Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

National Hygiene Services Quality Review 2008

Our Lady's Hospital, Navan

Assessment Report

Assessment date: 21st 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 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 Our Lady's Hospital, Navan - Organisational Profile [1]

Our Lady's Hospital, Navan, is part of the Louth/Meath Hospital Group in Co. Meath serving a population of 162,621 and provides an elective Orthopaedic Service to the Health Services Executive, Dublin North East with a total bed capacity of 173.

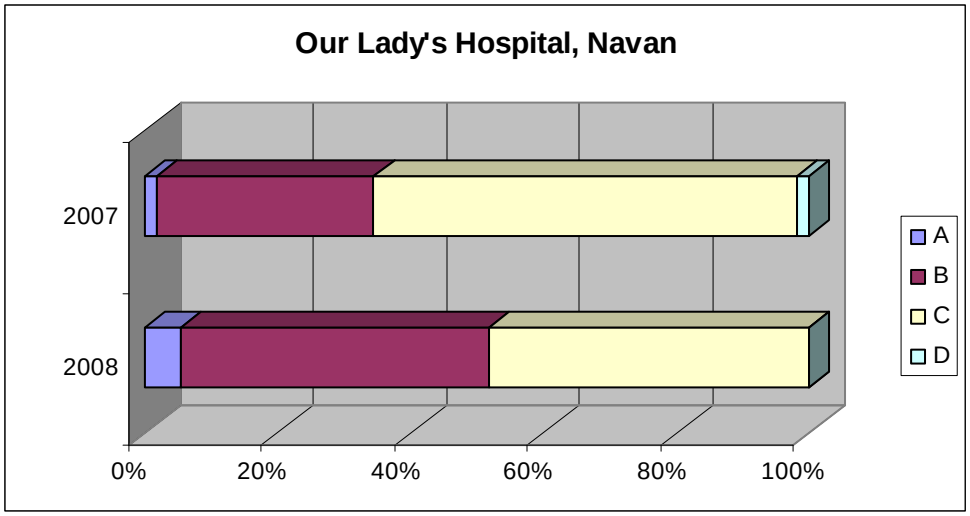
2.2 Areas Visited

- Male medical ward
- Female surgical ward
- Emergency department
- Outpatient department
- Waste compound
- Laundry service

[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 previous page 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.

Our Lady's Hospital, Navan has achieved an overall rating of:

Fair

Award date: 2008

2.4 Standards for Corporate Management

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

PLANNING AND DEVELOPING HYGIENE SERVICES

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

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

- There was evidence demonstrated of active involvement of organisational management and the Hygiene Services Committee in Hygiene Service planning.
- There was evidence demonstrated that the needs-assessment was completed through the service planning process in addition to the results of internal and external hygiene audits, infection rates, decontamination audits and complaints.
- There was evidence of a Hygiene Corporate strategic plan in place.
- There was no evidence of patient input into the needs-assessment process.
- There was no evidence demonstrated of a documented process for completing a needs-assessment.
- There was no evidence demonstrated of evaluation of the efficacy of the needs-assessment process.

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.

- There was evidence to demonstrate that environmental refurbishment work had been completed in 2008. This included the provision of a new waste compound.
- There was evidence to demonstrate that there was upgrade work required in a number of clinical areas. It was demonstrated that funding was approved and work was due to commence in two ward areas in November 2008.
- There was some evidence of evaluation of developments through the hygiene audits, however this process was not formalised.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

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

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

- The organisation demonstrated evidence of linkages with the National Hospital Office and Health Services Executive.
- It was demonstrated that the Hospital Manager was a member of the regional Hygiene Services Committee.
- Infection Control linked with the Strategy for the Control of Antimicrobial Resistance in Ireland (SARI) group and other relevant national infection control groups was demonstrated.
- The minutes of the meetings from the Meath Partnership Forum demonstrated the infection control linkage with this group.
- There was no evidence of staff or patient satisfaction surveys pertaining to hygiene demonstrated.
- A contract cleaning service was demonstrated in the outpatient area only.
- No evidence of evaluation of the efficacy of the linkages and partnerships was demonstrated.

