Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

National Hygiene Services Quality Review 2008

Our Lady's Children's Hospital, Crumlin

Assessment Report

Assessment date: 20th October 2008

About the Health Information and Quality Authority

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

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

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

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

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

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

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

1 Background and Context

1.1 Introduction

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

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

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

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

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

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

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

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

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

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

Hygiene is defined as:

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

Irish Health Services Accreditation Board Hygiene Standards

1.2 Standards Overview

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

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

The Standards are grouped into two categories:

(a) Corporate Management

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

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

(b) Service Delivery

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

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

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

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

1.3 Assessment Process

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

Before the onsite assessment:

- **Submission of a Quality Improvement Plan (QIP) and accompanying information by the hospital to the Authority.** Each hospital was requested to complete a quality improvement plan. This QIP outlined the plans developed and implemented to address the key issues as documented in the hospital's Hygiene Services Assessment Report 2007.
- **Off-site review of submissions received**. Each Lead Assessor conducted a comprehensive review of the information submitted by the hospital.
- **The Authority prepared a confidential assessment schedule**, with the assessment dates for each hospital selected at random.
- **Selection of the functional areas.** The number of functional areas selected was proportionate to the size of the hospital and type of services provided. At a minimum it included the emergency department (where relevant), the outpatient department, one medical and one surgical ward.

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

During the assessment:

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

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

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

Following the assessment:

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

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

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

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

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

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

Table 1: Compliance Rating Score

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

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

2 Hospital findings

2.1 Our Lady's Children's Hospital Crumlin – Organisational Profile[1]

Our Lady's Children's Hospital Crumlin is an acute paediatric teaching hospital with 248 beds, employing over 1,600 staff. It is Ireland's largest paediatric hospital and is responsible for the provision of the majority of tertiary care services for children and medical research for childhood illnesses. It is the national centre in Ireland for children's childhood cancers, cardiac diseases, medical genetics and major burns.

The hospital provides a high standard of care to the children availing of its services. The services provided are underpinned by a commitment to medical and nurse education and to the development of the skills of staff generally. The hospital is built on a site of approximately five hectares which was provided by the Archbishop of Dublin. It first opened its doors in 1956.

The quality of research carried out at the centre is best recognised by its international reputation in paediatric medicine and in its publications. The research laboratories constitute a major component of the activities of the Children's Research Centre. Molecular and cellular biology facilities are provided in a well equipped laboratory complex. The services and specialist medicine provided at the hospital have been significantly developed over the years.

2.2 Areas Visited

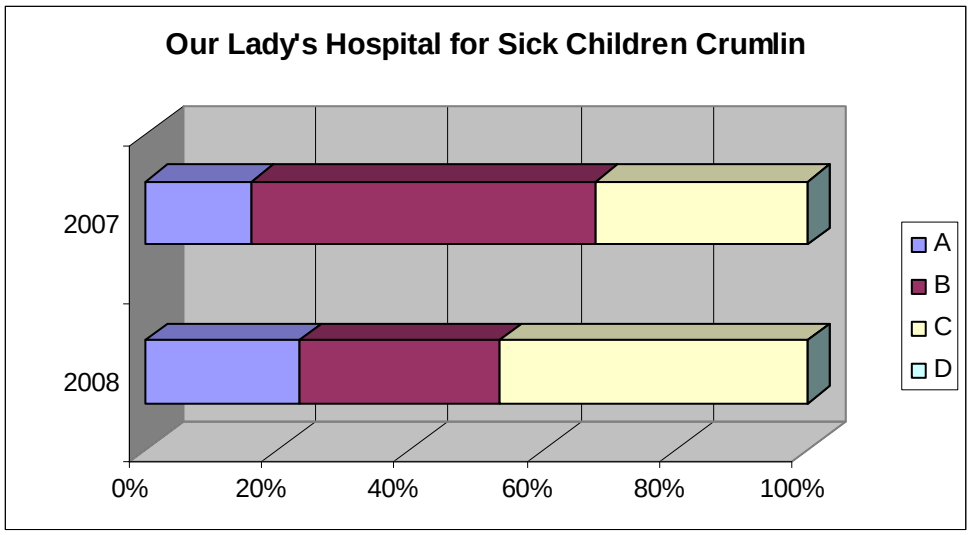
During the course of the assessment the following areas were visited:

- Emergency department
- Outpatient department
- St. Peter's Ward
- Surgical Day Unit
- St. Bridget's Ward
- St. Joseph's Ward
- Laundry services
- Waste compound.

