Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

National Hygiene Services Quality Review 2008

Wexford General Hospital

Assessment Report

Assessment date: 7th November 2008

About the Health Information and Quality Authority

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

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

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

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

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

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

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

1 Background and Context

1.1 Introduction

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

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

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

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

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

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

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

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

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

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

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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 report.

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

1.4 Patient Perception Survey

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

1.5 Scoring and Rating

Evidence was gathered in three ways:

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

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

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

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

Table 1: Compliance Rating Score

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 Wexford General Hospital - Organisational Profile[1]

Wexford General Hospital serves a population of 131,615 people with 283 treatment beds. The coronary care unit, medical, paediatric, gynaecology and maternity units along with the laundry area were built in the 1970s, the two surgical wards, theatre, accident & emergency and out patients were built in the 1990s and opened in 1992.

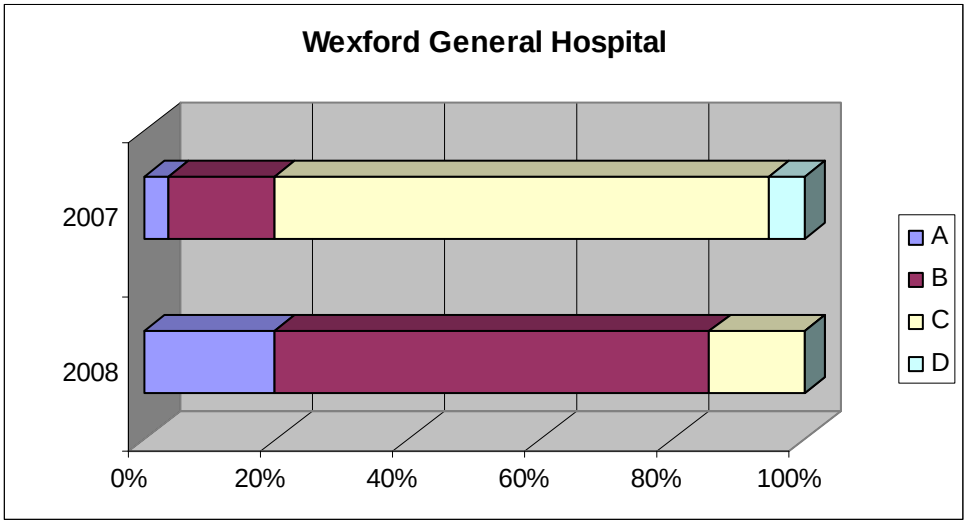
2.2 Areas Visited

- Outpatient department
- Emergency Department
- St Gabriel's Ward
- St Patrick's Ward
- St Josephs ward
- Maternity Ward
- Waste compound
- Laundry services.

[1] The organisational profile was provided by the hospital

2.3 Overall Rating

The graph below illustrates the organisation's overall compliance rating for 2008 and its overall rating for 2007. Appendix A at the end of this report illustrates the organisation's ratings for each of the 56 criteria in the 2008 National Hygiene Services Quality Review, in comparison with 2007. See page 8 for an explanation of the rating score.



An overall award has been derived using translation rules based on the number of criterion awarded at each level. The translation rules can be viewed in the National Report of the National Hygiene Services Quality Review 2008. Core criteria were given greater weighting in determining the overall award.

Wexford General Hospital has achieved an overall rating of:

Fair

Award date: 2008

2.4 Standards for Corporate Management

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

PLANNING AND DEVELOPING HYGIENE SERVICES

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

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

- There was evidence to demonstrate that the organisation regularly assesses and updates their current and future hygiene services needs. This was evidenced through the completion of a strengths, weaknesses, opportunities and threats (SWOT) analysis of the hygiene needs assessment for 2006 and 2007, which included for example, Human Resources, Health Promotion and Information Management for hygiene services.
- The needs assessment has resulted in the development of the Strategic Plan, Service Plan 2008, Operational Plan 2008 and the Annual Report for 2007.
- There was insufficient evidence of costings outlined. However the Finance Manager is a member of the Hygiene Services Committee and reviews cost and spend.
- There was evidence that the needs assessment process was reviewed at the Hygiene Services Committee.
- There was evidence that the environmental audits for each department are submitted to the line manager and collated results are sent to Hygiene Services Committee where they are reviewed.
- There was no evidence of evaluation of the efficacy of the needs assessment process demonstrated.

