



Hygiene Services Assessment Scheme

Assessment Report October 2007

The Rotunda Hospital

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1.0 Executive Summary

1.1 Introduction

This is the first National Hygiene Services Assessment Scheme (HSAS.) It is a mandatory scheme for all acute hospitals. The scheme aims to enhance cultural change in the area of hygiene services by not only focusing on the service delivery elements but also emphasising the importance of standards for corporate management. The HSAS is a patient-centred scheme which assists a hospital to prioritise the key areas in hygiene to be addressed. It is intended to promote a culture of best practice and continuous quality improvement.

The Irish Health Services Assessment Board developed these, the first set of National Hygiene Assessment Standards in 2006. This development plan involved an extensive desktop review of national and international best practice literature, working groups and extensive consultation. The feedback from these development components formed the final draft Standards and Assessment Process, which were then piloted in a number of acute hospitals. (*The Irish Health Services Accreditation Board was subsumed into the Health Information and Quality Authority in May 2007.*)

The Hygiene Services Assessment Scheme (HSAS) was launched by the Minister for Health Mary Harney on the 6th November 2006.

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”¹⁻⁴

More specifically, the Hygiene Services Assessment Scheme incorporates the following:

- Environment and Facilities: incorporates the condition of the building and all its fixtures, fittings and furnishings.
- Hand Hygiene: incorporates hand washing, antiseptic hand-rub and surgical hand antisepsis.
- Catering: incorporates kitchens (including ward kitchens) fixtures and fittings and food safety.
- Management of Laundry: incorporates management of linen and soft furnishings both in-house laundry and external facilities.
- Waste and Sharps: incorporates handling, segregation, storage and transportation.
- Equipment: incorporates patient, organisational, medical and cleaning equipment.

1.1.1 Standards Overview

The standards are divided into two sections: Corporate Management and Service Delivery. Each standard is divided into a number of criteria. These are specific steps, activities or decisions that must occur to achieve the standard.

The 14 Corporate Management standards facilitate the assessment of performance with respect to hygiene services provision to the organisation and patient clients at organisational management level. These standards commence at the planning stage and follow through to governing, implementation and evaluation. They incorporate four critical areas:

- Leadership and Partnerships
- Management of the Environment and Facilities
- Management of Human Resources
- Information Management.

The six Service Delivery standards facilitate the assessment of performance at team level. The standards address the following areas:

- Evidence based best practice and new interventions
- Prevention and Health Promotion
- Integration and coordination of hygiene services
- Implementing safe, efficient and effective hygiene services
- Protection of patient/clients rights
- Assessing and Improving performance.⁵

The standards and process have been assessed and internationally accredited by the International Society for Quality in Healthcare (ISQua).

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.

In the Corporate Management standards, the core criteria cover:

Allocation of resources, accountability, risk management, contract management and human resource management.

In the Service Delivery standards, core criteria cover:

Waste management, hand hygiene, kitchens and catering, management of linen, equipment, medical and cleaning devices and the organisation's physical environment.

1.1.2 Rating Scale

The rating of individual criterion is designed to assist self-assessment teams and the organisation in general, to prioritise areas for development. The rating for the criterion can be determined based on the percentage level of compliance.

The rating scale utilised by the Hygiene Services Assessment Process is a five-point scale:

A Compliant - Exceptional

- There is evidence of exceptional compliance (greater than 85%) with the criterion provisions.

B Compliant - Extensive

- There is evidence of extensive compliance (between 66% and 85%) with the criterion provisions.

- C Compliant - Broad**
 - There is evidence of broad compliance (between 41% and 65%) with the criterion provisions.
- D Minor Compliance**
 - There is evidence of only minor compliance (between 15% and 40%) with the criterion provisions.
- E No Compliance**
 - Only negligible compliance (less than 15%) with the criterion provisions is discernible.
- N/A Not Applicable**
 - The criterion does not apply to the areas covered by the Self Assessment Team. Rationale must be provided. This cannot be used for a core criterion.

1.1.3 Assessment process components

The assessment process involves four distinct components:

- **Preparation and self assessment undertaken by the organisation.**

The self-assessment process allows an organisation to systematically evaluate its hygiene services against a set of best practice standards. This was completed by a multidisciplinary team(s) over a period of two months. This process was preceded by regional education sessions.

- **Unannounced assessment undertaken by a team of external assessors**

The HIQA has recruited senior professionals from the areas of medicine, nursing and corporate management as assessors, in addition to independent senior professionals with specialist knowledge in the core areas. To assure consistency across all sites four leaders were chosen from this group to cover all unannounced visits. The assessor's performance was regularly evaluated based on feedback from participating organisations, HIQA staff and other assessors.

