



**Health  
Information  
and Quality  
Authority**

An tÚdarás Um Fhaisnéis  
agus Cáilíocht Sláinte

**National Hygiene Services Quality Review 2008**

**St Vincent's University Hospital**

**Assessment Report**

**Date of assessment: 5th 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](http://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](http://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.

- **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**

<b>A</b>	The organisation demonstrated exceptional compliance of greater than 85% with the requirements of the criterion.
<b>B</b>	The organisation demonstrated extensive compliance between 66% and 85% with the requirements of the criterion.
<b>C</b>	The organisation demonstrated broad compliance between 41% and 65% with the requirements of the criterion.
<b>D</b>	The organisation demonstrated minor compliance between 15% and 40% with the requirements of the criterion.
<b>E</b>	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 St Vincent's University Hospital – Organisational Profile<sup>1</sup>

In March 2002, St Vincent's University Hospital Ltd, incorporating St Michael's Hospital in Dun Laoghaire was established, governed by a Board of Directors. Further changes in governance (to incorporate St Vincent's Private hospital) resulted in the formation of St Vincent's Healthcare Group Ltd in January 2003. Each hospital has a separate management team and a Hospital Manager/Chief Executive Officer who reports to the Group Chief Executive Officer.

St Vincent's University Hospital is a major academic teaching hospital, with strong educational links to the Faculty of Medicine at University College Dublin at undergraduate and "post-graduate levels". St Vincent's University Hospital is part of the Dublin Academic Teaching Hospitals (DATHs) group.

The hospital has in excess of 500 inpatient beds, incorporating seven-day, five-day and day-care options.

#### Services provided

St Vincent's Healthcare Group (incorporating St Vincent's University Hospital, St Vincent's Private Hospital and St Michael's Hospital) provides acute general care serving the southeast region of Dublin and surrounding areas. A tertiary referral service is also provided for patients both regionally and nationally, and there is an extensive range of general and specialist services including a number of centres of specialisation.

### 2.2 Areas Visited

During the course of the assessment the assessors visited:

- Emergency department
- Outpatient department
- St Michael's Ward
- St Anne's Ward
- St Charles' Ward
- St Agnes Ward
- St Camillus Ward
- Laundry service
- Waste compound.

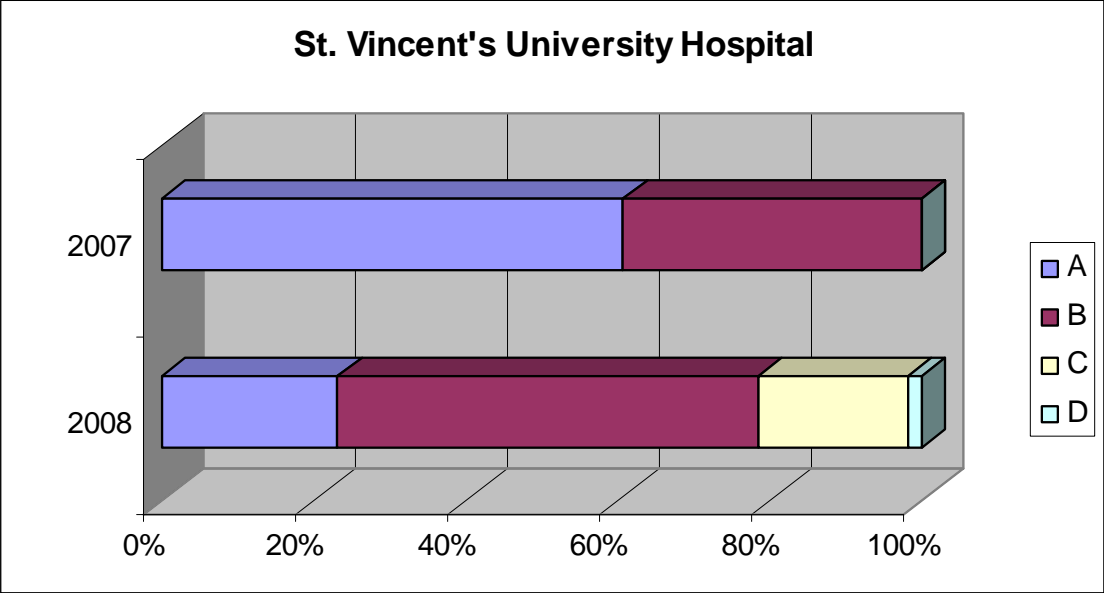
During the assessment, because of particular issues identified with toilet/washing facilities in St Charles' ward, it was necessary to visit St Kevin's and St James' wards also.