CORPORATE PLANNING FOR HYGIENE SERVICES

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

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

- There was evidence of a Hygiene Services Committee. There was evidence of a Hygiene Corporate Strategic Plan.
- The Risk Manager and Occupation Health representation were co-opted on to the Hygiene Services Committee as required.
- Strategic hygiene objectives and implementation plan were in place.
- A draft audit tool for the Corporate Strategic Operational Plan was demonstrated.
- There was evidence of evaluation of the Hygiene Corporate Strategic Plans, goals and objectives through the Hygiene Services Committee and Team and these were tracked through the Hygiene Services Plan 2008.
- There was no evidence demonstrated that patients were involved in the development of the Hygiene Services Strategic Plan.

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.

- There was evidence that hygiene was a standing agenda item at Louth Meath Hospitals Management Team meetings.
- The organisation demonstrated a draft suite of Performance Indicators for the Louth/Meath Hospital Group. Six key areas had been identified including Governance, Quality Assurance, Education and Training and these were demonstrated.
- The organisation demonstrated that standard operating procedures for cleaning and infection control were based on current best practice guidelines.
- There was evidence that Policies, Procedures and Guidelines (PPGs) were evidence-based and signed off by senior management.
- It was demonstrated that a number of external/internal hygiene audits were used to evaluate compliance.
- No evidence of evaluation of the appropriateness of the review of authority provisions for Hygiene Services was demonstrated

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

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

- There was evidence demonstrated that the Health Service Executive -North East Infection Control policies were in place.
- The Irish Acute Hospitals' Cleaning Manual was demonstrated to inform cleaning standard operating procedures.
- Hazard Analysis and Critical Control Point plans were demonstrated.
- A recently approved regional Standard Operating Procedure for the dissemination of best practice information was signed off by the Hygiene Services Team. A communication plan for hygiene information was demonstrated.
- The organisation demonstrated that the HSE (Health Service Executive) complaints process 'Your Service Your Say' process was in place. There was no documented evidence of results analysed and acted upon and it was demonstrated that the Hygiene Services Committee did not receive information relating to complaints made.

- Evidence was presented that hygiene was an agenda item at all departmental meetings.
- No evidence of evaluation of the appropriateness of Hygiene Services related research and best practice information available was demonstrated.

CM 4.3 Rating: B (66-85% 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 that all staff had access to the intranet and library.
- It was demonstrated that the Infection Control Guidelines for the North East Region 2006 were all evidence based.
- Health Services Executive 2004 Guidelines for the Management of Waste were demonstrated, however there was no evidence of a local policy. There was evidence that the Infection Control Team provided training on all aspects of hygiene.
- There was evidence demonstrated of a central database of training with tracking of attendance observed. Evidence was demonstrated of evaluation of individual training sessions.
- There was evidence demonstrated of evaluation of the appropriateness of Hygiene Services related to research and best practice information available.

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

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

- The organisation demonstrated evidence of using a regional template for development of Polices, Procedures and Guidelines. A regional process for the development of new and revised policies and procedures was in place with the process for sign-off by the Regional Quality and Safety Committee awaiting completion.
- There was evidence of regional policies in place, however the guidelines were not always adapted for local needs.
- No formal evaluation of the efficacy of the process for developing and maintaining of Hygiene policies, procedures and guidelines was demonstrated.

CM 4.5 Rating: C (41-65% compliance with this criterion)

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

- There was evidence demonstrated that the Infection Control Team were involved in capital project committees.
- Evidence of an Aspergillus prevention plan for all capital development projects was demonstrated.
- No evidence of evaluation of the efficacy of the consultation process between the Hygiene Services Team and the Governing Body and/or its Executive Management Team relating to capital development planning and implementation was demonstrated, however senior management were on the Hygiene Services Committee.
- There was no evidence demonstrated of a documented process for consultation with the Hygiene Services pre development of existing sites.

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 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 multi-disciplinary 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: C (41-65% compliance with this criterion)

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

- Evidence of a designated hygiene budget was not demonstrated.
- There was evidence demonstrated of allocation of resources. There was also evidence of minor capital works, which had been implemented based on the identified priorities. It was demonstrated that ward refurbishment funding had been approved for two wards and work was due to commence by the beginning of November 2008.
- The organisation demonstrated that contract staff was employed to address the cleaning needs in the Outpatient Department.
- A Hygiene Corporate Strategic Plan 2008-2011 was demonstrated.
- There was no evidence demonstrated of the documented process for the allocation of resources.

