Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of the announced monitoring assessment at Wexford General Hospital, Co Wexford

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

Date of announced on-site monitoring assessment: 12 February 2013

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.

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1. Background

The Health Information and Quality Authority (the Authority or HIQA) has the national statutory role[±] for developing standards for the quality and safety of healthcare services. The *National Standards for the Prevention and Control of 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 *National Standards for the Prevention and Control of Healthcare Associated Infections* 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. Wexford General Hospital[¥]

Wexford General Hospital provides acute services to the county of Wexford and also provides services to the adjoining counties of Waterford, Kilkenny, Carlow, South Tipperary and, particularly, maternity services to Wicklow.

Wexford General Hospital's Emergency Department processed 40,311 attendances in 2012 and has the second largest maternity unit in the southeast with 2,173 births in 2012.

Services provided at Wexford General Hospital:

▪ anaesthetics ▪ ENT clinic ▪ cardiology ▪ chest pain assessment ▪ COPD ▪ cardiac rehabilitation ▪ chaplaincy ▪ day hospital for the elderly ▪ Medical Admission Unit ▪ Day Surgery Unit ▪ Pre-admissions Assessment Clinic for general and gynaecological surgery ▪ Pre-assessment Anaesthetic Clinic ▪ Dermatology Clinic ▪ Dietetic Department	▪ gynaecology ▪ palliative care ▪ medicine for the elderly ▪ occupational therapy ▪ oncology ▪ pastoral care ▪ pharmacy ▪ phlebotomy ▪ physiotherapy ▪ early pregnancy assessment ▪ colposcopy service ▪ urodynamics ▪ surgical site surveillance ▪ dental surgery ▪ intensive care

[¥] 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.

▪ discharge liaison service ▪ emergency medicine ▪ endocrinology / diabetes medicine ▪ Respiratory Department ▪ general internal medicine ▪ general surgery including breast care ▪ radiology ▪ endoscopy ▪ laboratory	▪ coronary care ▪ Physiology studies ▪ Orthopaedic Outpatient Clinic ▪ paediatrics ▪ maternity inclusive of Domino ▪ CSSD ▪ speech and language service.

Activity

	Out-turn 2012	**Out-turn 2011**
Inpatient discharges	17,324	15,111
Day cases	8,708	8,191
Births	2,173	2,063
Emergency admissions	9,201	8,557
Outpatients	51,280	52,179
ED attendances	40,311	35,198

3. Findings

The findings of the announced monitoring inspection at Wexford General Hospital, County Wexford, are described below.

Authorised Persons from the Authority, Breeda Desmond, Naomi Combe and Catherine Connolly Gargan carried out the on-site component of the monitoring assessment on 12 February 2013 between 08:35hrs and 15:00hrs. The Authorised Persons from HIQA commenced the monitoring assessment in the Emergency Department (ED).

The areas subsequently assessed were:

- St Bridget's ward
- St Patrick's ward
- Maternity ward.

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)

Wexford General Hospital is a stand-alone hospital with formal working arrangements with Waterford Regional Hospital.

Governance structure

The Hospital is governed by a board of management, which includes the General Manager (Chairperson), Director of Nursing, Clinical Director and a local general practioner. The Director of Nursing reports to the General Manager, who reports to the Area Manager, Health Service Executive (HSE) South. The Clinical Director reports to the General Manager.

PCHCAI Governance

Infection Prevention and Control Team

An Infection Prevention and Control Team (IPCT) is in place in Wexford General Hospital. Terms of reference are in place, with formal meetings scheduled monthly as evidenced by documentation submitted to the Authority. Informal meetings occur weekly. Members of the IPCT include two infection prevention and control nurses (IPCNs) and the Consultant Microbiologist from Waterford Regional Hospital. The Infection Prevention and Control Team described a clear PCHCAI structure in Wexford General Hospital, with individuals aware of their roles and responsibilities. Whilst there was a surveillance manager in post at the time of the on-site assessment, this post is scheduled to be vacant from March 2013. A Wexford General Hospital pharmacist is part of the IPCT. However, the time allocated for

antimicrobial stewardship has greatly diminished due to non-replacement of the SARI (Strategy for Antimicrobial Resistance in Ireland) pharmacist. Antimicrobial stewardship undertaken by the pharmacist is a 'goodwill' practice rather than being part of any formal arrangements.

There is an Infection Prevention and Control Committee (IPCC) in Wexford General Hospital. Minutes reviewed demonstrated that information was forwarded from the IPCT to the Hospital's Infection Prevention and Control Committee and Board of Management. However, reciprocal communication links were not demonstrated. There was no evidence that feedback was received by the IPCC and the Infection Prevention and Control Team regarding many of the issues brought to the attention of the Board of Management.

There is no budget allocated specifically for PCHCAI in Wexford General Hospital. The Board of Management reported that it has access to some regional SARI funding. There has been no funding available for PCHCAI training since 2010 and the Board of Management reported that travel restrictions also inhibited educational possibilities.

The lack of a named accountable person for the coordination of the PCHCAI surveillance programme, in conjunction with the absence of a designated antimicrobial pharmacist and lack of designated PCHCAI funding poses a serious risk to patients of acquiring HCAIs in Wexford General Hospital.

