IN RECENT years much needed attention has focused on the cleanliness, or lack of it, in our hospitals. Many factors allowed the situation to deteriorate over a number of years, not least a perception that hygiene was someone else’s responsibility. This attitude, combined with an enormous increase in hospital activity, has undoubtedly exacerbated the problem.

The environment is rarely the primary source of infection outbreaks, however if the environment immediately around a patient becomes contaminated – either by direct patient shedding, i.e. droplet contact or airborne contact, or by healthcare workers touching surfaces and equipment with contaminated hands – secondary transmission can occur. It is therefore necessary to clean the environment to prevent the build-up of material that can harbour potential pathogens.

A clean, well-maintained healthcare facility is necessary to provide the required background to good standards of hygiene and asepsis. This also inspires confidence in the facility’s commitment to provide a safe, high standard of care in patients, staff and the public.

In February 2005, the National Hospitals Office (NHO) established a working group to evaluate the current status of cleaning services and infection control services in acute hospitals; however these services were subsequently separated. The group identified a need to develop uniform standards, guidelines and audit processes across the acute hospitals.

Later that year draft standards were developed which subsequently, in partnership with The Irish Health Services Assessment Board (IHSAB), now amalgamated into Health Information and Quality Authority (HIQUA), were re-aligned for accreditation purposes.

Road to improvement

In 2004, a UK-based company given a remit to establish current levels of hygiene in selected clinical areas, including accident and emergency departments, outpatient departments, ICUs, a medical and surgical ward and a speciality if applicable, and to make recommendations for the future. The audit represented a ‘spot check’ of standards observed on days of the visit with random selection of healthcare staff who were questioned on their practice of sharps, linen and waste disposal and cleaning of equipment. Hand hygiene practice was also observed.

Notification and information about the impending audit was sent to all hospital managers and a request to have specific information and documentation ready for inspection by the auditors.

The first national hygiene audit of a sample of clinical areas in 54 acute hospitals was completed in July/August 2005 with random unannounced visits using the Infection Control Nurses Association (ICNA) audit tool 2004.

This audit tool consists of sections with a checklist to examine each standard with an answer ‘yes’, ‘no’ or ‘not applicable’ (N/A) column. Following completion of each section the answers were calculated to determine each score. The audit had three standards: ‘good’ = 85%-100%; ‘fair’ = 76%-84%; and ‘poor’ = 75% or below.

Following completion of the first audit the results and recommendations report was sent to the NHO in August 2005 and released to the public and media. The results identified that from the 54 hospitals five achieved a ‘good’ result, 23 were graded ‘fair’ and 26 were found to be ‘poor’.

More to do

Generally, the audit found that significant work had been done to improve hygiene standards but that there was more to be done. Overall results did not vary significantly between hospitals with either in-house or contract cleaning services, or vary between small, medium and
large hospitals. The audit also identified little sharing of information and best practice between hospitals with some replication of trials on several sites and a lack of consistency in approach and methodology in some standards.

**National recommendations**

- The development of a multidisciplinary approach to hygiene, eg. hygiene teams
- Hygiene standards to form part of national monitoring performance framework
- Development of national policies and procedures, eg. cleaning manual, visiting policy guidelines
- Development of national training strategy to provide a framework for cleaning service staff and cleaning supervisors
- Establish forum for best practice clean hospital summit.

**Local recommendations**

- A senior manager at hospital level should take personal responsibility for hygiene services provided
- The development of a multidisciplinary hygiene group which would review results and findings of the audit and develop an action plan, review skill base of non-clinical staff and level of technical support
- Complete a baseline audit of all hospital areas.

Following publication of the audit results the NHO established a minor capital fund to enable hospitals to improve hygiene standards.

**Follow up**

The second national audit was completed in February, March and April 2006 by the same company using the same ICNA audit tool in the same 53 acute hospitals. Again, visits were random and unannounced but with a different geographical distribution, the same elements of hygiene in the same areas but not necessary the same wards were visited. The results identified that out of the 53 hospitals (one hospital recorded as N/A) 32 achieved a ‘good’ classification, 19 were found to be ‘fair’ and two were ‘poor’.

Overall, the results identified that almost all hospitals had bettered their scores with 48 improving, only three going down and two remaining the same. The two hospitals with the poor rating were further audited and both demonstrated an improved score.

**National recommendations of second audit**

- Development of national policies and procedures
- The promotion of continuous improvement in hygiene standards
- That examples of innovative approaches and best practice initiatives in hygiene be collected, collated and distributed
- That the structure and availability of technical support accessible in acute hospitals be reviewed
- That the scope of hygiene audits and promote hygiene education and training for both clinical and non-clinical staff be broadened.

**Local recommendations**

- Review progress to date and develop actions plans to address any elements where good score was not achieved
- Provide training and extend the scope of internal audits
- Review the responsibility for cleaning and designate ownership and develop service level agreements.

**National standards**

As there were no national cleaning standards for acute hospitals an important remit of the working group was to develop these. The aim when setting standards is to ensure that they can determine if the hospital is clean and that the standards of hygiene remain high.

