

National Hygiene Services Quality Review 2008

St Columcille's Hospital

Assessment Report

Date of assessment: 22nd September 2008

About the Health Information and Quality Authority

The Health Information and Quality Authority is the independent Authority which was established under the Health Act 2007 to drive continuous improvement in Ireland's health and social care services. The Authority was established as part of the Government's overall Health Service Reform Programme.

The Authority's mandate extends across the quality and safety of the public, private (within its social care function) and voluntary sectors. Reporting directly to the Minister for Health and Children, the Health Information and Quality Authority has statutory responsibility for:

Setting Standards for Health and Social Services – Developing person-centred standards, based on evidence and best international practice, for health and social care services in Ireland (except mental health services)

Monitoring Healthcare Quality – Monitoring standards of quality and safety in our health services and implementing continuous quality assurance programmes to promote improvements in quality and safety standards in health. As deemed necessary, undertaking investigations into suspected serious service failure in healthcare

Health Technology Assessment – Ensuring the best outcome for the service user by evaluating the clinical and economic effectiveness of drugs, equipment, diagnostic techniques and health promotion activities

Health Information – Advising on the collection and sharing of information across the services, evaluating, and publishing information about the delivery and performance of Ireland's health and social care services

Social Services Inspectorate – Registration and inspection of residential homes for children, older people and people with disabilities. Monitoring day- and pre-school facilities and children's detention centres; inspecting foster care services.

1 Background and Context

1.1 Introduction

In 2007, the Health Information and Quality Authority (the Authority) undertook the first independent National Hygiene Services Quality Review. The Authority commenced its second Review of 50 acute Health Service Executive (HSE) and voluntary hospitals in September 2008.

The aim of the Review is to promote continuous improvement in the area of hygiene services within healthcare settings. This Review is one important part of the ongoing process of reducing Healthcare Associated Infections (HCAIs) and focuses on both the service delivery elements of hygiene, as well as on corporate management. It provides a general assessment of performance against standards in a range of areas at a point in time.

The Authority's second *National Hygiene Services Quality Review* assessed compliance for each hospital against the National Hygiene Standards and assessed how hospitals are addressing the recommendations as identified in the 2007 National Hygiene Services Quality Review.

All visits to the hospitals were unannounced and occurred over an eight-week period. The Authority completed all 50 visits by mid-November 2008. The *National Hygiene Services Quality Review 2008* provides a useful insight into the management and practice of hygiene services in each hospital.

Following the Authority's Review last year, every hospital was required to put in place Quality Improvement Plans (QIPs) to address any shortcomings in meeting the Standards.

Therefore, in considering this background, the Authority would expect hospitals to have in place well established arrangements to meet the Standards and the necessary evidence to demonstrate such compliance as part of their regular provision and management of high quality and safe care.

Consequently, the Authority requested a number of sources of evidence from hospitals in advance of a site visit and this year the unannounced on-site review was carried out, with the exception of one hospital, within a 24-hour period – rather than the three days taken last year. The Authority also stringently required that all assertions by hospitals – for example, the existence of policies or procedures – were supported by clear, documentary evidence.

This “raising of the bar” is an important part of the process. It aims to ensure that the approach to the assessment further supports the need for the embedding of these Standards, as part of the way any healthcare service is provided and managed, and also further drives the move towards the demonstration of accountable improvement by using a more rigorous approach.

It must therefore be emphasised that the assessment reflects a point in time and may not reflect the fluctuations in the quality of hygiene services (improvement or deterioration) over an extended period of time. However, patients do not always choose which day they attend hospital. Therefore, the Authority believes that the one-day assessment is a legitimate approach to reflect patient experience given that the arrangements to minimise Healthcare Associated Infections (HCAIs) in any health or social care facility should be optimum, effective and embedded 24 hours a day, seven days a week.

Individual hospital assessments, as part of the *National Hygiene Services Quality Review 2008*, provide a detailed insight into the overall standard of each hospital, along with information on the governance and management of the hygiene services within each hospital. As such, the Review provides patients, the public, staff and stakeholders with credible information on the performance of the 50 Health Service Executive (HSE) and voluntary acute hospitals in meeting the *National Hygiene Services Quality Review 2008: Standards and Criteria*. The reports of each individual hospital assessment, together with the National Hygiene Services Quality Review 2008, can be found on the Authority's website, www.hiqa.ie.

