Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Hygiene Services Assessment Scheme

Assessment Report October 2007

Merlin Park Hospital

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1.0 Executive Summary

1.1 Introduction

This is the first National Hygiene Services Assessment Scheme (HSAS). It is a mandatory scheme for all acute hospitals. The scheme aims to enhance cultural change in the area of hygiene services by not only focusing on the service delivery elements but also emphasising the importance of standards for corporate management. The HSAS is a patient-centred scheme which assists a hospital to prioritise the key areas in hygiene to be addressed. It is intended to promote a culture of best practice and continuous quality improvement.

The Irish Health Services Accreditation Board developed these, the first set of National Hygiene Assessment Standards in 2006. This development plan involved an extensive desktop review of national and international best practice literature, working groups and extensive consultation. The feedback from these development components formed the final draft Standards and Assessment Process, which were then piloted in a number of acute hospitals. *(The Irish Health Services Accreditation Board was subsumed into the Health Information and Quality Authority in May 2007.)*

The Hygiene Services Assessment Scheme (HSAS) was launched by the Minister for Health Mary Harney on the 6th November 2006.

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" [1-4]

More specifically, the Hygiene Services Assessment Scheme incorporates the following:

- Environment and Facilities: incorporates the condition of the building and all its fixtures, fittings and furnishings.
- Hand Hygiene: incorporates hand washing, antiseptic hand-rub and surgical hand antisepsis.
- Catering: incorporates kitchens (including ward kitchens) fixtures and fittings and food safety.
- Management of Laundry: incorporates management of linen and soft furnishings both in-house laundry and external facilities.
- Waste and Sharps: incorporates handling, segregation, storage and transportation.
- Equipment: incorporates patient, organisational, medical and cleaning equipment.

1.1.1 Standards Overview

The standards are divided into two sections: Corporate Management and Service Delivery. Each standard is divided into a number of criteria. These are specific steps, activities or decisions that must occur to achieve the standard.

The 14 Corporate Management standards facilitate the assessment of performance with respect to hygiene services provision to the organisation and patient clients at organisational management level. These standards commence at the planning stage and follow through to governing, implementation and evaluation. They incorporate four critical areas:

- Leadership and Partnerships
- Management of the Environment and Facilities
- Management of Human Resources
- Information Management.

The six Service Delivery standards facilitate the assessment of performance at team level. The standards address the following areas:

- Evidence based best practice and new interventions
- Prevention and Health Promotion
- Integration and coordination of hygiene services
- Implementing safe, efficient and effective hygiene services
- Protection of patient/clients rights
- Assessing and Improving performance. [5]

The standards and process have been assessed and internationally accredited by the International Society for Quality in Healthcare (ISQua).

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.

In the Corporate Management standards, the core criteria cover:

> Allocation of resources, accountability, risk management, contract management and human resource management.

In the Service Delivery standards, core criteria cover:

> Waste management, hand hygiene, kitchens and catering, management of linen, equipment, medical and cleaning devices and the organisation's' physical environment.

1.1.2 Rating Scale

The rating of individual criterion is designed to assist self-assessment teams and the organisation in general, to prioritise areas for development. The rating for the criterion can be determined based on the percentage level of compliance.

The rating scale utilised by the Hygiene Services Assessment Process is a five-point scale:

A Compliant - Exceptional

- There is evidence of exceptional compliance (greater than 85%) with the criterion provisions.

B Compliant - Extensive

- There is evidence of extensive compliance (between 66% and 85%) with the criterion provisions.

C Compliant - Broad

- There is evidence of broad compliance (between 41% and 65%) with the criterion provisions.

D Minor Compliance

- There is evidence of only minor compliance (between 15% and 40%) with the criterion provisions.

E No Compliance

- Only negligible compliance (less than 15%) with the criterion provisions is discernible.

N/A Not Applicable

- The criterion does not apply to the areas covered by the Self Assessment Team. Rationale must be provided. This cannot be used for a core criterion.

1.1.3 Assessment process components

The assessment process involves four distinct components:

- **Preparation and self assessment undertaken by the organisation.**

The self-assessment process allows an organisation to systematically evaluate its hygiene services against a set of best practice standards. This was completed by a multidisciplinary team(s) over a period of two months. This process was preceded by regional education sessions.

- **Unannounced assessment undertaken by a team of external assessors**

The HIQA has recruited senior professionals from the areas of medicine, nursing and corporate management as assessors, in addition to independent senior professionals with specialist knowledge in the core areas. To assure consistency across all sites four leaders were chosen from this group to cover all unannounced visits. The assessor's performance was regularly evaluated based on feedback from participating organisations, HIQA staff and other assessors.

Site visits for the larger academic teaching hospitals were completed over 2.5 days with four assessors, and assessments were completed in the smaller hospitals over 2 days with three assessors. The assessment team were responsible for identifying the organisation's compliance with the standards and helping to guide its improvement.

