Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

National Hygiene Services Quality Review 2008

Mid Western Regional Hospital (St Jospeh's)

Assessment Report

Assessment date: 29th September 2008

About the Health Information and Quality Authority

The Health Information and Quality Authority is the independent Authority which was established under the Health Act 2007 to drive continuous improvement in Ireland's health and social care services. The Authority was established as part of the Government's overall Health Service Reform Programme.

The Authority's mandate extends across the quality and safety of the public, private (within its social care function) and voluntary sectors. Reporting directly to the Minister for Health and Children, the Health Information and Quality Authority has statutory responsibility for:

Setting Standards for Health and Social Services *– Developing person-centred standards, based on evidence and best international practice, for health and social care services in Ireland (except mental health services)*

Monitoring Healthcare Quality *– Monitoring standards of quality and safety in our health services and implementing continuous quality assurance programmes to promote improvements in quality and safety standards in health. As deemed necessary, undertaking investigations into suspected serious service failure in healthcare*

Health Technology Assessment *– Ensuring the best outcome for the service user by evaluating the clinical and economic effectiveness of drugs, equipment, diagnostic techniques and health promotion activities*

Health Information *– Advising on the collection and sharing of information across the services, evaluating, and publishing information about the delivery and performance of Ireland's health and social care services*

Social Services Inspectorate *– Registration and inspection of residential homes for children, older people and people with disabilities. Monitoring day- and pre-school facilities and children's detention centres; inspecting foster care services.*

1 Background and Context

1.1 Introduction

In 2007, the Health Information and Quality Authority (the Authority) undertook the first independent National Hygiene Services Quality Review. The Authority commenced its second Review of 50 acute Health Service Executive (HSE) and voluntary hospitals in September 2008.

The aim of the Review is to promote continuous improvement in the area of hygiene services within healthcare settings. This Review is one important part of the ongoing process of reducing Healthcare Associated Infections (HCAIs) and focuses on both the service delivery elements of hygiene, as well as on corporate management. It provides a general assessment of performance against standards in a range of areas at a point in time.

The Authority's second *National Hygiene Services Quality Review* assessed compliance for each hospital against the National Hygiene Standards and assessed how hospitals are addressing the recommendations as identified in the 2007 National Hygiene Services Quality Review.

All visits to the hospitals were unannounced and occurred over an eight-week period. The Authority completed all 50 visits by mid-November 2008. The *National Hygiene Services Quality Review 2008* provides a useful insight into the management and practice of hygiene services in each hospital.

Following the Authority's Review last year, every hospital was required to put in place Quality Improvement Plans (QIPs) to address any shortcomings in meeting the Standards.

Therefore, in considering this background, the Authority would expect hospitals to have in place well established arrangements to meet the Standards and the necessary evidence to demonstrate such compliance as part of their regular provision and management of high quality and safe care.

Consequently, the Authority requested a number of sources of evidence from hospitals in advance of a site visit and this year the unannounced on-site review was carried out, with the exception of one hospital, within a 24-hour period – rather than the three days taken last year. The Authority also stringently required that all assertions by hospitals – for example, the existence of policies or procedures – were supported by clear, documentary evidence.

This "raising of the bar" is an important part of the process. It aims to ensure that the approach to the assessment further supports the need for the embedding of these

Standards, as part of the way any healthcare service is provided and managed, and also further drives the move towards the demonstration of accountable improvement by using a more rigorous approach.

It must therefore be emphasised that the assessment reflects a point in time and may not reflect the fluctuations in the quality of hygiene services (improvement or deterioration) over an extended period of time. However, patients do not always choose which day they attend hospital. Therefore, the Authority believes that the one-day assessment is a legitimate approach to reflect patient experience given that the arrangements to minimise Healthcare Associated Infections (HCAIs) in any health or social care facility should be optimum, effective and embedded 24 hours a day, seven days a week.

Individual hospital assessments, as part of the *National Hygiene Services Quality Review 2008*, provide a detailed insight into the overall standard of each hospital, along with information on the governance and management of the hygiene services within each hospital. As such, the Review provides patients, the public, staff and stakeholders with credible information on the performance of the 50 Health Service Executive (HSE) and voluntary acute hospitals in meeting the *National Hygiene Services Quality Review 2008: Standards and Criteria.* The reports of each individual hospital assessment, together with the National Hygiene Services Quality Review 2008, can be found on the Authority's website, www.hiqa.ie.

Hygiene is defined as:

"The practice that serves to keep people and environments clean and prevent infection. It involves the study of preserving one's health, preventing the spread of disease, and recognising, evaluating and controlling health hazards. In the healthcare setting it incorporates the following key areas: environment and facilities, hand hygiene, catering, management of laundry, waste and sharps, and equipment."

Irish Health Services Accreditation Board Hygiene Standards

1.2 Standards Overview

There are 20 Standards divided into a number of criteria, 56 in total, which describe how a hospital can demonstrate how the Standard is being met or not. To ensure that there is a continual focus on the important areas relating to the delivery of high quality

and safe hygiene services, 15 Core Criteria have been identified within the Standards to help the hospital prioritise these areas of particular significance.

Therefore, it is important to note that, although a hospital may provide evidence of good planning in the provision of a safe environment for promoting good hygiene compliance, if the assessors observed a clinical area where patients were being cared for that was not compliant with the Service Delivery Standards and posed risks for patients in relation to hygiene that weren't being effectively managed, then a hospital's overall ratings may be lower as a result.

The Standards are grouped into two categories:

(a) Corporate Management

These 14 Standards facilitate the assessment of performance with respect to hygiene services provision to the organisation and patients/clients at organisational management level. They incorporate the following four critical areas:

- Leadership and partnerships
- Environmental facilities
- Human resources
- Information management.

(b) Service Delivery

These six Standards facilitate the assessment of performance at service delivery level. The Standards address the areas of:

- Evidence-based best practice and new interventions
- Promotion of hygiene
- Integration and coordination of services
- Safe and effective service delivery
- Protection of patient rights
- Evaluation of performance.

