Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

# National Hygiene Services Quality Review 2008

## Midland Regional Hospital at Tullamore

## Assessment Report

**Assessment date: 13th 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 Midland Regional Hospital at Tullamore – Organisational Profile[1]

The Midland Regional Hospital at Tullamore is located in Tullamore, Co Offaly. This hospital, with its complement of 227 beds, serves the population of the midlands comprising the counties Offaly, Laois, Westmeath and Longford. The hospital serves a population of circa 250,000. The hospital building was designed by Michael Scott from 1934 to 1937 and is listed as a protected structure.

Services provided include general medicine, including gastroenterology, respiratory medicine, cardiology and geriatric medicine, general surgery including vascular surgery, intensive care, coronary care, emergency department, orthopaedics, ear, nose and throat (ENT), oncology/haematology and renal dialysis.

## 2.2 Areas Visited

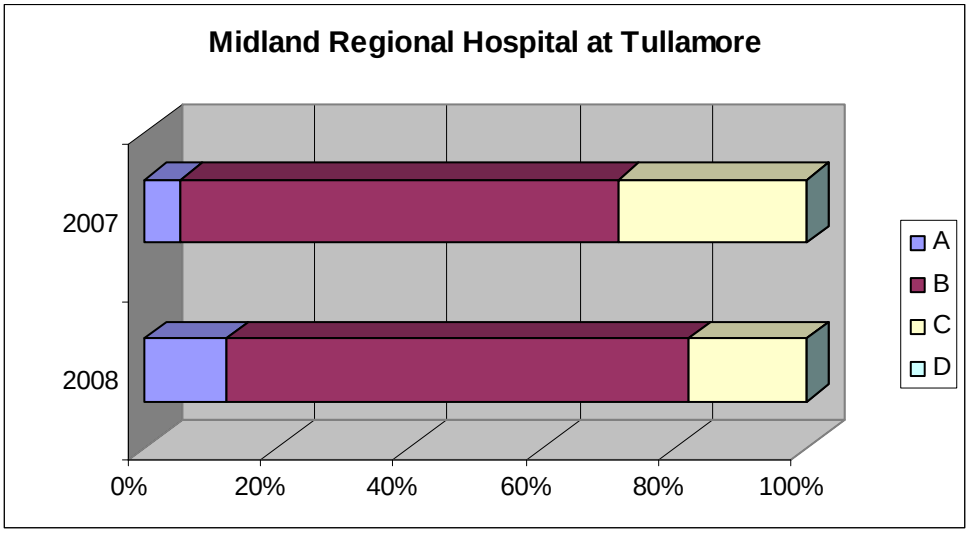
The Assessment team visited:

- Emergency department
- Outpatients department
- Medical ii Ward
- Medical iii Ward
- Surgical ward
- Orthopaedics ward
- Laundry service
- 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 at Tullamore 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: A (>85% compliance with this criterion)**

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

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

**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.**

- The organisation demonstrated, through the commissioning process for the new hospital, that hygiene services were developed to meet the health needs of the population served based on information collected.
- Other examples of modifications demonstrated included: the appointment of a dedicated waste management porter to collect waste from every clinical department, the development of a regional cleaning guidelines manual, and the development of a centralised dishwashing area.
- No evidence of evaluation of developments and modifications was demonstrated.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

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

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

- The organisation demonstrated, through e-mails, that there were linkages with the Network Manager and General Manager.
- They also demonstrated, through the Infection Control Nurses' job description, that the role extended into the community.

- A tour day, of the new hospital, for the general public and an open day for local transition year students were also demonstrated to include hygiene related information.
- The organisation also demonstrated a patient satisfaction survey, developed by the Hygiene Action Team, which was rolled out in September 2008. No recommendations or action plans were demonstrated.
- The organisation did not demonstrate any evaluation of the efficacy of the linkages and partnerships.

CORPORATE PLANNING FOR HYGIENE SERVICES

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

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

- The organisation demonstrated a Corporate Strategic Plan that was developed by the Environment and Facilities Team, however no documented process for its development was demonstrated.
- Evidence was provided to demonstrate that the plan detailed the organisation's objectives and the goals and priorities for 2008 were included in the Hygiene Service Plan which was also demonstrated.
- The 2007 Hygiene Annual Report was also demonstrated and included the 2007 achievements for Hygiene Services and the related costings.
- The organisation demonstrated a communication plan for Hygiene Services information
- They also demonstrated that a service user is a member of the Environment and Facilities Team.
- No evidence of evaluation of the strategy against defined needs was demonstrated to the assessors.

