Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of inspections at Our Lady of Lourdes Hospital, Drogheda.

Monitoring programme for unannounced inspections undertaken against the National Standards for the Prevention and Control of Healthcare Associated Infections

Date of on-site inspections: 11 June and 16 July 2015

About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is the independent Authority established to drive high quality and safe care for people using our health and social care services. HIQA's role is to promote sustainable improvements, safeguard people using health and social care services, support informed decisions on how services are delivered, 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.
- **Supporting Improvement –** Supporting services to implement standards by providing education in quality improvement tools and methodologies.
- **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. Introduction

The Health Information and Quality Authority (the Authority) carries out unannounced inspections in public acute hospitals in Ireland to monitor compliance with the *National Standards for the Prevention and Control of Healthcare Associated Infections*.[1] The inspection approach taken by the Authority is outlined in guidance available on the Authority's website, www.hiqa.ie – *Guide: Monitoring Programme for unannounced inspections undertaken against the National Standards for the Prevention and Control of Healthcare Associated Infections*.[2]

The aim of unannounced inspections is to assess hygiene in the hospital as observed by the inspection team and experienced by patients at any given time. It focuses specifically on the observation of the day-to-day delivery of services and in particular environment and equipment cleanliness and compliance with hand hygiene practice. In addition, following the publication of the 2015 *Guide: Monitoring Programme for unannounced inspections undertaken against the National Standards for the Prevention and Control of Healthcare Associated Infections*,[2] the Authority will assess the prevention of invasive device related infections by monitoring the implementation of infection prevention care bundles.[*] In particular this monitoring will focus upon peripheral vascular catheter and urinary catheter care bundles, but monitoring of performance may include other care bundles as recommended in national[3-4] and international[5] guidelines.

Assessment of performance will focus on compliance with the following Standards:

- Standard 3: The physical environment, facilities and resources are developed and managed to minimise the risk of service users, staff and visitors acquiring a Healthcare Associated Infection.
- Standard 6: Hand hygiene practices that prevent, control and reduce the risk of spread of Healthcare Associated Infections are in place.
- Standard 8: Invasive medical device related infections are prevented or reduced.

Other Standards may be observed and reported on if concerns arise during the course of an inspection. It is important to note that the Standards are not assessed in their entirety during an unannounced inspection and therefore findings reported are related to a particular criterion within a Standard which was observed during an inspection. The Authority uses hygiene observation tools to gather information about the cleanliness of the environment and equipment, hand hygiene practice and infection prevention care bundles in one to three clinical areas depending on the size of the hospital. The Authority's approach to an unannounced inspection against

[*] A care bundle consists of a number of evidence based practices which when consistently implemented together reduce the risk of device related infection.

these Standards includes provision for re-inspection within six weeks if Standards on the day of inspection are poor. This aims to drive improvement between inspections. In addition, in 2015, unannounced inspections will aim to identify progress made at each hospital since the previous unannounced inspection conducted in 2014.

Timeline of unannounced inspections:

An unannounced inspection was carried out at Our Lady of Lourdes Hospital Hospital, Drogheda on 11 June 2015 followed up with a re-inspection on 16 July 2015. The re-inspection examined the level of progress which had been made regarding infection prevention and control risks identified during the June 2015 inspection. This report was prepared after the re-inspection and includes the findings of both inspections and any improvements observed between the first and second inspections.

A summary of these inspections is shown in Table 1.

Table 1: Summary of inspections carried out at Our Lady of Lourdes Hospital Drogheda.

Date of Inspection	Authorised Persons	Clinical Areas Inspected/Visited	Time of Inspection
11 June 2015	Aileen O' Brien Katrina Sugrue Anna Delany Rachel Mc Carthy	6th Floor East and West inspected 3rd Floor Surgical inspected 3rd Floor Orthopaedic visited 2nd Floor Medical Ward (Stroke Unit Level 2) visited	10.45hrs - 17.30hrs
Re-inspection date: 16 July 2015	Aileen O' Brien Katrina Sugrue Anna Delany Rachel Mc Carthy	Oncology Day Unit inspected 6th Floor East and West re-inspected 3rd Floor Surgical re-inspected 3rd Floor Orthopaedic, Coronary Care Unit, Stroke Unit and Endoscopy Unit visited.	10.45hrs – 17.30hrs

The Authority would like to acknowledge the cooperation of staff during both unannounced inspections.

2. Our Lady of Lourdes Hospital, Drogheda Profile[‡]

Louth Hospitals comprises two hospitals: Our Lady of Lourdes Drogheda and Louth County Hospital Dundalk.

Our Lady of Lourdes Hospital, Drogheda is a 348 bed acute general hospital incorporating a regional neonatal unit and the Louth/Meath paediatric unit.

Summary of Services:

Surgical Services include general surgery, orthopaedics, urology, gynaecology and ear nose and throat surgery.

Medical services include general medicine, including sub specialties of cardiology, endocrinology, diabetes, gastroenterology, oncology, dermatology, elderly medicine, respiratory medicine, microbiology, pathology and palliative care.

Regional Trauma Orthopaedic Service including fracture clinics, providing trauma orthopaedic services for the populations of Cavan, Monaghan, Louth and Meath

Maternity Services for the Louth Meath area including a midwifery led unit.

Paediatric Services include 34 inpatient beds for medical, surgical and orthopaedic admissions and for children admitted with life-limiting conditions.

Emergency Medicine services for the Louth Hospitals supported by a Minor Injuries Unit in Louth County Hospital Dundalk. The Emergency Department in Our Lady of Lourdes is one of the top five in the Country in terms of numbers of presentations.

[‡] 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.

3. Findings

This section of the report outlines the findings of inspections undertaken at Our Lady of Lourdes Hospital, Drogheda on 11 June 2015 and 16 July 2015.

Overview of areas inspected

3rd Floor Surgical is a twenty three bed acute surgical ward with patient accommodation comprising three six bed rooms, one four bed room and one single isolation room.

6th Floor East and 6th Floor West were formerly two separate medical wards but have been managed as one ward since March 2015. The 6th Floor comprises 41 beds with patient accommodation comprising four six-bed rooms, four two-bed rooms, three single rooms and a six bed transit lounge to accommodate Emergency Department patients awaiting admission.

The **Oncology/Haematology Unit** provides an outpatient chemotherapy and infusion service and comprises seven patient treatment spaces.

