

National Hygiene Services Quality Review 2008

Lourdes Orthopaedic Hospital Assessment Report

Assessment date: 22nd September 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 Lourdes Regional Orthopaedic Hospital, Kilcreene – Organisational Profile¹

Lourdes Regional Orthopaedic Hospital, Kilcreene has bed capacity of 51 for elective orthopaedic services providing a service to the South Eastern region of Ireland. It covers the counties of Waterford, Wexford, Kilkenny, Carlow and South Tipperary, serving a population of 430,000. Lourdes Orthopaedic Hospital Kilcreene has links with St Luke's Hospital Kilkenny through its Corporate Management Structures.

Services provided include, pre-operative assessment, fracture clinic, diabetic and other specialist clinics are held on site. Waterford Regional Hospital provides elective services at Kilcreene including hip and knee joint replacements.

Consultant Orthopaedic Surgeons for the region are based at Waterford Regional Hospital, however perform their elective surgery in Kilcreene Hospital. The hospital is the second major player in national joint replacements, which also performs other elective orthopaedic surgery.

2.2 Areas Visited

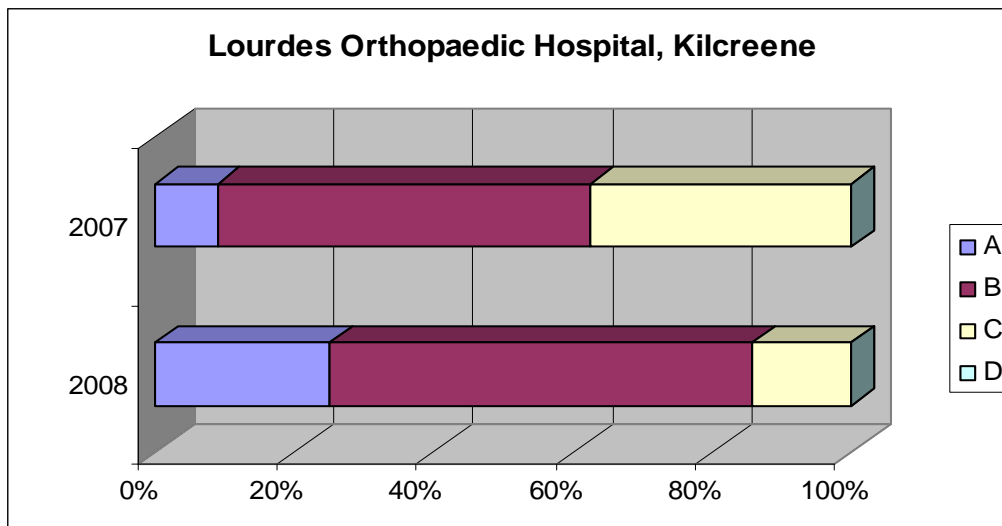
The Assessment Team visited the following areas:

- The Outpatients department
- The Female Orthopaedic ward
- The Medical Orthopaedic ward
- Waste compound
- Laundry services.

¹ The organisational profile was provided by the hospital

2.3 Overall Rating

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



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

**Lourdes Orthopaedic Hospital, Kilcreene has achieved an overall rating of:
Fair**

Award date: 2008

2.4 Standards for Corporate Management

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

PLANNING AND DEVELOPING HYGIENE SERVICES

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

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

- Evidence of a process for needs-assessment, which informs the organisations' corporate strategic, service and operational plan for hygiene services was demonstrated.
- There was evidence of evaluations of reports, service and operational plans and of the hygiene annual report.
- Evidence was demonstrated of a Patient Partnership Forum of which the Chair of the Hygiene Services Committee was a member.
- There was limited evidence of evaluation of the needs-assessment process 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 organisation had modified elements of the hygiene services following the 2007 National Hygiene Services Quality Review and an internal evaluation of the service.
- Evidence of the segregation of household duties, which was previously a shared role was demonstrated. No evidence was presented of its evaluation.
- A patient satisfaction survey had been undertaken and evidence was provided of actions taken as a result, for example, a service contract was terminated due to the identification of a hygiene related issue.
- It was demonstrated that all audit results are reported back to Department Heads and the Hygiene Services Team where they were evaluated.

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 Services Executive, various levels of Government and associated agencies, all staff, contract staff and patients/clients with regard to hygiene services.

