Working as a neonatal network to undertake enhanced peer review of infection prevention and control

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PATIENT SAFETY
Working together

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Infection control is at the core of patient safety. Ensuring that an environment has robust infection prevent and control measures for the neonatal patient group is essential for safe care. A network approach utilising 'new eyes' methodology can support simple actions and changes that make significant safety improvements for infants in neonatal units.

In 2013, the North Central and North East London Neonatal Operational Delivery Network (ODN) Lead Nurses and Practice Educators' subgroup initiated a project focused on infection control and improvements for the neonatal clinical environment. The aim of the project was to support a positive network approach, allow shared learning and improve the safety for the infants in our care.

The subgroup came up with an innovative idea of undertaking an enhanced audit looking at infection control and prevention across 13 of the 15 units in the network (two of the 15 units were due to merge with other units and were therefore not included).

The audit concept supported a peer review project and utilisation of the well-researched and best practice 'new' or 'fresh' eyes approach.[1,2] Within the ODN there are close and collaborative working relationships across traditional boundaries that had matured to allow openness, transparency and shared learning opportunities; by using a vehicle for networking, such as a pan-network audit, it was recognised that there would be patient safety benefits for all the units in the ODN.

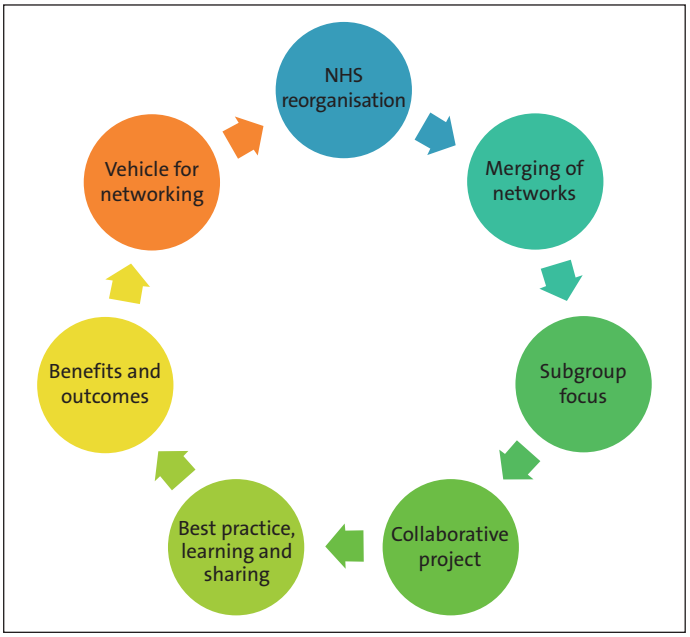

FIGURE 1 The factors influencing the audit project.

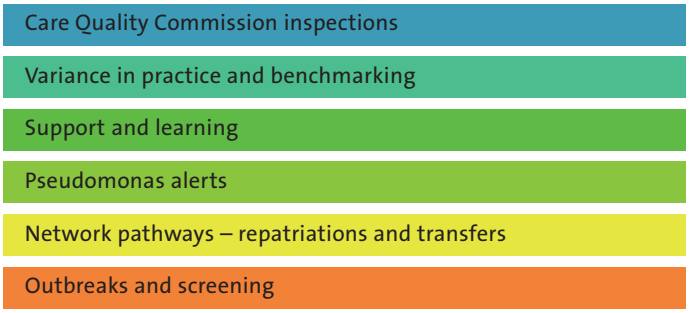

FIGURE 2 Key drivers for the audit.

A number of factors influenced the audit project (**FIGURE 1**) but the main driver was the embracement of patient safety as a key outcome. Following a literature review to identify relevant publications an audit tool was designed, with a focus on infection prevention and control in neonatal care that incorporated national safety alerts and learning from outbreaks of Pseudomonas in augmented care units. Specific pan-London and national key drivers at the time the audit was defined were carefully considered and are shown in **FIGURE 2**.

The audit tool was designed with a reference indicator for each audit point and with seven key areas for audit:

1. Entrance to the neonatal intensive care unit (NICU)
2. Entrances to nurseries and side rooms
3. At the cot sides in the nurseries and side rooms
4. Baby hygiene
5. Equipment cleaning
6. The milk kitchen
7. Isolation practice

The lead nurse from the East of England ODN tested the tool to facilitate in-practice critique. The North Central and North East London Neonatal ODN lead nurses performed the audit over the following year. Immediate verbal feedback was given after the audit was completed in each unit. This was followed-up with:

- a full compliance summary
- a percentage score from the audit score system

- an action plan that supported changes for each service to enhance infection control measures and patient safety.

Sharing of good practice was considered essential and at each subgroup meeting the ongoing audit was included as an agenda item allowing the lead nurses to share and learn from the audits that had already taken place. This approach supported momentum and enthusiasm and gave immediate 'wins' for all the ODN units. Good practices that were discovered in each and every unit were highlighted at all subgroup meetings.

Once the audit was complete, a full report of the findings was shared and key recommendations were agreed by the subgroup (**TABLE 1**).

1	The audit tool and process should be shared with other neonatal ODNs in the UK.
2	Individual neonatal units in the ODN should review and assess their services and practices again, looking at the improvement and shared learning points in the enhanced audit report.
3	Expansion of 'new eyes' approaches for areas of care across the ODN should be proactively encouraged and include peer reviews and collaborative working to uplift standards and outcomes for neonatal care.
4	Monitoring and incorporation of national policy for infection control in the NICU should be the role of the unit's infection control leads.
5	Dedicated staffing for cleaning of equipment in all NICUs should be included in the unit's staffing establishment to support patient safety in the service. The audit identifies the following whole time equivalent (WTE) allocations recommended by the ODN subgroup: Local and special care units = 2.0 WTE NICU = 4.5 WTE
6	Development of a neonatal breast milk storage and checking care bundle for pan-network use.

TABLE 1 Key recommendations that resulted from the pan-network audit.

Summary

Including the audit as part of the ODN work plan supported a proactive patient safety approach and gave immediate learning and reflection for all of the units that were audited.

Without exception the lead nurses were welcomed into every unit in the ODN; the attitude of the unit matrons and lead nurses was an inspiration to the value of networking and a credit to each of the units.

A full report of the audit will be published on the Neonatal ODN website for London, which launches at the end of March.[3] The North Central and North East London Neonatal Operational Delivery Network is happy to share the audit tool and reference base with other networks, and discuss how to best undertake the audit process.

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References

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3. **Neonatal Operational Delivery Network for London.** [Online]. Available from: www.londonneonatalnetwork.org.uk (from April 2015).