



Hygiene Services Assessment Scheme

Assessment Report October 2007

Bantry General Hospital

Table of Contents

1.0 Executive Summary	3
1.1 Introduction.....	3
1.2 Organisational Profile	7
1.3 Notable Practice	7
1.4 Priority Quality Improvement Plan	8
1.5 Hygiene Services Assessment Scheme Overall Score	9
2.0 Standards for Corporate Management.....	10
3.0 Standards for Service Delivery.....	21
4.0 Appendix A.....	27
4.1 Service Delivery Core Criterion	27
5.0 Appendix B.....	34
5.1 Ratings Summary	34
5.2 Ratings Details	34

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

Bantry General Hospital provides acute general hospital services to the population of the West cork area extending to locations as distant as the Beara Peninsula and Mizen Head.

Bantry General Hospital is a 118 bedded Acute General Hospital and provides within available resources a comprehensive range of inpatient, outpatient and day case services in response to identifying needs and in accordance with the principles of equity, people centeredness, quality and accountability.

Services provided

A wide range of specialities are delivered by the hospital. These are:

- General Medicine, which includes coronary, Endocrinology and ICU
- General surgery, which includes Casualty Services
- Old Age Medicine, which includes an 8 bedded Rehabilitation and Assessment Unit.
- Care of the Elderly & Respite Care.
- Radiology.
- Palliative Care
- Mental Health Services
- Outpatient Department

The following additional Specialist Out-Patient Services are provided by Visiting Consultants –

- Orthopaedic
- Paediatric
- Maternity
- Orthotic
- Urology

Physical structures

There are no negative pressure rooms in the hospital.

The following assessment of Bantry General Hospital took place between 3rd and 4th September 2007.

1.3 Notable Practice

The following were the areas of notable Practice identified:

- The refurbishment work completed in the ward areas and the main kitchen was of a high standard.
- The recently constructed waste compound is well located for convenience and completed to a secure standard.
- A good supply of waste bins were observed in the clinical areas for domestic and clinical waste and all appeared to be new and in excellent state of maintenance.
- The general cleanliness of the hospital was of a high standard.

- There was evidence of extensive staff commitment to the hygiene services.
- There was evidence of strong leadership in relation to hygiene services from hospital management.
- Excellent use of space for storage purposes was observed in the ward/department areas, especially those recently refurbished.

1.4 Priority Quality Improvement Plan

- The implementation of HACCP needs to be continued to ensure full compliance.
- It is recommended that documented processes be established for all hygiene functions.
- The organisation is recommended to expand internal hygiene auditing to include all areas. It must be structured according to an agreed sequence, with evaluation, actions, responsibilities and reports to the Executive Management Team.
- Staff facilities, while of a high standard, were fragmented and limited in supply. These should be replaced with a central facility in the near future.
- The Hygiene Services Committee should review its membership to include representation from all disciplines.
- The organisation is recommended to establish a Hygiene Services Team.
- The hospital should consider expanding the Policies, Procedures and Guidelines Committee to include representation from all disciplines.
- The main kitchen should commence the food sampling process immediately, as agreed during the assessment.
- Attention must be given to the ventilation system to ensure it is cleaned on a regular basis.

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 Bantry General Hospital has achieved an overall score of:

Fair

Award Date: October 2007

2.0 Standards for Corporate Management

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

PLANNING AND DEVELOPING HYGIENE SERVICES

CM 1.1 (C → C)

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

The Hospitals Executive Management Team regularly assesses the overview of the hygiene services. This was evidenced in the agenda and in the minutes of meetings of the management team. The hospital has reviewed the previous external hygiene audits and has reviewed its subsequent results and action plans. Evidence of this compliance was observed in changes to the waste management system at the hospital and the hospital hand wash sink replacement programme. The hospital has commenced internal hygiene audits in some clinical areas, the results of which were observed. Evidence of a Hygiene Corporate Plan and service plan was provided. The hospital has developed the national cleaning manual as the cleaning manual of choice at the hospital. This manual is in line with best practice, as well as the HACCP plan in relation to food safety at the hospital. There has been some evaluation in relation to HACCP and hygiene audits. However, no evaluation has been carried out in relation to the needs assessment process. It is recommended that a hospital-wide hygiene needs assessment is carried out. It is also recommended that all areas in the hospital are included in the hygiene audit process.

CM 1.2 (C → C)

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.

While the hospital carries out internal hygiene audits in clinical areas, (the results of which were available), limited evidence that the internal audit system actually reflects the hygiene plans at the hospital was observed. The hospital has a Hygiene Services Committee in place since January 2007. Evidence of the minutes of their meetings indicates some of the issues in the management of hygiene. These included hand hygiene, waste training, sink replacement and colour coding. Limited clinical area hygiene audits have been carried out and audit analysis for one area was observed. There is no system of information available as a result of incident reporting or patient satisfaction with the hygiene services. It is recommended that the hospital review its internal audits and extend the audit process to all areas of the hospital. It is also recommended that the hospital develop resultant actions, and Quality Improvement Plans and feedback procedures to enhance the hygiene journey at the hospital.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1 (C → C)

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.

