

National Hygiene Services Quality Review 2008

Coombe Women's University Hospital

Assessment Report

Date of assessment: 4th 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 Coombe Women's University Hospital – Organisational Profile¹

The hospital was established in 1967 on a "quite limited" budget, in the order of £400,000. In the ensuing 40 years, several additions and modifications have been implemented in an attempt to keep abreast of changing demands. During the same period, government cutbacks and "financial rectitude" programmes all contributed to a spartan and "emergency" approach to the facility. The cumulative effect of many years of inadequate financial provision is now manifest both in general appearance, and more critically, in the reliability of medical service plant and equipment.

The hospital's approved complement of beds/cots is 251, which includes 19 day-care/day-case treatment places.

2.2 Areas visited

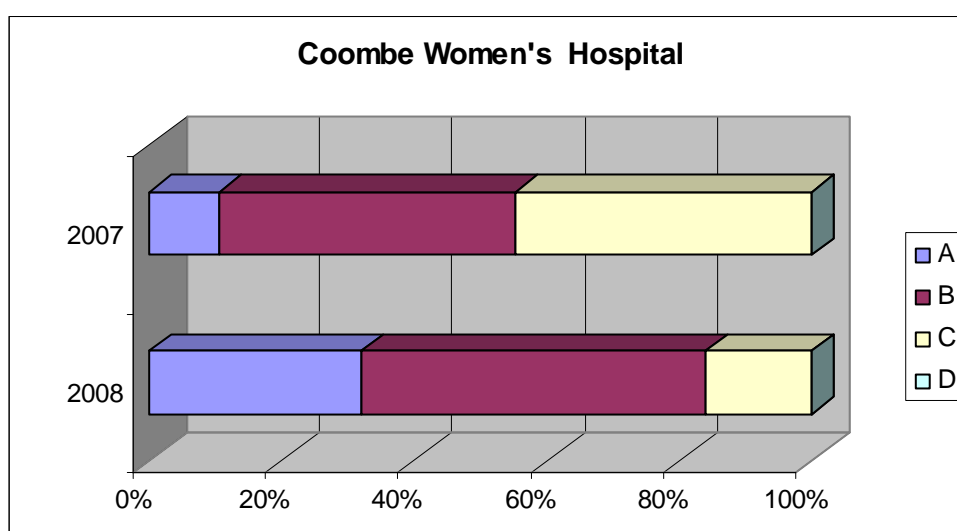
During the course of the assessment the following areas were visited:

- Our Lady's Ward
- St Gerard's Ward
- Emergency room
- Outpatient department
- Laundry services
- 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.

**The Coombe Women's University Hospital has achieved an overall rating of:
Fair**

Award date: 2008

2.4 Standards for Corporate Management

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

PLANNING AND DEVELOPING HYGIENE SERVICES

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

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

- It was demonstrated that the hospital had an undated Hygiene Corporate Strategy in place.
- The hospital advised that there was a process for identifying needs that involved regular multidisciplinary "walkarounds".
- It was demonstrated that from this process, and in consultation with the Hygiene Service Committee, a prioritised list of needs has been produced.
- The prioritised list of needs was not reflected in the Hospital's Service Plan that is dated 2007, but the hospital identified that it was currently reported to be in the process of being reviewed.
- There was limited evidence of the process of evaluation demonstrated.

CM 1.2 Rating: A (>85% compliance with this criterion)

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

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

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.

- The hospital demonstrated strong evidence of linkages with the HSE and other key stakeholders.
- Evidence was demonstrated of a comprehensive patient satisfaction survey with evaluation and changes.

- No evidence was demonstrated of the evaluation of the linkages and partnerships.

CORPORATE PLANNING FOR HYGIENE SERVICES

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

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

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

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.1 Rating: A (>85% compliance with this criterion)

The Governing Body and its Executive Management Team have responsibility for the overall management and implementation of the Hygiene Service in line with corporate policies and procedures, current legislation, evidence-based best practice and research.

