Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Hygiene Services Assessment Scheme

Assessment Report October 2007

Cork University Hospital

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1.0 Executive Summary

1.1 Introduction

This is the first National Hygiene Services Assessment Scheme (HSAS.) It is a mandatory scheme for all acute hospitals. The scheme aims to enhance cultural change in the area of hygiene services by not only focusing on the service delivery elements but also emphasising the importance of standards for corporate management. The HSAS is a patient-centred scheme which assists a hospital to prioritise the key areas in hygiene to be addressed. It is intended to promote a culture of best practice and continuous quality improvement.

The Irish Health Services Accreditation Board developed these, the first set of National Hygiene Assessment Standards in 2006. This development plan involved an extensive desktop review of national and international best practice literature, working groups and extensive consultation. The feedback from these development components formed the final draft Standards and Assessment Process, which were then piloted in a number of acute hospitals. *(The Irish Health Services Accreditation Board was subsumed into the Health Information and Quality Authority in May 2007.)*

The Hygiene Services Assessment Scheme (HSAS) was launched by the Minister for Health Mary Harney on the 6th November 2006.

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" [1-4]

More specifically, the Hygiene Services Assessment Scheme incorporates the following:

- Environment and Facilities: incorporates the condition of the building and all its fixtures, fittings and furnishings.
- Hand Hygiene: incorporates hand washing, antiseptic hand-rub and surgical hand antisepsis.
- Catering: incorporates kitchens (including ward kitchens) fixtures and fittings and food safety.
- Management of Laundry: incorporates management of linen and soft furnishings both in-house laundry and external facilities.
- Waste and Sharps: incorporates handling, segregation, storage and transportation.
- Equipment: incorporates patient, organisational, medical and cleaning equipment.

1.1.1 Standards Overview

The standards are divided into two sections: Corporate Management and Service Delivery. Each standard is divided into a number of criteria. These are specific steps, activities or decisions that must occur to achieve the standard.

The 14 Corporate Management standards facilitate the assessment of performance with respect to hygiene services provision to the organisation and patient clients at organisational management level. These standards commence at the planning stage and follow through to governing, implementation and evaluation. They incorporate four critical areas:

- Leadership and Partnerships
- Management of the Environment and Facilities
- Management of Human Resources
- Information Management.

The six Service Delivery standards facilitate the assessment of performance at team level. The standards address the following areas:

- Evidence based best practice and new interventions
- Prevention and Health Promotion
- Integration and coordination of hygiene services
- Implementing safe, efficient and effective hygiene services
- Protection of patient/clients rights
- Assessing and Improving performance. [5]

The standards and process have been assessed and internationally accredited by the International Society for Quality in Healthcare (ISQua).

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.

In the Corporate Management standards, the core criteria cover:

> Allocation of resources, accountability, risk management, contract management and human resource management.

In the Service Delivery standards, core criteria cover:

> Waste management, hand hygiene, kitchens and catering, management of linen, equipment, medical and cleaning devices and the organisation's' physical environment.

1.1.2 Rating Scale

The rating of individual criterion is designed to assist self-assessment teams and the organisation in general, to prioritise areas for development. The rating for the criterion can be determined based on the percentage level of compliance.

The rating scale utilised by the Hygiene Services Assessment Process is a five-point scale:

A **Compliant - Exceptional**

- There is evidence of exceptional compliance (greater than 85%) with the criterion provisions.

B **Compliant - Extensive**

- There is evidence of extensive compliance (between 66% and 85%) with the criterion provisions.

C **Compliant - Broad**

- There is evidence of broad compliance (between 41% and 65%) with the criterion provisions.

D **Minor Compliance**

- There is evidence of only minor compliance (between 15% and 40%) with the criterion provisions.

E **No Compliance**

- Only negligible compliance (less than 15%) with the criterion provisions is discernible.

N/A **Not Applicable**

- The criterion does not apply to the areas covered by the Self Assessment Team. Rationale must be provided. This cannot be used for a core criterion.

1.1.3 Assessment process components

The assessment process involves four distinct components:

- **Preparation and self assessment undertaken by the organisation.**

The self-assessment process allows an organisation to systematically evaluate its hygiene services against a set of best practice standards. This was completed by a multidisciplinary team(s) over a period of two months. This process was preceded by regional education sessions.

- **Unannounced assessment undertaken by a team of external assessors**

The HIQA has recruited senior professionals from the areas of medicine, nursing and corporate management as assessors, in addition to independent senior professionals with specialist knowledge in the core areas. To assure consistency across all sites four leaders were chosen from this group to cover all unannounced visits. The assessor's performance was regularly evaluated based on feedback from participating organisations, HIQA staff and other assessors.

Site visits for the larger academic teaching hospitals were completed over 2.5 days with four assessors, and assessments were completed in the smaller hospitals over 2 days with three assessors. The assessment team were responsible for identifying the organisation's compliance with the standards and helping to guide its improvement.

The assessment included a comprehensive documentation review, meetings with management, staff and patients. Throughout the assessment process the assessors worked as a team to cross reference their findings. This ensured that the ratings for each criterion were agreed upon and reflected an accurate picture of the organisation's level of compliance. Feedback was provided to the Chief Executive / General Manager and senior management team by the Assessment Team Leader, at the end of each day of the assessment.

- **Provision of an outcome report and determination of award status.**

The Internal Review Committee of the HIQA reviewed all the reports to ensure consistency, and based on the quantifiable translation guidelines, awards were made. Only organisation's which received a "very good" score were acknowledged with an award for the duration of one year. By the end of

October 2007 all 51 acute care hospitals had received a copy of their individual report.