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 Services Executive, various levels of Government and associated agencies, all staff, contract staff and patients/clients with regard to hygiene services.

- The organisation demonstrated that it links and works in partnership with the Health Services Executive staff and clients. This was evidenced through General Manager's meetings with the Network Manager. The minutes of these meetings were demonstrated
- It was demonstrated that the Network Manager is also a member of the regional Infection Control Committee.
- There was evidence demonstrated of a regional Network Quality and Risk Group. A member of the senior management team is a member of this group, and there was evidence of regular discussions regarding hygiene, however, hygiene is not a standing agenda item.
- There was evidence demonstrated of linkages between the hospital management, and primary, community, continuing care, where hygiene was discussed regularly, the minutes were demonstrated.
- There was evidence demonstrated of links with the HSE Population Health.
- There was evidence of a Patient Partnership Forum in place. This Forum meets monthly and was chaired by hospital management.
- There was evidence of a patient satisfaction survey for hygiene specifically in 2007, this included 50 patients and this was repeated in 2008 with 210 patients. There was evidence of a comparative study between the 2007 and 2008 results.
- There was no evidence demonstrated of evaluation of efficacy of the linkages and partnerships.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 Rating: B (66-85% 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 evidence of a Hygiene Services Strategic Plan that was developed in conjunction with the Hygiene Services Committee in 2007 which includes the majority of members of the Executive Management Committee and a service user.
- The three year maintenance plan with costings was demonstrated.
- There was evidence demonstrated that the Strategic Plan has been distributed to all clinical areas.

- There was evidence presented that the Strategic Plan is tracked through the Service Plan and the Operational Plan in some regards. There was evidence of a draft evaluation of the Hygiene Strategy.
- There was no evidence demonstrated of a documented process for the development of the Strategic Plan.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.1 Rating: B (66-85% 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 evidence of an algorithm demonstrating the reporting arrangement for the Hygiene Services Committee and Team in relation to other committees and groups. The Hygiene Services Committee included three members of the Executive Management Team.
- There was evidence demonstrated of a code of conduct for the governance of Hygiene Services, which was adopted from another hospital.
- There was evidence of a number of audits completed. There was no evidence demonstrated of evaluation of the authority provisions for hygiene services demonstrated.

CM 4.2 Rating: C (41-65% 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 some evidence demonstrated that the Executive Management Team regularly receives useful, timely and accurate evidence or best practice information. This is achieved through the monthly Quality and Safety Committee meeting, where three of the Executive Team members are members of this committee and are also members of the Hygiene Services Committee.
- There was evidence demonstrated of a presentation to the Quality and Safety Committee on a six weekly basis in relation to best practice information. This includes infection control surveillance data results.
- There was evidence demonstrated of a schedule of Quality and Safety Committee meetings for 2008 and the minutes were demonstrated.
- There was a suite of key performance indicators demonstrated in the Hygiene Services Annual Report for 2007. There was no evidence demonstrated of a formal process in place to review these or provide information on them on a regular basis to all members of the Executive Management Team.

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 to demonstrate that all staff have access to the intranet.
- A regional waste policy was demonstrated.
- The organisation demonstrated that the Executive Management Team access and use information to improve Hygiene Services through the infection control weeks held in 2007 and October 2008.
- The hospital accesses the services of a microbiologist who provides a service on a weekly basis.
- There is evidence demonstrated of a newsletter in place every second month, which includes Hygiene Services.
- There is evidence that all hygiene staff are trained to British Institute of Cleaning Science level.
- There is insufficient evidence of evaluation of the appropriateness of Hygiene Services related research and best practice information available.

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

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

- The organisation demonstrated evidence of a guideline on the formation and distribution of policies, procedures and guidelines (PPGs) which was in draft format and had been developed based on evaluation of the process in place for developing policies, procedures and guidelines .
- There was evidence that the organisation are complying with regional infection control policies.
- There was no evidence demonstrated of an evaluation of the efficacy of the process in place for the development of policies and procedures and guidelines as this policy was demonstrated to be in draft format.

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

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

- There was evidence to demonstrate that two members of the Executive Management Team are members of the Capital Development Project Team and the Hygiene Services Committee.
- There was evidence demonstrated that hygiene was introduced as an agenda item for the Capital Development Project Team meeting from November 24th 2008, however this was not formalised. It was demonstrated in the minutes of the meeting that this was to be a standing agenda item on each of these meetings going forward.