Bantry General Hospital is a member of the Health Services Executive South. The Executive Management Board report to the Network manager collectively and individually. The hospital links, through the Health Services Executive South, with Government agencies, the Department of Health and Children and the National Hospital officers, Health and Safety Authority and Environmental Health Officers. The hospital actively links with the Primary, Community and Continual Care locally through an integration programme. Evidence of this integrative approach was observed in the minutes and agendas of the integration committee. The hospital has adopted a Partnership approach with staff and management at the hospital (with documented processes). The hospital has strong linkages with the Friends of Bantry Hospital. It is recommended that the hospital instigate patient satisfaction surveys for hygiene. It is also recommended that the hospital evaluate the efficacy of its linkages and partnerships. The hospital is recommended to establish Quality Improvement Plans, feedback mechanisms and resultant actions.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 (C → C)

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

The Hospital has a clear Corporate Hygiene Service Plan and Operational Plan in place. There is multi-disciplinary Hygiene Committee in place. There is an organisational chart in place for the hygiene services with identified service accountabilities. There was no evidence of team membership lists, frequencies or terms of reference observed. However, there were goals, objectives and outcomes noted.

It is recommended that the hospital evaluate its corporate Strategic Plans goals, objectives and priorities. It is also recommended that a site specific hygiene needs assessment is completed.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.1 (C → C)

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

The Hospital Executive Management Board was established in 2006. Hygiene has been included in agendas and minutes. There are hospital policies in place, including procurement, hygiene, human resources, recruitment and clinical. There are authority provisions included in the role of the job description of the Director of Nursing for hygiene, risk, health and safety. The hospital adheres to a hospital code of corporate ethics for the Health Services Executive South and to a hospital mission statement. A suite of hospital policies, procedures and guidelines has been developed. It is recommended that the hospital evaluate its adherence to national guidelines and

legislation in relation to the hygiene services. It is also recommended that the hospital develop a documented process of development of policies, procedures and guidelines.

CM 4.2 (C → C)

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

The Executive Management Board at the hospital receive, through the Director of Nursing and the Hospital Manager, hygiene information, best practice guidelines and audit results on an irregular basis. The hospital has received best practice guidelines in relation to the Strategy for the control of Antimicrobial Resistance in Ireland (SARI), the National Cleaning Manual and Food safety regulations and has commenced implementation of these guidelines at the hospital. It is recommended that a formal structure of reporting to the Executive management Board for hygiene issues be developed and in particular detailed internal and external audits reports, quality improvement plans and resultant actions.

CM 4.3 (C → C)

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.

The hospital has an on site library, with internet access available all staff. The hospital has developed hygiene policies in relation to the management of the sink replacement, colour coding, hand gels, cleaning schedules and frequencies using the national cleaning manual and SARI guidelines. There is evidence that in-house training and education in relation to hand hygiene, waste, orientation and training programmes are available. Limited evaluation has been carried out in respect of in-house education and training programmes. It is recommended that evaluation of education and training is carried out and that a composite report system is established to look at attendance level efficacy and appropriateness of courses. It is recommended that the Hygiene Services evaluate its research and best practice information to ensure appropriate availability.

CM 4.4 (C → C)

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

The hospital has developed hygiene procedures for the hygiene services including schedules, frequencies, and product control. The hospital has a Clinical Policies, Procedures and Guidelines Committee in place. The hospital Hygiene Committee has progressed the development of hygiene policies and procedures in line with the national cleaning manual, including waste, colour coding and general cleaning procedures. No evaluation of the process of policy development and management has been carried out. It is recommended that the hospital introduce a documented system for the development of policies, procedures and guidelines with revision, approval and control systems. It is further recommended that the Clinical Policies, Procedures and Guidelines Committee is extended to include all areas of the hospital in line with a hospital-wide approach to the management and development of all hospital policies, procedures and guidelines.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

*Core Criterion

CM 5.1 (B → B)

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

The management and responsibility of the Hygiene Services from a corporate position lies with the Executive Management Board of the hospital. The office of the Director of Nursing manages the hygiene operational issues, staff and allocation of resources. Internal and external audits are evaluated and resultant actions are managed through Catering and Nurse Management. Health and Safety audits are reviewed by hospital management. Evidence of organisational charts was observed with linkages to all areas of the hospital. Details of accountabilities for all staff, including ward managers was observed. Membership of the Hygiene Committee was noted. Hospital management staff has responsibility for hygiene under the provision of a safe service to the service user and is detailed in the job descriptions for Director of Nursing and Hospital Manager. It is recommended that the hospital review its Executive Management Board (EMB) hygiene roles, responsibilities and accountability in formal and documented processes.

*Core Criterion

CM 5.2 (B → B)

The organisation has a multi-disciplinary Hygiene Services Committee.

A multi-disciplinary committee is in place at the hospital with membership and terms of reference available. Terms of reference, minutes of meetings and action plans were observed. Administrative support is provided through the general clerical support services at the hospital. It is recommended that the hospital consider the establishment of a Hygiene Services Team. It is also recommended that the Hygiene Services Committee is extended to include all services and groupings at the hospital.

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.

Resources have been provided to the hospital as a result of previous external hygiene audits and following recommendations of Environmental Health Officer reports and waste management reports. The hospital has allocated funding for sink replacement, refurbishment of ward kitchen area, Central Sterile Supply Department (CSSD), colour coding and single mop usage. There is Corporate Hygiene Strategic Plan and a service in place with allocated resources and costings, along with a priority list for development. Through the terms of reference of the Hygiene Committee, there is a documented process to ensure that the hospital's allocation of hygiene resources is provided in an appropriate manner. There is a documented process in the purchasing department for the management and supply of hygiene products.

