



**Health
Information
and Quality
Authority**

An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte

National Hygiene Services Quality Review 2008

Mercy University Hospital

Assessment Report

Assessment date: 3rd November 2008

About the Health Information and Quality Authority

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

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

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

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

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

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

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

1 Background and Context

1.1 Introduction

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

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

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

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

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

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

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

This “raising of the bar” is an important part of the process. It aims to ensure that the approach to the assessment further supports the need for the embedding of these

Standards, as part of the way any healthcare service is provided and managed, and also further drives the move towards the demonstration of accountable improvement by using a more rigorous approach.

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

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

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:

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 Mercy University Hospital – Organisational Profile¹

2.1 Organisational Profile

The Mercy University Hospital is a 349-bed acute general hospital providing inpatient, day patient, outpatient services and Emergency services. It is the second largest hospital in Cork, playing a very important role in the delivery of acute hospital care in Cork City and in the Health Service Executive—Southern Area.

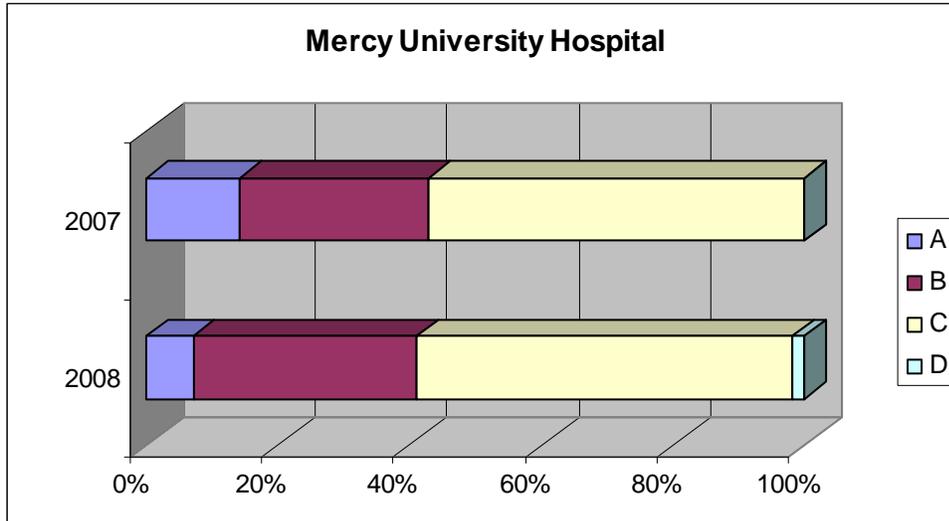
2.2 Areas Visited

- Outpatient department
- Emergency department
- St. Mary's ward
- St. Patrick's ward
- St. Theresa's ward
- Paediatric ward
- Waste compound
- Laundry service.

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 eight 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.

Mercy University Hospital has achieved an overall rating of:

Poor

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

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

- There was evidence demonstrated of a hygiene and cleaning strategic statement 2008-9. A Hygiene and Cleaning Operational Plan 2008 was also demonstrated. There was also evidence to demonstrate a 2006 Hygiene Services Annual Report which had been submitted to the Executive Management Board and signed off by the Deputy General Manager in January 2007.
- Items included on the capital list 2008 were demonstrated.
- The organisation demonstrated that the porters meetings were used to assess needs and the organisation advised that these were fed back through the line manager who was a member of the Hygiene Services Committee.
- A composite needs package for hygiene was identified through contractors meetings. A review of cleaning resulted in the introduction of isolation and washroom janitors.
- Evaluation of the efficacy of the needs assessment process was not demonstrated.

CM 1.2 Rating: B (66-85% compliance with this criterion)

There is evidence that the organisation's Hygiene Services are maintained, modified and developed to meet the health needs of the population served based on the information collected.

- A Hygiene Action Plan 2007/2008 based on the 2007 National Hygiene Services Quality Review was demonstrated
- The organisation demonstrated a number of changes to how cleaning services were delivered, monitored and evaluated and managed as a result of reviewing the cleaning services.
- The organisation advised that Contract Supervisors conducted twice daily reviews of cleaning and issues identified were addressed immediately.