The full set of Standards are available on the Authority's website, www.hiqa.ie.

Core Criteria:
To ensure that there is a continual focus on the principal areas of the service, 15 Core Criteria have been identified within the Standards to help the organisation and the hygiene services to prioritise areas of particular significance. Scoring a low rating in a Core Criterion can bring down the overall rating of a hospital even if, in general, they complied with a high number of criteria. It is worth emphasising that if serious risks

were identified by the assessors, the Authority would issue a formal letter to the hospital in relation to these risks.

1.3 Assessment Process

There are three distinct components to the *National Hygiene Services Quality Review 2008* assessment process: pre-assessment, on-site assessment, following up and reporting.

Before the onsite assessment:

- **Submission of a quality improvement plan (QIP) and accompanying information by the hospital to the Authority.** Each hospital was requested to complete a Quality Improvement Plan. This QIP outlined the plans developed and implemented to address the key issues as documented in the hospital's Hygiene Services Assessment Report 2007.
- **Off-site review of submissions received**. Each Lead Assessor conducted a comprehensive review of the information submitted by the hospital.
- **The Authority prepared a confidential assessment schedule**, with the assessment dates for each hospital selected at random.
- **Selection of the functional areas.** The number of functional areas selected was proportionate to the size of the hospital and type of services provided. At a minimum it included the emergency department (where relevant), the outpatient department, one medical and one surgical ward.

  The hospitals were grouped as follows:
  - Smaller hospitals (two assessors) – minimum of two wards selected
  - Medium hospitals (four assessors) – minimum of three wards selected
  - Larger hospitals (six assessors) – minimum of five wards selected.

During the assessment:

- **Unannounced assessments.** The assessments were unannounced and took place at different times and days of the week. All took place within one day, except for one assessment that ran into two days for logistical reasons. Some assessments took place outside of regular working hours and working days.

- Assessments were undertaken by a **team of Authorised Officers** from the Authority to assess compliance against the National Hygiene Standards. Health Information and Quality Authority staff members were authorised by the Minister of Health and Children to conduct the assessments under section 70 of the Health Act 2007.

- **Risk assessment and notification.** Where assessors identified specific issues that they believed could present a significant risk to the health or welfare of patients, hospitals were formally notified in writing of where action was needed, with the requirement to report back to the Authority with a plan to reduce and effectively manage the risk within a specified period of time.

Following the assessment:

- **Internal Quality Assurance**. Each assessment report was reviewed by the Authority to ensure consistency and accuracy.

- **Provision of an overall report to each hospital, outlining their compliance with the National Hygiene Standards**. Each hospital was given an opportunity to comment on their individual draft assessment in advance of publication, for the purpose of factual accuracy.

- **All comments were considered** fully by the Authority prior to finalising each individual hospital report.

- **Compilation and publication of the National Report** on the *National Hygiene Services Quality Review*.

1.4 Patient Perception Survey

During each assessment the assessors asked a number of patients and visitors if they were willing to take part in a national survey. This was not a formal survey and the sample size in each hospital would be too small to infer any statistical significance to the findings in relation to a specific hospital. Results from the questionnaires were analysed and national themes have been included in the National Hygiene Services Quality Review 2008.

1.5 Scoring and Rating

Evidence was gathered in three ways:

1. **Documentation** review – review of documentation to establish whether the hospital complied with the requirements of each criterion
2. **Interviews** – with patients and staff members
3. **Observation** – to verify that the Standards and Criteria were being implemented in the areas observed.

To maximise the consistency and reliability of the assessment process the Authority put a series of quality assurance processes in place, these included:

- Standardised training for all assessors
- Multiple quality review meetings with assessors
- A small number of assessors completing the assessments
- Assessors worked in pairs at all times
- Six lead assessors covering all the hospitals
- Ratings determined and agreed by the full assessment team
- Each hospital review, and its respective rating, was quality reviewed with selected reviews being anonymously read to correct for bias.

On the day of the visit, the hospital demonstrated to the Assessment Team their evidence of compliance with all criteria. The evidence demonstrated for each criterion informed the rating assigned by the Authority's Assessment Team. This compliance rating scale used for this is shown in Table 1 below:

Table 1: Compliance Rating Score

A	The organisation demonstrated exceptional compliance of greater than 85% with the requirements of the criterion.
B	The organisation demonstrated extensive compliance between 66% and 85% with the requirements of the criterion.
C	The organisation demonstrated broad compliance between 41% and 65% with the requirements of the criterion.
D	The organisation demonstrated minor compliance between 15% and 40% with the requirements of the criterion.
E	The organisation demonstrated negligible compliance of less than 15% with the requirements of the criterion.

This means the more A or B ratings a hospital received, the greater the level of compliance with the standards. Hospitals with more C ratings were meeting many of the requirements of the standards, with room for improvement. Hospitals receiving D or E ratings had room for significant improvement.

2 Hospital findings

2.1 Mid Western Regional Hospital, Nenagh – Organisational Profile[1]

The Mid Western Regional Hospital, Nenagh, serves mainly the adult population of North Tipperary for acute medical and surgical conditions. The hospital has 75 in-patient beds and 6 day beds.

