



Hygiene Services Assessment Scheme

Assessment Report October 2007

University College Hospital, Galway

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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

University College Hospital Galway is an acute hospital with capacity of 698 beds (including 99 day care beds and 43 psychiatric beds), serving the catchment of nearly 400,000. It is one of two Galway University Hospitals (the other is Merlin Park Hospital). The hospital plays a leadership role in acute service delivery, providing regional services for a wide range of specialities to support the policy of regional self-sufficiency.

Services provided

The hospital provides the following services:

- Accident & Emergency
- Acute and Chronic Pain Management
- Acute Psychiatry
- Anaesthesia
- Biochemistry
- Cardiothoracic Surgery
- Cardiology
- Care of the Elderly
- Clinical Pharmacology
- Decompression Chamber
- Dermatology
- Emergency Medical Admissions
- Emergency Surgical Admissions (except orthopaedics)
- Endocrinology and Diabetes Mellitus
- ENT
- Fertility
- Gastroenterology
- General Surgery
- G.I. Surgery
- Haematology
- Hepatology
- Histopathology
- Immunology
- Infectious Diseases
- Microbiology
- Neonatology
- Neurology
- Obstetric & Gynaecology
- Oncology
- Ophthalmology
- Oral Maxillofacial
- Orthodontics
- Paediatrics
- Palliative care
- Plastic Surgery
- Radiology
- Radiotherapy
- Respiratory medicine
- Symptomatic Breast Care
- Urology
- Vascular Surgery

Out-patient services provided include:

- General Medicine
- General Surgery
- ENT
- Ophthalmology
- Pre-Assessment Nurse-led clinic (Ophthalmology)
- Dermatology
- Orthopaedics
- Plastics
- Oncology
- Haematology
- Paediatrics
- Obstetrics
- STD
- Dental
- Fertility
- Dental Surgery
- Cardiology

Physical structures

University Hospital Galway is a 1950's building with one main block and several satellite buildings on the site. Two major development phases have just been completed with new and improved services in A & E, Endoscopy, Theatres, Radiology, EEG, Upgrading of ICU, HDU, Burns Unit, Orthopaedic Trauma, Cardiology, Cardiac Surgery, Cardiac Rehabilitation, Physiotherapy, Chapel, MRI, Medical Social Work and Radiotherapy. A number of ward upgrades have also been completed. Considerable infrastructural work as also carried out to support these services.

An Infection control ward has been designated for patients colonised or infected with multi-resistant organisms or infectious diseases.

The following assessment of University College Hospital, Galway took place between the 17th and 19th of July 2007.

1.3 Notable Practice

- The significant progress that has been achieved within the organisation in the past 12-18 months.
- New capital development plans and refurbishment of clinical areas.
- The new posts that have had direct impact and input into the hygiene services.
- Adherence to hand hygiene and the uniform policy requirements throughout the organisation.
- The commitment from contracted services to hospital hygiene improvements.
- The palpable culture of desire to improve hygiene requirements.

1.4 Priority Quality Improvement Plan

- Installation of dedicated clinical wash hand basins in key clinical areas as identified and the provision of splash backs as required.
- More appropriate storage of waste in the designated waste storage areas within the hospital and adoption of system of labelling in keeping with the Department of Health and Children Waste Guidelines 2004.
- Sharps management should be improved.
- Review of storage of items in clean and dirty utility rooms.
- Greater multidisciplinary approach to internal auditing, training and document development.

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 University College Hospital, Galway has achieved an overall score of:

Fair

Award Date: October 2007

2.0 Standards for Corporate Management

The following are the ratings for the Corporate Management standards, as validated by the Assessment team. The Corporate Management standards allow the organisation to assess and evaluate its activities in relation to Hygiene Services at an organisational level. There are fourteen Corporate Management standards, all of which are focused on four critical areas: leadership and partnerships, environment and facilities, human resources and information management. They include such subjects as corporate planning, allocating and managing resources, enhancing staff performance and contractual agreements. There are eight core criteria within these standards.