Infection Prevention and Control Committee

There is an Infection Prevention and Control Committee (IPCC) in Wexford General Hospital. As per the documentation submitted, the IPCC reports to the Hospital's Board of Management. Terms of reference were in place which indicated that meetings are held quarterly. However, just two meetings were convened in 2012 despite repeated documented requests from the Infection Prevention and Control Team to meet in order to comply with the NSPCHCAI recommendations. Terms of reference also described membership of the Committee, which included corporate and clinical representation. Review by the Authority of the documentation submitted indicated that the General Manager attended these meetings infrequently. This led to an amendment of the terms of reference, which outlined that the Deputy General Manager would attend the meetings 'should the need arise'. Poor attendance by management at IPCC meetings and lack of priority to attend these meetings suggests a deficit in corporate commitment to the programme of PCHCAI.

Drugs and Therapeutic Committee

There is a Drugs and Therapeutic Committee (DTC) in place in Wexford General Hospital. Terms of reference are in place and meetings are held three times a year. The DTC reports to the Hospital's Quality and Safety Committee.

South East (SE) Acute Hospitals Network Antimicrobial Stewardship Group

Wexford General Hospital is part of the South East (SE) Acute Hospitals Network Antimicrobial Stewardship Group. Their terms of reference were reviewed by the Authority and they indicated that antimicrobial stewardship should be a standing item on the Drugs and Therapeutics Committee agenda. However, neither the agenda nor the minutes from 16 April 2012 reflected antimicrobial stewardship. While antimicrobial stewardship was an agenda item on the DTC meeting of 23 September 2012, the minutes did not reflect that it was discussed.

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)

Surveillance and audit of caesarean section surgical site infections was undertaken in 2012 in Wexford General Hospital and this resulted in review and change of surgical closure practices. This quality improvement initiative addressed the issues identified. Catheter related bloodstream infection surveillance (CRBSI) was in place at the time of the monitoring assessment and results showed there were no catheter related bloodstream infections recorded. Monitoring of gentamicin and vancomycin usage by the pharmacist was ongoing. The pharmacist outlined that when usage is not in adherence with best practice guidelines, it is brought to the attention of the attending consultant for action. Antimicrobial surgical prophylaxis audits viewed by the Authority showed good compliance with best practice.

Research has shown that surgical site infections (SSI) are the third highest risk to patients in acute hospitals. Wexford General Hospital had the lowest SSI rate nationally for 2012. Surgical site infection surveillance (SSIS) has been in place in Wexford General Hospital since 2010 and the IPCT, along with the Surveillance Manager (in post at the time), won the regional and national HSE achievement awards for their SSIS surveillance in 2011. They presented SSIS to the regional Quality and Safety Forum and proposed that it would be introduced to the HSE's South region. Information sessions regarding SSIS were facilitated by the infection prevention and control nurses (IPCNs) in different acute hospitals. Wexford General Hospital's SSIS also included post-discharge surveillance and the aforementioned initiates were undertaken to mitigate the concerns identified. However, the future of SSIS in Wexford General Hospital is uncertain due to the absence of a surveillance manager.

Several minuted Infection Prevention and Control Team meetings in 2011 and 2012 identified poor compliance with hand hygiene practices amongst medical staff and poor attendances amongst all staff at educational sessions in the Hospital. An internal hand hygiene audit of March 2012 showed 59% compliance. This was re-audited and results showed 65% compliance rate. Results were relayed to the Board of Management. However, reciprocal quality improvement initiatives were not initiated.

Audits were undertaken by laboratory staff for blood culture response times and false positives. The results of the response times were positive. They demonstrated that response times and the ambient transport temperatures were consistent and within the optimum range, which would suggest best practice. It is envisaged that new blood culture packs will be in place to further mitigate the risk of false positives.

Audit of the efficacy and effectiveness of the provision of maintenance services at the Hospital has not been undertaken. The documentation reviewed by the Authority prior to the on-site component of the monitoring assessment showed that many items were repeatedly appearing in Infection Prevention and Control Team minutes for attention due to their HCAI risk, for example, some hand-wash taps required maintenance and the non-replacement of ceiling tiles in the Maternity ward. These issues had not been addressed at the time of the monitoring assessment. This poses both a direct and indirect risk to patients of HCAIs.

With the departure of the surveillance manager, lack of a designated antimicrobial pharmacist and in the absence of audit of some services, decision making regarding effective and efficient PCHCAI cannot be robust. Under these circumstances, it is not possible for the accountable person to be confident that PCHCAI will be managed effectively and thus be able to make a judgment on the level of risk to patients.

The Authority found that the corporate and clinical governance arrangements in Wexford General Hospital did not adequately support the present PCHCAI initiatives within the Hospital. This is of significant concern to the Authority given that antimicrobial stewardship and surveillance are essential elements in the prevention and control of Healthcare Associated 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)

There is no PCHCAI communication strategy in place in Wexford General Hospital. While the Infection Prevention and Control Team gave a comprehensive description in discussions with the Authority, of upward PCHCAI information communications, reflected in documentation submitted to the Authority, there appeared to be shortcomings in multi-directional communications. An effective PCHCAI communication strategy ensures that information relating to HCAIs is communicated and responded to in an efficient, timely, effective and accurate manner. Therefore, the absence of a formal, written PCHCAI communication strategy poses an indirect risk of HCAIs to patients.

