Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

National Hygiene Services Quality Review 2008

Letterkenny General Hospital

Assessment Report

Assessment date: 10th November 2008

About the Health Information and Quality Authority

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

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

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

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

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

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

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

1 Background and Context

1.1 Introduction

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

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

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

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

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

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

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

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

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

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

Hygiene is defined as:

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

Irish Health Services Accreditation Board Hygiene Standards

1.2 Standards Overview

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

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

The Standards are grouped into two categories:

(a) Corporate Management

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

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

(b) Service Delivery

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

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

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

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

1.3 Assessment Process

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

Before the onsite assessment:

- **Submission of a quality improvement plan (QIP) and accompanying information by the hospital to the Authority.** Each hospital was requested to complete a Quality Improvement Plan. This QIP outlined the plans developed and implemented to address the key issues as documented in the hospital's Hygiene Services Assessment Report 2007.
- **Off-site review of submissions received**. Each Lead Assessor conducted a comprehensive review of the information submitted by the hospital.
- **The Authority prepared a confidential assessment schedule**, with the assessment dates for each hospital selected at random.
- **Selection of the functional areas.** The number of functional areas selected was proportionate to the size of the hospital and type of services provided. At a minimum it included the emergency department (where relevant), the outpatient department, one medical and one surgical ward.

  The hospitals were grouped as follows:
  - Smaller hospitals (two assessors) – minimum of two wards selected
  - Medium hospitals (four assessors) – minimum of three wards selected
  - Larger hospitals (six assessors) – minimum of five wards selected.

During the assessment:

- **Unannounced assessments.** The assessments were unannounced and took place at different times and days of the week. All took place within one day, except for one assessment that ran into two days for logistical reasons. Some assessments took place outside of regular working hours and working days.

- Assessments were undertaken by a **team of Authorised Officers** from the Authority to assess compliance against the National Hygiene Standards. Health Information and Quality Authority staff members were authorised by the Minister of Health and Children to conduct the assessments under section 70 of the Health Act 2007.

- **Risk assessment and notification.** Where assessors identified specific issues that they believed could present a significant risk to the health or welfare of patients, hospitals were formally notified in writing of where action was needed, with the requirement to report back to the Authority with a plan to reduce and effectively manage the risk within a specified period of time.

Following the assessment:

- **Internal Quality Assurance**. Each assessment report was reviewed by the Authority to ensure consistency and accuracy.

- **Provision of an overall report to each hospital, outlining their compliance with the National Hygiene Standards**. Each hospital was given an opportunity to comment on their individual draft assessment in advance of publication, for the purpose of factual accuracy.

- **All comments were considered** fully by the Authority prior to finalising each individual hospital report.

- **Compilation and publication of the National Report** on the *National Hygiene Services Quality Review*.

1.4 Patient Perception Survey

During each assessment the assessors asked a number of patients and visitors if they were willing to take part in a national survey. This was not a formal survey and the sample size in each hospital would be too small to infer any statistical significance to the findings in relation to a specific hospital. Results from the questionnaires were analysed and national themes have been included in the National Hygiene Services Quality Review 2008.

1.5 Scoring and Rating

Evidence was gathered in three ways:

1. **Documentation** review – review of documentation to establish whether the hospital complied with the requirements of each criterion
2. **Interviews** – with patients and staff members
3. **Observation** – to verify that the Standards and Criteria were being implemented in the areas observed.

To maximise the consistency and reliability of the assessment process the Authority put a series of quality assurance processes in place, these included:

- Standardised training for all assessors
- Multiple quality review meetings with assessors
- A small number of assessors completing the assessments
- Assessors worked in pairs at all times
- Six lead assessors covering all the hospitals
- Ratings determined and agreed by the full assessment team
- Each hospital review, and its respective rating, was quality reviewed with selected reviews being anonymously read to correct for bias.