The assessment included a comprehensive documentation review, meetings with management, staff and patients. Throughout the assessment process the assessors worked as a team to cross reference their findings. This ensured that the ratings for each criterion were agreed upon and reflected an accurate picture of the organisation's level of compliance. Feedback was provided to the Chief Executive / General Manager and senior management team by the Assessment Team Leader, at the end of each day of the assessment.

- **Provision of an outcome report and determination of award status.**

The Internal Review Committee of the HIQA reviewed all the reports to ensure consistency, and based on the quantifiable translation guidelines, awards were made. Only organisation's which received a "very good" score were acknowledged with an award for the duration of one year. By the end of

October 2007 all 51 acute care hospitals had received a copy of their individual report.

At the same time the HIQA launched a National Report of the findings of all assessment reports. These standards are different from the first two hygiene audits, therefore a direct correlation of results were not possible.

- **Continuous Improvement**

Going forward a quality improvement plan should now be structured from the self assessment and recommendations from the external report. This will then be monitored by the HIQA.

The areas of notable practice, quality improvement plans, areas of priority action, overall score, criterion ratings and comment and are presented in the following pages of the report.

[1] Boot, M and Cairncross, S "Actions Speak" Delft, The Netherlands, IRC and LSTHM, British Occupational Hygiene Society.

[2] New York Department of Health and Mental Hygiene

[3] The Columbia Electronic Encyclopaedia, Sixth Edition. Columbia University Press. 2003

[4] Irish Acute Hospitals Cleaning Manual, HSE (2006)

[5] Hygiene Services Assessment Scheme. Irish Health Services Accreditation Board (2006)

1.2 Organisational Profile

Merlin Park University Hospital is one of two acute hospitals that constitute Galway University Hospitals Group. It is a 194-bedded hospital with additional 81 long stay beds for geriatric patients and 27 day beds.

Services provided

- Anaesthesia
- Radiology
- Care of the Elderly
- Orthodontics
- Emergency Medical Admissions
- Orthopaedic Surgery
- Haemodialysis
- Respiratory Medicine
- Nephrology
- Rheumatology

Physical Structures:
The Special Care Unit has a negative/positive air isolation room. This is actually a 2 bed area but when required for isolation one bed is not used.

Unit 7 has 2 isolation rooms. This is an out-patient haemodialysis service.

There are 41 single rooms in other wards/units that are used to accommodate patients who require source isolation. However, these rooms do not have ante-rooms and only 8 have en-suite facilities.

The following assessment of Merlin Park University Hospital took place between 14th and 15th August 2007.

1.3 Notable Practice

- Staff commitment to the hygiene services and processes
- Strong leadership in catering, waste and infection control
- Senior management support was evident
- Adherence to hand hygiene and uniform policy
- Catering
- Health promotion
- Service user's involvement in the hygiene services.

1.4 Priority Quality Improvement Plan

- It is recommended the organisation establish staff satisfaction surveys in relation to hygiene services.
- It is recommended that the organisation introduce a design template for policy development.
- It is recommended that the organisation establish a formalised structured feedback communication loop in relation to hygiene and documented evidence of same.
- It is recommended that the organisation standardise its process for monitoring contractors.

- It is recommended that the organisation introduce documented action plans, timescales and accountability for the hygiene related committees.
- It is recommended that the organisation review and upgrade the physical aspects of the Haemodialysis.

1.5 Hygiene Services Assessment Scheme Overall Score

The decision mechanism used to translate an organisation's criteria, risk ratings to a Hygiene Service Assessment Scheme score is based on a quantitative analysis of the assessment results which ensures consistency of application. The decision regarding a score is made by the Internal Review Committee of HIQA, based on the findings of the Assessment Team; the Merlin Park Hospital has achieved an overall score of:

Fair

Award Date: October 2007

2.0 Standards for Corporate Management

The following are the ratings for 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. There are fourteen Corporate Management standards, all of which are focused on four critical areas: leadership and partnerships, environment and facilities, human resources and information management. They include such subjects as corporate planning, allocating and managing resources, enhancing staff performance and contractual agreements. There are eight core criteria within these standards.

PLANNING AND DEVELOPING HYGIENE SERVICES

CM 1.1 (B → B)

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

A comprehensive approach was utilised to assess hygiene needs including thorough review of relevant best practice guidelines, legislation and information. A comprehensive analysis of both internal and external environment was performed and the information was utilised in the Corporate Strategy for the future and the Hygiene Corporate Strategic Plan. Quality improvement activities to date included building upgrades and training programme development. It is recommended that the Team progress the Quality Improvement Plan for reviewing and improving processes for performing hygiene needs assessment.

CM 1.2 (A ↓ B)

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 has used a multi-disciplinary team approach to review the hygiene needs of the population served and have demonstrated a comprehensive list of improvements, for example a change in the meal time policy and upgrading of the hand-wash facilities. The organisation needs to establish a formalised approach to maintaining and upgrading the facility. Changes to the organisation's hygiene services should be monitored and evaluated to ensure that they continue to meet the needs of service users.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1 (B → B)

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.