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<sup>1</sup> 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.

**St Vincent's University Hospital has achieved an overall rating of:**

**Fair**

**Award date: 2008**

## 2.4 Standards for Corporate Management

The following are the ratings for the organisation's compliance against the Corporate Management standards, as validated by the Assessment Team. The Corporate Management standards allow the organisation to assess and evaluate its activities in relation to hygiene services at an organisational level.

### PLANNING AND DEVELOPING HYGIENE SERVICES

#### CM 1.1                      **Rating : A (> 85% compliance with this criterion)**

**The organisation regularly assesses and updates its 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 that it had commenced undertaking hygiene audits in clinical areas in 2008.
- It was demonstrated that, following a mid-term review of the contract cleaners' contract, some changes were made to the cleaning specifications. The organisation advised that the Irish Acute Hospitals Cleaning Manual 2006 informed this process.
- It was demonstrated, through a report in relation to a recent Methicillin Resistant *Staphylococcus aureus* (MRSA) outbreak, that cleaning was increased in the affected area in response to this.
- There was a refurbishment programme underway in relation to toilet and washing facilities within the hospital.
- No evidence was demonstrated of any evaluation of the developments and modifications to the organisation's hygiene services in relation to meeting the service users needs

### ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

#### CM 2.1                      **Rating: A (>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 compliance of greater than 85% with the requirements of this criterion.

## 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.**

- The organisation advised that the governing body received best practice information through the hospital's committee reporting structures, and that the Infection Prevention and Control Team reported and made presentations to the Clinical Governance Committee and Board of Directors. Minutes confirming this were not demonstrated.
- The hospital demonstrated that it had developed performance indicators based on the hygiene audit results.
- The organisation advised that progress against the performance indicators is reported to the Hygiene Services Committee. Minutes of the meeting of 16<sup>th</sup> July 2008 confirmed this.
- Evidence was also demonstrated that these results being considered by the Hygiene Services Quality Improvement Group.
- Evidence demonstrated that audits commenced at the beginning of 2008 and the audit tool had recently been changed.
- No evaluation of the appropriateness of information received was 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 advised that the staff in the hospital had access to a library and the intranet.
- The hospital was beginning the process of introducing a computerised document management system. However, the hospital advised that while hygiene related policies, procedures and guidelines were on this system, they were not yet available at ward level. At ward level, policies, procedures and guidelines (PPG) were available in manual folders.
- Evidence was demonstrated that a hygiene awareness week was held in September 2008 with stands in the front hall and an education centre. There was evidence that contractors were involved in this process.
- Evidence was demonstrated that hygiene audits had been introduced in 2008 with validation audits undertaken by the Infection Prevention and Control Team and an external contractor who visited some clinical areas for the purpose of auditing against the hospitals hygiene check list.
- No evidence was demonstrated of evaluation of the appropriateness of 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 that there was a policy in place for the development of policies, procedures and guidelines. This was dated 15/06/07. A process flow chart on the development of policies was demonstrated.
- Evidence was demonstrated of a template being included in the Infection Control Manual as a front cover. There was no evidence that it applied to each individual guideline.
- There was no process demonstrated for identifying policies in need of updating, for example evidence was demonstrated of an e-mail communication in relation to the need to notify *Clostridium difficile* infection. However, the guideline was not reviewed to reflect the change communicated in the e-mail.
- It was advised that the hospital had acquired a computerised document management system and some policies, procedures and guidelines had been uploaded onto this system. However it had not yet been made available at ward level. Manual folders were available at ward level.
- The organisation advised that a policy, procedure and guideline group was in place and that this group was responsible for reviewing policies. However, no documentary evidence was demonstrated.
- It was reported that this group had informally reviewed how the template was working and that changes had been made as a consequence for example a

footer was included on the internet version of policies, procedures and guidelines which included date of printing to ensure out of date policies were not kept in folders.

