Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

National Hygiene Services Quality Review 2008

University College Hospital, Galway

Assessment Report

Date of assessment: 23rd October 2008

About the Health Information and Quality Authority

The Health Information and Quality Authority is the independent Authority which was established under the Health Act 2007 to drive continuous improvement in Ireland's health and social care services. The Authority was established as part of the Government's overall Health Service Reform Programme.

The Authority's mandate extends across the quality and safety of the public, private (within its social care function) and voluntary sectors. Reporting directly to the Minister for Health and Children, the Health Information and Quality Authority has statutory responsibility for:

Setting Standards for Health and Social Services *– Developing person-centred standards, based on evidence and best international practice, for health and social care services in Ireland (except mental health services)*

Monitoring Healthcare Quality *– Monitoring standards of quality and safety in our health services and implementing continuous quality assurance programmes to promote improvements in quality and safety standards in health. As deemed necessary, undertaking investigations into suspected serious service failure in healthcare*

Health Technology Assessment *– Ensuring the best outcome for the service user by evaluating the clinical and economic effectiveness of drugs, equipment, diagnostic techniques and health promotion activities*

Health Information *– Advising on the collection and sharing of information across the services, evaluating, and publishing information about the delivery and performance of Ireland's health and social care services*

Social Services Inspectorate *– Registration and inspection of residential homes for children, older people and people with disabilities. Monitoring day- and pre-school facilities and children's detention centres; inspecting foster care services.*

1 Background and Context

1.1 Introduction

In 2007, the Health Information and Quality Authority (the Authority) undertook the first independent National Hygiene Services Quality Review. The Authority commenced its second Review of 50 acute Health Service Executive (HSE) and voluntary hospitals in September 2008.

The aim of the Review is to promote continuous improvement in the area of hygiene services within healthcare settings. This Review is one important part of the ongoing process of reducing Healthcare Associated Infections (HCAIs) and focuses on both the service delivery elements of hygiene, as well as on corporate management. It provides a general assessment of performance against standards in a range of areas at a point in time.

The Authority's second *National Hygiene Services Quality Review* assessed compliance for each hospital against the National Hygiene Standards and assessed how hospitals are addressing the recommendations as identified in the 2007 National Hygiene Services Quality Review.

All visits to the hospitals were unannounced and occurred over an eight-week period. The Authority completed all 50 visits by mid-November 2008. The *National Hygiene Services Quality Review 2008* provides a useful insight into the management and practice of hygiene services in each hospital.

Following the Authority's Review last year, every hospital was required to put in place Quality Improvement Plans (QIPs) to address any shortcomings in meeting the Standards.

Therefore, in considering this background, the Authority would expect hospitals to have in place well established arrangements to meet the Standards and the necessary evidence to demonstrate such compliance as part of their regular provision and management of high quality and safe care.

Consequently, the Authority requested a number of sources of evidence from hospitals in advance of a site visit and this year the unannounced on-site review was carried out, with the exception of one hospital, within a 24-hour period – rather than the three days taken last year. The Authority also stringently required that all assertions by hospitals – for example, the existence of policies or procedures – were supported by clear, documentary evidence.

This "raising of the bar" is an important part of the process. It aims to ensure that the approach to the assessment further supports the need for the embedding of these Standards, as part of the way any healthcare service is provided and managed, and also further drives the move towards the demonstration of accountable improvement by using a more rigorous approach.

It must therefore be emphasised that the assessment reflects a point in time and may not reflect the fluctuations in the quality of hygiene services (improvement or deterioration) over an extended period of time. However, patients do not always choose which day they attend hospital. Therefore, the Authority believes that the one-day assessment is a legitimate approach to reflect patient experience given that the arrangements to minimise Healthcare Associated Infections (HCAIs) in any health or social care facility should be optimum, effective and embedded 24 hours a day, seven days a week.

Individual hospital assessments, as part of the *National Hygiene Services Quality Review 2008*, provide a detailed insight into the overall standard of each hospital, along with information on the governance and management of the hygiene services within each hospital. As such, the Review provides patients, the public, staff and stakeholders with credible information on the performance of the 50 Health Service Executive (HSE) and voluntary acute hospitals in meeting the *National Hygiene Services Quality Review 2008: Standards and Criteria.* The reports of each individual hospital assessment, together with the National Hygiene Services Quality Review 2008, can be found on the Authority's website, www.hiqa.ie.