- Evidence was provided to demonstrate that weekly self audits were completed on wards and reported to a member of the Hygiene Services Committee.
- Evidence was not demonstrated of evaluation of developments and modifications to the organisation's hygiene services in relation to meeting the patient's needs.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

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

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

- Evidence of linkages with the Network Manager was demonstrated.
- The organisation demonstrated that the Contract Cleaning Site Manager was a member of the Hygiene Service Committee and Team.
- A Patient Satisfaction Survey was completed in September 2008
- Evidence was provided to demonstrate that a patient representative was a member of the Hygiene Services Committee and included in the audit process.
- There was no documented evaluation of efficacy of the linkages and partnerships demonstrated.

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 that the Hygiene Services Committee developed the hygiene strategic plan which was based on the review of the 2007 National Hygiene Services Quality Review.
- The organisation demonstrated that the Hygiene Services Strategic Plan was presented to the Executive Management Board.
- The Hygiene Services Operational Plan 2008 was signed off by the Deputy Chief Executive Officer who chaired the Hygiene Services Committee and Hygiene Services Team and was a member of the Executive Management Board. Costings were not demonstrated.
- The organisation demonstrated that the Hygiene Strategic Plan was available on the network for staff information.

- No formal evidence of evaluation of the Hygiene Corporate Strategic plans, goals objectives and priorities was demonstrated.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.1 **Rating: C (41-65% 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.

- There was evidence provided to demonstrate the organisational structure.
- The overall responsibility for the organisation resided with the Chief Executive Officer and the Executive Management Board and that the Deputy Chief Executive Officer who was a member of the Executive Management Board had delegated responsibility for Hygiene Services.
- The organisation advised that the Deputy Chief Executive was supported by a hotel services manager, who liaised with the Cleaning Contractor.
- No formal code of corporate ethics was demonstrated.
- The organisation demonstrated that all infection control guidelines were reviewed in 2008 and that the infection control team were involved in the development of cleaning polices for the cleaning contractors. The colour coding was introduced as part of this.
- The household and contract cleaning manuals observed to be currently in use were not dated, evidence based or signed off.
- No evidence of evaluation of the appropriateness of the review of authority provisions in hygiene services areas was 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 evidence that hygiene audit reports were tracked monthly and reported to the sub group of the Hygiene Services Committee every 6-10 weeks.
- The organisation advised that trending of contractor audit results was in place, however this was not demonstrated.
- There was evidence that infection rates were collated and discussed at the Executive Management Team meetings.
- The organisation advised that financial reviews were conducted every three weeks.

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**

- A documented process for Hygiene Service Committee involvement in the organisation's capital development planning and implementation was not demonstrated; however a hygiene service representative was on the capital development team and reported back to the Hygiene Services Committee.
- The organisation advised that evaluation of capital development needs took place informally. There was no evidence demonstrated.
- The Hygiene and Cleaning Plan for 2008 included that laundry and hospital sterile supplies department had been identified as two areas needing significant resource input.
- There was a process in place to contract out laundry service and the organisation advised that this was at the tendering stage.
- A minor capital list was demonstrated and the organisation advised that its implementation was dependant of end of year allocation, however the organisation advised that hygiene was not identified as a priority due to a more critical clinical equipment need in the laboratory.
- Evidence of evaluation of the efficacy of the consultation process was not demonstrated.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES***Core Criterion****CM 5.1****Rating: B (66-85% compliance with this criterion)****There are clear roles, authorities, responsibilities and accountabilities throughout the structure of the Hygiene Services.**

- The Hygiene Services Team and Committee membership and organisational management structure for Hygiene Services were demonstrated.
- The organisation advised that evaluation of the membership, which identified Hygiene responsibility and accountability, was completed and revised in 2008.
- The Risk Manager was on the Hygiene Services Committee and the Health and Safety Officer reported to the Risk Manager.
- The job description for the Deputy Chief Executive Officer, who had delegated responsibility for hygiene services, did not demonstrate the responsibility. Clinical Nurse Manager 1 job description had been revised to include hygiene responsibility for future new appointments.

