Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Hygiene Services Assessment Scheme

Assessment Report October 2007

Lourdes Orthopaedic Hospital, Kilcreene, Co. Kilkenny

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1.0 Executive Summary

1.1 Introduction

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

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

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

Hygiene is defined as:
"The practice that serves to keep people and environments clean and prevent infection. It involves the study of preserving one's health, preventing the spread of disease, and recognising, evaluating and controlling health hazards. In the healthcare setting it incorporates the following key areas: environment and facilities, hand hygiene, catering, management of laundry, waste and sharps, and equipment" [1-4]

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

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

1.1.1 Standards Overview

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

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

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

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

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

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

Core Criteria:

To ensure that there is a continual focus on the principal areas of the service, 15 core criteria have been identified within the standards to help the organisation and the hygiene services to prioritise areas of particular significance.

In the Corporate Management standards, the core criteria cover:

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

In the Service Delivery standards, core criteria cover:

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

1.1.2 Rating Scale

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

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

A Compliant - Exceptional

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

B Compliant - Extensive

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

C Compliant - Broad

- There is evidence of broad compliance (between 41% and 65%) with the criterion provisions.

D Minor Compliance

- There is evidence of only minor compliance (between 15% and 40%) with the criterion provisions.

E No Compliance

- Only negligible compliance (less than 15%) with the criterion provisions is discernible.

N/A Not Applicable

- The criterion does not apply to the areas covered by the Self Assessment Team. Rationale must be provided. This cannot be used for a core criterion.

1.1.3 Assessment process components

The assessment process involves four distinct components:

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

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

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

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

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

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

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

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

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

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

- **Continuous Improvement**

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

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

[1] Boot, M and Cairncross, S "Actions Speak" Delft, The Netherlands, IRC and LSTHM, British Occupational Hygiene Society.
[2] New York Department of Health and Mental Hygiene
[3] The Columbia Electronic Encyclopaedia, Sixth Edition. Columbia University Press. 2003
[4] Irish Acute Hospitals Cleaning Manual, HSE (2006)
[5] Hygiene Services Assessment Scheme. Irish Health Services Accreditation Board (2006)

1.2 Organisational Profile

Lourdes Regional Orthopaedic Hospital, Kilcreene has bed capacity of 51 for elective orthopaedic services providing a service to the South Eastern region of Ireland. It covers the counties of Waterford, Wexford, Kilkenny, Carlow and South Tipperary, serving a population of 430,000**.**
Lourdes Orthopaedic Hospital Kilcreene has links with St Luke's Hospital Kilkenny through its Corporate Management Structures.

Services provided

Pre-operative assessment, fracture clinic, diabetic and other specialist clinics are held on site. Waterford Regional Hospital provides elective services at Kilcreene including hip and knee joint replacements.
Consultant Orthopaedic Surgeons for the region are based at Waterford Regional Hospital, but perform their elective surgery in Kilcreene Hospital. The hospital is the second major player in national joint replacements, which also performs other elective orthopaedic surgery. In recent years the age profile of the patients at Kilcreene has changed dramatically and we now deal with younger patients for joint replacements who require different type of rehabilitation.

Physical structures

Kilcreene Hospital has three single rooms with en suite facilities designated for isolation and 10 single rooms with clinical sink without en suite facilities may be used for isolation purposes. There are no negative pressure rooms.

The following assessment of Lourdes Hospital Kilcreene took place between 26th and 27th March 2007.

1.3 Notable Practice

- Staff co-operation, knowledge and enthusiasm were evident.
- A controlled environment. The hospital is an elective hospital and has a planned admission process.
- The organisation has developed the role of the multi-disciplinary Hygiene Services Committee with clear roles and responsibilities, and have developed a comprehensive hygiene services annual report, strategic plan, service plan and operational plan.
- Concerns such as out-of-date food, identified on day 1 of the assessment were followed up and corrected, where possible, on day 2.

1.4 Priority Quality Improvement Plan

- The involvement of corporate management in the hygiene process needs to be strengthened.
- It is recommended that the kitchen becomes fully compliant with all relevant Hazard Analysis and Critical Control Point (HACCP) standards.
- Greater attention to the cleaning of the Physiotherapy Department is required.
- Issues relating to waste management must be addressed.

- Full colour coding practice and policy for cleaning requires review.
- General attention to detail for cleaning of fixtures and furniture should be addressed.
- A process for documentation review and control is recommended.
- A process should be put in place for the evaluation of the hygiene process in relation to the specific Hygiene Services Assessment Scheme standards.
- It is recommended that quality improvement plans be further developed.
- Greater links with St Luke's Hospital, Kilkenny should be developed.

