

National Hygiene Services Quality Review 2008

Mid Western Regional Maternity Hospital Assessment Report

Assessment date: 5th November 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 Mid Western Regional Maternity Hospital, Limerick – Organisational Profile¹

The Mid West Regional Maternity Hospital, Limerick is a stand alone maternity hospital providing Obstetric and Neonatology services for Limerick, Clare and Tipperary North Riding. The hospital has 84 Obstetric beds and 19 Neonatal cots. The hospital has responsibility for the delivery of approx 5,200 babies annually and also caters for 900 admissions to our neonatal unit.

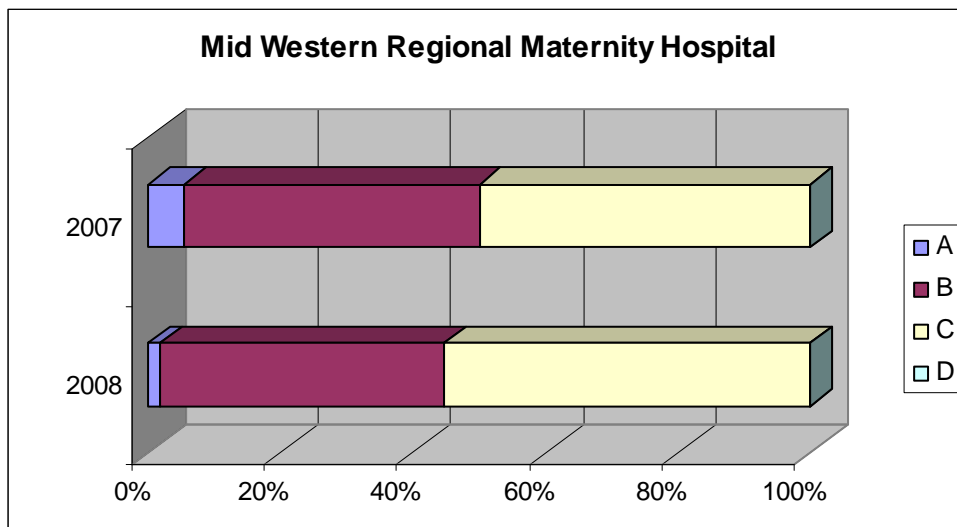
2.2 Areas Visited

- Outpatient department
- Maternity ward 1
- Maternity ward 2
- Maternity ward 3
- 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.

Mid Western Regional Maternity Hospital has achieved an overall rating of:

Fair

Award date: 2008

2.4 Standards for Corporate Management

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

PLANNING AND DEVELOPING HYGIENE SERVICES

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

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

- The organisation demonstrated a regional Hygiene Corporate Strategic Plan 2007-2009, which had been adopted locally.
- A regional hygiene policy had been evaluated and signed off.
- Evidence was demonstrated of a hygiene service and an operational plan.
- It was demonstrated that a consumer group was established in September 2008 and input from the members in relation to their experiences of the hospitals services included hygiene. No evidence of terms of reference were demonstrated.
- No evidence of a documented process for completing a needs assessment regarding the requirements for hygiene services including environment and facilities was demonstrated.
- No evaluation of the needs assessment process was 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.

- An assessment tool for the evaluation of new products was demonstrated.
- There was evidence demonstrated that evaluation of new cleaning products had been undertaken in consultation with the Infection Control Nurse.
- It was demonstrated that new cleaning cloths were introduced following the evaluation of a number of products.
- Evidence was demonstrated that flat mop system usage was evaluated in 2008.
- No evidence of evaluation of developments and modifications to the organisation's hygiene services in relation to meeting the service-user's needs was demonstrated.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

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

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

- The organisation demonstrated evidence of linkages with the HSE through the Regional Steering Committee for Hygiene and Cleanliness in Network 7 and with the National Hospitals Office.
- Evidence was demonstrated of a Hygiene Services Team which was multidisciplinary.
- Evidence was demonstrated that patient linkage had recently been established.
- Some evidence of linkages with contractors was demonstrated.
- No formal evaluation of linkages and partnerships was demonstrated.

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.