[1] The organisational profile was provided by the hospital

2.3 Overall Rating

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



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

Our Lady's Children's hospital, Crumlin, has achieved an overall rating of:

Fair

Award date: 2008

2.4 Standards for Corporate Management

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

PLANNING AND DEVELOPING HYGIENE SERVICES

CM 1.1 Rating: B (66-85% compliance with this criterion)
The organisation regularly assesses and updates the organisation's current and future needs for Hygiene Services.

- The hospital demonstrated that they had a multidisciplinary Hygiene Services Committee.
- The Committee produced a Strategic Plan through consultation, feedback and using information from the last National Hygiene Assessment in 2007.
- There was evidence of hygiene audits being undertaken with action plans being fed back to local areas however no evidence was demonstrated of completion/closure of the loop with corrective actions being taken.
- Evidence of a patient survey recently completed from the surgical day ward was demonstrated however this did not include any information in relation to hygiene.
- No evidence of the evaluation of the efficacy of the needs assessment process was demonstrated

CM 1.2 Rating: A (>85% compliance with this criterion)
There is evidence that the organisation's Hygiene Services are maintained, modified and developed to meet the health needs of the population served based on the information collected.

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

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1 Rating: B (66-85% compliance with this criterion)
The organisation links and works in partnership with the Health Service Executive, various levels of Government and associated agencies, all staff, contract staff and patients/clients with regard to hygiene services.

- Evidence was demonstrated that the hospital is a part of the DATHS group of hospitals.
- A Dangerous Goods Service Advisor (DGSA) was available to the hospital through this group.

- Evidence of the hospital working in partnership with staff and others through Health and Safety Authority audits along with EHO and HACCP audits was demonstrated.
- The assessors were informed that the hospital was part of a Regional Infection Control network however no documentary evidence was demonstrated to support this.
- No evaluation of the linkages was 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.

- Evidence of a strategic plan covering the time scale 2007 -2010 was demonstrated. This plan set out goals and objectives for the hospital.
- The Hygiene Services Committee terms of reference set out roles and responsibilities relating to hygiene services.
- Evidence was demonstrated that their function had been evaluated.
- Through minutes of the Hygiene Service Committee there was evidence that they had reviewed their quality improvement plan.
- The strategic plan was communicated to the executive management team however was not widely circulated.
- There was no evidence of any evaluation taking place.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.1 Rating: B (66-85% compliance with this criterion)
The Governing Body and its Executive Management Team have responsibility for the overall management and implementation of the Hygiene Service in line with corporate policies and procedures, current legislation, evidence based best practice and research.

- Membership of the Hospital Executive Council was demonstrated.
- There was evidence from minutes dated 4th September 2008, and 25th September 2008, that hygiene issues were discussed. The assessors were informed that hygiene was routinely discussed at quarterly meetings however hygiene was not a standing agenda item for the meeting of the Executive Council.
- There was no evidence of any evaluation taking place.

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.

- Evidence of some multidisciplinary hygiene audits were conducted
- While key performance indicators were reported to be in the process of being developed, none had yet been produced other than those required to be presented to the Health Protection Surveillance centre.
- There was evidence of an evaluation relating to hand hygiene products along with an examination of products available on the market.
- A lockable dispenser had been identified. This was demonstrated through minutes of the Hygiene Services Committee dated 18th June 2008.
- No formal evaluation of the appropriateness of the information received was demonstrated.

CM 4.3 Rating: B (66-85% compliance with this criterion)
The Governing Body and/or its Executive Management Team access and use research and best practice information to improve management practices of the Hygiene Service.