On the day of the visit, the hospital demonstrated to the Assessment Team their evidence of compliance with all criteria. The evidence demonstrated for each criterion informed the rating assigned by the Authority's Assessment Team. This compliance rating scale used for this is shown in Table 1 below:

Table 1: Compliance Rating Score

A	The organisation demonstrated exceptional compliance of greater than 85% with the requirements of the criterion.
B	The organisation demonstrated extensive compliance between 66% and 85% with the requirements of the criterion.
C	The organisation demonstrated broad compliance between 41% and 65% with the requirements of the criterion.
D	The organisation demonstrated minor compliance between 15% and 40% with the requirements of the criterion.
E	The organisation demonstrated negligible compliance of less than 15% with the requirements of the criterion.

This means the more A or B ratings a hospital received, the greater the level of compliance with the standards. Hospitals with more C ratings were meeting many of the requirements of the standards, with room for improvement. Hospitals receiving D or E ratings had room for significant improvement.

2 Hospital findings

2.1 Letterkenny General Hospital - Organisational Profile[1]

Letterkenny General Hospital is the only acute hospital in County Donegal serving a catchment area of approximately 137,000 people. The hospital has 312 beds (excluding psychiatry) and has been developed over the last 40–50 years. The services provided by the hospital include: Accident and Emergency; Dental Surgery; Dermatology; Endocrinology; General Medicine; Maxillofacial; Nephrology; Ophthalmology; Otolaryngology (ENT); Respiratory Medicine; Rheumatology; Warfarin Clinic; Intensive Care Services; Coronary Care Services; General Medicine Services; Geriatric Services; Renal Dialysis Services; General Surgical and Urology Services; Obstetric & Gynaecology Services; Paediatric Services (including Neo-Natal Unit Services); Orthopaedic Services and Oncology and Haematology Services.

2.2 Areas Visited

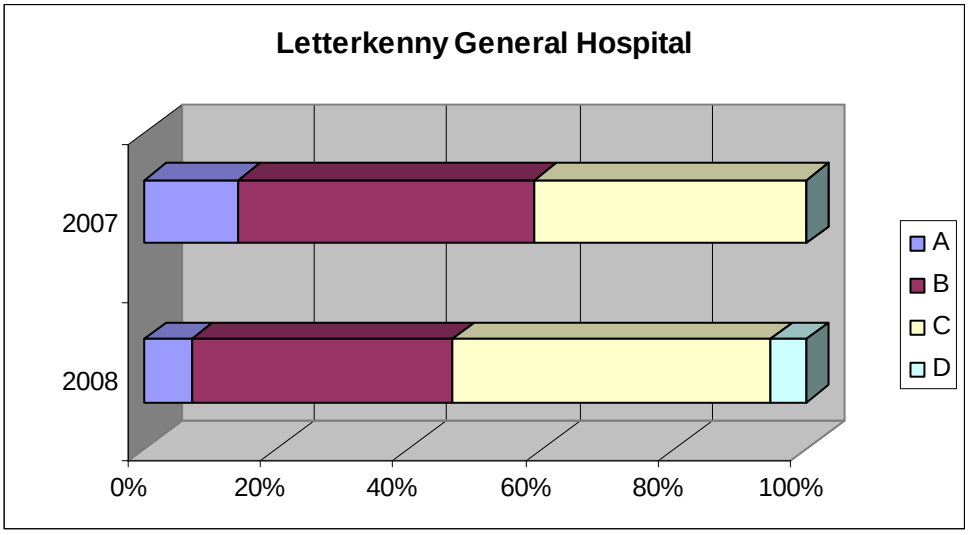
During the course of the assessment the following areas were visited:

- Surgical Two
- Oncology/ Haematology
- Medical Two
- Paediatric unit
- Out Patients department
- Emergency department
- Waste compound
- Laundry services.

[1] The organisational profile was provided by the hospital

2.3 Overall Rating

The graph below illustrates the organisation's overall compliance rating for 2008 and its overall rating for 2007. Appendix A at the end of this report illustrates the organisation's ratings for each of the 56 criteria in the 2008 National Hygiene Services Quality Review, in comparison with 2007. See page 8 for an explanation of the rating score.



