

National Hygiene Services Quality Review 2008

Mid Western Regional Hospital, Ennis

Assessment Report

Assessment date: 13th 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 review 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 Mid Western Regional Hospital Ennis – Organisational Profile¹

The Mid Western Regional Hospital Ennis is an 88 bedded in-patient acute general hospital. It has a 6 bedded Day Care Unit.

The hospital was built in 1946, along with the 'Nurses Home Building' and the Outpatient Department.

During the 1990's the advancement of technology resulted in the Nurses Home Building being modified and this now contains the Hospital Library, Out-Patient Clinic Rooms and Administration Office for some of the Clinical Nurse Specialists, amongst others.

The Acute Psychiatric Unit was added to the main hospital building in 2003 but remains an independently managed unit with a separate entrance and reception. There was a number of services provided at the hospital which include: Accident and Emergency, Male and Female Medical Wards, Surgical Wards, Elderly Acute Care Unit, Day Ward, Theatre & ICU and Palliative Care Service and Out Patients Department.

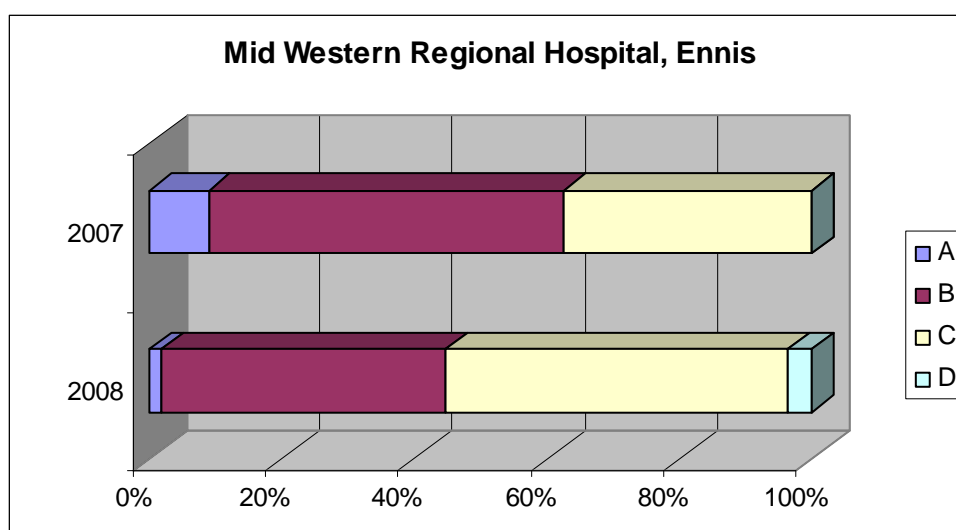
2.2 Areas Visited

- Outpatient department
- Emergency department
- The elderly ward, which was accommodating the surgical ward due to refurbishment, was visited by the assessment team as the patients from the emergency department use the facilities from this clinical area and the staff utilise the sluice room.
- The surgical ward was also visited as the patients from the elderly ward share facilities in this area.
- Female medical ward
- Male medical ward
- Laundry service
- Waste compound.

¹ The organisational profile was provided by the hospital

2.3 Overall Rating

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

**Mid Western Regional Hospital, Ennis has achieved an overall rating of:
Poor**

Award date: 2008

2.4 Standards for Corporate Management

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

PLANNING AND DEVELOPING HYGIENE SERVICES

CM 1.1 Rating: C (41-65% compliance with this criterion)

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

- A documented needs assessment for 2008 was demonstrated; however this was at final draft stage.
- The agenda from the Hygiene Services Committee meeting demonstrated that this was due to be signed off at the next meeting.
- There was evidence demonstrated of a Regional Corporate Hygiene Strategic plan in place for 2007-2009 with regional objectives defined. These were reflected in the hospital's Hygiene Service Plan for 2008.
- There was no evidence demonstrated of associated costings identified in the service plan. There was evidence provided that the plan is reviewed twice yearly through evaluation of the hygiene services key performance indicators. The key performance indicators included the numbers of governance meetings, audits completed, training sessions completed and policy procedure and guidelines developed.
- The addition of a service-user on the hygiene and infection control committees was demonstrated. The outcome of these was not demonstrated as a key performance indicator.
- There was a lack of evidence demonstrated of evaluation of the needs assessment process.

