University Hospital Waterford (UHW) – Quality improvement Plan - HIQA PCHAI Unannounced Monitoring Inspection on 5.9.2017 – (*Report Published 4th December 2017)*

QIP dated 31st January 2018

Recommendations Section 2

	ACTIONS REQUIRED	EVIDENCE OF COMPLIANCE	RESPONSIBLE PERSON/COMMITTEE	COMPLETION DATE	PROGRESS
2.1 Governance	Improve medical attendance at IPCC meetings	IPPC meeting records	Clinical Directors	Q 1 2018	
	Review functional committees – number and remit	Revise QSR Organogram to reflect changes post review	EMB/ QPS	Q 1 2018	
	Formalise oversight of building works with IPCT	Communication pathway developed for major building works and signed off by Executive Management Board (EMB)	Consultant Microbiologist /DGM/ EMB	Completed Q 4 2017	
	Admin support for IPCT	Business case submitted to SSWHG July 2017	GM/IPCC Cmte	Q 4 2018	
	Follow up business case for 2wte additional IPC nurse posts for CPE Management	Business case submitted to SSWHG in July 2017 for full implementation of national CPE policy and resubmission to SSWHG in January 2018 for essential minimum requirement. Confirmation of approval received on 24.01.18 for 1wte CNM2 Infection Prevention & Control Nurse.	DoN/DGM	February 2018	In progress - seeking to fill post as a priority.
	Implement fully the Anti-Microbial Stewardship Program in UHW as a priority	Medicine & Therapeutic Minutes of meetings IPCC Cmte Minutes	Meds and Therapeutic Cmte	July 2018	Replacement Consultant Microbiologist to be appointed
	Re-establish dedicated AMR pharmacist post	AMR pharmacist post in place since 8th January 2018	Chief Pharmacist / HR	Completed	Closed
	Progress clinician-led surveillance of key HCAI KPIs	The Root Cause Analysis process has been agreed by EMB and commenced in January 2018 Meeting minutes	Clinical Directors/Primary Clinician / Senior Nurse Manager /Consultant Microbiologist/DGM	Completed	

		Ongoing audit of RCA completion			
	Review incident reporting mechanism to hospital management for HCAI related incidents	Clinical Risk Manager (CRM) is a member of IPCC Cmte. Formal report on HCAI clinical incidents at MDT IPCC Cmte	CRM /General Manager	February 2018	In progress
2.2 Risk Management	Secure additional resources for CPE screening	Business Case submitted to SSWHG in July 2017. Resubmitted January 2018 for minimum essential human resources requirements and approval received on 24.01.18 for a 1wte CNM2 Infection Prevention & Control Nurse and Laboratory Scientist.	GM/ DGM	January 2018	In progress – fill posts as a priority
	Align IPCT risk register and Hospital Risk Register	Hospital Risk Register and IPCT aligned.	Quality & Patient Manager	Completed Q 4 2017	
2.3 Policies, Procedures and Guidelines	Guidelines adopted from other hospitals must clearly identify that they have been appropriately approved for use in UHW	PPPG Development and Control policy in place. Once policy/guideline approved for use in UHW, attach cover sheet stating the formal approval.	Quality & Patient Manager	Completed	
	Ensure that all PPGs are reviewed and updated as necessary within the 3 year time frame	Revise and update policies due for revision. PPPG Owner alerted to update. Requirement. Reminder process. Updated PPPGs located on Q Pulse Audit.	QA/Audit Officer with Q Pulse Administration/IPCT	Q 3 2018	In progress (incremental)
	Remove out of date hard copies of PPPGs from all clinical areas	Out of date PPGS removed Audit and ongoing monitoring.	Nurse managers	Completed	
	Ensure that staff refer to Q Pulse for controlled version of PPPGs	Induction. Leadership and promotion ongoing. Audit.	Nurse managers/ Service managers/ Consultants/ QA/ Audit Officer	Ongoing	Ongoing