An overall award has been derived using translation rules based on the number of criterion awarded at each level. The translation rules can be viewed in the National Report of the National Hygiene Services Quality Review 2008. Core criteria were given greater weighting in determining the overall award.

Letterkenny General 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.

- The organisation demonstrated some evidence of a process for assessing and updating the organisation's current and future needs for hygiene services through its facilities management team (hygiene services), facilities standards advisory group, team-based performance management group, infection control committee and facilities project group.
- Evidence of audit result discussions at the Facilities Heads of Service meetings was demonstrated. However, the Facilities Management team or Project Group meetings as audit results were not a regular agenda item.
- Limited evidence of a documented process for completing a needs assessment regarding the requirements for hygiene services including environment and facilities, human resources, information management and health promotion was demonstrated.
- No evidence of evaluation of the efficacy of the needs assessment process was demonstrated.

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

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

- The Organisation demonstrated evidence of a number of modifications to the Hygiene Service based on identified need, which included the introduction of cleaning schedules to all areas, a Flat Mop system trial for eight weeks, a pilot of Terminal Clean checklist and initial phased work on the waste compound.
- No evidence of evaluation of the developments and modifications to the organisation's Hygiene Services in relation to meeting patients' needs was demonstrated.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

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

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

- The organisation demonstrated evidence of links with the HSE through the Network Manager, Regional Infection Control Committee, Regional Capital Projects Group, Department of Public Health, Primary Continuing and Community Care, Environmental Health Officer and National Accreditation Managers' Group.
- There was some evidence of linkages with staff and patients with regard to Hygiene Services through a catering staff satisfaction survey and through the Hospitals Comment Card System. However, no hygiene specific patient satisfaction survey was demonstrated.
- No evaluation of the efficacy of linkages and partnerships was presented.

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.

- The organisation provided no evidence of a documented process for the development of its Hygiene Services Corporate Strategic Plan.
- The organisation advised the assessors that the strategy was developed by a multidisciplinary subgroup; however no minutes of meetings were presented.
- No evidence of patient input into the strategy development or that the strategy objectives were being formally monitored was demonstrated.
- An Operational Plan and Service Plan were demonstrated however, costings were not documented.

GOVERNING AND MANAGING HYGIENE SERVICES

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

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

- The organisation demonstrated that they were in the early stages of the development of a governance framework.

- An organisational chart was presented with outlined reporting relationships for Hygiene Services, which were in line with the organisations corporate policies and procedures.
- There was evidence in the minutes of the Hospital Management Board that hygiene was not a regular agenda item however was included on a periodic basis.
- It was demonstrated that at the September meeting, it was agreed that hygiene would be a standing agenda item on a quarterly basis going forward and that the minutes of all meetings of the Facilities Management Group would be circulated to the Executive Management Team.
- No evidence of a review of the authority provisions in the hygiene services area was demonstrated however it was reported that a formal review is planned for December.

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

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

- The organisation demonstrated limited evidence that the Executive Management Team/ Hospital Management Board regularly and formally receive evidence or best practice information in relation to the hygiene services.
- It was demonstrated at the September meeting of the Hospital Management Board that hygiene was to be a standing agenda item on a quarterly basis going forward and that the minutes of Facility Management Committee were to be circulated to all members.
- No evidence was demonstrated of a formal suite of key performance indicators (KPIs).
- The organisation advised that results of hygiene audits was discussed at the Infection Control Committee, however no evidence was presented to demonstrate such discussions in the minutes of meetings.
- There was some evidence demonstrated of discussions in relation to hygiene at the Regional Infection Control Committee, which was noted to have representation of the Hospital Management Board.

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

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

- The organisation demonstrated evidence that a library, internet and intranet facilities were available to all staff.
- Evidence was presented in relation to the introduction of the flat mop system and steam clean of beds based on best practice information. It was reported that upgrade of the endoscopy washers was planned following the decontamination audit.

- Mandatory and ongoing hygiene training for staff was demonstrated.
- Introduction of a document management system had commenced, however, a significant number of policies and procedures were in place which had passed their review date.
- No evidence of an evaluation of the appropriateness of hygiene services related research and best practice information available was demonstrated.