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

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

- There was evidence demonstrated through interview and observation that the hygiene services are modified and developed to meet the needs of the population. These included the wash hand basin replacement programme, which has resulted in 37 wash-hand basins being replaced in 2008 with seven wash-hand basins out standing.
- There was evidence that the replacement programme included wash-hand basins being fitted at the front and back doors of the hospital.

- There was evidence demonstrated that the storage area for clean linen has also been developed in 2008 following the hygiene services review in 2007. It was demonstrated that the storage facilities in many of the clinical areas were reviewed under the space utilisation group, which forms part of the Hygiene Services Committee.
- There was no evidence demonstrated of a systematic approach to evaluation of the developments and modifications to the hygiene services in relation to meeting the service user's needs.

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.

- There was evidence demonstrated of a report furnished to the National Hospital's Office in April 2008 identifying how the hospital is addressing hygiene quality improvement plans.
- There was evidence demonstrated that the Infection Control Team continue to build linkages with the community. There was evidence that a patient representative had attended the last two Hygiene Committee meetings.
- Evidence was demonstrated that a hygiene-related patient satisfaction survey was completed in 2008.
- There was no evidence demonstrated of formalised linkages with the Network Manager in relation to hygiene services at the hospital for example no evidence was demonstrated of attendance at meetings or minutes being sent to the Network Manager. Evidence was demonstrated of a request to attend a Regional Hygiene Meeting however no evidence was demonstrated of attendance.
- It was demonstrated from minutes of meetings that hygiene services is a standing agenda item on the Infection Control Committee meetings.
- There was a lack of evidence demonstrated of any formal evaluation of linkages and partnerships.

CORPORATE PLANNING FOR HYGIENE SERVICES

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

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

- There was evidence of a regional corporate Hygiene Strategic Plan in place for the network.

- There was evidence demonstrated of a documented process for the development of the Hygiene Services Corporate Strategic Plan.
- It was identified that the minutes of the in-house meetings for hygiene services have been circulated to most staff. This was demonstrated.
- There was no evidence demonstrated of a formal evaluation of the hygiene services corporate strategic plan, however it was demonstrated that this was reviewed informally through risk and audit reports.

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.

- It was demonstrated that overall responsibility for hygiene services resides with the Director of Nursing.
- It was also demonstrated that an Assistant Director of Nursing was appointed 18 months ago with overall responsibility for the operational aspects of hygiene services.
- An algorithm was demonstrated which clearly identifies the responsibility for hygiene services.
- It was demonstrated that all disciplines of staff are represented on the Hygiene Services Committee.
- There was no evidence of evaluation of the appropriateness of the review of authority provisions in the hygiene services areas.

CM 4.2 Rating: C (41-65% compliance with this criterion)

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

- It was demonstrated that the Hospital Administrator is a member of the Hygiene Services Committee.
- There was some evidence demonstrated that the Executive Management Team receive useful, timely and accurate evidence that reflects issues identified through audit results and hygiene related risks.
- There was a lack of evidence that hygiene services is an agenda item for the Executive Team meetings and evidence demonstrated indicated that the information they receive is sporadic.
- A member of the management team demonstrated through email that they received feedback in relation to hygiene audits completed at ward level. This process was not formalised.
- There was no evidence of evaluation of information received.

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

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

- There was evidence demonstrated that a Policy and Procedures Committee has been recently established.
- It was advised that awareness of best practice on hygiene is per National Reports and Best Practice Guidelines.
- Infection Control study days were demonstrated.
- There was evidence that staff has access to the library and intranet.
- There was some evidence demonstrated that line managers have been made responsible for ensuring the awareness of the staff in their areas to best practice.
- There was no evidence demonstrated of evaluation of the appropriateness of hygiene services related research and best practice 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

- A Policy, Procedure and Guideline Committee was established in 2008
- The first meeting of this group was in February and this was demonstrated through minutes of meetings.
- A documented process has been established in 2008 for the development, approval, revision and control of all policies and this was demonstrated.
- It was demonstrated that a significant number of policies have been reviewed in 2008 which reflect the hygiene and infection control services in place.
- There was a lack of evidence demonstrated of evaluation of the efficacy of the process for developing policy procedure 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

- There was evidence demonstrated of the hygiene services involvement in capital development planning in some instances.
- This was demonstrated in the planning/installation of new air conditioning units for the Intensive Care Unit.
- It was advised that there was an ongoing significant capital development project plan in place for the hospital for the past ten years. It was advised that funding is awaited to commence this project. This was not demonstrated.
- A Capital Development Committee was in place and this was demonstrated. Minutes of the meeting for February 2007 were demonstrated and it was

