Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

# Report of the unannounced inspection at Mayo General Hospital, Castlebar, Co Mayo

Monitoring programme for unannounced inspections undertaken against the National Standards for the Prevention and Control of Healthcare Associated Infections

Date of on-site inspection: 12 March 2015

## About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is the independent Authority established to drive high quality and safe care for people using our health and social care services. HIQA's role is to promote sustainable improvements, safeguard people using health and social care services, support informed decisions on how services are delivered, and promote person-centred care for the benefit of the public.

The Authority's mandate to date extends across the quality and safety of the public, private (within its social care function) and voluntary sectors. Reporting to the Minister for Health and the Minister for Children and Youth Affairs, 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 those health and social care services in Ireland that by law are required to be regulated by the Authority.
- **Supporting Improvement –** Supporting services to implement standards by providing education in quality improvement tools and methodologies.
- **Social Services Inspectorate** – Registering and inspecting residential centres for dependent people and inspecting children detention schools, foster care services and child protection services.
- **Monitoring Healthcare Quality and Safety** – Monitoring the quality and safety of health and personal social care services and investigating as necessary serious concerns about the health and welfare of people who use these services.
- **Health Technology Assessment** – Ensuring the best outcome for people who use our health services and best use of resources by evaluating the clinical and cost effectiveness of drugs, equipment, diagnostic techniques and health promotion activities.
- **Health Information** – Advising on the efficient and secure collection and sharing of health information, evaluating information resources and publishing information about the delivery and performance of Ireland's health and social care services.

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## 1. Introduction

The Health Information and Quality Authority (the Authority) carries out unannounced inspections in public acute hospitals in Ireland to monitor compliance with the *National Standards for the Prevention and Control of Healthcare Associated Infections*.[1] The inspection approach taken by the Authority is outlined in guidance available on the Authority's website, www.hiqa.ie – *Guide: Monitoring Programme for unannounced inspections undertaken against the National Standards for the Prevention and Control of Healthcare Associated Infections*.[2]

The purpose of the unannounced inspection is to assess hygiene as experienced by patients at any given time. It focuses specifically on the observation of the day-to-day delivery of hygiene services, in particular environmental and hand hygiene under the following standards:

- Standard 3: Environment and facilities management
- Standard 6: Hand hygiene.

Other Standards may be observed and reported on if concerns arise during the course of an inspection. It is important to note that the Standards are not assessed in their entirety during an unannounced inspection and therefore findings reported are related to a particular criterion within a Standard which was observed during an inspection. The Authority uses hygiene observation tools to gather information about the cleanliness of the environment and equipment as well as monitoring hand hygiene practice in one to three clinical areas depending on the size of the hospital. The Authority's approach to an unannounced inspection against these Standards includes provision for re-inspection within six weeks if standards on the day of inspection are poor. This aims to drive improvement between inspections. In addition, in 2015, unannounced inspections will aim to identify progress made at each hospital since the previous unannounced inspection conducted in 2014.

An unannounced inspection was carried out at Mayo General Hospital on 12 March 2015 by Authorised Persons from the Authority, Aileen O'Brien, Alice Doherty, Katrina Sugrue and Leanne Crowe between 09:15hrs and 16.45hrs. The areas assessed were:

- The **Elderly Medicine Ward** which has 22 beds and consists of three six-bedded wards, three single en-suite rooms and an isolation unit with an ante room.
- The **Oncology/Haematology Day Ward** which has eight designated treatment chairs used for patients requiring infusions. In addition, on the day of inspection a further eight chairs were located in this Ward. These additional chairs were located between the designated treatment chairs. The Authority was informed that these additional chairs were being used for patients

requiring blood tests. There are also two designated treatment chairs in a second room used for patients requiring blood transfusions. Likewise, a further two additional chairs had been located in this room alongside the designated treatment chairs to treat extra patients.

In addition, Wards A and D, which were inspected during an unannounced inspection by the Authority on 3 July 2014, were re-visited to assess the level of progress which had been made after the 2014 inspection.

The Authority would like to acknowledge the cooperation of staff with this unannounced inspection.

## 2. Mayo General Hospital Profile[‡]

Mayo General Hospital provides acute general hospital services to the population of Co. Mayo 130,552 and a proportion of the populations of West Roscommon, North Galway. The annual budget is €78 million and a whole time equivalent of 914.

### Inpatient Services

Mayo General Hospital has 306 beds in-patient (including Adult Mental Health).