Inspectors may visit but not inspect a clinical area to follow up information received during an inspection or to determine progress in implementing a prior quality improvement plan (QIP). 3rd Floor Orthopaedic and 2nd Floor Medical Ward were inspected in 2014 and revisited during the June 2015 inspection. The Coronary Care Unit, 3rd Floor Orthopaedic, the Intensive Care Unit, The Paediatric Ward and the Endoscopy Unit were visited during the July 2015 inspection.

Structure of this report

The structure of the remainder of this report is as follows:

- **Section 3.1** describes the immediate high risk findings identified during the inspection on 11 June 2015 and the mitigating measures implemented by the hospital in response to these findings. Copies of the letter sent to the hospital regarding findings and the QIP prepared by the hospital in response are shown in Appendices 1 and 2 respectively.
- **Section 3.2** summarises additional key findings relating to areas of non-compliance observed during the unannounced inspections in 2015 and the level of progress made by the hospital in response to the findings of the first inspection at the time of re-inspection on 16 July 2015.
- **Section 3.3** outlines the progress made 3rd Floor Orthopaedic and 2nd Floor Medical following the unannounced inspection by the Authority on 8 May 2014.
- **Section 3.4** describes the key findings relating to hand hygiene under the headings of the five key elements of the World Health Organization (WHO)

multimodal improvement strategy[3] during the inspections on 11 June 2015 and 16 July 2015.

- **Section 3.5** describes the key findings relating to infection prevention care bundle implementation at the hospital.

This report outlines the Authority's overall assessment in relation to the inspections and includes key findings of relevance. In addition to this report, a list of additional low-level findings relating to non-compliance with the standards has been provided to the hospital for completion. However, the overall nature of key findings are fully summarised within this report.

3.1 Immediate high risk findings

Introduction

During the unannounced inspection on 11 June 2015, a number of high risks were identified, the composite of which presented an immediate high risk finding. Risks were identified regarding hand hygiene compliance and hand hygiene facilities, safe injection practice, environmental and patient equipment hygiene, infrastructure, maintenance and aspergillus and legionella control measures. Cumulative findings were such that the Authority deemed that a re-inspection was necessary within six weeks.

Details of these risks were communicated to the hospital (see Appendix 1) and in response (see Appendix 2) a QIP was prepared by the hospital to address the findings. The level of progress made in the implementation of the QIP was assessed during the re-inspection on 16 July 2015 and is outlined below.

Hand hygiene compliance and hand hygiene facilities

Hand hygiene compliance at the hospital was significantly below the HSE national key performance indicator for hand hygiene compliance in 2014 in both hospital wide and local hand hygiene audits.[4] Hand hygiene compliance observed by inspectors in June 2015 was very good on 3rd Surgical but poor on the 6th Floor.

Facilities for and access to hand hygiene facilities in the areas inspected were less than optimal. Hand hygiene facilities in a hospital need to be accessible, for example hand wash sinks should be conveniently located in patient care areas and alcohol hand rubs should be available at the bedside so that staff can easily clean their hands as necessary. Inspectors observed that there was no hand hygiene sink within the transit lounge on the 6th Floor and up to three clinical hand wash sinks were out of order for example in an isolation room and a patient toilet. It was reported that recurring technical problems in relation to some sinks had not been successfully addressed. Authorised persons were informed that sink faults were not addressed in a timely fashion. It was also observed that water flow to several sinks was poor, and the water was hotter than desirable for hand washing. Sealant between several of the sinks and walls were not intact.

Access to hand hygiene sinks in multi-bedded wards was significantly obstructed by beds or armchairs. Sinks in multi-occupancy rooms were located within a patient zone which meant that when curtains were drawn around the bed, access to the sink was inaccessible to other staff. Additional hand hygiene sinks had been installed on corridors in the areas inspected, however these were small in size and drainage of water from these sinks was slow. Waste bins to facilitate paper towel disposal were not always located beside clinical hand wash sinks. Alcohol gel was not

available at each point of care on 3rd Floor Surgical and alcohol gel dispensers in multi-occupancy rooms were positioned such that they were not easy to see or access. These factors combined with reduced spatial separation between patients in multi occupancy wards did not facilitate optimal performance of hand hygiene by staff.

Two infection prevention and control nurse positions were vacant in the hospital at the time of inspection which reduced training and auditing activities. To address this deficit the hospital had temporarily engaged external staff to deliver staff training and assist with audit.

Re-inspection on 16 July 2015

Hand hygiene was re-audited by the hospital on 3rd Floor surgical and 6th Floor West soon after the June inspection and these wards achieved compliance scores of 75% and 64.3% respectively; again not in compliance with the national target of 90%. It was reported that an additional three local hand hygiene audits were carried in 3rd Floor Surgical in mid June and July and compliance of 91% was achieved in the July audit. Although feedback to staff highlighted practice deficits, audit findings had not been followed up with refresher hand hygiene training.

Hand hygiene compliance results viewed in respect of the Emergency Department that indicated scores of less than 40% in February and July 2015 were of concern to the Authority as this is a high risk area. Very poor compliance in individual clinical areas will impact on overall hospital compliance scores and requires concentrated education and re-evaluation.

Alcohol hand gels had been placed at each point of care in 3rd Floor Surgical Ward. Ongoing problems in relation to poor sink drainage, temperature control and poor water flow to hand wash sinks in two areas inspected had not been successfully addressed.

A hand hygiene sink survey performed by the hospital in 2013 identified that 73% of sinks in clinical areas were non compliant with recommended standards. Hand wash sinks in high risk areas had been replaced and were compliant with standards. It was reported that funding required to replace remaining sinks had not been allocated to the hospital in 2015. No timeframe could be provided in respect of completion of the sink replacement programme.

It was reported that a risk assessment was conducted around access to hand wash sinks in relation to bed capacity, the results of which were to be discussed. No timeframe for repositioning of sinks was presented.

A new system of recording hand hygiene training was implemented in January 2015 and it was reported that a breakdown of training per discipline and department

would be facilitated at the end of the year. The hospital estimated that 70% of hospital staff had undertaken hand hygiene training in 2015.

The hospital had produced a draft comprehensive action plan for hand hygiene improvement which included immediate and longer term activities. Actions reported to have been implemented since the previous inspection included:

- retraining of hand hygiene facilitators involved in training and auditing and use of a variety of visual training aids
- daily visits to clinical areas by hospital management team members to promote good practice
- scheduled weekly spot audits incorporating hand hygiene observation audit
- white boards fitted in ward public areas to display local compliance with audit key performance indicators
- screen savers on ward computers to remind staff of hand hygiene.