Site visits for the larger academic teaching hospitals were completed over 2.5 days with four assessors, and assessments were completed in the smaller hospitals over 2 days with three assessors. The assessment team were responsible for identifying the organisation's compliance with the standards and helping to guide its improvement.

The assessment included a comprehensive documentation review, meetings with management, staff and patients. Throughout the assessment process the assessors worked as a team to cross reference their findings. This ensured that the ratings for each criterion were agreed upon and reflected an accurate picture of the organisation's level of compliance. Feedback was provided to the Chief Executive / General Manager and senior management team by the Assessment Team Leader, at the end of each day of the assessment.

- **Provision of an outcome report and determination of award status.**

The Internal Review Committee of the HIQA reviewed all the reports to ensure consistency, and based on the quantifiable translation guidelines, awards were made. Only organisation's which received a "very good" score were acknowledged with an award for the duration of one year. By the end of

October 2007 all 51 acute care hospitals had received a copy of their individual report.

At the same time the HIQA launched a National Report of the findings of all assessment reports. These standards are different from the first two hygiene audits, therefore a direct correlation of results were not possible.

- **Continuous Improvement**

Going forward a quality improvement plan should now be structured from the self assessment and recommendations from the external report. This will then be monitored by the HIQA.

The areas of notable practice, quality improvement plans, areas of priority action, overall score, criterion ratings and comment and are presented in the following pages of the report.

¹ Boot, M and Cairncross, S "Actions Speak" Delft, The Netherlands, IRC and LSTHM, British Occupational Hygiene Society.

² New York Department of Health and Mental Hygiene

³ The Columbia Electronic Encyclopaedia, Sixth Edition. Columbia University Press. 2003

⁴ Irish Acute Hospitals Cleaning Manual, HSE (2006)

⁵ Hygiene Services Assessment Scheme. Irish Health Services Accreditation Board (2006)

1.2 Organisational Profile

The Rotunda Hospital is a 189 bedded Hospital situated in central Dublin. It is over 250 years old and this presented its own challenges in relation to the infrastructure, architectural history and preservation orders on parts of the hospital complex. The hospital provides a comprehensive range of services to meet the needs of pregnant women and their babies, women with gynaecological conditions and women and men suffering infertility

The Rotunda Hospital is an important training school for both doctors and midwives. The hospital's 4.5 acres campus consists of nine main buildings that vary in age from 1757 to buildings commissioned in 2003. The Main Hospital was built in the year 1757 and parts of the building have been extended in the 19th century.

Services provided

Antenatal services are provided in both the hospital and the community and the complexity of services provided support women from low risk through the spectrum to women with high-risk complications requiring their care to be supervised by a consultant obstetrician in collaboration with a medical/surgical consultant. Examples of the range of services are:

- Midwifery clinics in the hospital and community including DOMINO care
- Teenage pregnancy clinic
- Hypertension clinic
- Metabolic clinic
- Cardiac Clinic
- DOVE clinic (Danger of Viral Exposure)

A full range of diagnostic and support services are available, including:

- Ultrasound
- Laboratory – haematology, microbiology, histopathology, biochemistry, blood transfusion, endocrinology, cytology, electron microscopy
- Physiotherapy
- Radiology
- Pharmacy
- Parent Education
- Social Work
- Foetal and Maternal Day Care Assessment
- Prenatal Genetic Diagnostic Clinic

Physical structures

The overall number of designated beds is 189. The breakdown of beds is as follows:

3rd Floor

- **Lillie Suite (29)**

Private: 11 beds (11 individual rooms)

Semi Private: 15 beds (3x4 bedded, 1x3 bedded)

Public: 3 beds (1x3 bedded)

2nd Floor

- **General Pre-natal (31)**

Private: 5 beds (5 individual rooms)

Semi Private: 5 beds (1x5 bedded)

Public: 21 beds (1x10 bedded, 1x7 bedded, 1x4 bedded)

- **Delivery Suite (14)**

Non-Designated: 14 beds

- **Neonatal Ward (36)**

Intensive Care: 7 beds

High Dependency: 9 beds

Special Care:

Semi Private 8 beds

Public 12 beds

1st Floor

- **Gynaecology Ward (31)**

Private: 4 beds (4 individual rooms)

Semi Private 4 beds (1x4 bedded)

Public: 23 beds (1x5 day ward), (1x8 bedded), (2x4 bedded) & 2 individual rooms used for Obstetric HDU patients

- **General Postnatal (48)**

Private: Nil

Semi Private: Nil

Public: 48

5-Bedded Day Care Unit

*41 Inpatient beds (1x6 bedded), (2x7 bedded),
(1x10 bedded), (1x11 bedded).*

2 Beds (2 individual Isolation Rooms)

The following assessment of the Rotunda Hospital took place between 12th and 13th July 2007.

