



**Health
Information
and Quality
Authority**

An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte

National Hygiene Services Quality Review 2008

Louth County Hospital Assessment Report

Assessment date: 15th 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 (HCAs) 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 Louth County Hospital – Organisational Profile¹

Louth County Hospital has a complement of 142 beds (including a 20-bedded Day Services Unit) and serves a catchment area with a population of over 90,000. The hospital opened in 1959 and is one of two hospitals in the Louth Hospital Group.

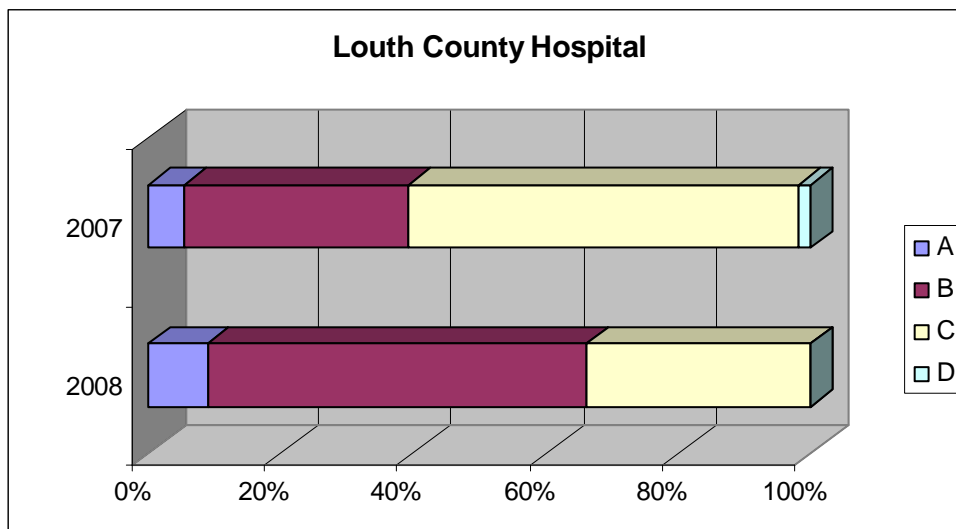
2.2 Areas Visited

- Emergency department
- Outpatient department
- Male Medical
- Surgical Ward
- Waste compound
- Laundry services.

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.

**Louth County Hospital 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.

- The organisation demonstrated that the organisation has developed a corporate strategic, service and operational plan for hygiene services.
- It was demonstrated that the hygiene needs-assessment is based on their service planning process.
- While there was evidence of a patient satisfaction survey there was no evidence demonstrated that the organisation had engaged with community partners, patients and clients in relation to future needs.
- There was no evidence demonstrated that feedback from the infection Control audits is used to assess the needs for hygiene services.
- There was no evidence demonstrated of a documented process for completion of the needs-assessment process.
- There was no evidence demonstrated of evaluation of the needs-assessment processes.

CM 1.2 Rating: B (66-85% 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.

- There was evidence that a number of initiatives have been developed in the past 12 months by the Hygiene Services Team as highlighted in the National Hygiene Services Quality Review report for 2007. These initiatives include improvements to one laundry room and the commission of the new theatre and the replacement programme for new hands hygiene facilities.
- These improvements were identified in the Hygiene Service Plan for 2008.
- There was no evidence demonstrated by the organisation of evaluation of these developments.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

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

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.

- The organisation has demonstrated that it links with the Health Services Executive network, and, through that structure with the Department of Health and Children in relation to hygiene services. There was no evidence demonstrated that this was a formalised process.
- There were documented processes in place to ensure the organisation works in partnership with the staff through the Hygiene Services Committee and Team.
- The minutes of these are maintained and are available to all staff and were observed.
- The organisation demonstrated that it has begun to formalise it's linkages with patient client groups through the comment and complaint system.
- There is no evidence demonstrated of staff satisfaction with hygiene services, nor has the organisation demonstrated that it has moved to formally evaluate the efficacy of the linkages now in place.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 Rating: B (66-85% 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.

- There was evidence demonstrated that the organisation has addressed the significant deficit outlined in the 2007 National Hygiene Services Quality Review report and produced evidence of a strategic plan for hygiene services for 2008 to 2010.
- It was advised through interview with staff members that they were involved to some degree in the development of these plans. This was not demonstrated.
- There was evidence demonstrated that the goals and objectives for hygiene service's are contained within the strategic plan and details of the Governing Body and Executive Management Team members' responsibility for the development of the hygiene corporate strategic plan was also demonstrated.
- It was demonstrated that the plan has been widely distributed throughout the hospital.
- It was demonstrated that evaluation of the hygiene corporate strategic plans and goals has recently commenced through the Continuous Quality Improvement (CQI) process. This process was not demonstrated as formalised.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.1 Rating: B (66-85% 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.

