

National Hygiene Services Quality Review 2008

Kerry General Hospital Assessment Report

Assessment date: 2nd 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 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 Kerry General Hospital- Organisational Profile¹

Kerry General Hospital is the second largest of the Health Service Executive – South's seven acute hospitals. The hospital provides acute general hospital services to the population of Co. Kerry (139,616) and additionally to a proportion of the populations of West Limerick and North Cork.

The hospital has 273 acute general beds; 50 Acute Psychiatric beds. 46-bed elderly continuing care beds and an Annual Budget of approximately €70m. The hospital treats over 20,000 inpatients per annum and approximately 41,000 patients attend the Outpatients Department. Accident & Emergency Department attendances are approximately 34,346 annually.

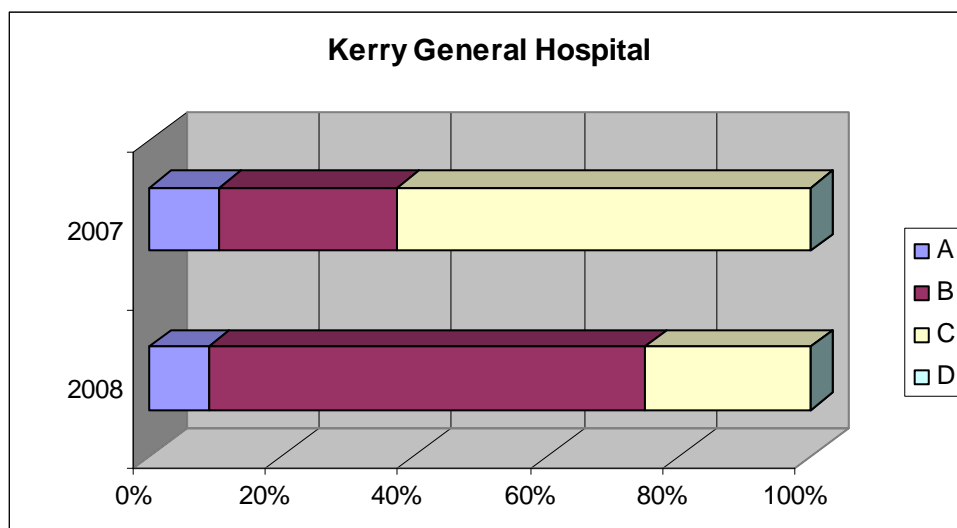
2.2 Areas Visited

- Outpatient department
- Emergency department
- Clonfert ward
- Muckross ward
- Rathass ward
- Loher ward
- Waste compound
- Laundry services.

¹The 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.

Kerry General 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 of a needs assessment completed for Hygiene Services. This has resulted in the development of the Hygiene Service and Operational Plans for 2008 which highlighted needs, in particular, the need for additional staffing shifts in Hygiene Services.
- Details of legislation and best practice and national guidelines were demonstrated, for example the need to introduce colour coding in the kitchen.
- The documented process for the development of a needs assessment was demonstrated to be in draft format.
- Evaluation of the efficacy of the needs assessment process was not demonstrated.

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

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

- There was evidence that the hospital has implemented developments and modifications within the last 12 months for hygiene services, and these were highlighted in the Hygiene Services Annual Report for 2007.
- There was some evidence of evaluation in relation to these initiatives noted in the documentation. This included the evaluation of extra hours, cleaning products and hygiene equipment.
- A formalised process of evaluation 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.

It was demonstrated that Hygiene Services is a standard agenda item on the Executive Management Board meetings. Minutes were demonstrated in this regard.

- It was advised that a member of the Management Team liaises with the Network Manager in relation to hygiene services. This was not demonstrated.
- Written correspondence to the National Hospital Office in relation to hygiene services was demonstrated.
- There was evidence demonstrated through minutes of meetings that a regional Infection Control Committee was in place, which supports the Hygiene Services and Infection Control function of the hospital.
- There was evidence that the hospital links in partnership with its patients as evidenced through the patient satisfaction survey. Results from inpatient/and outpatient hygiene surveys demonstrated improvements.
- A patient representative had been identified for the Hygiene Services Committee; however, there was no evidence to demonstrate that the representative had attended the meetings.
- There was no evidence demonstrated of evaluation of the linkages in place.