CM 6.2**(B ↓ C)****The Hygiene Committee is involved in the process of purchasing all equipment / products.**

There is a clear purchasing policy at the hospital. In general, all products are provided from a central procurement process in the Health Service Executive South central procurement office and according to Health Services Executive (HSE) National Procurement Policies. Additional non-stock items are purchased in line with local purchasing policy. The Hygiene Services Team has direct input into the hygiene purchases. The Infection Control Nurse also liaises with the supplies department and the Hygiene Committee in relation to the appropriateness of hygiene products. Limited pre-purchase process and evaluation is carried out as many items, for example, colour coding products, gels and waste bags, are carried out centrally. Approval for in-house purchasing of non-stock items is in accordance with local policy. It is recommended that evaluation of the efficacy of the consultation process is carried out.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

CM 7.1**(B ↓ C)****The organisation has a structure and related processes to identify, analyse, prioritise and eliminate or minimise risk related to the Hygiene Service**

The hospital has a structure in place for the management of the identification and recording of risks. The hospital submitted incident forms to the STARS system of management. However, no composite results from STARS or composite reports of risks are received by the hospital. The hospital deals with risk incidents through the office of the Director of Nursing on an individual risk incident basis, but no annual report or composite evaluation is carried out. There have been no major hygiene risks at the hospital. It is recommended that the hospital review the management of the recent Small Round Structured Virus (SRSV) outbreak and complete an action plan for further reference. Areas of potential risk addressed to the hospital during the assessment such as catering, pharmacy and building works were dealt with a satisfactory manner. The hospital does not have a risk management officer or department. There was evidence of Health and Safety Authority and Environmental Health reports, with subsequent outcomes and remedial actions. There was evidence of internal and external hygiene reports for clinical areas. It is recommended that the hygiene audits be extended to all areas of the hospital. It is also recommended that Risk Management and Health and Safety annual reports are compiled.

CM 7.2**(C → C)****The organisation's Hygiene Services risk management practices are actively supported by the Governing Body and/or its Executive Management Team.**

There is no Risk Management Department at the hospital. There is an intention that Risk Management Services will be provided from a regional base and will support internal risk management services. The hospital, through the office of the Director of Nursing, reviews risk incident reporting and instigates investigation and referral to Occupational Health Services if required (for example in such areas as needle stick injuries).

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion

CM 8.1 (B ↓ C)

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

In general, all contracts for service, equipment and products are developed and managed through the centralised material management department at regional level. Local contracts are managed by the hospital supplies department in line with the purchasing policy at the hospital. Regional contracts for waste, linen, water maintenance, and food were observed. The local linen policy is a verbal agreement with the local laundry. It is recommended that this contract is formalised and monitored by the hospital. Ventilation unit contracts were observed. It is recommended that the hospital review its monitoring process of contractors supplying services in order to ensure compliance with terms of both regional and local contracts.

CM 8.2 (B ↓ C)

The organisation involves contracted services in its quality improvement activities.

There are no contracted services for staff at the hospital. All hygiene services staff such as cleaning, waste and portering are employed by the hospital. There was evidence that the external linen contractor has been involved with the linen Quality Improvement Plan (QIP) in the linen disposal and linen bag areas. There has been extensive consultation with the waste contractor, both domestic and clinical, during the development of the new waste management system. There was no evidence available at the hospital of the involvement of a contractor in the development of quality improvement plans at regional level. It is recommended that the hospital review its consultation processes with both local and regional contractors.

PHYSICAL ENVIRONMENT, FACILITIES AND RESOURCES

CM 9.1 (B ↓ C)

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

The main hospital was built in the 1950s in line with building regulations of the period. The hospital has reviewed and renewed areas in line with best practice in the intervening period, including fire safety issues and the provision of clinical hand wash sinks in line with current standards. New flooring has been laid in accordance with current best practice and the CSSD was renovated to current building regulations.

There is a current capital development project underway at the hospital which will allow a review of current bed allocation. The purpose of this Capital Development Plan is to comply with SARI Guidelines for Infection Control and provide more hygiene facilities and increased bed space. The hospital is encouraged to complete an Aspergillus Risk Assessment for the current project. This was identified as a concern by the assessment team and remedial actions were carried out, including a Statement of Intent, immediate sealing of an external door to prevent dust coming into an open medical ward and the development of a documented process for the management of Aspergillus. The remedial actions carried out during the assessment were satisfactory.

*Core Criterion

CM 9.2 (B → B)

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

The hospital complies with legislation and best practice. It adheres to the National Waste Management Programme, Food Safety (HACCP) and Health and Safety Regulations. The hospital has a corporate and service Hygiene Plan and a Hygiene Committee. It also has a documented process for the management and audit of waste, linen, clinical areas, daily check lists and operational policies for cleaning, equipment, and procurement. There are limited clinical area audits and outcomes and resultant actions in those areas. It is recommended that the audit and evaluation in the hospital be systematic and hospital-wide

CM 9.3 (B → B)

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

The hospital's internal and external audit processes, risk incident reporting and management of patient complaints are used to ensure that the hygiene services are effective and efficient. The commencement of education evaluation will ensure consistency in the hygiene education programmes. The Occupational Health Department reports on sharps incidents and slips, trips and falls identify other mechanisms to ensure that the hygiene services are efficient and effective. The introduction of an Infection Control nurse and the management of infections at the hospital, as well as monitoring and evaluation, will develop trends for hygiene services.