	Ensure that staff have Q Pulse access and navigation skills	List of new starters Training records of ongoing monthly training on site re. key word search skills Audit compliance.	QA/ Audit Officer with Q Pulse Administration	Ongoing	
	Ensure content management and search tool on Q Pulse so that staff can find PPPG quickly and easily	Consistent use of naming conventions for PPPGs – in August 2017 the system made more user friendly ("1 Click") in terms of navigation and search. Organisation of Q Pulse system reviewed updated.	QPS with Q Pulse Administration	Completed	
Line of Enquiry 3					
	ACTIONS REQUIRED	**EVIDENCE OF COMPLIANCE**	**RESPONSIBLE PERSON/COMMITTEE**	**TARGET COMPLETION DATE**	**PROGRESS**
2.4 Staff Training and Education	Develop system which accurately captures and reports hand hygiene training records to management	Hand hygiene Training records for all staff HSEland certificate Current database under review	DGM	Ongoing Q 2 2108	
	Improve medical staff attendance/ completion of hand hygiene training	NPER Induction program HSEland reports	Clinical Directors Medical Manpower	Q 2 2018	
4.0 & 4.1 Prevention of and surveillance of Invasive Device related and Surgical Site Infections	Seek the necessary resources to establish Care Bundles and surveillance programs for Surgical Site Infection (SSI) Central Vascular Catheter infection (CVC), Ventilator Associated Pneumonia (VAP), Catheter Associated Urinary Tract Infection (CAUTI)	Commencement of implementation of HCAI surveillance is resource dependent. Gap analysis Business Case	IPCT/EMB	Q 4 2018	
	Reduce number of forms used to record invasive device care/ observations in Neonates	All forms/documentation being reviewed alongside SSWHG Neo Natal colleagues	Director of Midwifery	Q 2 2018	

4.2 Preventing the spread of AMR organisms	Establish process for regular checks, cleaning and replacement of mattresses	Process In place for regular checks.	Ward Nurse Managers	Completed	
	Hand washing facilities for 3 single rooms on wards Install clinical hand wash sinks compliant with HBN Install clinical hand wash sinks in the Dirty Utility Room	Business case seeking minor capital funding for existing rooms	DGM and Technical Services	Q 4 2018	New build that will be available for use in on stream in Q 2 2019 has hand wash sink in all singe rooms
	Resource and support near patient equipment cleaning program in line with National Cleaning Manual Standards (commode, bedside chair) and monitor ongoing (checklists)	Revised cleaning process and schedule – from January 2018 daily hours assigned to HCA on Surgical Wards to complete this task. Revised process will be reviewed in 3/12 with view to extension across other services.	Nurse Manager (each ward)	January 2018 Q 2 2018	
	Resource and support environment cleaning (bedside curtain, wall surfaces)	Revised cleaning specification for wards. UHW Escalation Algorithm for cleaning /hygiene services issues in place for Ward Mangers (Rev 5 July 2017) – reissued January 2018 Transfer Team' in place 7/7 incorporating Laundry (curtain changes), Health Care Assistant (HCA as Lead Coordinator); Porter and Cleaning Operative to facilitate speedier access to beds and assure the appropriate cleaning and readiness of room /bed space for next patient. Additional hours per level implemented in the evening time for toilet checks and cleaning on wards and corridors external to wards.	DGM /Cleaning & Waste Contracts Manager	January 2018 November 2016 November 2017	 Ongoing monitoring in place Ongoing monitoring in place