Collaboration with the Health Service Executive and government agencies was evident through regular communication and minutes of meeting observed. Evidence was observed of comprehensive hygiene related linkages with relevant external and internal bodies and the public as outlined in self assessment documentation and validated on site, for example, through regular hygiene services newsletters and comment cards, which specifically seek feedback in relation to hygiene. It is recommended that the organisation further develop processes to evaluate the efficacy of its hygiene related linkages and partnerships.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 (B → B)

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

The Galway University Hospital (GUH) Strategy for the Future 2006–2010, developed by the Executive Management Team included the future service developments for Merlin Park University Hospital. A Hygiene Corporate Strategic Plan for Merlin Park is in draft format, and the organisation is currently seeking feedback from staff and patients in relation to the plan. The organisation intends to approve this plan at its next Executive Management Team meeting.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.1 (B → B)

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.

Overall responsibility for hygiene lies with the Executive Management Team of GUH. Within Merlin Park Hospital, the responsibility for hygiene services is clearly defined. Corporate policies are in place (for example health & safety, risk management and code of corporate ethics policies) and these are reflective of current legalisation and best practice guidelines. There was evidence that the organisation adheres to legislation and relevant national guidelines (for example catering, HACCP and waste management legislation). It is recommended that the organisation develop formalised processes for the evaluation of adherence to all corporate policies and procedures.

CM 4.2 (B ↓ C)

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

Comprehensive evidence is available to show that the Executive Management Team receives best practice information. However, there was no evidence of performance indicators for the hygiene services. It is recommended that the organisation formalises the information that is presented to the Executive Management Team and evaluate this to ensure it is correct.

CM 4.3 (B → B)

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

There was evidence to suggest the organisation uses research and best practices to improve practices within the organisation, for example, its sink replacement programme. Staff have access to the internet and library facilities in order to access best practice. Infection control staff use every opportunity to update staff on issues of hand washing. In-service training is provided and two monthly hygiene newsletters are issued.

CM 4.4 (B → B)

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

The hospital has developed policies and procedures for Hygiene services. There is a framework for the development of policies. This has been applied to infection control policies that have been recently developed. It is recommended that the organisation ensures all policies have a signature of approval by the relevant committee and that this framework is applied to all policies. The team is encouraged to evaluate the efficacy of the process for developing and maintaining hygiene services, procedures and guidelines.

CM 4.5 (B → B)

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

The hospital demonstrated that the Hygiene Committee are involved in the planning consultation process. This has been evidence in the sink replacement programme. The planning group consists of members of the hygiene services committee and outcomes from these meetings are discussed with the senior Management Team. There was evidence that the users of the service were involved in the planning process. It is recommended that the efficacy of the process is evaluated.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

*Core Criterion

CM 5.1 (B → B)

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

There was evidence of clear roles and responsibilities for the hygiene services, The Hygiene Service Committee has a representative from Senior Management. A recent job description of a management representative outlined his/her role and responsibility in relation to the hygiene service and the reporting relationship was clearly defined.

*Core Criterion

CM 5.2 (B → B)

The organisation has a multi-disciplinary Hygiene Services Committee.

The Hygiene Services Committee is multi-disciplinary. Terms of reference are in place. The organisation has also developed a Hygiene Services Team which meets on a weekly basis. The organisation encourages open communication between all teams and it was evident that members of the team were aware of each others' roles and responsibilities. The outcomes of committee meetings and results of audits completed were discussed with relevant people to ensure corrective action is taken.

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

*Core Criterion

CM 6.1 (B → B)

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

It was evident that capital development and minor capital funding was defined for hygiene services. There was evidence that funding was made available on the basis of the needs assessment performed (for example the replacement of the water tanks as recommended in the Legionnaire Needs Assessment and upgrade of hand wash sinks). This is monitored within the service plan.

CM 6.2 (B → B)

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

It was demonstrated that equipment procurement procedures were in line with National Procurement Policy. The Hygiene Committee were represented on the Medical Equipment Committee. The organisation is encouraged to roll out their QIP to develop an integrated process for the development of equipment procurement process.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

CM 7.1 (A ↓ B)

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

A robust risk management system is in place, as well as a healthcare risk management strategy which includes risk incident reporting/analysis. There is a multidisciplinary Risk Management Committee in place and the organisation has appointed clinical risk advisors. Health and safety statements and risk assessment have been completed. The HACCP system was well defined and is evaluated externally by the Environmental Health Officer. Also, monthly STARS reports are generated and acted-upon. There was a lack of evidence of closure of the quality improvement loop (feedback to staff on risks identified) which would also encourage learning in the organisation. It is recommended that this be addressed.

