National Hygiene Services Quality Review 2008

Royal Victoria Eye and Ear Hospital

Assessment Report

Assessment date: 7th 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 risk letter to the hospital in relation to these risks.

1.3 Assessment Process

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

Before the onsite assessment:

- **Submission of a Quality Improvement Plan (QIP) and accompanying information by the hospital to the Authority.** Each hospital was requested to complete a quality improvement plan. This QIP outlined the

plans developed and implemented to address the key issues as documented in the hospital's Hygiene Services Assessment Report 2007.

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

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

During the assessment:

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

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

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

Following the assessment:

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

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

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

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

1.4 Patient Perception Survey

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

1.5 Scoring and Rating

Evidence was gathered in three ways:

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

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

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

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

Table 1: Compliance Rating Score

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

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

2. Hospital Profile

2.1 Royal Victoria Eye and Ear Hospital - Organisational Profile[1]

Royal Victoria Eye and Ear Hospital is located on Adelaide Road, Dublin 2. It was built in 1897 for the provision of ophthalmic; ear, nose & throat; head and neck services. The hospital has 80 beds, of which 20 are located in the hospital's Day Care Unit. 60 beds are designated in-patient. Ten of these beds accommodate children. Two thirds of the beds are designated ophthalmic beds and one third are designated to ear, nose & throat, head and neck. Both private and public patients are accommodated. There is a large Outpatient Unit accommodating circa 45,000 patient visits per annum and a separate X-Ray building and emergency department accommodating circa 40,000 patient visits per annum.

2.2 Areas Visited

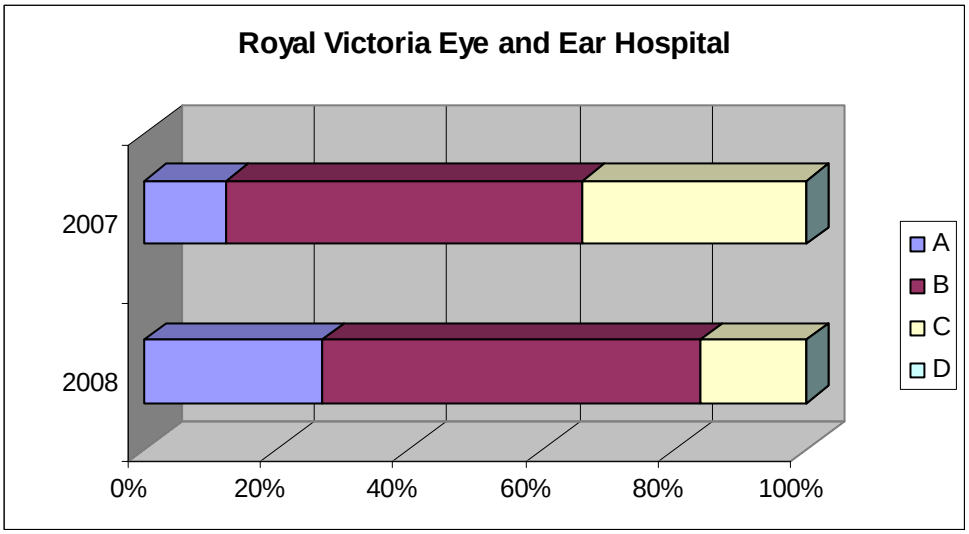
During the course of the assessment the following areas were visited:

- Outpatient department
- Emergency department
- Ward
- Ophthalmology
- Otolaryngology (ENT) 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 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.

Royal Victoria Eye and Ear Hospital has achieved an overall score of:

Fair

Award date: 2008

2.4 Standards for Corporate Management

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

PLANNING AND DEVELOPING HYGIENE SERVICES

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

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

- There was evidence demonstrated that the Hospital Council and Hospital Management Group have Hygiene services on the agenda of their quarterly meetings. It was demonstrated that a member of the senior management team updates the Executive Management Group in relation to Hygiene Services.
- The organisation demonstrated that the Hospital Management Group also functions as the Hygiene Committee and was involved in assessing and updating the hygiene services.
- There was evidence demonstrated of a needs-assessment completed in 2008 by the Project Manager and Director of Strategy and Corporate Affairs in conjunction with all ward/line managers and this was incorporated into the Executive summary of the Hospitals strategic plan.
- Costings for hygiene services were completed and reviewed in the minutes of Hospital Management Group meetings.
- It was demonstrated that the needs-assessment process includes all staff; however there was no evidence of patients involved. The 2008 Hygiene Services plan and Infection Control service plans were demonstrated. This was completed through the Directorate structure; however, there was no documented process in place for the establishment of same.
- There was no evidence of evaluation of the efficacy of the needs-assessment 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.