GOVERNING AND MANAGING HYGIENE SERVICES

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

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

- The organisation demonstrated, through an organisational chart and job descriptions, that their provisions for hygiene services were clearly defined at all levels.

- The organisation also demonstrated that they evaluated adherence to legislation and relevant national guidelines through internal and external audits.
- The organisation did not demonstrate any evidence of evaluation of the review of provisions in the area of hygiene services.

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

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

- The organisation demonstrated that all hygiene related information is discussed at the Environment and Facilities Team of which the Executive Management Team are members.
- Evidence was provided demonstrating that results of audits were forwarded to the Hospital Management Team.
- The organisation demonstrated that an evaluation of the Environment and Facilities Team had been undertaken in June 2008 and it was demonstrated that the team were satisfied with the information received.
- There were no performance indicators demonstrated.

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

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

- The organisation demonstrated that a library, Internet and intranet were available to all staff members.
- All policies, procedures and guidelines demonstrated were evidence based.
- The organisation demonstrated that the Environment and Facilities Team produced their first newsletter in August 2008 which included best practice information. Evidence was also provided demonstrating that this newsletter was circulated to line managers via e-mail.
- A number of hygiene related memorandums circulated to department heads from the Hospital Manager were demonstrated.
- No evaluation was demonstrated of the appropriateness of hygiene services related research and best practice information available.

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

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

- The organisation demonstrated a regional guideline for the management of policies, procedures and guidelines which was out of date.

- The organisation's infection control manual followed the template, however a large number of the policies, procedures and guidelines were out of date. A revised manual had been developed and was demonstrated, however it had not been circulated.
- The organisation advised the assessors that a regional cleaning manual, based on the Irish Acute Hospital Cleaning Manual, had also been developed and was with the printers at the time of the assessment.
- No evaluation of the efficacy of the process for developing and maintaining Hygiene Services policies, procedures and guidelines was demonstrated.

**CM 4.5 Rating: A (>85% compliance with this criterion)**

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

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

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

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

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

- The organisation demonstrated their hygiene services structure through an organisational chart.
- The Environment and Facilities Team terms of reference and roles and responsibilities were also demonstrated.
- The job descriptions for the Executive Management Team were demonstrated.
- Evidence was also provided to demonstrate that ward managers had responsibility and accountability for hygiene services in their areas.
- The organisation advised the assessors that segregation of household and catering duties had not been achieved to date.

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

**The organisation has a multidisciplinary Hygiene Services Committee.**

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

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

***Core Criterion**
**CM 6.1 Rating: 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 that a business plan was completed when departments were requesting to purchase equipment and products. There was evidence provided that business plans were discussed at the Environment and Facilities Team meetings.
- No evidence of evaluation of the efficacy of the consultation process between the Hygiene Services Committee and senior management was demonstrated.

MANAGING RISK IN HYGIENE SERVICES

***Core Criterion**
**CM 7.1 Rating: A (>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 compliance of greater than 85% with the requirements of this criterion.

**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 that a designated Risk Manager was available for the hospital however this person was based in a regional office.
- While it was reported that there was no Health and Safety Officer, evidence was provided to demonstrate that the Risk Manager dealt with clinical and non-clinical risks.

- The Health and Safety Committee was demonstrated to meet monthly with representation from the Environment and Facilities Team and hygiene related incidents were demonstrated to be discussed at this meeting.
- Incidents were also demonstrated to be reviewed every two months by the Hospital Management Team and the Risk Manager.
- Evidence was provided that a local Infection Control Committee was established in May 2008 and as part of their terms of reference, meet quarterly and reported to the Environment and Facilities Team.

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 that contracts were negotiated utilising the national Procurement Policy.
- Evidence was provided of the contract for pest control, linen and waste however not for water sampling, the shop or sanitary bins.
- There was no evidence provided of monitoring of contracts or reporting relationships.

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

**The organisation involves contracted services in its quality improvement activities.**

- The organisation demonstrated the development of an audit tool in September 2008 for contractors providing service contracts.
- This tool was developed by the Maintenance Manager and was demonstrated to be discussed at the Environment and Facilities Team.
- An induction sheet was also utilised for all contract staff.