1.3 Notable Practice

- There was clear evidence of commitment to a quality agenda from hospital governors and the Management Team.
- There was a culture of pride and visual evidence of the key performance indicators in relation to hygiene on notice boards.
- Sinks and hand wash facilities, including gels, were recently installed throughout the hospital.
- There was evidence of development of isolation facilities/rooms and plans for further ones, and the hospital was well maintained.

1.4 Priority Quality Improvement Plan

- While the majority of the environment was maintained to a high standard, some areas such as the waste storage compound and laboratory waste area require further attention. It is recommended that all waste is labelled, including high risk containers such as sharps bins.

1.5 Hygiene Services Assessment Scheme Overall Score

The decision mechanism used to translate an organisation's criteria, risk ratings to a Hygiene Service Assessment Scheme score is based on a quantitative analysis of the assessment results which ensures consistency of application. The decision regarding a score is made by the Internal Review Committee of HIQA, based on the findings of the Assessment Team; the Rotunda Hospital has achieved an overall score of:

Good

Award Date: October 2007

2.0 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. There are fourteen Corporate Management standards, all of which are focused on four critical areas: leadership and partnerships, environment and facilities, human resources and information management. They include such subjects as corporate planning, allocating and managing resources, enhancing staff performance and contractual agreements. There are eight core criteria within these standards.

PLANNING AND DEVELOPING HYGIENE SERVICES

CM 1.1 (A → A)

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

There was very comprehensive evidence that the Board of Governors and senior management assesses and update the future needs of the hygiene services. This data is gathered from activity, occupancy level, and staff turnover rates. The hospital's Hygiene Strategic Plan/Hygiene Plan/Operational Plan and Corporate Hygiene Policy (for example catering) reflect the organisation's assessment of its hygiene requirements. Household/catering restructuring has taken place to embrace best practice. A well- defined committee system is in place from the Board of Governors to department level with strong inter-linkage with all levels. The hospital benchmarks its hygiene standards against internal and external audits, Environmental Health Officer's reports, health and safety reports and waste management.

CM 1.2 (A → A)

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.

A review of annual activities and services, to identify the need in relation to its population's health takes place. Through internal audits the hospital has improved in relation to the separation of the household/catering re-structuring, installation of HBN 95 hand wash sinks, introduction of cleaning frequencies and sign off, introduction of hygiene trolleys and flat mopping system. The Space Utilisation Committee has a central role in developing services. The hospital values the results of the input of the Board of Governors' commitment to hygiene and its visible presence in walkabouts and subsequent documented comments. The hospital also makes use of the patient/client satisfaction surveys.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1 (B → B)

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 of linkages and partnerships were observed. Samples of senior management minutes with the National Hospital Office, Health Protection

Surveillance Centre were available. Evidence of links with staff and patient/clients were observed and the efficacy of linkages and partnerships evaluated.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 (B → B)

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

Evidence was presented to support the development process of the Corporate Hygiene Development Plan. The plan was ratified by the Board of Governors for the period of 2007-2011. There is documented intent that the Strategic Plan would be reviewed annually by the Board of Governors in order to evaluate the plans, goals, objectives and priorities. It is recommended that the hospital develop a documented process for the development of the Corporate Hygiene Service plan. It is also recommended that the input from patient/clients would be included in the consultation process.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.1 (B → B)

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.

There are very clear and documented processes for the management of the hygiene services by the governing body and the Senior Management Team. Organisational charts identify reporting relationships for Governing Board members. The chairs of the General Purpose Committee and the Property Committee have specific hygiene responsibilities. A member of the Governing Board is also a member of the Hygiene Services Team. Evaluation is provided through internal audit results, in order to ensure compliance with best practice and compliance to legislation.