CM 9.4 (C → C)

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

There was limited information available, as the hospital has not conducted any patient satisfaction surveys to date. There are plans to develop a patient satisfaction and staff satisfaction survey in an indeterminate timeframe. There have been no complaints received in relation to the Hygiene Services. The hospital has very active Friends of the hospital who provide valuable support. The hospital Hygiene Committee is seeking a nomination from this group onto the Hygiene Services Team. Service users questioned during the assessment expressed satisfaction with the processes in place for the management of Hygiene Services at the hospital. It is recommended that formal patient and staff satisfaction surveys and processes are developed.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 (A ↓ B)

The organisation has a comprehensive process for selecting and recruiting human resources for Hygiene Services in accordance with best practice, current legislation and governmental guidelines.

There is a robust recruitment policy at the hospital which ascribes to best practice guidelines as laid down by the National Recruitment Policies. Job descriptions were noted for all grades of hygiene staff. Four staff records were reviewed for compliance with recruitment standards and were deemed appropriate. Sample templates of job specifications, pre-employment occupational health assessments and interview

procedures were noted. It is recommended that the hospital would evaluate its recruitment process for the selection and recruitment of its Hygiene Services staff.

CM 10.2 (C → C)

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

Human resources are assigned on a planned rostered basis in line with service level and human resource agreements. Additional staff are assigned as required and were available during the recent SRSV outbreak. It is recommended that the hospital complete a hygiene needs assessment for human resources to ensure appropriate levels of service.

CM 10.3 (C ↑ B)

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

The recruitment process at the hospital ensures appropriateness of qualifications and training and fit for purpose job specifications in line with national Human Resources (HR) standards, agreements and professional recommendations. Additional training is available during the induction process for new staff at the hospital. External contractors for linen, waste and food products have qualifications and education as a core component of the tender and contract process.

CM 10.4 (C → C)

There is evidence that the contractors manage contract staff effectively.

Contract staff for external services such as linen and waste have documented processes for the management of staff in line with specific company policies. There are no in house contract staff employed. It is recommended that the hospital ensures that the occupational health needs of contract companies are established and that a review of training and education of contract staff is validated by the hospital in accordance with the terms of the tender/contract process.

*Core Criterion

CM 10.5 (C → C)

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

The Corporate and Service Hygiene Plans have identified the staffing levels for the Hygiene Service in line with the hospital's allocation of finances and resources. Additional staff are employed on a needs basis, such as in the case of an SRSV outbreak. New capital projects have staffing requirements for hygiene and have hygiene support facilities incorporated, including domestic service rooms.

ENHANCING STAFF PERFORMANCE

*Core Criterion

CM 11.1 (B → B)

There is a designated orientation / induction programme for all staff which includes education regarding hygiene

There is a designated orientation and induction programme for all grades of staff at the hospital, which includes a completed checklist of mandatory training and education on commencement of duty and a defined six-week sign-off period.

Mandatory training includes hand hygiene, moving and handling, fire safety and hospital policies and procedures. Attendance at occupational health services and vaccination programmes is available as appropriate. An induction package is given to all staff. It is recommended that the hospital internally audit attendance records at induction and orientation.

CM 11.2 (N/A ↓ C)

Ongoing education, training and continuous professional development is implemented by the organisation for the Hygiene Services team in accordance with its Human Resource plan.

On-going education is available at the hospital for hand hygiene, waste and sharps. Training is also part of the induction programme. Education and training is being further developed in association with the Infection Control nurse. It is recommended that education is continued and a system of evaluation is put in place to ensure staff satisfaction, efficacy of the education programmes and effectiveness of the Hygiene Services.

CM 11.3 (C → C)

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

Evidence that Hygiene services are effective was provided through the results of internal hygiene audits, improvements in external audit reports, health and safety reports and environmental health audits, outcomes and resultant actions. Risk management results such as needle-stick injuries and slips, trips and falls statistics provided evidence that few incidents related to hygiene. Limited patient complaints indicating patient dissatisfaction with the Hygiene Services are received. It is recommended that staff evaluation and satisfaction is carried out for all education and training and that attendance records are monitored and evaluated.

CM 11.4 (B ↓ C)

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

There is a documented process within the recruitment structure for all new staff at the hospital. Education and training records were observed, as were personnel records of four staff members. There is a process for the management of disciplinary procedures in line with the national People Management Framework. No formal staff evaluation is carried out. In addition, no performance appraisal is performed on a managed basis.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (B ↓ C)

An occupational health service is available to all staff

A limited occupational health service is available to the hospital and is provided by the Occupational Health Department of the HSE South based at Cork University Hospital. There was some evidence of evaluation by the Occupational Health Department (OHD) in relation to the prevalence of needle-stick injuries at the hospital. All vaccinations and staff records are maintained by Cork University Hospital. No staff satisfaction surveys of the OHD have been carried out at Bantry General Hospital.

It is recommended that a staff satisfaction survey is carried out in relation to the Occupational Health services provided.