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 Hygiene Services Team demonstrated evidence of their involvement in the process of purchasing equipment, for example mattress project, disposable hand towels and cleaning equipment.
- There was evidence of a Standard Operating Procedure in place for evaluation of products and hygiene interventions. A template was in place for staff in assessing existing Hygiene Services prior to changing from existing products/services.
- The organisation advised that it adhered to the National Procurement Guidelines. It was demonstrated that the Supplies Officer, Infection Control Nurse and Hospital Manager were members of the Hygiene Services Committee.
- No evidence of the evaluation of the efficacy of the consultation process was demonstrated.

***Core Criterion**

CM 7.1 Rating: C (41-65% compliance with this criterion)
The organisation has a structure and related processes to identify, analyse, prioritise and eliminate or minimise risk related to the Hygiene Service.

- The organisation did not demonstrate a comprehensive integrated structure and related processes for Hygiene Services risk incident reporting, analysis, minimisation and elimination. However aspects of risk management were demonstrated.
- There was evidence of a regional risk advisor available to the hospital.
- A regional report for incidents and near misses was demonstrated and this included records of all incidents, however there was limited trending, benchmarking and resultant actions.
- It was demonstrated that a member of the Management team was responsible for the analysis of incidents and complaints. Evidence was demonstrated that reports specific to this hospital were issued every six months and hygiene related issues are identified by category.
- The organisation identified that they had addressed an adverse event in the last two years.
- The organisation demonstrated that external and internal audits were conducted.
- It was advised that risks that cannot be addressed locally were brought to the Hygiene Services Committee. This was not demonstrated.

CM 7.2 Rating: B (66-85% compliance with this criterion)

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

- There was evidence of a shared risk advisor for the hospital group. It was demonstrated that hygiene quality improvement initiatives were based on risk assessment.
- The organisation demonstrated that the establishment of a regional Quality and Safety Committee was in progress
- Infection Control plans and reports and screening as per Strategy for the Control of Antimicrobial Resistance in Ireland (SARI) guidelines were demonstrated.
- Quarterly reports on infection rates were demonstrated and these were discussed at Infection Control Committee meetings.
- The organisation advised that there were no major Hygiene Services adverse events in the last two years.

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.

- The organisation advised that it adhered to the Health Services Executive procurement policy.
- Some contracts were negotiated regionally for example, Waste Management. Evidence of compliance was monitored locally and this was demonstrated. Evidence of monitoring compliance with contracts for pest control, water treatment and flushing of showerheads and air handling unit servicing was demonstrated. It was advised that the organisation's own staff accompanied contractors for water contamination testing.
- There was no evidence demonstrated of a documented process for establishing contracts, managing and monitoring contractors.

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

The organisation involves contracted services in its quality improvement activities.

- The organisation advised that there was a small number of contract services in the hospital.
- The organisation demonstrated that there was no contractor representation on the Hygiene Services Committee. The organisation advised that the Nurse Manager of the unit met with the contract staff on a regular basis and communicates relevant information, however no formal structure was demonstrated.

PHYSICAL ENVIORNMENT, FACILITIES AND RESOURCES

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

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

- There was evidence of poor design and lay out in some of the organisation's current physical environment, especially the wards prioritised for refurbishment, and also the Accident and Emergency Department.
- A list of capital projects 2008-2011 was identified.
- Plans were demonstrated for the upgrade of two wards, which were prioritised for refurbishment.
- Soiled linen was observed to be stored in a multipurpose storage area for furniture.
- A waste compound area had been implemented in 2008.
- There was evidence of upgrading of ward kitchens to Hazard Analysis and Critical Control Point standards in 2008.
- A wash-hand basin replacement programme was demonstrated.

***Core Criterion**

CM 9.2 Rating: B (66-85% 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.

- A Hygiene Manual was demonstrated in all clinical areas visited.
- The procedure for the management of linen was included in the Infection Control Policy Manual. All linen including flat mops were laundered in Cavan General Hospital laundry.
- The Health Service Executive Guideline for waste management was demonstrated.
- A sharps policy was in place and compliance was observed.
- Ward kitchens were observed to be upgraded and Hazard Analysis and Critical Control Point plans were observed to be in place. There was no dedicated kitchen staff observed at ward level.