CM 4.5 (B → B)

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

The Space Utilisation Committee reviews the provision of on-site services and ensures that they are planned in an effective and constructive manner, given the confines of the site. The Corporate Hygiene Services Committee is represented on this committee by cross membership of senior management. An active Minor Capital Project Plan for 2007 is in place and issues related to hygiene are identified, prioritised and costed. A Major Capital Plan is in progress for the refurbishment of the main reception area and new Emergency Room. The Space Utilisation Committee is responsible for the progression of the project. It is recommended that the hospital would evaluate the efficacy of the consultation process in this criterion.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

*Core Criterion

CM 5.1 (A → A)

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

Substantial documentary evidence was provided to support the organisation's hygiene structure, which included: Corporate Responsibility Statement, function, roles and responsibility of the Governing Board, Master, Secretary/ Manager and Director of Nursing. Comprehensive organisational charts were observed for executive responsibility, Board of Governors committees and reporting lines which identified sub-committees to deal with a range of governance issues, including a committee for General Purposes and Property. Hygiene is included as a standing order with responsibility for reports invested in the chairperson.

*Core Criterion

CM 5.2 (A → A)

The organisation has a multi-disciplinary Hygiene Services Committee.

There was extensive documentary evidence of a multi-disciplinary approach to the management of hygiene services. The hospital had a very inclusive and well documented Corporate Management Hygiene Service Committee, which had senior representation from all service/disciplines. The committee also had representation from the Board of Governors. Through the documented organisational chart available there were clear lines of roles and responsibilities identified. A well-structured Terms of Reference was observed which included defined membership, quorums, frequency of meetings and minute notation. The Hygiene Services Committee has secretarial support. The hospital has an Environmental and Facilities Team, which matches the structures of the Hygiene Services Team. There were extensive minutes of meeting with agreed actions plans and designated personnel to ensure completed actions.

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

*Core Criterion

CM 6.1 (A → A)

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.

There was comprehensive evidence of a Corporate Hygiene Strategy and Hygiene Plan. A range of Quality Improvement Plans (QIPs) and actions plans, with detailed evidence of progression, were in place. Resources were allocated and evidenced through minor capital, external contracts for specialised hygiene function and the annual budgets. There was evidence of continuing audits and action plans and named responsibilities to ensure that hygiene issues were managed. Evidence was available through the Board of Governors' minutes of meetings, and their adjunct committee, that funding requirements were allocated. The Board of Governors had at the time of assessment approved €490,000 for hygiene initiatives which included, but not exclusively, wash-hand basin and waste bins replacement throughout the hospital.

CM 6.2 (A ↓ B)

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

There was evidence of a detailed Materials Management Policy, which outlined the procedures, consultation process and code of ethics that were expected. The hospital also purchases the services of contractors with other Dublin maternity hospitals. A detailed organisational chart for materials management clearly outlined and named the role of the hygiene services in the purchasing process. An itemised financial statement was observed of all hygiene products purchased. Details of internal communication from the Hygiene Services Committee, Hygiene Services Team and Department Heads and Governing Body (Property/General Purpose Committee) were observed in relation to all purchasing. It is recommended that the evaluation process be completed in relation to efficacy of the consultation process between senior management and the Hygiene Service Committee. The Corporate Hygiene Service Strategy and Plan have documented annual review procedures and evaluation processes by the Governing Authority.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

CM 7.1 (A → A)

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

There was evidence of a robust system of the risk management.

This was demonstrated in terms of reference membership, accountability, reporting relationships, action plans, minutes of meetings. There was no evidence of a major hygiene adverse incident in the last two years. Extensive audit reports, and subsequent action plans and resultant actions, following both internal and external hygiene audits, were provided.

CM 7.2 (A → A)

The organisation's Hygiene Services risk management practices are actively supported by the Governing Body and/or its Executive Management Team.

The Board of Governors and the senior management at the hospital actively support the management of risk. Assessments and hazard identification have been initiated to review the structure of household services. Issues, related to the management of waste and linen, were identified and minor capital funding for motorised hoists systems have been allocated to improve manual handling issues.

Relevant risk-related committees have formal reporting structures documented and annual risk management, health and safety and clinical reports are published. It is intended that an annual report for this year be compiled.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion

CM 8.1 (A → A)

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.

A very robust materials management policy, which incorporates the guidelines of the National Procurement Policy, was in place. There was strong evidence of

consultation, competitiveness and evaluation of the services provided. The hospital hygiene committee have direct access to the Materials Management Department and all new products/equipment adhere to the department's guidelines. An external contract is in place for healthcare waste and linen. The hospital provided documented evidence of audit and inspection of the external contract premises.

PHYSICAL ENVIRONMENT, FACILITIES AND RESOURCES

CM 9.1 (B → B)

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

The Space Utilisation Committee oversees and monitors all major capital projects. The health and safety and risk management forums ensure that safety and risk was on the active agenda. The management of hygiene was challenging, given the age and situation of the hospital.