CM 7.2 (B → B)

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

There was evidence that risk management practices were supported by the governing body through the appointment of a clinical risk advisor and support of risk management education at the organisation. The risk management committee is multidisciplinary with representatives on the Hospital Services Committee. There was evidence of regular evaluation of risk within the organisation and local feedback.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion

CM 8.1 (B ↓ C)

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 hospital had a tendering and procurement policy in place in line with national policy and legislation and this was evident with the waste contract. There is little evidence (with the exception of the waste contract) of monitoring of contractors, their professional liability and their procurement process policy. There was limited evidence of monitoring the effectiveness of contractors and their presence on site (for example the validation of equipment such as bedpan washers, water testing and air conditioning systems). It is advisable to develop robust organisation guidelines that would establish the monitoring, professional liability and effectiveness of contracted services to the organisation. It is recommended that the organisation implements the tendering and procurement process across all contracts including the vending machine contract. This should include lines of accountability and evaluation.

CM 8.2 (B ↓ C)

The organisation involves contracted services in its quality improvement activities.

There is evidence that the cleaning and waste contractors are involved in their own quality improvement programme. There was no evidence of a contracted services representative on the Hygiene Committee at Merlin Park. It is advised that the organisation actively involve contracted services in its quality improvement activities and that this is reflected in the hygiene services guidelines and policies.

PHYSICAL ENVIRONMENT, FACILITIES AND RESOURCES

CM 9.1 (B → B)

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

A comprehensive list of relevant design specifications was provided. Evidence of evaluation was included in fire and health & safety reports observed. There are elements within the physical environment that require up-grading and on-going maintenance to ensure these meet best practice. There is a programme in place to address these issues.

*Core Criterion

CM 9.2 (B → B)

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

There was evidence in place that the organisation manages the environment, equipment/devices, kitchens, linens, sharps and other hygiene related risks in line with best practice guidelines and regulations (for example, catering and waste).

CM 9.3 (B → B)

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 its management of the environment and facilities, kitchens and sharps and linen are effective through the use of internal and external audit, risk management EHO, internal hygiene audit and through patient satisfaction surveys and comment cards. Changes as a result of audit included: the up-grading of waste management systems, upgrading of ward areas/hand hygiene facilities and floor replacement.

CM 9.4 (B → B)

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 actively encourages patient feedback through the provision of comment cards. The performance of patient satisfaction surveys post discharge has been completed (which includes feedback on hygiene and the environment). The organisation has demonstrated that they have implemented recommendations following the receipt of feedback from patients. The team was encouraged to assess staff satisfaction through their cleaning surveys in October as planned.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 (B ↑ A)

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 national HSE Human Resources (HR) recruitment policy is being adhered to. A job description reviewed had been established in line with the recruitment policy. There was evidence of evaluation of the recruitment process. Contract staff are utilised in the organisation; their recruitment is in line with best practice.

CM 10.2 (B ↓ C)

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

It was established that the organisation is currently reviewing the human resource needs for hygiene services. Current services providers perform a dual role, for example cleaning and catering. It is recommended that that the organisation progress the process of segregating cleaning and catering with a view to providing a single role hygiene services operative. The team is encouraged to conduct an evaluation of work capacity and volume review processes.

CM 10.3 (B → B)

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

The organisation adheres to national requirements for pre-employment of hygiene staff. Site specific induction is provided which includes all areas of risk and hand hygiene. On-going training needs are reviewed on an annual basis, and there was evidence that relevant hygiene training was provided, (for example, FETAC, Health

and safety, HACCP, and risk management). There is a very effective 'train the trainer' system in place in the catering department, which is commended.

CM 10.4 (B ↓ C)

There is evidence that the contractors manage contract staff effectively.

The organisation has demonstrated that there are processes in place to ensure contractors manage contract staff effectively. Training records viewed were current and in line with best practice. The waste management contractors effectively manage their contract staff. It is recommended that this is rolled out to include all contractors in the organisation. The team is encouraged to conduct an evaluation of the appropriate use of staff.

*Core Criterion

CM 10.5 (B ↓ C)

There is evidence that the identified human resource needs for hygiene services are met in accordance with hygiene corporate and service plans.

The hospital has performed a human resource needs assessment; this is not inclusive of the hygiene staff. There is a roster system in place to ensure hygiene services are completed. The hygiene services strategic plan is in draft format and the service plan is completed. The organisation is encouraged to develop a needs assessment for the hygiene services in line with the hygiene services strategic plan when formally approved.

ENHANCING STAFF PERFORMANCE

*Core Criterion

CM 11.1 (A → A)

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

A comprehensive induction programme, covering all relevant areas of hygiene, is in place for all staff. A staff handbook is provided to staff on commencement of employment. Attendance records at induction were viewed. It is recommended that the organisation incorporate care of the environment and roles/responsibilities of staff in relation to the hygiene services into the induction programme.

CM 11.2 (N/A ↓ C)

On-going education, training and continuous professional development is implemented by the organisation for the hygiene services team in accordance with its human resource plan.

Ongoing continuous education is in place and staff are provided with training as needed. This includes on-going revision training. On-site training is provided to staff within their own areas to encourage attendance. Documented processes for on-going professional development of hygiene staff is in place. It is recommended that Key Performance Indicators are established for training for hygiene services. It is recommended that the organisation further evaluates the relevance of education and training provided to ensure all staff receive the appropriate training. This needs to be systematically defined.

