Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Hygiene Services Assessment Scheme

Assessment Report October 2007

Adelaide and Meath Hospital Dublin Incorporating the National Children's Hospital

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1.0 Executive Summary

1.1 Introduction

This is the first National Hygiene Services Assessment Scheme (HSAS.) It is a mandatory scheme for all acute hospitals. The scheme aims to enhance cultural change in the area of hygiene services by not only focusing on the service delivery elements but also emphasising the importance of standards for corporate management. The HSAS is a patient-centred scheme which assists a hospital to prioritise the key areas in hygiene to be addressed. It is intended to promote a culture of best practice and continuous quality improvement.

The Irish Health Services Accreditation Board developed these, the first set of National Hygiene Assessment Standards in 2006. This development plan involved an extensive desktop review of national and international best practice literature, working groups and extensive consultation. The feedback from these development components formed the final draft Standards and Assessment Process, which were then piloted in a number of acute hospitals. *(The Irish Health Services Accreditation Board was subsumed into the Health Information and Quality Authority in May 2007.)*

The Hygiene Services Assessment Scheme (HSAS) was launched by the Minister for Health Mary Harney on the 6th November 2006.

Hygiene is defined as:
"The practice that serves to keep people and environments clean and prevent infection. It involves the study of preserving one's health, preventing the spread of disease, and recognising, evaluating and controlling health hazards. In the healthcare setting it incorporates the following key areas: environment and facilities, hand hygiene, catering, management of laundry, waste and sharps, and equipment" [1-4]

More specifically, the Hygiene Services Assessment Scheme incorporates the following:

- Environment and Facilities: incorporates the condition of the building and all its fixtures, fittings and furnishings.
- Hand Hygiene: incorporates hand washing, antiseptic hand-rub and surgical hand antisepsis.
- Catering: incorporates kitchens (including ward kitchens) fixtures and fittings and food safety.
- Management of Laundry: incorporates management of linen and soft furnishings both in-house laundry and external facilities.
- Waste and Sharps: incorporates handling, segregation, storage and transportation.
- Equipment: incorporates patient, organisational, medical and cleaning equipment.

1.1.1 Standards Overview

The standards are divided into two sections: Corporate Management and Service Delivery. Each standard is divided into a number of criteria. These are specific steps, activities or decisions that must occur to achieve the standard.

The 14 Corporate Management standards facilitate the assessment of performance with respect to hygiene services provision to the organisation and patient clients at organisational management level. These standards commence at the planning stage and follow through to governing, implementation and evaluation. They incorporate four critical areas:

- Leadership and Partnerships
- Management of the Environment and Facilities
- Management of Human Resources
- Information Management.

The six Service Delivery standards facilitate the assessment of performance at team level. The standards address the following areas:

- Evidence based best practice and new interventions
- Prevention and Health Promotion
- Integration and coordination of hygiene services
- Implementing safe, efficient and effective hygiene services
- Protection of patient/clients rights
- Assessing and Improving performance. [5]

The standards and process have been assessed and internationally accredited by the International Society for Quality in Healthcare (ISQua).

Core Criteria:

To ensure that there is a continual focus on the principal areas of the service, 15 core criteria have been identified within the standards to help the organisation and the hygiene services to prioritise areas of particular significance.

In the Corporate Management standards, the core criteria cover:

> Allocation of resources, accountability, risk management, contract management and human resource management.

In the Service Delivery standards, core criteria cover:

> Waste management, hand hygiene, kitchens and catering, management of linen, equipment, medical and cleaning devices and the organisation's' physical environment.

1.1.2 Rating Scale

The rating of individual criterion is designed to assist self-assessment teams and the organisation in general, to prioritise areas for development. The rating for the criterion can be determined based on the percentage level of compliance.

The rating scale utilised by the Hygiene Services Assessment Process is a five-point scale:

A Compliant - Exceptional

- There is evidence of exceptional compliance (greater than 85%) with the criterion provisions.

B Compliant - Extensive

- There is evidence of extensive compliance (between 66% and 85%) with the criterion provisions.

C Compliant - Broad

- There is evidence of broad compliance (between 41% and 65%) with the criterion provisions.

D Minor Compliance

- There is evidence of only minor compliance (between 15% and 40%) with the criterion provisions.

E No Compliance

- Only negligible compliance (less than 15%) with the criterion provisions is discernible.

N/A Not Applicable

- The criterion does not apply to the areas covered by the Self Assessment Team. Rationale must be provided. This cannot be used for a core criterion.

1.1.3 Assessment process components

The assessment process involves four distinct components:

- **Preparation and self assessment undertaken by the organisation.**

The self-assessment process allows an organisation to systematically evaluate its hygiene services against a set of best practice standards. This was completed by a multidisciplinary team(s) over a period of two months. This process was preceded by regional education sessions.

- **Unannounced assessment undertaken by a team of external assessors**

The HIQA has recruited senior professionals from the areas of medicine, nursing and corporate management as assessors, in addition to independent senior professionals with specialist knowledge in the core areas. To assure consistency across all sites four leaders were chosen from this group to cover all unannounced visits. The assessor's performance was regularly evaluated based on feedback from participating organisations, HIQA staff and other assessors.

Site visits for the larger academic teaching hospitals were completed over 2.5 days with four assessors, and assessments were completed in the smaller hospitals over 2 days with three assessors. The assessment team were responsible for identifying the organisation's compliance with the standards and helping to guide its improvement.

The assessment included a comprehensive documentation review, meetings with management, staff and patients. Throughout the assessment process the assessors worked as a team to cross reference their findings. This ensured that the ratings for each criterion were agreed upon and reflected an accurate picture of the organisation's level of compliance. Feedback was provided to the Chief Executive / General Manager and senior management team by the Assessment Team Leader, at the end of each day of the assessment.

- **Provision of an outcome report and determination of award status.**

The Internal Review Committee of the HIQA reviewed all the reports to ensure consistency, and based on the quantifiable translation guidelines, awards were made. Only organisation's which received a "very good" score were acknowledged with an award for the duration of one year. By the end of October 2007 all 51 acute care hospitals had received a copy of their individual report.

At the same time the HIQA launched a National Report of the findings of all assessment reports. These standards are different from the first two hygiene audits, therefore a direct correlation of results were not possible.

- **Continuous Improvement**

Going forward a quality improvement plan should now be structured from the self assessment and recommendations from the external report. This will then be monitored by the HIQA.

The areas of notable practice, quality improvement plans, areas of priority action, overall score, criterion ratings and comment and are presented in the following pages of the report.