Theme 1: Leadership, Governance and Management – Conclusion

The absence of several fundamental roles to PCHCAI poses a serious risk of HCAIs, both directly and indirectly, to patients in Wexford General Hospital. These deficits include the lack of a named accountable person for the coordination of the PCHCAI

surveillance programme, a designated antimicrobial pharmacist to oversee an antimicrobial stewardship programme, combined with the deficit of PCHCAI-related audit in some areas and a formal PCHCAI communication strategy. All this would suggests to the Authority that the prevention and control of HCAIs is not managed effectively.

There was no evidence provided to the Authority as to how the Board of Management at Wexford General Hospital can be assured that the prevention and control of HCAIs is regularly considered, assessed and managed to comply with the National Standards, and the associated risks to patients monitored and mitigated.

The Authority concluded that the corporate and clinical governance arrangements in Wexford General Hospital were not sufficiently effective to ensure compliance with the NSPCHCAI.

Theme 1: Leadership, Governance and Management – Recommendations

Recommendation 1. *The governance arrangements will include PCHCAI specific strategies and aligned cost-effective initiatives.*

Recommendation 2. *The corporate and clinical governance arrangements at Wexford General Hospital should be reviewed in order to ensure compliance with the National Standards for Prevention and Control of Healthcare Associated Infections.*

Recommendation 3. *A formal system of communication regarding PCHCAIs should be developed and implemented in Wexford General Hospital.*

Recommendation 4. *There should be a named accountable person for the coordination of the PCHCAI surveillance programme.*

Recommendation 5. *An efficient antimicrobial stewardship programme should be developed and implemented.*

3.2. Theme 2: Workforce

Theme 2: Workforce

The hospital should always be in a position to assure patients, 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)

While members of the PCHCAI team are appropriately qualified, it was reported to the Authority that continuing professional development was severely curtailed due to lack of funding. Staff reported that they endeavoured to remain abreast with current research in relation to PCHCAI through online fora as well as relevant periodicals. However, there was no evidence that structured continuing professional education and development was in place.

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)

Hand hygiene is recognised internationally as the most significant preventative measure to prevent HCAIs in healthcare services. It was outlined to the Authority following liaison with the Department of Nursing in the Institute of Technology, Waterford, that student nurses' hand hygiene education is completed prior to commencement of their work placement.

Training in relation to PCHCAI is not mandatory in Wexford General Hospital and this has resulted in very poor attendances, especially amongst certain cohorts of staff. While hand hygiene education sessions for all disciplines are held monthly in Wexford General Hospital, attendance at these education sessions has been low. Training records indicated that some staff had no training, while others have not had this education since 2005. The Authority was informed in discussions that there is no follow-up of non-attendances of doctors at PCHCAI education in Wexford General Hospital. There was no evidence provided to the Authority that the Hospital had

prioritised hand hygiene education and training in order to meet the NSPCHCAI and reduce the risks to patients of contracting a HCAI. This was despite this issue being highlighted as far back as September 2010 by the Infection Prevention and Control Committee. Members of the Board of Management acknowledged that there was a deficit in the necessary clinical leadership to champion PCHCAI.

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)

There were no arrangements in place in Wexford General Hospital to ensure that visiting clinical staff and undergraduates had completed and were competent in PCHCAI.

Theme 2: Workforce – Conclusion

Documentation supplied and discussions with members of the Board of Management indicate that members of the core PCHCAI team are appropriately qualified.

PCHCAI training in Wexford General Hospital is not mandatory. Arrangements are not in place to ensure that staff, both permanent and temporary, have completed theoretical and practical training in relation to the prevention and control of Healthcare Associated Infections. Documentation submitted to the Authority confirmed that while attendances were audited, there were no quality improvement initiatives to remedy the degree of non-attendance and ensure compliance.

The extent of non-attendance at hand hygiene training and failure to stipulate that such training be mandatory poses a significant risk of HCAIs to patients at Wexford General Hospital.

Theme 2: Workforce – Recommendations

Recommendation 6. *PCHCAI staff should be facilitated to attend ongoing professional development.*

Recommendation 7. *Hand hygiene training should be made mandatory for all staff.*

Recommendation 8. *Wexford General Hospital must put in place arrangements to ensure that all staff receive mandatory theoretical and practical training in relation to the prevention and control of Healthcare Associated Infections.*

Recommendation 9. *Arrangements should be put in place for all visiting clinicians and undergraduates to ensure that they are competent in the core principles for the preventions and control of HCAIs.*

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 is no microbiology laboratory in Wexford General Hospital. Staff at Wexford General Hospital have 24-hour, seven-days-a-week access to specialist microbiological services at the accredited laboratory in Waterford Regional Hospital. A consultant microbiologist from Waterford Regional Hospital has four hours per week allocated to Wexford General Hospital for PCHCAI and microbiological services. It was reported to the Authority that best practice policies, procedures and guidelines in place in Waterford Regional Hospital for microbiology are implemented in Wexford General Hospital. Samples are sent to Waterford Regional Hospital for analysis and advice is regularly sought over the telephone by physicians. There are three consultant microbiologists in Waterford Regional Hospital who cover on-call in rotation. This system is supported by formal policies, procedures and guidelines.

