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

Hygiene Services Assessment Scheme

Assessment Report October 2007

Mid Western Regional Orthopaedic Hospital, Croom

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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.

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[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

The Mid-Western Regional Orthopaedic Hospital is located approx. on a 6 acre site situated a few hundred yards from the main Limerick/Cork road at Croom, approximately 11 miles from the Mid-Western Regional General Hospital.
The site has recently been listed by Limerick County Council as a protected structure and all new developments are referred to the Limerick County Conservation Officer for his review. The last few years have seen a ward refurbishments programme carried out under capital and NDP funding.
The hospital has a current bed complement of 67 in-patient beds and 10 day beds. The full range of services includes radiology, physiotherapy and out- patient facilities.

Services provided

- Elective Orthopaedic surgery
- Minor Day Ward trauma
- Paediatric services
- Rheumatology
- Acute Pain services
- Social Work
- Radiology
  - MRI
  - CT Scanning
  - Nuclear Medicine
- Physiotherapy/Hydrotherapy
- Joint Replacement Nurse Services
- Bone Bank
- Pre-assessment clinic
- Cancer Services including radiotherapy.
- Medical Day Services \ Surgical Day Services \ Pulmonary Function \ Endoscopy \ OPD etc.
- Cardiac catheterisation Laboratory

The following assessment of the Mid Western Regional Orthopaedic Hospital Croom took place between 20th and 21st August 2007.

1.3 Notable Practice

- It was evident that the patient/client was central to the service design and delivery at Croom Orthopaedic Hospital. A multi-disciplinary Hygiene Services Team is in place.
- The hospital participates proactively and efficiently in the network and uses the links and structures with the Mid-Western Regional General Hospital effectively.
- Since 2006 new practices and procedures have been introduced. Structural changes have also taken place, such as the introduction of a colour-coding system; upgrading of the hydrotherapy pool in the Physiotherapy Department, the laundry and wash-hand basins, to meet national requirements. All clinical areas have had curtains replaced. A laundry trolley has been introduced for its transfer to the disposal facility. The upgrading of signage both internal and external and effective infection control training for all staff has also occurred.

- The”Patient/Client Narratives” project is innovative and very worthwhile.

1.4 Priority Quality Improvement Plan

- The organisation should consider reviewing and monitoring the window cleaning service.
- The hygiene committee should agree a template for development of policies, procedures and guidelines relating to the hygiene services.
- The canteen floor is scheduled for upgrade by year end and changing facilities, exclusively for catering staff, will be introduced following refurbishment of designated area.
- A waste-recycling compound is to be incorporated in the waste segregation/storage yard.
- On-going upgrading of sinks in line with capital works is recommended.
- Provision of dedicated location for cleaning equipment within each clinical area is recommended.
- It is recommended that the organisation review the hygiene management structure and terms of reference to expand the existing stakeholders for example patient/client representative, consultant.

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 Mid Western Regional Orthopaedic Hospital, Croom has achieved an overall score of:

Fair

Award Date: October 2007

1.6 Significant Risks

CM 9.1 (Rating D)
The design and layout of the organisation's current physical environment is safe, meets all regulations and is in line with best practice.

Potential Adverse Event
Fungal infection risk due to seeping dampness on the landing between the entrances to St. Ann's Ward, Radiology and Out Patient Departments.

Risks

Likelihood of Event	Rated: M (2)
Impact of Event	Rated: M (2)
Urgency of Action	Rated: H (3)
TOTAL	**Total: 7**

Recommendations
The source of this dampness should be identified and treated as a matter of urgency.

