

National Hygiene Services Quality Review 2008

Connolly Hospital, Blanchardstown

Assessment Report

Date of assessment: 29th 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 were being implemented in the areas observed.

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

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

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

Table 1: Compliance Rating Score

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

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

2 Hospital findings

2.1 Connolly Hospital, Blanchardstown - Organisational Profile¹

Connolly Hospital, Blanchardstown (CHB) is a major teaching hospital providing a wide range of services to a population of 290,000. The hospital's catchment area extends into west Dublin, Meath and Kildare. Emergency services are provided 24 hours a day, 365 days a year.

The hospital was founded in 1955 in response to the rise in the incidence of tuberculosis. In the early 1960s the introduction of effective antibiotics revolutionised the treatment of tuberculosis and there was no need for the hospital to continue in its original role. By this stage however, there was increasing urban development in the area around the hospital and it became a General Hospital in 1973. By the early 1980s, the increasing population of the catchment area, and pressures on other hospitals, resulted in its integration into the emergency department service for north Dublin.

2.2 Areas Visited

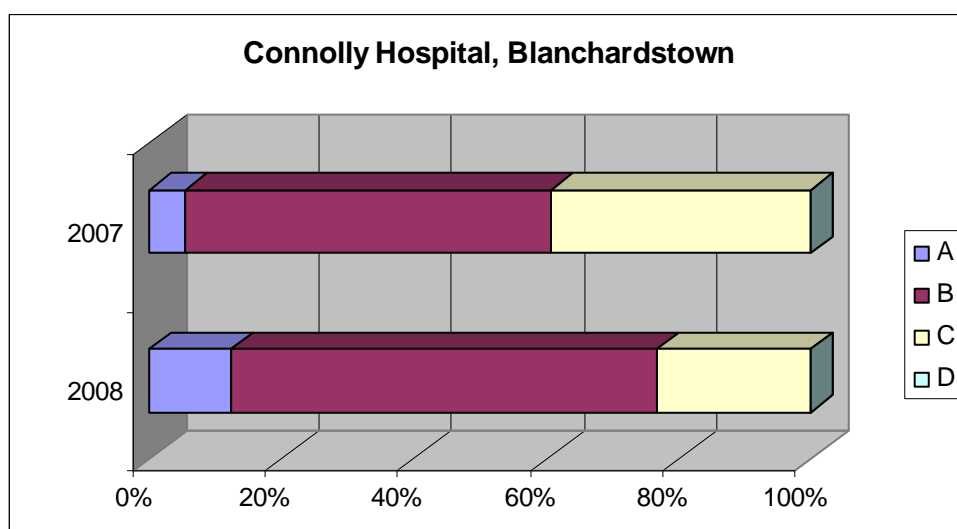
During the course of the assessment the following areas were visited:

- Emergency department
- Outpatient department
- Cypress ward
- Laurel ward
- Pine ward
- Redwood ward
- Laundry service
- 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.



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.

Connolly Hospital, Blanchardstown 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: C (41-65% 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 identified their needs through a strengths weaknesses opportunities threats (SWOT) analysis/brainstorming session undertaken by the hygiene standards group. They also used the National Hygiene Assessment report 2007 to identify their needs.
- It was advised that this information was used to inform their Corporate Hygiene Strategic Plan.
- No evidence was demonstrated of consultation with patients in relation to the process.
- There was no evidence demonstrated of evaluation of the needs assessment process.

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 of monthly meetings between the Health Service Executive (HSE) network manager and the Hospital Executive Team with evidence of hygiene related costs being discussed.
- The hospital identified that they were a part of a local implementation team encompassing the hospital and Primary Continuing and Community Care (PCCC) for North Dublin and evidence was demonstrated of infection control issues being discussed here.

- There was evidence demonstrated that the hospital has run a community health fair which was advertised in the local papers. This involved information stands which included hygiene related ones.
- It was also demonstrated that there had been a staff fair and there is a “News and Views” Newsletter that includes articles on hand hygiene and skin care.
- Patient and staff satisfaction surveys were conducted in 2007 but not in 2008.
- There was no evidence of evaluation of the efficacy of the linkages with partnerships.