PHYSICAL ENVORNMENT, FACILITIES AND RESOURCES

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

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

- While the organisation had a newly built hospital on the day of the review the majority of patients were accommodated in the older building. The organisation demonstrated that agreement had been reached the night before the review to move to the new area in the first week of December.

- The Emergency Department had one toilet in the department for an annual throughput of 33,000 patients and the Orthopaedic Ward had 4 showers for 47 beds.
- Air Dryers were observed in all patient bathrooms in the new building.
- Risk assessments of the new building were demonstrated.

***Core Criterion**

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

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

- The organisation provided evidence of policies, procedures and guidelines for waste management, sharps, linen, Hazard Analysis and Critical Control Point plan, cleaning and decontamination of equipment, however some of the documentation was out of date.
- There was no segregation of cleaning and kitchen duties demonstrated.

**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.**

- The organisation demonstrated that they utilised Environmental Health Officer and Health and Safety Authority reports and action plans were provided as evidence.
- Some internal environmental audits were also demonstrated as evidence, however there was no evidence presented of internal catering audits.
- The organisation provided evidence to demonstrate that disposal of food waste had been reviewed and new arrangements were in place.

**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 that a service user was a member of the Environment and Facilities Team.
- They also demonstrated that a patient satisfaction survey had been undertaken in the last couple of months, however there were no recommendations or action plan demonstrated.

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.**

- While the organisation did not demonstrate a documented process for selection and recruitment for hygiene services the Commission for Public Service Appointments Code of Practice was demonstrated.
- Job descriptions for Clinical Nurse Managers 2 and 3, a porter and catering assistant were demonstrated as were recruitment records.
- No evaluation of the process for recruitment and selection of human resources was demonstrated.

**CM 10.2 Rating: B (66-85% compliance with this criterion)**

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

- The organisation demonstrated that they had undertaken a manpower planning exercise (400 additional staff required) when planning the services for the new hospital to include extended twilight cover and weekend work, however the tool utilised was not demonstrated.
- The new hospital was reported to be three times larger than the old.
- Evidence of new posts included a designated waste manager, linen porter, waste porter and a catering officer who had responsibility for ward kitchens was demonstrated.
- Evidence was demonstrated of agreement, the night before the review, to engage 16 additional whole time equivalent contract cleaners.

**CM 10.3 Rating: B (66-85% compliance with this criterion)**

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

- The organisation demonstrated that human resources processes ensured that staff members had the appropriate qualifications. A range of job descriptions were demonstrated however not all detailed qualifications or training needs.
- It was also demonstrated that staff members were not assigned to the ward kitchens until they had been provided with Hazard Analysis and Critical Control Point training.

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

**There is evidence that the contractors manage contract staff effectively.**

- The organisation demonstrated that they have developed a contract employees' handbook, however, it had only been distributed to one contractor.
- No evidence was demonstrated of reporting processes within contracts.

***Core Criterion**
**CM 10.5 Rating: B (66-85% compliance with this criterion)**
**There is evidence that the identified human resource needs for Hygiene Services are met in accordance with Hygiene Corporate and Service plans.**

- The organisation demonstrated a manpower planning process, however, the tool utilised was not demonstrated.
- New designated positions for a waste manager, linen porter, waste porter and fulltime microbiologist were also demonstrated.
- Hygiene corporate strategic, service and operational plans and a 2007 Hygiene Services Annual Report were demonstrated.

ENHANCING STAFF PERFORMANCE

***Core Criterion**
**CM 11.1 Rating: C (41-65% compliance with this criterion)**

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

- The organisation demonstrated that new staff members attended the Dublin Mid-Leinster corporate induction programme however the only hygiene related presentation demonstrated was from the Occupational Health Department who presented on occupational blood exposures.
- Evidence was provided to demonstrate that the employee induction booklet included a section with hygiene related information.
- Evidence was also provided of a support service staff induction handbook which detailed training needs included Further Education and Training Awards Council Skills, infection control, sharps disposal, hand hygiene, basic food hygiene, food safety and special diet training.
- A five-day buddying system for support service staff was also presented as evidence.
- No attendance levels were demonstrated for orientation/induction.

