



**Health
Information
and Quality
Authority**

An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte

Report of the inspections at Connolly Hospital, Blanchardstown, Dublin

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

Date of on-site inspections: 10 April and 29 May 2014

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

Preventing and controlling infection in healthcare facilities is a core component of high quality, safe and effective care for patients. In order to provide quality assurance and drive quality improvement in public hospitals in this critically important element of care, the Health Information and Quality Authority (the Authority or HIQA) monitors the implementation of the *National Standards for the Prevention and Control of Healthcare Associated Infections*.¹

These Standards will be referred to in this report as the Infection Prevention and Control Standards. Monitoring against these Standards began in the last quarter of 2012. This initially focused on announced and unannounced inspections of acute hospitals' compliance with the Infection Prevention and Control Standards.

The Authority's monitoring programme will continue in 2014, focusing on unannounced inspections. This approach, 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 – will include scope for re-inspection within six weeks where necessary. The aim of re-inspection is to drive rapid improvement between inspections.

The purpose of unannounced inspections is to assess hygiene as experienced by patients at any given time. The unannounced inspection focuses specifically on observation of the day-to-day delivery of hygiene services and in particular environment and equipment cleanliness and adherence with hand hygiene practice. Monitoring against the Infection Prevention and Control Standards¹ is assessed, with a particular focus, but not limited to, environmental and hand hygiene under the following standards:

- Standard 3: Environment and Facilities Management
- Standard 6: Hand Hygiene.

Other Infection Prevention and Control Standards may be observed and reported on if concerns arise during the course of an inspection. It is important to note that the Standards may not be assessed in their entirety during an unannounced inspection and therefore findings reported are related to a criterion within a particular Standard which was observed during an inspection. The Authority uses hygiene observation tools to gather information about the cleanliness of the environment and equipment as well as monitoring hand hygiene practice in one to three clinical areas depending on the size of the hospital. Although specific clinical areas are assessed in detail using the hygiene observation tools, Authorised Persons from the Authority also observe general levels of cleanliness as they follow the patient's journey through the

hospital. The inspection approach taken is outlined in guidance available on the Authority's website.²

In line with the inspection programme for 2014, the Authority may re-inspect a hospital in some circumstances. The aim of the re-inspection is to rapidly drive improvement at the hospital. Where a re-inspection occurs, a single report is prepared following the second inspection and includes the findings of both inspections and any improvements observed between the first and second inspections. An unannounced inspection was carried out in Connolly Hospital Blanchardstown on 10 April 2014 followed by a re-inspection on 28 May 2014. The following sections present the findings from these inspections.

1.1. Timeline of inspections at Connolly Hospital April – May 2014

Unannounced inspection on 10 April 2014

An unannounced inspection was carried out at Connolly Hospital Blanchardstown on 10 April 2014. During this inspection, specific issues which were deemed to present a high risk to the health or welfare of patients and which required mitigation measures to be implemented were identified by the Authorised Persons. The issues identified during the inspection were such that the General Manager of Connolly Hospital was informed by the Authorised Persons during the inspection, and in writing following the inspection, that a re-inspection would be carried out within six weeks of the first inspection. The issues were also communicated nationally to the National Director of Quality and Patient Safety, the National Director of Acute Hospitals and the Regional Director for Performance and Integration, HSE Dublin North East. A copy of this communication is shown in Appendix 1. The response from Connolly Hospital to the letter outlining the high risks identified during the April unannounced inspection is shown in Appendix 2.

Unannounced re-inspection on 29 May 2014

In line with the Authority's inspection programme for 2014, a re-inspection was carried out at Connolly Hospital Blanchardstown on 29 May 2014. The re-inspection examined the level of progress which had been made in relation to environmental hygiene in the two clinical areas that were inspected during the April inspection where environmental and hand hygiene were observed to be poor. During the re-inspection, hand hygiene training and auditing were also assessed.

A summary of the unannounced inspections carried out by the Authority at Connolly Hospital in 2014 are shown in Table 1.

Date of Inspection	Authorised Persons	Clinical Areas Inspected	Time of Inspection
10 April 2014	Alice Doherty Katrina Sugrue Judy Gannon	Maple Ward Laurel Ward	09.00hrs –13.25hrs
29 May 2014	Alice Doherty Katrina Sugrue	Maple Ward Laurel Ward	08.00hrs –14.25hrs

Table 1: Summary of inspections carried out at Connolly Hospital in 2014.

Section 3 of this report sets out a high level summary of the findings of the unannounced inspections carried out in Connolly Hospital in 2014. A detailed description of the findings of the two unannounced inspections undertaken by the Authority in 2014 is shown in Appendix 3.

The Authority would like to acknowledge the cooperation of staff with the two unannounced inspections.

2. Connolly Hospital Blanchardstown Profile[‡]

Connolly Hospital is located in the West Dublin Village of Blanchardstown. It services a catchment population of 331,000 in Dublin West (including Finglas West and Lucan), North Kildare and South County Meath and is one of the fastest growing catchment population areas in the country.

Connolly Hospital is a Major Academic Teaching Hospital providing a range of acute medical and surgical services, acute psychiatric services, long stay care, day care, outpatient, diagnostic and support services. Emergency services are provided on a 365-day, 24 hour basis. Multidisciplinary teams representative of medical, nursing, allied health professionals, management and general support staff play a pivotal role in the development, delivery, monitoring and evaluation of these services.

The Hospital is affiliated to the Royal College of Surgeons in Ireland for medical education, to Dublin City University for nursing education and to University College Dublin, Trinity College Dublin and the Institute of Technology for allied health professional education. A Regional Centre for Nurse Education is located on site.

Hospital Specialties

Specialty areas included in service provision in Connolly Hospital are outlined below:

Anaesthesia and Intensive Care	General Medicine	Orthopaedics
Acute Medicine for the Elderly / Rehab / Day Hospital / Extended Care	General Surgery	Pathology
Cardiology	Gynaecology	Plastic Surgery
Dermatology	Haematology	Radiology
Emergency Department	Intensive Therapy	Respiratory Medicine
Endocrinology	Microbiology	Rheumatology
ENT	Neurology	Urology
Gastroenterology	Oncology	Vascular Medicine
General Adult Psychiatry Psychiatry of Old Age	Ophthalmology	Nephrology

Bed Numbers

Total Bed Capacity 407
Includes Acute and Non Acute Beds

[‡] 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. Overview of Findings

3.1 Unannounced inspection on 10 April 2014

During this inspection, specific issues were identified by Authorised Persons which were deemed to present a high risk to the health or welfare of patients and which required mitigation measures to be implemented. Issues identified during the inspection were outlined to the hospital management team. The following is a list of issues following the unannounced inspection in April 2014:

- **The cleanliness of patient equipment on Maple Ward** – During the inspection on Maple Ward, it was noted that numerous items of frequently used patient equipment were unclean which posed a potential risk of cross infection. Examples of equipment that were observed to be unclean were a pulse oximeter which was stained with a red substance, thermometers probes which were unclean, commodes which had brown staining on their underside, and mattresses and mattress covers which were visibly stained. It was explained to the Authorised Person undertaking the inspection that a system of daily sign-off signifying cleaning of patient equipment was in place, but had not been operational since 12 January 2014.
- **Environmental hygiene** – The environmental hygiene on both Laurel and Maple Wards as witnessed by the Authority on the day of the inspection was very poor, and not in compliance with Criterion 3.6 of the Infection Prevention and Control Standards.

In addition to these high risks, Authorised Persons noted that the only hand hygiene auditing that routinely occurred on Maple and Laurel Wards was either in response to national audit requirements, or as a reactive measure in response to an outbreak on either ward. In practice, this meant that hand hygiene auditing had not occurred on Maple Ward since March 2013 and since May 2013 on Laurel Ward. More frequent routine audit and feedback, as is found in many other hospitals, was not conducted on either ward inspected. Furthermore, observation of hand hygiene practices at the time of the inspection raised a concern as only 19 of the 34 opportunities observed were taken. The Authority was concerned that the mechanisms in place for assuring best practice in hand hygiene practices were not sufficiently robust. The hospital participated in the twice yearly national hand hygiene audits and achieved compliance in line with the national target set by the HSE.³ However, it was noted during the inspection that only the areas randomly selected for the national audits and areas involved in an outbreak were audited within the year which meant that the remaining areas within the hospital were not audited.

The issues identified above during the inspection were such that the Authority deemed it necessary to carry out a re-inspection of Connolly Hospital within six weeks of the first inspection.