- The organisation demonstrated evidence of a regional Hygiene Corporate Strategic Plan 2007-2009, which included high-level priorities, goals and objectives, which they had adopted locally.
- Evidence was demonstrated that the plan was developed by the Regional Hygiene Services Committee, which had representation from the Hospital Executive Team.
- No evidence of evaluation of the Hygiene Corporate Strategic plans, goals, objectives and priorities was demonstrated.

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 members of the Hospital Executive Team had overall responsibility for the hospital's hygiene services.
- It was demonstrated that the link between Hygiene Services and the Hospital Executive Team was through the common management membership on both teams.
- The organisation advised that the hygiene services staff reported to the Senior Midwifery Manager.
- It was demonstrated that there was no local hygiene services supervisor in place.
- It was demonstrated that the Clinical Midwife Managers had responsibility for supervision of hygiene service delivery through observation and sign off of cleaning records which were completed by hygiene services staff. The evidence of this was fragmented and it was identified that there was limited understanding of the scope of their responsibility.
- The organisation advised that training records for hygiene services staff was held centrally by Senior Midwifery Management. Ward Managers were unable to demonstrate what training the ward based hygiene staff had undertaken.
- The organisation demonstrated evidence of a Mission Statement for the Mid-Western Health Board 2005.
- No formal evaluation of the appropriateness of the review of authority provisions in the hygiene service areas was demonstrated.

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.

- The organisation advised that best practice information was received through the Regional Hygiene Services Committee.
- Evidence was demonstrated that a Microbiologist and Infection Control Nurse reviewed literature in relation to current best practice including hygiene related issues. A 0.5 Whole Time Equivalent (WTE) Infection Control Nurse had recently been appointed to the hospital however they had yet to take up the post.
- The organisation used the Irish Acute Hospitals cleaning manual to inform hygiene service delivery. A draft localised manual was demonstrated.

- Hazard Analysis and Critical Control Point monitoring and records were demonstrated.
- Hygiene audit results were demonstrated however there was no evidence of processes for tracking and trending.
- No evaluation of the appropriateness of the information received was demonstrated.

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.

- The organisation demonstrated that there was a regional library in place at Limerick Regional hospital, and information was circulated via the intranet.
- It was demonstrated that internet and intranet access was available.
- Hand-hygiene leaflets were available however not widely evident in the clinical areas.
- Induction and ongoing education was demonstrated. It was demonstrated that the Infection Control Nurse who was regionally based provided the hygiene related training.
- It was demonstrated that the most recent hygiene training was through use of a DVD and attendance records demonstrated 75% of staff were trained in 2008.
- There was a lack of clarity demonstrated regarding whether hygiene training was mandatory.
- No evidence of evaluation of the appropriateness of the best practice information available was demonstrated.

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

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

- The National Hospital Office template for policies, procedure and guidelines (PPG) development was demonstrated. There was evidence that PPGs followed a standard structure and were signed off by senior management.
- The organisation demonstrated that the Infection Control Service was at a regional level. The regional Infection Control Manual, which contained a decontamination section, was demonstrated.
- Evidence was demonstrated of local standard operating procedures for hygiene based on the template.
- There was evidence of a strategic multidisciplinary (Midwifery and Medical) PPG Committee. It was demonstrated that the committee was evaluated in 2007. Evidence was also demonstrated of peer review by an external body.

- There was no evaluation of the efficacy of the process for developing and maintaining hygiene services PPGs demonstrated.

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

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

- There was evidence of involvement of the Hygiene Service Team in the organisation's capital development, planning and implementation process, for example the brief for the future of Maternity Services which was submitted to the HSE.
- Evidence was demonstrated of consultation with the Hygiene Services Committee in relation to a recently commissioned building for patient education.
- No evidence of evaluation of the efficacy of the consultation process between Hygiene Services Team and Senior Management was demonstrated.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

***Core Criterion**

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

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

- The organisation advised that the overall responsibility and accountability for cleaning services was a delegated function to the ward/ department manager.
- The hygiene services structure was limited to service delivery staff, ward /department managers and senior midwife management.
- There was a lack of clarity demonstrated at ward /department level as to the scope of the manager's responsibility/accountability in regard to hygiene service delivery.
- There was no evidence in the Clinical Midwife Manager's job description of their responsibility for hygiene.

***Core Criterion**

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

The organisation has a multidisciplinary Hygiene Services Committee.