- It was demonstrated that the Hygiene Services Committee is responsible for the management of hygiene services locally as outlined in the corporate strategic plan for the Louth/Meath Hospital Group.
- It was demonstrated that the staff handbook includes the expected code of conduct for hygiene staff.
- It was demonstrated that plans to evaluate the efficacy of the authority provisions are at an early stage of development.
- There was no evidence demonstrated of a formalised approach to evaluate the team's adherence to legislation.

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.

- The organisation demonstrated evidence that there are many sources of information received by the Governing Body, however there was no evidence of formal key performance indicators developed for the hygiene services.
- There was evidence that best practice information has been reviewed by the governing body (for example the flat mopping system).
- There was no evidence of a formal evaluation of the information received.

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.

- The organisation demonstrated there was evidence of research and best practice available throughout the organisation, for example through the library, education sessions and newsletter including a hygiene awareness session.
- It was demonstrated that the Infection Control Department has provided hand hygiene training in line with best practice.
- It was demonstrated that some evaluation of best practice related research and best practice information was in place.
- There was no evidence demonstrated of resultant actions, feedback and continuous quality improvement.

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

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

- It was demonstrated that the hospital has a process in place through the Nurse Practice Development Unit to develop Policies, Procedures and Guidelines.
- It was advised that there is a regional policy in place for the development of Policies, Procedures and Guidelines.
- There was a lack of evidence demonstrated that all policies in place adheres to this framework.

CM 4.5 Rating: B (66-85% compliance with this criterion)

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

- There was evidence demonstrated of input from the Hygiene Services Committee and Team in the pre purchasing of equipment and the capital development process, for example, the sink replacement programme.
- There was extensive evidence of a multidisciplinary approach to same.
- The process has commenced for evaluation, however, this was not fully formalised and 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.

- There was some evidence demonstrated that there is a hygiene services structure in place and that some authorities, responsibilities and accountabilities are clearly defined. Details of roles, responsibilities and accountabilities are outlined within the corporate strategic plan.
- It was demonstrated that the hygiene services committee are in the process of ensuring that all job descriptions will include roles and responsibilities for hygiene services.
- Ward Managers' responsibilities and accountabilities for hygiene in their department was not 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 there is an incident reporting process in place to report hygiene services incidents.
- The regional Risk Management Department supports the Louth/Meath hospitals with local risk management support within the hospital.
- There was some evidence that the organisation discuss hygiene risks informally through the Hygiene Services Committee.
- It was advised that there was an annual report in place for risk management that includes hygiene services, however this was not demonstrated.
- There was no evidence demonstrated of a formal process in place to trend and track hygiene related risk in the organisation.

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.

- It was demonstrated that there is a regional Risk Management Department for the Louth/Meath group with local risk management support within the hospital.
- There was evidence demonstrated that risks are dealt with by the management of the hospital, however this process was not formalised and documented.
- There is limited evidence of a formalised approach to risks management and closure of the loop in relation to hygiene risks.

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 of processes in place for the establishment of contracts as per the procurement policy.
- The hospital has commenced the process of managing and monitoring contractors, minutes of recent meetings were demonstrated.

- There was no evidence of a documented process for establishing, managing and monitoring contractors and their professional liability in the area of hygiene services.

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

The organisation involves contracted services in its quality improvement activities.

- It was demonstrated that meetings have commenced with support services and the wheelchair contractor in February 2008.
- It was demonstrated that the licensee of the shop have links with the catering facility through health promotion initiatives.
- It was demonstrated that hygiene issues in relation to the shop are communicated to the hospital administrator.
- There was a lack of evidence demonstrated that these processes are formalised and evaluation has not been demonstrated.

PHYSICAL ENVIRONMENT, 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.

- It was demonstrated that the design and layout of the current facilities does not always meet best practice, as it was observed that a number of the wash-hand basins are not in line with the Strategy for the control of Antimicrobial Resistance in Ireland (SARI) guidelines.
- There were limited washing/showering facilities for patients, the hospitals were addressing this with alternative methods of hand hygiene and it was observed that a refurbishment programme has begun.

***Core Criterion**

CM 9.2 Rating: B (66-85% 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.