- There was no evidence demonstrated that the Infection Control Team were involved in the planning and follow through of the refurbishment work that was in place in the surgical ward at the time of assessment.
- There was no evidence demonstrated of a documented process for consulting with the hygiene services pre development of existing sites.
- There was no evidence demonstrated of evaluation of the efficacy of the consultation process in place between the hygiene services team and senior management.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

***Core Criterion**

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

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

- There was some evidence that clear roles, authority and responsibilities are defined throughout the hygiene services.
- There was evidence demonstrated of the role, responsibility and accountability of the governing body.
- There was evidence demonstrated of an algorithm in place.
- There was evidence that accountabilities and responsibilities were demonstrated in the job descriptions for the newly appointed Clinical Nurse Manager 1s. The remaining job descriptions demonstrated did not reflect line manager's hygiene responsibility.
- It was identified from discussion with staff that all Registered Nurses report to Clinical Nurse Manager 2 and housekeeping staff report to the assistant Director of Nursing for hygiene services.
- There was evidence demonstrated that the introduction of segregation of cleaning and catering was in the process of being progressed by the hospital. This was not the practice observed during the assessment.

***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: C (41-65% 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 evidence demonstrated of a defined hygiene budget available for whole time equivalent housekeeping and portering staff.
- The identification of spend on hygiene developments/minor capital was available and demonstrated.
- There was also evidence demonstrated of resources allocated for consumables.
- There was insufficient evidence demonstrated of a formalised corporate approach to allocating resources for hygiene services or trending of same.

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

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

- It was demonstrated by the organisation that the hospital administrator and Director of Nursing are members of the Hygiene Services Committee.
- There was evidence demonstrated through minutes of Hygiene Services Committee meetings that the committee was involved in the pre-purchasing of bins.
- It was demonstrated that the Infection Control team, on behalf of the Hygiene Services Committee was involved in the purchasing of wash-hand basins and this was demonstrated.
- There was no evidence demonstrated of evaluation of the efficacy of the consultation process between the Hygiene Services Committee and senior management.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

CM 7.1 Rating: D (15-40% compliance with this criterion)

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

- There was evidence demonstrated that the hospital has access to a Regional Risk Manager and a half-time Risk Advisor is also available to the hospital.
- It was demonstrated that the Risk Manager is a member of the Risk, Hygiene, Health and Safety, and Infection Control Committees in the hospital.
- The hospital did not demonstrate any hygiene-related adverse events for 2008. The hospital advised that the organisation consider an adverse event equates to an outbreak only.
- It was demonstrated that the STARSweb reports are routinely forwarded to the Hospital Administrator.
- It was demonstrated that the current safety statement dated 2006 was under review and a draft safety statement for 2008 was demonstrated; however, it was demonstrated that this had not yet been signed off by the Risk Committee.
- Bi-annual risk reports for 2006 were demonstrated. There was no risk report demonstrated for 2007. However, there was evidence demonstrated of a recent quarterly risk report for 2008.
- It was not demonstrated that the organisational structure and related processes to identify, analyse, prioritise and eliminate or minimise risk relating to the Hygiene Service had managed the risk to patients of Aspergillus Infection associated with the reopening of a surgical ward to patients.
- There was no evidence demonstrated through documentation or interview that an assessment of risks to patients had been completed. There was no evidence to demonstrate that the Infection Control Team was involved in the decision to reopen the ward prematurely.
- There was no evidence demonstrated that the hospital was complying with its own Aspergillus procedure.
- Therefore a significant risk to patient safety was identified.

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.

- There was evidence demonstrated that a number of the teams in the hospital had amalgamated which had resulted in the establishment of the Quality, Risk, Health and Safety Committee since August 2008. Terms of reference for the Committee were demonstrated. This included the production of annual reports and monthly meetings.

- The standard precautions for infection isolation were demonstrated to be in place, and the policy was revised in July 2008.
- There was some evidence demonstrated that evaluation of risks is completed and there was evidence that a risk report was forwarded to a member of the management in 2008.
- There was no evidence provided of follow-through of hygiene risk incidents in 2008. The only documentation regarding risk follow up was in the form of an email from a member of the management team.

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.

