTIFIED IMPROVEMENT REQUIRED**	**QUALITY IMPROVEMENT ACTIONS REQUIRED**	**RESPONSIBLE PERSON(S)**	**TARGET TIME FRAME**	**STATUS**
3.6	Improve and maintain Patient equipment cleaning procedures and processes to required standards.	Implement a validation system that patient equipment is cleaned to standards.	*Hygiene Services Co-ordinator*	October 2015	
	Ensure accountability and responsibility for cleaning of patient equipment is embedded at department level and across all services.	Implementation of agreed schedules and checklists	Nursing Directorate Department Managers	October 2015	
		Schedule of training and competency assessment to be developed and implemented.	*Chair of IPC/ HSSG group* *Hygiene Services Co-ordinator*	November 2015	
3.8	Monitor and evaluate the quality of services delivered.	Devise audit schedule with and agree tool of patient equipment to ensure compliance with cleaning standards.	*Hygiene Services Co-ordinator* Department Managers	November 2015	

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Std. 3.	Environment and facilities Management: CLEANLINESS AND MAINTENANCE OF PATIENT EQUIPMENT The physical environment, facilities and resources are developed and managed to minimise the risk of service users, staff, and visitors acquiring a Healthcare associated infection.				
REF.	**IDENTIFIED IMPROVEMENT REQUIRED**	**QUALITY IMPROVEMENT ACTIONS REQUIRED**	**RESPONSIBLE PERSON(S)**	**TARGET TIME FRAME**	**STATUS**
3.6	Refurbish ,repair and replace patient furniture and equipment where surfaces are not intact thereby hindering effective cleaning	Identified equipment requiring refurbishment/ replacement risk assessed and prioritised accordingly depending on funding availability. Business case submitted to Saolta for equipment replacement. Programme of bed table replacement in place.	Department Managers. Hygiene Services Co-ordinator Management team	Q1 2016	
		Damaged furniture/patient equipment requiring repair that may pose a health and safety risk to service users, staff, visitor identified for repair or removal by each department manager.	Department Managers Maintenance.	August 2015 Immediate implementation	
3.6	Ensure patient mattresses are intact and fit for purpose	Implement foam mattress management guideline	*Ward Managers*	September 2015	

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Std. 3.	Environment and facilities Management: USE, MANAGEMENT AND STORAGE OF HOUSEHOLD EQUIPMENT The physical environment, facilities and resources are developed and managed to minimise the risk of service users, staff, and visitors acquiring a Healthcare associated infection				
3.6	**IDENTIFIED IMPROVEMENT REQUIRED**	**QUALITY IMPROVEMENT ACTIONS REQUIRED**	**RESPONSIBLE PERSON(S)**	**TARGET TIME FRAME**	**STATUS**
	Correct and improve compliance in the use, management and maintenance of hospital cleaning equipment	Develop and implement guideline on Use, management and maintenance of household service cleaning equipment	*Chair of IPC & HSSG group* *Hygiene Services Co-ordinator*	November 2015	
		Schedule of training and competency assessment to be developed and implemented.	*Hygiene Services Co-ordinator*	Commence November 2015	
		Commence and implement BICCS training for all existing and incoming HSE/contract cleaning staff working in PHB for to both the environment and equipment cleaning	Hygiene Services Co-ordinator Contract and Household services Managers	December 2015 and ongoing	

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Std. 3.	Environment and facilities Management: USE, MANAGEMENT AND STORAGE OF HOUSEHOLD SERVICES CLEANING PRODUCTS The physical environment, facilities and resources are developed and managed to minimise the risk of service users, staff, and visitors acquiring a Healthcare associated infection.				
Std. 3.	**IDENTIFIED IMPROVEMENT REQUIRED**	**QUALITY IMPROVEMENT ACTIONS REQUIRED**	**RESPONSIBLE PERSON(S)**	**TARGET TIME FRAME**	**STATUS**
	Ensure accountability and responsibility for safe use, management and storage of cleaning products is embedded at department level.	Schedule of training and competency assessment to be developed and implemented	*Hygiene Services Co-ordinator*	Commnence December 2015	
		Develop and implement a guideline reflecting safe and appropriate use and storage of household cleaning products	*Chair of IPC & HSSG group* *Hygiene Services Co-ordinator*	December 2015	
		Introduce a product smart dose system.	Hygiene Services Co-ordinator Contract and Household services Managers	November 2015	