- It was demonstrated that a bed cleaning initiative is in place.
- The hospital has developed a number of policies, procedures and guidelines in relation to hygiene management.
- A number of hospital upgrades have taken place in 2008.
- It was demonstrated that a number of infection control audits have taken place and the hospital is in the process of establishing a hygiene audit schedule.

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

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

- The organisation demonstrated some evidence of evaluation of staff education programmes for infection control and some changes have been made based on this evaluation.
- There is no evidence demonstrated of the development of key performance indicators in relation to education and training.
- No evidence of evaluation of attendance levels was demonstrated.
- There was no evidence of evaluation of education to each staff member.

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.

- The organisation demonstrated an informal performance review. This includes a review of all the hygiene checklists completed.
- The organisation demonstrated that this process is being formalised.
- It was demonstrated that there is a lack of a documented process in place for review of performance of hygiene services staff.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

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

An occupational health service is available to all staff.

- There was evidence provided that an occupational health service is available to staff. Evidence of the service was demonstrated.
- There was evidence demonstrated that all new employees receive health assessments.
- There was no evidence demonstrated of the appropriateness of the service provided by occupational health for staff.

CM 12.2 **Rating: B (66-85% compliance with this criterion)**

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

- It was demonstrated that staff satisfaction of the occupational health department was completed in 2008 and this was demonstrated.

- The outcomes from this have resulted in improvements including, changes to the clinic times to facilitate access for staff members.
- There was no evidence demonstrated of evaluation of mechanisms for monitoring staff satisfaction.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.1 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.

- The organisation demonstrated that there are processes in place to collect and provide access to quality hygiene services data and information. These include HACCP reports, Incident reports, infection control audit results, leave reports, outbreaks Internet and the library.
- There was no evidence demonstrated of a documented process for collecting and providing access to data and information.
- There was no evidence demonstrated of evaluation of quality data reliability, validity and appropriateness.

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.

- There was evidence that the recently developed Hygiene Services Committee and Team receive weekly updates from clinical areas on hygiene related issues.
- The organisation demonstrated evidence that some of this information is considered and action plans are drafted. However, there was no evidence demonstrated that these plans had been introduced.
- There was no evidence demonstrated of evaluation of user's satisfaction in relation to reporting of data and information.

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 some evidence that the organisation assess the data through the infection control audits.
- The Annual report was not demonstrated as being signed off prior to the Assessment.

***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.

- It was demonstrated on observation of the areas visited that patient equipment was found to be clean apart from the equipment in the emergency department which was very dusty.
- The tagging system for clean equipment in place was demonstrated to be effective.
- There was evidence observed that all patient fans have been removed from the clinical areas in 2008 based on the national Hygiene Services Quality Review report for 2007.
- It was demonstrated that the findings of a 2008 audit of storage areas were used to draft the hospital policy in this area.

***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.

- There was evidence demonstrated that the Hoover filters are being changed on a weekly basis by the cleaning staff as per the 2007 hygiene report recommendation.
- Colour coding for mop heads was observed to be in place.
- Personal protective equipment were observed to be readily available.
- Storage facilities for cleaning products are in place however they were observed to be inadequate in size in one area.
- The cleaning products were observed stored in locked rooms; however they were not always in locked presses. It was observed that cleaning products were stored in patient areas in the emergency department.

***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.

- The ward kitchens visited were observed to be clean and there was evidence of processes in place to manage these areas.
- Separate toilet facilities for food workers are located on a separate floor.

- In the emergency department there was an informal arrangement to prepare snacks (tea and toast) for patients in the staff room. This practice is not in line with hospital policy or best practice. It was observed that this room required cleaning.

***Core Criterion**

SD 4.5 Rating: A (>85% 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 to demonstrate compliance of greater than 85% with the requirements of the criterion.

***Core Criterion**

SD 4.6 Rating: A (>85% compliance with this criterion)

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

- There was evidence to demonstrate compliance of greater than 85% with the requirements of the criterion.

***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 the Strategy for the control of Antimicrobial Resistance in Ireland (SARI) guidelines.

