Royal Victoria
Eye and Ear Hospital
Dublin - Ireland - Established 1897

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Infection Control Annual Report

2014

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1.0 Executive Summary

The Infection, Prevention and Control Team strive to provide services in an efficient and cost-effective manner.

Surveillance carried out indicated low rates of infection. The Key Performance Indicators (KPI's) for Healthcare Associated Infections (HCAIs), set by the HSE and the Infection prevention & Control Committee (IPCC) in the RVEEH, were all met. See Tables 2 & 3 in section 3.1 for RVEEH's KPI's. Alcohol Gel consumption continues to compare favourably with other health institutions (*see appendix 2 for more detailed information).* Post operative surgical site infection rates and HCAI continue to remain low. The excellent results were attributed to:

- Continual monitoring of services and consulting with all relevant disciplines of staff.
- Good working relationships across clinical services and between directorates.
- Service amendments and improvements based on feedback, internal and external audits, regulations, National & International standards and guidelines.

External Audits:

JCI: In April 2012 the hospital management team voluntarily applied for accreditation from Joint Commission International (JCI), who are a recognised world leader in health care quality and patient safety**.** Their focus is on health care quality improvement and patient safety with expertise in infection control, medication safety, facility safety, and accreditation preparation. JCI confirmed their decision to award "Accredited Hospital" status to the RVEEH in June 2014.

HIQA paid an unannounced visit to the hospital on the 20/3/2014. The unannounced inspection focused specifically on observation of the day-to-day delivery of hygiene services and in particular environment and equipment cleanliness and adherence with hand hygiene practice. Overall the areas visited were clean and it was observed that the hospital demonstrated a steady improvement in hand hygiene performance. However, HIQA noted that the hospital needs to build on compliances achieved to date regarding hand hygiene, to ensure that good practice is improved and maintained, and national targets are sustained. See appendix 12 for a summary of their findings.

Risk Register

Identified risks were documented and evaluated through the Hospital's "Integrated Risk, Quality & Safety" (IRQS) Committee, which meets monthly and is chaired by the Hospital's Medical Director. All departments are responsible for completing a risk assessment in their area and recording in a risk register. The major risks identified by the infection control team are as follows

Table 1 - Identified Registered Risks

Risk	Risk to Whom	Risk Rating	Risk Category
1 Inadequate air changes due to no conventional ventilation in theatres	Patient	15	High
2 Some clinical hand wash sinks in the hospital are not compliant with recommended HBN 00-10 Part C standard	Patient//Staff	8	Moderate
3 Non-compliance with Infection Control standards due to lack of en-suite isolation rooms.	Patient	15	High
4 Legionnaires disease.....due to old water plumbing system	Patient/Staff	8	Moderate

2.0 Introduction

This annual document reports on the infection prevention and control service, including surveillance of infection in RVEEH. This report includes information on:

- Progress and achievements against the Infection Prevention Control Team (IPCT) annual programme to prevent and control HCAIs;
- Specific targets relating to the prevention and control of HCAIs;
- Key Performance Indicators (KPI), including the HSE Infection Control indicators;
- The resources made available to prevent and control HCAIs
- Recent independent external audits including JCI in February & May 2014 and the HIQA audit in March 2014.

The Infection Prevention and Control Team (IPCT) are comprised of a Consultant Microbiologist (10 hours per week) and two Infection Control Nurses who share a 1 WTE position. The Surveillance Scientist, based in the National Maternity Hospital, also contributes to the surveillance service in RVEEH. A work plan and IPCT programme (Appendix 1) is developed annually and the team meets weekly to discuss all matters relating to infection prevention and control. The team has representation on the Infection Prevention & Control committee (IPCC) and the Drugs, Therapeutics & Antimicrobial Stewardship committee . The team also has representation on the Integrated, Risk, Quality & Safety Committee, the Hygiene & Decontamination Committee, the Facilities Committee, the Medical Board and Clinical Nurse Managers Committee.

The IPCC is chaired by Mr D Dunne, Chief Executive. It is a multidisciplinary committee which is responsible for the development and review of the service to prevent and control HCAIs; see Appendix 9 for Terms of Reference. The annual work plan and programme are reviewed signed off by this committee.

See Appendix 8 for membership and attendance in 2014.

3.0 Surveillance

Standard 11: Healthcare associated infections and antimicrobial resistance are monitored, audited and reported through a systematic surveillance programme

3.1 Table 2 - RVEEH key performance indicators (KPI's)

HCAI Key Performance Indicators	Target	2010	2011	2012	2013	2014
Post-operative endophthalmitis (elective cataract surgery)	≤0.1%	0.06%	0.05%	**0.08%**	**0.10%**	**0%**
Endophthalmitis post intravitreal injections	≤0.05%	0%	0.03%	**0.02%**	**0%**	**0.04%**
Keratitis post corneal collagen cross linking		Surgery not done	0%	**3.38%**	**0%**	**0%**
Other Eye Infections		0%	0%	**0.01%**	**0%**	**0.03%**
Post op ENT Infections		0%	0%	**0.05%**	**0%**	**0.48%***
Number of RVEEH acquired MRSA **colonization**	**≤4 patients**	1	1	**0**	**0**	**1**
Number of RVEEH acquired MRSA infection	**≤2**	0	0	**1**	**0**	**0**
Number of MRSA blood stream infections	**≤1**	0	1	**0**	**0**	**0**
Device related infections (Peripheral IV catheter infection)	**≤5**	2	2	**3**	**1** (~0.014%)	**1**
Clostridium difficile Infections	**≤2**	1	0	**0**	**0**	**0**

**Change to methodology of infection surveillance in 2014; additional cases of post-operative ENT infection identified compared to methodology used in previous years.*

Surveillance involves a range of procedures including scientific, technical, communication, information/computer and data management, and quality control. The Health Service Executive (HSE) healthcare associated infection (HCAI) governance group has set the

following goals and objectives: to reduce HCAI by 20%, to reduce MRSA infections by 30% and to reduce antibiotic consumption by 20%.

The RVEEH had no MRSA HCAI and were below and within all targets.

Surveillance in the RVEEH includes the following:

- RVEE Hospital acquired infections
- Antimicrobial resistance
- Surgical site infections
- Patient device related infections
- Notifiable infectious diseases

Table 3 - RVEEH & HSE KPIs target for 2014

RVEEH KPIs	RVEEH 2013	RVEEH 2014	HSE 2014 KPIs
MRSA Blood Stream Infection per 1000 bed days used (BDU)	**0**	**0**	0.057
New cases of healthcare associated Clostridium difficile infection per 10,000 BDU	**0**	**0**	≤ 2.5
Antibiotic consumption (daily defined doses per 100 BDU)	**55.8**	Q1 & Q2 **55.67**	Q1 & Q2 79.54
Alcohol gel consumption (litres per 1,000 BDU)	**53**	Q1-Q4 52	25
HSE hand hygiene audit compliance	**90%** in May **83%** in Nov	**89%** in May **88%** in Nov	≥90%

Alcohol gel rub usage in the RVEEH was well above the national amount for 2014.

See Appendix 2 KPI Table for more detail

3.2 MRSA

MRSA screening is requested prior to admission on all patients in an at-risk category. The profile for 2014 was as follows:

Table 4: MRSA Profile for 2014

	2013	2014
Number of MRSA screening swabs and patients tested	2,502 (632 patients)	3,402* (681 patients)
Number of positive patients	53 (8.4%)	59 (8.7%)
Number of previously known carriers	19 (35.8%)	24 (40.7%)
Number of MRSA HCAI	0	1
MRSA decolonisation carried out prior to surgery	36 (67.9%)	34 (57.6%)

*Throat swab testing was added to a routine MRSA screen in 2014 resulting in an increase in MRSA swabs

The IPCT liaise wirh patients and their GPs when MRSA eradication is being carried out. Thirteen patients out of the thirty four (38.2%) were sucessfully decolonised and surgery proceeded. Decolonisation was attempted in 21 patients but they were not successfully cleared (61.8%). However, surgery proceeded in all patients and recommened infection control precautions were adhered to.