- There was evidence demonstrated of national contracts in place for waste and sanitary bins.
- It was advised that the contracts are centrally managed at regional level.
- The annual tender for window cleaning was in place and was demonstrated.
- It was advised that the Assistant Director of Nursing with responsibility for Hygiene reviewed the window cleaning completed on the day and brought attention to any deficits. There was a lack of documented evidence in support of this process.
- There was evidence demonstrated of Aspergillus training provided to contractors.
- There was insufficient evidence demonstrated that the contractors for the vending machines are formally managed.
- It was advised that a member of the management team liaises with the contractor in this regard.
- There was no of evidence on site of local sign off of contracts. There was no evidence demonstrated of documented processes for the management of contractors.

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

The organisation involves contracted services in its quality improvement activities.

- There was evidence demonstrated through the minutes of meetings that the sanitary provider has liaised with the hospital to provide a more user-friendly bin.
- It was advised that the contractor completing external work is trained in Aspergillus containment.

- A process to involve other contractors in quality improvement activities was not demonstrated.

PHYSICAL ENVIRONMENT, FACILITIES AND RESOURCES

CM 9.1 Rating: D (15-40% 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 advised that the organisation is a protected building and developments are constrained accordingly. However, there was evidence of refurbishment ongoing at the time of the assessment. There was evidence observed of refurbishment in the clinical areas.
- There was evidence demonstrated of upgrade in the main kitchen. There was evidence observed of a clean linen storage area, which was recently developed.
- There was evidence demonstrated of a space utilisation team in place as an element of the Hygiene Services Committee.
- The organisation did not demonstrate that the design and layout of the organisation's current physical environment is safe, meets all regulations and is in line with best practice as a ward that was undergoing renovation, had been re-opened to accommodate day patient surgical admissions.
- There was no evidence provided that this area had been fully cleaned prior to patients being placed there.
- There was evidence that the floor in the side room of this ward area was being sanded and dust was evident throughout the ward area including areas where sterile consumables were being stored. Therefore a significant risk to patient safety was identified.

***Core Criterion**

CM 9.2 Rating: C (41-65% 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 evidence demonstrated of policies and procedures in place in line with best practice to manage the environment and facilities, equipment and devices, kitchens, waste and sharps and linen.
- There was some evidence demonstrated that there was a process in place to ensure staff awareness of these policies.
- There was no evidence demonstrated that all policies, procedures and guidelines were being monitored at clinical level.
- There was evidence that adherence to policies, was not demonstrated at all times.

- There was evidence demonstrated that equipment replacement is completed on an ad hoc basis only. There was no evidence demonstrated of a formalised process in place in this regard.

CM 9.3 Rating: C (41-65% compliance with this criterion)

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

- The organisation demonstrated that hygiene and infection control audits are completed by the organisation and the maintenance department and stores had recently been included in the audits.
- The findings from the stores department audits resulted in a deep clean being completed. This was demonstrated through documentation.
- There was evidence demonstrated that a number of the Clinical Nurse Managers have been trained to complete peer audits. There was no evidence that this training had been evaluated.
- There was a lack of evidence demonstrated of a schedule of audits.
- There was some evidence demonstrated of follow up of audits undertaken. The emergency department have commenced the process of presenting formalised feedback to a member of the management team as a result of audits completed.
- The key performance indicators in place in relation to audits demonstrates the number of audits completed rather than the trending and closure of the loop of same.

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.

- There was evidence demonstrated that a patient had recently been co-opted onto the Hygiene Services Committee and the Infection Control Committee.
- There was evidence that a patient satisfaction survey was completed in 2008, the analysis was reviewed and recommendations were not demonstrated.

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 recruitment is managed at a regional level.
- The current recruitment practice has been used for Clinical Nurse Manager 1 and medical professionals only and this was demonstrated.
- There was evidence that the regional process was delivered in line with best practice guidelines.
- There was no evidence of evaluation of the selection and recruitment of human resources demonstrated.

CM 10.2 Rating: C (41-65% 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.

- It was demonstrated that the organisation works within its whole time equivalent allocation and redeploys staff as necessary.
- There was insufficient evidence of a defined tool utilised to determine or review hygiene services work capacity and volume.
- The process was informally managed and was not documented and demonstrated.

CM 10.3 Rating: C (41-65% compliance with this criterion)

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

- There was evidence demonstrated of weekly infection control training sessions in place.
- There was evidence that waste management training sessions were completed by an external trainer and the records of these were demonstrated.
- There was evidence of a manual system in place for recording of training sessions completed by staff.
- Defined competencies for house keeping staff have not been demonstrated.
- The process to track non attendees at training sessions was not demonstrated.