CM 11.3 (B ↓ C)

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

Staff have completed evaluations of training provided. The organisation is encouraged to establish a systematic approach to evaluations and monitoring of training attendance levels and to develop Key Performance Indicators for hygiene training.

CM 11.4 (B ↓ C)

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

A formal probationary performance assessment is in place for permanent staff. The nursing management observe that hygiene staff complete their tasks as required. Contract staff performance is monitored by the contractor. The organisation is encouraged to implement a systematic approach to the performance evaluation of all staff.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (B → B)

An occupational health service is available to all staff.

A robust Occupational Health Department is provided by the sister hospital (GUH). It is recommended that the organisation evaluate the effectiveness of this service as per the hospital's QIP.

CM 12.2 (B ↓ C)

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

An occupational health service is provided to all staff of the hospital and this is monitored on an on-going basis. The hospital is encouraged to develop a systematic approach to monitor staff satisfaction. There is currently no system in place to capture staff feedback.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.1 (B → B)

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.

Evidence of adherence to Freedom of Information and Data Protection Acts in relation to data collection was observed. There was evidence of compliance in data collection for, e.g., catering, waste management and infection control. It is recommended that the organisation develop processes for the evaluation of the quality, reliability, accuracy and validity of data collected.

CM 13.2 (B → B)

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 how data and information is reported, for example health & safety reports and HACCP reports. It is recommended that the organisation

evaluate information and data to ensure that it is timely and accurate, easily interpreted and based on the needs of hygiene services.

CM 13.3 (B → B)

The organisation evaluates the utilisation of data collection and information reporting by the hygiene services team.

There is evidence that the organisation utilises data systems to provide information to the organisation (for example in the hygiene newsletter, at the infection control committee, "Think Clean Day" and product evaluation committee).

The organisation is encouraged to roll out their QIP to evaluate the utilisation of data collection and information reporting within the organisation.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

CM 14.1 (B → B)

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

It was demonstrated that the governing body and Executive Management Team foster and support a quality and improvement culture through the use of FETAC training to support staff, catering services have been extended to weekends for staff. This should include training on risk management for all staff, extended restaurant hours at weekends, customer care training for staff, the roll out of protected meal times for patients and staff, and facilities upgrade, e.g. waste compound, HSSD upgrade for example.

CM 14.2 (B ↓ C)

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 to support that the organisation is focused on quality improvement, for example the introduction of recycling system, changes in catering in line with IS340 and IS 22000. Internal audits have been completed in relation to hygiene and have shown improvement. Health promotion initiatives and introduction of patient focus groups, community education sessions are commended. It is recommended that the organisation develop Key Performance Indicators in relation to hygiene services.

3.0 Standards for Service Delivery

The following are the ratings for 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. There are six Service Delivery standards, which focus on such areas as prevention and health promotion, implementing hygiene services and patients/clients rights. There are seven core criteria within these standards.

EVIDENCE BASED BEST PRACTICE AND NEW INTERVENTIONS IN HYGIENE SERVICES

SD 1.1 (B ↓ C)

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

There was evidence to suggest that the Hygiene Services team had commenced a process of adopting best practice in relation to hygiene services. However, these processes were at a developmental stage and were not well established. It is recommended that the organisation proceed with the processes and that they evaluated their efficacy.

SD 1.2 (B → B)

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

There was evidence of processes for assessing new hygiene services intervention in line with national policies. These included: piloting of new linen colour-coding processes in line with best practice piloting of flat mopping systems and the introduction of new systems of temperature probing in the catering department. It is recommended that the organisation evaluate their initiatives and documented in the same way.

PREVENTION AND HEALTH PROMOTION

SD 2.1 (B → B)

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 strong evidence to support the organisation's participation and support of health promotion activities. These included: Notices and leaflets for service users in relation to hygiene and infection control issues, including hand hygiene, publication of a hygiene newsletter, visits to local community and schools in relation to environmental matters and 'Think Clean Days'. It is recommended that the Team should evaluate its activities and document the changes.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1 (B → B)

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

There was evidence that there was a multi-disciplinary presence on both the Hygiene Services Committee and Hygiene Services Team. The HST meets on a weekly basis and terms of reference for both teams exist. The outcomes of hygiene audits were discussed with all members and actions taken by the appropriate people. It is recommended that the organisation evaluate the structure of the team and document its efficacy.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

SD 4.1 (A → A)

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

Overall the organisation's physical environment was clean and maintained to a high standard. However, there was evidence that high dust remains a problem throughout the organisation. It is recommended that high dusting become part of the cleaning schedule.

For further information see Appendix A.

*Core Criterion

SD 4.2 (A → A)

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

There was evidence that the organisation's equipment, medical devices and cleaning devices were clean and maintained to a high standard.

For further information see Appendix A.

