Hygiene Services Assessment Scheme
Quality Improvement Plan

Our Lady of Lourdes Hospital Drogheda

April 2009

Hygiene Services Advisory Group Our Lady of Lourdes Hospital, Drogheda
Operational Services Manager,
Group General Manager
Director of Nursing and Midwifery Services.
Hospital Accreditation coordinator
Supplies Manager
Assistant Director of Nursing
Clinical Nurse Specialist Infection Prevention and Control
Group Human Resource Manager.
Group Finance Manager.
Hygiene coordinator

CRITERION NUMBER	HOSPITAL 2008 HYGIENE RATING	SIGNIFICANT RISK/ OPPORTUNITY FOR IMPROVEMENT IDENTIFIED	GOAL	PROGRESS MADE	RESPONSIILILTY (TITLE ONLY)	TIMEFRAME TO COMPLETION
CM 1.1	B	PLANNING AND DEVELOPING HYGIENE SERVICES **The organisation regularly assesses and updates the organisation's current and future needs for Hygiene Services.** ➢ The organisation demonstrated a hygiene services corporate strategic plan and service plan and there was evidence demonstrated of consultation and review of the strategy through minutes of the Hygiene Services Advisory Committee. ➢ Evidence that an independent review was undertaken to examine hygiene services was demonstrated and the findings of this report and infection control reports had been incorporated into the needs assessment process. ➢ The organisation also demonstrated that the Hygiene Services Advisory Committee had developed an audit tool to review the Strategic Plan however no evidence that its introduction was demonstrated.	A	_____ - The progress of the implementation of the Hygiene Corporate Strategic Plan will be reviewed using the audit tool by the Hygiene Services Advisory Committee. _____ - Governance structures including reporting relationships and reporting frequencies throughout the organisation are currently	_____ HSAC _____ Quality & Risk Committee EMB	_____ May '09 _____ Oct 2008 and ongoing

				being revised in line with the implementation of the HSE Integrated Quality, Safety & Risk Management Framework - Identify all the relevant information sources to inform our needs assessment for hygiene services. Example: - HIQA audit Report, Internal Audit hygiene programme, IPC control rates, patient and staff satisfaction surveys, complaints, incident reports, organisational development and capital project plans and health stat. reports. - New reporting template currently being developed and will be introduced to provide assurances from the HST to the HSAC and in turn to the SMT in a succinct and timely way in line with QSRM implementation & governance review. - Evaluate efficacy of new reporting arrangements 3 months post introduction	Operational Services Manager, Hygiene Co coordinator, and Accreditation coordination with HSAC HSAC & HST HSAC & HST	April 09 and ongoing May 09 and ongoing September 2009
CM 1.2	B	**There is evidence that the organisation's Hygiene Services are maintained, modified and**	A			

		developed to meet the health needs of the population served based on the information collected. ➢ The organisation demonstrated evidence of a "Deep Clean Team", a mobile team of five contractors, in place since June 2007. ➢ A schedule of planned works for this team was demonstrated with a formalised works programme. ➢ While the work of the deep clean team was signed off by the ward manager at local level no formal evaluation of the mobile team was demonstrated. ➢ The organisation also demonstrated a revised cleaning schedule in the Neonatal Intensive Care Unit following review of infection rates. ➢ A hygiene audit reward and recognition scheme had been developed however no evidence of its introduction was demonstrated.		_____ - Conduct formal evaluation of the mobile team - Consider reconfiguration of the deep clean team and towards the development of a Discharge Team concept in line with learning from the 'Peer Assist' Visit. _____ _____ - Review and further develop the Internal Hygiene Audit programme to increase the frequency of auditing to facilitate trend analysis and identification of wards/depts. with sustained improvements. - Introduce the reward and recognition scheme. _____	_____ Operational Services Dept. HST. _____ _____ HST/Hygiene Coordinator _____	_____ May - Dec 2009 _____ _____ April 09 and ongoing _____

CM 2.1	B	ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES **The organisation links and works in partnership with the Health Service Executive, various levels of Government and associated agencies, all staff, contract staff and patients/clients with regard to hygiene services.** ➢ The organisation demonstrated the development of a centralised list of linkages. ➢ Evidence was provided demonstrating that a number of staff members had linkages with regional and national groups including senior management, infection prevention and control, catering, quality/accreditation. ➢ A partnership process was also demonstrated to be in place. ➢ Evidence was provided to demonstrate that a patient satisfaction survey had been undertaken in 2007 however no action plan was demonstrated. ➢ There was no evaluation of the efficacy of the linkages and partnerships demonstrated.	A	See above CM 1.1 regarding identification information sources from relevant linkages and partnerships. - Endeavour to adopt learning from Peer Assist Visit namely; the structured agenda and meeting schedule which has 'Linkages' as a standing item. This provides a forum to discuss hospital	HSAC	April and ongoing 2009

				activities as discussed at other fora which have hygiene implications in the context of the hygiene scheme and standards of best practice i.e. Capital Projects, Environmental Monitoring, Infection Prevention and Control. _____ Evaluate the efficacy of linkages and partnerships. Monitor continuously as an agenda item and review at year end. _____ Patient satisfaction survey currently being conducted and 2009 action plan being developed. _____	_____ HSAC _____ HPH coordinator/ HST _____	_____ Monthly monitoring and Dec 2009 for overall review. _____ April 2009 _____
CM 3.1	B	CORPORATE PLANNING FOR HYGIENE SERVICES **The organisation has a clear corporate strategic planning process for Hygiene Services that contributes to improving the outcomes of the organisation.** ➢ Evidence was demonstrated of a strategic plan which had been signed off by the Hygiene Services Advisory Committee earlier in 2008. ➢ A full communication plan was demonstrated in	A			

		addition to local sign off sheets where staff acknowledged receiving the Strategic Plan. ➢ The organisation's goals and objectives were demonstrated to be clearly outlined within the Strategic Plan and the Hygiene Services Advisory Committee's terms of reference, provided as evidence, detailed the committee's responsibilities. ➢ Evidence that a draft audit tool had been developed to evaluate the effectiveness of the strategy was demonstrated however no evidence of its introduction was demonstrated.		Evaluate the progress of the implementation of the Corporate Hygiene Strategic plan in line with bi-annual review using the audit tool.	HSAC	May 2009
CM 4.1	B	GOVERNING AND MANAGING HYGIENE SERVICES **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 organisation demonstrated through its organisational chart that the Hospital Management Team had overall responsibility for hygiene services. ➢ The Strategic Plan had documented roles and responsibilities for the management team in relation to hygiene services.	B			

		➢ Evidence was demonstrated that the Hospital Management Team was represented on the Hygiene Services Advisory Committee and hygiene was a standing agenda item on management team meetings. ➢ The organisation demonstrated that a cleaning manual, adapted from the Irish Acute Hospitals Cleaning Manual had been developed and recently implemented. ➢ The organisation did not demonstrate any evaluation of the appropriateness of the Hygiene Services provisions.		- See CM 1.1 Revised governance structures and KPI's development and quarterly reporting - Evaluate the appropriateness of the hygiene services provision by ensuring that standards of best practice as outlined in corporate policies and procedures legislation and national guidelines are implemented. For example compliance with, Waste Guidelines, EHO Reports Health and Safety, HACCP regulations, Infection prevention and control outbreak management. - This needs to be included as key performance indicator and reported on regularly to provide the most senior accountable manager with assurance that policies and best practice guidelines are being implemented.	HSAC HST	Quarterly May 09 and ongoing