PLANNING AND DEVELOPING HYGIENE SERVICES

CM 1.1 (B → B)

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

The organisation's document "Strategy for the Future 2006-2010" stated that the organisation will "manage the environment and improve quality for patients". The document also referred to HIQA for increased focus by the organisation on quality. The introduction of new structures relevant to hygiene services e.g. Hygiene Services Committee and Hygiene Services Team has increased the focus on hygiene across the organisation. The Organisation has a draft Hygiene Corporate Plan and a Hygiene Operational Service Plan, which has input from relevant department heads in place. Compliance with all relevant national legislation and guidelines is addressed. An external consulting firm utilised to evaluate long term catering identified the need for a new purpose built kitchen on site. The National Visitor Policy has been implemented and signage in the front hall informs the public of the policy. Individual area hygiene audits are performed, and care attendants sign off cleaning sheets at ward level. An Infection control ward has been designated for patients colonised or infected with multi-resistant organisms or infectious diseases. Specific cleaning team have been identified for decontaminating rooms throughout the organisation. The organisation would benefit from evaluating the current system of auditing – a more multidisciplinary approach with staff moving from their own speciality areas and involvement of senior management on site or area audits would further enhance the whole process.

CM 1.2 (A ↓ B)

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

The organisation's Strategic Plan includes further developments, which will enhance its hygiene services, namely catering refurbishment and laundry facilities. Waste storage rooms have been designated. Progress to date includes hand hygiene awareness for patients, staff and public. Close liaison between the Organisation's Infection Control Team and Hygiene Services facilitates the provision of additional cleaning arrangements to deal with outbreaks of infection. Dedicated personnel within hygiene services are allocated to the hygiene requirements of the rooms or areas where patients are colonised or infected with resistant micro-organisms. A system to record the cleaning schedule of patient related equipment being cleaned would appear to be very effective as there was a very high standard of cleanliness evident during assessment. This process was being evaluated by members of the hygiene services team and resultant actions managed at local level.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1 (B → B)

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

Evidence of the specific linkages with the Health Service Executive and the Department of Health and Children and minutes of meetings were viewed during the hygiene assessment. The organisation's management structures for both internal and contracted Hygiene Services were compliant with Legislation and National Best Practice guidelines. A well established patient focus group is actively involved within the Hygiene Services structure and is represented on the Hygiene Services Committee. As per the organisation's continuous quality improvement plan the utilisation of the hygiene services team and committee structures to evaluate patients/clients/staff comments and suggestions would strengthen the linkages and partnerships for hygiene services.

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.

The Hygiene Services Corporate Strategic Plan was at draft stage as it required extensive consultation throughout the organisation and this process incurred delays during the nursing industrial relations dispute. The Hospitals Corporate Strategic Plan was discussed at Hygiene Services Team meeting dated 3rd July, and the minutes indicated that the document was circulated to all heads of department for comment. Feedback viewed during the hygiene assessment indicated the commitment to this process which was commended by the assessors.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.1 (B → B)

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

The documented Hygiene Management structures make provision for clear lines of accountability and responsibility for hygiene within the organisation including the Executive Management Team. Professional Codes of Ethics within the organisation for various disciplines as outlined in self assessment documentation were observed. Evidence of external monitoring, for example, National Standard Authority of Ireland report was viewed during the assessment, and internal monitoring is undertaken through the individual areas' auditing process. Resultant actions were identified, managed locally and specific issues discussed with the Services Manager.

CM 4.2 (B → B)

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

Best practice information was reviewed and discussed at meetings of the Hygiene Services Team and Hygiene Services Committee. The project management methodology for the introduction of new products or initiatives should be implemented across the entire organisation with key stakeholders aware of its workings.