At the same time the HIQA launched a National Report of the findings of all assessment reports. These standards are different from the first two hygiene audits, therefore a direct correlation of results were not possible.

- **Continuous Improvement**

Going forward a quality improvement plan should now be structured from the self assessment and recommendations from the external report. This will then be monitored by the HIQA.

The areas of notable practice, quality improvement plans, areas of priority action, overall score, criterion ratings and comment and are presented in the following pages of the report.

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[1] Boot, M and Cairncross, S "Actions Speak" Delft, The Netherlands, IRC and LSTHM, British Occupational Hygiene Society.
[2] New York Department of Health and Mental Hygiene
[3] The Columbia Electronic Encyclopaedia, Sixth Edition. Columbia University Press. 2003
[4] Irish Acute Hospitals Cleaning Manual, HSE (2006)
[5] Hygiene Services Assessment Scheme. Irish Health Services Accreditation Board (2006)

1.2 Organisational Profile

Cork University Hospital (CUH) is the principal teaching hospital attached to University College Cork. It has 611 beds (including 7-day, 5-day and 1-day beds). It operates as part of a citywide group of hospitals including St. Finbarr's Hospital, Erinville Maternity Hospital (whose services were subsumed into CUH following the assessment) and St. Mary's Orthopaedic Hospital. CUH also works in partnership with the Voluntary Hospitals, namely the Mercy University Hospital and the South Infirmary University Hospital.

Services provided
Cork University Hospital is the only Level 1 trauma centre for the Republic of Ireland. A wide range of specialities are delivered by the hospital, including: Cardiac services (Cardiology and Cardio-thoracic Surgery), Neurosciences, General Surgery and Urology, Ophthalmology, Emergency Medicine and Trauma Services, Radiotherapy and Oncology, Orthopaedics, Gynaecology, General Medicine including Medicine of the Elderly, Endocrinology/Diabetes, Gastroenterology, Nephrology (Renal Medicine), Respiratory Medicine, Rheumatology, Haematology, Pain Relief, Paediatrics Services and Dental Surgery.

The following assessment of Cork University Hospital took place between March 20th and 22nd, 2007. The hospital was revisited on 22nd June in order to complete the assessment programme in relation to the Catering Department. This department was undergoing immediate transfer on the dates of the original assessment.

1.3 Notable Practice

- The Household Induction Programme and the Household Cleaning Manual are of a high standard.
- The colour-coding system for personal protective equipment in ICU to prevent cross- infection is to be commended.
- The hygiene Task Sheet developed in dialysis with detailed responsibility for all grades is innovative.
- The draft Incident Report Policy is commendable.
- The new structure and layout of the kitchen is excellent.
- The Environmental Audit Tool is commendable.
- The Patient Satisfaction Survey Template is commendable.
- The general commitment and enthusiasm of staff in particular nursing and household is to be commended.

1.4 Priority Quality Improvement Plan

- Sharps disposal management (this was addressed during the assessment).
- The Male staff facilities require upgrading.
- Catering: during the revisit it was noted that the process of integrating all areas of the new department was on-going and it is recommended that the complete programme is completed with expediency. The Hazard Analysis and Critical Control Point Plan (HACCP) needs to be fully implemented, monitored and verified.

- Health promotion (hygiene-signage and hand gels) requires further development.
- Documentation Trail and Organisation requires further improvement.
- Effective on-going hygiene training and education is recommended.
- It is recommended that hygiene become a mandatory requirement on all service/executive meeting agendas.
- Clear co-ordination of hygiene as a function within the organisation is recommended.

1.5 Hygiene Services Assessment Scheme Overall Score

The decision mechanism used to translate an organisation's criteria, risk ratings to a Hygiene Service Assessment Scheme score is based on a quantitative analysis of the assessment results which ensures consistency of application. The decision regarding a score is made by the Internal Review Committee of HIQA, based on the findings of the Assessment Team; the Cork University Hospital has achieved an overall score of:

Fair

Award Date: October 2007

1.6 Significant Risks

CM 10.4 (Rating D)
There is evidence that the contractors manage contract staff effectively.

Potential Adverse Event
Suboptimal monitoring of the contractors could lead to breaches in appropriate duty of care.

Risks

Likelihood of Event	Rated: L (1)
Impact of Event	Rated: M (2)
Urgency of Action	Rated: H (3)
TOTAL	**Total: 6**

Recommendations
It is recommended that the organisation develops its on-site monitoring processes of all contractors providing a service to the organisation.

2.0 Standards for Corporate Management

The following are the ratings for 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. There are fourteen Corporate Management standards, all of which are focused on four critical areas: leadership and partnerships, environment and facilities, human resources and information management. They include such subjects as corporate planning, allocating and managing resources, enhancing staff performance and contractual agreements. There are eight core criteria within these standards.

PLANNING AND DEVELOPING HYGIENE SERVICES

CM 1.1 (B → B)

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

Hygiene strategies have been developed under the Hygiene Corporate and Service Plans. However these plans/objectives need to be incorporated in hospital-wide documentation as a core subject. A good patient/client satisfaction template is available.

CM 1.2 (C → C)

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.

It is clear that functional hygiene services issues are discussed at hospital capital project meetings, however, it is not clear who raises these as issues. There is no clear representative who submits/gives direction on the hygiene issues on capital projects.

