Report of the announced monitoring assessment at Midland Regional Hospital Portlaoise

Monitoring Programme for the National Standards for the Prevention and Control of Healthcare Associated Infections

Date of announced on-site monitoring assessment: 4 December 2012

About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is the independent Authority established to drive continuous improvement in Ireland's health and personal social care services, monitor the safety and quality of these services and promote person-centred care for the benefit of the public.

The Authority's mandate to date extends across the quality and safety of the public, private (within its social care function) and voluntary sectors. Reporting to the Minister for Health and the Minister for Children and Youth Affairs, the Health Information and Quality Authority has statutory responsibility for:

- **Setting Standards for Health and Social Services** – Developing person-centred standards, based on evidence and best international practice, for those health and social care services in Ireland that by law are required to be regulated by the Authority.

- **Social Services Inspectorate** – Registering and inspecting residential centres for dependent people and inspecting children detention schools, foster care services and child protection services.

- **Monitoring Healthcare Quality and Safety** – Monitoring the quality and safety of health and personal social care services and investigating as necessary serious concerns about the health and welfare of people who use these services.

- **Health Technology Assessment** – Ensuring the best outcome for people who use our health services and best use of resources by evaluating the clinical and cost effectiveness of drugs, equipment, diagnostic techniques and health promotion activities.

- **Health Information** – Advising on the efficient and secure collection and sharing of health information, evaluating information resources and publishing information about the delivery and performance of Ireland's health and social care services.

Table of Contents

1.   Background

The Health Information and Quality Authority (the Authority) has the national statutory role[±] for developing standards for the quality and safety of healthcare services. The *National Standards for the Prevention and Control Healthcare Associated Infections* (NSPCHCAI) were approved by the Minister for Health and Children on 26 May 2009. Under the Health Act 2007, the Authority has the statutory responsibility, amongst other functions, for monitoring compliance with National Standards and advising the Minister for Health as to the level of compliance.

The NSPCHCAI provide a framework for health and social care providers to prevent or minimise the occurrence of Healthcare Associated Infections (HCAIs) in order to maximise the safety and quality of care delivered to all health and social care service users in Ireland. The NSPCHCAI aim to drive a culture of responsibility and accountability among all staff involved in the management and delivery of health and social care services – all of whom must play their part in preventing and controlling HCAIs. While services may differ in terms of scale, service-user population, the nature of care provided, staffing levels, location and history, the principles for the prevention and control of HCAIs are applicable to all health and social care services.

The Authority commenced Phase 1 of the monitoring programme for the *National Standards for the Prevention and Control of Healthcare Associated Infections* (the National Standards) in the last quarter of 2012. This initially focused on announced and unannounced assessment of acute hospitals' compliance with the National Standards.

Phase 2 commenced in January 2013, and will continue throughout 2013 and into 2014 to include announced assessments at all acute hospitals in Ireland, and the National Ambulance Service.

This phase of monitoring is a contributory phase towards preparing service providers for the eventual monitoring of services against the *National Standards for Safer Better Healthcare*. In line with this aim, the Authority reviewed the NSPCHCAI and framed them within three themes of the *National Standards for Safer Better Healthcare*. These themes are:

- Theme 1: Leadership, Governance and Management
- Theme 2: Workforce
- Theme 3: Safe Care.

[±] The Authority is given the remit for setting standards for quality and safety in healthcare services under section 8 of the Health Act 2007.

1.1. Essential elements for safe, high quality care

To facilitate the overall NSPCHCAI monitoring programme, the NSPCHCAI and their respective criteria were reviewed and amalgamated in order to develop **essential elements** which would be representative of what an organisation must have in place as the foundation for the provision of safe, high quality care through the prevention and control of Healthcare Associated Infections (see Appendix 1). Accordingly, the monitoring methodology was developed to assess organisations for their compliance with these overarching essential elements. Therefore it is important to note that the Authority is not assessing against each of the individual standards and their criteria. It should also be noted that hygiene forms only one component of this announced assessment approach*.*

2. Overview

2.1. Midland Regional Hospital Portlaoise[¥]

The Midland Regional Hospital, Portlaoise, Co Laois is a 150-bed acute hospital that has in addition a 50-bedded acute psychiatric unit on site. It primarily serves the population bases of Co Laois but has also significant attendances from people in Co Offaly, Co Kildare and Co Tipperary. The population of Co Laois at the last census (2011) shows a 20% increase in population to 80,559. The Hospital has been providing inpatient and outpatient services for its population base since 1936. The services provided include:

- general medical
- general surgery
- obstetrics/gynaecology
- paediatrics
- special care baby services
- 24-hour emergency services
- anaesthesia/pain
- outpatient services
- physiotherapy
- occupational therapy
- speech and language therapy
- cardiac rehabilitation services
- dietetics
- intensive care unit
- coronary care unit.

A range of services including ophthalmology, haematology, pathology and urology are provided by visiting consultants with joint sessions and linkages with the Royal

---

[¥] The hospital profile information contained in this section has been provided to the Authority by the hospital, and has not been verified by the Authority.

Victoria Eye and Ear Hospital, Dublin, Midland Regional Hospital Tullamore, and St James's Hospital, Dublin.

The budgetary allocation in 2012 for the hospital was €44.97 million. Some of the activity levels are

Speciality	2012 Activity Levels
Emergency attendances	27691 adult 7845 paediatric 5381 obstetrics/gynaecology
Inpatients	13844
Day cases	5759
Diagnostics	44865
Outpatients	52973
Live births	2059

3.   Findings

The findings of the announced monitoring assessment at Midland Regional Hospital Portlaoise, are described below.

Authorised Persons from the Authority, Mary Dunnion, Naomi Combe, Breeda Desmond, Catherine Connolly Gargan and Emily McLoughlin carried out the onsite component of the monitoring assessment on 4 December 2012 between 08:30hrs and 15:30hrs. The Authorised Persons from HIQA commenced the monitoring assessment in the Emergency Department (ED).

The areas assessed were:

- Intensive Care Unit
- Medical Ward
- Surgical Ward
- Coronary Care Unit
- Maternity Unit.

3.1.   Theme 1: Leadership, Governance and Management

Theme 1: Leadership, Governance and Management

Robust leadership, governance and management structures and processes underpin what hospitals should have in place to assure the public and themselves that the arrangements for the prevention and control of Healthcare Associated Infections (PCHCAI) are effective.