- Evidence of ongoing communication, through St Luke's Hospital, with the HSE and Government agencies was demonstrated.
- It was demonstrated that Hygiene was a standing agenda item for all Executive Management Team and local management meetings.
- An Executive Hygiene Committee had recently been established with one meeting held.
- It was demonstrated that patient satisfaction surveys had been conducted and included reference to the cleanliness of the hospital.
- There was limited evidence presented of formal evaluation of the linkages and partnerships.
- No staff satisfaction surveys had been undertaken.

CORPORATE PLANNING FOR HYGIENE SERVICES

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

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

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

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 local organisational chart demonstrated clear reporting lines for the hygiene services, which were in line with the organisations corporate policies and procedures.
- The roles and responsibilities of the Hygiene Services Committee and Team were documented.

- It was demonstrated that Hygiene was a standard agenda item at Executive Management Team meetings.
- It was demonstrated that the Deputy General Manager was a member of the Hygiene Services Team.
- Evidence that an Executive Hygiene Management Committee had recently been established in St Luke's Hospital with executive management representation from the hospital was demonstrated.
- It was demonstrated that a patient representative had recently agreed to become a member of the Hygiene Services Committee; however her remit had yet to be formally documented.
- No evidence of evaluation of the appropriateness of the review of the authority provisions on the hygiene services area was demonstrated.

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.

- The organisation demonstrated that the Management Team regularly receive information, including minutes from the Hygiene Service Committee meetings, hygiene audits and best practice information.
- It was demonstrated that the Deputy General Manager was a member of the Hygiene Services Committee and reports back information to the Management Team in St Luke's.
- There was limited evidence of evaluation of information disseminated and/ or received demonstrated.
- Key Performance Indicators specifically for hygiene were at an early stage of development.

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 had a library, Internet and Intranet facilities.
- There was evidence of best practice research information being available through the organisations policies, procedures and guidelines.
- They also demonstrated that best practice information was considered by the management team and improvements were made as a consequence.
- There was limited evidence of formal evaluation demonstrated to the assessors.
- The organisation provides regular training and education sessions, however limited evidence of formal evaluation by participants 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.

- The organisation had a process in place for the development, approval, revision and control of all policies, procedures and guidelines.
- Evidence was provided of a multidisciplinary policy committee which had formal links to the policy committee in St Luke's Hospital.
- A member of staff was trained in Integrated Pathway Tools.
- There was a process in place for the local sign off by staff members of policies reviewed.
- It was demonstrated that the organisation adheres to the Irish Acute Hospitals Cleaning Manual.
- There was no evidence demonstrated of a formal process for the evaluation of the efficacy of the process used for developing and maintaining policies, procedures and guidelines.

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

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

- In conjunction with St Luke's Hospital it was demonstrated that an Executive Hygiene Management Committee, with membership from the organisation and St Luke's Hospital had recently been established.
- It was proposed that this committee would be advised of all capital projects.
- Limited evidence was available to demonstrate Hygiene Services Committee's involvement in capital development planning and the implementation process.
- No documented evidence of evaluation was demonstrated.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

***Core Criterion**

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

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

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

***Core Criterion**

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

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

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

***Core Criterion**

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

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

- There was no dedicated budget for hygiene in the Hospital, although evidence was provided that resources are made available through the General Manager in St Luke's hospital, when needs are identified and evaluated through the internal audit process.

CM 6.2 Rating: B (66–85% compliance with this criterion)

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

- The organisation demonstrated evidence that all equipment and products are purchased through the Central Materials Management Department in St Luke's.
- It was demonstrated that the Chair of the Hygiene Services Committee was a member of the Purchasing Committee in St Luke's which was actively involved in the process of purchasing equipment/ products.
- Evidence was provided of equipment lists produced and submitted to the Hygiene Services Committee, which were signed off by the Hygiene Services Team.
- The Hospital uses the National Procurement Policy Guidelines in the evaluation of new products.
- Limited evidence of formal evaluation of the efficacy of the consultation process between the Hygiene Services Committees 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.

- The organisation demonstrated evidence that an advisory risk management service was available via the Risk Manager in St Luke's hospital.
- Evidence of unannounced risk management audits was demonstrated.
- The organisation demonstrated evidence of a draft Risk Management Strategy.
- It was demonstrated that there was an incident reporting process in place and evidence was presented of actions taken as a consequence of incident analysis.
- Evidence was provided to demonstrate that monthly reports of all incidents were submitted to the Executive Management Team
- The risk assessment process had not been formally documented.