CM 4.3 (B → B)

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

Information is communicated through many channels as documented in self assessment and verified during the hygiene assessment. There is ongoing induction, continuing education and in-house training relevant to each staff discipline. Training is evaluated through evaluation forms and at local level during auditing by checking the level of knowledge gained from education and training.

CM 4.4 (B ↓ C)

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

The organisation had many policies and guidelines in place; however a system for the development, approval, revision and control of all policies, procedures and guidelines including those relating to Hygiene Services was not evident on review of documentation. Many policies and draft documents were not dated on approval or given a review date. A more structured process to establish and manage policies and procedures were suggested.

CM 4.5 (B → B)

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

There was evidence from the documentation of the hygiene services involvement in development plans for the organisation – the evaluation of the efficacy of the consultation process is recommended.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

*Core Criterion

CM 5.1 (B ↓ C)

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

The reporting relationships and responsibilities/accountabilities for hygiene services are documented. All Ward/Clinical Department heads are the identified persons responsible for Hygiene Standards in their own area. An organisational flow diagram specific to hygiene services would enhance the clarity of the Hygiene services structure within the organisation.

*Core Criterion

CM 5.2 (B ↓ C)

The organisation has a multi-disciplinary Hygiene Services Committee.

The recently established Hygiene Services Committee and Hygiene Services Team are multidisciplinary, have clear terms of reference, meeting schedules and administrative support as recommended by HIQA. While roles and responsibilities were documented and job descriptions were available, the hygiene assessment team would suggest an evaluation of the effectiveness of the multidisciplinary approach and would support the management's view that a Support Services Officer would greatly enhance the hygiene services outcome for the patients/clients.

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.

Documented processes were available with reference to national guidelines for specific areas of hygiene service requirements. While the corporate strategic plan was still in draft form, the organisation has a hygiene services operational plan and through established working relationships with cleaning services, can increase resources during outbreaks of infection. The dedicated isolation ward and specific cleaning team for areas where patients have infections, demonstrates the priority by management to hygiene services.

CM 6.2 (B ↓ C)

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

While the organisation has a medical equipment committee with representation from the hygiene services committee, the assessment team would encourage the organisation to develop a more integrated process for the purchase of equipment /products involving the Hygiene Services Committee. This would be in keeping with the quality improvement plan identified by the organisation in self assessment. This process should be evaluated.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

CM 7.1 (A ↓ C)

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

A recently established risk management process was evident within the organisation at the time of assessment, however the process was not utilised on the occasion of a medical device being used at ward level for wound management. The organisation rectified this situation by withdrawing this piece of equipment from use.

CM 7.2 (B → B)

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

The termination of an external contract due to breach of Health & Safety legislation was identified through the risk management process - evaluation of the issue led to a new contract being put in place with another provider.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion

CM 8.1 (B ↓ C)

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

While the organisation establishes contracts in line with EU legislating and Health Service Executive policies there was no documented process evident for contract and contractors' management and monitoring evident. With regard to Linen, a service agreement exists within their own operation and with external agencies, however no service contracts were identified for roller towels and floor mats. A contract was in place with the main cleaning contractor. A new contract for window cleaning is in place, as referred to in CM 7.2. A service level agreement was in place for purchased bottled water as the hospital was located in an area of high risk (Cryptosporidium incident.). A National waste contract is in operation. The Catering contract was viewed during the assessment. To improve compliance with standards, national contracts should be on hospital file.

PHYSICAL ENVIRONMENT, FACILITIES AND RESOURCES

CM 9.1 (B ↓ C)

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

The recently refurbished clinical delivery areas were evident of best practice and details of regulations and code were adhered to. The organisation needs to address the requirement to place splash-backs behind all clinical wash hand basins and revise the utilisation of storage facilities in use.

*Core Criterion

CM 9.2 (B ↓ C)

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

The Organisation had processes in place to manage its environment and facilities, equipment and devices, kitchens, waste and sharps and linen, and plans are in place to develop a central waste compound, however as discussed with the organisation, greater attention to written processes and best practice were needed in relation to waste management and linen; specifically the process of laundering curtains.

