



**Health
Information
and Quality
Authority**

An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte

National Hygiene Services Quality Review 2008

**Midland Regional Hospital at Mullingar
Assessment Report**

Assessment date: 26th September 2008

About the Health Information and Quality Authority

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

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

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

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

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

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

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

1 Background and Context

1.1 Introduction

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

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

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

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

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

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

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

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

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

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

Hygiene is defined as:

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

Irish Health Services Accreditation Board Hygiene Standards

1.2 Standards Overview

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

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

The Standards are grouped into two categories:

(a) Corporate Management

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

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

(b) Service Delivery

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

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

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

Core Criteria:

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

1.3 Assessment Process

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

Before the onsite assessment:

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

The hospitals were grouped as follows:

- Smaller hospitals (two assessors) – minimum of two wards selected
- Medium hospitals (four assessors) – minimum of three wards selected
- Larger hospitals (six assessors) – minimum of five wards selected.

During the assessment:

- **Unannounced assessments.** The assessments were unannounced and took place at different times and days of the week. All took place within one day, except for one assessment that ran into two days for logistical reasons. Some assessments took place outside of regular working hours and working days.
- Assessments were undertaken by a **team of Authorised Officers** from the Authority to assess compliance against the National Hygiene Standards. Health Information and Quality Authority staff members were authorised by the Minister of Health and Children to conduct the assessments under section 70 of the Health Act 2007.
- **Risk assessment and notification.** Where assessors identified specific issues that they believed could present a significant risk to the health or welfare of patients, hospitals were formally notified in writing of where action was needed, with the requirement to report back to the Authority with a plan to reduce and effectively manage the risk within a specified period of time.

Following the assessment:

- **Internal Quality Assurance.** Each assessment report was reviewed by the Authority to ensure consistency and accuracy.
- **Provision of an overall report to each hospital, outlining their compliance with the National Hygiene Standards.** Each hospital was given an opportunity to comment on their individual draft assessment in advance of publication, for the purpose of factual accuracy.
- **All comments were considered** fully by the Authority prior to finalising each individual hospital report.
- **Compilation and publication of the National Report** on the *National Hygiene Services Quality Review*.

1.4 Patient Perception Survey

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

1.5 Scoring and Rating

Evidence was gathered in three ways:

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

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

- Standardised training for all assessors
- Multiple quality review meetings with assessors
- A small number of assessors completing the assessments
- Six lead assessors covering all the hospitals
- Assessors worked in pairs at all times
- 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 Midland Regional Hospital at Mullingar – Organisational Profile¹

Midland Regional Hospital Mullingar is a part of a network of hospitals, also working from sites in Portlaoise and Tullamore. With capacity of 215 beds (including 11 day-beds and a six-bedded Medical Assessment Unit) the hospital provides an extensive range of services for the catchment area of Longford/Westmeath. The hospital has undergone major development since 1980s. The most recent development stage commenced in 2006 and is due for completion in 2008, which will lead to increasing bed number to 260. The following services are provided by the hospital:

- Emergency department
- Child psychiatry
- General medical services with sub specialities in respiratory, cardiology and care of the elderly
- General surgical
- Obstetrics and gynaecology (including EPU, colposcopy and urodynamics)
- Ophthalmology
- Paediatrics (to include special baby care unit)
- Pathology
- Radiology.

The hospital also provides outpatient services as well as full range of support services including physiotherapy, occupational therapy, speech and language therapy, cardiac services, cardiac rehabilitation, pulmonary function laboratory and respiratory.