CORPORATE PLANNING FOR HYGIENE SERVICES

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

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

- It was identified that the Hygiene Standards Group developed the Hygiene Strategic Plan. Group input was multidisciplinary. No documented process around this was demonstrated.
- It was demonstrated that goals and objectives are set out in the strategic plan but no costings are included.
- It was identified that executive management team involvement was through common membership of the hygiene standards group.
- No evidence was demonstrated of patient input.
- It was identified that the strategic plan was circulated through all heads of department
- There was no evidence demonstrated of evaluation of plans against defined needs.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.1 Rating: C (41-65% compliance with this criterion)

The Governing Body and its Executive Management Team have responsibility for the overall management and implementation of the Hygiene Service in line with corporate policies and procedures, current legislation, evidence based best practice and research.

- The position of the hygiene standards group within the hospital committee structure was demonstrated.
- It was identified that the executive management team does not receive minutes of hygiene standards group meetings, but it was identified that information is provided informally by the co-chairs of the hygiene standards group (minutes of April 2008 confirm update to the executive management team by the co-chairs)
- It was identified that the hospital adheres to the Code of Corporate Ethics provided by the HSE.

- Evidence was demonstrated of money spent on upgrading areas including wash hand-basins within the hospital to meet Strategy for the control of Antimicrobial Resistance in Ireland (SARI) guidelines.
- No evidence was demonstrated of the appropriateness of the review of authority provisions in the hygiene services area.

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 was demonstrated from minutes of meetings of the co-chairs of the hygiene standards group presenting/updating the executive management team on hygiene related information.
- No formalised suite of performance indicators was demonstrated.
- Evidence was demonstrated of household, catering and waste services doing regular audits.
- It was identified that the chair of the hygiene standards group was made aware of the audits but there was no evidence that the results were being reported formally to the hygiene standards group or upwards to the executive management team.

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

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

- The organisation advised the assessors that the hospital has two libraries on site, that there is access to the internet and intranet and that access is available to the HSE intranet where policies and guidelines are available.
- It was identified that the Infection Control Team takes regular slots on grand rounds throughout the year to update staff on infection control issues but documented evidence of this was not demonstrated.
- A dress code policy based on best practice was demonstrated but there was no evidence demonstrated that this policy had been signed off by management.
- No evidence of evaluation of the appropriateness of Hygiene Services related research and best practice information available was demonstrated.

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

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

- A policy for the development of policies, procedures and guidelines was demonstrated dated 1/11/07.

- It was identified that the hospital has a policy and guideline committee and terms of reference were observed along with minutes of meetings.
- It was identified that all policies are notified to the quality and risk department where a manual document management system is in place to identify those needing review.
- It was identified that an electronic document management system is in place within the laboratory.
- While it was reported that evaluation had taken place no evidence of this was demonstrated.

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

- It was identified that the linkage between the hygiene standards group and the project steering group is through common membership.
- It was identified that the hygiene standards group had prepared a brief for the project steering group relating to hygiene services for the new surgical block but this was not demonstrated.
- Evidence was demonstrated of communications between the quality and risk department and clinical indemnity scheme, and also a member of the infection control team and a member of the executive management team regarding this development.
- Minutes of meetings between hospital management and the design team regarding Strategy for the control of Antimicrobial Resistance in Ireland (SARI) guidelines were demonstrated.
- As a result of issues identified a decision was made to have a microbiologist sit on the project steering group.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

***Core Criterion**

CM 5.1 Rating: C (41-65% compliance with this criterion)

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

- The hygiene services structure was demonstrated through the Corporate Hygiene Services Structure algorithm. It was not clearly defined what the reporting lines, roles and authorities were particularly in relation to key personnel and committees.
- Evidence was demonstrated of the hygiene standards group reporting through the risk manager to the general manager, with no direct reporting to the executive management team.