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

CM 4.2 Rating: A (>85% compliance with this criterion)

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

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

CM 4.3 Rating: A (>85% compliance with this criterion)

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

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

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.

- The hospital demonstrated that it had a policy for the development of policies, procedures and guidelines (PPGs).
- It was observed that the hygiene services manual was due for review.
- The hospital had a project plan in place for using a document management system.
- No evaluation of the process for developing PPGs was demonstrated.

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

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

- There was evidence demonstrated of strong linkages between Capital Development Projects and the Hygiene Services Committee (HSC) through common membership.
- It was demonstrated that formal communication re capital development was now a standard agenda item on the Hygiene Services Committee e.g. the refurbishment of sanitary facilities verified by minutes of meeting of 08/09/08.
- While no formal evaluation of the efficacy of the consultation process between the HSC and Senior Management has taken place, the hospital identified that the process is working through achievements in the upgrading plan and satisfaction surveys.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

***Core Criterion**

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

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

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

***Core Criterion**

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

The organisation has a multidisciplinary Hygiene Services Committee.

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

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

***Core Criterion**

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

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

- The hospital demonstrated evidence of a priority list of needs.
- This is developed through the hospital's needs-assessment process (walkabouts).
- It was advised that through quality and risk mechanisms issues are assessed, however, there was no formalised template/recording process in place.
- It was identified through interview that this process is being linked into the service planning process.
- There was evidence demonstrated of resources being made available for capital development, including hygiene related upgrading of areas (sanitary facilities).

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

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

- The hospital demonstrated evidence of a procurement policy.
- This policy requires that infection control and hygiene services should assess all equipment prior to purchasing. This policy was dated August 2008.
- There was evidence demonstrated of the Hygiene Services Committee's involvement in the trialling of the flat mop system, with evaluation and costing being considered.
- There was also evidence demonstrated that a presentation had been made to the Hygiene Services Committee by Infection Control on the Bag and Mask system for consideration.
- There was no evidence of formal evaluation of the consultation process demonstrated.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

CM 7.1 Rating: B (66-85% compliance with this criterion)

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

- It was identified through interview that risk assessments were undertaken as part of the process for the development of the hospital's safety statement, however, no evidence was demonstrated.
- The hospital did not demonstrate that it had a risk register in place.
- There was evidence of an incident reporting information leaflet but no incident reporting policy or risk assessment process was demonstrated.
- There was evidence of incident reports being considered at the Clinical Governance Risk Management Committee.
- Evidence was demonstrated of common membership of Hygiene and Risk Committees.
- There was no evidence demonstrated of risk management or health and safety annual reports.
- There was no evidence demonstrated of reports on hygiene incidents being submitted/considered by the Hygiene Services Committee.

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 of resources being allocated to hygiene services to address risks identified (sanitary upgrades).
- There is common membership on the Hygiene Services and Clinical Governance Risk Management committees, however, there was no evidence of information sharing between committees.
- While there was evidence demonstrated of risks identified being acted upon, there was no documented evidence of reports from the Risk Committee being considered by the Executive Management team.
- There was no evidence demonstrated of evaluation of adverse events or sharing of information on root causes.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

***Core Criterion**

CM 8.1 Rating: B (66-85% 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 hospital's procurement policy covered liability.
- Evidence was demonstrated that new contracts had a requirement for quality and monitoring e.g. the contract for cleaning of windows, walls and high dusting.
- The Hospital advised that it had a plan in place to review all contracts as they come up for renewal.
- Evidence was demonstrated that the Hospital now met weekly with new contractors to monitor quality.

CM 8.2 Rating: B (66-85% compliance with this criterion)

The organisation involves contracted services in its quality improvement activities.

