Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

National Hygiene Services Quality Review 2008

Sligo General Hospital

Assessment Report

Assessment date: 11th 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.

1. 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.

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

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

1.4 Patient Perceptiom 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 Sligo General Hospital - Organisational Profile[1]

Sligo General Hospital is part of Network 4, Western Region of the Health Service Executive (HSE) and currently has a total of 323 in-patient beds and 36 day beds.

The Hospital serves an area of 2,600 square miles with a population of 213,000 for the regional specialities and focuses in on the counties of Sligo, Leitrim, South Donegal and West Cavan (110,000) for its general acute service. In addition, some regional services are provided which include all of county Donegal which gives a population catchment of 213,000 for these services.

The mainstream acute services provided are:

- Anaesthesia, cardiology, diabetology, dermatology, emergency medicine, ENT, gastroenterology, geriatrics, haematology, medicine, microbiology, nephrology, obstetrics/gynaecology, oncology, ophthalmology, orthopaedics, oral and maxillofacial, orthodontics, paediatrics, palliative medicine, pathology, radiology, respiratory medicine and surgery.

Services which are structured on a regional basis with support provided to Letterkenny General Hospital include ENT, Ophthalmology and Dermatology Services. Out patient clinics are also provided at community hospitals.

A regional Rheumatology service is based at Our Lady's Hospital, Manorhamilton.

Consultant Services in Immunology and Radiation Oncology are provided via University College Hospital, Galway with additional Consultant Radiation Oncology services provided from St. Luke's Hospital, Dublin.

2.2 Areas Visited

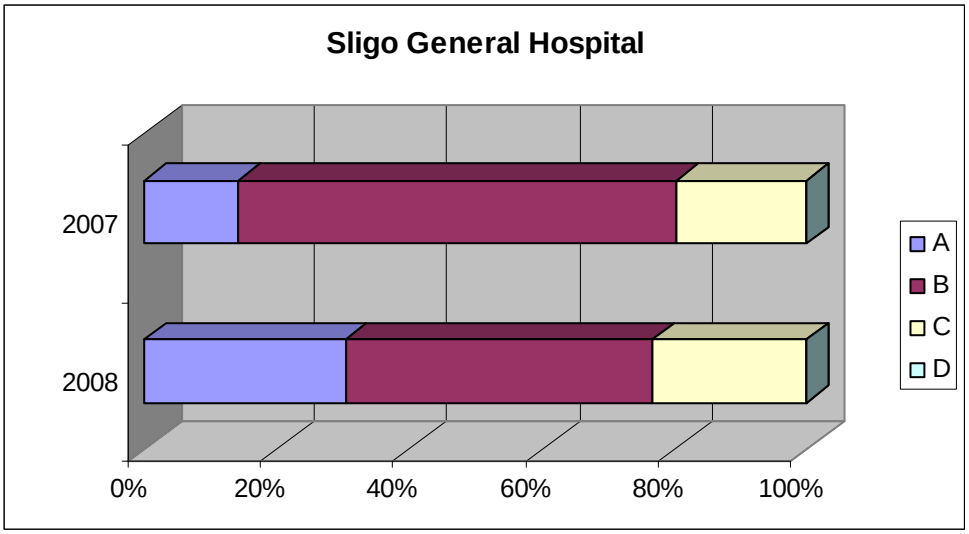
During the course of the assessment the following areas were visited:

- Emergency department
- Outpatient department
- Paediatric ward
- Orthopaedic ward
- Maternity unit
- Medical unit
- 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.

Sligo General Hospital has achieved an overall rating of:

Fair

Award date: 2008

3.0 Standards for Corporate Management

The following are the ratings for the Corporate Management standards, as validated by the Assessment team. The Corporate Management standards allow the organisation to assess and evaluate its activities in relation to Hygiene Services at an organisational level.

PLANNING AND DEVELOPING HYGIENE SERVICES

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

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

- Evidence was demonstrated of input from key stakeholders into the development of the Hygiene Services corporate strategy.
- There was evidence of patient and staff satisfaction surveys also feeding into the process.
- It was demonstrated that these surveys identified the need for 24 hour cleaning which fed into the 2008 service plan.
- Minutes of meeting of Hygiene Management Operational Team of 23rd July 2008 confirm this.
- An equipment matrix was developed in 2007 and the service plan reflects this.
- No evidence of evaluation of the efficacy of the needs assessment process was demonstrated.