*Core Criterion

SD 4.3 (B → B)

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

There was evidence that robust processes for maintaining and cleaning of the cleaning equipment were in place, however, storage facilities and their maintenance should be reviewed.

For further information see Appendix A.

*Core Criterion

SD 4.4 (A → A)

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

There was strong evidence that the organisation's kitchens both ward and departmental were managed and maintained to a high standard in line with current

legislation and best practice. There was strong evidence to the commitment of management and staff in the area to achieve these standards.

For further information see Appendix A.

*Core Criterion

SD 4.5 (A → A)

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 were robust processes in place within the organisation to the inventory, handling, storage, use and disposal of hygiene services hazardous materials, sharps and waste in accordance with best practice and current legislation. There was evidence of strong leadership from the waste management co-ordinator in relation to management of waste, audit and staff training and awareness.

For further information see Appendix A.

*Core Criterion

SD 4.6 (A → A)

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

There was evidence that the organisation's linen supply and soft furnishings were managed and maintained to a high standard.

For further information see Appendix A.

*Core Criterion

SD 4.7 (A → A)

The team works with the Governing Body and/or its Executive Management team to manage hand hygiene effectively and in accordance with SARI guidelines

There were robust policies and processes in place to manage hand hygiene effectively and in accordance with SARI guidelines.

For further information see Appendix A.

SD 4.8 (B → B)

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

There was evidence that the organisation takes reasonable steps to maintain the safety of patients/clients from accidents, injuries or adverse events. These included processes for incident reporting, and risk management incidents. There is a timely response to non routine situations with the investigations of all sharps injuries and these incidents are evaluated on a regular basis. There is participation in the National STARS reporting system for all incidents.

SD 4.9 (B → B)

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

There was evidence that patients/clients are encouraged to participate in improving hygiene services. These included: comment cards for service users including

hygiene related matters, a patient focus committee and in developing complaints processes. The development of a new visitors policy in line with national guidelines and pro-active health promotion initiatives is in place. It is recommended that the organisation evaluates its initiatives for documentation and review.

PATIENT'S/CLIENT'S RIGHTS

SD 5.1 (B → B)

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

There was evidence of professional and organisational guidelines in place regarding the rights of patients/clients.

These included: the organisation's mission statement, patient charter, protected mealtimes, new visitor policy and a special needs room in care of the elderly services. It is recommended that the organisation evaluate its initiatives and make the necessary changes.

SD 5.2 (B → B)

Patients/clients, families, visitors and all users of the service are provided with relevant information regarding hygiene services.

There was strong evidence that patients/clients, families and all visitors are provided with relevant hygiene information. These included: hand hygiene posters, signage and information leaflets; a public address system; and a patient information leaflet. A patient information pack is issued to all patients on admission.

It is recommended that the information given to patients or visitors is evaluated and the appropriate amendments made.

SD 5.3 (B ↓ C)

Patient/client complaints in relation to hygiene services are managed in line with organisational policy.

Although there was evidence of a robust and well established complaints management system, this was more of a general complaints policy. The hospital intends to implement the national HSE complaints policy as soon as national training has been completed.

It is recommended that the organisation further enhance the access to this system for patient/clients in relation to hygiene matters as discussed with patients during the assessment.

ASSESSING AND IMPROVING PERFORMANCE

SD 6.2 (B → B)

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 that the organisation's hygiene services team monitored, evaluated and benchmarked the quality of its hygiene services.

SD 6.3 (B → B)

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

There was evidence of the preparation and publishing of a Hygiene Services Annual Report for 2006. This report included evaluation of work to date with plans and objectives for hygiene services going forward.

4.0 Appendix A

The following are the scores received for the Service Delivery core criteria compliance requirements. The organisation must provide evidence of exceptional compliance (greater than 85%) to achieve an 'A' rating. All 'core criteria' must have achieved an 'A' rating to receive a score of 'very good' and be acknowledged with an award.

4.1 Service Delivery Core Criterion

Compliance Heading: 4. 1 .1 Clean Environment

(1) The environment is tidy, well-maintained, free of rust, blood or body substances, dust, dirt, debris and spillages.
Yes - However, high dust was evident in all areas.

(2) All high and low surfaces are free from dust, cobwebs and flaking paint.
No - Dust was observed in all areas. Flaking paint was evident in some areas.

(3) Wall and floor tiles and paint should be in a good state of repair.
Yes - Flaking paint was evident in some areas, however wall and floor tiles were generally in a good state of repair. The floor area in renal dialysis needs attention.

(4) Floors including edges, corners, under and behind beds are free of dust and grit.
Yes - The flooring in renal dialysis needs attention.

Compliance Heading: 4. 1 .2 The following building components should be clean:

(17) Switches, sockets and data points.
Yes - Generally switches, sockets and data points are clean and dust free.

(18) Walls, including skirting boards.
Yes - In general, walls are well maintained, with some flaking paint noticed in areas.