- The hospital demonstrated evidence of the contractors' involvement in best practice design, e.g. minutes of meetings with consultants regarding the new neonatal unit; and, minutes of meetings with the linen contractor.
- Evidence was provided to demonstrate that contractors attend the Hygiene Services Committee, with the attendance of the waste contractors at a recent meeting that was confirmed through minutes.
- There was no evidence of evaluation of their involvement.

PHYSICAL ENVIRONMENT, FACILITIES AND RESOURCES

CM 9.1 Rating: B (66-85% compliance with this criterion)

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

- There was evidence of an extensive hygiene related refurbishment and upgrade programme at the hospital, including upgrading of sanitary facilities, wards and waiting areas.
- It was identified that risk assessments are undertaken as part of the hospital's safety statement, however, these were not available for review.
- There was a prioritised minor capital list informing the ongoing refurbishment programme demonstrated.

- Architects had undertaken a study for the redevelopment of the hospital.
- Some evidence of the evaluation of the safety of the environment was demonstrated.

***Core Criterion**

CM 9.2 Rating: A (>85% compliance with this criterion)

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

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

CM 9.3 Rating: A (>85% compliance with this criterion)

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

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

CM 9.4 Rating: A (>85% compliance with this criterion)

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

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

SELECTION AND RECRUITMENT OF HYGIENE STAFF

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

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

- It was demonstrated that the hospital adheres to the national and HSE recruitment policies.
- It was identified at interview that the hospital had just recruited a hygiene services coordinator, who at the time of the survey had not taken up his/her post.
- It was identified at interview that the Board of the Hospital was currently reviewing/evaluating the recruitment process.

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.

- The hospital demonstrated evidence of a planning process in place for manpower.
- The hospital demonstrated that it had reviewed the cleaning and portering duties, which had been assessed as currently meeting its needs.
- Evidence was demonstrated that the Hospital was currently progressing the role of care assistants.

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.

- Evidence was demonstrated of extensive hygiene related training, including hand hygiene, universal precautions, hazard analysis and critical control point (HACCP) and British Institute of Cleaning Science (BICS).
- Evidence observed indicated that training records were being held in a number of separate departments.
- There was no evidence of a unified approach to the tracking and monitoring of attendance at training.
- It was identified through interview that the Hospital was in the process of recruiting a training officer.
- There was evidence demonstrated of the evaluation of training sessions and of changes to improve the process, e.g. sessions were held on wards to facilitate access to training by staff.

CM 10.4 Rating: B (66-85% compliance with this criterion)

There is evidence that the contractors manage contract staff effectively.

- Evidence was demonstrated that the Household Supervisor meets with one particular contractor weekly (under the terms of the newly introduced contract policy).
- Evidence was demonstrated that quality management and regular meetings have been written into new contracts. Method statements and reporting relationships are also set out in new contracts as is induction/orientation requirements.
- It was identified through interview that the new contract will be evaluated when it has been in place for sufficient time (introduced in August 2008).

***Core Criterion**

CM 10.5 Rating: B (66-85% compliance with this criterion)

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

- There was evidence demonstrated that human resource needs assessments were undertaken. As a result the hospital is progressing with the conversion of auxiliaries to the role of healthcare assistants.
- It was identified through interview that it is planned that human resource information will feed into future strategic plans.

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 evidence demonstrated that the induction programme for staff covered hand hygiene, sharps, waste and infection control.
- While the induction programme was in place, evidence demonstrated that it did not cover all staff.
- The exception to this was the Infection Control Department who meet with everybody. Records of this were kept.
- Some records are kept of other induction meetings.
- A staff handbook was demonstrated with an infection control section.
- It was identified through interview that ensuring accurate records of attendees and evaluation will be the responsibility of the training officer when this role was in place.

CM 11.2 Rating: C (41-65% compliance with this criterion)

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

- It was demonstrated that there was a programme of ongoing education within the hospital and staff were responsible for holding their own training records.
- No formal process for identifying staff that had not attended mandatory training was demonstrated.
- Evidence was demonstrated that some records were kept by Infection Control staff.
- It was demonstrated through interview that time was allowed to attend training.