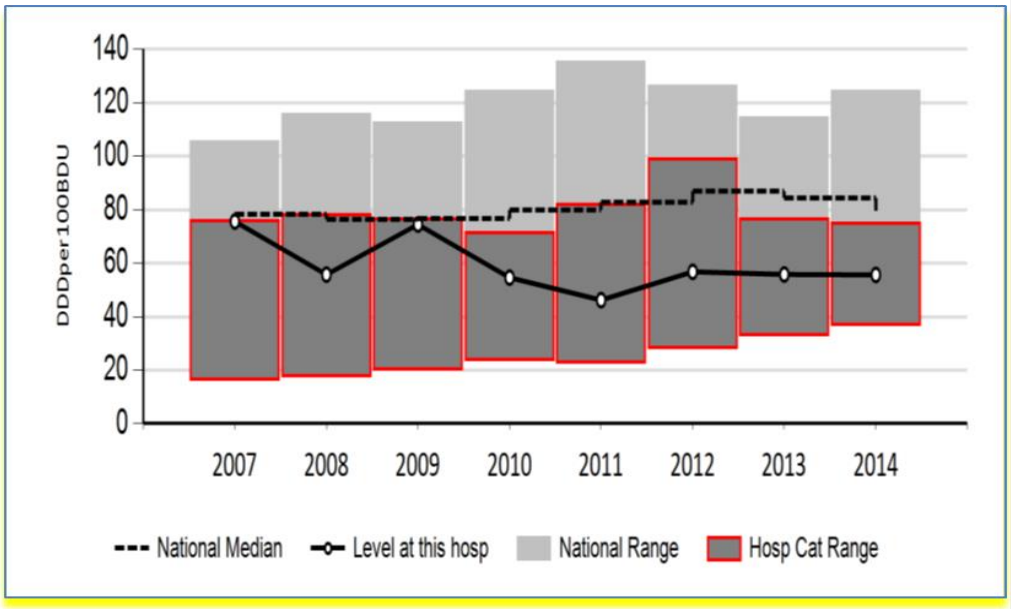
***There was one MRSA HCAI (colonisation) in the RVEEH in 2014.**

3.3 Antimicrobial Consumption

Hospital data is reported to the HPSC by the Pharmacy Department. This data is discussed at the Hospital's Drugs, Therapeutics & Antimicrobial Stewardship Committee.

- Antibiotic consumption was well below National consumption in 2013. 55.8 versus the National Average of 85.
- Antibiotic consumption for Q1 & Q2 in 2014 was 55.6 versus the National average of 79.5
- The RVEEH had a higher consumption of fluoroquinolone than the national median. This is in keeping with previous years. However, the consumption of clindamycin for Q1 & Q2 was below the national median in 2014. See appendix 6

Rate of RVEEH hospital antibiotic use



See Appendix 3 to 7 for additional National and RVEEH Antimicrobial Data

3.4 European Antimicrobial Resistance Surveillance Network (EARS-Net)

The Surveillance Scientist contributes RVEEH blood stream infection data to the European Antimicrobial Resistance Surveillance Network (EARS-Net). There were no blood stream infections with EARS-Net organisms in 2014 in RVEEH

3.5 Incidence of Common Transmissible Organisms in RVEEH Patients:

Most of these organisms were present or incubating on attendance to RVEEH, unless indicated.

Table 5: No. of Common Transmissible Organisms in RVEEH 2010 – 2014

	2014	2013	2012	2011	2010
Acanthamoeba	4	4	8	2	3
Adenovirus	47	111	61	87	--
Chlamydia trachomatis	11	11	9	7	8
Clostridium difficile	0	0	0	0	1
N. gonorrhoeae	5	8	2	4	1
Group A Streptococcus	7	10	13	8	8
Hepatitis B	0	0	0	0	0
Hepatitis C	0	0	0	0	1
HIV	0	0	0	0	0
MRSA (BSI)	0	0	0	1	0
MRSA (healthcare **acquired colonisation**)	1	0	0	0	2
MRSA (HCAI acquired infection	0	0	1	0	0
Mumps	0	0	0	0	1
Norovirus	0	0	0	0	1
Syphilis	0	4	4	0	1
Toxoplasmosis	0	0	0	1	0
TB Pulmonary	0	0	0	0	0
TB Extra-pulmonary	0	0	1	0	0
VRE	0	0	0	0	0

BSI= Blood Stream Infection ; HCAI= healthcare associated infection ; VRE= Vancomycin Resistant Enterococci

3.6 Surgical Site Infection

Table 6: Total Surgeries indicating number of infections

Eye Surgey	2012			2013			2014		
	Total	Infected Patients	%	Total	Infected Patients	%	Total	Infected Patients	%
Cataract Surgery	2,522	2	0.08	2,860	3	0.10%	2,427	0	0%
Other Eye Surgery	2,645	3	0.11	2,726	0	0%	2,948	2	0.06%
Total eye surgeries	**5167**	**5**	**0.1**	**5,586**	**3**	**0.05%**	**5,375**	**2**	**0.03%**
Total Intravitreal Injections	3,670	1	0.02	3,988	0	0%	**4,516	2	0.04%

** Total intrvitreal injections of 4,516 may be adjusted by circa 30-50 additional when data from hipe confirmed later this year.

2014 Eye Surgery:

There was a total number of 5,375 eye operations carried out in 2014 (excluding intraviteal injections). Of this total 0.03% returned with a post-operative infection (2 patients). Both patients were readmitted and commenced on appropriate antibiotic therapy.There were no post op cataract endophthalmitis infections in 2014. There were two post op intravitreal injection infections. Both patients were admitted and treated appropriately.

Table 7

ENT Surgery									
	2012			2013			2014		
	Total	Infected Patients	%		Infected Patients	%	Total	Infected Patients	%
Parotidectomy	23	0	0%	17	0	0%	24	0	0%
Neck Dissection + laser	6	0	0%	3	0	0%	6	0	0%
Laryngectomy	3	0	0%	0	0	0%	0	0	0%
Tracheostomy	-	-	-	-	-	-	4	0	0%
Mastoid Exploration	40	0	0%	48	0	0%	39	1	2.5%
Septoplasty	37	1	2.7%	27	0	0%	54	1	1.8%
Fess -/+ septoplasty	-	0	0%	83	0	0%	56	0	0%
Tympanoplasty	32	0	0%	32	0	0%	18	1	5.5%
Combined approach Tympanoplsty	-	-	-	-	-	-	19	1	5.2%
Submandibular gland excision	7	0	0%	15	0	0%	10	1	10%
R/Ostone from submandibular duct	-	-	-	-	-	-	3	1	33.3%
Tonsilectomy	----	----	----	216	----	----	165	0	0%
Other ENT Surgery		0	0%	1,299	0	0%	1,222	2	0.16%

2014: ENT Surgery: There were 1,650 ENT surgical procedures in total.
There were eight post op infections which accounted for 0.48%. All patients were re-admitted and commenced on the appropriate IV antibiotic.

Four sputa samples from 2 post-operative patients returned positive in 2014. Patients received appropriate treatment.

Three patients returned to OT for treatment of a primary haemorrhage post tonsillectomy (1.8%).

