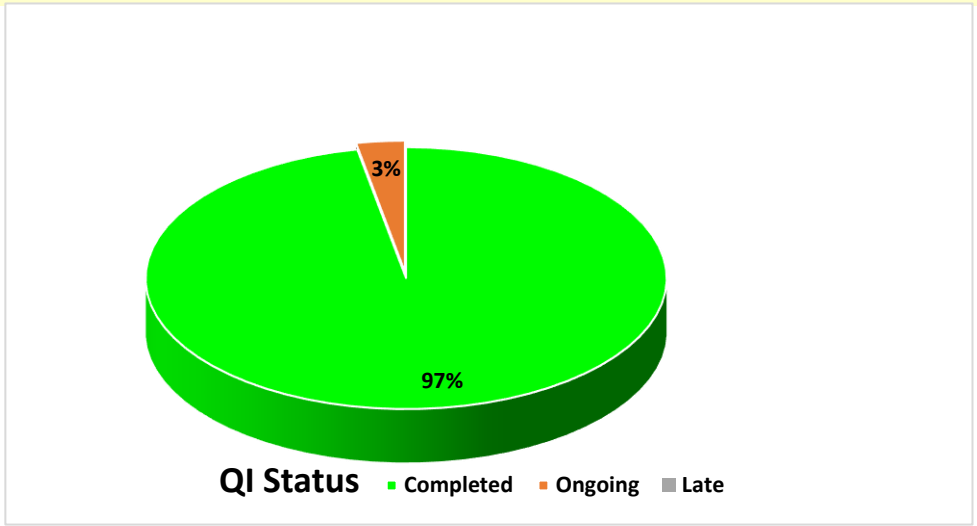
QIP 2021 - A summary of Quality Improvement Activities from HIQA Inspection - December 2020

HIQA Inspection

Tallaght University Hospital | Ospidéal Ollscoile Thamhlachta

An Academic Partner of Trinity College Dublin



Description of Improvement from HIQA Report	Status	Comments
At the time the Inspectors found that the COVID Pathway was not in line with HSE guidelines and presented a potential weakness to the rapid identification and streaming of patients into COVID-19 and non-COVID-19 pathways, prior to being streamed into COVID-19 and non-COVID-19 pathways. This risk was further potentiated by limited waiting capacity, less than optimal entry control of accompanying adults.	Completed	A risk assessment was conducted based on the HSE Guidance. Patient flow process have been developed and implemented. There has been an additional focus on reducing triage times and ensuring rapid streaming of patients in the COVID and non-COVID pathways. Security are taking measures to ensure that there is entry control of accompanying adults.
Measures to prevent crossover of staff between COVID-19 and non-COVID-19 streams was not in place in the ED	Completed	The ED teams split themselves as much as possible and use appropriate levels of PPE at all times.
Designated COVID-19 resuscitation bays were not functionally separated from non-COVID -19 resuscitation bays.	Completed	The ED is on one ventilation system and this is standard compliant design, there is one pressured isolation room with a dedicated air system. The Hospital have now installed a new set of doors to isolate bays 4 and 5 from remainder of ED Resus and within this sub area installed two large HEPA filtered air cleansing units certified to remove viruses and cleanse air constantly.

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Insufficient cleaning resources were allocated in the ED to maintain appropriate levels of cleanliness and decontamination particularly in patient waiting areas.	Completed	A risk assessment has been completed and additional cleaning has been put in place. There is also now additional seating located in the COVID area.
Controls in place in the ED to limit entry points, reduce entry to accompanying adults, ensure adequate cleaning resources and reduce risks associated with staff crossover were insufficient. Traffic control into the Hospital and the ED require improvement. HIQA also raised concerns related to the use of the smoking area.	Completed	TUH have four entrances to the Hospital (including ED) for the public. Two of the entrances have been closed since March 2020. There is only one entry point to ED from external comprising of two adjacent doors. There is signage in place to direct walk-ins to one door only and other is ambulance use and exit. Security are based at ED internal doors to prevent unauthorised entry. Additional security has been put in place to patrol the campus particularly the main entrance ED and set down area. There is also a manned security desk in atrium checking on all visitors. In addition the Hospital has communicated widely with the public through social media, posters, local newsletters and by engagement with local representatives to remind them of the visiting restrictions. Patient supports such as the Patient Care Package service are in place to reduce the need for the public to visit the Hospital. The Hospital have issued patient information leaflets, asking patients to limit their movements with particulare attention for patients on COVID ward areas. Security monitor the smoking area. To reduce mingling of patients in the smoking hut all the benches have been removed and it is regularly patrolled by security every 30 mins. signage has been placed in the smoking area.
From a hospital-wide perspective, more stringent monitoring of compliance with infection prevention and control interventions and precautions was required to ensure consistent adherence to recommended precautions.	Completed	Facilities & Estates co-ordinate MDT Environmental/ Hygiene audits. IPC carry out daily rounds to all clinical areas. Results & IPC matters including COVID are discussed with CNM's in clinical area every day. COVID matters are also discussed at the daily/bi-daily IPC/OH meetings which is chaired by the DCEO.