[1] Boot, M and Cairncross, S "Actions Speak" Delft, The Netherlands, IRC and LSTHM, British Occupational Hygiene Society.
[2] New York Department of Health and Mental Hygiene
[3] The Columbia Electronic Encyclopaedia, Sixth Edition. Columbia University Press. 2003
[4] Irish Acute Hospitals Cleaning Manual, HSE (2006)
[5] Hygiene Services Assessment Scheme. Irish Health Services Accreditation Board (2006)

1.2 Organisational Profile

The Adelaide and Meath Hospital, Dublin Incorporating the National Children's Hospital is a Public Voluntary Teaching Hospital linked to the University of Dublin, Trinity College with a total bed capacity of six hundred.
The Hospital serves as a primary referral centre for South West Dublin, North Kildare and West Wicklow. It also accepts secondary and tertiary referral from the county and regional hospitals with a population of approximately 560,000.

Services provided

- A major Accident & Emergency centre with a large surgical department in Gastrointestinal, Breast / Endocrine, Hepatobilary, Vascular, Orthopaedics, Genitourinary and Gynaecology, Medical Oncology, Nephrology, Neurology, Respiratory Medicine, Cardiology and Haematology.
- Elderly patients are catered for in a purpose-built Age Related Health Care Department
- In 2006 a new 39 bed "Transition Unit" opened as an intermediary facility between Accident & Emergency and Ward areas.

Physical structures
Included in the total bed numbers are nineteen (19) Isolation Rooms with Positive / Negative pressure.

The following assessment of Adelaide and Meath Hospital, incorporating the National Children's Hospital took place between 20th and 22nd March 2007.

1.3 Notable Practice

- The progress to-date in addressing the renovation of the physical environment was looked at.
- The commitment of the multi-disciplinary team was very evident throughout the assessment.
- The overall level of hygiene was excellent in a number of clinical areas, especially in high dependency areas.
- The communication strategy in the organisation, in terms of communication flow, is well established.

1.4 Priority Quality Improvement Plan

- It is recommended that the organisation continue the upgrade of the physical environment. Defined time frames for completion should be assigned and particular emphasis should be placed on clinical areas and the hospital kitchen.
- The identification of a comprehensive suite of key performance indicators for hygiene services is recommended.
- It is recommended that the organisation expedite its plans for greater use of patient/client participation in designing hygiene services.

- The organisation should focus attention on the identified clinical areas in relation to hygiene excellence in the short term, to ensure that the standards of all areas meet best practice.

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 Adelaide and Meath Hospital Dublin Incorporating the National Children's Hospital has achieved an overall score of:

Good

Award Date: October 2007

2.0 Standards for Corporate Management

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

PLANNING AND DEVELOPING HYGIENE SERVICES

CM 1.1 (A ↓ B)

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

The organisation has a dedicated hygiene services department, which reports directly to the Director of Environmental Services. An Organisational Strategic Plan for hygiene services is in place, which is reviewed annually, in line with relevant legislation and best practice. Consultation processes with the Health Protection Surveillance Centre, National Strategy for Antimicrobial Resistance in Ireland Committee (SARI), Health Services Executive and the Department of Health and Children exist, and the organisation complies with ISO340 and HACCP systems. Monthly meetings take place between the Hygiene Services Manager and the Director of Environmental Services to evaluate performance, discuss developments and analyse activity related to hygiene services. Resultant actions and quality improvement plans include internal audit reports covering the full scope of hygiene services and an independent external audit of the health care risk waste management process. The organisation should consider a comprehensive consultation process to include all stakeholders including patients and service providers.

CM 1.2 (A → A)

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

A multi-disciplinary group has been established to advise senior management on hygiene best practice. There is an excellent waste segregation system in place and specifications are regularly reviewed for all waste management and meetings are held with the relevant contractors. On-going improvements are noted in cleaning methods and additional staff has been appointed. These include a Linen Officer, a Surveillance Scientist in the Microbiology Department and a Needle Stick Injury Nurse to the Occupational Health Department.

The introduction of new best practice cleaning methods was noted. Also, improvements in the physical environment of the clinical areas were evident. Additional dedicated staff wash-hand basins are being installed throughout the clinical areas, based on recommendations by the Health and Safety Authority.

Patient/client food services have introduced a number of improvements in accordance with best practice and the organisation has been awarded the "Excellence Ireland Quality Association Hygiene Mark" for its catering department and patient food services department. Hand hygiene information and facilities, waste

segregation and improved signage are other recent relevant improvements. Plans have also been developed for further environmental improvements.
All developments are based on ongoing evaluations including infection control, hygiene contractors, Excellent Ireland Quality Association (EIQA) audits, Health and Safety Authority inspections and activity analysis.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1 (A ↓ 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.

Considerable evidence was provided to demonstrate the range of key stakeholders, both internal and external, with which the organisation works with in relation to hygiene services. External links and partnerships include the Health Protection Surveillance Centre, National Strategy for Antimicrobial Resistance in Ireland Committee, Health Service Executive Infection Control Committee, Health Service Executive, Department of Health and Children, Infection Control Nurses' Association and the Hospital Infection Society.
The Surveillance Scientist also reports to National Surveillance Centre. Specifications for cleaning and waste management services are reviewed regularly and meetings with relevant contractors are held.
A dangerous goods safety advisor audits the health care risk waste management process. In addition to infection control audits, the infection control team conducts patient and staff satisfaction surveys. Members of senior management conduct tours of the organisation to inspect the effectiveness of its hygiene services.
The organisation's interest in greater input from its patient/client service representatives in the area of hygiene is acknowledged and encouraged. Hygiene services are evaluated. However, there is no formal evaluation of its linkages and partnerships. It is recommended that this evaluation process is commenced in the future.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 (B → B)

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

The organisation's Corporate Strategic Plan includes hygiene services. It has clearly defined goals, priorities and relating costings, which are approved by the Executive Management Team and are inputted and communicated to the relevant multi-disciplinary team members. The Director of Environmental Services and the Chief Executive Officer's portfolio are the two elements of the Executive Management Team with responsibility for hygiene services.
The multi-disciplinary team has input from each area relevant to hygiene, however, no formal input from patient/clients' families is sought. A communication system between all service providers is in place. There is a link hygiene nurse for all clinical areas and internal meetings, town hall meetings, a newsletter and notice boards are in place. The organisation is in the process of developing a communication strategy.
The Health and Safety Department carries out an annual audit and the organisation was a pilot site for the Health and Safety Authority audit. A quality improvement plan has been developed as a result of the findings.