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

There is evidence that the contractors manage contract staff effectively.

- It was demonstrated that there was no contract staff directly employed in the hospital.
- There was documentary evidence of Aspergillus training provided to the construction staff from Infection Control.

- A daily checklist is completed to monitor construction contractors on site and this was demonstrated.
- There was a lack of evidence demonstrated that this process was being utilised for the construction work being completed at the time of the assessment in the surgical ward.

***Core Criterion**

CM 10.5 Rating: C (41-65% compliance with this criterion)

There is evidence that the identified human resource needs for Hygiene Services are met in accordance with Hygiene Corporate and Service plans.

- It was advised at interview that the current whole time equivalent is sufficient for the needs of the hospital
- The hospital has 1.2 whole time equivalent Infection Control nurses in place. There was evidence that a catering supervisor and hygiene supervisor was in place.
- The implementation of the segregation of catering and cleaning roles was demonstrated as being addressed. The communication in respect of this process has begun. This was not completed at the time of the assessment.
- No Human Resource needs assessment was demonstrated by the organisation.

ENHANCING STAFF PERFORMANCE

***Core Criterion**

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

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

- There was evidence demonstrated of an induction programme in place.
- This was evidence that the recently appointed Clinical Nurse Manager 1s commencing in July had received induction, the agenda for same was demonstrated and this included hygiene training.
- There was evidence demonstrated of evaluation of the induction programme.
- There was some evidence that the information is used to make changes.
- There was evidence of an Infection control induction pack and support staff induction booklet in place.
- It was demonstrated that the Non-Consultant Hospital Doctors Information booklet had been recently developed.
- This was a regional document and included hygiene. Records of awareness/circulation of this manual were not demonstrated.

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.

- It was demonstrated that the remit of the Policy, Procedure and Guideline Committee includes developing a policy on training.
- There was evidence demonstrated of Hazard Analysis Critical Control Points training completed by some staff. It was demonstrated that two staff are currently completing Skills training and two staff are also completing the Health Care Assistant Further Education Training and Awards Council (FETAC) training course.
- There was evidence demonstrated that some staff have completed mandatory hand-hygiene training, however there was no evidence demonstrated of a centralised system to record training or to track non attendees. It was demonstrated that some staff have not completed hand hygiene training. The total figures were not demonstrated.
- The organisation demonstrated that a checklist to monitor training had been developed to assist this process going forward and this was demonstrated.
- There was no evidence of evaluation of the relevance of education to each staff member.

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 the Infection Control Team had completed some evaluation of the training they provide.
- There was evidence of an evaluation of the induction programme; however there was no evidence that this information was collated and improvements were not demonstrated.
- There was some evidence of improvement demonstrated from the audit results; however there was no evidence of trending this information and therefore the link to training could not be demonstrated.
- There was insufficient evidence demonstrated that attendance levels at training are evaluated.

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.

- It was advised that the process in place to monitor hygiene staff performance is through the reported incidents and complaints for hygiene.

- There was evidence that performance review is managed through the formal disciplinary process in place.
- There was no evidence demonstrated of a systematic approach to performance evaluation of staff.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 Rating: C (41-65% compliance with this criterion)

An occupational health service is available to all staff

- There was evidence demonstrated of a regional occupational health service which all staff had access to.
- It was identified that the records of vaccinations of hygiene staff were held by the Occupational Health Department regionally and were not demonstrated.
- There was evidence demonstrated that the occupational health service tracked non-attendees.
- The work life balance day was completed in the hospital on the 29th February 2008 and evidence was demonstrated of same.
- There was documentary evidence demonstrated of a survey of staff wellness for nurses completed by a member of the occupational health department in September 2007 as part of a thesis. This was an independent study, and recommendations were made and were demonstrated. There was no evidence demonstrated that action plans were implemented due to the nature and origin of study.

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 available to demonstrate monitoring by the organisation of hygiene services satisfaction, occupational health and well being.
- It was advised that stress management sessions are completed by a member of staff for all staff; however there was no evidence of records of attendance demonstrated.
- There was no evidence demonstrate of a staff survey completed by the organisation to monitor staff satisfaction.
- There was no evidence demonstrated of key performance indicators for staff satisfaction defined for hygiene services.

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.