- There was evidence demonstrated that Hygiene upgrades to include the external area have been completed in 2008. This was completed despite no additional funding for hygiene services. There have also been developments in the information utilised and shared in the organisation.

- There was evidence demonstrated that Hand gel monitoring is completed quarterly and this was evaluated against the key performance indicator set by the Health Service Executive.
- It was demonstrated that a Hygiene Patient satisfaction survey was completed and the actions implemented are reflected in cleaning records. This process was ongoing and the report was being compiled.
- There was evidence demonstrated that key performance indicators and results of audits and reports are now circulated to Ward Managers on a six monthly basis.
- There was evidence demonstrated that evaluation of improvements was based on audit outcomes against national best practice. The resultant actions and quality improvement plan was not demonstrated.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

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

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

- There was evidence demonstrated that the organisation meet with the Health Service Executive (HSE) regarding hygiene services on a monthly basis. Minutes of meetings were viewed.
- There was evidence demonstrated that nursing and Household, Health Care Assistants and Nurses meet quarterly to discuss hygiene issues, Minutes of meetings were viewed. Meetings with Department Heads were also viewed.
- There was evidence that ward managers meet monthly, hygiene is routinely on their agenda and minutes were viewed. The Infection Control Team meeting monthly and minutes were demonstrated. A Hygiene action plan has been developed based on feedback from the many groups in place.
- Patient and staff satisfaction surveys have been completed.
- There was insufficient evidence demonstrated that efficacy of the linkages and partnerships are evaluated.

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.

- There was evidence of hospitals Strategic Plan which includes hygiene issues. There was a lack of evidence demonstrated of a strategic plan for Hygiene Services. There is however a Hygiene Service Plan for 2008, formulated by the Hospital Management Group (HMG). The Hygiene objectives for 2008 are

tracked in line with the needs-assessment completed and the responsibility for each objective is defined with each Directorate Manager.
- There was evidence that results of audits are communicated to the Hospital Management Group and the Hospital Council on a quarterly basis.
- It was not demonstrated that there is a formalised process to evaluate the hygiene services against needs apart from through the audit programme.

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.

- There was evidence that the authority provisions for hygiene services are clearly defined. The role of each directorate manager was discussed. There was no evidence that these roles were documented.
- The evaluation of the Hygiene Services Teams' adherence to legislation was noted through the minutes of the hospital council. There was no evidence of resultant actions based on evaluation.

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

The Governing Body and / or its Executive Management Team regularly receive useful, timely and accurate evidence or best practice information.

- There was evidence demonstrated that the hospital has defined a number of key performance indicators for Hygiene Services. The results of these were presented to the Hospital Council and evidence was demonstrated that the Council had asked for further information, and evidence of provision of same was demonstrated in minutes of their meetings.
- There was evidence demonstrated that the Hygiene Report is presented by a senior member of staff at the Hospital Council meetings.
- There was no evidence demonstrated of documented processes for receiving and acting on information on the performance of the Hygiene Service team.

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

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

- There was evidence demonstrated of a new learning and library centre developed in the hospital.
- There was evidence of E-learning facilities available to all staff.
- A DVD for hygiene training was demonstrated and made available to all staff.

- There was evidence demonstrated that there has been a number of in-house education sessions organised by the Infection Control Team and records were demonstrated.
- The organisation have demonstrated some evidence of evaluation of appropriateness of hygiene services related best practice, as evidenced through the bin maintenance programme, there has been a change from top closing bins to front–opening bins.
- This process of evaluation was not demonstrated as formalised.