Hygiene is defined as:

"The practice that serves to keep people and environments clean and prevent infection. It involves the study of preserving one's health, preventing the spread of disease, and recognising, evaluating and controlling health hazards. In the healthcare setting it incorporates the following key areas: environment and facilities, hand hygiene, catering, management of laundry, waste and sharps, and equipment."

Irish Health Services Accreditation Board Hygiene Standards

1.2 Standards Overview

There are 20 Standards divided into a number of criteria, 56 in total, which describe how a hospital can demonstrate how the Standard is being met or not. To ensure that there is a continual focus on the important areas relating to the delivery of high quality and safe hygiene services, 15 Core Criteria have been identified within the Standards to help the hospital prioritise these areas of particular significance.

Therefore, it is important to note that, although a hospital may provide evidence of good planning in the provision of a safe environment for promoting good hygiene compliance, if the assessors observed a clinical area where patients were being cared for that was not compliant with the Service Delivery Standards and posed risks for patients in relation to hygiene that weren't being effectively managed, then a hospital's overall ratings may be lower as a result.

The Standards are grouped into two categories:

(a) Corporate Management

These 14 Standards facilitate the assessment of performance with respect to hygiene services provision to the organisation and patients/clients at organisational management level. They incorporate the following four critical areas:

- Leadership and partnerships
- Environmental facilities
- Human resources
- Information management.

(b) Service Delivery

These six Standards facilitate the assessment of performance at service delivery level. The Standards address the areas of:

- Evidence-based best practice and new interventions
- Promotion of hygiene
- Integration and coordination of services
- Safe and effective service delivery
- Protection of patient rights
- Evaluation of performance.

The full set of Standards are available on the Authority's website, www.hiqa.ie.

Core Criteria:

To ensure that there is a continual focus on the principal areas of the service, 15 Core Criteria have been identified within the Standards to help the organisation and the hygiene services to prioritise areas of particular significance. Scoring a low rating in a Core Criterion can bring down the overall rating of a hospital even if, in general, they complied with a high number of criteria. It is worth emphasising that if serious risks were identified by the assessors, the Authority would issue a formal letter to the hospital in relation to these risks.

1.3 Assessment Process

There are three distinct components to the *National Hygiene Services Quality Review 2008* assessment process: pre-assessment, on-site assessment, following up and reporting.

Before the onsite assessment:

- **Submission of a Quality Improvement Plan (QIP) and accompanying information by the hospital to the Authority.** Each hospital was

requested to complete a Quality Improvement Plan. This QIP outlined the plans developed and implemented to address the key issues as documented in the hospital's Hygiene Services Assessment Report 2007.

- **Off-site review of submissions received.** Each Lead Assessor conducted a comprehensive review of the information submitted by the hospital.
- **The Authority prepared a confidential assessment schedule**, with the assessment dates for each hospital selected at random.
- **Selection of the functional areas.** The number of functional areas selected was proportionate to the size of the hospital and type of services provided. At a minimum it included the emergency department (where relevant), the outpatient department, one medical and one surgical ward.

The hospitals were grouped as follows:

- Smaller hospitals (two assessors) – minimum of two wards selected
- Medium hospitals (four assessors) – minimum of three wards selected
- Larger hospitals (six assessors) – minimum of five wards selected.

During the assessment:

- **Unannounced assessments.** The assessments were unannounced and took place at different times and days of the week. All took place within one day, except for one assessment that ran into two days for logistical reasons. Some assessments took place outside of regular working hours and working days.
- Assessments were undertaken by a **team of Authorised Officers** from the Authority to assess compliance against the National Hygiene Standards. Health Information and Quality Authority staff members were authorised by the Minister of Health and Children to conduct the assessments under section 70 of the Health Act 2007.
- **Risk assessment and notification.** Where assessors identified specific issues that they believed could present a significant risk to the health or welfare of patients, hospitals were formally notified in writing of where action was needed, with the requirement to report back to the Authority with a plan to reduce and effectively manage the risk within a specified period of time.

Following the assessment:

- **Internal Quality Assurance.** Each assessment report was reviewed by the Authority to ensure consistency and accuracy.
- **Provision of an overall report to each hospital, outlining their compliance with the National Hygiene Standards.** Each hospital was given an opportunity to comment on their individual draft assessment in advance of publication, for the purpose of factual accuracy.
- **All comments were considered** fully by the Authority prior to finalising each individual hospital.