The following specialties are provided;

| | |
|---|---|
| General Surgery | General Medicine |
| Gynaecology | Orthopaedics |
| Paediatrics | Pathology |
| Intensive/Coronary Care | Anaesthetics |
| Obstetrics | Palliative Care |
| Radiology | Emergency Medicine |

### Visiting Regional Services:

| | |
|---|---|
| ENT | Radiotherapy |
| Dermatology | Nephrology |
| Urology | Haematology |
| Genital/Urinary Medicine | Oncology |

### Service Departments:

| | |
|---|---|
| Pharmacy | Dietetics |
| Physiotherapy | Occupational Therapy |
| Laboratory Services - Biochemistry, Haematology, Histopathology, Microbiology | Speech & Language<br>Social Work<br>Cardiac Services |

### 2014 Hospital Activity

- 19,051 Inpatient Discharges
- 22,359 Day Cases
- 33,704 Emergency Presentations
- 64,932 Outpatient Attendances
- 1,738 Births

[‡] The hospital profile information contained in this section has been provided to the Authority by the hospital, and has not been verified by the Authority.

## 3. Findings

This report outlines the Authority's overall assessment in relation to the inspection, and includes key findings of relevance. A list of additional low-level findings relating to non-compliance with the standards has been provided to the hospital for completion. However, the overall nature of all of the findings are fully summarised within this report.

The report is structured as follows:

- **Section 3.1** outlines the level of progress made in the implementation of the quality improvement plan (QIP)[3] prepared after the unannounced inspection on 3 July 2014.
- **Section 3.2** presents the key findings of the unannounced inspection on 12 March 2015.
- **Section 3.3** describes the key findings relating to hand hygiene under the headings of the five key elements of the World Health Organization (WHO) multimodal improvement strategy[4] during the unannounced inspection on 12 March 2015.

### 3.1 Progress since the last unannounced inspection on 3 July 2014

#### Isolation rooms

An immediate high risk was identified during the 2014 inspection regarding the care being provided to a patient with a suspected airborne communicable/transmissible disease. In response to this finding, the Authority was informed that risk assessments are being carried out regarding the closing of isolation room doors, such patients are discussed at handover meetings, and the patients and their visitors are educated on the importance of keeping isolation room doors closed. Safety issues such as this one are highlighted and discussed at daily safety pauses on Ward A and if it cannot be resolved are escalated to the Hospital Patient Safety Meeting which takes place five times each day.

#### Environmental hygiene

The Authority reviewed the QIP[3] published by Mayo General Hospital following the 2014 inspection and was informed that a number of the action items are ongoing. Some of the findings identified during the 2014 inspection, such as dust levels, were also evident during the current inspection. It was explained to the Authority that hygiene services are provided by an external company who report to the Service Manager and by hospital-based cleaners who report through nursing structures to the Director of Nursing. However, the allocation of responsibility of cleaning tasks was unclear. The Authority was informed that a meeting was held after the 2014 inspection to disseminate the findings of the inspection in which all ward managers

attended. However, the overall findings on both areas inspected in 2015 indicated that not all lessons had been learned and significant improvements are required in the management and maintenance of environmental hygiene within the hospital. The results of infection prevention and control (IPC) environmental audits viewed by the Authority indicated that some of the results for the environmental elements of the audits were low and it was not clear what actions were being taken by the hospital to address these results. The different reporting structures for the external cleaning company and the hospital-based cleaners, in addition to the lack of clarity surrounding the responsibility of cleaning tasks which was evidenced during the inspection suggests that there is a lack of a coordinated approach to hygiene services.The Authority was informed that the hospital is proposing to carry out senior managerial audits and that a business case for a hygiene manager or co-ordinator for the hospital is being considered to address the deficiencies identified.

### Ward A

A specific QIP was developed for Ward A to address the findings of the 2014 inspection. Equipment such as commodes and armchairs were replaced and a further six armchairs were re-upholstered. The Authority was informed by senior management that 50 chairs had been purchased by the hospital. A cleaning checklist for every item of equipment was devised and completion of the checklist is monitored by the ward manager two to three times a week. Extra assistance was provided for the cleaning of patient equipment and the Authority was informed that this has led to an improvement in cleaning. The practice relating to near patient blood glucose testing on the ward has changed. Integrated sharps trays which are labelled for specific use during blood glucose testing are used to hold only the equipment required for a single procedure and are cleaned after each procedure. Local ownership of environmental hygiene was targeted as an area for improvement on the ward which has resulted in increased awareness of individual staff responsibility. There is a cleaning schedule for high level dusting and beds are physically moved during cleaning to facilitate access for floor cleaning.