The organisation would benefit from the development of a longer-term strategic approach to the overall hygiene service, including quality improvement of the organisation's environment and standards of hygiene. This plan should include maintenance of the physical infrastructure, focusing on issues such as rising damp and leaking shower units. A more structured approach to the evaluation of the Hygiene Corporate Strategic Plan is recommended.

GOVERNING AND MANAGING HYGIENE SERVICES

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.

Information is collected mainly through the Infection Control Committee meetings and internal/external audit reports. Hygiene Services Department heads liaise with the Hygiene Services Manager and the Director of Environmental Services. A review of membership of the hygiene management structures, to ensure they reflect the representation as outlined in the Hygiene Services Assessment Scheme standards, is recommended. Hygiene service performance indicators are in the process of being established, for example occupational health and waste management. It is recommended that this process is expanded and strengthened.

CM 4.3 (A → A)

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.

Research and best practice information are available through a variety of sources, including the use of well-resourced library facilities (which includes internet access) and staff attendance at relevant national and international meetings. A number of recent safety /quality initiatives were noted during the assessment.

The Chief Executive Officer and Senior Managers have introduced open session town hall meetings to discuss topics of concern, including hygiene related matters. The organisation has a dedicated education and training officer attached to the Human Resource department. On–going education and training includes regular ward/department-based sessions on hygiene for the multi-disciplinary ward-based hygiene team.

Training is also provided for contract staff. An annual awareness week is jointly organised by the Infection Control and Hygiene Services teams. A staff handbook, hospital newsletter, information leaflets, and a notice board, in main atrium for the public, are some of the communication tools used. The most recent development has been the introduction of ward/department hygiene link nurses. The main methods of evaluation are the hygiene audits and patient/client and staff satisfaction surveys, which are carried out by the Infection Control Team.

CM 4.4 (A ↓ B)

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

Policies, procedures and guidelines across the spectrum of hygiene services are reviewed and updated in accordance with best practice guidelines and current legislation. All adhere to the organisation's specific policy regarding development. The Health and Safety Department, Infection Control Team, contract cleaners and Catering Department monitor compliance with policies. Continuous quality improvement for the development of best practice, policies, procedures and guidelines in these areas is encouraged.

CM 4.5 (A → A)

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

The Director of Environmental Services assumes responsibility for capital development planning on behalf of the management team. Evidence of involvement of the Hygiene Services Team in a number of capital development projects, both past and present, was noted. This involvement included prevention and control of infection, related to construction work, and the on-going hygiene services related to these developments. An inventory/ priority list is reviewed and annual targets are assessed at the end of each year.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

*Core Criterion

CM 5.1 (A ↓ B)

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

The hygiene services structure is clearly identified with reporting relationships through the Hygiene Services Manager and the Director of Hygiene Services. It was evident during the assessment that roles, responsibilities and accountabilities between the various departments, including the contract services, were well defined**.** Clarity of roles, responsibilities and accountabilities are reflected in job descriptions, service contracts with external agencies, governance structures, and terms of reference for the Infection Control Committee. However, there appeared to be some opportunity for improvement in relation to responsibility for specific operational issues at front line service delivery. The identification of the Ward Managers' role, including a duty of care for hygiene management in their areas, is to be commended. The recent identification of a dedicated Hygiene Services Representative at ward/department level, with responsibility for coordinating and liaising with the Hygiene Services Manager was deemed by staff to be beneficial. It is recommended that the organisation consider extending this practice to all clinical areas.

*Core Criterion

CM 5.2 (A → A)

The organisation has a multi-disciplinary Hygiene Services Committee.

The organisation's Infection Control Committee has a membership consistent with the Hygiene Services Assessment Scheme recommendations for the Hygiene Services Committee, and holds quarterly meetings. Evidence of a comprehensive and committed multidisciplinary committee exists and there are clear terms of reference in place. The scope of their responsibility includes capital projects and continuous quality improvement for hygiene services. In addition to this, all various constituent services hold their own regular department meetings. The Infection Control Team and the Hygiene Services Department meet regularly to discuss and examine hygiene matters throughout the hospital. The hygiene portfolio meets monthly to review relevant matters. The Hygiene Services Manager and the Infection Control department hold monthly meetings with the dedicated ward/department Hygiene Services Representatives. Administrative support is available.

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

*Core Criterion

CM 6.1 (B → B)

The Governing Body and/or its Executive/Management Team allocate resources for the Hygiene Service based on informed equitable decisions and in accordance with corporate and service plans.

The organisations Corporate Strategic and Hygiene Services plans include resources for hygiene services. The plans are based on information from the Infection Control, Hygiene Services, Human Resources and Financial departments and reflect annual and bi–annual reviews of hygiene service contracts. Additional resources are identified in response to new guidelines and recommendations and applications are made to the Health Services Executive for additional funding. Financial resource issues continue to be an impediment in relation to providing optimum physical environment and facilities. The financial resources required to address the current needs are considerable, however, the organisation is committed to making every endeavour to realise these. Despite these constraints, considerable progress has been made to address the issues.

CM 6.2 (A ↓ B)

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

Senior Management are, either members of, are represented at all stages of the procurement process. The organisation has a comprehensive tendering process and there is provision for the involvement of the Hygiene Services and Infection Control staff at the early stages of the procurement process, the testing of all new equipment and the training of staff in its use. Evaluation of the potency of the consultation process has, to date, not been formally undertaken. However, significant expressions of satisfaction with the Senior Management consultation process by relevant line managers in the hygiene services was observed during the assessment.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

CM 7.1 (A ↓ B)

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

The organisation has a Health and Safety Department under the jurisdiction of the Human Resources Department and Health and Safety statements are produced for all relevant areas. There is a Health and Safety Plan (developed in March 2006) in place. A Risk Management Department, with a Risk Management Coordinator is in place and the STARS risk data base register is in use. Information is gathered through the risk management system and dealt with on an individual issue basis. The Forum for Adverse Incident Review (FAIR) addresses and implements recommendations arising from clinical incidents including hygiene related issues. Structured analysis and feedback are planned but have yet to be implemented. An extensive suite of audits, covering all aspects of hygiene services and involving internal and contract staff, are in place. Environmental Health Officers and Health and Safety Authority inspections are also conducted. It is recommended that the evaluation process is developed and progressed.