Hygiene is defined as:

"The practice that serves to keep people and environments clean and prevent infection. It involves the study of preserving one's health, preventing the spread of disease, and recognising, evaluating and controlling health hazards. In the healthcare setting it incorporates the following key areas: environment and facilities, hand hygiene, catering, management of laundry, waste and sharps, and equipment."

Irish Health Services Accreditation Board Hygiene Standards

1.2 Standards Overview

There are 20 Standards divided into a number of criteria, 56 in total, which describe how a hospital can demonstrate how the Standard is being met or not. To ensure that there is a continual focus on the important areas relating to the delivery of high quality and safe hygiene services, 15 Core Criteria have been identified within the Standards to help the hospital prioritise these areas of particular significance.

Therefore, it is important to note that, although a hospital may provide evidence of good planning in the provision of a safe environment for promoting good hygiene compliance, if the assessors observed a clinical area where patients were being cared for that was not compliant with the Service Delivery Standards and posed risks for patients in relation to hygiene that weren't being effectively managed, then a hospital's overall ratings may be lower as a result.

The Standards are grouped into two categories:

(a) Corporate Management

These 14 Standards facilitate the assessment of performance with respect to hygiene services provision to the organisation and patients/clients at organisational management level. They incorporate the following four critical areas:

- Leadership and partnerships
- Environmental facilities
- Human resources
- Information management.

(b) Service Delivery

These six Standards facilitate the assessment of performance at service delivery level. The Standards address the areas of:

- Evidence-based best practice and new interventions
- Promotion of hygiene
- Integration and coordination of services
- Safe and effective service delivery
- Protection of patient rights
- Evaluation of performance.

The full set of Standards are available on the Authority's website, www.hiqa.ie.

Core Criteria:
To ensure that there is a continual focus on the principal areas of the service, 15 Core Criteria have been identified within the Standards to help the organisation and the hygiene services to prioritise areas of particular significance. Scoring a low rating in a Core Criterion can bring down the overall rating of a hospital even if, in general, they complied with a high number of criteria. It is worth emphasising that if serious risks were identified by the assessors, the Authority would issue a formal letter to the hospital in relation to these risks.

1.3 Assessment Process

There are three distinct components to the *National Hygiene Services Quality Review 2008* assessment process: pre-assessment, on-site assessment, following up and reporting.

Before the onsite assessment:

- **Submission of a Quality Improvement Plan (QIP) and accompanying information by the hospital to the Authority.** Each hospital was requested to complete a Quality Improvement Plan. This QIP outlined the plans developed and implemented to address the key issues as documented in the hospital's Hygiene Services Assessment Report 2007.

- **Off-site review of submissions received**. Each Lead Assessor conducted a comprehensive review of the information submitted by the hospital.
- **The Authority prepared a confidential assessment schedule**, with the assessment dates for each hospital selected at random.
- **Selection of the functional areas.** The number of functional areas selected was proportionate to the size of the hospital and type of services provided. At a minimum it included the emergency department (where relevant), the outpatient department, one medical and one surgical ward.

  The hospitals were grouped as follows:
  - Smaller hospitals (two assessors) – minimum of two wards selected
  - Medium hospitals (four assessors) – minimum of three wards selected
  - Larger hospitals (six assessors) – minimum of five wards selected.

During the assessment:

- **Unannounced assessments.** The assessments were unannounced and took place at different times and days of the week. All took place within one day, except for one assessment that ran into two days for logistical reasons. Some assessments took place outside of regular working hours and working days.

- Assessments were undertaken by a **team of Authorised Officers** from the Authority to assess compliance against the National Hygiene Standards. Health Information and Quality Authority staff members were authorised by the Minister of Health and Children to conduct the assessments under section 70 of the Health Act 2007.

- **Risk assessment and notification.** Where assessors identified specific issues that they believed could present a significant risk to the health or welfare of patients, hospitals were formally notified in writing of where action was needed, with the requirement to report back to the Authority with a plan to reduce and effectively manage the risk within a specified period of time.

Following the assessment:

- **Internal Quality Assurance**. Each assessment report was reviewed by the Authority to ensure consistency and accuracy.

- **Provision of an overall report to each hospital, outlining their compliance with the National Hygiene Standards**. Each hospital was given an opportunity to comment on their individual draft assessment in advance of publication, for the purpose of factual accuracy.

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

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

1.4 Patient Participation Survey

During each assessment the assessors asked a number of patients and visitors if they were willing to take part in a national survey. This was not a formal survey and the sample size in each hospital would be too small to infer any statistical significance to the findings in relation to a specific hospital. Results from the questionnaires were analysed and national themes have been included in the National Hygiene Services Quality Review 2008.