There are robust local, monitoring and reporting arrangements in place thereby ensuring infection control is managed at a consistently high level of quality with minimal variation in the delivery of that care. There are effective regional and national PCHCAI reporting arrangements in place, infection control activities provided are compliant with the relevant legislation, clinical care programmes and evidenced-based practice, and the organisation is acting on national standards and recommendations from statutory bodies.

Essential Element 1(a). A comprehensive corporate and PCHCAI governance structure supported by an integrated organisational framework is in place. The governance arrangements will include PCHCAI specific strategies, aligned cost effective initiatives and defined responsibilities for externally contracted services.

Findings Essential Element 1 (a).

Midland Regional Hospital Portlaoise (MRHP) is a member of the Midlands Regional Hospitals Group. The other hospitals which make up this Group are the Midlands Regional Hospital Mullingar and Midlands Regional Hospital Tullamore.

PCHCAI Governance

Infection Prevention and Control Team

A regional Infection Prevention and Control Team (IPCT), which encompasses the Midlands Regional Hospitals Group, is in place, and MRHP is a member. Terms of reference are in place, with meetings scheduled approximately once a month, as evidenced by the minutes provided to the Authorised Persons from the Authority. Membership of the team includes the regional Consultant Microbiologist, infection prevention/control clinical nurse specialists from the regional acute hospitals and community and Surveillance Scientist. The overall aim of the group was to minimise the risk of transmission of infections to patients, visitors and staff within all healthcare facilities in the Midlands region. Documentation provided, in addition to discussions with members of the IPCT, demonstrated that the IPCT supported the local management of Healthcare Associated Infections at MRHP.

However, it was reported that consistent application of clinical PCHCAI initiatives from this forum can be challenged due to the absence of a group clinical directorate structure across the region.

Infection Prevention and Control Committee

At a local level, MRHP has an Infection Prevention and Control Committee (IPCC). The IPCC had terms of reference in place, and met approximately every six to eight weeks. Membership of the committee included corporate and clinical representation. However, the minutes provided to the Authority showed that attendance from senior management was not always consistent, and substitute arrangements were not formally identifiable.

> **Recommendation 1.** *The Hospital should ensure that, in line with the terms of reference of the Infection Prevention and Control Committee, appropriate substitution is arranged for absent members, and the attendance of substitutes is recorded.*

In compliance with the National Standards, the Committee had a PCHCAI annual work plan in place, which outlined the programme to prevent and control HCAIs at

the Hospital. There was evidence to support that this was being actively updated by the Committee. The Committee also produced a PCHCAI annual report.

Drugs and Therapeutics Committee

The Authority reviewed documentation pertaining to the Hospital's Drugs and Therapeutics Committee Meeting. Terms of reference were provided.

The terms of reference identified a meeting frequency of every three months, or more often if required. However, from the minutes submitted, it would appear that the Committee had met only twice in 2011, and once in 2012 up to the time of the assessment.

> **Recommendation 2.** *The Hospital should review the frequency at which the Drugs and Therapeutics Committee is meeting in reflection of its term of reference and the significance of the role of such a committee in a hospital.*

Corporate Governance arrangements to support compliance with the NSPCHCAI

At a local level, the Hospitals' governance structure is based on a departmental structure of administration, clinical, and nursing. The clinical model included divisions of Women and Children, Surgery, Medicine (including Emergency Medicine) and Diagnostic Services.

The overall management structure of the Hospital was through the Hospital Management Committee (HMC). There were no terms of reference for the HMC available at the time of the assessment, nor was other alternative documentation provided to demonstrate the working principles and governance arrangements for the HMC.

> **Recommendation 3.** *Terms of reference should be established for the Hospital Management Committee at the Hospital, including governance, membership, frequency of meeting and roles and responsibilities.*

In addition, there was no hospital annual report available at the time of assessment. From the minutes provided, the HMC was made up of the Clinical Director, Hospital Manager, Director of Nursing, Chair of the Medical Board, Secretary of the Medical Board and Hospital Group Manager. At a local level, it was reported that there was no one person accountable for the quality and safety of services, with a collective team accountability being described. In accordance with robust governance arrangements and the NSPCHCAI, MRHP should identify one accountable person at

local level for the quality and safety of services provided. This is to ensure the appropriate integration of corporate and clinical governance arrangements at MRHP.

From the documentation submitted, the HMC had met three times in 2012 up to the time of the assessment, with one further meeting scheduled for December 2012. From the minutes submitted, the prevention and control of Healthcare Associated Infections (to include aligned cost-effective initiatives) was not a standing item on the agenda, nor was there evidence to demonstrate that this was discussed or that there was any direct reporting of PCHCAI related matters to the Hospital Management Committee. On discussing this with members the HMC, it was explained that these issues are instead brought to the Level 2 Governance Committee at the Hospital.

Level 2 Governance Committee

Consequently, the Authority requested and reviewed on-site the minutes of the Level 2 Governance Committee meetings. The membership of the Level 2 Governance Committee was broad including representation from the HMC, nursing, allied health professionals and general management.

This Level 2 Governance group meet approximately once a month, with an agenda and minutes being recorded. As per the submitted terms of reference, the Infection Prevention and Control Committee reported to the Level 2 Governance Committee. However from the minutes reviewed on-site of the Level 2 Governance Committee, the exact nature of this reporting structure was unclear, as PCHCAI related topics, for example, the PCHCAI work programme, were not substantially reflected in the minutes provided nor was it a specific standing agenda item. On exploring this with members of the Committee, it was outlined that a culture of informal communication was more prominent than formal communication structures.

In addition, there are no clinical leads at consultant level nominated to represent their respective clinical divisions. It is also of significant concern to the Authority that the risk management representation at the meeting is in a regional advisory capacity only, and that there is no local dedicated risk or quality manager employed at the Hospital.

> **Recommendation 4.** *The Hospital should identify, and put in place, a dedicated risk manager.*

At MRHP, the principal forum for discussions and communication within the clinical division was reported to be through a Medical Board. However, it was reported that attendance was low at these meetings, minutes were not taken and therefore could not be circulated for information purposes. Clinical leads reporting to a Clinical

Director would enhance effective communication pathways and would ensure consistency and accountability for the implementation of, for example, hospital quality and safety initiatives.

During the course of the monitoring assessment, it was identified to the Authority that initiatives had been undertaken to strengthen the governance arrangements at MRHP, including engagement with the National Lead for Clinical Governance Development, and the establishment of a hospital Quality and Safety Clinical Governance Development Project Group Meeting. This Group held its inaugural meeting on 24 September 2012, with minutes for this meeting, and subsequent meetings, being provided to the Authorised Persons from HIQA during the on-site assessment. The Authority welcomes this initiative, and would recommend that the governance findings of this report be reflected in the discussions at this forum, as well as at the Hospital Management Committee.