				_____	_____	_____
CM 4.2	B	**The Governing Body and/or its Executive Management Team regularly receive useful, timely and accurate evidence or best practice information.** ➢ The organisation demonstrated that the Hospital Management Team received information including complaints, infection rates and soap and gel usage on a quarterly basis. ➢ Evidence was provided to demonstrate that feedback from the Hygiene Services Team was brought to the Hygiene Services Advisory Committee and it also featured on the agenda of the regional Louth/Meath Hospital Group. ➢ Evidence that hygiene audits commenced in April 2008 was also demonstrated and the results of same were forwarded to the Hospital Management Team. ➢ No formal evaluation of the appropriateness of the information was demonstrated.	B	_____ See CM 4.1 _____	_____ See CM 4.1 _____	_____ See CM 4.1 _____
CM 4.3	B	**The Governing Body and/or its Executive Management Team access and use research and best practice information to improve management practices of the**	A	- Maintain all activities as outlined in 2008 report in relation to library facilities, newsletter etc. Hospital Hygiene Handbook needs to	HST subgroup	May 2009

		Hygiene Service. ➢ The organisation demonstrated that a library and Internet facilities were available to all staff members and that it had developed a guideline for the dissemination of best practice information. ➢ Evidence was provided demonstrating that best practice information was made available to staff through referenced policies, procedures and guidelines, weekly bulletins and a newsletter. ➢ A local hygiene manual based on the Irish Acute Hospitals Cleaning Manual was demonstrated. ➢ The organisation demonstrated it had also recently introduced a colour coding tagging system for equipment to distinguish whether it was clean, in need of repair or for disposal. This had been accompanied by a standard operating procedure which was also demonstrated. ➢ A number of "Road Show" days had been held for staff to advise them of hygiene related best practice information. ➢ No evaluation of the appropriateness of hygiene services related research and best practice information available to the organisation was demonstrated.		be evaluated at 6/12 after implementation. - Monthly report to Senior Management Team for approval and submission to the Executive Management Board regarding KPI's in line with key corporate functions. - Training needs assessment to identify gaps in knowledge skill and experience in support services to inform the provision of training and education therefore ensuring that research and best practice guides hygiene services delivery. - Further roll-out of attendance management policy and monitoring of absenteeism rates as KPI	HSAC Support Services Manager HR & HOD's	Initial report Sept 2009 and quarterly Oct- Dec 09 Ongoing
CM 4.4	B	**The organisation has a process for establishing and maintaining best practice policies, procedures and guidelines for Hygiene Services.** ➢ The organisation demonstrated it utilised the HSE North East Area template for developing policies, procedures and guidelines.	B			

		➢ The organisation also demonstrated it was in the early stages of developing a database of all policies, procedures and guidelines. ➢ Evidence was provided demonstrating that hygiene services standard operating procedures were adopted through the Hygiene Services Team. The introduction of the locally based cleaning manual was an example of this which was demonstrated through minutes of the Hygiene Services Team ➢ No formal evaluation of the efficacy of the process for developing and maintaining hygiene services policies, procedures and guidelines was demonstrated.		- Implement HSE new PPPG's template. - Use of multidisciplinary cross site PPPG's subgroup of Quality and Risk Committee to ensure that all PPPG's are established in line with HSE policy. - To evaluate effectiveness of new structures six months post commencement.	HSAC/HST with PPPG's subgroup.	June 2009 Dec 2009
CM 4.5	B	**The Hygiene Services Committee is involved in the organisation's capital development planning and implementation process.** ➢ Evidence was provided demonstrating that the Capital Development Planning Group included three members of the Hygiene Services Advisory Committee and five members from the Hygiene Services Team. ➢ Some evidence was demonstrated of capital	A	- Capital Developments is standing agenda item at HST level introduced in February 2009 - See CM 2.1 regarding linkages and partnerships discussed as standing agenda item, this will capture capital development activity with	HST HSAC	Feb 09 and ongoing April 09 and ongoing

		developments being discussed at both Hygiene Services teams, however it was not a standing agenda item nor was it included in the terms of reference.		implications for hygiene services. - Review terms of reference of HSAC to ensure focus of committee encapsulates information from all relevant fora discussing hygiene related issues. _____	HSAC _____	May 2009 _____
CM 5.1 *Core Criterion	A	ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES **There are clear roles, authorities, responsibilities and accountabilities throughout the structure of the Hygiene Services.** The organisation demonstrated compliance of greater than 85% with the requirements of this criterion.	Maintain 'A'	Maintain Standard		
CM 5.2 *Core Criterion	A	**The □organization has a multidisciplinary Hygiene Services Committee.** ➢ The □organization demonstrated compliance of greater than 85% with the requirements of this criterion.	Maintain 'A'	Maintain Standard		
CM 6.1 *Core Criterion	B	ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES **The Governing Body and/or its Executive/Management Team allocate resources for the Hygiene**	A	Maintain Standard		

		Service based on informed equitable decisions and in accordance with corporate and service plans. ➢ The organisation demonstrated that while there was no devolved hygiene budget the Service Plan detailed the hygiene funding requirements. ➢ Evidence was provided to demonstrate that each department submitted a priority list to the Hygiene Services Team who formalised an organisational priority list. This list was demonstrated to be forwarded to the Hygiene Services Advisory Committee. The organisation did not demonstrate a formal process for allocating the resources once in receipt of the organisational priority list. ➢ The organisation demonstrated that funding had been provided for Hygiene Services including addressing the safety issues with the main stairs and laundry chute following the 2007 National Hygiene Services Quality Review. ➢ It also demonstrated the replacement of mattresses following an audit of same which resulted from a		- Hygiene requirements priority list to be compiled by the Hygiene Services Team, for review and approval by the Hygiene Services Advisory Committee (follow 2008 process). - The allocation of resources for hygiene will be discussed and approved at Senior Management Team when appropriate. - Finance Department will explore possibility and feasibility of developing a specific hygiene budget for 2010	HST HSAC Finance Manager	May 2009 and ongoing January 2010

		reported incident.				
CM 6.2	C	**The Hygiene Committee is involved in the process of purchasing all equipment/products.** ➢ The organisation demonstrated a procurement policy; however this did not detail the involvement of the Hygiene Services Advisory Committee or Hygiene Services Team. ➢ There was no reference to procurement within either the committee or team's terms of reference which were provided as evidence. ➢ Evidence was provided demonstrating that the Materials Manager had introduced an assessment form for the purchase of all equipment which required the person requesting the equipment to discuss the item with the Infection Control and Hygiene Services Teams. ➢ No evaluation of the efficacy of the consultation process between the Hygiene Services Advisory Committee and senior management was demonstrated.		- Product Evaluation Group (PEG) to reconvene to include representative from the Hygiene Services to Team - To continue use of the multidisciplinary assessment form - To adopt the (SD 1.2) SOP for the evaluation of new hygiene interventions/products prior to changes to existing practice for use when considering procurement generally in the hospital - Linkages from the Hygiene Services Advisory Committee to the Senior Management Team is through membership. - development of KPI's to	Supplies Manager HST HSAC	May 2009 May 2009 and ongoing