3.2 Follow-up re-inspection on 29 May 2014

The following is a list of the main issues observed by the Authority following the unannounced inspection in May 2014:

- **The cleanliness of patient equipment** - Overall, the maintenance and management of patient equipment on Maple Ward had improved since the April inspection but some exceptions were noted. For example, compromised mattresses were found on both wards and daily cleaning checklists of patient equipment was not completed for some days viewed on Maple Ward.
- **Environmental hygiene** – The Authority found that further improvements in the cleanliness and maintenance of the environments on both wards were required. It was observed that many of the non-compliances and maintenance issues which were observed during the April inspection, particularly on Laurel Ward were still evident during the re-inspection in May. An environmental hygiene audit had been undertaken on Laurel Ward after the first inspection on 1 May 2014. However, many of the non-compliances observed by the Authority during both inspections did not appear to have been identified in the audit undertaken by the hospital on Laurel Ward on 1 May.
- The Authority was concerned that environmental hygiene audits had not been carried out on Maple Ward since the first inspection even though environmental hygiene on Maple Ward had been highlighted as a high risk and communicated to the hospital management team. Furthermore, documentation provided to the Authority showed that the last environmental audit carried out on Maple Ward was in 2012. Two environment audits were carried out on Laurel Ward in 2012 and no environmental audits were carried out in 2013. The deficits in the monitoring of environmental hygiene in Maple and Laurel Wards were reflected in the level of non-compliances which were evident during both unannounced inspections and indicate a lack of local ownership and oversight from senior management.
- In 2013, areas audited in the hospital which did not achieve the hospital's pass rate of 85% compliance in each element of the hygiene audits were not re-audited in line with the hospital's quality improvement plan. The hospital's 'Hygiene Annual Report 2013' stated that this was due to resource constraints. In addition, the Authority noted that there was a decrease in the number of areas audited achieving the 85% compliance rate from 2011 to 2013 and there was no

evidence provided that demonstrated that this decline in compliance was being addressed either at a local or senior level.

- **Hand hygiene** – The Authority found that hand hygiene audits had not been carried out on Maple Ward between the first inspection in April and the re-inspection in May. A hand hygiene audit was ongoing on Laurel Ward for the month of May as part of the national hand hygiene audit. During the first inspection, 19 out of 34 opportunities observed by the Authority (56%) were taken by staff. In the re-inspection, 19 out of 31 opportunities (61%) were taken by staff. Observational hand hygiene audits are an important means of measuring performance, and act as an effective method for both raising staff awareness and driving improvement in hand hygiene practice. It is of concern to the Authority that the hospital did not carry out any local hand hygiene audits as part of its governance assurance and improvement strategy in the interim between the two inspections.

3.3 Environment and facilities management

Standard 3. Environment and Facilities Management

The physical environment, facilities and resources are developed and managed to minimise the risk of service users, staff and visitors acquiring a Healthcare Associated Infection.

3.3.1 Key findings relating to non-compliance with Standard 3

The Authority found evidence during the two unannounced inspections of both compliance and non-compliance with Standard 3 of the Infection Prevention and Control Standards.¹ An overview of the most significant non-compliances relating to Standard 3 is discussed below. A detailed description of the findings of the two unannounced inspections undertaken by the Authority in 2014 is shown in Appendix 3.

Patient equipment

The Authority found that the management of the cleanliness of patient equipment, and especially frequently used patient equipment, was suboptimal during both unannounced inspections. This issue was highlighted to the hospital as a risk following the first unannounced inspection in April when frequently used patient equipment such as glucometers, commodes, thermometer probes and oxygen saturation monitors were observed to be unclean. Even though improvements were implemented by the hospital after the first inspection, the Authority found that the daily cleaning of patient equipment checklists were not fully completed on Maple

Ward during the 29 May re-inspection. In addition, red splashes were observed on a wheel, on the bed rail and under the bed in one of the six-bedded wards in Laurel Ward. The Authority was informed that the bed had just been transferred to the ward from theatre in this condition. The findings suggest that improvements in the management of patient equipment from a local and hospital perspective are still required.

Environmental Hygiene

The environmental hygiene on both Laurel and Maple Wards as witnessed by the Authority on the day of the April unannounced inspection was very poor, and not in compliance with Criterion 3.6 of the Infection Prevention and Control Standards. Unacceptable levels of dust were observed in all areas inspected on Maple Ward and the Authority found that Maple Ward was generally unclean during the first inspection. Laurel Ward also required considerable improvement in the cleanliness and maintenance of the environment.

During the re-inspection, the Authority found that further improvements in the cleanliness and maintenance of the environments on both wards were required. It was observed that many of the non-compliances and maintenance issues which were observed during the April inspection, particularly on Laurel Ward were still evident during the re-inspection in May.

The Authority was concerned that environmental hygiene audits had not been carried out on Maple Ward since the first inspection even though environmental hygiene on Maple Ward had been highlighted as a high risk and communicated to the hospital management team. An environmental hygiene audit had been undertaken on Laurel Ward after the first inspection on 1 May 2014. The audit tool comprises 16 areas. Responsibility for each area is assigned to ward/department, household/estates or hospital management. Scores were assigned to each area and the results showed 94% compliance for ward/department level, 97% compliance for household/estates and 96% for hospital management. However, the Authority found that many of the non-compliances observed during the re-inspection were similar to the April inspection and they did not appear to have been identified in the audit undertaken on Laurel Ward on 1 May. It is a concern to the Authority that the assurance mechanism used for measuring the environmental hygiene within the hospital was not capturing issues which were relevant to the maintenance and management of environmental hygiene.

According to the 'Hygiene Annual Report 2013', the hospital has no hygiene specific budget. In addition, the 'Hygiene Annual Report 2013' indicates that environmental audits were last carried out on Laurel Ward in February and April 2012. There were no environmental audits carried out on the ward during 2013. Similarly, on Maple

Ward, the Authority viewed a hygiene audit undertaken in 2012 which demonstrated 94% compliance; however there was no date on the audit report. There was no environmental hygiene audit undertaken on Maple Ward between the two unannounced inspections. Moreover, areas which were audited and achieved less than or equal to 85% were not re-audited as a quality improvement strategy due to reported resource constraints. The 'Hygiene Annual Report 2013' also outlined that overall compliance with areas audited which achieved the 85% pass rate in hospital hygiene had decreased from 80% in 2011, to 79% in 2012 to 69% in 2013. The deficits observed in the monitoring of environmental hygiene suggest that there is a lack of local ownership and management of issues relating to environmental hygiene and indicate poor assurance at a more senior management level.

Maintenance

The findings from both inspections indicate that the management of issues relating to estates and maintenance is not optimal. The Authority was informed that there was no system in place to follow up and close out maintenance issue. There is therefore a lack of an assurance mechanism in place to ensure that the physical environment and facilities are managed to minimise the risk of Healthcare Associated Infections.

3.3.3 Summary of environmental auditing at Connolly Hospital

Environmental audits were discussed at the close out meeting with the General Manager and Director of Nursing. It was explained to the Authority that regular technical audits and waste management audits are carried out throughout the year. A multidisciplinary hygiene team conducted 16 audits over a two year period as a peer assessment, however not all areas were audited as part of the peer review. The audit schedule had been reviewed since the first inspection and had been increased for 2014 to include all areas in the hospital. The hygiene audit plan for 2014 outlines that in addition to the peer review hygiene audits, hygiene audits will also be carried out by an external contractor six times per year in all areas. Furthermore, the household supervisor will conduct internal household department hygiene audits twice a year. In response to the first unannounced inspection conducted by the Authority, a memo was sent to all staff by the senior management team informing them of the main findings of the inspection. Walkabouts were undertaken by members of the senior management team once a week and the Assistant Directors of Nursing carried out more focussed walkabouts twice a week.

The 'Hygiene Annual Report 2013' demonstrated that 13 audits were completed in 2013. The pass score for environmental audits is 85%. The hospital achieved an overall 88% compliance rating for areas audited in 2013. Of the 13 areas audited, 69% achieved compliance. This was a decrease in compliance of 80% achieved in

2012 and 79% achieved in 2011. The hygiene audit coordinator develops a quality improvement plan from the findings of each audit which are given to the Ward Managers of each area to action as appropriate. According to the hospital's 'Hygiene Annual Report 2013', there was no hygiene budget allocation in 2013. The report also states that it was intended that wards would be re-audited if scores were less than 85%. However, due to reported resource constraints, repeat audits were not carried out. The hospital did however fund painting and walls repairs, cleaning of high areas in the hospital concourse, internal window cleaning (prioritised areas), the purchase of curtains, and new bins when requisitioned.

The hospital hygiene committee is co-chaired by the Director of Nursing and an Assistant Director of Nursing. It met four times in 2013 and reports on an annual basis to the Clinical Governance and Quality Committee. The Authority viewed the minutes of the hygiene committee meetings for 17 December 2013, 11 March 2014 and 15 April 2014.

The Authority recommends that the management and maintenance of the environment and facilities be reviewed to ensure it is effectively managed and maintained according to the Infection Prevention and Control Standards.¹

The Authority was informed at the close out meeting during the first inspection that there was no schedule for auditing or replacing mattresses, however a visual audit of mattresses was carried out in late 2013 by the tissue viability nurse and approximately 70 mattresses were replaced. In response to the first inspection, a quality improvement plan was developed for each of the areas that were inspected which addresses some of the issues communicated to the Ward Managers and hospital management at the close out meeting. For example, a mattress audit and mattress replacement programme was initiated since the first inspection; six mattresses were replaced on Laurel Ward and five mattresses were replaced on Maple Ward.

The standard operating procedure for the role of the health care attendants was amended in April 2014 following the first inspection to include a daily timetable which enables protected time for health care attendants to be dedicated to indirect care such as the cleaning of patient equipment. The Authority was informed that four new health care attendants were due to commence on Maple Ward by the end of May 2014.

In conclusion, the findings of this report highlight that there were improvements in the maintenance and management of patient equipment between the first and second inspections. However, similar findings were observed in the maintenance and management of the environment for both inspections. A hygiene audit was not undertaken on Maple Ward between the two inspections despite the fact that the hospital was made aware of the high risks relating to environmental hygiene which

were observed following the first inspection. The lack of auditing is of concern, and suggests a lack of governance and management of these issues by the management team of Connolly Hospital. Quality improvement plans for Maple and Laurel Wards were developed and their implementation was ongoing at the time of the re-inspection. The Authority was informed that there is a limited capital budget available which necessitates that issues which arise are addressed on a priority basis; the remaining issues remain on a list until funding becomes available. However, the maintenance and management of the environment in which patients are accommodated should be a routine priority for all hospitals. Failure to adequately maintain a ward environment increases the risk of patients and staff acquiring Healthcare Associated Infections.