> **Recommendation 5.** *The Hospital should ensure that it continues to strengthen the governance arrangements, both clinical and corporate, at the Hospital, including through the addressing of the findings of this report, and national and international best practice.*

> **Essential Element 1(b).** There is clear monitoring and reporting of defined PCHCAI performance metrics, with trend analysis, reciprocal quality improvement initiatives and reporting at a local, regional and national level.

Findings Essential Element 1(b).

MRHP was able to provide documentation, and describe in detail the systems and structures in place for the monitoring and reporting of PCHCAI performance metrics. Trend analysis and quality improvement initiatives were in place at a local and regional level within the local Infection Prevention and Control Committee and regional Infection Prevention and Control Team. MRHP also reports nationally to the Health Service Executive's Health Protection Surveillance Centre. It was not clear, however, how these initiatives and performance metrics reported into the local corporate governance structures (as discussed in Findings Essential Element 1 (a)).

It was reported that the Hospital did not have an integrated information management system. Consequently, there were reported challenges in timely information technology (IT) access to microbiology reports. For example, the system in place at the time of the assessment could not support effective surgical-site

infection audits. It was reported that the IPCC was in the process of exploring alternative means to commence monitoring of surgical-site infections.

Essential Element 1(c). A clear PCHCAI communication strategy, supported by robust operational arrangements, to assure the effective communication of appropriate and timely information throughout the service, to service providers and appropriate agencies is in place.

Findings Essential Element 1 (c).

An effective communication strategy which helps to disseminate useful and important information, both internally and externally, can improve the quality of patients' care. It can also help to inform service users, visitors and staff on how they can help to prevent and control the spread of HCAIs.[*]

Whilst the Hospital did provide a number of information leaflets, MRHP did not provide a specific communication strategy for patients and their relatives, Hospital staff and other service providers relating to the prevention and control of Healthcare Associated Infections. MRHP should develop a specific communication strategy for PCHAIs.

Recommendation 6. The Hospital should develop a communication strategy for the prevention and control of Healthcare Associated Infections, supported by robust operational arrangements, to assure the effective communication of appropriate and timely information throughout the service, to service providers and external agencies.

---

[*] NSPCHCAI, Standard 5, Rationale.

Theme 1: Leadership, Governance and Management – Conclusion

The effective prevention and control of HCAIs is underpinned and dependent upon an effective governance structure with clear lines of accountability and responsibility.

The PCHCAI governance arrangements in place at MRHP included a regional Infection Prevention and Control Team (IPCT) with local Infection Prevention and Control Committee (IPCC). Evidence provided demonstrated a proactive local and regional approach to the prevention and control of Healthcare Associated Infections by the IPCC and IPCT for MRHP.

The corporate governance arrangements in place at MRHP included a Hospital Management Committee (HMC), Level 2 Governance Committee and Quality and Safety Clinical Governance Development Project Meeting. However, from the evidence provided, it was not clear how these corporate governance arrangements supported the prevention and control of Healthcare Associated Infections at MRHP. There was no one accountable person for the quality and safety of services at a local level. Corporate attendance at the IPCC was not consistent, and HCAI related items were not standing items on agendas of the above corporate forums.

On raising these observations with staff members, it was reported that a culture of informal communication was in place as opposed to formal. It is also of significant concern to the Authority that there is no local dedicated risk or quality manager employed at the Hospital. The corporate governance structures of a hospital should proactively support the operational management of, including accountability and responsibility for, Healthcare Associated Infections. This was not demonstrated in MRHP.

During the course of the monitoring assessment, it was identified to the Authority that initiatives had been undertaken to strengthen the governance arrangements at MRHP. The Authority welcomes these initiatives, and would recommend that the governance findings of this report be reflected in the discussions at this forum, as well as at the Hospital Management Committee.

Theme 1: Leadership, Governance and Management – Recommendations

Recommendation 1. *The Hospital should ensure that, in line with the terms of reference of the Infection Prevention and Control Committee, appropriate substitution is arranged for absent members, and the attendance of substitutes is recorded.*

Recommendation 2. *The Hospital should review the frequency at which the Drugs and Therapeutics Committee is meeting in reflection of its term of reference and the significance of the role of such a committee in a hospital.*

Recommendation 3. *Terms of reference should be established for the Hospital Management Committee at the Hospital, including governance, membership, frequency of meeting and roles and responsibilities.*

Recommendation 4. *The Hospital should identify, and put in place, a dedicated risk manager.*

Recommendation 5. *The Hospital should ensure that it continues to strengthen the governance arrangements, both clinical and corporate, at the Hospital, including through the addressing of the findings of this report, and national and international best practice.*

Recommendation 6. *The Hospital should develop a PCHCAI communication strategy, supported by robust operational arrangements, to assure the effective communication of appropriate and timely information throughout the service, to service providers and external agencies.*

3.2. Theme 2 Workforce

Theme 2: Workforce

The hospital should always be in a position to assure the service users, the public and themselves that everyone working in the service is contributing to the prevention and control of Healthcare Associated Infections. The individual members of the workforce must be skilled and competent, they must be supported to continuously update and maintain their knowledge and skills, whether they are directly employed or in contractual employment.

Essential Element 2(a). Members of the core PCHCAI team must have the appropriate qualifications, specific training, skills and competencies in infection control, antimicrobial stewardship and HCAI surveillance. They must undergo continuing professional education and development on a regular basis.

Findings Essential Element 2(a).

The Authority found that the Infection Prevention Control programme at MRHP had a number of arrangements in place to ensure that the core team had the appropriate qualifications, specific training, skills and competencies in infection control and hand hygiene.

Antimicrobial stewardship is discussed in Essential Element 3c.

Essential Element 2(b) All hospital staff receive mandatory theoretical and practical training in relation to the prevention and control of Healthcare Associated Infections.

Findings Essential Element 2(b).

The Authority found that MRHP had a number of arrangements in place to ensure that all staff had the appropriate qualifications, specific training, skills and competencies in infection control and hand hygiene. As part of these arrangements, MRHP provided the Authority with the Hospital's 2012 PCHCAI education and training programme schedule. This schedule identified the staff groupings for training, the training to be undertaken and date of training.

Essential Element 2(c) There are arrangements are in place to ensure visiting clinical, undergraduates and agency staff are competent in the core principles for the prevention and control of HCAIs.