CM 9.4 (B → B)

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

The Organisation participated in the National Patient Survey conducted by the Irish Society of Quality and Safety in Healthcare 2004. Patients interviewed during the assessment spoke with very high regard of all members of staff they had encountered during their hospital admission. An active patient focus group was in existence prior to the development of the HIQA hygiene assessment scheme and evidence viewed indicated their involvement in the hygiene process.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.3 (B ↓ C)

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

Induction and staff training programmes are in place for all new staff. On-going education and training is provided as required and evaluated through auditing of knowledge of cleaning process.

*Core Criterion

CM 10.5 (B ↓ C)

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

There was evidence of the establishment of new posts relevant to Hygiene services as the result of a needs assessment. While the Hygiene Corporate strategic plan was not completed, a hygiene services operational plan was in place. The assessor team were in agreement with the Organisation that the human resource need of a hygiene services manager or co-ordinator would greatly enhance the outcome of hygiene services for the organisation.

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

Induction/orientation is provided for all new staff with input from all other relevant disciplines. Ongoing hygiene awareness training is in place for all staff. The content delivered over two days covers all key areas for hygiene services.

Manual attendance records were in place and staff Handbooks are provided.

CM 11.4 (B ↓ C)

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

The extension of appraisal and performance evaluation to all hygiene services staff will improve compliance with HIQA standards

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (B ↓ C)

An occupational health service is available to all staff

A broad range of occupational health services is available within the organisation. As documented in the organisation's self assessment review, the planned audit of the service provided should allow for evaluation for the appropriateness of the service for staff.

CM 12.2 (B → B)

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

Systems of reporting, investigating, monitoring and analysing data regarding to health incidents, accidents and claims are in place in Occupational Health, Health and Safety and Risk Management. The Occupational Health Department uses a number of indicators including a staff survey, Employee Well Being Hospital Steering Committee, absenteeism rates to monitor staff satisfaction and occupational health. Staff morale was observed to be very positive during the hygiene assessment.

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.

While the organisation had (as listed in the self assessment) many documents providing access to information, the system or process for managing the documentation needs improvement. Many documents and policies were not dated or reviewed. It would further enhance the documentation system if there were greater multi-disciplinary involvement. Evaluation of the data needs to be undertaken.

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.

The extensive list of evidence of compliance submitted in the self assessment accurately reflected the Organisation's culture and management's support in striving to attain high standards in all areas relating to hygiene services. The commitment to extensive structural changes, equipment purchasing and allocation of human resources was palpable during the hygiene assessment.

CM 14.2**(B → B)**

The organisation regularly evaluates the efficacy of its Hygiene Services quality improvement system, makes improvements as appropriate, benchmarks the results and communicates relevant findings internally and to applicable organisations.

The Organisation participated in the two national hygiene assessments and has a system for ongoing internal audits. In keeping with the HIQA recommended hygiene management structures it formulated the Corporate and Service delivery teams to address its hygiene services requirements. The identification by the organisation of key personnel and the employment of these posts holders are indications of the organizations commitment to quality improvement. The organisation identified the additional microbiology, senior infection control, waste and environment manager and risk advisors as necessary human resources to assist in the improved delivery of hygiene services. With the addition of these posts the assessment team evaluated that hygiene service performance indicators, increased evaluation and benchmarking can be achieved.

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.

Guidelines and policies as submitted in the self assessment were evident during the hygiene assessment. The documentation demonstrated the positive culture for providing hygiene services to a high standard. However, many policies and documents were due for renewal in keeping with best practice, for example, the management of waste and sharps. Greater involvement with the Policies and Procedures committee in developing and utilising a template for policy and procedures would be of benefit to the organisation. The hospital had identified the need for this and have commended addressing this.

SD 1.2 (B → B)

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

Many interventions have been introduced as documented in self assessment and through evaluation have been shown to be beneficial to patient care and hygiene services. However the process for introduction, assessment and evaluation requires further documented control.