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 demonstrated of a Corporate Strategic Plan in place, dated 2007 to 2010.
- The Hygiene Service Plan 2008 was signed off in April 2008 by the Executive Management Board. A documented process for its development was demonstrated.
- There was some evidence demonstrated that the goals and objectives as set out in this Strategic Plan are tracked via the hospitals Hygiene Service Plan.
- It was demonstrated that the Service Plan is revised annually. Costings for Hygiene Services are identified on the Hygiene priority list. These were demonstrated. A minor capital update list was also demonstrated.
- There was no evidence demonstrated of patient's involvement in the development of the Strategic Plan.

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.

- The organisational structure for hygiene services was demonstrated.
- The code of corporate ethics for hygiene services was also demonstrated.
- There was evidence through documentation review that policies and procedures are in place in relation to the governing body and many of these have been updated. These included the "Professional Appearance" policy.
- There was evidence that the Irish Acute Hospitals Cleaning Manual has been adapted by the Executive Management Board.
- There was evidence demonstrated that results of hygiene Management Audits which were completed every two months.
- It was demonstrated that hygiene was discussed at the Executive Management Board meetings.
- There was no evidence of evaluation of the appropriateness of the responsibility for hygiene services.

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 there have been eleven key performance indicators identified for Hygiene Services in 2008.
- These include hygiene training, infection incidents and results of hygiene audits. There was evidence demonstrated of one PowerPoint presentation in relation to these indicators to the Executive Management Board.
- It was demonstrated that an evaluation of the appropriateness of the information received by the Executive Management Board has been undertaken and this information has been modified.
- There was no evidence of trending of this information as this process has recently been developed.

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 that the Journal of Hospital Infection is circulated to the Hygiene Services Committee and Hygiene Services Team for review prior to distribution.

- The Library Skills training update records were demonstrated.
- It was demonstrated that a Hygiene Newsletter was circulated quarterly by the Hygiene Services Co-coordinator. Hygiene was a standing agenda item at the Executive Management Board meetings.
- There was documentary evidence of updated laundry and draft Methicillin resistant *Staphylococcus aureus* (MRSA) guidelines in 2008.
- There was a lack of evidence demonstrated that the organisation had evaluated the appropriateness of hygiene services related best practice and information.

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

- There was evidence to demonstrate that the infection control manual dated 2005 is currently being updated.
- The hospital demonstrated that it is working with the Infection Control Committee from a regional perspective in developing policies, procedure and guidelines.
- A policy was demonstrated on "Professional Appearance for Clinical Staff" and included the circulation sign off sheet which demonstrated as read by staff following introduction of the policy.
- The process for policy procedure and guidelines establishment and review was demonstrated to be inherent in each policy.
- The organisation advised that evaluation of the efficacy of the process for developing and maintaining hygiene services policy procedure and guidelines occurred, however this was not 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

- There was evidence demonstrated through the central sterile supply department and operating theatre projects of the Hygiene Services Committee involvement in capital planning.
- These were evidenced demonstrated through the Hygiene Services Committee meetings and individual capital development teams that members of the hygiene services were represented.
- There was however, no evidence demonstrated of a documented process in place for consulting with the Hygiene Services pre development of existing sites.
- There was also no evidence demonstrated of evaluation of the efficacy of the consultation process between the Hygiene Services team and senior management.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

***Core Criterion**

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

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

- Details of the hygiene services' structure were demonstrated, and roles and responsibilities were outlined. These were observed in the roles/job descriptions of the governing body which were demonstrated.
- It was demonstrated that there is medical representation on the Hygiene Services Committee.
- There was insufficient evidence demonstrated within the documented organisational structure presented of where Hygiene Services Committees/Team reporting structures were in relation to other committees in the organisation.