				improve reporting of information - New reporting template currently being developed and will be introduced to provide assurances from the HST to the HSAC and in turn to the SMT in a succinct and timely way in line with QSRM implementation & governance review. - Evaluate efficacy of new reporting arrangements 3 months post introduction	Hygiene Services Co-ordinator	September 2009
CM 7.1 *Core Criterion	D	MANAGING RISK IN HYGIENE SERVICES **The organisation has a structure and related processes to identify, analyse, prioritise and eliminate or minimise risk related to the Hygiene Service.** ➢ The organisation demonstrated a regional risk management structure and related process in place for managing risk. ➢ A risk management policy was demonstrated that was currently under review. ➢ Evidence was provided to demonstrate incident	B	Remedial action was undertaken to address the risk identified. A Risk log was developed to manage and monitor the water quality system and ongoing problems which includes:- • A significant infrastructural programme to replace calorifiers. • Significant ongoing critical controls based on HACCP principle ie	OSM GGM with Water Quality Committee	Oct 2008 June 2009 Ongoing

		reporting forms and risk assessments. ➢ Evidence that risk assessment training had taken place for Clinical Nurse Manager 2's was demonstrated. ➢ The organisation did not demonstrate through documentation or interview that a full assessment of the risks to patients, associated with the contamination of the water supply with Legionella species, had been completed. There was no evidence provided to demonstrate that a documented process was in place to monitor and manage Legionella species levels within the water supply throughout the organisation. ➢ Therefore a significant risk was identified.		regular flushing of little used outlet. • Planned preventative maintenance programme. • Chemical sanitisation • Staff education session. • Public information leaflet .		Ongoing Ongoing Jan 09 April 2009
CM 7.2	C	**The organisation's Hygiene Services risk management practices are actively supported by the Governing Body and/or its Executive Management Team.** ➢ The organisation demonstrated risk management resources including a Risk Advisor and deputy based on-site and a regionally based Health and Safety Officer. ➢ The organisation demonstrated a forum for Adverse Incident Review, which was chaired by the Hospital Manager, however there was no Risk Management Committee. ➢ The organisation demonstrated it was in the process of assessing itself against the HSE Quality and Safety Framework. ➢ Evidence was provided demonstrating that following a reported incident an audit was undertaken of mattresses which established that the integrity of mattresses being used within the organisation were of a poor quality. Evidence was provided to demonstrate that a large number of the	B	- Executive Management Board has been established. - The Quality and Risk Committee established. - Implementation of HSE integrated quality safety and risk management framework commenced in Jan 09. - Governance structures currently being revised. - Committees being re-aligned. - QSRM framework self assessment - Risk Register Development	Network Manager with GGM Quality and Risk Committee Quality and Risk Committee LM Quality and Risk committee Q&R Committee & Speciality Governance Groups & Departments	20th Jan 09 17th Feb 09 Ongoing Jan 09 and ongoing Jan – April 2009

		mattresses were replaced.				April – Dec 2009
CM 8.1 *Core Criterion	D	CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES **The organisation has a process for establishing contracts, managing and monitoring contractors, their professional liability and their quality improvement processes in the areas of Hygiene Services.** ➢ The organisation demonstrated that a number of hygiene services contractors were operating on site including waste, laundry, cleaning and sanitary bins. ➢ The organisation reported that the majority of these contracts had been established regionally and that the contracts were held in the regional office. ➢ The organisation advised that the Support Services Department monitored these contracts, however no documentation was demonstrated. ➢ The organisation advised that it had recently introduced a team of contract cleaners. A contract was not demonstrated, however a service level agreement was provided as evidence. There was no evidence within the document specifying the duration, liabilities, conflict resolution or specifications of the contract.	B	- Regular meetings between Operational Services Manager and the Cleaning Contract Operations Manager have been established and minutes recorded. - Currently developing KPI's to ensure effective service provision from contractor cleaners which will include 'Value for Money', Audit and Response Times. - Daily meeting between Acting Support Services Manager and Contract Cleaners Supervisor regarding the allocation and management of contract staff on site. - Comprehensive contract for contract cleaners in place since Nov. 2008. - Comprehensive file in Support Services Department which provides insurance details of contract cleaning	OSM/ Contractors OSM Contract Supervisor and A/ Support Services Manager. Operational Services Department OSM and Contractors	Nov 2008 June 09 Ongoing Ongoing Nov 08

		➢ Therefore a risk was identified.		company, contract staff details such as training, vaccinations etc - Currently developing a planned weekly schedule which will be reviewed on a daily basis and amended in terms of staffing deficits, volume and work capacity to ensure priority needs of the organisation are met.	Acting Support Services Manager	April 09 and ongoing
CM 8.2	B	**The organisation involves contracted services in its quality improvement activities.** ➢ The organisation demonstrated that the cleaning contractor's supervisor was a member of the Hygiene Services Team and evidence was also demonstrated of this supervisor's involvement in meetings in relation to the requirements for deep cleaning. ➢ Evidence was also demonstrated of the supervisor's involvement in developing a standard operating procedure for cleaning computer keyboards. ➢ The organisation advised that the cleaning contractors were also working with them on the development of a software programme to assist with the environmental audits however there was no evidence demonstrated. ➢ Meetings with other contractors were reported to	A	- Service Trac© audit programme in place - Plan to monitor audit programme and results - Draft a formal documented process for meeting with	Contractor Supervisor/ HST HST OSM	March and ongoing April and ongoing June 2009

		be on a much more informal basis with no evidence demonstrated.		hygiene service contactors within the remit of OLOL (as distinct from contracts managed from regional perspective...)		
CM 9.1	D	PHYSICAL ENVORNMENT, FACILITIES AND RESOURCES **The design and layout of the organisation's current physical environment is safe, meets all regulations and is in line with best practice.** ➢ The organisation demonstrated that the risks identified in the 2007 National Hygiene Services Quality Review had been resolved. ➢ A number of projects were underway including the installation of fire doors on the east side of the building and an Aspergillus's risk assessment by the Infection Control Team was demonstrated. There was no local Aspergillus's policy, however the organisation demonstrated that it was working to national guidelines. ➢ A number of kitchens and sluice rooms had been upgraded. ➢ The Emergency Department project was scheduled for completion in March 2009. However, patient breakfasts and tea and toast were observed being prepared in a staffroom in the current Emergency Department, with patient food and staff food being refrigerated in the same fridge. This did not comply with best practice standards.	B	_____ - Local aspergillus policy drafted based on SARI guidelines and for approval in April 2009 _____ - Segregation of patient food from the staff area in the Emergency Dept. in line with standards of best practice i.e. HACCP regulations.	_____ Infection Control Committee _____ Operational Services	_____ April 2009 _____ Dec 2008

		➢ The organisation demonstrated that a bathroom facility for patients had been decommissioned due to the level of Legionella species detected in a water sample, however the assessors observed this bathroom to be still in use. ➢ Therefore a significant risk was identified		- Comprehensive water quality programme in place. - SOP regarding the management of decommissioned outlets and the management of legionella. Staff education sessions and also see above CM 7.1.	OSM and Water Quality Committee	Ongoing
CM 9.2 *Core Criterion	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 provided evidence of a linen and sharps policy and a waste guideline. ➢ A wash hand basin replacement system was demonstrated. ➢ Evidence was provided demonstrating that infection control policies, procedures and guidelines were signed off by Regional Strategy for the control of Antimicrobial Resistance in Ireland group, however the organization did not demonstrate a policy for the management of Legionella species in the water system.	B	Site specific policy for the management of Legionella currently drafted and for approval Staff education planned regarding the policy for June 09.	Water Quality Committee Water Quality Committee	May 09 June 09