Longer term actions were drafted but a timeframe for completion had not been finalised, these included an official hand hygiene campaign launch, revised hand hygiene governance, league tables, implementation of the WHO multimodal strategy, patient empowerment and the establishment of a working group.

Vacancies in the infection prevention and control nursing team are to be filled this year and additional infection prevention and control resources are to be allocated to hand hygiene practice improvement.

It was apparent that the hospital management team were in the process of proactively striving to improve hand hygiene compliance in line with national recommendations. However, significant barriers to effective hand hygiene practice including inadequate bed spacing and poor access to clinical hand wash basins remain and need to be addressed in order to effect improvement.

Safe injection practice

The preparation of medication for intravenous administration and the management of multi-dose medication vials were not in line with evidence based practice.

During the inspection of the 6th Floor, the Authority observed the opening of several sterile syringes at the same time directly on a work top adjacent to a clinical hand wash sink. Appropriate hand hygiene and aseptic non touch technique was not applied during this procedure. The Authority informed relevant personnel of this immediate high risk and the issue was addressed at the time of the inspection. The practice observed had the potential to increase the risk of transmission of infection to patients. Intravenous medications should be prepared in a clean environment

using an aseptic technique and should be administered as soon as possible following reconstitution. [5]

Poor practice relating to the use of multi-dose vials of insulin and anticoagulant medication was observed in one of the wards inspected in that these vials were not designated single patient use. Inappropriate use of multi-dose vials has been linked to outbreaks of infection.[5,6]

Re-inspection on 16 July 2015

Risks in relation to safe injection practice and multi-dose vial use were addressed by the hospital. Insulin vials in 3rd Floor Surgical were designated single patient use and the hospital was exploring options in relation to supplying single dose anticoagulant medication. Local targeted training and support regarding the administration of intravenous medication had been carried out and local practice in respect of the intravenous medication preparation area was revised. Learning was shared across the hospital by way of an internal memorandum to all clinical staff regarding the safe use of multi-dose vials and insulin pens. In addition multi-dose vial management was reviewed in other clinical areas. Actions agreed included the proposed revision of multi-dose vial management and drug labelling practice to be performed by the drugs and therapeutic committee in addition to a formal audit of labelling of multi-dose vials by pharmacy staff.

It is recommended that local practice is re-audited on a regular basis and that ongoing training for staff regarding safe injection practice and aseptic non touch technique is provided to staff.

Environmental Hygiene

Environmental hygiene in 6th Floor East and West was poor overall with unacceptable levels of dust observed in most areas assessed. Dust was present on the undercarriages and frames of beds inspected, on floor edges, skirting and over bed trunking. Dust was also present in most areas in the clean utility rooms, which are used for the preparation of intravenous medications and the storage of medical equipment.

It was reported at the time of inspection that there was an insufficient supply of floor mop heads required for daily cleaning sessions. It was also reported that a vacuum cleaner was not available on the 6th Floor for up to three months prior to the inspection which impacted on dust control. Dust control should be performed prior to floor mopping in line with national cleaning guidelines.[7] Assurance was not provided that reusable spray bottles containing detergent for general purpose cleaning were effectively cleaned and dried at the end of each cleaning session. Cleanliness of an isolation room following a terminal clean was insufficient such that armchairs

remained stained, residue was present behind pipe work and floor edges, corners and skirting were dusty. In addition, window curtains were not removed prior to terminal cleaning in line with local policy.

It was reported than the 6th Floor scored 86% in an environmental hygiene audit at the end of May 2015; however, this was not consistent with the findings of the June inspection. Although inadequate dust control was highlighted in a recent internal hospital hygiene audit, findings at the time of inspection did not provide assurance that this deficit in cleaning process was effectively addressed. A clean environment not only reduces the risk of healthcare associated infection but also promotes patient and public confidence and demonstrates the existence of a positive safety culture.[8]

The three wards inspected did not have a designated housekeeping equipment room. Cleaning equipment was inappropriately stored in 'dirty' utility rooms which had been equipped with low level janitorial sinks and detergent dispensing systems. In addition, a vacuum cleaner was stored in a staff changing room on 3rd Surgical. Although additional ancillary rooms were added in recent years to 3rd Surgical by way of a modular structure no provision was made at that time for a designated housekeeping utility room. Failure to appropriately segregate functional areas and incomplete implementation of best practice guidelines in relation to environmental cleaning and related equipment management poses a risk of cross contamination and potentially places patients at risk of infection.

Re-inspection on 16 July 2015

The hospital management team were actively involved in promoting improvements at corporate and local level. Daily visits to clinical areas by the hospital management team were being performed since the June inspection to monitor progress and support improvements. It was reported that the hospital management team had also carried out daily spot checks on the 6th and 3rd floor wards and any environmental hygiene deficits highlighted were addressed.

Deep cleaning of the areas inspected in June had been performed and improvement was observed in the overall standard of environmental hygiene on the 6th Floor with the exception of one isolation room in which surfaces were dusty. It is recommended that isolation rooms are cleaned in line with national cleaning guidelines.

An environmental hygiene audit had been carried out shortly after the June inspection and the 6th Floor had achieved a score of 74%. Dust control issues were again identified in patient areas. The desirable score for hygiene audits is greater than 85%. It was noted that a formal follow up audit had not been conducted on the 6th Floor by the time of the July inspection. Less than optimal environmental hygiene audit results should be repeated to identify deficits and facilitate improvement. It

was reported however, that hygiene issues were being actively followed up by regular visits to the ward by the hospital management team.

Deficits in cleaning resources on the 6th Floor had been reviewed and addressed in that cleaning hours had been increased and additional cleaning equipment and supplies were available. Increased cleaning session duration on the 6th Floor was reported to have positive effect and should be maintained. Revised dust control measures included daily vacuum cleaning which was reported to be effective. Discussions were underway regarding increasing supervision of cleaning practices in the hospital. The Authority was informed of planned arrangements for internal and external window cleaning. Refresher training for auditors was under review. It was reported that housekeeping staff employed had previously undergone formal cleaning training. However, additional training had been provided to housekeeping staff following the June inspection but it was of concern to the Authority that training content did not address core cleaning principles and processes.