Department service plans are available for some areas, though there was no cohesive agenda for hygiene planning. It is recommended an evaluation of developments and modifications to the organisation's hygiene services, in relation to meeting the service user's needs, is conducted.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1 (C → C)

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

There was evidence of inter-agency meetings available but no evidence of hygiene on the agendas. Good evidence of CUH's interaction with national hygiene processes was observed during the assessment. This was noted in the development of the hygiene services manual, introduction of colour coding and hand hygiene training. It is recommended that the team evaluate the potency of linkages and partnerships.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 (B → B)

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

There are clear management and departmental service plans and a Strategic Hygiene Plan. This high level plan needs to be included in the Hospital Strategic Plan and put on all hospital agendas for discussion and action. It is recommended that an evaluation of the Hygiene Corporate Strategic plans' goals, objectives and priorities against defined needs be undertaken.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.1 (C → C)

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.

Hygiene, as an issue in the hospital, is identified at the highest level but the evidence needs to be built in the minutes of meetings, agenda and actions. The hospital did provide evidence of the meetings of the Hygiene Service Committee and Team, the Clinical Nurse Managers' and Risk Management teams. Operational management of hygiene services is the responsibility of the Hygiene Services Manager. An evaluation of the Hygiene Services Team's adherence to legislation and national guidelines is undertaken.

CM 4.2 (C → C)

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

The Hospital Management Team receives all reports of sub committees in the hospital and receives national and international best practice guidelines. It is recommended that hygiene is considered a standard agenda item on all management meetings.

CM 4.3 (C → C)

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.

Best practice information, assessed by the management team, is circulated to all heads of departments, for example medical device alerts, national cleaning manual and Strategy for the control of Antimicrobial Resistance in Ireland (SARI) guidelines. These recommendations assist in the formulation of in-house hygiene action plans, for example colour coding and cleaning schedules.

CM 4.4 (B → B)

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

There is a hospital policy for the development of all hospital policies, procedures and guidelines which comply with recommendations. There is an automated policy control system in place. An evaluation of the potency of the process for developing and maintaining hygiene services policies, procedures and guidelines is recommended.

CM 4.5 (C → C)

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

No documentary evidence was presented to support the role of hygiene in capital development projects. However, at the team meeting, it was clear that there are processes in place to ensure representation on capital projects. Department heads have access, through their representative or by the Risk Manager, to the Capital Projects Team. Through this mechanism, hygiene issues, related to capital projects, were identified and progressed. It is recommended that an evaluation of the efficacy of the consultation process between the Hygiene Services Team and Senior Management be conducted.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

*Core Criterion

CM 5.1 (B ↓ C)

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

No evidence of job descriptions for supervisors/managers was observed during the assessment. Management structures are in place, however, some operational areas are undefined. There appeared to be no sense of an overall designated person to lead hygiene. It is recommended that a designated person be assigned in the near future.

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

*Core Criterion

CM 6.1 (C → C)

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.

The Hospital budget allocation is assigned according to staff budget, projects budgets, equipment and specific department budgets. No documentary evidence of a dedicated hygiene capital/replacement budget was observed. During the assessment team meeting, the Environmental Sub-group (Hygiene Services Committee) stated that they received funding for hygiene upgrades as part of the Hygiene Service Plan and Quality Improvement Plan (QIP). A planned process of hygiene upgrades is in place.

CM 6.2 (C → C)

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

A procurement policy exists for use in CUH, however, there is no evidence that the Hygiene Services Committee are either represented on the Hospital Procurement Team or that they channel any hygiene procurement issues through the committee. It is recommended that this area be further developed. Hygiene products are, at present, bought through the ward/department system of materials management. However it is intended that, as with the flat mop system, the Hygiene Committee will take a lead role in this area.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion
CM 7.1 (B → B)
The organisation has a structure and related processes to identify, analyse, prioritise and eliminate or minimise risk related to the Hygiene Service
A new Draft Incident Policy, which includes non-clinical event recording and specifically mentions hygiene related risk-reporting guidelines has been drawn up and the draft version is currently being reviewed by selected staff, including the Hygiene Services Team. It is recommended that this be progressed.

CM 7.2 (C → C)
The organisation's Hygiene Services risk management practices are actively supported by the Governing Body and/or its Executive Management Team.
No documented evidence to indicate that risk management issues/outcomes/ recommendations are a standing order on the Executive Management Board (EMB) was observed during the assessment. The Risk Manager contributes to the compilation of the annual report and also reports verbally three times a year to the EMB. No minutes were available. A Draft Incident Policy has been distributed for discussion. This new policy has a very comprehensive section for hygiene in the risk manual. It is recommended that an evaluation of the occurrence of major hygiene services adverse events over the last two years be conducted.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion
CM 8.1 (B ↓ C)
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.
The hospital complies with the National Procurement Policy and also with HSE South Procurement Policy. There is a Regional Procurement Department, which is used by the hospital. These policies include monitoring of contractors. There are a number of hygiene-related service contracts, including catering equipment, water coolers, theatre, and air conditioning. Records of services were available. No evidence of formal internal monitoring of contractors by the hospital was observed. It is recommended that a process be put in place and that the hospital monitor contractors.

CM 8.2 (C → C)
The organisation involves contracted services in its quality improvement activities.
There is evidence that the hospital involves its contractors in the decisions on services, not as quality improvement activity, but rather as a service requirement. There is evidence from capital project minutes of meetings that the contractors on-site are involved in the Capital Team meeting. There is also evidence, through Material Management, that contractors are involved in the evaluation and testing of new products before purchase.

PHYSICAL ENVORNMENT, FACILITIES AND RESOURCES

CM 9.1 (C → C)

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

The hospital is undergoing major on-site construction. These areas are being built in line with a major capital plan for the hospital and in line with modern building requirements.