- It was identified that staff had access to the intranet and internet.
- The library was now located in the main hospital.
- During the week of the assessment the hospital was running a health and safety week within the hospital.
- It was demonstrated that hospital policies follow a defined template however this does not apply to guidelines and standard operating procedures as yet.
- It was demonstrated that there was an infection control programme in place and mandatory hand hygiene training was available.
- Infection control training records were kept on an excel spreadsheet.
- The ward manager kept her own records separately.
- There had been no evaluation to date of the appropriateness of hygiene related best practice information available.

CM 4.4 Rating: C (41-65% compliance with this criterion)
The organisation has a process for establishing and maintaining best practice policies, procedures and guidelines for Hygiene Services.

- Evidence was demonstrated of a template in place for policies, procedures and guidelines. However guidelines and standard operating procedures did not follow this as yet.
- Evidence was demonstrated that since August 2007 records of policies, procedures and guidelines had been kept on an Excel spreadsheet.
- It was identified that the Nurse Practice Development Unit were undertaking audits using an IT-based audit tool.
- There was no evidence of evaluation demonstrated.

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.

- Evidence was demonstrated that the project management coordinator was a member of the Hygiene Services Committee.
- A sub-group of the Hospital Executive Committee and the Hygiene Services Committee was to look at capital development projects for 2008-2009.
- A tender specification dated 9th July 2008 included a requirement for Infection Control involvement.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

***Core Criterion**
CM 5.1 Rating: A (>85% compliance with this criterion)
There are clear roles, authorities, responsibilities and accountabilities throughout the structure of the Hygiene Services.

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

***Core Criterion**
CM 5.2 Rating: A (>85% compliance with this criterion)
The organisation has a multidisciplinary Hygiene Services Committee.

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

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

***Core Criterion**
CM 6.1 Rating: B (66-85% compliance with this criterion)
The Governing Body and/or its Executive/Management Team allocate resources for the Hygiene Service based on informed equitable decisions and in accordance with corporate and service plans.

- It was advised that the allocation of resources was based on the service plan.
- No evidence was provided to demonstrate that it was considered by the Hygiene Services Committee.
- Evidence of consideration of hygiene needs at clinical versus non-clinical level was demonstrated. A group was convened with draft terms of reference drawn up, the purpose of which was to prioritise clinical areas for hygiene services.
- Evidence of a list of issues to be addressed was demonstrated and contained in an undated letter.

CM 6.2 Rating: B (66-85% compliance with this criterion)
The Hygiene Committee is involved in the process of purchasing all equipment/products.

- The hospital demonstrated that a plan for an equipment procurement group was currently with the CEO for consideration and approval.
- Once in place it will link with the Executive Management Team.
- At the time of the assessment the hospital demonstrated that the materials management team make contact with "relevant people" for advice.
- The organisation demonstrated that new requisitioning guidelines dated 2007 require that new products or equipment be considered by Health and Safety, Infection Control and Hygiene Committees prior to purchasing.
- It was identified that the materials manager sits on the Health and Safety Committee.
- No evidence of evaluation was demonstrated.

MANAGING RISK IN HYGIENE SERVICES

***Core Criterion**
CM 7.1 Rating: C (41-65% compliance with this criterion)
The organisation has a structure and related processes to identify, analyse, prioritise and eliminate or minimise risk related to the Hygiene Service.

- There was no evidence of any integrated risk management or incident reporting policy demonstrated, with limited evidence of feedback at ward or local level as a result of incident reporting.
- No formal performance indicators were demonstrated for hygiene services.
- It was identified that Healthcare Associated Infections were reported to the Infection Control Committee.
- There was no evidence demonstrated that they were considered by risk management or logged on STARSweb.
- Incidents were a standing agenda item on the Hygiene Services Committee.

CM 7.2 Rating: C (41-65% 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 hospital resources risk management through funding of staff for both clinical and non-clinical risk.
- A detailed report, collating non-clinical incidents and risks was demonstrated, however reporting of clinical risks (including hygiene-related) was not demonstrated.

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.

- A control of contractors document dated December 2007 was demonstrated.
- No evidence was demonstrated of contracts that were in date relating to hygiene services.
- It was advised that as contracts expired, these were replaced with service level agreements.
- No evidence was demonstrated that these agreements included relevant issues such as liability, duration, quality, specifications etc.

CM 8.2 Rating: A (>85% compliance with this criterion)
The organisation involves contracted services in its quality improvement activities.