(23) Radiators and Heaters.
No - Dust was evident at the rear of radiators. Also these radiators required further cleaning.

(25) Floors (including hard, soft and carpets).
Yes – A carpet replacement programme is in place.

Compliance Heading: 4. 1 .3 Organisational Buildings and Facilities (note: while list is not exhaustive, the following compliance is required):

(30) Fixtures: Fixtures (i.e. a piece of equipment or furniture which is fixed in position) should be clean. This includes all electrical fixtures e.g. all light fittings and pest control devices.
No - High dust was evident on light fittings and equipment.

(31) Furniture and fittings: Furniture and fittings in direct patient care environment must be clean and dust free i.e. cleaned on a daily basis. Horizontal surfaces (high and low) around the patient i.e. ledges, worktops, window ledges, flat surface suction apparatus, bed table, locker, curtain rail and chairs.
Yes - However, attention to high dusting is required.

(32) Shelves, benchtops, cupboards are clean inside and out and free of dust and spillage.
No - Plans to replace timber shelving are in place.

(208) There should be a process for the cleaning of curtains and blinds. Curtains should be changed after each known case of infected patient/client where required. Records should be maintained of curtain changing.
Yes – A processes is now in place to reflect routine curtain cleaning.

Compliance Heading: 4. 1 .6 All sanitary fixtures and appliances should be clean and well-maintained. This includes but is not limited to:

(51) Baths and Showers.
No - Evidence of older baths in situ in some areas was observed, which require replacement.

(53) Bidets and Slop Hoppers.
Yes - Slop hoppers in some areas require upgrading.

(54) Wash-Hand Basins.
Yes – The hand washing sink replacement programme is almost complete.

(55) Sluices.
Yes - Some sluices should be upgraded.

(58) Sluice rooms should be free from clutter and hand washing facilities should be available.
No - This area is waiting for an upgrade of hand washing facilities.

Compliance Heading: 4. 2 .2 Direct patient contact equipment includes:

(66) Medical equipment, e.g., intravenous infusion pumps, drip stands and pulse oximeters, suction apparatus and tubing, cardiac monitors, blood pressure cuffs, blood gas machines.
Yes - Medical equipment was clean in most areas, however, in some areas, the underneath of IV stands are not cleaned routinely.

Compliance Heading: 4. 2 .3 Close patient contact equipment includes:

(80) All office equipment (e.g. telephones, computers, fax machines) should be clean and well-maintained.
Yes - Some VDU's observed were dusty.

(272) Splashes of water or hand-wash gel should not be present on the wall, floor, bed or furniture, splash backs should be provided.
Yes - Some evidence of splashes from hand gel was observed, however, overall no residual staining was evident.

Compliance Heading: 4. 3 .1 Cleaning Equipment & Products (note: while list is not exhaustive, the following compliance is required):

(82) Vacuum filters must be changed frequently in accordance with manufacturer's recommendations—evidence available of this.
No - No evidence was available for this. This should be addressed.

(90) Storage facilities for cleaning equipment should be provided in each work area with adequate ventilation, a hot and cold water supply and hand-wash facilities.
No - No hand hygiene sinks are available, however alcohol hand gel was available.

(91) Storage facilities for cleaning equipment should be clean and well maintained.
No - Storage facilities for cleaning equipment mainly in cleaning sluice rooms not well maintained.

(93) Cleaning products and equipment should comply with the relevant colour coding policy.
Yes - There is evidence of compliance with colour coding.

Compliance Heading: 4. 4 .1 Kitchens, ward/department kitchens & kitchen fittings/appliances (note: while list is not exhaustive, the following compliance is required):

(215) There should be a documented ward kitchen food safety policy which should be signed off by the person in charge of the ward kitchen and the hospital manager.
No - No evidence of a ward kitchen safety policy was observed.

Compliance Heading: 4. 4 .2 Facilities.

(221) Staff clothing/uniforms/shoes personal belongings should not be stored in food rooms.
Yes - Personal belongings were not observed in food rooms.

(223) Separate toilets for food workers should be provided.
Yes - Separate toilet facilities available in main kitchen area.

Compliance Heading: 4. 4 .5 Management of Chill Chain in a Hospital.

(240) A Hospital using a cook-chill system should comply with Guidance Note No. 15 Cook-Chill Systems in the Food Service Sector (Food Safety Authority of Ireland) The temperatures of fridges, freezers, cold rooms and chill cabinets shall be capable of maintaining the temperature of foodstuffs
Yes - The hospital does not use a cook-chill system.

(241) Ice cream display units can operate at -12℃ as long as it can be demonstrated that the product has been held at this temperature for less than 7 days.
Yes - The hospital does not have ice cream display units.

Compliance Heading: 4. 4 .7 Food Processing.

(246) The thawing of food shall be carried out under appropriate conditions such as in a thawing unit, a fridge or a microwave oven with thawing cycle.
Yes - This system is not in use.

Compliance Heading: 4. 4 .10 Plant & Equipment.