Monitoring of these standards requires internal and external audits, establishing a system that supports continuous improvements and gives staff the authority and accountability to maintain standards. Internal audits should form part of a quality programme and should be followed up according to the location and the extent of the problem.

In autumn 2005, following a request from the Department of Health, the IHSAB met with the NHO to discuss the process of working with the HSE to develop hygiene and infection control standards and a national assessment process, with the need to accredit the standards and establish an award system. The draft hygiene standards completed by the working group were realigned/reconfigured by IHSAB and piloted at three sites.

In June 2006 a cleaning manual for acute hospitals was circulated by the NHO with the aim of providing national guidelines and advice in the area of the environment and environmental cleanliness. The manual was designed to support the IHSAB hygiene services standards and complement existing national policies and procedures. The guideline document can be amended to suit the requirements of individual hospitals.

In November 2006 the IHSAB launched the Hygiene Services Assessment Scheme (HSAS) which is now mandatory for all acute hospitals. Regional educational sessions were organised by IHSAB in late 2006 to explain the new process, including information on preparing self assessment.

In early 2007, 52 acute hospitals completed a self assessment. Self assessment allows an organisation and its hygiene service team to examine day-to-day service and activities and assess them against national standards using structure, process and outcome.

In March 2007, the hygiene audits got underway. These were unannounced, external and independent and included all areas of the hospital both clinical and non-clinical as potential areas for audit.

The hygiene service standards are structured differently to the previous two audits. These standards follow the quality improvement process: plan, do, check, act. These standards are divided into corporate management standards and service delivery standards. This method involves a standard, which is the goal to be achieved, and the criteria required to achieve the standard. Certain criteria are core, i.e. the 15 core criteria, must be passed. This ensures that there is focus on the principal areas of hygiene service and hospitals must have these core criteria in order to deliver and maintain hygiene services.

- Corporate Management Standards – these relate to the responsibility of hygiene services at an organisational management level. It incorporates four critical areas
- Leadership and Partnership, Environmental Facilities, Human Resources and Information Management – there are 14 standards with eight core criteria within these standards
- Service Delivery Standards relate directly to operational day-to-day work in the provision of hygiene services at a team level.
Hygiene Service team in conjunction with the ward/department manager and the hygiene services committee. There are six standards with seven core criteria within these standards. Core criteria have been identified within the standards to help the organisation and hygiene services to prioritise areas of particular significance which are core to provide quality hygiene services.

Quality is represented by four quality dimensions which form the basis of the structure of the standard. Each criterion is linked to one of the quality dimensions which are responsiveness, system competency, patient/client/community focus and work environment. Descriptors assist in describing each of the dimensions.

There are five levels of compliance/rating scale (see Table): Where a criterion receives a D or E rating a risk assessment must be completed. This requires an evaluation of the following likelihood of event, impact, urgency and potential adverse event. Each category with the exception of potential adverse event must be scored as ‘high’, ‘medium’ or ‘low’ but giving details of the potential adverse event.

The HSAS was completed in September 2007, new areas assessed, included operating theatres, main kitchens, pharmacy, stores, laboratory, mortuary, physiotherapy and staff facilities. Results were based on self-assessment, visual inspection, and discussion with healthcare staff and management. The results were subsequently made public at the end of 2007.

The results were that seven hospitals received a ‘good’ rating, 35 received a ‘fair’ rating and nine received a ‘poor’ rating with no hospital receiving the top rating.

<table>
<thead>
<tr>
<th>Compliance rating scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
</tr>
<tr>
<td>B</td>
</tr>
<tr>
<td>C</td>
</tr>
<tr>
<td>D</td>
</tr>
<tr>
<td>E</td>
</tr>
</tbody>
</table>

Present

The next quality review will take place over the coming months and will assess hygiene services against the current hygiene standards.

A number of acute hospitals will be revisited but not exclusively those that were identified as having significant risks. The visits will be unannounced and will not be restricted to 8am-5pm Monday to Friday. There will also be a requirement to resubmit a self assessment.

Over many years it was unfortunate that hospital hygiene was allowed to deteriorate to a point where the poor standards were evident to the public as well as staff.

The initial audit highlighted what we knew or suspected: that standards of hygiene in many hospitals were not reaching an acceptable level.

The benefits of HIQA Hygiene Services Quality Review is that responsibility now has to be taken by management. Budget concerns should not in the future determine the cleanliness or otherwise of our hospitals. Everyone has a role to play including ward/department managers to ensure that their patient’s environment is clean and well maintained.

Patients and their visitors, however, have an important role to play also by adhering to visiting times and numbers allowed and by complying with no smoking rules except in designated areas.

Working together we can achieve and maintain good standards of hygiene in our hospitals for the benefit of patients, visitors and healthcare staff.

Breda Corrigan is a nurse specialist in infection control in the Midland Regional Hospital, Mullingar.

References on request from nursing@medmedia.ie (quote Corrigan WIN 2008; 16(4): 20-23)