- Records were demonstrated of monthly Hygiene Services Team meetings.
- The organisation advised that there was no dedicated administrative support for the team in place and that minutes were taken by a member of the team and circulated by an administrative secretary to all line managers.
- Terms of reference were demonstrated however the organisation did not demonstrate a documented process to ensure team awareness of their roles and responsibilities.
- No evidence was demonstrated of a patient or medical representative on the hygiene services team.

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.

- It was demonstrated that one of the stated objectives for the regional Hygiene Corporate Strategic plan 2007-2009 was to ensure funding was ring fenced for both capital and revenue to address deficits of non-compliance with the national hygiene and cleanliness standards. There was no evidence of an allocated hygiene budget demonstrated.
- The organisation demonstrated that there was a hygiene service staff of twenty four whole time equivalents, excluding catering, and there was an identified budget for pay costs demonstrated. There was also evidence demonstrated of tracking of pay and non-pay costs for hygiene related services month on month.
- The organisation advised that an additional cleaning resource was identified for the new physical structure which had recently been commissioned. This was addressed through evaluation and redeployment within the existing resources.
- Minor capital requirements were identified for example, replacement of sinks, however the organisation demonstrated that this development was not progressing due to financial and environmental constraints.
- No costings were demonstrated for the outstanding minor capital list.

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

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

- Evidence was demonstrated of the involvement of the Hygiene Committee in the pre-purchasing of equipment through the minutes of meetings, for example the purchasing of the baby-tagging system and the cleaning equipment and products.
- No evidence of evaluation of the efficacy of the consultation process between the hygiene services team 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.

- Evidence was demonstrated of a part-time risk manager, a risk-management strategy and a risk reporting system with three monthly clinical incident reviews.
- It was demonstrated that all incidents and risks were logged. There was evidence demonstrated of root cause analysis being conducted on moderate and major incidents with the issuing of resultant reports to the Clinical Review Group and staff directly involved.
- Evidence was demonstrated of an infection outbreak in 2007, which resulted in a full investigation, evaluation and implementation of appropriate actions.
- Evidence was demonstrated of a Health and Safety Committee with two staff members trained as health and safety representatives.
- No evidence was demonstrated of an annual report for risk or Health and Safety.
- It was demonstrated that hygiene audit reports were discussed at the Hygiene Team and Midwifery Management meetings. It was reported that the minutes of these meetings were issued and circulated to all wards/ departments.
- Limited tracking or trending of incident rates was demonstrated.

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 organisation demonstrated evidence that there was no Risk Management Committee in place.
- It was demonstrated that the risk manager was a member of the Hygiene Services Team.
- It was demonstrated that risk reports were presented to hospital management on a quarterly basis.
- It was reported that the Infection outbreak in the Neo–Natal Unit in 2007 was the only major adverse event reported over the last two years and evidence of analysis 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 advised that all contracts were negotiated either nationally for Hazardous Waste or regionally for non–clinical waste.
- There was documented evidence of two meetings with the contractors for Hazardous Waste.
- Records of collections and service delivery were demonstrated for example, for waste, pest control and sani–bin services.
- No contracts were demonstrated.

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

The organisation involves contracted services in its quality improvement activities.

- There was documented evidence of two meetings with the contractors for Hazardous Waste
- Evidence of monitoring of compliance for service provision by a member of the Hospital Executive Team was demonstrated.
- Environmental Health Officer meetings with management were demonstrated.

- There was limited evidence of the involvement of contractors in quality improvement activities.

PHYSICAL ENVIRONMENT, FACILITIES AND RESOURCES

CM 9.1 Rating: C (41-65% compliance with this criterion)

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

- The design of the hospital was observed to be sub-optimal in relation to storage and hygiene facilities. Cleaner's rooms were observed to be small or non-existent. Some store rooms were observed to be multipurpose.
- There was evidence demonstrated that a number of hand wash basins were non-compliant.
- Waste and soiled linen was observed to be stored inside the back entrance to the hospital, which was en route to some clinical areas.
- Waste was observed to be held at the bottom of stairs near the lift prior to removal to the waste compounds. However there was evidence of frequent collections.
- It was demonstrated that there were two waste storage locations at opposite ends of the campus which were well maintained.