*Core Criterion

CM 9.2 (A ↓ B)

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

A very clear hygiene management structure, with input from all levels of the organisation, is in place. There were documented policies, procedures, and guidelines. The hospital engaged in rigorous local auditing of the elements of the hygiene services. It is recommended that internal hygiene audits be carried out on a regular basis to ensure that all documented processes in place are adhered to. The hospital, through its incident reporting structure, ensures that it limits risks.

CM 9.3 (B → B)

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.

Extensive and continuous internal and external audits, the review of risk management reports, patient/client satisfaction surveys and the complaints procedure, demonstrated that this is effective and efficient.

CM 9.4 (A ↓ B)

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

A high satisfaction level was observed. Substantial evidence was available that six-monthly patient/client satisfaction surveys were carried out, results collated and actions implemented. However it is recommended that the hospital include more hygiene-specific sections in future surveys. The complaints and comment system indicated the information received in relation to hygiene was incorporated into the minutes of the Hygiene Services Committee. Quality Initiative Plans take cognisance of all feedback.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 (A ↓ B)

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

There were recruitment and selection policy and procedures, HR strategy, annual report and Key Performance Indicators. There was a full range of appropriate job descriptions. It is recommended that Human Resource processes be evaluated.

CM 10.2 (B → B)

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 hospital has systems in place to ensure that the staffing of the hygiene services is comparative to service levels. Additional hygiene services, such as window cleaning, were periodically contracted out. Linen and waste were contracted to external agencies.

CM 10.4 (B → B)

There is evidence that the contractors manage contract staff effectively.

There was substantial evidence that the hospital, through the processes of the National Procurement Policy and the Materials Management system, ensures monitoring and review of contractors' obligations in relation to contracted staff. Hospital HR policy ensures that all contract staff records are on file.

*Core Criterion

CM 10.5 (A → A)

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

There was evidence that the hospital, through its Strategic Hygiene Plan/Service Plan, identified human resource needs for this area. Evidence of the consultation and evaluation process with the introduction of the re-structuring of the household and catering service was available. The Corporate Plan also identifies the human resources need for the hospital services. A documented process was observed, which clearly identified the process by which new services were evaluated for human resource requirements. Documented evidence was available for staff rosters, both household and maternity care assistants. Evidence of the annual hygiene report, which identified human resources, was provided. A comprehensive Human Resources Plan for 2007 is in place.

ENHANCING STAFF PERFORMANCE

*Core Criterion

CM 11.1 (A → A)

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

Comprehensive evidence of this was noted and a formal induction policy is in place. A record of staff attendance and course content was available. All staff receives formal induction, a staff handbook and mandatory training, which includes, waste, sharps and hand hygiene. There are departmental orientation programmes.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (B → B)

An occupational health service is available to all staff

This is provided through an external contract with the Occupational Health Department at the Mater Hospital. It is supported by the Occupational Health Physician and CNM2 and is available to all staff. It provides a full range of service e.g. vaccinations (Hep B & Flu), pre-employment screening and staff health promotion. A review of the service has been completed and a draft report was observed.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.2 (C → C)

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.

Minor capital expenditure, risk management incident reports were provided. The hygiene internal and external audits were reviewed and monitored. The hospital provided information and documented reports to the Governing Board, National Hospitals Office (NHO), the Health Surveillance Boards and other bodies as required.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

CM 14.1 (B → B)

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 very evident through staff, patient/clients and management that a quality environment and service for all the users was paramount in the ethos of the hospital.

CM 14.2 (B → B)

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.

Extensive compliance in this area, evidenced by extensive documentation such as internal and external audits, infection control, risk incidents, patient/client complaints and patient/client/staff satisfaction. There is a strong culture of communication and dissemination of information.

3.0 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. There are six Service Delivery standards, which focus on such areas as prevention and health promotion, implementing hygiene services and patients / clients rights. There are seven core criteria within these standards.

EVIDENCE BASED BEST PRACTICE AND NEW INTERVENTIONS IN HYGIENE SERVICES

SD 1.1 (B → B)

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

Documented evidence of these processes was observed. New interventions and products are introduced on a trial basis and are reviewed by members of the Corporate Management Hygiene Services Committee. Areas included are: sharps, waste, decontamination policies, colour-coding systems, upgrading of isolation rooms, restructuring of catering services so that catering staff are responsible for the provision and delivery of catering services to patient/clients, introduction of sinks and taps to meet HBN95 requirements. The efficacy of the process was evaluated by Environmental Health Officer (EHO) audits, hygiene, waste, sharps and health and safety audits with resultant actions/plans by designated staff.