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

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

- The organisation demonstrated that it evaluated the environment against its service plan goals ands objectives through the Hygiene Services Team and Committee, and also through the external/internal audit results.
- There was no evidence of a formalised process in place for follow through of audit results.

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 'Your Service Your Say' process was demonstrated. There was one recorded complaint pertaining to hygiene in 2007 demonstrated. The organisation advised that complaints pertaining to hygiene were sent to the ward area and other key individuals for learning purposes.
- There were no hygiene specific patient satisfaction surveys demonstrated.

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 organization advised that the Human Resources regional recruitment system for permanent staff was in accordance with the Commission for Public Service Appointments Guidelines was demonstrated.
- Human resource records were held at regional level for permanent staff, with duplicate copies, were demonstrated at hospital level. Temporary staff records were demonstrated at hospital level.
- There had been no evidence of recruitment in last two years.
- There was no documented evidence to demonstrate evaluation of the regional processes for selecting and recruiting human resources.

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 demonstrated that it had identified and allocated additional hours required for Hygiene Services based on environmental audit results.
- There was evidence to demonstrate that evaluation of the appropriateness of work capacity and volume processes was based on subsequent environmental audit results.
- There was no evidence of a formalised needs-assessment process in place to identify hygiene services work capacity and volume.

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

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

- The organisation demonstrated that hygiene education was provided regularly.
- There was no documented plan that identified the hygiene training needs of Hygiene Services staff. The organisation demonstrated that training was recorded and attendance records circulated to line managers for information and compliance management.
- There was evidence presented that all Health Care Assistants had Further Education and Training Awards Council level 5 training completed. All Catering staff have undertaken Hazard Analysis and Critical Control Point training.
- It was demonstrated that all staff had training in infection control, hand hygiene and sharps and waste management and decontamination of equipment. Infection control and hand hygiene training were mandatory for all staff. Staff involved in environmental cleaning received relevant practical training.

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

There is evidence that the contractors manage contract staff effectively.

- There was evidence that contract cleaning staff undertook induction which included hygiene related training and familiarisation with the cleaning manual. Method statements were provided by the organisation for work practices to be observed by contract cleaning staff.
- Evaluation of cleaning contract staff performance was demonstrated through the audit system.
- It was demonstrated that the contract staff's employer provided for their staffs occupational health needs for regular services. In the circumstance of an adverse

event on-site contract staff attend the emergency department and are followed through in the organisation's regional occupational health department.
- There was no evidence demonstrated that the management processes in place for contract cleaners existed for other contractors.
- No evidence of evaluation of the appropriate use of contract staff was demonstrated.

***Core Criterion**

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

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

- There was evidence of the provision of additional human resources allocated to Hygiene Services and revision of staff duties to address deficits identified through audit.
- The Hygiene Services Corporate Strategic Plan and Hygiene Services Plan demonstrated limited integration with a hospital wide human resource plan for Hygiene Services.
- It was demonstrated that identification of human resource needs was not identified in the terms of reference of either the Hygiene Service Committee or the Hygiene Services Team.
- There was no reference to human resources being identified within the Hygiene Corporate Strategic Plan or the Service Plan.
- No Hygiene Services 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.

- There was evidence of a formalised induction programme with elements pertaining to hygiene.
- Evidence of attendance sign off was demonstrated.
- A Health Services Executive staff handbook was demonstrated in all departments and on the intranet. Information was also provided at induction on the visiting policy, information leaflets available within the Hospital and the Health Services Executive Training prospectus 2008 were demonstrated.

- The organisation had a database of all staff training attended and these records were demonstrated.
- A staff handbook was demonstrated. However, it did not contain hygiene related information. There was no evidence of a needs-assessment for education 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.

- There was evidence demonstrated that hygiene training was provided on an on-going basis by the Infection Control Nurse. Staff was released from duties to attend training and training programmes had been amended to incorporate better access to hand hygiene training.
- No documented process was demonstrated for ensuring continuous professional development of all Hygiene Services staff;
- No evidence of evaluation of the relevance of education to each staff member was demonstrated.

