HIQA UNANNOUNCED INSPECTION 19th April 2018
QUALITY IMPROVEMENT PLAN

Tallaght University Hospital | Ospidéal Ollscoile Thamhlachta
An Academic Partner of Trinity College Dublin

Reference	Findings	Response	Action Lead	Target Date	Additional Actions / Update	Target Date	Status
2.1 Risk Identified during unannounced inspection 19 April 2018	**A Risk was identified in relation to failure to effectively and consistently implement transmission- based precautions:** **Inspectors observed that the two doors to two single isolation rooms on Lynn Ward accommodating patients requiring airborne infection isolation precautions were open at the beginning of the ward based inspection.**	Decision documented in nursing notes giving reason for same. This was also confirmed in the letter dated 26th April 2018 from Daragh Fahey (Director of QSRM) Key actions included • Daily Inspections by the Executive Management team to ensure compliance with airborne infection isolation precautions • Education to clinical staff on the management of patients with actual or suspected tuberculosis (TB). The IPCNs have implemented an audit tool to assess the doors and compliance with Care plans. The aim is to improve non-compliance. An audit report is due by the end of 2018.	Áine Lynch Ward CNMs Áine Lynch IPCN	End of year report			**Completed** **Completed** **Completed** **Completed**

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2.2 Governance and Risk Management pg. 4 par 2/3	**The team found that the recent changes in hospitals governance for Infection Prevention and control were not fully communicated or understood in practice leading to ambiguity amongst some senior members of the Infection Prevention and Control Team. The Organogram provided to HIQA did not reflect the proposed dual reporting structure as explained by senior management during Interview. The lack of clarity was a concern.**	The IPC Committee reviewed & agreed the IPC Governance Structure in 2018. TOR & Organogram was also updated and agreed by the Committee and the EMT.	Lucy Nugent	May 2018			**Completed**
Governance and Risk Management pg. 3 par 4	**It was reported at interview that demands of training up and supporting newly appointed infection prevention and control nurses further impacted on implementation of an infection prevention and controls programme at the hospital.**	3.5 IPCNs were recruited at the end of 2017 and into 2018. One WTE was covering Mat leave. The total in April was one ADON, 4 IPCNs and one WTE mat leave cover. Of which 2.5 were not qualified or experienced. Two IPCs let in Q3 2018 which has left the following in Oct 2018. 1 ADON and 3 WTE. (1.5	Áine Lynch		Following further investment there are now 5.8 WTEs in place		**Local Induction Completed**

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		are not qualified or experienced). Recruitment in progress for 2 WTE and it is hoped that they will	Dec 2018				
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2.2 Governance and Risk Management pg. 5 par 1	**Staff on one of the wards Inspected reported that they had difficulty accessing and locating polices procedures and guidelines on the hospitals controlled document management system.**	All ward based staff have received training on access to Q-Pulse (central repository for all hospital PPPGs) and specifically on how to log in, search for and locate PPPGs	Mary Hickey	Dec 2018			**Completed**
2.2 Governance and Risk Management Pg. 5 par 6	**Documentation indicated that 77% of hospital staff had attended mandatory hand hygiene training in the previous two years management stated that this was an underestimation of overall compliance as deficiencies in respect of accurately quantifying the number of staff trained were reported.**	HR carried out an audit to ensure that all staff who attended Face to Face education were recorded on CORE. Corrective action was also taken. The hospital has launched the "TUH Learning Station" in conjunction with HSElanD which will assist with the recording and management of online mandatory training.	Lucy Nugent	13th July 2018			**Completed**
2.2 Governance and Risk Management	**National guidelines recommend that the process for reporting and Investigating**	Root-Cause analysis of hospital acquired *C difficile* cases and *S*	Dr J. Fennell	Mid Oct 2018		**IFC Meeting**	**In Progress**

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Pg 6 par1/2	**HCAI's by systems analysis should be aligned with the governance arrangements that apply for other types of incidents in the hospital. Inspectors were informed that HCAI system analysis were not routinely performed for all HCAI'S at the time of the 2018 inspection.**	*aureus* bacteraemia has commenced. Dr Fennell & Chair of the IPC Committee to meet mid-October to sign off on the process.					
Reference	**Findings**	**Response**	**Action Lead**	**Target Date**	**Additional Actions/ Update**	**Target Date**	**Status**
2.3 Infection Surveillance Pg8 par 5/6	**Care Bundles: Inspectors reviewed documentation and spoke to staff relating to care plans for peripheral vascular access devices, urinary catheters and central venous access devices in the areas inspected .They observed that compliance with documentation of care bundles elements was variable and demonstrated that there was scope for improvement in the management and documentation of invasive device management Care Bundle implementation was monitors every two months using NIQA (Nursing Instrument of**	We have delivered formal and informal training to nursing staff on care bundles. Care bundles have been included in the new Admission Booklet – nursing assessment document - which has been designed to increase compliance. Education has been provided on the correct use of the documentation. There is continuing refresher education in clinical skills and a NIQA audit is conducted bimonthly. There is also education provided on invasive devices.	Áine Lynch	Last Clinical audit took place on 1st July 2017	CVAD Compliance now 90% and PVAD compliance increased to 70.6% on Oct NIQA Audit. Refresher education and monitoring of compliance continues (At time of HIQA inspection compliance was 58% PVAD &		**Care Bundles are audition Bi-Monthly** **Refresher education and monitoring of compliance is ongoing**