- There was evidence demonstrated of staff evaluation questionnaires after each session but no overall evaluation of the training programme.

CM 11.3 Rating: B (66-85% compliance with this criterion)

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

- There was evidence demonstrated that the hospital had identified a deficit in training attendance (20% non-attendance rate for hand-hygiene training).
- As a result the hospital made hand-hygiene training mandatory with subsequent improvement in attendance rates. (Performance Indicator – hand-hygiene training in previous 12 months.)
- Staff knowledge post-infection-control training had also been evaluated.

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

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

- It was identified through interview that the hospital had planned to work with the HSE in a pilot team-based performance project but this has not been progressed by HSE to date.
- It was also identified through interview that the hospital was endeavouring to resolve industrial relations issues around monitoring of sign-off/checklist sheets for cleaning.
- Performance management would be progressed with contractors through the weekly quality review meeting as part of new contracts.

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.

- Evidence was demonstrated that the hospital currently provided an occupational health service through a University College Dublin (UCD) GP practice on site and “Well at Work” from a private company.
- A plan to progress an occupational health service with a nearby hospital had been reviewed in light of proposed plans for maternity services in Dublin and this was now being explored with another nearby hospital where agreement in principal had been reached.
- This plan was progressed following a review of current services and needs identified as a consequence.

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

- In order to meet the occupational health needs of staff a review of the occupational health service took place and the hospital was progressing with plans for a co-located/shared occupational health service.
- There was limited evidence otherwise of evaluation apart from a staff satisfaction survey conducted in 2006.

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.

- There was evidence demonstrated that a lot of information in relation to hygiene services was available to the hospital from many different sources.
- Evidence was also demonstrated that the hospital participates in the STARSweb incident reporting process.
- There was no evidence demonstrated of any formal process to collate and evaluate all of the available information.

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

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

- There was evidence demonstrated of all available hygiene related information being reported through various committees to the Executive Management Team.
- Evidence was demonstrated that this was timely (at regular meetings).
- Overall interpretation was limited because of the lack of an overall information gathering process facilitating comprehensive hygiene related evaluation (e.g. complaints, audits, incidents are reported separately to different committees).
- It was observed that a newsletter and microbiology report facilitate some reporting to staff.
- There was no evidence of staff evaluation.

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 reported to the Hygiene Services Committee, Executive Management Team, Clinical Governance/Risk Management Committee and Governing Board.
- Evidence was demonstrated that the Hygiene Services Committee had included a "New Technologies" item as a standing agenda item for Committee Meetings and this was verified by reviewing minutes of meetings.
- No evidence of evaluation was seen.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

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

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

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

CM 14.2 Rating: A (>85% compliance with this criterion)

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

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

2.5 Standards for Service Delivery

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

EVIDENCE-BASED BEST PRACTICE AND NEW INTERVENTIONS IN HYGIENE SERVICES

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

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

- The hospital has a policy on the development of policies, procedures and guidelines (PPGs) and there was evidence demonstrated of hygiene related policies, procedures and guidelines in clinical areas.
- The Hygiene Services Committee had a standard agenda item for "New Technologies" to ensure practices were up to date.
- The hospital demonstrated that it had progressed the procurement of a document management system to ensure that PPGs were easily accessible and flagged for routine review.

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

There is a process for assessing new Hygiene Services interventions and changes to existing ones before their routine use in line with national policies

- The hospital demonstrated it had a system for piloting new interventions and evaluating these prior to any decision regarding routine use.
- Evidence was demonstrated through minutes of piloting of absorbent pads for clinical waste bags, automatic paper dispensers and the flat mop system.
- No evaluation of the efficacy of the process for interventions was seen.

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.

- The hospital demonstrated that it linked with the community in relation to hygiene through its patients' representatives who undertake Board "walkarounds" and also accompany the Master on "walkarounds".
- There was evidence demonstrated of a patient focus group but no recent minutes were available (2007 seen).
- There was evidence of hygiene related posters and leaflets informing the public of hygiene issues.
- It was identified through interview that there was a link with the South Dublin Inner City GP network.
- No evidence was demonstrated of evaluation.