4.0 Monitoring

Standard 1: (HIQA. HCAI) Structures, systems and processes are in place to effectively manage and implement the programme to prevent and control Healthcare Associated Infections

4.1 Hygiene and Infection Control Audits

The Hygiene Service Committee carries out internal hygiene audits every two months. There are 10 teams and each team is made up of two members from different disciplines. The results of these audits and a Quality Improvement Plan are fed back to the committee and evaluated at the monthly meetings. Where possible, any hygiene problems are acted on and corrected at the time of audit or as soon as possible. The IPCT carried out two Infection Control audits in March and August 2014. All completed audits are available on the shared intranet for all staff to access. See Appendix 7 for a summary of the IPCT audits. The following are audited:

- Waste management
- Linen management
- Sharps management
- Training effectiveness
- Environmental Monitoring
- Facilities
- Environmental Cleaning
- Hand Hygiene
- Patient equipment Mgt.
- Peripheral IV and urinary catahter care bundles

4.2 Hand Hygiene

Standard 6: (HIQA. HCAI) Hand hygiene practices that prevent, control and reduce the risk of the spread of Healthcare Associated Infections are in place

97% of RVEEH staff who have interaction with patients received Hand Hygiene education and training during the 2-year period 2013-2014.

Observational hand hygiene audits were carried out monthly using the tool newly developed by the Health Protection Surveillance Centre (HPSC). Seven clinical areas are observed every two months.The results are fed back to the HST, IRQS & IPCC committees and are available on the hospital's shared intranet. The months of May & November are very large audits and these are submitted to the HSE. For 2014 the HSE set a target of ≥90% compliance. When the result falls below this a re-audit was carried out following evaluation of hand hygiene facilities and hand hygiene education. The RVEEH achieved a score of 89% in May and 88% in November.The average compliance rate among the Nursing staff was

91% and the average for the medical staff was 82% (which is an improvement on 2013 (78%) compliance among the medical staff). Educational sessions regarding hand hygiene are on-going.

Two hand hygiene awareness days were held by the IPCT in May and September 2014.

- An ultraviolet light cabinet was used to demonstrate hand hygiene technique to staff of all disciplines;
- Approximately seventy staff took part. On site education regarding the WHO 5 moments for Hand Hygiene was given to all who participated.

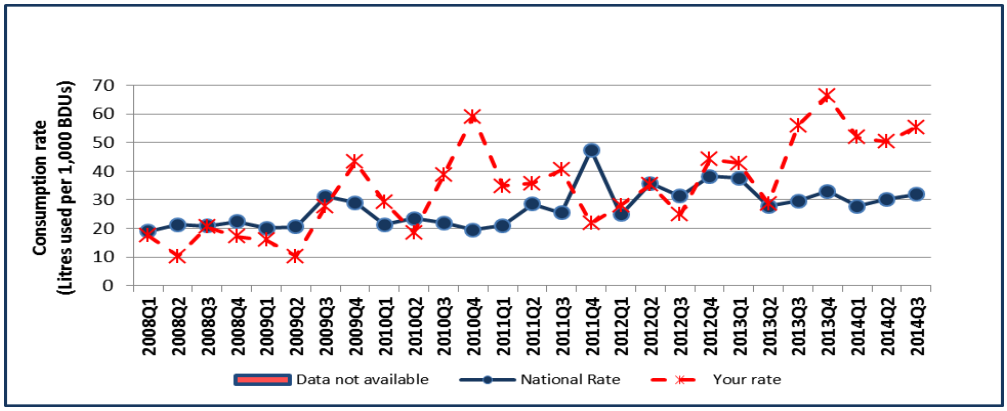
Hand Hygiene Complaints

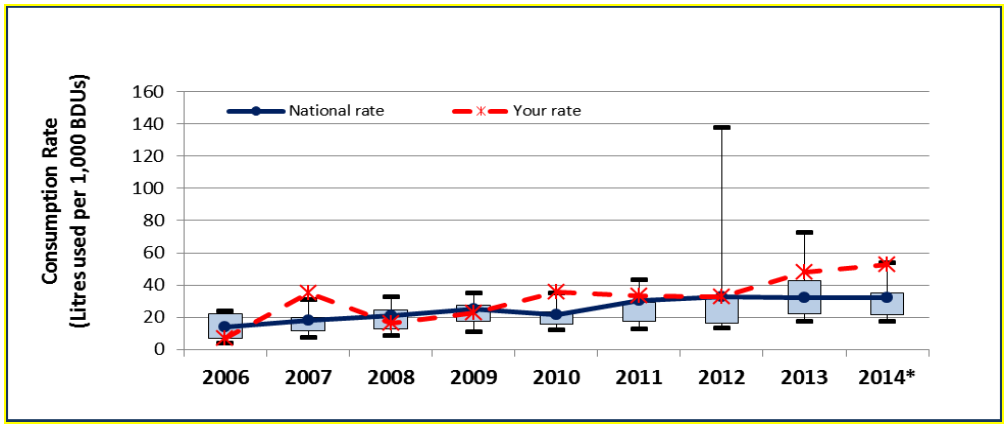
- No complaints were received from patients or visitors regarding hand hygiene compliance in the RVEEH in 2014.

4.3 Alcohol Hand Gel Consumption

The HPSC audits the usage of alcohol hand gel in all hospitals quarterly. This is used as an indication of compliance with hand hygiene and usage is compared with other hospitals by use of a decile score (a score of 10 meaning very low consumption of alcohol gel and a score of 1 meaning a very high consumption). The RVEEH had a decile score of 1 in Q1 and a score of 2 in Q2 in 2014. RVEEH used 51 L/1000 BDU in the period Q1 & Q2 in 2014 compared with the HSE expected national KPI of 25 L/1000 BDU. The hospital's alcohol gel consumption compares favourably with other hospitals and specialist hospitals in the network.

Consumption of Alcohol Gel in RVEEH versus national rate





4.4 External Audits

The Hospital was externally audited by the following 3 bodies:

- **JCI---- February & May 2014**
- **HIQA----March 2014**
- **Dangerous Goods Safety Advisor** (**DGSA)---10/6/2014 & 22/12/2014**

Data reporting: Since April 2014, monthly indicators are being reported to the HSE from the RVEEH on hospital acquired S. aureus bloodstream infection/10,000 BDU, on Hospital acquired new cases of C. difficile infection/10,000 BDU and on hand hygiene education for all staff who interact with patients.

The RVEEH continue to strive to comply fully with all standards and elements set out by JCI.
See appendix 12 for detailed findings from HIQA report.
See Appendix 13 for summary of DGSA bi-annual audits.

5.0 Facilities

Standard 3: (HIQA. HCAI) The physical environment, facilities and resources are developed and managed to minimise the risk of service users, staff and visitors acquiring a healthcare Associated Infection

5.1 Environmental Monitoring - Water Quality & Legionella Prevention

Legionella Controls

- Quarterly external & regular internal water temperature monitoring is carried in the hospital.
- Flushing of infrequently used water outlets. This is carried out throughout the hospital. All documentation is held with the cleaning supervisor.
- Quarterly shower head cleaning as per policy.
- Quarterly quality testing for indicator organisms (legionella) & total viable counts is carried out.
- All water tanks are cleaned annually
- Annual independent legionella risk assessment
- TMV servicing

The IPCT received positive Legionella culture results in February, November and December. Additional flushing controls were put in place immediately and a review of the water system including temperature checks was conducted. Flushing in these areas continues as some outlets are infrequently used.

The CE arranged for an extensive independent Legionella Risk Assessment to be carried out in December. This took 8 working days and the hospital will receive a full report in January 2015. Upgrading of the water system is due to be carried out pending this report. The RVEEH water system is currently on the RVEEH risk register.