- There was a lack of demonstrated evidence of a process in place to ensure consultation between the Hygiene Services Team and the Capital Development Team.
- There was no evidence demonstrated of evaluation of the efficacy of the consultation process between the Hygiene Services Team and senior management.

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

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

- There was evidence to demonstrate that the Executive Management Team allocated resources for hygiene services based on equitable decisions and in accordance with the corporate and service plans.
- The pay and non pay budget demonstrated that there is no specific budget allocated to the hygiene services.
- There was no evidence demonstrated of a costed strategic and service plan. There was evidence however of a three year costed maintenance plan.
- There are processes in place to view the hygiene expenditure for hygiene services for 2007 as outlined in the 2007 Hygiene Services Annual Report.

There was no evidence demonstrated of review of spend or trending same routinely.

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 to demonstrate that the Procurement Committee and Hygiene Services Committee are multidisciplinary and share the same membership.
- The terms of reference of the Hygiene Services Committee includes procurement.
- There was evidence demonstrated of the terms of reference of the procurement committee who meet every six weeks.
- There was evidence demonstrated that the Hygiene Services Committee discuss procurement, however this is not a standing agenda item.
- There was a lack of evidence of evaluation of the consultation process between the Hygiene Services Committee and senior management.

MANAGING RISK IN HYGIENE SERVICES

***Core Criterion**
CM 7.1 Rating: C (41-65% 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 some evidence in place to demonstrate that the organisation has a structure and related process to identify priorities, eliminate or minimise risks related to hygiene services.
- The organisation advised that there was a clinical risk management policy in place; however this policy was not demonstrated. There was evidence of a regional guideline on the management of risk.
- It was advised that all non-clinical incident reports which include hygiene are forwarded to hospital management. These are then forwarded to the Health and Safety Officer and the clinical risks are forwarded to the Risk Manager.
- There was evidence demonstrated of one report from Health and Safety for 2008 in relation to hygiene risks. This was evidence demonstrated that this is discussed at the Quality and Risk Committee.
- There was no evidence demonstrated that this information is tracked to the individual ward area or evidence to demonstrate a formalised process to demonstrate closure of the loop in relation to hygiene risks identified.

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 organisation demonstrated evidence that the hygiene services risk management practices are actively supported by the governing body as there was evidence of an acting Clinical Risk Manager and a Health and Safety Officer who supports the identification and management of hygiene related incidents.
- There is a Quality and Risk Management Committee, a Health and Safety Committee and a Hygiene Services Committee in place who are multidisciplinary in composition.
- There was no evidence demonstrated of evaluation of these functions to ensure there is a formalised approach to the management of hygiene risk.

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 to demonstrate that the hospital has addressed the significant risk identified in this area in 2007 national hygiene services quality review report.
- There was evidence of the establishment of the contract service for sanitary services in January 2008 and there was evidence of evaluation and monitoring of this contract since its establishment.
- There was evidence to demonstrate that the shop contract is being managed on a regular basis. The minutes and audits were demonstrated.
- The organisation has developed a contractor handbook in 2008 and this was demonstrated.
- There was evidence that the organisation is in the process of developing an induction programme and pack for contractors and drafts of both documents were demonstrated.
- There was evidence demonstrated of other contracts in place. There was evidence that these were informally managed, however, there was a lack of evidence of formal processes in place to manage these contracts.
- The hospital advised that there is a named person to manage each contract; however, this was not demonstrated.
- There was no evidence that the windows have been cleaned in 2008 due to the construction work ongoing.

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 ENVORNMENT, FACILITIES AND RESOURCES

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

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

- The organisation demonstrated evidence of design specifications in place for the new and existing facility.
- There was evidence to demonstrate that the Technical Services Department have completed an evaluation of the new and existing buildings, however, there was no date specified on this evaluation demonstrated. The recommendations were outlined; however these were no evidence that these were introduced.
- There was evidence of a waste, and health and safety audit completed and recommendations were demonstrated, however there was no evidence that these have been introduced.

***Core Criterion**

CM 9.2 Rating: C (41-65% compliance with this criterion)

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

- There was evidence that the organisation refer to local guidelines for the handling, transportation and storage of Linen, this policy was due for review in February 2008.
- This policy refers to an audit tool to measure compliance; however there was no evidence that this had been utilised.
- The organisation demonstrated that they meet regionally to discuss laundry and have developed a template to record when linen is disposed of at ward level.
- There was evidence demonstrated of a waste management plan for the HSE South East. There was a lack of evidence of a waste management policy for the hospital.
- There was evidence demonstrated that the hospital refers to the national Aspergillus guidelines, however there was a lack of evidence demonstrated of a local policy.

