Portiuncula University Hospital

Quality Improvement Plan September 2016 in respect of HIQA National Standards for the Prevention and Control of HealthCare Associated Infections.

This Quality Improvement Plan (QIP) was developed following the HIQA unannounced monitoring assessment in Portiuncula Hospital Ballinasloe on 24th May 2016.
Implementation and monitoring of the QIP is the responsibility of the Hospital's Infection Prevention and Control and Hygiene Services Sub Committee.

Standard 3 Environment and Facilities Management.
The Physical Environment, facilities and resources are developed and managed to maintain and minimise the risk of service users, staff and visitors acquiring a Healthcare associated Infection.

Standard 6 Hand Hygiene.

Hand Hygiene Practises that prevent, control, and reduce the risk of spread of Health Care Associated Infections are in place.

Standard 8 Invasive Medical Device Related Infections.

Invasive medical device related infections are prevented or reduced

- The HIQA Inspection Report 24th May 2016 and resultant Quality Improvement Plan will be circulated to all Department managers via the designated directorates.
- Focused meetings with Department managers will be facilitated via the designated directorates to clarify responsibility and accountability for Hygiene services within their departments.
- Immediate clean arranged to all environmental areas and sanitary accommodation as per verbal feedback received on day of inspection and following report publication to action cleaning deficits noted.
- Hygiene remains an agenda item at all Departmental, Directorate and hospital management team meetings

Std. 3. 3.1.	**Environment and facilities Management:** ▪ *When a facility does not conform to evidence based practise in the prevention of and control of HCAIS, risk management and other specialised design specifications there should be a refurbishment program to upgrade the facility.*				
REF.	**IDENTIFIED IMPROVEMENT REQUIRED**	**QUALITY IMPROVEMENT ACTIONS REQUIRED**	**RESPONSIBLE PERSON(S)**	**TARGET TIME FRAME**	**STATUS**
2.1	Provision of Patient isolation facilities in Oncology day ward	Planned replacement ward block to address infrastructural deficits. Design team appointed to Hospital block planning permission granted. To progress to tendering stage – procurement - builds. Multidisciplinary local steering group established.	HSE Estates Saolta Hospital Group. Management team. Maintenance Services Manager.	August 2016	
	Provision of identified cleaning equipment storage room for Cleaning equipment –Oncology Day Ward			September 2016	
2.2.	Infrastructural Issues identified in Maternity department including walls, paintwork, wood finishes and flooring do not facilitate effective cleaning.	Senior Management/Maintenance Services group established to review and progress infrastructural deficits identified within the report	Management team. Maintenance Services Manager. *Business Support Manager Hygiene Services.*	Commenced August 2016	
		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 Services Manager.	September 2016	

Std. 3. 3.5	**Environment and facilities Management: LEGIONELLA CONTROL** ▪ *All systems including water and ventilation systems are designed maintained and audited in line with National guidelines and legislation to minimise the possible spread of HCAIS.*				
REF.	**IDENTIFIED IMPROVEMENT REQUIRED**	**QUALITY IMPROVEMENT ACTIONS REQUIRED**	**RESPONSIBLE PERSON(S)**	**TARGET TIME FRAME**	**STATUS**
2.1	Review and document the management in the prevention and control of Legionella. Written scheme of actions and control measures to be maintained	Review current PUH Legionella control hospital risk assessment and update as required.	*Maintenance Services Manager* *EMC Committee*	October 2016	
		Implement documented action plans based on risk assessment review.	*Management Team* *Maintenance Services Manager* *EMC Committee*	November 2016	
		Progress implementation of identified required actions through relevant committees and document same.	*EMC Committee* *Maintenance Services Manager*	November 2016	