Provision of a designated housekeeping equipment room with low level sink and hand hygiene facilities was underway on 3rd Floor Surgical and identification and fit out of designated rooms on the 6th Floor was reported to be in progress.

Patient equipment hygiene

The system in place for the cleaning of patient equipment requires improvement. A labelling system was used to identify equipment that had been cleaned. However, at the time of the June inspection equipment on the 6th Floor including thermometer probe holders, suction apparatus, shower seats, observation monitoring trolleys, dressing trolleys, chair weighing scales, resuscitation trolleys and drip stands were dusty or stained despite being labelled as cleaned on the day of the inspection. It was reported that both nurses and healthcare assistants were responsible for cleaning.

It is recommended that patient equipment cleaning specifications provide clarity in relation to cleaning frequency, methodology and responsibility.

Re-inspection on 16 July 2015

Improvements in the cleanliness of patient equipment were observed during the re-inspection of the 6th Floor. A new cleaning checklist and tagging system for patient equipment cleaning was developed on the 6th Floor. A regular mattress checking system was in place in all areas inspected in June both weekly and on patient discharge. Information and communication with regard to cleaning was circulated to ward staff.

Infrastructure and maintenance

Maintenance of the patient environment in the older part of the hospital was of concern to the Authority at the time of the June inspection. Surfaces, finishes and some furnishings in patient rooms including windows, wall paintwork, wall coverings, woodwork, wood finishes and bed tables were worn and poorly maintained and as such did not facilitate effective cleaning. Ceiling paintwork was stained in some areas. Some bed tables were in poor condition with damaged woodwork and rusted metalwork and upholstery was worn on some patient chairs.

The hospital management team attributed poor maintenance to bed capacity in excess of 100% at times and related difficulty in accessing areas in order to facilitate maintenance works.

Documentation viewed by the Authority indicated that a risk assessment performed on the 6th Floor in 2014 identified inadequate bed spacing as a high risk with the potential to increase the risk of cross infection. In order to mitigate this risk it was reported that patients requiring isolation were transferred to a more suitable area of the hospital. It was evident at the time of inspection that bed spacing in multi-bedded wards in the three areas inspected was not in compliance with best practice guidelines. Limited spatial separation between beds did not facilitate ease of movement of staff or mobilisation of patients. Staff should be able to attend to one patient without impinging on the adjacent patient or patient zone and without compromising infection control practices. Bedside chairs that were occupied by patients restricted access to hand hygiene sinks. Patients' belongings were stored directly on the floor in wards as patients did not have individual wardrobes. Required upgrading of older beds to larger profiling beds further restricted space in patient rooms.

Re-inspection on 16 July 2015

Limited improvements were made in the hospital in relation to maintenance deficits identified during the June inspection in patient care areas. The woodwork on patient bedside tables on 3rd Surgical and on the 6th Floor had been resurfaced and it was planned to recoat metal surfaces of these tables. One bed space was renovated with wall and floor covering replacement on 3rd Surgical. A number of chairs on 3rd Surgical had been reupholstered to facilitate effective cleaning and damaged commodes had been replaced. In addition, sealant around hand wash basins in patient toilets had been addressed. Despite intensive efforts to clean floor covering in a patient toilet on 3rd Floor Surgical an unpleasant odour remained in the room. Attempts had been made to remove staining from toilet bowls with limited success. Further action to address the issues identified is recommended. Efforts were made to remove ceiling stains in 3rd Floor Surgical.

No additional maintenance work had been carried out in the three wards inspected in June to address paintwork, woodwork, exposed pipe work or other floor covering since the previous inspection. The hospital had prepared an assessment and estimation of costs in relation to maintenance works required in the area inspected.

A comprehensive plan outlining intermediate maintenance work required for three wards and associated costs had been prepared by the hospital but the performance of this work plan was dependant on a number of factors. These included the transfer of patients to the community, allocation of HSE funding and the provision of a modular unit to facilitate decanting of wards to facilitate works. At the time of reporting there was no agreed timeframe for the commencement of these maintenance works.

No changes were made to increase bed spacing and there was no agreed timeframe in which bed spacing would be increased other the longer term plan to construct additional patient accommodation estimated for completion in the year 2017. Deficits in relation to storage of patient property were not addressed due to space limitations in wards.

Notwithstanding existing infection prevention and control arrangements, the Authority was not assured that bed spacing in the areas inspected in June 2015 was sufficient. Limited space between beds increases the risk of cross infection and likely contributes to overall poor hand hygiene compliance in the hospital. In the interim of planned facility upgrading it is recommended that bed configuration on 3rd Floor Surgical, the 6th Floor and similarly laid out wards be reassessed as a matter of priority.

The Authority acknowledges that a new extension for inpatient accommodation, an operating theatre suite and emergency department extension is likely to be completed towards the end of 2017. However, notwithstanding future facility upgrade plans, acute healthcare facilities need to be continuously maintained and care should be provided in a safe environment. Poor maintenance and poor environmental hygiene have been cited as contributory causal factors in serious outbreaks of infection in hospitals.[9]

Aspergillus control

Deficiencies were identified during the inspection relating to aspergillus control measures during renovation works in progress on a stairwell adjacent to 6th Floor East Ward. Inspectors viewed method statements specific to this project and although these documents indicated that dust control measures were required they were not in place.

Re-inspection 16 July 2015

Breaches identified in dust control during construction activity identified during the June inspection were formally addressed by the hospital with relevant stakeholders.

A list of all ongoing works and related aspergillus control measures had been prepared and it was reported that robust dust control measures were in place and that there was increased frequency of routine checks regarding control measures. It was also reported that to protect at risk patients during dust generating activity patients were relocated or planned works were rescheduled.

Documentation reviewed indicated that training was provided to external contractors by the Infection Prevention and Control Team in relation to aspergillus control between January and July 2015.

The Authority recommends that the hospital should ensure that aspergillus control measures in line with national guidelines are consistently implemented. [10]

Legionella control measures

During initial inspection, the Authority identified that the hospital's ongoing programme of environmental water testing had identified the intermittent presence of *Legionella species* in water samples in some patient areas in the older hospital block. This issue has persisted despite significant investment in works which included installation of a water treatment system 18 months prior to this inspection to address this issue. When legionella counts exceeded desirable limits the hospital informed the Authority that affected outlets were fully decommissioned and retested. It was reported by the hospital that no patients at Our Lady of Lourdes Hospital had been identified as having Legionnaire's disease.