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 (A ↓ B)

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

Documentation was available which identified the requirements for hygiene services, including environment and facilities and human resources. The organisation is recommended to identify a proposed timeframe for the achievement of these needs and include them in its Hygiene Corporate Strategic Plan, together with relevant costs. The Hygiene Corporate Strategic Plan, Service Plan and Operational Plan should be revisited to ensure its terms of reference are in accordance with the terms and key concepts outlined in the Acute Hospital Hygiene Services Assessment Scheme. The introduction of internal Infection Control Nurses Association (ICNA) audits and Patient Satisfaction Surveys, and the evaluation of outcomes, is commendable. The Hygiene Services Committee is recommended to reconsider the frequency of the hygiene audits to allow for more realistic timeframes for resolution.

CM 1.2 (B → 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 is actively involved in improving its hygiene services. Considerable progress has been made over the last two years. Hygiene services management structures, internal audits, infrastructural and equipment improvements have all taken place. Considerable work is still required in relation to the replacement of wash hand basins and splash backs. However the standard of cleanliness, especially in the clinical areas was most commendable.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1 (A ↓ C)

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 is linked through the Regional Steering Committee for hygiene and cleanliness with the other acute hospitals in the region. It is also linked with the Acute Hospital Network for contact with the Health Services Executive. Regional links for Health and Safety and Risk Management affords the benefit of wider expertise. There is also very good partnership with staff. Patient/client satisfaction surveys are conducted on a continuous basis and are evaluated at regional level. Feedback is

provided in a user-friendly format and action taken as necessary. Development of links and partnerships is encouraged on the basis that it is a single specialty stand-alone hospital. There was no formal evaluation of links and partnerships.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 (B ↓ C)

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

It is recommended that clear goals, objectives, priorities and related costs be defined in the Hygiene Corporate Strategic Plan 2007-2009. This is also recommended for the Annual Service Plan and Review and progress should be benchmarked and documented at regular pre-determined intervals. These should be incorporated in the Hygiene Services Annual Report. Formal evaluation had not taken place to date. The continuous quality improvements are based on outcomes of the previous national hygiene audits (2005 and 2006) and other external and internal audits.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.1 (C → C)

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.

An Executive Management Committee has overall responsibility for hygiene services. A Regional Hygiene and Cleaning Committee, which has representation from all the acute hospitals in the region, are in place. No documented Code of Corporate Ethics was observed. However, philosophies for care are displayed in the clinical areas. Master copies of legislation and best practice guidelines are also available.

CM 4.2 (C ↑ B)

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

This is available through the Regional Steering Committee on hygiene and cleanliness. This in turn is considered/acted upon by the Hygiene Services Committee. Internal information (for example hygiene audits, risk reports/health and safety reports) are compiled and forwarded to the relevant Regional Managers. The information is evaluated and quarterly reports issued with the relevant Regional Managers visiting the hospital to discuss actions/outcomes. The findings are reviewed at Quality Forum and Clinical Nurse Manager meetings.

CM 4.3 (B ↓ C)

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 is access to internet and intranet at all locations and through the Regional Steering Committee on hygiene and cleanliness. Also, the Hospital Network Management structure has access to current legislation and best practice. The Quality Forum, which comprises mainly nurse managers, is actively involved in the local review and application of this information. The organisation is recommended to

consider the composition of this committee to reflect the multi-disciplinary membership.

CM 4.4 (C → C)

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

There is, to date, no agreed standard template for the development, approval, revision and control of all policies, procedures and guidelines. The format varies. However, some policies displayed a high standard. It is commendable that the Quality Forum approves all current nursing practice policies, procedures and guidelines. Evaluation of the efficacy of current processes is recommended and there is a need to ensure Quality Improvement Planning in this area.

CM 4.5 (C → C)

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

The Hygiene Services Committee comprises senior members of the Management Team and is involved in capital planning and implementation. The fact that the future role of the hospital in the delivery of acute health services had yet to be identified was perceived to be unhelpful in terms of its capital development.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

*Core Criterion

CM 5.1 (C ↑ B)

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

Staff all reported to an Assistant Director of Nursing who had responsibility for selection/recruitment, induction and on-going education. There was evidence of integrated working practices and all staff displayed considerable knowledge of relevant hygiene. Ward/Department Managers have overall responsibility and were involved in ensuring high hygiene standards are obtained in their specific areas. The Hospital Administrator is the designated person responsible for waste management in the organisation.