- There was evidence demonstrate of a draft Legionella policy dated 2005. This was adhered to in relation to the monthly water temperature monitoring process demonstrated.
- There was evidence demonstrated that the Infection Control Team provide reports to the Quality and Safety Committee as per schedule. There was a lack of evidence of a consistent approach to provide routine information to this committee or the Executive Management Team. However, there was evidence that a number of the Executive Management Team were members of the Quality and Safety Committee.
- The organisation demonstrated that they have identified a number of maintenance issues as a result of the environmental audits and the maintenance department was in consultation with the Hygiene Services Committee in relation to the progress of these issues. There are a number of issues highlighted that had not completed. It was advised that the maintenance department provided a service to the region and it was demonstrated that the organisation are introducing a process to ensure all maintenance issues identified can be tracked to ensure the organisation knows the status of these issues.

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.

- The organisation demonstrated that a number of hygiene related audits were completed in 2008 and the schedule of audits was demonstrated. These include environmental audits which are completed by the Clinical Nurse Managers monthly in their clinical areas.
- There was some evidence demonstrated of improvements made based on these audits.
- There was also a lack of evidence demonstrated of collation of results of these audits or trending of the results as the organisation was in the progress of formalising this process.
- There was evidence of Infection control audits, which include alcohol based hand rub usage audits, hand-hygiene, standard precautions, Hospital Acquired Infections, Personal Protective Equipment, out break management and adherence to the organisations Methicillin Resistant *Staphylococcus Aureus* policy.
- The infection control audits results ensure trending and the same was demonstrated.
- The hospital has introduced a Hazard Analysis and Critical Control Point meeting to ensure the recommendations from the catering audits can be introduced and the evidence of these were demonstrated.
- There was a lack of evidence presented that results of audits are routinely discussed at the Hygiene Services Committee.

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 evidence demonstrated that the hospital has completed hygiene satisfaction surveys in 2007 and 2008. The results of these were demonstrated. There was evidence presented that a patient representative from the Patient Partnership Forum and a patient from the Hygiene Services Committee reviewed the results.
- The organisation demonstrated that the recommendations for the 2008 hygiene services assessment are being implemented.
- The organisation is currently in the process of reviewing their visitor's policy.
- The Patient Advisory Liaison Service in place has provided a presentation to the Quality and Safety Committee who provide a report on a three monthly basis on the status of complaints and feedback from in patients. This was demonstrated.
- There was evidence provided that the Hygiene Services Committee has asked for further breakdown of trends from this department going forward.

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.

- There was evidence demonstrated that the organisation adheres to the national recruitment policy.
- There was some evidence to demonstrate that the organisation had begun the process of ensuring all job descriptions include the requirements of hygiene. This was demonstrated for the Household Supervisor.
- There was evidence to demonstrate that the Human Resources Department has developed an evaluation questionnaire in relation to the recruitment process and this was forwarded to all hospital staff in October.
- There have not been any results demonstrated in relation to this evaluation.

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 some evidence to demonstrate that the organisation have assigned human resources based on changes in work capacity and volume, and this

was demonstrated through the introduction of the house keeping staff on a bleep at night. There was evidence demonstrated that this was based on a needs assessment and from hygiene related complaints.
- The process for assignment of human resources is yet to be formalised and was not demonstrated.

CM 10.3 Rating: C (41-65% compliance with this criterion)

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

- There was evidence to demonstrate that all cleaning staff had completed British Institute of Cleaning Science training.
- The organisation has established a training matrix in each of the departments since 2007. This includes mandatory training and is monitored by the Department Manager.
- There was evidence from the records demonstrated that not all staff have attended mandatory training.
- There was evidence of the external waste contractor providing some training for staff. There was a lack of evidence demonstrated of a systematic approach to providing training for staff in relation to waste and/ or linen management.
- There was a lack of evidence demonstrated that the job descriptions include qualifications and training requirements.

CM 10.4 Rating: A (>85% compliance with this criterion)

There is evidence that the contractors manage contract staff effectively.