- **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 St. Columcille's Hospital – Organisational Profile¹

St. Columcille's Hospital is an Acute Hospital with staffing for 133 beds. The total occupancy was 98% for 2006. The hospital was built in the 1840s as a workhouse and is in need of major repair.

The hospital provides each of the following services: General Medicine, Acute elderly assessment and rehabilitation , Intensive/Coronary care, General Surgery, Vascular Surgery, Gynaecology, Dental Surgery, Urology, Cardiology, Endocrinology, Nephrology, Pathology, Ophthalmology, Respiratory Medical, Psychiatry, Gerontology, Orthopaedics, Anaesthetics, Emergency Department

2.2 Areas visited

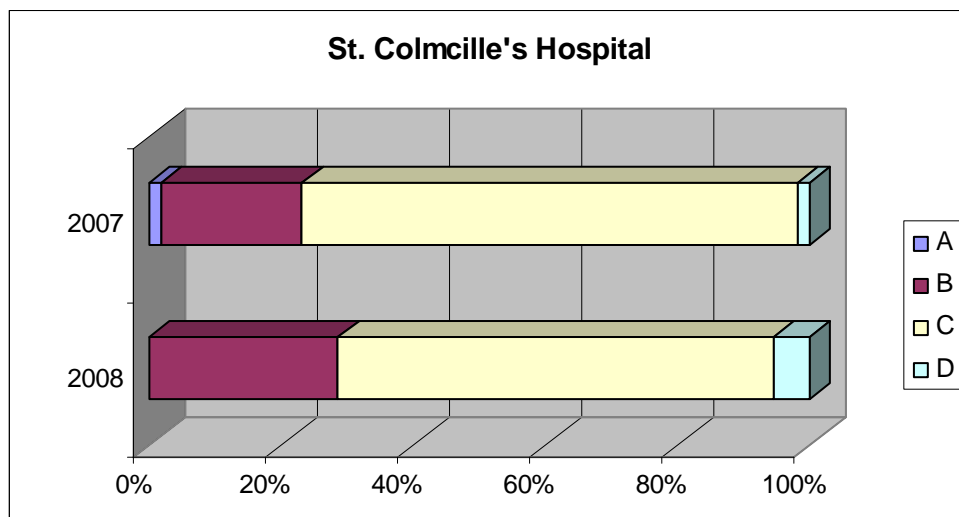
During the course of the assessment the following areas were visited:

- Emergency Department
- Outpatient Department
- Lourdes Ward
- St. Bridget's 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.

St. Columcille's Hospital 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.

- It was identified that a strategic plan was in the process of being developed.
- The hospital demonstrated that there was a process for needs assessment.
- It was demonstrated that needs assessments had been completed for St. Brigid's and Lourdes Wards and funding sought. Some work had commenced.
- It was advised that patient surveys were used to inform the process.
- It was identified that the organisation was progressing with plans to co-opt a patient representative onto the Hygiene Standards Committee.
- There was no evidence demonstrated of evaluation of the efficacy of the process to date.

CM 1.2 Rating: C (41-65% 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.

- It was demonstrated that the organisation had sourced funding for improvements to hygiene facilities following the national hygiene report in 2007 and upgrading had commenced.
- It was identified that funding had been approved for audit training.
- Evidence was demonstrated of audits being undertaken.
- No evidence was demonstrated of results being collated or evaluated.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

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

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

- Evidence was demonstrated of links with the HSE through the Network Manager who it was reported was a member of the Infection Control Committee.

- Evidence was also demonstrated of links with the HSE Dept. of Public Health through membership of this committee.
- There were links demonstrated through infection control with other hospitals in the network.
- It was identified that the hospital was actively seeking a patient representative for the hygiene standards committee.
- Evidence was demonstrated that this committee met monthly.
- Evidence was demonstrated that the hygiene support services team met twice monthly.
- Evidence was demonstrated that staff and patient satisfaction surveys had been used to gather information regarding hygiene services.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 **Rating: C (41-65% compliance with this criterion)**

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

- It was advised that a member of the executive management team was developing a corporate strategic plan.
- A documented process to support its development was not demonstrated.
- A corporate service plan was demonstrated and it was advised that there had been input from staff and service users.
- There was evidence demonstrated of goals and objectives as identified in the service plan being progressed.