CM 7.2 (A → A)

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

Additional resources allocated in relation to Hygiene Services Risk Management in the last two years include the appointment of: a Linen officer (in 2004), a Surveillance Scientist (in 2005), a Needle stick injury nurse in the Occupational Health department (in 2005), a Quality Control Manager and a Microbiology laboratory (in 2007). Portering services have been revised to ensure an improved "out of hour's" hygiene services. Line manager Health and Safety training has also been introduced, placing specific emphasis on risk assessment and management. Health and Safety annual reports are produced. The laboratories in the organisation have applied for Clinical Pathology Accreditation. If successful, it is anticipated that this will be awarded in July 2007. A policy/procedure for the management of major adverse incidents is in place. A member of staff has recently been trained in adverse incident report writing and all reports are summarised according to incident/ issue/department. The production of statistical reports is also due to commence. No major hygiene service adverse events have occurred during the last to years.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion

CM 8.1 (A → A)

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

Extensive evidence of good practice in this regard was noted during the assessment. The Materials Management department has a dedicated Contracts Manager and contracts are in place for an extensive range of hygiene services including Pest Control, cleaning services (contract awarded in 2001 has been extended to 2006), Linen (contract awarded 2005), and Health care risk waste (where the organisation is included in central purchasing). The organisation adheres to national procurement/ purchasing legislation. Quarterly meetings are held with contractors regarding performance and service delivery. Audits are carried out and unannounced visits are made to the contractor's premises, for example the waste contractor.

CM 8.2 (A → A)

The organisation involves contracted services in its quality improvement activities.

Numerous examples of Contractor involvement in hygiene quality initiatives noted. The collaborative/participative approach between contractors and the organisation in relation to quality improvement activities is very significant and is to be commended.

PHYSICAL ENVORNMENT, FACILITIES AND RESOURCES

CM 9.1 (A ↓ B)

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 has systems in place to ensure best practice in relation to building and renovation work. There are 144 single rooms available and 19 are fitted with positive and negative pressure. A number of new developments have been introduced for example a transition unit, a post anaesthesia care unit and a discharge

lounge to enhance patient care facilities. Other improvements within the organisation include advanced hand hygiene facilities, the introduction of splash backs at ward wash hand basins, and washable fabric replacement for soft fabrics. The physical environment in some critical areas is not consistent with best practice for example isolation facilities in critical areas and the impact of damp and leaking shower units in some areas. The main kitchen area did not meet best practice in relation to the physical environment and equipment. The organisation has recognised the need for improvements in these areas and has prioritised them.

*Core Criterion

CM 9.2 (A ↓ B)

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

The organisation has policies and procedures in place to plan and manage its environment and facilities, equipment and devices, kitchens, waste and sharps and linen, which conform to current legislation and best practice guidelines. It monitors compliance to these policies and procedures through internal/external auditing and conformances to the following: the Waste Management Act (2001), WEE Directive (2006), ADR Guidelines form the National Hospitals Office, the Irish Acute Hospitals Cleaning Manual, Health Technical Memoranda, ISO 340, HACCP, BTS, COSHH, Health Services Executive / Department of Health and Children Guidelines for Infection Control and DOE (EPA Guidelines for Emissions and hold South Dublin County Council licence for effluent discharge). A plan is in place to address the identified kitchen environment issues, and it is recommended that these are expedited.

CM 9.3 (A ↓ B)

There is evidence that the management of the organisation's environment and facilities, equipment and devices, kitchens, waste and sharps and linen is effective and efficient.

Internal /external audits are carried out to ensure effective and efficient management. Numerous examples of continuous quality improvement across the spectrum of hygiene services were observed including Contract cleaner review meetings and audits, Infection Control audits, Environmental Health reports, procurement process evaluation and monthly meetings with Hygiene Link Representatives at ward level. It is recommended that the evaluation process is expanded and embedded into the culture of the organisation.

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 Infection Control Team conducts patient/ staff satisfaction surveys. The Patient food service and Catering service also conduct bi-monthly satisfaction surveys. During the assessment, information received during the patient interviews was also very positive. The organisation has a Patient Advocacy department and a Patient Complaints Coordinator. As identified in the organisations quality improvement plan, there is opportunity to expand the scope of these surveys and to increase the patient input in respect of hygiene services in the future.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 (A → A)

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 Human Resource departments' recruitment process is in accordance with legislation and the Health Services Executive guidelines. It has been subject to survey and independent review, with priority areas for improvement identified. Job descriptions exist for contract staff, which have been developed using input from organisations Human Resource department and Line Managers. Technical Services contract staff are task specific. A generic wording in relation to hygiene awareness has been agreed and incorporated into all organisations own and contract staff job descriptions since March 2007.

CM 10.2 (B ↑ A)

Human resources are assigned by the organisation based on changes in work capacity and volume, in accordance with accepted standards and legal requirements for Hygiene Services.

Systems are in place for identifying work capacity and volume in the hygiene services. The standards of work are monitored by the Hygiene Services Contractor and the Infection Control department and additional resources are allocated on the basis of identified needs. Developments in the organisation include the creation and filling of new positions and the meeting of 24 hour janitorial needs in all clinical areas. Also, the allocation of dedicated Portering services for waste management is a recent development and is to be commended.

CM 10.3 (B → B)

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

Job descriptions identify minimum qualifications for each role and pre–admission screening includes the verification of qualifications. Tender specification identifies appropriate training for Contract Cleaning staff. Mandatory orientation for all staff and ongoing training and development is provided by the organisation.

CM 10.4 (B → B)

There is evidence that the contractors manage contract staff effectively.

Both the Contract Cleaning and the Linen Contract companies have on-site managers and a system is in place to ensure regular meetings with the Hygiene Services Manager and Senior Management. The services of the organisations Occupational Health department are available to all staff. Appropriate training is provided for Contract staff and orientation is mandatory for all staff. The audit cycle provides on-going evaluation, review and feedback to both management and contract staff.

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

Mandatory corporate orientation for all staff includes presentations from the Infection Control department, Occupational Health and Health and Safety teams. Departmental orientation includes relevant training for example HACCP training. A staff competency appraisal programme has been introduced and a training matrix has been established. An Annual training plan is developed and the organisations dedicated Education and Training manager is responsible for the education/training needs of all staff. Regular education updates by the Infection Control Team are also carried out. Staff directly engaged in hygiene services have specific training pertinent to their individual roles. Orientation for cleaning staff is organised by the contractor and training for the organisations staff is also provided by contractors where relevant for example risk waste management.