2.2 Areas visited

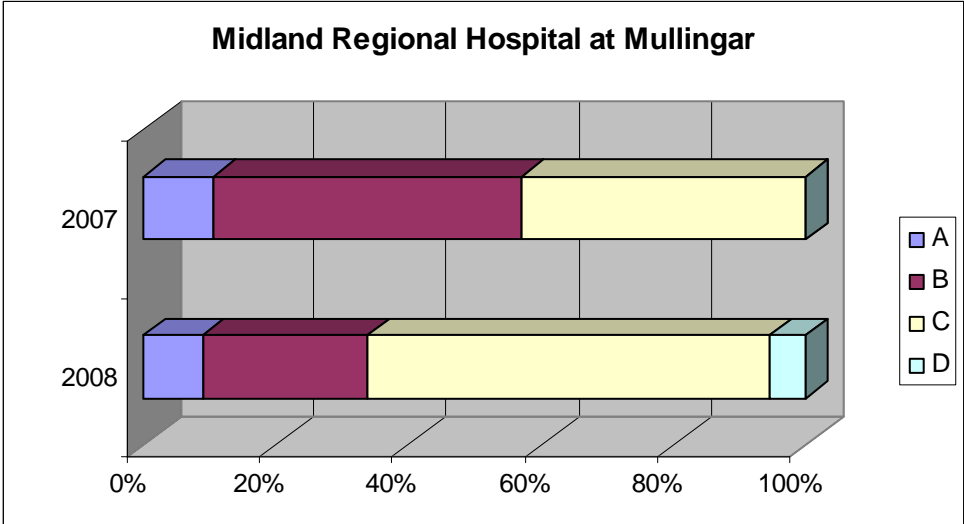
During the course of the assessment the following areas were visited:

- Level 1 West Wing
- Paediatric Ward
- Emergency department
- Outpatients department
- The laundry services
- The 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.

Midland Regional Hospital Mullingar has achieved an overall score of:

Poor

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: B (66-85% 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 and consideration at Environment and Facilities Committee meetings.
- The organisation demonstrated evidence of a hygiene services corporate strategic and service plan.
- There was evidence demonstrated of a patient representative on the Environment and Facilities Committee.
- There was no evidence demonstrated of an evaluation of the efficacy of the needs assessment process.

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

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

- There was some evidence demonstrated of modifications to hygiene services in light of the needs assessment process such as an increase in the number of hand gel dispensers available throughout the hospital.
- There was no evidence demonstrated of resultant actions, feedback or continuous quality improvement plan.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

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

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

- The organisation demonstrated evidence of linkages between the Hospital Manager and the General Manager.
- There was evidence demonstrated of a staff partnership process and of patient satisfaction surveys with a reference to hygiene.

- The assessors were advised that the General Manager meets with the Network Manager, however there was no evidence demonstrated that hygiene is on the agenda.
- 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.

- The organisation demonstrated evidence of a hygiene services corporate strategic plan, which was developed regionally and adopted locally.
- There was no evidence demonstrated of local input by the hygiene services at developmental stage, however there was evidence demonstrated of minor adaptations afterwards.
- There was no evidence demonstrated of an evaluation of the Hygiene Corporate Strategic plans' goals, objectives and priorities against defined needs.

GOVERNING AND MANAGING HYGIENE SERVICES

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

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

- The organisation demonstrated evidence of informal linkages with the Governing Body through reporting relationships through the Hospital Manager and General Manager.
- There was evidence demonstrated of an evaluation of the Environment & Facilities Committee (Hygiene Services Team) resulting in a reduction in the number of members and there was evidence of a review of the Terms of Reference, however no changes were made.
- There was evidence demonstrated that the Irish Acute Hospitals Cleaning Manual is in the process of being adapted locally by the Environment & Facilities Team, but there was no evidence demonstrated of a timeframe for completion.
- There was no evidence of corporate policies and procedures available throughout the organisation.

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

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

- There was evidence demonstrated that internal hygiene audits recommenced in August 2008 following a lapse and while issues have been identified, there was no evidence of follow-up.
- There was insufficient evidence demonstrated of documented processes for reviewing or acting on information received.
- There was no evidence demonstrated of Hygiene Service Performance Indicators reviewed on a regular basis.
- There was no evidence demonstrated of an evaluation of the appropriateness of information received.

CM 4.3 Rating: C (41- 65% 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 the Irish Acute Hospitals Cleaning Manual being considered regionally and evidence that the Hygiene Services Team are in the process of adapting the manual for local use.
- There was evidence demonstrated of a newsletter available to staff that contained information regarding hygiene within the hospital.
- There was evidence demonstrated of policies, procedures and guidelines in the Infection Control Master File, but these were not in evidence in clinical areas.
- There was some evidence demonstrated of the provision of ongoing hygiene services training and education.
- 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 was evidence demonstrated of a regional template and process for establishing policies, procedures and guidelines and these are implemented by infection control.
- There was no evidence demonstrated of hygiene services policies, procedures and guidelines available in clinical areas.
- There was no evidence demonstrated of evaluation of the process for developing hygiene services policies, procedures and guidelines.