*Core Criterion

CM 9.2 (C → C)

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

There are documented processes for the management of the environment and facilities, equipment and devices, kitchens, waste and sharps and linen. On both the site inspection and document search, it was decided appropriate to re-assess the main kitchens. Following a revisit, it is noted that the new facility is in very good condition, however attention to the principles of HACCP and upgrading of the processes in the department need to be continued. There are very well constructed and user friendly staff hygiene manuals. There are also well-defined and structured induction programmes for new staff.

CM 9.4 (B → B)

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

There is evidence that patient/client satisfaction surveys have been carried out, and that hygiene and cleanliness were included as questions in the survey. Three patients were interviewed during the assessment and discussed their hospital experience in CUH from a hygiene and cleanliness perspective. These patients stated that they had noticed, from their experience of previous admissions, an improvement in hygiene and access to hygiene services if required. On discussion with staff at ward and department level, the majority of staff stated that there was a marked awareness of hygiene issues, positive feedback and knowledge. On the ground, hygiene staff was well versed on their duties and responsibilities, had access to knowledge and were enthusiastic in their approach.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 (B → B)

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 hospital demonstrates full compliance with national and regional recruitment best practice. Job descriptions are available for HCA, household and porter staff but no evidence of specific responsibility for hygiene with other grade job descriptions was observed during the assessment. It is recommended that an evaluation of the process for selecting and recruiting human resources be conducted.

CM 10.2 (C → C)

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.

There is evidence that the Cleaning Strategy of 2001 has been effective in procuring additional hygiene staff. A Mobile Hygiene Services Team was set up in Summer 2006. It is available at short notice to deal with hygiene issues as they arise, and they also have a planned schedule of tasks to complete. This team has been very successful. A plan is in place to replace staff if absent, and it is recommended that this be developed. It is recommended that an evaluation of work capacity and volume review processes be undertaken.

CM 10.3 (C ↑ B)

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

Appropriate training manuals are available as are induction programmes and hygiene training. Records of same are kept at ward and departmental level. HACCP training is also provided.

CM 10.4 (B ↓ D)

There is evidence that the contractors manage contract staff effectively.

No documentary evidence was observed. The Assessment Team found no sense of where the contractors fit into the management and monitoring system at the hospital. There was no evidence that contract cleaning staff, or their supervisors, reported to a defined structure within the hospital. It is recommended that a process to monitor contractors, to ensure compliance with terms of contract, be developed and an evaluation of the appropriate use of contract staff be progressed.

*Core Criterion

CM 10.5 (C ↑ B)

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

CUH is staffed to the approved WTE Level. Replacement staff are approved for Statutory Leave. The Corporate Hygiene Plan identifies staffing needs. The Infection Control Nursing Strategy identifies IC nursing needs. Proposals are given to management for additional staff to service the hospital, based on needs assessment.

ENHANCING STAFF PERFORMANCE

*Core Criterion

CM 11.1 (C → C)

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

There are induction programmes developed for most grades of staff. Further development of the induction programme is required to specifically address hygiene as a stand-alone section. Induction is mandatory and attendance levels were noted during the assessment. Continuous on-going training is provided and a training matrix was noted.

CM 11.2 (C → C)

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

Education and training is available. However it was difficult to procure training records specifically relating to hygiene and hand hygiene. No central database of training was available and some departments had no records of training available. It is recommended that an evaluation of the relevance of education and training sessions regarding hygiene services be undertaken.

CM 11.3 (C → C)

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

The hospital reviews its hygiene effectiveness through internal and external hygiene audits, risk management incident results and complaint procedures. It is recommended that training and education programmes for hygiene and attendance at the courses be evaluated.

CM 11.4 (C → C)

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

The hospital adheres to the principles of the National Human Resources Recruitment Best Practice Guidelines and Policy. This provides performance review for new staff at defined periods during the probationary period, prior to permanent appointment. Temporary staff complete job progress review reports. It is recommended that the hospital inspect performance review procedures with the cleaning contractor for its staff. It is recommended that an evaluation of the number of hygiene services, including contract/agency staff undergoing performance evaluation, be undertaken.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (B ↓ C)

An occupational health service is available to all staff

An Occupational Health Service is available to all staff as is an employee assistance programme. There was clear knowledge from staff of the value and services of the Occupational Health Department. An evaluation of the appropriateness of the service provided is conducted.

CM 12.2 (C → C)

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

A “Wellness at work” programme is in place. A staff survey has taken place in one pilot area in relation to this programme. It is recommended that a hygiene services’ staff satisfaction survey be conducted.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.2 (C → C)

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.

Data is collected and discussed at ward/department level. The Hygiene Services Committee is currently commencing a review of the data. The Executive Management Board (EMB) is starting to receive hygiene data and information. It is recommended that the team conduct an evaluation of user satisfaction in relation to the reporting of data and information.

CM 13.3 (C → C)

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

The hospital has a mechanism, through the audit process, risk management and patient complaints' process to ensure that hygiene data is collected, collated and reported to appropriate management structures. Hygiene services collect and receive hygiene information, audit feedback, and compiles action plans and resultant actions. It is recommended that the team conduct an evaluation of data and information utilisation in relation to service provision and improvement.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

CM 14.1 (B ↓ C)

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

Some innovative awards systems are currently in place. A Quality Department and a Quality Manager, who has direct access to the Management Team, are in place.

