Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

National Hygiene Services Quality Review 2008

Mallow General Hospital

Assessment Report

Assessment date: 17th November 2008

About the Health Information and Quality Authority

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

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

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

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

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

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

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

1 Background and Context

1.1 Introduction

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

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

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

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

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

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

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

This "raising of the bar" is an important part of the process. It aims to ensure that the approach to the assessment further supports the need for the embedding of these Standards, as part of the way any healthcare service is provided and managed, and also further drives the move towards the demonstration of accountable improvement by using a more rigorous approach.

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

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

Hygiene is defined as:

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

Irish Health Services Accreditation Board Hygiene Standards

1.2 Standards Overview

There are 20 Standards divided into a number of criteria, 56 in total, which describe how a hospital can demonstrate how the Standard is being met or not. To ensure that there is a continual focus on the important areas relating to the delivery of high quality and safe hygiene services, 15 Core Criteria have been identified within the Standards to help the hospital prioritise these areas of particular significance.

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

The Standards are grouped into two categories:

(a) Corporate Management

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

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

(b) Service Delivery

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

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

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

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

1.3 Assessment Process

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

Before the onsite assessment:

- **Submission of a quality improvement plan (QIP) and accompanying information by the hospital to the Authority.** Each hospital was requested to complete a Quality Improvement Plan. This QIP outlined the

plans developed and implemented to address the key issues as documented in the hospital's Hygiene Services Assessment Report 2007.

- **Off-site review of submissions received**. Each Lead Assessor conducted a comprehensive review of the information submitted by the hospital.
- **The Authority prepared a confidential assessment schedule**, with the assessment dates for each hospital selected at random.
- **Selection of the functional areas.** The number of functional areas selected was proportionate to the size of the hospital and type of services provided. At a minimum it included the emergency department (where relevant), the outpatient department, one medical and one surgical ward.

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

During the assessment:

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

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

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

Following the assessment:

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

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

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

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

1.4 Patient Perception Survey

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

1.5 Scoring and Rating

Evidence was gathered in three ways:

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

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

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

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

Table 1: Compliance Rating Score

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

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

2 Hospital findings

2.1 Mallow General Hospital – Organisational Profile[1]

Mallow General Hospital is an acute 76-bedded hospital situated in Cork. The hospital opened as a General Hospital in 1957 and presently serves the population of 85–90,000 people. It is part of the Cork University Hospital Group. The hospital is involved in teaching nursing, medical and paramedical students.

Services provided

Services provided at Mallow General Hospital include:

- General Surgery including Urology and ENT
- General Medicine including Cardiology and Gastroenterology
- Day Procedures Unit
- Emergency
- Intensive Care/Coronary Care
- Radiology

Additional services by visiting consultants (OPD)