1.5 Hygiene Services Assessment Scheme Overall Score

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

Fair

Award Date: October 2007

2.0 Standards for Corporate Management

The following are the ratings for the Corporate Management standards, as validated by the Assessment team. The Corporate Management standards allow the organisation to assess and evaluate its activities in relation to Hygiene Services at an organisational level. There are fourteen Corporate Management standards, all of which are focused on four critical areas: leadership and partnerships, environment and facilities, human resources and information management. They include such subjects as corporate planning, allocating and managing resources, enhancing staff performance and contractual agreements. There are eight core criteria within these standards.

PLANNING AND DEVELOPING HYGIENE SERVICES

CM 1.1 (A ↓ B)

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

Senior management were instrumental in the establishment of the Hygiene Services Committee. A process is in place to highlight hygiene issues with all hospital committees and to discuss future hygiene requirements in line with future services, for example the planned refurbishment of St Patrick's' Ward. No formal documented evidence of evaluation was submitted.

CM 1.2 (A ↓ B)

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.

Kilcreene Hospital uses information received from sources such as previous national hygiene audits, waste management audits, infection control rates and patient/client satisfaction surveys, to plan its hygiene programme. It is recommended that a formal approach be adopted to co-ordinate these and implement action plans.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1 (A ↓ B)

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

Local management minutes observed identify hygiene as part of their agenda. The hospital is represented at Health Service Executive and Government level by the management team at St Luke's Hospital, Kilkenny. Kilcreene Hospital links with staff and patient/clients regarding hygiene. This was demonstrated at departmental and management meetings and by patient/client satisfaction surveys and the Patient/Client Forum. However, it is suggested that hygiene be included on the agenda for the Executive Management Team.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 (A ↓ B)

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

The Corporate Strategic Plan was observed on site and all staff, through the Hygiene Service Committee members, were involved in its formulation. Local management involvement was very evident, however, corporate management (cross site involvement) in the hygiene process was not observed. There was no standard process for the development of Corporate Strategic Plans which would be suitable for all hospitals in the area.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.1 (A ↓ C)

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 local management structure of the hospital is very involved in hygiene services. The administrator communicates with the General Manager and issues that needed to be addressed are progressed this way.

CM 4.4 (A ↓ B)

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

Internal and external hygiene audits are carried out, evaluated and issues of concern addressed with Quality Improvement Plans.

In-house training programmes are available through the relevant departments to ensure training in general hygiene and hand hygiene is provided. Best practice is maintained through this training, however, it is recommended that the organisation centrally co-ordinate, monitor and further develop staff training. It is recommended that formal links be established with Corporate Management in St Luke's Hospital.

CM 4.5 (C → C)

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

Within the scope of their job descriptions, the Hospital Administrator or Director of Nursing, verbally and formally communicate with the General Manager and other relevant services as required. Evidence of letters to the General Manager in relation to hygiene issues (for example refurbishment, sinks and waste) was observed. While anecdotal evidence of hygiene being included in the Capital Development Programme was observed, it is recommended that this process be formally developed as has been done with the business plan for the refurbishment of St Patrick's Ward. It is also recommended that documented evidence be collated to reflect the position of hygiene on Kilcreene's capital project. No formal documented evidence of evaluation was submitted.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

*Core Criterion

CM 5.1 (A → A)

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

This is in place. Comprehensive job descriptions are available for hygiene staff in line with national Human Resource guidelines, including defined reporting relationships. Hygiene is part of Departmental/Senior Managers' duties.

*Core Criterion

CM 5.2 (A → A)

The organisation has a multi-disciplinary Hygiene Services Committee.

It is well structured, committed and is inclusive of all grades of staff and areas of the hospital. It has developed the hospital Hygiene and Operational Plan. Job descriptions and the terms of reference clearly outline each person's role on the committee. Assistance is provided by the Administrator's Support Office. Terms of reference and minutes of meetings were observed.

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

*Core Criterion

CM 6.1 (C → C)

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.

No allocation of resources for hygiene purposes was observed. Whole time equivalents and associated costs are historically linked. Kilcreene must apply to the General Manager in St Luke's Hospital for specific core and hygiene funding.

CM 6.2 (B → B)

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

All equipment and products for Kilcreene are purchased through the Central Materials Management Department in St Luke's. New products and systems of exceptional cost must be applied for through the General Manager in St Luke's. Kilcreene hospital can also access products through the Procurement committee at St Luke's. This committee manages infection control, estates and facilities. The hospital uses the National Procurement Policy guidelines in the evaluation of new products.