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.

- An organisational chart was demonstrated with evidence of reporting lines to the management team.
- Evidence was demonstrated of linkages with infection control, catering, health and safety and support services through common membership.
- Evidence was demonstrated of clearly defined terms of reference for the management team, the infection control team, hygiene standards group and services support team.
- Hygiene was observed to be a standard item on the agenda of the management team.

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

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

- It was demonstrated that the Management team received information including minutes of the Hygiene Standards Committee.
- There was evidence demonstrated of acting on information, for example, hygiene staff shifts were changed to meet evolving needs and this is being monitored.

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 of best practice information being considered by the Management team and improvements made as a consequence, for example, there was evidence of new equipment in the laundry, which had also been reconfigured to include segregated areas for used and unused linen.
- There was evidence of best practice information received through staff membership of professional bodies and in-house training.
- While the organisation demonstrated that policies, procedures and guidelines were evidence based they were not available locally on the day of the assessment.

CM 4.4 Rating: C (41-65% compliance with this criterion)

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

- There was no documented process demonstrated for the development of policies, procedures and guidelines.
- There were policies and guidelines for hygiene services and infection control observed.
- It was advised that some textbooks in Polish have been sourced for staff whose first language was not English.
- No evidence of evaluation was demonstrated.
- It was advised that policies were normally held on the wards, but this was not observed on the day of the assessment.
- It was advised that these documents had been collected from clinical areas for the purpose of review.

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.

- Evidence was demonstrated that the Hygiene Services Committee had contributed to the capital development plan.
- There was a plan in place to upgrade areas of the hospital in relation to hygiene needs.
- Minutes of meetings demonstrated that hygiene related issues were considered by the Management team.
- No evidence of evaluation of the process was demonstrated.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

***Core Criterion**

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

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

- The hygiene services structure was demonstrated.
- Evidence was demonstrated of roles and responsibilities of team members being defined.
- It was advised that to facilitate more active involvement of nurse managers in hygiene related issues funding had been approved for audit training for department heads to enable hygiene audits take place.

***Core Criterion**

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

The organisation has a multidisciplinary Hygiene Services Committee.

- Evidence was demonstrated that a hygiene standards committee was in place.
- Membership confirmed that it was multidisciplinary in nature.
- Attendance at meetings was reviewed.
- It was advised that the hospital was actively seeking a patient representative for the committee.
- Minutes confirmed that the team met monthly.

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

*Core Criterion

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

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

- It was identified that hygiene related resources had been allocated on the basis of needs identified through the hygiene audit and also on internal needs assessments.
- There was no evidence demonstrated of a dedicated budget.
- Evidence was demonstrated that resources had been made available as needs were identified.
- This included wash-hand basins in wards, laundry upgrade, St. Bridget's kitchen upgrade as examples.

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

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

- Evidence was demonstrated that the Hygiene Standards Committee and Services Support Group contributed to the procurement process through the monthly meetings of the Management Team.
- There was a local purchasing policy demonstrated which was awaiting approval by the Management Team. This policy was based on the National Procurement Policy.
- No evaluation of the process was demonstrated.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

CM 7.1 Rating: C (41-65% 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 an incident reporting procedure, which fed into the Occupational Health Department.
- A formalised process was not demonstrated but there was evidence of action as a consequence of incidents.
- It was identified that some risk assessments were carried out and the outcomes were given to the Hygiene Standards Committee, which in turn contributed to the development of safety statements.

- No process for identifying clinical incidents was demonstrated.
- It was identified that following the recent decontamination audit an action plan had been developed resulting in actions such as the transfer of sterilisation to St. Vincent's Hospital.
- There had been an audit conducted of the organisation's adherence to its own policies and procedures after a recent suspected Health Care Associated Infection (HCAI) outbreak.

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 no evidence demonstrated of a formal risk management structure.
- It was identified that the infection control team and the hospital management committee considered major adverse events but there was no risk management committee.
- It was identified that resources were allocated to address risks identified.
- There was no evidence demonstrated of a formalised process for prioritising risks.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

***Core Criterion**

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

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

- Evidence was demonstrated that the organisation adhered to the HSE procurement policy.
- Evidence was also demonstrated of a local procurement policy dated 1st February 2008 that reflected the procurement policy of the HSE.
- It was demonstrated that audit of clinical and special waste management facilities had been carried out.
- There was evidence that the laundry contractor and clinical waste contractor had also been audited.