- The organisation advised that the computerised document management system was recommended by the policies, procedures and guidelines group.
- No evidence was demonstrated of evaluation of the efficacy of the process for developing and maintaining hygiene services policies, procedures and guidelines.

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

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

- The organisation advised that the Estates Management Group was responsible for capital development projects within the hospital. Members of the senior management team were on this group and represented hygiene services.
- A sign off sheet was demonstrated which identified that the Infection Prevention and Control Team must have considered equipment prior to purchasing.
- The organisation did not provide evidence of hygiene related issues being discussed at the Estates Management Group or correspondence in relation to hygiene issues between the Estates Management group and the Executive Team.

**ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES**

**\*Core Criterion**

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

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

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

**\*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: B (66-85% 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.**

- Evidence was demonstrated of allocation of resources for capital development including refurbishment of some bathroom facilities and wards.
- The organisation advised that resources were allocated through the service planning process and the Estates Management Group were responsible for allocating resources for capital planning of which hygiene was considered to be a part. No supporting documentary evidence was demonstrated.
- Evidence was demonstrated of a report on an outbreak of Methicillin Resistant *Staphylococcus aureus* (MRSA) that required, and was allocated, extra cleaning resources.
- The organisation advised of extra resources allocated to St Christopher's ward, however did not provide supporting documentation.

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

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

- Responsibility for the purchasing of equipment or products was not included in the Terms of Reference of the Hygiene Services Committee or Hygiene Services Quality Improvement Group.
- A procurement policy was demonstrated along with a flow chart which did not include hygiene or infection control input.
- A capital purchase/approval form including an evaluation sheet was demonstrated which required sign off by the Director of Operations, Director of Finance, Purchasing and Procurement Manager and Infection Control Team prior to purchasing.
- No evidence was demonstrated of evaluation of the process

## MANAGING RISK IN HYGIENE SERVICES

### \*Core Criterion

#### CM 7.1                      **Rating: B (66-85% compliance with this criterion)**

**The organisation has a structure and related processes to identify, analyse, prioritise and eliminate or minimise risk related to the Hygiene Service.**

- The hospital had a Risk Manager and a Director of Quality, Risk and Consumer Affairs in place.
- There was an Incident Reporting System and the organisation advised the assessors that risk assessments were carried out.
- There was evidence that incidents were logged on STARSweb and sent to the Patient Safety Committee, which was set up in September 2008. Members of the senior management team were members of the Patient Safety Committee and the Chief Executive Officer also attended. This was confirmed from attendance list of meetings.
- The organisation advised that some members of the Executive Management Team were also members of the Patient Safety Committee and this was the mechanism for keeping the Executive Management Team informed. The organisation did not provide any record of minutes to demonstrate that the Executive Management Team was updated.
- A Health and Safety Annual Report 2006 was demonstrated. No Health and Safety or Risk Management reports were demonstrated for 2007.

#### 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.**

- There was evidence of major capital allocation which was reported to include Hygiene Services.
- The posts of Hygiene Coordinator and Waste Marshall had been filled.
- The General Services Manager was chair of the Quality and Safety Committee and the Director of Operations was the Chair of the Patient Safety Committee which replaced the Risk Management Committee and had been functioning since September 2008.
- An external validation of cleaning which included some areas of the hospital was undertaken in September 2008.
- The organisation demonstrated, through documentation, a list of hygiene related incidents/events.
- There was no evidence demonstrated that any of these were major adverse events.
- No evidence of evaluation of hygiene related incidents was demonstrated.

## CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

### \*Core Criterion

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

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

- The hospital had a purchasing and procurement department.
- A draft "Purchasing and Procurement" policy dated 2007 was demonstrated. The organisation advised that the policy had been signed off. However, this was not demonstrated.
- A flow sheet covering the process for awarding contracts was demonstrated and contract award criteria, marked as Annex 2 was demonstrated.
- The organisation advised that there had been no new hygiene related contracts in the last two years with the exception of the window cleaning contract.
- The contract for window cleaning was demonstrated and included performance indicators.
- Contracts for water coolers and household waste collection were also demonstrated.