In summary, some improvement was observed between inspections with respect to the cleaning of patient equipment on Maple Ward. Improvements were also observed in the environments of both wards. However considerable additional improvements in the maintenance and management of both environments were still required as many of the non-compliances which were observed during the first inspection were also observed during the re-inspection. An ongoing extensive programme of improvement is required to raise standards of environmental hygiene at Connolly Hospital Blanchardstown.

Summary of waste management

The Authority observed practices in the management of clinical waste that did not fully comply with criteria 3.7 of the Infection Prevention and Control Standards¹ or best practice.⁴ The waste sub-collection room on the corridor adjacent to Maple Ward was not secured during the re-inspection and posed a potential risk of access to unauthorised persons. In addition, the Authority observed the door to the waste sub-collection room which was adjacent to the main reception was also unsecured at the time of the re-inspection. The door was wedged open, and tape was placed over the locking mechanism. The Authority informed the Hospital Manager of these findings at the close out meeting and assurances were given that these issues would be addressed immediately.

3.4 Hand Hygiene

Assessment of performance in the promotion of hand hygiene best practice occurred using the Infection, Prevention and Control Standards¹ and the World Health Organization (WHO) multimodal improvement strategy.⁵ Findings are therefore presented under each multimodal strategy component, with the relevant Standard and criterion also listed.

WHO Multimodal Hand Hygiene Improvement Strategy

3.4.1 System change⁵: *ensuring that the necessary infrastructure is in place to allow healthcare workers to practice hand hygiene.*

Standard 6. Hand Hygiene

Hand hygiene practices that prevent, control and reduce the risk of the spread of Healthcare Associated Infections are in place.

Criterion 6.1. There are evidence-based best practice policies, procedures and systems for hand hygiene practices to reduce the risk of the spread of Healthcare Associated Infections. These include but are not limited to the following:

- the implementation of the *Guidelines for Hand Hygiene in Irish Health Care Settings, Health Protection Surveillance Centre, 2005*
 - the number and location of hand-washing sinks
 - hand hygiene frequency and technique
 - the use of effective hand hygiene products for the level of decontamination needed
 - readily accessible hand-washing products in all areas with clear information circulated around the service
 - service users, their relatives, carers, and visitors are informed of the importance of practising hand hygiene.
-
- The design of clinical hand wash sinks on Laurel Ward did not conform to Health Building Note 00-10 Part C: Sanitary assemblies.⁶
 - While the majority of alcohol hand gel dispensers were securely fixed in position at the entrance to multi-bedded wards on Laurel Ward, two dispensers were observed during the first inspection and one dispenser was observed during the re-inspection which were not securely fixed into position.

3.4.2 Training/education⁵ *providing regular training on the importance of hand hygiene, based on the 'My 5 Moments for Hand Hygiene' approach, and the correct procedures for handrubbing and handwashing, to all healthcare workers.*

Standard 4. Human Resource Management

Human resources are effectively and efficiently managed in order to prevent and control the spread of Healthcare Associated Infections.

Criterion 4.5. All staff receive mandatory theoretical and practical training in the prevention and control of Healthcare Associated Infections. This training is delivered during orientation/induction, with regular updates, is job/role specific and attendance is audited. There is a system in place to flag non-attendees.

Hospital hand hygiene training

- Hand hygiene training is mandatory at Connolly Hospital on an annual basis. Records demonstrated that 620 staff had so far attended infection prevention and control standard precaution and hand hygiene training from the 1 January to 10 April 2014. This represents 62% of the total staffing levels. A breakdown of training for staff groups outlined that 60% of allied health professions, 27% of clerical, household and healthcare attendants and 74.3% of nursing staff had been trained. However only 2 out of 47 Consultants (4%) have been trained to date. The hospital has 99% compliance with hand hygiene training for non-consultant hospital doctors (NCHDs). The hospital reported that the high attendance rate for NCHDs was in part likely to be a result of an initiative to withhold parking permits until hand hygiene training was completed.

Local area hand hygiene training

- The Authority was informed during the first inspection that all staff on Laurel Ward had attended hand hygiene training in the last year. However, at the time of the inspection, hand hygiene training records were only available for 2009 and 2010. The Authority was informed that monthly hand hygiene training sessions were carried out on the ward by the Infection Prevention Control Nurse. During the re-inspection, the Authority was informed that hand hygiene training is mandatory and 22 out of 30 staff on Laurel ward had completed training in 2014. The most recent hand hygiene training carried out on the ward at the time of the re-inspection was 15 May 2014, and five staff attended. Records of hand hygiene training are kept by the Ward Manager and the Infection Prevention Control

Nurse. The Ward Manager is emailed with dates of training and these are inserted into the ward diary and posted in the staff room. The Authority was informed that hand hygiene training would be increased following an outbreak.

- On Maple Ward, hand hygiene records are kept by the Infection Prevention Control Nurse who emails the updated hand hygiene records to the Ward Manager. Staff attend hand hygiene training annually and 100% of staff had attended in 2013. The Authority was informed that six staff members had attended hand hygiene training since the first inspection and between 60%-70% of all staff on Maple Ward have been trained since January 2014. The training consists of a combination of face-to-face training sessions, ward based hand hygiene training on technique which encourage patient and visitor participation. In addition, staff are encouraged to complete the HSElanD e-learning training programme⁷ (the HSE's online resource for learning and development).
- The hospital has an infection prevention and control link practitioner system in place. There are 10 link practitioners at Clinical Nurse Manager 1 grade who act as hand hygiene champions within the hospital. It is planned by the hospital to train the link practitioners to local auditor level to participate in hand hygiene audits. There was one lead auditor in Connolly Hospital at the time of the first inspection which had increased to two lead auditors at the time of the re-inspection. Members of the hospital senior management team are also hand hygiene champions and include the General Manager and the Director of Nursing. In addition a Consultant Microbiologist and Clinical Nurse Specialists are also hygiene Champions. A new Clinical Director is due to be appointed and it is hoped that the prospective new Clinical Director will also become a champion for hand hygiene.

3.4.3 Evaluation and feedback⁵: *monitoring hand hygiene practices and infrastructure, along with related perceptions and knowledge among health-care workers, while providing performance and results feedback to staff.*

Criterion 6.3. Hand hygiene practices and policies are regularly monitored and audited. The results of any audit are fed back to the relevant front-line staff and are used to improve the service provided.

The following sections outline audit results for hand hygiene.

National hand hygiene audit results

- Connolly Hospital participates in the national hand hygiene audits which are published twice a year.⁸ The results below taken from publically available data from the Health Protection Surveillance Centre's website demonstrates that Connolly Hospital has achieved the overall compliance for the HSE's national

target since the commencement of the national hand hygiene audits in June 2011. The overall compliance of 91.9% for 2013 is above the HSE's national target of 90%.³

Period 1-6	Result
Period 1 June 2011	85.7%
Period 2 October 2011	85.7%
Period 3 June/July 2012	89.5%
Period 4 October 2012	80.5%
Period 5 May/June 2013	91.0%
Period 6 October 2013	91.9%

Source: Health Protection Surveillance Centre – national hand hygiene audit results.⁸

Hospital hand hygiene audit results

First inspection -10 April 2014

- It was explained to the Authorised Persons that hand hygiene audit results are emailed to the Ward Managers. Issues relating to poor compliance are highlighted at clinical nurse manager meetings, at the quality and safety review meetings and escalated to clinical group level as required. Spot check audits are carried out by the Infection Prevention Control Nurse, the most recent of which was undertaken in February 2014. These results were not available to the Authority to view on the day of the inspection.

Re-inspection -29 May 2014

- The Authority was informed that hand hygiene audits had not been carried out on Maple Ward between the first inspection on 10 April and the re-inspection on 29 May 2014. A hand hygiene audit was ongoing on Laurel Ward for the month of May as part of the national hand hygiene audit.

Local area hand hygiene audit results

- During the first inspection, the most recent hand hygiene audit results that were available for Laurel Ward were dated May 2013 and showed a compliance rate of 97%. The Authority was informed that the Infection Prevention Control Nurse would be carrying out three-monthly hand hygiene audits in 2014.

- The Authority was informed that Maple ward was audited on hand hygiene compliance in March 2013 and achieved 89% compliance. The Authorised Persons viewed an audit result for October 2011 which demonstrated a compliance of 77%.

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 the 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 inspections are based on guidelines promoted by the WHO⁹ and the HSE.¹⁰ 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^r 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 a total of 65 hand hygiene opportunities between the first inspection on 10 April and the re-inspection on 29 May 2014. During the first inspection, 19 out of 34 opportunities (56%) were taken by staff. In the re-inspection, 19 out of 31 opportunities (61%) were taken by staff. The results for hand hygiene opportunities observed during both inspections are grouped below.
- Thirty-eight of the 65 hand hygiene opportunities were taken. The 27 opportunities which were not taken comprised of the following:
 - 10 before touching a patient
 - three before clean/aseptic procedure
 - three after touching a patient
 - 10 after touching patient surroundings

^r The inspectors observe if all areas of hands are washed or alcohol hand rub applied to cover all areas of hands.