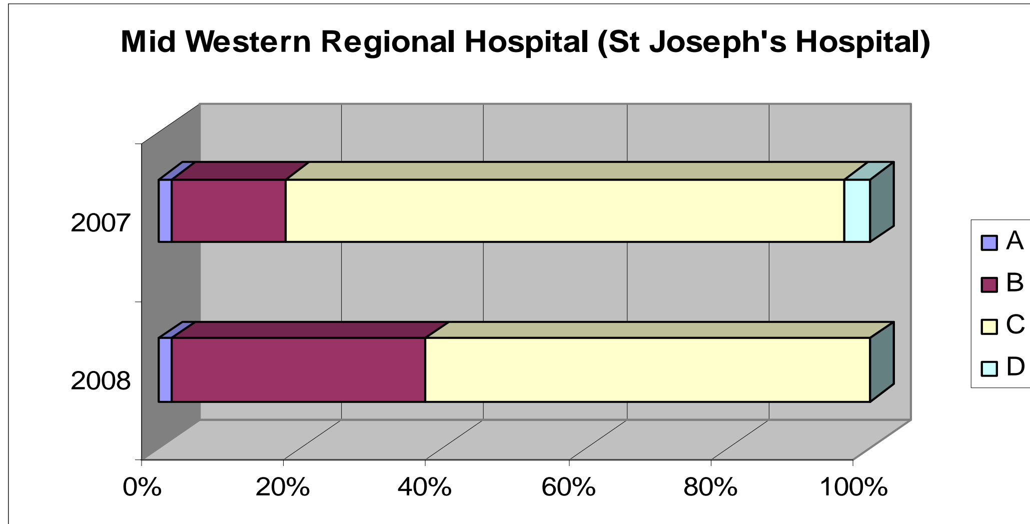
2.2 Areas Visited

- Emergency department
- Outpatient department
- Male Surgical
- Female Medical
- Waste compound
- Laundry service.

[1] The organisational profile was provided by the hospital

2.3 Overall Rating

The graph below illustrates the organisation's overall compliance rating for 2008 and its overall rating for 2007. Appendix A at the end of this report illustrates the organisation's ratings for each of the 56 criteria in the 2008 National Hygiene Services Quality Review, in comparison with 2007. See page 8 for an explanation of the rating score.



An overall award has been derived using translation rules based on the number of criterion awarded at each level. The translation rules can be viewed in the National Report of the National Hygiene Services Quality Review 2008. Core criteria were given greater weighting in determining the overall award.

Mid Western Regional Hospital (St Joseph's) has achieved an overall rating of:

Fair

Award date: 2008

2.4 Standards for Corporate Management

The following are the ratings for the organisation's compliance against the Corporate Management standards, as validated by the Assessment Team. The Corporate Management standards allow the organisation to assess and evaluate its activities in relation to hygiene services at an organisational level.

PLANNING AND DEVELOPING HYGIENE SERVICES

CM 1.1 Rating: C (41- 65% compliance with this criterion)

The organisation regularly assesses and updates the organisation's current and future needs for Hygiene Services.

- There was evidence demonstrated of a regional Hygiene Corporate Strategic Plan (2007-2009) for the Mid Western Acute Hospitals. There was evidence to demonstrate that there was a three monthly operational plan in place for hygiene services developed by the Hygiene Services Committee.
- The organisation advised that the Clinical Nurse Manager 2 in each department was responsible for identifying their hygiene needs. This process was not demonstrated.
- The organisation demonstrated that they had recently developed a Hygiene Services Team, who were responsible for assessing hygiene needs.
- There was evidence demonstrated that two representatives of the hospital were members of the regional Steering Committee on Hygiene and Cleanliness for the network.
- There was evidence demonstrated of a Capital Development Plan which informed the hygiene needs for the organisation.
- There was no structured process demonstrated for the regular assessment and updating of current and future needs of hygiene services.
- No formal evaluation process of the efficacy of the needs assessment process was demonstrated.

CM 1.2 Rating: C (41- 65% compliance with this criterion)

There is evidence that the organisation's Hygiene Services are maintained, modified and developed to meet the health needs of the population served based on the information collected.

- The organisation demonstrated that they had recently implemented a Hygiene Services Team and there was evidence demonstrated of increase communication in clinical areas in relation to hygiene services.
- There was evidence of a recent introduction of a three monthly Operational Plan developed by the Hygiene Services Committee. There was evidence

demonstrated that the 2007 National Hygiene report was used to inform the 2008 action plan and a progress report was demonstrated.
- There was no evidence demonstrated of evaluation of the developments and modifications to the organisation's hygiene services in relation to meeting the service user's needs.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1 Rating: C (41- 65% compliance with this criterion)

The organisation links and works in partnership with the Health Service Executive, various levels of Government and associated agencies, all staff, contract staff and patients/clients with regard to hygiene services.

- The organisation advised that the Hygiene Services Committee linked with the Network Manager and the Health Service Executive through the regional Steering Committee for Hygiene and Cleanliness. This was not demonstrated.
- There was evidence demonstrated that the Assistant Director of Nursing attended the Regional Steering Committee meetings.
- There was evidence demonstrated that a patient satisfaction survey was introduced in July 2008. There as evidence that this included one question on hygiene.
- The organisation advised that monthly discussions with staff occurred regarding the results. However, no minutes of the discussion were demonstrated.
- There was no formal evaluation of the linkages and partnerships demonstrated.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 Rating: C (41- 65% compliance with this criterion)

The organisation has a clear corporate strategic planning process for Hygiene Services that contributes to improving the outcomes of the organisation.

- A regional hygiene corporate strategic plan (2007-2009) for the Mid Western Acute Hospitals was demonstrated. There was no evidence of a hospital hygiene corporate strategic plan. There was evidence of a three monthly Operational Plan in place. The organisation advised that the corporate responsibility for the hygiene service rests jointly with the Director of Nursing, and the Hospital Manager, supported by the Hygiene Services Committee.

- There was no evidence of evaluation of the 2007 hygiene corporate strategic plans, goals, objectives and priorities against defined needs was demonstrated.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.1 **Rating: C** (41-65% compliance with this criterion)

The Governing Body and its Executive Management Team have responsibility for the overall management and implementation of the Hygiene Service in line with corporate policies and procedures, current legislation, evidence based best practice and research.