1.5 Scoring and Rating

Evidence was gathered in three ways:

1. **Documentation review** – review of documentation to establish whether the hospital complied with the requirements of each criterion
2. **Interviews** – with patients and staff members
3. **Observation** – to verify that the Standards and Criteria were being implemented in the areas observed.

To maximise the consistency and reliability of the assessment process the Authority put a series of quality assurance processes in place, these included:

- Standardised training for all assessors
- Multiple quality review meetings with assessors
- A small number of assessors completing the assessments
- Assessors worked in pairs at all times
- Six lead assessors covering all the hospitals
- Ratings determined and agreed by the full assessment team
- Each hospital review, and its respective rating, was quality reviewed with selected reviews being anonymously read to correct for bias.

On the day of the visit, the hospital demonstrated to the Assessment Team their evidence of compliance with all criteria. The evidence demonstrated for each criterion informed the rating assigned by the Authority's Assessment Team. This compliance rating scale used for this is shown in Table 1 below:

Table 1: Compliance Rating Score

A	The organisation demonstrated exceptional compliance of greater than 85% with the requirements of the criterion.
B	The organisation demonstrated extensive compliance between 66% and 85% with the requirements of the criterion.
C	The organisation demonstrated broad compliance between 41% and 65% with the requirements of the criterion.
D	The organisation demonstrated minor compliance between 15% and 40% with the requirements of the criterion.
E	The organisation demonstrated negligible compliance of less than 15% with the requirements of the criterion.

This means the more A or B ratings a hospital received, the greater the level of compliance with the standards. Hospitals with more C ratings were meeting many of the requirements of the standards, with room for improvement. Hospitals receiving D or E ratings had room for significant improvement.

2. Hospital findings

2.1 University College Hospital, Galway - Organisational Profile

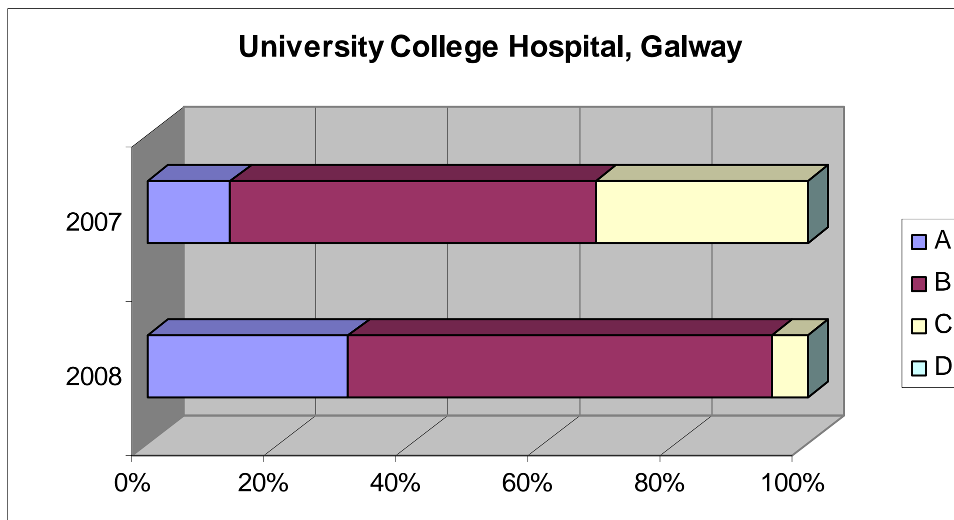
University College Hospital Galway is an acute hospital with a capacity of 698 beds (including 99 day-care beds and 43 psychiatric beds), serving a catchment of nearly 400,000. It is one of two Galway University Hospitals (the other is Merlin Park Hospital). The hospital plays a leadership role in acute service delivery, providing regional services for a wide range of specialties to support the policy of regional self-sufficiency.

2.2 Areas Visited

- Maternity ward
- St. Gerard's ward
- Outpatient department
- Emergency department
- St Nicholas ward
- St Enda ward
- St Anthony ward
- St Rita ward
- Waste compound
- Laundry service

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.