#### **CM 8.2                    Rating: A (>85% compliance with this criterion)**

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

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

## PHYSICAL ENVIRONMENT, FACILITIES AND RESOURCES

#### **CM 9.1                    Rating: D (15-40% 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.**

- The hospital combines old and new developments. A significant capital development project was observed to be under way on the day of the assessment.
- It was advised that the new project design specifications adhered to relevant regulations and were based on best practice.
- The organisation did not provide evidence of any risk assessment in relation to the allocation of washing facilities in areas visited where renovations works were underway.

- There was a toilet refurbishment programme and lighting had been upgraded.
- It was observed on the day of the assessment that due to the upgrade works:
  - There were no shower facilities on St Charles' ward which accommodates 27 patients.
  - The only shower on St James' ward was out of use, due to maintenance work on the day of the assessment. The one shower on St Kevin's ward, which normally services 12 patients, had to be shared with the patients from St Charles' and St Kevin's also; i.e. one shower was available for 46 patients.
  - It was observed that one bath and three wash basins were available to patients on St Kevin's Ward.
  - In St Agnes ward, the washing facilities were one shower, one bath and three wash basins for 14 patients.
  - These facilities were being shared with the 25 bedded St Laurence's ward, whose facilities, with the exception of a bath were out of use.
  - The bathroom in St Agnes ward was being used to store medical equipment.
  - Paint work on window sills in St Agnes and St Michael's wards were noted to be badly chipped thus making surfaces uneven and difficult to clean.

**\*Core Criterion**

**CM 9.2                      Rating: B (66-85% compliance with this criterion)**

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

- The organisation advised that the ward kitchens were operating in line with ISO 340 and were Hazard Analysis and Critical Control Point compliant, however the organisation did not provide any evidence to demonstrate this.
- A Linen Policy dated 2006, a Sharps Policy dated 2006 and a Waste Management Policy dated 2007 were demonstrated and were contained within the Infection Control Manual.
- There was an equipment cleaning policy. However, records of cleaning were not always available.
- Evidence was demonstrated that further training of senior managers to undertake hygiene audits was planned. However, there was no evidence demonstrated that this had happened.
- A policy was demonstrated for clinical engineering. However, this did not contain any specific reference to hygiene management.
- There was a document demonstrated outlining the general requirements for managing contractors.

**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.**

- There was evidence demonstrated of an Estates Strategy Group and the organisation advised that it was through this group that the environment and facilities were managed.
- The organisation advised that they were using their rolling list of priority projects for the management of the organisations' environment, facilities, equipment, devices, kitchens, waste, sharps and linen.
- There was evidence of an in-house information technology system introduced for logging of maintenance requests.
- The organisation advised that audit results were reviewed by technical services and logged on this system. The organisation did not demonstrate that the audit results were reviewed by the Hygiene Service Committee.

**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.**

- It was identified through interview that monitoring of patient satisfaction was through the complaints and incident reporting processes.
- Comment cards were demonstrated to be available in some areas.
- A patient survey was conducted in June 2008 and the organisation advised that access to toilets and washing facilities was identified as an issue at that stage.
- Evidence was demonstrated of a staff survey having been conducted; however there was no hygiene component to it.
- Evidence was demonstrated of another survey conducted in one clinical area. However, no follow-up actions were 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.**

- The hospital demonstrated a recruitment and selection policy dated December 2006 which adhered to relevant legislation.
- Job descriptions were demonstrated and these included a standard paragraph covering responsibility in relation to hygiene.
- The hospital utilised the services of a contract cleaning company.

- Evidence was demonstrated that the hospital had a recruitment evaluation form, however, the organisation did not provide any evidence of evaluation of the process for selecting and recruiting human resources.

**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 advised that there was a process for filling posts which included, assessing the need for the post which was then reviewed by the employment control committee.
- No process for reviewing changes in work capacity and volume were demonstrated.
- The organisation advised that hygiene related posts of; Hygiene Coordinator, Assistant Director of Nursing with responsibility for Infection Control, Waste Marshall, Porters and hospital sterile services department staff were filled in the last 2 years. No evidence was demonstrated.
- The organisation also advised that cleaning staff were moved to cover areas of increased need and this was identified to be due to ward closures. No evidence was demonstrated.