PREVENTION AND HEALTH PROMOTION

SD 2.1 (B → B)

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

There was extensive evidence of health and hygiene promotion activities having been offered to the community. The involvement of the Infection Control and Waste Management in National University of Ireland, Galway student education and development of an information leaflet (Sharps management for self- users) was commendable. The Organisation had evidence to show that their patient focus group was in existence and active since 2002. The voice recording message was noted to be a good innovation but evaluation of its effectiveness should be undertaken. While hand gel and information posters were available in the entrance lobby of the hospital the assessment team felt more of a visual display to promote hand hygiene and use of gels would be beneficial as this area was restricted by space.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1 (B ↓ C)

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

There was evidence of multi disciplinary membership in the Organisation's Hygiene Services team and committee. While it was noted that significant efforts have been made in educating staff on hygiene related issues i.e. hand hygiene, waste management, a more multidisciplinary approach would enhance the outcome of the education and ensure further awareness of each others roles and responsibilities.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

SD 4.1 (A → A)

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

The organisation's physical environment and facilities were clean and portrayed a commitment by staff involved in cleaning. However, further attention to detail in the documented process of curtain cleaning needed attention and was highlighted to the organisation.

For further information see Appendix A

*Core Criterion

SD 4.2 (A → A)

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

There is an excellent standard of cleaning in relation to equipment, medical devices and cleaning devices. The checklist system in the ward areas would appear to be a very successful initiative. Splash-backs need to be put in place in order to assist with compliance with SARI guidelines.

For further information see Appendix A

*Core Criterion

SD 4.3 (A → A)

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

Excellent standard of cleaning was in evidence in relation to the cleaning equipment. Structural issues, for example hand hygiene facilities for cleaning equipment storage, need to be addressed within the organisation.

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.

Training was provided by the Waste and Environmental Manager. There is strong leadership from the Environmental and Waste Management Coordinator in relation to the management of waste. It is recommended that the hospital review the utilisation of space in the Sub Collection Stations and review the storage and handling practices of domestic waste to ensure they meet the requirements of the Packaging, and Storage Guidelines for Health Care Risk Waste, Department of Health Guidelines 2004.

For further information see Appendix A

*Core Criterion

SD 4.6 (B → B)

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

The redevelopment of the existing laundry will enhance an already good service. Laundry facilities in other areas of the organisation would benefit from linking with the Laundry Manager and members of the Hygiene Services Committee.

For further information see Appendix A

*Core Criterion

SD 4.7 (A ↓ 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.

Evidence of training on hand hygiene was viewed during the hygiene assessment. Adherence to hand hygiene and uniform hygiene amongst the staff appeared to be good. The organisation needs to improve structural facilities to comply with SARI guidelines.

For further information see Appendix A

SD 4.8 (B ↓ C)

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

The organisation had documented processes for risk minimization. While it was noted that the risk management structure was relatively new, the organisation had many commendable examples of utilizing risk management in a constructive manner as documented in self assessment and observed during the hygiene assessment.

Documented incidents were viewed and personal injuries such as a needle-stick injury suffered by a member of staff and discussed with an assessor highlighted good levels of satisfaction with the management of inoculation injury process.

It was suggested by the assessor team that risk incident forms should also be utilised to capture specific hygiene and infection control related incidents and other ongoing difficulties.

SD 4.9**(B ↓ C)****Patients/Clients and families are encouraged to participate in improving Hygiene Services and providing a hygienic environment.**

The Hospital visiting policy was in place and displayed in the front lobby of the hospital, however there was no documented evidence of the evaluation of its efficacy. The Patient Council is in existence and documentation on its activity was viewed. Patient Satisfaction Surveys have been undertaken as part of the national survey. Patient information leaflets were available and modifications to these leaflets had been made to those in use in the Isolation ward – laminated information cards are placed at each bedside with information pertinent to their reason for isolation care. Patients interviewed during the assessment stated their high levels of satisfaction with the service provided and commented positively on the cleaning service. While customer/client surveys were part of the national surveys local evaluation would allow for comparison to national statistics and provide an opportunity to address possible local issues and would therefore be recommended by the assessor team.