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.

Findings Essential Element 3(b)

The Authority was informed that urinary catheter (UC) care bundles were implemented on a pilot basis in two clinical areas, St Patrick's ward and the Intensive Care Unit (ICU), two weeks prior to the assessment by the Authority. 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 while senior ward staff mentored staff at clinical level on a day-to-day basis.

St Patrick's Ward

The Authority observed practice on St Patrick's ward and found that urinary catheter (UC) patient care plans were developed to support the use of urinary catheter care bundles. Care bundles for central venous catheter (CVC) and peripheral vascular catheters (PVCs) were not yet in use.

The Authority found that monitoring of urinary catheters was recorded in a care plan with daily checklists, for example, continuous connection of the system is assured, cleaning of insertion site is completed, timely emptying of catheter, correct positioning of the drainage bag, all hand hygiene opportunities are taken and all hand hygiene procedures are performed in line with best practice. Details of insertion and removal details were recorded. The records reviewed were consistently maintained, for example, to indicate the name and title of the person who inserted the urinary catheter. Variances or adverse findings were documented as a narrative in the patients' care plan progress notes which meant that these were seperately retained from the care bundle documentation. This may pose a risk to the patient as information may be overlooked.

Auditing of compliance with completing checklist documentation was undertaken by the Clinical Nurse Manager, who forwarded a weekly report to the lead.

The findings of the Authority were that urinary catheter care bundle implementation was at an early stage. It was reported that UC care bundles were soon to be implemented in all inpatient areas in the Hospital. Staff whom the Authority spoke with were knowledgable in the safe use of urinary catheters.

St Bridget's ward

Care bundles were not in place in St Bridget's ward. The Authority reviewed the use of the early warning score for peripheral vascular catheter (PVC) care on St Bridget's ward.

There are daily checklists as part of the early warning score, which are included in the patient's end-of-bed documentation. These are completed by the assigned nurse on duty. Items to be completed on PVC are: date and time of insertion, reason for insertion, type/gauge, daily inspection signature, removal date, reason for removal and signature of staff member who removed the device. Some of the patients were admitted via the Emergency Department and the documentation reviewed

demonstatrated that records had commenced there, as is appropriate. PVC devices should be checked daily. One patient's early warning score chart indicated that there were two PVCs inserted on 2 February 2013. However, the next and only other entry to the early warning score was on 9 February 2013. One PVC was removed but there was no documentation to indicate when this occured, and whether the PVC in situ was the original one inserted 10 days previously, which is not in keeping with best practice.

The implementation of a structured set of processes has been proven internationally to improve patient outcomes regarding PCHCAI and prevent or reduce medical device related infections. Early warning score documentation reviewed by the Authority relating to peripheral vascular catheters would suggest that the relevance and value of such a chart in reducing or preventing a HCAI is not comprehensively understood in Wexford General Hospital.

Recommendation 10. *Wexford General Hospital must put in place arrangements to ensure that specific care bundles and/or policies, procedures and guidelines are developed, communicated, implemented and their efficacy monitored.*

Essential Element 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.

Findings Essential Element 3(c)

Surgical site infection rates

Audit provides a useful key quality indicator to enable adequate monitoring of infection. Audits of surgical site infection rates is undertaken regularly in Wexford General Hospital. This was supported by documented evidence. Discussion with the Infection Prevention and Control Team demonstrated their knowledge and commitment to surgical site infection surveillance and the subsequent reduction in surgical site infections following quality initiatives as described earlier.

Environmental and equipment hygiene

Environmental and equipment hygiene audits were undertaken by Wexford General Hospital in 2011. There were no audits were undertaken in the first three quarters of 2012, but were completed in the fourth quarter of 2012. Regular audit of the environment and equipment hygiene demonstrates compliance with evidence-based best practice regarding effective management, decontamination and maintenance.

Antimicrobial prescribing feedback

The Authority was informed that PCHCAI-related medication issues are brought by the pharmacist to the Infection Prevention and Control Team, which in turn highlights issues with the Infection Prevention and Control Committee. When necessary, these matters are bought to the attention of the Board of Management and appropriate action taken, which was evidenced by minutes of meetings reviewed by the Authority.

The 2012 updated 'Use of Antibiotics in HSE Acute Hospitals' which included restrictions and surgical prophylaxis, was demonstrated to the Authority. However, there is no formal antimicrobial prescribing feedback in Wexford General Hospital. Antimicrobial prescribing feedback is a significant strategy that has shown demonstrable benefits in the prevention and control of HCAIs. The absence of formality of such feedback poses a risk of HCAIs to patients in Wexford General Hospital.

Hand hygiene

There was evidence of good practice which included the following:

- Authorised Persons spoke with staff in the areas assessed, who demonstrated their knowledge verbally and in practice regarding hand hygiene best practice.

- The Authority viewed laminated posters to demonstrate appropriate hand hygiene technique displayed by sinks used for hand hygiene with the exception of some sinks in the Maternity ward. Reminder hand hygiene notices were located at various high visibility points throughout the patients' journey from the Outpatients' Department and the Emergency Department to inpatient accommodation.