Findings Essential Element 2(c).

The Hospital reported a number of arrangements in place to ensure visiting clinical, undergraduate and agency staff are competent in the core principles for the prevention and control of HCAIs. However, these arrangements are primarily externally based with little or no formal monitoring arrangements or controls in place at the Hospital to ensure the efficacy of these arrangements.

> **Recommendation 7.** *The Hospital should ensure it has the necessary monitoring and control arrangements in place to ensure the efficacy of training provided to visiting staff to the Hospital in relation to the prevention and control of Healthcare Associated Infections.*

Theme 2: Workforce – Conclusion

The Authority found that MRHP had a number of arrangements in place to ensure that all staff, including the local core PCHCAI team, had the appropriate qualifications, specific training, skills and competencies in infection control and hand hygiene.

However, the Midland Regional Hospital Portlaoise should put in place arrangements to ensure that the Hospital is assured of the training provided to visiting staff at MRHP, in addition to the opportunity to develop a formal hospital-wide antimicrobial stewardship programme.

Theme 2: Workforce – Recommendations

> **Recommendation 7.** *The Hospital should ensure it has the necessary monitoring and control arrangements in place to ensure the efficacy of training provided to visiting staff to the Hospital in relation to the prevention and control of Healthcare Associated Infections.*

3.3. Theme 3 Safe Care

Theme 3: Safe Care

The hospital recognises that the prevention and control of Healthcare Associated Infections is paramount. The cleanliness of the physical environment and equipment is effectively managed and maintained. The hospital learns from all information relevant to the provision of safe PCHCAI services, in addition to when things go wrong.

There is an embedded focus on quality and safety improvement, evidence-based decision making and active engagement in local, national and international initiatives to minimise the risk of HCAIs.

Essential Element 3(a). There is 24-hour seven-days-a-week access to specialist microbiological advice and services.

Findings Essential Element 3(a).

There was 24-hour seven-days-a-week access to specialist microbiological advice. The Regional Consultant Microbiologist is on-site in MRHP for one session per week. This is a standalone position with locum arrangements for holiday and emergency cover in place. MRH Group must consider the sustainability of one microbiologist providing a 24/7 service.

Within the MRH Group, there are three microbiology laboratories, one of which is accredited. The laboratory at MRHP is not accredited. However, the laboratory surveillance function was shared across the three sites, with MRHP being aligned to policies, procedures and guidelines of the accredited laboratory.

From the documentation provided, discussions were ongoing in relation to the relocation of the MRHP Microbiology Department to Midland Regional Hospital Tullamore. A proposed date of 1 December 2012 was in place for the relocation, however, on the date of the assessment (4 December 2012), the relocation had not occurred, with no indication of an alternative date for the move.

The absence of an accredited laboratory at MRHP is a direct non-compliance with the *National Standards for the Prevention and Control of Healthcare Associated Infections*. This non-compliance must be addressed.

Recommendation 8. *The Hospital must make the necessary arrangements to ensure that laboratory access for the Hospital is to an accredited laboratory.*

Essential Element 3(b). There are specific care bundles and/or policies and procedures developed, communicated, implemented and their efficacy monitored with the use of:

- peripheral intravenous catheter

- urinary catheter

- central venous catheter.

One quarter of all HCAIs are related to the use of invasive medical devices (devices that are put into a patient's body or skin, for example urinary catheters, peripheral intravenous catheters or central venous catheters). To increase patient safety, all services should have a specific set of processes to improve patient outcomes, for example, care bundles for the prevention and control of invasive medical device related infections. In the Midland Regional Hospital Portlaoise, the Authority reviewed the use of care bundles in the five areas assessed.

Findings Essential Element 3(b).

Care bundle implementation was led by the Infection Control Nursing team with senior ward staff also reporting their involvement in this process to the Authority. As lead, the Infection Control Nurse was available to support and guide the staff through the implementation phase.

The Authority observed that patient care plans were developed to support the use of care bundles. A central venous catheter (CVC) care plan was available in the Intensive Care Unit and care bundles for UCs and PVCs were available electronically but not in hardcopy format.

HIQA found that monitoring of urinary catheters and peripheral venous catheter was recorded in daily checklists, for example, the general condition of the insertion site, and the length of time the peripheral venous catheter was inserted. The date of insertion of peripheral venous catheter was documented on the wound dressing. However, the records reviewed were not consistently maintained, for example, to indicate the name and title of the person who inserted the peripheral venous catheter.

Variances or adverse findings were documented as a narrative in the patients' progress notes which meant that these were seperately retained from the care bundle checklist.

The overall findings of the Authority was that urinary catheter and peripheral venous catheter care bundles were developed and were at varying stages of implementation

into practice in each of the five areas assessed with central venous catheter care bundles in use in the Intensive Care Unit. Staff spoken with by Authorised Persons from HIQA were knowledgable in the safe use of invasive medical devices.

Essential Element 3(c). There are defined PCHCAI performance metrics and audit process in place with a particular emphasis on:

- hand hygiene

- surgical-site infection rates

- environmental and equipment hygiene

- antimicrobial prescribing

- infection related to the use of invasive medical devises

- HCAI trend rates and analysis.

Findings Essential Element 3(c).

Hand hygiene

Hand hygiene is recognised internationally as the single most important preventative measure in the transmission of HCAIs in healthcare services. It is essential that a culture of hand hygiene practice is embedded in every service at all levels.

Hand hygiene training was reported to be undertaken by the Infection Control Nurse. A database was maintained on each ward with information regarding mandatory training for individual ward staff members. Hand hygiene training was mandatory every two years. Training records for all other staff was maintained by the Infection Prevention and Control Team. Hand hygiene training schedules were demonstrated and were facilitated at various locations throughout the Hospital to encourage staff attendance.

The Hospital demonstrated that hand hygiene practices were monitored through internal audits and the national hand hygiene compliance audits. The Hospital reported that bimonthly hand hygiene training was in progress, with periodic focused training aimed at providing training to specific grades of staff, for example, non-consultant hospital doctors (NCHDs) on their medical rotational training scheme in January and July each year. Training records were demonstrated. Monitoring of hand hygiene practices was demonstrated by internal monthly and national hand hygiene compliance audits.

The Authority observed hand hygiene signage displayed, including prompts, reminders and instruction signage. All hand hygiene signage was laminated and therefore could be effectively cleaned. Hand hygiene gels were available throughout the clinical areas assessed. An automatic gel dispenser was located inside the ICU door.

