



Hygiene Services Assessment Scheme

Assessment Report October 2007

St. James's 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

St James's Hospital is the largest academic teaching hospital in Ireland with capacity of 1,015 beds and has several national, supra-regional and regional specialities. The hospital was established in 1971.

Services provided

The hospital provides the following services:

National Specialties/Services

- Burns
- Haemophilia Services for adults
- Bone Marrow Transplant Unit
- Maxillo-Facial Surgery
- National Medicines Information Centre
- National Pharmaco-Economics Centre
- National Dementia Information and Development Centre
- National MRSA Reference Laboratory
- National TB Reference Laboratory

Supra-Regional Specialities/Services

- Genito-Urinary Medicine/Infectious Diseases
- Oesophageal Surgery
- Cardiac Surgery
- Vascular Surgery
- Cardiology
- Gastro-Intestinal Medicine
- Clinical Haematology
- Medical Oncology

Regional Specialities/Services

- Cardiology
- Respiratory Medicine
- ENT
- Gastro-intestinal medicine
- Gynaecology
- Clinical Haematology
- Thoracic Surgery
- Medical Oncology

Catchment Specialities/Services

- Major Emergency Unit
- Major Care of the Elderly Centre
- Orthopaedics (trauma)
- Palliative Care

- Dermatology
- Neurology
- Nephrology
- General Medicine
- General Surgery
- Urology
- Rheumatology
- Endocrinology
- Genito-Urinary Medicine

Physical structures

There are 156 side rooms with ensuite. 21 of them are positive pressure rooms, and 23 are negative pressure rooms.

31 rooms have HEPA filters installed.

The following assessment of St James's Hospital took place between the 9th and the 11th July 2007.

1.3 Notable Practice

- A strong commitment from senior management regarding hygiene services was evident.
- Good corporate structures for hygiene services in place.
- Extensive documentation including policies, procedures, and guidelines was in place.
- Recent on-going development of hygiene services' structures such as a hand-wash sink replacement programme, the provision of and up-grade to cleaners store rooms, were provided.
- Compliance with hand hygiene procedures was evident.
- Compliance with Hazard and Critical Control Point (HACCP) guidelines in the kitchen.
- The involvement and participation of patients/clients in hygiene services is to be commended.
- An extensive audit programme.
- A strong commitment to training staff in mandatory education sessions and documented surveillance to follow up attendance.

1.4 Priority Quality Improvement Plan

- Documented roles and responsibilities for the membership of hygiene services operational and quality groups must be developed.
- It is recommended that the organisation develop a process to ensure that equipment which is out of order is removed promptly from common areas and corridors.
- The provision of cleaners' rooms in all wards and departments should be implemented.
- The organisation is encouraged to address the variance between hospital policy/guidelines and actual practice at ward level.

- Clarity regarding responsibility for hygiene in certain areas (for example clogs, computer keyboards, phones, wheelchairs) must be determined and communicated.
- The programme for repairing damaged walls, floors and flaking paint must be expanded to include all areas.
- Responsibility for hygiene must be documented in each staff member's job description and in the staff and patient/client handbook.
- The audit process should be expanded to include allied health departments.

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; St. James's Hospital has achieved an overall score of:

Good

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 (A → A)

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

St. James's Hospital has developed documented processes, based on the previous national hygiene audits (2005 and 2006), Independent Desford Review 2006, the outcome of the Environment and Facilities Team's accreditation process and various internal hygiene audits. A Hygiene Corporate Strategic Plan, a Service Plan for 2007 and an operational plan were all noted.

Structures were in place to ensure consultation with service users such as local community groups and the Patient/Client Advocacy Forum. This forum is also represented on the hygiene services Quality Improvement Group and the Hygiene Services Committee.

The Hygiene Services Committee is a division of the Environment and Facilities Committee, with an expanded membership to ensure the more urgent aspects of its agenda are addressed. Both of these committees share common membership and are chaired by the Deputy Chief Executive.

Evaluation of the efficacy of the needs assessment was mainly confined to audit reports. Daily supervisor visits and informal inspections by management also take place. The organisation is benchmarking their ratings from external/internal audit outcomes. Key Performance Indicators (KPIs) such as MRSA, C. Difficile rates, needle stick injuries and incorrect disposal of waste were being monitored.

A lack of clarity regarding responsibility for the cleaning of certain items exists. It is recommended that an inventory of all equipment be developed, with associated cleaning responsibilities, in line with the quality improvement plan.

CM 1.2 (A → A)

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.

Significant developments, in both the structures for the management of hygiene services and the processes employed to ensure a clean and safe environment, were observed. These developments included the establishment of current hygiene services management structures and the appointment of a Head of Housekeeping in January 2007, whose role it is to manage both in-house and contract cleaning functions and ensure similarities in terms of processes and outcomes.

Improvements were also noted with facilities and equipment. However, work in this area is still in progress. Restructuring of cleaning staff rosters on a cost neutral basis has influenced an improvement in cleaning services in areas such as the Emergency

Department. Plans are in place to upgrade and increase the number of cleaners' rooms.

Cleaning equipment was observed in a variety of areas including corridors. New bins had been introduced, for hazard and non-hazard clinical waste, in most clinical areas; however, it was unclear in many instances what should be disposed of. There are regular audits across a wide range of hygiene services as well as patient/client and staff satisfaction surveys.

Considerable progress was observed in the development of organisational structures and processes; however, there were still considerable gaps in the areas of knowledge and practice by frontline staff.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1 (A → A)

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.

St. James's Hospital has linkages and works in partnership with all key stakeholders in provision of hygiene services. Examples include the National Hospitals Office, the Department of Population Health, Primary, Community and Continuing Care Services, and the Dublin Academic Teaching Hospitals Risk Management Forum.

A well-established Partnership Committee is in existence, which is a vehicle for change and innovation. Meetings are regular, with action points and responsible persons identified, minutes recorded and circulated.

An in-house newsletter featured hygiene information for staff and 'Welcome', the community newsletter, provided similar information for local communities. Documented processes were in place to ensure the organisation works in partnership with all in-house staff, contract staff, and patient/clients.