- The organisation demonstrated that the minutes of the Hygiene Services Team were reviewed at the Hygiene Committee and that the minutes of the Executive Board were available to the Hygiene Services Committee.
- The organisation demonstrated that the Executive Management Board signed off on policies.

***Core Criterion**

CM 5.2 Rating: A (>85% compliance with this criterion)

The organisation has a multi-disciplinary 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 demonstrated of a Corporate Hygiene Strategic and Hygiene Operational Plan. The organisation advised that there was provision within the Hygiene Strategic Plan, which was part of the hospital service plan, for funding prioritisation and allocation, however that no minor capital or hygiene funding was available for 2008 other than for one item of essential laboratory equipment.
- An equipment list had been compiled however it had been rolled over from 2007.
- The Director of Development dealt with capital issues. A revenue budget was in place and was managed.

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

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

- The organisation demonstrated that procurement of new products was informally completed through the Product Equipment Evaluation Committee, however, no documented process was demonstrated.

- The organisation advised that Hygiene Service Committee and hygiene team members were involved in the purchasing process for equipment including hygiene related equipment through their other roles in the organisation.
- No evidence of evaluation of the efficacy of the consultation process between the Hygiene Services Committee and senior management was demonstrated.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

CM 7.1 **Rating: D (15-40% 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.

- A Safety Policy Committee was demonstrated
- An incident reporting process was also demonstrated.
- The organisation demonstrated that the Risk Manager was a member of the Hygiene Services Committee.
- The Risk and Safety management combined annual report was demonstrated.
- The Environmental Health Officer report was demonstrated.
- Audits for hygiene services including ward environment, hand hygiene, waste, linen and catering were demonstrated with no follow-up.
- A quality improvement plan for needle stick injuries was introduced, with evidence of reduced incidence.
- There was no hospital *Legionella* policy demonstrated and practices to manage and monitor were informal. There was evidence that though the two low levels of *Legionella* had been identified in the water system, one area had been closed and the other was still in operation. There was no evidence of a documented process of actions taken. The organisation advised that the Technical Services Officer had reported these incidents verbally to a member of the management team with verbal agreement of the action to be taken.
- Therefore a risk was 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 advised of a risk management department and that the Risk Manager is a member of the Hygiene Services Committee.
- The STARSweb incident reporting system was demonstrated for recording incidents, and some evidence of close off was also demonstrated. There was

evidence of quarterly reporting on all incidents to the Executive Management Board.

- A Risk and Health/ Safety Annual Report was demonstrated.
- The Hospital Safety Statement was updated. Environmental risk assessment per ward was not demonstrated.
- The organisation advised that there were no major Hygiene Services' adverse events over the past two years.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion

CM 8.1 **Rating: C (41-65% 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 of contracts having been established. The cleaning contract had been amended and changes were demonstrated, for example the introduction of special cleaning with areas and frequencies included.
- Service contracts were demonstrated for mats, sani-bins, vending machines, and the shop.
- There was evidence of weekly meetings with the cleaning contract site manager which demonstrated attendance by the contractors and senior management.
- Hygiene training was demonstrated for cleaning staff and shop staff however not for other contracted services.
- The organisation advised that water testing was on a quarterly ad hoc basis. A dosing system was completed and routine flushing records were held by the Maintenance Department and were not demonstrated.

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

The organisation involves contracted services in its quality improvement activities.

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

PHYSICAL ENVIRONMENT, FACILITIES AND RESOURCES

CM 9.1 Rating: C (41-65% 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 new clinical buildings were identified to demonstrate adherence to relevant regulations and best practice. The emergency department capital development project was the most recent where hygiene staff were involved in a capital development project team. No other environmental upgrades were identified in the last two years.
- Health and safety statements for the hospital and the wards were in place and in the process of review.
- There was evidence of "Patient Comfort rounds" being completed by Senior Nurse Managers in the ward areas on a weekly basis and recorded in a log.
- The organisation advised that only half the sink replacement programme had been completed due to insufficient funding.

. *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.

- Waste management documentation was demonstrated and policies, procedures and guidelines relating to segregation were revised.
- Hazard Analysis and Critical Control Point (HACCP) standards were evidenced in kitchens and the shop. There was evidence demonstrated of closure of the loop on supplier non-conformance issues.
- Linen segregation and colour coding was in place for soiled linen.
- The organisation advised that the Household and Health Care Assistant tasks included flushing of water outlets, however a documented process for flushing or flushing records was not demonstrated.