However, there was also evidence of practice that was not compliant with the *National Standards for the Prevention and Control of Healthcare Associated Infections* including:

- Some disciplines had very poor attendances at hand hygiene training. There was no evidence of a resultant specific, targeted hand hygiene strategy to address this issue.

- Hand hygiene audits undertaken by Wexford General Hospital for 2011 showed 59.9% compliance. This was re-audited and results demonstrated

65% compliance rate, indicating that Wexford General Hospital did not reach its target of 75%.

- While alcohol-based hand gels and foams were widely available for use throughout the Hospital, the dispensers located at one location in the Hospital entrance were empty.

Observation and hand hygiene opportunities

The Authority observed 20 hand hygiene opportunities during the monitoring assessment. These hand hygiene opportunities comprised:

- 6 opportunities before touching a patient
- 6 opportunities after touching a patient
- 1 opportunity before a clean/aseptic procedure
- 7 after touching the patient's surroundings.

Of the 20 opportunities available, 15 were taken, 12 of which complied with best practice hand hygiene technique. Of the five hand hygiene opportunities not taken, two were before touching a patient and three were after touching the patient's surroundings. Three opportunities taken were observed to be non-compliant due to not following best practice technique for hand washing or and/or length of time taken to complete the hand hygiene procedure.

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 hand hygiene training is not prioritised and a culture of hand hygiene is not yet embedded across the organisation, and this must be addressed as a priority by the Hospital.

Conclusion

The poor level of hand hygiene training attendance in Wexford General Hospital suggests that a culture of hand hygiene best practice is not operationally embedded throughout the Hospital.

Recommendation 11. *A specific, targeted, hand hygiene strategy should be developed and implemented.*

Recommendation 12. *There should be clear and visible support from the Wexford General Hospital's board of management, including senior clinicians, to drive the hand hygiene campaign and ensure compliance from all levels of seniority and disciplines.*

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).

Documentation submitted to the Authority indicated that no HCAI adverse incidents or complaints were documented in 2012. On discussion with staff it was clarified that no HCAI incidents or complaints were received in that period.

Patient satisfaction surveys were undertaken in 2012, and it was reported in discussions with the PCHCAI team that feedback regarding hygiene issues included:

- cleaning at night-time was problematic (main thoroughfares were unclean, bins were overfull)
- bins overflowing at night-time
- doctors' hand hygiene practices were 'poor'
- cleanliness of patients' lockers was 'poor'.

Remedial action to address night-time cleaning included:

- emptying bins as part of the night-time routine
- specific areas identified by patient feedback are targeted at night-time for cleaning.

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

Findings Essential Element 3 (e)

St Bridget's Ward

Environment and equipment

Overall, the Authority found the area assessed to be clean with some exceptions. The Authority observed the following:

- Displayed information was appropriate, up to date and laminated or covered with a washable surface for effective cleaning in all areas throughout the environment and patient areas assessed.

- Work station equipment in all areas assessed, including telephones and keyboards, was observed to be free of dust and clutter.

- A 'clean' equipment storeroom was found to be clean, free of dust, dirt, spillages and clutter.

However, there was also evidence of practice that was not compliant with the *National Standards for the Prevention and Control of Healthcare Associated Infections*, such as:

- A mould-like substance was found in the area around the base of one water tap and around the edges of the grid in the water outlet in the 'dirty'[¥] utility room. Dried water splashes and stains were found on the splash back behind the sink in the cleaners' room.

- Hand-wash sinks in some clinical areas were not compliant with the HSE's Health Protection Surveillance Centre's *Guidelines for Hand Hygiene* (2005), for example, the water jet was directly located over the plughole and the plughole had a metal grid in situ.

- Moderate levels of dust were found on the bed frames of beds assessed by the Authority.

- The Authority found that there was a moderate level of dust on the floor of the clean utility room.

- The Authority found a wall in a patient area was damaged, with part of the plaster missing exposing the masonry underneath, which hindered effective cleaning.

- Two glucometers used for near-patient testing were assessed and found to be unclean and smeared.

- The clean utility room was found to be unlocked and therefore unauthorised access was not restricted in line with best practice.

- While wall tiles were clean in the 'dirty' utility room, their surface was worn and this may impede effective cleaning.

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

Waste segregation

There was evidence of good practice, such as the following:

- Clinical waste information posters identifying waste segregation were observed in the 'dirty' utility room and waste segregation areas in each area assessed.

Cleaning equipment

There was evidence of good practice, such as the following:

- Cleaning staff spoken with by the Authority were knowledgeable regarding infection prevention and control protocols.
- Authorised Persons from HIQA observed that rooms containing potentially hazardous cleaning solutions were locked and were inaccessible to the public in line with best practice.
- Cleaning equipment was clean and a colour-coded system was in place and demonstrated in the area assessed.
- Appropiate advisory signage was observed for use of products used for cleaning and disinfection. Safety data sheets were accessible within the clinical areas.

Patient isolation rooms

There were 11 single-occupancy rooms, of which two had negative pressure technology fitted as part of the patient accommodation. The Authority observed the following:

- Appropriate signage was in place identifying isolation procedures in progress, which described the precautionary measures to be undertaken on entering the rooms.
- Foot operated clinical non-risk and clinical risk waste bins were in place in the negative pressure room being used for isolation purposes. Foot operated non-clinical waste bins were in place in all the other single rooms being used for isolation purposes. This resulted in personal protective equipment being discarded in a non-risk healthcare waste bin, following use in an isolation room where a patient with confirmed communicable infection was being cared for. This poses a health and safety risk to patients and staff.