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Stronger leadership and management to improve awareness and compliance with infection prevention and control practices was required.	Completed	Considerable management time is afforded to Infection Prevention & Control. Some additional measures/resources put in place over the last few years are as follows: - The DCEO Chairs the IPC Governance Committee - The DCEO chairs the IPC/OH COVID group - The COO chairs the Outbreak Committee - WTE Consultant Microbiologist posts has increased from 2.8 to 3.2 (locum 0.4 WTE post). - Micro Registrars WTE has increased from 1 WTE to 2 WTE in July 2020. - Appointment of an IPC ADON. - Increase in WTE IPCNs from 3.5 to 6.6 WTE. - All IPCNs have completed the required education which was 100% funded by IPC. Some of the IPCNs have just been approved for additional education Inc. Masters. - Surveillance Scientist WTE 0 to 2 - Increase in Microbiology Scientists by 4 - .5 admin to Microbiology for CPE - Additional resources provided to IPC for the Pandemic. - New IPC electronic system called IC Net has been commissioned in early 2021.
Breaches in PPE and physical distancing between staff members during breaks was a reported recurring issue.	Completed	Considerable efforts have been assigned to this, including PPE champions, EMT PPE rounds, regular communications Inc. Emails, Flyers, IPC Newsletters and screensavers that run throughout the Hospital.
The inspectors observed poor compliance relating to local uniform policy and isolation precautions.	Completed	Efforts will continue to improve compliance with hospital policy and national guidance. Since 2019 there are new changing facilities for staff including showers. PPE champions monitor compliance. The Dress code policy was updated in 2020 and specifically references the unacceptability of all uniformed staff wearing uniforms coming to and leaving TUH. Ongoing audits of compliance with uniform policy will continue.
Improved awareness of COVID-19 governance structure needed amongst all staff.	Completed	Article in newsletter about the Governance structures. COVID Organogram published in the June IPC Bulletin.
Improved attendance by a consultant microbiologist at the Executive Management Team COVID Pandemic Steering Committee is needed.	Completed	Consultant Microbiologists are invited and attend all meetings and provide a verbal IPC update report to the group at each meeting.

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The Hospital should review OH resources provided to ensure they are sufficient to support the IPC Team in investigating outbreaks. Better oversight & co-ordination needed in OH provided for screening & contact tracing of staff.	Completed	A review of resources in OH took place with the Director of HR. OH /IPC meetings are held daily during outbreaks and weekly thereafter. OH are members of the Outbreak Committee and the IPC Governance Committee. OH provide contract tracing support seven days per week and there are no delays in contact tracing of staff. With regards to outbreak management, an outbreak screening co-ordinator was put in place to monitor staff attendance for outbreak screening 21 staff were assigned to OH over the course of the COVID Pandemic: An IT system was developed to share information between IPC & OH OH Represented at the COVID steering group committee. The IPCN ADON & OH CNM 3 linked in regularly each week. Formal structures agreed between OH & IPC in relation to the communication of staffs results.
There was a lack of isolation facilities with ventilation systems designed to minimise the spread of infection.	Completed	Facilities & Estates and IPC completed a risk assessment of current isolation facilities. Facilities have refurbish negative pressure rooms, including the installation new extract fans, door seals and new digital guages. Education provided to staff. The Hospital is working with HSE estates in relation to a capital build of 72 single rooms.
Hospital guidance provided to inspectors for review was dated 14 April 2020 and did not reflect updated national public health guidance updates.	Completed	TUH PPE Guidance is updated regularly- in line with National Guidelines. This guidance is currently up to date and as always is available on the TUH COVID Intranet site. IPC PPE guideline was updated to reflect COVID guidance whenever new national guidelines are issued.
Goggles: The local policy related to the use of goggles went beyond national recommended, the auditors found that the application of this policy was inconsistently applied.	Completed	The Hospital reviewed the risk assessment and no changes were made to TUH Guidance. Hospital management acknowledged this policy was outside (but exceeded) national guidelines. On the foot of growing international evidence and guidance around the use of eye protection TUH introduced eye protection for all close patient and staff encounters. National guidance was subsequently updated to include this recommendation. The Hospital remains committed to protecting its patients and staff and will follow internationally accepted best practice even when it goes above that recommended nationally pending national updates. IPC Guidance changed in May 2021, Goggles are now only required when working with positive, suspected or contact COVID patients, and patient contact where there is risk of blood, body fluid, excretions or secretions splashing to the eye.