**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 in excess of 85% with the requirements of this criterion.

**CM 10.4                      Rating: B (66-85% compliance with this criterion)**

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

- Evidence was demonstrated that the contract cleaner had an organisational structure which included a reporting structure.
- The Contracts Manager reports to the Operations Manager who in turn reports to the General Services Manager.
- It was reported that there was a weekly meeting between the contractor and the Services Manager. A hand-written note of one meeting was demonstrated.
- Evidence was demonstrated that the Contract Manager was a member of the Hospital Hygiene Quality Improvement Group.
- The contract cleaner provided an induction programme for their own staff while the hospital provides hand-hygiene and other hygiene related training. Training records for the period 2005-2007 were demonstrated.

- The contract cleaners had a performance management system in place for staff and evidence was demonstrated of a personal development plan with a form that was completed on an annual basis.
- No evidence of evaluation of the appropriate use of contract staff was demonstrated.

**\*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 advised that the service plans prompted heads of department to complete staff requirements requests and in this way needs assessment were completed by the head of department. However, this was not demonstrated nor was there evidence of a documented process.
- All requests were considered by the Employment Control Committee and the organisation's needs for a Hygiene Coordinator and a Waste Marshall had been met.

**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.**

- It was identified at interview that a personal development planning process which was designed by the health services executive was in use in the hospital, however this was not demonstrated.
- The Human Resource Department undertook a training-needs analysis in 2007 and evidence was demonstrated of the results of a departmental needs analysis with hygiene training being identified by a number of staff as a requirement.

- No evaluation of the relevance of education to each staff member was demonstrated
- Protected time was allocated for the Skills/Further Education and Training Awards Council programme. This was demonstrated.
- It was demonstrated that the Infection Control Team and catering department also provide training.
- There was evidence that staff training records are being entered onto a HR IT system.
- The organisation demonstrated that there had been low levels of attendance of support services staff at hand-hygiene training.

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

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

- The organisation advised that evaluation was included in all training, however this was not demonstrated.
- It was identified through interview that evaluation was also assessed through the audit process. This was not demonstrated.
- There was evidence demonstrated that records of attendance at training were being recorded onto an IT system.

**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.**

- It was demonstrated that there was a personal development planning process for contract staff and performance evaluation yearly.
- The hospital advised it had a team based performance process in place, however this was not demonstrated.
- No documented process for in-house hygiene staff performance evaluation was demonstrated.
- No evaluation of the appropriateness of the performance evaluation process was demonstrated.

**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 wellbeing is monitored by the organisation on an ongoing basis.**

- Evidence was demonstrated that a staff satisfaction survey was conducted in 2006.
- The organisation identified through interview that as a result of this survey communication with staff was enhanced. The number of staff briefings had been increased and they extended to facilitate night staff.
- A newsletter "Newsround" was demonstrated.
- No evidence of evaluation of the appropriateness of the 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 provided evidence of the Infection Control team gathering and disseminating information.
- It was advised that data collected in relation to hygiene services including hygiene audits and, information from the waste contractor regarding the inappropriate mixing of waste, was shared with the Infection Control team and the mechanism was through the Hospital Hygiene Quality Improvement Group.
- A Balance Score Card was used and the hospital advised that it was introducing specific software to collate data gathered.
- No evidence of evaluation was demonstrated.

**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 identified through interview that data was provided to the Infection Prevention and Control Committees and Hospital Hygiene Quality Improvement Group on a quarterly basis. No evidence was demonstrated.
- Information was returned to wards in the form of percentage compliance and the organisation identified through interview that this was done immediately, this was not demonstrated.
- No documentary evidence of evaluation of data turnaround, or user satisfaction was provided.

**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.**

- The organisation identified through interview that the committees who received information evaluated this through the committee structure. This was not demonstrated.
- It was advised that committees dictated reporting time frames. This was not demonstrated.
- It was demonstrated that the patient safety committee changed the type of report it received for example. changes were made to the audit data presentations thus changing the way graphs were presented.

**ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES**

**CM 14.1                      Rating: A (>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.**

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

**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 identified through interview that the Hygiene Services Committee evaluated the hospitals quality improvement system and that this was done through monitoring of audits. This was not demonstrated.
- Communication with staff was through the Hospital Hygiene Quality Improvement Group with dissemination down to all staff.
- It was demonstrated that there were infection control awareness sessions, a link nurses' programme and staff briefings.
- There were informal links with other hospitals demonstrated.
- While there was evidence demonstrated of trending of surveillance rates, there was no formal benchmarking in place.
- It was demonstrated that hygiene performance indicators were in their developmental stage and there had been no benchmarking against these.

## 2.5 Standards for Service Delivery

The following are the ratings for 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.**

- There was a policy demonstrated for the development of policies, procedures and guidelines.
- All infection control guidelines demonstrated in clinical areas were due for review in November 2008.
- The organisation did not provide evidence that policies were reviewed between automatic review dates for example if a change occurred in reporting requirements.
- A colour coding system was in place for cleaning, linen and waste management and the contract cleaners had a cleaning manual available.
- There was no evidence demonstrated of evaluation of the efficacy of processes used to develop best practice guidelines.

#### **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**

- There was evidence demonstrated of a form for the assessment/approval of new products having been developed. However, no evidence of its use was demonstrated.
- There was no evidence demonstrated of evaluation of the efficacy of the assessment process for new/changed Hygiene Services interventions.

## 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: 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.**

- There was evidence that the Hospital Hygiene Quality Improvement Group was multidisciplinary and included contractors.
- There was no evidence demonstrated that a patient representative was on the group.
- The organisational structure set out linkages with other groups.
- The organisation did not demonstrate evaluation of the efficacy of the multidisciplinary team structure.

## IMPLEMENTING HYGIENE SERVICES

### **\*Core Criterion**

### **SD 4.1                      Rating: C (41-65% compliance with this criterion)**

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

- Dust was noted in St Anne's ward and St Michael's ward, while in St Anne's ward, the vents were also noted to be dusty and a soiled dressing was found behind a radiator.
- The tiles in the shower unit in St Agne's Ward, St Charles' Ward and St Kevin's Ward, along with the tiles in the bathrooms in St Michael's ward, were found to have had a black substance with an appearance consistent with mould on them. A shower curtain in St Michael's ward had evidence of a black substance with an appearance consistent with mould. There was no record of cleaning in bathrooms/toilets visited.
- In St Agne's ward there were flies noted in some light fittings.

- The flooring in the room containing beds 7-12 on St Agne's ward needed attention as the floor had been repaired with tape.
- There was evidence of severely chipped paintwork on window sills in St Agne's and St Charles' wards.

**\*Core Criterion**

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

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

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

**\*Core Criterion**

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

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

- The majority of trolleys/cleaning carts were observed not to be clean at the start of the cleaning shift.
- Cleaning products were stored in unlocked areas.
- There was no wash-hand basin in the cleaners' rooms. However, alcohol-based hand gel was available.
- Colour coding was in use for mops and cloths and mop heads were washed daily.
- Cleaning products were observed on cleaning carts when visited in the late evening in an outside area which was uncovered and accessible to the public.

**\*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.**

- Kitchens visited were observed to be unlocked and signs identifying that access was restricted were not obvious.
- No personal protective equipment was available to assessors visiting ward kitchens.
- Access to kitchens was through an area where household and clinical waste was stored.
- There were no fly screens on windows.
- Kitchen areas were cluttered and food rotation especially in relation to cereal stored in plastic containers was not obvious.

- Temperature check records were not available in all kitchen areas.

**\*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.**

- Holding areas for household and clinical waste visited were all noted to be unlocked and easily accessible by the public and patients.
- Healthcare risk waste bins were found to be unclean with items found outside the bin liners including a urine sample.
- Household waste was noted to be left unattended on corridors and porters collecting household and clinical waste were observed not to be wearing personal protective equipment.

**\*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**

- Mechanisms were observed to be in place for the segregation of soiled linen.
- At ward level, linen was observed to be collected in bags that were more than three quarters full.
- Linen was observed to be placed in soiled red bags inappropriately.
- The laundry service was contracted out.
- There was evidence that laundry processes at the point of receiving and dispensing both clean and soiled laundry were being managed.
- Backs of chairs were observed to be in need of cleaning.