- Orthopaedics
- Paediatrics
- Psychiatry

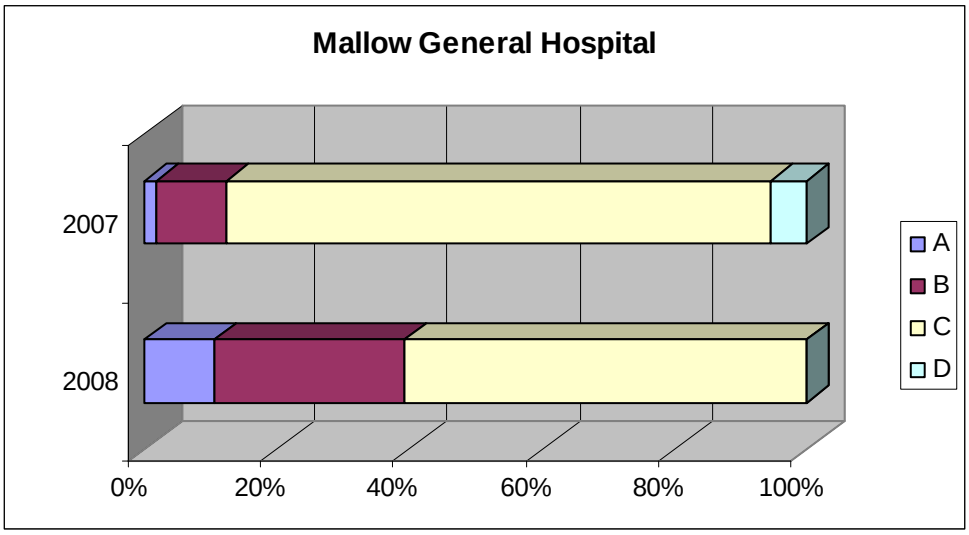
2.2 Areas Visited

- Clinical areas visited during the assessment were:
- Emergency department
- Outpatients Department
- St. Mary's,
- St. Joseph's
- Laundry services
- Waste compound

[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.

Mallow General 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.

- There was evidence demonstrated of a needs-assessment process based on internal hygiene audits with resulting action plans and evidence of completion.
- There was evidence demonstrated of a self-assessment against the National Hygiene Services Standards and Criteria.
- There was evidence demonstrated of a hygiene services corporate strategic plan and a combined hygiene services service/operational plan.
- The assessors were advised that staff consultation in relation to hygiene occurred through Clinical Nurse Managers meetings and there was evidence demonstrated that hygiene issues are routinely discussed in this forum.
- There was insufficient evidence demonstrated of consultation with patients/clients or community partners in relation to current and future needs of the organisation.
- There was no evidence demonstrated of an evaluation of the efficacy of the needs-assessment process.

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 demonstrated of recent developments and modifications to the hygiene services in light of needs analysis including the replacement of wash-hand basins to comply with Strategy for the control of Antimicrobial Resistance in Ireland (SARI) guidelines, new floor covering and drop ceilings in the emergency department
- There was evidence demonstrated of a pilot patient satisfaction survey being undertaken in one ward since September 2008. This included one question on hygiene.
- There was insufficient evidence demonstrated of a structured process for evaluating developments and modifications in relation to meeting the needs of the service users.

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.

- There was evidence demonstrated that Mallow General Hospital is a member of the Cork University Hospital Group.
- There was evidence demonstrated that hygiene issues are discussed at Senior Management Team meetings.
- There was extensive evidence demonstrated of communications with the HSE and associated agencies where hygiene is discussed.
- There was evidence demonstrated of meetings with Trade Union Representatives to address staff concerns.
- There was no evidence demonstrated of a patient or staff satisfaction survey.
- There was no evidence demonstrated of evaluation of the efficacy of linkages and partnerships.

CORPORATE PLANNING FOR HYGIENE SERVICES

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

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

- There was evidence demonstrated of a documented process for the development of the corporate strategic plan.
- There was evidence demonstrated of a corporate strategic plan, however it did not identify priorities and related costings.
- There was evidence demonstrated of circulation of the Hygiene Corporate Strategic Plan to members of the Hygiene Services Team and to members of the Senior Management Team however there was insufficient evidence demonstrated of communication of the plan to all stakeholders.
- There was no evidence demonstrated of input from patients, families and service users in the development of the plan.
- There was no evidence demonstrated of evaluation of the hygiene corporate strategic plans' goals, objectives and priorities against defined needs.

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

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

- There was evidence demonstrated of a range of corporate policies and procedures available throughout the organisation.
- There was insufficient evidence demonstrated through the organisational structure that the authority provisions for hygiene services are clearly defined.
- There was no evidence demonstrated of an evaluation of the appropriateness of the review of authority provisions in the hygiene service areas.

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

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

- There was evidence demonstrated of a documented process for receiving and acting on information on the performance of the Hygiene Service Team through quarterly reports to the Senior Management Team, from the Hygiene Services Team, and the Infection Control Committee. There was evidence that these had just commenced with one report having gone to the Senior Management Team. This report included the result of the hygiene audit.
- There was no evidence demonstrated of an evaluation of the appropriateness of 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.