CM 9.3	C	**There is evidence that the management of the organisation's environment and facilities, equipment and devices, kitchens, waste and sharps and linen is effective and efficient.** ➢ The organisation demonstrated that a number of environmental audits took place in April 2008. ➢ Evidence was also provided demonstrating that the Infection Control Department had undertaken an audit of sharps, isolation signage and hand hygiene. Results were reported back to departments and the Infection Control Committee however limited action plans were demonstrated.	B	- Review of existing Internal Hygiene Audit programme to include new Service Trac© programme. Corrective action planning is an integral part of all hygiene audits. Feedback mechanism to be revised to ensure that action plans are implemented.	Hygiene Services Team and the Hygiene Services Co-ordinator	March 2009 and ongoing
CM 9.4	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 demonstrated that it utilised the national complaints policy and had a system for gathering information through "Your Service, Your Say". ➢ The organisation advised that verbal complaints are logged in local diaries or communication books however this was not demonstrated. ➢ Correlation or trending of complaints was not		- A range of Heads of Departments and Line Managers have attended training on 'Your Service	Heads of Department	April 2009

		demonstrated.		Your Say' and complaints management. - Introduction of log book for recording and managing hygiene related complaints at ward level. - Hygiene complaints log will be correlated by Infection Prevention and Control Department and submitted to the Patient Liaison Department for reporting.	Ward Managers/ Heads of Department and Infection Prevention and Control Department	March 2009
CM 10.1	B	SELECTION AND RECRUITMENT OF HYGIENE STAFF **The organisation has a comprehensive process for selecting and recruiting human resources for Hygiene Services in accordance with best practice, current legislation and governmental guidelines.** ➢ The organisation demonstrated that the recruitment and selection of staff was based on national guidelines.	B	- This process will be further developed as recruitment is transferred to the Shared Services Centre (SSC) in Manorhamilton - Job Descriptions are currently being reviewed and updated	Group Human Resource Manager Group Human Resource Manager	June 2009 June 2009

		➢ Job descriptions demonstrated detailed the required qualifications however they were not all dated. ➢ There was no evidence demonstrated that the Human Resources Department evaluated the process for selecting and recruiting human resources.		- All recruitment is in compliance with the Public Appointments Service (PAS) Strict standards are adhered to and benchmarking processes are in place. - The PAS continuously evaluate interview boards and practices - Monthly data is produced regarding starters and leavers and percentage turnovers of staff	Group Human Resource Manager	May 2009
CM 10.2	C	**Human resources are assigned by the organisation based on changes in work capacity and volume, in accordance with accepted standards and legal requirements for Hygiene Services.** ➢ The organisation demonstrated that it worked to the Commission for Public Service Appointments guidelines and had been involved in a national audit. ➢ Evidence was provided demonstrating that a consultant microbiologist took up post in September 2008.		See CM 10.1 _____ - Louth/Meath Hospital Group are leading nationally in terms of reconfiguration and redeployment of staff in line with work capacity, activity and volume within the transformation programme. The hygiene agenda is a core component for this. - Currently developing a planned weekly schedule	See CM 10.1 _____ Group HR Manager Support Services	See CM 10.1 _____ Ongoing

		➢ There was limited formalised assessment of work capacity and volume demonstrated. ➢ Segregation of household and food workers in the ward kitchens was not demonstrated to be fully operational.		which will be reviewed on a daily basis and amended in terms of staffing deficits, volume and work capacity to ensure priority needs of the organisation are met. - Internal review of staffing levels in hygiene services with a view to reconfiguration and redeployment of staff to address service deficits.	Manager Support Services Manager Senior Management Team	May 2009 May 2009
CM 10.3	B	**The organisation ensures that all Hygiene Services staff, including contract staff, have the relevant and appropriate qualifications and training.** ➢ Human Resources recruitment processes were demonstrated to ensure that staff members had the appropriate qualifications. ➢ The organisation demonstrated on-going training of catering staff and healthcare assistants. ➢ Evidence was provided that the Infection Control Department provided training on hand hygiene and waste management for all staff members. ➢ Ten staff members were demonstrated to have completed the British Institute of Cleaning Sciences training programme. ➢ There was no evaluation of the ongoing training needs of hygiene staff members demonstrated.	B	- Training needs assessment to identify gaps in knowledge skill and experience in Support Services to inform the provision of training and education therefore ensuring that research and best practice guides hygiene services delivery.	Support Services Manager	Sept 2009

CM 10.4	C	**There is evidence that the contractors manage contract staff effectively.** ➢ Evidence was provided to demonstrate that the contract cleaning supervisor was on site, was a member of the Hygiene Services Team and was involved in the last internal audit in April 2008. ➢ While it was advised that the contract cleaning supervisor reported to the Operations Manager there was no contract to demonstrate this process. ➢ There were no documented processes for the management of contract staff demonstrated.	A	See CM 8.1	See CM 8.1	See CM 8.1
CM 10.5 *Core Criterion	C	**There is evidence that the identified human resource needs for Hygiene Services are met in accordance with Hygiene Corporate and Service plans.** ➢ The organisation reported that the identified human resources needs for hygiene services were completed through the service planning process, however there was limited evidence of a formal human resources needs assessment process in the last three years. ➢ Evidence was provided to demonstrate that the organisation had identified the need to augment the current level of portering staff to collect waste. Due to the HSE employment ceiling the organisation advised that it was not possible to employ another resource, so agreement had been reached that support services staff would cover annual leave. This was demonstrated through	B	- Internal review of staffing levels in hygiene services with a view to reconfiguration and redeployment of staff to address service deficits	Group HR Manager with Senior Management Team	May 2009

		minutes of the Hygiene Services Advisory Group meetings.				
CM 11.1 *Core Criterion	B	ENHANCING STAFF PERFORMANCE **There is a designated orientation/induction programme for all staff which includes education regarding hygiene.** ➢ Evidence was demonstrated of the induction programme for hygiene staff however it was reported that due to low levels of recruitment the programme had not been delivered in the last 12 months. No evidence was demonstrated to support this. ➢ The organisation demonstrated that all new members of staff received local induction and there was a buddying system in place for new support services staff. ➢ Evidence was provided to demonstrate that mandatory training included manual handling, infection control, waste management, sharps and fire training. ➢ The organisation also demonstrated that it utilised the HSE employee handbook however there was minimal information within the handbook regarding hygiene. ➢ There was no evidence of attendance levels at induction/orientation demonstrated.	A	- Develop monthly hospital wide induction programme for all new employees supported by role specific training at departmental - Attendance records to be maintained at induction - Hospital induction programme to include an information sheet on hygiene specific matters - Recommendation to the HSE Corporate to include hygiene related matters in the handbook i.e. mandatory training, hand washing, sharps management, waste management, linen environmental and equipment.	Corporate Learning & Induction Group HR & GGM HST HSAC	Sept 2009 June 2009 May 2009