***Core Criterion**

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

The organisation has a multi-disciplinary Hygiene Services Committee.

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

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

***Core Criterion**

CM 6.1 Rating: A (>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 demonstrated compliance of greater than 85% with the requirements of this criterion.

CM 6.2 Rating: A (>85% compliance with this criterion)

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

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

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 of risk management process in place. It was advised by the organisation that there were no adverse events in hygiene Services for the past two years.
- It was advised by the organisation that there has been no Risk Manager in the hospital since January 2008, although the hospital has access to a Regional Risk Manager.
- There was evidence provided in the Hygiene Services Committee minutes of risks being documented and discussed.
- The organisation demonstrated that they have introduced a needle free system as per the report by the occupational health department at the hospital which was demonstrated. There was no evidence of a risk management Annual Report for hygiene services demonstrated by the organisation.
- There was no evidence of root cause analysis being undertaken in relation to hygiene services in the organisation.

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.

- It was advised by the organisation that in the absence of a hospital wide Risk Manager, the responsibility for risk management has been devolved to Department Heads.
- There was evidence that the hospital has access to a Regional Risk Manager.
- It was advised and through the minutes of the Hygiene Services Committee meetings that risks identified are reviewed informally and some corrective action has been taken, however this was not demonstrated as a formalised process.
- There was no evidence demonstrated of overall responsibility for risk management in the absence of the regional Risk Manager.

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.

- The organisation demonstrated that contracts are established at a regional level.
- There is extensive evidence of ongoing communication with the cleaning contractor in relation to the contract and this contract was demonstrated.
- Minutes of monthly meetings with the cleaning contractor were evidenced, which demonstrated monitoring and managing of the contract.
- The contract for the shop (dated May 2004) was demonstrated and included employers' and product liability. This contract is managed on an informal basis and one record was demonstrated of communication from a member of the Management team to the shop contractors in 2007.
- There was no evidence demonstrated of a documented process for the monitoring and managing of contracts.

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 through minutes of meetings with the cleaning contract that they are involved in quality improvement initiative, in particular through membership of the Hygiene Services Committee.
- There was no evidence of a systematic approach to involve all other contracted services in its quality improvement activities.

PHYSICAL ENVIRONMENT, FACILITIES AND RESOURCES

CM 9.1 Rating: B (66-85% 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.

- There was evidence demonstrated of the plan for the painting update for the organisation and this was demonstrated.
- Evidence was presented of the work completed to date in 2008 and a list of work outstanding was also demonstrated.
- It was demonstrated that the opportunities for improvement in the catering area were addressed as per the National Hygiene Services Quality Review report of 2007.

- The update plan in relation to the sink replacement was demonstrated as part of the minutes for the Executive Management Team.
- The organisation advised that there were no wash hand basins replaced in 2008 due to a lack of funding.

***Core Criterion**

CM 9.2 Rating: B (66-85% compliance with this criterion)

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

- There was extensive evidence of upgrading of the main catering area as a result of the hygiene services National Hygiene Services Quality Review report for 2007.
- The colour coding policy for the kitchens was introduced in 2008 and was demonstrated.
- The organisation demonstrated that they have reviewed their visiting policy; which was dated 29/09/08 and it was demonstrated that this is awaiting sign off.

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 demonstrated that environmental audits were completed in June 2007, August and September 2008.
- The organisation demonstrated that it has evaluated the vacuum steam cleaner and this evaluation was demonstrated.
- The organisation demonstrated that the Flat Mopping System was introduced in 2008. There was evidence of an evaluation of cleaning products; which did not result in changes based on the findings.
- The process of evaluation has yet to be formalised and demonstrated.

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

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

- The minutes of the Hygiene Services Team meetings demonstrated that day to day issues on behalf of the patients are brought to the Hygiene Services Team.
- There was evidence of a catering survey completed in 2008, the findings were reviewed. There was no evidence that actions have been implemented.