5.1.2 Operating Theatre Bacterial Counts

- Quarterly bacterial counts are carried out in all operating theatres. They were all within normal limits with the exception of ENT OT 1. This theatre was just slightly above the accepted range and will be monitored over time. The ENT OT 1, on each occasion had a lot of staff present. The Theatre Manager was advised to keep the number of people present during surgery to a minimum . Air conditioning remains on at all times to maintain ambient temperature within range. *See Appendix 11 for detail of bacterial counts*.
- The IPCT would like to reiterate the lack of conventional ventilation, air changes or standard pressure differentials in the OTs in the RVEEH.

5.2 Upgrading work

Upgrade works were carried out in many areas of the hospital in 2014 as follows:

- ENT OPD moved location to the newly refurbished area on east wing of ground floor.
- Complete paint works and floor covering in A&E.
- Paint touch up carried out in different areas around the hospital.
- Upgrading of sinks to HBN 00-10 Part C standard continued in 2014 (5).
- Complete paint works carried out in childrens bathroom.
- Smoking shelter removed and area cleaned

6.0 Policies, Procedures and Guidelines updated in 2014

Standard 1: (HIQA. HCAI) Structures, systems and processes are in place to effectively manage and implement the programme to prevent and control Healthcare Associated Infections

The following policies were reviewed, updated and/or created in 2014

1. Antimicrobial Guidelines 2. Aseptic Non Touch Technique 3. Audit Policy 4. Influenza Policy 5. C. difficile Policy 6. Environmental Monitoring 7. Standard Precautions 8. Hand Hygiene 9. Head lice guidance 10. Isolation 11. Outbreak Management 12. MRSA 13. Severe acute respiratory infection 14. Sepsis Policy 15. Scabies 16. Policy for out of date supplies 17. Policy for management of Ocuscan 18. Infection Control in OT	All updated by the Infection Control Team in 2014. See 2014 work plan

7.0 Major Risks Identified by IPCT

7.1 Ventilation in OT

The ventilation system in the operating theatres does not meet internationally recognised standards for operating theatres. This increases the risk of post-operative infection. The situation has been highlighted to the HSE, the Hospital Management Group (HMG), the Medical Board and the Council numerous times in the past. No funding has been made available. The IPCT recommends that Operating Theatres design should comply with HBN 26 (Facilities for surgical procedures) and HTM 2025 (ventilation in healthcare premises). The design should have appropriate ventilation with a minimum of 25 air changes per hour. The instrument set-up area should be dedicated for use, have 35 air changes per hour. There should be appropriate pressure differentials between adjacent rooms in the theatre

department to minimise airborne contamination of clean areas. This risk is currently on the hospitals risk register. The IPCT carry out air sampling in all the theatres and the Central Decontamination Unit every 3 months. See Appendix 11.

7.2 Isolation Room

The RVEEH does not have a single room with en-suite facilities for standard isolation purposes or with a positive pressure ventilated lobby for airborne isolation. A suitable location has been identified; 3 quotes have been obtained and funding has been requested. The matter has been brought to the attention of HMG. The IPCT reiterates the importance of proper isolation facilities in preventing the spread of infection in the hospital environment. Currently a bathroom is dedicated for the patient when isolation is required.

7.3 Hand Hygiene Facilities

A lot of existing sinks do not conform to an appropriate design standard for sinks in healthcare settings. Funding has been requested from the HSE to upgrade the hospitals sinks. The project to upgrade all hand hygiene sinks to comply with HBN 00-10 Part C standard is on going. The IPCT recommends the use of alcohol hand gel in areas where there are inadequate or insufficient hand washing sinks. The HPSC strongly recommend the use of hand alcohol gel as a means of hand decontamination.

7.4 Risk of Legionnaires disease incident

There is an old and complicated water system in RVEEH with inadequate overall Legionella Management. Factors contributing to this include:

- Structural deficiencies in the hospital's overall water system.
- Inadequate overall management of legionella control with no clear allocation of responsibilities
- Possible risk of a legionnaires disease incident for patients and staff.
- Additional controls need to be in place.

8.1 Appendix 1

Infection Prevention & Control (IPC) Plan for 2014
Royal Victoria Eye & Ear Hospital

Target	Action	Action by	Date Complete
To provide infection prevention and control education for staff and students in the Hospital Education forms a very important part of the Infection Control Program.	**The Infection Control Nurse provides training and education to all staff, patients and relatives. Training is preceded by a needs assessment. The training programme includes the following:** **1**. Provide **Hand Hygiene** education including demonstrations and lectures for all clinical staff annually. Hand Hygiene education is appropriate for grade of staff. Education is evaluated through questionnaire and observational audit. Hand Hygiene awareness days are held two times a year as part of the Hand Hygiene Education Program. This includes demonstration and analysis of technique using ultraviolet light box. Prompts are provided in the form of posters and leaflets in all departments. **2**. Provide general infection control education including lectures on waste disposal, isolation procedures and standard precautions and correct use of personal protective equipment. **3**. Ensure all staff aware of procedure for accessing infection control information on hospital intranet. **4**. Provide advice and updates on matters relating to IPC to all relevant clinical staff give advice and support regarding IPC policy and related issues. **5** Provide infection control education as part of the one day medical induction. **6** Co-author "Bugs & Drugs" newsletter. **7** Develop an "Infection Surveillance newsletter"	SF, MMcC SF/MMcC SF/MMcC SF/MMcC SF/MMcC SF/MMcC SF/MMcC	 Refer to hand hygiene attendance records. See documenmtation in IPCT office. Refer to in house study day attendance records. Polices updated every two years. All policies approved at IPCC quarterly meetings. See minutes of meetings.
Develop and review infection control policies, procedures and guidelines in accordance with legislation and evidence-based	Antimicrobial Guidelines Aseptic Non Touch Technique Audit Policy Influenza Policy C. difficile Policy Environmental Monitoring	SF, MMcC, & SK.	All policies approved at IPCC quarterly meetings.

practice. Policies for updating in 2014	Standard Precautions Hand Hygiene Head lice Policy Isolation Outbreak Management MRSA MERS incl SARS Sepsis Policy Scabies Policy for out of date supplies Policy for management of Ocuscan Infection Control in OT	MMcC/SF/SK MMcC/SF/SK MmCc/SF/SK MmCc/SF/SK MmCc/SF/SK MmCc/SF/SK MmCc/SF/SK MMcC/SF/SK MMcC/SF/SK MMcC/SF/SK MMcC/SF/SK MMcC/SF/SK MMcC/SF/SK	See minutes of meetings for dates when theses policies were signed off. Policies are available on Q pulse.
Infection Control Audits of practice and facilities	• Bi annual IPCT audits. • Monthly IV care bundle audit. • HST audits of facilities (See audit schedule for 2014) Compile summary of outstanding issues. Report to IRQS on outstanding issues. Distribute results and feedback of the audits to all relevant CNMs and Heads of Departments. • Observational hand hygiene audits every month. Twice a year hand hygiene audits carried out are submitted to HSE. re-audit is done where necessary. Disseminate hand hygiene audits to relevant clinical staff and heads of Departments.	MMcC/SF MMcC/SF MMcC/SF SF/ MMcC DK/SMcC	March and September 2014 Every month. See HST audit results and summary for detail and dates. Every month. See hand hygiene attendance dates for evidence.
Monitor and report rates of infection, healthcare associated infections, notifiable diseases antimicrobial resistance, antimicrobial consumption and alcohol gel usage.	1. Daily ward based and laboratory surveillance 2. Collect, analyse and report post-operative endothalmitis infection rates. 3. Collect, analyse and report data on infections and antibiotic resistant organisms 4. Collect and report data on statutory notifiable diseases 5. Collect and report data to the European Antimicrobial Resistance Surveillance Network (EARS-Net) 6. Collect and report data on alcohol gel use. 7. Collect and report data on antibiotic consumption. 8. Distribute quarterly surveillance reports to Infection Control Committee 9. Distribute quarterly or as required surveillance reports to all relevant clinical staff.	SF, MMcC, SK SF, MMcC, SK SF, MMcC, SK, SK Pharmacy, SF, MMcC Pharmacy SF, MMcC SF, MMcC	Ongoing Actioned All actioned in 2014 Actioned (SK) Actioned and submitted to HSE Actioned see minutes See e-mails, minutes news letter & display boards.
Investigate and lead on outbreak management	Monitor and control outbreaks in a timely manner. Provide information to staff and	SF, MMcC, SK, others as required	Only when required. No outbreak in 2014