CM 12.2 (B ↓ C)

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

There has been a wellness at work programme at the hospital. Details of this programme were noted. Staff attendance is formally monitored and recorded and appropriate action taken (i.e. referral to Occupational Health or Employee Assistance Programme (E.A.P)). Staff turnover rates are reviewed as an indicator of staff satisfaction.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.1 (B ↓ C)

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

The hospital receives (through the Health Service Executive (HSE), Department of Health and Children (DOHC), statutory and professional bodies) relevant information and data in relation to the Hygiene Services, such as National Cleaning Manual from HSE and food safety data from the Food Safety Authority. The hospital also supports the education programme of the infection control department, such as control nurses attending specialist higher diploma courses in infection control. The hospital also implemented the National Visiting Policy as devised by the HSE. It is recommended that the hospital evaluate its data information processes to ensure that all relevant statutory regulations and legislation and issues of best practice are incorporated in the Hygiene Services.

CM 13.2 (C → C)

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

There is evidence that the hospital reports information throughout the organisation in a structured approach, through departmental meetings, hygiene committee meetings and hospital newsletters. Results, outcomes and resultant actions are circulated throughout the hospital following internal and external audits. Some evidence was available on incident reporting and patient complaints but there were no composite reports or trend analysis developed.

CM 13.3 (C → C)

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

There are limited evaluation processes at the hospital. Clinical areas are audited and evaluated, with outcomes and resultant actions taken. Some evaluation of individual education programmes has commenced but no actual report of the evaluation was available. There was no evidence of evaluation of processes, education or linkages. It is recommended that the hospital review its evaluation processes in a systematic manner.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

CM 14.1 (B ↓ C)

The Governing Body and/or its Executive Management Team foster and support a quality improvement culture throughout the organisation in relation to Hygiene Services

The Executive Management Board and the Hospital Management Team support quality improvement in the hospital. There was evidence of the management of hygiene processes in the hospital through the hygiene committee, minor capital expenditure, development of Policies, Procedures, Guidelines (PPGs) and hospital newsletters. There is no Quality Manager or department at the hospital.

CM 14.2 (C → C)

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

Evidence was provided of methods utilised to evaluate Hospital Hygiene Services and make improvements for example the use of external audits such as previous National hygiene audits (2005 and 2006), EHO reports and waste management reports. The hospital has carried out internal audits in clinical areas. The results of these audits both internal and external have instigated improvements in a programme of hand hygiene facilities, hygiene education, colour coding and waste management. The hospital's Hygiene Services Committee has circulated minutes of meeting to committee members and these have been circulated to staff. The hospital newsletter under the auspices of the Partnership Committee is be commended and encouraged to continue. A specific hygiene update has been included in this newsletter. There was little evidence of benchmarking; however, the hospital visited another acute hospital in the region in relation to the preparation for the current assessment. This other hospital had benchmarked itself against previous audits of the hospital and other hospitals in Ireland, but unfortunately no formal documentation was available to support that initiative. Continuous evaluation has been carried out in clinical areas.

It is recommended that the hospital continue to audit and evaluate Hygiene Services at the hospital and extend the process to all areas.

3.0 Standards for Service Delivery

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

EVIDENCE BASED BEST PRACTICE AND NEW INTERVENTIONS IN HYGIENE SERVICES

SD 1.1 (B ↓ C)

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

The hospital had a system for the acquisition and application of relevant legislation and best practice guidelines, with a good network system observed in place to other acute hospitals. The hospital had its own Nurse Practice Development unit, which has responsibility for development of policies, procedures and guidelines. Good library facilities were observed in place. A colour-coding system was in operation for cleaning in the hospital and it is recommended that the organisation introduce colour-coding for soiled linen. No formal evaluation of the efficacy of the processes used to develop best practice guidelines was in place, however, the Hygiene Services Committee, which had only been established in recent months, are enthusiastic regarding this process. The organisation is recommended to establish a Hygiene Services Team to ensure involvement/ownership by front line staff.

SD 1.2 (B ↓ C)

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

There were no documented processes in place for assessing new Hygiene Interventions and changes to existing ones. There was considerable evidence of new Hygiene Interventions during the last two years, which included new cleaning systems and products. Hygiene audits have commenced in the ward areas and should be extended to all areas of the hospital as planned by the Hygiene Services Committee. There should be a formal evaluation process developed for all changes in Hygiene Services Interventions. The Hygiene Services Committee plans to evaluate their Hygiene Agenda following the outcome of this assessment, which is recommended. There should be a system of evaluation with action points and identified responsible persons following each Hygiene Audit Outcome. This should be trended and reported to the Executive Management Board.