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	Quality Assurance). Low levels of compliance achieved in some areas demonstrated the need for ongoing audit followed by targeted training and education to ensure compliance with infection control bundles.				61.5% CVAD)		
2.3 Infection Surveillance Pg9 par 2	**Action was required in monitoring of catheter-associated urinary tract infection rates in the Intensive Care Unit which were not actively monitored at the time of Inspection.**	All ICU patients are screened for urinary infections on admissions and as medical required. Results are then discussed and inputted via the Microbiology round which is done three times a week in the ICU.	Lead Clinician in ICU				**Catheter associated urinary tract infections are monitored regularly in ICU**
Reference	**Findings**	Response	**Action Lead**	**Target Date**	**Additional Actions/ Update**	**Target Date**	**Status**
2.4 Prevention and control of healthcare associated infections and multidrug resistant organisms Pg 11 par 5	**Antimicrobial Stewardship: National guidelines recommend that hospitals have a process in place to facilitate pre-authorisation for use of all Carbapenem antibiotics bay an infection specialist (Consultant or Specialist Registrar in Clinical Microbiology or Infectious Disease. Hospital guidelines detailed a list of restricted antimicrobials including**	We are currently undertaking a project to development and introduction of a new Drug Kardex which will have a specific section for Antimicrobial Drug and is due to be implemented mid 2019	**Dr. Prior**				**Continuous**

	meropenem. However pre-authorisation from a Consultant Microbiologist was not essential and post prescription intervention was described as persuasive rather than restrictive, comprising a post-prescribing review rather than pre-authorisation of restricted agents .The hospital needs to review the current approach to restrictive prescribing rights with an initial focus on a smaller number of important antimicrobials such as carbapenems.						
Reference	**Findings**	**Response**	**Action Lead**	**Target Date**	**Additional Actions / Update**	**Target Date**	**Status**
2.4 Prevention and control of healthcare associated infections and multidrug resistant organisms Pg 12 par 2	**<u>CPE Cohorting:</u> Inspectors were informed that the hospital planned to locate a three-bed HDU for surgical patients within Lynn Ward however, an updated infection prevention and control risk assessment had not been undertaken by senior management to support this decision. It is HIQA's view that the intended location of the HDU is inappropriate and needs to**	A new Sluice has been provided on Lynn Ward for HDU specific use only.	Ciaran Faughnan				**Completed**

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	be reconsidered in the context of current arrangements, infrastructure and ongoing CPE outbreak.						
2.4 Prevention and control of healthcare associated infections and multidrug resistant organisms Pg 12 par 3	**The inspection team found that refurbishment of designated CPE isolation rooms was in progress at the time of the inspection, In general the cohort ward was clean but cluttered in places .However on the day of the inspection, the doors to all 18 single rooms accommodating CPE patients in the designated infection cohort ward had been left open .This is a similar finding to the 2015 inspection and is not in line with best practice and should not occur.**	All doors of the single isolation rooms on Lynn ward are closed when occupied by a patient. If a door has to be left open the reason is documented in the nursing notes. This was also confirmed in the letter dated 26th April 2018 from Dr. Daragh Fahey (Director of QSRM).As per 2.1. The IPCNs have implemented an audit tool to assess the doors and compliance with Care plans. The aim is to improve non-compliance. An audit report is due by the end of 2018.	Áine Lynch				**Completed managed by local CNMs**
Reference	**Findings**	**Response**	**Action Lead**	**Target Date**	**Additional Actions / Update**	**Target Date**	**Status**
2.4 Prevention and control of healthcare associated infections and multidrug	**National guidelines recommend that isolation and cohort areas have a higher ratio of staff to patients (patient care and cleaning staff) that that which applies in most**	There is a regular review of nursing staffing levels with ongoing recruitment	Áine Lynch				**Additional Nursing and HCAs have been provided within the constraints of WTEs and**

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resistant organisms Pg 13 par 2	**circumstances ,in particular if patients have high care requirements .While additional cleaning resources were allocated to the affected wards to manage the CPE outbreak ,it was reported by ward staff that sufficient numbers of frontline nursing and healthcare assistants had not been provided .These findings reflect the risk identified by the hospital relating to deficits in frontline staffing. Local risk assessment or audit is recommended to ensure that there is adequate staffing and skill mix to meet clinical needs of patients in isolation**						**funding nationally**
Reference	**Findings**	**Response**	**Action Lead**	**Target Date**	**Additional Actions / Update**	**Target Date**	**Status**
2.4 Prevention and control of healthcare associated infections and multidrug resistant organisms Pg 13 par 3	**Scope for Improvement was identified relating to other issues identified on the infection control cohort ward at the time of Inspection** 1. Dedicated equipment was not always available for patients in isolation 2. A lack of awareness among staff on cohort	**1.** Lynn Ward has 16 new Dynomaps – dedicated equipment for patients in isolation. **2.** Education is provided to staff regularly on	ADONs IPC				**Completed** **Completed** **Raised at Medical Board agreed**