CM 14.2 (C → C)

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 hospital has reviewed its previous internal and external audit reports and has adjusted its hygiene practice in line with the audit outcomes and best practice available. Examples of this include flat mopping, the mobile cleaning team and increased waste collections. It is recommended that the organisation continue to roll-out hygiene related data, best practice information and changes to hygiene practice, in accordance with the National Cleaning Manual. The team is encouraged to conduct an evaluation of improved outcomes in hygiene services delivery as a result of the Quality Improvement System.

3.0 Standards for Service Delivery

The following are the ratings for 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. There are six Service Delivery standards, which focus on such areas as prevention and health promotion, implementing hygiene services and patients / clients rights. There are seven core criteria within these standards.

EVIDENCE BASED BEST PRACTICE AND NEW INTERVENTIONS IN HYGIENE SERVICES

SD 1.1 (C → C)

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

There is suite of hygiene related policies, procedures and guidelines in place which has been updated and revised to include current best practice, as outlined in the National Cleaning Manual. Examples include Flat Mopping and formal work schedules. These policies are formulated in accordance with the hospital template for the development, revision and control of all policies at the hospital. There are also policies, procedures and guidelines in relation to national guidelines and published best practice for waste management, laundry and hand hygiene. Time must be allocated for staff to consult the documentation. It is recommended that an evaluation of the efficacy of processes, used to develop best practice guidelines by the Hygiene Services Team is undertaken.

SD 1.2 (C ↑ B)

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 is a process in place, through the National and Regional Procurement Policy, to ensure that the formal tender processes for new products at the hospital include pre-purchase and post purchase evaluation. Evidence was provided of evaluation of the new flat mopping systems and hand gels. The Flat mopping system was introduced March 2007, following a pilot evaluation. It is recommended that the hospital continue to develop its Quality Improvement Plan as stated, which will develop the same structures for localised contracts. It is recommended that an evaluation of the efficacy of the assessment process for new/changed hygiene services interventions be conducted.

PREVENTION AND HEALTH PROMOTION

SD 2.1 (C → C)

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

While there are hygiene gel stations throughout the hospital, the hand gels stations at the entrance were not very prominent. Hand hygiene posters and leaflets, were noted, and there were some great examples of children's art on hygiene posters throughout the hospital. There were MRSA, SARS and Norovirus leaflets available.
It is recommended that the hospital evaluate its community involvement in hygiene health promotion.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1 (B → B)

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

Evidence was provided of the membership, roles and responsibilities of the Hygiene Services Team, which is reflective of the interdisciplinary nature and the rationale of the team. The terms of reference, minutes and resultant actions were reflective of the linkages with all services throughout the hospital. The team also formally linked with the Theatre Governance Team and Hygiene Services Committee. There was good evidence of a multi-disciplinary team involvement in hygiene services. It is recommended that the hospital evaluate the efficacy of the hygiene team structure.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

SD 4.1 (C ↑ B)

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

In general, housekeeping levels of cleanliness were of a very good standard throughout. There was enthusiasm voiced by housekeeping staff for the higher profile of hygiene. However some dust was observed and there was poor quality of internal signage, lack of cleaning safety signs and some external areas require attention.
It is recommended that greater attention to high dusting, laminated signage, and use of safety signs be developed.

For further information see Appendix A

*Core Criterion

SD 4.2 (B → B)

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

In general items inspected were clean and processes were in place to ensure compliance and monitoring of the required standards. It was noted that some pulse oximeters were in a poor condition, and that some patient/client washbowls were damaged and not stored as recommended.

For further information see Appendix A

*Core Criterion

SD 4.3 (B ↑ A)

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

The hospital has a good system for the management of the household service equipment. Staff are informed and knowledgeable in their use, cleaning and had been appropriately trained. Household services, system and staff were found to be of a high standard. All cleaning equipment inspected was of a high standard.

For further information see Appendix A

*Core Criterion

SD 4.4 (B → B)

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.

The hospital kitchens were revisited following relocation, re-structuring and revamp. The new kitchen was of an exceptional standard. The hygiene standard was good during the assessment. The following Critical Control Points of the HACCP system need tighter control: cooling, thawing, hot holding and chill display.The HACCP system must be continually monitored and verified.

For further information see Appendix A

*Core Criterion

SD 4.5 (B ↑ A)

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.

Waste documentation and training was good. Issues in relation to inappropriate use of yellow healthcare risk bags were addressed during the assessment. Overfilled sharps containers were frequently noted. It is recommended that this matter be addressed.

For further information see Appendix A

*Core Criterion

SD 4.6 (B ↑ A)

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

The processes in place for the management of linen were of a very high standard.

For further information see Appendix A

*Core Criterion

SD 4.7 (B ↑ A)

The team works with the Governing Body and/or its Executive Management team to manage hand hygiene effectively and in accordance with SARI guidelines

Practical hand hygiene was of a high standard and good practice was observed in all clinical areas.

For further information see Appendix A

SD 4.9 (B ↓ C)

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

The hospital does not provide external hygiene consultation to the community but it does interact with its patient/clients and visitors on hygiene issues through hygiene stations, posters and leaflets on hand hygiene, MRSA, SARS and Norovirus. The hospital also uses information received from the public through patient satisfaction surveys, incident reporting and patient/client complaints. There is strong and visible adherence of the National Visiting Policy. This is managed by the Security Department, which has a full-time presence in the main hospital entrance. The organisation is encouraged to identify processes to enable patient/clients and families to participate in improving hygiene services and evaluate their satisfaction with participation in Service Delivery.

