

National Hygiene Services Quality Review 2008

St Mary's Orthopaedic Hospital

Assessment Report

Date of assessment: 9th October 2008

About the Health Information and Quality Authority

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

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

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

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

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

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

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

1 Background and Context

1.1 Introduction

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

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

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

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

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

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

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

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

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

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

Hygiene is defined as:

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

Irish Health Services Accreditation Board Hygiene Standards

1.2 Standards Overview

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

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

The Standards are grouped into two categories:

(a) Corporate Management

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

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

(b) Service Delivery

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

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

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

Core Criteria:

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

1.3 Assessment Process

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

Before the onsite assessment:

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

plans developed and implemented to address the key issues as documented in the hospital's Hygiene Services Assessment Report 2007.

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

The hospitals were grouped as follows:

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

During the assessment:

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

Following the assessment:

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

- **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. Mary's Orthopaedic Hospital – Organisational Profile¹

St. Mary's Orthopaedic Hospital is a specialist 125-bed hospital serving Cork, Kerry and the Munster area. The hospital is located on the northern side of Cork City and is comprised of a series of separate buildings across a large site. These buildings contain wards and other treatment areas plus an operating theatre complex.

The hospital provides orthopaedic services for persons requiring joint replacement and other complex elective orthopaedic surgery. Joint replacement, arthroscopic surgery, minor orthopaedic procedures and plastic procedures are performed in the theatre complex. Rehabilitation services are provided on-site through physiotherapy and occupational therapy.

The hospital provides inpatient services for post-trauma patients transferred from Cork University Hospital and it also provides a service for plastic surgery and caters for clients from other Health Service Executive areas.

2.2 Areas Visited

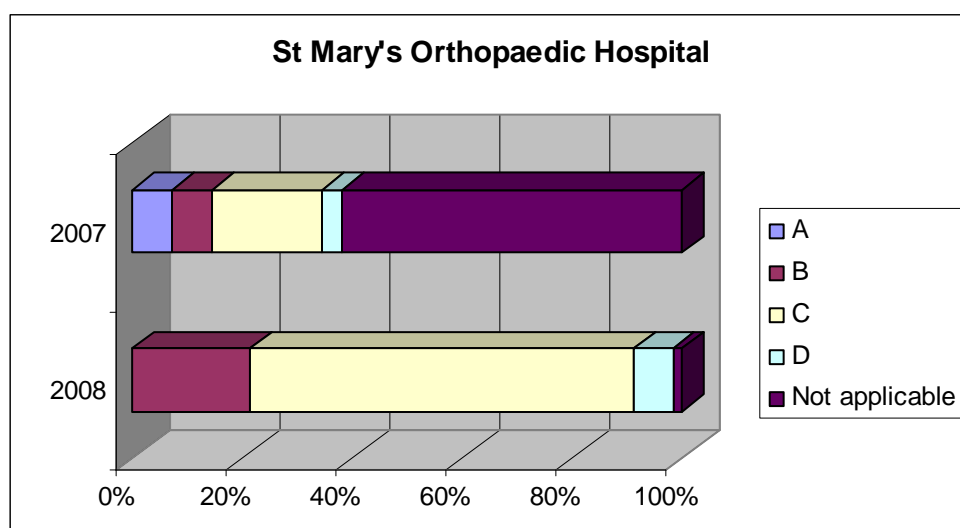
During the course of the assessment the following areas were visited:

- OPD
- Block 2
- Block 8
- Waste Compound
- Laundry Service
- Physiotherapy Department.

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 Mary's Orthopaedic 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 demonstrated that St Mary's Orthopaedic Hospital (SMOH) operates to the Cork University Hospital (CUH) strategic plan and is a division of CUH.
- It was demonstrated that a quality improvement plan was developed in response to last year's hygiene survey and this forms the basis of SMOH's service and operational plans.
- No evidence of any direct input by the hospital into the strategic plan was demonstrated.
- No evidence was demonstrated of any needs assessment completed by St Mary's Orthopaedic Hospital.
- No evidence demonstrated of any Cork University Hospital needs assessment that included St Mary's Orthopaedic Hospital.
- No formalised documented process for undertaking a needs assessment was demonstrated.