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

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

- The organisation demonstrated that a senior member of a senior nursing staff member was responsible for the development of Policies, Procedures and Guidelines (PPGs) for Hygiene Services.
- There was evidence of a nursing polices and procedures Committee in place.
- There was evidence of review of the Aspergillus policy in 2008 and this was utilised in relation to recent physical upgrading work. The policy for the management of laundry has been recently developed.
- There was evidence that the Infection Control policies, which include the hygiene policies, are updated every two years. The review was tracked through an information management system and evidence of the master plan was demonstrated. There was a process in place to ensure that Infection control staff brings new policies to the attention of the line manager for staff awareness.
- There was evidence demonstrated that a number of the policies were not completed as per the corporate approach. There is a lack of evidence demonstrated of a policy evaluation system in place other than through audit findings and adverse events.
- There was no evidence demonstrated of evaluation of the efficacy of the process for developing and maintaining hygiene services policies, procedures and guidelines.

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

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

- The Hospital Management Group which includes the Chief Executive also functions as the Hygiene Service Committee and demonstrated it's involvement in the organisation's capital development planning and implementation process.
- The organisation demonstrated that there is a Project Officer in post on an interim position, and this person was consulted as required, and attends relevant Hygiene Committee meetings.

- There was no documented process for consultation with the hygiene services pre development of existing sites.
- There was no evidence demonstrated of evaluation of the consultation process between the Hygiene Services Committee and senior management.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

***Core Criterion**

CM 5.1 Rating: A (>85% compliance with this criterion)

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

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

***Core Criterion**

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

The organisation has a multidisciplinary Hygiene Services Committee.

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

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

***Core Criterion**

CM 6.1 Rating: B (66-85% compliance with this criterion)

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

- The organisation advised that there was no specific hygiene budget in place, however it was demonstrated that funding is protected for hygiene services, for example, the external contracts for linen, waste and cleaning.
- It was demonstrated by the organisation that revenue and on-going costs are identified to the Hospital Management Team (HMT) by the Director of Nursing and these are also considered by the Finance Committee.
- There was no evidence demonstrated of a formalised approach to review costings against spend for hygiene services.

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

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

- There was evidence demonstrated of a Hospital Management Group Purchasing policy in place, which was in draft format and identifies a check list of Hygiene services personnel to be consulted before a procurement order is signed off.
- The organisation demonstrates that they adhere to the Health Service Executive Procurement Policy in this regard.
- There was evidence of informal processes in place to include infection control in the process of purchasing.
- There was no evidence demonstrated of evaluation.

MANAGING RISK IN HYGIENE SERVICES

***Core Criterion**

CM 7.1 Rating: B (66-85% compliance with this criterion)

The organisation has a structure and related processes to identify, analyse, prioritise and eliminate or minimise risk related to the Hygiene Service

- There was evidence demonstrated that the Risk Manager was a member of the Hygiene Services Team and Health and Safety Committee.
- The organisation demonstrated that a new risk assessment form was introduced in 2008 and training was provided for staff. Records of this training provided were demonstrated.
- Documented evidence of risk assessments in relation to hygiene services was demonstrated.
- There was evidence demonstrated of hygiene risk reports for the last two years.
- There was evidence demonstrated of a follow-up letter sent out from Occupational Health Department in relation to incidents pertaining to staff.
- There was some evidence that the closure of loop in relation to identified hygiene risks is managed verbally. There was no evidence that this process is formalised.

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.

- There was evidence of a Risk, Health and Safety Committee in place. It was demonstrated that this committee meets three-four times per year.

- Health and Safety quarterly and annual reports are issued and were demonstrated.
- There was evidence of a Decontamination Risk Register currently being populated; this was not demonstrated for hygiene services.
- There was evidence demonstrated that risk information which includes *Methicillin-Resistant Staphylococcus aureus* (MRSA), Vancomycin Resistant Enterococcus (VRE), Clostridium difficile results for example are forwarded and discussed by the Executive Management team.
- There was some evidence demonstrated of corrective action taken to address hygiene risks identified in the organisation; for example the waste recovery program, however there was no evidence demonstrated of a formalised approach to addressing risk and continuous quality improvement.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

***Core Criterion**

CM 8.1 Rating: B (66-85% compliance with this criterion)
The organisation has a process for establishing contracts, managing and monitoring contractors, their professional liability and their quality improvement processes in the areas of Hygiene Services.