***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.

- Processes were demonstrated for the planning and managing of the environment and facilities.
- It was demonstrated that a quality improvement plan was developed in January 2008 and reviewed in April and September 2008. The plan identified processes and equipment needing implementation and there was evidence of progress in a number of areas.
- Regionally developed documented processes for the handling and segregation of linen were demonstrated. It was demonstrated that linen skips had been upgraded to facilitate best practice compliance.
- It was demonstrated that new curtains had been purchased.
- It was also demonstrated that disposable sheets had been introduced for couches in the Outpatient Department.
- There was evidence of waste segregation policy and notices with facilities in place for compliance.

- There was evidence of outstanding maintenance issues although a plan had been submitted to the regional Technical Services Department.
- New cleaning standard operating procedures were being developed regionally in line with the national standards, however had not been implemented.

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.

- There was evidence demonstrated of internal audits, staff feedback on the flat mop system and cleaning products and spill kits had been introduced to clinical areas.
- There was evidence demonstrated that the main kitchen and one ward kitchen had been updated. hazard analysis and critical control point (HACCP) standards were demonstrated.
- It was demonstrated that the organisations policy regarding the use of personal protective equipment and colour coded flat mops was not always adhered to.

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

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

- Mechanisms were in place for patients, providers and visitors to provide feedback, for example comment cards and 'Your Service Your Say' were demonstrated.
- Evidence was demonstrated of a complaints process.
- No patient satisfaction survey on hygiene services was demonstrated.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 Rating: C (41-65% 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 advised the assessors that recruitment of staff was managed through Regional Human Resource Department and duplicate

- copies of records were held locally. No contract hygiene services staff were employed.
- There was evidence demonstrated that job descriptions for ward managers was not explicit regarding responsibility for hygiene.
- No evidence of evaluation of the process for selection and recruitment of human resources was 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.

- There was no evidence demonstrated of a documented process in place for reviewing changes in work capacity and volume.
- The organisation advised the assessors that the new parent education unit replaced a smaller structure and that additional cleaning hours were identified. It was reported that this need was addressed through redeployment within the existing resource.
- The organisation advised that audit results were the main methodology for the identification of the appropriateness of work capacity and volume.

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

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

- The organisation demonstrated that Health Care Assistants undertook the Further Education and Training Council level 5 course, and some staff had undertaken SKILLS training.
- The organisation advised that catering staff and the shop staff had undergone HACCP training.
- A list of duties was demonstrated for cleaning staff.
- There was evidence that mandatory induction training was available for all hygiene staff, which included hygiene.
- It was demonstrated that ongoing hygiene training was provided.
- It was demonstrated that education and training records were monitored as part of the training and education key performance indicators (KPIs).

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 no contract staff were employed for the delivery of hygiene services.
- There was evidence demonstrated that the shop employee had induction training in HACCP standards and was due to complete a refresher course.

***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.

- The only evidence of human resource needs assessment demonstrated was in relation to the new building recently commissioned.
- There was evidence demonstrated of the identification of the need for infection control resource at local level which was reported to be in the process of being addressed.
- Identification of the need for a domestic supervisor was included in the quality improvement plan, however it was not demonstrated that this was being addressed.
- The Hygiene Corporate Strategic plan was in place.
- The Hygiene Services and Operational Plans and the Hygiene Services Annual Report 2007 were in place however these did not identify human resource needs.

ENHANCING STAFF PERFORMANCE

***Core Criterion**

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

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

- There was evidence demonstrated of a health services resource pack.
- The staff handbook demonstrated did not include hygiene.
- The organisation advised that induction was mandatory and included hygiene training. Attendance levels were recorded and held centrally within the organisation by the Senior Midwife Managers. Staff follow-up for training was managed at this level also.
- It was demonstrated that ongoing hygiene training was provided.

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.

- The organisation advised that staff were released for necessary education and training during rostered working time.
- It was demonstrated that education and training records were monitored as part of the training and education key performance indicators.
- There was evidence demonstrated of ongoing hygiene training, however no schedule was demonstrated.
- Evidence was demonstrated of attendance records for training which were monitored centrally with records maintained in each staff member's file.
- Evidence was demonstrated of plans to employ a part time Infection Control Nurse which it was proposed would enhance hygiene training.
- Evidence was demonstrated of a digital versatile disc "Standard Precautions in the Healthcare Setting" which was available in the clinical areas.
- It was demonstrated that seventy five percent of staff had participated in training in 2008. It was also demonstrated that hand hygiene techniques were assessed at these training sessions.
- It was demonstrated that staff were released and financially supported for external courses deemed relevant for example professional, Further Education and Training Awards Council and SKILLS courses.
- No evidence of evaluation of the relevance of education to each staff member was demonstrated.