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

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

- The organisation demonstrated evidence of a policy on the development, maintenance and review of hospital policies, procedures and guidelines which was issued in June 2008.
- Introduction of a document management system had commenced, however, a number of policies and procedures were in place which had passed their review date (2006) and were not observed to be in accordance with the approved template.
- No evidence of evaluation of the efficacy of the process for the development and maintenance of hygiene services policies, procedures and guidelines 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

- The organisation demonstrated evidence that the Facilities Management Team (which functioned as the Hygiene Services Committee) had representation from Infection Control, Capital Projects, Estates, Hygiene Services and Occupational Health. No evidence was demonstrated of discussions at the meetings in relation to capital projects or of a formal process for consultation.
- Evidence was demonstrated through the Regional Capital Projects team minutes, (of which a number of the Executive Management Team and Facilities Management team were members) of discussions in relation to hygiene implications of capital projects.
- No evidence of evaluation of the efficacy of the consultation process between the Facilities Management Team and senior management was demonstrated.

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 organisation demonstrated evidence through budgetary control reports that funding and resources were allocated to hygiene services.
- Evidence of a documented human resource needs assessment undertaken in June 2007 was demonstrated, which identified staffing shortfalls which the organisation reported that they were unable to rectify due to financial constraints.

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 organisation demonstrated evidence that all equipment purchases were dealt with by the Regional Procurement Group in accordance with the Health Services Executive Procurement Policy.
- A local Medical Equipment and Point of Care Testing Committees had been established with linkages to the Regional Procurement Group. The Infection Control Nurse and the Facility Manager were members of both committees.
- Limited evidence was demonstrated through the minutes of the Facility Management Team of the latter's involvement in the process of purchasing equipment and products, i.e. Endoscope washers were discussed at the September meeting.
- No evidence of evaluation of the efficacy of the consultation process was demonstrated.

MANAGING RISK IN HYGIENE SERVICES

***Core Criterion**

CM 7.1 Rating: D (15-40% compliance with this criterion)
The organisation has a structure and related processes to identify, analyse, prioritise and eliminate or minimise risk related to the Hygiene Service.

- The organisation demonstrated evidence of their risk-management and recently established health and safety structures and processes.
- The organisation had an incident reporting policy in place and was in the process of developing a risk management strategy.
- The organisation provided evidence of a Patient Safety Committee.
- No evidence was demonstrated of hygiene related incidents or complaints being submitted or considered by the Facilities Management or Project Committee.
- The organisation presented no evidence of a recent risk assessment following identification of *Legionella species* in the water supply.. No evidence of a documented process to monitor and manage legionella species was demonstrated. Therefore a significant risk was identified.

CM 7.2 Rating: C (41-65% compliance with this criterion)
The organisation's Hygiene Services risk management practices are actively supported by the Governing Body and/or its Executive Management Team.

- The organisation demonstrated evidence of a dedicated risk management advisor and a Patient Safety Committee of which the General Manager was a member.
- It was reported that the Hospital Risk Advisor meets with the Director of Nursing on a weekly basis, however no minutes or documentary evidence was available to demonstrate this.
- The organisation advised the assessors that due to limited resources, incidents and near misses had not been recorded on the hospitals data base since August.
- A document management system was currently being implemented across the organisation and the hospital's incident form was available on the system.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

***Core Criterion**

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

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

- The organisation had a limited number of contracted services.

- It was evident that all contracts were established and managed through the regional Health Services Executive procurement office in Sligo.
- No evidence of a contract for the vending machine contractor or for the contractor who transports clinical waste from the external holding area to the closed compound was demonstrated.

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

The organisation involves contracted services in its quality improvement activities.

- The organisation had a limited number of contracted services for hygiene with all catering and cleaning services being provided in-house.
- No evidence of formal arrangements for meeting with contractors was presented and the organisation reported that meetings take place as required.