PATIENT'S/CLIENT'S RIGHTS

SD 5.2 (C → C)

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

A good visitor policy is in place but hygiene is not adequately promoted. Leaflets and posters were available at ward level in relation to hygiene. A patient/client satisfaction survey was in place but no evaluation and quality improvement plan was noted. It is recommended that an evaluation of patient/client, family and visitor’s comprehension and satisfaction with the information provided by the hygiene service team is conducted.

SD 5.3 (C → C)

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

The hospital has a policy on dealing with complaints. It is monitored, and a report was available. There is a plan to complete an annual report of complaints and incidents. It is recommended that an evaluation of patient/client complaints, relating to hygiene services is conducted.

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1 (C → C)

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

A Patient Satisfaction Survey was in use; however, changes in hygiene services as a result were not evident. This must be included in the Quality Improvement Plan.

SD 6.2 (C ↑ B)

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

The hospital received the EIQA award for 2006. There is an extensive internal auditing system in place which has resulted in a suite of Quality Improvement Plans. There is a Hygiene Committee and Team in place, who review internal audit results, evaluate and develop actions plans to address outstanding issues. It is recommended that the hospital be required to verify the HACCP system by way of internal audits.

SD 6.3 (C → C)

The multi-disciplinary team, in consultation with patients/clients, families, staff and service users, produce an Annual Report.

There is no hygiene annual report, however, a hospital annual report is produced. Risk management, complaints and hygiene are noted in the report. This is planned but not in place as of yet. Internal audits of the system in place should provide areas for improvement for the annual report. The team is encouraged to progress the development of a hygiene services annual report.

4.0 Appendix A

The following are the scores received for the Service Delivery core criteria compliance requirements. The organisation must provide evidence of exceptional compliance (greater than 85%) to achieve an 'A' rating. All 'core criteria' must have achieved an 'A' rating to receive a score of 'very good' and be acknowledged with an award.

4.1 Service Delivery Core Criterion

Compliance Heading: 4. 1 .1 Clean Environment

(1) The environment is tidy, well-maintained, free of rust, blood or body substances, dust, dirt, debris and spillages.
Yes - A major building project is under construction at the hospital. The areas assessed for this process did not include these areas.

(2) All high and low surfaces are free from dust, cobwebs and flaking paint.
No - High dusting needs attention.

(7) Areas should be adequately ventilated with ventilation units cleaned and serviced accordingly and documentation available regarding service.
No - High vents noted to be dusty and no service documentation was noted.

(8) All entrances and exits and component parts should be clean and well maintained.
No – The entrance was poorly controlled and needs cleaning.

(10) Internal and external signage should be clean, updated, well maintained and laminated to enable cleaning.
No - Internal and external signage is poorly laminated and maintained.

(13) External areas including grounds, gardens, footpaths, ramps and car parks should be clean and well-maintained.
No - Non-construction external areas were poorly maintained.

(15) Where present a designated smoking area must comply with the national legislation on tobacco control and local organisational policies, a cigarette bin must be available and the floor area should be free of cigarette ends, matches etc.
No - These areas were poorly controlled.

(29) A warning sign “cleaning in progress” must always be used, position to be effective.
No - Poor use of “cleaning in progress” signs was noted.

Compliance Heading: 4. 1 .2 The following building components should be clean:

(26) Nozzles of wall mounted alcohol gels and hand disinfectants must be cleaned daily.
Yes - Units inspected were noted to be clean but no documentation to support cleaning was observed.

Compliance Heading: 4. 1 .3 Organisational Buildings and Facilities (note: while list is not exhaustive, the following compliance is required):

(207) Bed frames must be clean and dust free
No - Bed frames observed were dusty at bed heads.

(209) Air vents are clean and free from debris.
No - Air vents were dusty and high cleaning is needed here.

Compliance Heading: 4. 1 .4 All fittings & furnishings should be clean; this includes but is not limited to:

(34) Beds and Mattresses
No - Bed head frames observed were dusty, however, beds were clean.

Compliance Heading: 4. 1 .5 Sanitary Accommodation

(46) Bathrooms / Washrooms must be cleaned on a daily basis. When necessary, they must be disinfected. This must be monitored and recorded.
No - No monitoring was noted and no checklists were available.

Compliance Heading: 4. 1 .6 All sanitary fixtures and appliances should be clean and well-maintained. This includes but is not limited to:

(52) Toilets and Urinals
Yes - Male staff facilities require more frequent cleaning.

(58) Sluice rooms should be free from clutter and hand washing facilities should be available.
No - Sluices are used for storage. Leaking taps were noted in some units, as was a lack of wash hand basins.

(60) All outlets (including shower outlets) should be flushed at a temperature in accordance with current legislation.
No - No records were available to verify this.

Compliance Heading: 4. 2 .1 Organizational Equipment and Medical Devices and Cleaning Devices (note: while list is not exhaustive, the following compliance is required):

(64) All equipment, including component parts, should be clean and well-maintained with no blood or body substances, rust, dust, dirt, debris and spillages.
No - Ivacs and pulse oximeters required greater attention to cleaning.

Compliance Heading: 4. 2 .2 Direct patient contact equipment includes

(66) Medical equipment e.g. intravenous infusion pumps, drip stands and pulse oximeters, suction apparatus and tubing, cardiac monitors, blood pressure cuffs, blood gas machines.
No - Pulse oximeters observed required greater attention to cleaning.

(69) Patient washbowls should be decontaminated between each patient, and should be stored clean, dry and inverted. Damaged washbowls should be replaced.
No - Some bowls observed were damaged and not inverted.