University College Hospital Galway has achieved an overall score of:

Fair

Award date: 2008

PLANNING AND DEVELOPING HYGIENE SERVICES

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

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

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

CM 1.2 Rating: A (>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 compliance of greater than 85% with the requirements of this criterion.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

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

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

- There was evidence demonstrated of linkages with the hospital and the regional Infection Control Committee and also with the Network Manager and the local Infection Control Committee in relation to hygiene services. There were minutes of meetings to demonstrate this.
- There was evidence that senior management was represented on the Infection Control Committee.
- It was demonstrated that the Executive Management Team and the hospital management were informed of results of key performance indictors, which included indicators for infection control.
- The links with the public health and the universities and the centre for nurse education were demonstrated. A staff satisfaction survey was completed in the latter part of 2007 and recommendations had been introduced.
- There was no evidence demonstrated of evaluation of linkages.

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.

- There was evidence demonstrated that results of hygiene key performance indicators were forwarded to the Hygiene Services Committee. The hospital management team received information in relation to infection control results and had recently received some hygiene update information, however, they did not receive routine information in relation to indicators for hygiene as these were demonstrated to be in their infancy.
- There was no evidence demonstrated of any evaluation of the appropriateness of the information received.

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

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

- There was evidence that all staff had access to the Library service in the hospital.
- The 2008 internal training and development plan was demonstrated.

- The induction programme and attendees were demonstrated. Records of waste training were also demonstrated as was the schedule for the year ahead.
- The hospital hygiene newsletter was demonstrated. The organisation had begun the process of implementing an information management system to ensure staff have access to the service plan, policies, procedures and guidelines, audit reports, contracts and service level agreements.
- There was a lack of evidence demonstrated of evaluation in this regard.

CM 4.4 Rating: B (41-65% compliance with this criterion)

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

- There was documented evidence and from the tours of the organisation it was apparent that an information management system was in the process of being rolled out to the entire hospital.
- The policy template for new policies was demonstrated.
- There was evidence of the development of a policy on the development, approval, revision and control of policies, procedures and guidelines.
- There was evidence that a number of infection control policies are in place in the clinical areas in hard copy until the information management system was introduced to all areas.
- The training records for staff on this system were demonstrated.
- The Irish Acute Hospitals Cleaning Manual was demonstrated in the clinical areas.
- There were a number of polices demonstrated by the hospital that are due for review.

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.

- There was evidence that all capital development projects to date have involved the Hygiene Services Committee, as they had included the Hygiene Services Manager and the Infection Control team. Both of these members were on the Hygiene Services Committee. This was evidenced in relation to the upgrade of the Hospital Sterile Services Department as evidenced through the Hygiene Services Committee meetings and the heads of Department Meetings.
- Evaluation of the efficacy of the consultation process was not demonstrated.

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 of greater than 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: A (>85% compliance with this criterion)

The Governing Body and/or its Executive/Management Team allocate resources for the Hygiene Service based on informed equitable decisions and in accordance with corporate and service plans.

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

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

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

- There was evidence that the hygiene services are involved in the process of purchasing all equipment/products. This was evidenced in the wash-hand basin replacement programme and the trial of the colour-coding system for cleaning.
- There was evidence of a product evaluation group in place who evaluate new equipment and medical equipment. There was a draft "Procurement Policy" in place and a draft policy on receipt of medical equipment on loan /trial.
- The use of the HSE National Finance Regulations in relation to purchasing was demonstrated. There was evidence that the Procurement Committee reported to the Medical Equipment Committee and the terms of reference for the procurement committee were demonstrated. A Draft "Product Evaluation" document was in place which refers to consultation with Infection Control in the process of purchasing. Minutes of meetings with the hygiene services demonstrated their involvement with the above mentioned committees and the discussion of the progress of purchasing.
- There was evidence that these draft policies had yet to be signed off.

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.

- There was evidence of a Risk Management Strategy and policy in place. An incident reporting policy was also demonstrated. There was evidence that risk management are members of the Hygiene Services Committee and the Infection Control Committee. It was advised that a senior member of staff received copies of all incidents relating to hygiene services from risk management. This evidence was not demonstrated.
- There was evidence demonstrated that the Hygiene Committee submitted reports to the Risk Management Committee on a biannual basis.
- There was evidence demonstrated that root cause analysis was completed on incidents of infection by the Infection Control Committee. Training records in relation to risk management were held centrally.
- The hospital advised that it was in the process of developing a departmental risk register. This was not demonstrated.
- There was evidence that the Hygiene Services Committee discussed risks as evidenced in the minutes of meetings, however, there was a lack of evidence demonstrated that incidents in relation to hygiene are tracked or trended consistently and the results/follow up in relation to incidents were not discussed at the meetings.