CM 7.2 Rating: B (66–85% compliance with this criterion)

The organisation's Hygiene Services risk management practices are actively supported by the Governing Body and/or its Executive Management Team.

- The Clinical Risk Manager in St Luke's provides an advisory service to the organisation and evidence of unannounced risk audits, care reviews and investigations of adverse incidents was demonstrated.
- There was also a Regional Health and Safety Officer.
- Evidence of a Quality and Risk Management Committee of which the Chair of the Hygiene Services Committee is a member was demonstrated.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

***Core Criterion**

CM 8.1 Rating: C (41-65% compliance with this criterion)

The organisation has a process for establishing contracts, managing and monitoring contractors, their professional liability and their quality improvement processes in the areas of Hygiene Services.

- The organisation demonstrated evidence that all contracts for services and stocks/ materials were established and managed through Technical Services in St Luke's hospital.
- It was demonstrated that contracts were informally monitored.
- Contracts, or copies, were not available during the assessment as they were held in St Luke's hospital.

CM 8.2 Rating: C (41-65% compliance with this criterion)

The organisation involves contracted services in its quality improvement activities.

- The organisation demonstrated evidence that the Technical Services Department in St Luke's Hospital establishes and monitors all contract services for the Group.
- Limited evidence was demonstrated of contractors' involvement in quality improvement activities within the organisation.
- Evidence was provided of a pilot project which had been set up in the Operating Theatre to monitor services provided by contractors and involved some consultation with contractors relating to 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.

- The hospital is an old building and had significant limitations in terms of environment, design and layout in a number of areas.
- It was demonstrated that refurbishment of a number of areas had been undertaken and that further work was planned as outlined in the Capital Development Plan.
- Wash-hand basins in a number of areas were not compliant with best practice.
- Departmental safety statements were in place and up to date.

***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: A (>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.

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

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

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

- The organisation provided evidence of patient satisfaction surveys with a specific hygiene element.
- The organisation demonstrated that they were in the process of developing a patient satisfaction survey questionnaire specifically for hygiene, which it was proposed would be used in St Luke's.
- No evidence of staff satisfaction surveys was demonstrated.
- Evidence was provided to demonstrate that a member of the Patient Partnership Forum had recently agreed to sit on the Hygiene Services Committee.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

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

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

- The organisation demonstrated evidence of a process for the selection and recruitment of hygiene services staff members which was in line with national guidelines.

- It was demonstrated that the organisation had a generally low turnover of staff.
- Job descriptions were observed to clearly outline roles and responsibilities.
- The Human Resource department was based in St Luke's Hospital, however the organisation provided evidence to demonstrate their involvement in the interview process.
- There was limited evidence of evaluation of processes used for selection and recruitment demonstrated to the assessors.

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.

- As the organisation provides an elective service, there was evidence provided of a planned workload and staff allocated in accordance with resources.
- The organisation demonstrated evidence of an evaluation of work capacity and volume in 2008, with the resultant establishment of a partnership to facilitate the allocation of core hygiene duties to specific staff. No evidence was demonstrated that this action had yet been evaluated.

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 provided evidence of a recruitment process which aimed to ensure that hygiene services staff members have the appropriate qualifications and included ongoing revision and monitoring of job descriptions.
- It was reported that no new hygiene services staff members had been employed in the last number of years due to low turnover rates.
- Evidence of an induction programme was demonstrated.
- Evidence of: in house training; staff member's participation in the FETAC and Skills training programme and of a train the trainer programme was demonstrated.
- Limited evaluation of training provided was demonstrated.
- It was demonstrated that contracts for Waste Management (from external compound to final destruction) and sanitary bins were managed and monitored in St Luke's hospital. The qualification and training for these contract staff members was also monitored within St Luke's with limited input from Kilcreene.

CM 10.4 Rating: C (41-65% compliance with this criterion)

There is evidence that the contractors manage contract staff effectively.

- The organisation demonstrated evidence that all contractors for Hygiene services are recruited, managed and monitored through St Luke's Hospital.
- There was limited evidence available within Kilcreene to demonstrate that contractors manage contract staff members effectively.
- Evidence of reports which were received from contractors directly included: autoclave reports for CSSD and regeneration ovens service reports.