- one opportunity where there were two indications for one hand hygiene action which was after touching a patient and before touching the next patient.
- Of the 38 opportunities which were taken, the hand hygiene technique was observed (uninterrupted and unobstructed) by the Authorised Persons for 23 opportunities. Of these, the correct technique was observed in 20 hand hygiene actions.

In addition the Authorised Persons observed:

- 12 hand hygiene actions that lasted greater than or equal to (\geq) 15 seconds as recommended.
- Two healthcare workers wearing a wrist watch and one healthcare worker wearing more than one plain ring, which may act as a barrier to good hand hygiene practice.
- A member of medical staff wore a shoulder bag while attending to patients, which potentially presented a risk to patients of cross-infection.
- Inappropriate wearing of personal protective equipment which contributed to some of the missed opportunities observed.

3.4.4 Reminders in the workplace⁵: *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 the areas inspected at Connolly Hospital. It was noted on Laurel Ward that there was a sign posted on the door of a single room reminding staff entering the room that they were entering 'a bare below the elbow zone'.

3.4.5 Institutional safety climate⁵: *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.*

- Connolly Hospital achieved 91.9% compliance in 2013 in the national hand hygiene audits which is above the HSE's national target.³ The Authority observed 65 hand hygiene opportunities over the course of the two inspections, 38 of which were taken, demonstrating a 58% compliance rate. The compliance rate for the first inspection and the May inspection was 56% and 61% respectively. The Authority notes that both percentages are based on over 30 opportunities for each inspection which is the recommended sample size per area for the national hand hygiene audits. The hand hygiene compliance observed on both Maple Ward and Laurel Ward during both inspections was well below the 90% national target.³ The hospital

did not undertake local hand hygiene audits in these areas between the two inspections as part of a quality improvement strategy to ensure an increase in compliance, which may indicate a lack of awareness on the importance of regular, extensive hand hygiene audit as a tool for incentivising improvement in hand hygiene compliance. The Authority was informed that there was a 50% deficit in the Infection Prevention and Control Nurse Specialist staff complement from February 2013 to May 2014. The resource constraints and lack of local auditors may have contributed to the deficits in local hand hygiene audits which was evident in response to the poor compliance observed during the first inspection .

- The Authority's observations during the inspection, combined with discussions in meetings with hospital staff, suggested that a culture of hand hygiene best practice was not embedded at all levels. The hospital has made hand hygiene training mandatory for all staff every year. It is planned that disciplinary sanctions will be applied where staff fail to comply if required, however the type of sanctions to be used were not defined at the time of the inspection.

In conclusion, the Authority acknowledges that the hospital has consistently achieved hand hygiene compliance with HSE's national targets³ since the commencement of the national hand hygiene audits in June 2011. It was also noted that the hospital had implemented a number of initiatives to improve hand hygiene which was outlined in documentation provided to the Authority. However, observation of hand hygiene compliance during both unannounced inspections was well below the national target. It is a concern to the Authority that the poor compliance in hand hygiene practices in the areas inspected could be more reflective of other areas within the hospital. In addition, the failure of the hospital to seek assurance on its compliance with hand hygiene practices between the unannounced inspections and the deficits reported in the monitoring of hand hygiene throughout the service and at all levels within the hospital on a regular basis indicates that a culture of hand hygiene practice is still not operationally embedded throughout the hospital. Monitoring, evaluation and feedback are one of the essential elements of a hand hygiene improvement multimodal strategy. Regular hand hygiene audits are recommended in all areas where patient care occurs, the frequency of which should be determined at local level and depending on the level of compliance achieved.¹⁰ The lack of local hand hygiene auditing between the two inspections indicated a lack of awareness on the importance of regular, extensive hand hygiene audit with feedback as a tool for incentivising improvement in hand hygiene compliance.

The hospital needs to continue to build on the awareness and best practices relating to hand hygiene to ensure that its performance is improved particularly in reaching the national target of 90%³ hand hygiene in both the national⁸ and local audits.

4. Summary

The risk of the spread of Healthcare Associated Infections is reduced when the physical environment and equipment can be readily cleaned and decontaminated. It is therefore important that the physical environment and equipment is planned, provided and maintained to maximise patient safety.

During the course of the two unannounced inspections in 2014 the Authority found that the cleanliness of frequently used patient equipment was not managed in line with criterion 3.6 of the Infection Prevention and Control standards.¹ During the April inspection on Maple Ward, it was noted that numerous items of frequently used patient equipment were unclean which posed a potential risk of cross infection. Examples of equipment that were observed to be unclean were a pulse oximeter, thermometers probes, commodes, mattresses and mattress covers. In addition the daily cleaning check list for patient equipment on Maple Ward had not been operational since January 2014.

The Authority found that improvements were observed between the two unannounced inspections. An action plan was developed and was ongoing for Maple Ward and Laurel Ward at the time of the May re-inspection. More robust systems were observed during the re-inspection in both areas. For example, the maintenance and management of glucometer holders was reviewed along with the practices for monitoring blood sugars. The Authority was informed that random spot checks of glucometers are now being carried out by Ward Managers. A green label tagging system which alerts staff that equipment is clean was operational. A mattress audit had been conducted in both Laurel and Maple Wards and mattresses deemed to be compromised were replaced. Issues relating to commodes were addressed and waste bins were replaced as required. In addition, healthcare assistants have been assigned two hours of protected time for cleaning patient equipment. Four new healthcare attendants were due to commence working on Maple Ward the week following the inspection and will be responsible for the daily cleaning of patient equipment.

However, the Authority observed findings related to the management of patient equipment during the re-inspection which indicate the improvements are still required. For example some patient equipment on Maple Ward were not signed off as being cleaned such as dressing trolleys, weighing scales, intravenous feeding pumps, thermometer probes and an ECG machine. A mattress on Maple ward was compromised and a bed frame and mattress on Laurel ward had visible red stains which was brought to the attention of the Ward Manager and addressed at the time of the inspection. In addition, a hygiene audit was not undertaken on Maple Ward between the two inspections. This was despite the fact that the hospital was made aware of the high risks relating to environmental hygiene which were observed

following the first inspection. The lack of auditing is of concern, and suggests a lack of ownership at local level and indicates poor assurance mechanisms at a more senior level.

The findings from both inspections indicate that the management of issues relating to estates and maintenance is not optimal. The Authority was informed that there was no system in place to follow up and close out maintenance issue. There is therefore a lack of an assurance mechanism in place to ensure that the physical environment and facilities are managed to minimise the risk of Healthcare Associated Infections. The Authority recommends that the management and maintenance of the environment and facilities be reviewed to ensure it is effectively managed and maintained according to the Infection Prevention and Control Standards.¹

The reported lack of a hygiene specific budget, the deficits evidenced in the monitoring, auditing and strategies for the improvement in the management of environmental hygiene and the lack of a robust system for addressing issues relating to maintenance is of significant concern for the Authority. The Authority recommends that Connolly Hospital review its systems and processes relating to the management and maintenance of the physical environment to assure its compliance with standard 3 of the Infection Prevention and Control Standards.¹

The Authority observed practices relating to the management of healthcare risk waste which not compliant with criterion 3.7 of the Infection Prevention and Control Standards.¹ The findings of this report on the management of waste should be reviewed to ensure that waste management in all areas complies with best practice.⁴

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

The hospital did not undertake local hand hygiene audits on either ward between the two inspections which may indicate a lack of awareness on the importance of regular, extensive hand hygiene audit as a tool for incentivising improvement in hand hygiene compliance. In addition, the Authority's observations during the inspection, combined with discussions in meetings with hospital staff, suggested that a culture of hand hygiene best practice was not embedded at all levels. Whilst the Authority recognises that the hospital had implemented a number of initiatives to improve hand hygiene since the previous announced inspection in 2012, the findings of this report would indicate that a culture of hand hygiene is not yet operationally embedded within the hospital. This should be addressed as a priority by the hospital.

The effectiveness of the governance arrangements for infection, prevention and control at the hospital were a concern for the Authority. The findings from both the unannounced inspections conducted thus far in 2014, indicates that deficits in governance remains an issue and manifested itself in this case during the inspection process as poor environmental and hand hygiene practices as experienced by the patients. The Authority found that there is little evidence to support that Connolly Hospital is effectively monitoring and auditing both environmental hygiene and hand hygiene in order to drive improvements in this area. Under these circumstances, it is not possible for the accountable person to be confident that the prevention and control of Healthcare Associated Infections will be managed effectively at the hospital.

The evidence observed and processes initiated since the April unannounced inspection indicate that the hospital has implemented a Quality Improvement Strategy to address the findings of first unannounced inspection and improvements were evident between the two unannounced inspections. The Authority recommends that Connolly Hospital evaluates the governance of infection, prevention and control in the context of the findings of this report to assure itself that the hospital continues to build on the awareness and best practices relating to hand hygiene and environmental hygiene practices to ensure that its performance achieves full compliance with the Infection, Prevention and Control Standards.¹

In response to the first unannounced inspection conducted by the Authority, a memo was sent to all staff by the senior management team informing them of the main findings of the inspection. Walkabouts were undertaken by members of the senior management team once a week and the Assistant Directors of Nursing carried out more focussed walkabouts twice a week.

The Authority observed some improvement between inspections with respect to the cleaning of patient equipment on Maple Ward. Improvements were also observed in the environments of both wards. However, further improvements in the maintenance and management of both environments were required as many of the findings which were observed during the first inspection were also observed during the re-inspection.