PREVENTION AND HEALTH PROMOTION

SD 2.1 (C → C)

The team in association with the organisation and other services providers participates in and supports health promotion activities that educate the community regarding Hygiene.

Evidence of participation in the DOMINO Community Support Service and Early Transfer Home Programme. Patient/client information leaflets were given to all patient/clients and hygiene notices were on display. It is recommended evaluation takes place.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1 (B → B)

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

There was evidence of this through membership of the Environmental and Facilities, Corporate Management Hygiene Services teams, their job descriptions and minutes of the team meetings. Members of these committees report to the Quality Care, Risk Management, Infection Control, Health and Safety and Space Utilisation Review committees. Membership of the team was reviewed regularly and additional staff members were requested to attend meetings on specific issues, for example the Complaints Manager. Minutes were circulated with clear roles of responsibility and timeframes.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

SD 4.1 (A → A)

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

Overall there was evidence of a clean physical environment throughout all areas.

For further information see Appendix A

*Core Criterion

SD 4.2 (A → A)

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

With the exception of dust on televisions, high standards of cleaning were noted.

For further information see Appendix A

*Core Criterion

SD 4.3 (A → A)

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

The maintenance and upkeep of cleaning equipment in the majority of areas is compliant. Further attention is required to the storage of equipment at unit level.

For further information see Appendix A

*Core Criterion

SD 4.4 (A → A)

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.

Good compliance with Hazard Analysis and Critical Control Point (HAACP) was observed.

For further information see Appendix A

*Core Criterion

SD 4.5 (A → A)

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.

In general, systems of waste management were satisfactory. It is recommended that the management of waste through the production area of the kitchen be stopped.

For further information see Appendix A

*Core Criterion

SD 4.6 (A → A)

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

Good systems were observed.

For further information see Appendix A

*Core Criterion

SD 4.7 (A → A)

The team works with the Governing Body and/or its Executive Management team to manage hand hygiene effectively and in accordance with SARI guidelines

Good compliance noted.

For further information see Appendix A

SD 4.8 (A ↓ B)

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

There was evidence that the organisation take reasonable steps to keep patients/clients safe from accidents, injuries or adverse events, through on-going upgrade of kitchens, isolation rooms, Central Sterile Supply Department (CSSD), hand wash facilities and storage areas in some clinical areas. It is recommended that these continue to completion.

PATIENT'S/CLIENT'S RIGHTS

SD 5.1 (B → B)

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

There was evidence of documented processes for maintaining patient/client dignity during hygiene services delivery. For example the work route for the Household Services staff requires them to check in with the departmental manager. There was evidence of education and training programmes for household staff and Maternity Care Assistants. A process was in place for the management of patient/client complaints, which were reviewed with designated staff responsible for action plans. There was evidence of patient/client/staff satisfaction surveys.

SD 5.3 (A → A)

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

Documented processes were in place for dealing with patient/client's complaints. Records of complaints, and actions taken, were available. The organisation is benchmarking against other hospitals such as the Mater Hospital.

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1 (B → B)

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

This is carried out through patient/client satisfaction surveys and comment cards. The organisation intends to develop focus groups in the near future, which is recommended.

SD 6.2 (B → B)

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

Examples of this include: minutes of the Environmental and Facilities Management Team, hygiene services and annual report, and the introduction of new sinks and bins. There was evidence of audit for example in catering and by the EHO, Infection Control, Health and Safety and hygiene services check lists, with resultant action plans and designated staff with responsibility for them. There was evidence of benchmarking with other hospitals, such as The Mater Hospital.

4.0 Appendix A

The following are the scores received for the Service Delivery core criteria compliance requirements. The organisation must provide evidence of exceptional compliance (greater than 85%) to achieve an 'A' rating. All 'core criteria' must have achieved an 'A' rating to receive a score of 'very good' and be acknowledged with an award.

4.1 Service Delivery Core Criterion

Compliance Heading: 4. 1 .1 Clean Environment

(2) All high and low surfaces are free from dust, cobwebs and flaking paint.

No - Dust was observed in high surfaces throughout the organisation.

(3) Wall and floor tiles and paint should be in a good state of repair.

Yes - However a number of rooms, including staff area, were in need of painting.

(10) Internal and external signage should be clean, updated, well maintained and laminated to enable cleaning.

Yes - Excellent signage observed throughout the hospital.