CM 11.2 (A → A)

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 organisations Annual Education and Training schedule is based on the needs of the service and involves all Line Managers and Senior Managers in its development. Staff are facilitated to attend relevant education and training. The organisation is participating in the national skills programme and facilitates staff to attend FETAC approved courses, which include a hygiene module. On-going in-house education and training sessions, Infection Control manuals, a Waste Management handbook, information leaflets, and the notice board are available to all staff. Cleaning supervisors undertake competency training and assessment courses and all operatives either hold, or are undergoing assessment for the cleaning operative proficiency Certificate stage 1 from the British Institute of Cleaning Science. Records of attendance at education and training are maintained and an electronic system has recently been introduced to record this information. The organisation organises Annual Infection Control, Health and Safety and Health Promotion awareness weeks. An evaluation tool is used for education evaluation. This is to be commended.

CM 11.3 (A ↓ B)

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

Whilst the training itself is evaluated, continuous quality improvement to patient care and service delivery as a result of education and training is not monitored in a structured way. Measured outcomes for a number of key performance indicators in this regard should be considered. The introduction of an electronic system is a first step in skills analysis by the department to ensure staff are equipped to meet legislation and best practice standards. It is recommended that this process is developed and strengthened.

CM 11.4 (B → B)

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

Performance of the Hygiene Services is evaluated through the audit process by the Contractors and Infection Control Teams. The organisation acknowledges the scope

for further development in this area. The organisation is currently piloting the Health Services Executive performance evaluation system.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (A → A)

An occupational health service is available to all staff

The organisation has a well-resourced Occupational Health department, offering a broad range of services including occupational immunisation and vaccination programmes for all staff. There is also an employee assistance service in place. A number of audits are conducted in conjunction with the Infection Control department and the Occupational Health department plans to develop its own key performance indicators. The organisation, through its Human Resource department, promotes a positive work environment culture which is evaluated through on-going staff surveys and demonstrates continuous quality improvement.

CM 12.2 (A → A)

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

Health and Safety key performance indicators were established in 2005 and are monitored. The organisation is a pilot site for the Health and Safety Authority audit and conducts annual audits, which produce quality improvement plans. The organisation was awarded the Bronze Safety Practitioner Award for the Safety Marshall System in 2003. The Occupational Health Department's pre-employment medical assessment programme was evaluated in 2006 and is in the process of being implemented. Further vaccination and staff satisfaction audits are planned.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.1 (A → A)

The organisation has a process for collecting and providing access to quality Hygiene Services data and information that meets all legal and best practice requirements.

All policies and procedures observed are evidence based and there is a system in place for their approval and updating. Cleaning specification schedules and reports are available in accordance with the Environmental Health Office, ISO 340 and the EIQA. The Catering department carries out sampling analysis and annual risk assessments. The Surveillance Scientist has a structured surveillance and notification system in place. They liaise daily with Infection Control Team and have a regular reporting system with management.

CM 13.2 (A → A)

Data and information are reported by the organisation in a way that is timely, accurate, easily interpreted and based on the needs of the Hygiene Services.

The Hygiene Services produce an Annual report, which forms part of the organisations Annual report. There are well-developed systems in place for Infection Control surveillance through structured clinical site visitation, Microbiology notification and incident and near miss reporting and follow- up. The weekly Hygiene Services meeting is an excellent forum for the regular review of feedback on Infection Control and Contract Cleaner audits and other action report results. There is evidence of quality improvement planning, which is endorsed by the Infection Control Committee.

CM 13.3 (A ↓ B)

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

Hygiene Services activity is now available electronically, which is to be commended. The Microbiology department also uses an electronic quality assurance tool. The evaluation of these systems is recommended in the future.

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

Hygiene is enjoying an increasing high profile among the organisations services and a clear culture of quality improvement was noted during the assessment. Considerable evidence of development in this area was observed. This was especially evident following the Hospital Accreditation process and a number of quality initiatives are now in place. These initiatives are supported by Senior Management for example town hall meetings, which are chaired by the organisations Chief Executive Officer. Improvements were observed in relation to structure and processes of the organisation and include environment and equipment across a range of clinical and non-clinical areas relevant to hygiene improvement (for example shower and hand washing facilities, Waste management, the Catering department and ward pantries, Patient accommodation and Theatre, Theatre recovery and Endoscopy facilities as well as changes in cleaning products and practices). The organisation has also achieved a number of Catering Quality Assurance Awards in the past two years.

CM 14.2 (A ↓ 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.

There is considerable evidence of continuous quality improvement across the spectrum of hygiene services during the past two years. Of particular note are the following: the involvement of Managerial staff at all levels of the organisation, the introduction of town hall meetings, the identification of Hygiene Link Nurses in the clinical areas and the close working relationships between the organisation and its Contractors and all relevant departments. The hygiene management structures in place facilitate a comprehensive approach to continuous quality improvement of hygiene services. Staff, Patient and Public communication systems include use of notice boards, information leaflets, a newsletter, minutes of meetings, audit reports, education/training sessions and specific awareness weeks. As outlined previously in this report, there is on-going audit, Staff and Patient Infection Control satisfaction surveys in 2006 and a six month orthopaedic ward surveillance programme in 2006, planned for repeat in 2007. There are key performance indicator monitoring in some areas and the organisation would benefit from having key performance indicators pertaining to all aspects of hygiene. There is an excellent basis in existence on which to continue to develop the service.

3.0 Standards for Service Delivery

The following are the ratings for the Service Delivery standards, as validated by the Assessment team. The service delivery standards allow an organisation to assess and evaluate its activities in relation to Hygiene Services at a team level. The Service Delivery standards relate directly to operational day-to-day work and responsibility for these standards lies primarily with the Hygiene Services Team in conjunction with Ward/Departmental Managers and the Hygiene Services Committee. There are six Service Delivery standards, which focus on such areas as prevention and health promotion, implementing hygiene services and patients / clients rights. There are seven core criteria within these standards.

EVIDENCE BASED BEST PRACTICE AND NEW INTERVENTIONS IN HYGIENE SERVICES

SD 1.1 (A → A)

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

Documented polices and procedures are in place. Work plans have been established for staff and cleaning specifications have been developed in relation to best practice. Information posters are available in ward kitchens and cleaning stores. Colour coding systems are in place and greater attention to compliance is recommended in areas such as the main kitchen. Staff are facilitated to attend hygiene meetings and training sessions. Patient and staff satisfaction surveys and internal/external audits have been completed, with evidence of resultant actions noted during the assessment.

SD 1.2 (A → A)

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

A documented process for assessing new hygiene service interventions is addressed under the procurement process and is monitored through the hygiene services audits. Details regarding the system trials and validation reports were noted. Infection Control research is conducted in relation to new products prior to their introduction and feedback received is addressed.