PREVENTION AND HEALTH PROMOTION

SD 2.1 (C → C)

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

Posters were observed informing patients and the public of Hand Hygiene requirements and procedures and the visiting policy was widely displayed. Information leaflets were available on Hand Hygiene and Methicillin Resistant Staphylococcus Aureus (MRSA). The media were utilised to communicate with the public in relation to a recent outbreak of Winter Vomiting Bug in the hospital. There was no formal evaluation of the efficacy of the activities undertaken and this should be addressed in respect of all changes/developments. This will ensure a continuous quality improvement culture/best practice is an integral part of the Hygiene Agenda. Consideration should be given to identification of any external service providers such as visiting hairdressers and the organisation should ensure that there are documented processes to ensure their awareness/compliance with relevant Infection Control/Hygiene issues.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1 (C → C)

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

There was evidence of good multidisciplinary working in relation to Hygiene Issues. The Hygiene Services Committee should review its membership to ensure full inclusion of all disciplines. The organisation is recommended to formally establish a Hygiene Services Team and the efficacy of the multidisciplinary team should be reviewed on a structured basis.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

SD 4.1 (B → B)

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

Overall the physical environment was neat, tidy and clean. There was no evidence of any unnecessary equipment. There was evidence of continuous upgrading of all areas with much hard rock and stainless steel surfaces and fittings. Bin holders all appeared to be replaced recently and were in excellent condition. Most patient and staff shower/toilet facilities had been recently upgraded. While sluice rooms were multipurpose, they were well maintained. The grounds were neat and tidy, windows were clean, and a high level of staff interest in the overall standards of hygiene was observed.

For further information see Appendix A

*Core Criterion

SD 4.2 (B ↑ A)

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

All equipment was cleaned regularly and generally to a schedule. Overall, the standards observed were very good, however some exceptions were noted (for example, bed frames). Documented method statements /schedules should be developed for the cleaning of all equipment.

For further information see Appendix A

*Core Criterion

SD 4.3 (B ↑ A)

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

New cleaner's stores were created in the clinical areas during the recent refurbishment, which were not very large but well maintained and used for equipment storage only. New stainless steel locked cupboards were available in the sluice rooms for cleaning products. Cleaning equipment was well maintained. A colour-coded system with disposable mop heads was in place. High dusting sleeves and dishcloths from the main kitchen (which were stated to have the approval of the Environmental Health Officer) were laundered at a local commercial laundry. Written evidence of compliance with section 61 HSG 95(18) should be sought from the local laundry and the contract process formalised.

For further information see Appendix A

*Core Criterion

SD 4.4 (B ↑ A)

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

The main kitchen had been recently refurbished. New staff facilities were provided. Hard rock and stainless steel surfaces were provided in the food preparation areas. The full implementation of HACCP was a work in progress and considerable development had been achieved in recent months. There was an interlinking door between the main kitchen and staff/public canteen which was open. This door should have been closed at all times to control inappropriate access and a coded lock fitted to permit appropriate access of catering staff. Food sampling should have been commenced immediately and steps had been taken in consultation with the Environmental Health Officer (EHO) to put this process in place during the assessor's visit. The main/only dishwasher was in need of replacement. A new dishwasher was ordered during the assessor's visit and delivery was expected within one week. Temporary measures were put in place to manage the process in the intervening period. The revised Safety Statement for the main kitchen was in progress and had yet to be completed.

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.

There was evidence of best practice in relation to the whole management of Hygiene Services hazardous materials. The waste compound, which was a recent development, was secure, convenient to the main hospital building, and well maintained.

For further information see Appendix A

*Core Criterion

SD 4.6 (B → B)

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

A central linen contract was in place for bed linen. There was no clean linen store and linen was stored in containers on a corridor. A clean linen holding area should be provided. At ward/department level, clean linen was stored in wooden shelved presses. This should be replaced with washable shelving. All soiled linen was transported in clear plastic bags with alginate bags for contaminated linen. The process for internal transportation and central storage of soiled linen should be reviewed. Both clean and soiled linen holding areas should have hand wash facilities. National colour-coding should be introduced as soon as possible. Some items, for example dishcloths and high dusting sleeves, are washed in a local laundry. The organisation should formalise this contract and seek evidence of compliance with Section 61 HSG 95 (18).

For further information see Appendix A

*Core Criterion

SD 4.7 (B → B)

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

There was evidence of considerable development in the area of Hand Hygiene Facilities throughout the clinical areas. These included replacement of sinks, provision of splash backs, hand wash products, disposable towels and pedal operated bins. The Hospital is to be commended on the extent of these developments, which had taken place over a short period of time. Staff are recommended to continue this development in the remaining areas in accordance with their QIP. The recent appointment of an Infection Control Nurse should further the expertise available in this aspect of Hygiene and SARI guidelines implementation and monitoring. The hospital should consider establishing a Hygiene Services Team at this stage of the evolution of Hygiene Services Management.

For further information see Appendix A

SD 4.8 (B ↓ C)

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

Risk Management is managed locally through the Hospital Management System. Incidents reported are followed up and reported through the STARS reporting system. The hospital was not, as yet, receiving regular reports and request for same was made during the assessment visit. A consultation process had commenced with the Network Manager to identify risk management structure for the hospital. Formal processes introduced to evaluate incident types and rates should be developed.

SD 4.9 (C → C)

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

Hygiene Information is available in the form of notices and leaflets. The hospital was in the process of developing a Hospital Handbook, which was intended to provide useful information for patients/public. A Hospital Visiting Policy, based on the National Guidelines, is in place. Additional security resources had been made available to manage restricted visiting during the recent outbreak of winter Vomiting Bug. There has been no formal evaluation of patient satisfaction with service delivery. However 'Your Service, Your Say' evidenced positive remarks about the hospital. The Hygiene Services Committee was reviewing a process to gather patient satisfaction information and was encouraged to progress this exercise. Patients interviewed during the assessment visit were very positive in their comments on their experiences of Hygiene Services.