Std. 3. 3.6	**Environment and facilities Management: USE, MANAGEMENT AND STORAGE OF HOUSEHOLD EQUIPMENT /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** ▪ *All equipment medical and non medical including cleaning devices are effectively managed, decontaminated and maintained.*				
	IDENTIFIED IMPROVEMENT REQUIRED	**QUALITY IMPROVEMENT ACTIONS REQUIRED**	**RESPONSIBLE PERSON(S)**	**TARGET TIME FRAME**	**STATUS**
	Correct and improve compliance in the use, management maintenance and storage of hospital cleaning equipment	Develop and implement guideline on Use, management maintenance and storage of household service cleaning equipment	*Business Support Manager Hygiene Services* *HSSG sub group*	October 2016	
	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	*Business Support Manager Hygiene Services* *HSSG sub group*	June 2016	
	Monitor and evaluate the quality of services delivered.	Schedule audit to ensure compliance to standards	*Business Support Manager Hygiene Services* *HSSG sub group*	Audit on- going	

Std. 3. 3.6	**Environment and facilities Management: DECONTAMINATION 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** ▪ *All equipment medical and non medical including cleaning devices are effectively managed, decontaminated and maintained.*				
REF.	**IDENTIFIED IMPROVEMENT REQUIRED**	**QUALITY IMPROVEMENT ACTIONS REQUIRED**	**RESPONSIBLE PERSON(S)**	**TARGET TIME FRAME**	**STATUS**
2.2.	Improve and maintain Patient equipment cleaning procedures and processes to required standards.	Review current cleaning frequencies of patient equipment to ensure that scheduled cleaning frequencies are compliant to standards	*Business Support Manager Hygiene Services* *HSSG sub group*	September 2016	
		Review department patient equipment cleaning checklists and update if required	*Nursing Management Teams* *Department Managers*	October 2016	
		Review decontamination of patient equipment guideline and ensure all staff are familiar with cleaning processes and required standards. Update if required	*Business Support Manager Hygiene Services* *HSSG sub group* *IPC Team*	October 2016	
		Implement cleaning checklist systems in all departments to ensure patient equipment is decontaminated as per National guidelines and recommended frequencies	*Nursing Management Teams* *Department Managers*	October 2016	
2.2.	Monitor and evaluate the quality of services delivered.	Schedule audit of patient equipment to ensure compliance to standards	*Business Support Manager Hygiene Services* *HSSG sub group*	October 2016	

Std 3. 3.7	**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*				
REF.	**IDENTIFIED IMPROVEMENT REQUIRED**	**QUALITY IMPROVEMENT ACTIONS REQUIRED**	**RESPONSIBLE PERSON(S)**	**TARGET TIME FRAME**	**STATUS**
2.2.	Inappropriate storage of waste at department level.	Review hospital waste management systems to ensure compliance to the correct segregation handling, storage/ holding bays and transportation of waste.	*Hospital Management Team* *Maintenance Services Manager* *Business Support Manager Hygiene Services* *HSSG sub group*	Q1 - 2017	
		Review and update hospital waste management guidelines for safe use, management and storage of waste.	*Business Support Manager Hygiene Services* *HSSG sub group*	December 2016	
		Ensure all staff are familiar with their accountability in the safe segregation, handling, storage and transport of hospital waste	*Business Support Manager Hygiene Services* *HSSG sub group*		
		Schedule of training and competency assessment to be developed and implemented	*Business Support Manager Hygiene Services* *HSSG sub group*	*Bi – annual training*	
		Schedule audit of waste management practices to ensure compliance to standards	*Business Support Manager Hygiene Services* *HSSG sub group*	October 2016	

Std. 6	**Hand Hygiene** ▪ *System Change-ensuring that the necessary infra structure is in place to allow healthcare workers to practice hand hygiene*					
REF.	**IDENTIFIED IMPROVEMENT REQUIRED**	**QUALITY IMPROVEMENT ACTIONS REQUIRED**	**RESPONSIBLE PERSON(S)**	**TARGET TIME FRAME**	**REVIEW**	**STATUS**
2.3.1	Ensure hand hygiene sinks are compliant to required standard and in place in identified areas. Further funding required.	On-going refurbishment and sink replacement programme in place	Hospital Management, Maintenance manager. IPC (support with advice on siting when requested).	Current – ongoing.	Ongoing review	
2.3.1	Ensure that all departments have Hand Hygiene advisory posters available and appropriately displayed	Display hand hygiene posters in all Departments.	Department manager. IPC (support by giving access to suitable materials.)	September 2016	Ongoing review	