**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.**

- The organisation demonstrated a Learning and Development Policy, however it was out of date (2002).
- The organisation did not demonstrate a formal schedule of training, however it did demonstrate that hand hygiene, standard precautions, Hazard Analysis and Critical Control Point, Further Education and Training Awards Council skills level five for support staff, and Health Care Assistants had taken place.
- The organisation demonstrated that the Infection Control Team and Accreditation Manager were involved in training.
- Evidence was provided to demonstrate that attendance records of hand hygiene training for 2008, and only four porters have been trained in waste management since March 2007.
- No evaluation of the relevance of the education to each staff member was demonstrated, however evidence was provided that hand hygiene training had been evaluated.

**CM 11.3 Rating: B (66-85% compliance with this criterion)**

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

- The organisation demonstrated that they utilised hygiene audits to assess the effectiveness of hand hygiene training.
- Evidence was also provided demonstrating that Methicillin-Resistant *Staphylococcus aureus* (MRSA) rates had reduced by 16% in 2008.
- No evidence was demonstrated regarding the effectiveness of standard precautions training.
- The organisation did not demonstrate any other Performance Indicators utilised to evaluate the effectiveness of 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 a probation period review at five and 10 months from commencement of employment.
- Evidence was provided to demonstrate that the Support Services Manager has commenced inspections of departmental cleaning services to assess the member of cleaning staffs performance. However there was no consistency with this process as some departments cleaning schedules were observed to be regularly signed off by the supervisor and others were not.

- The organisation did not demonstrate any 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.**

- A regional Occupational Health Service, which was adjacent to the hospital, was available to all staff members and this was demonstrated in the employee handbook.
- Evidence was provided to demonstrate that the Occupational Health Department presented at the Dublin Mid-Leinster corporate induction programme.
- Evidence was also provided to demonstrate that Hepatitis B, Influenza and Tetanus vaccines were available to staff members.
- An evaluation of the appropriateness of the regional service was demonstrated however no recommendations or action plans were demonstrated.

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

**Hygiene Services staff satisfaction, occupational health and wellbeing is monitored by the organisation on an ongoing basis.**

- The organisation demonstrated that the Hospital Management Team monitored and reviewed absenteeism rates.
- Evidence was provided to demonstrate that staff members returning from sick leave had a return to work interview.
- The organisation demonstrated that staff members on long term sick leave were referred to the Occupational Health Department. An Employee Assistance Programme was also demonstrated.
- Evidence was provided to demonstrate an employee award system which had been introduced and one member of the Hygiene Services staff had recently won this award
- No evaluation of the appropriateness of mechanisms for monitoring staff satisfaction was demonstrated.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

**CM 13.1 Rating: B (66-85% compliance with this criterion)**

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

- The organisation demonstrated that it collected hygiene related information through satisfaction surveys, incident reporting processes, complaints, audits and infection rates.
- Evidence was provided to demonstrate that the organisation utilised a computer programme to aid access to audit findings.
- A folder was demonstrated to be available at department level with minutes of the Environment and Facilities team meetings and Health and Safety meetings.
- No evaluation was demonstrated of data reliability, accuracy, validity or 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.**

- The organisation demonstrated the reporting of data and information in minutes of meetings, audit results, Environment and Facilities Newsletter and the Hygiene Services annual report.
- No evaluation of data and information turnaround or user satisfaction in relation to reporting of data and information was demonstrated.

**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.**

- Evidence was demonstrated that one committee (the Environment and Facilities Team) had evaluated the appropriateness of the utilisation of data collection and information reporting. Evidence was provided that the majority were satisfied.
- No other evidence of utilisation of data was demonstrated.

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.**

- Evidence was provided to demonstrate that the Hospital Management Team were members of the Environment and Facilities Team. This team was demonstrated to drive hygiene related quality improvements throughout the organisation.

- The organisation demonstrated an Environment and Facilities Team quality improvement project which had six sub sections: quality, hand hygiene, new equipment, hygiene, health and safety and decontamination.
- Health and Safety walkabouts were demonstrated, however there were no action plans demonstrated.

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

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

- The organisation demonstrated that they had reviewed their internal audit process.
- An evaluation of staff members who had been involved in the Environment and Facilities quality improvement project was also demonstrated with positive feedback.
- Evidence was presented of communication to staff members and department managers of changes made through quality improvement processes.
- The organisation did not demonstrate that hygiene related Performance Indicators were routinely used to assess the effectiveness of the Hygiene Services provided.

