Portiuncula Hospital Ballinasloe
Hygiene Services Quality Improvement Plan
September 2013

This Quality Improvement Plan (QIP) was developed following the HIQA unannounced monitoring assessment in Portiuncula Hospital Ballinasloe on 9th July 2013.Implementation and monitoring of the QIP is the responsibility of the hospital's Hygiene Services Committee. The chairperson of this Committee will provide fortnightly updates on the QIP's progress to the hospital's management team.

Standard 3 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 spread of HCAIs		
Environment and equipment	**Quality Improvement Actions September 2013**	**Time-fame**
Cleaning: to ensure all areas and equipment are clean and dust free in compliance with the National Standards for the Prevention and Control of HCAIs	The hospital is working towards a culture where hygiene is everyone's responsibility • Hygiene Services is an agenda item at all departmental, Directorate and Management Team meetings. • Responsibility for hygiene services is overseen by the departmental manager in each area. This work is further supported by the household manager/ contract supervisor. • The HIQA Report of the 9th July 2013 has been circulated to all departments via the Directorates. In addition focused meetings and 1/1 meetings have been held with departmental managers to clarify their responsibly for hygiene for their departments. • The hospital has developed a monthly Key Performance Indicator for compliance in respect of the hygiene services 55 element standards and where non-conformances are identified corrective actions are developed. • Environmental cleaning schedules reviewed and compliance monitored. • Equipment cleaning responsibilities documented for each department. • Monthly Unannounced Management Audit Schedule revised to include relevant Assistant Director of Nursing in a lead auditor role in association with department manager and to include Senior Management Representation. • Technical hygiene audits undertaken weekly by the household manager and contract cleaning Supervisor. Any non – conformances identified have corrective action timelines identified which are over-seen by household / contract supervisor in conjunction with the departmental manager. • Infection Prevention Control Audits are undertaken on a quarterly basis.	Complete On-going Complete On-going On-going On-going On-going On-going On-going

	Maintenance: implementation of minor works programme to enable compliance with National Standards for the Prevention and Control of Healthcare Associated Infections.	• The Quality Improvement Plan including the maintenance plan is a standing agenda item at both the Hygiene Services and Management Team meetings. Implementation of a traffic light system as part of the quality improvement plan to identity progress and areas of risk and close out of all non-conformances • A prioritised maintenance plan is in place to address infrastructural deficits identified. • The hospital has undertaken immediate remedial works to address identified deficits. **Maintenance Works Undertaken:** <u>St. Francis Ward</u> Painting of Ward. Installation of IPC compliant hand hygiene sinks. Repair of damaged walls and application of corner protectors. Completion of Kan-Ban storage system Additional Kan- Ban storage to be introduced and the introduction of a Top Up system <u>St. Clares Ward</u> Painting of Ward. Repair of damaged walls and application of corner protectors. <u>Sluice Rooms</u> Full refurbishment of Sluice rooms St. Francis, St. Clares and Maternity ward. <u>Floor Covering and Ceiling Tiles Replacement Programme</u> Prioritised replacement programme on going throughout the hospital. Exploring alternative system for the transport of linen and waste to improve flow and collection.	On-going On-going On going Complete On-going Complete Complete On-going Complete Completed On-going

	Management of Equipment and waste to identify suitable storage, stocking and waste management solutions.	There are key challenges posed by the age and fabric of the hospital and limited storage facilities within ward areas for the increasing amount of equipment required. Staff at all levels continuously review work practices to identify opportunities to increase efficiencies with regard to storage, stock levels and use of space. **<u>Measures/Initiatives undertaken</u>** • Identification of appropriate storage rooms and spaces for the storage of patient equipment. This will enable space to be cleared on the ward corridors and improve access and egress for patient's staff and visitors.	On-going
		• Agreed Minimum stock levels for each ward • Pilot 'Top-up' system planned for St. Francis Ward • Review of linen use and stock levels has been undertaken. • Area identified for week-end linen supply	On-going To Commence On-going Complete
		• A Porter has been identified who will be dedicated to provide improved waste and soiled linen collection to be in place by 1st October 2013 to prevent a build-up of waste/ soiled linen.	To commence in Oct 2013
	Management of the Storage of Hazardous Solutions and Chemical materials	• All areas in the context of ensuring secured storage for chemical/cleaning products. • All dirty utility rooms and store rooms are fitted with key code door locks and automatic closing devices. These doors are to be kept locked when not in use. • Departmental managers are charged with responsibility to ensure compliance. • Installation of lockable cupboards in all ward kitchenettes.	On-going On-going On going On-going

Standard 6 Criterion 6.1		
There are evidence-based best practice policies, procedures and systems for hand hygiene practices to reduce the risk of spread of HCAIs		
	Quality Improvement Initiative	**Time-fame**
Culture: Embedding culture of adherence to hand hygiene policy and procedure	Compliance with Hand Hygiene standards is an agenda item at all departmental and Directorate meetings throughout the hospital. • Annual attendance at hand-hygiene training is mandatory for all staff. Target to achieve 90% compliance by end of 2013 and 100% compliance by June 2014. • Each department is issued with quarterly hand hygiene compliance rates. • Targeted departmental training undertaken throughout the hospital. • The hospital has introduced a monthly Key Performance Indicator for compliance with hand hygiene standards which is reviewed at the hospital management team meeting. • Three additional staff members have undertaken Lead Auditor Hand Hygiene Training. • Observational hand hygiene audits are on-going. Non-conformances addressed immediately. • Non Compliance is brought to the attention of the staff member's line manager for appropriate follow-up. • Members of the Senior Management Team participate in Hand Hygiene Observational Audits. • Introduction of 'It's OK to ask!!!' poster to facilitate and encourage the involvement of patients and visitors in compliance with hand hygiene and reducing the risk of spread of infection. • Review of all Hand Hygiene sink signage. • Consultant Microbiology 2 sessions per week has been secured and this will assist and support the promotion of Hand Hygiene. • Introduction of the Departmental Hand Cleaning Pledge • Infection Control Link Nurse Programme to be established.	Immediate On-going On-going On-going On-going Complete On going On-going On-going Oct 2013 Complete On-going Nov 2013 Dec 2013
	Dress code policy: • The hospital is reviewing current dress codes and developing a dress code policy to promote best practice in hand hygiene, to include promotion of 'bare below the elbow' • Wearing of scrub suits in a non-appropriate setting will not be condoned and the Line Manager will take immediate corrective actions with the individual concerned.	On-going monitoring to ensure compliance

Standard 7		
The spread of communicable disease is prevented, managed and controlled		
	• The Hospital recognises that it is best practice to keep all doors closed when a patient requires isolation with the exception of patients who require isolation for contact precautions and are considered at risk (of falls etc). In these circumstances a Risk Assessment will be undertaken in conjunction with the relevant Clinical Team to assess whether from a patient safety perspective the door is required to be left open and this will be documented in the patient's chart.	On-going

Approved By:

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Ms Chris Kane:
General Manager
Portiuncula Hospital