- There was evidence demonstrated of processes in place for collecting and providing access to quality hygiene services data and information.
- These included the environmental audits.
- The minutes of meetings were demonstrated for hygiene services and Infection Control Committees to demonstrate this.
- No evidence of evaluation 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 demonstrated of reports produced by the Hygiene Services Committee at regional and hospital level and minutes of the meetings and the reports were demonstrated. These include a quarterly report of risks and an annual report for hygiene services for 2007.
- It was demonstrated that the Executive Management Team receives data in relation to infection rates.
- There was a lack of evidence of a process to circulate the minutes of all hygiene meetings to line managers.
- There was a lack of evidence 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 demonstrated that data and information provided to the Executive Management Team had evolved in the past year.
- This included key performance indicator data and some of this was provided to the Executive Management Team.
- There was evidence of a service user on the Hygiene Services Committee.
- There was evidence demonstrated that the number of audits for hygiene services had increased in 2008.
- There was evidence demonstrated that a hygiene patient satisfaction survey had also been completed in 2008.
- It was demonstrated that the data in relation to risk management had also increased in the form of reporting on a quarterly basis to the management team.

- It was advised that the information in relation to complaints was now forwarded to the area from which the complaint emerged.
- No policy changes based on information provided on these changed processes was demonstrated.
- There was a lack of evidence demonstrated of evaluation of the appropriateness of data collection and information reporting.

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 demonstrated that the management team foster and support a quality improvement culture throughout the organisation, through their membership of the Hygiene Services Committee.
- It was demonstrated that the Executive Management Team receive information in relation to hygiene services and Infection control.
- There was evidence of improvements in Hygiene Services, these include the linen room upgrade, bin and wash hand basin replacement and the refurbishment of clinical areas.
- There was evidence that processes are in place to progress the segregation of cleaning and catering functions.
- There was evidence that the policies, procedures and guidelines for Hygiene and Infection Control have been further developed in line with the new template.
- There was some evidence demonstrated that all of the executive management team have an involvement in the improvements for hygiene services as there was some evidence that they all receive routine information in relation to hygiene services.

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

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

- There was evidence that key performance indicators for hygiene services have been recently developed and the hospital is in the process of trending same.
- The informal evidence of improvement was demonstrated through interview.

- It was advised that the hospital invited the Director of Nursing from a neighbouring hospital to complete an audit of hygiene services; however, no report of same was demonstrated.
- The hospital advised that they bench mark their performance against the other hospitals in their region through regional meetings and the Infection Control reports are benchmarked against national figures.
- There was no evidence provided of a formalised process for benchmarking. The process to trend the audit report and act on improvements is yet to be formalised and 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.

- There was evidence demonstrated that a number of policies, procedures and guidelines were recently developed for the Hygiene Services Team and guidelines were available in the kitchen of each of the clinical areas for all staff to access.
- There was evidence of a lack of awareness of these policies in the clinical areas from many staff interviewed.
- It was observed that the standard infection control precautions are in place for the isolation of patients. ('Management of suspected enteric infections').
- It was observed that there was a lack of audit of same in place.
- There was no evidence demonstrated of evaluation of the efficacy of the process used to develop 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.

- There was evidence demonstrated of a process in place for assessing new interventions and changes to existing ones prior to their use.
- This was evidenced in the documentation and minutes of meetings specifically relating to the introduction of new mop heads, disposable blood pressure cuffs, alcohol gel and hand wipes.
- Evaluation of the efficacy of the assessment process for new/changed hygiene services interventions was not demonstrated.

PREVENTION AND HEALTH PROMOTION

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

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

- There was evidence demonstrated that the visiting policy in place was revised in 2007.
- There was evidence observed of the recent introduction of talking hygiene signs in the front hall of the hospital.
- Information leaflets were observed to be in place for many aspects of hygiene and infection control and these were demonstrated.
- There was evidence of a planned public information session for County Clare General Practitioners and the schedule for the day was demonstrated and this included hygiene.
- There was some evaluation in this regard; however the improvements were not demonstrated.

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.

- The Hygiene Services Team has amalgamated into the Hygiene Services Committee in July 2008, and this Committee feeds into the regional Hygiene Services Committee and minutes of both were demonstrated.
- It was demonstrated that there is cross representation of functions on the hospital and regional committee.

- There were no minutes demonstrated which reflected the reason for the amalgamation.
- No evidence was demonstrated of an evaluation of the changes made.