PHYSICAL ENVORNMENT, FACILITIES AND RESOURCES

CM 9.1 Rating: D (15-40% compliance with this criterion with a risk assessment)

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

- The facility is an older building; however significant refurbishment work had been undertaken in line with the Hospital's Development and Control Plan.
- The current physical environment in a number of areas, however in particular the laundry facility, did not meet best practice requirements, i.e. flaking wall paint, roof leaks in two areas, broken flooring, visible dust on ceiling joists, unclean vents, and wooden linen storage shelving.
- In addition, it was established that the Hospital had an identified contamination of its water supply with legionella species on a report dated December 2007. No evidence of further testing after this date was demonstrated. Evidence was demonstrated of thermal flushing of the system on a three weekly basis, however no evidence was provided to demonstrate that this was effective. Therefore no evidence was demonstrated that the water system was clear of Legionella contamination.

***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.

- The organisation provided evidence of documented processes to plan and manage its environment and facilities, equipment and devices, kitchens, waste and sharps and linen.

- However, there was evidence that a number of policies were overdue for review, e.g. Waste Management, Methicillin-Resistant *Staphylococcus aureus* (MRSA) and Sharps policy all due for review in 2006.
- Evidence of a formal preventative and ongoing maintenance programme was demonstrated, however the organisation failed to demonstrate evidence of a documented process to monitor and manage the levels of Legionella species in the water supply.
- Evidence of thermal disinfection flushing on a three weekly basis was demonstrated, however its effectiveness had not been determined. Evidence was presented of a legionella risk assessment undertaken in 2005 by an external company. No evidence of an action plan to meet the recommendations outlined in the latter report was demonstrated.

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

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

- The organisation provided evidence of a number of audits of environment and facilities, equipment and devices, kitchens, waste and sharps and linen.
- Some evidence was presented to demonstrate that issues identified in these audits were dealt with at a local level.
- No evidence was presented to demonstrate that the results of audits were considered by the Facilities Management team or senior management.
- No evidence of a completed patient satisfaction survey was demonstrated, although a draft questionnaire with a hygiene specific element was presented.
- As referred to in Criterion 7.1 and 9.1, the organisation failed to demonstrate that their management and monitoring of Legionella species in the water supply was effective or efficient.

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.

- The organisation demonstrated evidence of a staff satisfaction survey with analysed results undertaken by the Human Resource Department in 2008.
- Evidence of a catering comment card survey was presented, with details of a change in meal times as a result.
- A complaints process was demonstrated, however there was limited evidence that the Facility Management Team formally considering trend reports.
- It was demonstrated that the organisation's patient Focus Group had not met in more than one year.
- It was reported that regular meetings of management with the organisation's MRSA Family Group occur and that hygiene issues are discussed, however no minutes of meetings were available.

- No evidence of a patient satisfaction survey were presented, however a draft satisfaction survey questionnaire was demonstrated and it was reported that the organisation were planning to undertake a pilot survey in maternity.

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.

- The organisation demonstrated evidence of a process for the selection and recruitment of human resources which was in accordance with the national guidelines.
- Some clinical management job descriptions presented did not refer specifically to their responsibilities in relation to hygiene services.
- No evidence of local evaluation of the process for selecting and recruiting was presented.

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.

- The organisation provided evidence of a human resource needs assessment in 2007, which identified staffing shortfalls.
- The organisation reported that they were unable to address the shortfalls identified due to financial constraints.
- The organisation was unable to provide evidence of a documented process for reviewing changes in work capacity and volume.
- Evidence through emails was demonstrated the movement of staff from ward closure areas to other areas and of additional cleaning allocation to the new breast care unit.
- No evidence of formal evaluation of the appropriateness of work capacity and volume review processes was demonstrated.

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

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

- The organisation demonstrated evidence of a process which attempted to ensure that Hygiene Service staff had the appropriate qualification and training through its recruitment process and ongoing education sessions.
- Evidence of a training matrix, plan and record of attendance, which was held on the PPARs system and locally within departments was demonstrated.

- Job descriptions were observed to include requirements in relation to qualifications and experience.
- Limited evidence was demonstrated of a formal system for identifying staff who required training.