- It was demonstrated that the terms of reference for the Executive Management Team sets out roles of members and hygiene was not specifically covered in this.
- At ward level it was demonstrated that the job description of the Clinical Nurse Manager 2 includes responsibility for hygiene.

***Core Criterion**

CM 5.2 Rating: B (66-85% compliance with this criterion)

The organisation has a multidisciplinary Hygiene Services Committee.

- Evidence was demonstrated that the hygiene standards group was multidisciplinary.
- It was demonstrated that roles were set out in the terms of reference.
- It was identified that dedicated administrative support was not available to the team with a system in place whereby minutes were taken on rotation by team members.
- It was demonstrated that the team met monthly – sub-division of the group into a committee and team led to some lack of clarity which was being addressed with the re-alignment into a group since October.

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.

- Evidence was demonstrated that there is an Expenditure and Procurement Committee which is responsible for the minor capital budget.
- It was advised that decisions were made around value for money and risk however no evidence was demonstrated.
- Business cases are made and templates used were demonstrated.
- Evidence was demonstrated of allocations for kitchen upgrades and Strategy for the control of Antimicrobial Resistance in Ireland (SARI) upgrades.
- It was advised that no service plan had been requested by the HSE and funding had been provided on the basis of previous years' activity.
- Evidence was demonstrated that a case had been made for a hygiene co-ordinator but this had not been approved.

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

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

- Terms of Reference for the hygiene standards group were demonstrated and these do not cover involvement in the purchasing process.
- It was advised that the process of purchasing of equipment and products is conducted through the Expenditure and Procurement Committee. Infection Control sits on this committee
- It was demonstrated that the local procurement procedures 2007 require that there be input from health and safety, infection control and risk management in the purchasing process.
- No evidence of evaluation of the efficacy of the consultation process between the hygiene standards group and senior management was demonstrated.

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

- A policy for the reporting of accidents, incidents and near misses was demonstrated.
- It was demonstrated that the hospital uses the STARSweb incident reporting system and reports generated were observed.
- Evidence was demonstrated that these reports go to heads of all departments quarterly.
- It was identified that hygiene audits are undertaken annually.
- No evidence was demonstrated of hygiene related complaints or incidents being considered by the hygiene standards 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.

- Evidence was demonstrated that the risk management department had lost positions for a clinical risk co-coordinator, an audit co-coordinator, a risk manager and a secretary. An acting risk manager is in position.
- It was identified that business cases have been made for replacements but none have been approved.
- It was identified that the post of hygiene co-coordinator has not been approved.

- It was demonstrated that the hospital has an integrated safety and quality committee and hygiene is represented on this. There is also common membership between this committee and the hygiene standards group.

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.

- Evidence was demonstrated that the majority of the hospitals contracts are negotiated nationally or regionally through a central contracts department based in Cherry Orchard.
- It was demonstrated that the contract for the contract cleaning company was out of date at the time of assessment however a roll over process was in place.
- Professional liability was not demonstrated in the absence of an in date contract.

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

The organisation involves contracted services in its quality improvement activities.

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

PHYSICAL ENVIRONMENT, FACILITIES AND RESOURCES

CM 9.1 Rating: A (>85% compliance with this criterion)

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

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

*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: 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 was demonstrated that hygiene audits are undertaken yearly.
- Waste, linen and kitchen audits are undertaken separately by the respective heads of department.
- No evidence was demonstrated that results of audits feed into the hygiene standards group.
- Evidence was demonstrated of progress notes in relation to issues identified through audits and the assessors were informed that these are brought to the co-chairs of the hygiene standards committee but no minutes confirmed this.

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.

- Evidence of patient and staff satisfaction surveys for 2007 were demonstrated with review in 2008.
- It was identified that as a result of this the need for a preventative maintenance programme was established and this is currently being progressed.
- Evidence was demonstrated of two hygiene related complaints for the previous year with resultant actions.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

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

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

- Evidence was demonstrated that the hospital follows the HSE code of practice in relation to recruitment.
- Evidence was demonstrated of the process for requesting of the filling of a post.
- Evidence was demonstrated that the contract cleaner provided induction and training.
- It was identified that internal recruitment was being audited through the North East network but no evidence was demonstrated of this.