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	ward regarding the highly mobile resistance mechanisms Of CPE	CPE especially in the affected wards. Hand Hygiene & Breaking the Chain of Infection is also mandatory for all staff.	Lucy Nugent				**process in place Completed**
	3. Inconsistent and inaccurate documentation of patient CPE status .For example ,documentation of patient CPE status in one record viewed was in correctly recorded	**3.** The clinical microbiologist and infection control team liaise with the clinical team in relation to every new case of CPE and request they inform the patient and document in the patient's medical chart	Áine Lynch				**Completed**
	4. Poor performance demonstrated in a recent infection prevention and control audit of patient equipment ,transmission-based precautions ,infection control knowledge and practice and multidisciplinary hygiene audit	**4.** The DON has confirmed that the CNMs have all taken corrective action on the IPC audits for their areas and the Environmental audits.					**Completed**
	5. A fridge specifically for storing patient food and a microwave (used for heating patient hot packs and food) were inappropriately located in the clean utility room	**5.** The fridge and microwave have been relocated from the clean utility room on Lynn ward.					

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Additional findings relating to the prevention and control of healthcare-associated infections and multidrug-resistant organisms	**On the day of inspection other outstanding areas that need to be addressed included** 1. Issues relating to patient equipment were highlighted as a concern by the hospital through audits conducted in 2017. Inspectors were informed that arrangements regarding staff's responsibility for cleaning the patient equipment were under review .Appropriate cleaning and management of patient equipment is of particular importance in the midst of an ongoing CPE outbreak and therefore needs to be prioritised by the hospital as a focus of improvement 2. Screening for Vancomycin-resistant Enterococci(VRE) did not occur in line with national guidelines	1. The DON is in the process of drafting a business case 2. Plans are in place to bring the hospital in line with the National Screening for Vancomycin – resistant Enterococci (VRE) and include this as part of the CPE test	Áine Lynch Dr Prior	Q4 2018	Proposal to develop additional		**Business Case submitted for approval in progress funding dependent** **Awaiting funding for molecular screening**

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	3. The Hospital had insufficient numbers of ventilated isolation rooms	3. EMT Risk Register.	Ciaran Faughnan	On-going program	onsite single rooms requires HSE funding		**Awaiting HSE Capital Funding**
	4. Some maintenance issues were observed relating to wall surfaces, damaged paintwork and finishes on bed tables and bed space curtains in one area inspected	4. We use disposable curtains at ward level.	Ciaran Faughnan				**Ongoing refurbishment**
	5. In two of the three wards inspected ,minimal spatial separation between beds did not comply with best practice guidelines	5. As per number 3 above.	Ciaran Faughnan	Q4 2018			**HSE Capital Funding**
	6. Poor practice in relation to manual cleaning and disinfection of reusable bedpan supports between uses	6. Education has been provided to all relevant staff on the use of bedpans both in relation to manual cleaning and disinfection of reusable bedpans supports between uses.	Áine Lynch				**Completed**
	7. Some mobile clinical waste collection bins were unlocked and inappropriately placed	7. Education provided to cleaning and portering staff	C Faughnan / Mick Dunne				**Completed**
	8. Inconsistent application of personal protective equipment by staff	8. IPC Audits and education sessions on PPE		Q4 2018			

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	9. Not all single rooms in the hospital had dedicated hand wash sinks	9. Review completed of all room by facilities and IPC. Retrofitted where space allowed	C Faughnan				**Completed**
	10. The design of clinical hand wash sinks in some clinical areas did not conform to Health Building Note 00-10 Part C :Sanitary assemblies	10. Continuous focus on this area with a number of initiatives	C Faughnan				Retrofitted where plumbing where infrastructure allowed .all new buildings will have sinks that comply legislation
	11. Local leadership and management of ongoing audit followed by targeted training and education. A wide variation of performance was observed in local hand hygiene audits carried out in March 2018 .The low level of compliance achieved in some wards and failure to meet the HSE's desirable target of 90% in the national hand hygiene audit in October/December 2017 demonstrated the need for ongoing audit and leadership	11. Compliance discussed at monthly Directorate meeting. Corrective actions meetings	Dr.Fennell				**Completed**

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	12. A formal legionella hospital site risk assessment had been performed at the hospital in July 2016 .However assurance was not provided that annual review of risk assessment had been undertaken by the hospital in line with national guidelines	12. New Policy with Risk review approved and in place	C Faughnan				**Completed**