	patients as required		
Identify infection risks and advise on appropriate action to prevent or minimize these risks	Liaise with patients, GPs and medical teams regarding patients colonized and infected with transmissible diseases or organisms. Analyse Infection Control related incidents and follow up to prevent these risks occurring in the future.	SF, MMcC, SK	Actioned in 2014
Provide advice and support regarding infection prevention and control policy and related issues	• Patient isolation • Antimicrobial utilisation and antimicrobial resistance • Decontamination • Facilities and engineering, including new facilities, renovation, ventilation and water • Catering services • Household service • Laundry service • Waste management	SF, MMcC, SK	See attendance records for evidence.
Attend regular meetings and educational seminars relevant to infection prevention and control	• Infection Control Committee • Infection Control Team meetings • Hygiene Committee • IRQS Committee • Antimicrobial stewardship committee • IPS Conference • HPSC Study Day • ENT seminar • Other relevant conferences	SF, MMcC, SK SF, MMcC, SK SF, MMcC SF, MMcC, SK SF, MMcC, SK, SF, MMcC, SK, SF, MMcC SF, MMcC SF, MMcC SF,MMcC SK	March 2014,June 2014, sept 2014, December 2014. Monthly Quartely Quarterly (See minutes) May 16th 2014 10/10/2014
Produce an annual work plan and annual report	IPC Work Plan 2014 IPC annual report 2013	SF, MMcC, SK SF, MMcC, SK	March 2014 March 2014 Signed off at IPCC meeting.

SF = Sinead Fitzgerald, Infection Control Nurse; MMcC = Margie McCarthy, Infection Control Nurse, SK = Susan Knowles, Consultant Microbiologist,

Signed_____ **Date**_____

Appendix 2 National and RVEEH Alcohol hand Gel Consumption

	2010	2011	2012	2013	2014 Q1 to Q4
No. of participating hospitals	**43**		**43**	**43**	**44**
Bed Days used (BDU's)	**6,466**	**6,582**	**5,869**	**5,320**	**5,003**
Total vol hand rub used	**230**	**218**	**193**	**256**	**268**
RVEEH consumption rate	**35.6**	**33**	**32.8**	**48**	**53.6**
Decile score	**1**	**3**	**3**	**2**	**Q1 & Q2 2**
National consumption rate vol/1000BDU's	**21.7**	**30.2**	**28.2**	**26.3**	**Q1 & Q2 30**

1. The alcohol gel consumption rate is the volume of alcohol hand rub consumed (in litres) during the defined time period per 1,000 bed days used (BDUs)

2. The RVEEH consumption rate for 2014 compared favorably with the national average.

3. To get the decile score, the total number of hospitals are sorted by their quarterly rate and then divided into 10 groupings. Hospitals with a decile score of 10 have the lowest alcohol gel consumption and 1 have the highest alcohol gel consumption rates.

Royal Victoria
Eye and Ear Hospital
Dublin - Ireland - Established 1897

Appendix 2 RVEEH Alcohol Gel Consumption 2014

	2006	2007	2008	2009	2010	2011	2012	2013	2014¥	2014Q1	2014Q2
Your Hospital Data:											
Number of participating hospitals	**52**	**50**	**50**	**49**	**45**	**43**	**44**	**44**	**40**	**40**	**35**
Beds days used (BDUs) [a]	**10,750**	**8,824**	**8,950**	**7,135**	**6,466**	**6,582**	**5,869**	**5,320**	**2,698**	**1,403**	**1,295**
Total vol hand rub used (L)	**76**	**311**	**147**	**163**	**230**	**218**	**193**	**256**	**137.8**	**72.7**	**65.2**
Consumption rate [b] (vol/1,000 BDUs)	**7.0**	**35.3**	**16.5**	**22.9**	**35.6**	**33.1**	**32.8**	**48.1**	**51.1**	**51.8**	**50.3**
Decile score [c]	**8**	**1**	**7**	**4**	**1**	**3**	**3**	**2**	**1**	**1**	**2**
% Hospitals used for decile score	**100%**	**100%**	**100%**	**100%**	**94%**	**93%**	**96%**	**96%**	**87%**	**87%**	**76%**
										-	-
By Hospital Type:	**Specialist**						-	-	-	-	-
Specialist consumption rate (median)	**7.0**	**10.4**	**12.4**	**22.6**	**18.2**	**20.9**	**32.8**	**47.3**	**32.7**	**30.5**	**41.5**
										-	-
By Region:	**DublinMidLeinster**						-	-	-	-	-
Dublin Mid-Leinster rate (median)	**12.0**	**20.0**	**19.7**	**20.2**	**22.5**	**28.6**	**25.3**	**29.9**	**37.4**	**34.7**	**41.4**
										-	-
National:	**National data**						-	-	-	-	-
Overall Consumption rate	13.7	17.9	20.9	24.9	21.5	30.2	32.5	32.0	29.7	28.0	31.6
Consumption rate (median)	**10.3**	**14.9**	**18.1**	**22.1**	**19.2**	**21.2**	**23.9**	**26.3**	**27.1**	**27.4**	**27.1**

As can be seen from the above table---RVEEH decile score has remained very low since 2007. (the higher the alcohol gel usage>> the lower the decile score)

Appendix 3

Drug Type: Antibiotic **DDD per 100 BDUs (*2014 is Q1 & Q2 only)**

RVEEH		National Levels			Hospital Category Levels		
Year		Median	Min	Max	Median	Min	Max
2007	75.63	78.24	16.06	105.78	45.23	16.06	76.38
2008	55.75	76.51	17.26	116.24	34.48	17.26	78.58
2009	74.51	76.59	20.08	112.85	35.92	20.08	76.95
2010	54.63	80.02	23.64	124.92	33.89	23.64	71.99
2011	46.22	82.81	22.66	135.60	28.97	22.66	82.38
2012	56.81	87.05	27.86	126.74	56.81	27.86	99.41
2013	55.81	84.45	32.80	114.83	47.22	32.80	77.11
*2014	55.67	79.54	36.76	124.73	42.61	36.76	75.47

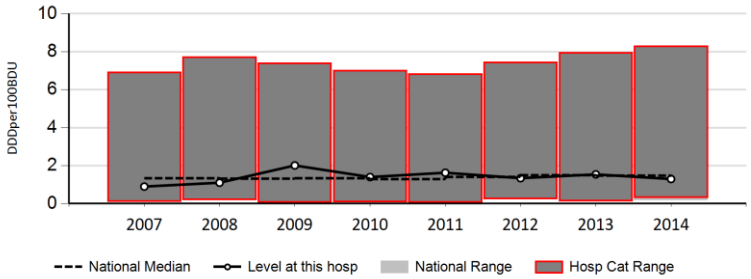
Appendix 4 - National & RVEEH Antimicrobial Statistics