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Std. 3.	**Environment and facilities Management:** CLEANLINESS OF PATIENT ENVIRONMENT- STAFF CLEANING RESOURCE ALLOCATION **The physical environment, facilities and resources are developed and managed to minimise the risk of service users, staff, and visitors acquiring a Healthcare associated infection.**				
REF.	**IDENTIFIED IMPROVEMENT REQUIRED**	**QUALITY IMPROVEMENT ACTIONS REQUIRED**	**RESPONSIBLE PERSON(S)**	**TARGET TIME FRAME**	**STATUS**
	Ensure that staff resources are sufficient to meet cleaning service requirements.	There is a rostered allocation of cleaning staff and HCA's to meet hygiene services needs at each department. The situation reviewed daily in response to activity/unplanned absences to meet demand and ensure standards met. Progress appointment of HSE Household Manager to manage daily allocation of household staff allocation.	*Director of Nursing, Department Managers, Operational Site manager*	On-going	
Std 3.	**Environment and facilities Management:** WASTE MANAGEMENT PRACTICES **The inventory ,handling storage, use and disposal of hazardous material/equipment is in accordance with evidence based codes of best practice and current legislation**				
	Ensure that healthcare staff participate in required training on correct segregation, handling and transport of waste.	Staff training arranged on a bi annual basis.	*Hygiene Services Co-ordinator*	December 2015	
	Monitor and evaluate the quality of services delivered	Schedule audit of waste management practices to ensure compliance to standards	Portering Manager and Hygiene Services Co-ordinator	December 2015	

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Std. 3.	**Environment and facilities Management:** INFRA STRUCURAL DEFICITS IDENTIFIED ON HIQA March /April 2015 Inspection. Insufficient isolation facilities within the current infrastructure of the hospital Lack of isolation facility within Oncology Day Care Unit **The physical environment, facilities and resources are developed and managed to minimise the risk of service users, staff, and visitors acquiring a Healthcare associated infection.**				
REF.	**IDENTIFIED IMPROVEMENT REQUIRED**	**QUALITY IMPROVEMENT ACTIONS REQUIRED**	**RESPONSIBLE PERSON(S)**	**TARGET TIME FRAME**	**STATUS**
3.1	Refurbishment of existing isolation rooms to ensure compliance to required standards	Planned replacement ward block to address infrastructural deficits. Design team appointed to Hospital block development and planning permission phase December 2015	Senior Management Team Maintenance Manager	Q 1 2016	
	Minimise potential risk associated with current available isolation facilities	Ensure that all staff are aware of and follow required interventions and IPC guidelines to mitigate risks of Infection in the hospital environment.	IPC Team	September 2015	
		Ensure staff are aware and familiar with current IPC Isolation and Outbreak management policies procedures and guidelines	IPC Team Department Managers	September 2015	
		Ensure household staff receive training on correct processes and procedures to be followed in cleaning Isolation facilities	Hygiene Services Co-ordinator Contract and Household services Managers	January 2016	

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Std. 3.	Environment and facilities Management: INFRA STRUCURAL DEFICITS IDENTIFIED ON HIQA March /April 2015 Inspection. The physical environment, facilities and resources are developed and managed to minimise the risk of service users, staff, and visitors acquiring a Healthcare associated infection.				
REF.	**IDENTIFIED IMPROVEMENT REQUIRED**	**QUALITY IMPROVEMENT ACTIONS REQUIRED**	**RESPONSIBLE PERSON(S)**	**TARGET TIME FRAME**	**STATUS**
3.1	Prioritised maintenance plan to address infrastructural deficits identified within the report	Develop maintenance plan and submit business case to Saolta and HSE estates for funding and commence prioritised implementation of plan with focus on high risk issues identified.	HSE Estates Saolta Hospital Group Management team Maintenance Manager	**Q1 2016**	

HAND HYGIENE

Standard 6

Hand Hygiene practices that prevent control and reduce the risk of the spread of Healthcare Associated infections are in place

Criterion 6.1.