PATIENT'S/CLIENT'S RIGHTS

SD 5.1 (B ↓ C)

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

There was a Hospital Mission, Vision and Values Statement on display. Each ward has a Philosophy of Care for that specific area. There are single rooms for isolation and Infection Control nursing advice was sought for ensuring best practice. A complaints system is in place and all complaints are followed up according to best practice. Four staff had recently been trained in the Complaints Management Procedure. There was no formal evaluation of the process in place and this should be implemented.

SD 5.2 (C → C)

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

Documented information provided includes hand hygiene, visiting and no smoking policies. Hand hygiene gel is available at the entrance to the hospital. Health Information leaflets are also widely available in the Outpatients Department and in ward areas. There have been no patient satisfaction surveys undertaken to date.

SD 5.3 (C → C)

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

There were documented processes for dealing with patient/client complaints. These were acknowledged in accordance with best practice. There was no isolation of complaints in relation to Hygiene Services. Complaint levels in general were very low

and tended not to relate to hygiene. These should be identified, where present, and presented to the Hygiene Services Committee.

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1 (C → C)

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

There was no formal involvement of patients'/clients' families in evaluating the Hygiene Services of the organisation. The Hygiene Services Committee was in the process of identifying a mechanism for the inclusion of representation of patients'/clients' families in the Hygiene Services Committee and should proceed to implement this QIP.

SD 6.2 (C → 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.

The Hygiene Services Committee had established a process of internal hygiene audits in recent months. They were encouraged to extend the process to all areas relevant to hygiene services and identify a schedule to ensure consistency and continuity. The main quality initiatives undertaken over the last two years included the appointment of an Infection control nurse and a chef, along with environmental and equipment improvements, the establishment of the Hygiene Services Committee and the implementation of actions identified in National Hygiene Audits 2005 and 2006, along with EHO reports. The organisation is recommended to focus on developing formal evaluation processes leading to continuous quality improvement implementation and recording.

SD 6.3 (D ↑ C)

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

The Hygiene Services Committee has planned to produce a Hygiene Annual Report from 2007 onwards. Prior to this, the hospital report was part of the Acute Hospital Group Report. Communication to stakeholders is through line manager and committee meetings and intranet was also available. The organisation is evaluating its Hygiene policies, procedures and guidelines through its internal/external audit reports

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 - All high and low surfaces were free from dust, cobwebs and flaking paint. Some flaking paint on radiators and walls was observed.

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

No - Some areas required painting and some damaged floor tiles were noted.

(4) Floors including edges, corners, under and behind beds are free of dust and grit.

Yes - These were generally clean, however, some grit was noted on stairs and lifts.

(7) Areas should be adequately ventilated with ventilation units cleaned and serviced accordingly and documentation available regarding service.

No - Service records were available of recent services completed. The cleanliness of ventilation units needed improvement.

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

Yes - Some signage required laminating. Out-of-date signs (for example winter vomiting) were still in situ, despite this not being current at the hospital.

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

Yes – In the majority, however, one broken waste bin was observed in the ICU.

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

No –None were observed.

(16) Hospitals are non smoking environments. However, cigarette bins should be available in external designated locations.

No - None were observed.

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

(20) Doors

Yes - A few doors were damaged at the edges.

(21) Internal and External Glass.

Yes – In the majority very good, however, some internal areas needed cleaning.

(24) Ventilation and Air Conditioning Units.

No – These required improvement.

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

(32) Shelves, benchtops, cupboards are clean inside and out and free of dust and spillage

Yes - Wooden shelving in linen cupboards should be replaced.

(207) Bed frames must be clean and dust free

No - Remedial action was taken following recommendations during the assessment.

(209) Air vents are clean and free from debris.

No - The organisation was non-compliant in this regard.

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

(34) Beds and Mattresses

No - Some needed further attention.

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

(51) Baths and Showers

Yes - No baths were observed. Showers were observed in all bathrooms.

(52) Toilets and Urinals

Yes - No urinals were observed.

(53) Bidets and Slop Hoppers

Yes - No bidets were observed.

(55) Sluices

Yes - These were multifunctional.

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

No - Some sink taps/plug holes needed attention and one dirty toilet brush was observed.

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

No - Routines/check lists for cleaning were observed but no method statements were observed. The organisation is recommended to develop method statements for the cleaning of all equipment.

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

Yes - Sluice rooms were cluttered in some areas.

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

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

No - Some fans were observed in clinical areas and were not clean.

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

(74) Patient's personal items, e.g. suitcase which should be stored in an enclosed unit i.e. locker / press.

Yes - Lockers/wardrobes were available for all patients.

(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 – An ad hoc arrangement was in place. The organisation is recommended to develop a documented standard policy.

(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 - Evidence of compliance was observed.

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

(211) Personal Protective Equipment is available and appropriately used and disposed of.

Yes - A review of type of theatre clogs in use is recommended to ensure compliance with best practice.

(83) Mop heads are laundered daily and are stored according to local policy or are disposable i.e. single use.

Yes - Disposable mop heads were in use.

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

Yes – A local colour coding system was in place. The implementation of National Guidelines is recommended.

(87) All cleaning equipment should be approved by the Hygiene Services Committee and ensure sufficient supply.