Royal Victoria
Eye and Ear Hospital
Dublin - Ireland - Established 1897

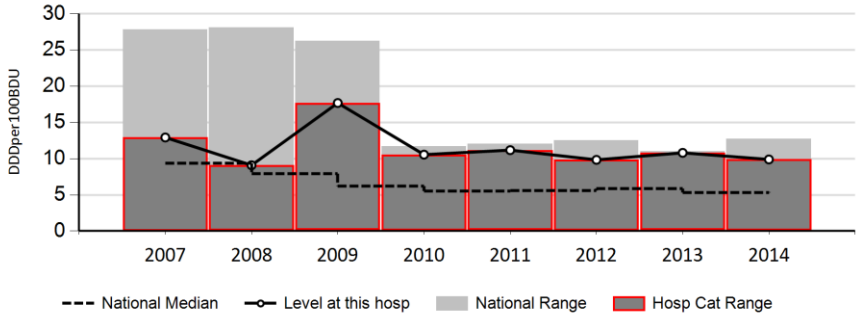
RVEEH

Measure	Year	Level	% Change	Nat Median	Decile
DrugType:Antibiotic	2014	55.67	0%	79.54	2
AlertAgents:A_AntiGPosAgents	2014	0.94	20%	2.59	1
AlertAgents:B_Gen2Cephs	2014	1.36	34%	1.98	4
AlertAgents:C_Gen3Cephs	2014	1.30	-16%	1.42	5
AlertAgents:D_fQs	2014	9.90	-8%	5.35	10
AlertAgents:E_BroadSpecPens	2014	16.49	15%	26.83	2
AlertAgents:F_Carbapens	2014	0.35	0%	1.76	1
AlertAgents:G_Clinda	2014	0.86	-74%	1.07	4
A_Alerts:1_O_Lin	2014	0.00	-100%	0.18	1
A_Alerts:2_P_Lin	2014	0.00	0%	0.10	1
A_Alerts:3_O_Van	2014	0.75	-9%	1.58	2
E_Alerts:1_O_CoAmox	2014	7.37	20%	12.66	1
E_Alerts:2_P_CoAmox	2014	8.54	10%	6.36	9
E_Alerts:3_P_Tazo	2014	0.58	15%	6.02	1
IVProp:SwitchIV	2014	7.97	-66%	6.42	6
IVProp:AllIV	2014	52.44	-17%	51.03	6
DrugType:Antifungal	2014	1.05	-37%	1.38	4
DrugType:Antibiotic_Cost	2014	5.67	13%	4.08	8

Appendix 5 National & RVEEH

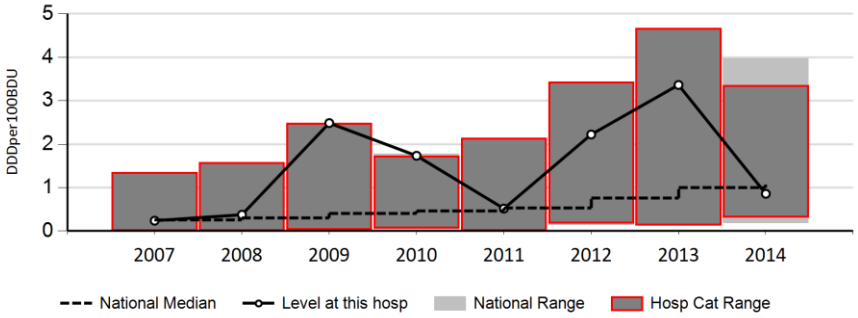


Rate of hospital 3rd generation cephalosporin use

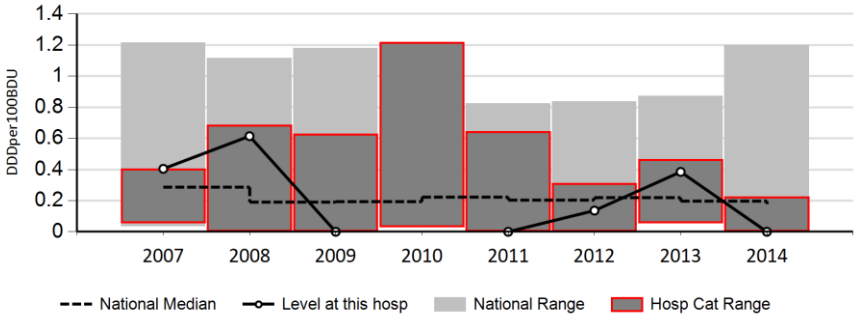


Rate of hospital fluoroquinolone use

Appendix 6



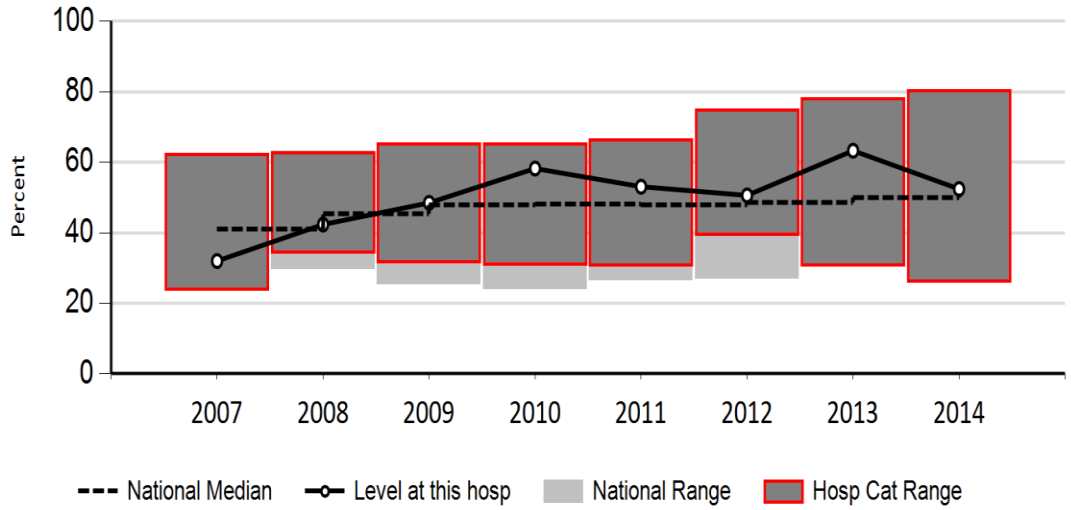
Rate of hospital clindamycin use



Linizolid use in RVEEH

Appendix 7

Proportion of hospital all IV use



Appendix 8 – HSE Rates of MRSA, Hand Hygiene Compliance plus Alcohol Hand Rub & Antibiotic Consumption Rates.