- The organisation demonstrated that they have completed two patient satisfaction surveys in relation to hygiene services in 2008. The recommendations in relation to these surveys were not demonstrated.
- There was no evidence demonstrated that the organisation have consulted with the staff in relation to their satisfaction with the organisations hygiene services facilities and environment.

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.

- There was evidence demonstrated that selection and recruitment processes are based on the Health Service Executive policy/code of practice.
- It was demonstrated that recruitment is managed regionally. The job descriptions for the domestic supervisor and a cleaning operative were demonstrated. Their role includes undertaking environmental audits.
- The organisation demonstrated through the minutes of meetings that the Hygiene Services Committee has considered the need for evaluation of the processes for selecting and recruitment Human Resources; however, this was not demonstrated.

CM 10.2 Rating: B (66-85% compliance with this criterion)

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

- There was evidence demonstrated that staff are assigned by the organisation based on changes in work capacity and volume. This was demonstrated through an evaluation completed of the 15.00 to 23.00 shift and there have been two extra shifts introduced in November 2007 as a result of this.
- Evaluation of the appropriateness of work capacity and volume review processes was not demonstrated.

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

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

- The organisation demonstrated that the induction programme in the hospital was mandatory and the infection control and hygiene elements of these sessions were demonstrated. There was evidence that some progress had been made in relation to evaluation of the induction programme.
- There was evidence demonstrated that two induction sessions had been evaluated.

- Mandatory hand hygiene training was in place and was demonstrated.
- The development of the organisations prospectus for training had been established and was demonstrated, however, there was no evidence demonstrated of its implementation.

CM 10.4 Rating: B (66-85% compliance with this criterion)
There is evidence that the contractors manage contract staff effectively.

- There was evidence demonstrated that the cleaning contractor in place manages contract staff through the local audits which are completed by the contractors. Audit results were demonstrated.
- There was evidence that monthly meetings with the cleaning contractors are in place. Minutes of these meeting were demonstrated.
- Evidence was provided that the cleaning contractor is a member of the Hygiene Services Committee.
- It was demonstrated that actions from the audits completed by the contractor are discussed at this forum.
- The monitoring process in place for the management of contract cleaning staff had not been demonstrated for all contracts provided on site, for example the shop.

***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.

- The human resource needs assessment was demonstrated as part of the strategic planning process.
- The service plan also identified the needs for human resources and this was demonstrated.
- There was no evidence demonstrated of a documented formalised process for the completion of the needs assessment.
- The details of hygiene services staff cover to provide the necessary services were not demonstrated by the hospital.

ENHANCING STAFF PERFORMANCE

***Core Criterion**

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

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

- There was evidence demonstrated that induction programmes was in place for all staff, which includes infection control and hygiene services.

- There was evidence that the hospital has begun the process of evaluation as two induction sessions have been evaluated.
- The results of this feedback have yet to be analysed and the necessary recommendations implemented and demonstrated.
- The staff handbook was demonstrated; however this document does not specifically refer to hygiene.

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

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

- The organisation demonstrated that Infection control and hygiene training was currently scheduled on a month by month basis only and there was no evidence demonstrated of a schedule for hygiene training for 2008.
- Records of training for hand hygiene and waste management are held centrally by the Infection Control Department.
- It was demonstrated that there was currently no system in place to identify and flag hygiene staff who had not attended training.
- It was demonstrated that it was the responsibility of the department manager to ensure ward staff had received training.
- There was evidence that evaluation of hand hygiene and needle stick training had taken place. There was no evidence that the recommendations had been introduced.