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.**

Patient/visitor leaflets were available. Use of generic isolation signs reduces the risk of privacy violation when patients/clients need isolation for infection control issues. Education provided to staff of all grades increased knowledge of infection and hygiene issues. Isolation facilities in a dedicated ward have improved the care and outcome for the patients. The patient focus group as evident through documentation is widely consulted on hygiene and patient care issues.

ASSESSING AND IMPROVING PERFORMANCE**SD 6.1****(B → B)****Patient/Clients, families and other external partners are involved by the Hygiene Services team when evaluating its service.**

The patient focus group is involved with the organisation. Evidence of new innovations as documented in the self assessment has been evaluated by patients/clients with positive results.

SD 6.2**(B → B)****The Hygiene Services team regularly monitors, evaluates and benchmarks the quality of its Hygiene Services and outcomes and uses this information to make improvements.**

Significant improvements have been achieved in hygiene services over the last 2 years. The organisation is to be commended for the extensive list of projects it has undertaken which have impacted positively on the hygiene service provided. As many of these initiatives were at the time of the assessment relatively recently, new full evaluation of their impact and resultant action will greatly assist the organisation in reaching the high standards.

SD 6.3

(B → B)

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

A hygiene services report was produced for 2006, by compiling reports from individual team members in consultation with the hygiene services committee.

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

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

Yes - Some high level surfaces need more attention ie cylinder on top of slop hopper in St Gerard's and St Nicholas ward, dry goods in main kitchen.

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

Yes - Not all signage laminated, extensive use of selotape was observed.

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

Yes - More attention to cleaning of waste bins in main kitchen is required.

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

(30) Fixtures: Fixtures (i.e. a piece of equipment or furniture which is fixed in position) should be clean. This includes all electrical fixtures e.g. all light fittings and pest control devices.

Yes - However, the light fixture in disabled toilet at main entrance was loose and the frame dusty.

(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 - The process surrounding the cleaning of curtains and blinds was vague. The hospital does not keep manual records of all curtains that are changed. A clear log should be maintained of all curtains, the area they were removed from, date, and other details.

Compliance Heading: 4. 1 .5 Sanitary Accommodation

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

Yes - There is good attention to daily recording of cleaning. However, poor attention to detail of cleaning in disabled toilet at main entrance was noted however during the hygiene assessment.

(47) Bathrooms / Washrooms are clean and communal items are stored e.g. talc or creams.

Yes - In general, the bathrooms and washrooms were clean and did not contain communal items.

(49) Cleaning materials are available for staff to clean the bath / shower between use.

Yes - Products were viewed during assessment.

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

(57) Clear method statements / policies should be in place for guidance on all cleaning including sanitary cleaning and maintenance processes.

Yes - Further attention to documentation of operational procedures required.

(58) Sluice rooms should be free from clutter and hand washing facilities should be available.

No - In sluice rooms the facilities for hand washing are inadequate and not in keeping with SARI guidelines.

(210) Consumables should be readily available and stored in a suitable environment, e.g. liquid soap, paper towels, toilet paper. Clean and well maintained dispensers should be available for consumables.

Yes - These are stored in an open press in a sluice room - best practice indicates closed cupboard is required. The organisation needs to implement a plan to address this situation.

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

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

Yes - The cleaning of weighing scales in St. Patrick's needed attention. All commodes checked during the assessment were of an excellent cleaning standard.

(66) Medical equipment e.g. intravenous infusion pumps, drip stands and pulse oximeters, suction apparatus and tubing, cardiac monitors, blood pressure cuffs, blood gas machines.

Yes - One of the blood gas machines in ICU was not adequately decontaminated after use. This issue was dealt with immediately by the senior Nurse Manager during the assessment.