				- Ensure hygiene is inherent in all training programmes	Corporate Learning & Induction	May 2009
CM 11.2	B	**Ongoing education, training and continuous professional development is implemented by the organisation for the Hygiene Services team in accordance with its Human Resource plan.** ➢ The organisation demonstrated that continuing education and training was provided for all staff in accordance with the HSE Dublin North East Human Resources plan and the regional prospectus book. ➢ Evidence was provided demonstrating that application for study leave was through a study leave form which was available to all staff members. ➢ Evidence was also provided that hygiene staff members participated in the SKILLS programme and British Institute of Cleaning Science training. ➢ The organisation provided evidence to demonstrate that 18 staff members had been trained as auditors and evidence was also provided of risk assessment training. ➢ The organisation demonstrated staff education facilities including a library, classrooms and Internet. ➢ There was limited evidence of evaluation of the relevance of training to staff members.	B	_____ - Further develop use of the SAP module for training and education to facilitate training needs and staff attendance analysis. - Training needs will be	_____ Group HR Manager Corporate Learning & Development Senior Management Team	_____ Oct/Nov 2009

				included in the internal review of hygiene services staff.		May 2009
CM 11.3	C	**There is evidence that education and training regarding Hygiene Services is effective.** ➢ The organisation demonstrated a draft suite of performance indicators in relation to education and training. ➢ Evidence was provided demonstrating that attendees at training were requested to complete evaluation forms, however the organisation did not demonstrate any formal evaluation of education or training or of attendance levels.	B	See CM 11.2 - Develop evaluation process following implementation of training programme	See CM 11.2 Group Human Resources Manager	See CM 11.2 Sept 2009
CM 11.4	C	**Performance of all Hygiene Services staff, including contract/agency staff is evaluated and documented by the organisation or their employer.** ➢ While the organisation provided evidence of a competency based tool which had recently been developed for Healthcare Assistants, the organisation did not demonstrate a formal performance monitoring process for all hygiene service staff. ➢ The "Deep Cleaning" carried out by the five contract staff members was demonstrated to be evaluated at the end of each deep clean process by the Department Manager.	B	- Further review of Internal Hygiene Audit programme including Service Trac© to monitor performance of hygiene services staff.	HST / Contract Supervisor	April 2009

CM 12.1	B	PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF **An occupational health service is available to all staff.** ➢ The organisation demonstrated a regional Occupational Health Department that was on-site three days a week. ➢ Evidence was provided to demonstrate that the services available were detailed in the regional handbook and were also notified to staff via email, posters and the hospital tannoy system. ➢ The organisation also demonstrated that Hepatitis B and influenza vaccines were provided for staff as part of the service. ➢ Evidence was provided of the Occupational Health Department participating in a review of Occupational Health Services in the HSE Dublin North East; however the organisation did not demonstrate an action plan from the findings.	B	The Occupational Health service is in fact available five days a week with on site support for three days. Confidential and general consultation is available off site on all other clinic sites to the employee's convenience, and at request for five days of the week. _____ The Occupational Health Department participated in a review of the service in 2008. As a result of the review and recommendations, a number of actions are underway, some are complete and some ongoing. ➢ **High Level Actions;** Discussion and planning HR/OH regarding development of OH services within the region. ➢ **Internal OH**	OHD HR/OH OHD	Complete Ongoing Every 2 months

				Actions: Development of governance standards, reviewed 2/12 **An Annual Report was completed for 2008 and included an Occupational Health action plan for 2009**. The Annual Report was disseminated to all linked areas. As part of the action plan a number of key areas were identified, including. Blood Exposure Management, and Counselling Service. Please see below in relation to actions proposed fro these two areas. 1. Aim: Improvement in Blood Exposure Management. ➢ Review of training materials, regular 6/12 training on site. ➢ Update, reprint and circulation of injury flow chart. ➢ Evidence base review of PEP treatment for HIV.	OHD	Ongoing Complete May 2009 Sept 2009 Ongoing August 2009

				. ➢ Develop updated OBE Policy. ➢ New one page injury report. ➢ Develop Source Patient pack ➢ Associated Pilot & training. The user group will meet again in Sept 2009 to review the efficacy of the measures implemented. 2. Aim: to ensure equitable access to a Counselling Service for all employees. Actions ➢ Staff Care Phone Number printed on all pay slips, Jan 09 ➢ Review 6/12, with report from Contractor, reasons for referral and rates. The contract will be reviewed in August with regard to equitable provision and use		
CM 12.2	B	**Hygiene Services staff satisfaction, occupational health and well-being is monitored by the organisation on an ongoing basis.**	B			

		• The organisations demonstrated performance indicators relating to staff wellbeing included absenteeism and occupational blood exposures. • No staff satisfaction survey was demonstrated. • Evidence of the development of an attendance management policy was demonstrated and return to work interviews had been implemented. • The organisation also demonstrated a partnership committee. ➢ An evaluation of the Occupational Health regional service was demonstrated however no recommendations or action plans were provided as evidence.		Two Staff Satisfaction Surveys were conducted in 2008 in relation to the OHD. The surveys were reviewed and action plans identified in relation to the feedback. Please see below actions complete and ongoing **Staff Satisfaction Survey.** **'Management Referral'.** **Actions.** *Complete* ➢ Increased Clinic Availability: ➢ Inclusion of Map, and OH Leaflet: First appointment. ➢ Client Charter and development of complaints procedure, Displayed in all areas. ➢ Call divert from external sites to ensure prompt access. ➢ Triage of all referrals to ensure most appropriate professional appointment.	OHD	Ongoing

				➢ Copy of letter to Manager available to client. The Client Satisfaction Survey will be repeated **Review of the Occupational Health Service, and Client Satisfaction Survey, Included in review**: **Customer Satisfaction** ➢ Update Dublin North East Occupation Health website to National HSE site. *Complete* ➢ Increased Clinic Availability ➢ Inclusion of Map, and OH Leaflet with first appointments. ➢ Client Charter. Development of complaints procedure, Displayed in all areas. **In relation to the Organisational Review of the OH Service please see Section 12.1**	OHD OHD OHD	August 2009 September 2009 Attendance Review September 2009

CM 13.1	B	COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES **The organisation has a process for collecting and providing access to quality Hygiene Services data and information that meets all legal and best practice requirements.** ➢ The organisation demonstrated that it gathered information through incident reporting, complaints, infection control rates, the limited number of audits undertaken in April 2008 and financial reports. ➢ The organisation also demonstrated a draft suite of hygiene related key performance indicators (KPI). ➢ Evidence was provided demonstrating that hygiene related information is shared with staff members via newsletters and bulletins. ➢ There was no evidence demonstrated of collating all of this information or evaluating its appropriateness, reliability, accuracy or validity.	A	- Hygiene KPI's to be approved regionally to facilitate benchmarking - Reporting structure and template agreed at Quality & Risk Committee to facilitate timely reporting of hygiene services performance against agreed KPI's. Evaluate new reporting processes	Hospital Accreditation Co-ordinators /Hygiene Services Co-ordinator HSAC with Quality & Risk Committee	April 2009 May 09
CM 13.2	B	**Data and information are reported by the organisation in a way that is timely, accurate, easily interpreted and based on the**	A			

		needs of the Hygiene Services. ➢ There was evidence provided, through minutes of meeting, to demonstrate that information was considered at the Hygiene Services Advisory Group. ➢ The organisation demonstrated that the group had identified that the results of the audit schedule in April 2008 were not timely and a new audit tool was being developed to improve the timeliness of results. ➢ With the appointment of the new Consultant Microbiologist, they also demonstrated that surveillance reports were also under review.		- Review Internal Audit programme in context of learning from 'Peer Assist Visit'. 'Action Plan' results in a timely manner. - Service Trac© audit process introduced March 09. - Review monthly analysis of results, and trends by Hygiene Committee. - Introduce "Spot Audits" process by members of HSAC/HST. Benchmark results of department's hospital wide. - Improved new surveillance of EARRS. New C. Diff surveillance Forms. - Surveillance of MRSA, VRE. Norovirus, ESBL's, salmonella.(alert organisms). - Outbreaks reported Weekly. - Education on legionnella. Aspergillus guidelines in	HST/ Hygiene Services Co-ordinator Support Services with Cleaning Contractors HST HST/HSAG/ Auditors ICN's Microbiologist, Infection control team.	May 2009 March 2009 May 2009 May 2009 1/52 Oct 08 and ongoing.