MANAGING RISK IN HYGIENE SERVICES

CM 7.2 (B ↓ C)

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

There was no evidence of any corporate input into risk management. Local management at Kilcreene review hygiene risk incidents with department managers. To-date, no major hygiene adverse event has occurred. It is recommended that a process be put in place to actively involve the Governing Body in supporting hygiene services risk management practices.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion

CM 8.1 (B ↓ C)

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.

All contracts for services and stocks/materials are managed through St. Luke's. Documented and informal processes are in place to access these contracted services. Greater input from Kilcreene Hospital is recommended.

PHYSICAL ENVORNMENT, FACILITIES AND RESOURCES

*Core Criterion

CM 9.2 (A ↓ B)

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

In conjunction with St Luke's, the hospital has a clear pathway to plan, manage and co-ordinate its environment and facilities, equipment and devices, kitchens, waste and sharps and linen. It is recommended that the hospital actively engage with St Luke's Hospital Kilkenny to ensure that parity of policies, procedures guidelines and access to relevant specialist service (for example catering and waste) are further developed.

CM 9.3 (B ↓ C)

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.

Some evidence of effective and efficient management was observed including audits, a patient/client satisfaction survey and feedback comment cards. Greater involvement from management is required in the area of the kitchen and waste, with designated officers in these areas necessary. These officers are presently based at St Luke's. It is recommended that a representative from Kilcreene hospital be present on the Hazard Analysis and Critical Control Point (HACCP) team.

CM 9.4 (A ↓ B)

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

Extensive and comprehensive patient/client satisfaction surveys are carried out. Documented evidence was available in a report outlining a Quality Improvement Plan to address a patient/client recommendation. The patient/client satisfaction survey template includes a specific section relating to hygiene. Patient/client correspondence and thank you letters also reflect the degree of satisfaction with the hospital's hygiene services. No staff or visitor satisfaction survey is carried out at present. It is recommended that this be reviewed.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 (A ↓ B)

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

A very comprehensive overall recruitment policy, in line with Health Service Executive criteria, is in place. Recruitment records were observed but not evaluated, which is recommended.

CM 10.2 (B → B)

Human resources are assigned by the organisation based on changes in work capacity and volume, in accordance with accepted standards and legal requirements for Hygiene Services.

As this hospital provides an elective service, there is a planned workload and staff are allocated to each area according to the resources available and the services offered. As the workload is capped and the hospital is not an acute hospital with emergency admissions, the workload can be planned and prioritised.

CM 10.3 (B ↓ C)

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

Contract staff are not employed for hygiene duties. Waste management (from external compound to final destruction) and personal female hygiene bins are externally contracted. These contracts are generated and monitored at St Luke's. Qualifications/training for contract staff is also monitored at St Luke's. The job descriptions for the employment grades reflect the national standard. Both induction and cleaning manuals were available, which were based on best practice. No formal induction programme was observed and it is recommended that this be reviewed. Training in cleaning procedures, as part of the staff induction programme, was not observed. In-service training is provided as required. A very low rate of staff turnover was noted and, as new products are introduced, training is provided. An Infection Control Officer has just been employed and will address hygiene training.

CM 10.4 (C → C)

There is evidence that the contractors manage contract staff effectively.

All contractors are managed and recruited by St Luke's and are their responsibility. All external contractors are recruited in line with the Recruitment and Procurement Policy. A Quality Improvement Plan was identified for this, which will strengthen links with St Luke's in relation to contractors' obligations. It is recommended that this be implemented immediately.

*Core Criterion

CM 10.5 (B → B)

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

Kilcreene is an elective service hospital with no emergency or out-of-hours admissions.

The hygiene service can be planned, managed and maintained with few variances to the hygiene programme. Rosters are in place.

ENHANCING STAFF PERFORMANCE

*Core Criterion

CM 11.1 (A ↓ B)

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

Evidence of induction packs, mandatory training and sign--off was observed. However, no formal orientation programme is in place for hygiene staff. Kilcreene is a very small hospital with little staff turnover and no problems with attendance were noted. A more formalised and practical approach to induction was expressed during the assessment.

CM 11.2 (A ↓ C)

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

Education programmes require more formal development, expansion and evaluation. Infection control, manual handling and risk management programmes are all in place at present. Processes are in place for staff to apply for continuing professional development if they wish. Small staff numbers cause no difficulties.