INTEGRATING AND COORDINATING HYGIENE SERVICES

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

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

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

IMPLEMENTING HYGIENE SERVICES

***Core Criterion**

SD 4.1 Rating: A (>85% compliance with this criterion)

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

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

***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.

- On observation the equipment seen was clean.
- Cleaning schedules were seen but these were not completed.
- There was no evidence in the clinical areas visited that formalised audits had occurred in the last year.

***Core Criterion**

SD 4.3 Rating: A (>85% compliance with this criterion)

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

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

***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.

- There was no evidence seen of a cleaning schedule in ward kitchens but these were noted to be clean.
- Staff were noted not to be wearing personal protective equipment (PPE) in these areas.

***Core Criterion**

SD 4.5 Rating: A (>85% compliance with this criterion)

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

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

***Core Criterion**

SD 4.6 Rating: A (>85% compliance with this criterion)

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

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

***Core Criterion**

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

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

- Many of the hand-washing sinks did not meet SARI guidelines.
- Some upgrading of hand-washing sinks had taken place in a number of areas.
- Hand hygiene was otherwise effectively managed.

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

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

- There was evidence that complaints and risk were managed at ward level in line with hospital policy.
- Evidence was not observed that feedback to ward level/learning was occurring.

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

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

- There was evidence that patients were actively involved in the hospital's hygiene process with patients accompanying the Master on "walkabouts" and also accompanying members of the Board of Governors.
- There was evidence observed of patient satisfaction surveys with evaluation and changes recorded on foot of information obtained.

PATIENT'S/CLIENT'S RIGHTS

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

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

- Evidence was observed at ward level of a documented process to protect patient dignity during cleaning of windows.
- Job descriptions confirmed the requirement for confidentiality
- This was monitored through incident reporting.
- It was observed that confidentiality was also covered in the staff handbook.
- There was no evidence of evaluation.

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

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

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

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

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

- Evidence was demonstrated of a complaints policy (dated 23/10/07) in the hospital that had been signed off.
- The Complaints Committee met every two to three weeks.
- Evidence was observed of a complaint being considered, best practice information sought, and feedback to the complainant by the Master.
- Evidence was not demonstrated of hygiene related complaints being fed to the Hygiene Services Committee from the Complaints Committee.
- The comments/complaints system had informed changes in Hygiene Services which were seen.

ASSESSING AND IMPROVING PERFORMANCE

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

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

- There was evidence of patients being involved in “walkabouts” by the Hygiene Services Team and the Master and by the Board of the Hospital.
- A comprehensive patient satisfaction survey was also seen along with evidence of change as a direct result of information gained, for example, the sanitary upgrade.
- There was no evidence of evaluation of patients’ involvement.

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

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

- Evidence was seen of key performance indicators produced by the Master for the Board of Governors.

- It was identified through interview that the hospital also used the last Health Information Quality Authority assessment report to benchmark itself against other hospitals.
- The Master used “Rate my Hospital” information as an indicator of how the hospital compared with other similar hospitals.

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

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

- The hospital includes a hygiene section in its general Annual Report.
- This section is produced on behalf of and reviewed by members of the Hygiene Services Committee.
- The report is widely available on the web.
- 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.

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

Criteria	2007	2008
SD 2.1	C	C
SD 3.1	C	A
SD 4.1	B	A
SD 4.2	A	B
SD 4.3	C	A
SD 4.4	B	B
SD 4.5	B	A
SD 4.6	A	A
SD 4.7	B	B
SD 4.8	B	B
SD 4.9	B	B
SD 5.1	C	B
SD 5.2	B	A
SD 5.3	C	B
SD 6.1	B	B
SD 6.2	B	B
SD 6.3	C	B