Connolly Hospital must now revise and amend its QIP¹¹ that prioritises the improvements necessary to fully comply with the Infection, Prevention and Control 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 Connolly Hospital 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 Infection, Prevention and Control Standards¹ and is making quality and safety improvements that safeguard patients.

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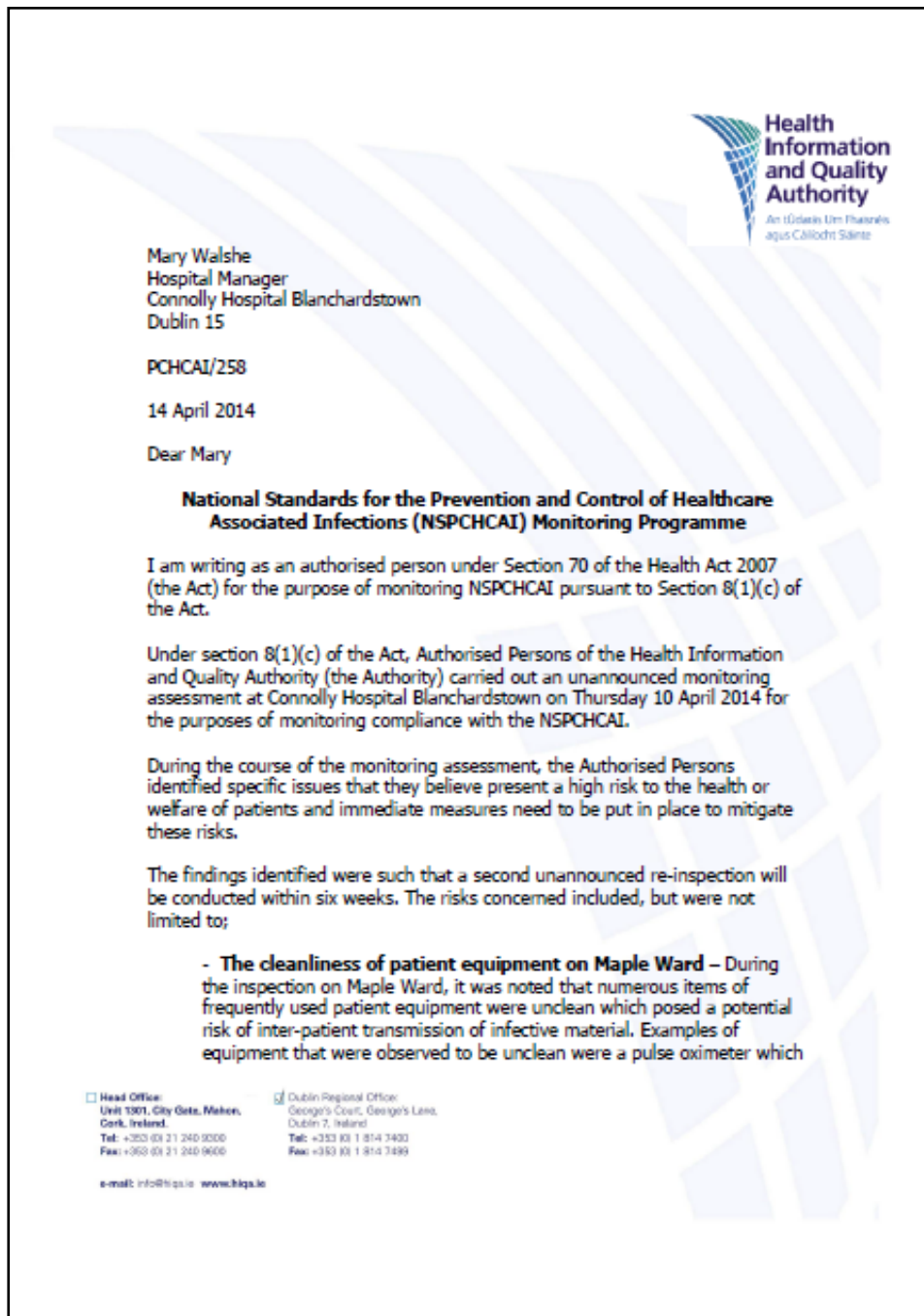
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¥ All online referencesⁱ were accessed at the time of preparing this report

6. **Appendix 1 - Copy of letter issued to Connolly Hospital following the unannounced inspection carried out on 10 April 2014.**





was stained with a red substance, temperature thermometers which were unclear, commodes which had brown staining on their underside, and mattresses and mattress covers which were visibly stained. It was explained to the Authorised Person undertaking the inspection that a system of daily sign-off signifying cleaning of patient equipment was in place, but had not been operational since 12 January 2014.

- **Environmental hygiene** – The environmental hygiene in general on both Laurel and Maple Wards as witnessed by the Authority on the day of the inspection was very poor, and not in compliance with Criterion 3.6 of the Infection Control Standards.

The issues identified on the ward by the Authorised Persons were not in compliance with Criterion 3.6 of the Infection Control Standards. These concerns with respect to the cleanliness of equipment and the environment were raised with the ward manager on the ward at the time of the inspection, and with hospital management at the inspection close out meeting. Given the level of potential risk associated with these findings, and the urgent requirement for its mitigation, the Authority ask that you respond back to this letter **within 2 working days** to confirm that the patient equipment has been adequately cleaned. Furthermore, the Authority request assurance in your response that robust systems have been put in place and are fully operational, to ensure the ongoing cleanliness of patient equipment throughout the hospital.

Details of the risks identified will be included in the report of the monitoring assessment. This will include copies of the Authority's notification of high risks and the service provider's response.

Should you or your colleagues have any queries in relation to the above, please do not hesitate to contact a member of the team at qualityandsafety@higa.ie.

Yours sincerely,

Sean Egan Authorised Person

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Cc

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**7. Appendix 2 - Copy of letter received from Connolly Hospital
following the unannounced inspection carried out on 10 April 2014.**

**Mr Sean Egan
Authorised Person
Health Information and Quality Authority
Dublin Regional Office
George's Court
George's Lane
Dublin 7**

15th April, 2014

Dear Mr Egan

I wish to acknowledge receipt of your correspondence dated 14th March. 2014, received by email.

The issues identified in your correspondence have been addressed with the relevant managers and the specific risk issues in relation to equipment have been actioned.

I wish to assure you that systems have been put in place to ensure the ongoing cleanliness of equipment and compliance with protocols throughout the hospital.

Please find attached relevant documentation requested by the Inspectors.

If you have any further queries please revert to me.

Yours sincerely



**Mary Walshe
Hospital Manager**

8. Appendix 3 – Detailed description of findings from unannounced inspections on 10 April and 29 May 2014

On inspection at Connolly Hospital on 10 April and the re-inspection on 29 May 2014, there was evidence of both compliance and non-compliance with the criteria selected in the Infection Prevention and Control Standards.¹ In the findings outlined below for Laurel Ward and Maple Ward, observed non-compliances are grouped and described alongside the relevant corresponding Standard/criterion.

Environment and Facilities Management

Standard 3. Environment and Facilities Management

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.

Criterion 3.6. The cleanliness of the physical environment is effectively managed and maintained according to relevant national guidelines and legislation; to protect service-user dignity and privacy and to reduce the risk of the spread of Healthcare Associated Infections. This includes but is not limited to:

- all equipment, medical and non-medical, including cleaning devices, are effectively managed, decontaminated and maintained
- the linen supply and soft furnishings used are in line with evidence-based best practice and are managed, decontaminated, maintained and stored.

Laurel Ward (Surgical and Medical)

Laurel Ward is a 31-bedded which consists of four six-bedded wards, six single rooms and one isolation room with an ante room. The single rooms are primarily used for isolating patients who are colonised or infected with transmissible infective diseases as required. There were four patients isolated on the ward during both inspections. On both inspections all 31 beds were occupied, and in addition one extra patient was accommodated on a trolley in a clinical treatment room on the ward as part of the hospital's escalation policy in response to overcrowding in the Emergency Department. The Authority was informed that the treatment room is used for patient accommodation as required. Laurel Ward is used to accommodate both medical and surgical patients but is predominantly a surgical ward.

The Authority was informed that Laurel Ward has been participating in the HSE's Productive Ward Programme¹² since March 2014. The productive ward programme is a national programme that aims to empower front line staff to drive changes and improvements in how healthcare is delivered. The programme also focuses on increasing the time front line staff spend with the patient and on patient safety issues by streamlining and redesigning how services are delivered. Two staff on the ward have been trained on the programme and will be assisted by a link nurse in implementing the programme.

Environment and equipment

First inspection – 10 April 2014

Overall, Laurel Ward required considerable improvement in the cleanliness and maintenance of the environment.