Compliance Heading: 4. 2 .3 Close patient contact equipment includes:

(80) All office equipment (e.g. telephones, computers, fax machines) should be clean and well-maintained.
No - Computer keyboards were dusty and required greater attention to cleaning.

(272) Splashes of water or hand-wash gel should not be present on the wall, floor, bed or furniture, splash backs should be provided.
Yes - No residue was observed on the surface, however, staining from the product was evident.

Compliance Heading: 4. 3 .1 Cleaning Equipment & Products (note: while list is not exhaustive, the following compliance is required):

(87) All cleaning equipment should be approved by the Hygiene Services Committee and ensure sufficient supply.
No - No evidence to verify this was available.

Compliance Heading: 4. 4 .1 Kitchens, ward/department kitchens & kitchen fittings/appliances (note: while list is not exhaustive, the following compliance is required):

(213) Environmental Health Officer (Senior EHO/EHO) reports on food safety inspections including the completed summary stage of compliance with HACCP and annual water analysis reports should be retained on the Hospital Food Safety Manual. Action plans/ actions taken on foot of issues raised in the reports should be documented.
Yes - Water is tested. The EHO report was available and most areas were good. However, a documented corrective action plan should be drawn up.

(214) The person in charge of catering shall develop, implement and maintain a permanent system based on the seven principles of HACCP. A standard HACCP Plan should be fully completed.
No - A new HACCP plan has been developed, but this must be more evident in the operational practices noted in the kitchen. Awareness of the plan needs improvement for example using signage. Internal audits must take place to assess compliance with the HACCP system. Tighter control of records of the Critical Control Points (CCPs) is required.

Compliance Heading: 4. 4 .2 Facilities

(217) Access to the main kitchen and ward kitchens should be restricted to designated personnel i.e. food workers.
Yes – An excellent new sensor-operated wash hand station is in place and visitor PPE is available at the kitchen entrance.

(220) Staff must not consume food or beverages intended for patient use, food should not be consumed in the ward kitchen and no food is to be routinely prepared in the ward kitchen other than beverages and toast.
Yes – In the majority, however, one staff member was noted with coffee in the kitchen.

(222) A wash hand basin should be provided at the ward kitchen, in addition to a sink, along with a liquid soap dispenser and hygienic hand drying (e.g. paper towels).
No - Some ward kitchens have no wash hand basins; however, a plan however is in place.

(223) Separate toilets for food workers should be provided.
Yes – A new toilet and locker rooms are provided, however, these were slightly untidy and require a cleaning checklist in place.

(224) The ventilation provided for all cooking and steam emitting equipment shall be sufficient to prevent condensation on walls, ceilings and overhead structures during normal operations.
Yes – The kitchen has a new system in place but was considered hot during the assessment.

(226) Containers used to store foods shall be made of food grade materials, be in good condition, easy to clean and disinfect.
Yes - Good systems were in place.

(227) Flour, cereals, sugar etc shall be stored in a dry environment and when opened stored in covered containers.
Yes - These products were stored correctly.

Compliance Heading: 4. 4 .3 Waste Management

(232) Waste storage containers shall be smooth, durable, easy to clean and disinfect, well maintained and closable.
Yes - Bins observed were clean.

Compliance Heading: 4. 4 .4 Pest Control

(238) Electric fly killer (EFK) units when used shall be located in an area free from draughts, away from natural light and not directly above an area where food or materials that come into contact with food are located. The EFK units shall be left on at all times and have shatter-proof sleeves. The ultraviolet (UV) light tubes shall be replaced at least annually and records of replacement should be retained. The EFK shall be fitted with a catch tray and emptied as required.
No - Units were well sited, however, the units over the sandwich preparation area and the pot wash at canteen were not operational.

Compliance Heading: 4. 4 .5 Management of Chill Chain in a Hospital

(240) A Hospital using a cook-chill system should comply with Guidance Note No. 15 Cook-Chill Systems in the Food Service Sector (Food Safety Authority of Ireland) The temperatures of fridges, freezers, cold rooms and chill cabinets shall be capable of maintaining the temperature of foodstuffs
No - Cook-chill records were not available during the initial tour of the kitchen. Chilling not adequately monitored for children's food at service area on the ward. All high-risk chilled food must be less than 5 degrees at this point.

(241) Ice cream display units can operate at -12℃ as long as it can be demonstrated that the product has been held at this temperature for less than 7 days.
Yes – None were observed in use.

(242) Temperatures for Food in Fridges / Freezers and Displays should comply with I.S.340:2006 requirements
No – The salad bar and chill display units were all outside temperature specifications. This is a Critical Control Point (CCP) and had not improved since the assessment in March 2007.

(243) Preparation of High Risk Foods should comply with I.S. 340:2006 requirements
Yes - Very good zoning was in place.

(244) Temperature for food when cooked, held or reheated should comply with I.S. 340:2006 requirements
No - Most of the dials on the hot holding units were not operational and hence temperatures were not monitored for these units.

Compliance Heading: 4. 4 .6 Food Preparation

(245) Cleaned and disinfected work surfaces, equipment and utensils shall be provided for preparing ready to eat foods and foods to be cooked to prevent the risk of contamination. In addition to the HSE hospital colour coded system (see Appendix 6 Irish Acute Hospitals Cleaning Manual 2006), the food colour coding of work surfaces, equipment and utensils should be provided for (see I.S. 340:2006).
No - Food contact surfaces and equipment were considered clean, however, floors in certain areas require deep cleaning. All sanitiser bottles must be labelled. Cleaning checks were not completed for the past two days.