(249) Machines should dispense ice but where ice-scoops are used, they should be stored separately from the ice-making machine and there should be a process for the appropriate decontamination of the ice scoops. The making of ice cubes other than in ice machines is prohibited.
Yes - Ice machine only in physiotherapy department. These are only used for treatment.

(250) The dishwasher's minimum temperature for the disinfecting cycle should be compliant with I.S.340:2006 requirements and should be monitored regularly. There should be digital readouts on dishwashers.
Yes – A dial system is in place.

Compliance Heading: 4. 5 .1 Waste including hazardous waste:

(145) A record is kept of tags used for each ward/department for at least 12 months.
Yes - A record is maintained of tags used on healthcare risk waste. There is a manual labelling system of non healthcare risk waste in operation which is local policy. It is recommended to utilise the same tagging system for both health care risk waste and non healthcare risk waste.

(152) When required by the local authority the organization must possess a discharge to drain license.
No - The organisation is currently involved in a procedure to access this with the City Council.

Compliance Heading: 4. 5 .3 Segregation.

(156) Healthcare risk waste must be segregated from healthcare non risk waste.
Yes - Waste is segregated; however, in theatres, a designated locked area to ensure segregation of risk and non risk waste would be of benefit.

(256) Mattress bags are available and are used for contaminated mattresses ready for disposal; mattresses are disinfected.
No - The hospital does do not use mattress bags.

Compliance Heading: 4. 6 .1 Management of Linen and Soft Furnishings (note: while list is not exhaustive, the following compliance is required):

(261) Clean linen store is clean, free from dust and free from inappropriate items.
Yes - This area is clean and there is a plan in progress to replace wooden shelving.

(262) Linen is segregated into categories and in appropriate colour coded bags (i.e. clean/unused linen, dirty/used linen, dirty/contaminated linen).
Yes - Linen is segregated and there is a local policy in place. A pilot-scheme is in progress in relation to new colour coding scheme in line with national guidelines.

(263) Bags are less than 2/3 full and are capable of being secured.
No - Linen bags greater than 2/3 full were observed in most areas.

(271) Hand washing facilities should be available in the laundry room.
No - This is currently being addressed as part of the sink replacement programme.

Compliance Heading: 4. 7 .1 Management of hand hygiene (note: while list is not exhaustive, the following compliance is required):

(190) All sinks should be fitted with washable splash backs with all joints completely sealed.
No - This is not in place for all sinks. Work is in progress to address this deficit.

(192) Taps should be hands free and should be mixer taps to allow temperature regulation.
No - The hospital has implemented a hand washing sink replacement programme to address this.

(204) Hand wash sinks conform to HBN 95. They should not have plugs, overflows and the water jet must not flow directly into the plughole.
No - A sink replacement programme is on-going.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team		Assessor Team	
	FREQ	%	FREQ	%
A	9	16.07	8	14.29
B	46	82.14	35	62.50
C	0	00.00	13	23.21
D	0	00.00	0	00.00
E	0	00.00	0	00.00
N/A	1	01.79	0	00.00

5.2 Ratings Details

Criteria	Self Assessment	Assessor	Difference
CM 1.1	B	B	→
CM 1.2	A	B	↓
CM 2.1	B	B	→
CM 3.1	B	B	→
CM 4.1	B	B	→
CM 4.2	B	C	↓
CM 4.3	B	B	→
CM 4.4	B	B	→
CM 4.5	B	B	→
CM 5.1	B	B	→
CM 5.2	B	B	→
CM 6.1	B	B	→
CM 6.2	B	B	→
CM 7.1	A	B	↓
CM 7.2	B	B	→
CM 8.1	B	C	↓
CM 8.2	B	C	↓
CM 9.1	B	B	→
CM 9.2	B	B	→
CM 9.3	B	B	→
CM 9.4	B	B	→
CM 10.1	B	A	↑
CM 10.2	B	C	↓
CM 10.3	B	B	→
CM 10.4	B	C	↓
CM 10.5	B	C	↓
CM 11.1	A	A	→
CM 11.2	N/A	C	→
CM 11.3	B	C	↓
CM 11.4	B	C	↓
CM 12.1	B	B	→

CM 12.2	B	C	↓
CM 13.1	B	B	→
CM 13.2	B	B	→
CM 13.3	B	B	→
CM 14.1	B	B	→
CM 14.2	B	C	↓
SD 1.1	B	C	↓
SD 1.2	B	B	→
SD 2.1	B	B	→
SD 3.1	B	B	→
SD 4.1	A	A	→
SD 4.2	A	A	→
SD 4.3	B	B	→
SD 4.4	A	A	→
SD 4.5	A	A	→
SD 4.6	A	A	→
SD 4.7	A	A	→
SD 4.8	B	B	→
SD 4.9	B	B	→
SD 5.1	B	B	→
SD 5.2	B	B	→
SD 5.3	B	C	↓
SD 6.1	B	B	→
SD 6.2	B	B	→
SD 6.3	B	B	→