CM 7.2 Rating: B (66-85% compliance with this criterion)

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

- The risk management function of the hospital consisted of two risk advisors and a Quality and Risk Manager. There was also the support of a Database Manager who managed the STARSweb, a quality and risk manager, a consultant microbiologist and three clinical nurse managers in infection control. It was demonstrated that members of the Executive Management Team are members of the Hygiene Services Committee.
- The recruitment of an antimicrobial pharmacist had been identified as a position to support the risk management function.
- There was evidence through minutes of meetings that Hygiene related incidents were discussed at the Risk Management Committee and the Hygiene Services Committee, however, there was no evidence demonstrated of formal reports presented to the Hygiene Services Committee as yet.

- The hospital had provided some evidence that it had responded to risks identified in the past 12 months. The application of a formalised approach to evaluation and follow up in relation to risks was not 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.

- There was evidence that contract cleaners and contract catering provided on-site services in the hospital.
- There was evidence that a Site Manager was available for the management of the contract cleaners and six supervisors were also in place. There was evidence of meetings at regional and local level with the contract manager and members of the Hygiene Services Committee.
- The contract in place for the contract cleaners had been in place since 2004 and was being renewed. The new contract was demonstrated.
- The catering contract in place was dated 2006, there were quarterly meetings demonstrated with the Regional Services Manager and Finance Manager and the minutes were demonstrated.
- There was evidence demonstrated of the new sanitary contract. This involved an audit of the service by the hospital prior to the development of the contract.
- The contract in relation to waste management was also managed, this included second party audits.
- There was evidence demonstrated that audits were completed by the hospital cleaning contract with key performance indicators established. There was evidence that these were trended, and were discussed at the hygiene services committee meeting.
- There was a lack of evidence demonstrated of the process to ensure corrective action was implemented in relation to these audits when the rating was below 85% and there was a lack of evidence demonstrated of a consistent approach to auditing of the catering contract and follow-up in this regard.

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 ENVIORNMENT, FACILITIES AND RESOURCES

CM 9.1 Rating: B (66-85% compliance with this criterion)

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

- There was evidence demonstrated that the hospital included a member of the Infection Control Team as the hygiene services representative on its on-site developments.
- This included a construction permit and risk assessment being completed and evidence of these were demonstrated. There were clear method statements from all contractors providing a service on-site, these were signed off by the hospital management.
- The safety statement in place was dated 2006 and the updated version was awaiting circulation.
- There was evidence demonstrated that the hospital completed an internal review of storage and identified opportunities for improvement. It was advised that the recommendations will be added to the service plan for 2009. There was a wash-hand basin replacement programme ongoing. The central waste compound had been refurbished and was due to be open in November 2008.

***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 information management system which ensures tracking of maintenance requests to ensure they were logged and signed off was demonstrated. There was evidence through a documented laundry process that the curtains were due to be changed twice yearly. This policy was updated recently, however, it was not dated or in the template developed for policies.
- There were also gaps in the evidence that was presented in relation to when the routine curtains were due to be replaced.
- The system of colour coding of laundry bags was reviewed and the red bag was piloted.
- There was a Linen Policy in place and this was demonstrated.
- The Operational Environmental Management team were evidenced as a structure in place to manage the environment. The management of *Legionella* levels identified in the Paediatric Ward was managed through this team. This included the input of a member of the Infection Control team. There was evidence demonstrated that the organisation continued to take action to address this issue.
- There was, however, no evidence of a consistent approach to the flushing of outlets at clinical level, it was identified by the hospital that this happened as part of the cleaning process, apart from those outlets which had been identified as out of use and were flushed by the maintenance department.

- There was evidence that a tagging system was in place to manage the cleaning equipment, however, this was not consistent throughout the hospital.

CM 9.3 Rating: B (66-85% compliance with this criterion)

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

- There was evidence demonstrated of a number of methods utilised to determine the efficacy of the organisations environment and facilities. This included the review of the waste management systems, reviews of a number of service level agreements and contracts for example the cleaning contract.
- There was evidence of a project management system developed for reviewing projects.
- The recent introduction of the tagging of clinical waste bags was demonstrated. This was introduced in 2008.
- Hygiene audits were demonstrated in the areas of waste, cleaning and catering. These are inclusive of the Executive Management Team.
- There was evidence that the changes in relation to the environment and facilities had yet to be embedded and demonstrated.