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 hospital demonstrated a method of needs assessment dated 29/10/08 (date of the hygiene assessment).
- Evidence was demonstrated that a needs assessment associated with the expansion of the hospital identified staff shortages and these were addressed by contract services.
- Evidence was also demonstrated that the allocation of resources in February 2007 prioritised staff allocation.
- There was no evidence of evaluation of the appropriateness of work capacity and volume review processes.

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.

- Evidence was demonstrated that the hospital ensures hygiene staff have the appropriate qualifications through the development of job descriptions for in-house staff, and ensuring that contract staff have the appropriate induction and training.
- The hospital demonstrated evidence that they supported ongoing education and training through a skills project for up-skilling of support staff and Further Education and Training Awards Council (FETAC) level 5.
- It was identified that the hospital currently record attendance at induction and training and are in the process of introducing an IT HR training programme to facilitate enhanced monitoring.

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

There is evidence that the contractors manage contract staff effectively.

- The hospital demonstrated that they have a written reporting process in place for agency staff.
- The hospital demonstrated that it has in place a process to monitor contractors by ensuring that they sign in when coming on site.
- While the contract cleaner's contract was demonstrated to be out of date this was being rolled over while awaiting renegotiation.
- Evidence was demonstrated that the contractor is required to provide for the occupational health needs of contract staff and provide induction and training.
- There was no evidence of evaluation demonstrated.

***Core Criterion**

CM 10.5

Rating: B (66-85% 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.

- Evidence was demonstrated of a needs assessment process dated 29/10/08 and of a document dated 21/5/08 identifying service requirements to be met through contract staff relating to the hospital expansion.
- There was evidence that Human Resource requirements are identified in the corporate strategic plan.
- The annual report did not demonstrate that it addresses staff needs.

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

- Evidence was demonstrated of the hospitals induction programme including agenda and records of attendance.
- It was identified that there is a database recording ongoing training this was not demonstrated.
- Attendance levels were not demonstrated with the exception of Non Consultant Hospital Doctors (NCHDs)
- Evidence was demonstrated that staff induction includes information on hand washing, waste and sharps management.
- Evidence was demonstrated that evaluation sheets are completed following training but there was no evidence of collating of these.
- A HSE staff handbook along with a local handout relevant to the hospital was demonstrated.

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.

- Evidence was demonstrated that NCHD induction along with training required by legislation is mandatory.
- The hospital has run a course on undertaking risk assessments for heads of departments and evidence was demonstrated of forty attendees at this.
- It was advised that time for attending training is facilitated if at all possible.
- There was evidence demonstrated that education is facilitated through the nurse practice development unit and clinical placement co-coordinators.

- Evidence was also demonstrated of the hospital supporting SKILLS training and FETAC along with a back to education programme with Blanchardstown Vocational Educational Committee.
- No evidence of evaluation of the relevance of education to staff members was demonstrated.

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

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

- The hospital did not demonstrate evidence of a formal suite of performance indicators for education and training.
- It was advised that the numbers of sharps injuries are used as an indicator of effectiveness in this area but no evidence was demonstrated.
- Evidence was demonstrated of evaluation sheets being completed post training but these were not collated.
- While evidence was demonstrated that the numbers attending training are recorded no evidence was observed that attendance levels were being monitored.

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.

- Evidence was demonstrated that in-house health care attendants undergo a performance evaluation as part of their increment process but there is no formal performance evaluation for any other grade of hygiene service staff.
- The organisation advised the assessors that staff are evaluated indirectly through the hygiene audit process and through the disciplinary route.