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 evidence of community Health Promotion activities such as focused awareness weeks. Also, the organisations Contractors are directly involved in all the organisations activities which are pertinent to them. Customer notice boards, leaflets, posters, news letter and town hall meetings were evidence observed of continuing community education. Greater focus on the evaluation on the efficacy of the organisations Health Promotion activities in relation to hygiene is recommended.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1 (A ↓ B)

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

Hygiene services are provided by a multi-disciplinary Infection Control Committee, which is the overall structure within the organisation for ensuring compliance with legislation and best practice. Clear links with all key stakeholders in relation to hospital hygiene and external Contractors was evident during the assessment. Infection Control Committee terms of reference are in place and were observed. Also, tender documents and job descriptions outline roles and responsibilities of individual team members. The inclusion of a contract cleaning representative on the hygiene services multi disciplinary team is recommended. Evidence of formal evaluation of the efficacy of the multi-disciplinary team structure is also recommended.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

SD 4.1 (B ↑ A)

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

Evidence that significant developments have taken place in the areas of training and improving the organisations physical environment was observed. However, there is scope for further development in a number of areas for example splash backs at hand sinks, furniture replacements (for example commodes) the location of the sluice room in a high risk area, damaged wall surfaces in wards due to lack of bed buffers, evidence of sticky tape residue and non laminated signage was noted in some areas). It is recommended that the replacement of flooring continues especially in high risk areas, which warrants priority attention. Also, external surfaces of bed pan washers/macerator would benefit from increased cleaning. It is recommended that the up grading of shower facilities and designated sinks for hand washing continues to progress according to the organisational plan. Best practice includes the provision of en-suite facilities in all isolation rooms. Documented evidence of service to bed pan washers on bi-annual basis was available, however this process requires validation in accordance with best practice.

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.

The organisations equipment, medical devices and cleaning devices were well managed and generally clean. It is recommended that a designated responsible person for the cleaning of all equipment is identified. A risk analysis must be completed on current reusable items. Adherence to cleaning policy for fans in non clinical areas (for example offices) must be improved.

For further information see Appendix A

*Core Criterion

SD 4.3 (A ↓ B)

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

Cleaning equipment was well managed and maintained. Storage restrictions were noted in some areas. No evidence was available for the changing of vacuum filters. Local evidence of colour coding charts was also not observed.

For further information see Appendix A

*Core Criterion

SD 4.4 (A ↓ B)

The team ensures the organisation's kitchens (including ward/department kitchens) are managed and maintained in accordance with evidence based best practice and current legislation.

The main kitchen was operating to best practice guidelines, however, a lack of compliance regarding structural issues dealing with the fabrication of the building, equipment and traceability was observed. The ward kitchens also demonstrated evidence of compliance.

For further information see Appendix A

*Core Criterion

SD 4.5 (A → 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.

Evidence of best practice was noted during the assessment. Overall, good and well managed facilities were observed; however, during the assessment debris was noted in external areas.

For further information see Appendix A

*Core Criterion

SD 4.6 (A → A)

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

Overall, a very good and well-managed system with a dedicated team was in place.

For further information see Appendix A

*Core Criterion

SD 4.7 (A → A)

The team works with the Governing Body and/or its Executive Management team to manage hand hygiene effectively and in accordance with SARI guidelines

Hand hygiene facilities were observed to be good. Further improvements on existing policies/procedures are underway to fully comply with SARI guidelines.

For further information see Appendix A

SD 4.8 (A ↓ B)

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

Health and safety statements are in place for all areas. A risk management system with adverse and near miss analysis was noted. The organisation has a health and safety plan approved by the management team and hospital board (2006), which was applicable to all staff, contractors, patients and visitors. The organisation has a dedicated health and safety officer with annual health and safety audits and quality improvement plans in place. Weekly monitoring of risk occurrence forms and accident activity was also observed. All adverse incidents are recorded and reported to the risk management department. The patient advocacy representative also evaluates incidents relating to complaints regarding hospital hygiene. The hospital has safety marshals/representatives at ward and department level, with a bi-monthly meeting structure in place. It is recommended that the organisation address the issues identified in the main kitchen. Also, it is recommended that a designated person is identified to assume responsibility for the maintenance of arterial blood gas analysers.

SD 4.9 (C → C)

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

Documented processes are in place for the involvement of patients/clients and families in improving hygiene services. Information leaflets and hygiene posters are in use in the organisation. The organisations visiting policy is based on the national hospital visiting policy and special arrangements for infection outbreak situations are provided for. The invitation of patient representation on relevant hospital committees is planned. Patient comment cards are under consideration and these quality improvement plans are advocated and encouraged.

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.

Infection Control policy guidelines make provision for privacy and confidentiality of Patients/ Clients, who are risk of/have adequate communicable disease. Orientation and Infection Control training address staff awareness in this regard and relevant Patient/Client information leaflets are available. All adverse incidents/complaints are addressed through Risk Management/ Infection Control services and the infection control tracking system, which is in place. Regular communication between Infection Control, Hygiene Services and Management also occurs.

SD 5.2 (B → B)

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

Information is provided through specialist information leaflets, the Patients hand book, the hospital news letter and the hospital notice board. Patient satisfaction surveys are completed by the Infection Control team and continuous quality improvement plans were evident. Greater attention to detail is desirable for ensuring public compliance with hand hygiene and other practices.

SD 5.3 (C → C)

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

A documented process for dealing with customer complaints is in place, with a dedicated Patient advocate to address complaints that are not satisfactorily resolved by front line staff. This Patient advocate is currently evaluating all complaints over a specified time to ascertain the percentage of complaints which are relevant to hygiene. This development is recent and is strongly encouraged.

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1 (B ↓ C)

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

To date, the involvement of Patients/Clients and families in relation to hygiene services is limited to the availability of the Patient advocacy department and the involvement of Patients in the development of an MRSA information leaflet. The organisations plan to include a Patient representative on the hygiene services committee is acknowledged and greater focus is required in relation to Patients/Clients/ families satisfaction with hygiene services. The organisations plan to support isolation information with symbols and to translate infection control information leaflets into most common languages is commendable.

SD 6.2 (B ↓ C)

The Hygiene Services team regularly monitors, evaluates and benchmarks the quality of its Hygiene Services and outcomes and uses this information to make improvements.

Hygiene services have introduced a number of quality improvements over the last two years including additional human resources, changes to cleaning practices and products, environmental upgrades, notice boards and town hall meetings. The hygiene services Annual report contains input from each of the elements of hygiene services. However, the organisation would benefit developing a suite of key performance indicators for hygiene services and a structured system for evaluation and benchmarking. The developments to date provide a good basis to progress these recommendations.