CM 9.4 Rating: B (66-85% compliance with this criterion)

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

- There was some evidence demonstrated that the patients/clients, staff visitors were satisfied with the organisation's hygiene services facilities and environment. This was demonstrated through the patient comment cards feedback that was reviewed regularly.
- The complaints process "Your Service Your say" was in place and evidence of feedback to the Hygiene Services Committee in relation to complaints was demonstrated.
- Regular catering surveys were ongoing with recommendations addressed and these were demonstrated.
- It was demonstrated that a staff satisfaction survey was completed in the latter part of 2007 and an aspect of this included hygiene services.
- The evidence of the "Think clean, Think green" days at the end of October 2008 and plans for repeat of this in 2009 was demonstrated.
- There was evidence of the patient focus group in place and hygiene was a standing agenda. It was demonstrated that the patient focus group had one meeting the week prior to the assessment and the minutes were not available. It was advised that the management continued to encourage this group to

meet. The process to ensure patients were satisfied with the services facilities and environment was yet to be fully embedded and not 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 Human Resource strategy for 2004-2010 was demonstrated. There was evidence demonstrated that the Health Service Executive (HSE) national code of practice for recruitment and selection had been in place for the selection and recruitment of inhouse staff.
- Evidence of the contractor application form was demonstrated.
- An employee terms and conditions handbook was demonstrated. In relation to the catering contract, the policy and process for recruitment was demonstrated. It was identified that there was an evaluation of the recruitment process for hospital staff some years ago from an external company, however, there was no evidence demonstrated of this evaluation or changes made as a result.

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.

- There was evidence demonstrated of redeployment of staff for the transportation of waste. Increased frequency of cleaning was demonstrated within the whole time equivalent in response to infection control needs. These include change of work frequencies in the emergency department to 24 hours. The hospital has transferred the ordering of foods to the role of the catering staff.
- There was some evidence of evaluation of the changes in and the emergency department through local meetings maintained by the Services Manager. The formalised approach to evaluation of the appropriateness of work capacity and volume was not demonstrated.

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

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

- The 2008 operational training plan was demonstrated. This plan identified the mandatory training. There was evidence demonstrated of training cards

completed for all contract cleaning staff only and this detailed the training received to date. This did not, however, identify their ongoing training needs or identify when these should be completed.

- The training records are maintained on the Human Resource IT System. There was evidence that a number of staff had completed the British Institute of Cleaning Science (BICS) training as this was mandatory for some staff.
- Some of the staff had also completed the FETAC training.
- A schedule of ongoing hygiene training was not demonstrated.

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

There is evidence that the contractors manage contract staff effectively.

- There was evidence demonstrated that the catering company had a formal appraisal process in place for its staff, this was not demonstrated for the contract cleaning company.
- It was identified that the health needs of the contract staff were the responsibility of the contractors. This was included in the service level agreement. The vaccination status was identified for the catering company and a policy was in place.
- This was not demonstrated fully in relation to the contract cleaners as the records were not 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 Human Resource strategy was demonstrated. There was evidence of a clinical services plan in place which had identified Human Resource impacts.
- The Strategic Plan and Operational Plan were also demonstrated which identified the needs for hygiene services. There was some evidence demonstrated that the needs of hygiene services had been reviewed in a sporadic fashion to meet the clinical needs, for example the 24-hour service in the emergency department. These are in line with the service plan.
- There had been a review of the maintenance function and staffing. A formalised needs assessment was not demonstrated.

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: A (>85% compliance with this criterion)

Ongoing education, training and continuous professional development is implemented by the organisation for the Hygiene Services team in accordance with its Human Resource plan.

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

CM 11.3 Rating: A (>85% compliance with this criterion)

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

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

CM 11.4 Rating: C (41-65% compliance with this criterion)

Performance of all Hygiene Services staff, including contract/agency staff is evaluated and documented by the organisation or their employer.

- The organisation demonstrated that the formal performance appraisal in place in the hospital was during the probationary period only.
- There was evidence demonstrated that the cleaning audits were the only means utilised to assess performance rather than at individual performance level.
- The Key Performance Indicator for cleaning of 85% was trended and demonstrated. There was currently no performance evaluation in place for the cleaning contract; the process in place to review the catering contract was demonstrated through monthly catering reports received from the Catering Contractor.
- It was advised that monthly departmental meetings, nursing support monthly meetings and staff training records were used to assess performance of hospital hygiene staff. This was not demonstrated.

- There was no evidence demonstrated of a documented process for hygiene services staff including contract staff performance and evaluation.

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.