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

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

- There was evidence demonstrated that an evaluation of hand hygiene and waste management training has taken place in March and September 2008. The recommendations arising are yet to be introduced in a formalised manner. There was evidence demonstrated however that particular issues, for example, the rigid containers with black lids for the correct disposal of metal waste have been put in place in appropriate areas which include ICU, A+E and theatre.
- It was advised that records of attendance at training sessions were communicated to department managers on an ad hoc basis, with the records maintained at ward level.
- The hospital has demonstrated that it has begun the process of developing performance indicators for training.
- The collection of data and trending of these performance indicators was not demonstrated.

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

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

- There was evidence demonstrated that team based performance management began in 2007 and the hospital was progressing in this regard. However, currently performance of contract staff is monitored through the 'walk about' completed by management and contract staff.
- There was no evidence demonstrated of a formalised approach to this aspect of monitoring and the organisation did not demonstrate evaluation of the appropriateness of performance evaluation processes.

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

- There was evidence that an Occupational Health Service was provided to staff including contracted staff.
- An evaluation of the appropriateness of the service was demonstrated.
- Changes have been made as a result of the evaluation. These changes were not demonstrated.

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

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

- A staff satisfaction survey of the occupational health service was demonstrated.
- There was evidence that a staff satisfaction survey in relation to cleaning hours has resulted in increased hours being introduced.
- There was insufficient evidence demonstrated of an evaluation of the appropriateness of mechanisms for monitoring 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 demonstrated that staff have access to the Intranet. It was demonstrated that the library provides up to date information in relation to hygiene services.

- There was evidence demonstrated that an evaluation of the newsletter has been completed with the recommendations yet to be introduced.
- There was evidence demonstrated of an Infection Control Journal in place.
- There was evidence from one report demonstrated that results of Audits, Incidents and Complaints were among the information provided to the Executive Management Team in a report.
- It was advised that this information will be formalised going forward.
- The organisation did not demonstrate evaluation of quality data reliability, accuracy and validity.

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

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

- There was evidence demonstrated that the hospital produce reports for hygiene services, these include the hygiene services annual report and minutes of hygiene meetings.
- There was no evidence demonstrated of evaluation of data and information turn around.
- There was no evidence demonstrated of evaluation of user satisfaction in relation to the reporting of data and information.

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.

- There was evidence to demonstrate that there have been a number of changes to the reporting structures in the hospital and the information presented in this regard.
- It was demonstrated that data is now presented in a more usable format to the Executive Management Team based on feedback.
- There was no evidence demonstrated that this process was formalised.

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

- There was evidence to demonstrate that the Hygiene Quality Co-ordinator presents hygiene information to the Executive Management Board each quarter.

- This information demonstrated is based on a number of hygiene objectives and some performance indicators which included individual results for infection rates, results from the Infection Control Nurses Association Audit tool and the hygiene management audit results for the months January, February and March 2008.
- There was insufficient evidence demonstrated of ongoing trending of this information.

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

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

- The organisation had demonstrated that it has begun the process of evaluation through completed hygiene management and infection control audit results, and initial monitoring against the recently established key performance indicators (KPIs).
- There were plans demonstrated for this to continue and trending of information going forward.
- There was no evidence demonstrated of a formalised approach to benchmarking.

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 of best practice guidelines in place in the hospital. The process for establishing and review of guidelines was demonstrated.
- Best practice guidelines in relation to linen management and colour coding in the kitchen have been recently established and were demonstrated.
- It was evidenced that the use of audits ensures that the implementation of these guidelines is evaluated and this was demonstrated.

- There was no evidence of evaluation of the efficacy of the process used to develop the best practice guidelines.

SD 1.2 Rating: B (66-85% 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.

- The process was demonstrated for assessing new interventions in relation to cleaning products and equipment.
- The evaluation of the efficacy of the assessment process was also demonstrated.
- There was a lack of evidence demonstrated that this is completed in a consistent formalised manner.

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.

- The hospital demonstrated that health promotion is provided in the hospital.
- Hand hygiene was also promoted through local media when restricted visiting times were communicated to the public and this was demonstrated.
- There was no evidence of evaluation of the efficacy of activities undertaken and/or participated in by the team in the community in relation to hygiene.