	Surgical 7 - remove all patient personal and cleaning supplies from 'Dirty' Utility' room to a designated appropriate storage area	Inappropriate items removed Monitor and audit	Ward Nurse Manager Hygiene services Team	Completed	
	ACTIONS REQUIRED	**EVIDENCE OF COMPLIANCE**	**RESPONSIBLE PERSON/COMMITTEE**	**TARGET COMPLETION DATE**	**PROGRESS**
Equipment	Establish processes for escalation when equipment e.g. bed pan washer repair required urgently	Email to TSD Helpdesk specifying urgency– (*automatic Job Order number will be issued).* Ward must also contact TSD by phone.	Ward Nurse Manager/Technical Services	October 2017	Ongoing monitoring.
Safe Injection Practice	Neonates – establish dedicated area for medication preparation on ward	Dedicated area established.	Director of Midwifery /CNM 3	Completed	
	Neonates – ensure blood glucose monitors are cleaned after each use	Educate and Audit.	Ward Nurse manager	Completed	
	Neonates - ensure re-usable procedure trays are cleaned/ decontaminated between use, or use disposable ones	New process in place. Educate and Audit.	Ward Nurse manager	Completed	
	Neonates – trolleys brought to bedside to contain items for the single procedure only	Educate and Audit.	Ward Nurse Manager	Completed	
	Neonates – sterile supplies are kept in closed cupboards/ drawers	Educate and Audit.	Ward Nurse manager	Completed	
	Neonates –acquire suitable location for blood gas analyser	Location for new analyser under review	Ward Nurse Manager	Quarter 2 2018	
	Surgical 7 – remove procedure chair from medication preparation area to more appropriate location	Review and cost option of dividing the room and submit cost proposal for minor capital allocation in 2018.	Perioperative Directorate LT	Q 3 2018	

	Ensure re-usable procedure trays are cleaned/ decontaminated between use, or use disposable ones	Educate and Audit	Ward Nurse Manager	Completed	
	Ensure that sterile supplies are stored in a dedicated clean supply store room or in fully enclosed units	Educate and Audit	Ward Nurse Manager	Completed	
	ACTIONS REQUIRED	**EVIDENCE OF COMPLIANCE**	**RESPONSIBLE PERSON/COMMITTEE**	**TARGET COMPLETION DATE**	**PROGRESS**
2.6.3 Aspergillosis prevention	Develop hospital policy for the prevention of aspergillosis during construction, building, renovation and maintenance works	Develop local policy. *(interim communication algorithm developed and implemented – includes review of required infection control precautions)*	TSD Manager /IPCT	Q 3 2018 Completed Q 4 2017	In progress
2.6.4 Hand hygiene	Continue trajectory of consistently high compliance results in the national hand hygiene audits.	Period 14 (October 2017) audit result was 97% (national compliance target 90%). Comprehensive hand hygiene training schedule 2018 distributed and attendance recorded. Additional training provided as/when required. UHW Partnership Forum annual Awareness days (including hand hygiene) – held twice yearly	Heads of Services /Clinical Directorates /IPCC	March & Sept 2018	
	Neonates - ensure all products at wash hand basins are labelled	Audit	Ward Nurse Manager	Completed	Ongoing spot checks
Prevention of water-borne infection	Ensure formal governance arrangements are established for	Water System Governance Group established in June 2017.	Water Governance Group	Completed June 2017	

	the management of water borne infection prevention	External Risk Assessment (RA) sought and completed end July 2017 and QIP under progression by Water System Governance Group.		Completed July 2018	In progress (incremental)
2.8 Review of progress since last inspection	**Insufficient number of single rooms for isolation purposes**	Capital project involving a new 5 storey block in progress at time of inspection. On completion in Q 2 2019, a total of 72 single rooms will become available to the hospital.	EMB/Estates Project Group	Q2 2019	Build progressing to schedule.
	Infrastructure deficiencies Address infrastructural and isolation deficits in the Intensive Care Unit.	Upgrade critical facilities ICU and HDU) to address issues identified. Business plan submitted to SSWHG Leadership proposing an interim solution (until permanent solution finalised) to address as a propriety the infrastructural deficiencies as identified. On Risk Register.	EMB	Q 4 2018	
	Address infrastructure deficit in the Contract Cleaners laundering facility.	Submission made for 2017 minor capital funding allocation to complete the required modification to address this issue – no allocation received. Resubmit for 2018 minor capital funding. Local measures in place to mitigate risk pending completion of remodelling works.	Deputy General Manager/Technical Services Manager	Q4 2018	