*Core Criterion

CM 5.2 (B → B)

The organisation has a multi-disciplinary Hygiene Services Committee.

The committee is multi-disciplinary; however, it lacks medical representation. This is an issue, which should be addressed. Awareness of roles and responsibilities were not documented, which should be addressed also. There was no administrative support, however, a member of the committee, which meets on a weekly basis, acted as secretary. The frequency of meetings should be reviewed and in the interest of efficiency and effectiveness and the practicality of members' ability to attend.

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.

The hygiene services have an identified budget for human resources. Due to an increase in the volume and scope of clinical services provided, the approved whole time equivalent has been reviewed to ensure safe hygiene standards. There were identified, documented and costed infrastructural needs. Hygiene services improvements such as cleaning agents, equipment and fittings are identified, prioritised and notified to the Regional Steering Committee for approval and implementation. Additional financial resources have been allocated in the last two years to address some of the identified hygiene shortcomings. The outstanding issues should be implemented as expeditiously as possible.

CM 6.2 (B ↓ C)

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

There are no documented processes for the involvement of the committee in this area. There is, however, a well-established practice for the inclusion of relevant staff in this process, together with follow-up training/education in the use/maintenance of equipment. A documented process for staff involvement in the pre-purchasing of equipment/ products should be developed. Some members of the Senior Management Team are also members of the Hygiene Services Committee.

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.

The organisation is part of the Regional Risk Management Structure. There are documented processes for risk incident identification, reporting, analysis, minimisation and elimination in place. An electronic system is in use and training is provided to relevant staff. Reports are generated quarterly and reviewed at Clinical Nurse Manager meetings. These should be included in Key Performance Indicators. On-going internal external audit reports covered all aspects of hygiene services.

CM 7.2 (C ↑ B)

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

There were no major adverse events over the last two years and the organisation works closely with the Regional Risk Management Committee to manage risk. Infection rates are low and the infection control practices are commendable.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion
CM 8.1 (B → B)
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.
Contracts are mainly managed on a regional basis. These included waste, water maintenance etc. Window cleaning is the only exception and this is managed locally and delivered on a twice-yearly basis.

CM 8.2 (C → C)
The organisation involves contracted services in its quality improvement activities.
Contractors are involved in the area of quality improvement activities and examples of this were identified in relation to linen services. The organisation should consider involving the waste contractor in the progression of the waste segregation initiative, which was identified by the organisation as a Quality Improvement Plan.

PHYSICAL ENVIORNMENT, FACILITIES AND RESOURCES

CM 9.1 (B ↓ D)
The design and layout of the organisation's current physical environment is safe, meets all regulations and is in line with best practice.
The hospital was built in the early 19th century and has many challenges in relation to the environment and facilities. However, staff are to be commended on the optimisation of the available facilities in the interest of good hygiene. Some wards and departments have been upgraded in recent years and offer a good standard of patient/client accommodation and facilities. Dedicated storage areas for cleaning equipment and dedicated changing facilities for catering staff need to be addressed. Identified infrastructural and facilities developments in the clinical areas should be developed in accordance with the Quality Improvement Plan. Local safety representatives are in place and staff are encouraged to bring any health and safety issues to their attention. The area of dampness between two clinical areas needs to be addressed.

*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.
Well-developed processes for planning and managing the environment and facilities, equipment and devices including standard operating procedures are in place. There was evidence of considerable progress over the last two years in this area.

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.
In addition to the internal/external audits, patient/client satisfaction surveys and evaluation of complaints and compliments, a "Patient/Client Narratives" quality initiative had begun. Patient/clients are asked to share their hospital experiences with a staff member. This is recorded and reflected on, to develop best practice.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 (B ↓ C)

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.