The Authority was informed that most of the issues identified during the 2014 inspection relating to sanitary facilities on Ward A have not been resolved. A request for the replacement of shower seats and toilet seats has not been addressed. The design of showers, which has been identified as a patient risk factor for falls, slips and trips also remain an issue. It was explained to the Authority at the close out meeting with senior management that the capital requirements for the upgrade of the sanitary facilities on the ward were deemed to be too high for minor capital funding and have now been forwarded for major capital funding.

The appropriate use of personal protective equipment by staff on Ward A was described as a 'work in progress' by staff; awareness and adherence to best practice

has improved but further improvement is required. The ward achieved 83% compliance in a local hand hygiene audit carried out in October 2014.

### Ward D

A cleaning checklist for patient equipment was devised for Ward D and the Authority was informed that it is working well. Three mattresses were replaced following a recent audit and chairs are due to be replaced. The Authority was informed that hand hygiene practice by staff on the ward had improved particularly in relation to staff wearing jewellery acting as a barrier to the correct technique. However, hand hygiene audit results displayed on the ward showed a compliance of only 67% in July 2014.

### Waste

The entrance to a waste sub-collection area was not secured during the current inspection and a healthcare risk waste bin in the area was open even though there was a sign stating that it should be locked. This finding was also highlighted during the 2014 inspection. The Authority was informed that increased resources for waste collection are being considered and the hospital is now waiting on approval for recruitment of additional staff.

### *Legionella*

It was highlighted at the 2014 inspection that the risk assessment for the prevention and control of *Legionella* at the hospital needed to be reviewed. The Authority was informed that this is due to be carried out by an external company in the near future. However at the time of the most recent inspection this had still not been conducted.

## 3.2 Key findings of the unannounced inspection on 12 March 2015

### Patient accommodation

At the time of the current inspection, 20 patients were accommodated in two rooms on the Oncology/Haematology Day Ward. This is double the number of treatment spaces listed for the hospital in a National Cancer Control Programme (NCCP) Oncology Medication Safety Review Report published in February 2014.[5] The review was conducted across 26 hospitals in Ireland involved in the administration of systemic cancer therapy in adults and children. The report states that 'the designated day ward space in some hospitals was never intended to cater for the volume of patients currently attending the service' which seems to be the case at Mayo General Hospital. The Authority was informed that the ward was set-up about five years ago as a temporary facility.

Sixteen out of the 20 patients on the Oncology/Haematology Day Ward were accommodated in an open-plan room which is not in line with best practice guidance for cancer treatment facilities which state that 'open-plan areas should be divided into smaller zones of no more than six chairs'.[6] Treatment of patients in very close proximity to each other increases the risk of droplet and contact transmission of respiratory pathogens such as influenza. It was also noted in the NCCP report that there was less than a metre between patients receiving treatment in some units.[5] There are no designated isolation facilities on the ward for patients with known or suspected transmissible infection and there is only one designated patient toilet for use by patients undergoing treatment and patients in the ward waiting area. Access to one of three clinical hand wash sinks in the open-plan room was restricted at the time of the inspection.

## Patient equipment

Opportunities for improvement were identified in the management of patient equipment on the Elderly Medicine Ward. For example, a red stain was present on a white blood pressure cuff and there was dust on the base of a mobile patient observation monitoring unit, an electro cardiograph machine, a cardiac monitor and the resuscitation trolley. There was no checklist for the daily cleaning of patient equipment which did not provide assurances that all equipment is cleaned completely on a daily basis in line with best practice. This was also highlighted during the 2014 inspection.

Patient equipment on the Oncology/Haematology Day Ward was generally clean and well maintained. However, the under surface of the seat on the commode was unclean and there was rust-coloured staining on the frame. Due to space restriction in the 'dirty'[±] utility room, the commode was stored in the patient toilet which is not ideal. In addition, there is no space or privacy at the patient 'bedside' for the use of a commode and the Authority was informed that it is not used frequently. The 'dirty' utility room was not equipped with a bed pan washer which is necessary for the effective decontamination of commode pans, in addition to urine measuring jugs which are used on the ward. There was also no low level sink in the cleaning equipment room to facilitate the filling of mop buckets and the disposal of liquid waste from cleaning.