While sinks in the 'dirty'[*] utilities, toilets and shower areas were not all hands-free, hand-wash sinks were observed by the Authority in the patient areas to comply with the HSE's Health Protection Surveillance Centre's *Guidelines for Hand Hygiene (2005).*

Observation of hand hygiene opportunities

The Authority observed 41 hand hygiene opportunities during the monitoring assessment. These hand hygiene opportunities comprised:

- 14 opportunities before touching a patient
- 13 after touching a patient
- 14 after touching the patient's surroundings.

Of the 41 opportunities available, 32 were taken, 26 of which complied with best practice hand hygiene technique. Of the nine hand hygiene opportunities not taken, one was before touching a patient and eight were after touching the patient's surroundings. The remaining six opportunities taken were observed to be non-compliant due to not following best practice technique for hand washing or use of alcohol gel and/or length of time taken to complete hand hygiene.

Whilst the Authority recognises that the Hospital had a number of audit and training mechanisms in place for hand hygiene, the reported compliance rates for the Hospital would indicate that a culture of hand hygiene is not yet embedded across the organisation, and this must be addressed as a priority by the Hospital.

Surgical-site infections rates

Surgical-site infections are one of the most common Healthcare Associated Infections (HCAI).[†] The rate of surgical site infections is recognised as an important indicator of patient care and quality. It was reported that the Hospital did not have an integrated information management system and the current system could not support effective surgical site infection audits. It was reported that the IPCC was in

---

[*] A 'dirty' utility room is a temporary holding area for soiled/contaminated equipment, materials or waste prior to their disposal, cleaning or treatment.

[†] "Surveillance of Surgical Site Infection in Ireland", SARI, Health Protection and Surveillance Centre

the progress of exploring alternative means to commence monitoring of surgical site infections.

Recommendation 9. *As a matter of priority, the Hospital should progress initiatives to ensure the monitoring of surgical-site infections.*

Environmental and equipment hygiene

All cleaning in the Hospital was completed by internal Hospital staff. During the assessment, the Hospital demonstrated ongoing audit practices and training programmes in place.

Antimicrobial prescribing

The inappropriate use of antimicrobials is associated with the emergence and the rising levels of antimicrobial resistance. Antimicrobial resistance can be controlled with an effective antimicrobial stewardship programme.

Antimicrobial stewardship

The Hospital reported it had elements of an antimicrobial stewardship programme in place including antibiotic prescribing guidelines, surgical prophylaxis guidelines and restricted laboratory reporting of antibiotic susceptibilities. However, there was no Antimicrobial Stewardship Committee in place at MRHP, nor a dedicated antimicrobial pharmacist. It was reported that one pharmacist had begun attending medical ward rounds, however, it was reported that this resource was not sufficient to cover all disciplines. The allocation of this resource was not based on any critical analysis of highest need. It is important, with limited resources, that the Hospital allocates resources based on greatest need and potential risk.

Recommendation 10. *The Hospital should consider the most effective use of the available antimicrobial resources based on a risk-based approach.*

In the absence of a fully functioning antimicrobial stewardship programme, the Authority would have expected alternative arrangements to be in place, for example, through the Hospital's Drugs and Therapeutics Committee.

Drugs and Therapeutics Committee

There was no evidence provided to indicate that antimicrobial stewardship was a standing item on the agenda of the Drugs and Therapeutics Committee, nor was it reflected in the minutes of the meeting. This would indicate that there are minimal systems in place at MRHP to reduce and control antimicrobial resistance. This should be addressed as a priority.

> ***Recommendation 11.*** *As a matter of priority and in light of the significance of effective antimicrobial stewardship, the Hospital should review and further develop the current systems in place for antimicrobial stewardship.*

Infection related to the use of invasive medical devices

The Authority observed that Midland Regional Hospital Portlaoise carried out five audits in six clinical areas to date in 2012 with the overall implementation of Urinary Care bundle compliance documented as 100%.

At the time of monitoring assessment, the overall compliance with the implementation of peripheral venous catheter care bundles was not available. The Authority reviewed the peripheral venous catheter compliance results for Quarter 3, 2012, which were reported to range from 50% in the Coronary Care Unit and surgical ward to 100% in the Intensive Care Unit. Non-compliance was reported to be attributed to the following

- The length of time the peripheral venous catheter was in situ was greater than the target removal time of 72 hours.
- The peripheral venous catheter was not in use and consequently should have been removed.
- The peripheral venous catheter site wound dressing had to be reinforced.

This was evidenced at ward level and during the assessment meetings which supported that the team were proactive in adressing these areas of non-compliance.

HCAI trend rates and analysis

The regional Infection Prevention and Control Team and local Infection Prevention and Control Committee provided the Authorised Persons from the Authority with an overview of HCAI trending and analysis practices in place at MRHP. This was further evidenced by the documentation provided to whilst on site.

Conclusion

The Authority found there were defined PCHCAI performance metrics and audit processes in place to support the prevention of Healthcare Associated Infections (HCAIs).

There was evidence of a commitment by the Hospital to putting structures and processes in place to promote best practice in hand hygiene by staff. The Authority's observations suggested that there were some improvements to be made regarding staff undertaking hand hygiene practice following contact with the patients' environment.

The absence of a comprehensive and fully developed antimicrobial stewardship programme, with no substantial alternative arrangements in place, is non-compliant with the *National Standards for the Prevention and Control of Healthcare Associated Infections*. Antimicrobial stewardship is essential in reducing the inappropriate use of antimicrobials, and in turn, antimicrobial resistance, and this deficit should be addressed as a matter of priority at MRHP.

The Hospital did not have sufficient integrated information management systems in place in order to support effective surgical-site infection audits. It was reported that the Infection Prevention and Control Committee was in the progress of exploring alternative means to commence monitoring of surgical-site infections. Considering the importance of surgical-site infection rates, the Hospital should address this deficiency as a matter of priority.

> **Essential Element 3(d).** There is proactive reporting, identification, evaluation and management of information to include PCHCAI-related adverse events, risks, patients' complaints, audits and satisfaction surveys.

Findings Essential Element 3(d).

At the time of assessment, MRHP reported that there had not been an outbreak in the Hospital in the 12 months prior to the monitoring assessment.

MRHP had systems and structures in place to support the proactive reporting, identification and management of PCHCAI related adverse events, risks, patients' complaints and audits. Risks were reported at a functional level (administration, nursing and clinical), with a centralised database in place. Minutes provided, and further evidenced in meetings with staff, identified that risks, complaints and incidents are brought to the Level 2 Governance Committee.