- The organisation advised that the corporate responsibility for the Hygiene Service rested jointly with the Director of Nursing and the Hospital Manager, supported by the Hygiene Services Committee. Documented evidence of this was not demonstrated.
- There was no Executive Management Team for the demonstrated. There was evidence to demonstrate that household staff report to the Director of Nursing. There was no evidence of a household supervisor in place.
- There was evidence to demonstrate that the Clinical Nurse Managers 1 have responsibility for hygiene in their area.
- There was evidence demonstrate that the weekly education sessions on hygiene/infection control were in place for hospital attendants.
- There was evidence demonstrated that the Hygiene Services Committee was multidisciplinary in composition and included the Director of Nursing and Hospital Manager.
- There was evidence that the Infection Control Committee met quarterly. There was evidence that Hygiene Services was included; minutes were recorded and circulated to staff.
- There was no evaluation of the appropriateness of review of authority provisions for hygiene demonstrated.

CM 4.2 **Rating: C (41- 65% compliance with this criterion)**

The Governing Body and / or its Executive Management Team regularly receive useful, timely and accurate evidence or best practice information.

- There was evidence demonstrated that the hospital staff had access to the Irish Acute Hospitals Cleaning Manual and there was evidence demonstrated of infection control manuals in the clinical areas.
- There was no evidence of key performance indicators (KPIs) developed for hygiene services.

- There was evidence demonstrated that the Hospital Manager received information in relation to risk and infection control on a monthly basis.
- No evidence of the evaluation of the appropriateness of the information received was demonstrated.

CM 4.3 Rating: B (66-85% compliance with this criterion)

The Governing Body and/or its Executive Management Team access and use research and best practice information to improve management practices of the Hygiene Service.

- There was evidence demonstrated that there was a library and Internet access available to all staff. There was evidence demonstrated that staff had access to a research officer in the region.
- The Infection Control Nurse met weekly with household staff to discuss issues and provide training. This was demonstrated.
- There was evidence demonstrated that the Infection Control Nurse audited staff and public hand hygiene practices. Evidence was provided to demonstrate that feed back was provided to the Hygiene Services Committee.
- The organisation demonstrated that they had begun the process of evaluation and training, however this had not been formalised.

CM 4.4 Rating: B (66-85% compliance with this criterion)

The organisation has a process for establishing and maintaining best practice policies, procedures and guidelines for Hygiene Services.

- There was evidence demonstrated of an organisational approach to the development of Policies, Procedures and Guidelines (PPGs). Infection Control Guidelines were evidenced to be in line with this standard format.
- There was evidence that the Irish Acute Hospitals Cleaning Manual was in place.
- There was evidence that a senior nurse manager was in the process for reviewing policies.
- There was no evidence demonstrated of a documented process for the approval, revision and control of all policies procedures and guidelines relating to hygiene services.
- No evaluation of the efficacy of the process for developing and maintaining policies, procedures and guidelines was demonstrated.

CM 4.5 Rating: C (41- 65% compliance with this criterion)

The Hygiene Services Committee is involved in the organisation's capital development planning and implementation process

- The organisation demonstrated that the Infection Control Team and all relevant clinical/hygiene staff were involved in capital development planning, and this was evidenced through the Theatre and Hospital Sterile Services Project. There was evidence of this in the Hygiene Services Committee meeting minutes where senior management were members. There was no evidence of a documented process for consultation of the Hygiene services pre development of existing sites demonstrated.
- No evaluation of the efficacy of the process between the Hygiene Services Committee and senior management was demonstrated.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

***Core Criterion**

CM 5.1 Rating: B (66-85% compliance with this criterion)

There are clear roles, authorities, responsibilities and accountabilities throughout the structure of the Hygiene Services.

- The organisation advised that the corporate responsibility for the Hygiene Service rested jointly with the Director of Nursing and the Hospital Manager supported by the Hygiene Services Committee. Documented evidence of this was not demonstrated.
- The organisation advised that the Hospital Manager and Assistant Director of Nursing represented the hospital on the Regional Steering Committee on Hygiene and Cleanliness and the Hospital Manager and Director of Nursing are members of the Hygiene Services Committee. This was not demonstrated.
- There was evidence demonstrated that the roles, in relation to hygiene services, of the Clinical Nurse Managers 1 & 2 were clearly defined in their job descriptions.
- There was evidence that the Assistant Director on night duties, nursing and porter job descriptions identified responsibility for hygiene.
- The hospital had been zoned for cleaning purposes.
- There was no evidence demonstrated of reporting relationships for all members of the Hygiene Services Team.

***Core Criterion**

CM 5.2 Rating: A (> 85% compliance with this criterion)

The organisation has a multidisciplinary Hygiene Services Committee.

- The organisation demonstrated compliance of greater than 85% with the requirements of this criterion.

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

***Core Criterion**

CM 6.1 Rating: C (41- 65% compliance with this criterion)

The Governing Body and/or its Executive/Management Team allocate resources for the Hygiene Service based on informed equitable decisions and in accordance with corporate and service plans.

- There was evidence demonstrated that the organisation allocated resources on an informal basis to meet hygiene needs.
- This was evidenced through the deep cleaning processes that were ongoing.
- There was no evidence of a formal process in place to allocate resource.

CM 6.2 Rating: C (41- 65% compliance with this criterion)

The Hygiene Services Committee is involved in the process of purchasing all equipment / products.

- There was evidence to demonstrate the involvement of the Hygiene Services Committee in the pre-purchasing of equipment and products.
- There was no evidence of formal process for the involvement of the Hygiene Services Committee in purchasing.
- No evidence of evaluation of the efficacy of the consultation process between the Hygiene Services Committee and senior management was demonstrated.

MANAGING RISK IN HYGIENE SERVICES

***Core Criterion**

CM 7.1 Rating: C (41- 65% compliance with this criterion)

The organisation has a structure and related processes to identify, analyse, prioritise and eliminate or minimise risk related to the Hygiene Service.