Compliance Heading: 4. 1 .2 The following building components should be clean:

(21) Internal and External Glass.

No - Internal glass required greater attention.

Compliance Heading: 4. 1 .3 Organisational Buildings and Facilities (note: while list is not exhaustive, the following compliance is required):

(30) Fixtures: Fixtures (i.e. a piece of equipment or furniture which is fixed in position) should be clean. This includes all electrical fixtures e.g. all light fittings and pest control devices.

No - Light fittings over beds were dusty.

(207) Bed frames must be clean and dust free

No - Bed frames in a number of wards dusty.

Compliance Heading: 4. 1 .4 All fittings & furnishings should be clean; this includes but is not limited to:

(34) Beds and Mattresses

No - Dusty beds, base and wheels were observed in a number of areas.

Compliance Heading: 4. 1 .5 Sanitary Accommodation

(44) Hand hygiene facilities are available including soap and paper towels.

Yes - Hand wash guidelines missing in a number of areas.

(46) Bathrooms / Washrooms must be cleaned on a daily basis. When necessary, they must be disinfected. This must be monitored and recorded.

Yes - However the checklist was not complete in all areas.

Compliance Heading: 4. 1 .6 All sanitary fixtures and appliances should be clean and well-maintained. This includes but is not limited to:

(53) Bidets and Slop Hoppers

Yes - However cleaners' room in the Colposcopy Unit needs a review regarding storage.

(55) Sluices

Yes - However some sluices were used for storage.

(56) All associated bathroom fittings including component parts e.g. tiles, taps, showerheads, dispensers, toilet brushes etc should be clean and well maintained.

Yes - However, the organisation is recommended to install splash backs instead of tiles.

Compliance Heading: 4. 2 .3 Close patient contact equipment includes:

(72) Trolleys, e.g. chart trolleys, drug trolleys, linen trolleys, shop trolleys, emergency trolleys, suction apparatus, resuscitation equipment i.e. ambubag and mask.

Yes - However dust observed on a number of chart trolleys and mobile x-ray machines.

(73) TV, radio, earpiece for bedside entertainment system and patient call bell.

No - High dusting was observed to be an issue on all TV's.

(80) All office equipment (e.g. telephones, computers, fax machines) should be clean and well-maintained.

Yes - However, no keyboard covers were observed in any area.

Compliance Heading: 4. 3 .1 Cleaning Equipment & Products (note: while list is not exhaustive, the following compliance is required):

(90) Storage facilities for Cleaning Equipment should be provided in each work area with adequate ventilation, a hot and cold water supply and hand-wash facilities.

No - Limited storage space was observed.

Compliance Heading: 4. 4 .1 Kitchens, ward/department kitchens & kitchen fittings/appliances (note: while list is not exhaustive, the following compliance is required):

(216) Documented processes for manual washing-up should be in place

Yes - However dishwasher was out of order. The organisation is awaiting installation of a new machine.

Compliance Heading: 4. 4 .3 Waste Management

(232) Waste storage containers shall be smooth, durable, easy to clean and disinfect, well maintained and closable.

No - Two of the dedicated food bins were used for builder's waste and plastic items.

Compliance Heading: 4. 4 .5 Management of Chill Chain in a Hospital

(240) A Hospital using a cook-chill system should comply with Guidance Note No. 15 Cook-Chill Systems in the Food Service Sector (Food Safety Authority of Ireland) The temperatures of fridges, freezers, cold rooms and chill cabinets shall be capable of maintaining the temperature of foodstuffs

Yes - Food was cooked fresh.

(241) Ice cream display units can operate at -12°C as long as it can be demonstrated that the product has been held at this temperature for less than 7 days.

Yes - No display units were observed as ice cream is stored in the main freezer.

Compliance Heading: 4. 4 .7 Food Processing

(246) The thawing of food shall be carried out under appropriate conditions such as in a thawing unit, a fridge or a microwave oven with thawing cycle.

No - Thawing was observed in the designated area of the walk in fridge.

Compliance Heading: 4. 4 .10 Plant & Equipment

(249) Machines should dispense ice but where ice-scoops are used, they should be stored separately from the ice-making machine and there should be a process for the appropriate decontamination of the ice scoops. The making of ice cubes other than in ice machines is prohibited.

Yes - None observed.

(250) The dishwasher's minimum temperature for the disinfecting cycle should be compliant with I.S.340:2006 requirements and should be monitored regularly. There should be digital readouts on dishwashers.

No - Dishwasher observed was out of order. The organisation is awaiting installation of new dishwasher. Manual washing is occurring in the interim.