CM 11.3 (B ↓ C)

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

There was some evidence of this. Staff are aware of their roles and responsibilities and were knowledgeable about hygiene manuals, procedures and policies. No actual documented evidence of evaluation of the effectiveness of hygiene training and education was presented. However, during the assessment, patient/clients reported a high satisfaction rating with hygiene and hygiene processes and the awareness of staff of hygiene issues. Feedback comments were complimentary and patient/client satisfaction surveys showed a high regard for the standard of hygiene in the hospital.

CM 11.4 (A ↓ C)

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

Mechanisms are available to deal with specific issues under the “People Management Programme”. Formal evaluation processes are recommended.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (A ↓ B)

An occupational health service is available to all staff

A service is provided at the parent site of St. Luke’s Hospital in Kilkenny. Staff are very familiar with how to access the service. Evidence of policies was observed and the service is evaluated using a staff questionnaire. As the occupational health service is also provided by St Luke’s hospital for the Kilkenny/Carlow hospital group. Further information was not available. It is recommended that the Hospital Management at Kilcreene actively engage with the Occupational health department to ensure that the are aware of the Occupational Health status, concerns and satisfaction rates of its staff.

CM 12.2 (A ↓ B)

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

Evidence was observed that on-going individual monitoring is occurring, however, this is not taking place at corporate level. Local attendance and occupational health referrals are formally monitored. A "Wellness at Work" programme is also in place.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.1 (A ↓ C)

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.

Policies and procedures for this were in place. Education and training is provided on best practice and new interventions. No evidence was observed of research or on-line accessibility to information and no formal documented evidence of evaluation was submitted.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

CM 14.1 (A ↓ C)

The Governing Body and/or its Executive Management Team foster and support a quality improvement culture throughout the organisation in relation to Hygiene Services

Evidence was observed of local management involvement in the quality improvement cycle but no plans were submitted as part of the self-assessment.

Evidence of items to be included as part of the development of the Quality Improvement Plans was noted in the minutes of local hygiene services meetings, however, these need to be developed as formal action plans using the quality improvement cycle template. A more formal process for the involvement of hygiene services at Kilcreene on the corporate agenda is recommended.

CM 14.2 (A ↓ B)

The organisation regularly evaluates the efficacy of its Hygiene Services quality improvement system, makes improvements as appropriate, benchmarks the results and communicates relevant findings internally and to applicable organisations.

Evidence of local evaluation of the hygiene process was observed through the Hospital Management Team, Hygiene Services Team and the Departmental Team meetings and was noted in minutes of team meetings and hospital management business plans.

Business plans are submitted to Executive Management Team. Examples of improvements which have been approved include the refurbishment of St Patrick's' Ward, improvements to the Hospital Sterile Services Department (HSSD) and the sinks colour coding ands mop system replacement system. Little documented evidence that hygiene is on the Kilcreene corporate agenda was observed. However, funding has been given for defined hygiene projects.

3.0 Standards for Service Delivery

The following are the ratings for the Service Delivery standards, as validated by the Assessment team. The service delivery standards allow an organisation to assess and evaluate its activities in relation to Hygiene Services at a team level. The Service Delivery standards relate directly to operational day-to-day work and responsibility for these standards lies primarily with the Hygiene Services Team in conjunction with Ward/Departmental Managers and the Hygiene Services Committee. There are six Service Delivery standards, which focus on such areas as prevention and health promotion, implementing hygiene services and patients / clients rights. There are seven core criteria within these standards.

EVIDENCE BASED BEST PRACTICE AND NEW INTERVENTIONS IN HYGIENE SERVICES

SD 1.1 (A ↓ C)

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

There is evidence that best practice guidelines have been developed. However, implementation and evaluation is in its infancy. The principles of Hazard Analysis and Critical Control Point (HACCP) must be fully implemented and waste management policies should be further developed and implemented at Kilcreene.
Some components of the Irish Acute Hospitals Cleaning Manual have been adopted.

PREVENTION AND HEALTH PROMOTION

SD 2.1 (A ↓ B)

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

Wall signage and hand hygiene posters are in place to promote hygiene, as are patient/client information booklets, which has a sub section on hygiene.
Patient/clients are screened for MRSA and leaflets are provided. The Patient/Client Forum also provides input into hygiene services. Evidence was provided to support health promotion activities that educate the community regarding hygiene. This programme was rolled out nationally by the Health Service Executive and supported by the local hospitals and care centres. It is recommended that this be evaluated.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1 (A ↓ C)

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

Formalised support links need to be developed and integrated at Kilcreene for hygiene services. Waste, catering and materials management personnel are all located at St Luke's. It is recommended that their designated specialist officers become involved at Kilcreene.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion
SD 4.1 (A ↓ B)
The team ensures the organisation's physical environment and facilities are clean.
All areas were assessed under mandatory compliance and this grading reflects the standard. Comments have been included where appropriate. More attention needs to be given to waste bins, lockers and floor covering in certain areas.