These included tender documents/contracts, job descriptions, induction training and the standardisation of cleaning processes for both in-house and contract cleaning staff. General support services have exclusive responsibility for the delivery of hygiene services.

This corporate function, in conjunction with the Infection Prevention and Control and all directorates/departments, have responsibility for providing a clean and safe environment for patients/clients, families and staff. A patient satisfaction survey was conducted in 2005 by the Patient/Client Advocacy Committee. Following this, new initiatives were introduced to monitor and improve hygiene services.

A staff satisfaction survey, which also focused on hygiene issues, was conducted in 2006. Evaluation of the efficacy of linkages and partnerships was through internal/external audit outcomes and these were linked to actions and continuous quality improvements.

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.

An Organisational Corporate Strategic Plan (2004-2009) is in place. A separate Corporate Hygiene Strategy 2007-2009 has also been developed, which is based on the organisation's Corporate Strategic Plan. A Hygiene Services Plan (2007) and a Hygiene Services Operation Plan are also in place.

The organisation has identified the need for a hygiene services manual to be developed and the target date for this was 2008. Evidence that identified priority areas had received, or were receiving, attention at the time of the assessment was observed. An example is the establishment of the Hygiene Services Committee whose aim is to ensure all aspects of hygiene services, the restructuring of cleaning rosters, the implementation of additional cleaning equipment, the introduction of new processes such as flat mopping system and colour coding for cleaning linen segregation are incorporated.

These priority areas identified were based on the outcomes of the independent Desford Consultancy Review 2006 and previous national hygiene audits in 2005 and 2006.

Strong governance structures for the management and delivery of hygiene services are in place, which included considerable involvement of senior management. As the corporate strategic planning processes for hygiene services are relatively recent, there has been little opportunity to-date to evaluate their effectiveness.

The outcome of the Acute Care Accreditation Scheme survey was identified as an evaluation of progress to-date. It is recommended that the organisation's identified Quality Improvement Plan be progressed.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.1 (A → A)

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

The General Support Services Manager has exclusive responsibility for the management of hygiene services. A head of service is present in each hygiene services department. A head of housekeeping was appointed in 2007 to ensure co-ordination of standards and compliance by in-house and contract staff for cleaning services. A Corporate Ethics Programme was in place with an explicit code of corporate ethics. This is reflected in vision, mission and values statements and widely documented. Systems were in place to ensure compliance with legislation and best practice guidelines. Examples include the risk management system, infection control surveillance (performance indicators), sharps/waste management and Hazard Analysis and Critical Control Point (HACCP). Policies, procedures and guidelines are in place. Internal/external audits, informal inspections by Senior Management, patient/client and staff satisfaction surveys and a Patient Advocacy Committee were all in place.

CM 4.2 (A ↓ B)

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

A robust integrated corporate management structure is in place, which comprises a Hospital Board, an Executive Management structure and a Clinical Management Directorate structure. The hygiene services department is well resourced and has a reporting relationship to the Chief Executive Officer via the General Support Services Manager.

The main hygiene assets of the Corporate Governance Programme were the Acute Hospital Accreditation, Patient Advocacy, Performance Indicator and the Safety and Risk Management Programmes. St. James's Hospital also participates in the Dublin Hospitals Group Risk Management Forum. Hygiene services performance indicators

reviewed on a regular basis were mainly in the area of infection prevention and control. It is recommended that the Quality Improvement Plan be progressed.

CM 4.3 (A ↓ 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.

Excellent facilities such as the Internet, intranet, library and a continuing education centre for access and use of research and best practice information were observed. Hygiene services staff are encouraged and supported to undertake the SKILLS programme.

A number of quality initiatives, which are based on best practice information, have been introduced over the last two years. Others were in the process of being introduced. These transcended all areas of hygiene services and included improvements in facilities, processes and product monitoring.

Staff are informed of latest research, legislation and best practice through a variety of methods including meetings, line managers, newsletter, training, intranet, policies, procedures and guidelines, notices and information leaflets. The organisation has a Quality Improvement Plan which will expand the Key Performance Indicator Programme to include additional hygiene related areas. This is to be commended and should be progressed in the near future. It is also recommended that performance indicators be identified for each element of the hygiene service.

CM 4.4 (A → A)

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

An approved process is in place. Evidence of compliance was noted. A comprehensive suite of best practice policies, procedures and guidelines for hygiene services, which are available on the intranet and in hard copy format, were observed. Evaluation of the efficacy of these was based on internal and external audit outcomes such as the Decontamination Audit (2007), the Acute Hospital Accreditation Survey (2006), the Dangerous Goods Advisory Report (2005), infection prevention and control performance indicators and Environmental Health Officer reports.

Evidence was observed of resultant action planning and identification of responsibilities. Timeframes for resolution/improvement should be considered in all instances.

CM 4.5 (A → A)

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

The Hygiene Services Committee is represented on the capital development and implementation process. The Planning and Technical Services Manager is a member of the Hygiene Services Committee. Evidence of a strong interface between the Infection Prevention and Control Department/hygiene services and the capital development and implementation process was observed. Hygiene services, such as Infection Prevention and Control, Housekeeping, Health and Safety and Risk Management, were also included in the purchase of new equipment. Documented evidence was provided of this.

A medical device trial and evaluation policy is in place. The Quality Improvement Plan, to apply a design and planning document for the cleaner's rooms should be implemented in the near future.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

*Core Criterion

CM 5.1 (A → A)

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

The hygiene services management structure identifies the Chief Executive Officer as having overall responsibility for hygiene services in the organisation. The General Support Services Manager reports directly to the Chief Executive Office and, with the exception of nursing and care assistants, has exclusive responsibility for all elements of hygiene services.

The Director of Nursing assumes responsibility for hygiene, relating to both nursing and care assistants. Line managers and supervisors for all elements of the hygiene services were observed in place. A Head of Housekeeping had been introduced to co-ordinate both in-house and contract cleaning services. There were leaseholders (shops/food outlets) providing services to patients/clients, staff and visitors on a long-term lease basis. A system is in place to liaise with these leaseholders regarding any relevant hygiene matters. Job descriptions, identifying roles, responsibilities and accountability, and reporting relationships for all members of the housekeeping service were observed. Ward Managers' job descriptions clearly identify their responsibility for ensuring the safety and cleanliness for wards and equipment, in consultation with the domestic supervisor.