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

PHYSICAL ENVORNMENT, FACILITIES AND RESOURCES

CM 9.1 Rating: 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 hospital's physical environment was observed to be old, however some modifications and extensions had taken place.
- The project management co-ordinator was a member of the Hygiene Services Committee.
- A plan had been put in place to form a subgroup of the Hospital Executive Committee including the Hygiene Services Committee to review all capital development projects going forward.
- Evaluation of the safety of the design, layout and environment was reported to be contained in the updated Safety statement.

***Core Criterion**
CM 9.2 Rating: B (66-85% compliance with this criterion)
The organisation has a process to plan and manage its environment and facilities, equipment and devices, kitchens, waste and sharps and linen.

- The hospital demonstrated that a laundry review had taken place (a guideline for safe handling and storage of laundry at ward level dated 2nd September 2003 and amended 14th June 2007 was demonstrated).

- A guideline for the management of sharps dated May 2005 was also demonstrated as was a waste policy.
- A catering review had taken place and a food safety manual had been produced.

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.

- Evidence demonstrated that multidisciplinary audits take place.
- It was advised that a HACCP team had been set up.
- An audit system had been sourced and the multidisciplinary audit tool was now being put up on it.
- There was no evidence of any satisfaction surveys in relation to this criterion demonstrated apart from a questionnaire for ward staff in relation to the children's menu.
- Evidence that recommendations from audits were considered by the Executive Management Team was 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.

- There was evidence of the evaluation of non-clinical complaints demonstrated, however no evidence of the evaluation of clinical complaints was demonstrated.
- The organisation provided evidence of six hygiene-related complaints in 2007 and six up to July 2008.
- No evidence of action was demonstrated.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 Rating: C (41-65% 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.

- It was identified that the hospital adheres to HSE recruitment policies that are in line with legislation and best practice.
- It was identified that relevant line managers provide input into job descriptions.
- There was no evidence of evaluation demonstrated.

CM 10.2 Rating: B (66-85% compliance with this criterion)
Human resources are assigned by the organisation based on changes in work capacity and volume, in accordance with accepted standards and legal requirements for Hygiene Services.

- The 2007-2008 Service Plan identified Human Resource needs, however no documented process around this was demonstrated.
- There was evidence that a waste monitoring officer had been appointed.
- Changes identified through the Household/Catering Group of the Hygiene Services Team were being progressed with SIPTU.
- There was no evidence of Evaluation having taken place.

CM 10.3 Rating: A (>85% compliance with this criterion)
The organisation ensures that all Hygiene Services staff, including contract staff, have the relevant and appropriate qualifications and training.

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

CM 10.4 Rating: C (41-65% compliance with this criterion)
There is evidence that the contractors manage contract staff effectively.

- It was advised that quality was monitored through audit.
- There was a requirement that contract staff who commence employment receive training however no updates were required.
- Documents were demonstrated for 2006.
- Reporting relationships for contract staff was through their supervisor who liaises with the household services manager.
- With the exception of sharps injuries which were managed through the hospital occupational health department, other occupational health requirements were met by the contractor.

***Core Criterion**
CM 10.5 Rating: A (>85% compliance with this criterion)
There is evidence that the identified human resource needs for Hygiene Services are met in accordance with Hygiene Corporate and Service plans.

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

ENHANCING STAFF PERFORMANCE

***Core Criterion**

CM 11.1 Rating: B (66-85% compliance with this criterion)
There is a designated orientation/induction programme for all staff which includes education regarding hygiene.

- The organisation had an induction programme in place.
- Evidence was demonstrated that this was a 2.5 hour process and included hygiene.
- An employee handbook was demonstrated.
- Evidence of ongoing training in relation to hand hygiene and mandatory training including fire safety and manual handling was demonstrated.
- No process was demonstrated for identifying staff who need training updates.

CM 11.2 Rating: B (66-85% compliance with this criterion)
Ongoing education, training and continuous professional development is implemented by the organisation for the Hygiene Services team in accordance with its Human Resource plan.