- There was evidence demonstrated that a Risk Manager had been recently recruited to the organisation.
- The organisation advised that the Environmental Health Officer reports were discussed by the Catering Supervisor with a senior member of nursing staff.
- There was some evidence of infection control audits and hand -hygiene audits.
- There was no evidence demonstrated of a Risk Management Committee. The organisation advised that there had been no adverse events for hygiene services in the last twelve months.
- There was evidence that an incident reporting form was in place, however there was no evidence demonstrated that each current incident/near miss was followed up. There was some evidence that risk was managed informally by the Hygiene Service Committee.
- There was evidence demonstrated that the health and safety representative had attended the Hygiene Services Committee meetings, however this was not formalised.
- There was no evidence demonstrated of a documented process for the management of incidents and near misses.

CM 7.2 Rating: C (41- 65% compliance with this criterion)

The organisation's Hygiene Services risk management practices are actively supported by the Governing Body and/or its Executive Management Team.

- There was some evidence demonstrated that hygiene services risk management practices were actively supported by the governing body. There was evidence of hygiene audits in place, however there was no evidence demonstrated that results were analysed and evaluated.
- The organisation advised that a STARSweb system was in place for recording incidents and near misses.
- There was no evidence of a risk management committee in place.
- There was no evidence of a risk management representative on the Hygiene Services Committee.

- There was some evidence that risks were addressed through the Hygiene Services Committee. However this was not formalised.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

***Core Criterion**

CM 8.1 Rating: B (66-85% compliance with this criterion)

The organisation has a process for establishing contracts, managing and monitoring contractors, their professional liability and their quality improvement processes in the areas of Hygiene Services.

- There was evidence demonstrated that there were no contract staff directly employed in the delivery of hygiene services for cleaning. There was evidence of contracts in place for existing contractors and these included waste disposal and water treatment services.
- There was some evidence demonstrated that these contractors were being managed through the technical services department.
- There was evidence of a documented process for establishing contracts, managing and monitoring contractors.

CM 8.2 Rating: B (66-85% compliance with this criterion)

The organisation involves contracted services in its quality improvement activities.

- The organisation advised that there were no regular contract staff employed in the provision of hygiene services.
- No evidence was demonstrated of involvement of contract staff. For example waste disposal contractors in quality improvement initiatives.

PHYSICAL ENVORNMENT, FACILITIES AND RESOURCES

CM 9.1 Rating: C (41- 65% compliance with this criterion)

The design and layout of the organisation's current physical environment is safe, meets all regulations and is in line with best practice.

- There was evidence demonstrated of a capital development plan in place.
- There was evidence that the Hygiene Services Committee had been involved in the planning to the changes in design and layout of the organisation. A

plan for the theatre/hospital sterile supplies department developments was demonstrated.
- It was observed that storage space was limited in the wards and kitchen areas. There was no evidence demonstrated that there was a plan to improve this.
- It was demonstrated that an outdated Hospital Safety Statement was in place, dated 2003. There was no evidence of an update demonstrated.

***Core Criterion**

CM 9.2 Rating: C (41- 65% compliance with this criterion)

The organisation has a process to plan and manage its environment and facilities, equipment and devices, kitchens, waste and sharps and linen.

- There was evidence of some processes in place to manage the environment and facilities, equipment and devices, kitchens, waste and sharps and linen.
- There was evidence of records demonstrating curtain changing as per policy.
- Colour coding was implemented for linen and waste. However, segregation was not always compliant with segregation policy.
- A flat mop system and high duster system were in place.
- There was evidence that cleaning method statements were under development.

CM 9.3 Rating: C (41- 65% compliance with this criterion)

There is evidence that the management of the organisation's environment and facilities, equipment and devices, kitchens, waste and sharps and linen is effective and efficient.

- There was evidence demonstrated of infection control audits and of sharps and waste audits in 2008.
- It was advised that the results of these audits were forwarded to the individual ward area, however there was no evidence of corrective actions being taken based on these findings.
- Hygiene Analysis and Critical Control Point standards were demonstrated.

CM 9.4 Rating: C (41- 65% compliance with this criterion)

There is evidence that patients/clients, staff, providers, visitors and the community are satisfied with the organisation's Hygiene Services facilities and environment.

- The organisation demonstrated that the Health Service Executive complaints process 'Your Service Your Say' was in place and provided patients and visitors opportunity to provide feedback.
- The organisation advised that there were no written complaints regarding Hygiene Services.
- The organisation advised that informal complaints were managed at ward level, however these were not demonstrated.
- There was evidence demonstrated of a patient satisfaction survey, however there was no evidence of analysis based on these surveys.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 Rating: B (66-85% compliance with this criterion)

The organisation has a comprehensive process for selecting and recruiting human resources for Hygiene Services in accordance with best practice, current legislation and governmental guidelines.

- The organisation advised that the regional human resources department recruited hygiene staff and advised that records were maintained in the central human resources office in Limerick.
- The organisation demonstrated that Human Resource Manager's guidelines were adhered to in the recruitment of temporary hygiene staff and records were demonstrated.
- There was evidence that job descriptions included hygiene services.
- No evaluation of the process for the selecting and recruiting of human resources was demonstrated.

CM 10.2 Rating: C (41- 65% compliance with this criterion)

Human resources are assigned by the organisation based on changes in work capacity and volume, in accordance with accepted standards and legal requirements for Hygiene Services.

- The organisation demonstrated that human resources had been assigned based on work capacity and volume. This was demonstrated in the

introduction of the cleaning zones and introduction of additional human resource needs for Theatre.
- No formal evaluation of the appropriateness of work capacity and volume was demonstrated.

CM 10.3 Rating: C (41- 65% compliance with this criterion)

The organisation ensures that all Hygiene Services staff, including contract staff, have the relevant and appropriate qualifications and training.

- The organisation demonstrated that they had recently developed an orientation /induction programme.
- There was no evidence demonstrated of specific qualifications requirement for staff demonstrated in their job specification.