				draft format.		
CM 13.3	C	**The organisation evaluates the utilisation of data collection and information reporting by the Hygiene Services team.** ➢ The organisation demonstrated a draft audit tool to evaluate the effectiveness of the Corporate Hygiene Strategy and another tool was being developed for the internal audits however there was no evidence of either tools having been introduced demonstrated. ➢ There was no evidence provided to demonstrate that the organisation evaluated the appropriateness of the data and information utilisation in relation to service provision and improvement.	B	- As per CM 13.1 and 13.2 in relation to Audit processes. _____ - Consider introduction of a structured agenda specifically 'trended reports' to identify trends in the organisation - Evaluate effectiveness of this approach and appropriateness of information received _____	_____ HSAC & HST _____	_____ June 2009 _____
CM 14.1	B	ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES **The Governing Body and/or its Executive Management Team foster and support a quality improvement culture throughout the organisation in relation to Hygiene Services.**	A	- Regional Benchmark on HIQA 2008 results and targets set. Further developing as follows :- - Hygiene Audit programme to include corporate participation in unannounced internal audits. - Education sessions provided	Hospital Accreditation Co-ordinators HST & HSAC	December 2008 May 2009

		➢ The organisation demonstrated ongoing quality initiatives through their quality improvement plan, communication plan and hygiene awareness days. ➢ Evidence was also provided to demonstrate that these initiatives were linked to the region through the Hygiene Services Co-coordinator ➢ Evidence was provided demonstrating that members of the Hospital Management Team were members of the Hygiene Advisory Committee and were reported to carry out walkabouts though this was not demonstrated.		to each site by Group General Manager regarding 2008 Hygiene Results and Targets for 2009 - Introduce Reward & Recognition scheme. - Hygiene Communication plan to be evaluated and revised to ensure hygiene information permeates the organization.	Group General Manager HSAC HST	April 2009 June 2009 May 2009
CM 14.2	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.** ➢ Evidence was provided to demonstrate that evaluation of the efficacy of the organisation's Hygiene Services quality improvement system was completed via a self assessment against hygiene standards and the quality improvement plan. ➢ The organisation demonstrated that newsletters and bulletins were circulated internally to staff conveying hygiene related information and evidence of a range of information sessions for staff members regarding hygiene related issues was	A	- Review Internal Audit programme in context of 'Peer Assist Visit'. 'Action Plan' results in a timely manner. - 'Service Trac© audit process introduced March 09. - Review monthly analysis of results, and trends by Hygiene Committee. - Introduce "Spot Audits" process by members of HSAC/HST. Benchmark results of department's hospital wide. - Regional Benchmark on HIQA 2008 results and	HST/ Hygiene Services Co-ordinator Support Services with Cleaning Contractors HST HST/HSAG/ Auditors Hospital	May 2009 March 2009 May 2009 May 2009 December 2008

		demonstrated. ➢ A draft suite of KPI was also demonstrated. ➢ A limited number of audits were demonstrated to have been completed in April 2008 with resultant action plans however there was no evidence of benchmarking demonstrated.		targets set.	Accreditation Co-ordinators	
SD 1.1	B	EVIDENCE-BASED BEST PRACTICE AND NEW INTERVENTIONS IN HYGIENE SERVICES **Best Practice guidelines are established, adopted, maintained and evaluated, by the team.** The organisation demonstrated it had developed a local cleaning manual based on the Irish Acute Hospitals Cleaning Manual and this was demonstrated to have been approved by the Hygiene Services Team and Advisory Group and were available in all areas. Evidence was provided that colour coding processes were in place for cleaning, linen and waste. The organisation demonstrated that infection control polices, procedures and guidelines were developed by the regional Strategy for the control of Antimicrobial Resistance in Ireland group. Hygiene awareness days, newsletters and bulletins were demonstrated to inform staff members of changes in practice. No evaluation of the efficacy of the processes used to develop best practice guidelines by the Hygiene Services Team was demonstrated	A	- See CM 4.4 Regarding HSE PPPG template and procedure for development of PPPG.s - Introduction of Service Trac© Continuous evaluation of same during 2009 (subgroup) - Continue Hygiene education programme for 2009. HODS of dept meetings. - Evaluate Cleaning Manual /SOP. (subgroup) - Endeavour roll out - flat mopping commencing May 2009. (Subgroup) - Surveys for newsletter and evaluation of efficacy of	HSAC Hygiene Services Team (HST) A/DON &ICN HST HST HST	See CM 4.4. March 2009 Schedule agreed 1st Meeting took place 31st March 09 May 2009 Full implementation by May '09 and complete audit 6/12 June 2009

				newsletter. (subgroup) _____ - Comprehensive water quality programme 2009 guidelines. Water quality PPPG's developed and introduced, together with regular surveillance. _____ - Introduction of alcohol theatre scrub. _____ - Endeavour to re-configure the Deep Clean programme in the context of Peer Assist visit. _____ - Aspergillus guidelines OLOL Hospital. _____ - Automated dispenser for detergents. Pilot scheme in operation called the Command System _____ - Internal Hygiene Audit Programme to verify that standards of best practice are being adhered to.	_____ Water Quality Committee Operational Services Mgr. _____ ICN's _____ HST _____ ICN's & Microbiologists _____ Support Services _____ Hygiene Services Coordinator	_____ March '09 _____ April 2009 _____ May 2009 _____ May 2009 _____ June 2009 _____ May 2009
SD 1.2	A	**There is a process for assessing new Hygiene Services**	Maintain A	Maintain current standard		

		interventions and changes to existing ones before their routine use in line with national policies. The organisation demonstrated compliance of greater than 85% with the requirements of this criterion.				
SD 2.1	A	PREVENTION AND HEALTH PROMOTION **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 organisation demonstrated compliance of greater than 85% with the requirements of this criterion.	Maintain A	Maintain current standard		