	Hospital	Bed Days Used	Bed Days Used	Rate of MRSA bloodstream infections per 1,000 bed days used					% Hand Hygiene Compliance		Alcohol hand rub consumption (L per 1000 BDU)*			Antibiotic Consumption Rate (DDD per 100 beds per hospital			
		Standard 2012		<0.067					85%		≥23			<83			
		Standard 2013		<0.060					90%		≥25			<83.7			
	Data up to:	2012	2013 Q1+Q2	2010	2011	2012	2013 Q1	2013 Q2	2012 P4	2013 P5	2012 Q3	2012 Q4	2013 Q1+Q2	2010	2011	2012	2013 Q1+Q2
General	MRH at Tullamore	55,243	28,552	.120	.086	.091	0	.069	81.9	71.9	71.0	66.6	79.8	80.6	103	111.6	103.2
	MRH at Mullingar	65,921	33,916	.066	.108	.030	0	.117	87.6	76.7	43.8	55.6	52.2	83.2	86.5	ND	ND
	MRH at Portlaoise	43,107	22,505	.069	.043	0	0	.175	81.4	87.1	41.2	58.9	41.2	ND	ND	100.2	94.3
	Naas Gen Hospital	65,880	35,496	.109	.014	.091	0.111	0	90.5	92.4	ND	37.9	18.5	90.1	97.1	96.0	83.6
	Loughlinstown	38,152	18,501	0	.026	0	0	0	85.2	86.2	24.0	35.6	26.5	81.5	93.1	85.3	98.9
Tertiary	AMNCH Tallaght	173,929	88,963	.064	.038	.040	.069	.022	82.9	80.0	43.1	26.5	23.6	95.2	91.8	88.6	95.7
	St. Vincent's	154,925	85,323	.079	.135	.065	.144	.092	87.1	91.0	ND	23.2	21.0	124.9	135.4	126.7	110.8
	St. James's Hospital	294,854	149,546	.077	.058	.017	.040	.027	84.3	83.3	20.2	22.6	24.5	80.0	81.3	81.4	84.4
Specialist	Coombe Hospital	39,690	23,208	0	.018	0	0	ND	84.3	89.8	21.4	24.3	31.0	29.9	28.9	33.7	39.2
	NMH, Holles St.	44,709	24,804	0	0	0	0	0.00	85.7	94.3	14.5	15.6	62.9	23.6	22.7	28.8	36.7
	CUH Temple St.	19,475		0	0	.074	0	0.00	73.3	77.6	38.8	40.5	ND	68.8	82.4	99.4	73.4
	OLCH Crumlin	44,740	28,847	.067	.066	.017	.068	0.00	92.8	93.3	35.6	37.1	40.4	72.0	74.5	70.3	80.9
	St. Lukes Rathgar	28,411	17,676	.023	0	0.00	0	.119	84.8	91.9	11.3	ND	17.5	26.8	25.7	30.7	32.4
	St. Michael's (DunL	16,278	11,322	.123	.043	.047	0	0.00	85.1	89.0	ND	ND	23.4	97.2	93.3	96.6	104.4
	RVEEH	**4,476**	**2688**	**0**	**.153**	**0**	**0**	**0.00**	**86.1**	**91.0**	**24.8**	**44.2**	**35.4**	**55.6**	**46.0**	**56.8**	**52.8**

Our Antibotic Consumption rate is 4th lowest of the 15 Hospitals listed, in 2013.

Appendix 9 - Membership of Infection Control Committee

Committee Members	**No of Meetings Attended in 2014** (4 Meetings Held)
Chief Executive Officer - Danny Dunne (Chair)	4
Consultant Microbiologist - Dr Susan Knowles	4
Nursing Adnin - Elspeth Finlay (1) - Mary Casey (2) -Caitriona Steele (1)	4
Infection Control Manager - Sinead Fitzgerald	4
Infection Control Manager - Margie McCarthy	4
Risk Manager - Sarah McCarthy (2) Risk Manager -Deirdre Kelly (2)	4
Theatre Manager - Mary Doherty	2
Pharmacist -Jane Anne O' Connor (3) Pharmacist (clinical) - Ellen Gill (1)	4
CDU Manager - Carol Gaskin	4
Catering Supervisor - Ann Gillick	3
Quality Officer 4 hrs/week -Caroline Murnane	1
ENT NCHD - Dr Lulianna Moariu	1

Appendix 10 -------Terms of Reference - Infection Control Committee

Creation Date: March 2014 **Chairperson:** Mr Danny Dunne CEO

Committee Members:

CEO (Chair)	Consultant Microbiologist	CNS Infection Control
Nursing Administration	Theatre Manager	CDU Manager
Pharmacist	Quality Officer	IC Link Nurse
Catering Manager	Risk Health and Safety Department	

Committee Reports To: Integrated Risk Quality & Safety Committee

Frequency of Meetings: Four times per year **Schedule of Meetings:** Quarterly

Quorum for Meeting: 50% of membership plus one. Meetings cannot be held in the absence of a quorum.

Distribution of Agenda and Minutes:

- Agenda is to take the form of matters arising from the previous minutes with a few added items at the commencement of the meeting.
- The agenda and any relevant supporting documents will be circulated in advance of the meeting.
- Minutes shall be taken of the proceedings & presented at the next meeting of the Committee for approval.
- A summary report will be prepared for submission to the Integrated Risk, Quality & Safety Committee

Role & Objectives of the Committee:

- Review and approve the annual infection prevention and control programme
- Advise and support the Infection Prevention and Control Team (IPCT) in the implementation of the programme
- Advise on resource requirements for the Infection Prevention & Control Programme
- To produce an annual report on Infection Prevention & Control
- To produce and review Infection Prevention & Control policies and guidelines regularly
- To audit the implementation of Infection Control Policies and Guidelines
- To promote and facilitate the education of all grades of hospital staff in Infection Prevention and Control
- To participate in national healthcare associated infection surveillance schemes, in addition to locally agreed surveillance programs including alert organism surveillance
- To provide advice and support during outbreaks and review outcomes
- To review and approve all infection prevention and control aspects of decontamination policies
- To provide relevant reports to Quality, Risk, Health & Safety
- To comply with legislative requirements i.e. Safety, health, Welfare at work Act 2005.
- To support and monitor the implementation of national standards policies and guidelines.

Appendix 10 – Infection Control Audit Summary - March 2014

Infection Control Audits March 2014	DCU	WW	HLW	ENT OPD	A&E	EYE OPD	OT
Waste Management	85%	100%	91%	77%	82%	90%	91%
Linen Audit	79%	75%	82%	n/a	n/a	n/a	75%
Handling and Disposal of Sharps Audit	86%	85%	92%	92%	96%	96%	96%
Hand Hygiene facilities	90%	95%	94%	75%	90%	87%	87%
Use of Personal Protective Equipment Audit	87%	93%	100%	90%	94%	94%	93%
Care of Patient Equipment	98.0%	88.0%	100.0%	100.0%	95.0%	96.0%	100%

For QIP & Action go to Infection Control shared drive on the hospital intranet.

Appendix 10 - Infection Control Audit Summary – September 2014

Audit Summary Table	Sep-14							
	DCU	In-patient	HLW	ENT OPD	A&E	EYE OPD	Pacu	OT
Waste Handling and Disposal Audit	87%	100%	100%	83%	89%	76%	91%	87%
Linen Audit	66%	75%	91%	N/A	N/A	N/A	60%	75%
Handling and Disposal of Sharps Audit	91%	100%	100%	96%	100%	100%	92%	96%
Hand Hygiene facilities & Audit	97%	81%	85%	94%	80%	82%	94%	92%
Use of Personal Protective Equipment Audit	94%	100%	100%	100%	100%	100%	94%	100%
Management of Patient Equipment Audit	100%	100%	100%	100%	100%	100%	97%	100%

For QIP & Action go to Infection Control shared drive on the hospital intranet.

Appendix 11 - Operating Theatre & CDU Bacterial Counts 2014

The 2014 Bacterial Audit Counts
Acceptable Level: ≤25 CFU per 90mm agar plate per hour. Colony Forming Units (CFU)
Bacterial counts are taken in the Central Decontamination Unit (CDU) every four months. These include settle plates (bacterial and fungal) and surface contact plates. All were within acceptable ranges. (copies of these results are hels by the CDU manager and the IPCT).