*Core Criterion

CM 5.2 (A → A)

The organisation has a multi-disciplinary Hygiene Services Committee.

The Hygiene Services Committee liaises and works closely with the Environment and Facilities quality improvement group. Its membership, which exceeded twenty, was representative of a wide cross section of staff. The committee meets on a weekly basis and was observed to be a very active and committed group.

Administrative support is provided by the secretariat of the CEO's office. It is recommended that the organisation implement their Quality Improvement Plan to establish a Waste Management Committee. It is also recommended that the roles and responsibilities of each member of the Hygiene Services Committee be made explicit in its terms of reference, and that its membership reflect all disciplines involved in direct patient/client care.

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

*Core Criterion

CM 6.1 (A → A)

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.

A budget plan, which generates reports (such as budget versus cost centre reports), is prepared on a monthly basis. They are distributed to all directorates and budget holders, including hygiene services departments. Costs have been identified for hygiene services developments. The organisation demonstrated innovative approaches to the resolution of staffing issues and the management of improvements. The identified developments were based on the Corporate Hygiene Strategic Plan and the Hygiene Services Plan 2007.

CM 6.2 (A ↓ B)

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

Well-established processes were observed for the involvement of hygiene services staff in the pre-purchasing of clinical and non-clinical equipment. Structures included the procurement policy ensuring compliance with National/European Union directives and all other legislation and the Medical Device Trial and Evaluation Policy 2006. All new housekeeping equipment must be approved by Housekeeping Services, and Infection Prevention and Control. Other recent examples include the establishment of a task force, which includes housekeeping, infection control, health and safety, materials, and risk management to trial a number of safety devices in the control of needle stick injuries.

Once a decision is made at this level, recommendation to purchase is submitted to the Executive Management Group. Staff identified this approach as satisfactory. No formal evaluation of the efficacy of the consultation process between the Hygiene Services Committee and Senior Management was observed, however as previously identified this committee had senior management representation.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

CM 7.1 (A → A)

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

The Risk Management Strategy 2006 was developed as a support to the hospital's quality programme to ensure that risk and safety issues are managed in a cohesive and co-ordinated manner. This strategy had provision for risk incident identification, reporting, minimisation and elimination. There were no major adverse hygiene related events identified in the last two years.

Quarterly risk incident reports are available on the intranet and annual risk management and health and safety reports are produced. There was evidence of hygiene services audits for infection control and waste; hand hygiene and safety and risk audits are conducted to identify and assess identified risks in clinical areas. External audits include the Emergency Department Audit 2007, the Desford Consultancy Audit 2006, the previous National Hygiene Audits 2005 and 2006, the National Decontamination Audit 2007, Environmental Health Reports for kitchens, water testing for Legionella and the Dangerous Goods Advisory Report 2007.

CM 7.2 (A → A)

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

A Safety and Risk Management Committee is in place whose responsibility it is to oversee and guide continued development, implementation, review and evaluation of the Safety and Risk Management Programme. The Executive Management Group in collaboration with Risk Management Committee identified four high-impact and high-risk areas (Sterivigilance, Infection Control Surveillance, Tracheostomy Safety and Pharmacovigilance). Dedicated programmes to reduce risk in these areas were established. A TSE/CJD committee is in place to identify patient/clients at risk.

Extensive representation of hygiene services on the Risk Management Committee was observed. A comprehensive list of organisational safety/risk reports is made available to the Executive Management Group. No major adverse hygiene events were reported over the last two years.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion

CM 8.1 (A → A)

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.

Contracted hygiene services include linen, waste, sanitary waste, sharps, mats, and some of the cleaning services. A process for establishing contracts, which is based on legislation and best practice guidelines, was in place. Contract managers work with hygiene services to award, manage and monitor contracts. The Contracts Department liaise with the Risk, Legal, Insurance, and Infection Control Departments to ensure relevant legislation, best practice guidelines and professional liability are incorporated into the tender design and contract agreements. Six-monthly meetings are held with suppliers, and more frequently where necessary. A number of performance indicators are also considered. In-house and contractor audit processes are in place. Health and Safety Officer inspections of the campus are performed.

CM 8.2 (A → A)

The organisation involves contracted services in its quality improvement activities.

Contract cleaning staff undergo a specific competency-based training programme, prior to commencing work and are subject to the same standard operating policies as in-house cleaning staff for cleaning and hygiene services. Cleaning contractors are represented on the Hygiene Services and the Environment and Facilities Committees at managerial level. Contractors have equal involvement in quality improvement initiatives and are subject to the same audit processes.

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 Outline Development Control Plan for the hospital campus, undertaken by an external design team, has been recently developed. It is based on best practice information in relation to demographic change and population health information. A comprehensive review of the internal and external physical environment was completed in 2005 and an action plan drawn up, which was being implemented. Improvements include the refurbishment of ward pantries and storage rooms, the refurbishment of cleaners' rooms, the renovation of the HSSU and upgrades in the Technical Services Department. Some of these works were finished, others were on-going with plans to conclude them by year-end, depending on financial resources.

*Core Criterion

CM 9.2 (A → A)

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

Responsibility for this is assumed by five different departments: General Support Services/Materials Management, Technical Services Department, Infection Control,

Medical Physical and Bioengineering, incorporating Radiation Protection, all of which are represented on the Environment and Facilities Group. Policies and procedures were based on relevant legislation and best practice. Of particular note were:

- Sterivigilance Programme introduced in 2004, to provide hospital-wide education and monitoring on decontamination and traceability.
- TSE/CJD initiative.
- Planned Preventative Maintenance Programme.
- PAT testing (for the servicing and maintenance of contract cleaning staff equipment).

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.