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.

- The organisation demonstrated evidence of consultation with the Corporate Lead Group (Hygiene Services Committee) regarding capital development.
- There was evidence demonstrated of communication between the Hygiene Services teams and Executive Management regarding capital development.
- There was no evidence demonstrated of evaluation of the efficacy of the consultation process between the Corporate Lead Group and senior management regarding capital development

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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 the Hygiene Services Structure and reporting relationship of all members of Hygiene Services.
- There was evidence demonstrated of an organisational structure, detailing roles and responsibility and accountability of the Governing Body in relation to the Hygiene Services.
- There was no evidence demonstrated of responsibility and accountability of ward managers for hygiene in their ward.

***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: A (>85% 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.

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

CM 6.2 Rating: B (66-85% compliance with this criterion)

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

- The organisation demonstrated evidence that processes for the procurement of equipment and products follows regional guidelines.
- There was evidence demonstrated of consultation with Corporate Lead Group on an informal basis in relation to purchases of equipment/products.
- There was no evidence demonstrated of an evaluation of the efficacy of the consultation process between the Corporate Lead Group and senior management in relation to procurement.

MANAGING RISK IN HYGIENE SERVICES

***Core Criterion**

CM 7.1 Rating: B (66-85% 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

- The organisation demonstrated evidence that Risk Management policies, procedures and guidelines are available on the intranet.
- There was evidence demonstrated of access by the organisation to a Risk Manager, however this service was not available on-site despite evidence of a proposal for this service to be available within the organisation.
- There was evidence demonstrated of a risk management annual report.
- There were no reported major hygiene related adverse events.

CM 7.2 Rating: B (66-85% 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.

- The Organisation demonstrated evidence of access to a Risk Manager and evidence of a Quality & Risk Committee, which is chaired by the Hospital Manager.
- There was evidence demonstrated of representation from the Hygiene Services Committee on the Quality & Risk Committee.
- There was no documentary evidence demonstrated of consideration by the Governing Body of hygiene related items from the Quality & Risk Committee.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

***Core Criterion**

CM 8.1 Rating: C (41- 65% 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.

- The organisation demonstrated evidence of a regional process for establishing and managing contracts.
- There was evidence demonstrated that contracts such as waste management and pest control are monitored by the Maintenance Department.
- There was no evidence demonstrated of written contracts for the provision of hygiene services available locally.
- There was no evidence demonstrated of a process for establishing contracts locally.

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 the organisation works in partnership with the coffee shop contractor to ensure best practice and quality improvement in relation to waste and hygiene.
- There was insufficient evidence demonstrated of the involvement of all contractors in the organisation's quality improvement initiatives.

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.

- There was evidence demonstrated that the organisation's current capital development project is in line with best practice.
- There was evidence demonstrated that wash hand basins incorporate mixer taps that are hands-free, however water flows directly into the plughole.
- There was insufficient evidence demonstrated of actions as a result of issues identified through the internal hygiene audit process.

***Core Criterion**

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

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

- There was evidence demonstrated of a linen management policy, however this was still in draft stage.
- There was evidence demonstrated of waste management, sharps and equipment policies contained in the infection control folder, however this was not readily available in clinical areas.

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

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

- The organisation demonstrated evidence that internal hygiene audits, discontinued in 2007, had recently been reintroduced (Aug 2008).
- There was evidence demonstrated of information gathering through the audit process, however there was insufficient evidence demonstrated of resultant actions.