## Patient environment

Varying unacceptable levels of dust were observed in patient areas on the Elderly Medicine Ward. Dust was present on the undercarriages and frames of all beds inspected, on floor edges, curtain rails, some bedside lockers and casements over

[±] A 'dirty' utility room is a temporary holding area for soiled/contaminated equipment, materials or waste prior to their disposal, cleaning or treatment.

beds. Dust was also present in most areas inspected in the clean utility room which is a multifunctional room used for the preparation of intravenous medications, the storage of medical equipment, medication and patient notes, and an office area for clinical staff. The Authority was informed that it is planned to move the medication preparation area and the storage of medications to a designated room in the near future.

Opportunities for improvement were identified in the cleaning/housekeeping equipment room on the Elderly Medicine Ward where dust was observed on the floor and some of the cleaning equipment was unclean. Inappropriate items were stored on a cleaning trolley suggesting that it was not cleaned after use on a daily basis. In addition, the room was unlocked, potentially allowing unauthorised access to hazardous cleaning products.

Varying unacceptable levels of dust were also present in the patient areas on the Oncology/Haematology Day Ward on floor edges, behind radiators, skirting boards and ventilation extract grilles. Almost all sink outlets on the ward were unclean which is of concern given that the cleaning of sinks was identified as a required corrective action after an outbreak of *Pseudomonas aeruginosa* in the hospital in August 2014. Two treatment chairs inspected on the ward were unclean with dust and grit in the creases and folds of both chairs. The footrest on one of the treatment chair's was also damaged. The Authority was informed that treatment chairs are cleaned after patient use and in the evenings when the ward is closed and a 'full clean' of the ward environment is carried out once daily in the evening.

Hospital hygiene plays an important role in the prevention and control of healthcare associated infections and should be a key priority for all healthcare organisations.[7] A clean environment not only reduces the risk of acquiring an infection but also promotes patient and public confidence and demonstrates the existence of a positive safety culture.[8] The level of risk determines cleaning frequency and how often an area is audited.[9] The impact of poor standards of hygiene on infection risks is greater in some areas of a hospital than others. The Oncology/Haematology Day Ward provides invasive treatment to patients where the risk of transmission of infection is increased and is thereby classified as a high infection risk functional area.[9] It is recommended that the frequency of cleaning on the ward be reviewed so that assurances are provided that it is sufficient to mitigate the risk of contamination of the physical environment.

### Aspergillosis

Temporary high efficiency particulate air (HEPA) filter air purifier units were observed in the clean utility room and in the clinical examination room in the Oncology/Haematology Day Ward. The Authority was informed that these units were installed prior to the construction of the nearby cystic fibrosis unit as a control

measure for aspergillosis. In both rooms the window glass had been replaced with sheets of uncoated wood to facilite the HEPA filter unit pipework, this type of uncoated surface does not facilitate effective cleaning and there was an obvious draught in the window of the clean utility room indicating that the window was not completely sealed resulting in an ingress of unfiltered air which is inappropriate in a room which is used to prepare chemotherapy treatments and other medications.

### Hand hygiene

Hand hygiene compliance observed by the Authority at the time of the inspection on both the Elderly Medicine Ward and the Oncology/Haematology Day Ward was low with only 28.5% (10 out of 35) of hand hygiene opportunities being taken across the two wards. On the Elderly Medicine Ward, personal protective equipment contributed to poor compliance in addition to a lack of awareness of what constitutes the patient zone and the healthcare area. These matters were also highlighted during the unannounced inspection in 2014 and it is of concern that learning from this finding has not been fully disseminated across the hospital.

On the Oncology/Haematology Day Ward, hand hygiene compliance before clean/aseptic procedures was low which is of concern given the nature of activities carried out on this ward. The ward achieved 90% compliance in a recent hand hygiene audit in 2015. However, it was noted that none of the hand hygiene opportunities observed in that particular audit were before clean/aseptic procedures.

The challenges faced by Mayo General Hospital in relation to hand hygiene training and auditing due to reduced IPC resources was acknowldedged by the Authority at the 2014 inspection. The Authority was informed that the hospital only recently returned to its full complement of 2.5 whole time equivalent IPC nurses (from a complement of 0.8 whole time equivalents in 2014) and is in the process of preparing a business case for an assistant director of nursing for IPC. In the intervening period, an external company was engaged by the hospital to carry out hand hygiene training and audits. Since the full IPC complement has been in place, the hospital is re-starting to monitor compliance of all staff with hand hygiene training and to carry out monthly hand hygiene audits. The Authority was also informed that a full-time Consultant Microbiologist post at the hospital which is currently vacant is due to be filled in July 2015. The hospital previously had locum cover, and currently has interim on-call cover on a 24/7 basis. It is very important that this Consultant Microbiologist post is filled at the hospital as a priority.