Documented processes for the selection and recruitment of staff are compliant with legislation and best practice. Job descriptions are available for all grades. No contract staff were employed at the time of assessment. Human resource records are held locally for all temporary staff and locally and centrally for all permanent staff. The process for selecting and recruiting human resources has, to date, not been formally evaluated.

CM 10.2 (C → 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.

There are no documented processes for reviewing changes in work capacity and volume. This is currently determined on the professional judgement of the Manager and based on the expansion of service delivery and service areas to be cleaned/serviced. The outcome of the Infection Control Nurses Association's hygiene audits is used as an indicator of resource capacity versus work to be done.

CM 10.3 (C ↑ B)

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

Job descriptions identify pre-employment qualifications where necessary. Staff, who haven't any prior qualification, undertake an induction programme. This includes identified theory and mentoring by an experienced colleague for the first two weeks. A system for the evaluation of courses attended is in place. The evaluation and effectiveness of induction and on-going training is recommended.

CM 10.4 (B ↓ C)

There is evidence that the contractors manage contract staff effectively.

Contract staff, such as waste removal and water maintenance, are involved on an informal basis. The organisation should ensure that reporting processes for contract staff are adhered to.

*Core Criterion

CM 10.5 (C → C)

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

A review of the Hygiene Corporate Strategic Plan, Hygiene Service and Operational Plans is recommended to ensure their compliance with the key recommendations and the terms of the Hygiene Services Assessment Scheme. A hygiene services annual report should be developed.

ENHANCING STAFF PERFORMANCE

*Core Criterion

CM 11.1 (B → B)

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

This is in place and includes hand hygiene, waste segregation and manual handling. Fire safety training is also available to all staff and on-going education is provided and arranged to facilitate staff attendance. Records of attendance are maintained and a staff handbook is available. At the time of the assessment, four staff were participating in the SKILLS programme and there was active encouragement for all staff to participate in this.

CM 11.2 (B → B)

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

Identified relevant education and training is available for staff (for example Management Courses, Hazard Analysis and Critical Control Point (HACCP), Health and Safety, risk management, customer service and use of new equipment). Staff are facilitated in attending education and training during rostered time, where appropriate. Some education and training is provided by in-house staff, while facilitators are sourced externally, where relevant.

CM 11.3 (B → B)

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

There are some Key Performance Indicators for hygiene, for example Needle Stick Injury Reports, Risk Incident Reports and Hospital Acquired Infection rates. It is recommended that the Hygiene Services Committee identify a comprehensive list of performance indicators, which will facilitate better evaluation.

CM 11.4 (C → C)

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

Evaluation of staff performance is based on supervision and audit outcomes, which form the basis for continuous quality improvements. The practice of exposing new staff to experience in all relevant areas, in order to empower them for relief duties, is to be commended.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (B ↓ C)

An occupational health service is available to all staff

This is available through the regional structure and includes the provision of vaccinations. There is no evidence of evaluation of the service provided. This is recommended as part of a staff satisfaction survey.

CM 12.2 (B ↓ C)

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

Sick leave is monitored and followed up via the Occupational Health Service. Risk assessments for pregnant staff are also provided. Changes introduced over the last

two years included the use of needle-proof gloves, spring-loaded laundry trolleys and spill kits. Progression of the Quality Improvement Plan for the introduction of the "Wellness at Work" programme is recommended.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.1 (B ↓ C)

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.

Information collected includes the internal/external audit reports, "Patient/Client Narratives" and quarterly reports for Risk, Health and Safety. This information is considered at Clinical Nurse Manager meetings. The organisation is recommended to consider developing a communication strategy to ensure information is collected, disseminated and evaluated in accordance with best practice.

CM 13.2 (B ↓ C)

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.

Reports generated in hygiene services include minutes of meetings and internal/external audit reports. Their outcomes are considered and relevant quality improvements are identified and implemented where possible. No formal evaluation of user satisfaction was observed, which is recommended.