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 advised that SMOH has clarified its hygiene service structure with reference to CUH.
- It was advised that it reports through the division of orthopaedics to the senior management team in CUH. It also reports through its hygiene group to the CUH hygiene group.
- The hospital demonstrated that it had introduced a flat mopping system and this was reported to be working well although no formal evaluation was demonstrated of either the flat mop system or the hygiene service structure.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1 Rating: C (41-65% compliance with this criterion)

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

- It was demonstrated that the hospital, through its hygiene services team, has strong linkages with the CUH Hygiene Services Committee.
- This was confirmed by the organisational chart and minutes of meetings.
- There was evidence of hygiene risks discussed at management team (clinical division) meetings.
- A patient survey was undertaken in 2007 and this was demonstrated.
- It was identified that as a result of the evaluation of this survey cleaning staff working shifts were changed with a consequent improvement in sick leave and quality of cleaning.
- No supporting documentation was demonstrated.

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 SMOH works to the Hygiene Strategic Plan of CUH.
- It was identified that the hospital had no input into the development of this plan.
- It was advised that the hospital's quality improvement plan acts as their service plan.
- The Terms of Reference of the Hygiene Service Group contains goals and objectives in relation to hygiene and these were demonstrated.
- SMOH Hygiene Services Group reported in to the CUH Hygiene Services Committee which in turn reported to the Executive Management Board of CUH and this was demonstrated through the organisational committee structure.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.1 Rating: C (41-65% 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 SMOH was governed by the Executive Management Board of CUH and its code of corporate ethics was reported to also apply to SMOH.
- It was advised that the SMOH Divisional Manager was accountable to CUH Executive Management Team.
- Evidence was demonstrated that the Hygiene Services Group of SMOH had reviewed its terms of reference in June 2008.
- This included strategic objectives confirmed in minutes of the meeting of June 2008.
- There was no evidence of evaluation of the appropriateness of the review of the organisation's provisions in the hygiene services areas.

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

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

- Evidence was demonstrated that information in relation to hygiene (audits and incidents) is discussed at the Hygiene Services Group while the Divisional Management Team met with the Executive Management Team twice a year.
- It was advised that funding deficits are brought to the Executive Management Team.
- Evidence was demonstrated from minutes of infection rates being discussed at Divisional Management Team meetings and there was evidence from minutes of the Infection Control Team updating the Divisional Management Team on hand-hygiene techniques.
- No evidence of evaluation 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.

- Evidence was demonstrated that the Infection Control Team circulated an infectious disease newsletter widely.

- There was also evidence of monthly education/study days on hand hygiene, incident reporting etc..
- It was identified that a library was available for clinical staff while hygiene related information was circulated through the line management structure.
- There was no evidence demonstrated of evaluation of the appropriateness of Hygiene Services related research and best practice information available.

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.

- It was demonstrated that SMOH operated as part of the CUH group and all Policies Procedures Guidelines must go through CUH Quality and Safety Policy Evaluation Group.
- It was advised that the Clinical Placement Co-ordinator was the link with CUH in this regard.
- Infection Control Guidelines for SMOH were demonstrated, and were dated 2004.
- There was no evidence demonstrated of evaluation of the efficacy of the process for developing and maintaining Hygiene Services policies, procedures and guidelines.

CM 4.5 Rating: N/A

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

- It was advised that there had been no capital development in the last two years and therefore no hygiene services group involvement.

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.

- A diagram of the Hygiene Services Structure within SMOH and its links with CUH was demonstrated.

- It was demonstrated that membership and roles of the Hygiene Services Committee were set out in the terms of reference, and job descriptions cover hygiene responsibilities
- Reporting relationships and responsibility at ward level for hygiene were not clearly defined.

***Core Criterion**

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

The organisation has a multidisciplinary Hygiene Services Committee.

- Terms of reference observed for the Hygiene Services Group confirmed its multidisciplinary membership.
- Minutes confirmed the group meets at least once every two weeks and administrative support was available.

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 identified that the hospital has no specific budget allocation for hygiene services.
- It was identified that monies were sourced from non-pay budget and one member of the Management Team prioritised needs.
- No formal process was demonstrated for the allocation of resources for hygiene services.
- The hospital advised that estimates at year end were sent to finance seeking resources and these were demonstrated.