CM 10.4 Rating: C (41- 65% compliance with this criterion)

There is evidence that the contractors manage contract staff effectively.

- It was demonstrated that were no contract staff directly employed in the delivery of hygiene services for cleaning.
- Waste disposal and water treatment contracts were demonstrated.
- The organisation used hygiene audits to monitor these services.

***Core Criterion**

CM 10.5 Rating: B (66-85% compliance with this criterion)

There is evidence that the identified human resource needs for Hygiene Services are met in accordance with Hygiene Corporate and Service plans.

- The organisation demonstrated that they had reviewed their human resource needs in the introduction of the zoning plan.
- There was evidence of an increased janitorial service to meet the hospital's needs.
- There was no evidence of formal evaluation.
- A Hygiene Services Annual report was not demonstrated.

ENHANCING STAFF PERFORMANCE

***Core Criterion**

CM 11.1 **Rating: B** (66-85% compliance with this criterion)

There is a designated orientation/induction programme for all staff which includes education regarding hygiene

- The organisation demonstrated that they had recently introduced an orientation /induction programme. The programme was being rolled out. This induction programme included infection control training.
- There was evidence that a staff handbook was being developed. This was in draft format.
- There was no evidence of evaluation of the induction programme.

CM 11.2 **Rating: C (41- 65% compliance with this criterion)**

Ongoing education, training and continuous professional development is implemented by the organisation for the Hygiene Services team in accordance with its Human Resource plan.

- There was evidence demonstrated that hygiene training was provided to staff. There was some evidence of training provided by an external agency in addition to that provided by the in-house infection control team.
- There was some evidence of evaluation of training through the use of audits. However there was no record of improvement based on the evaluation.
- Training records were demonstrated.

CM 11.3 **Rating: C (41- 65% compliance with this criterion)**

There is evidence that education and training regarding Hygiene Services is effective.

- There was evidence demonstrated that hygiene audits were ongoing and completed by the Infection Control Team. There was some evidence demonstrated that the audit results fed into training schedules where results scored low.
- There was no evidence demonstrated of staff satisfaction with education and training.

CM 11.4 Rating: C (41- 65% compliance with this criterion)

Performance of all Hygiene Services staff, including contract/agency staff is evaluated and documented by the organisation or their employer.

- There was evidence demonstrated that performance review for Hygiene Services staff was completed through audit and surveillance.
- There was no evidence of a documented process for Hygiene Services staff performance evaluation.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 Rating: B (66-85% compliance with this criterion)

An occupational health service is available to all staff

- There was evidence demonstrated of a regional occupational health service in place with service provision fortnightly to the hospital. There was evidence that vaccinations were available for all staff.
- No formal evaluation of the appropriateness of the service provided was demonstrated.

CM 12.2 Rating: C (41- 65% compliance with this criterion)

Hygiene Services staff satisfaction, occupational health and well-being is monitored by the organisation on an ongoing basis

- The organisation demonstrated that attendance and absenteeism was routinely monitored by the organisation.
- No performance indicators were demonstrated to monitor Hygiene Services staff satisfaction, occupational health and well being.
- There were no formal processes demonstrated for monitoring staff satisfaction.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.1 Rating: C (41- 65% compliance with this criterion)

The organisation has a process for collecting and providing access to quality Hygiene Services data and information that meets all legal and best practice requirements.

- Data collection processes were demonstrated and included infection rates, minutes of meetings audit reports and training records.
- The organisation advised that they had increased their information that was provided to the Primary, Community and Continuing Care.
- No formal evaluation process to establish reliability, accuracy, validity and appropriateness of the data was demonstrated.

CM 13.2 Rating: C (41- 65% compliance with this criterion)

Data and information are reported by the organisation in a way that is timely, accurate, easily interpreted and based on the needs of the Hygiene Services.

- The organisation demonstrated the data and information for Hygiene Services was reported via minutes of meetings and infection control records. It was advised that this information was timely.
- No evaluation of user satisfaction was demonstrated.

CM 13.3 Rating: C (41- 65% compliance with this criterion)

The organisation evaluates the utilisation of data collection and information reporting by the Hygiene Services team.

- There was evidence demonstrated that the organisation had assessed the appropriateness of data. This included the introduction of the rotas for curtain changing and introduction of checklist for cleaning.
- There was no evidence demonstrated of changes in data collection and information reporting over the last two years.
- There was no evidence demonstrated of formal evaluation.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

CM 14.1 Rating: B (66-85% compliance with this criterion)

The Governing Body and/or its Executive Management Team foster and support a quality improvement culture throughout the organisation in relation to Hygiene Services.

- The organisation demonstrated that management foster and support quality improvement culture. This was demonstrated through the recent establishment of the Hygiene Services Committee. It was demonstrated that a Risk Manager had recently been appointed.
- The organisation demonstrated that the responsibility for hygiene has been clearly defined in job descriptions.
- There was evidence of an external training agent providing hygiene training which was linked to audit results.
- Regional reports for infection control were demonstrated.
- There was evidence that a number of these initiatives were in an infancy stage and were yet to be embedded.

CM 14.2 Rating: B (66-85% compliance with this criterion)

The organisation regularly evaluates the efficacy of its Hygiene Services quality improvement system, makes improvements as appropriate, benchmarks the results and communicates relevant findings internally and to applicable organisations.

- The organisation demonstrated that it had developed a quality improvement plan (QIP) based on the findings from the 2007 Hygiene Services Quality Review of 2007.
- Many of these changes were demonstrated.
- The organisation demonstrated that the use of audits had resulted in some improvements to hygiene services and had begun the process of benchmarking these results.
- The organisation advised that audit reports were circulated to management.
- There was evidence demonstrated of a patient satisfaction survey, however there was no evidence of analysis based on these surveys.