For further information see Appendix A

*Core Criterion
SD 4.2 (A ↓ B)
The team ensures the organisation's equipment, medical devices and cleaning devices are managed and clean.
All areas were assessed under mandatory compliance and this grading reflects the standard. Comments have been included where appropriate.

For further information see Appendix A

*Core Criterion
SD 4.3 (A ↓ C)
The team ensures the organisation's cleaning equipment is managed and clean.
Further attention is required in the maintenance and care of cleaning equipment.

For further information see Appendix A

*Core Criterion
SD 4.4 (A ↓ B)
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.
It is recommended that the kitchen becomes compliant to all relevant Hazard Analysis and Critical Control Point (HACCP) standards. A process needs to be put in place to ensure all food is checked regularly and discarded if out of date.

For further information see Appendix A

*Core Criterion
SD 4.5 (A ↓ B)
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.
This was rated using mandatory compliance criteria and comments have been included where appropriate.

For further information see Appendix A

*Core Criterion

SD 4.6 (A → A)

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

This was rated using the mandatory compliance criteria and comments have been included where appropriate.

For further information see Appendix A

*Core Criterion

SD 4.7 (A ↓ B)

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

All areas were assessed under mandatory compliance and this grading reflects the standard. Comments have been included where appropriate.

For further information see Appendix A

SD 4.8 (A ↓ B)

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

'Cleaning in progress' safety signage was not evident. Attention to the reconfiguration of storage items along the corridor storage area is required. Food was noted to be out of date in some ward kitchen fridges. However, this issue was addressed promptly during the assessment.

PATIENT'S/CLIENT'S RIGHTS

SD 5.1 (A ↓ B)

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

Management policies are in place for cleaning at ward and department level. These include the privacy, and respect, of the patient/clients. A Patient/Client Charter was noted and professional codes of conduct were also observed. No formal documented evidence of evaluation was submitted.

SD 5.2 (A → A)

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

Wall signage and hand hygiene posters are in place to promote hygiene. Patient/client information booklets are given out. This booklet has a sub section on hygiene.

Patient/clients are screened for MRSA and MRSA leaflets are provided. The Patient/Client Forum is also involved in the hygiene process. Evidence was provided to support health promotion activities that educate the community regarding hygiene. This includes local advertisements in papers and on radio and television on the need for hygiene awareness. This programme was rolled out nationally by the Health Service Executive and supported by the local hospitals and care centres. Evaluation of patient/client letters, surveys and incidents of infection is also carried out.

SD 5.3 (B → B)

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

A formal Risk Management Policy and procedure is in place as is a Complaints Policy.

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1 (B ↓ C)

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

Patient/client satisfaction surveys, a Complaints Policy and risk management incident reporting were all noted. It is recommended that formal evaluation structures for hygiene services be developed and implemented.

SD 6.2 (B ↓ C)

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

Formal processes to monitor, evaluate and benchmark the quality of hygiene services at Kilcreene require further development. Internal and national audits, outcomes and Quality Improvement Plans were all noted.

SD 6.3 (A ↓ C)

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

This was developed with the involvement of senior management, departmental heads, staff and the Hygiene Services Team. No evidence was observed that patient/clients were involved in the process to produce the first Annual Hygiene Report, however, the patient/client forum is actively involved in hygiene services (this forum is chaired by the Kilcreene representative with hygiene on their agenda continuously). The Patient/Client Forum is also involved in the Hygiene Services Team.

4.0 Appendix A

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

4.1 Service Delivery Core Criterion

Compliance Heading: 4. 1 .1 Clean Environment

(2) All high and low surfaces are free from dust, cobwebs and flaking paint.
Yes - In the majority, however, the Physiotherapy Department requires further attention.

(3) Wall and floor tiles and paint should be in a good state of repair.
No - Wall and floor surfaces in a number of areas require upgrading.

(4) Floors including edges, corners, under and behind beds are free of dust and grit.
Yes - In the majority, however, the Physiotherapy Department requires further attention.

(5) Cleanable, well-maintained furniture, fixtures and fittings used.
No - Two lockers were broken and a number were in need of repair. Some replacements were also required.