It is a significant concern that the risk of legionella persists in the hospital water supply despite significant financial investment to address the problem. Authorised Persons were informed that shower heads were removed from patient wash rooms in the affected areas approximately 18 months previously as a risk control measure, and that these had not been replaced because of the potential for aerosolisation of legionella bacteria into the environment. It is unacceptable that patients have been subjected to inadequate showering facilities for a prolonged period in affected areas. Due to the nature of their underlying medical conditions and treatment modalities, some patients are at a higher risk of opportunistic infection than others. It is essential that management of legionella risk at Our Lady of Lourdes Hospital Drogheda is effectively managed, with a particular focus placed upon protecting patients who may be especially vulnerable to infection.

In response to concerns raised by the Authority the hospital reported that they were satisfied that their systems to monitor water quality were sufficient to reduce any

potential risks to patients. However, the Authority was not assured that the issue had been sufficiently resolved to a satisfactory conclusion in that many patients are still unable to avail of proper showering facilities. Indeed a patient information sheet communicating the need to remove shower heads for essential maintenance purposes viewed by the Authority on a ward was dated 2009, indicating that this has been a long term issue. The Authority does not deem it acceptable that shower heads are not available in some wards, as a shower is a basic requirement to meet personal hygiene needs. Failure to routinely provide showers which have shower heads (and instead only rely on use of a headless hose) for patients to wash under is unacceptable and does not promote patient hygiene, dignity or comfort.

The Authority's initial inspection identified a deficit in the undertaking of a formal risk assessment of the hospital's water system in accordance with national guidelines.[11] It was reported at the time of the July inspection that a formal site legionella risk assessment by an independent contractor had commenced on 6 July 2015. It is imperative that the hospital uses this risk assessment as a tool to identify and systematically address any outstanding water supply remedial works, such that the problem of legionella detection in the water supply is resolved. Moreover, it is important that ongoing review of the water system occurs at least annually in line with national guidelines.[11] If it is assessed that shower heads cannot be safely used at particular outlets, the hospital needs to make alternative shower arrangements for patients in affected areas. In addition, a risk assessment of the appropriateness of placement of patients who are especially vulnerable to legionella infection in each affected area, by a person competent to do so, should also occur.

Finally, on a related note, there was evidence of non-adherence to the hospital policy in relation to the management of nebulisers at the time of the inspection. Single use only nebulisers were reused which was not in accordance with best practice.[12] Contaminated nebulisers are potential reservoirs for infection therefore adherence to best practice in the management of respiratory equipment is essential.

Visits to other clinical areas 16 July 2015

The Coronary Care Unit, 3rd Floor Orthopaedic, the Intensive Care Unit, the Paediatric Ward and the Endoscopy Unit were visited during the July 2015 inspection. There was evidence of shared learning in respect of safe injection practice and multi-dose vial usage communications from the hospital management team. There were no designated cleaning rooms on 3rd Floor Orthopaedic or the Paediatric Ward. Instead, cleaning equipment and facilities were located in 'dirty' utility rooms not in line with best practice. This issue needs to be addressed in line with recommendations already made in this regard. Notice boards had been fitted in some areas to facilitate public display of key performance indicators. Four of the areas visited had all achieved environmental hygiene scores of greater than 85%.

Two of the areas inspected had achieved hand hygiene compliance scores greater than 90% in recent audits. Of the five areas, restricted access to hand hygiene sinks was reported in the Paediatric Ward and on 3rd Floor Orthopaedic only. A patient equipment labelling system to record cleaning was in place for patient equipment across all five areas visited. Shower heads were not available in some of the areas inspected.

3.2 Additional key findings of the 2015 inspections

Introduction

The key findings relating to areas of non-compliance observed during the June inspection and the level of progress that was evident during the re-inspection in July are discussed below.

Isolation precautions

Precautionary signage was absent on the door of an isolation room which was occupied by a patient at risk of infection. This issue was reported to the ward manager and addressed immediately.

Infection prevention and control education

Infection prevention and control education was regularly provided to staff. It is recommended that the formal education programme be expanded to provide ongoing education to staff in respect of infection control and aseptic non touch technique.

Oncology Day Unit inspection 16 July 2015

The environment and equipment in the Oncology Unit was found to be generally clean. The unit was well designed to a high specification. There was evidence of good local ownership with regard to hygiene in general.

3.3 Progress since the unannounced inspection on 8 May 2014

In 2014, the Authority conducted an unannounced inspection at Our Lady of Lourdes Hospital, Drogheda. During that inspection, 3rd Floor Orthopaedic and 2nd Floor Medical wards were inspected. During the June 11 inspection of this year, the Authority revisited 3rd Floor Orthopaedic and 2nd Floor Medical Ward. All of the issues listed in the QIP developed following the 2014 inspection had been documented as completed but some were not fully addressed. For example, some maintenance issues, bed spacing and the provision of a designated room for cleaning equipment and utility had not been addressed. The Authority notes that issues in relation to bed spacing had been risk assessed but not resolved other than a longer term plan to relocate wards to new inpatient accommodation due for completion in 2017.

3.4 Key findings relating to hand hygiene

3.4.1 System change[3]: *ensuring that the necessary infrastructure is in place to allow healthcare workers to practice hand hygiene*.

- None of the clinical hand wash sinks in 3rd Floor Surgical and the 6th Floor complied with HBN 00-10.[14]
- Deficits in relation to the necessary infrastructure for hand hygiene were identified as an immediate high risk and are discussed in Section 3.1.

3.4.2 Training/education[3]: *providing regular training on the importance of hand hygiene, based on the 'My 5 Moments for Hand Hygiene' approach, and the correct procedures for hand rubbing and hand washing, to all healthcare workers*.

- Due to failure to meet the national hand hygiene compliance targets mandatory hand hygiene training frequency for staff was proactively increased from two yearly to yearly. The hospital informed the Authority in July 2015 that approximately 70% of all staff at the hospital had attended mandatory hand hygiene training since January 2015. A breakdown of hand hygiene training by staff and department for all areas was not available but poor attendance by medical staff at hand hygiene training was acknowledged and was being addressed by the hospital. A new electronic recording system to record and analyse training by staff and department is in use.
- Authorised persons reviewed local training records in 6th Floor East and West which documented that 92% of nurses and health care assistants on 6th West and 73% of the nurses and health care assistants on 6th East attended hand hygiene training since January 2015.
- Good practice was observed in the Oncology Unit whereby staff carried out peer review to perform hand hygiene in line with the five moments for hand hygiene

3.4.3 Evaluation and feedback[3]: *monitoring hand hygiene practices and infrastructure, along with related perceptions and knowledge among health-care workers, while providing performance and results feedback to staff*.