2.5 Standards for Service Delivery

The following are the ratings for the organisation's compliance against the Service Delivery standards, as validated by the Assessment Team. The service delivery standards allow an organisation to assess and evaluate its activities in relation to hygiene services at a team level. The service delivery standards relate directly to operational day-to-day work and responsibility for these standards lies primarily with the Hygiene Services Team in conjunction with ward/departmental managers and the Hygiene Services Committee.

EVIDENCE BASED BEST PRACTICE AND NEW INTERVENTIONS IN HYGIENE SERVICES

SD 1.1 Rating: B (66-85% compliance with this criterion)

Best Practice guidelines are established, adopted, maintained and evaluated, by the team.

- There was evidence that the Irish Acute Hospitals Cleaning Manual was recently made available on the wards.
- There was evidence that protected time was provided for staff to attend training.
- A library was accessible to staff since May 2008. There was evidence of National guidelines available in the library.
- There was evidence of current cleaning policies in place.
- The Infection control policy was not current.
- There was some evidence of evaluation of polices through the audits, however this was not formalised.

SD 1.2 Rating: C (41- 65% compliance with this criterion)

There is a process for assessing new Hygiene Services interventions and changes to existing ones before their routine use in line with national policies.

- There was evidence of the trialling of different products prior to introduction.
- There was evidence of a template in place to evaluate new products, however, this had just been developed and had not been utilised.
- There was evidence of the zoning project which had been recently introduced for cleaning purposes had been informally evaluated.
- There was no evidence of reports of new/changed Hygiene Service interventions.

- There was no evidence of evaluation of the assessment process for new/ changed hygiene service interventions.

PREVENTION AND HEALTH PROMOTION

SD 2.1 Rating: B (66-85% compliance with this criterion)

The team in association with the organisation and other services providers participates in and supports health promotion activities that educate the community regarding Hygiene.

- There was evidence of the national visiting policy in place. The organisation advised that the media had been used to promote the visiting policy. There was evidence of a talking sign and hand-hygiene signs and information leaflets were observed.
- There was no evidence demonstrated of hygiene services activity in the community.
- Evaluation of the efficacy of the health promotion activities were not demonstrated.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1 Rating: B (66-85% compliance with this criterion)

The Hygiene Service is provided by a multidisciplinary team in cooperation with providers from other teams, programmes and organisations.

- There was evidence of a Hygiene Services Team in place which met fortnightly. The Terms of Reference were demonstrated for the team.
- Roles and responsibilities of each team member were not demonstrated.
- There was evidence that the minutes of the Hygiene Services Team were discussed at the Hygiene Services Committee.
- It was advised that the team membership was multidisciplinary, however this was not demonstrated.

IMPLEMENTING HYGIENE SERVICES

***Core Criterion**

SD 4.1 Rating: B (66-85% compliance with this criterion)

The team ensures the organisation's physical environment and facilities are clean.

- There was evidence that the hospital has been painted.
- There was evidence observed that documented cleaning processes were circulated on the day of the assessment.
- There was evidence of a de-cluttering schedule in place, however clutter was observed. Therefore cleaning was difficult. Sticky tape residue was observed in some areas.
- Records were demonstrated of curtain changes, however curtain changing was not demonstrated to be a systematic approach.

***Core Criterion**

SD 4.2 Rating: B (66-85% compliance with this criterion)

The team ensures the organisation's equipment, medical devices and cleaning devices are managed and clean.

- The equipment appeared to be clean in many areas, however there was no documented record of cleaning.
- There was evidence observed of an air hand-dryer still in use in one location.
- There was evidence that bedpan washers needed cleaning.
- Storage of urinals/wash basins needed attention.

***Core Criterion**

SD 4.3 Rating: B (66-85% compliance with this criterion)

The team ensures the organisation's cleaning equipment is managed and clean.

- Cleaning trolleys and equipment were observed to be generally clean, however many cleaning trolleys were observed to be stored in inappropriate areas and these need attention.

***Core Criterion**

SD 4.4 Rating: C (41- 65% compliance with this criterion)

The team ensures the organisation's kitchens (including ward/department kitchens) are managed and maintained in accordance with evidence based best practice and current legislation.

- Kitchens were observed to be clean in most areas.
- There was evidence that ward kitchens were deep cleaned every three months.
- Most bins appeared to be new, however many of the bin interiors were not clean.
- There was no separate toilet observed for food workers in ward areas, and no separate staff hand-wash sink was observed in one of the ward areas.
- There was evidence observed of meals already set up being stored on the corridor due to space issue in ward kitchens.
- No Personal Protective Equipment was observed.

***Core Criterion**

SD 4.5 Rating: C (41- 65% compliance with this criterion)

The team ensures the inventory, handling, storage, use and disposal of Hygiene Services hazardous materials, sharps and waste is in accordance with evidence based codes of best practice and current legislation.

- There was evidence observed that waste was segregated in line with best practice on some occasions.
- There was evidence observed of waste being stored in blue bins throughout the organisation and it was observed that one waste container had no bag.
- There was evidence that the waste compound was locked, however sub holding areas were observed not to be locked.
- Some waste containers were observed not to be clean.
- Waste was observed being handled without personal protective equipment.

***Core Criterion**

SD 4.6 Rating: C (41- 65% compliance with this criterion)

The team ensures the Organisations linen supply and soft furnishings are managed and maintained.

- Evidence was demonstrated that ward laundry processes were delivered in line with policy.
- There was evidence demonstrated of implementation of a recent curtain policy.
- The main laundry facilities were not in line with best practice. There was evidence observed that two washing machines were out of action. There was evidence demonstrated that the handling of clean and dirty laundry was not in accordance with best practice.

***Core Criterion**

SD 4.7 Rating: B (66-85% compliance with this criterion)

The team works with the Governing Body and/or its Executive Management team to manage hand hygiene effectively and in accordance with Strategy for the control of Antimicrobial Resistance in Ireland (SARI) guidelines.