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 hospital demonstrated that it had upgraded the Paediatric, Oncology and ICU Departments including providing a negative pressure facility in the ICU. The waste compound has been upgraded.
- Evidence was demonstrated of an electronic system for logging of maintenance calls introduced in the last year.
- Evidence was demonstrated of a health promotion day held on 30th October 2008.
- It was demonstrated that the hospital commissioned an external company to look at the maintenance department in April 2008.
- No evidence of evaluation of the developments and modifications to the organisation's Hygiene Services in relation to meeting the service user's needs 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.

- Evidence was demonstrated of linkages with the Health Service Executive Network West, the Health Promoting Hospital Network, Irish Society for Quality and Safety in Healthcare, and the Irish Hospice Friendly Hospitals.
- Evidence was demonstrated of public health linkages through Infection Control Department contacts.
- Evidence was presented of a partnership process.
- The hospital has a representative on the Health Information and Quality Authority group developing National Infection Control Standards.
- No evidence of evaluation of linkages and partnerships was demonstrated.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 Rating: A (>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 compliance of greater than 85% with the requirements of this criterion.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.1 Rating: A (>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 compliance of greater than 85% with the requirements of this criterion.

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.

- Evidence was demonstrated that hygiene was a standard agenda item on the HMOT.
- Evidence was demonstrated that the hospital had a suite of Key Performance Indicators.
- One of these was in relation to patient satisfaction with hygiene.
- Evidence was demonstrated that the HMOT had been evaluated and recommendations made.
- No evidence was demonstrated of actions implemented or evaluation of the appropriateness of information received

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

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

- It was identified at interview that the Executive Management Team received best practice information through reviewing national reports and information generated from committees.
- The hospital demonstrated that it had an education and training centre and a library.
- It was identified through interview that the hospital had reviewed the waste practices in a nearby hospital and as a result changed their own practices. The hospital demonstrated that they had achieved a national achievement award following this.
- There was a newsletter demonstrated that included hygiene issues and was circulated within the hospital and wider community
- No evidence of evaluation of the appropriateness of hygiene related research and best practice was demonstrated

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 hospital demonstrated that it had a policy in place for the development of policies, procedures and guidelines.
- The hospital demonstrated that it was implementing a document management system for their policies, procedures and guidelines.
- A corporate template dated January 2008 was presented.
- No evidence was demonstrated of the efficacy of the development and maintenance of policies, procedures and guidelines relating to Hygiene Services.

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

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

- A hospital Capital Steering Group Committee was demonstrated.
- Minutes of meeting of April 2008 were demonstrated and identified that infection control should be involved in this process.
- The organisation advised that Hygiene Committee involvement with capital development planning and implementation was by common membership of Capital Steering Group Committee members who were also members of the Hygiene Services Committee.
- Evidence was demonstrated that there had been an evaluation of the HMOT but this did not cover the efficacy of their consultation process.

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.

- Evidence was demonstrated of the Hygiene Service Committee structure.
- It was identified through interview that the terms of reference of all committees were currently being reviewed.
- Roles, authorities and responsibilities were set out.
- Responsibility for hygiene was not included in the job description for general Clinical Nurse Manager 2 positions, apart from the job description for the Clinical Nurse Manager 2 – Oncology.

***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.

- It was identified through interview that the hospital adhered to the HSE procurement policy.
- It was identified that a representative from the hygiene group looks at purchases from a cleaning perspective.
- A decontamination form was presented that must be completed by the supplier and signed off by the Infection Control Team before medical equipment can be purchased.
- Evidence was demonstrated of the flat mop system and hand towels considered at the Hygiene Services Committee.
- No evidence was demonstrated of evaluation of the consultation process between the Hygiene Services Committee and senior management.

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: A (>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 compliance of greater than 85% with the requirements of this criterion.

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.