Linen

There was evidence of good practice, such as the following:

- Clean linen was stored appropriately. Used linen was segregated in line with best practice, evidenced by colour-coded linen bags and alginate bags used in the clinical areas.
- Clean linen assessed by the Authority was found to be free of stains and tears. Clean linen was stored in a dedicated linen cupboard.
- The Authority reviewed records which demonstrated that window curtain changing was undertaken twice a year and that bed screen curtains are routinely changed on a three-monthly basis by household staff and on patient discharge from single rooms.

Water outlet flushing

There was evidence of good practice, with records of routine water outlet flushing being demonstrated.

St Patrick's Ward

Environment and equipment

Overall the Authority found that the patient environment and the equipment assessed in St Patrick's ward were clean, with some exceptions. The Authority observed the following:

- Floors throughout were observed to be clean and free of dirt, grit and spillages.
- Clean linen was stored in a dedicated linen cupboard which was clean and free of dust, and inappropriate items. Clean linen assessed by the Authority was found to be clean and free of tears. Used linen was colour coded and segregated in line with best practice.
- In the 'dirty' utility area, patient commodes were clean, and appropriately stored.

However, there was also evidence of practice that was not compliant with the *National Standards for the Prevention and Control of Healthcare Associated Infections*, such as:

- Assisted shower rooms were not available for dependent patients. Dependent patients requiring showers must go to another ward to be accommodated.

- Paint was found to be missing from the base of bed tables. Paint was flaking and missing from some bedrail clamps and the grid base underneath mattresses, therefore hindering safe and effective cleaning.

- Paint was found to be missing from some wall surfaces in patient areas.

- Radiators in patient areas were stained and had visible dried fluid spillages evident on their surface.

- The Authority found that the area behind two toilet bowls, base of a wall adjacent to a one toilet bowl and the floors of two toilets assessed was heavily soiled. Grit and dust was also evident on toilet floors assessed.

- The Authority found the area around the wheels of some dressing trolleys to be soiled and rusted.

- The base of a hoist in storage 'ready for use' was smeared.

- A storeroom was found to be cluttered with six intravenous fluid stands and an ECG electrocardiograph machine preventing easy access to the patient equipment on shelving behind them.

- Hand hygiene sinks in some clinical areas assessed did not comply with the HSE's Health Protection Surveillance Centre's *Guidelines for Hand Hygiene* (2005). A domestic-type sink was used for hand washing in the clean utility room. Heavy semi-solid matter was found at the point where the bung chain was fixed to the sink and around the water outlet. Hand towels were located a distance from the sink resulting in water dripping across the floor from wet hands.

- The Authority found that the area between sinks and splash backs was not sealed on some hand-wash sinks in patient areas and in the 'dirty' utility room. Water outlets were rusted and many had a mould-like substance around their borders.

- A light level of dust was found on cupboard shelving in the 'dirty' utility room.

- All displayed signage was not up to date. A 'Laundry Delivery and Collection' record was displayed on the back of the 'dirty' utility room door and the last entry recorded was 05/08/2011.

Waste segregation

There was evidence of good practice, such as the following:

- Clinical waste information posters identifying waste segregation were observed in the 'dirty' utility and waste segregation areas in each area assessed.

- The Authority was informed that all waste, including clinical waste was tagged before leaving the point of production ensuring traceability if necessary. There were no waste bags awaiting collection during the assessment.

However, there was also evidence of practice that was not compliant with the *National Standards for the Prevention and Control of Healthcare Associated Infections*, such as:

- The Authority was informed of three waste management policies available at local level which were found to be out of date or incomplete as follows:

  - 'Operational Policy for Waste Management in Wexford General' dated April 2011. There was no review date provided
  - 'Guideline for Disposal and Distruction of Confidential Waste' dated June 2009
  - 'Waste Management Plan' dated July 2008 with a review date stated as July 2009.

Cleaning equipment

There was evidence of good practice, such as the following:

- Cleaning staff spoken with were knowledgeable regarding infection prevention and control protocols and procedures.

- Authorised Persons observed that rooms containing potentially hazardous cleaning solutions were locked and were inaccessible to the unauthorised persons in line with best practice.

- Cleaning equipment was clean with an established cleaning process evident. A colour-coded system was in place and demonstrated in the area assessed.

- Appropiate advisory signage was observed for use of products used for cleaning and disinfection. Safety data sheets were accessible within the clinical areas.

Patient isolation rooms

There was evidence of good practice, such as the following:

- Appropriate displayed signage was in place identifying isolation procedures in progress and describing the precautionary measures to be undertaken on entering the rooms.

- The Authority was informed of the procedure used for disposing of hazardous waste; it was secured at the patient's bedside in colour-coded waste bags and disposed of in a hazardous waste bin located at a central point within the ward.

Linen

There was evidence of good practice, such as the following:

- Clean linen was stored appropriately. Used linen was segregated in line with best practice, evidenced by colour-coded linen bags and alginate bags used in the clinical areas

- Clean linen assessed by the Authority was found to be free of stains and tears. Clean linen was stored in a dedicated linen cupboard.