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 - In general all trolleys in use as listed were clean however no cleaning records were in place for the cardiac arrest trolley. The organisation has discussed this issue with the Resuscitation training officer. The Checklist is to be amended to reflect this requirement.

(78) Personal food items, other than fruit, should only be brought in with the agreement and knowledge of the ward manager and should preferably be stored in an airtight container.

Yes - No personal food items were observed.

(272) Splashes of water or hand-wash gel should not be present on the wall, floor, bed or furniture, splash backs should be provided.

No - While splashes were not identified in any of the areas visited, many clinical wash hand basins, including intensive care units, had no splash backs. This issue has already been raised by the staff in intensive care. The plan to address this issue needs to be given greater attention.

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

(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 - In rooms where cleaning equipment was stored the facilities for hand washing were inadequate and not in keeping with SARI guidelines. There are plans in place to address this.

(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.

Yes - All equipment in use with this contract are in compliance.

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

(212) Irish Standard 340: 2006 Hygiene in Food Service (Draft) of the National Standards Authority of Ireland (NSAI) specifies guidance to compliance with the requirements of S.I. 369 of 2006 EC (Hygiene of Foodstuffs) Regulations and Regulation (EC) No. 852/2004 on Hygiene of Foodstuffs. This should be complied with.

Yes - Complies with the main requirements of IS 330, S/O/369 and EC No. 852/2004.

(216) Documented processes for manual washing-up should be in place.

Yes - While a documented process is required in the standard, this was non applicable in this organisation as no manual washing occurs.

Compliance Heading: 4. 4 .2 Facilities

(222) A wash hand basin should be provided at the ward kitchen, in addition to a sink, along with a liquid soap dispenser and hygienic hand drying (e.g. paper towels).

No - Access to wash hand basin was obstructed by cleaning equipment in St. Gerard's and St Nicholas' wards.

Compliance Heading: 4. 4 .3 Waste Management

(232) Waste storage containers shall be smooth, durable, easy to clean and disinfect, well maintained and closable.

Yes - Greater attention to cleaning of foot operated pedal bins is required.

Compliance Heading: 4. 4 .4 Pest Control

(235) A system of pest control developed by a competent person shall be in place.

Yes - A contract with a Pest Control contractor is in place.

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

(241) Ice cream display units can operate at -12°C as long as it can be demonstrated that the product has been held at this temperature for less than 7 days.

Yes - The practice of taking the temperature of the ice cream fridge in staff canteen was verbalised but not documented.

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 are in use.

(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.

No - Some of the dishwashers in the ward kitchens do not have a digital read out.

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

(138) Details of current legislation and codes of best practice adhered to in relation to all waste types.

Yes - In general, the disposal of Health Care risk waste and non risk waste is carried out in accordance with Guidelines issued by the DOHC. However, the practice of manually labelling Health Care Risk Waste should be reviewed to ensure it is in line with best practice guidelines.

(142) Healthcare risk waste should be tagged and secured before leaving the area of production.

No - There was no evidence of a procedure in place regarding the tagging of Health Care Risk Waste Containers prior to removal from the place of origin. The method used to tag and secure the health care risk waste is not in keeping with best practice.

(145) A record is kept of tags used for each ward/department for at least 12 months.

No - The method of tagging in operation in the hospital should be reviewed.

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

No - Safety Data Sheets in relation to Spill Kits were not viewed.

(152) When required by the local authority the organization must possess a discharge to drain license.

No - The Hospital currently does not hold a Waste Discharge Licence. However, they are in the process of applying for a Waste Discharge Licence and documentation to that effect was reviewed.

Compliance Heading: 4. 5 .3 Segregation

(156) Healthcare risk waste must be segregated from healthcare non risk waste.

Yes - In general, segregation was adequate. However, on one occasion, clinical waste bags were transported with domestic waste.

(159) Sharps boxes are correctly sealed, labelled and stored in a safe environment.