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

The organisation involves contracted services in its quality improvement activities.

- It was identified that the laundry contractor in the hospital had undertaken an audit of the hospitals laundry process.

- The contractor providing alcohol hand gels had audited the use and functionality of the dispensers.

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.

- It was identified that some improvements to the physical environment had been made including hand wash facilities in all sluice rooms, hand wash facilities in all 4+ bedded rooms and other minor improvements.
- A significant lack of space was observed.
- It was observed that due to there being no laundry room in St Bridget's ward clean laundry was being stored in the stairwell in an open area.
- A lack of shower facilities was observed, for example in Lourdes ward there was 1 shower, 1 bath and 7 toilets for 39 patients.
- In St. Bridget's ward there was 1 shower for 23 patients including 5 isolation patients. There were 3 toilets in this area.
- There was a lack of storage space for domestic cleaning equipment observed.
- In St. Bridget's ward the dayroom was being used to store cleaning and medical equipment including infusion pumps.
- At the time of the assessment there was evidence that the hospital's water supply was contaminated with *Legionella species*.
- Therefore a significant risk to patients was identified

*Core Criterion

CM 9.2 Rating: D (15-40% compliance with this criterion)

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

- The hospital demonstrated that there was a plan in place to manage the environment and facilities
- Evidence was demonstrated of audits having been undertaken.
- There was evidence of a process for managing waste and linen but there was evidence that this was not being adhered to in all areas
- Healthcare risk and non-risk waste was observed to be held in an area accessible to the public.
- Therefore a significant risk to patients was identified.

CM 9.3 Rating: B (66-85% compliance with this criterion)

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

- There was evidence that the hospital had implemented many improvements following the 2007 National Hygiene Audit including upgrade of the ward kitchen in Lourdes Ward, installation of hand washing facilities at ward level and upgrading of sluice rooms.
- Audits had been undertaken and there was evidence of action as a consequence.

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.

- There was evidence demonstrated of the organisation seeking the views of patients and staff in relation to hygiene services
- The hospital also used the National "Your Service, Your Say" system for gathering information.
- A discharge cleaning service now included ensuring that patients had information and comment cards to feedback on hygiene issues.
- The hospital was actively seeking a patient representative to participate in the Hygiene Standards Committee.

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.

- Evidence was demonstrated that all recruitment processes followed national requirements.
- It was identified that the hospital had a very low turnover of hygiene staff.
- It was identified that the hospital had recently advertised for temporary staff via FAS and they had contributed to the development of the job specification and interview process.
- It was demonstrated that on commencing employment, all staff completed an induction programme.
- While it was advised that there were plans to review and evaluate this programme no evidence that this had occurred was demonstrated.

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

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

- No formal process was demonstrated for reviewing changes in hygiene services work capacity
- There was evidence demonstrated that the hospital had introduced a 3pm to 11pm cleaning shift based on complaints received.
- Evidence was demonstrated of staff reorganisation to cover higher risk areas.
- There was no evidence of evaluation of the appropriateness of the work capacity assessment process.

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.

- It was demonstrated that the hospital ensured that its hygiene services staff had the appropriate qualifications through revision and ongoing monitoring of job descriptions.
- An induction programme for hygiene services staff was demonstrated
- Records of attendance were seen.
- There was evidence of some in-house training demonstrated.

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

There is evidence that the contractors manage contract staff effectively.

- There was evidence demonstrated of audits being undertaken of contractors such as linen services.
- There was evidence that the hospital inputted into the job specification and interview process for contractors.
- Reporting lines were defined within written contracts.

***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.

- There was no formal human resource needs assessment process demonstrated.
- There was no strategic plan in place.
- There was evidence that the hospital had progressed the implementation of some division of roles in relation to cleaning and catering.

ENHANCING STAFF PERFORMANCE

***Core Criterion**

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

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

- There was documentary evidence of staff induction which included some attendance lists and hygiene issues covered. Evidence was demonstrated of skills courses attended by staff.
- There was limited evidence demonstrated of ongoing education and training regarding hygiene.
- A staff handbook was also available.
- No evidence of monitoring of attendance levels at induction/orientation was 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.