There are evidence based best practice policies, procedures and systems for hand hygiene practices to reduce the risk of the spread of Healthcare Associated Infections

- The number and location of hand washing sinks
- Hand hygiene frequency and technique
- The use of effective hand products for the level of decontamination needed
- Readily accessible hand washing products in all areas with clear information circulated around the service
- Service users, relatives, carers and visitors are informed of the importance of practicing hand hygiene

Criterion 6. 3

Hand hygiene practices and policies are regularly monitored and audited. The results of any audit are feedback to relevant frontline staff and used to improve the service provided

- Compliance with Hand Hygiene standards remains an agenda item at all departmental and Directorate meetings throughout the hospital.
- Annual attendance at hand-hygiene training is mandatory for all staff with targeted departmental training undertaken throughout the hospital.

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Std. 6.	IDENTIFIED ISSUE: Hand hygiene sinks in areas non-compliant to standard Health building Note 00-10 Part C Sanitary assemblies. Ensure hand hygiene sinks in clinical areas are compliant to standards				
REF.	**IDENTIFIED IMPROVEMENT REQUIRED**	**QUALITY IMPROVEMENT ACTIONS REQUIRED**	**RESPONSIBLE PERSON(S)**	**TARGET TIME FRAME**	**STATUS**
	1. Ensure hand hygiene sinks are compliant to required standard and in place in identified areas. Further funding required.	Submit proposal for funding to Saolta/HSE Estates for funding for prioritised sink replacement programme and implementation based on key areas highlighted in the HIQA report.	Hospital Management, Maintenance manager.	December 2015	
3.3.1 System change: ensuring that the necessary infrastructure is in place to allow healthcare workers to practice hand hygiene. (HIQA report page 13)					
REF.	**IDENTIFIED IMPROVEMENT REQUIRED**	**QUALITY IMPROVEMENT ACTIONS REQUIRED**	**RESPONSIBLE PERSON(S)**	**TARGET TIME FRAME**	**STATUS**
3.3.1.1	Alcohol hand rub dispensers were not available at each point of care in some patient areas on St Therese's Ward/Children's Ward. Hand hygiene toggles were available on the ward but they were not used routinely by staff because they were difficult to access when wearing personal protective equipment.	Pocket sized alcohol hand rub has been made available to staff and re- education on importance of use and 5 moments of hand hygiene and review of dispensers has taken place to ensure available at point of care.	Ward manager.	September 2015	

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REF.	IDENTIFIED IMPROVEMENT REQUIRED	QUALITY IMPROVEMENT ACTIONS REQUIRED	RESPONSIBLE PERSON(S)	TARGET TIME FRAME	STATUS
3.3.1.2	A lack of alcohol hand rub dispensers was also noted on St Clare's Ward in the day care unit.	Review of dispensers to take place and ensure availability at point of care.	Ward manager.	September 2015	

3.3.2 Training/education: providing regular training on the importance of hand hygiene, based on the 'My 5 Moments for Hand Hygiene' approach, and the correct procedures for hand-rubbing and hand-washing, to all healthcare workers.
(HIQA report page 13)

REF.	IDENTIFIED IMPROVEMENT REQUIRED	QUALITY IMPROVEMENT ACTIONS REQUIRED	RESPONSIBLE PERSON(S)	TARGET TIME FRAME	STATUS
3.3.2.1	There were 3 staff out of 26 noted that hand hygiene training was out of date St Terese's. The Authority was informed that the three staff whose training was out-of-date had just returned from long term sick leave.	Training on hand hygiene provided regularly for all staff and these 3 individuals have received training. Hospital monitors compliance with training monthly as a KPI and current rate is 94%	Ward manager	December 2015	

3.3.2.1	The majority of staff on St Josephs ward (90%) were up to date with hand hygiene training	**As per point above and currently this ward has 100% staff trained**	Ward manager	September 2015	

3.3.3 Evaluation and feedback: monitoring hand hygiene practices and infrastructure, along with related perceptions and knowledge among health-care workers, while providing performance and results feedback to staff.