- Evidence was demonstrated that the hospital adhered to the HSE regional policy on establishing contracts and a number of service level agreements were also in place.
- Evidence was also demonstrated that a process was being put in place to monitor contractors when on-site in areas around time of arrival, leaving.
- No evidence was demonstrated that the hospital monitors contractors activities while on site.

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

The organisation involves contracted services in its quality improvement activities.

- The organisation advised the assessors that the hospital had limited contractors.
- Evidence was demonstrated that the waste contractor did education sessions with staff in the hospital.
- Evidence was observed that the contractor sits on the environment and facilities committee (also known as the hygiene services committee)
- No evaluation of the involvement of contractors' quality improvement activities was demonstrated.

PHYSICAL ENVORNMENT, FACILITIES AND RESOURCES

CM 9.1 Rating: B (66-85% 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.

- Evidence was demonstrated that the hospital had addressed many of the deficits identified in last years hygiene report including air conditioning in the neonatal unit, upgrade of electrical works, a fire replacement panel and that all of this work complied with current building regulations.

- The organisation advised that evaluation was through patient satisfaction surveys, complaints analysis and a review by the fire officer.
- It was demonstrated that an IT based logging system for maintenance requests had been introduced.

***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 hospital demonstrated that it had a waste management policy dated 2006 and due for review in 2008.
- A linen policy was dated 2007.
- The *Legionella* policy was dated 2005 and was due for review in September. 2006.
- The hospital demonstrated that it had undertaken a process mapping exercise of the maintenance department from which 33 QIPs were identified for action and are being progressed.

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

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

- The organisation advised the assessors that the hospital consider that evaluation of the efficacy of its environment and facilities, equipment and devices, kitchens, waste and linen was through the results of patient satisfaction surveys, consumer panel input, along with a fire audit and a recent waste award.
- Evidence was demonstrated that the ward manager undertakes hygiene audits but no evidence was demonstrated that senior management had undertaken any audits this year.

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

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

- Evidence was demonstrated that the hospital had undertaken a patient satisfaction survey which had covered hygiene/cleanliness.
- It was identified at interview that the hospital had a consumer panel with a focus group and feedback in January 2008.
- No evidence was demonstrated of changes as a result of issues identified through the survey results and focus group feedback.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 Rating: A (>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.

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

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.

- Evidence was demonstrated that the hospital undertook a review of portering services in 2007 with an evaluation in 2008.
- As a result a "bleep" system for porters was introduced.
- Evidence was demonstrated of a review of housekeeping services with actions agreed but not yet implemented.
- Evidence was demonstrated through minutes of contingency planning group dated 5th August 2008 identifying that extra cleaning be available for outbreaks but the organisation advised that no extra cleaning hours were required/provided during a recent norovirus outbreak.

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

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

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

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

There is evidence that the contractors manage contract staff effectively.

- Evidence was demonstrated that the hospital had put in place a process to ensure they know when contractors come on site.
- No evidence was demonstrated that the hospital monitor or manage contractors while on-site.
- No evaluation of the appropriate use of contract staff was demonstrated.

***Core Criterion**

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

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

- The organisation advised, regarding this criterion, that the hospital meets its increasing needs for hygiene services for example at the time of outbreaks through overtime by hygiene staff. No supporting evidence was demonstrated.
- The hospital demonstrated that they had reduced absenteeism from 9% to 4.5%.
- No evidence was demonstrated in the Strategic or Operational plans or Draft Annual Report of any human resources needs assessment.

ENHANCING STAFF PERFORMANCE

***Core Criterion**

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

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

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

CM 11.2 Rating: B (66-85% 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 advised that the hospital had a human resource strategy including a training strategy.
- There was evidence demonstrated of a training committee and a nurse practice development unit.
- It was demonstrated that the hospital supports Hazard Analysis and Critical Control Point (HACCP) processes and Further Education and Training Awards Council (FETAC) training
- The hospital advised that while there was no protected time for training, the hospital try to facilitate staff attendance.
- Staff training was recorded on a Human Resources IT system within the HR department.
- It was identified that evaluation will be within the remit of the newly developed training committee.