Std. 6	**Hand Hygiene** ▪ *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.*					
REF.	**IDENTIFIED IMPROVEMENT REQUIRED**	**QUALITY IMPROVEMENT ACTIONS REQUIRED**	**RESPONSIBLE PERSON(S)**	**TARGET TIME FRAME**	**REVIEW**	**STATUS**
2.3.2	Continue to build on the awareness and best practices on Hand Hygiene to ensure performance continues to improve and the national target of 90% is reached in both local and National Audits.	Management team and Senior Clinical leaders to lead on hand hygiene by speaking to colleagues and acting as exemplars of good practice Senior Clinical Leaders (Medical and Nursing) to record speaking with teams at least at every team change regarding hand hygiene and to support IPC team by acting on any reports of team members reluctant to engage constructively with IPC team Ongoing local Hand Hygiene training by IPC CNS team Ongoing Hand Hygiene auditing with feedback. Repeat audits monthly in high risk areas and in areas that achieve ≤ 90% hand hygiene compliance the previous month. Participate in WHO hand hygiene week Continue education from company reps on alcohol hand rub and hand care	Senior management team and Clinical Leadership. IPC Team IPC Team IPC Team IPC Team IPC Team IPC Team	Ongoing	Ongoing	

Std. 6	**Hand Hygiene** ▪ *Local and National Hand Hygiene Audit.-Hand Hygiene practices and policies are regularly monitored and audited. The results of any audit are fed back to relevant frontline staff and are used to improve the service provided.*					
REF.	**IDENTIFIED IMPROVEMENT REQUIRED**	**QUALITY IMPROVEMENT ACTIONS REQUIRED**	**RESPONSIBLE PERSON(S)**	**TARGET TIME FRAME**	**REVIEW**	**STATUS**
2.3.3	Sample size for Hospital wide Hand Hygiene audits below recommendation of 30 opportunities for ward unit.	Increase the number of opportunities observed on each hand hygiene audit. (note this will necessitate reduction in the number of hand hygiene audits)	IPC team	October 16		
2.3.3	Improve compliance to re audit departments that do not reach 90% Hand Hygiene audit target	Increase the frequency of re-audit of departments that do not reach target as per hand hygiene action plan. Hospital management to enhance IPC team staffing to allow for increased frequency of re-audit IPC team to increase frequency of re-audit	IPC Team	October 16		

Std. 8	**Invasive Medical Device Related Infections** ▪ *Invasive Medical Device Related Infections are prevented or reduced.*				
REF.	**IDENTIFIED IMPROVEMENT REQUIRED**	**QUALITY IMPROVEMENT ACTIONS REQUIRED**	**RESPONSIBLE PERSON(S)**	**TARGET TIME FRAME**	**STATUS**
2.4.	System for recording daily checks for PVC complications in Nursing notes does not readily facilitate audit of care bundle compliance	Change recording systems to facilitate recording of checks for PVC complications by introducing New Nursing Care Plan documentation incorporating twice daily recording of PVC complications	NMPDU Department managers	August 2016	
2.4.	Continue to build and implement Infection Prevention care bundles into routine practice	The PVC care bundles audits will be undertaken weekly until 100% compliance target is reached in all 5 elements of the tool consistently for a 4 week period. PVC Care bundles audits will then be undertaken monthly. If the score falls to less than 100% in any element revert to weekly audits. Schedule quarterly audit with IPC CNS.	NMPDU Department managers IPCNS	August 2016	
	Continue to build and implement Infection Prevention care bundles into routine practice	New Nursing Care Documentation facilitates recording of checks for Urinary catheter care bundles.	NMPDU Department managers	August 2016	
		Monthly audit of catheter care bundles by Department Manager and NMPDU using Nursing metrics System	NMPDU Department Managers	August 2016	