- No formalised written process was demonstrated for ensuring continuing professional development of all hygiene services staff.
- Evidence was demonstrated that infection control targets all groups.
- There was protected time for one infection control training day per year for nursing staff.
- FETAC training was made available to hygiene services staff.
- Some evaluation had taken place with restructuring reported to the format of some days.

CM 11.3 Rating: B (66-85% compliance with this criterion)
There is evidence that education and training regarding Hygiene Services is effective.

- The organisation did not demonstrate evidence of any formal performance indictor being used to evaluate the education and training programme.
- The organisation provided evidence of evaluation sheets completed after education sessions however no evidence of any changes as a consequence was demonstrated.
- Infection control demonstrated evidence that VRE rates reduced, the reduction coinciding with hand hygiene training.

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 identified that there was no performance management system in place and that performance management was completed through the audit system.
- Performance was monitored during a staff member's probationary period.
- No evaluation was demonstrated.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 Rating: B (66-85% compliance with this criterion)
An occupational health service is available to all staff

- The organisation had an occupational health service staffed by two Clinical Nurse Manager 2 grades, and an occupational health physician on a sessional basis.
- Vaccinations were available to all staff except contract staff who must provide evidence of vaccination prior to commencement.
- The occupational health service had conducted a review in relation to flu vaccine and MRSA however no overall evaluation of the service had taken place.

CM 12.2 Rating: C (41-65% compliance with this criterion)
Hygiene Services staff satisfaction, occupational health and wellbeing is monitored by the organisation on an ongoing basis.

- No performance indicators in relation to staff satisfaction, occupational health and well being were demonstrated.
- MRSA screening for staff was introduced in 2007 and some evaluation had taken place.
- No staff satisfaction survey had taken place.

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 it was in the process of introducing a computerised audit system.
- Training had been undertaken however the hospital had not yet started using the system.

- Infection control had undertaken some evaluation of the reliability of information gathered however this was not widespread.

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.

- Evidence was demonstrated that the organisation was undertaking hygiene audits.
- The organisation advised that it plans to collate these and give them to the Hygiene Services Committee every 6 months.
- Some evaluation of the audit tool had taken place, and as a consequence it was identified that it needs to be more user-friendly. There had been no evaluation of data presentation methods or user satisfaction.

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.

- No formal process for assessing the appropriateness of data collection and information reporting was demonstrated.
- An evaluation of the multidisciplinary audit tool had taken place and changes to make it more user-friendly have been identified.

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.

- The hospital informed the assessors that they had used the quality improvement plan (QIP) developed after the last national hygiene assessment as a quality improvement tool for hygiene services going forward.
- It was identified that the CEO undertakes hygiene related walkabouts.

CM 14.2 Rating: B (66-85% compliance with this criterion)
The organisation regularly evaluates the efficacy of its Hygiene Services quality improvement system, makes improvements as appropriate, benchmarks the results and communicates relevant findings internally and to applicable organisations.

- Evidence was demonstrated that the organisation had set up its Hygiene Service Committee and Hygiene Service Team in the last two years prior to the assessment visit.

- Evidence of memos to staff in relation to infection control issues was demonstrated.
- The hospital had developed a “benchmarking” type questionnaire to send to other hospitals to fact find in relation to hygiene issues.
- Evidence of improved VRE figures following hand hygiene education was 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: C (41-65% compliance with this criterion)
Best Practice guidelines are established, adopted, maintained and evaluated, by the team.

- While the organisation had a policy in place for the development of policies no template was demonstrated to be in use for guidelines or standard operating procedures.
- In clinical areas there was no consistency evident in relation to the format of these.
- No process was demonstrated for reviewing of PPGs in clinical areas.
- A policy working group had been put in place.
- No evidence was demonstrated that evaluation had taken place.

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.

- While no documented process was demonstrated for the assessment of new hygiene service interventions the organisation was able to demonstrate that consideration had been given to the most appropriate type of alcohol gel to be used.
- No evidence of formal evaluation was demonstrated.

PREVENTION AND HEALTH PROMOTION

SD 2.1 Rating: C (41-65% 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.