Comprehensive documented policies, procedures and guidelines covering all aspects of Hygiene services were observed. Internal/external audits and patient/client and staff satisfaction surveys are in place. Resultant evaluation and action points for quality improvement initiatives, covering the scope of hygiene services, noted included:

- Improvements in the environment and facilities
- Restructuring of existing human resources to provide an improved frontline service and improve service management for cleaning services
- The acquisition of new equipment
- Improvements in monitoring with senior management involvement
- An increase in audit and evaluation

The feedback process and continuous quality improvement culture was strongly established across hygiene services. Progression of the organisation's quality improvement plan is recommended.

CM 9.4 (A → A)

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

Patients/clients, staff, providers and communities satisfaction with hygiene services and facilities is evaluated by means such as the Patient Advocacy Committee and its involvement in the Hygiene Services Committee; patients'/clients' satisfaction surveys; structured Executive Management/Community consultation meetings and the General Practitioner liaison forum.

A complaints procedure, which uses a computerised system to categorise complaints according to service type (for example, 'Hygiene', 'Hotel Facilities'), is in use. A number of quality improvement plans are in place with feedback provided to the General Support Services Manager. Localised Partnership Committee initiatives were also evident in some hygiene departments, which empowered staff in these areas to promote and implement their own quality improvement culture. Progression of the Quality Improvement Plan is recommended.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 (A ↓ B)

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.

There were documented processes for this. Job descriptions are available for all staff disciplines and grades. The contractor is responsible for contract cleaning staff recruitment. Both in-house and contract staff (tender document specification for contract staff) recruitment and selection processes were in accordance with legislation and best practice. Records for in-house staff are maintained by the organisation and the contractor retains those of the contract staff in accordance with the tender document. A one-week generic and service-specific induction programme is undertaken by all new staff. It included mandatory training in areas such as manual handling and hand hygiene. No evidence of evaluation of the recruitment process was observed.

CM 10.2 (A → A)

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 is an established practice of active management for staff vacancies, which included prioritisation of work and re-allocation of staff by the supervisor. The allocation of a janitor and supervisor to the Emergency Department at all times (i.e. including nights and weekends) and the creation of a housekeeping management position, from the existing whole-time equivalent, was based on audit outcomes of health and safety, safe working practices and ISO 340. Progression of the Quality Improvement Plan is recommended.

CM 10.3 (B → B)

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

Contract cleaning staff are required to be proficient in identified competencies for their role, in advance of commencement of employment. Cleaning contracts require Contract Cleaning Supervisors to have taken the Operatives Proficiencies course 1 and 2 in accordance with the British Institute of Cleaning Services (BICS) Standards. Waste Management and Linen Contractors are also required to provide relevant training. Infection Prevention and Control provided training for all staff, including contract staff.

CM 10.4 (A → A)

There is evidence that the contractors manage contract staff effectively.

Both in-house and Contract Cleaning Services Managers report to the Housekeeping Manager to facilitate the delivery of a standardised integrated cleaning service. The Contract Cleaning Manager meets with the contractor on a weekly basis to discuss services and outcome evaluation. The Contract Cleaning Manager is also a member of the Hygiene Services Committee. Also of note was the establishment of a Mandatory Training Committee, chaired by the OHR. It is recommended that the implementation of standardised training for all contract staff be further progressed to ensure consistency/compliance with hospital policies.

*Core Criterion

CM 10.5 (A → A)

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

The Hygiene Corporate Strategic plan, Hygiene Services Plan 2007 and Hygiene Services Operational Plans, together with audit reports and departmental activity, outline the hygiene services' human resource needs. Changes, based on these factors, were evident and included incorporation of additional duties. There was an identified staff whole time equivalent budget for hygiene services. An annual report was available for 2005, which included a specific hygiene services report. It is recommended that the Hygiene Services Committee develop the hygiene services annual report as part of their Quality Improvement Plan.

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.

The programme includes aspects such as infection prevention and control, waste and sharps disposal and hand hygiene. Further local-specific induction is also provided, which includes the use of a 'Buddy' system. Evidence of strong commitment to staff participation in the SKILLS programme was noted. On-going training is provided by the Infection Prevention and Control Department, using a staff-friendly approach, which facilitates ease of attendance. Computerised attendance records are maintained and are available to all line managers. A staff handbook and code of behaviour are available. The handbook is in the process of being revised and it is recommended that staff responsibility for hygiene standards compliance, is considered for inclusion.

CM 11.2 (B → B)

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.

A Mandatory Training Committee has been established to monitor compliance and develop action plans to increase participation in mandatory training. Mandatory training is monitored monthly as a Key Performance Indicator and feedback is reported to the Executive Management Group. Staff have access to a range of on-going education and training and continuous professional development. Examples include Health and Safety/Risk Assessment, Complaints Management, Infection Prevention and Control and Standard Operational Procedures for the cleaning and maintenance of equipment (including medical and cleaning devices). Staff are facilitated in attending training while on duty and training is structured and organised to facilitate maximum participation.

CM 11.3 (B → B)

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

Effectiveness is evaluated using performance indicators such as competency achievement, a food quiz in the Catering Department and performance evaluation in Cleaning Services. Some relevant training-specific Key Performance Indicators were observed in place for example:

- Moving and handling incidents.
- Fire activation rates.
- Incidents of violence and aggression.
- Environmental Health Officer reports.
- Evidence of compliance with legislation, for example the Dangerous Goods Advisory Report 2005.

Progression of the organisation's Quality Improvement Plan is recommended.

CM 11.4 (B → B)

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

Staff performance evaluation is based on audit outcomes and performance indicator monitoring which includes:

- Absenteeism.
- Analysis of adverse incidents.
- Specialist reports such as complaints.
- Patient Satisfaction Surveys.

Relevant Quality Improvement Plans observed were evidence-based and focused on areas of concern such as Mandatory Training Committee and the Absenteeism Management Programme.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (A → A)

An occupational health service is available to all staff.

A multi-disciplinary service is available on-site. It is introduced to staff as part of the induction programme. It aims to promote the health, safety and well-being of each staff member through an extensive range of services including screening, vaccinations, risk assessments and sickness absence reviews.

An Employee Assistance Programme is also provided. The performance indicators monitored include:

- Hepatitis B vaccination uptake.
- Stress related absenteeism.
- Needle stick/exposure incidents.