***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.

- A formalised needs-assessment process was not documented, however as the organisation provides an elective service, hygiene services were planned, managed and maintained in line with its Service and Operational plan.
- A Hygiene Annual Report was produced in 2007.
- Evidence was provided to demonstrate that audits were regularly conducted.
- Earlier this year an evaluation was undertaken of work capacity and volume and subsequently a process had been put in place for the segregation of roles for hygiene services.
- Further to a resource need identified through the Hygiene Services Committee, the organisation demonstrated that they were in the process of considering additional resources for the weekends.
- No evidence of evaluation was demonstrated.

ENHANCING STAFF PERFORMANCE

***Core Criterion**

CM 11.1 Rating: A (>85% compliance with this criterion)

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

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

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.

- There was evidence that the organisation supported ongoing education and training.
- An audit of training needs had been completed.
- In-house training for staff members in relation to infection control and hand hygiene was evident however limited evidence of evaluation by participants was demonstrated.
- Attendance records were maintained however there was limited evidence of monitoring made available to the assessors.
- There was no documented process to ensure that staff members were released to attend training however they were generally facilitated to attend during work hours.

CM 11.3 Rating: C (41-65% compliance with this criterion)
There is evidence that education and training regarding Hygiene Services is effective.

- The organisation demonstrated evidence of evaluation of the FETAC training course however not of all other training courses.
- Evidence of a hand hygiene compliance tool was demonstrated.
- Training attendance records were maintained however limited evidence was made available of monitoring.
- There was also limited evidence of the use of key performance indicators to evaluate the effectiveness of education and training 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.

- Informal processes for the evaluation of the performance of hygiene services staff members occurs through: internal audits using the Quasar audit tool, departmental checklists and regular supervision by department heads and/or supervisor.
- The organisation demonstrated evidence that the results of audits and hygiene reviews were discussed at the Hygiene Services Committee and reported back to individual departments.
- No evidence was demonstrated of formal 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.

- An Occupational Health Service is available for all staff members at the parent site of St Luke's Hospital.
- No evidence of an evaluation of Occupational Health services was demonstrated.

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

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

- There was limited evidence of evaluations of staff satisfaction.
- Absenteeism reports are presented at Executive Management team meetings on a monthly basis.
- The Human Resources department maintains records of staff members on long term sick leave.
- It was demonstrated that an occupational health service was available for all staff, however there was no monitoring of uptake or evaluation of the service demonstrated.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.1 Rating: B (66–85% compliance with this criterion)

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

- The organisation demonstrated evidence that hygiene services data and information was available to staff members through; evidenced based policies, procedures and guidelines; education and training; membership of committees; minutes of meetings circulated to department heads; checklists and audit reports.
- It was demonstrated that research on new equipment was considered by the Hygiene Services Team.
- Evidence was presented to demonstrate that infection control specialists monitor and collect data in accordance with national guidelines and informally evaluate.
- Limited evidence of formal evaluation of the process for collecting and accessing information or evaluation of data quality, reliability, accuracy and appropriateness was demonstrated.

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

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

- There was evidence of regular hygiene audits with the results submitted to the Hygiene Services Committee, Team and the Executive Management Team with resultant actions.
- It was demonstrated that a hygiene report was presented to the Infection Control Committee on a quarterly basis.
- Limited evidence of evaluation of user satisfaction in relation to the reporting of data or actions taken as a consequence 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 organisation demonstrated evidence that internal audit outcomes were reviewed at the Hygiene Service Committee and Team meetings.
- It was demonstrated that results were also reported back to department heads.
- Evidence that the Service and Operational plan was evaluated by the Hygiene Services Team and the Patient Partnership Forum was demonstrated.
- There was limited evidence of evaluation of the appropriateness of the data and information utilisation in relation to service provision and improvement demonstrated.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

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

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

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

CM 14.2 Rating: 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.

- Evidence was provided to demonstrate that the organisation evaluates its hygiene process through the Hospital Management team, Hygiene Services Committee and Team, internal audits and departmental team meetings.
- Some refurbishment work had been undertaken and it was demonstrated that further work was planned pending funding.
- A limited evaluation of the Service Plan for 2007 was demonstrated to have informed the Hygiene Annual Report for 2007.
- A suite of performance indicators had been developed in the organisation however were not demonstrated to relate specifically to hygiene.
- No evidence of benchmarking was demonstrated

2.5 Standards for Service Delivery

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

EVIDENCE BASED BEST PRACTICE AND NEW INTERVENTIONS IN HYGIENE SERVICES

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

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

- The organisation demonstrated evidence of a process for the development and approval of policies procedures and guidelines.
- There was evidence of their implementation at a local level although limited audits for compliance had been undertaken.
- It was demonstrated that further to the 2007 National Hygiene Services Quality Review, that the Hazard Analysis and Critical Control Point manual and the Waste Management Plan had been further developed and implemented.
- No evidence of evaluation of the efficacy of the processes used to develop best practice guidelines was demonstrated.