- Heavy layers of dust were visible on the bases of beds. In addition, a black sticky substance was present on the base of one bed.
- Dust and grit were visible on the floors of the patient areas assessed.
- There was chipped paint on bedside tables and a bedside locker was chipped, hindering effective cleaning. Radiators were unclean.
- Brown stains were visible on a window blind in one of the wards.
- Brown staining was visible along the edges of a mattress.
- A light layer of dust was visible on the bottom shelf of the resuscitation trolley.
- The wheel areas of dressing trolleys were unclean.
- The internal surface of a temperature probe holder was unclean.
- Dust was visible on the wheels of a sphygmomanometer which was labelled as clean (dated 2/03/14 and 16/03/2014) and there was chipped paint on the base, hindering effective cleaning.
- Black plastic covers were missing in three places from the horizontal legs of two patient hoists. The exposed sections of the wheel areas underneath and the covers were unclean.
- Rust-coloured staining was visible on the wheel areas of two drug trolleys and the wheel areas were unclean. The bottom shelves of both drug trolleys were dusty and unclean. There was chipped paint and sticky tape residue on the drug trolleys, hindering effective cleaning.
- The following non-compliances were observed in patient washrooms/toilets:
 - The edge of the floor in a shower room was dusty and unclean. Dust was also visible at the shower door. Brown staining was visible at shower doors in another two patient shower rooms.
 - Rust-coloured staining was visible on the wheel areas of a chair in a shower room.

- Adhesive tape was wrapped around a door in one of the patient toilets, hindering effective cleaning.
- The following non-compliances were observed in the clean utility room:
 - Black staining was visible on the sealant behind the hand wash sink and at the side of the sink. There was a crack in the sink and a white/green residue was visible on the taps.
 - The floor covering under the hand wash sink was torn and a piece of the floor covering was missing, hindering effective cleaning. The coving under the sink was unclean.
 - White staining was visible on a second sink on the taps and around the taps. Brown staining was visible in the sink and there was a plastic tube caught in the grate in the sink. There was a plastic bottle containing liquid at the sink labelled 'actichlor' and dated 10/4/2014. There was a considerable amount of label residue on the bottle, hindering effective cleaning and there was no lid on the bottle.
 - Heavy layers of dust were visible in the drawers of plastic storage units and the shelving used to support the drawers. The drawers contained patient supplies such as nutritional supplements and intravenous fluid bags. White and brown staining was visible on the outer surface of the units and in the drawers.
 - A considerable amount of sticky tape residue was visible on a locked cupboard and on a plastic storage unit, hindering effective cleaning.
 - A cupboard door was not attached on one side and was hanging off its hinges.
 - Brown stains were visible on a notice board above the sink and on notices posted on the board. There were some paper notices on the board which were not laminated, hindering effective cleaning.
 - The vent at the front of a fridge was unclean. There was sticky tape residue on the outer surface of the door, hindering effective cleaning and the interior surface of the fridge was unclean.
 - Rust-coloured staining was visible on the metal shelving unit used for storage.
- The following non-compliances were observed in the 'dirty'[±] utility room:
 - There was dust and debris on the floor. Waste material was present on the floor behind the clinical waste disposal bin and access to the bin was restricted by linen trolleys stored in front of it. There was white staining on the floor under the hand wash sink and a white residue under the sink on the coving between the floor and the wall. The coving was not fully attached to the wall in places for example, beside the radiator and behind the bed pan washer, hindering effective cleaning. There was black and white staining on the floor around the bed pan washer, and the pipe work behind the bed pan washer was dusty and unclean.

- There was black staining beside the hand wash sink and on the sealant behind the sink. A white/green residue was visible on the taps.
- There was a white residue on the pipe work connected to the sluice hopper.
- Rust-coloured staining was visible on the wheel areas of four commodes and the wheel areas were unclean. White staining was visible on the vinyl covering on two of the commodes. There was a yellow splash stain on the seat and a drip stain on the armrest of one of the commodes.
- There were white splash stains on the side panel of a cupboard and sticky tape residue on the side panel of another cupboard, hindering effective cleaning.
- Rust-coloured staining was visible on the shelving used for storage and the wheel areas were unclean.
- A moderate layer of dust was visible on top of the bed pan washer and splash stains were visible on the external surfaces of the washer.
- Two buckets were stored on the floor under the sink used for cleaning patient equipment, hindering effective cleaning.
- There was sticky tape residue on the notice board and on the surfaces of notices posted on the board, hindering effective cleaning.
- The following non-compliances were observed in a store room:
 - Labels were stuck to the floor and cardboard boxes were stored on the floor, hindering effective cleaning. There was dust and debris on the floor.
 - Rust-coloured staining and debris were observed on the surface of the trolley used to store oxygen cylinders.
 - Black marks and sticky tape residue were observed on the interior surface of the door in the store room, hindering effective cleaning.
- Rust-coloured staining was observed on foot stools and they were also dusty and unclean.
- Paintwork on walls and skirting boards throughout the ward was scuffed and chipped, hindering effective cleaning.
- Two ceiling tiles were missing in the corridor, close to the entrance to the ward.

Environment and Equipment

Re-inspection – 29 May 2014

While some improvements were observed on Laurel Ward between the first inspection and the re-inspection, further improvements in the maintenance of the environment were required as many of the findings which were observed during the first inspection were also observed during the re-inspection.

- Red splashes were observed on a wheel, on the bed rail and under the bed in one of the six-bedded wards. This matter was brought to the attention of staff at the time of the inspection for immediate cleaning. The Authority was informed

that the bed had just been transferred to the ward from theatre in this condition. In addition, the cover on the mattress on the bed was torn and the surface of a pillow was cracked.

- Similar to the first inspection, heavy layers of dust were visible on the bases of beds.
- Chipped paint was observed on bedside tables and bed rails, hindering effective cleaning. Bedside lockers were chipped, also hindering effective cleaning.
- While intravenous stands were generally clean, sticky tape residue was observed on the bases of some stands, hindering effective cleaning. Rust-coloured staining was also observed on the wheel areas of one stand.
- Splash marks and brown stains were observed on the under-surfaces of shelves on dressing trolleys.
- The fabric on a wheelchair was observed to be torn on the backrest, arms and step, hindering effective cleaning.
- The vinyl covering on chairs in patient areas were observed to be torn, hindering effective cleaning.
- The non-compliances observed during the first inspection regarding patient hoists were still evident. One of the hoists' was labelled as being cleaned on 28 May 2014.
- A staff member was observed leaving an isolation room wearing personal protective equipment and re-entering the room wearing the same personal protective equipment, including the same gloves which were used when opening and closing the door of the isolation room when leaving and re-entering.
- The following non-compliances were observed in patient washrooms/toilets:
 - Rust-coloured staining was visible on the wheel areas of a chair in a shower room.
 - Adhesive tape was wrapped around a door in one of the patient toilets, hindering effective cleaning.
 - Dust was observed on the floor in a toilet in a six-bedded ward.
 - Black staining was visible around the shower tray in another six-bedded ward and the shower head was not attached correctly. Brown staining was observed on the floor under the door and around the toilet.
- While some improvements were observed in the clean utility room, the following non-compliances were evident at the re-inspection:
 - There was a crack in the hand wash sink.
 - White staining was visible on a second sink and brown stains were visible on a notice board above the sink.
 - The drawers of plastic storage units which contained patient supplies such as nutritional supplements were dusty and unclean. Sticky tape residue was visible on the drawers, hindering effective cleaning.

- The vent at the front of a fridge was unclean. There was sticky tape residue on the outer surface of the door, hindering effective cleaning.
- While some improvements were observed in the 'dirty' utility room, the following non-compliances were evident at the re-inspection:
 - White staining was observed on the floor under the hand wash sink and the coving was not fully attached to the wall in places, hindering effective cleaning. Pipe work behind the bed pan washer was dusty and unclean.
 - There was black staining on the sealant behind the hand wash sink.
 - There was a white residue on the pipe work connected to the sluice hopper.
 - Rust-coloured staining was visible on the wheel areas of one commode. White staining was visible on the back rests of two commodes and on the bases of the seats of two commodes.
 - Rust-coloured staining was visible on shelving.
 - Dust was visible on top of the bed pan washer.
 - Two buckets were stored on the floor under the sink used for cleaning patient equipment, hindering effective cleaning.
- The non-compliances observed in the store room during the first inspection were also evident during the re-inspection. In addition, sticky tape and label residues were observed on a syringe pump stored in the room, hindering effective cleaning.
- Paintwork on walls and skirting boards throughout the ward was scuffed and chipped, hindering effective cleaning.

Linen

First inspection – 10 April 2014

- The wheel areas of trolleys used to store dirty and contaminated linen were unclean.
- Wooden shelving in the linen store room was chipped, hindering effective cleaning.
- Dust was visible on the floor of the linen store room and on the wheel areas of shelving used for storage.
- The wheel areas of trolleys used to store small amounts of patient supplies and linen were unclean.
- Cardboard boxes and other items were stored on the floor in the linen store room, hindering effective cleaning.
- Ceiling tiles in the linen store room were not sitting in place correctly, which increased the risk of dust from the ceiling space entering the room.
- Inappropriate items including mobile phone chargers, personal protective equipment and disinfectant wipes were stored in the linen store room. This is not

in line with best practice¹³ as such items attract and retain dust and other microbiological material, and therefore increase the risk of linen contamination.

Re-inspection – 29 May 2014

In addition to the above non-compliances, an alginate bag which is used for contaminated linen was observed in a white linen bag, which is not in line with best practice.¹³

Cleaning Room

First inspection – 10 April 2014

- White staining was visible on the floor covering under the sink used for the disposal of waste cleaning liquids. The coving was not fully attached to the wall in places, hindering effective cleaning.
- Rust-coloured staining was visible on the metal trolley/shelving unit used for storage in the cleaning room and the wheel areas were unclean.
- The outer surface of a shelf in the cleaning room was chipped, hindering effective cleaning.
- The vent in the door of the cleaning room was missing.