SD 3.1	A	INTEGRATING AND COORDINATING HYGIENE SERVICES **The Hygiene Service is provided by a multidisciplinary team in cooperation with providers from other teams, programmes and organisations.** The organisation demonstrated compliance of greater than 85% with the requirements of this criterion.	Maintain A	Maintain current standard.		
SD 4.1 *Core Criterion	C	IMPLEMENTING HYGIENE SERVICES **The team ensures the organisation's physical environment and facilities are clean.** Some areas of the hospital visited were found to be clean however there was evidence of dust in many areas visited, especially in the Emergency Department where trolleys had high levels of dust and the seating in the waiting area required attention. • The assessors observed limited evidence of cleaning schedules or monitoring. • A number of sluice rooms visited were observed to be cluttered. • Documentation was not available to ensure all outlets were flushed in accordance with current legislation.	B	- Endeavour to re-structured HST agenda to report on implementation of outstanding actions a per 2007 Hygiene Report within available resources. - Review Cleaning Schedules - Introduce scheduled 'Deep Clean' Emergency Dept - Assess dirty utility in context of Storage. - Consider introduction of "Command System" for	HST/HSAC Heads of Services Support Services Support Services Support Services HOD's CNM's / Support Services/ Contract	May 2009 Nov 08 April 09 June 09 May 09

				management of cleaning products. Pilot project currently ongoing. _____ - Introduce regular "Spot Audit" Programme in the context of' Peer Assist Visit. _____ - Agree Business plan for delivery of hygiene services for new ED _____ - Review management of Water Quality throughout the hospital. - Implement PPPG's / Robust monitoring system and staff education programme.in accordance with current legislation	Supervisor _____ HST/HSAC _____ OSM _____ Water Quality Committee HST OSM	_____ Feb 09 _____ June 09 _____ May' 09 Nov- June 2009
SD 4.2 *Core Criterion	B	**The team ensures the organisation's equipment, medical devices and cleaning devices are managed and clean.** The management of cleaning devices was not formalised. Unused medical devices were observed to be stored in open areas and in a number of cases they were not clean.	A	- Address all outstanding action plans from 2007 HIQA Report within available resources. _____ - SOP to be established which must include Manufactures instructions to be available for all products. _____ Identify responsibility for cleaning.	HST/ HSAC _____ HST _____ Sub group established to monitor	Ongoing _____ June _____ April 2009

		A new colour coding system had recently been introduced for medical devices indicating whether they had been cleaned, required repair or disposal however this process was not being complied with in all areas visited		_____ - Use of colour coded labels to be evaluated. Audit tool to evaluate effectiveness of 'colour coding system 'to be developed and introduced to ensure all medical devices are cleaned between patient use. _____ - Internal audit program to be progressed with timely feedback. _____ - Review storage of equipment in all areas. - Additional storage space as per SARI building guidelines included in all new builds and refurbishments- Included in Estates meetings. _____ - Develop SOP for all cleaning equipment in context of the standards in National Cleaning Manual. _____	management of cleaning devices _____ ICN's _____ Hygiene coordinator _____ HST/HOD's Senior Management Team _____ Support Services Manager _____	_____ June 09 _____ April 2009 _____ Ongoing Feb / March 09 _____ June '09 _____
SD 4.3 *Core Criterion	B	**The team ensures the organisation's cleaning equipment**	A	- Develop SOP for all cleaning equipment in context of the standards in	HST	Ongoing

		is managed and clean. In general cleaning equipment was clean however a couple of cleaning carts observed were in need of attention. A colour coding system was demonstrated to be in place. Some cleaning equipment was stored in sluice rooms or on corridors due to lack of storage facilities. Products were observed to be stored in unlocked cupboards.		National Cleaning Manual. - Storage facilities and cleaning equipment to be included in Service Trac© audit tool - Memo sent to all HODs/ CNMs regarding need to lock all presses where solutions/ chemicals are stored. - Audit of storage presses to be included in Service Trac© audit- - Provide education regarding the importance of safe storage of chemicals.	ICN /Contract cleaners HST HST Health & Safety Advisor with OSM Hygiene Services Co-ordinator	May 2009 April '09 Aug '09 April 2009
SD 4.4 *Core Criterion	C	**The team ensures the organisation's kitchens (including ward/department kitchens) are managed and maintained in accordance with evidence based best practice and current legislation.** Ward kitchen food safety policies were observed to be in place. Access was restricted to designated personnel	B	- Audit standard in ward Kitchens- education /action plans for all relevant areas/ staff. - Review Signage for Kitchen doors - Audit fly screens in all kitchens and repair and	ICN's / Support services HST Maintenance Services Dept	April' 09 April '09 April 2009

		though some kitchen doors were observed to be open. Personal Protective Equipment was available and wash hand-basins were in place. Fly screens were noted to be missing in two kitchen areas. A staff kitchenette in the Emergency Department was being used to prepare breakfasts and patient food was being stored in the staff fridge. This did not comply with the Hazard Analysis and Critical Control Point plan. In two clinical areas, temperature records demonstrated that dishwashers were not reaching a significantly high temperature on their rinse cycles to ensure that the crockery or utensils had been disinfected appropriately. This had also been reported by the Environmental Health Officer in January 2007.		replace as necessary. _____ - See CM 9.1 - Process for delivery of patient meals in the Emergency Dept was reviewed in Nov 08 and new system for management of patient meals in this area introduced in line with HACCP regulations. _____ - Review and replacement of dishwashers. Complete audit involving 20 dishwashers conducted by Engineer in the conjunction of OLOL Supplies Manager 1st April 09. All temperatures set at 82° for 3 minutes. Engineer commissioned 4 additional machines. Service Contract to be implemented	_____ Support Service Mgr./CNM _____ Supplies Manager	_____ Nov 2008 _____ April 09
SD 4.5 *Core Criterion	A	**The team ensures the inventory, handling, storage, use and disposal of Hygiene Services hazardous materials, sharps and waste is in accordance with evidence based codes of best practice and current legislation.** The organisation demonstrated compliance of greater than 85% with the requirements of this criterion.	A	Maintain current standard		

SD 4.6 *Core Criterion	A	**The team ensures the Organisation's linen supply and soft furnishings are managed and maintained.** The organisation demonstrated compliance of greater than 85% with the requirements of this criterion.	A	Maintain current standard		
SD 4.7 *Core Criterion	B	**The team works with the Governing Body and/or its Executive Management team to manage hand hygiene effectively and in accordance with the Strategy for the control of Antimicrobial Resistance in Ireland guidelines** Evidence was provided to demonstrate that hand hygiene training had been extensive to all staff and evidence was provided to demonstrate that "hand hygiene champions" were in place. A number of wash hand basins were observed to be non-compliant to best practice standards and a number were not accessible due to storage issues. An upgrade schedule for wash hand basins was demonstrated, however it was reported that progress had been delayed due to financial restrictions.	A	- Hand hygiene program for 2009 established y the IP&C team. Hygiene Services Advisory Committee endorsed program. Includes KPI'S and evaluation mechanisms. _____ - Review sink replacement programme to identify priority replacements - Financial approval required for sink replacement programme - Installation also depends on facilitating bed management of patients around installation of sinks.	IP&C team HSAC _____ OSM / Bed Management	March 2009 _____ June 2009

SD 4.8	B	**The team ensures all reasonable steps to keep patients/clients safe from accidents, injuries or adverse events.** There was evidence provided to demonstrate the incident reporting process, however there was no formal evaluation at a local level unless it was a major incident. Evidence was provided to demonstrate that mattresses were replaced following a reported incident. A comprehensive audit was undertaken following the incident and the findings of the audit resulted in a large number of mattresses being replaced. Safety signs during the cleaning process were observed.	A	- Revised governance structures and reporting relationships in line with the implementation of the Quality, Safety & Risk Management framework to support management of quality and risk at operational level. - The development of the risk register will support local incident management _____ - Introduction of "Complaints log" in April 09 to record/ monitor all complaints which are managed by HOD locally. in line with the recommendations of 'Your Service Your Say'	Risk Management _____ HST Patient Liaison Dept	May 2009 _____ April 2009
SD 4.9	B	**Patients/Clients and families are encouraged to participate in improving Hygiene Services and providing a hygienic environment.** A health promotion corner, prominent hand hygiene stations, as well as signage and relevant information leaflets were observed. The national visiting policy was demonstrated to be in place. There was no patient satisfaction survey demonstrated in the last 12 months.	A	- Patient perception survey carried out April 09 _____ - HST seeking patient representation on Committee	HPH coordinator/ HST _____ HST	April 2009 _____ May 2009