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

There is evidence that the contractors manage contract staff effectively.

- Although only a small number of contract staff work on-site, the organisation did not demonstrate a documented process for the management of contract staff.
- No contract was demonstrated for the vendor machine contractor or the contractor who moved the clinical waste within the external grounds of the hospital.
- No evidence was demonstrated of evaluation of the appropriate use of contract staff.
- It was reported that the Facilities Manager meets with the Clinical Waste contractor on a regular basis, however no documentary evidence was available.

***Core Criterion**

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

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

- The organisation provided evidence of a human resource needs assessment in 2007, which identified shortfalls.
- The organisation advised they were unable to address the shortfalls due to financial constraints.
- No evidence was provided of a Hygiene Services plan and Hygiene Services staff cover was not outlined in the organisations strategy or operational plan.
- No evidence of a Hygiene Annual Report 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

- The organisation demonstrated evidence of a corporate and local induction programme which included specific education in relation to hygiene.
- The Health Service Executive Staff handbook was demonstrated and reported to be made available to staff.

- Limited evidence of attendance levels and evaluation was demonstrated.

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

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

- The organisation demonstrated evidence of a training plan, matrix and records for the ongoing training of the Hygiene Services staff.
- Evidence was provided that two senior Hygiene Services staff were certified cleaning trainers.
- Training records were held locally within departments, with some but not all being logged on a central data base.
- Training provided included SKILLs, Furthur Education and Training Award Council and British Institute of Cleaning Science, standard precautions and hand hygiene.
- Limited evidence was demonstrated of evaluation of training provided.

CM 11.3 Rating: C (41-65% compliance with this criterion)
There is evidence that education and training regarding Hygiene Services is effective.

- Limited evidence of performance indicators utilised to evaluate the effectiveness of education and training provided was demonstrated.
- Records for training were held within departments with some held on a central data base.
- Evidence was provided of evaluation of staff satisfaction with individual training sessions, however limited evidence was presented to demonstrate that attendance levels are evaluated.

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

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

- The organisation demonstrated evidence that the catering department have begun the process of a formal staff performance evaluation.
- Evidence was presented in relation to a yearly meeting with staff regarding their attendance levels.
- Informal processes for the evaluation of the performance of Hygiene Services staff members occurs through: internal audits; departmental checklists and regular supervision by department heads and / or supervisor.
- No evidence was demonstrated of a formal process for staff performance evaluation

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.

- The organisation demonstrated evidence of a comprehensive regional occupational health service.
- A partial evaluation of the service was demonstrated through the Human Resource Staff satisfaction survey in 2008.
- No evidence of actions taken as a result was demonstrated.

CM 12.2 Rating: B (66-85% compliance with this criterion)

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

- The organisation demonstrated evidence of a human resources staff satisfaction survey which was undertaken earlier in the year.
- Resultant actions had not been implemented.
- Evidence was presented of once yearly meetings with staff regarding attendance levels. It was noted that absenteeism reports are presented at the Executive Management Team meetings on a monthly basis.
- No evidence of evaluation of the appropriateness of the mechanisms used for monitoring staff satisfaction 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 organisation provided evidence of collecting some hygiene services data through: its incident reporting and complaints process; infection control surveillance and auditing process.
- Limited evidence was presented to demonstrate the tracking and trending of data on incidents and complaints relating to hygiene services or of their formal consideration by the Facility Management Team.
- Evidence of providing access was demonstrated through evidenced based policies, procedures and guidelines; education and training; membership of committees; minutes of meetings circulated to departments, hygiene checklists; audit reports submitted to some departments and infection control surveillance reports submitted at the quarterly Infection Control Committee meetings.
- No evidence was presented to demonstrate that the Facilities Management Team or the Executive Team formally access and or consider audit results.

- It was demonstrated that the Facilities Manager liaises directly with departments in relation to audit results.
- It was demonstrated that the Waste Officer had access to a data base supported by Waste Disposal Company to assess the quantities of clinical waste generated by the Hospital and its community partners.
- No evidence of evaluation of the processes used for collecting and accessing information or of data reliability, accuracy, validity and appropriateness was demonstrated.