Re-inspection – 29 May 2014

The wheel areas on the metal trolley/shelving unit used for storage in the cleaning room were clean. Apart from this, the above non-compliances were still evident. In addition, a mop head stored in the cleaning room was unclean.

Maple Ward

Maple Ward is a 31-bedded acute medical unit which consists of four six-bedded wards, six single rooms and one isolation room with an ante room. The single rooms are primarily used for isolating patients who are colonised or infected with transmissible infective diseases as required. Six patients were isolated during the first inspection and two patients were isolated during the re-inspection. All 31 beds were occupied, and in addition one extra patient was accommodated on a trolley in a clinical treatment room on the ward during both unannounced inspections.

The Authority found that the physical environment on Maple Ward was generally unclean and the equipment inspected was not effectively managed, decontaminated and maintained in line with criteria 3.6 of the Infection Prevention and Control Standards.¹

Environment and equipment

First inspection – 10 April 2014

- Authorised Persons observed a patient walking on the main corridor of the ward. The patient's clothing was visibly stained with blood due to an injury sustained prior to admission. The Authority had previously observed this patient on the main stairwell leading to the hospital reception area. The Authority had concerns regarding the management of this patient and brought this to the attention of the Ward Manager to be addressed immediately. The Authority was informed that the patient was admitted overnight and would not consent to being assisted with hygiene. The patient required contact isolation precautions and was isolated in a single room. The issue was addressed by the Ward Manager during the inspection process.
- A syringe containing clear fluid was observed on the floor beside a patient locker. This issue was of concern to the Authorised Persons who brought it to the attention of the Ward Manager at the time of the inspection. The issue was addressed and resolved immediately by hospital staff.
- The Authority inspected two mattresses during the inspection. The cover of one mattress was visibly torn around the edges and staining was observed on the inside of the second mattress cover and mattress base. Both mattresses posed a potential risk to the patient and staff of transmissible infective microorganisms as the integrity of the covers were compromised and no longer impermeable to bodily fluids.
- A patient call bell was visibly unclean.
- Two ceiling tiles were missing in the corridor adjacent to the six single rooms.
- A moderate layer of dust was observed on the skirting boards in a patient bathroom.
- Brown staining was visible on a raised toilet seat.
- Brown-coloured residue was visible on the floor under the door of a patient shower.
- A shower room in a six-bedded ward had an 'out of order' sign on the door. The Authority was informed that this issue had been ongoing for two months up to the day of the inspection
- A heavy layer of dust was observed on different areas on a resuscitation trolley and the oxygen tank holder was visibly unclean.
- The internal surfaces of two thermometer probe holders were unclean. This issue was of concern to the Authority and was brought to the attention of the Ward Manager. This finding was addressed and resolved immediately.
- Red-coloured staining was observed on the surface of an oxygen saturation probe which was brought to the attention of the Ward Manager. The oxygen saturation probe was immediately taken out of use.

- A chair in a patient area assessed was unclean and the vinyl cover was torn, hindering effective cleaning.
- Light to moderate layers of dust were observed on equipment inspected such as intravenous pumps, suction apparatus, a patient hoist, fire extinguishers, an electrocardiograph (ECG) machine and a patient wheelchair. The shelving used to hold patient notes, a keyboard and phone in the ward work station were also visibly dusty.
- The following non-compliances were observed in the clean utility room:
 - Reddish/brown-coloured staining was observed on the external surface of a glucometer holder. This raised a concern for the Authority who brought it to the attention of the Ward Manager and was addressed.
 - Debris was visible on the floor.
 - Rust-coloured staining was visible on the metal shelving unit used for storage of medical supplies and equipment, hindering effective cleaning.
 - A moderate layer of dust was observed on lower level shelving and a heavy layer of dust was visible over a cupboard.
 - Both drug trolleys inspected were visibly unclean, for example, the lower shelf and lid of one trolley had a considerable amount of sticky tape residue as well as orange-coloured staining, there was visible staining on the side of the other trolley and the wheel areas of both trolleys were unclean and had rust-coloured staining.
 - The surrounding area of a second sink used for cleaning patient equipment was stained and the draining area was unclean.
 - Brown staining was visible on the sealant behind the designated hand hygiene sink.
 - A foot stool was visibly unclean.
- The following non-compliances were observed in the 'dirty' utility room:
 - Brown staining and residue was observed underneath the seat area of two commodes inspected. In addition, parts of the frame under the seat area were visibly dusty and rust-coloured staining was observed. Rust-coloured staining was also observed on the wheel areas of both commodes. The vinyl cover on one of the commodes was torn, hindering effective cleaning. The cleanliness of the commodes raised a concern for the Authorised Persons who brought it to the attention of the Ward Manager.
 - White residue was visible on the front surface of the door of the bed pan washer.
 - White staining was observed on the floor area under the sluice hopper. The floor covering under the sink was damaged and lifting around the edges, hindering effective cleaning.
 - The floor edges and corners were visibly dusty.
 - The walls near the sluice hopper were visibly stained.

- The work top was chipped, hindering effective cleaning.
- Whilst most of the signage observed was laminated, one paper sign was not laminated, hindering effective cleaning. Furthermore, the waste segregation signage was curling at the edges and not adhered fully to the wall.
- The shelving under the bed pan rack holder was unclean.
- Dust and grit were visible on the floor of the patient areas assessed. In addition, brown-coloured staining was observed on the floor under two of the beds inspected.
- The base of a bed-table was visibly unclean.
- Heavy layers of dust were visible on the casement over a patient bed assessed.
- The curtains surrounding a patient bed were visibly stained.
- Moderate layers of dust were visible on the bases underneath the beds assessed. In addition, red-coloured dust was observed on the gridded frame of one of the beds inspected. Dust was also observed on the end of all of the beds in a six bedded ward.

Environment and equipment (Maple Ward)

Re-inspection – 29 May 2014

The Authority found that the cleanliness of the environment on Maple Ward had improved, however further improvements in the maintenance and management of the environment were required as many similar findings observed during the course of the first inspection were also seen during the re-inspection. Significant improvements were observed in the maintenance and management of patient equipment; however some exceptions were still noted.

- Dust was observed in the following areas:
 - Moderate layers of dust were observed on the floor edges and corners of the patient areas of an isolation room, a patient shower room and two six bedded units assessed.
 - Brown-coloured grit was observed on the floor of the 'dirty' utility room.
 - A light to moderate layer of dust was visible on the casement over a patient bed assessed in an isolation room; a heavy layer of dust was also present on the bed frame.
 - Dust was visible on different areas of the resuscitation trolley.
 - Light dust was visible on the base of a patient hoist, a wheelchair, the base of a portable blood pressure monitoring equipment, a weighing scales and an electrocardiograph (ECG machine). A green label attached to the weighing scales showed that it was last cleaned on 17 May 2014. There was no label to indicate when the ECG machine was last cleaned. In addition, sticky residue was also present on the surface of the ECG machine which may attract microbial contamination.

- The following non-compliances were observed in the clean utility room:
 - Debris was visible on the floor.
 - Rust-coloured staining was visible on the metal shelving unit used for storage of medical supplies and equipment, hindering effective cleaning.
 - A moderate layer of dust was observed on lower level shelving and a heavy layer of dust was visible over a drug cupboard.
 - Light dust levels were present on shelving in a storage cupboard and sticky residue was also observed on the shelving, hindering effective cleaning.
 - Heavy dust was visible on a fan observed in the clean utility room.
 - Rust-coloured staining and sticky residue was visible on the bottom shelf of a drug trolley.
 - Stainless steel shelving racks had visible rust-coloured staining.
 - The surrounding area of a second sink used for cleaning patient equipment was stained.
- Rust-coloured staining was observed on the wheel areas of four of the six commodes inspected. The vinyl cover on one commode was torn, hindering effective cleaning.
- The curtains surrounding a patient bed were visibly stained.
- Two mattresses were inspected during the re-inspection of Maple Ward, one of which the cover and base were compromised. This finding was brought to the attention of the Ward Manager and was replaced immediately.
- Similar to the first inspection, ceiling tiles in the corridor outside the isolation rooms were not securely in place.

Linen (Maple Ward)

First inspection – 10 April 2014

- Varying levels of dust was observed in the linen room. For example, a light level of dust was visible on the window sill and shelving used for storage. Heavy dust was observed on the skirting boards. Dust and grit was visible on floor corners and edges.
- Rust-coloured staining was visible on a mobile foot stool stored in the linen room at the time of the inspection. The plastic casing was damaged and unclean.
- The wheel areas of the mobile shelving unit used to store clean linen was unclean.
- Linen bags were observed to be more than two thirds full which is not in line with best practice.¹³

Re-inspection – 29 May 2014

While there was some improvement in the dust levels observed in the linen room, similar non-compliances were evident which related to best practice.¹³

- Linen bags were observed to be more than two thirds full which is not in line with best practice.¹³
- Infected linen was not placed in an alginate bag prior to being placed into appropriate colour coded bag for transportation in line with best practice.⁶
- Two boxes were observed in the middle of the floor space and beside the linen storage trolley, hindering effective cleaning.
- Two ceiling tiles were not secured into position.

Cleaning equipment (Maple Ward)

First inspection – 10 April 2014

- Rust-coloured staining was visible on the metal gridded trolley/shelving unit used for storage in the cleaning room and the wheel areas were unclean.
- The two floor buffers inspected in the cleaning storage room were visibly dusty.
- Two uncovered wall cavities were observed; the covers were sitting in the cavities and a heavy layer of dust was observed in the cavity surround.
- The Authority viewed daily cleaning records for the cleaning of the cleaning storage room. Hospital staff told the Authority that the cleaning equipment and storage room were cleaned daily, however the records demonstrated that 30 March, 4 and 5 April 2014 were the only days signed in a 12 day period.
- The outlines of two objects were visible through the cover of a ceiling mounted light fitting.