- There was evidence of contracts in place for cleaning, linen and waste. There was evidence that these are monitored.
- There was evidence demonstrated that organisation has made improvements in the management of the contract in the coffee shop. This was identified in the National Hygiene Services Quality Review 2007.
- There was evidence that the shop are now complying with Hazard Analysis and Critical Control Point (HACCP).
- There was no evidence demonstrated of a formalised process in place to manage this contract and there was no evidence of minutes of meetings with this contractor.

CM 8.2 Rating: B (66-85% compliance with this criterion)

The organisation involves contracted services in its quality improvement activities.

- There was evidence demonstrated that the Hygiene Supervisor is a member of the Hygiene Services Committee.
- There was evidence demonstrated that the supervisor was on site daily.
- There was evidence that 'un–announced' environmental audits are completed in four areas per week by the Cleaning Supervisor, a member of management and Infection Control personnel.
- There was evidence that result of audits below 70% are followed up.
- Minutes of monthly meeting between the cleaning contractor and Hospital management were demonstrated. This process was yet to be demonstrated to include all contracted services in quality improvement initiatives.

PHYSICAL ENVIORNMENT, 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.

- It was advised that the hospital is 100 years old and is a listed building.
- The hospital has demonstrated that they have utilised private rooms to accommodate isolation facilities as required.
- The organisation demonstrated their work plan in relation to hygiene services.
- The organisation demonstrated that the Health and Safety Committee continue to review the environment.
- It was observed that the roof in the clinical waste compound requires repair. The hospital management has completed an option appraisal for resolution of problem and were waiting funding to progress same.
- It was observed that wooden floors are in place in day rooms in the hospital. These were observed to be clean. There were a number of sinks throughout which did not comply with best practice.

***Core Criterion**
CM 9.2 Rating: A (>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 organisation demonstrated compliance of greater than 85% with the requirements of this criterion.

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

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

- There was evidence of a recycling project which is ongoing.
- The organisation demonstrated that the linen room and process has been redeveloped. A policy was demonstrated.
- It was demonstrated that there was a number of audits completed by the organisation; results of these audits are forwarded to Hospital Management Group and Hospital Council quarterly. There was some evidence of implementation of recommendations and closure of the loop in relation to these; however this was not demonstrated to be a formalised process.

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

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

- The organisation demonstrated that patient and staff hygiene surveys are ongoing and there was evidence of some changes based on these surveys.
- The Health Service Executive complaints and comments process, "Your Service Your Say" was also demonstrated.
- It was advised that the hospital has introduced a process to include patients on the audit team. This was not demonstrated.
- There was no evidence of a formalised approach to the implementation of recommendations from the hygiene surveys.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 Rating: A (>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 compliance of greater than 85% with the requirements of this criterion.

CM 10.2 Rating: A (>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 organisation demonstrated compliance of greater than 85% with the requirements of this criterion.

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

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

- The organisation demonstrated that competency assessment is completed by the Contract Cleaning Supervisor to ensure all contract staff has the appropriate qualifications and training.
- The organisation advised of an informal system is in place to deal with shortcomings identified by to the Supervisor. Evidence of issues communicated was demonstrated in the Hygiene Services Team meetings.
- A Schedule of training was demonstrated for Health Care Assistants and Household Staff.

- There was no evidence demonstrated that the competency assessment was introduced for all hygiene staff.

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

There is evidence that the contractors manage contract staff effectively.

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

***Core Criterion**
CM 10.5 Rating: 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 demonstrated of a needs-assessment process in place completed through the audits and feedback from each directorate.
- There was evidence of a Hygiene Service Plan and annual report for 2007 in place. There was no evidence of a reference to a Hygiene Services needs-assessment in the Hygiene Services annual report.
- There was no evidence demonstrated of a documented process for completion of a human resource needs-assessment
- There was a lack of evidence demonstrated of evaluation of the needs-assessment process.