**\*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.**

- There was a mechanism in place for identifying hand-hygiene training needs however it did not include contract staff.
- Records demonstrated that high levels of staff overall had completed mandatory hand-hygiene training.

- There was evidence demonstrated of low levels of attendance of support staff at hand-hygiene training.

**SD 4.8                      Rating: C (41-65% compliance with this criterion)**

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

- There was a risk management system in place that included incident reporting.
- There was evidence of hygiene related risks including deficiencies in toilet and washing facilities and trailing leads from sockets with multiple plugs in sockets.
- The organisation provided no evidence of risk assessments for these hygiene related risks.
- There was no evidence at local level of feedback from risk management in relation to incidents reported.

**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.**

- Evidence was demonstrated of leaflets and posters available in relation to hygiene services.
- There was a visitor's policy and this was communicated through information leaflets and the use of televisions.
- A departmental satisfaction survey (referred to by the organisation as a blitz) conducted on one day was demonstrated.

**PATIENT'S/CLIENT'S RIGHTS**

**SD 5.1                      Rating: C (41-65% compliance with this criterion)**

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

- There was evidence demonstrated of a visitor's policy.
- Confidentiality was a requirement of staff contracts and the issue of mutual respect was covered in patient information leaflets.
- No process was demonstrated for addressing patient dignity during the refurbishment process with the resultant need of patients to share toilet/washing facilities between wards.

**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.**

- There was evidence of information leaflets and posters available in relation to hygiene services.
- The hospital had held an awareness week for staff, patients and the public.
- The organisation did not provide evidence of evaluation of patient, family and visitor comprehension of and satisfaction with the information provided by the Hygiene Services team.

**SD 5.3                      Rating: B (66-85% compliance with this criterion)**

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

- There was evidence of a complaints policy within the hospital.
- There was also a risk management/incident reporting policy.
- There was limited evidence of feedback to ward/department level.

**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 provided evidence that the hospital had undertaken a patient satisfaction survey.
- There was also a public engagement strategy and the hospital identified through interview that consideration of the opinion of patients with cystic fibrosis was taken into account.
- There was no evidence demonstrated of evaluation of the extent to which patients, families and other organisations were involved by the hygiene services team when evaluating its hygiene services.

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

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

- It was identified that the hygiene services team had identified an 85% target for audit compliance as a mechanism for evaluation.

- It was demonstrated that the hospital had introduced hygiene audits in clinical areas as a quality initiative since this year and one full hospital wide audit had been conducted however no evidence of action plans were demonstrated.
- An annual report was demonstrated.
- No evidence of evaluation was demonstrated of the extent to which hygiene services quality initiatives were undertaken by the hygiene services team as a result of evaluation and bench marking.

**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 hospital had produced an annual report that had been approved by the Hospital Hygiene Quality Improvement Group and Hygiene Services Committee.
- Relevant department heads contributed to the production of the report and it was available on the hospital intranet.
- There was no evidence demonstrated of the appropriateness of the hygiene services Annual Report.

## Appendix A: Ratings Details

The table below provides an overview of the individual rating for this hospital on each of the criteria, in comparison with the 2007 Ratings.

Criteria	2007	2008
CM 1.1	A	A
CM 1.2	A	B
CM 2.1	B	A
CM 3.1	A	A
CM 4.1	A	A
CM 4.2	A	B
CM 4.3	A	B
CM 4.4	A	B
CM 4.5	B	B
CM 5.1	A	A
CM 5.2	A	A
CM 6.1	A	B
CM 6.2	B	B
CM 7.1	B	B
CM 7.2	A	B
CM 8.1	A	B
CM 8.2	A	A
CM 9.1	B	D
CM 9.2	A	B
CM 9.3	A	C
CM 9.4	B	C
CM 10.1	A	B
CM 10.2	A	B
CM 10.3	A	A
CM 10.4	A	B
CM 10.5	A	B
CM 11.1	A	A
CM 11.2	A	B
CM 11.3	B	C
CM 11.4	B	C
CM 12.1	B	A
CM 12.2	A	B
CM 13.1	B	B
CM 13.2	A	B
CM 13.3	B	B
CM 14.1	A	A
CM 14.2	B	B
SD 1.1	B	B
SD 1.2	A	B

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