A feedback mechanism for relevant department groups is also in place.

CM 12.2 (A → A)

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

Performance indicators used to monitor staff (including hygiene services staff) satisfaction, occupational health and well-being include:

- Attendances/analysis for Employee Assistance Programme. For example personal problems, combination of work/family related stress.
- Pre-employment Medical Form Risk Assessment.
- Adverse events, trends analysis.
- Absenteeism related to work-associated stress

Quality improvements noted included the establishment of local partnership committees for issues' identification/resolution and the identification of key areas for non-violent crisis intervention training.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.1 (A → A)

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.

A number of hygiene specific committees are in place. An agenda and minutes for each meeting are circulated to relevant line managers. Key Performance Indicators have been identified across all aspects of the service and are regularly reviewed. Internal and external audit reports were evident. Policies, procedures and guidelines reflect current legislation on best practice. Evaluation observed during the assessment included Hazard Analysis and Critical Control Point (HACCP) records, Environmental Health Officer reports in the catering area, the PAT system for testing of non-medical equipment and waste traceability records. Evidence of feedback and quality improvement was noted in all areas and information is disseminated and communicated throughout all levels of the organisation.

CM 13.2 (A ↓ 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.

There are annual reports for all departments, including the Hygiene Services Department. Other reports observed included a broad range of hygiene/infection control and risk management audits and monthly performance indicator reports to the Executive Management Group. However, some gaps were evident in the knowledge and understanding of some frontline hygiene services staff in relation to processes.

CM 13.3 (A ↓ B)

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

Changes in data collection and information reporting have taken place. These include an additional external/internal audit, with specific audit tool adaptation for specific areas, and additional Key Performance Indicator monitoring. Symbols were introduced to the electronic patient/client record to identify necessary infection prevention and control precautions. Documents and tender processes were amended to reflect changes in hygiene services in the last two years. Evaluation of the dissemination process for hygiene information was based on the outcomes of staff and patient/client satisfaction surveys. There was considerable well-organised support documentation available.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

CM 14.1 (A → A)

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 evidence of considerable quality improvement initiatives over the past two years, which included the establishment of Hygiene Services Committee, the development of Hygiene Corporate Strategic, Annual Service and Operational Plans. A number of other developments included the commissioning of an independent Desford review in 2006, the recommendations of which are still being implemented.

These included improvements to environment and facilities, improvements for internal and external hygiene equipment, reallocation of human resources to improve hygiene service cover and an improved management structure. Significant quality improvement was also noted in the areas of audit and quality improvement planning. Hygiene services report to the General Services Manager, the Executive Management Team and the Hospital Board. Of particular note was the increased visibility of management involvement in assessments (walkabouts), which helped to raise the profile of hygiene services and reinforce the fact that there was corporate responsibility for hygiene services.

CM 14.2

(A → A)

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.

Considerable evidence was observed of this, which included increased audit, relevant performance indicators and benchmarking against previous outcomes. New structures were introduced to deal with areas requiring improvement/poor performance such as the Mandatory Training Committee and the Housekeeper Manager, to coordinate/integrate standards and service delivery. The involvement of service users in the community was particularly noteworthy.

The culture of audit and Key Performance Indicator monitoring was well established and is also to be commended.

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 (A ↓ B)

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

These are available in a comprehensive list of areas that impact on hygiene services. Examples include: the Environmental Cleaning and Disinfection Policy, the Infection Control Manual, linen, sharps, waste hand hygiene and catering). A plan for the development of policies and guidelines was developed in 2005. Limited evidence of evaluation of the efficacy of the process, utilised to develop these guidelines, was observed. Some confusion among staff was noted in relation to colour coding of cleaning equipment and the linen policy.

SD 1.2 (A → A)

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

The hospital has introduced a number of new initiatives in the past two years including the following:

- A janitorial service in the Emergency Department.
- The restructuring of allocated cleaning staff resources.
- Alcohol hand gel dispensers.
- The restructuring of the Hygiene Management Team.
- The establishment of the housekeeping position.
- The purchasing of additional cleaning equipment.

Weekly audits are undertaken by the multi-disciplinary team, and follow up actions included in the minutes of the operational hygiene meeting. However, from the evidence produced, their focus appeared to be regarding in-patient/client facilities. No evidence of audits in allied health areas was noted, for example X-ray and Physiotherapy. Cleaning of 'grey areas', such as telephones and computer keyboards, is being targeted in a structured manner. Evaluation, following the introduction of alcohol hand gel, was also available. The Sterivigilance nurse's annual report identifies clear achievements in decontamination and highlights areas for on-going improvement.

PREVENTION AND HEALTH PROMOTION

SD 2.1 (A ↓ 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.

The hospital is a member of the Dublin Academic Teaching Hospitals Health Promotion Group. A hand hygiene promotion display was observed at the main entrance. A 'Welcome' information leaflet for the community group was noted as a valuable health promotion tool. There was a Patient Advocacy Committee and community consultations are held every two months. A Health Promotion Co-ordinator was in place. There is a General Practice Liaison Group in place and a GP web page on the hospital intranet site. Patient/client satisfaction surveys in a range of areas were noted and alcohol hand gel was evaluated after its introduction. Leaflets on hand hygiene, MRSA and Vancomycin-Resistant Enterococcus (VRE) were made available, however, limited evidence that all these leaflets were available at ward level for patient/clients and visitors. A patient/client information booklet was available. It is recommended consideration be given to providing information identified by the hospital in their Quality Improvement Plan in the booklet. Limited evidence was provided to demonstrate evaluation of the effectiveness of the health promotion activities that educate the community.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1 (A ↓ B)

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

A comprehensive structure for the management of hygiene services was apparent. These committees were multi-disciplinary with representatives from nursing, medical, senior management, service delivery, technical services, patient's/client's organisation and risk management. Terms of reference were evident and minutes clearly documented. Weekly audits were conducted by members of the operational group, with resulting actions included in the minutes. In addition audits on sharps bins, infection control, hand gel use, extensive catering and linen audits were available. There were however, no documented processes to ensure the team's awareness of each others roles and responsibilities, which is recommended.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

SD 4.1 (A ↓ B)

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

In general the overall physical environment was clean. Flaking paint on walls, particularly behind bins, was noted. Floor coverings were not always intact. Chair coverings needed attention in some areas. Some mattress covers in the Accident and Emergency Department and X-Ray were in need of repair. Couches observed in the Physiotherapy Department required attention. Curtain changing (shower and cubicle) was at variance with the documented policy. Tile grouting in some shower areas requires upgrading/replacement. Signage in areas was falling off walls and there was evidence of sticky tape remaining from old signs. In most instances, signs were laminated, which is recommended. The interior of ward waste bins required

attention, with the responsibility for, and frequency of, cleaning unclear at ward level. While the introduction of recycling initiatives is welcomed, a cleaning schedule is required.