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

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

- No evidence was demonstrated of formal performance indicators to evaluate the effectiveness of education and training.
- The organisation advised that the human resource IT system produce reports in relation to mandatory training.
- The organisation identified that a review of attendance at fire training identified that those working a four-day week were constantly being missed because training is always on Friday.
- No evidence was demonstrated of action taken as a consequence of this.

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 advised that the hospital monitors performance through daily supervision and monitoring of cleaning checklists.
- A personal development plan was in place within the hospital for senior management but not for any other staff at present.
- No evidence was demonstrated of evaluation of the appropriateness of performance evaluation processes.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 Rating: A (>85% compliance with this criterion)

An occupational health service is available to all staff

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

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

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

- The organisation advised that the hospital monitors attendance levels, staff turnover and referrals to occupational health as performance indicators.
- The hospital provides access to health promotion and screening services.
- No evidence was demonstrated of any evaluation of the mechanisms for monitoring staff satisfaction.

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 advised that it's mechanism for collecting and providing access to hygiene related data was through its document management system, through its newsletter and through E-Mail reminders.
- It was identified that the hospital had a management steering committee that meets monthly
- The organisation confirmed that an evaluation of the document management system had taken place.
- No evidence was demonstrated of the evaluation of the reliability or accuracy of the data collected.

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.

- Evidence was demonstrated that the hospital produced reports relating to infection control, hygiene and risk management.
- Complaints reports were demonstrated to be generated quarterly.
- The organisation advised that the reports were produced in a timely manner but no evidence was demonstrated to support this.
- No evidence was demonstrated of evaluation of user satisfaction in relation to the reporting of data and information.

CM 13.3 Rating: C (41-65% compliance with this criterion)

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

- The organisation advised that the hospital had undertaken an evaluation of the document management system but no evidence was demonstrated of any mechanisms to assess the appropriateness of data collection and information reporting.
- It was identified that complaints are analysed and that there is a review of the consumer service.
- It was identified that a new safety statement template and format had been introduced.

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

- It was demonstrated that the hospital had developed a quality improvement strategy (September 2008).
- Information leaflets, posters and plasma screens were observed.
- It was demonstrated that managerial audits had been introduced in 2007 but that none had taken place this year.

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.

- There was evidence demonstrated that the hospital had developed an electronic incident reporting system. A paperless system was being piloted in three wards.
- Evidence was demonstrated that the hospital had developed a medical equipment policy.
- It was demonstrated that changes were communicated through a newsletter, an action plan on the document management system, and an open forum twice a year chaired by a member of the Executive Management Team.
- No evidence was demonstrated of any evaluation of improved outcomes in Hygiene Services delivery as a result of the quality improvement system.

2.5 Standards for Service Delivery

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

EVIDENCE BASED BEST PRACTICE AND NEW INTERVENTIONS IN HYGIENE SERVICES

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

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

- The hospital demonstrated a policy for the development of PPGs.
- There were policies in relation to waste, linen, and sharps observed but not all of these were observed to be in a current review date.
- Some evidence of best practice guidelines were observed around waste and linen. However, it was observed that some electrical work including drilling through a wall was being undertaken in an area accessible to patients, without evidence of a risk assessment having been undertaken in relation to aspergillus infection.
- No evidence of evaluation of the efficacy of the process of developing best practice guidelines was demonstrated.

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

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

- No formal documented process for assessing new Hygiene Service interventions was demonstrated; however examples of product trialling were demonstrated with the result of the trial considered by the HSC. (e.g. a type of hand dryer and also biodegradable hand towels)
- No evidence was demonstrated of evaluation of the efficacy of the assessment process.

PREVENTION AND HEALTH PROMOTION

SD 2.1 Rating: A (>85% 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.

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

INTEGRATING AND COORDINATING HYGIENE SERVICES

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

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

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

IMPLEMENTING HYGIENE SERVICES

***Core Criterion**

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

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

- Overall the physical environment was noted to be clean.
- Carpet was observed on the floor in two of the rooms in Out Patients Department.
- Areas visited were noted to be dusty.

***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.

- Overall equipment and medical devices were noted to be clean.
- The equipment was observed to be dusty in many of the areas visited.
- Fans were observed in many areas.
- Toys observed in the Emergency Department and Paediatric departments were observed to be in need of attention.