- The Authority was informed that, as standard, window curtains were changed on a six-monthly basis and, as standard, bed screen curtains were changed on a three-monthly basis by household staff. Curtains were also changed following each patient discharge in the isolation rooms. Local records of curtain changing viewed by the Authority confirmed this.

Water outlet flushing

While there was evidence of good practice, improvement opportunities were available to ensure compliance with the *National Standards for the Prevention and Control of Healthcare Associated Infections*, such as:

- Records of water outlet flushing were demonstrated. While the Authority was informed that all outlets were flushed daily by cleaning staff, there were no records available referencing the location of the showers and taps flushed, therefore, comprehensive audit of this practice was not feasible.

The Maternity Ward

Environment and equipment

Overall the Authority found the Maternity ward environment and some patient equipment assessed were unclean. The Authority observed the following:

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

- In the 'dirty' utility area, the Authority observed patient commodes were clean, and appropriately stored.

However, there was also evidence of practice that was not compliant with the *National Standards for the Prevention and Control of Healthcare Associated Infections*, such as:

- The Authority observed that ceiling tiles were missing along the ward corridor exposing plumbing infrastructure and masonry, preventing safe and effective cleaning. This finding places patients and newborn babies at significant risk of HCAIs.

- Chipped and flaking paint was found on some walls in the patient areas and in a patient bathroom.

- Light levels of dust were found on the base of an intravenous fluid stand and a blood pressure monitor stand. Dust was also found on the resuscitation trolley.

- Hand-wash sinks in some clinical areas were not compliant with the HSE's Health Protection Surveillance Centre's *Guidelines for Hand Hygiene* (2005), for example, the water outlet was directly located under the tap water jet in some hand-wash sinks in the clinical areas assessed.

- The Authority found that a wooden splash back behind a sink in the clean utility room was chipped and damaged. A metal hand-wash soap holder was rusted.

- While a storeroom was found to contain a neat shelving unit for storing stock, Authorised Person observed boxes of IV fluids, sharps bins and other items stored on the floor, thereby hindering effective cleaning.

- The surface of some bedpans was scratched, hindering effective cleaning.

Waste segregation

There was evidence of good practice, such as the following:

- Clinical waste information posters identifying waste segregation were observed in the area assessed.
- The Authority was informed that all waste including clinical waste was tagged before leaving the point of production ensuring traceability if necessary. The door was locked restricting unauthorised access to the room where waste was placed, in line with best practice.

Cleaning equipment

There was evidence of good practice, such as the following:

- Cleaning equipment was clean, with an established cleaning process evident. A colour-coded system was in place and demonstrated in the area assessed.
- Appropriate advisory signage was observed for use of products used for cleaning and disinfection.

However, there was also evidence of practice that was not compliant with the *National Standards for the Prevention and Control of Healthcare Associated Infections*, such as:

- Cleaning staff spoken with by the Authority were not knowledgeable in all areas of infection prevention and control protocols and procedures.
- The Authority observed that rooms containing potentially hazardous cleaning solutions were not accessible due to building work in progress, necessitating storage of cleaning equipment on a corridor, which was not in line with best practice.

Linen

There was evidence of good practice, such as the following:

- Clean linen was stored in a dedicated linen cupboard.
- The Authority was informed that, as standard, window curtains were changed on a six-monthly basis and, as standard, bed screen curtains were changed on a three-monthly basis by household staff. Curtains were also changed following each patient discharge from the isolation rooms.

However, there was also evidence of practice that was not compliant with the *National Standards for the Prevention and Control of Healthcare Associated Infections*, such as:

- The Authority found baby cot blankets to be worn with evidence of pilling. Cot sheets were worn and frayed.

Theme 3: Safe Care – Conclusion

In conclusion, the Authority found that the ward area environment and equipment was generally clean, with the exception of the Maternity ward. A corridor ceiling in the Maternity ward required urgent improvement with replacement of ceiling tiles to be prioritised to militate against the risk of patients and newborn babies contracting HCAIs. Cleaning equipment was also inappropriately stored in this area due to building works in progress. Toilet cleaning required improvement in St Patrick's ward.

The majority of hand hygiene sinks in the clinical areas assessed did not comply with the HSE's Health Protection Surveillance Centre's *Guidelines for Hand Hygiene* (2005). The cleaning of sinks and accessories used for hand hygiene required improvement in all areas assessed.

Appropriate information was displayed outside isolation rooms. Linen was stored and segregated appropriately. Clinical and non-clinical waste was dealt with appropriately, although an up-to-date local waste management policy was not available in St Patrick's ward.

Theme 3: Safe Care – Recommendations

Recommendation 13. *Wexford General Hospital should review the placement of clinical waste bins in isolation rooms in order to minimise the risk of the spread of communicable/transmissible diseases.*

4. Overall Conclusion

4.1. Overview

In advance of the commencement of this monitoring programme, the Authority advised all service providers that the assessment would focus on the essential capacity and capability factors necessary to implement four of the practices that international research has shown to contribute significantly to reducing Healthcare Associated Infections and improve patient safety. These are:

1. Hand hygiene compliance.
2. The cleanliness of the environment and equipment.
3. The appropriate use of antimicrobial antibiotics (antimicrobial stewardship).
4. The prevention of Healthcare Associated Infections associated with invasive medical devices such as intravenous lines and urinary catheters.