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

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

- The organisation demonstrated evidence of regular hygiene audits, however it was noted that the results of same were not considered by the Facilities Management Team.
- Evidence of infection control surveillance reports submitted to the Infection Control Committee on a quarterly basis was demonstrated.
- Evidence of reports on needle stick injuries presented on a yearly basis was demonstrated.
- No evidence of a Hygiene Services Annual Report or of regular trended reports on hygiene related incidents, near misses or complaints were demonstrated.
- No formal evidence of evaluation of user satisfaction in relation to the reporting of data or actions taken as a consequence was demonstrated.

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

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

- The organisation provided limited evidence of evaluation of the appropriate utilisation of data collection and information reporting by the Hygiene Services Team.
- It was reported that informal and un-minuted discussions took place.
- It was demonstrated that a documentary control system was in the process of being rolled out across the organisation.

CM 14.1 Rating: B (66-85% compliance with this criterion)

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

- The organisation demonstrated that hygiene was discussed at the Hospital Management Board meeting in September 2008, upon which time it was agreed that hygiene would be a standing agenda item on a quarterly basis going forward. Previous to date it was demonstrated that hygiene was discussed on a periodic basis.
- Evidence was also provided of infection control surveillance reports and presentations being presented to the Hospital Management Board.
- Evidence was presented to demonstrate that Executive Management are represented on the Facilities Management Committee and that all quality initiatives are approved by the Hospital Management Board.
- The organisation are in the early stages of development of a ward based " house keeper" role which it was noted is being supported by executive management.
- It was reported that the General Manager and Director of Nursing undertake 'walkabouts', however no documentary evidence of same or resultant actions were demonstrated.

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.

- The organisation demonstrated evidence of: the introduction of cleaning schedules which were first piloted and evaluated with resultant changes; a terminal clean checklist pilot in Medical Two ward and informal benchmarking through the Regional Infection Control Committee.
- No evidence was demonstrated of a formalised suite of Hygiene Service performance indicators or of evaluation of improved outcomes in the hygiene services delivery as a result of the quality improvement system.

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 organisation demonstrated evidence of a policy on the development, maintenance and review of hospital policies, procedures and guidelines, which was issued in June 2008.
- It was demonstrated that the organisation were in the process of implementing a document control management system.
- A number of policies and procedures were observed not to be following the approved template and to be overdue for review.
- There was evidence demonstrated of document implementation at local level however limited evidence of audit for compliance was demonstrated.

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

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

- The organisation demonstrated evidence of new hygiene services being evaluated before their routine use, e.g. disposable curtains, and altered meal times.
- Evidence of current trials which were awaiting evaluation included a new alcohol based hand gel, drug dispensing unit in the emergency department and flat mopping system.
- No evidence was demonstrated of evaluation of the efficacy of the assessment process used for new or changed hygiene services interventions.

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 organisation demonstrated evidence of some hygiene related promotional posters and information which were accessible to the public, however it was observed that they were not displayed in a number of prominent areas.

- It was reported that hand hygiene leaflets are disseminated to patients with their admission letters.
- The hospital's Patients' Focus Group had not met in the past twelve months.
- Evidence was presented in relation to the hospital's Think Clean Campaign and Clinical Waste Awareness week.
- No evidence of evaluation of the efficacy of activities undertaken was presented.

INTEGRATING AND COORDINATING HYGIENE SERVICES

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

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

- The organisation presented evidence to demonstrate that it had evaluated the membership and terms of reference of its Facility Management Team at the end of 2007 and reported a planned review at the end of 2008.
- It was demonstrated that the Facility Management Team did not have a medical or patient representative.
- Linkages with other committees and teams was evident however not clearly documented, i.e. Quality Circle Group.