Compliance Heading: 4. 5 .1 Waste including hazardous waste:

(141) Documented procedures for the segregation, handling, transportation and storage of waste.

Yes - However, it is recommended that segregation posters be placed in sluices and waste storage areas. Waste is taken through production area in Kitchen, which is not recommended.

(142) Healthcare risk waste should be tagged and secured before leaving the area of production.

No - In the majority, however, un-tagged waste was observed in some areas.

Compliance Heading: 4. 5 .3 Segregation

(159) Sharps boxes are correctly sealed, labelled and stored in a safe environment.

No - Not all health care waste was labelled or tagged. This was not the case in all areas and was addressed during assessment.

(162) Hazardous wastes (chemical etc) must be segregated, stored and disposed of correctly.

No - A laboratory storage area was not locked.

(255) Within Healthcare risk waste, all special wastes including drugs & cytotoxic drugs / materials are segregated.

Yes - Waste is segregated, however, not all waste was labelled or tagged. This was addressed.

(256) Mattress bags are available and are used for contaminated mattresses ready for disposal; mattresses are disinfected.

No - Mattress bags are not in use.

Compliance Heading: 4. 5 .5 Storage

(258) Waste receptacles should be sanitised, secure and in a good state of repair when used.

Yes - However, non health care risk waste bins for cardboard and recyclables were observed overfilled and open to the elements.

Compliance Heading: 4. 6 .1 Management of Linen and Soft Furnishings (note: while list is not exhaustive, the following compliance is required):

(173) Documented processes for the use of in-house and local laundry facilities.

Yes - Only contracted services are used.

Compliance Heading: 4. 7 .1 Management of hand hygiene (note: while list is not exhaustive, the following compliance is required):

(188) Hand and wrist jewellery should be removed prior to performing all levels of hand hygiene with the exception of a plain wedding band.

Yes - In the majority, however, some nursing staff were observed wearing jewellery.

(190) All sinks should be fitted with washable splash backs with all joints completely sealed.

Yes - The organisation is recommended to install splash backs instead of tiles.

(196) Waste bins should be hands free.

Yes - All bins observed were in an excellent condition.

(198) Hand hygiene posters and information leaflets should be available and displayed throughout the organization.

No - Hand hygiene posters are required in some areas and appropriately placed.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team		Assessor Team	
	FREQ	%	FREQ	%
A	26	46.43	21	37.50
B	26	46.43	31	55.36
C	4	07.14	4	07.14
D	0	00.00	0	00.00
E	0	00.00	0	00.00
N/A	0	00.00	0	00.00

5.2 Ratings Details

Criteria	Self Assessment	Assessor	Difference
CM 1.1	A	A	→
CM 1.2	A	A	→
CM 2.1	B	B	→
CM 3.1	B	B	→
CM 4.1	B	B	→
CM 4.2	B	B	→
CM 4.3	B	B	→
CM 4.4	B	B	→
CM 4.5	B	B	→
CM 5.1	A	A	→
CM 5.2	A	A	→
CM 6.1	A	A	→
CM 6.2	A	B	↓
CM 7.1	A	A	→
CM 7.2	A	A	→
CM 8.1	A	A	→
CM 8.2	A	A	→
CM 9.1	B	B	→
CM 9.2	A	B	↓
CM 9.3	B	B	→
CM 9.4	A	B	↓
CM 10.1	A	B	↓
CM 10.2	B	B	→
CM 10.3	A	A	→
CM 10.4	B	B	→
CM 10.5	A	A	→
CM 11.1	A	A	→
CM 11.2	B	B	→
CM 11.3	B	B	→
CM 11.4	C	C	→
CM 12.1	B	B	→

CM 12.2	B	B	→
CM 13.1	B	B	→
CM 13.2	C	C	→
CM 13.3	C	C	→
CM 14.1	B	B	→
CM 14.2	B	B	→
SD 1.1	B	B	→
SD 1.2	B	B	→
SD 2.1	C	C	→
SD 3.1	B	B	→
SD 4.1	A	A	→
SD 4.2	A	A	→
SD 4.3	A	A	→
SD 4.4	A	A	→
SD 4.5	A	A	→
SD 4.6	A	A	→
SD 4.7	A	A	→
SD 4.8	A	B	↓
SD 4.9	A	A	→
SD 5.1	B	B	→
SD 5.2	B	B	→
SD 5.3	A	A	→
SD 6.1	B	B	→
SD 6.2	B	B	→
SD 6.3	B	B	→