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

***Core Criterion**

CM 10.5 Rating: A (>85% compliance with this criterion)

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

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

ENHANCING STAFF PERFORMANCE

***Core Criterion**

CM 11.1 Rating: B (66-85% compliance with this criterion)

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

- There was evidence to demonstrate that there is a corporate and departmental induction in place. This is supported by the HSE National Resource Booklet.
- There was evidence that the departmental induction is developed by the department manager and the staff nurses have access to an induction booklet and same was demonstrated. This includes information on waste, sharps, hand hygiene and incident reporting. The management of linen is not included in this booklet.
- There was no evidence demonstrated of an organisation wide local induction programme.

CM 11.2 Rating: B (66-85% compliance with this criterion)

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

- There was evidence to demonstrate that hygiene staff has completed the British Institute of Cleaning Science training and updates in relation to this are completed annually.
- The organisation demonstrated that they had implemented Personal Professional Development for hygiene staff only. There was evidence of training completed and an evaluation template which is utilised.
- There was no central system demonstrated to record the hygiene training completed.

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

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

- There was some evidence to demonstrate that education and training regarding hygiene services is effective. This was demonstrated through a suite of key performance indicators for hygiene services that include training; these are reviewed on an annual basis as evidenced in the 2007 hygiene services annual report.
- There was evidence of an evaluation form completed by staff at the end of all training; this was demonstrated by the Infection Control Team for hand hygiene.

- There have been changes as a result of evaluations completed; this included the change of venue.
- The organisation demonstrated that it is not meetings its target for hand hygiene and sharps training.

CM 11.4 Rating: B (66-85% compliance with this criterion)

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

- There was evidence demonstrated that performance of hygiene staff is evaluated through the Personal Professional Development process which was demonstrated.
- There was a lack of evidence of evaluation of this process.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 Rating: B (66-85% compliance with this criterion)

An occupational health service is available to all staff.

- There was extensive evidence that an occupational service is available to staff. This consists of a regional Occupational Physician who visits monthly and nurse led service weekly.
- It was demonstrated that the records of attendance are maintained within the services. There was evidence that non attendees are monitored.
- The organisation demonstrated that the service had completed an evaluation through team based performance; this included a review of the waiting times, staff immunity to Hepatitis B and uptake by nurses and doctors. This was demonstrated.
- There have been a number of key performance indicators developed and reviewed by the service, these include the need to develop a two day induction programme where sharp training would be included. This was not demonstrated at the time of the assessment.

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

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

- The organisation demonstrated that the Occupational Health Department has identified a number of key performance indicators.
- It was demonstrated that absenteeism rates are monitored by senior management in the hospital on a monthly basis.
- The processes in place to monitor satisfaction from the staff perspective were not demonstrated.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.1 Rating: B (66-85% compliance with this criterion)

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

- There was evidence demonstrated that the organisation have processes in place for collecting and providing access to quality hygiene services data and information, this includes the Quality and Safety Committee, the Hygiene Services Team and Committee.
- There was evidence demonstrated of an evaluation completed of the Hygiene Services Team in 2007, this included reviewing minutes of meetings which included section on considering if the Team adheres to national guidelines.
- Evidence was not demonstrated of evaluation of quality data reliability, accuracy, validity and appropriateness.

CM 13.2 Rating: B (66-85% compliance with this criterion)

Data and information are reported by the organisation in a way that is timely, accurate, easily interpreted and based on the needs of the Hygiene Services.

- The organisation demonstrated evidence that data and information is reported by the organisation in a way that is timely, accurate, easily interpreted and based on the needs of the hygiene services.
- This includes reports to the Quality and Safety committee. The schedule of reports was demonstrated. This also includes the environmental audits reports and the Infection Control Nurses Association tools.
- There was no evidence demonstrated of evaluation of user satisfaction in relation to the reporting of data and information.

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

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

- There was evidence that the organisation have informally reviewed data and information needs from the Hygiene Services Committee and Team.
- There was evidenced through the minutes of the meetings that the organisation has reviewed the information in relation to the environmental audits and the information generated by the Patient Advisory Liaison Service data. This process has yet to be formalised.
- There was no evidence demonstrated of evaluation of the appropriateness of the data and information utilisation in relation to service provision and improvement.