IMPLEMENTING HYGIENE SERVICES

***Core Criterion**

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

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

- Many areas within the organisation were observed to be in general needed of attention.
- There was evidence of dust; this included high and low surfaces in numerous areas.
- There were a number of areas where the alcohol gel needed to be replaced and paper towel dispensers needed to be refilled.
- There was a standard operating procedure in place for cleaning and it was advised that the cleaning staff were involved in the development of these; however there was a lack of evidence demonstrated of records of cleaning completed.
- There was evidence of a policy for flushing of outlets in place. This process is monitored by the maintenance department, however the evidence of flushing of outlets routinely completed at local level was not demonstrated.
- There was a lack of storage space in many areas; and storage facilities tended to be multipurpose, however a space utilisation committee had been established to address this.
- It was advised that the staff in the emergency department utilise the facilities of the sluice room in the elderly care ward.

***Core Criterion**

SD 4.2 Rating: C (41-65% compliance with this criterion)

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

- In general the equipment, medical devices and cleaning devices observed were clean. However, there was insufficient documentary evidence of records of cleaning of equipment, medical devices and cleaning devices.
- A number of sluice rooms were used to store cleaning equipment, soiled linen and waste.
- It was advised that nursing staff cleaned the medical equipment. There was evidence observed that equipment was dusty in many areas.
- This process of cleaning equipment was not observed to be consistent in the organisation.

- There was evidence observed that the bed pan washer was not working in the surgical ward.

***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.

- There was evidence that the flat mopping system was in place and the colour coding system had been recently introduced.
- Personal Protective Equipment was available, however these were not observed to be worn at all times.
- The cleaning equipment observed did not appear clean in all areas visited and this included the cleaning in progress signs which were available but not in use.
- The cleaning rooms and sluice rooms did not all have additional hand wash sinks available as required.

***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.

- In general the hygiene in the kitchens visited was not to a very high standard.
- Evidence was demonstrated that colour coded equipment was purchased for the central kitchens however, the organisation were unable to demonstrate a documented process for their use.
- Bait boxes were observed in all kitchens. These were not clean in many areas.
- Staff clothing was observed in some kitchens visited.
- The fly screens in place in some kitchens were ill fitting.
- It was advised that the hospital have considered the need for new catering trolleys however, there was no evidence demonstrated that any decision had been made to purchase these.
- Restricted access signs were observed to be in place, however, this was not adhered to in many areas.
- Staff other than catering staff were observed entering kitchens without the use of personal protective equipment which was provided.
- There was evidence of cutlery and crockery stored in one patient area and covered with a cloth. This was within an area which was occupied by patients and it was observed that ongoing refurbishment was in progress.

***Core Criterion**

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

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

- There was evidence demonstrated of waste management training being provided.
- The policy for the management of waste was revised in March 2008.
- A policy for the management of sharps was also demonstrated.
- The segregation of waste was observed to be adhering to best practice in many clinical areas.
- There was documentary evidence of a waste collector's permit, a waste license for clinical and non-clinical waste, C1 forms and the discharge to drain license were also demonstrated.
- The hospital demonstrated that it has access to a designated dangerous goods safety advisor for the region. Training records were demonstrated for those handling waste.
- There was no evidence of hand washing facilities in the external clinical and domestic waste compounds.
- There was evidence observed of double handling of waste between removal from ward areas and placement in waste compound was observed.
- There was evidence of many discarded bins and a large quantity of unused furniture in the grounds of the hospital.

***Core Criterion**

SD 4.6 Rating: C (41-65% compliance with this criterion)

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

- The hospital demonstrated their linen policy.
- Segregation of linen according to national colour coding was observed in all areas.
- Disposable curtains were in use in some areas. Audits are in place for the management of linen however these were observed to be completed on an ad hoc basis only.
- There was evidence that the linen policy was not adhered to in all areas as many of the linen bags were not closed once three quarters full and some laundry bags were observed on the floor in the sluice room areas.
- There were a number of mattresses not in use in the clinical areas and these were stored behind beds, and mattress bags were observed however no evidence of use was demonstrated.
- The used linen was noted in an open container at the back entrance to the hospital until transfer to the holding areas. This was observed as not being a

secure location. It was demonstrated that linen is collected daily from this holding area.

***Core Criterion**

SD 4.7 **Rating: C** (41-65% 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 SARI guidelines

- There was evidence demonstrated that twice yearly hand hygiene audits were completed. Records of these were demonstrated.
- A number of staff demonstrated hand hygiene in line with best practice.
- Signage for hand hygiene was observed to be in place, and this included the talking sign at reception.
- It was observed that not all wash hand basins are compliant with best practice.
- It was observed that alcohol based hand rub was not being used at bedsides within clinical areas where there were a limited number of wash-hand basins.