CM 13.3 (B ↓ C)

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

Changes introduced over the last two years included the introduction of internal audits, the generation of user-friendly and hygiene reports both regionally and locally. The organisation is recommended to formally assess data collection and information reporting.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

CM 14.1 (B ↓ C)

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

There was strong leadership by the Management Team in the progression of hygiene services. A Quality Forum was initiated and considerable progress has been made in the development of hygiene services over the last two years. The issues identified should continue to be addressed. Evaluation of all aspects of hygiene standards and their inclusion in Key Performance Indicators for benchmarking purposes should continue.

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.

Significant progress has been made over the last two years across all aspects of hygiene quality improvements. The National audits 2005 and 2006, the Regional Hygiene and Cleaning Forum and the on-going internal hygiene audits have been the catalyst for these improvements and benchmarking. There was evidence of strong organisational commitment to a continuous hygiene quality improvement culture for which there is now a well-established foundation. The organisation is to be commended on its achievements to date.

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.

This was in place. Staff, in the clinical area, has a clearly defined role in the delivery of hygiene services. Staff feedback is encouraged. A recently introduced colour-coding system is a welcome innovation and records of staff training are comprehensive. However, due to the short time frame between its introduction and the assessment, evaluation had not been documented. Audit trails such as a clinical waste audit, are carried out to examine the efficacy of the tagging system.

SD 1.2 (B ↓ C)

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

No hospital procurement policy was in place as this is conducted centrally. The National Hospitals Organisation's cleaning manual is followed. The Quality Improvement Plan for negotiating the service contract for the provision of HEPA vac filters in vacuum cleaners is followed. This will further enhance the efficacy of the hygiene service delivery. It is recommended that cleaning solutions used in the Mid Western Network be evaluated as there is a considerable amount of corrosion to stainless steel sinks in kitchen and sluice areas. It is also suggested that the organisation adapt a hospital procurement policy.

PREVENTION AND HEALTH PROMOTION

SD 2.1 (B ↓ C)

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

In a recent survey, patient/clients satisfaction regarding the cleanliness of the hospital was sought. Information regarding hygiene services is displayed; however there is a paucity of information for the public regarding hand hygiene and their role in the provision of hygiene services. The patient/client information leaflet is due for updating and will include specific hygiene services details.

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.

This is inter-disciplinary team with strong co-operation from staff. A Hygiene Corporate Strategic Plan was observed in place. There was clear oral communication on a daily basis among staff. The multi-disciplinary team works in co-operation with other providers, such as waste management, catering. It is recommended that continuous evaluation take place to ensure the Hygiene Services Team is effective and that a member of the public or patient/client representative be included.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

SD 4.1 (B ↑ A)

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

The integrity of the floor surfaces is suboptimal in some cases (for example the canteen service area and St Patrick's Ward) making cleaning of these surfaces difficult. Floor tiles were missing in the reception area. The team, however, has developed a Quality Improvement Plan, which will address this issue. A number of external doors require replacement and some doors, which have already been replaced, require painting. A dishwasher is required in the day ward. The storage of vacuum cleaners in the clean linen room in a clinical area is not recommended.

For further information see Appendix A

*Core Criterion

SD 4.2 (B ↑ A)

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

Excellent records were observed in the clinical areas of direct patient/client equipment cleaning. It is recommended that the organisation consider a hospital specific procurement policy.

For further information see Appendix A

*Core Criterion

SD 4.3 (B ↑ A)

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

All of the cleaning equipment observed was in very good condition. The current vacuum cleaners do not have an easily replaceable HEPA filtration system and this should be considered when purchasing new replacement machines. The practice of storing vacuum cleaners in with the clean linen store should cease. The organisation should consider separate cleaning rooms with hand-washing facilities and sinks.

For further information see Appendix A

*Core Criterion

SD 4.4 (B ↑ 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.

