Beaumont Hospital

Quality Improvement Plan(QIP) - Updated March/April 2015

HIQA Announced on-site monitoring assessment -31st October and 1st November 2013

Introduction: On the 31st October and 1st of November 2013 the Health Information Quality Authority(HIQA) carried out an announced assessment in Beaumont Hospital as part of the National Standards for the Prevention and Control of Healthcare Associated Infections monitoring programme. The areas assessed in Beaumont Hospital were the Emergency Department (ED), Richmond Intensive Care Unit, St Patrick's Ward (Medical Assessment and Short Stay Unit), Banks Ward (Orthopaedic). The areas assessed in St Joseph's Hospital were: the Rehabilitation and Medical Wards and the Surgical - 5 Day Ward. As a result of the announced monitoring assessment the auditors made a number of recommendations for improvement. In response Beaumont Hospital developed this quality improvement plan. The hospital is committed to consistently improving patient safety and in learning from external reviews. This QIP will be published on our website and updated periodically, updates are in italics.

Approved by:

Mr. Liam Duffy
Chief Executive

Date: 09/04/2015

Dr. Paul Brennan
Lead Clinical Director

Prof. Edmond Smyth
Chair of Clinical Governance

No.	Theme 1 Leadership, Governance and Management				
	Opportunities for Improvement	**Action Required**	**By Whom (will deliver action)**	**Timeframe / status**	**Monitoring & Evaluation**
1	There should be a clear communication strategy in place on the prevention and control of Healthcare Associated Infections, supported by robust operational arrangements, to ensure the effective communication of appropriate and timely information throughout the service, to service providers and appropriate agencies.	Integrate current operational data & key information into a communication strategy ***Update March 2015, this is under review with a draft ready for approval.***	CNM2 Infection Prevention & Control	Document to be approved before end second quarter 2015.	HCAI Task Group to receive updates
2	All patients who are found to be colonised and/or infected with a significant communicable/transmissible healthcare associated infection or organism should be	A communication process is already in place. In order to further verify the process, tests of change will be commenced in one directorate. Utilising the 'Plan, Do, Study, Act (PDSA)' cycle, an	Chair of Clinical Governance	Ongoing monitoring	Hospital Clinical Governance Committee to monitor this action

	informed of their infection and/or colonisation status by the clinician, or clinical team, primarlily responsible for their care as soon as diagnosis is made, and should be supplied with any relevant information.	audit model will be put in place, which utilises concurrent data. Audit findings will be discussed at the Directorate Clinical Governance Committee. A report on the learnings from these tests of change will be given to the Hospital Clinical Governance Committee and the learning will be utilised across directorates. ***Update March 2015, Audit of February figures underway. Based on provisional audit figures a letter will be sent from the Consultant Microbiologist to the patient's consultant in all new cases of MRSA. Letter being drafted.***			
	Theme 2	Workforce			
3	All hospital staff should receive mandatory standard precautions theoretical and practical training in relation to the prevention and control of Healthcare Assosciated Infections.	The National Standards for the Prevention and Control of Healthcare Associated Infections (NSPCHCAI)outlines that mandatory theoretical and practical training in the prevention and control of HCAIs should be "job/role specific".The Chair of Clinical	Chair of Clinical Governance	Ongoing monitoring	Hospital Clinical Governance Committee to monitor this action

		Governance will formally request that all directorates discuss & analyse training records at their clinical governance meetings, putting in place quality improvement plans as appropriate. This analysis will examine training in a "job/role specific" context.June 2014: Letter sent to HIQA. Training records are being discussed at Directorate Clinical Governance meetings			
4	The hospital should have a multidisciplinary infection prevention and control team in place which reflects the size, complexity and specialities of the service.	The HIQA Annouced Inspection found that the number of Consultant Microbiologists had not increased since 2008 despite significant increases in activity in the hospital. Two x 0.5 WTE consultant micobiologist posts were approved at the Consultant Appointments Committeee (CAC) on 12th December 2013. The Hospital will proceed with advertisment. Infection prevention and control nurse complement to be maintained June 2014: Advertisement & interviews have taken place. Consultants appointed	Chair of Clinical Governance	Complete,	HCAI Task Group to monitor this action
	Theme 3	Safe Care			

5	Relevant, useful and standardised Healthcare Associated Infection and Antimicrobial Resistance surveillance data regarding surgical site infection should be collected.	Circulate recently collated hospital-wide data on antimicrobial consumption to Directorate Clinical Governance Committees with a request that this data be discussed and analysed. Discuss collating data on antimicrobial consumption at HCAI Task Group . June 2014: QIP discussed at HCAI, date April 16th 2014. Discussed at Hospital Clinical Governance Commitee with representatives from the directorates present June 2014. July 2014: A test of change has been introduced in the Surgical Directorate which aims to monitor & improve surgical site infection utilising the IHI model for improvement, learning to be disseminated. ***March 2015: A test of change has been done. Plan to disseminate the learning via HCAI Task Group in 2015.***	Chair of Clinical Governance	Discuss at HCAI during 2015	HCAI Task Group to monitor this action

6	There should be a structured set of processes, policies and procedures developed, communicated and implemented hospital wide for the prevention and control of invasive medical device related infections, including urinary cathether care bundles.	***June 2014: Urinary Catheter Bundle has been rolled out hospital wide. The policy is under review due for approval June 2015***	Head of Nurse Practice Development	Urinary Catheter Bundle in place. Policy to be approved end June 2015	HCAI Task Group to monitor this action