SD 6.3 (C → C)

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

An Annual report was issued, however, further consultation with Patients, Clients, families, staff and service users is recommended. It is recommended that methods used to evaluate resources used by the Hygiene Services Team are identified and evaluated.

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 - The organisation was predominantly compliant. Flaking paint was noted in some areas; however, an action plan was in place to address this issue.

(3) Wall and floor tiles and paint should be in a good state of repair.
Yes - The organisation was predominantly compliant. Some ward and kitchen areas require further attention.

(10) Internal and external signage should be clean, updated, well maintained and laminated to enable cleaning.
Yes - Overall, signage was very good; however, some signage observed was not laminated.

(14) Waste bins should be clean, in good repair and covered.
Yes - A bin replacement programme is in progress and is well advanced. Some uncovered bins still exist, which should be addressed.

(15) Where present a designated smoking area must comply with the national legislation on tobacco control and local organisational policies, a cigarette bin must be available and the floor area should be free of cigarette ends, matches etc.
Yes - A designated smoking area exists; however, this is shared by staff in uniform and general public.

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

(18) Walls, including skirting boards.
Yes - The organisation was predominantly compliant; however, some marks were noted on lightly coloured walls and surface damage was observed at ward level.

Compliance Heading: 4. 1 .5 Sanitary Accommodation

(44) Hand hygiene facilities are available including soap and paper towels.
Yes - Hand hygiene facilities are available and requisites are in place. The position of alcohol dispensers in some areas requires review to ensure optimum use.

(46) Bathrooms / Washrooms must be cleaned on a daily basis. When necessary, they must be disinfected. This must be monitored and recorded.
Yes - Bathrooms / Washrooms are attended to daily or as required. Full compliance with recording is suggested.

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

(56) All associated bathroom fittings including component parts e.g. tiles, taps, showerheads, dispensers, toilet brushes etc should be clean and well maintained.
Yes - Associated bathroom fittings were clean and maintenance/replacement scheme is in place.

(57) Clear method statements / policies should be in place for guidance on all cleaning including sanitary cleaning and maintenance processes.
Yes - Cleaning chemical dilution instructions were observed in place, however, it is recommended that their visibility in local areas is improved.

(58) Sluice rooms should be free from clutter and hand washing facilities should be available.
Yes - Overall, sluice rooms were free from clutter and hand washing facilities were available. Some inappropriate storage in sluice sinks in high-risk areas was noted.

(60) All outlets (including shower outlets) should be flushed at a temperature in accordance with current legislation.
No - Evidence of adherence was not observed.

(61) Hand gel containers / dispensers must be replaced when empty, it is not permissible to 'top-up' containers / dispensers.
Yes - Overall, evidence of the replacement of hand gel containers and dispensers was observed; however, greater attention to the replacement of hand gel dispensers in clinical areas is advised.

(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 - Consumables were available and stored in a suitable environment. Increased frequency of checking in high use areas is recommended.

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

(64) All equipment, including component parts, should be clean and well-maintained with no blood or body substances, rust, dust, dirt, debris and spillages.
Yes - Equipment observed was clean and well maintained. It is recommended that clarity of responsibility for the maintenance of blood gas analysers is ensured.

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

(65) Commodes, weighing scales, manual handling equipment.
Yes - Commodes, weighing scales and manual handling equipment were well maintained overall. Some commodes require replacement due to damaged seating/ back support.

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

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 - Overall, trolleys, suction apparatus and resuscitation equipment was well maintained. Replacement of damaged trolleys, for example medication trolleys, is advocated in all areas.

(79) Flower vases where present should be clean with water changed minimum daily. Wilted flowers should be removed and disposed of accordingly. Note: flowers not recommended in high risk areas.
No - Increased attention to the daily changing of water in flower vases is recommended. It is recommended that role responsibility for this task is established.

(272) Splashes of water or hand-wash gel should not be present on the wall, floor, bed or furniture, splash backs should be provided.
Yes - Compliance was noted and a quality improvement plan has been identified in areas where splash backs have not yet been provided.

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

(82) Vacuum filters must be changed frequently in accordance with manufacturer's recommendations - evidence available of this.
No - No written evidence was observed during the assessment that this process occurs.

(84) Products used for cleaning and disinfection comply with policy and are used at the correct dilution. Diluted products are discarded after 24 hours.
Yes - Products used for cleaning and disinfection complied with company policy, however, increased monitoring at local level is recommended to ensure total compliance.

(86) Information on the colour coding system is available to all hygiene staff (according to national guidelines).
No - Colour coding posters were not observed in areas.

(90) Storage facilities for Cleaning Equipment should be provided in each work area with adequate ventilation, a hot and cold water supply and hand-wash facilities.
Yes - Hand wash sinks were provided in most areas inspected, however, due to space constrictions separate hand wash facilities were difficult to achieve in some locations. It is suggested that an alternative, for example hand gel, is made available in these locations.

(94) Health and Safety policies should be in place for the use of ladders/steps when cleaning.
No - A Health and Safety policy for the use of ladders/steps was in the early stage of development.

(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 - As part of the tender specification, electrical equipment is supplied with circuit breakers.

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

(214) The person in charge of catering shall develop, implement and maintain a permanent system based on the seven principles of HACCP. A standard HACCP Plan should be fully completed.
Yes - An active HACCP team and plan is in place in the organisation.

Compliance Heading: 4. 4 .2 Facilities

(218) Authorised visitors to the food areas should wear personal protective clothing (PPE) and wash hands on entering the food area during food preparation/serving times.
Yes - Currently, a wash hand basin is not provided at the main entrance. This provision has been included as part of the kitchen refit plan. It is recommended that clearer instructions are available and alcohol gel is provided for visitors.

(220) Staff must not consume food or beverages intended for patient use, food should not be consumed in the ward kitchen and no food is to be routinely prepared in the ward kitchen other than beverages and toast.
No - Bottles of staff drinking water were noted in a number of food preparation and storage areas in the kitchen.

(221) Staff clothing/uniforms/shoes personal belongings should not be stored in food rooms.
Yes - It is recommended that the organisation ensure that chill room clothing is adequately stored. This area should also be clearly identified.

(224) The ventilation provided for all cooking and steam emitting equipment shall be sufficient to prevent condensation on walls, ceilings and overhead structures during normal operations.
No - No ventilation is provided over the cooking equipment in the dietary preparation room.