Re-inspection – 29 May 2014

- Rust-coloured staining was visible in smaller amounts on the metal gridded trolley/shelving unit used for storage in the cleaning room and the wheel areas were much improved.
- The two objects observed through the cover of a ceiling mounted light fitting during the first inspection were still visible during the re-inspection. This finding was highlighted to the household supervisor who stated that a request had previously been sent to the Estates Manager but had not been followed up. Further discussion showed that there was no system in place to confirm that requests to estates had been actioned and closed off. The only means of determining if a request was addressed was to physically check if it had been completed.
- A portion of the wall above the floor was not intact, hindering effective cleaning.
- White-coloured staining was visible on the floor covering under the fluid disposal unit.

Environmental audits and equipment findings

Laurel Ward

First inspection – 10 April 2014

Records of environmental audits were not available on Laurel Ward during the first inspection and the Authority was unable to verify if audits were carried out regularly on the ward. According to the hospital's 'Hygiene Annual Report 2013' which was provided to the Authority after the inspection, environmental audits were last carried out on Laurel Ward in February and April 2012. There were no environmental audits carried out the ward during 2013.

Re-inspection – 29 May 2014

After the first inspection, an environmental audit was carried out on Laurel Ward on 1 May 2014 and the results were viewed by the Authority. The audit tool comprises 16 areas and responsibility for each area is assigned to ward/department, household/estates or hospital management. Scores were assigned to each area and the results showed 94% compliance for ward/department level, 97% compliance for household/estates and 96% for hospital management. The Authority found that many findings observed during the re-inspection were similar to the April inspection. These findings did not appear to have been identified in the audit undertaken on Laurel ward between the two inspections. This raised a concern for the Authority that the assurance mechanism used for measuring the environmental hygiene within the hospital was not capturing issues which were relevant to the maintenance and management of environmental hygiene.

Following the first inspection carried out in April, an action plan, dated 30 April 2014, was prepared for Laurel Ward. The Authority was informed that cleaning on the ward is more specific and that healthcare assistants have been assigned two hours of protected time for cleaning patient equipment. Prior to this, only one hour of protected time was assigned for cleaning. Cleaning checklists have been designed for each area and these are signed off by a healthcare assistant and the person in charge of the ward. Also, since the first inspection, checklists were designed for weekly cleaning of patient equipment and monthly cleaning of other areas such as containers and cupboards. Patient equipment is also cleaned between each use. In addition, a glucometer was replaced and a standard operating procedure was prepared for the cleaning of glucometers. The Authority was informed that random spot checks of glucometers are now being carried out by Ward Managers.

The Authority was informed that a business plan had been prepared for the replacement of waste disposal bins since the first inspection and as a result two non-clinical and three clinical waste disposal bins were replaced on the ward. Two

commodes had also been replaced since the first visit and six chairs were re-upholstered.

A mattress audit was carried out on the ward after the first inspection. The Authority was informed that mattresses were checked every day for three weeks and this was subsequently reduced to weekly checks. Six mattresses were replaced since the first inspection.

Maple Ward

First inspection – 10 April 2014

Daily cleaning records were viewed by the Authority for the sluice room, clinical room and linen room on Maple Ward. The records were last completed on the 12 January 2014. The Ward Manager informed the Authorised Persons that protected time had not been allocated to healthcare attendants to complete the cleaning of equipment on a daily basis due to the level of ward activity and reduced staffing levels. The Ward Manager had verbally communicated these concerns to the Line Manager in charge of this area. The Ward Manager explained that staff are verbally reminded about cleaning of patient equipment on a regular basis.

The findings of the first inspection demonstrated that frequently used patient equipment was not maintained or managed in line with criterion 3.6 of the Infection Prevention and Control Standards.¹ The Authority was informed that healthcare attendants were responsible for the cleaning of patient equipment. Maple Ward operates an alert tagging system for patient equipment with a green label indicating that the equipment is clean, however, at the time of the inspection, Authorised Persons observed only one intravenous drip stand which had a green label attached indicating that the system was not operational.

The Authority was informed by the Ward Manager that the last environmental hygiene audit was carried out in October/November 2013. However at the time of the inspection the results were not available to view as the Ward Manager had not yet received them. A previous audit undertaken in 2012 was viewed which demonstrated 94% compliance, however there was no date on the audit report.

The Authority was informed that mattresses are assessed following the discharge of patients however this assessment does not include the examination of the inside of mattress covers, whether the mattress cover is impermeable to fluids, or inspection of mattress bases.

The Authority was informed by the General Manager of the hospital at the close out meeting that the issue of protected time for healthcare assistants for indirect care was under review.

Re-Inspection – 29 May 2014

The Authority found that an environmental hygiene audit had not been conducted between the first and second inspections. It was explained by the Ward Manager that dates had been arranged for the audit but these were cancelled on three occasions. The Authority was informed that it was planned that future audits would be carried out between neighbouring wards where the Ward Manager of one ward would audit the neighbouring ward.

Daily sign off sheets were viewed which demonstrated a more robust system for maintaining patient equipment on a daily basis and after each patient use. However, some patient equipment was not signed off as being cleaned such as dressing trolleys, weighing scales, intravenous feeding pumps, thermometer probes and an ECG machine. The sign off sheets are reviewed by the Ward Manager, Divisional Manager and Director of Nursing. The evidence witnessed on the day of the re-inspection found that patient equipment was clean and well maintained with some exceptions.

The Authority was informed that the broken clinical waste bins had been replaced since the first inspection, three large domestic waste bins had been ordered and the ward was waiting on delivery. All staff were informed that it is the responsibility of each staff member to ensure that patient equipment is cleaned between patient use. In addition, the practice of taking the glucometer holder to the patient bedside is being discouraged; only the equipment required should be taken to the patient bedside for blood sugar monitoring.

A mattress audit was carried out on the ward after the first inspection. The Authority was informed that six mattresses were replaced and three more were ordered on 27 May 2014.

Four new healthcare attendants were due to commence working on Maple Ward the week following the inspection. It was communicated that it is intended that they will have the responsibility for the daily cleaning of patient equipment.

Waste

Criterion 3.7. The inventory, handling, storage, use and disposal of hazardous material/equipment is in accordance with evidence-based codes of best practice and current legislation.

Laurel Ward

First inspection – 10 April 2014

- The interior surface of the lid on a non-clinical waste disposal bin in a female six-bedded ward was unclean, the closing mechanism was not operating correctly and as a result it was not closing automatically. The bin was more than two thirds full, which is not in line with best practice.⁴
- Rust-coloured staining was visible on the lid and side panel of the non-clinical waste disposal bin in the clean utility room.
- The safety locking mechanisms on sharps bins stored in the clean and 'dirty' utility rooms were not engaged.
- The non-clinical waste disposal bin in the 'dirty' utility room was unclean.
- There was chipped paint on the foot lever of the clinical waste disposal bin in the 'dirty' utility room, hindering effective cleaning.
- A trolley used to store a yellow sharps bin was unclean. Red stains were visible on the lid, the bin and on a sign attached to the trolley.

Re-inspection – 29 May 2014

- Similar to the first inspection, the closing mechanism on a non-clinical waste disposal bin in a female six-bedded ward was not operating correctly.
- The safety locking mechanisms on sharps bins on the resuscitation trolley, a phlebotomy trolley and in the clean and 'dirty' utility rooms were not engaged. In addition, a red stain was observed on the lid of a sharps bin in the 'dirty' utility room.
- A free standing sharps bin was observed on a window sill in a single room which was not in line with best practice.
- Similar to the first inspection, chipped paint was observed on the foot lever of the clinical waste disposal bin in the 'dirty' utility room, hindering effective cleaning.

Maple Ward

First inspection – 10 April 2014

- Sharps bin holders in the clean and 'dirty' utility rooms were visibly unclean.
- The door of a clinical waste bin outside an isolation room was taped closed.

- A sharps bin on an integrated tray was more than two thirds full, which is not in line with best practice.⁴
- The temporary closure mechanism was not in use on a purple lidded clinical waste bin.
- The Authority observed that there was neither a domestic waste bin nor a clinical waste bin located in two of the single rooms used for isolating patients on the day of the inspection. Two domestic waste bins and one clinical waste bin were located outside the rooms. The clinical waste bin was situated between the two rooms. Furthermore, the sanitary waste bin was overfilled with paper towels. These issues were brought to the attention of the Ward Managers as they were not in line with best practice.⁴
- The integrity of the paintwork on the lid of a recycling bin beside the hand hygiene sink located in the clean utility room was compromised and stained. Rust-coloured staining was visible on the foot pedal of a domestic waste bin.

Re- Inspection – 29 May 2014

- The designated waste sub-collection storage area was viewed. The area was located on the main corridor leading into Maple Ward and was not secure which posed a potential risk of access to unauthorised persons. In addition, clinical waste posters identifying waste segregation were not present in the sub collection area.
- Similar to the first inspection, the temporary closure mechanism was not activated in four sharps bins inspected in the clean utility room.
- Sharps bin holders in the clean and 'dirty' utility rooms were visibly unclean which was similar to the first inspection.

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