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 organisation demonstrated pre-purchase evaluation through the Hygiene Services Team and Committee.
- Evidence was provided to demonstrate the trialing of a new cleaning system, i.e. mop system. This had not yet been evaluated.
- No evidence of evaluation of the efficacy of the assessment process for new/changed hygiene services interventions was demonstrated.

PREVENTION AND HEALTH PROMOTION

SD 2.1 Rating: A (>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 organisation demonstrated compliance of greater than 85% with the requirements of this criterion

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 that the Hygiene Services Team and Committee were multidisciplinary in nature with good attendance levels.
- Roles and responsibilities were outlined in the organisations hygiene service and operational plan.
- Through common membership with other internal committees and the committee reporting structure, the organisation demonstrated strong linkages.
- Limited evaluation of the efficacy of the multidisciplinary team structure or work of the committee 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.

- In general, the physical environment of the areas visited was observed to be clean, although some high and low dusting was observed in areas.
- Schedules for cleaning were observed to be held locally.
- It was demonstrated that departmental audits were undertaken on a fortnightly basis.

***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.

- The organisation had a process in place for the cleaning of equipment after use and a “special clean” rota.
- However on inspection a number of oxygen cylinder cages were observed to be dusty and the wheels of trollies were in need of further attention.

***Core Criterion**

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

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

- The organisations cleaning equipment and storage area were generally observed to be clean, although equipment in a small number of areas was found not to meet the required standard.
- The organisation demonstrated that they had a cleaning schedule in place for the cleaning of all equipment and that education sessions for staff members in relation to cleaning had been provided.

***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.

- In general the ward kitchens in the areas visited were found to be clean and tidy.
- Refurbishment of some areas is required and evidence demonstrated that it was planned pending funding.

***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 (SARI) guidelines.

- The organisation demonstrated that attendance at hand hygiene training is mandatory and there was good attendance.

- Evidence of hand hygiene audits undertaken was provided.
- The use of alcohol hand gels was evident.
- It was demonstrated that wash-hand basin audits had been undertaken with a business case submitted to the Executive Hygiene Management Committee.
- Wash-hand basins in a number of areas did not meet best practice requirements.

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

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

- The organisation demonstrated evidence of an incident reporting process, departmental safety statements with written risk assessments and HACCP compliance reports.
- It was demonstrated that the organisation had access to advisory support from the Risk Manager in St Luke's Hospital.
- It was reported that there had been a low number of hygiene related incidents reported in the past two years.
- The organisation did not demonstrate that risk or incident reporting training is being provided for staff members on an ongoing basis.

SD 4.9 Rating: A (>85% compliance with this criterion)

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

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

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.

- Evidence of a patient charter, professional codes of conduct and reference in the cleaning policies to privacy and respect of the patient was demonstrated.
- A visitor's policy has recently been launched.
- Limited evidence of formal evaluation was demonstrated.

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

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

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

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

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

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

ASSESSING AND IMPROVING PERFORMANCE

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

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

- The organisation demonstrated evidence of patient satisfaction surveys, a complaints process and a risk/ incident reporting process.
- It was demonstrated that a representative from the Patient Partnership Forum was a member of the Hygiene Services Committee and that internal audits and satisfaction surveys are reviewed and acted upon at this committee.
- The organisation provided evidence that the Patient Partnership Forum had undertaken unannounced hygiene audits of areas.
- There was limited evidence demonstrated of evaluation regarding the extent to which patients, families and other organisations were involved by the team when evaluating its hygiene service.

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

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

- The organisation demonstrated evidence of the Hygiene Services Committee and Management Team monitoring and evaluating the Hygiene Service through internal audits.
- It was demonstrated that further to the 2007 National Hygiene Services Quality Review, linkages with St Luke's Hospital had improved, with the

Deputy General Manager, Catering Officer, Waste manager and Project Nurse noted as being members of the Hygiene Services Team.

- There was limited evidence of benchmarking demonstrated.

SD 6.3 Rating: A (>85% compliance with this criterion)

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

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

Appendix A: Ratings Details

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

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

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