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

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

- It was identified that many products for purchasing are the subject of HSE contracts and, as such, SMOH had no input pre-purchasing.
- It was identified that the hospital used the flat mop system.
- The hospital had developed a product evaluation form and this was demonstrated.

- No evidence was demonstrated of evaluation of the process of purchasing.

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.

- It was identified that the hospital used the STARSweb incident reporting system, and this was locally implemented.
- There was evidence demonstrated of incidents and other risks being discussed at health and safety committee meetings – this committee met every three months.
- There was evidence demonstrated of incidents being evaluated and some actions taken (e.g. falls).

CM 7.2 Rating: C (41-65% compliance with this criterion)

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

- There was evidence demonstrated that the hospital had a health and safety committee which met regularly and considered risk issues.
- There was shared common membership with the Hygiene Services Group and this was confirmed through minutes of meetings.
- Evidence was demonstrated of hygiene related issues being considered and the process of evaluation beginning.

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.

- It was identified that contract arrangements were organised through CUH and there was no evidence demonstrated of any contracts seen in SMOH.

- The maintenance department in SMOH had developed guidelines for monitoring contractors while on-site, and a checklist was demonstrated.

CM 8.2 Rating: D (15-40% compliance with this criterion)

The organisation involves contracted services in its quality improvement activities.

- No documented evidence was demonstrated of contractors' involvement in any quality improvement initiatives in SMOH.
- There was no evidence demonstrated that contractors were involved in the audit process, and therefore a risk in relation to potential suboptimal management of contracts exists.

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.

- On revisiting the baby-changing area in the physiotherapy department following last year's review it was noted that the radiator in the baby changing area was still rusty.
- There was no light bulb in this area and the front casing around the electrical fittings was missing. Thus, there was a risk of injury to patients in this area.
- No evidence was demonstrated of these risks having been considered by the Hygiene Services Group or Divisional Management Team.

***Core Criterion**

CM 9.2 Rating: C (41-65% compliance with this criterion)

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

- There was evidence demonstrated of policies, procedures and guidelines in relation to the kitchen, waste, sharps and linen at ward level.
- A health and safety risk report had been conducted on the laundry in June 2007. This was due to be reviewed in June 2008 but there was no evidence demonstrated that this had taken place.

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.

- It was identified that weekly informal audits of wards and kitchens took place with verbal follow-up.
- No written evidence was demonstrated of follow-up.
- There was evidence of a patient survey conducted in relation to catering, which was considered at the food standards committee, and changes were made to tea-time and evening menus as a consequence.
- There was evidence of some audit results discussed at Hygiene Services Group (e.g. hand hygiene).

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.

- It was identified that hygiene services shifts had changed on foot of staff feedback (12-hour shifts) but no documentary evidence was demonstrated.
- It was advised that a patient survey was currently being undertaken.

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 hospital adheres to the HSE policy on recruitment which was in line with national policy and legislation.
- A job description for Clinical Nurse Manager 1 was seen but had no direct responsibility set out for hygiene.
- It was identified that there has been no recruitment in the last two years.

CM 10.2 Rating: C (41-65% compliance with this criterion)

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

- It was identified that a review of hygiene related work capacity had been undertaken and this had resulted in changes in shift patterns.
- No formal evaluation of the change was demonstrated.

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

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

- It was identified that job specifications were developed by human resources, and the hospital set out its requirements in relation to its needs.
- No documented process was seen around this.
- A number of job descriptions were reviewed but did not specifically identify hygiene responsibilities.

CM 10.4 Rating: D (15-40% compliance with this criterion)

There is evidence that the contractors manage contract staff effectively.

- There was no evidence demonstrated of the hospital having any process for the management of contract staff and it was reported that contracts are managed centrally through CUH.
- The Maintenance Department requires that contractors check in and check out when on-site at the hospital, and evidence of this was demonstrated.
- Monitoring of quality/effectiveness was not demonstrated and therefore a risk that suboptimal monitoring of contractors could lead to breach of duty of care.

***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 evidence of a formalised human resources needs assessment process for hygiene services.
- It was identified that the hospital had considered the work of their multitask attendants (cleaning and kitchen duties) and these were considered to be appropriate.
- No documented evidence of this was demonstrated.

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.