No – The Hygiene Services Committee was of recent origin. It was anticipated that the Committee would be involved in all future changes.

(94) Health and Safety policies should be in place for the use of ladders/steps when cleaning.

No – The introduction of a policy is required.

(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 - Most equipment observed was under five years old.

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

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

No - HACCP was in the process of being implemented and this needed to be progressed as expeditiously as possible.

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

Yes - EHO reports were available and recent recommendations observed were being implemented.

(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.

No - HACCP was in the process of being implemented. Training needed to be extended to the remaining two staff members. The recently appointed chef was recommended to network with hospital catering officers where there was a track record of full HACCP compliance.

Compliance Heading: 4. 4 .2 Facilities

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

No - Access should be restricted between the main kitchen and canteen and this door to be kept closed at all times to ensure restriction to kitchen/canteen staff only.

(221) Staff clothing/uniforms/shoes personal belongings should not be stored in food rooms.

Yes - Not all staff observed were wearing protective footwear. This was a work in progress and should be implemented. A policy on aprons should be introduced.

(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 - The ventilation system had been serviced in recent days and fulfilled its purpose, however, it had not been cleaned.

(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.

Yes - There were very few food items in ward kitchens, other than limited items in fridge. The main kitchen is recommended to check food samples in food laboratory on a regular basis and retain samples in accordance with agreed policy.

Compliance Heading: 4. 4 .3 Waste Management

(229) Animal and pest control measures shall be in place in all waste handling and storage areas.

Yes - Cleaning maintenance needed attention from the contractor.

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

Yes - The bulk container in the waste compound was compliant, however better attention to internal cleaning is recommended.

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 - This information was not available as all food is sourced fresh.

(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 - No ice cream display units are in use.

(243) Preparation of High Risk Foods should comply with I.S. 340:2006 requirements

Yes - Colour coded knives should be introduced. Hand wash sink should be fitted into the meat preparation area.

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 - Not available, as all food is sourced fresh as required other than salmon, which is cooked directly from frozen.

Compliance Heading: 4. 4 .10 Plant & Equipment

(250) The dishwasher's minimum temperature for the disinfecting cycle should be compliant with I.S.340:2006 requirements and should be monitored regularly. There should be digital readouts on dishwashers.

No - The dishwasher was leaking for seven weeks. There was concerns expressed that the displayed temperature was not being reached. Interim arrangements were put in place during the assessment visit to manage this issue. A new dish washer was ordered with expected delivery date within one week.

(251) All temperature probes shall be calibrated annually. Calibration may be carried out internally or externally (instrumentation firm). Documentation should be retained of the procedures used to control, calibrate and maintain inspection, measuring and test equipment used to demonstrate compliance with the HACCP Plan.

Yes – The availability of a spare probe at all times is recommended.

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

(139) Documented evidence that waste collectors are permitted to collect the waste concerned by virtue of holding a valid waste collection permit.

Yes - A National Contract is in place.

(146) A tracking system should be in place to trace all hazardous waste from generation to disposal and therefore an audit trail is available to trace waste to final disposal.

No - The hospital needed to be aware of track/audit hazardous waste from source to final disposal by central contractor.

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

Yes – This is not required.

Compliance Heading: 4. 5 .3 Segregation

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

Yes – These were recently sourced but not yet in use in all areas.

Compliance Heading: 4. 5 .4 Transport

(163) Documented processes for the transportation of waste through the hospital which minimizes manual handling of waste (and ensures that segregation of healthcare risk waste from non-risk waste is maintained) are in place.

No - Documented process needed to be developed.

(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 - The services of the Health and Safety Officer HSE South is available to the hospital as the Dangerous Goods Adviser Safety Advisor.

Compliance Heading: 4. 5 .6 Training

(259) There is a trained and designated waste officer.

No - The Hospital should designate a Waste Officer

(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 – The newly appointed Infection Control Nurse will provide training in use of spill kits.

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 – These were not available.

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

No - Colour bags were not compliant with National policy. The local policy in use is in line with provision for dirty/used dirty contaminated linen. The implementation of National Linen Segregation policy appendix 9 is recommended.

(267) Documented process for the transportation of linen.

No - Documented process need to be developed.

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

No - No clean linen store area was observed. Clean linen is stored in delivery trolleys on corridor. No hand wash basin is available in the dirty linen store.

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.

Yes – In the majority, however, some sinks require splashbacks.

(191) Hand washing facilities i.e. sinks, taps and splash backs must be clean and intact.

No - Dirty tap joints and plug holes were observed.

(192) Taps should be hands free and should be mixer taps to allow temperature regulation.

No – A programme was in place for replacement.

(198) Hand hygiene posters and information leaflets should be available and displayed throughout the organization.

Yes - Patient Hygiene information in the Endoscopy waiting area should be improved.

(204) Hand wash sinks conform to HBN 95. They should not have plugs, overflows and the water jet must not flow directly into the plughole.

No - New sinks had overflow outlets which had been plugged. A number of sinks still needed replacement.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team			Assessor Team
	FREQ	%	FREQ	%
A	2	03.57	4	07.14
B	26	46.43	11	19.64
C	26	46.43	41	73.21
D	1	01.79	0	00.00
E	0	00.00	0	00.00
N/A	1	01.79	0	00.00

5.2 Ratings Details

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

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