- The human resources satisfaction survey completed in 2007 was demonstrated, this reviewed occupational health needs.
- The resultant actions and quality improvement plans were not demonstrated.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.1 Rating: C (41-65% compliance with this criterion)

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

- The organisation demonstrated that it was in the process of introducing a document management system to support this criterion. It was demonstrated that Hygiene was a standing agenda item on the Executive Management Team and Hospital Management Team and minutes were demonstrated.
- A newsletter for staff regarding hygiene was demonstrated. A number of key performance indicators were in the development stage and there was evidence that the data in relation to these had been presented in some regard over the past three months.
- There was no evidence that this data was presented to the hygiene services committee routinely.
- The 2007 Hygiene services annual report was demonstrated. The records demonstrated in relation to hand hygiene training were incomplete as the process to manage this system was not fully realised.
- There was no evidence available of evaluation of data accuracy, reliability and validity.

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.

- There was evidence of reports presented to the Hygiene Services Committee. The Dangerous Goods Safety Advisor report, and the reports of complaints were now presented to the Hygiene Services Committee.
- It was demonstrated that hygiene was a standing agenda item on the hospital management team and the executive management team. The Risk Management Department received a report from the hygiene services biannually.
- The newsletter for hygiene services was reviewed by the Hygiene Services Committee before its release.
- Evaluation of user satisfaction in relation to reporting of data was not demonstrated.

CM 13.3 Rating: B (66-85% compliance with this criterion)

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

- There was some evidence demonstrated that the organisation evaluated the utilisation of data collection and information reporting by the hygiene services team. This was demonstrated through the product evaluation sub-group, incident reporting, the review of the cleaning contract, the waste management system, the sanitary bins and the screens.
- It was demonstrated that the lead complaints officer reported to the Hygiene Services Committee.
- These processes were in their infancy and were yet to be formalised and demonstrated.

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.

- There was evidence demonstrated of a number of improvements to hygiene services in the past two years. These include the multidisciplinary audits where management were involved.
- There was evidence that the recommendation as per the Environmental Health Officers reports were addressed in a systematic approach.
- A number of wash-hand basins had been upgraded. The new tagging system for clinical waste bags was demonstrated.
- The key performance indicator for reduced food wastage was demonstrated; the infection control indicators were tracked and trended and demonstrated.
- There was evidence that specific hygiene indicators were developed three months prior to the assessment and the data in relation to these was yet to be trended and utilised.

2.5 Standards for Service Delivery

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

EVIDENCE-BASED BEST PRACTICE AND NEW INTERVENTIONS IN HYGIENE SERVICES

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

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

- There was evidence demonstrated of a policy in place for the development of polices, procedures and guidelines, however, it was demonstrated that a number of policies were due for review. The organisation was in the process of introducing a document management system.
- A review of the policies was planned, however, it has not commenced at the time of the assessment.

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 a process in place for assessing new hygiene services interventions and changes to existing ones before there routine use. This was demonstrated in relation to the new tagging system for clinical waste, the bleach free products in the kitchen, the detergent wipe and the flat mopping system evaluation.
- It was advised that the equipment and trial policy was at pilot consultation stage and was yet to be introduced and demonstrated.
- There was no evidence of evaluation of the efficacy of the assessment process for new 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: A (>85% compliance with this criterion)

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

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

IMPLEMENTING HYGIENE SERVICES

***Core Criterion**

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

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

- In general the environment was clean, however, there were some areas that required attention, these included the sluice rooms as they were not all free from clutter.
- Chipped paint was observed in some sluice rooms and not all sluice rooms had separate wash-hand basins.
- There were no clear method statements for cleaning demonstrated.
- There was hand gel in place, however, the nozzles were observed not to be clean.

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

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

- There was evidence that the equipment was clean.
- There was no documentary evidence or a policy or process relating to cleaning equipment.
- There were cleaning products observed stored in unlocked cupboards or on the floor in cleaning rooms that were open in the majority of areas visited.

***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.

- There was evidence observed that personal clothing was being stored in the catering areas visited.
- The cleaning equipment was observed stored in the kitchen in all areas visited.
- All kitchen doors were observed to be opened in the areas visited.
- There was no personal protective equipment observed to be worn by the staff working in the catering areas visited and there was also none available in these areas.

- Staff members did not demonstrate their awareness of a food safety policy in place and the policy was not evident in many of the ward kitchen areas visited.