SD 5.1	B	PATIENT'S/CLIENT'S RIGHTS **Professional and organisational guidelines regarding the rights of patients/clients and families are respected by the team.** Patient dignity was demonstrated to be supported through the visiting policy. Patient dignity was observed by the assessors while cleaning of wards was in progress however there was no documented process for maintaining patient dignity during hygiene services demonstrated. The HSE employee handbook was demonstrated to detail information regarding dignity at work. The organisation reported that there had been no violation of patient rights.	A	- Patient perception survey included an question to ascertain if patients perceived that their '*dignity was respected during the cleaning process?'* _____ - Develop SOP re maintenance of patient dignity during delivery of hygiene related activities. (subgroup) _____ - Chaperoning policy in practice	HPH/HST _____ HST _____ Policy Ref	May .09 _____ June 2009 _____ In place and ongoing
SD 5.2	B	**Patients/Clients, families, visitors and all users of the service are provided with relevant information regarding Hygiene Services.** There was evidence of hygiene related information leaflets and posters available for patients and visitors. Signage was also observed at hand gel stations. There was no formal evaluation of patient, family and visitor comprehension of and satisfaction with the information provided by the Hygiene Services team demonstrated.	A	- Audit of draft visiting policy to be conducted. - Introduce visiting policy and evaluate in line with National Policy. _____ - Patient and staff satisfaction survey conducted _____ - Quarterly News letter available at key strategic points throughout the organisation for patients and visitors. Formal review Dec. 09. _____	HST/HPH coordinator _____ HST /HPH _____ HST _____	April 2009 June 2009 _____ May 2009 _____ Dec '09 _____

				- Review literature currently in use for patients hospital wide in context of hygiene standards towards the development of a suite of hygiene specific information _____ - Service user to be invited to join the 'patient's perception' subgroup.	HST _____ HST / Patient Focus	May '09 _____ June/July 2009
SD 5.3	C	**Patient/Client complaints in relation to Hygiene Services are managed in line with organisational policy.** There was evidence of a complaints policy in place; however the policy was from the North Eastern Health Board which had been replaced by the HSE Dublin North East Region. There was limited awareness of "Your Service Your Say" by staff members or patients in the areas visited. While evidence was demonstrated that information regarding complaints was reported to the Hygiene Services Advisory Committee by the Patient Liaison Department there was no evidence provided to demonstrate that feedback was provided to the Hygiene Services Team or departments.	B	- Introduce log of ward hygiene complaints and SOP at Hygiene Team. - Provide education for staff re "Your Service your Say". - Six additional complaints officers trained for OLOLH. The complaints management structure to be reviewed and restructured in light of enhanced focus. _____ - Develop quarterly reports from both the formal complaints procedure and the informal complaints log - Communicate report on hygiene related complaints to all staff using Hygiene Communication Plan	HST Regional Consumer Affairs SMT _____ HST/ HSAC	1st Session to HOD 31.3.09. 2.04.09 March '09 and ongoing _____ July '09

SD 6.1	C	ASSESSING AND IMPROVING PERFORMANCE **Patient/Clients, families and other external partners are involved by the Hygiene Services team when evaluating its service.** The organisation demonstrated that hygiene related information was gathered from complaints and feedback from "Your Service Your Say". It was reported that no major issues had been identified for action. Evidence was provided of a maternity service's service user group "Birth Matters", however hygiene was not a standing agenda item for this group. There was no evaluation demonstrated of the extent to which patients, families and other organisations were involved by the team when evaluating its Hygiene Services.	B	- Birth matters / Agenda to include hygiene matters. - Catering audit of food satisfaction to be conducted – April 2009 and evaluated by July '09. - Memo to be sent to all groups/ HODs/ CNMs advising them of the need to include generic hygiene questions in all surveys, audits, questionnaires if applicable. Sub- group to be established in HST to lead on this. - Feedback from 'STARS' system to HST/HSAC regarding trends in complaints. - Feedback from' Your Service Your Say' to be established on quarterly basis. - Include hygiene related complaints in suite of KPI	A/DON Midwifery HST HST HST HST/HSAC Patient Liaison HST/HSAC HSAC/HST	Autumn Meeting April 2009 August '09 June 2009 Quarterly Quarterly June 2009
SD 6.2	C	**The Hygiene Services team regularly monitors, evaluates and benchmarks the quality of its**	B	- List of KPIs to be established for audits. 85% target for environmental audits.	ICN's/ Support Services/ HOD	Ongoing

		Hygiene Services and outcomes and uses this information to make improvements. The organisation demonstrated that it evaluated its hygiene services via the hand hygiene, sharps and linen audits undertaken by the Infection Control team and the limited number of environmental audits carried out in April 2008. Evidence was provided demonstrating that the Hygiene Services quality improvement plan had been developed following the results of the 2007 National Hygiene Services Quality Review and was reviewed at each Hygiene Team and Advisory Committee meeting. A task list was populated from the actions required with a timeline and responsible person assigned and this was also demonstrated. • Evidence was demonstrated that the organisation had begun the process of developing key performance indicators. • No evidence of evaluation of the extent to which hygiene services quality initiatives were being undertaken by the Hygiene Services Team as a result of evaluation was demonstrated.		_____ - Hand hygiene education attendance 85% agreed. _____ - List of planned environmental audits to be established and monitored, monthly by HST and HODs. _____ - External KPI'S to be monitored in reaching targets in relation to hand hygiene audits and alcohol gel consumption. Minimum 'Decile 2' to be achieved annually for alcohol gel consumption. _____ - All planned audits to be documented and reviewed on a quarterly basis including trends in IP&C reports and hygiene related surveys. _____ - Surveillance on antimicrobial resistant organisms is presented at infection control meetings and feedback to HST _____ - Annual report to be completed with input from all HOD's.	_____ ICN's/ HOD/ Support Services _____ HOD/ HST/ HSAC _____ ICN's _____ HST _____ ICN's _____ HST/Hygiene Coordinator	_____ Ongoing _____ Ongoing _____ Ongoing _____ Quarterly _____ Ongoing _____ May 09 and Ongoing

				_____	_____	_____
SD 6.3	B	**The multidisciplinary team, in consultation with patients/clients, families, staff and service users, produce an Annual Report.** Evidence was provided demonstrating that the Hygiene Services Advisory Committee produced an annual report in 2007, however there was no evidence of patient or family consultation into the process demonstrated. There was no evaluation of the appropriateness of the Hygiene Services Annual Report demonstrated.		- Complete 2008 Annual Report through consultation with all HOD's. _____ - Review the process and methodology utilised for development of the Hygiene Annual Report	Hygiene Coordinator All HOD's _____ HST/HSAC	June 2009 _____ June 2009