ENHANCING STAFF PERFORMANCE

***Core Criterion**

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

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

- There was evidence demonstrated of an induction training programme in place and records were demonstrated. It was demonstrated that records of induction are maintained by department managers.
- Hygiene responsibilities are defined as per job descriptions and are included on the new edition of Staff Handbook which was demonstrated as being at the print stage.
- The organisation demonstrated interim arrangements in place in this regard with the production of a loose leaflet detailing responsibilities.
- A formalised approach to the management of induction training records was not demonstrated.

CM 11.2 Rating: A (>85% compliance with this criterion)

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

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

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

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

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

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

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

- There was evidence demonstrated of informal processes in place to review performance of contract staff, this includes audits.
- There was evidence demonstrated of plans in place to introduce Professional development planning for all staff, this was not demonstrated.
- There was no evidence of a documented process for hygiene staff including contract staff performance evaluation and development.

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

- There was evidence demonstrated of a formalised external Occupational Health Service in place.
- It was advised that the programme is now at development stage and is being refined. There was no evidence of evaluation of the appropriateness of the service.

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

Hygiene Services staff satisfaction, occupational health and wellbeing is monitored by the organisation on an on-going basis.

- There was evidence demonstrated that the organisation monitors staff satisfaction.
- There was no evidence of a formalised approach to the implementation of recommendations from the hygiene surveys.
- There was no evidence demonstrated of evaluation of the appropriateness of mechanisms used to monitor staff satisfaction.

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.

- There was evidence of processes in place for collecting and providing access to quality hygiene services data and information, through the audits and the hygiene services committee.
- There was evidence demonstrated of informal process for evaluation in place, this was demonstrated through requests for clarification/further information from the Hospital Council in relation to Hygiene Services. This was no evidence demonstrated that this information was being submitted to the Hospital Council.

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

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

- There was evidence demonstrated through minutes of the Executive Management Team meetings to demonstrate that there have been changes to the information presented to them in relation to hygiene services.
- There was no evidence demonstrated of evaluation of user satisfaction in relation to reporting of data and information apart from the evaluation of the information with the Executive Management Team.

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

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

- There was evidence of a comprehensive series of reports generated and circulated to management and staff. These include the audit results and the minutes of the hygiene services Committee.
- There was no evidence demonstrated of evaluation of the appropriateness of the data and information utilization in relation to service provision and improvement.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

CM 14.1 Rating: A (>85% compliance with this criterion)

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

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

CM 14.2 Rating: B (66-85% compliance with this criterion)

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

- There was evidence demonstrated of fortnightly reporting of the progress of hygiene services to the Executive Management Group.
- There was evidence of hygiene key performance indicators in place.
- There was evidence demonstrated of trending of audit results in the 2007 Hygiene Services Annual Report; however there was no evidence of a systematic approach to trending and improving performance based on the results of audit findings and key performance indicators.

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.

- There was evidence demonstrated that all new policies, procedures and guidelines in relation hygiene services are available on the intranet and the hard copy of is also circulated to the clinical areas for staff to access.
- There was evidence through documentation review that for some policies staff have been signed off by staff as they read and understood these.
- It was demonstrated that policies are reviewed through the audit process.
- There was no evidence of evaluation of the efficacy of processes used to develop best practice guidelines.

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.

- There was evidence demonstrated that the Hospital management Group function as the Procurement Committee.
- There was evidence through the minutes of the hygiene Team Meetings that interventions are reviewed prior to and after their introduction.
- There was no evidence demonstrated of evaluation of the efficacy of the assessment process.
- There was no evidence demonstrated of a documented process in place for assessing new Hygiene Services interventions.

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.

- There was evidence demonstrated of Health promotion provided by the organisation in relation to hygiene services. This was demonstrated through Infection Control and hygiene activities. There was evidence of patient information leaflets available through out the organisation.
- There was a lack of evidence presented of a health promotion plan in place.
- There was a lack of evidence demonstrated of evaluation of health promotion.

INTEGRATING AND COORDINATING HYGIENE SERVICES

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

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

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

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

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

- The majority of the cleaning equipment viewed was clean.
- There was evidence of a central store area to manage cleaning equipment. This room was not designed in line with best practice.
- Cleaning products were observed located in this storage room and the door was observed to be unlocked.
- There was also a lack of storage space observed for cleaning equipment through out the hospital.
- The areas that were provided were observed to be suboptimal and multipurpose.