***Core Criterion**

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

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

- Tagging of clinical waste bags was introduced in the hospital in June 2008. These were demonstrated. It was advised that the new waste compound was due to open in November 2008. Segregation of general waste from clinical risk waste did not adhere to best practice on all occasions.
- There were opened healthcare risk waste containers observed stored in unlocked compounds in three areas visited.

***Core Criterion**

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

The team ensures the organisation's linen supply and soft furnishings are managed and maintained.

- The laundry upgrade work was demonstrated. There was a Linen Policy in place and this was demonstrated.
- There was a lack of segregation observed in all areas in contravention of policy.
- There was evidence of a pilot of colour coding for linen in one area, however, the policy did not reflect this.
- There was no consistent approach to the management of curtains. The pilot of the disposable curtains was completed and the hospital had decided based on the evaluation not to progress with this.
- The linen presses in many areas were observed to be wooden.

***Core Criterion**

SD 4.7 Rating: A (>85% compliance with this criterion)

The team works with the Governing Body and/or its Executive Management team to manage hand hygiene effectively and in accordance with the Strategy for the control of Antimicrobial Resistance in Ireland (SARI) guidelines.

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

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

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

- There was evidence of processes in place to identify risks through the incident reporting system.
- There was evidence that the hospital had responded to adverse events in 2008.
- The health and safety committee, risk management committee and the infection control committee and hygiene services committee were demonstrated as compliance.
- There was a lack of a systematic approach to providing feedback to staff in relation to risks identified.

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.

- There was evidence of patient comments cards that are trended and reported on. "Your Service Your Say" process was demonstrated.
- The complaints policy was in place and was demonstrated.
- There are a number of information leaflets for patients. The hospital visiting policy was demonstrated.
- The "Think Clean/Think Green" days were demonstrated.
- A catering survey was completed and was ongoing. The recommendations from this survey were not demonstrated. A hospital-wide patient satisfaction survey had yet to be completed.

PATIENT'S/CLIENT'S RIGHTS

SD 5.1 Rating: B (66-85% compliance with this criterion)

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

- There was evidence that dignity of patients was discussed at induction training for staff.
- A computerised flagging system if a patient has an infectious disease was demonstrated.
- Evaluation of violations of patient's rights was not in place, however, no incidents in this regard were identified. The process to review violations was not demonstrated.

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

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

- There was evidence that patients are provided with information in relation to many infectious diseases.
- There was evidence that the comment card processes was in place and comments are reviewed. Hand hygiene information leaflets were demonstrated. "Your Service Your Say" complaints process was in place.
- There was a lack of evidence demonstrated of evaluation of patients' comprehension of and satisfaction with information provided, as the satisfaction survey that had been completed in the hospital was in relation to catering only.

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 that the national Health Service Executive complaints policy was in place.
- There was a lead complaints officer and local complaints officers across the hospital. Many of the complaints were managed informally at the clinical level and it was advised that they were not recorded.
- There was a good level of awareness of complaints process across the hospital, however, there was no evidence of trending demonstrated.

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.

- It was demonstrated that the hospital had a patient focus group in place and it was demonstrated that the hospital was striving to include service users further in this process.
- There was evidence that the catering patient survey was ongoing.
- The complaints process is established. It was advised that the process in place to include staff was yet to be formalised.

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

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

- The organisation demonstrated that it has begun the process of evaluating hygiene services as there was evidence demonstrated of a number of key performance indicators developed three months ago.
- There was evidence that the Quality Improvement Plan was tracked through the Hygiene Services Committee.
- A review of the waste transport system in 2008 was demonstrated.
- There are a number of audits completed in relation to hygiene services and these included waste management, however, there was no consistent approach to implementing the actions identified.
- There was evidence of the introduction of 24-hour cleaning to and the emergency department in 2008. The evaluation of this process had not been demonstrated. There was a review of storage facilities in the surgical wards with actions identified.
- There was no evidence demonstrated that the key performance indicators (KPIs) which were a recent initiative were formalised, or tracked.

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 Hygiene Services Annual Report for 2007 was in place and was demonstrated.
- There was evidence that this was signed off by the Hygiene Services Committee.
- There was insufficient evidence demonstrated of patient involvement in the development of same.

Appendix A: Ratings Details

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

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

Criteria	2007	2008
SD 4.6	B	B
SD 4.7	B	A
SD 4.8	C	B
SD 4.9	C	B
SD 5.1	B	B
SD 5.2	B	B
SD 5.3	B	B
SD 6.1	B	B
SD 6.2	B	B
SD 6.3	B	B