- There was evidence that the organisation supported ongoing education and development.
- In house training occurred particularly in the area of infection control however there were difficulties in relation to accessing external training and continual professional development for staff.
- There was no documented process that ensured continuous professional development for all hygiene service staff.

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

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

- While there was evidence of staff satisfaction in relation to education and training, there was no documented evidence seen regarding the effectiveness of training provided.
- There was no evidence of key performance indicators (KPI) to evaluate training.

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.

- No formal process for performance appraisal was demonstrated.
- It was identified that ward managers monitored performance informally through audits.

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.

- It was identified that there was an off-site occupational health department.
- It was advised that there was an on-site clinic held each month.
- It was advised that records were not held locally.
- No evidence of evaluation was demonstrated.

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

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

- The hospital identified that it adhered to Health and Safety legislation.
- The hospital demonstrated that it had participated in a recent HSE review of absenteeism.
- A staff satisfaction survey had been completed.
- No evidence of ongoing evaluation 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.

- The organisation demonstrated that it was investigating the acquisition of a suitable IT system to collate and log its audits etc.
- Evidence was demonstrated that the management team was given results of audits.
- No evidence of evaluation was demonstrated.
- An annual report had been produced.

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

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

- There was evidence of some audits taking place and of the information from these being considered by the Hygiene Standards Committee and Management team.
- No evidence was demonstrated that results were received in a timely manner.
- The hospital was in the process of sourcing training in audit for staff and a suitable IT system to support the process.
- No evidence was demonstrated of evaluation of the appropriateness of the information gathered.

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.

- There was evidence of information being considered by the hygiene services committee.
- There was no evidence demonstrated of a systematic process to support this.
- Evidence was presented that the hospital was endeavouring to source a suitable IT system to assist in this process.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

CM 14.1 Rating: C (41-65% compliance with this criterion)

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

- It was demonstrated that hygiene was a standard item on the agenda of all Management team meetings.
- It was identified that management supported training and provided funding where possible.

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.

- It was identified that the organisation had made a policy decision that ward managers assumed responsibility for hygiene in their own areas.

- No documentary evidence of this was demonstrated.
- Evidence was demonstrated of some evaluation taking place following changes as a result of audits.

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.

- It was advised that policies, procedures and guidelines were normally held in every ward area.
- These were not observed on the wards on the day of the assessment.
- These were seen centrally as it was advised that they had been brought in for review.
- Evidence was demonstrated that they were in line with best practice, for example colour coding for cleaning.
- There was no formal process for developing policies, procedures and guidelines demonstrated.
- It was reported that protected time was allocated to staff for the development of policies.
- There was no evidence of evaluation.

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.

- Evidence was demonstrated that new hygiene interventions were evaluated through the audit process.
- An evaluation sheet has been introduced.
- There was evidence demonstrated of results being considered at hygiene services committee meetings.

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 observed of hygiene related promotional information and posters accessible to the public.
- There was evidence demonstrated of the hospital involving contractors in the health promotion process with an audit of hand gel being conducted as an example.
- Plans for the company providing hand gel to undertake an awareness day for the public was in place and it was identified that this initiative received a good response last year.

INTEGRATING AND COORDINATING HYGIENE SERVICES

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

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

- Evidence was demonstrated that the Hygiene Standards Committee and Hygiene Services Team was multidisciplinary.
- This was confirmed by team membership and attendance records.
- Through common memberships these teams linked with other relevant hospital committees as set out in the organisational structure.
- No formal evaluation of the process had yet taken place.

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 of visible dirt in the shower room on Lourdes Ward this was the only shower available to patients in this area.
- It was observed that records of cleaning the toilet and washing areas was not up to date in any of the areas visited.
- Ward areas were noted to be poorly ventilated.
- Clear cleaning method statements were not evident in all areas.
- Due to observed lack of space cleaning equipment was being stored in the day room in St. Bridget's Ward along with clinical monitoring equipment.

***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.

- The hospital demonstrated that it had a system for cleaning and tagging medical equipment.
- Storage of patient care equipment with cleaning equipment in the day room of St. Bridget's Ward did not meet with best practice.