CM 9.3 Rating: C (41-65% compliance with this criterion)

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

- Sharps injuries were reported and managed through risk management.

- Audit of sharps and linen were included in the environmental ward audits and this was demonstrated.
- The organisation demonstrated that upgrade work had been completed in the main kitchen.
- An Environmental Health Report for 2008 with follow up actions was demonstrated.
- The organisation advised that a quality improvement plan was in place to complete the roll out of the new system to ward kitchens and evaluate its implementation. This was not demonstrated.

CM 9.4 Rating: C (41-65% compliance with this criterion)

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

- Evidence of the complaints process was demonstrated.
- A patient handbook and complaint information leaflet – 'Your Service Your Say' was demonstrated.
- There was a Complaints Officer position, which was currently vacant; however the organisation advised that this function was being implemented by the Nursing Office on an interim basis.
- The organisation advised that the public feedback process consisted of comments boxes located around the hospital, and these were demonstrated. Evidence of feedback from patients to senior nurse manager regarding environment was demonstrated in the weekly comfort round log,
- The organisation advised that a register of complaints and compliments existed.
- A patient survey which included hygiene was not demonstrated.
- There was no evidence demonstrated of collated and trended complaints.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 Rating: B (66-85% compliance with this criterion)

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

- The organisation demonstrated that recruitment of permanent and temporary staff was managed through the hospital's Human Resource Department and that recruitment processes were based on the Commission for Public Service Appointments Guidelines.

- A new human resource policy was developed in 2007 however it had not been approved.
- Job descriptions were demonstrated however hygiene responsibilities were not explicit for Clinical Nurse Manager 2 and Health Care Assistants.
- The contract for contract cleaning staff was in place. A new cleaning contract document had been developed however it had not yet gone to tender.
- Evidence of evaluation of the process for selecting and recruiting human resources was not demonstrated.

CM 10.2 Rating: C (41-65% compliance with this criterion)

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

- There was evidence demonstrated that audit reports had been used to identify needs in hygiene services, for example janitorial services introduction and enhanced cleaning input in an area with a low audit score.
- There were no documented processes demonstrated for reviewing changes in hygiene services work capacity and volume.
- The human resource quality improvement plan had not been implemented.
- Evidence of evaluation of the appropriateness of work capacity and volume review processes was not demonstrated.

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

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

- All cleaning services supervisors had British Institute of Cleaning standard training level 1 and 2 and had completed a "Train the Trainer" programme.
- All contract cleaning staff were retrained annually
- It was identified that contractor training records were now maintained on the hospital site in accordance with the quality improvement plan.
- There was evidence that catering staff received annual Hazard Analysis and Critical Control Point (HACCP) training.
- In house staff job descriptions demonstrated had not been updated to reflect hygiene responsibilities:

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

There is evidence that the contractors manage contract staff effectively.

- There was evidence demonstrated of processes in place for regular meetings between contract supervisors and site manager with hospital management.
- There was evidence that the contractor was represented on the Hygiene Services Team and the Hygiene Service Committee.
- There was evidence of a financial penalty clause in the contract for default and to date this had not been implemented.
- The occupational health department provides vaccination services for contract staff.
- Induction and ongoing hygiene training was provided and recorded.
- It was advised that hand-hygiene was mandatory for all staff at induction however not thereafter. Evidence was demonstrated that hand-hygiene training was provided at ward level and the Ward Manager managed attendance.
- The cleaning contractor conducted their own audits and presented their reports to the Hygiene Services Team sub group.
- No evidence of evaluation of the use of contract staff was demonstrated.

***Core Criterion**

CM 10.5 Rating: C (41-65% 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.

- There was evidence of a Hygiene Corporate Strategic and Services Plan in place however most of the hygiene quality improvement plan (QIP) had yet to be implemented.
- The organisation advised that there was a staff shortfall for Hygiene Service delivery. The Hygiene and Cleaning Operational Plan 2008 demonstrated a review of cleaning staff per bed with other hospitals in the region and Dublin, with evidence to support the need for more cleaning staff.
- A Cleaning Contractor Annual Report for 2007 and a six-month report for the first half of 2008 were demonstrated.
- The Hygiene Services Committee Annual Report for 2006 was demonstrated.