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 to demonstrate that there have been a number of improvements to the hygiene services in 2008. These include addressing the risk identified in the National Hygiene Services Quality Review report in 2007.
- The organisation have demonstrated that they have developed a number of key performance indicators for Hygiene Services and these are monitored on a one off basis annually only as identified in the 2007 hygiene annual report.
- There was evidence of communication of the quality improvement initiatives to all staff through the minutes of the Hygiene Services Committee and Team meetings.
- There was a lack of evidence of benchmarking in relation to hygiene services.
- There some evidence of improvements based on hygiene audits, however the closure of the loop was not formalised

2.5 Standards for Service Delivery

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

EVIDENCE BASED BEST PRACTICE AND NEW INTERVENTIONS IN HYGIENE SERVICES

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

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

- The catering service was demonstrated to comply with the hazard analysis and critical control point (HACCP) guidelines.
- Segregation of linen, waste management and colour coding for cleaning was demonstrated to comply with national guidelines. However, it was demonstrated that there is no documented policy demonstrated for the above mentioned.
- The policy on the management of sharps was demonstrated and this was developed by the Occupational Health Department.
- The Strategy for the control of Antimicrobial Resistance in Ireland (SARI) guidelines were referred to in relation to hand hygiene.
- It was demonstrated that protected time of half and hour, per six weeks is allocated to hygiene services staff to review policies. This was agreed at the Hygiene Services Team.
- It was demonstrated that a number of Infection Control audits were completed at ward level by the staff in their own areas to demonstrate compliance to these policies and the national guidelines.
- There was evidence that improvements in relation to these audits are addressed locally, however a formalised process was not demonstrated.
- The policy for the development of polices, procedures and guidelines were demonstrated to be in draft format, and therefore it was demonstrated that a number of the policies observed were not complying with this policy as yet.

SD 1.2 Rating: A (>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

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

PREVENTION AND HEALTH PROMOTION

SD 2.1 Rating: B (66-85% 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.

- It was demonstrated that a health promotion committee is in place. Health promotion literature was observed in all clinical areas.
- It was demonstrated that the Traveller Link person is trained in hand hygiene and is employed as liaison with the HSE South East.
- It was also demonstrated that the infection control week was facilitated by the link Infection Control Nurses. This was completed in October 2008. It was demonstrated through review of documentation that information stands were available for the public during this week.
- It was demonstrated that the media are involved if there is an out break of infection in the hospital.
- There was evidence of hygiene information leaflets and posters in place. There was evidence demonstrated of a Patient Partnership Forum in place who met monthly which supports Health Promotion.
- There was no evidence demonstrated that there has been an evaluation of the efficacy of the health promotion activities completed.

INTEGRATING AND COORDINATING HYGIENE SERVICES

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

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

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

***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.

- The organisation's physical environment in the main was clean. There was high and low dust observed in some areas visited.
- Debris was observed on the ground floor where spare linen containers are stored.
- The sluice rooms observed were small and cramped.
- There was sticky residue observed in some areas.
- One bathroom sink was observed not to be clean.
- The policy on flushing outlets was observed and this is completed daily in the clinical level. However, there were some gaps noted on these checklists.

***Core Criterion**

SD 4.2 Rating: B (66-85% compliance with this criterion)

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

- The organisations equipment, medical devices and cleaning devices were observed to be managed and clean.
- There were fans observed in two areas visited. This conflicts with hospital policy.
- Some equipment observed was dusty in areas visited.

***Core Criterion**

SD 4.3 Rating: A (>85% compliance with this criterion)

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

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

***Core Criterion**

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

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

- Food management practices were observed are in accordance with HACCP standards.
- The cleaning equipment was observed stored in a separate press in the kitchen in one ward kitchen.
- It was observed that there is no personal protective equipment outside of kitchens, although this was in use and was stored inside the kitchen in a press.
- The kitchen doors were held open despite signage identifying no unauthorised entry in some areas visited.
- There were bait boxes in some areas; however, there was no bait box or map in one area visited.
- There were no separate catering staff toilets observed at ward level.

***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.

- The segregation of clinical and non-clinical waste observed was in line with best practice guidelines.
- There was evidence of two sharps containers observed awaiting collection, these were closed and signed off, however not tagged as per policy. Waste was observed on the floors in the sluice rooms. It was observed that there is frequent collection of waste from the clinical areas to address storage issues. This was not demonstrated.

***Core Criterion**

SD 4.6 Rating: B (65-85% compliance with this criterion)

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

- There was evidence that the organisations linen supply and soft furnishings in the main are managed and maintained. It was observed that soiled linen is segregated and stored at ward level in the sluice rooms. However, there is frequent collection to address the storage issue

- There were two examples of inappropriate placement of soiled linen in white linen bags at the collection site observed.
- There was debris observed in the base in some of the linen transport containers. The linen is transported to the ward areas in steel trolleys which were observed to be clean.