However, it is of significant concern to the Authority that the risk management representation at the meeting is in a regional advisory capacity only, and that there

is no local dedicated risk or quality manager employed at the Hospital. This concern was also recorded by the Hospital in the Quality and Safety Clinical Governance Development Project Group minutes. However, it was not clear from the minutes how the Hospital intended to address this concern, or to mitigate the associated risks of the absence of a dedicated Risk or Quality Manager.

> **Essential Element 3(e).** The cleanliness of the physical environment and equipment is effectively managed and maintained.

Findings Essential Element 3(e).

The Authority observe general levels of cleanliness as they follow the patient's journey through the Hospital. The environment throughout the Midland Regional Hospital Portlaoise was found to be clean and well maintained. Five clinical areas were assessed.

1. *Maternity Unit*

Environment and equipment

- Overall the Authority found that the Maternity Unit environment assessed was clean. Floors throughout were observed to be clean and free of dirt, grit and spillages.

- Clean linen was stored appropriately. Used linen was segregated in line with best practice, evidenced by colour coding and foot operated linen bins used in the clinical areas.

- The Authority observed that waste management was in line with best practice. Clinical non-risk waste bins were intelligently placed and appropriately used and a clinical risk waste bin was available in the 'dirty' utility.

- Surfaces of equipment observed, for example, vital sign monitoring stands, intravenous stands, wound dressing trolleys and baby cots in use, were clean. A process was in place and observed by Authorised Persons from HIQA where equipment was labelled and dated on completion of cleaning indicating 'ready for use'.

Overall, the Authority found that the Maternity ward was clean, however, there were several areas requiring attention:

- While Authorised Persons from the Authority observed that bed frames and mattresses assessed were clean, not all pillows were clean, evidenced by staining

observed on a pillow on a bed ready for use. This finding was brought to the attention of ward staff during the assessment.

▪ In accordance with best practice, used equipment should not be stored on corridors and should be cleaned after use. However, the Authority observed six baby cots awaiting cleaning stored along the corridor outside patients' rooms which was brought to the attention of ward staff. One foetal monitor was observed to be unclean evidenced by staining on its surfaces.

▪ In the patient areas assessed, paintwork on borders at the base of walls was observed to be cracked with paint missing in some areas. Paint was also missing from parts of radiator surfaces observed and some bedside lockers were worn around the edges which prevented completion of effective cleaning, thereby posing a hygiene risk to patients.

▪ While the surfaces of the ward work station were observed to be cluttered and untidy, telephones, keyboard and fax machines were clean.

2. *Medical Ward.*

Environment and equipment

• Overall the Authority found the Medical Ward environment assessed was clean. Floors throughout were observed to be clean and free of dirt, grit and spillages.

▪ The Authority observed that clean linen was stored in a designated linen cupboard which was clean and free of dust, dirt and inappropriate items. Used linen was colour coded and segregated in line with best practice.

▪ Reusable equipment was stored and transported for decontamination and re-sterilisation in line with the HSE Code of Practice for Contamination of Reusable Invasive Medical Devices (RIMDs), evidenced by placement in a covered tray observed by the Authority.

▪ The Authority observed foot-operated clinical non-risk waste bins throughout the patient areas. A clinical risk waste bin was appropriately placed to collect waste from an occupied isolation room in line with best infection control and prevention practices. Appropriate disposal of personal protective equipment by staff was observed.

▪ In the clean utility area, the Authority observed patient equipment was clean, labelled indicating completion of the cleaning process and appropriately stored, for example, syringe drivers, intravenous stands and pumps.

▪ Equipment in patient areas, for example, beds, bed frames, pillows, mattresses and lockers were observed to be clean, free of rust and dust and spillages.

Overall, the Authorised Persons from HIQA found that the Medical Ward was clean, however, there were several areas requiring attention:

- While clinical non-risk waste bins were available, a clinical risk waste bin was not available in the 'dirty' utility area for collecting healthcare risk waste at this point. Authorised Persons from the Authority also observed that the edges of floors in the 'dirty' utility had light dust residue suggesting that cleaning was not fully adequate in this area.

- The Authority observed that the border along the edge of the flooring in patient areas was lifting in some areas hindering effective cleaning throughout. In addition light dust was observed on high surfaces, for example, on top of electric units and curtain rails posing a hygiene risk to patients.

- HIQA observed that the edges of bed tables assessed were worn, limiting the effectiveness of cleaning.

- A black residue was observed in the area between the floor and the shower. In addition, rusting was also observed on the side of a shower seat.

3. Surgical Ward

Environment and equipment

- Overall the Authority found the Surgical Ward environment assessed was clean. Patients that were spoken with expressed their satisfaction to the Authority regarding the level of environmental and hand hygiene.

- Floors throughout were observed to be clean and free of dirt, grit and spillages.

- A monthly curtain changing schedule as standard was in place, demonstrated by supporting documentation.

- HIQA observed that clean linen was stored in a designated linen cupboard which was clean and free of dust, dirt and inappropriate items. Used linen was colour coded and segregated in line with best practice.

- In the 'dirty' utility area, the Authority observed patient commodes were clean, labelled indicating completion of the cleaning process and appropriately stored.

- Equipment in patient areas, for example, beds, bed frames, pillows, mattresses and bed tables were observed to be clean, free of rust, dust and spillages.

- HIQA observed use of sharps boxes which were hands-free with foot pedal operated lid opening units.

Overall, the Authority found that the Surgical Ward was clean. However, there were several areas requiring attention:

- In both patient and non-patient areas of the Surgical ward, Authorised Persons from HIQA observed that dust was observed on high surfaces in moderate amounts, for example over doorframes.

- The Authority observed that the paintwork was chipped at the base of walls and on a radiator in patient areas.

- Two patient lockers assessed were broken and worn.

- Light dust was observed on a keyboard in the ward workstation.

- Shower areas were assessed by HIQA Authorised Persons who observed moderate soiling along the edges of the glass substitute on a patient shower door.

- A non-functioning electric weighing chair was inappropriately stored in a shower room and was removed on the Authority notifying ward staff.

- The foot pedal-operated lid opening mechanism was not functioning on a clinical non-risk waste bin in a patient shower room.

- In the clinical room, a clinical sharps waste bin was not signed on assembly therefore hindering traceability in line with best practice.

- While advisory signage was appropriate, not all signage displayed on a notice board in the clinical room was laminated or manufactured with a surface that could be cleaned.