## 3.3 Key findings relating to hand hygiene

**3.3.1 System change[4]:** *ensuring that the necessary infrastructure is in place to allow healthcare workers to practice hand hygiene*.

- The design of some clinical hand wash sinks in the two clinical areas inspected did not conform to Health Building Note 00-10 Part C: Sanitary assemblies.[10] The Authority notes that the hospital's sink replacement plan was reviewed as part of the QIP.[3]

**3.3.2 Training/education[4]:** *providing regular training on the importance of hand hygiene, based on the 'My 5 Moments for Hand Hygiene' approach, and the correct procedures for handrubbing and handwashing, to all healthcare workers*.

- Overall, 81% of staff at Mayo General Hospital attended infection control training events which includes hand hygiene training from 1 February 2013 to 23 February 2015. The majority (95%) of staff on the Elderly Medicine Ward and all staff on the Oncology/Haematology Ward were up-to-date with hand hygiene training at the time of the inspection.

**3.3.3 Evaluation and feedback[4]:** *monitoring hand hygiene practices and infrastructure, along with related perceptions and knowledge among health-care workers, while providing performance and results feedback to staff*.

### National hand hygiene audit results

- Mayo General Hospital participates in the national hand hygiene audits which are published twice a year.[11] In May/June 2014, the hospital was above the target of 90% set by the Health Service Executive (HSE) for 2014.[12] However, compliance decreased in the latter half of 2014 to 81.9% with only two out of the seven areas included in the audit achieving greater than 90% compliance.

| Period 1-7 | Result |
|---|---|
| Period 1 March/April 2011 | 61.9% |
| Period 2 October/November 2011 | 69.4% |
| Period 3 May/June 2012 | 76.2% |
| Period 4 October/November 2012 | 82.2% |
| Period 5 May/June 2013 | 83.8% |
| Period 6 October/November 2013 | 86.7% |
| Period 7 May/June 2014 | 91.4% |
| Period 8 October/November 2014 | 81.9% |

Source: Health Protection Surveillance Centre – national hand hygiene audit results.[11]

## Local hand hygiene audit results

- The Elderly Medicine Ward achieved 83% compliance in a hand hygiene audit carried out in May 2014, and the Oncology/Haematology Ward achieved 90% compliance in the most recent audit carried out in 2015.

## Observation of hand hygiene opportunities

Authorised Persons observed hand hygiene opportunities using a small sample of staff in the inspected areas. This is intended to replicate the experience at the individual patient level over a short period of time. It is important to note that the results of the small sample observed is not statistically significant and therefore results on hand hygiene compliance do not represent all groups of staff across the hospital as a whole. In addition results derived should not be used for the purpose of external benchmarking.

The underlying principles of observation during inspections are based on guidelines promoted by the WHO[13] and the HSE.[14] In addition, Authorised Persons may observe other important components of hand hygiene practices which are not reported in national hand hygiene audits but may be recorded as optional data. These include the duration, technique[ϒ] and recognised barriers to good hand hygiene practice. These components of hand hygiene are only documented when they are clearly observed (uninterrupted and unobstructed) during an inspection. Such an approach aims to highlight areas where practice could be further enhanced beyond the dataset reported nationally.

The Authority observed 35 hand hygiene opportunities in total during the inspection. Hand hygiene opportunities observed comprised the following:

- three before touching a patient
- eight before clean/aseptic procedure
- five after body fluid exposure risk
- eight after touching a patient
- 11 after touching patient surroundings.

Ten of the 35 hand hygiene opportunities were taken. The 25 opportunities which were not taken comprised the following:

- three before touching a patient
- seven before clean/aseptic procedure

[ϒ] The inspectors observe if all areas of hands are washed or alcohol hand rub applied to cover all areas of hands.

- seven after touching a patient
- eight after touching patient surroundings.

Of the 10 opportunities which were taken, the hand hygiene technique was observed (uninterrupted and unobstructed) by the Authorised Persons for five opportunities and the correct technique was observed in all five hand hygiene actions.

**3.4.4 Reminders in the workplace[4]:** *prompting and reminding healthcare workers about the importance of hand hygiene and about the appropriate indications and procedures for performing it*.