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

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

- The organisation advised that the effectiveness of training was monitored through the results of audits, incidence of opportunistic infections, and the occurrence of adverse incidents.
- There was evidence of review of records of attendance and follow up by the Infection Control Nurse and Line Managers.
- There were continuing education sessions at the Health Services northeast training centre.
- No Key Performance Indictors for Hygiene Training were demonstrated.
- Continuing education/ training was provided locally on occasions.

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

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

- There was evidence demonstrated that Nursing Staff met with their line manager six months after induction for review meetings.

- A formal appraisal system for all staff was not demonstrated.
- Evaluation was based on audit results and complaints.
- No evidence of evaluation of the appropriateness of performance evaluation process(es) was demonstrated

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

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

An occupational health service is available to all staff.

- There was demonstrated that an occupational health service was provided for staff.
- There was occupational health representation at Infection Control meetings. Occupational representation was demonstrated on the Hygiene Services Committee meetings and this was evidenced through minutes of a meeting. Reports of the Hygiene Services Committee were provided to the Infection Control Team.
- It was demonstrated that the Human Resources Department conducted a staff satisfaction survey of Occupational health service in 2008. However the overall figures for the region were not demonstrated for specific hospitals. No resultant actions had been implemented.
- The Occupational health annual report was demonstrated.
- A new policy has recently been circulated relating to HIV and Hepatitis B.

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

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

- The organisation was a member of the National Health Promoting Hospitals Network. A Health Promotion Coordinator and Committee were demonstrated.
- Staff health promotion was demonstrated. An information card advising staff to wash hands was demonstrated and observed on wards.
- There were no structured processes demonstrated to evaluate the appropriateness of mechanisms for monitoring staff satisfaction.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.1 Rating: B (66-85% compliance with this criterion)

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

- The organisation demonstrated a Hygiene Communication Plan developed in relation to hygiene information.
- A variety of monitoring related to Hygiene Services was demonstrated. There was evidence demonstrated of surveillance for MRSA, and trending and tracking which included results of hygiene audits, infection control, catering audits and water testing and Environmental Health Officer reports was demonstrated. The audit schedule included sharps and hand hygiene.
- The audit programme had been reviewed and a corrective action plan was demonstrated. It was demonstrated that nine staff were trained to act as peer auditors for environmental hygiene audits.
- There was no process demonstrated to evaluate the quality, data reliability, accuracy, validity and appropriateness of data.

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.

- It was demonstrated that minutes of all hygiene related meetings were circulated promptly to team members following meetings.
- A local adaptation of the cleaning manual took place to make it more user-friendly and this was demonstrated.
- There was no formal evaluation in place of user satisfaction in relation to the reporting of data and information, however no complaints had been made regarding the hygiene information presented.

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.

- Documented data collection was demonstrated as being based on audit reports, complaints, incident reports and infection rates.

- It was demonstrated that information was gathered through the Hygiene Team and Hygiene Committee meetings.
- There was no formal evaluation demonstrated of the appropriateness of data and information utilisation in relation to hygiene service provision and improvement.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

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

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

- The organisation demonstrated a number of quality improvements for Hygiene Services in the last two years. These included:
  - The waste compound;
  - All ward kitchens were observed to be upgraded to Hazard Analysis and Critical Control Point standard;
  - Some toilets in the public areas were observed to be upgraded;
  - Hygiene training has been increased and customised;
  - Cleaning human resources had been enhanced.

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.

- There was evidence demonstrated of developments in the area of environmental improvements, however there were still significant outstanding areas to be addressed.
- There was evidence of developments in the overall hygiene management structures, however there was still no patient/public representation on the Hygiene Services Committee.
- Progress was demonstrated in the implementation of the audit process, however follow through was demonstrated as still at a developmental stage. Performance indicators were identified, however no evidence of reporting against the indicators was demonstrated.
- Evaluation of improved outcomes in Hygiene Services delivery as a result of the quality improvement system was still very limited.