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

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

- Evidence was demonstrated of key performance indicators for training and education attendance records.
- No other evidence of key performance indicators were demonstrated.
- It was reported that all hygiene training was mandatory, however no documented evidence of this was demonstrated.
- No evidence of evaluation of training was demonstrated.

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

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

- There was evidence that there was no formal performance review.
- Informal performance evaluation was reported to occur through hygiene audits and records of training uptake.
- The organisation advised that issues in relation to staff performance would be dealt with through the disciplinary pathway
- No evidence of evaluation of the appropriateness of performance evaluation processes was demonstrated.

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.

- The organisation advised that the Occupational Health Service was regional and delivered by an Occupational Health Nurse and Occupational Health Physician.
- An evaluation of the services needs was conducted in 2007 to identify and evaluate resource needs for the service. The organisation advised that there was no input into this evaluation by the organisations staff.

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.

- No performance indicators were identified to monitor hygiene staff satisfaction with occupational health and well being.
- Evidence was demonstrated of an employee assist programme.
- No staff satisfaction survey was 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.

- It was demonstrated that minutes of meetings and audit reports were recorded and circulated to all areas.
- There was no evidence of trending or tracking of audit results demonstrated
- It was demonstrated that infection rates were recorded and submitted to management.
- It was demonstrated that risk management reports were returned quarterly to the hospital management team.
- No evidence of evaluation of the quality data reliability, accuracy, validity and appropriateness was demonstrated

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

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

- It was demonstrated that the minutes of hygiene services team meetings were circulated prior to the next meeting and validated at that meeting.
- Information on trends was not included.
- It was demonstrated that items remained on the agenda until resolved.
- Audit reports were presented numerically however were not trended
- No evidence of evaluation of user satisfaction in relation to the reporting of data and information was demonstrated.

CM 13.3 Rating: C (41-65% compliance with this criterion)

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

- A comprehensive list of maintenance requirements developed in August 2008 based on hygiene audit results and department managers lists compiled for their areas was demonstrated. It was reported that the list had been submitted to the Regional Maintenance Department.
- No other evidence of change or improvements in data collection and information reporting was demonstrated.

- No evidence of evaluation of the appropriateness of the data and information utilisation in relation to service provision and improvement was demonstrated.

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.

The organisation demonstrated that improvements had been implemented. These included:

- Neonatal refurbishment completed September 2007.
- Painting was completed in two areas.
- Infection Control Nurse 0.5 whole time has been recruited however it was advised that she had not yet taken up post.
- The visiting policy was reviewed and updated in 2007.
- Spill kits were implemented in all clinical areas.
- New storage cabinets were installed in some areas.
- Disposable sheets were introduced to the Outpatient Department in September 2008
- Following review in 2008 television shelves were removed and replaced with brackets for hygiene improvement purposes.
- Linen skip were introduced to facilitate segregation in accordance with best practice.

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.

- A hygiene quality improvement plan was demonstrated. The plan was developed in January 2008 and there was evidence that it had been evaluated twice since.
- Following the infection outbreak in 2007 there was evidence that the outbreak was managed and contained to a small number of patients. The organisation advised that no further outbreaks had occurred in the interim.
- It was demonstrated that Performance Indicators for hygiene were still at an early stage of development.
- A template was introduced for the evaluation of new hygiene products.

- It was demonstrated that internal hygiene audits were the main evaluation process in place.
- No evidence of evaluation of improved outcomes in hygiene services delivery as a result of the quality improvement system 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: C (41-65% compliance with this criterion)

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

- There was evidence of the Irish Acute Hospitals' Cleaning Manual, however draft standard operating procedures were demonstrated.
- There was evidence that policies, procedures and guidelines followed a standard structure and were signed off by senior management.
- It was demonstrated that the Infection Control Manual contained a decontamination section.
- Evidence was demonstrated that colour coding had been introduced for cleaning, linen and waste segregation.
- It was demonstrated that Hazard Analysis and Critical Control Point was in place in the catering service.
- There was evidence demonstrated that the policy for the use of personal protective equipment and colour coding of mop heads was not complied with by staff on all occasions.
- No evaluation of the efficacy of the processes used to develop best practice guidelines by the hygiene services team 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.