For further information see Appendix A.

*Core Criterion

SD 4.2 (A ↓ B)

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

Medical equipment was free from dust and residue, and well maintained. The attention to cleaning equipment requires improvement and staff were unaware of hospital policy regarding changing procedures for pads and filters.

Computer keyboards and telephones required cleaning in some areas. There was no clarity on the cleaning regime or the person responsible for cleaning this equipment.

For further information see Appendix A.

*Core Criterion

SD 4.3 (A ↓ B)

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

Attention to cleaning equipment varied throughout the hospital. Some cleaning staff was unaware of the vacuum filter changing policy and no evidence of this practice was noted. Variance in colour coding of cleaning products and equipment to the documented hospital policy was observed, and contract cleaning company education documentation provided was not consistent with its practice on wards, possibly as a result of this. While hospital colour coding observed was not compliant with national guidelines, local variance, if consistent, is acceptable. The use of multiple systems for the dilution of detergents 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.

These are Hazard Analysis and Critical Control Point (HACCP) compliant, well managed and maintained with clear roles and responsibilities evident. Documentation was clear, accessible and well organised. The main kitchen building is an old structure and requires on-going attention. For example, floor tiles, and other flooring, in high traffic areas). Some machinery such as the chiller and fridges in the main kitchen area, require attention.

For further information see Appendix A.

*Core Criterion

SD 4.5 (A ↓ B)

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.

Overall, the waste management was very good. Identified persons responsible for, and frequencies of, the cleaning of non-hazard waste bins and recycling bins require clarification. Documented processes for replacement of bins should be developed. The introduction of recycling initiatives on all wards is welcomed and commendable.

For further information see Appendix A.

*Core Criterion

SD 4.6 (A ↓ B)

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

Overall, the management of linen was very good. The revision of the current linen segregation protocol, when completed, should reduce confusion at ward level. The development of documented processes for the in-house laundry and training of staff is recommended.

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.

Clinical hand hygiene sinks were fitted with mixer taps, clean and free from obstructions. Sinks observed in some areas did not meet the standard. However, plans to replace these have been developed. The presence of jewellery, especially wrist watches, was noted on allied health professionals and medical staff, during hand-washing procedures. The strength of the Infection Control Team was noted to have an impact on improvement in practice, signage and the provision of information.

For further information see Appendix A.

SD 4.8 (A ↓ B)

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

A comprehensive Risk Management Strategy is in place. The Risk Occurrence Reporting Policy, regarding the reporting and minimisation of risk, was developed in 2005. Technical Services prioritise reports of faulty equipment with a response time of 30 minutes for high priority items. A Sentinel Event Management Report has been developed, which allows trends to be noted and analysed on a quarterly basis. Actions, resulting from these reports, are implemented by relevant committees. Examples include the Needlestick Taskforce and the Safety and Risk Management Steering Committee. Evidence of training on prevention of accidents for service users was also observed.

SD 4.9 (A → A)

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

The patient information booklet provides advice on topics such as the policy on flowers and reducing clutter by minimising personal belongings. The "Welcome" leaflet promotes good hygiene practices such as hand hygiene. There is a patient representative on the Hygiene Services Operational Group. A Patient Advocacy Committee is also in place and community consultations occur frequently. Patient satisfaction surveys have been conducted in many areas and follow up actions taken, with subsequent weekly audits carried out to review the process. The Patient information booklet outlines visiting arrangements, this booklet is under review.

PATIENT'S/CLIENT'S RIGHTS

SD 5.1 (A → A)

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

The staff booklet and Maybin training documents specifically mention confidentiality and respecting the needs of patient/clients. Isolation door notices observed were discreet. A patient/client charter is in place. The patient/client information booklet refers to the complaints procedure and the Data Protection Act. It is recommended that information for patient/clients regarding accessing their records and the existence of a patient/client charter is included in the booklet. Root cause analysis of incidents are conducted and actions implemented, and a root cause analysis education programme is in place, well attended and evaluated.

SD 5.2 (A → A)

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

A patient/client information booklet is available. It is under review and plans are in place to have a bigger focus on hygiene. Patient/client information leaflets are available on hand hygiene, VRE, MRSA and the winter vomiting virus. Patient/client satisfactory surveys have been conducted in a number of areas. A patient/client representative is a member of the Hygiene Services Operational Group and a Patient/Client Advocacy Committee is in place.

SD 5.3 (A → A)

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

A complaints policy was observed and evidence that complaints relating to hygiene are followed up was provided. The Complaints database is used for analysis. Evidence was provided of quarterly reports and there is a specific category referring to hygiene. Results of patient/client satisfaction surveys are followed up by the hygiene operational group. The development of the janitor position in the Emergency Department was based on patient/client feedback. It is recommended that the organisation consider repeating these surveys.

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1 (A ↓ B)

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

Evidence of this includes the Desford consultancy review (2006).

A sharps audit was carried out by an external company, and there are Environmental Health Officer's reports.

Further evidence includes the previous National Acute Hospitals Audits (2005 and 2006); General Practitioner liaison group; a patient/client representative as a member of the Hygiene Services Operational Group; Community consultations; the Patient/Client Advocacy Group.

No evidence was provided that the organisation evaluates the extent to which patient/clients, families and other organisations are involved by the team when evaluating its hygiene services. This is recommended.

SD 6.2 (A → A)

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 is a Key Performance Indicator Programme in place, examples of which include MRSA rates, needlestick injuries and incorrect disposal of clinical waste.