- There was evidence demonstrated of access and use of research and best practice information through a range of policies and procedures contained in an Infection Control Manual and the Irish Acute Hospitals Cleaning Manual available in each clinical area.
- There was evidence demonstrated of a library with internet access available to all staff.
- There was evidence of quality initiatives related to hygiene services including a new van for transporting waste that facilitated the segregation of clinical from domestic waste, the refurbishment of the emergency department,

recycling of glass, batteries and ink cartridges and an equipment storage facility for infrequently used equipment.
- There was evidence demonstrated that ongoing hygiene related training is facilitated.
- There was evidence demonstrated of an Infection Control newsletter distributed to all staff.
- There was no evidence demonstrated of evaluation of the appropriateness of hygiene services related research and best practice information available.

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.

- There were a range of policies, procedures and guidelines (PPGs) contained in a regional infection control manual available in each of the clinical areas.
- There was evidence demonstrated of a Nursing Policies, Protocols & Clinical Guidelines Committee including Terms of Reference, policy template and document control procedures, however there was no evidence that the policy template had been utilised for the development of hygiene related policies to date.
- There was no evidence demonstrated of an evaluation of the efficacy of the process for developing and maintaining hygiene services PPGs.

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

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

- There was evidence demonstrated that the Hospital Manager and Maintenance Foreman are involved in Capital Development and both are members of the Hygiene Services Team.
- There was no evidence demonstrated of a documented process for the involvement of the Hygiene Services Team in the organisation's capital development planning and implementation process.
- There was no evidence demonstrated of an evaluation of the efficacy of the consultation process between the Hygiene Services Team and senior management.

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 evidence demonstrated of a Hygiene Services Team reporting to the Senior Management Team.
- There was evidence demonstrated that the Senior Management Team are accountable for hygiene services.
- There was evidence demonstrated that ward managers' job descriptions detail accountability for hygiene.
- There was insufficient evidence demonstrated of reporting relationships of all members of the Hygiene Services Team.

***Core Criterion**

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

The organisation has a multi-disciplinary Hygiene Services Committee.

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

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

***Core Criterion**

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

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

- There was evidence demonstrated of a dedicated budget for hygiene services including pay and non-pay budgets, however minor capital developments relevant to hygiene services are dependant on end-of-year funding.
- There was evidence of a hygiene corporate strategic plan and a hygiene service/operational plan, however they did not make reference to costings.

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

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

- There was evidence demonstrated in the Terms of Reference for the Hygiene Services Team of a role in the process of purchasing equipment.
- There was evidence demonstrated that the organisation's equipment/product purchases are primarily procured by a HSE regional contracts department.
- There was evidence demonstrated of a Schedule 5 tendering document to allow for Infection Control Risk assessment, however there was no documented process to ensure assessment from a hygiene perspective.
- There was no evidence demonstrated of an evaluation of the efficacy of the consultation process between the Hygiene Services Team and senior management in relation to procurement.

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 of a Hospital Safety Management Team developed to review and update the hospital Safety Statement.
- The organisation demonstrated evidence of Near Miss/Incident forms that are investigated locally and uploaded to the STARSweb system.
- The organisation advised the assessors that there have been no hygiene related adverse events in the last two years.
- There was evidence demonstrated of external reports from the Health and Safety Authority and Environment Health and resultant action plans.
- There was evidence demonstrated of internal hygiene audits and resulting actions, however there was no evidence of tracking or trending of audit results.
- There was no evidence demonstrated of a risk management annual report.

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

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

- There was evidence demonstrated of Health and Safety Reports and Environmental Health reports.
- There was evidence demonstrated of representation from the Hospital Safety Management Team on the Hygiene Services Team.

- There were no reported hygiene service adverse events in the last two years.
- There was no evidence demonstrated of collated feedback from the STARSweb system.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

***Core Criterion**

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

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

- There was evidence demonstrated that Waste Management, pest control and sanitary bin contracts are negotiated regionally and copies were available locally.
- There was evidence demonstrated that the laundry service is provided by the HSE laundry service.
- There was evidence demonstrated that contractors, such as waste management and pest control, are monitored by the maintenance department.
- There was evidence demonstrated that routine curtain cleaning was provided by a local dry cleaning service, however there was no evidence demonstrated of a written contract.
- There was no documented evidence demonstrated of a local policy for establishing and monitoring contracts.