SD 4.8 **Rating: C** (41-65% compliance with this criterion)

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

- There was evidence that a Risk Management and Quality Committee was in place.
- There was evidence demonstrated that the Risk Manager and Infection Control personnel attend all Clinical Nurse Manager 2 meetings.
- It was demonstrated through minutes of meetings that hygiene services is not a standard agenda item at these meetings due to the time limit on meetings of two hours.
- There was no evidence demonstrated of formalised feedback from incident reporting to clinical areas, however it was advised that the forum of the Clinical Nurse Manager 2 meetings was used, this was not demonstrated.
- Risk assessment as part of the safety statement has been completed by individual staff members; however there has been no follow up in relation to these.
- Management advised during the course of the interviews that the STARSweb report was forwarded to all clinical areas, however this process could not be validated at local level.
- No evidence was demonstrated of risk management intervention into the use of the surgical ward for use by patients when construction work was ongoing in this area.

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

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

- There was evidence demonstrated of the recent introduction of a patient representative onto the Hygiene Committee.
- The process of 'Your service your say' is in place. The visiting policy was in place. This was reviewed in 2008.

- There was adequate signage observed to be in place. Alcohol-based hand-hygiene and sinks have been fitted at back and front entrances to the hospital.
- The organisation demonstrated that a patient satisfaction survey was completed in 2008, however the action points from this have not yet been agreed and were not demonstrated.

PATIENT'S/CLIENT'S RIGHTS

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

- There was evidence demonstrated of a Patient Charter in place.
- It was advised that a confidentiality clause was included in staff job descriptions and contracts, however, the same was not available to be demonstrated.
- There was no evidence demonstrated of violations of rights of patients.
- The hygiene facilities for patients were limited and necessitated patients from the emergency department using facilities in the elderly care ward area.
- There was evidence of equipment stores in the close vicinity of patients beds in two clinical areas visited.

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 demonstrated of information leaflets in particular for infection control and hygiene available for patients.
- The patient satisfaction survey for hygiene services included questions in relation to information, however it was demonstrated that this information had not been analysed.

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 the HSE policy, 'Your service your say' was in place, and a log was maintained of all complaints.
- There was evidence of one complaint relating to hygiene demonstrated.
- The numbers of complaints received was demonstrated to be one of the Key Performance Indicators for the Hygiene Services Committee recently established.
- It was advised by management that there had been training provided to staff on the management of complaints, however records of training were not demonstrated.
- There was evidence to demonstrate that the complaints process will be tracked by the complaints officer.
- There was some evidence demonstrated of follow up in relation to complaints.
- A formalised process was not demonstrated.

ASSESSING AND IMPROVING PERFORMANCE

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

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

- There was evidence demonstrated that a patient satisfaction survey was completed in 2008 with 50 patients and the agenda for the next Hygiene Services Committee meeting identified that the survey will be discussed and the findings and action plans will be forwarded to the Hospital Executive Team.
- It was demonstrated that there was now a patient representative on the Hygiene Services Committee.
- There have been letters of commendation circulated to the clinical area for hygiene services. These were demonstrated.
- The evaluation of this criterion was not demonstrated.

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

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

- There was evidence that hygiene audits are ongoing and the results of these were demonstrated, however there was no schedule of audits demonstrated.
- There was evidence that there is ongoing tracking of infection rates in clinical areas and the information is relayed to a member of the management team.
- There was evidence demonstrated that a hospital wide quality improvement plan for hygiene was in place and was being tracked through the Hygiene Services Committee.
- The annual report for Hygiene Services for 2006 and 2007 was demonstrated.
- There was evidence demonstrated that many policies, procedure and guidelines have been developed for Hygiene Services and Infection Control and these were updated in 2008.
- There was evidence that a grounds maintenance standard operating procedure was developed in 2008. There was no documented evidence of compliance with procedure.
- There was no evidence demonstrated of evaluation of the extent to which hygiene services initiatives are being undertaken by the Hygiene Services Team as a result of evaluation.

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

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

- There was evidence of an Annual Report for Hygiene Services in place for 2007.
- It was demonstrated that this was developed in line with the regional report and hygiene regional committee.

- The service user involvement in this report was not demonstrated. There was no evidence of evaluation of the appropriateness of the Hygiene Services Annual Report.

Appendix A: Ratings Details

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

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

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