Evidence of extensive on-going hygiene audits (weekly in places) was presented with actions followed up by operational group. Examples included:

- Infection Control audits.
- Alcohol hand gel usage figures.
- Safety and Risk Management audits.
- Catering audits.
- Patient/client satisfaction survey audits.
- Desford Consultancy Review (2006).
- Sterivigilance nurse audits.

There is evidence that 'grey areas' (such as bins, computers and phones) identified during audit are being addressed in a structured manner. This has been achieved by the expansion of the role of cleaners with 10 additional duties.

Evidence was provided of quality initiatives such as:

- Janitorial service 24 hours a day in Emergency Department.
- Restructuring of allocated resources of cleaning staff following the external Desford Review 2006.
- Introduction of alcohol hand gel dispensers at every ward entrance.
- Restructuring of the management team with responsibility for hygiene.
- Development and appointment of the Head of Housekeeping position.
- Upgrading of ward kitchens.
- Annual report.

SD 6.3 (A → A)

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

Hygiene services were addressed in the service division reports of the 2005 annual report. The 2006 report was not available during the assessment. However, a draft report was provided for review. Developments in hygiene services were itemised. The Cascade Programme is a valuable information tool for staff. A documented

process has been developed for the compilation of each annual report. Extensive evidence for audit of hygiene services, both internal and external, was observed.

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.

No - Clutter was noted in a number of areas visited. Rusty trolley wheels were observed in many areas (for example the HSSU). Evidence of dust, debris and spillages was noted in a number of areas.

(2) All high and low surfaces are free from dust, cobwebs and flaking paint.

No - Damaged wall and floor surfaces were observed and a lack of wall protection evident in many areas (for example behind bins). Flaking paint was also noted in many areas.

(3) Wall and floor tiles and paint should be in a good state of repair.

No - Damaged wall and floor surfaces were observed.

(5) Cleanable, well-maintained furniture, fixtures and fittings used.

No - Tearing to soft chairs coverings was noted in many areas.

(10) Internal and external signage should be clean, updated, well maintained and laminated to enable cleaning.

No - Signage noted was inadequately fixed to the wall in areas and missing in other areas. Sticky tape residue was evident on many surfaces.

(14) Waste bins should be clean, in good repair and covered.

No - Many open bins were noted (including some containing contaminated waste). Also, some bins observed needed attention.

(15) Where present a designated smoking area must comply with the national legislation on tobacco control and local organisational policies, a cigarette bin must be available and the floor area should be free of cigarette ends, matches etc.

No - The floor area was littered with cigarette ends.

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

(22) Mirrors.

Yes - However, exposed screw heads were noted in some areas.

(25) Floors (including hard, soft and carpets).

Yes - However, a review of the cleaning frequency in the catering corridor and office areas is recommended.

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

(207) Bed frames must be clean and dust free.

Yes - Some exceptions were noted, however, the majority of beds reviewed were clean.

(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.

No - A documented process is in place, however, compliance and awareness with the processes was deficient in many areas.

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

(34) Beds and Mattresses.

Yes - Some exceptions were noted, however, the majority of beds and mattresses reviewed were clean.

(35) Patient couches and trolleys.

No - mattresses were noted in the Emergency Department and X-Ray and couches in the Physiotherapy Department needed attention.

(39) Waste Receptacles (e.g. sani-bins, nappy bins, sharps bins, leak proof bins).

Yes - However, blood stains were noted on some sharps bins (for example in the blood gas analyser room).

Compliance Heading: 4. 1 .5 Sanitary Accommodation.

(44) Hand hygiene facilities are available including soap and paper towels.

Yes - However, some exceptions were noted (for example the laundry).

(46) Bathrooms/Washrooms must be cleaned on a daily basis. When necessary, they must be disinfected. This must be monitored and recorded.

Yes - While these areas were clean, no records are maintained. This does not comply with the revised local policy.

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 - Not applicable as no bidets were observed.

(56) All associated bathroom fittings including component parts e.g. tiles, taps, showerheads, dispensers, toilet brushes etc. should be clean and well maintained.

No - Tile grouting and floors seals needed attention and were chipped/dicoloured in some areas.

(60) All outlets (including shower outlets) should be flushed at a temperature in accordance with current legislation.

No - A draft policy outlining procedures and documentation is being developed.

Compliance Heading: 4. 2 .1 Organizational Equipment and Medical Devices and Cleaning Devices (note: while list is not exhaustive, the following compliance is required):

(64) All equipment, including component parts, should be clean and well-maintained with no blood or body substances, rust, dust, dirt, debris and spillages.

No - Some cleaning equipment observed needed attention and in some instances, used buffer pads and mop heads had not been removed.

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

(65) Commodes, weighing scales, manual handling equipment.

Yes - However, commodes in some areas required further attention. A lack of clarity regarding the person responsible for this area was also noted.

(68) Patient fans which are not recommended in clinical areas.

No - Fans were noted in clinical areas.

(70) Bedpans, urinals, potties are decontaminated between each patient.

Yes - Disposable bedpans were in use in the X-ray Department, however, the appropriate facilities for their disposal were not in place (i.e. macerator). Documented instructions on emptying bedpans prior to insertion into the bedpan washer should be reviewed.

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

(72) Trolleys, e.g. chart trolleys, drug trolleys, linen trolleys, shop trolleys, emergency trolleys, suction apparatus, resuscitation equipment i.e. ambubag and mask.

Yes - However, in one area, a medicine trolley needed closer attention.

(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 - Local knowledge of the hospital policy for changing vase water daily was limited, however, no evidence of vases needing attention, or wilting flowers, was observed.

(80) All office equipment (e.g. telephones, computers, fax machines) should be clean and well-maintained.

No - Computer keyboards and telephones needed attention in many areas and a lack of clarity regarding the person responsible for this area was noted.

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

(81) All cleaning equipment should be cleaned daily.

No - While compliance was observed in some areas, variance throughout the organisation was noted.

(82) Vacuum filters must be changed frequently in accordance with manufacturer's recommendations - evidence available of this.

No - No evidence was observed at ward level that this is in place.