(14) Waste bins should be clean, in good repair and covered.
No - A number of bins observed were unclean. Some were in need of repair/replacement. It is recommended that front opening bins be installed, which will enhance cleaning access.

(27) Local policies should be in place for guidance on all cleaning processes, colour coding, use of equipment, use of protective clothing and fluids and spillages.
Yes - Colour-coding practice did not reflect policies observed. Colours for assigned tasks currently in use were incorrect in some areas.

(28) Before cleaning commences, a work route should be planned and when necessary, furniture and equipment should be removed from the area.
No - No evidence of planned routes were noted during cleaning.

(29) A warning sign “cleaning in progress” must always be used, position to be effective.
No - No “cleaning in progress” signs were visible on entry to wards where cleaning was in progress.

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

(18) Walls, including skirting boards.
Yes - In the majority, however, the Physiotherapy Department requires further attention.

(21) Internal and External Glass.
No - External glass and window frames require further attention. Internal windows had a sticky residue.

(26) Nozzles of wall mounted alcohol gels and hand disinfectants must be cleaned daily.
No - A number of nozzles examined required greater attention to detail.

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

(30) Fixtures: Fixtures (i.e. a piece of equipment or furniture which is fixed in position) should be clean. This includes all electrical fixtures e.g. all light fittings and pest control devices.
Yes - In the majority, however, a socket cover is required for the disused call bell system in the in-patient/client gym.

(31) Furniture and fittings: Furniture and fittings in direct patient care environment must be clean and dust free i.e. cleaned on a daily basis. Horizontal surfaces (high and low) around the patient i.e. ledges, worktops, window ledges, flat surface suction apparatus, bed table, locker, curtain rail and chairs.
No - The back of chair seats and lockers require more detailed attention.

(32) Shelves, benchtops, cupboards are clean inside and out and free of dust and spillage
No - The inside of cupboards in the High Dependency Unit were dusty. Also the outside of a number of cupboard doors were noted to have sticky tape residue, which should be removed.

(207) Bed frames must be clean and dust free
No - A number of bed frames were dusty in several areas visited and a sticky residue was present on all bed frames.

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

(34) Beds and Mattresses
No - Mattresses observed were clean, however a number of bed frames were dusty in several areas and a sticky residue was present on all bed frames.

(35) Patient couches and trolleys
Yes - In the majority, however, the frames of all trolleys in the Physiotherapy Department were dusty.

(36) Lockers, Wardrobes and Drawers
No - The interior of a number of lockers observed required further attention.

(39) Waste Receptacles (e.g. sani-bins, nappy bins, sharps bins, leak proof bins
No - The interior and exterior of bins observed were unclean and a sticky residue was also found on many bins examined.

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

(54) Wash-Hand Basins
No - The majority of sink outlets examined require attention.

(58) Sluice rooms should be free from clutter and hand washing facilities should be available.
No - A separate hand wash sink was not available.

Compliance Heading: 4. 2 .1 Organizational Equipment and Medical Devices and Cleaning Devices (note: while list is not exhaustive, the following compliance is required):

(64) All equipment, including component parts, should be clean and well-maintained with no blood or body substances, rust, dust, dirt, debris and spillages.
No - Cleaning equipment is a particular issue requiring attention. For example heads of vacuum cleaners and floor mopping equipment. Computers were also noted to need further cleaning.

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

(72) Trolleys, e.g. chart trolleys, drug trolleys, linen trolleys, shop trolleys, emergency trolleys, suction apparatus, resuscitation equipment i.e. ambubag and mask.
Yes - In the majority, however, a sticky residue was noted on drug and chart trolleys. These require further attention.

(76) Hand-wash dispenser holders and brackets should be free of product build-up around the nozzle.
No - A build up of grit was noted around the heads of dispenser nozzles.

(78) Personal food items, other than fruit, should only be brought in with the agreement and knowledge of the ward manager and should preferably be stored in an airtight container.
No - Patient/client food was noted in ward kitchens. This was out of date and requires closer monitoring at ward level.

(80) All office equipment (e.g. telephones, computers, fax machines) should be clean and well-maintained.
No - A number of computers and telephones requiring attention were observed.

(272) Splashes of water or hand-wash gel should not be present on the wall, floor, bed or furniture, splash backs should be provided.
Yes - In the majority, however, the Physiotherapy Department requires further attention.

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

(211) Personal Protective Equipment is available and appropriately used and disposed of.
Yes - Further education regarding appropriate glove usage should be provided. Also, no personal protective equipment was observed in the waste compound.