CM 9.4 Rating: B (66-85% compliance with this criterion)

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

- The organisation demonstrated evidence of utilisation of the HSE comment and complaint policy "Your Service, Your Say".
- There was also evidence demonstrated of consultation with patients by the Director of Nursing regarding hygiene.
- There was evidence demonstrated that this information is being collated, however there was no evidence demonstrated of resulting alterations or modifications to hygiene services.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

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

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

- There was evidence demonstrated that the selection and recruitment of human resources for hygiene services is coordinated regionally by the HSE.
- There was evidence demonstrated in job descriptions of responsibility and accountability of hygiene services staff
- 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 demonstrated evidence of a review of work capacity and volume completed in preparation for a new building extension.
- There was no evidence demonstrated of a division of roles between catering and cleaning for attendant staff in line with best practice.
- There was no evidence demonstrated of an evaluation of the appropriateness of work capacity and volume review processes.

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

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

- There was evidence demonstrated that monitoring of relevant qualifications and training for staff is achieved through the recruitment process.
- There was evidence demonstrated of an induction programme for new staff that included relevant hygiene training.
- There was insufficient evidence demonstrated of a structured process for the provision of ongoing training relevant to hygiene services.

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

There is evidence that the contractors manage contract staff effectively.

- The organisation demonstrated evidence that contractors are managed regionally by the HSE.
- There was insufficient evidence demonstrated of local involvement in the management of contract staff.

- There was no evidence demonstrated of evaluation of the appropriate use 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.

- The organisation demonstrated evidence that the deployment of human resources is based on HSE staff whole time equivalent ceilings.
- There was evidence demonstrated of a hygiene corporate strategic plan, hygiene service and operational plans.
- There was evidence demonstrated of a compilation of hygiene services activities contained in a folder, but this was not collated in an annual report format.
- There was no evidence demonstrated of a needs assessment process to verify current work capacity and volume requirements.

ENHANCING STAFF PERFORMANCE

***Core Criterion**

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

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

- The organisation demonstrated evidence of an induction programme for hygiene services staff that included hand hygiene training.
- There was evidence demonstrated of the recent introduction of a monitoring process for attendance at induction training.
- There was no evidence demonstrated of a staff handbook, as this was reported to have recently been withdrawn from circulation.
- There was no evidence demonstrated of mandatory ongoing hygiene related training.

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 of access to library facilities and evidence that some staff have access to Internet and intranet.

- The organisation demonstrated evidence of the provision of facilitators and educators through participation in a “train the trainers” programme for waste management and handling.
- There was insufficient evidence demonstrated of a continuing professional development programme for hygiene services staff.
- There was no evidence demonstrated of a process to ensure staff members are freed from duties to attend ongoing education and training.
- There was no evidence demonstrated of an evaluation of the relevance of education to each staff member.

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 no evidence demonstrated of key performance indicators (KPI) used to evaluate the effectiveness of education and training.
- There was no evidence demonstrated of evaluation of attendance levels at education and training.

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

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

- The organisation demonstrated evidence of performance evaluation through the formal process of probationary periods for new staff and disciplinary procedures.
- There was no evidence demonstrated of an evaluation of the number of hygiene services staff who undergo performance evaluation.
- There was no evidence demonstrated of an evaluation of the appropriateness of performance evaluation processes.

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.

- The organisation demonstrated evidence that an occupational health service is available to all staff.
- There was evidence demonstrated that the Occupational Health Department is based in the Midlands Regional Hospital Tullamore, however a satellite service is available locally for initiatives such as the influenza vaccination programme.
- There was evidence demonstrated of the range of services provided by occupational health, including vaccinations.

- There was no documented evidence of an 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 of a low staff turnover rate and a low absenteeism rate relative to national statistics, used as a measure of staff satisfaction, occupational health and well-being.
- 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 evaluation 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.

- The organisation demonstrated evidence of a process for collecting hygiene services information through the incident reporting process, complaints, internal hygiene audits, patient satisfaction surveys and walkabouts.
- There was no evidence demonstrated of an evaluation of the process for collection and accessing information.
- There was no evidence demonstrated of an evaluation of quality data reliability, accuracy, 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 demonstrated that hygiene services information was considered at the Environment and Facilities Committee meetings.
- There was evidence demonstrated that information was reported using graphics to support interpretation.
- There was no evidence demonstrated of evaluation of data presentation methods or user satisfaction in relation to the reporting of data and information.