CM 8.2 Rating: C (41-65% compliance with this criterion)

The organisation involves contracted services in its quality improvement activities.

- There was evidence demonstrated that waste contractors are involved in regional quality improvement activities.
- There was insufficient evidence demonstrated that the organisation involves other local contract services in its quality improvement activities.

PHYSICAL ENVIORNMENT, FACILITIES AND RESOURCES

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

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

- There was evidence demonstrated that the design and layout of the current physical environment is safe through Health and Safety reports, Environmental Health reports and Hazard Analysis and Critical Control Point (HACCP) reports.
- There was evidence demonstrated of a Health and Safety Authority assessment conducted in 2008.
- There was evidence demonstrated of an Aspergillus Policy, however there was no documented evidence that infection control were consulted prior to the commencement of work currently in progress in one ward area.
- There was evidence demonstrated during the assessment process that storage facilities are an identified shortcoming in the physical environment.

***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.

- There was evidence demonstrated of policies and procedures in relation to linen segregation, waste management, HACCP and medical equipment cleaning.
- There was no evidence demonstrated of segregation of duties between catering and cleaning for multitask attendants. Staff take universal precautions when carrying out either duty and have appropriate training for same.

CM 9.3 Rating: B (66-85% compliance with this criterion)

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

- There was evidence demonstrated that evaluation of the management of the environment and facilities, equipment and devices, kitchens, waste and sharps and linens is through internal hygiene audits and the monitoring of weekly cleaning checklists.
- There was evidence demonstrated of changes made during the last two years including the upgrade of all ward kitchens, a new linen trolley to facilitate the segregated transport of clean and used linen, a new van to facilitate the

segregated transportation of domestic and clinical waste and the introduction of recycling.
- There was no evidence demonstrated of the involvement of patients in the evaluation process.

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

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

- There was evidence demonstrated of the utilisation of the HSE comments and complaints policy "Your Service, Your Say".
- There was evidence demonstrated that the Hospital Manager is the designated complaints officer.
- There was evidence demonstrated of a pilot patient satisfaction survey in one ward with one hygiene related question.
- There have been no reported hygiene related complaints.
- There was no evidence of feedback from the "Your Service, Your Say" comment and complaint process.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 Rating: C (41-65% compliance with this criterion)

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

- There was evidence demonstrated that recruitment processes complied with HSE recruitment policy and the Commission for Public Service Appointments Code of Practice.
- There was no evidence demonstrated that job descriptions for Multitask attendants and Healthcare Assistants contained a specific reference to hygiene.
- There was no evidence demonstrated of an evaluation of the process for selecting and recruiting human resources.

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

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

- The organisation advised the assessors that human resource work capacity is based on the HSE Whole Time Equivalent staff numbers.
- There was no evidence demonstrated of a documented process for reviewing changes in hygiene services work capacity and volume.
- There was no evidence demonstrated of evaluation of the appropriateness of work capacity and volume review processes.

CM 10.3 Rating: A (>85% compliance with this criterion)

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

- The organization demonstrated compliance in excess of 85% with the requirements of this criterion.

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

There is evidence that the contractors manage contract staff effectively.

- The majority of hygiene services were provided by directly employed staff.
- There was evidence demonstrated of consultation with contractors and reporting relationships were defined in written contracts e.g. Sani-bins, waste and pest control.
- There was no evidence demonstrated of hygiene training and orientation of contract staff.

***Core Criterion**

CM 10.5 Rating: C (41-65% compliance with this criterion)

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

- There was evidence demonstrated that the organisation's human resources are based on the HSE whole time equivalent ceilings.
- There was evidence demonstrated that the corporate strategic plan's terms of reference refers to human resource management, however there is no reference to human resource needs contained in the service/operational Plan.
- There was no evidence demonstrated of a documented human resource needs-assessment process.
- There was no evidence demonstrated of a hygiene service annual report.