- A template for the evaluation of new products and equipment was demonstrated
- New interventions included new cleaning products for example, disposable cloths instead of cotton tea towels, cleaning cloths for cleaning, and multi wipes in ante-natal and admissions areas.

- The organisation advised the assessors that the flat mop system was evaluated in 2008. No evidence was demonstrated.

PREVENTION AND HEALTH PROMOTION

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

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

- The organisation advised that the hospital had membership of the National Health Promoting Hospital Network.
- Evidence was demonstrated of a range of health promotion leaflets.
- It was demonstrated that health promotion activities occurred through antenatal classes, posters, patient information pack and leaflets that included hygiene information.
- No evidence of evaluation of efficacy of activities undertaken or participated in by the team in the community in relation to hygiene was demonstrated.

INTEGRATING AND COORDINATING HYGIENE SERVICES

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

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

- The organisation demonstrated evidence of a multidisciplinary hygiene services team in place; however it was not fully representative of all disciplines.
- It was demonstrated that the Patient Forum had recently been established and had cross membership with the Hygiene Services Team.
- It was demonstrated that the Hygiene Services team linked and reported into the Hospital Executive Group and the Regional Hygiene Services Committee through shared membership.
- No evidence of evaluation of the efficacy of the multidisciplinary team structure was demonstrated.

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.

- There was evidence demonstrated that the organisations' physical environment was not well maintained.
- There was evidence of high and low dust in many areas.
- There was a system in place for the change of curtains however documentation for changing was not always demonstrated.
- There were checklists for completion of cleaning, however these were not always in place, or always signed off by the department manager.
- Some chairs were observed not to have washable covering and a few were torn.
- Sticky tape residue was demonstrated on a number of surfaces.
- It was observed that a number of bedpans were not clean.
- There was evidence of a lack of documentation to demonstrate the flushing of showers.

***Core Criterion**

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

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

- There was evidence demonstrated that not all equipment was managed and clean, for example some equipment was dusty, fans were in use in some clinical areas, bed pans and wash bowls were not clean and a number were not stored appropriately.

***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 demonstrated that the organisation's cleaning equipment was managed and clean.

- Cleaning equipment was stored in a variety of inappropriate areas, for example sluice room, multi purpose store room and adjacent to fire escape stairs.
- Some equipment was observed to be inappropriately used, for example ward floor mop handle was observed to be in use in the ward kitchen.
- Evidence was not always demonstrated of knowledge of cleaning product dilution.
- There were no dilution charts demonstrated in cleaning rooms.

***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.

- The organisation demonstrated evidence that temperature recording was in place
- There was evidence demonstrated that some Hygiene Services staff had combined ward kitchen and ward cleaning duties during the same shift.
- It was observed that a number of ward fridges required defrosting.
- There was evidence of staff food storage in the ward kitchen and feed preparation room fridges.
- There was no food safety policy observed in the ward kitchens.

***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.

- External waste storage facilities were demonstrated to be secure and well maintained.
- There was evidence of insufficient internal storage for collected waste, although it was reported to be collected on a regular basis.
- The colour-coding demonstrated was not clear, as all bins were white and the identification of the colour coding was by way of a wall-mounted notice only with no information provided on the bin lids in many areas.
- There was evidence of household waste being placed in clinical waste bags.

***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

- There was evidence demonstrated of segregation of linen via colour coding and disposable linen implemented in high use areas, for example the Outpatient Department
- There was evidence demonstrated of a lack of storage for linen, for example clean linen was held in crates on a corridor, and although soiled linen was collected frequently from clinical areas and stored in wire crates inside the back entrance to the hospital, this area was part of the main thoroughfare to some clinical areas. It was demonstrated that soiled laundry was transported to the external laundry area three times per week.