2.5 Standards for Service Delivery

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

EVIDENCE-BASED BEST PRACTICE AND NEW INTERVENTIONS IN HYGIENE SERVICES

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

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

- Evidence was demonstrated of a standard operating procedure for the dissemination of best practice information. Infection control and cleaning manuals were evidence based on current best practice guidelines. Colour coding was in place for cleaning and waste and linen segregation and disposal.
- Ward kitchens adhered to Hazard Analysis and Critical Control Point standards in place.
- Supervisory staff had protected time for consultation with best practice documentation.
- Mechanisms for formal input into best practice guidelines development by patients, clients and contractors were not demonstrated.
- There was no evidence demonstrated of evaluation of the efficacy of the processes used to develop best practice guidelines.

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

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

- Evidence was demonstrated of documented processes in place for assessing new hygiene interventions and changes to existing ones for example, the trialing of new disposable hand towels, mattresses and mop systems.
- There was no formal evaluation of the efficacy of the assessment demonstrated.

PREVENTION AND HEALTH PROMOTION

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

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

- There was evidence demonstrated that hygiene awareness days were held in the hospital at regular intervals.
- There was evidence of an active health promotion culture in the organisation demonstrated through its membership of the National Health Promoting Hospitals Network.
- There was evidence of a comprehensive package of health promoting activities for staff and patients which included the provision of targeted information days, education sessions and information leaflets. Hygiene posters and information leaflets were appropriately disseminated throughout the organisation. There was an information screen observed in the main reception displaying information on hand hygiene and the visiting policy.
- There was no evidence of evaluation demonstrated.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1 Rating: A (>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 demonstrated compliance of greater than 85% with the requirements of this criterion.

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 environment including toilets and high surfaces were generally dusty. Sticky tape residue was observed in a number of areas. Sluice rooms were cluttered

and multipurpose in most instances. Storage facilities were generally very small and cleaning items were stored in different areas.
- The patient toilets in one ward were accessed through the sluice room. This ward was identified for immediate refurbishment in the coming weeks.
- The environment in most clinical areas was observed to be in a poor state of repair and decoration especially the emergency department.
- Cleaning check lists were not always for the current week.

***Core Criterion**

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

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

- A record label was in place to identify cleaned clinical equipment.
- Storage facilities were limited and much of the equipment in use and in storage was dusty.
- Some commodes were not clean.
- Patient wash basins were clean however stored on the floor in one instance due to storage constraints.
- Fans were used for terminally ill patients however these were observed to be cleaned and stored in plastic packaging when not in use.

***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.

- Cleaning equipment was observed to be stored in a variety of areas due to storage constraints.
- Cleaning equipment including mop buckets was observed to not always be clean. There was evidence of redundant cleaning equipment in storage areas. Storage facilities for cleaning equipment were observed to not always be ventilated and there were not always wash-hand basins in situ.

***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.

- Ward kitchens visited had recently been upgraded to Hazard Analysis and Critical Control Point standards.
- Although there were restricted entry signs in place, one kitchen door was held open.
- There was inconsistent use of hair covering.

***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.

- There was evidence demonstrated that the Health Service Executive Guidelines for Healthcare Waste 2004 were in place.
- Evidence was provided of waste collection permits, completed C1 forms and certificate of destruction.
- It was advised that the waste advisor provided training for waste compound staff.
- Segregation of waste was observed to be compliant
- Some bins were observed not to be clean especially the large external storage bins which were adjacent to the main hospital building.
- There was very limited internal storage space for waste bags awaiting collection however there was evidence of frequent collections from clinical areas.
- Staff handling waste was observed wearing personal protective equipment.

***Core Criterion**

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

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

- There was evidence of the organisation’s linen being generally managed and maintained despite the limited storage. Linen was observed to be clean and in

good condition. A curtain change policy was demonstrated and records of change maintained. Clean linen was generally packaged in cellophane wrap.
- Segregation of soiled linen was compliant with best practice.
- Clean linen storage rooms/presses were observed not always to be available in the clinical areas.
- Soiled linen storage at ward level was limited however there was evidence of frequent collections observed. Clean blankets were observed to be stored on open shelves close to an examination cubicle in the Emergency Department.
- The clean linen central storage area did not have a wash-hand basin in place.
- The external storage area was not in line with best practice.

***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 Strategy for the Control of Antimicrobial Resistance in Ireland (SARI) guidelines.