- It was identified that there had been no new staff employed in the last three years in hygiene services.
- Details of an induction programme for hygiene was demonstrated which included hygiene and confidentiality.
- There was evidence demonstrated of ongoing health and safety training including infection control and hand hygiene.
- Attendance records were demonstrated.
- It was identified that a waste trail has been mapped for staff training.

CM 11.2 Rating: B (66-85% compliance with this criterion)

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

- There was evidence demonstrated of ongoing training in hand hygiene and infection control.
- Evidence was demonstrated of the post of Clinical Placement Co-ordinator in place who links with CUH.
- It was identified that the line manager is responsible for monitoring staff training requirements.
- There is a computerised rostering system in place within the hospital which records study leave and staff training and evidence of this 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.

- No evidence was demonstrated of formal performance indicators in place in relation to the effectiveness of education and training.
- There was evidence demonstrated of some evaluation sheets for on-site training in hand hygiene and incident reporting.
- There was no evidence demonstrated of evaluation of the effectiveness of training or no evidence of action/quality improvement.

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

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

- It was identified that performance evaluation at the hospital is monitored through checklists and audits and through monitoring of absenteeism records, however, no formal performance evaluation system was demonstrated.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 Rating: B (66-85% compliance with this criterion)

An occupational health service is available to all staff.

- It was identified that there was an occupational health service available to staff and this was provided by CUH.
- This service included employee assistance, vaccinations, pre-employment assessment and absenteeism monitoring.
- It was identified that the occupational health service had undertaken a staff survey in relation to their service and as a result had made some changes to the way the service was delivered.

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

- It was identified that absenteeism rates are monitored and an improvement was noted after changes were introduced to the shift patterns.
- No evaluation of the changes was demonstrated.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.1 Rating: C (41-65% compliance with this criterion)

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

- The hospital demonstrated that it has commenced the process of holding all hygiene related information (audits, incidents, complaints etc.) in one centralised area.
- No collation of the data and information was demonstrated.

- Evaluation of quality data reliability, accuracy, validity and appropriateness was not 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.

- There was evidence of information being gathered from many sources.
- No evidence was demonstrated of collation of the data and information in order to present the information in a meaningful manner.

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.

- It was advised that the organisation has begun the process of evaluating data through its newly implemented risk management process and health and safety committee.
- Some changes had been made on foot of evaluation. The process had not yet been extended to evaluating hygiene related data.

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

- There was evidence of some quality improvement initiatives having occurred.
- The hospital demonstrated that as a result of a patient survey changes were made to the patients' menus, and following consultation with hygiene staff changes were made to rosters, the flat mop system was introduced, and on foot of incident reporting a falls prevention programme was introduced.

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.

- SMOH identified that they had evaluated its hygiene related initiatives through its audit system.

- There was no evidence of key performance indicators, trending of audits or benchmarking demonstrated.
- A list that had been drawn up for the National Hospitals Office of quality initiatives in the last 12 months was demonstrated.
- Minutes of the Hygiene Committee meetings were circulated to all clinical areas.

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.

- A policy on the development of policies, procedures and guidelines produced by CUH was demonstrated.
- The SMOH infection control manual and hygiene services standard operating procedures were observed.
- It was observed that these did not conform to the policies, procedures and guidelines template.
- No evidence was demonstrated of evaluation of the efficacy of processes used to develop best practice guidelines by the Hygiene Services Team.

SD 1.2 Rating: C (41-65% 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

- It was identified that the hospital had introduced the flat mop system.
- Evidence of an evaluation was demonstrated.
- It was identified that many products were introduced into SMOH after trialling in CUH but without input from SMOH.

PREVENTION AND HEALTH PROMOTION

SD 2.1 Rating: C (41-65% 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 of hygiene related posters and information leaflets throughout the hospital.
- The hospital had access to the health promotion unit based in the Eye, Ear and Throat Hospital in Cork and there was a proposal to link with schools in relation to hand hygiene.
- It was identified that there was a “health promotion walk” within the grounds.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1 Rating: C (41-65% 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 Services Group was multidisciplinary.
- The organisational structure set out links with other groups within CUH.
- There was shared common membership with other committees within SMOH.
- There had been no evaluation of the efficacy of the multidisciplinary team structure.