***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 hand hygiene preparation and practice followed the defined standard.
- It was demonstrated that a number of wash hand wash basins were not in line with best practice.
- There was evidence that not all waste bins were hands free.

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

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

- There was evidence demonstrated of a risk management system that included incident reporting.
- Staff interviewed demonstrated knowledge of risk management processes.
- There was a Legionella policy in place with evidence of a recent negative reading demonstrated.
- Successful response to non-routine situations was demonstrated through the processes implemented in 2007 to deal with an infection outbreak.
- Cleaning in progress signs were observed to be used.

- Limited evidence of track and trend reports on risks and incidents to departments was demonstrated.

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

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

- No documented patient satisfaction survey was demonstrated: however evidence of patient feedback through department manager logs and the feedback from the Patient Forum was demonstrated.
- Evidence of information leaflets and posters was demonstrated.
- Evidence of an information pack, issued to the patients on first antenatal visit which included hygiene information was demonstrated.
- Evidence was demonstrated that the visiting policy was updated recently and included a section on hygiene.

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.

- It was observed that a notice was displayed in the colposcopy room outlining the rights of patients.
- Documented standards of care for privacy and dignity were demonstrated.
- The Visitor code was demonstrated.
- The organisation advised that there was a working group established in June 2007 with a focus on patient-centered care issues.
- There was no evidence of violation of patients rights demonstrated.
- There was no evaluation demonstrated.

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

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

- There was evidence demonstrated that: an information pack was given to patients on their first antenatal visit, which included information on hygiene, and a special discharge information sheet, which also covered hygiene issues.
- Poster and leaflets were provided.
- There was no evaluation demonstrated.

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 in excess of 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.

- A Consumer Forum was established in September 2008. Participation was by way of invitation through the local media. Evidence of documented feedback from their first meeting was demonstrated.
- The Saturday walkabouts by senior managers with verbal patient interviews and diary log of patient comments were demonstrated.

SD 6.2 Rating: C (41-65% 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 advised that infection rates, internal audit outcomes and training records were monitored.
- A Hygiene Services Annual Report for 2007 was demonstrated.
- No key performance indicators for hygiene were demonstrated.
- A quality improvement plan for 2008 with review recorded in April and September was demonstrated.
- There were a number of improvements implemented in 2008, which included environmental and service delivery areas.

SD 6.3 Rating: C (41-65% compliance with this criterion)

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

- There was no evidence demonstrated of a process for the development of the Hygiene Services Annual Report 2007.
- No evidence of its evaluation or sign-off by senior management was demonstrated. However senior management advised that they were involved in its compilation.

- The organisation advised that hygiene audits were the main source of evaluation of implementation policies, procedures and guidelines.
- There was no evidence demonstrated that patients and visitors had input into the Annual Report.

Appendix A: Ratings Details

The table below provides an overview of the individual ratings 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	C	B
CM 3.1	C	B
CM 4.1	B	B
CM 4.2	B	C
CM 4.3	B	C
CM 4.4	C	B
CM 4.5	C	B
CM 5.1	B	C
CM 5.2	B	B
CM 6.1	B	C
CM 6.2	C	B
CM 7.1	B	B
CM 7.2	B	B
CM 8.1	C	C
CM 8.2	C	C
CM 9.1	C	C
CM 9.2	C	C
CM 9.3	C	C
CM 9.4	B	C
CM 10.1	C	C
CM 10.2	C	C
CM 10.3	B	B
CM 10.4	C	C
CM 10.5	C	C
CM 11.1	C	B
CM 11.2	B	B
CM 11.3	C	C
CM 11.4	C	C
CM 12.1	C	C
CM 12.2	C	C
CM 13.1	C	B
CM 13.2	C	C
CM 13.3	C	C

CM 14.1	B	B
CM 14.2	C	C
SD 1.1	C	C
SD 1.2	B	B
SD 2.1	C	B
SD 3.1	B	B
SD 4.1	B	C
SD 4.2	A	B
SD 4.3	B	C
SD 4.4	A	C
SD 4.5	A	C
SD 4.6	B	C
SD 4.7	B	C
SD 4.8	B	B
SD 4.9	B	B
SD 5.1	B	B
SD 5.2	B	B
SD 5.3	B	A
SD 6.1	C	B
SD 6.2	B	C
SD 6.3	C	C