## 2.5 Standards for Service Delivery

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

EVIDENCE-BASED BEST PRACTICE AND NEW INTERVENTIONS IN HYGIENE SERVICES

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

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

- The organisation demonstrated a documented process for the establishment, adoption, maintenance and evaluation of best practice policies, procedures and guidelines, however it was out of date.
- A cleaning manual was demonstrated to have been developed regionally however it had not been circulated to departments.
- A colour coding system was demonstrated to be in place for cleaning, waste, sharps and linen.
- Infection control policies, procedures and guidelines were also observed to be out of date however an updated manual was demonstrated which was ready for distribution to departments.
- An evaluation of the operations of the regional group who had developed the cleaning manual was also demonstrated.

**SD 1.2 Rating: B (66-85% 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.**

- The organisation demonstrated that all new and changed hygiene services interventions were processed via a business plan which was reviewed at the Environment and Facilities Committee.
- A procurement policy and a standard operating procedure for managing new equipment/products trials was also demonstrated which referred to consulting with the Environment and Facilities Committee and Infection Control Team.
- New products/equipment introduced included the introduction of wipes in the Intensive Care Unit and hot and cold food distribution trolleys.

- No formal evaluation of the interventions was demonstrated.

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.**

- A hygiene information leaflet was demonstrated to be included in an admission pack posted to all elective admissions.
- Two infection control awareness days were also demonstrated during 2008.
- No evaluation of the efficacy of activities undertaken was demonstrated.

INTEGRATING AND COORDINATING HYGIENE SERVICES

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

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

- The organisation demonstrated that the Environment and Facilities Committee is multidisciplinary.
- They also demonstrated that the Hygiene Action Team, a sub-group of the Committee, meets fortnightly and feeds in to the Committee on a quarterly basis.
- There was limited evidence provided, apart from shared membership that appropriate linkages exist between various teams and committees.
- There was limited knowledge in departments visited by the assessors of who represented them on the Environment and Facilities Committee.
- No evidence was demonstrated of evaluation of the efficacy of the hygiene services team structures.

IMPLEMENTING HYGIENE SERVICES

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

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

- Patient areas in both the new and old areas of the hospital were visited.

- The physical environment and facilities in the new hospital were mainly clean with evidence of some light dust on bed frames. The old facilities were poor, with poor layout and congestion due to a lack of storage areas.
- The Emergency Department was very cluttered and evidence of sticky tape residue was observed throughout. The sluice room was also used as the plaster room and cleaner's room. An imminent move to the new facility was demonstrated.
- Air dryers were in place in all patient bathrooms.

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

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

- In general equipment was well maintained.
- Records of cleaning had ceased and were incorporated within the environmental audit tool.
- Fans were observed in a number of wards some of which were dusty. There was no evidence demonstrated of a fan cleaning policy.

***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.**

- The cleaning equipment was generally well maintained.
- Storage facilities for cleaning equipment in the new areas of the hospital were designated and suited to purpose. In the older areas storage facilities were limited with storage occurring in different locations including sluice rooms.
- Personal protective equipment was not observed being used in all areas.

***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.**

- Access restriction notices were on all kitchen doors and within departments in the new building visited they were observed to be closed. However, nursing and medical staff were observed having a meeting in one ward kitchen. In the older building two open doors were observed.
- Hand-washing facilities were available for kitchen staff.
- Management of kitchen waste was demonstrated. Within the new building kitchen waste was brought to a local storage room where collection times and

records were maintained. In one kitchen in the older building the household waste disposal bin was on a corridor due to lack of space.
- There was evidence that personal protective equipment was neither provided nor worn within the ward kitchens in the building. The organisation advised the assessors that the policy for ward cleaning staff who clean ward kitchens was for personal protective equipment to be worn for ward cleaning and to be removed for kitchen duties. This was not demonstrated.
- Evidence was demonstrated that food storage was not managed in accordance with best practice. Out-of-date food was observed in both areas of the hospital.
- Ice machines were not working in two kitchens.