ENHANCING STAFF PERFORMANCE

***Core Criterion**

CM 11.1 Rating: C (41-65% compliance with this criterion)

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

- There was evidence of induction and sign off demonstrated.
- Ongoing education records were not complete and were located in different areas depending on who provided the training.
- The Human Resource Services Plan demonstrated was in draft format and included a section on Human Resource management.
- The staff hand book demonstrated was in draft format.

CM 11.2 Rating: C (41-65% compliance with this criterion)

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

- The organisation advised that staff were released for mandatory hygiene training, however records demonstrated that not all staff had attended the mandatory training.
- Infection control staff provided training, however no schedule was demonstrated.
- The organisation advised that evaluation was not always completed, and effectiveness was measured through hygiene audits.
- Evidence of relevance of education to each staff member was not demonstrated.

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

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

- The organisation advised that the Infection Control Team evaluated infection control training. There was no formal process in place for evaluation of hygiene training other than through changes made from audit results.
- No evidence of staff satisfaction rates with training was demonstrated.
- No performance indicators for training were demonstrated.

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

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

- The organisation advised that a staff appraisal form was in place for nursing staff. This was not demonstrated.
- Work attendance records were in place and follow up was by relevant line managers.
- No formal appraisal system was demonstrated for hygiene staff, other than by regular hygiene audit.
- No evidence of evaluation of the appropriateness of performance evaluation processes was demonstrated.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 Rating: C (41-65% compliance with this criterion)

An occupational health service is available to all staff

- The organisation advised that an occupational health service was provided and that vaccinations were provided for all staff including contract staff.
- An occupational health annual report was stated to be in place, however this was not demonstrated.
- .No evidence of evaluation of the appropriateness of the service was demonstrated.

CM 12.2 Rating: C (41-65% compliance with this criterion)

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

- The organisation advised of a referral and follow up process for specific cases.
- No evidence of key performance indicators for Occupational Health were demonstrated
- Evidence of evaluation of the appropriateness of mechanisms for monitoring staff satisfaction was demonstrated.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

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

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

- The organisation advised that hygiene data collection was completed through audits, minutes of meetings, validation was completed by walkabouts and patient comfort round log reports which were demonstrated.
- No evidence of evaluation in relation to reliability, accuracy validity and appropriateness of data was demonstrated.

CM 13.2 Rating: C (41-65% compliance with this criterion)

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

- There was evidence that infection control audit results were presented in graphic form, and that Infection Control reports were presented to the Executive Management Board.
- There was evidence that numerical presentation was used for environmental hygiene audits. Reports from the Environmental Health Officer 2008 are provided to staff.
- The organisation advised that the Hygiene Services Team and Hygiene Services Committee minutes were approved at the next meeting, however this was not demonstrated. There was no defined process for turn around time for reports.
- The Hygiene Services Committee did not produce an annual report for 2007.
- No evaluation of user satisfaction in relation to reporting of data and information was demonstrated.

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 demonstrated that all data pertaining to hygiene was available electronically.
- Data collected included minutes of meetings, and reports made to the Executive Board, infection rates, some training records, audit reports, annual reports and absentee records.

- Evidence was demonstrated that the Executive Management Board received information every six weeks regarding hygiene and infection control and annually through the contractor annual report and Hygiene Services Committee Annual Hygiene Report for 2006. The organisation advised that the Executive Management Board also received information on a needs basis.
- The evaluation of data collection and reporting for Hygiene Services was a quality improvement identified however it had not been implemented.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

CM 14.1 **Rating: C (41-65% 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.

- 50% of sink replacement was completed in 2007 and this was an identified quality improvement initiative however the organisation advised that there had been no progress in 2008 due to financial constraints.
- There was evidence that some changes were made to the cleaning services for example introduction of janitorial service.
- An outpatient department patient satisfaction survey by an external agency was being implemented on the same day of the Hygiene Review site visit. The survey included a question on hygiene. The organisation advised that there was a project team in place and a process to review the findings; however the process and project membership were not demonstrated.
- Patient representation had been included on the Hygiene Services Committee and the contractor representation had been increased.
- There was an extensive quality improvement plan (QIP) in place however there was limited progress demonstrated on its implementation.