- There was evidence demonstrated of good knowledge and application of hand hygiene guidelines at operational level. Many staff members demonstrated their proficiency in this area.
- The link nurse programme was demonstrated.
- There were a number of deficits observed in relation to hand wash facilities and the hospital was in the process of addressing these. In the meantime the use of alcohol gels was observed.
- A hand dryer was observed in a toilet in the male medical area however, this was removed during the assessment visit.
- Hand-hygiene training was provided to staff members on a monthly basis and had been evaluated. Some changes in relation to this evaluation were 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 evidence of incident reporting, risk assessment training, and follow up of complaints.
- It was demonstrated that infection control audits are undertaken. There was no evidence demonstrated of a strategic approach to follow up and learning from infection control audits, however these are informally progressed through the Hygiene Services Team.
- The hospital demonstrated that there was a plan in place to implement hygiene audits and were in the process of training auditors to complete same.
- There was no evidence demonstrated of tracking or trending reports for hygiene related incidents.

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 is some evidence of mechanisms for involving patients in hygiene services improvements.
- There are patient information leaflets and input through "Your Service Your Say".
- Signage in the hospital was demonstrated.
- A phone survey was completed in 2008 and some recommendations were addressed.
- There was no evidence of evaluation of patient/client and families satisfaction with their participation in service delivery.

PATIENT'S/CLIENT'S RIGHTS

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

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

- There was evidence demonstrate of colour coded signage in place for transmission based precautions outside isolated patients room to support confidentiality.
- There was evidence that this process is monitored daily by Infection Control.
- There was evidence of patients/clients information leaflets.
- There was no evidence of evaluation of patients/clients and families rights violations in relation to hygiene services.

SD 5.2 **Rating: B (66-85% 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 of patient information regarding hand-hygiene; MRSA etc are available in public areas.
- There was no evidence demonstrated of evaluation of patients, families and visitors comprehension of and satisfaction with the information provided by the Hygiene Services Team.

SD 5.3 **Rating: B (66-85% compliance with this criterion)**

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

- There was evidence of “Your service your say” in progress.
- All Complaints in relation to hygiene services are reviewed at the Hygiene Services Team meeting.
- There was some evidence that the hospital has begun the process of reviewing trends in relation to hygiene complaints. This process was not demonstrated as formalised.

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1 **Rating: B (66-85% 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 a patient was included in the review of the visiting policy.
- It was demonstrated that this policy is due to be rolled out as a regional policy.
- There was some evidence of comment cards in place however there was no evidence of evaluation of the findings.
- The organisation demonstrated evidence of a patient hygiene satisfaction survey; there was no evidence of implementation of resultant recommendations.

SD 6.2 **Rating: B (66-85% 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 that Infection Control Audits are completed with resultant improvements demonstrated.

- The organisation has demonstrated that they have completed a self assessment which has resulted in the development of a continuous Quality Improvement planning process. There was evidence that this is being introduced to track improvements in hygiene services.
- There was evidence to demonstrate that the organisation is developing hygiene services key performance indicators however these were not developed at the time of the assessment.

SD 6.3

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

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

- There was evidence demonstrated that a Hygiene Services Annual Report was produced for 2007. There was no evidence that this was signed off by the organisation.
- There was evidence that this report reflects the changes made to the hygiene services in 2007 and the targets for 2008.
- There was no evidence demonstrated of time frames for completion of these targets.

Appendix A: Ratings Details

The table below provides an overview of the individual rating 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	B
CM 2.1	B	B
CM 3.1	D	B
CM 4.1	C	B
CM 4.2	C	C
CM 4.3	B	B
CM 4.4	C	C
CM 4.5	B	B
CM 5.1	B	B
CM 5.2	B	A
CM 6.1	C	B
CM 6.2	C	B
CM 7.1	C	C
CM 7.2	C	C
CM 8.1	B	B
CM 8.2	C	B
CM 9.1	C	C
CM 9.2	C	B
CM 9.3	C	C
CM 9.4	C	B
CM 10.1	B	B
CM 10.2	C	B
CM 10.3	B	B
CM 10.4	C	C
CM 10.5	C	C
CM 11.1	B	B
CM 11.2	B	B
CM 11.3	C	C
CM 11.4	C	C
CM 12.1	B	B
CM 12.2	C	B
CM 13.1	C	C
CM 13.2	C	C
CM 13.3	C	C
CM 14.1	B	B
CM 14.2	C	C
SD 1.1	C	C
SD 1.2	C	B
SD 2.1	B	A

Criteria	2007	2008
SD 3.1	C	A
SD 4.1	A	B
SD 4.2	B	B
SD 4.3	A	B
SD 4.4	B	C
SD 4.5	B	A
SD 4.6	A	A
SD 4.7	B	B
SD 4.8	C	C
SD 4.9	C	B
SD 5.1	B	B
SD 5.2	B	B
SD 5.3	C	B
SD 6.1	C	B
SD 6.2	C	B
SD 6.3	C	C