INTEGRATING AND COORDINATING HYGIENE SERVICES

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

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

- There was evidence through interview and documentation that hygiene services was provided by a multidisciplinary team.
- The evaluation of the structure of the Hygiene Services Team was reviewed in 2008 and this was demonstrated through minutes of meetings. Changes were made to the structure to ensure all areas were represented on the team.
- There was insufficient evidence demonstrated of a documented process to ensure awareness of each others roles and responsibilities.

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.

- There was some evidence that the organisation's physical environment is clean. However, there was evidence that high and low surfaces were generally dusty in many areas observed.
- Bed frames were also found to be dusty sticky tape residue was observed in some areas.
- There was chipped paint observed in many clinical areas. Broken lino on the stairwell was observed.
- There was evidence observed of chipped wall surfaces in some shower areas observed.
- Hand gel was not observed at some lift areas and at entrances to some ward areas. Some alcohol gel nozzles were observed to be blocked. Some signage observed was not laminated.
- The policy in relation to the changing of curtains in clinical areas was demonstrated; however not all curtains were clean.
- There was evidence observed that two of the sluice room doors were open in two clinical areas and it was observed that the bin lid in one area was broken.
- There was a cracked wash hand basins observed in the disabled toilet in Loher ward.
- There was rust observed on the pipes adjacent to one of the wash hand basins in Rathass ward.

***Core Criterion**

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

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

- There was evidence demonstrated that the organisations equipment, medical devices and cleaning devices are managed and clean in the most part, however dust was observed on many pieces of equipment.
- There was a lack of evidence demonstrated of a system in place to monitor or identify if equipment was cleaned.

***Core Criterion**

SD 4.3 Rating: C (41-65% compliance with this criterion)

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

- In the main the cleaning equipment was clean, however, storage areas visited in some areas were observed to be cluttered; and there were no wash hand basins observed in some of the cleaning store rooms visited.
- Cleaning products were observed in rooms which were not locked. Personal Protective Equipment was not observed being worn in all of the areas visited.

***Core Criterion**

SD 4.4 Rating: C (41-65% 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.

- There was evidence that issues highlighted in the National Hygiene Services Quality Review 2007 in the main kitchen were addressed.
- However, it was not demonstrated that all ward kitchens are managed and maintained at all times in accordance with evidence based best practice and current legislation.
- It was observed that the kitchen safety policies were not presented in the kitchens of any of the clinical areas visited.
- Access was not restricted in some ward kitchens for example, a door lock was broken on the kitchen in Muckross Ward and in Loher Ward it was observed that the door to the kitchen was open, however a "restricted access" notice was displayed.
- The fridge in Muckross ward was being utilised as a staff fridge as a lunch box was observed.
- There was no evidence of Personal Protective Equipment observed available in ward kitchens.

***Core Criterion**

SD 4.5 Rating: A (>85% compliance with this criterion)

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

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

***Core Criterion**

SD 4.6 Rating: A (>85% compliance with this criterion)

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

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

***Core Criterion**

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

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

- There was evidence demonstrated that hand hygiene training was mandatory and records were maintained by the line managers.
- Hand hygiene notices were displayed throughout the hospital.
- It was observed that not all taps observed in the clinical areas were in line with best practice.
- There was evidence that a large number of soap and alcohol containers did not have soap dispensers in place.
- A wash hand basins replacement programme was commenced in 2007 and funding is awaited in order to progress with this plan.

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 to demonstrate that method statements from the cleaning contract include the identification and minimisation of risk.
- The incident reporting process was in place and was demonstrated.
- There was evidence demonstrated through the occupational health report that sharps injuries were reviewed and a needle free system was introduced as a response to increasing numbers.
- There was insufficient evidence demonstrated that incidents are trended routinely and information provided to the clinical areas in relation to reported incidents.

SD4.9**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.