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

- Evidence was demonstrated that the occupational health service is based on site with two Whole Time Equivalent (WTE) occupational health nurses, 0.5 WTE nurse, 1.5 WTE occupational health physicians and a secretary.
- It was advised that the service is shared with the Dublin – North East area.
- Evidence was demonstrated of a full range of occupational health services being provided.
- It was demonstrated that a staff satisfaction survey was undertaken on 13/5/08.
- Evidence was demonstrated that this had been collated but there was no evidence of changes as a result.

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

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

- The hospital provided evidence of staff turnover of 10% and an absenteeism rate of 4.7 - 4.9%
- An integrated management report is produced monthly for the network manager
- Evidence was demonstrated that the hospital has set up a partnership committee and has allocated funding to support cultural diversity and interpretive services.
- A staff satisfaction survey has been completed. This has been collated but no evidence of evaluation was demonstrated.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

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

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

- The hospital demonstrated that they had developed an Information Communication Technology (ICT) strategy in 2003. The nursing department uses an IT audit tool and statistical package while the lab use a separate IT system.
- It was advised that a business case has been made to extend the laboratory system but no decision has been taken as yet.
- Hygiene audits are undertaken but there was no evidence demonstrated that the results are discussed at the hygiene standards group.
- Evidence was demonstrated of hygiene updates being submitted to the integrated quality and safety committee in April, May, June and July 2008.
- No evidence was demonstrated of any evaluation of the usefulness or processes of data collection

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.

- A programme of hygiene audits was demonstrated but there was no evidence demonstrated of these being considered at the hygiene standards committee.
- Evidence was demonstrated of submissions and presentations to the executive management team and separately submissions to the integrated quality and risk committee.

- No evidence of evaluation was demonstrated

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

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

- The hospital demonstrated that it has an IT based data collection system but identified a number of deficiencies in this system and upgraded it one year ago.
- The organisation advised the assessors that alterations were being considered including expanding the availability of a document management system within the hospital.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

CM 14.1 Rating: B (66-85% 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

- It was demonstrated that the hospital has initiated a programme of hygiene audits along with education and training for staff.
- Evidence was demonstrated that members of the executive management team are involved in these.
- It was identified that following the division of roles of catering and cleaning the hospital won a "Better service, best improvement" award for the catering department in 2007.
- Evidence was demonstrated of a patient information booklet being produced which includes a section on hygiene.

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 of many quality improvement initiatives undertaken during 2007-2008.
- It was demonstrated that a staff communication folder was in place.
- An internal hygiene audit programme is in place.
- No evidence was demonstrated of performance indicators in use.
- There was no evidence demonstrated of evaluation.

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.

- A policy for the development of policies procedures and guidelines (PPGs) was demonstrated. This was developed by the Policy and Guidelines Committee.
- All Infection Prevention and Control policies, procedures and guidelines were observed to follow this template and were available on the Intranet.
- It was identified that the template has recently been revised.
- Policies observed showed evidence that national and international best practice was considered with relevant references included.
- There was evidence that colour coding was in use in relation to linen management and cleaning.
- No evidence of evaluation of their efficacy of the processes used to develop best practice guidelines was demonstrated.

SD 1.2 Rating: C (41-65% compliance with this criterion)

There is a process for assessing new Hygiene Services interventions and changes to existing ones before their routine use in line with national policies

- There was evidence of informal assessment/evaluation processes for new hygiene interventions prior to roll out across the hospital e.g. the flat mopping system
- No formal documented process for assessing new hygiene interventions was demonstrated.

PREVENTION AND HEALTH PROMOTION

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

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

- Evidence was demonstrated that the hospital had held hand hygiene awareness days along with a "Health Fair" – a health promotion day including hygiene related issues that was open to the public and was advertised in local newspapers.
- Evidence was demonstrated of newsletters used to promote health among staff and community and there was evidence demonstrated of information leaflets for the public and patients around the hospital.
- There was no evidence of evaluation

INTEGRATING AND COORDINATING HYGIENE SERVICES

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

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

- Evidence was demonstrated through terms of reference and attendance at meetings that the hygiene standards group was multidisciplinary in nature.
- The organisational structure was demonstrated and sets out where the hygiene standards group sits within the hospital structure while terms of reference for the group define roles.
- No evidence of evaluation of the team or structure was demonstrated.