ENHANCING STAFF PERFORMANCE

***Core Criterion**

CM 11.1 Rating: A (>85% compliance with this criterion)

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

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

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

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

- There was evidence demonstrated that ongoing education and training related to hygiene is facilitated for all staff.
- There was evidence demonstrated that the organisation provides facilitators and educators to support staff education and training.
- There was no evidence demonstrated that staff received training in health and safety hazards, conducting risk assessments or the handling of patient's complaints.

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

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

- There was evidence demonstrated of evaluation of staff satisfaction rates with education and training provided.
- There was evidence demonstrated of evaluation of attendance levels of all staff at education and training provided.
- There was no evidence demonstrated of Performance Indicators used to evaluate the effectiveness of education and training.
- There was no evidence demonstrated of resultant actions and continuous quality improvement in response to attendance levels at training provided.

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

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

- There was evidence demonstrated that performance review of staff was conducted on a quarterly basis during the first year of employment only.

- There was no evidence demonstrated of ongoing performance evaluation and development.
- There was no evidence demonstrated of evaluation of the appropriateness of the performance evaluation process.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

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

An occupational health service is available to all staff.

- There was evidence demonstrated that an Occupational Health Service based in Cork University Hospital is available to all staff.
- There was evidence demonstrated of a full range of services, including vaccinations available to staff.
- There was no evidence demonstrated of evaluation of the appropriateness of the service provided by the Occupational Health Department for staff.

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

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

- There was evidence demonstrated that staff satisfaction, occupational health and wellbeing is monitored through attendance and absenteeism records.
- There was no evidence demonstrated of changes initiated as a result of ongoing monitoring over the last two years.
- There was no evidence demonstrated of the appropriateness of mechanisms for monitoring staff satisfaction.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

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

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

- There was evidence demonstrated of a process for collecting and providing access to hygiene services data through internal hygiene audits, infection control rates, minutes of Hygiene Services Team meetings, environmental health reports and health and safety reports.
- There was no evidence demonstrated of an evaluation of the process for collection and accessing information and adherence to legal and best practice requirements.
- There was no evidence demonstrated of evaluation of data reliability, accuracy, validity and appropriateness.

CM 13.2 Rating: B (66-85% 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 demonstrated of reports of internal hygiene audits reported to ward managers immediately, to the Senior Management Team quarterly and to the Hygiene Services Team monthly.
- There was evidence demonstrated of infection control rates monitored daily and reported to the Infection Control Committee on a monthly basis and to the Senior Management Team quarterly.
- There was evidence demonstrated of a self-assessment against the Hygiene Services Standards and a resulting Quality Improvement Plan.
- There was no evidence demonstrated of an evaluation of data presentation methods or of an evaluation of user satisfaction in relation to the reporting of 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 evidence demonstrated of changes in data collection and information reporting including an alert to identify patients with prior MRSA infections, reporting of infection rates to the Senior Management Team, and an infection control newsletter distributed to all staff.
- The organisation demonstrated insufficient evidence of mechanisms used to assess the appropriateness of data collection and information reporting.
- There was no evidence demonstrated of an evaluation of the appropriateness of the data and information utilisation in relation to service provision and improvement.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

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

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

- There was evidence demonstrated of quality improvement initiatives instigated over the last two years including the formation of a multidisciplinary Hygiene Services Team to coordinate the delivery of hygiene services and report to the Senior Management Team.

- There was evidence demonstrated of Senior Management Team involvement in quality improvement initiatives through membership of the Hygiene Services Team.
- Evidence was demonstrated that all CNM2 job descriptions incorporate a responsibility to foster a culture of continuous quality improvement.
- There was no evidence demonstrated of coordinating quality improvement activities with other performance monitoring activities.

CM 14.2 Rating: C (41-65% compliance with this criterion)

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

- There was evidence demonstrated of evaluation of the efficacy of the hygiene services quality improvement system through internal hygiene audits and external reports.
- There was evidence demonstrated that communications to staff in relation to hygiene services findings is only facilitated through Clinical Nurse Manager meetings and meetings with multi-task attendants.
- There was no evidence demonstrated of a benchmarking process to evaluate the efficacy it s quality improvement system.
- There was no evidence demonstrated of evaluation of improved outcomes in hygiene services delivery as a result of the quality improvement system.