***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.

- While cleaning equipment was observed to be clean, storage presented a challenge.
- Cleaning equipment in St. Bridget's Ward was observed to be stored with clinical equipment in the day room.

***Core Criterion**

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

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

- A process of upgrading of ward kitchens was in place and work was observed on Lourdes Ward.

***Core Criterion**

SD 4.5 Rating: D (15-40% 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.

- It was observed that waste was not being managed in accordance with best practice in all areas.

- Healthcare risk and non-risk waste was observed being held in a common open container accessible to the public near the main entrance.
- Waste was observed to be carried to holding areas by staff rather than being transported in containers.
- Staff were observed not to be wearing personal protective clothing in all instances while transporting waste.
- Thus there was a serious risk to patients identified.

***Core Criterion**

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

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

- In St. Bridget's Ward the clean linen supply was not being stored in a manner that meets best practice.
- Linen was being stored in an open area at the top of a stairwell on open shelves.

***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 the Strategy for the control of Antimicrobial Resistance in Ireland guidelines

- There was evidence that hand hygiene training had taken place.
- An extensive programme of improvements in relation to wash-hand basins was observed to be in progress.
- Many additional hand hygiene facilities were observed to have been added to ward areas.
- There continued to be deficits in hand hygiene facilities.

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 demonstrated of an incident reporting process for health and safety issues relating to staff.
- It was also demonstrated that the hospital was using the STARS system for incident reporting.
- It was observed that infection control incidents did not routinely feed into the incident reporting process.

SD 4.9 Rating: C (41-65% compliance with this criterion)

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

- The hospital demonstrated that it used comment cards and the "Your Service, Your Say" complaints system to seek patient/ public input into hygiene services.
- The hospital demonstrated that it had actively sought patient's views and ensured that mechanisms were in place for gathering information by facilitating the dissemination of comment/feedback cards.
- It was identified that they were actively seeking a patient representative to join their Hygiene Standards Committee.

PATIENT'S/CLIENT'S RIGHTS

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

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

- It was observed that patient charters were available.
- It was reported that there had been no complaints regarding patients' dignity/rights in the past 12 months.

SD 5.2 Rating: C (41-65% compliance with this criterion)

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

- There was evidence of posters, leaflets and patient information in relation to hygiene available in public areas.
- The hospital had introduced a procedure associated with the discharge cleaning process to ensure that information and feedback forms are available to patients.
- No evidence of evaluation was demonstrated.

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

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

- It was demonstrated that the hospital followed National Guidelines in relation to complaints.
- Complaints were logged locally and evidence was demonstrated of 3 hygiene related complaints concluded in the first 6 months of the year.
- No evidence of evaluation was demonstrated.

ASSESSING AND IMPROVING PERFORMANCE

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

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

- Evidence was demonstrated that the hospital had involved patients and contractors in the evaluation of the hygiene service.
- Evidence was demonstrated that contractors had undertaken audits in relation to alcohol gel and the laundry service.
- It was advised that the hospital was endeavouring to find a patient representative for the Hygiene Standards Committee.

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.

- It was advised that the hospital had sourced funding for audit training and a plan was in place to commence auditing in the near future.
- No evidence of key performance indicators to monitor the quality of hygiene services was demonstrated.

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.

- The hospital had produced a hygiene services annual report.
- No evidence was demonstrated of communication to stakeholders.
- There was no evidence of evaluation.

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. The colour green indicates that the organisation has improved its performance on the criterion. Red is used to indicate that the organisation's performance has deteriorated in comparison with the 2007 assessment.

Criteria	2007	2008
CM 1.1	C	C
CM 1.2	C	C
CM 2.1	B	B
CM 3.1	C	C
CM 4.1	C	B
CM 4.2	B	B
CM 4.3	C	C
CM 4.4	C	C
CM 4.5	C	C
CM 5.1	C	B
CM 5.2	B	B
CM 6.1	C	B
CM 6.2	C	C
CM 7.1	C	C
CM 7.2	C	C
CM 8.1	C	C
CM 8.2	C	C
CM 9.1	D	D
CM 9.2	C	D
CM 9.3	C	B
CM 9.4	C	C
CM 10.1	C	C
CM 10.2	B	B
CM 10.3	B	B
CM 10.4	C	C
CM 10.5	C	C
CM 11.1	C	C
CM 11.2	C	C
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	C	C
CM 14.2	C	C

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