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Infection prevention & control nurse vacancy should be filled as a priority in light of the significant challenges faced by the team on a day-to-day basis.	Completed	Vacant post was filled in Jan 2021. Overtime was offered to all the IPCNs to assist with the second and third wave, was taken up and continued into 2021. Additional resources were alloacted to IPC during 2020.
Fit testing should be available for clinical staff likely to undertake procedures that involve or may involve the generation of aerosols should be progressed.	Completed	Fit Testing is now available
88% of staff had completed hand hygiene training between November 2018 and November 2020. PPE training delivered to staff who had patient contact was relatively low. 65% of staff had completed “Breaking the chain of infection.	completed	The Hospital has worked with Managers and staff to increase the compliance with Hand Hygiene training. Improvement plan in place.
Doors to three isolation rooms were observed to be open.	Completed	This was addressed with the ward manager. The IPCNs will continue to monitor and remind staff when on daily rounds. IPC will also schedule an audit for 2021.
PPE was available at the point of care and in all but two exceptions was observed to be applied appropriately.	Completed	PPE Champions in place. PPE is also monitored in IPC audits and in Hand Hygiene audits.
Heavy dust was observed on air vents.	Completed	The cleaning of the surface of vents is part of the cleaning schedule. This has been addressed with the cleaning company. The Hospital are going to replace all extract fans. Duct cleaning on-going.
Both plain soap and antimicrobial soaps were located at hand hygiene sinks on one ward.	Completed	This was addressed with the dept. Manager, and the antibacterial soap was removed from the areas. IPC re-issued the poster in March 2021 and sent a Memo to CNMs & line managers.
There was scope to improve the cleaning of hand hygiene dispensers and trays.	Completed	This was addressed with the Hygiene Services Dept. Some of the trays are stained rather than soiled.
Inappropriate storage of supplies on the floor of an ante room was observed and suboptimal cleaning of this room was also evident.	Completed	This was addressed with the Dept. Manager. This is also on the IPC auditing template and will be monitored by IPC.
There was evidence of wear and tear noted on two wards	Ongoing	Facilities & Estates are progressing a refurbishment plan, there are challenges in completing these work as the Hospital is at full capacity. One ward has been fully refurbished in July/ August 2021.

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The overall management of patient equipment needs to improve to ensure sufficient supplies of dedicated patient equipment is available and prioritised for dedicated COVID-19 and isolation ward. Compliance with patient equipment audits conducted in 2020 was poor and needs to improve.	completed	Dynamaps are on the minor capital list for 2021, 45 additional Dynamaps were purchased. this is in additional to a large amount of equipment purchased in 2020. Directorate Nurse Managers are overseeing these monthly audits and will submit reports to the IPCC.
Three commodes assessed on one Ward were unclean.	Completed	Immediate corrective action was taken and the CNM reminded to monitor the cleaning of equipment. CNM Hygiene audits commenced in May 2021 & include the auditing of patient equipment including Commodes.
More assurance is required to ensure that the Infection Prevention & Control Governance Committee retain oversight and receive regular updates as to the progress of infection prevention & control-related risks entered on other hospital wide risk registers.	completed	Risks are reviewed at monthly directorate meetings with DCEO & Director QRSM. A full review of IPC related risks have been completed and will be reviewed by the IPC Committee. Manager led technical audits were also introduced in Q4 2020. It is hoped that this will increase focus on the management of patient equipment.
Inspectors noted that a number of risks were on the risk register for between three to seven years with limited progress made in fully addressing these risks.	completed	The IPC lead consultant reviews the risk register quarterly. The latest reviews took place in March & May 2021 and at least two were downgraded due to progress made.
Infection prevention & control of C. diff must remain a priority for all relevant staff and hospital management.	Completed	Infection prevention and control of C diff remains a clear priority for the IPC team, the Hospital and the wider hospital group. All cases are reviewed and discussed to look for evidence of transmission within TUH. Trends are reviewed weekly at team meeting, monthly at DMHG group level and quarterly at the IPCC chaired by the DCEO and attended by the clinical directors & the Director of QRSM. Any severe cases (national definition) are to have a root cause analysis performed. An information leaflet has been distributed to heighten staff awareness. A C. difficile awareness day is planned for Oct 2021.
The inspectors noted a lack of toilet facilities and available patient waiting capacity.	Completed	TUH have identified space in the Paediatric ED for additional toilet facilities when the space reverts back to TUH in 2021. Separate toilets have been assigned to patients in ED who are on the COVID pathway.
The inspectors noted the lack of involvement by the PHD in attendance at outbreak control team meetings.	Completed	Public Health attend outbreak meetings since January 2021.