4. Intensive Care Unit

The Intensive Care Unit at the Hospital could accommodate up to four non-ventilated patients or up to two ventilated patients. The ICU was not a self-contained unit, sharing the dirty utility, clean utility and bathroom facilities of the adjoining surgical ward.

At the time of assessment, there were four non-ventilated patients in the ICU, and doctors' rounds were taking place. Due to the size of, and the number of beds in the ICU, the Authority found the facility very crowded, which could potentially compromise patient privacy, comfort and confidentiality. It also restricted the ability of staff to move freely within the unit or the comfort of family members visiting a patient in the ICU.

> **Recommendation 12.** *The Hospital should review the number of beds within the Intensive Care Unit in the context of patient privacy, comfort and confidentiality.*

Environment and equipment

- Overall, the Authority observed that within the Intensive Care Unit (ICU) the environment and equipment assessed was clean.

- Floors throughout the patient areas were observed to be clean and free of dirt, grit and spillages.

- Clean linen was stored appropriately. Used linen was segregated in line with best practice, evidenced by colour coding and foot operated linen bins used in the clinical areas.

- The Authority observed that waste management was in line with best practice. Clinical non-risk waste bins were intelligently placed and appropriately used, and a clinical risk waste bin was available.

- The ICU store room was observed to be clean with designated clinical storage areas. Patient equipment in this area was clean. The cleaning schedules were complete and up to date.

However, although the Authorised Persons from HIQA found that the ICU facilities were generally clean, there were areas both within the facility and on the adjacent corridor that required attention:

- The plaster surface on a wall was cracked and dust in moderate amounts was observed on high surfaces, for example, over door frames and on top of curtain rails.

- Although cleaning schedules were available for cleaning patient equipment, they were observed to be inadequate in some areas, evidenced by the Authority's observation of a residue of white powder on one locker and splashes of liquid on a radiator. A drip stand observed had visible smearing on its base and evidence of a sticky residue from adhesive materials, also indicating that cleaning was inadequate.

  - In the 'dirty' utility used by the ICU, light amounts of grit and dirt were visible in corners and behind equipment, for example, the bedpan washer. Authorised Persons from the Authority also observed light dust on the surface of the sink and in moderate amounts over the door frame. Exposed plaster was visible by the sink in this area. In addition two bedpans, although observed to be clean, were not stored in an inverted position in line with best practice.

  - In the dirty utility used by the ICU a hot water tap was dripping.

- HIQA observed that there were no paper hand towels in a dispenser.

In the assisted shower area of the ICU, HIQA observed that the shower was stained. An electric hand drier was in use which is contrary to best practice.

5. Coronary Care Unit

Environment and equipment

- Overall, the Authority found the Coronary Care Unit environment and patient areas assessed to be clean.

- Clean linen was stored appropriately. Used linen was segregated in line with best practice, evidenced by colour coding and foot operated linen bins used in the clinical areas.

- The Authority observed that waste management was in line with best practice. Clinical non-risk waste bins were intelligently placed and appropriately used and a clinical risk waste bin was available in the 'dirty' utility.

- Surfaces of equipment observed, for example, vital sign monitoring equipment, intravenous stands and two near-patient testing glucometers were clean.

- While HIQA observed bed frames, mattresses, pillows and bedside lockers to be clean and intact, the edges of the surface of a patient bed table were broken hindering effective cleaning, thereby posing a hygiene risk to patients.

- The Coronary Care Unit work station was observed to be tidy and clean.

Theme 3: Safe Care – Conclusion

The Authority found that the cleanliness of the environments assessed at the Hospital were generally clean. HIQA was informed by Hospital management at the end of the monitoring assessment that refurbishment work on an endoscopy unit has recently been completed and may account for the levels of high dust observed in the adjacent surgical ward.

Equipment for patient use was generally clean in areas assessed.

Service users expressed their satisfaction to the HIQA Authorised Persons regarding the level of environmental and hand hygiene. The level of cleanliness observed would suggest that the physical environment was being effectively managed and maintained to protect service users and reduce the risk of the spread of HCAIs.

Theme 3: Safe Care: Recommendations

> ***Recommendation 8.*** *The Hospital must make the necessary arrangements to ensure that laboratory access for the Hospital is to an accredited laboratory.*
>
> ***Recommendation 9.*** *As a matter of priority, the Hospital should progress initiatives to ensure the monitoring of surgical-site infections.*
>
> ***Recommendation 10****. The Hospital should consider the most effective use of the available antimicrobial resources based on a risk based approach.*
>
> ***Recommendation 11****. As a matter of priority and in light of the significance of effective antimicrobial stewardship, the Hospital should review and further develop the current systems in place for antimicrobial stewardship.*
>
> ***Recommendation 12****. The Hospital should review the number of beds within the Intensive Care Unit in the context of patient privacy, comfort and confidentiality.*

4.   Overall Conclusion

4.1.   Overview

The Authority found that the cleanliness of the environments assessed at the Midland General Hospital Portlaoise, and equipment within these areas, to be generally clean. Service users expressed their satisfaction to the Authority regarding the level of environmental and hand hygiene. The level of cleanliness observed would suggest that the physical environment was being effectively managed and maintained to protect service users and reduce the risk of the spread of HCAIs.

However, the effective and sustained prevention and control of HCAIs is underpinned and dependent upon an effective governance structure with clear lines of accountability and responsibility.

The prevention and control of Healthcare Associated Infections governance arrangements in place at the Hospital included a Regional Infection Prevention and Control Team (IPCT) with a local Infection Prevention and Control Committee (IPCC). Evidence provided demonstrated a proactive local and regional approach to the prevention and control of Healthcare Associated Infections by the IPCC and IPCT for MRHP.

The corporate governance arrangements in place at the Hospital included a Hospital Management Committee (HMC), Level 2 Governance Committee, and Quality and Safety Clinical Governance Development Project Meeting. However, from the evidence provided, it was not clear how these corporate governance arrangements supported the prevention and control of Healthcare Associated Infections at the Hospital. At a local level, there was no one person accountable for the quality and safety of services. Corporate attendance at the IPCC was not consistent, and items related to Healthcare Associated Infections were not standing items on agendas of the above corporate forums. It is also of significant concern to the Authority that there was no local dedicated risk or quality manager employed at the Hospital.