CM 14.2 **Rating: C (41-65% compliance with this criterion)**

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

- There was evidence demonstrated that trending in relation to the audits was completed within the hospital.
- Evidence was demonstrated that Methacillin Resistant *Staphylococcus Aureus* (MRSA) rates were benchmarked externally.
- There was no long term Hygiene Strategic Plan demonstrated. The Hygiene Services Strategic Statement was for 2008-2009 and this identified strategic

- Performance indicators for hygiene were not demonstrated.

2.5 Standards for Service Delivery

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

EVIDENCE BASED BEST PRACTICE AND NEW INTERVENTIONS IN HYGIENE SERVICES

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

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

- The Infection Control Manual was available in all the clinical areas visited and contained policies, procedures and guidelines in relation to colour coding, waste management, and waste segregation processes. Policies, procedures and guidelines were structured according to the same template and approved by the Executive Management Board. Input from the relevant personnel was identified however there was no documented process for this.
- There was evidence that the national colour coding policy had been adopted.
- No evidence of evaluation of the efficacy of processes used to develop best practice guidelines for the Hygiene Services Team was demonstrated.

SD 1.2 Rating: C (41-65% 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.

- It was identified that hygiene developments in the last two years included:
 - Washroom and isolation janitorial service in the afternoon.
 - Introduction of a new cleaning agent, which was not trialled, based on the evidence of trialling in another local hospital. Records of evaluation by the Clinical Nurse Manager 2 in each area were demonstrated.
- No evidence of evaluation of the efficiency of the assessment process for new/changed Hygiene Services interventions was demonstrated.

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 observed that there were posters in link corridors to highlight high risks during the relevant season, for example norovirus, scabies, salmonella. Relevant hygiene posters and leaflets were observed to be in place.
- Patient and relatives sessions, where patients/relatives were invited to meet with the Infection Control Nurse to discuss issues of concern, were demonstrated.
- There was evidence that the hospital held a health promotion week.
- The organisation advised that a two-day education seminar was held for general practitioners and practice nurses on the treatment of leg ulcers.
- No evidence of evaluation of the efficacy of activities undertaken or participated in by the team in the community in relation to hygiene was demonstrated.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1 Rating: B (66-85% compliance with this criterion)

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

- There was evidence of a multidisciplinary Hygiene Service Committee, a Hygiene Service Team and a Clean Environment Team in place.
- Medical staff representation was identified as a gap.
- It was identified that a patient representative had recently joined the Hygiene Service Committee.
- No evidence of evaluation of the efficacy of the multidisciplinary team structure was demonstrated.

IMPLEMENTING HYGIENE SERVICES

***Core Criterion**

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

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

- The environment was generally clean and tidy, however there was evidence of light dust on high surfaces and the undercarriage of beds.
- Uncovered mattresses were observed to be stored on the floor in one ward.
- It was reported that there was a process in place for curtain changing however documentation to support this was limited.

***Core Criterion**

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

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

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

***Core Criterion**

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

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

- Colour coding systems were demonstrated.
- Cleaning products were observed to be stored in locked rooms.
- One cleaners' storeroom had a sink however there was no sluice. Cleaning equipment was located in one sluice room (due to space constraint) and this room had a sluice however there was no wash hand basin.

***Core Criterion**

SD 4.4 Rating: A (>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.

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

***Core Criterion**

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

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

- There was evidence demonstrated that the waste segregation policy was adhered to.
- The waste compound was adjacent to the hospital and close to the main entrance and readily accessible to the public.
- A large bin for the collection of clinical waste in the compound was left unlocked with the lid open for ease of access by staff disposing of clinical waste.
- Collection permits dated 2001-2006 were demonstrated.
- The tracking system was demonstrated including C1 forms, certificates of destruction and records of tags assigned to each ward/department.