National hand hygiene audit results

Our Lady of Lourdes Hospital, Drogheda participates in the national hand hygiene audits, results of which are published twice a year.[15] The results in the table below are taken from publically available data from the Health Protection Surveillance Centre's website. Hand hygiene compliance at the hospital was significantly below the HSE national key performance indicator for hand hygiene compliance in 2014 in both hospital wide and local hand hygiene audits as outlined in Table 2.

Table 2: Our Lady of Lourdes Hospital national hand hygiene compliance results 2011-2015

Period	Result
Period 1 March/ April 2011	71.4%
Period 2 Oct/Nov 2011	79.5%
Period 3 May/June 2012	83.3%
Period 4 Oct/Nov 2012	68.6%
Period 5 May/June 2013	81.0%
Period 6 Oct/ Nov 2013	78.6%
Period 7 May/June 2014	67.1%
Period 8 Oct/Nov 2014	74.3%

Source: Health Protection Surveillance Centre – national hand hygiene audit results.[15]

Local hand hygiene audits

Hand hygiene audits conducted in February 2015 in the 6th Floor and 3rd Surgical demonstrated 57% and 60% hand hygiene compliance respectively. Feedback was given at the time of the audit to ward managers and discussed with staff. 6th Floor West was re-audited within days and achieved 93% compliance. Oncology Unit local audit compliance rates were fully compliant with national guidelines and achieved scores of 97% and 96% in March and June 2015 respectively. A hand hygiene audit conducted in February 2015 demonstrated 60% compliance of hand hygiene in 3rd Surgical.

Observation of hand hygiene opportunities

Authorised Persons observed hand hygiene opportunities using a small sample of staff in the inspected areas. This is intended to replicate the experience at individual patient level over a short period of time. It is important to note that the results of the small sample observed is not statistically significant and therefore results on hand hygiene compliance do not represent all groups of staff across the hospital as a whole. In addition results derived should not be used for the purpose of external benchmarking.

The underlying principles of observation during inspection are based on guidelines promoted by the WHO[16] and the HSE.[17] In addition, Authorised Persons may observe other important components of hand hygiene practices which are not reported in

national hand hygiene audits but may be recorded as optional data. These include the duration, technique[ϒ] and recognised barriers to good hand hygiene practice. These components of hand hygiene are only documented when they are clearly observed (uninterrupted and unobstructed) during an inspection. Such an approach aims to highlight areas where practice could be further enhanced beyond the dataset reported nationally.

The Authority observed 51 hand hygiene opportunities in total during the June and July 2015 inspections. Hand hygiene opportunities observed comprised the following:

- four before touching a patient
- two before a clean/aseptic procedure
- nine after body fluid exposure risk
- four after touching a patient
- 30 after touching patient surroundings
- two which were a combination of the above

- Thirty three of 51 hand hygiene opportunities were taken. Eighteen opportunities not taken comprised the following:
    - one before touching a patient
    - two before clean/ aseptic procedure
    - two after body fluid exposure risk
    - one after touching a patient
    - 12 after touching a patient surroundings

- Of 33 opportunities which were taken, hand hygiene technique was observed (uninterrupted and unobstructed) by Authorised Persons for 30 opportunities and correct technique was observed in 24 hand hygiene actions.

3.4.4 Reminders in the workplace[3]: *prompting and reminding healthcare workers about the importance of hand hygiene and about the appropriate indications and procedures for performing it*.

- Hand hygiene advisory posters were available, up-to-date, clean and appropriately displayed in all areas inspected.

[ϒ] The inspectors observe if all areas of hands are washed or alcohol hand rub applied to cover all areas of hands.

- Posters to remind staff of the hospital "bare below the elbow" policy were also in place. The hospital management team demonstrated good leadership regarding this policy.

3.4.5 Institutional safety climate[3]: *creating an environment and the perceptions that facilitate awareness-raising about patient safety issues while guaranteeing consideration of hand hygiene improvement as a high priority at all levels*.

- The hospital's compliance in the national hand hygiene audit at the end of 2014 had slightly improved to 74% compared to 67% in May/June 2014. However, the hospital has failed to meet the HSE national target of 90% compliance.
- The Authority was informed that hand hygiene is a rolling agenda at team monthly meetings and hand hygiene audits are revised every quarter.

The hospital should progress implementation of the multimodal strategy in addition to addressing infrastructural deficits to achieve hand hygiene compliance in line with national targets.

3.5 Infection prevention care bundles

Care bundles to reduce the risk of different types of infection have been introduced across many health services over the past number of years, and there have been a number of guidelines published in recent years recommending their introduction across the Irish health system.

Authorised Persons looked at documentation and practices relating to peripheral venous catheter bundles in the areas inspected. Peripheral venous catheter care bundles were in use across the hospital. Urinary catheter care bundles were not in use, however, the hospital plans to implement these shortly. Documentation reviewed indicated that the hospital policy for intravascular device management had not been revised as scheduled and therefore there was no up-to-date policy in place.

Inspectors reviewed practice and documentation relating to care bundle application and audit in relation to peripheral venous catheters on 3rd Surgical and 6th Floor wards. Staff clearly articulated and demonstrated the management of peripheral vascular catheters and care bundle at the time of the inspection. Care bundle components were not consistently recorded for all cases and on one ward there was inconsistency with regard to the type of dressing used to cover the insertion site. Full compliance with peripheral venous catheter care bundles was not demonstrated in the areas inspected. The system for recording care bundle components did not readily facilitate audit of bundle compliance.

Care bundle compliance audits in the areas inspected in June indicated that overall compliance with peripheral venous catheter care bundle application was poor and

audit findings were similar to the issues identified by inspectors. The hospital is in the process of reviewing care bundle implementation and related documentation and plans to train additional staff at local level to facilitate improvements in care bundle implementation across the hospital.

In the Oncology Unit, recording of peripheral venous catheter placement was included in patients' chemotherapy administration and assessment forms.