- Sinks in general were observed to be clean.
- Alcohol based hand rub, antiseptic hand wash and paper towels were observed to be in place.
- Hand-washing technique was observed to be in line with best practice.
- There was evidence demonstrated that a number of wash-hand sinks were observed not to be compliant with best practice standards.
- One hand air dryer was noted in a patient toilet.

SD 4.8 **Rating: C (41-65% compliance with this criterion)**

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

- There was evidence demonstrated of additional cleaning time provided in response to audit results.
- The cleaned equipment labelling system was demonstrated.
- The general storage space was limited and was observed to be used for multiple purposes generally and were often cluttered.

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.

- Hygiene information was observed to be provided through signage, posters and health promotion initiatives. The visiting policy, was demonstrated to be based on the national visiting policy and had recently been amended to provide for an afternoon rest period for patients.
- There was no evidence demonstrated of evaluation of patient, client and family satisfaction with participation in service delivery.

PATIENT'S/CLIENT'S RIGHTS

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

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

- There was evidence demonstrated that the HSE complaints procedure 'Your service your say' was in place.
- There was evidence demonstrated of a patient information leaflet including references to patient rights.
- The organisation demonstrated how it had incorporated the National Trust in Care policy into its documentation.
- Isolation facilities were observed to be limited.
- Professional and organisational guidelines were observed to be in place regarding patients' rights, however some aspects of practice were not in line with best practice for example, signage displayed over one patient's bed identified routine blood screenings for infectious organisms; proximity of couches in the emergency department limited ease of communication for private matters.
- No evidence of evaluation of patients' clients and families' rights violations in relation to Hygiene Services 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 demonstrated of hygiene related information available to patients. This included posters and leaflets.
- There was no evidence of evaluation of patient/client and family satisfaction pertaining to hygiene in place.

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.

- There was evidence demonstrated of a complaints procedure.
- There was evidence demonstrated of the HSE complaints procedure 'Your Service Your Say' leaflets in place.
- It was advised that there was one hygiene related complaint recorded for 2007. The organisation advised that verbal complaints were resolved locally, however this was not demonstrated
- No evidence of an evaluation process was demonstrated.

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 that patient /client involvement in evaluating Hygiene Services was through the complaints process.
- There was no evidence demonstrated of direct patient involvement in evaluating Hygiene Services.

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.

- There was evidence of monitoring the quality of Hygiene Services through an established system of internal and some external hygiene related audits with results benchmarked against previous audit results. There was no evidence demonstrated of a systematic approach to the implementation of recommendations from audits.
- There was evidence demonstrated of Draft Key Performance Indicators for the region, however there were no local indicators for Hygiene Services. Key Performance Indicators reflected infection rates rather than hygiene issues.

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

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

- There was no evidence demonstrated of a formalised Hygiene Services Annual Report however there was evidence of results of audits which were benchmarked. Results on trended audits were demonstrated.

Appendix A: Ratings Details

The table below provides an overview of the individual ratings for this hospital on each of the criteria, in comparison with the 2007 Ratings.

Criteria	2007	2008
CM 1.1	C	C
CM 1.2	B	B
CM 2.1	C	B
CM 3.1	D	B
CM 4.1	C	B
CM 4.2	B	B
CM 4.3	C	B
CM 4.4	C	C
CM 4.5	B	C
CM 5.1	B	A
CM 5.2	B	A
CM 6.1	C	C
CM 6.2	C	B
CM 7.1	C	C
CM 7.2	C	B
CM 8.1	C	B
CM 8.2	C	C
CM 9.1	E	C
CM 9.2	B	B
CM 9.3	B	B
CM 9.4	B	C
CM 10.1	B	B
CM 10.2	C	C
CM 10.3	C	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	C
CM 13.1	C	B
CM 13.2	C	B
CM 13.3	C	C
CM 14.1	B	B
CM 14.2	C	C
SD 1.1	C	C
SD 1.2	C	B
SD 2.1	C	B
SD 3.1	B	A
SD 4.1	B	C
SD 4.2	B	C
SD 4.3	B	C
SD 4.4	B	B
SD 4.5	B	C
SD 4.6	A	C
SD 4.7	B	B
SD 4.8	C	C
SD 4.9	C	B
SD 5.1	C	C
SD 5.2	C	B
SD 5.3	B	B
SD 6.1	C	C
SD 6.2	C	C
SD 6.3	C	C