- The pamphlet "your hospital your health" was implemented in 2007 and provides a guide to visitors on their responsibilities for hygiene.
- The pamphlet was currently being evaluated however the evaluation was not demonstrated.
- There was evidence through documentation that patients have been involved in assessing their satisfaction with being involved in service delivery.
- There was a lack of evidence that the recommendations from the hygiene patient satisfaction surveys were implemented.

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.

- It was demonstrated that the visiting policy pertains to access being restricted during rest periods. It was advised by the hospital that these hours have assisted the maintenance of patient dignity.
- There was no evidence demonstrated of any breaches of confidentiality reported in the past year.
- There was no evidence to demonstrate that the policy in relation to environmental cleaning includes the maintenance of patient's dignity.
- The organisation advised that dignity of patients is discussed at induction. This was not demonstrated

SD 5.2**Rating: B (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 of information provided to patients on admission and there was evidence demonstrated of patient information leaflets.
- There was no evidence demonstrated of evaluation of patient/client comprehension of and satisfaction with the information provided by the hygiene services team.

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.

- It was demonstrated that patient complaints were managed as per the Health Service Executive guidelines.
- The organisation advised that there were no formalised written complaints for Hygiene Services in the past two years demonstrated.
- The hospital demonstrated that they are progressing with complaints/feedback received through the patient satisfaction surveys process and evidence of recommendations introduced as a result of complaints was demonstrated on an informal basis only.

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 demonstrated that two inpatient and outpatient hygiene satisfaction surveys have taken place in 2008. Action plans in this regard were identified in the Hygiene Services Committee meeting minutes. These had yet to be progressed and documented.
- The organisation had yet to establish a formalised process to include other external partners when evaluating its Hygiene Services.

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.

- Performance indicators for Hygiene Services have been recently developed and there was some evidence that these have been presented to the Executive Management Team through the Hygiene Services Committee.
- Performance indicators for education and training for Hygiene Services have also been established and were demonstrated.
- There was a lack of evidence that Key Performance Indicators are trended on an ongoing basis.

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.

- Documented processes for the development of the Annual Report were demonstrated.
- The Annual Report was also demonstrated. There was evidence demonstrated that this report was forwarded to all department heads and the Executive Management Board.
- A number of audit results were included in this report, in addition to the budget for hygiene services for 2007.
- There was insufficient evidence demonstrated of an evaluation of the appropriateness of the Hygiene Services annual report or patient involvement in developing same.

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	B
CM 1.2	B	B
CM 2.1	C	B
CM 3.1	C	B
CM 4.1	C	B
CM 4.2	C	B
CM 4.3	B	B
CM 4.4	C	B
CM 4.5	C	B
CM 5.1	B	B
CM 5.2	A	A
CM 6.1	C	A
CM 6.2	C	A
CM 7.1	B	B
CM 7.2	B	C
CM 8.1	B	C
CM 8.2	B	B
CM 9.1	C	B
CM 9.2	C	B
CM 9.3	B	B
CM 9.4	C	C
CM 10.1	C	B
CM 10.2	C	B
CM 10.3	C	B
CM 10.4	C	B
CM 10.5	C	B

CM 11.1	C	C
CM 11.2	C	C
CM 11.3	C	C
CM 11.4	C	C
CM 12.1	C	B
CM 12.2	C	B
CM 13.1	C	C
CM 13.2	C	C
CM 13.3	C	B
CM 14.1	C	B
CM 14.2	C	C
SD 1.1	C	B
SD 1.2	C	B
SD 2.1	C	B
SD 3.1	B	B
SD 4.1	B	B
SD 4.2	A	B
SD 4.3	A	C
SD 4.4	A	C
SD 4.5	A	A
SD 4.6	A	A
SD 4.7	B	B
SD 4.8	B	B
SD 4.9	C	B
SD 5.1	C	C
SD 5.2	C	C
SD 5.3	B	B
SD 6.1	B	B
SD 6.2	B	B
SD 6.3	C	B