(81) All cleaning equipment should be cleaned daily.
No - No evidence of daily cleaning was observed.

(82) Vacuum filters must be changed frequently in accordance with manufacturer's recommendations - evidence available of this.
No - No evidence of this was available.

(83) Mop heads are laundered daily and are stored according to local policy or are disposable i.e. single use.
No - Evidence was observed to suggest that high dusting mop heads are stored and not laundered daily.

(88) All cleaning equipment should be left clean, dry and tidy in the storage area after use.
No - Dust control mops were noted to be dusty and fluffy Hoover heads and floor-mopping equipment also required attention.

(90) Storage facilities for Cleaning Equipment should be provided in each work area with adequate ventilation, a hot and cold water supply and hand-wash facilities.
No - No wash hand basin is provided.

(93) Cleaning products and equipment should comply with the relevant colour coding policy.
No - Practice observed does not reflect documented policies.

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

(214) The person in charge of catering shall develop, implement and maintain a permanent system based on the seven principles of HACCP. A standard HACCP Plan should be fully completed.
Yes - However, it is recommended that a representative from Kilcreene become a member of the HACCP team. Also, a copy of the HACCP plan should be kept on site and fully implemented.

Compliance Heading: 4. 4 .2 Facilities

(220) Staff must not consume food or beverages intended for patient use, food should not be consumed in the ward kitchen and no food is to be routinely prepared in the ward kitchen other than beverages and toast.
No - Sandwiches are prepared at ward kitchen level.

(224) The ventilation provided for all cooking and steam emitting equipment shall be sufficient to prevent condensation on walls, ceilings and overhead structures during normal operations.
No - Ventilation in the main kitchen is inadequate.

(225) Staff in charge of Ward Kitchens shall ensure that product traceability is maintained while the product is in storage (Regulation (EC) 178/2002). Stock shall be rotated on a first in / first out basis taking into account the best before / use by dates as appropriate. Staff food should be stored separately and identifiable.
No - Patient/client foods observed in three fridges was out of date, which required immediate attention. Greater attention to use by dates is recommended.

(226) Containers used to store foods shall be made of food grade materials, be in good condition, easy to clean and disinfect.
No - Not all opened cereals observed were in covered containers.

Compliance Heading: 4. 4 .3 Waste Management

(230) A supply of water should be available to clean down external waste storage areas.
Yes - This was not observed.

Compliance Heading: 4. 4 .4 Pest Control

(238) Electric fly killer (EFK) units when used shall be located in an area free from draughts, away from natural light and not directly above an area where food or materials that come into contact with food are located. The EFK units shall be left on at all times and have shatter proof sleeves. The ultraviolet (UV) light tubes shall be replaced at least annually and records of replacement should be retained. The EFK shall be fitted with a catch tray and emptied as required.
Yes - In the majority, however, an electric fly killer unit is recommended at the back door.

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

(242) Temperatures for Food in Fridges / Freezers and Displays should comply with I.S.340:2006 requirements
Yes - Full documentation of all fridge freezers is required. Also, regular probe checks are required.

(243) Preparation of High Risk Foods should comply with I.S. 340:2006 requirements
No - No colour-coded boards were noted. Also designated preparation areas and sinks are required.

Compliance Heading: 4. 4 .6 Food Preparation

(245) Cleaned and disinfected work surfaces, equipment and utensils shall be provided for preparing ready to eat foods and foods to be cooked to prevent the risk of contamination. In addition to the HSE hospital colour coded system (see Appendix 6 Irish Acute Hospitals Cleaning Manual 2006), the food colour coding of work surfaces, equipment and utensils should be provided for (see I.S. 340:2006).
No - No colour code system is in use.

Compliance Heading: 4. 4 .7 Food Processing

(246) The thawing of food shall be carried out under appropriate conditions such as in a thawing unit, a fridge or a microwave oven with thawing cycle
Yes - The preparation and cooking kitchen is based at St. Luke's hospital.

Compliance Heading: 4. 4 .8 Food Cooking

(247) All foods shall be cooked to a temperature to ensure that the products are safe for consumption. The core temperature of the food shall be assessed at he thickest point of the food and should be compliant with I.S. 340:2006
Yes - The preparation and cooking kitchen is based at St. Luke's hospital.

Compliance Heading: 4. 4 .9 Food Cooling

(248) Cooling Times for Cooked Food should comply with I.S. 340:2006 requirements
Yes - The preparation and cooking kitchen is based at St. Luke's hospital.