***Core Criterion**

SD 4.7 Rating: B (66-85% compliance with this criterion)

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

- Hand washing demonstrations were in line with best practice.
- There was no evidence observed of jewellery being worn by staff in the clinical areas.
- Hand-hygiene notices/ hand-hygiene instructions were not demonstrated in all areas visited where hand wash basins were present.
- A wash hand basin replacement programme is ongoing; however, not all sinks were observed to be compliant in all areas visited.

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

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

- An incident reporting system was in place and was demonstrated.
- There was evidence demonstrated of a regional guideline on the management of risk. There was no evidence demonstrated of an organisational risk management policy.
- It was advised that incident feedback may be informal at times, however there was some evidence that a number of hygiene incidents reports completed were viewed by the organisation and the local action plan completed was demonstrated.
- The formal follow up and trending in relation to these risks was not demonstrated.

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.

- The patient information booklet was observed.
- The 2007 and 2008 hygiene patient satisfaction surveys were demonstrated and it was demonstrated that the results and findings of the 2007 survey were progressed through the Patient Partnership Forum.

- It was demonstrated that the recommendations and results of the 2008 patient satisfaction survey were reviewed by the Patient Partnership Forum.
- There was no evidence provided that these findings been introduced.
- It was demonstrated that the current visiting policy is under review.

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.

- It was demonstrated in the clinical areas visited that the notices on doors to identify isolation and protect patients rights.
- Rest periods for patients were also demonstrated.
- Patient information leaflets and 'Your Service Your Say' is in place.
- The Patient Advisory Liaison Service was demonstrated and there is quarterly verbal feedback to the clinical areas in respect of these findings. It was demonstrated that the confidentiality policy was in place and was due for review in February 2008. This was not demonstrated at the time of the assessment.

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.

- The patient information on hygiene services was demonstrated. The voice over in reception was observed.
- There was no evidence demonstrated of evaluation of patients' or visitors' comprehension and satisfaction with information provided by the Hygiene Services Team.

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

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

- There was evidence demonstrated that patients complaints are managed in line with organisational policy.
- The Patient Advisory Liaison (PALs) Service was demonstrated. It was demonstrated that the Complaints Officer provides feedback to the Quality and Safety Committee quarterly on complaints. This information is not directly reported to the Hygiene Services Committee or team. However, there was evidence demonstrated that the Quality and Safety Committee consists of members from the Hygiene Services committee and Team.

- There was a lack of evidence that there is a systematic approach to the trending of incidences of complaints and the action taken to prevent a reoccurrence was not demonstrated in a formalised manner.
- There was evidence demonstrated that an evaluation of the PALs service was undertaken in 2008, this included 20 service users via a postal survey.
- There was a lack of evidence demonstrated of the recommendations or improvements based on this evaluation.

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.

- There was evidence that a service user was represented on the Hygiene Services Team and Committee.
- It was demonstrated through minutes of meetings that the Patient Partnership Forum is currently reviewing the visiting policy. This was not completed and demonstrated.

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.

- There have been a number of improvements to the Hygiene Services in 2008 a number of these were based on the findings from the National Hygiene Services Quality Review report of 2007. These include ward upgrades, flat mopping which was evaluated and the review of bins.
- The organisation demonstrated that the sanitary facilities were introduced and evaluated in 2008.
- The introduction and evaluation of the night time cleaning service was demonstrated. The changes include a revision of the duties and the frequencies. These improvements were identified in the hygiene services Annual Report.
- There was evidence demonstrated that the audits that are completed at clinical level have also been a new initiative; however the results of these have not yet been trended and demonstrated.
- There was some evidence that the organisation has developed key performance indicators for Hygiene Services. These were reported on in the hygiene services Annual Report only and there was no evidence demonstrated that these are trended on an ongoing basis.

SD 6.3 Rating: A (>85% compliance with this criterion)

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

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

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

Criteria	2007	2008
SD 4.5	B	B
SD 4.6	A	B
SD 4.7	B	B
SD 4.8	C	C
SD 4.9	C	B
SD 5.1	C	B
SD 5.2	C	B
SD 5.3	C	B
SD 6.1	C	B
SD 6.2	C	B
SD 6.3	C	A