IMPLEMENTING HYGIENE SERVICES

***Core Criterion**

SD 4.1 Rating: B (66-85% compliance with this criterion)

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

- Ward areas were observed to have some light dust.
- The hand-gel container was empty at the entrance to Block 2 and there was no hand gel available at the treatment room.
- Signage was found to be limited in some areas.
- Windows were observed to be in need of cleaning.
- Cleaning materials were found to be stored in unlocked cupboards.
- Flip top bins were found in clinical areas.

***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.

- Equipment was found to be dusty in all areas, with the exception of the outpatient department.
- There was no record of cleaning demonstrated.

***Core Criterion**

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

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

- In general the organisation's cleaning equipment was managed and clean.
- Cleaning products were not in locked cupboards in some areas.

***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.

- Fly screen was found to be open in ward kitchen.
- The assessors were informed of a plan to replace a sink in the kitchen in Block 2 in the coming week, as the one in place was visibly stained.

***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.

- The assessors could not verify waste traceability records due to inconsistent dates, and manual overwriting of forms.
- Sharps boxes were noted not to be tagged on occasions and the waste compound was found to be open while unattended.

***Core Criterion**

SD 4.6 Rating: D (15-40% compliance with this criterion)

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

- The organisation of the linen supply at ward level was managed according to policy.
- SMOH on-site laundry was in a very poor condition.
- The environment is not managed appropriately with evidence of lack of cleaning methods, mould on walls, substances dripping from the ceiling and malfunctioning washing machines resulting in washing cycles that could not be relied upon to ensure satisfactory cleaning of linen.
- Therefore, there is a risk of cross contamination /infection.

***Core Criterion**

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

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

- The management of hand hygiene was to a good standard and included staff training, availability of hand hygiene products and monitoring through audit.
- Wash hand basins were not compliant in many areas.

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.

- Evidence was observed that the hospital had begun monitoring incidents and responding to these.
- Incidents were considered at the health and safety committee and Clinical Nurse Managers were represented here, facilitating feedback to clinical areas.
- There was evidence of evaluation of some incidents with trends identified in one area (falls) and these were being addressed. This process had yet to be rolled out to all hygiene related issues.

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.

- Patient satisfaction surveys have been carried out in 2006 and 2007 and evidence was seen of changes on foot of these.
- Evidence was also seen of a hospital handbook and information leaflets.

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.

- The assessors saw evidence of the patients' charter displayed in clinical areas.
- Patient's rights, dignity and confidentiality form part of the induction programme.
- No evidence of evaluation was demonstrated.

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 that the hospital had in place many posters and leaflets regarding hygiene and hygiene-related issues.
- There was no evidence of evaluation.

SD 5.3 Rating: C (41-65% compliance with this criterion)

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

- The hospital uses the Health Services Executive "Your Service, Your Say" process for capturing comments and complaints.
- Informal complaints were dealt with locally. It was advised that formal complaints were considered at the Hygiene Service Group meetings. No evidence of this was demonstrated
- There was no evidence of any evaluation.

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1 Rating: C (41-65% 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 patient satisfaction surveys had been conducted and staff had been consulted in relation to hygiene services.
- There was evidence of change as a result of consultation e.g. shift patterns.
- There was no evidence of evaluation.

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 Hygiene Services Group used audits to monitor hygiene services.
- The hospital had introduced a flat mop system and staff had evaluated this positively.
- There was no evidence demonstrated of key performance indicators for hygiene services, trending of audits or benchmarking 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 has produced a list of achievements for the year while CUH produced an Annual Report.
- No evidence of an annual report was demonstrated.

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.

Corporate Management

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

Criteria	2007	2008
CM 14.1	N/A	C
CM 14.2	N/A	C
SD 1.1	C	C
SD 1.2	C	C
SD 2.1	C	C
SD 3.1	C	C
SD 4.1	A	B
SD 4.2	A	B
SD 4.3	A	B
SD 4.4	B	B
SD 4.5	B	C
SD 4.6	B	D
SD 4.7	A	B
SD 4.8	C	B
SD 4.9	B	B
SD 5.1	C	C
SD 5.2	C	C
SD 5.3	C	C
SD 6.1	C	C
SD 6.2	C	C
SD 6.3	C	C