Yes - Greater attention needs to be paid to temporary closure mechanisms.

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

No - A local system is in place to deal with this as per self assessment. There is a policy in place and this should be reviewed to ensure it is in line with best practice.

Compliance Heading: 4. 5 .5 Storage

(257) Adequate segregation facilities for the safe storage of healthcare risk waste are locked and inaccessible to the public. Appropriate warning signs restricting public access should be prominently displayed.

No - While the hospital had sub collection stations for waste, the utilisation of this area was under review. Funding has been allocated which will assist the waste compound in complying with the Segregation, Packaging and Storage guidelines for Health Care Risk Waste, Department of Health Guidelines 2004.

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 - Staff training provided by the Environmental and Waste Manager was excellent. More input from Infection Control would benefit the training outcome.

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

(172) Documented processes for the management, maintenance and safe handling of linen and soft furnishings throughout the organisation.

No - Documented processes were not in place for all linen/laundry in use throughout the organisation.

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

No - Linen is not being segregated to implement The National Colour Coding System, as per the National Cleaning Manual.

(265) Linen skips and bags must be used when collecting linen and taking it to the designated area. Soiled linen must not be left on the floor or carried by staff.

Yes - Linen skips and bags were used appropriately.

(268) Ward based washing machines are used only with the agreement of the Hygiene Services Committee.

No - The minutes of the Hygiene Services Committee viewed during the assessment did not indicate service agreement through the Hygiene Services Committee.

(271) Hand washing facilities should be available in the laundry room.

Yes - No hand wash facility available in area used by catering.

(270) If a washing machine is in use, a tumble drier is also in place which is externally exhausted. Documented processes for planned preventative maintenance of this equipment should be in place.

Yes – However, the Tumble drier operated by an external contractor and should be externally exhausted.

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 - Clinical wash hand basins were not available in all areas for example, all dirty utility rooms. The plan to address this issue needs to be given greater attention.

(190) All sinks should be fitted with washable splash backs with all joints completely sealed.

No - Splash backs are not provided at all wash hand basins.

(194) Dispenser nozzles of liquid soap or alcohol based hand rubs must be visibly clean.

Yes - Some of the alcohol nozzles were found to be visibly dirty.

(197) Wall mounted/Pump dispenser hand cream is available for use.

No - These are not provided in all areas.

(205) General wards should have one sink per 4-6 beds and critical areas should have one sink per 1-3 beds.

No - The older ward areas are not compliant.

(206) Documented records of mandatory attendance at hand hygiene education and practice is required for all staff members involved in clinical areas. This may be undertaken during hospital induction programme followed by annual updates.

Yes - The Hand hygiene policy does not reflect the mandatory requirement for annual training in keeping with SARI guidelines.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team			Assessor Team
	FREQ	%	FREQ	%
A	11	19.64	7	12.50
B	45	80.36	31	55.36
C	0	00.00	18	32.14
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	B	B	→
CM 1.2	A	B	↓
CM 2.1	B	B	→
CM 3.1	B	C	↓
CM 4.1	B	B	→
CM 4.2	B	B	→
CM 4.3	B	B	→
CM 4.4	B	C	↓
CM 4.5	B	B	→
CM 5.1	B	C	↓
CM 5.2	B	C	↓
CM 6.1	B	B	→
CM 6.2	B	C	↓
CM 7.1	A	C	↓
CM 7.2	B	B	→
CM 8.1	B	C	↓
CM 8.2	B	B	→
CM 9.1	B	C	↓
CM 9.2	B	C	↓
CM 9.3	B	B	→
CM 9.4	B	B	→
CM 10.1	B	B	→
CM 10.2	B	B	→
CM 10.3	B	C	↓
CM 10.4	B	B	→
CM 10.5	B	C	↓
CM 11.1	A	A	→
CM 11.2	A	A	→
CM 11.3	B	B	→
CM 11.4	B	C	↓

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