2.5 Standards for Service Delivery

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

EVIDENCE BASED BEST PRACTICE AND NEW INTERVENTIONS IN HYGIENE SERVICES

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

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

- The organisation demonstrated evidence of best practice guidelines including the use of a colour coding system for cleaning, linen segregation and waste and sharps management.
- There was evidence demonstrated of a documented process for the establishment, adoption and maintenance of best practice guidelines for hygiene services, however there was no evidence demonstrated that had been used to develop hygiene services guidelines to date.
- There was no evidence demonstrated of an evaluation of the efficacy of the processes used to develop best practice guidelines by the Hygiene Services Team.

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

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

- There was evidence demonstrated of new hygiene services interventions brought into use over the last two years, including a new disinfectant to replace the previous product, a mat replacement scheme and a new van for transporting waste.
- There was insufficient evidence of a documented process for assessing new hygiene service interventions.
- There was no evidence demonstrated of an evaluation of the efficacy of the assessment process for new/changed hygiene services interventions.

PREVENTION AND HEALTH PROMOTION

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

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

- There was evidence demonstrated of hygiene related posters and information leaflets displayed throughout the hospital.
- There was evidence demonstrated that the visiting policy has been amended to reflect national visiting policy.
- There was insufficient evidence demonstrated of the involvement of community groups, primary health teams and other organisations involved in the organisation's health promotion activities in relation to hygiene.
- There was no evidence demonstrated of an evaluation of the efficacy of activities undertaken and/or participated in by the team in the community in relation to hygiene.

INTEGRATING AND COORDINATING HYGIENE SERVICES

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

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

- There was some evidence demonstrated of a multidisciplinary Hygiene Services Team representative of all staff groups.
- There was evidence demonstrated of team awareness of each others roles and responsibilities contained in the Terms of Reference.
- There was evidence demonstrated of linkages and partnerships with other teams including the Senior Management Team and the infection control committee, however while it was advised that there was linkages with regional risk management there was no evidence demonstrated of this.
- There was no evidence demonstrated of consultation with patients regarding hygiene services.
- There was no evidence demonstrated of an evaluation of the efficacy of the multi-disciplinary team structure.

***Core Criterion**

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

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

- There was evidence of a generally clean and tidy environment, however there was evidence of light dust on high surfaces and on the underside of beds.
- There was evidence demonstrated that curtains were changed twice yearly, after each known case of infected patients and when soiled.
- There was evidence demonstrated that all water outlets, including shower outlets are flushed on a weekly basis.
- There was evidence of clutter throughout the environment with minimal storage facilities and limited space between beds.
- Alcohol based hand gel was not always available at the entrances to all rooms within the ward environment.
- There was evidence demonstrated that bathrooms were cleaned on a daily basis and there was evidence that this was monitored through the use of checklists.
- There are no bathroom facilities for patients within the emergency department.

***Core Criterion**

SD 4.2 Rating: A (>85% compliance with this criterion)

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

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

***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 cleaning equipment is cleaned and mop heads are laundered daily.
- There was evidence demonstrated of limited storage facilities for cleaning equipment and cupboards for cleaning products were not always locked.

- There was evidence demonstrated of a colour coding policy for cleaning equipment, however there was no evidence of a separate colour code for contaminated rooms.

***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.

- There was evidence demonstrated of a ward kitchen food safety policy.
- There was insufficient evidence to demonstrate that ward kitchens were restricted to designated personnel, as doors were not always locked and signs restricting access were not evident on all doors.
- There was insufficient evidence demonstrated of the use of personal protective equipment by kitchen staff.
- There was no evidence demonstrated of segregation of catering and cleaning duties of multi-task attendants.

***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.

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

***Core Criterion**

SD 4.6 Rating: B (66-85% compliance with this criterion)

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

- There was evidence demonstrated of segregation of linen into appropriate colour coded bags and there was evidence that bags were less than two thirds full.
- There was evidence of limited storage storage facilities for linen in the clinical areas.
- There was evidence that staff used the clean linen cupboards for their own personal belongings.