- There was evidence of hand hygiene audits in place.
- Hand-hygiene training was not identified as being mandatory.
- Hand-hygiene techniques were observed not to be in line with best practice.
- Wash-hand basins were mainly compliant with best practice standards, however an air hand dryer was demonstrated to be in use in one area.
- Hand-hygiene instructions were observed to be limited in some areas and alcohol hand rub product was observed not to be in place in some areas.
- There was evidence observed of a wrist watch being worn by laundry staff when hand-hygiene was being demonstrated.

SD 4.8 Rating: C (41- 65% compliance with this criterion)

The team ensures all reasonable steps to keep patients/clients safe from accidents, injuries or adverse events.

- There was some evidence demonstrated that the team ensured all patients are safe from accidents, injuries or adverse advents.

- The organisation advised that twenty hygiene services staff had completed clean pass training. There was no evidence of a training schedule based on identified need, or a database to identify the hygiene training status of each hygiene staff member.
- There was evidence that the health and safety meetings reconvened in September 2008. No evidence was demonstrated that hygiene was discussed at these meetings. Monthly statistics of infections were circulated.
- The organisation advised that a Risk Manager position had recently been filled. There was no evidence of a risk management report for hygiene.

SD 4.9 Rating: B (66-85% compliance with this criterion)

Patients/Clients and families are encouraged to participate in improving Hygiene Services and providing a hygienic environment.

- There was evidence demonstrated of staff and public satisfaction survey.
- There was evidence of visitor guidelines and keypads which had been communicated through local media.
- Hand hygiene information was available and alcohol based hand gel was available at entrances.
- There was no evidence of evaluation of patients, clients and families satisfaction with participation in service delivery.

PATIENT'S/CLIENT'S RIGHTS

SD 5.1 Rating: B (66-85% compliance with this criterion)

Professional and organisational guidelines regarding the rights of patients/clients and families are respected by the team.

- The organisation demonstrated that visitor information leaflets were in place.
- No evidence of violation of patient rights was demonstrated.
- There was no evidence of a documented process for maintaining patient/client dignity during Hygiene Service delivery was demonstrated.

SD 5.2 Rating: C (41- 65% compliance with this criterion)

Patients/Clients, families, visitors and all users of the service are provided with relevant information regarding Hygiene Services.

- There was evidence demonstrated of a hand-hygiene talking sign, posters and information leaflets available to patients and visitors.
- There was evidence demonstrated that a new information handbook had been developed and had yet to be signed off.

SD 5.3 Rating: C (41- 65% compliance with this criterion)

Patient/Client complaints in relation to Hygiene Services are managed in line with organisational policy.

- There was evidence that the HSE complaints process 'Your Service Your Say' was in place.
- The organisation advised that informal complaints were not documented, however they were managed informally.
- The organisation advised that the recent appointment of a Risk Manager would support the complaints process. There was no evidence demonstrated.

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1 Rating: C (41- 65% compliance with this criterion)

Patient/Clients, families and other external partners are involved by the Hygiene Services team when evaluating its service.

- There was evidence that the organisation had completed a patient satisfaction survey, however action points were not demonstrated.
- There was no evidence of changes made to hygiene services over the past two years based on patient feedback.

SD 6.2 Rating: C (41- 65% compliance with this criterion)

The Hygiene Services team regularly monitors, evaluates and benchmarks the quality of its Hygiene Services and outcomes and uses this information to make improvements.

- There was evidence demonstrated of monthly peer audits and weekly self audits.
- Evidence was demonstrated of monthly infection control audits and weekly hygiene audits of the clinical areas. There was some evidence of follow up demonstrated.
- There was evidence demonstrated that the Clinical Nurse Manager reviewed cleaning checklists on a daily basis, however, this process was not formalised.
- There was evidence of a three month operational plan in place which was demonstrated as progressed through the Hygiene Services Committee.
- There was no evidence of Performance Indicators for Hygiene Services.

SD 6. 3 Rating: C (41- 65% compliance with this criterion)

The Multidisciplinary Team, in consultation with patients/clients, families, staff and service users, produces an Annual Report that is received and signed off by the Board or Senior Management Team as applicable.

- There was no evidence of a defined Annual Report for 2007. There was evidence however of ongoing feedback in relation to audits and the process of benchmarking of reports had begun.

Appendix A: Ratings Details

The table below provides an overview of the individual ratings for this hospital on each of the criteria, in comparison with the 2007 Ratings.

Criteria	2007	2008
CM 1.1	C	C
CM 1.2	C	C
CM 2.1	C	C
CM 3.1	C	C
CM 4.1	B	C
CM 4.2	C	C
CM 4.3	C	B
CM 4.4	C	B
CM 4.5	C	C
CM 5.1	C	B
CM 5.2	C	A
CM 6.1	C	C
CM 6.2	C	C
CM 7.1	C	C
CM 7.2	D	C
CM 8.1	C	B
CM 8.2	C	B
CM 9.1	D	C
CM 9.2	C	C
CM 9.3	C	C
CM 9.4	C	C
CM 10.1	C	B
CM 10.2	C	C
CM 10.3	C	C
CM 10.4	C	C
CM 10.5	C	B
CM 11.1	B	B
CM 11.2	C	C
CM 11.3	C	C
CM 11.4	C	C
CM 12.1	B	B
CM 12.2	C	C
CM 13.1	C	C
CM 13.2	C	C
CM 13.3	C	C

Criteria	2007	2008
CM 14.1	C	B
CM 14.2	C	B
SD 1.1	C	B
SD 1.2	C	C
SD 2.1	B	B
SD 3.1	C	B
SD 4.1	C	B
SD 4.2	B	B
SD 4.3	C	B
SD 4.4	B	C
SD 4.5	B	C
SD 4.6	B	C
SD 4.7	A	B
SD 4.8	C	C
SD 4.9	C	B
SD 5.1	C	B
SD 5.2	C	C
SD 5.3	B	C
SD 6.1	C	C
SD 6.2	C	C
SD 6.3	C	C