- Hand hygiene advisory posters were available, up-to-date, clean and appropriately displayed in the areas inspected at Mayo General Hospital.

**3.4.5 Institutional safety climate[4]:** *creating an environment and the perceptions that facilitate awareness-raising about patient safety issues while guaranteeing consideration of hand hygiene improvement as a high priority at all levels*.

- Hand hygiene compliance observed by the Authority on the day of the inspection was poor. The hospital's compliance in the national hand hygiene audit at the end of 2014 decreased to 82.9% compared with 91.4% in May/June 2014. In response to the decrease in compliance, the Authority was informed that ward managers were emailed about issues relating to compliance and that the general manager was contacting staff groups in wards where compliance was poor to inform them of how they had affected the overall results of the audit. The hospital is also planning to introduce hand hygiene training cards showing the WHO '5 moments of hand hygiene' which will be given to staff when they have completed training. The year in which the training is carried out will be shown on the card and this will be colour coded for each year. In addition, a generic screen saver will be installed on all computer screens on the hospital campus. This will consist of 10 slides, one of which will advertise hand hygiene training dates.

## 4. Summary

While some improvement was identified by the Authority in the most recent inspection compared to a similar inspection in 2014, it was noted that some issues, for example unacceptable levels of dust, were still evident. Opportunities for improvement were identified regarding patient equipment on the Elderly Medicine Ward. Similar to a finding highlighted during the 2014 inspection, there was no checklist for patient equipment on the ward. The Authority inspects two to three clinical areas during an unannounced inspection. The aim of the inspection is to determine compliance with the Infection Prevention and Control Standards as well as to drive improvement in the areas inspected. The Authority recommends that Mayo General Hospital should review the findings of the areas inspected in 2014 and

implement the required improvements on a hospital-wide basis. The implementation of the QIP should be monitored so that the hospital can be assured that all areas comply with the Standards.

The general patient environment on the Oncology/Haematology Day Ward was overcrowded at the time of the inspection and there was also limited storage space and facilities on the ward. The hospital needs to ensure that overcrowding on this unit is prevented, and that the environment is properly planned and resourced to deal with the volume and needs of the patients and staff who both receive and provide care in this environment. In addition, it is recommended that the control measures for aspergillosis are reviewed in relation to this high risk area, and other further proposed building works on site.

Hand hygiene compliance on the day of the 2015 inspection was poor, and a decline in compliance was also evident in the national hand hygiene audit at the end of 2014. The Authority acknowledges that the hospital was operating with reduced IPC Team resources up to the end of 2014 and has implemented measures to address hand hygiene training and audits in the interim. However, a significant improvement in hand hygiene performance is needed, and improved awareness of the need for optimal hand hygiene performance as a core patient safety measure is required at all levels within the hospital. Poor practice in particular in relation to hand hygiene when donning and doffing personal protective equipment, and lack of differentiation between the patient zone and healthcare area as it relates to hand hygiene, were identified as recurrent problems in both the most recent inspection, and the previous inspection in 2014. This may indicate that the manner in which the findings from the 2014 inspection were disseminated across the hospital were not fully effective, and the method applied to share learning following this inspection should be reviewed to ensure that all areas can learn from each other by targeting areas of poor compliance, in order to improve collective practice.

On the day of this inspection at Mayo General Hospital, there was considerable scope for improvement in performance with respect to environmental hygiene, hand hygiene and other elements of the *National Standards for the Prevention and Control of Healthcare Associated Infection*. The Authority recommends that the hospital acts to comprehensively and effectively review and enhance the structures it has in place to ensure that cleaning services, waste management arrangements and infection control practices are effectively managed, and sufficiently resourced, so that a high quality service is achieved as a matter of routine.

## 5. Next steps

Mayo General Hospital must now revise and amend its QIP that prioritises the improvements necessary to fully comply with the Standards. This QIP must be approved by the service provider's identified individual who has overall executive accountability, responsibility and authority for the delivery of high quality, safe and reliable services. The QIP must be published by the hospital on its website within six weeks of the date of publication of this report and at that time, provide the Authority with details of the web link to the QIP.

It is the responsibility of Mayo General Hospital to formulate, resource and execute its QIP to completion. The Authority will continue to monitor the hospital's progress in implementing its QIP, as well as relevant outcome measurements and key performance indicators. Such an approach intends to assure the public that the hospital is implementing and meeting the Standards, and is making quality and safety improvements that safeguard patients.

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