IMPLEMENTING HYGIENE SERVICES

***Core Criterion**

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

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

- The physical environment and facilities of a number of areas visited did not meet the required cleaning standards, including the laundry area. In particular the assessors observed high and low dust, unsatisfactory curtains in the Out–Patients Department, flaking paint on some walls and window sills, dust under beds and unsuitable wall covering in Medical Two ward (i.e. wallpaper).
- Limited storage facilities were observed which impacted upon cleaning.
- Cleaning checklists were observed in all areas however the records were not always completed.

***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.

- The organisation had a process in place for the cleaning of equipment after use.
- However on inspection, the medical equipment in a number of areas visited was observed to be dusty.
- Some of the toys in the play area of the Paediatric ward were also not clean and there was no evidence of a cleaning schedule for same.

***Core Criterion**

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

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

- The organisation's cleaning equipment and storage facilities in a significant number of areas were not observed to be clean.
- Cleaning products were observed to be stored in unlocked cupboards in each of the areas visited.

***Core Criterion**

SD 4.4 Rating: A (>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.

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

***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 organisation demonstrated evidence of a Waste Management Policy dated 2004, which was overdue for review.
- Waste was observed to be held at ward level in unlocked rooms while awaiting collection.

- Large clinical waste bins although locked were observed to be held in an open area accessible to the public.
- The organisation advised the assessors that these bins were moved to a separate locked waste compound four times per week.
- Sharps bins in a number of areas were observed to be left in an open position.

***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's laundry facility did not meet best practice requirements and therefore impacts upon the organisations management and maintenance of its linen supply.
- Flaking paint, roof leaks in two areas, broken flooring, dust and cobwebs on ceiling joists and unclean vents were observed.
- Within the laundry and at ward level linen was observed to be stored on wooden shelves.

***Core Criterion**

SD 4.7 **Rating: A (>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 guidelines.

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

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.

- The organisation was observed to have risk management processes in place which included an incident reporting process with local evaluation and management by the department head and risk manager.
- Limited evidence of trended reports submitted to departments was demonstrated.
- Safety signs during the cleaning process were observed.

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 observed of posters, signage, relevant information leaflets and prominent hand hygiene stations on display.
- The organisation demonstrated evidence of their visitors policy, which it was reported was actively enforced by department heads.
- No evidence of evaluation or satisfaction survey was demonstrated.

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 of a patient charter, professional code of conduct and confidentiality clause in individual job descriptions was demonstrated.
- It was noted that patient dignity was supported through the hospitals visiting policy. Patients' dignity was observed to be respected during Hygiene Services delivery.
- The organisation had adapted the Irish Acute Hospitals Cleaning Manual, however, no local evidence of a documented process for maintaining patient dignity during Hygiene Service delivery was demonstrated.

SD 5.2 Rating: B (66-85% compliance with this criterion)
Patients/Clients, families, visitors and all users of the service are provided with relevant information regarding Hygiene Services.

- There was evidence of posters, leaflets, hand-gel stands and information in relation to hygiene services.
- No evidence of evaluation of patients' comprehension of and satisfaction with the information provided by the Hygiene Services Team was demonstrated.

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 organisation provided evidence of a complaints procedure in adherence with 'Your Service Your Say'.
- No evidence of trended reports of complaints relating to hygiene services being presented to the management team was demonstrated.
- Limited evidence was demonstrated of trended reports being considered by the Facilities Management Team on a regular basis.

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.

- The organisation demonstrated evidence of a catering survey which resulted in a change of meal times further to a trial period.
- The organisation's Patient Focus Group has not met in the past year.
- Limited evidence was presented to demonstrate patients and other service-user's involvement in evaluating the Hygiene Services of the Organisation.

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

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

- The organisation demonstrated evidence of internal hygiene audits with resultant actions, however it was evident that the results of audits were not formally considered or submitted to the Facilities Management Team.
- No evidence of performance indicators or formal benchmarking was presented.
- No evidence of an annual report was presented.

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.

- No evidence of a Hygiene Services Annual Report was demonstrated.
- It was reported that verbal reports by the designated manager with responsibility to the General Manager on a periodic basis occurs.
- It was demonstrated that members of the Executive Management team sit on the Facilities Management Committee.

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

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