- Evidence of availability of alcohol hand-gel and information posters was demonstrated however hygiene related information leaflets were not prominently displayed.
- Involvement with community groups in relation to hygiene was demonstrated.
- There was no evidence of evaluation demonstrated.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1 Rating: A (>85% compliance with this criterion)
The Hygiene Service is provided by a multidisciplinary team in cooperation with providers from other teams, programmes and organisations.

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

IMPLEMENTING HYGIENE SERVICES

***Core Criterion**
SD 4.1 Rating: A (>85% compliance with this criterion)
The team ensures the organisation's physical environment and facilities are clean.

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

***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: A (>85% compliance with this criterion)
The team ensures the organisation's cleaning equipment is managed and clean.

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

***Core Criterion**
SD 4.4 Rating: 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: A (>85% compliance with this criterion)
The team ensures the inventory, handling, storage, use and disposal of Hygiene Services hazardous materials, sharps and waste is in accordance with evidence based codes of best practice and current legislation.

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

***Core Criterion**
SD 4.6 Rating: B (66-85% compliance with this criterion)
The team ensures the Organisations linen supply and soft furnishings are managed and maintained.

- Wooden shelves were evident in some laundry rooms.
- Clean linen was observed to be stored in open trolleys on corridors in some areas.

***Core Criterion**
SD 4.7 Rating: A (>85% compliance with this criterion)
The team works with the Governing Body and/or its Executive Management team to manage hand hygiene effectively and in accordance with the Strategy for the control of Antimicrobial Resistance in Ireland (SARI) guidelines.

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

SD 4.8 Rating: B (66-85% compliance with this criterion)
The team ensures all reasonable steps to keep patients/clients safe from accidents, injuries or adverse events.

- The organisation demonstrated that it had an incident reporting system however there was no evidence of evaluation of incidents or feedback provided to ward level.
- There was evidence of a Health and Safety Committee and the Health and Safety Statement had been updated.

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.

- There was evidence of posters and some leaflets relating to hygiene available.
- A visitors' policy was in place.
- A patient satisfaction survey had been conducted however no evidence of evaluation was demonstrated.

PATIENT'S/CLIENT'S RIGHTS

SD 5.1 Rating: C (41-65% compliance with this criterion)
Professional and organisational guidelines regarding the rights of patients/clients and families are respected by the team.

- The organisation indicated that it protected children through its security policy which included swipe access to areas and locked areas at night.
- Patient information leaflets were available.
- While there was no evidence of root cause analysis of hygiene incidents demonstrated, there was evidence of actions being taken as a result of issues raised by families.

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.

- Evidence that families were provided with some information in relation to hygiene was demonstrated, however the admission booklet only details the visiting policy.
- Availability of information leaflets was observed.
- The organisation provided evidence that a patient satisfaction survey had been completed however there was no evidence that an evaluation took place.

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.

- The organisation did not demonstrate evidence of a complaints policy and the assessors were advised that it was being revised.
- There was no evidence of capture of verbal complaints demonstrated.
- While there was no evidence of evaluation demonstrated there was evidence that changes had happened as a consequence of complaints made. (for example, changes to the type of toys available in the Emergency Department.)

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.

- There was no evidence of patient representation on the hygiene services team.
- A complaints system was being revised with evidence of change as a result of hygiene issues raised.
- A patient satisfaction survey had taken place no evaluation was demonstrated.

SD 6.2 Rating: C (41-65% compliance with this criterion)
The Hygiene Services team regularly monitors, evaluates and benchmarks the quality of its Hygiene Services and outcomes and uses this information to make improvements.

- There was no evidence of hygiene related key performance indicators (KPIs) being developed.
- It was identified that a waste-monitoring officer and hygiene-services manager had been appointed.
- Evidence was demonstrated of an annual report that listed achievements
- There were no reporting or monitoring/evaluating activities demonstrated.

SD 6.3 Rating: C (41-65% compliance with this criterion)
The multidisciplinary team, in consultation with patients/clients, families, staff and service users, produce an Annual Report.

- An Annual Report which detailed achievements and was available on the intranet and disseminated at team meetings was demonstrated.
- This report was produced by the Hygiene Services Committee as a result of feedback from Committee members.
- The assessors were informed that a staff satisfaction survey was being conducted however no evidence was demonstrated.

Appendix A: Ratings Details

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

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

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