CM 13.3 Rating: B (66-85% compliance with this criterion)

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

- There was evidence demonstrated that hygiene services data was discussed at Environment and Facilities Committee meetings and evidence of some action plans as a result.
- There was evidence demonstrated of changes in data collection and information reporting over the last two years including the introduction of a newsletter and reintroduction of internal hygiene audits.
- There was no evidence demonstrated of 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: C (41- 65% 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 that the Hospital Manager is a member of the Environment and Facilities Committee .
- There was evidence demonstrated that the Hospital Manager received and acted on hygiene related information as appropriate.
- There was insufficient evidence demonstrated of quality improvement initiatives coordinated with other performance monitor activities e.g. the follow up of internal audit results was not demonstrated.

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.

- The organisation demonstrated evidence of a newsletter, which conveys hygiene services findings to patients, staff and the public.
- There was evidence demonstrated that internal hygiene audits had only recently recommenced.
- There was no evidence demonstrated of hygiene service performance indicators or benchmarking.
- 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.

- There was evidence demonstrated of a regionally developed template for the development of policies, procedures and guidelines.
- There was evidence demonstrated that the organisation are awaiting approval for adoption of the Irish Acute Hospitals Cleaning Manual.
- There was evidence demonstrated that the Environment and Facilities Committee use colour coded processes for cleaning, linen segregation and waste segregation.
- There was evidence demonstrated of library and internet access available for supervisory staff.
- There was no evidence demonstrated that hygiene related policies, procedures and guidelines were available at ward level.
- There was no evidence demonstrated of evaluation of the efficacy of the processes used to develop best practice guidelines by the Environment and Facilities Committee.

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 evaluation of new products.
- There was evidence demonstrated of a trial of a flat mopping system, however this has not been introduced.
- There was no evidence demonstrated of evaluation of reports of new/changed hygiene devices interventions.
- There was no documented evidence of a process for assessing new 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 a hospital newsletter, which promotes hygiene issues and is available in the reception area for members of the public.
- There was some evidence demonstrated of hygiene related information leaflets, however their availability was inconsistent throughout the organisation.
- There was no evidence demonstrated of participation with community groups or primary healthcare teams in hygiene related health promotion activities.
- There was no evidence demonstrated of evaluation of the efficacy of activities undertaken by the team in the community in relation to hygiene.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1 Rating: A (greater than 85% compliance with this criterion)

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

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

IMPLEMENTING HYGIENE SERVICES

***Core Criterion**

SD 4.1 Rating: D (15-40% compliance with this criterion)

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

- There was evidence of heavy dust in clinical areas on fixtures, equipment and signage throughout the organisation.
- Hand gel was widely available, however it was not readily visible.
- There was evidence of blood splatters on patient trolleys and disposable curtains.
- There was evidence that some wash hand basins appeared to have only been superficially cleaned.
- There was no evidence of documented processes for recording the cleaning of toilets in clinical areas.

- The assisted toilet in the Emergency Department was also used to store gas cylinders and Intravenous Stands.
- There was evidence of a 24-hour urine collection in progress in one ward and the collection jar was held in a common patient bathroom together with spare jars containing hydrochloric acid.
- There was no evidence demonstrated of a systematic documented process for routine curtain changing.
- There were cleaning solutions stored in an unlocked utility room easily accessible by children.
- There was evidence of dead flies on some high level surfaces.
- Therefore a potential risk to the health and welfare of patients existed.

***Core Criterion**

SD 4.2 Rating: D (15-40% compliance with this criterion)

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

- There was evidence of heavy dust on all equipment in use at patient's bedside.
- There was evidence of adhesive glue on some pieces of equipment.
- There was no evidence demonstrated of a system including documented process for cleaning medical devices.
- Therefore a potential risk to the health and welfare of patients existed.

***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 that mop heads are disposable.
- There was evidence demonstrated that solutions used for cleaning are at the correct dilution.
- There was evidence that Personal Protective Equipment (gloves, aprons), while available, were not appropriately used.

***Core Criterion**

SD 4.4 Rating: D (15-40% 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 of fly screens on kitchen windows, however these were not closed securely resulting in live flies in one ward kitchen area.