In Wexford General Hospital, the Authority found:

- While the Infection Prevention and Control Team and the Infection Prevention and Control Committee understood the importance of hand hygiene practice, there was little evidence to demonstrate a deep level of executive commitment to driving the hand hygiene agenda throughout Wexford General Hospital. Hand hygiene was not mandatory for all staff. The Infection Prevention and Control Team raised concerns about the low attendance of staff at hand hygiene training and the levels of compliance with hand hygiene. However, there was no evidence of an effective executive response and resultant action plan to manage this risk. Wexford General Hospital did not achieve its target of 75% compliance with hand hygiene.
- The clinical areas in St Patrick's and St Bridget's wards were generally clean.
- Corporate and clinical governance in Wexford General Hospital did not demonstrate effective leadership regarding PCHCAI. This is of significant concern to the Authority given that antimicrobial stewardship and surveillance are essential elements to prevent and control Healthcare Associated Infections. There was no formal antimicrobial prescribing feedback programme in place.
- There was an inconsistent completion of care bundle documentation and early warning score system in the areas assessed.

The Authority also assessed the essential elements of Leadership, Governance and Management, Workforce and Safe Care that an organisation must have in place as the foundation for providing safe quality care in order to prevent and control Healthcare Associated Infections. In Wexford General Hospital, the Authority found that PCHCAI governance is documented. However, key posts, such as a surveillance scientist and a designated antimicrobial pharmacist were absent from the structure. The evidence does not demonstrate an executive commitment to reducing the risk to patients of acquiring HCAIs or executive leadership championing PCHCAI.

Arrangements are in place to ensure that the accountable person is informed regarding PCHCAI activity in the Hospital through monthly reports submitted by the Infection Prevention and Control Team. However, it was not clear to the Authority how the Board of Management, the accountable person and in turn the HSE, assure themselves and the public that the arrangements for the prevention and control of Healthcare Associated Infections in Wexford General Hospital are effective.

Theoretical and practical training in relation to the prevention and control of HCAIs is not mandatory for staff; this poses a risk to patients of increased HCAIs. There was evidence to suggest to the Authority that PCHCAI staff are endeavouring to promote hand hygiene throughout the Hospital. The Authority's' observations, combined with discussions in meetings with hospital staff, suggest that a culture of hand hygiene best practice is not embedded at all levels and that there is a resistance to attendance at educational sessions.

It is acknowledged by the Authority that all hospitals face the challenges of restricted resources. However, the evidence demonstrates that a clean environment, best practice in hand hygiene, antimicrobial stewardship and the use of care bundles where invasive devices are employed, contribute significantly to the reduction of HCAIs. Therefore it is crucial that Wexford General Hospital's executive management prioritise these issues and direct resources toward their implementation in order to prevent and control the risk of HCAIs to patients in Wexford General Hospital.

In conclusion, the Authority found Wexford General Hospital to be partially compliant with the *National Standards for the Prevention and Control of Healthcare Associated Infections*. However, a significant number of risks were identified that could potentially increase the possibility of HCAIs to patients. These risks have resulted in 13 recommendations being made to improve PCHCAI governance and practice and to reduce risk of HCAIs to patients in Wexford General Hospital.

Wexford General Hospital 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's (HSE's) website within six weeks of the date of publication of this report.

The Hospital should ensure the continued monitoring of its 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.

5. Recommendations

Recommendation 1. *The governance arrangements will include PCHCAI specific strategies and aligned cost-effective initiatives.*

Recommendation 2. *The corporate and clinical governance arrangements at Wexford General Hospital should be reviewed in order to ensure compliance with the National Standards for Prevention and Control of Healthcare Associated Infections.*

Recommendation 3. *A formal system of communication regarding PCHCAIs should be developed and implemented in Wexford General Hospital.*

Recommendation 4. *There should be a named accountable person for the coordination of the PCHCAI surveillance programme.*

Recommendation 5. *An efficient antimicrobial stewardship programme should be developed and implemented.*

Recommendation 6. *PCHCAI staff should be facilitated to attend ongoing professional development.*

Recommendation 7. *Hand hygiene training should be made mandatory for all staff.*

Recommendation 8. *Wexford General Hospital must put in place arrangements to ensure that all staff receive mandatory theoretical and practical training in relation to the prevention and control of Healthcare Associated Infections.*

Recommendation 9. *Arrangements should be put in place for all visiting clinicians and undergraduates to ensure that they are competent in the core principles for the preventions and control of HCAIs.*

Recommendation 10. *Wexford General Hospital must put in place arrangements to ensure that specific care bundles and/or policies, procedures and guidelines are developed, communicated, implemented and their efficacy monitored.*

Recommendation 11. *A specific, targeted, hand hygiene strategy should be developed and implemented.*

Recommendation 12. *There should be clear and visible support from the Wexford General Hospital's board of management, including senior clinicians, to drive the hand hygiene campaign and ensure compliance from all levels of seniority and disciplines.*

Recommendation 13. *Wexford General Hospital should review placement of clinical waste bins in isolation rooms in order to minimise the risk of the spread of communicable/transmissible diseases.*

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.

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