(86) Information on the colour coding system is available to all hygiene staff (according to national guidelines).

Yes - However the local colour coding guideline (developed in 2006) was not in accordance with national guidelines and training documents from the contract cleaning company. Not all staff questioned were aware of guidelines.

(88) All cleaning equipment should be left clean, dry and tidy in the storage area after use.

No - Not all areas observed were compliant. A lack of sufficient cleaning rooms and storage space was a factor.

(89) Equipment with water reservoirs should be stored empty and dry.

Yes - However, a scrubber tank was observed in storage containing residue water.

(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 - Cleaning stores are not present in all areas and some cleaning rooms were without hand hygiene facilities.

(92) Cleaning products and consumables should be stored on shelves in locked cupboards.

No - There were not any locked cupboards noted.

(93) Cleaning products and equipment should comply with the relevant colour coding policy.

Yes - The local colour coding guideline (developed in 2006) was not in accordance with national guidelines and training documents from the contract cleaning company. Not all staff questioned was aware of the guidelines.

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

(213) Environmental Health Officer (Senior EHO/EHO) reports on food safety inspections including the completed summary stage of compliance with HACCP and annual water analysis reports should be retained on the Hospital Food Safety Manual. Action plans/actions taken on foot of issues raised in the reports should be documented.

Yes - Proposals for improvement have been developed, based on the Environmental Health Officer's comments, copies of which have been sent to the Chief Executive Officer and Technical Services.

Compliance Heading: 4. 4 .2 Facilities.

(217) Access to the main kitchen and ward kitchens should be restricted to designated personnel i.e. food workers.

Yes - However, open doors providing unrestricted access were noted in some areas.

Compliance Heading: 4. 4 .4 Pest Control.

(239) Fly screens should be provided at windows in food rooms where appropriate.

Yes - The windows in the food rooms do not open.

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

(143) Healthcare risk waste bags should be removed when no more than two-thirds full or at the maximum indicated by the bag manufacturers.

Yes - However some bags were more than two-thirds full.

(149) Inventory of Safety Data Sheets (SDS) is in place.

No - An inventory of Safety Data Sheets was not available on wards.

(151) Waste is disposed of safely without risk of contamination or injury.

Yes - As some of the bins observed were in need of attention, the practice of putting full rolls of waste bin liners into bins poses a potential hazard.

Compliance Heading: 4. 5 .3 Segregation

(256) Mattress bags are available and are used for contaminated mattresses ready for disposal; mattresses are disinfected.

No - Mattress bags were not available.

Compliance Heading: 4. 5 .4 Transport

(166) Drivers of vehicles transporting hazardous waste must be trained in accordance with the ADR Regulations.

No - Drivers of the external health care risk waste contractors are not requested to show driver's licence.

Compliance Heading: 4. 5 .5 Storage

(169) Documented process(es) for the replacement of all bins and bin liners.

No - While a documented process was available for the replacement of hazardous waste bins/liners, none was noted for non-hazardous waste bins/liners.

(258) Waste receptacles should be sanitised, secure and in a good state of repair when used.

No - The interiors of many bins observed were in need of attention.

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

(173) Documented processes for the use of in-house and local laundry facilities.

No - No documented processes noted in the laundry for performance of equipment etc.

(262) Linen is segregated into categories and in appropriate colour coded bags (i.e. clean/unused linen, dirty/used linen, dirty/contaminated linen).

No - The practice observed at wards level was not compliant with the documented hospital protocol. It was noted, however, that this protocol is under revision.

(263) Bags are less than two-thirds full and are capable of being secured.
Yes - Practices observed were generally compliant, with some exceptions noted.

(264) Bags must not be stored in corridors prior to disposal.
Yes - Practices observed were generally compliant, with some exceptions noted.

(268) Ward based washing machines are used only with the agreement of the Hygiene Services Committee.
Yes - No ward-based washing machines were observed.

(271) Hand washing facilities should be available in the laundry room.
No - There is a sink in the laundry room, however, no paper towels or soap were available.

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

(187) Nails should be kept short and nail varnish or false nails should not be worn by those working in a clinical setting.
Yes - However, some local variation was noted.

(188) Hand and wrist jewellery should be removed prior to performing all levels of hand hygiene with the exception of a plain wedding band.
Yes - However wrist watches were noted on some staff during patient/client care and during hand hygiene procedures.

(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 - A clinical hand hygiene sink was not present in all areas, however, a plan to replace old non-compliant sinks and taps has been developed.

(190) All sinks should be fitted with washable splash backs with all joints completely sealed.
Yes - However, attention is required in the Physiotherapy and Occupational Therapy Departments.

(192) Taps should be hands free and should be mixer taps to allow temperature regulation.
No - Not all areas were compliant, however, a plan to replace old non-compliant sinks and taps has been developed.

(198) Hand hygiene posters and information leaflets should be available and displayed throughout the organization.
Yes - However, ward areas require greater attention and updating.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team		Assessor Team	
	FREQ	%	FREQ	%
A	49	87.50	33	58.93
B	7	12.50	23	41.07
C	0	00.00	0	00.00
D	0	00.00	0	00.00
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	A	→
CM 1.2	A	A	→
CM 2.1	A	A	→
CM 3.1	B	B	→
CM 4.1	A	A	→
CM 4.2	A	B	↓
CM 4.3	A	B	↓
CM 4.4	A	A	→
CM 4.5	A	A	→
CM 5.1	A	A	→
CM 5.2	A	A	→
CM 6.1	A	A	→
CM 6.2	A	B	↓
CM 7.1	A	A	→
CM 7.2	A	A	→
CM 8.1	A	A	→
CM 8.2	A	A	→
CM 9.1	B	B	→
CM 9.2	A	A	→
CM 9.3	B	B	→
CM 9.4	A	A	→
CM 10.1	A	B	↓
CM 10.2	A	A	→
CM 10.3	B	B	→
CM 10.4	A	A	→
CM 10.5	A	A	→
CM 11.1	A	A	→
CM 11.2	B	B	→
CM 11.3	B	B	→
CM 11.4	B	B	→
CM 12.1	A	A	→

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