IMPLEMENTING HYGIENE SERVICES

***Core Criterion**

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

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

- Areas visited were generally clean
- Dust was noted in all areas visited.

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

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

- Overall ward kitchen areas visited were clean and managed in accordance with best practice.
- In one area staff were noted not to be wearing Personal Protective Equipment (PPE)
- In two areas the fridge temperature recording was above recommended levels

***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.

- In general the management of hazardous materials and waste was in line with best practice
- Bins were noted to be overflowing in some areas
- Clinical waste, including a sharp was noted in household waste in one area.
- One of the Health Care Assistants moving waste was noted not to be wearing PPE's.

***Core Criterion**

SD 4.6 Rating: B (66-85% compliance with this criterion)

The team ensures the Organisation's linen supply and soft furnishings are managed and maintained

- In general the management of linen was in line with best practice
- It was identified that over the period of the long weekend the hospital had run out of red laundry bags and on the day of the assessment white bags were being used in contravention of the policy.

***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.

- The hospital demonstrated that they had a risk management policy in place and that the process was operating at ward/departmental level.
- There is an incident reporting system and evidence was demonstrated of training in the risk management process.
- It was demonstrated that infection control policies procedures and guidelines are in place and safety statements were demonstrated dated 2008.
- Monthly Healthcare Associated Infections reports are circulated.
- No evidence of action following incidents identified was demonstrated

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

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

- Evidence was demonstrated of posters and information leaflets informing patients and the public about hygiene related issues.
- Evidence was demonstrated of a visitors policy in place
- There was evidence that a patient satisfaction survey has been conducted.

- A patient information booklet was demonstrated and is currently with the printers
- It was identified that satisfaction is monitored through the complaints process.

PATIENT'S/CLIENT'S RIGHTS

SD 5.1 Rating: B (66-85% compliance with this criterion)

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

- The hospital demonstrated a hygiene mission statement and have considered patient confidentiality in relation to patient isolation signage.
- It was observed that patient information leaflets are available and there is an implementation plan for a patient council with terms of reference.
- It was advised that the hospitals work practices are in accordance with the Dignity at Work Policy and the Trust in Care Policy and these are covered in Human Resources induction.
- It was identified that no violations were recorded

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.

- A patient information booklet is currently with the printers and a draft was demonstrated.
- Liquid Crystal Display (LCD) screens, talking posters and information leaflets were observed to inform patients and the public re hygiene issues.
- The hospital demonstrated that they had run a "community fair" for members of the public in relation to hygiene issues.
- A patient satisfaction survey was not demonstrated
- No evidence of evaluation was demonstrated

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

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

- The hospital demonstrated that they used the HSE "Your Service Your Say" complaints policy.
- Evidence was demonstrated that complaints are reviewed and presented to the hygiene service team.
- No evaluation of the complaints process was demonstrated.

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.

- The hospital demonstrated that it involved patients and families in the evaluation of the hygiene service through the use of satisfaction surveys, their complaints policy and involving contractors in undertaking audits.
- The organisation advised the assessors that the development of a patient council is nearing completion but no evidence was demonstrated.
- Changes as a result of patient/service user involvement and National Hygiene Reviews include upgrading of kitchens, provision of splashbacks behind wash-hand basins, provision of information via LCD screens.
- No evaluation of the extent to which patients, families and other organisations are involved by the team when evaluating hygiene services has taken place.

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

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

- The hospital demonstrated that there is an internal hygiene audit programme in place along with weekly hand hygiene audits
- There was evidence that MRSA audits are conducted weekly in the Intensive Care Unit and *Clostridium difficile* audits as required
- It was identified that waste audits are undertaken
- There was no evidence demonstrated of evaluation

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

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

- While no documented process for the compilation of the Annual Report was demonstrated the hospital has produced an Annual Report
- It was advised that it is circulated to key stakeholders.

Appendix A: Ratings Details

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

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

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