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

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

- A policy for segregation of clinical and non-clinical waste was demonstrated.
- Evidence was demonstrated of records of waste tags for each department, a waste collection permit, waste license, C1 forms and destruction records.
- Evidence was provided to demonstrate that a designated waste porter collected all the waste throughout the hospital.
- The waste compound for the new hospital area was observed to be a secure compound with separate refrigerated storage area for cytotoxic waste. A second compound was used for the older building where there was a leaking roof in the shed used to store clinical waste observed and there was no hand wash facilities provided. Domestic waste was also observed in a nearby open area.
- Within the new area of the hospital there were storage facilities for all waste, and collection times were documented, however neither the areas nor bins within the areas were locked.
- The Sharps Policy was not always adhered to as a number of sharps bins were left open when not in use and were not signed off for assembly.
- Training records demonstrated that four porters were trained in waste management in October 2008 the only training for porters since March 2007.

***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.**

- The assessors observed that the organisation had a large number of non-compliant sinks and taps in the old areas of the hospital.
- There was limited space in some areas to conveniently access the sinks.
- Air hand dryers were observed in bathrooms throughout the hospital.
- Hand hygiene posters and leaflets were not in place in all areas and there was a noted lack of posters demonstrating hand washing technique.
- 38% of staff members had attended mandatory hand hygiene training in 2008.

**SD 4.8 Rating: A (>85% compliance with this criterion)**

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

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

**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.**

- The organisation demonstrated hygiene related posters and information leaflets, a visiting policy and protected meal times.
- A satisfaction survey had been completed, however, the organisation did not demonstrate any recommendations or action plans following the survey.
- The visiting policy was demonstrated to be adhered to in the new areas of the hospital as there is a controlled access system, however it was not possible to adhere to it in the older areas as members of the public needed to walk through wards to access other areas of the hospital.

PATIENTS'/CLIENTS' 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.**

- Patient dignity was demonstrated to be supported through the visiting policy, protected meal times and appropriate signage on doors however there was no documented process for maintaining patient dignity during hygiene services delivery.
- The nursing philosophy displayed in ward areas was demonstrated to include dignity.
- There were no reported rights violations demonstrated.

**SD 5.2 Rating: B (66-85% compliance with this criterion)**

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

- The organisation demonstrated hygiene related information leaflets and posters that were available to patients and visitors.
- Waste bins were demonstrated to display details of what should be discarded in them.
- The organisation did not demonstrate any evidence of evaluation of patients and visitors satisfaction with information provided.

**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.**

- The organisation demonstrated that they had a formal process for dealing with hygiene related complaints through "Your Service Your Say".
- A guideline for investigating complaints was demonstrated, however it was undated and not in the policy, procedure and guideline template.
- Evidence was provided to demonstrate that complaints were reviewed monthly at the Hygiene Action Team meeting.
- There was no evidence of trending or analysis of complaints demonstrated due to reported low numbers. However, the organisation did demonstrate that it had developed a database for complaints.

ASSESSING AND IMPROVING PERFORMANCE

**SD 6.1 Rating: B (66-85% compliance with this criterion)**

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

- The organisation demonstrated that they utilised patient satisfaction surveys and complaints to evaluate hygiene services, however, there were no recommendations or action plans demonstrated following the survey.
- They also demonstrated that a service user was a member of the Environment and Facilities Committee.
- No evaluation of the extent to which patients and other organisations are involved by the team in evaluating hygiene services was demonstrated.

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

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

- The organisation demonstrated a number of completed audits and action plans.
- A satisfaction survey was also demonstrated to monitor the quality of hygiene services, however the organisation did not demonstrate any recommendations or action plan.
- No formal hygiene related performance indicators or evaluation was demonstrated.

**SD 6.3 Rating: B (66-85% compliance with this criterion)**

**The multidisciplinary team, in consultation with patients/clients, families, staff and service users, produce an annual report.**

- The organisation demonstrated a Hygiene Services Annual Report for 2007 which was approved by the Environment and Facilities Committee having consulted with the Hygiene Action Team.
- A process was demonstrated for its compilation.
- There was no evidence of any evaluation of the appropriateness of the report demonstrated.

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

| | | |
|---|---|---|
| SD 2.1 | C | C |
| SD 3.1 | C | B |
| SD 4.1 | B | B |
| SD 4.2 | B | B |
| SD 4.3 | B | B |
| SD 4.4 | B | C |
| SD 4.5 | A | C |
| SD 4.6 | A | A |
| SD 4.7 | B | B |
| SD 4.8 | B | A |
| SD 4.9 | B | B |
| SD 5.1 | B | B |
| SD 5.2 | B | B |
| SD 5.3 | C | B |
| SD 6.1 | C | B |
| SD 6.2 | B | B |
| SD 6.3 | C | B |