***Core Criterion**

SD 4.6 Rating: C (41-65% compliance with this criterion)

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

- Best practice in relation to linen segregation was demonstrated at ward level. Separate soiled and clean linen areas were demonstrated.
- The laundry department was observed to be in a state of disrepair. Evidence of heavy dust was demonstrated throughout the building with large chunks of plaster missing from wall surfaces and the floor surfaces were at different levels. Records were in place for water temperatures during the various wash cycles

- Patient's personal laundry was observed to be stored in plastic bags following laundering and stored on top of pipes, which had heavy layers of dust present.

***Core Criterion**

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

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

- There was evidence of hand preparation and hand-hygiene practices in line with recommended practice.
- Hand washing products were available.
- A large number of sinks did not meet best practice standards.

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.

- Incident reporting and follow-up was demonstrated with evidence of closure of some actions.
- Wet floor signs were demonstrated in use during cleaning processes.
- Records of flushing were not demonstrated although the organisation advised that these were kept off site.

SD 4.9 Rating: C (41-65% compliance with this criterion)

Patients/Clients and families are encouraged to participate in improving Hygiene Services and providing a hygienic environment.

- Hygiene posters and leaflets were observed to be in place.
- The visiting policy was demonstrated
- No hygiene related patient satisfaction survey was demonstrated.
- Patient input into hygiene services through a representative on the Hygiene Services Committee had only just commenced.

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.

- The organisation advised that the maintenance of patient/client dignity during hygiene service delivery was included verbally during induction. There was no evidence to demonstrate this.
- Local colour coding signage for isolation was demonstrated
- No patient rights violations were reported.

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 organisation advised that the admission office issued an information pack to patients, and this was demonstrated and included information on hygiene.
- Relevant posters and leaflets were displayed throughout the organisation.
- Patients/clients were reported to be satisfied however no survey was demonstrated.
- A patient satisfaction survey, which included a question on hygiene, was being carried out in outpatient department during the site visit by an independent body.
- Logs of "comfort rounds" were demonstrated.

SD 5.3 Rating: C (41-65% compliance with this criterion)

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

- A complaints policy was demonstrated to be in place. 'Your service your say' leaflets were demonstrated.
- The organisation advised that there was no complaints officer at present; and this function was being managed through a member of nursing management.
- No trending or evaluation of complaints was demonstrated.

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1 Rating: C (41-65% compliance with this criterion)

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

- The organisation advised that a patient representative recently joined the Hygiene Service Committee.
- A verbal patient survey conducted by senior nurse managers each week was demonstrated. There was evidence of a log however no recommendations were demonstrated.
- The organisation advised that a weekly verbal survey of two patients was carried out by the Chief Executive Officer however no documented evidence was demonstrated.
- No evidence of evaluation of the extent to which patients/clients, families and other organisations are involved by the team when evaluating its Hygiene Services was 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.

- The organisation advised that internal audits teams had been trained in audit processes and conducted the audits in each other's areas. Evidence of this was not demonstrated. Some trended results were presented.
- Audit reports were the only hygiene specific key performance indicator identified.
- Colour coding and the introduction of the janitorial services were identified as a quality improvement initiative developed during the last two years.
- No evidence of evaluation of the extent to which hygiene services quality initiatives are the result of evaluation and benchmarking was demonstrated.

SD 6.3

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

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

- There was a Cleaning Contractor Annual Report for 2007 and six-month report for the first half of 2008 demonstrated.
- A Hygiene Services Committee Annual Report 2006 signed off by the Deputy General Manager in January 2007 was demonstrated. No Hygiene Services Annual Report for 2007 was demonstrated.

Appendix A: Ratings Details

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

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

Criteria	2007	2008
CM 14.1	A	C
CM 14.2	B	C
SD 1.1	C	B
SD 1.2	C	C
SD 2.1	C	B
SD 3.1	C	B
SD 4.1	A	B
SD 4.2	A	A
SD 4.3	B	B
SD 4.4	A	A
SD 4.5	A	C
SD 4.6	A	C
SD 4.7	A	B
SD 4.8	C	C
SD 4.9	C	C
SD 5.1	C	B
SD 5.2	C	B
SD 5.3	B	C
SD 6.1	C	C
SD 6.2	C	B
SD 6.3	C	C