Findings (as provided by NHSI in their written feedback)	
Interviews	
IPC Team	• The IPC team reported that they did not have meetings with previous DIPC- concern. New DIPC in place; advise monthly 1:1s. • IPC team meets weekly. • IPC nurse team: band 8B, x2 7s and 6. • Staff mandatory training >85%. • Don't currently use national IPC audits from the IP Society. Advise to ensure the current audits used provide assurance above or equal to that of the IPS audit. • Variety of training methods used. • IPC Committee- poor attendance. 2/3 were not quorate. Written reports not received. Does not reflect ToR e.g. no hygiene code assurance, no IPC risk register. Only meets quarterly; advise to meet monthly as IPC concerns are significant. Overall impression is that the board is not sighted on IPC and governance need to be strengthened as concerns are not being escalated or addressed. • Trust Board paper does not provide assurance only appears to receive MRSA/C. difficile data. No reference to Hygiene Code assurance. • Identified poor clinical engagement with RCA. • ICD does not currently review blood culture contamination rates as not a requirement to do so. Advised that this should be undertaken to assess if there is a problem with practices in the clinical area.
Domestic Managers	• In-house provision. • Advised to report back to IPC committee with a written report for assurance. • Identified good working practices with IP team. • Developed good systems for identifying area for decontamination e.g. daily isolated list. • Undertaken a GAP analysis which has increased cleaning on wards from 4hrs to 11 hours. • Provide accredited training for staff which includes IPC. • Undertake PLACE audits- reported no concerns. • Attend outbreak meetings. • Undertake cleaning audits and undertake unannounced quality assurance audits. • Provide access for 24hr service. • Cleaning products: tristel and staff undertake HPV.
Estates Manager. Unfortunately arrived 15 mins late so unable to fully discuss:	• Advised to provide written reports back to IPC committee for assurance. In addition, I would advise that outstanding estates issues are reported back to IPC committee as this is a concern. • Unable to illicit assurance on authorized engineer or what mitigation had been put in place whist providers were being sourced. • Stated Water Safety Group met monthly- however clinical visits identified concerns. • Was not able to provide information on back-log maintenance. • Was not able to provide information on key risk on register but thought may be 30-40 items from high to low.
Matrons	• Identified delays in estates responsiveness- this was confirmed on ward visits. • Undertake quality audits which include IPC.

	• Identified that IPC appeared to be only nurses responsibility. Lessons learned are not disseminated outside matrons and nurses forums. • Confirmed that agency staff receive induction at ward level.
Clinical Visits	
Elizabeth - Loury Ward, Oncology- chosen by the Trust as they have had a previous MRSAb and wished to demonstrate good practice.	
Positive Observations.	• 15 steps 1st impression was good. • Wipes available on BP machines. • Gel at entrance. • Staff observed wearing appropriate personal protective equipment (PPE). • Staff only sign on kitchen door. • Legionella flushing documented. • Curtains dated. • Domestic trolley clean. • I am clean stickers in use.
Observations Requiring Attention.	• Kit under U bend of sink. • ANTT: tray prepared for venflon insertion in clinical room. Both venflon and needleless connectors had been removed from sterile wrapper in advance, potentially leading to contamination. • High dust in clinical room. • Waste room; hand wash basin in the corner. Bowl dry. No assurance it was on a flushing regime. Mouldy. Lime sale. • Lime scale on taps in augmented care area. • Dr s x2 not bare below the elbows (BBE). • Sharps bins overfull, not signed for on assembly. • Folders torn, therefore unable to decontaminate. • Gel not available at each bed space. • Cleaning schedules not displayed. • Fridge temperatures not recorded daily. • Documentation poor. • Missed opportunities for hand hygiene
MB1; pre-natal triage. Chosen by the Trust as concerned with sluice area.	
Observations Requiring Attention.	• Sluice; doubles up as a store room for Octenisan etc and is used as cleaners cupboard so stores cleaners' trolley and products; photo taken. This is significantly bad practice. • Macerator out of use for significant period of time. • Cleaners trolley dirty. • Tape holding light source together. • Toilet brush dirty. • Clean bed had shoe marks on the sheet and was stained. • Single use product being re-used- water. • Audits displayed were from Jan 2017. • CTG trolley thick with dust. • IV room; door left unlocked, shoes and bags under U bend. Umbrella left by IV fluids. Hand wash soap dispenser above decontamination sink
Neonatal Unit. (Chosen by NHSi)	
Positive Observations.	• Gel at entrance. • Clean bed space was clean. • Flushing documented.

	• I am clean stickers in use. • Gel at point of use.
Observations Requiring Attention.	• ABG room: decontaminating products in hand wash sink. • ABG blood gas pipette not discarded in sharps box but left on surface • Milk boxes stored on floor. • Linen on the floor. • Legionella filter expired on 3rd August (now 8th august). • Washing machine: connected but not used. Legionella risk. • Washing machine in cleaners cupboard- no hand wash facility- advise to put on risk register. • Cleaning schedules not displayed. • No toy cleaning schedule. • High dust. <u>Corridor/outside.</u> • Theatre staff had not covered up their scrubs- breach of uniform policy. • Waste compound not locked. • Waste trucks in unlocked compound were not locked allowing access to yellow waste and sharps boxes.
Blenheim Ward (Chosen by NHSi)	
Positive Observations	Hand wash wipes on meal trays
Observations Requiring Attention.	• Cleaning schedules not displayed. • Fridge temperature not monitored since May 2017. • Dusty computer. • Staff not BBE including nurses. • Signs not laminated. • Missed hand hygiene opportunities. • Staff not compliant with PPE. • Kit stored on floor. • Dishwasher not working for 5 weeks. • Pull cords dirty. • COSHH breach: sluice door not locked and COSHH products accessible. • Waste truck not locked. • Waste store room very, very dirty. • Pumps etc in waste store room were very, very dusty. • Blood on sharps boxes. • Mattress; extreme body fluid ingress. • Emergency suction very dusty. • Dirty commode. • Daily waste checklist not completed. • Documentation: same signature on documentation for am and pm (it was only 12.00) so obs not being undertaken at timely intervals.