***Core Criterion**

SD 4.7 Rating: A (>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.

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

SD 4.8 Rating: B (66-85% compliance with this criterion)

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

- There was evidence demonstrated of the minimisation of risk when Hygiene Services are provided through the adoption of guidelines contained in the Irish Acute Hospitals Cleaning Manual, including the use of warning signs.
- There was evidence demonstrated that hygiene services are carried out during periods of low activity, such as outside of meal times and visiting hours.
- There was no evidence demonstrated of a process for the delivery of hygiene services in response to non-routine situations.
- There were no reported 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 was evidence demonstrated that patients and families are encouraged to participate in improving hygiene services through the availability of hygiene related patient information leaflets, posters and the availability of hand gel.
- The organisation demonstrated evidence of adherence to the national visitor's policy.
- While a pilot patient satisfaction survey was underway there was no evidence demonstrated of evaluation of patients and families satisfaction with participation in service delivery.

PATIENT'S/CLIENT'S RIGHTS

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

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

- There was evidence demonstrated of a ward philosophy for each ward with reference to maintaining patient's dignity.
- There was evidence of isolation rooms with discreet signage to reflect the needs for privacy and confidentiality of patients who are at risk or have acquired a communicable infectious disease during hygiene service delivery.
- There were no reported rights violations in relation to hygiene services.
- There was evidence demonstrated that patient/visitor information leaflets were being updated and were in draft format.

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

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

- There was evidence of hygiene related posters and leaflets throughout the organisation, however they are not readily visible.
- There was no evidence demonstrated of a reference to hygiene in the organisation's Patient Information Leaflet.
- There was no evidence demonstrated of an evaluation of patient, family and visitor comprehension of and satisfaction with the information provided by the Hygiene Service Team.

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

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

- There was evidence demonstrated that the Hospital Manager is the designated complaints officer.
- The organisation utilises the HSE comment and complaint policy "Your Service, Your Say", however there was no evidence demonstrated of feedback in relation to complaints received through this process.
- There was no evidence demonstrated of staff training in relation to complaints.
- There were no reported hygiene related complaints.

ASSESSING AND IMPROVING PERFORMANCE

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

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

- There was evidence demonstrated of a pilot patient satisfaction survey containing questions related to hygiene.
- There was evidence demonstrated that evaluation of the extent to which patients and families involvement by the team when evaluating its service has resulted in the piloting of a patient satisfaction survey.
- There was no evidence demonstrated of changes to hygiene services as a result of service user information.

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

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

- There was evidence demonstrated that evaluation mechanisms used by the Hygiene Services Team are internal hygiene audits, environmental health reports and health and safety reports.
- There was evidence that internal hygiene audit results form the basis for the quality improvement plan.
- There was no evidence demonstrated of an evaluation of the extent to which Hygiene Services quality initiatives are undertaken as a result of evaluation and benchmarking.

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 in the organisation's quality improvement plan of a process for the development of a hygiene services annual report.
- There was no hygiene services annual report to date.

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	C	B
CM 3.1	D	C
CM 4.1	C	C
CM 4.2	D	C
CM 4.3	C	B
CM 4.4	C	C
CM 4.5	C	C
CM 5.1	C	B
CM 5.2	D	A
CM 6.1	C	C
CM 6.2	C	C
CM 7.1	C	C
CM 7.2	C	C
CM 8.1	C	B
CM 8.2	C	C
CM 9.1	C	C
CM 9.2	C	B
CM 9.3	C	B
CM 9.4	C	C
CM 10.1	C	C
CM 10.2	C	C
CM 10.3	C	A
CM 10.4	C	C
CM 10.5	C	C
CM 11.1	C	A
CM 11.2	C	C
CM 11.3	C	C
CM 11.4	C	C
CM 12.1	B	B
CM 12.2	C	C
CM 13.1	C	C
CM 13.2	C	B
CM 13.3	C	C
CM 14.1	C	B
CM 14.2	C	C
SD 1.1	C	C

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