***Core Criterion**

SD 4.3 Rating: C (41-65% compliance with this criterion)

The team ensures the organisation's cleaning equipment is managed and clean.

- Colour coding of cloths was demonstrated.
- Cleaning equipment in many areas visited was noted to be in need of cleaning.
- Buckets were demonstrated not to be stored inverted in many areas.
- Staff were observed not to be consistently wearing Personal Protective Equipment (PPE).
- Cleaning products were observed to be stored in unlocked presses in many areas visited.
- In one area a bucket was observed with dirty water and a mop in it for over an hour while not in use.

***Core Criterion**

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

The team ensures the organisation's kitchens (including ward/department kitchens) are managed and maintained in accordance with evidence based best practice and current legislation.

- There was no signed off food safety policy demonstrated in some ward kitchen areas.
- Kitchen doors were noted to be open in some areas and PPEs were not available in all areas.
- Cereal containers did not include dates in all areas.

***Core Criterion**

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

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

- Segregation of waste was observed.
- Bins were noted not t to be clean in all areas.
- Staff were noted not to be wearing PPEs while transporting waste in all circumstances.
- No wash hand basin was observed in the waste compound.

***Core Criterion**

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

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

- It was observed that segregation of linen did not comply with policy on all occasions.
- Wooden shelving was noted in most linen rooms visited.
- No wash-hand basin was observed in the central linen area.
- Records of curtain changing were not observed to be consistent across all areas visited.

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

- Signage in relation to hand washing was not obvious in all areas.
- Wash hand basins were not all Strategy for the control of Antimicrobial Resistance in Ireland (SARI) compliant.

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

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

- Evidence was demonstrated of hygiene-related incidents with action plans.
- A report of incidents was demonstrated but no evidence was observed of trends or evaluation of incident rates.

SD 4.9 Rating: A (>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 compliance of greater than 85% with the requirements of this criterion.

PATIENT'S/CLIENT'S RIGHTS

SD 5.1 Rating: A (>85% compliance with this criterion)

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

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

SD 5.2 Rating: A (>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 compliance of greater than 85% with the requirements of this criterion.

SD 5.3 Rating: A (>85% compliance with this criterion)

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

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

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1 Rating: A (>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 compliance of greater than 85% with the requirements of this criterion.

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.

- Evidence was demonstrated that the work of the Hygiene Services Team was evaluated through hygiene audits by ward managers and the Infection Control team.
- Evidence that many of the actions of the recent decontamination audit had been progressed was demonstrated.
- It was identified that there is a draft annual report.
- No evidence of formal evaluation was demonstrated.

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

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

- It was identified that there was no formal process for the development of the Hygiene Service Annual Report which was drawn up by two members of the committee following contributions from all committees. However, no supporting evidence was demonstrated.
- A draft annual report 2007 was demonstrated.
- No evidence was demonstrated that the annual report was circulated.
- There was no evidence of evaluation of the appropriateness of the Hygiene Services Annual 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	B
CM 1.2	B	B
CM 2.1	B	B
CM 3.1	A	A
CM 4.1	B	A
CM 4.2	B	B
CM 4.3	B	B
CM 4.4	C	B
CM 4.5	C	C
CM 5.1	A	B
CM 5.2	A	A
CM 6.1	A	A
CM 6.2	C	B
CM 7.1	A	A
CM 7.2	B	A
CM 8.1	B	C
CM 8.2	C	B
CM 9.1	C	B
CM 9.2	C	C
CM 9.3	C	C
CM 9.4	B	C
CM 10.1	B	A
CM 10.2	B	B
CM 10.3	B	A
CM 10.4	B	C
CM 10.5	B	C
CM 11.1	B	A
CM 11.2	B	B
CM 11.3	B	B
CM 11.4	C	C
CM 12.1	C	A
CM 12.2	B	B
CM 13.1	B	B
CM 13.2	B	B
CM 13.3	B	C
CM 14.1	A	B
CM 14.2	B	B
SD 1.1	C	C
SD 1.2	C	C

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