Compliance Heading: 4. 4 .10 Plant & Equipment

(249) Machines should dispense ice but where ice-scoops are used, they should be stored separately from the ice-making machine and there should be a process for the appropriate decontamination of the ice scoops. The making of ice cubes other than in ice machines is prohibited.
Yes - No ice machines were in use.

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

(141) Documented procedures for the segregation, handling, transportation and storage of waste.
No - No documented evidence was observed.

(146) A tracking system should be in place to trace all hazardous waste from generation to disposal and therefore an audit trail is available to trace waste to final disposal.
No - Documented process was not observed.

(149) Inventory of Safety Data Sheets (SDS) is in place.
No - No evidence was available relating to the inventory of Safety Data Sheets.

(253) Personal protective equipment is accessible to all staff involved in the generation, collection, transport and storage of waste.
No - No personal protective equipment was available at the waste compound.

Compliance Heading: 4. 5 .2 Maintenance of Records

(254) Documented process(es) for the retention of waste traceability records, certificates of destruction, consignment notes (C1 forms) and trans Frontier Shipment (TFS) tracking forms for at least 12 months. These should be retained for all hazardous waste types
No - Documentation relating to the certificates of destruction was not available.

Compliance Heading: 4. 5 .3 Segregation

(256) Mattress bags are available and are used for contaminated mattresses ready for disposal; mattresses are disinfected.
No - However, the Infection Control Nurse is actively sourcing this item.

Compliance Heading: 4. 5 .4 Transport

(163) Documented processes for the transportation of waste through the hospital which minimizes manual handling of waste (and ensures that segregation of healthcare risk waste from non-risk waste is maintained) are in place.
No - A documented process needs to be developed.

(166) Drivers of vehicles transporting hazardous waste must be trained in accordance with the ADR Regulations.
No - However, the Waste Officer, who is based at St Luke's, said the issue will be addressed.

Compliance Heading: 4. 5 .6 Training

(259) There is a trained and designated waste officer.
No - The waste officer is based at St Luke's. It is recommended that one be available on site to fulfil this role.

(260) There are documented records of staff training on the handling, segregation, transport and storage of healthcare risk waste including the use of spill kits and personal protective equipment.
No - A Quality Improvement Plan will be developed to address this.

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

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

(267) Documented process for the transportation of linen.
No - Laundry is transported regionally. There are no documented processes.

(268) Ward based washing machines are used only with the agreement of the Hygiene Services Committee.
Yes - No washing machines are used.

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

(191) Hand washing facilities i.e. sinks, taps and splash backs must be clean and intact.
No - Plughole outlets were not adequately clean.

(194) Dispenser nozzles of liquid soap of alcohol based hand rubs must be visibly clean.
No - Cartridge dispensers observed required attention.

(196) Waste bins should be hands free.
Yes - However, it is recommended that staff be trained regarding the correct use of foot operated bins and non-touch technique.

(204) Hand wash sinks conform to HBN 95. They should not have plugs, overflows and the water jet must not flow directly into the plughole.
No - However, a planned replacement programme is in place.

(206) Documented records of mandatory attendance at hand hygiene education and practice is required for all staff members involved in clinical areas. This may be undertaken during hospital induction programme followed by annual updates.
Yes - Training should be provided to incorporate correct elbow use technique when turning on taps.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team		Assessor Team	
	FREQ	%	FREQ	%
A	34	60.71	5	08.93
B	17	30.36	30	53.57
C	5	08.93	21	37.50
D	0	00.00	0	00.00
E	0	00.00	0	00.00
N/A	0	00.00	0	00.00

5.2 Ratings Details

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

CM 12.1	A	B	↓
CM 12.2	A	B	↓
CM 13.1	A	C	↓
CM 13.2	B	B	→
CM 13.3	B	B	→
CM 14.1	A	C	↓
CM 14.2	A	B	↓
SD 1.1	A	C	↓
SD 1.2	B	B	→
SD 2.1	A	B	↓
SD 3.1	A	C	↓
SD 4.1	A	B	↓
SD 4.2	A	B	↓
SD 4.3	A	C	↓
SD 4.4	A	B	↓
SD 4.5	A	B	↓
SD 4.6	A	A	→
SD 4.7	A	B	↓
SD 4.8	A	B	↓
SD 4.9	A	A	→
SD 5.1	A	B	↓
SD 5.2	A	A	→
SD 5.3	B	B	→
SD 6.1	B	C	↓
SD 6.2	B	C	↓
SD 6.3	A	C	↓