The main kitchen and ward kitchen environments were clean and in good condition. There is a well-documented system in place for recording fridge, freezer, food temperatures and the kitchen activities comply with the principles of Hazard Analysis and Critical Control Point (HACCP) guidelines. Staff are well trained and documented training records are available. However, the flooring in the canteen area behind the hot/cold serve area is in very bad condition and was not replaced, after a recommendation by the EHO in 2005. The dishwasher in the main kitchen area does not have a digital readout and there no dishwasher is in place in the day ward kitchen, which should be addressed.

For further information see Appendix A

*Core Criterion

SD 4.5 (B ↑ 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.

Waste management procedures were effective and staff very familiar with the process. Waste is handled by a single company, and is stored in a secure locked location.

For further information see Appendix A

*Core Criterion

SD 4.6 (B ↑ A)

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

Curtains, including shower and canteen, were clean and in good condition, with a documented cleaning and replacement programme in place. The organisation is currently using wheelchairs as transportation for linen to and from laundry. The provision of additional laundry trolleys, specifically for collecting clean laundry from clinical areas, should be considered.

For further information see Appendix A

*Core Criterion

SD 4.7 (B → B)

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 are excellent opportunities for staff to attend training sessions on hand hygiene with extensive documented evidence of high uptake. A plentiful supply of hand hygiene stations was noted in clinical areas. However hand hygiene posters and hand cleaning opportunities require improvement in patient/client and public areas.

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.

A Risk Management Strategy is in place, which reported to the regional risk management group through a designated risk management adviser. A well documented incident reporting policy and procedure is in place. A number of initiatives relating to hygiene, safety and health, such as cleaning prior to visiting times, lock on sluice room, have recently been introduced.

SD 4.9 (B ↓ C)

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

Patient/client's opinion is sought through feedback forms. A freepost envelope is provided to encourage comments. These are reviewed by the Clinical Nurse Management Committee and noted in meeting minutes. No patient/client or community member is represented on the Hygiene Services Committee. This should be considered. A visitor policy was in place and an information booklet (in draft form) for children and parents was produced and included visitor information. A patient/client satisfaction survey was also available and an initiative was in place concerning 'Patient/Clients Stories'. It is recommended that processes to include patient/ clients in the success of the hygiene services be further developed.

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.

The Hygiene Services Team ensures that the patient/clients, staff and public are advised when cleaning is in progress. The organisation strives to provide cleaning in clinical areas outside visiting times. Signs were observed in the clinical area indicating to all staff that the patient/client was an infection control risk and personal protective equipment was provided. The patient/client information leaflet is comprehensive and the Quality Improvement Plan to revise it and add hygiene services information is in progress. The parent and child information leaflet is very clear regarding visiting times and numbers of visitors and advises on suitable items for hospital visits.

SD 5.2 (B ↓ C)

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

More public awareness regarding hand hygiene would be beneficial on the main corridors as well as all exits and entrances to the organisation.

SD 5.3 (B → B)

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

Risk management information is collected locally but reported centrally. Reports are issued quarterly and feedback is given at the Clinical Nurse Management meetings. Issues are addressed with all staff in the clinical areas. The organisation has had no major risk management issue reported in relation to the hygiene services in the last 12 months.

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1 (B ↓ C)

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

There was documented evidence of Environmental Health Officer visits to the catering section and feedback received from regional offices of the HSE. Testing of water outlets and tanks for Legionella was carried out recently. A hygiene committee is in place with documented evidence of meetings noted. However, there was no patient/client or public representation on this committee. There was no section specifically relating to hospital hygiene in a Food Quality Survey. Although hand hygiene posters and gels were available in the clinical areas, they were scarce in public waiting areas where people might have more time to spend reading them.

SD 6.2 (B ↓ C)

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 a hygiene committee in place with documented evidence of minutes of meetings. Local and external audits are carried out and many changes, such as an on-going sink replacement programme and the provision of Personal Protective Equipment, have taken place in the past two years. There is on-going training in infection control and hand hygiene but documented evaluation is limited. Hazard Analysis and Critical Control Point (HACCP) guidelines are adhered to in kitchen areas.