Re-inspection on 16 July 2015

Overall, the Authority found that the hospital is working towards compliance with Standard 8 of the Infection Prevention and Control Standards and is committed to improving the management of invasive devices such as peripheral catheters.[1]

The hospital policy for peripheral venous cannulation had been revised since the June inspection to include information regarding care bundle implementation. The hospital standard operating procedure for peripheral venous catheter care bundles should also be updated to reflect revised data collection methods. A peripheral and central venous catheter care bundle end of bed recording sheet had been developed and was in use in 3rd Floor Surgical. It was reported that the revised system in place to standardise record keeping was working well and that it facilitated audit. Weekly care bundle compliance audit demonstrated significant improvement with evidence of 100% care bundle compliance in an audit performed following the June inspection. Central venous catheter care bundles had also been implemented on 3rd Surgical since the June inspection due to significant usage of these devices in the ward.

It was reported that the hospital participates in the European antimicrobial resistance surveillance system and performs detailed analysis of blood stream infection which facilitates identification of device related bloodstream infection. Central venous catheter related infection rates are collated in the Intensive Care Unit. It is recommended that device related infection metrics are used to assess the impact of care bundle implementation and that feedback is provided to staff in all clinical areas.

4. Summary

A number of high risks were identified during the unannounced inspection on 11 June 2015, the composite of which presented an immediate high risk finding. Cumulative findings were poor enough to require a re-inspection which was carried out on 16 July 2015.

The Authority acknowledges the improvements and progress made by the hospital management team and staff in respect of environmental hygiene, safe injection practice, multi-dose vial management, aspergillus control and care bundle implementation since the June inspection. The implementation of care bundles should be expanded to include urinary catheter care bundles as planned.

Despite these improvements, substantive risks in relation to maintenance, hand hygiene practice, hand hygiene facilities and ward infrastructure remain. In addition, the ongoing lack of availability of shower heads in some patient areas is not acceptable. The Authority was not assured that risks in relation to legionella were being effectively addressed in a systematic manner. The hospital needs to fully reevaluate and improve upon its approach to the management of legionella risks in light of findings in this report and in the latest site legionella risk assessment.

The Authority notes that a key contributory factor towards the non-resolution of maintenance and bed spacing issues is the ongoing high bed occupancy rate at the hospital. This factor has been cited by hospital management as a key barrier to improvement in ward infrastructure, including the upgrade of hand hygiene facilities. The deficits outlined in relation to current hand hygiene facilities on many wards do not facilitate effective hand hygiene performance.

The Authority acknowledges that it will be challenging for the hospital to perform well in relation to the risks identified in this report in the interim of short term hospital plans to decant wards to facilitate maintenance, and longer term plans to provide new inpatient accommodation in 2017.

Our Lady of Lourdes Hospital Drogheda, as a member of the wider RCSI Hospital Group, needs to be supported within the group structure to better address issues in relation to bed occupancy and ward infrastructure, in order to facilitate compliance with the *National Standards for the Prevention and Control of Healthcare Associated Infections*.

5. Next steps

Our Lady of Lourdes Hospital, Drogheda must now revise and amend its QIP that prioritises the improvements necessary to fully comply with the Standards. This QIP must be approved by the service provider's identified individual who has 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 website within six weeks of the date of publication of this report and at that time, provide the Authority with details of the web link to the QIP.

It is the responsibility of Our Lady of Lourdes Hospital, Drogheda to formulate, resource and execute its QIP to completion. The Authority will continue to monitor the hospital's progress in implementing its QIP, as well as relevant outcome measurements and key performance indicators. Such an approach intends to assure the public that the hospital is implementing and meeting the Standards, and is making quality and safety improvements that safeguard patients.

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Appendix 1 - Copy of high risk letter issued to Our Lady of Lourdes Hospital

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Marie Tighe
General Manager
Our Lady of Lourdes Hospital
Drogheda
Co Louth
lm.generalmanager@hse.ie

15 June 2015

Ref: PCHCAI/436

Dear Marie

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

I am writing as an Authorised Person under Section 70 of the Health Act 2007 (the Act) for the purpose of monitoring against the ***National Standards for the Prevention and Control of Healthcare Associated Infections (NSPCHCAI)*** pursuant to Section 8(1) (c) of the Act.

Under section 8(1)(c) of the Act, authorised persons of the Health Information and Quality Authority (the Authority) carried out an unannounced inspection **at Our Lady of Lourdes Hospital, Drogheda** on 11 June 2015.

During the course of the unannounced inspection, the Authorised Persons identified specific issues that may present a serious risk to the health or welfare of patients, visitors and staff and immediate measures need to be put in place to mitigate these risks.

The cumulative findings identified were such that a second unannounced re-inspection will be conducted within six weeks. The risks concerned included, but were not limited to;

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Cork, Ireland.
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- **Ongoing poor performance related to hand hygiene –** Hand hygiene compliance at the hospital was significantly below the HSE national key performance indicator for hand hygiene compliance in 2014 in both hospital wide and local hand hygiene audits. It was also observed to be poor during the Authority's inspection. Access to hand hygiene facilities at the point of care was observed to be restricted during the inspection, and this combined with reduced spatial separation between patients in multi occupancy wards did not facilitate optimal performance of hand hygiene by staff.
- **Safe injection practices –** The preparation of medication for intravenous administration and the management of multi-dose medication vials to reduce the risk of infection was not in line with evidence based practice.
- **Environmental and patient equipment hygiene** - The quality of cleaning on the 6th floor was insufficient on the day of inspection and local cleaning processes were not in line with best practice.
- **Infrastructure and Maintenance -** Deficits with respect to maintenance on both of the wards inspected were identified. Surfaces, finishes and some furnishings in patient rooms including windows, wall coverings, wood finishes and bed tables were worn and poorly maintained and as such did not facilitate effective cleaning. Ward infrastructure was such that space between patients was quite limited with less than desirable space for staff to circulate.
- **Legionella control –** The hospital management team reported that intermittent identification o*f Legionella species* in water samples in patient areas persists despite recent investment in the water system to address this issue. Authorised Persons were informed that shower heads were removed from patient wash rooms in the areas inspected approximately 18 months previously as a risk mitigation measure, and that these had not been replaced because of ongoing risk of aerosolisation of legionella into the environment. It is of particular concern to the Authority that patients

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known to be at high risk of opportunistic infection were accommodated in these areas at the time of inspection. It is recommended that while the hospital continues to address this issue, the hospital reviews its approach to the accommodation of patients who are at high risk of opportunistic infection in the affected areas to further mitigate against any risk of infection.