During the course of the monitoring assessment, it was identified to the Authority that initiatives had been undertaken to strengthen the governance arrangements at Midland General Hospital Portlaoise. The Authority welcomes these initiatives, and would recommend that the findings, with particular reference to the corporate and clinical governance findings of this report, be reflected in the discussions at the Level 2 Governance Committee, Quality and Safety Clinical Governance Development Project Meeting, as well as at the Hospital Management Committee.

In conclusion, the Authority found Midland Regional Hospital Portlaoise to be partially compliant with the *National Standards for the Prevention and Control of Healthcare Associated Infections*.

Midland Regional Hospital Portlaoise must now develop a quality improvement plan (QIP) that prioritises the improvements necessary to fully comply with the *National Standards for the Prevention and Control of Healthcare Associated Infections*. This QIP must be approved by the service provider's identified individual who has the overall executive accountability, responsibility and authority for the delivery of high quality, safe and reliable services. The QIP must be published by the Hospital on its webpage on the Health Service Executive (HSE) website within six weeks of the date of publication of this report.

The Hospital should ensure the continued monitoring of the Hospital's QIP as well as relevant outcome measurements and key performance indicators, in order to provide assurances to the public that it is implementing and meeting the NSPCHCAI and is making quality and safety improvements that safeguard patients.

Recommendations

Recommendation 1. The Hospital should ensure that, in line with the terms of reference of the Infection Prevention and Control Committee, appropriate substitution is arranged for absent members, and the attendance of substitutes is recorded.

Recommendation 2. The Hospital should review the frequency at which the Drugs and Therapeutics Committee is meeting in reflection of its term of reference and the significance of the role of such a committee in a hospital.

Recommendation 3. Terms of reference should be established for the Hospital Management Committee at the Hospital, including governance, membership, frequency of meeting and roles and responsibilities.

Recommendation 4. The Hospital should identify, and put in place, a dedicated risk manager.

Recommendation 5. The Hospital should ensure that it continues to strengthen the governance arrangements, both clinical and corporate, at the Hospital, including through the addressing of the findings of this report, and national and international best practice.

Recommendation 6. The Hospital should develop a communication strategy for the prevention and control of Healthcare Associated Infections, supported by robust

operational arrangements, to assure the effective communication of appropriate and timely information throughout the service, to service providers and external agencies.

Recommendation 7. *The Hospital should ensure it has the necessary monitoring and control arrangements in place to ensure the efficacy of training provided to visiting staff to the Hospital in relation to the prevention and control of Healthcare Associated Infections.*

Recommendation 8. *The Hospital must make the necessary arrangements to ensure that laboratory access for the Hospital is to an accredited laboratory.*

Recommendation 9. *As a matter of priority, the Hospital should progress initiatives to ensure the monitoring of surgical-site infections.*

Recommendation 10. *The Hospital should consider the most effective use of the available antimicrobial resources based on a risk-based approach.*

Recommendation 11. *As a matter of priority and in light of the significance of effective antimicrobial stewardship, the Hospital should review and further develop the current systems in place for antimicrobial stewardship.*

Recommendation 12. *The Hospital should review the number of beds within the Intensive Care Unit in the context of patient privacy, comfort and confidentiality.*

Appendix 1 – Themes and Essential Elements

NSPCHAI Standard	Theme	Essential Element
1,2,3, 4,5,6, 7,8,9, 10,11, 12.	**Leadership, Governance and Management** Robust leadership, governance and management structures and processes underpin what hospitals should have in place to assure the public and themselves that the arrangements for the prevention and control of Healthcare Associated Infections (PCHCAI) are effective. There are robust local monitoring and reporting arrangements in place thereby ensuring infection control is managed at a consistently high level of quality with minimal variation in the delivery of that care. There are effective regional and national PCHCAI reporting arrangements in place; infection control activities provided are compliant with the relevant legislation, clinical care programmes and evidenced-based practice; and the organisation is acting on national standards and recommendations from statutory bodies.	**1(a)** A comprehensive corporate and PCHCAI governance structure supported by an integrated organisational framework is in place. The governance arrangements will include PCHCAI specific strategies, aligned cost-effective initiatives and defined responsibilities for externally contracted services. **1(b)** There is clear monitoring and reporting of defined PCHCAI performance metrics, with trend analysis, reciprocal quality improvement initiatives and reporting at a local, regional and national level. **1(c)** A clear PCHCAI communication strategy, supported by robust operational arrangements, to assure the effective communication of appropriate and timely information throughout the service, to service providers and appropriate agencies is in place.

NSPCHAI Standard	Theme	Essential Element
1, 4, 5, 6.	**Workforce** The hospital should always be in a position to assure the service users, the public and itself that everyone working in the service is contributing to the prevention and control of Healthcare Associated Infections. The individual members of the workforce must be skilled and competent, they must be supported to continuously update and maintain their knowledge and skills, whether they are directly employed or in contractual employment.	**2(a)** Members of the core PCHCAI team must have the appropriate qualifications, specific training, skills and competencies in infection control, antimicrobial stewardship and HCAI surveillance. They must undergo continuing professional education and development on a regular basis. **2(b)** All hospital staff receive mandatory theoretical and practical training in relation to the prevention and control of Healthcare Associated Infections. **2(c)** There are arrangements in place to ensure that visiting clinical, undergraduates and agency staff are competent in the core principles for the prevention and control of HCAIs.

NSPCHAI Standard	Theme	Essential Element
1,2,3, 6,7,8, 9,11,12.	**Safe Care** The hospital recognises that the prevention and control of Healthcare Associated Infections is paramount. The cleanliness of the physical environment and equipment is effectively managed and maintained. The hospital learns from all information relevant to the provision of safe PCHCAI services, in addition to learning from when things go wrong. There is an embedded focus on quality and safety improvement, evidence-based decision making and active engagement in local, national and international initiatives to minimise the risk of HCAIs.	**3(a)** There is access to specialist microbiological advice and services, 24 hours a day, seven days a week. **3(b)** There are specific care bundles and/or policies and procedures developed, communicated, implemented and their efficacy monitored with the use of: ▪ peripheral intravenous catheter ▪ urinary catheter ▪ central venous catheter. **3(c)** There are defined PCHCAI performance metrics and audit process in place with a particular emphasis on: surgical site infection rates, environmental and equipment hygiene, antimicrobial prescribing, hand hygiene, infection related to the use of invasive medical devises, HCAI trend rates and analysis. **3(d)** There is proactive reporting, identification, evaluation and management of information to include PCHCAI-related adverse events, risks, patients' complaints, audits and satisfaction surveys. **3(e)** The cleanliness of the physical environment and equipment is effectively managed and maintained.