- Signs on ward kitchen doors outlined restricted access, however, doors were not locked.
- The sink in one ward kitchen did not appear to have been cleaned recently.
- There was no evidence of staff working in ward kitchens wearing Personal Protective Equipment (gloves, aprons or hairnets).
- There was no evidence of a division of roles between catering and cleaning at ward level.
- Therefore a potential risk to the health and welfare of patients existed.

***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: A (>85% compliance with this criterion)

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

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

- There was evidence demonstrated that hand hygiene complied with best practice and records of training were maintained.
- Wash-hand basins had mixer taps and were hands free.
- There was evidence that some wash basins were in need of cleaning and many taps discharged directly into the plug hole.

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 an incident reporting process and of collation of incident reports with feedback to the Hospital Manager and Director of Nursing, and, at the ward level on an individual basis for each ward related incident.
- There was evidence demonstrated that processes used for the minimisation of risk when hygiene services are being provided included the use of warning signs.
- There was no evidence demonstrated of resultant actions and continuous quality improvement plan.

SD 4.9 Rating: C (41- 65% compliance with this criterion)

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

- There was evidence demonstrated of a patient representative on the Environment and Facilities Committee.
- There was evidence demonstrated of patient consultation through the HSE comments and complaints policy.
- 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: C (41- 65% compliance with this criterion)

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

- There was evidence that the special needs for privacy and confidentiality are supported through the visiting policy and awareness is highlighted through the hospital information leaflet.
- There were no reported patients or families rights violations in relation to hygiene services.
- There was no documented evidence demonstrated of a process to maintain patient dignity during hygiene services delivery.

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

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

- There was evidence demonstrated that patients receive information leaflets from the admissions department by post prior to admission and these contain a reference to hygiene.
- There was evidence that hygiene related leaflets are available in public areas.
- There was evidence of signs highlighting the importance of using alcohol gel, however alcohol gel dispensers are not readily visible.
- There was no evidence demonstrated of evaluation of patient, family 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 demonstrated that the organisation utilises the HSE comment and complaints policy "Your Service, Your Say".
- There was evidence demonstrated of hygiene related complaints, which are dealt with individually.
- There was no evidence demonstrated of trending of hygiene related complaints for root cause analysis.

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 patient representative on the Hygiene Services Team.
- There was evidence demonstrated of patient involvement through the "Your Service, Your Say" comment and complaint policy.
- There was no evidence demonstrated of evaluation of the extent to which patients, families and other organisations are involved by the team when evaluating its hygiene services.

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 the internal hygiene audit process was interrupted and has only recently been reintroduced.
- There was insufficient evidence demonstrated that all clinical areas are included in the internal hygiene audit process.
- There was no evidence of evaluation of the extent to which hygiene services quality initiatives are being undertaken by the Environment and Facilities Committee as a result of evaluation and benchmarking.

SD 6.3 Rating: C (41- 65% compliance with this criterion)

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

- There was evidence of a compilation of activities undertaken by the Hygiene Services Team in 2007 contained in a folder, however this is not collated in an Annual Report format.
- There was evidence demonstrated that this folder is available to staff on request, however it is not collated or distributed widely throughout the organisation.
- There was no evidence demonstrated of evaluation of the appropriateness of the Hygiene Services Annual Report.

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	B	B
CM 1.2	B	C
CM 2.1	C	C
CM 3.1	C	C
CM 4.1	C	C
CM 4.2	C	C
CM 4.3	C	C
CM 4.4	C	C
CM 4.5	B	B
CM 5.1	B	B
CM 5.2	B	A
CM 6.1	A	A
CM 6.2	B	B
CM 7.1	B	B
CM 7.2	A	B
CM 8.1	C	C
CM 8.2	C	C
CM 9.1	C	C
CM 9.2	A	C
CM 9.3	B	C
CM 9.4	C	B
CM 10.1	C	B
CM 10.2	C	C
CM 10.3	B	C
CM 10.4	C	C
CM 10.5	C	C
CM 11.1	B	B
CM 11.2	C	C
CM 11.3	C	C
CM 11.4	B	C
CM 12.1	C	B
CM 12.2	C	C
CM 13.1	C	C
CM 13.2	C	C
CM 13.3	B	B
CM 14.1	B	C
CM 14.2	B	C
SD 1.1	B	C
SD 1.2	B	C

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