Settle Plates February 2014

Acceptable levels 0-20cfu					
	Trolley	Ledge	Attendees		Air con on
ENT OT 1	25	19	4		yes
ENT OT 2	11	1	2		yes
EYE OT 1	10	10	2		yes
EYE OT 2	10	16	4		yes
EYE OT 3	4	6	0		yes

Settle Plates May 2014

Acceptable levels 0-20cfu					
	Trolley	Ledge	Attendees		Air con on
ENT OT 1	7	8	5		yes
ENT OT 2	6	0	4		yes
EYE OT 1	7	15			yes
EYE OT 2	9	5	4		yes
EYE OT 3	23	15	4		yes

Comment [s1]: Remove red colour as this is <

Settle Plates August 2014

Acceptable levels 0-20cfu					
	Trolley	Ledge	Attendees		Air con on
ENT OT 1	25	33	2		yes
ENT OT 2	3	13	7		yes
EYE OT 1	7	16	3		yes
EYE OT 2	14	15	5		yes
EYE OT 3	13	15	4		yes

Settle Plates November 2014

Acceptable Levels 0-20cfu						
	Trolley	Ledge	avg	Antendees	Air Con	
ENT OT 1	25	8	16		No	in use
ENT OT 2	16	11	13.5		No	in use
EYE OT 1	6	10	8		Yes	in use
EYE OT 2	2	2	2		Yes	in use
Eye OT 3	6	17	11.5			

Appendix 12 - HIQA Inspection Aug 2014 - Summary of findings

HIQA paid an unannounced visit to the hospital on the 20/3/2014. The unannounced inspection focused specifically on observation of the day-to-day delivery of hygiene services and in particular environment and equipment cleanliness and adherence with hand hygiene practice. Overall the units visited were seen as clean and it was observed that the hospital demonstrated a steady improvement in hand hygiene performance. However, they noted that the hospital needs to build on compliances achieved to date regarding hand hygiene, to ensure that good practice is improved and maintained, and national targets are sustained.

HIQA Summary

Summary The risk of the spread of Healthcare Associated Infections is reduced when the physical environment and equipment can be readily cleaned and decontaminated. It is therefore important that the physical environment and equipment is planned, provided and maintained to maximise patient safety. The Day Care Unit and the West Wing Ward were clean and well maintained with some exceptions. The Automatic Endoscope Reprocessor unit, which was installed but not operational at the time of the 2013 inspection, was fully commissioned and validated. Environmental and equipment hygiene on the West Wing Ward was also improved compared to the previous inspection. Hand hygiene is recognised internationally as the single most important preventative measure in the transmission of Healthcare Associated Infections in healthcare services. It is essential that a culture of hand hygiene practice is embedded in every service at all levels. In general terms, the Royal Victoria Eye and Ear hospital has demonstrated a steady improvement in hand hygiene performance in national audits, but a fall in performance levels was observed in the October 2013 audit. The hospital has worked hard to ensure that all elements of the WHO multimodal strategy to promote hand hygiene practices are in place. The hospital needs to build on compliances achieved to date regarding hand hygiene, to ensure that good hand hygiene practice is improved and maintained, and national targets are sustained. The Royal Victoria Eye and Ear Hospital must now revise and amend its quality improvement plan (QIP) that prioritises the improvements necessary to fully comply with the Infection, Prevention and Control Standards. This QIP must be approved by the service provider's identified individual who has overall executive accountability, responsibility and authority for the delivery of high quality, safe and reliable services. The QIP must be published by the Hospital on its website

within six weeks of the date of publication of this report and at that time, provide the Authority with details of the web link to the QIP. It is the responsibility of the Royal Victoria Eye and Ear Hospital to formulate, resource and execute its QIP to completion. The Authority will continue to monitor the hospital's progress in implementing its QIP, as well as relevant outcome measurements and key performance indicators. Such an approach intends to assure the public that the Hospital is implementing and meeting the Infection Prevention and Control Standards and is making quality and safety improvements that safeguard patients.

Appendix 13

DGSA June 2014 Overall Comment

The level of compliance with the regulations and guidelines associated with the segregation, handling, storage and transport of dangerous goods was found to be good on the day of the audit.

In particular the following areas are to be commended:

- Management of clinical waste documentation for previous clinical waste consignments.
- Management of primary clinical waste compound.
- Segregation of healthcare waste and the safe storage of chemical products in the Operating Theatre.
- Availability of safety data sheets and documented chemical agent risk assessments in Catering Services.
- Tag traceability system in the Stores department.

The following non compliances relating to Infection control were as follows:

June 2014 DGSA Report>>>> Summary	
Waste Management **Observation 1**	The documented waste management policy requires updating to remove all references to C1 forms and to include references to current waste and transport legislation.
Recommendation	Update the current waste management policy to include references to the current waste and dangerous goods transport regulations. Remove all references to obsolete documents i.e. C1 forms. The documented waste policy is to be signed off and implemented by key personnel at the hospital.
Observation 2	One 17.5 litre purple lidded sharps bins located in the primary clinical waste compound was not signed upon closure.
Recommendation	Relevant staff to be reminded of the hospital policy that all sharps bins are to be signed upon assembly and closure. Sharps bins should not be collected from the wards unless signed upon both assembly and closure.

DGSA Report>>>> Summary	
Hospital Wards **Observation 3**	The door to the sluice rooms located in the Harvey Lewis Wing were found to be left open. In addition, sharps bins located in the Night Accident and Emergency room were found to be unsecured on the day of the audit. In accordance with section 7.1 of the *DOHC Segregation, Packaging and Storage Guidelines on Healthcare Risk Waste 2010*; it is recommended that healthcare risk waste packaging is secured against unauthorised access when not in immediate use.
Recommendation	Inform relevant staff that healthcare risk waste should be stored in a safe and secure manner to ensure clinical waste bins and sharps waste cannot be accessed by unauthorised personnel.

DGSA Report>>>> Summary	
Obsevation 4	One sharps bin located in the Night Accident and Emergency room was not signed upon assembly.
Recommendation	Remind relevant staff of the importance signing of sharps bins upon assembly and closure

DGSA Report>>>> Summary	
Observation 6	A segregation poster was not erected in the sluice room of the Harvey Lewis ward to communicate to staff the correct procedure for the segregation of healthcare waste.
Recommendation	A waste segregation poster is to be erected in the sluice room of the Harvey Lewis ward.

All the above were acted on and corrected.

Summary of December 2014 DGSA report

Overall Comment

- The level of compliance with the regulations and guidelines associated with the segregation, handling, storage and transport of dangerous goods was found to be good on the day of the audit.
- The following areas are to be commended from the audit:
- Retention of healthcare risk waste consignment documentation.
- Healthcare risk waste segregation practised in the ward areas.
- Secure, signed and locked chemical storage in the Catering and Maintenance department.
- Management of the medical gas cylinder storage cage and manifold rooms.
- Completed chemical agent risk assessments in the Catering Department.

Observation 1	One 4kg purple lidded sharps bin located in the healthcare risk waste compound did not have a traceability tag fitted. The sharps bin originated in the Eye Theatre. In accordance with DOHC guidelines all waste packaging must be fitted with a unique traceability tag allowing the waste packaging to be traced back to the department of origin.
Recommendation	Brief Theatre staff that all sharps bin must have a waste traceability tag attached prior to consignment to the waste compound.
Observation 5	Healthcare risk waste segregation poster was not available for staff reference in the treatment room of Eye OPD.
Recommendation	Source new healthcare risk waste segregation posters from SRCL and erect in all areas where healthcare risk waste packagings are in use.
Observation 18	One purple lidded 4kg sharps bin not signed and dated upon assembly in ENT. It is hospital policy that all sharps bins are signed and dated upon assembly and locking.
Recommendation	Remind Theatre staff that all sharps bins must be signed and dated upon assembly and locking as per the hospital waste policy.

All the above non compliances were corrected.