(HIQA report page 13)

REF.	IDENTIFIED IMPROVEMENT REQUIRED	QUALITY IMPROVEMENT ACTIONS REQUIRED	RESPONSIBLE PERSON(S)	TARGET TIME FRAME	STATUS
3.3.3.1	Hospital did not reach the Health Service Executive's (HSE's) national target of 90% for 2014, (compliance with hand hygiene).	The IPC CNSs have increased the frequency of local hand hygiene training and auditing and repeat audits monthly in high risk areas and in other areas that achieve ≤90% hand hygiene compliance the previous month. Initiatives such as hand hygiene week including education from company reps on alcohol hand rub and hand care to continue. Each ward displays monthly compliance rates on public notice boards.	Senior Hospital managers. Clinical area/ward managers. Directorate managers.	Quarter 1 2016	

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Local Audits (HIQA report page 14)					
REF.	**IDENTIFIED IMPROVEMENT REQUIRED**	**QUALITY IMPROVEMENT ACTIONS REQUIRED**	**RESPONSIBLE PERSON(S)**	**TARGET TIME FRAME**	**STATUS**
3.3.3.2	In March 2015, the overall result for five audits completed across different areas of the hospital was 86% and 71% in four audits completed in April 2015. The audits displayed <90% compliance in some wards which requires action.	Hand hygiene audits completed in these areas for April 2015. Areas receiving ≤ 90% hand hygiene compliance to be audited monthly.	IPC CNS's.	April 2015	

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Observation of hand hygiene opportunities. **(HIQA report page 14)**					
REF.	**IDENTIFIED IMPROVEMENT REQUIRED**	**QUALITY IMPROVEMENT ACTIONS REQUIRED**	**RESPONSIBLE PERSON(S)**	**TARGET TIME FRAME**	**STATUS**
	37 hand hygiene opportunities were observed and 11 opportunities were not taken and of the 26 opportunities taken 22 use the correct technique	Hand Hygiene education to continue twice monthly and as requested within clinical areas. This education encompasses the five moments of hand hygiene technique and Results of hand hygiene audits including technique compliance are fed back to clinical areas monthly.	Senior Hospital managers. Clinical area/ward managers. Directorate managers	September 2015	
	Staff on the Oncology Day Ward demonstrated a preference for hand washing over alcohol hand rub at the time of the March inspection which contributed to the non-compliances observed. However, little progress was observed to have been made on this issue during the April re-inspection. The Authority acknowledges that change of practice	Continued education on best practice on which hand hygiene product to use.	Local staff.		

	takes time and can be challenging. Notwithstanding this, the use of alcohol hand rub at the point of care can facilitate greater compliance with hand hygiene best practice and should be a focus for improvement.				
REF.	**IDENTIFIED IMPROVEMENT REQUIRED**	**QUALITY IMPROVEMENT ACTIONS REQUIRED**	**RESPONSIBLE PERSON(S)**	**TARGET TIME FRAME**	**STATUS**
3.3.5	Compliance in local audits (hand hygiene) carried out across all clinical areas between March 2014 and April 2015 indicates that there is significant room for improvement.	Devise monthly audit schedule. The IPC CNSs have increased the frequency of local hand hygiene auditing and repeat audits monthly in high risk areas and in other areas that achieve $\leq$ 90% hand hygiene compliance the previous month.	Senior Hospital managers. Clinical area/ward managers. Directorate managers	December 2015	

Approved by:

Ms. Chris Kane,
General Manager,
Portiuncula Hospital
Saolta University Healthcare Group

Date: 8th September 2015