SD 6.3 (B ↓ C)

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

The Infection Control annual report dated 2005 was produced by the Mid Western Regional Hospital and was not specific to Croom. It was recommended that an in-house annual report be compiled for 2006, which could be incorporated into the regional annual report. An annual hygiene services report has not been produced, however, Infection Control audit reports were available.

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

(3) Wall and floor tiles and paint should be in a good state of repair.
No - Many areas observed were damp with major problems in particular on the first floor in St Anne's and in the Out-patient lobby areas.

(13) External areas including grounds, gardens, footpaths, ramps and car parks should be clean and well-maintained.
Yes - In the majority, however, guttering requires immediate attention, and many flat roofs had residual rainwater in them. These are both contributing factors to dampness and resulting mould growth. Some areas, such as the back of clinical building and front of private rooms, require re-surfacing.

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

(18) Walls, including skirting boards.
Yes - In the majority, however, some dampness and mould was observed.

(20) Doors
Yes - In the majority, however, some external doors need replacing.

(21) Internal and External Glass.
No - Urgent cleaning of internal and external glass is required. There is a programme in place; however this needs to be reviewed.

(23) Radiators and Heaters
Yes - In the majority, however, some radiators were chipped and the paint is in need of attention.

(25) Floors (including hard, soft and carpets).
Yes - In the majority, however, flooring in serving units in canteen requires urgent attention.

Compliance Heading: 4. 1 .4 All fittings & furnishings should be clean; this includes but is not limited to:

(38) Dispensers (e.g. handwash dispensers), Holders and Brackets
Yes – None were observed in the clinical waste area. The organisation is recommended to provide more locations with hand-wash gel facilities.

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

(53) Bidets and Slop Hoppers
Yes – This was not applicable in this organisation.

(55) Sluices
Yes - However it is recommended that a cleaning agent, appropriate for the water hardness in the area, is used.

(58) Sluice rooms should be free from clutter and hand washing facilities should be available.
Yes - In the majority, however, the sluice area in Day Ward area was suboptimal.

(60) All outlets (including shower outlets) should be flushed at a temperature in accordance with current legislation.
Yes - Records were available.

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

(65) Commodes, weighing scales, manual handling equipment.
Yes - Good cleaning records for equipment were available.

(67) Bedside oxygen and suction connectors.
Yes – There is no piped oxygen in place. Oxygen cylinders are stored in an open area. Outdoor long-term storage of cylinders is not recommended, and is not in line with best practice.

(68) Patient fans which are not recommended in clinical areas.
Yes – No fans were observed.

(70) Bedpans, urinals, potties are decontaminated between each patient.
Yes - Bedpan macerator is available in all sluice rooms.

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

(79) Flower vases where present should be clean with water changed minimum daily. Wilted flowers should be removed and disposed of accordingly. Note: flowers not recommended in high risk areas.
Yes - No flowers were observed.

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 - A Quality Improvement Plan is being implemented to introduce HEPA filters.

(89) Equipment with water reservoirs should be stored empty and dry.
Yes - None were observed.

(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.
Yes - Cleaning equipment is stored in sluice rooms. The organisation should consider dedicated cleaning room/s in clinical areas.

(95) When using electrical cleaning equipment, a circuit breaker should be used if appropriate and the equipment should be plugged in while switched off using dry hands.
No – The organisation is awaiting the service contract for vacuum cleaners to be implemented.

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

(216) Documented processes for manual washing-up should be in place
No – There is no dishwasher available in the day ward kitchen. The manual dishwashing policy is not documented.

Compliance Heading: 4. 4 .2 Facilities

(223) Separate toilets for food workers should be provided.
No – The toilets in the main kitchen for staff are shared with ward attendants.

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

(242) Temperatures for Food in Fridges / Freezers and Displays should comply with I.S.340:2006 requirements
Yes - In the majority, however, one exception was noted.