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

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

- There was no evidence of waste stored at ward level.
- It was observed that routine collection of clinical and non-clinical waste is in place.
- The recycling project was demonstrated.
- There was evidence of C1 forms and destruction records in place and these were demonstrated. Records of waste tag retention were demonstrated. Safety Data sheets were also demonstrated.

- Segregation of waste at the compounds compound was in line with best practice. The policies for segregation of clinical and non clinical waste were demonstrated.
- It was observed that the waste compound facility did not meet best practice due to a leak in the roof. There was also no hand washing facility observed in this area. Spill kits had been introduced in 2008. Gates of the hospital were opened until 5pm; however, access to the waste compound was locked. There was evidence that the hospital management team demonstrated that an option appraisal for resolution of this problem was completed by finance, however, this is currently not completed.

***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.

- There was evidence demonstrated at clinical level of colour coding for segregation of linen.
- A small central linen for storage of clean linen was observed.
- The standard of linen observed was in line with best practice.
- Curtain laundering policy and documentation were demonstrated.
- The wrapped linen is collected by healthcare assistants on trolleys and stored on ward corridors due to space limitations.
- The collection, transportation and storage of linen and collection at ward level had been reviewed by the hospital in 2008.
- The contractor bins containing soiled linen were observed stored out of doors at all times.

***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 Strategy for the control of Antimicrobial Resistance in Ireland (SARI) guidelines.

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

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

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

- There was evidence of the introduction of the Aspergillus policy as Identified in the Hygiene Services report for 2007.
- There evidence demonstrated of risk management polices, procedures and incident reporting in place.
- There was evidence demonstrated of risk, health and safety management reports completed quarterly and annually.
- There was evidence demonstrated of informal processes in place to respond to risks identified, however there was insufficient evidence of documented follow up and reporting of risks.

SD 4.9 Rating: B (66-85% compliance with this criterion)

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

- There was evidence demonstrated of hygiene patient satisfaction completed in 2008 and it was demonstrated that this process is ongoing, there was evidence of some outcomes demonstrated, however there was no evidence demonstrated of a consistent approach to the introduction of these recommendations.

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.

- There was evidence demonstrated of a confidentiality policy in place. It was advised that non compliance by staff with this policy is dealt with through the organisations disciplinary policy. This process was not demonstrated.
- The organisation demonstrated that all staff members sign a confidentiality agreement when commencing employment. There was no evidence of breach of patient confidentiality.
- There was insufficient evidenced demonstrated of evaluation.

SD 5.2 Rating: C (41-65% compliance with this criterion)

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

- There was evidence demonstrated of hand hygiene notices and information leaflets available to patients.
- All patients advised that they were satisfied with the information provided by the hospital in relation to Hygiene Services.
- A hygiene satisfaction survey was completed in 2008, there is no question specifically relating to the patients/client, family and visitor comprehension of and satisfaction with the information provided by the Hygiene Services team.

SD 5.3 Rating: A (>85% compliance with this criterion)

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

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

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1 Rating: B (66-85% compliance with this criterion)

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

- There was evidence that there is a service user on the Hygiene Services Team. There was evidence that patients are involved in evaluating the hygiene services through the hygiene satisfaction surveys.
- There was some evidence demonstrated of changes to the hygiene services based recommendations from the surveys, however the process was not demonstrated as formalised.

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

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

- There was evidence demonstrated of a number of key performance indicators in place for hygiene services. There was some evidence in place that these are reported on quarterly.
- The organisation demonstrated the ongoing environmental and infection control audits. There was a lack of evidence that continuous quality improvement processes are introduced based on the audit findings.

SD 6.3 Rating: B (66-85% compliance with this criterion)

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

- There was evidence of a 2007 Hygiene Services Annual Report in place.

- There was evidence demonstrated that the Hygiene Services Annual Report is endorsed by the senior management team and Hospital Council and there was evidence that this was forwarded to all clinical areas.
- There was a lack of evidence of a documented process for the development of the hygiene services Annual Report.
- There was no evidence demonstrated of evaluation of the appropriateness of the Hygiene Services Annual Report.

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

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