- **Aspergillus control -** the method statement viewed by Authorised Persons for aspergillus control during renovation work on the 6th floor was not adhered during the inspection in that there were inadequate dust control measures during a dust generating activity in progress at the time.

The above issues were brought to the attention of senior management at the hospital during the inspection, with concerns related to Legionella and Aspergillus control highlighted for immediate mitigation. Given the level of potential risk associated with these cumulative findings, and the urgent requirement for the mitigation of the aspergillus related risk on the 6th floor and legionella related risk to at risk patients in particular, please formally report back to the Authority by **2pm on 18 June 2015** to qualityandsafety@hiqa.ie, outlining the measures that have been enacted to mitigate the identified risks. Details of the risks identified will be included in the report of the inspection. This will include copies of the Authority's notification of high risks and the service provider's response.

Should you have any queries, please do not hesitate to contact me at qualityandsafety@hiqa.ie. Please confirm receipt of this letter by email (qualityandsafety@hiqa.ie).

Yours sincerely

Aileen O'Brien

AILEEN O BRIEN
Authorised Person

CC: Bill Maher, CEO, RCSI Hospitals Group (Dublin North East)

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Appendix 2 - Copy of QIP received from Our Lady of Lourdes Hospital in response to correspondence from the Authority received on 18 June 2015.

Action Plan – HIQA PCHAI Unannounced Visit – June 2015 Version 1

	Issues to be addressed	How	Department with responsibility and named person	Timeframe
	Hand Hygiene Re-enforce 2015 Hand Hygiene Action Plan. Increase level of compliance with National Standards Audits to meet 90% Standard Ensure all Staff are fully compliant with Bare Below the Elbow and Hand Hygiene Policies Ensure all Staff are trained annually on Hand Hygiene Practices Ensure that alcohol hand gel is readily accessible in all areas of the Hospital Undertake Risk Assessment relating to accessibility to Hand Hygiene sinks	Hand Hygiene Action plan in place for 2015 and being rolled out – includes additional training, auditing, we remain on the yearly training system where other Hospitals are 2 yearly. Hand Hygiene Facilitator at ward level. Additional contract support in place to train staff due to vacancies at IPC level Risk assessment to be completed by Nursing and decision made on the most appropriate position of placement of hand gels. Not at end of beds in some wards due to patient risk but no documented risk assessment Hand Hygiene Compliance in the wards visited to be re-audited urgently but no later than 29th June Proof of training of all staff to be provided - both wards need to be	General Manager with overall responsibility. Delegated responsibility to Director of Nursing and Midwifery and Clinical Director.	Immediately and Ongoing Completed 17.06.15 To be completed by 29.06.15 Completed

		at 100% compliance Risk assessment on bed spacing and removing a bed to create more access to a sink to be undertaken not just for this ward but in general		Completed 17.06.15
	Safe Injection Practices Preparation of medication for intravenous administration	Agency Staff member removed pending undertaking necessary re-training and education Memo to all Staff from Clinical Director and Director of Nursing and Midwifery alerting staff to a detected breach of safe practice in this regard and a need for viligance and zero tolerance to any aspect of practice that may compromise patient safety The Practice Development Team to support the Ward Team with refresher training regarding best practice in this regard	Director of Nursing and Midwifery and Clinical Director	Immediately Completed 18.06.15 Initial re-training completed and ongoing refresher training will continue
	Management of Multi-dose Medication vials	Re-training of staff to take place	Director of Nursing and Midwifery	Completed

		Memo to be sent to all Clinical Areas regarding compliance	Chief of Pharmacy	Completed 18.06.2015
	Environmental and Patient Equipment Hygiene Quality of the Cleaning in one area was insufficient and local processes were not in line with best practice	Re-audit of areas inspected immediately Additional cleaning and deep cleaning to be undertaken MDT Staff meeting to be undertaken Re-training of cleaning staff on both wards to be undertaken SOP'S for review and re-establishment for all cleaning staff within 2 weeks Intermediate action on both wards to re-train regarding dust control Procedure for cleaning bed tables and chairs to be reviewed and communicated to all staff Cleaners rooms to be identified	Operational Services Manager/ Director of Nursing and Midwifery	12.06.2015 and 16.06.2015 respectively Commenced on 12.06.2015 Completed on 12.06.2015 Commenced on 12.06.2015 Commenced, SOPs to be completed by 29.06.2015 Completed 18.06.2015 Agreed and commenced 15.6.2015 Rooms identified. Maintenance ordering equipment and scheduling works

		Auditors to be retrained Supervision needs to be increased discussions currently ongoing with LRC –As interim measure floors to be allocated for daily walkabouts to senior managers		To be completed by 31.07.2015 pending same cohort of trained auditors identified to complete audits Allocation of managers to be completed by 26.6.2015.
	Infrastructure and Maintenance Full review by maintenance of the fabric of the ward to be undertaken.	Paintwork walls doors and skirting to be audited and action plan to be created to address same Windows and window frames especially seals to be reviewed with necessary actions undertaken to correct same Flooring to be audited and replaced were necessary Sinks – placement and HTM compliance to be reviewed, costed and submission for funding made Toilets – Odour in toilets to be investigated and addressed	Operational Services Manager	2 weeks for audit to be completed and action plan to be prepared to address the issues identified by 29.06.2015. This plan may require vacant possession and will therefore need to be risk assessed.
	Legionella control Potential Risks associated with intermittent identification of Legionella species in water samples	Full explanatory document to issue to HIQA regarding our Legionella Control measures currently in place Risk Assessment in place and will be reviewed as part of new water quality contract Continue to maintain all current practices and procedures regarding testing ,water flushing and identification of at risk patients	Operational Services	Completed 18.06.2015 6th July 2015.
	Aspergillus Control Contractor undertaking works did not comply with the Method Statement	Works immediately stopped and Contractor advised verbally and in writing the risk Procedures are in place for Method Statements approval including dust Control and sign of with the IP&C Department. These are to be re-enforced and re-communicated to all key stake holders Increase frequency of routine checks to construction sites are to be undertaken and documented	Operational Services	Immediately Underway and Ongoing Plan for sign-off by SMT on the 26.06.2015

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