Compliance Heading: 4. 4 .7 Food Processing

(246) The thawing of food shall be carried out under appropriate conditions such as in a thawing unit, a fridge or a microwave oven with thawing cycle
No - Food was thawed in a cold room but records of temperature should be maintained here.

Compliance Heading: 4. 4 .8 Food Cooking

(247) All foods shall be cooked to a temperature to ensure that the products are safe for consumption. The core temperature of the food shall be assessed at he thickest point of the food and should be compliant with I.S. 340:2006
Yes – All observed were greater than 75 degrees C.

Compliance Heading: 4. 4 .9 Food Cooling

(248) Cooling Times for Cooked Food should comply with I.S. 340:2006 requirements
Yes - The cooling times recorded were in compliance with IS 340.

Compliance Heading: 4. 4 .10 Plant & Equipment

(249) Machines should dispense ice but where ice-scoops are used, they should be stored separately from the ice-making machine and there should be a process for the appropriate decontamination of the ice scoops. The making of ice cubes other than in ice machines is prohibited.
Yes – None are in use.

(250) The dishwasher's minimum temperature for the disinfecting cycle should be compliant with I.S.340:2006 requirements and should be monitored regularly. There should be digital readouts on dishwashers.
Yes - Staff here were aware of rinse temperature. These were well recorded.

(251) All temperature probes shall be calibrated annually. Calibration may be carried out internally or externally (instrumentation firm). Documentation should be retained of the procedures used to control, calibrate and maintain inspection, measuring and test equipment used to demonstrate compliance with the HACCP Plan.
Yes - New probes are in use. These were calibrated and wipes were available.

Compliance Heading: 4. 5 .1 Waste including hazardous waste:

(142) Healthcare risk waste should be tagged and secured before leaving the area of production.
No - Untagged waste was observed in waste storage yard and clinical areas, however, this was addressed during assessment.

(144) Healthcare risk containers should only be filled up to the manufacturers' fill or line or maximum three quarters full.
No - Sharps bins were overfilled in many areas, which was addressed during the assessment.

Compliance Heading: 4. 5 .3 Segregation

(156) Healthcare risk waste must be segregated from healthcare non risk waste.
No - Healthcare risk waste and non-risk waste were observed together in cages and in sluice rooms awaiting collection. This was addressed during the assessment.

Compliance Heading: 4. 5 .5 Storage

(169) Documented process(es) for the replacement of all bins and bin liners.
No – This procedure is to be written.

Compliance Heading: 4. 6 .1 Management of Linen and Soft Furnishings (note: while list is not exhaustive, the following compliance is required):

(262) Linen is segregated into categories and in appropriate colour coded bags (i.e. clean/unused linen, dirty/used linen, dirty/contaminated linen).
No - Policy and practices were observed to be at variance.

Compliance Heading: 4. 7 .1 Management of hand hygiene (note: while list is not exhaustive, the following compliance is required):

(188) Hand and wrist jewellery should be removed prior to performing all levels of hand hygiene with the exception of a plain wedding band.
No - Jewellery was frequently observed.

(198) Hand hygiene posters and information leaflets should be available and displayed throughout the organization.
Yes – Good compliance was observed in clinical areas only.

(204) Hand wash sinks conform to HBN 95. They should not have plugs, overflows and the water jet must not flow directly into the plughole.
Yes - A planned programme is in place for sink replacement.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team		Assessor Team	
	FREQ	%	FREQ	%
A	0	00.00	4	07.14
B	20	35.71	15	26.79
C	36	64.29	36	64.29
D	0	00.00	1	01.79
E	0	00.00	0	00.00
N/A	0	00.00	0	00.00

5.2 Ratings Details

Criteria	Self Assessment	Assessor	Difference
CM 1.1	B	B	→
CM 1.2	C	C	→
CM 2.1	C	C	→
CM 3.1	B	B	→
CM 4.1	C	C	→
CM 4.2	C	C	→
CM 4.3	C	C	→
CM 4.4	B	B	→
CM 4.5	C	C	→
CM 5.1	B	C	↓
CM 5.2	B	B	→
CM 6.1	C	C	→
CM 6.2	C	C	→
CM 7.1	B	B	→
CM 7.2	C	C	→
CM 8.1	B	C	↓
CM 8.2	C	C	→
CM 9.1	C	C	→
CM 9.2	C	C	→
CM 9.3	C	C	→
CM 9.4	B	B	→
CM 10.1	B	B	→
CM 10.2	C	C	→
CM 10.3	C	B	↑
CM 10.4	B	D	↓
CM 10.5	C	B	↑
CM 11.1	C	C	→
CM 11.2	C	C	→
CM 11.3	C	C	→
CM 11.4	C	C	→
CM 12.1	B	C	↓

CM 12.2	C	C	→
CM 13.1	C	C	→
CM 13.2	C	C	→
CM 13.3	C	C	→
CM 14.1	B	C	↓
CM 14.2	C	C	→
SD 1.1	C	C	→
SD 1.2	C	B	↑
SD 2.1	C	C	→
SD 3.1	B	B	→
SD 4.1	C	B	↑
SD 4.2	B	B	→
SD 4.3	B	A	↑
SD 4.4	B	B	→
SD 4.5	B	A	↑
SD 4.6	B	A	↑
SD 4.7	B	A	↑
SD 4.8	C	C	→
SD 4.9	B	C	↓
SD 5.1	C	C	→
SD 5.2	C	C	→
SD 5.3	C	C	→
SD 6.1	C	C	→
SD 6.2	C	B	↑
SD 6.3	C	C	→