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 - No ice machines were noted in kitchen areas. Ice machines are located in the Physiotherapy Department> it is recommended that these have signage to highlight that they are for clinical use only.

(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 - One dishwasher in main kitchen did not have a digital readout. All others were compliant.

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

(149) Inventory of Safety Data Sheets (SDS) is in place.
Yes - The organisation is recommended to make the manual user-friendly.

(152) When required by the local authority the organization must possess a discharge to drain license.
Yes – This is not required by the Local Council.

(253) Personal protective equipment is accessible to all staff involved in the generation, collection, transport and storage of waste.
Yes - However hand hygiene signage is recommended in the risk waste area.

Compliance Heading: 4. 5 .3 Segregation

(256) Mattress bags are available and are used for contaminated mattresses ready for disposal; mattresses are disinfected.
No - Excellent practice was observed in the clinical area and in waste segregation/storage areas.

(156) Healthcare risk waste must be segregated from healthcare non risk waste.
Yes - Disposal mattress bags are recommended.

Compliance Heading: 4. 5 .4 Transport

(166) Drivers of vehicles transporting hazardous waste must be trained in accordance with the ADR Regulations.
Yes - Excellent records were observed.

Compliance Heading: 4. 5 .5 Storage

(258) Waste receptacles should be sanitised, secure and in a good state of repair when used.
Yes - All waste receptacles observed were compliant.

Compliance Heading: 4. 5 .6 Training

(260) There are documented records of staff training on the handling, segregation, transport and storage of healthcare risk waste including the use of spill kits and personal protective equipment.
Yes - Excellent records were observed.

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 - Compliance was noted.

(267) Documented process for the transportation of linen.
Yes - These were observed in place.

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

(189) Clinical hand wash sinks are required in all areas where clinical activities are performed. They should be centrally located and free from obstruction.
No - Not all sinks observed were compliant. A plan is in place for their replacement.

(190) All sinks should be fitted with washable splash backs with all joints completely sealed.
No - A number of sinks observed were without splash backs. A plan is in place for their replacement.

(192) Taps should be hands free and should be mixer taps to allow temperature regulation.
No - Although many taps were hands free, they were not mixer taps.

(193) Liquid soap is available at all hand washing sinks. Cartridge dispensers must be single use.
Yes - In the majority, however, liquid soap is recommended for the X-ray Department.

(197) Wall mounted/Pump dispenser hand cream is available for use.
Yes - Compliance was observed in the majority of areas.

(198) Hand hygiene posters and information leaflets should be available and displayed throughout the organization.
Yes - However the organisation is recommended to consider increasing hand hygiene information and posters in waiting areas, entrances and exits and main corridors.

(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 - Some older sinks had plugs. A replacement plan is in place.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team		Assessor Team	
	FREQ	%	FREQ	%
A	3	05.36	6	10.71
B	42	75.00	21	37.50
C	11	19.64	28	50.00
D	0	00.00	1	01.79
E	0	00.00	0	00.00
N/A	0	00.00	0	00.00

5.2 Ratings Details

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

CM 12.1	B	C	↓
CM 12.2	B	C	↓
CM 13.1	B	C	↓
CM 13.2	B	C	↓
CM 13.3	B	C	↓
CM 14.1	B	C	↓
CM 14.2	B	C	↓
SD 1.1	B	C	↓
SD 1.2	B	C	↓
SD 2.1	B	C	↓
SD 3.1	B	B	→
SD 4.1	B	A	↑
SD 4.2	B	A	↑
SD 4.3	B	A	↑
SD 4.4	B	A	↑
SD 4.5	B	A	↑
SD 4.6	B	A	↑
SD 4.7	B	B	→
SD 4.8	B	B	→
SD 4.9	B	C	↓
SD 5.1	B	B	→
SD 5.2	B	C	↓
SD 5.3	B	B	→
SD 6.1	B	C	↓
SD 6.2	B	C	↓
SD 6.3	B	C	↓