(225) Staff in charge of Ward Kitchens shall ensure that product traceability is maintained while the product is in storage (Regulation (EC) 178/2002). Stock shall be rotated on a first in / first out basis taking into account the best before / use by dates as appropriate. Staff food should be stored separately and identifiable.
No - Traceability of products at ward level was compliant. Batch code details/ use by dates were not recorded for red meat and poultry. Dairy delivery checks were not completed for traceability/temperature at intake. Out of date foods were noted in the dairy cold room in the main kitchen. Items were inadequately date labelled during storage, especially in the dietary section. The Catering Manager was made aware of the issues and evidence was provided before the end of the assessment of the relevant action completed.

(226) Containers used to store foods shall be made of food grade materials, be in good condition, easy to clean and disinfect.
Yes - Some mayonnaise buckets were noted in use for the storage of food ingredients.

Compliance Heading: 4. 4 .3 Waste Management

(233) In food preparation areas where lidded bins are provided they shall be foot pedal operated.
No - Bins in the kitchen areas were un-lidded. A plan in place for the replacement of un-lidded bins.

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

(240) A Hospital using a cook-chill system should comply with Guidance Note No. 15 Cook-Chill Systems in the Food Service Sector (Food Safety Authority of Ireland) The temperatures of fridges, freezers, cold rooms and chill cabinets shall be capable of maintaining the temperature of foodstuffs
Yes - Some older cook chill trolleys are not compliant with the FSIA cook chill guide No 15. New compliant trolleys are being phased in as replacements are required. Staff are vigilant at ward level to ensure temperature checks are completed upon arrival and regeneration.

(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 - Ice cream display units are not in use in the organisation.

(242) Temperatures for Food in Fridges / Freezers and Displays should comply with I.S.340:2006 requirements
No - All units were satisfactory with the exception of the chest freezer units, including the dietary freezer, which was not temperature checked as part of the kitchens monitoring system. Prior to the end of the assessment, evidence was provided by the catering manager of the revised monitoring system.

(243) Preparation of High Risk Foods should comply with I.S. 340:2006 requirements
No - Traceability of products at ward level was compliant. Traceability of raw product was not evident at intake in the main kitchen. Cross contamination was inadequately controlled. Raw meat was stored over ready to eat smoked salmon in the cold room. Dietary food portions were insufficiently protected/covered during frozen storage. Batch code details/ use by dates were not recorded for red meat and poultry. Dairy delivery checks were not completed for traceability/temperature at intake. Out of date foods were noted in the dairy cold room in the main kitchen. Inadequately date labelled items were observed, especially in the dietary section. The Catering Manager was made aware of the issues and evidence was provided before the end of the assessment of the relevant action completed.

Compliance Heading: 4. 4 .6 Food Preparation

(245) Cleaned and disinfected work surfaces, equipment and utensils shall be provided for preparing ready to eat foods and foods to be cooked to prevent the risk of contamination. In addition to the HSE hospital colour coded system (see Appendix 6 Irish Acute Hospitals Cleaning Manual 2006), the food colour coding of work surfaces, equipment and utensils should be provided for (see I.S. 340:2006).
No - Colour coded utensils were not adequately controlled. It is recommended that the organisation introduce the clear identification of utensils.

Compliance Heading: 4. 4 .7 Food Processing

(246) The thawing of food shall be carried out under appropriate conditions such as in a thawing unit, a fridge or a microwave oven with thawing cycle
Yes - However, best practice recommends that items frozen from fresh are adequately labelled.

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

(142) Healthcare risk waste should be tagged and secured before leaving the area of production.
Yes - Evidence of best practice included concurrent labelling and tagging of hazard waste bins.

(145) A record is kept of tags used for each ward/department for at least 12 months.
Yes - A record is kept of tags used for each ward/department for at least 12 months. Space for recording tag numbers in high use areas were difficult to read.

(152) When required by the local authority the organization must possess a discharge to drain license.
Yes - Evidence of a discharge to drain license was noted in theatre.

Compliance Heading: 4. 5 .3 Segregation

(155) Waste segregation should adhere to national colour coding scheme.
Yes - Bio degradable bags were in use for non risk waste - this is to be commended.

(256) Mattress bags are available and are used for contaminated mattresses ready for disposal; mattresses are disinfected.
No - Mattress bags are not in use, with the exception of contractor supplied pressure relieving mattresses.

Compliance Heading: 4. 5 .4 Transport

(165) There is a designated person trained as a Dangerous Good Safety Advisor (DGSA) or the services of a DGSA are available to the hospital.
Yes - A contracted service is in place.

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.
Yes - Locking was identified as impractical due to frequent emptying of waste bins.

(258) Waste receptacles should be sanitised, secure and in a good state of repair when used.
Yes - Sanitisation of temporary storage containers for sharps bins at ward level is recommended. A motorised internal transport cleaning vehicle should be considered also.

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 - Verbal evidence of training was available, however, written evidence was not observed.

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

(173) Documented processes for the use of in-house and local laundry facilities.
No - Guidelines on the use of this facility to ensure correct segregation and temperature for different products is recommended. Verbal evidence was provided throughout the assessment.

(261) Clean linen store is clean, free from dust and free from inappropriate items.
Yes - Overall, the process observed was very good. However, in some clinical areas where space is very restricted, some clean linen storage was noted on the floor. The cleaning of the motorised towing vehicle also needs to be addressed.

(262) Linen is segregated into categories and in appropriate colour coded bags (i.e. clean/unused linen, dirty/used linen, dirty/contaminated linen).
Yes - Linen is segregated into categories and also into appropriate colour coded bags. In accordance with best practice, trolley liners should be changed after each use when transporting dirty linen from clinical areas.

(268) Ward based washing machines are used only with the agreement of the Hygiene Services Committee.
Yes - Ward based washing machines were not observed.

(271) Hand washing facilities should be available in the laundry room.
Yes - This was not applicable in this organisation.

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

(190) All sinks should be fitted with washable splash backs with all joints completely sealed.
No - Washable splash back installation work was in progress regarding the fitting of washable splash backs at hand washing sinks. Sinks, where work had been completed, was satisfactory.

(205) General wards should have one sink per 4-6 beds and critical areas should have one sink per 1-3 beds.
Yes - However, the dialysis unit was an exception. Plans for upgrading are in place.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team		Assessor Team	
	FREQ	%	FREQ	%
A	37	66.07	23	41.07
B	16	28.57	28	50.00
C	3	05.36	5	08.93
D	0	00.00	0	00.00
E	0	00.00	0	00.00
N/A	0	00.00	0	00.00

5.2 Ratings Details

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

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