Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Hygiene Services Assessment Scheme

Assessment Report October 2007

Beaumont Hospital

Table of Contents

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

Beaumont hospital is one of the country's largest major acute hospitals and is located on the north side of Dublin. The hospital with its complement of 769 beds provides a continuous twenty-four hour emergency call service for its own catchment area of approximately 250,000 people. There are also 69 beds in St Joseph's Hospital in Raheny, which is Beaumont's off-site facility.
Beaumont Hospital is a medical training and research centre for the Royal College of Surgeons in Ireland and the principal hospital providing nurse education for Dublin City University.
The Hospital is also the national referral centre for the specialties of Neurosurgery, Cochlear Implantation, Renal and Pancreatic Transplantation, Poisons and National Histocompatibility and Immunogenetics Service for Solid Organ Transplantation (NHISSOT).

Services provided

In-patient care:

- National Neurosurgical Care
- National Renal/Pancreatic Transplantation Centre
- Cochlear Implantation Service
- Regional GI and ENT service
- Accident & Emergency
- Orthopaedics
- Plastic Surgery
- Maxillo-Facial
- Urology
- Cardiology
- Dermatology
- ENT
- Gynaecology
- Vascular Surgery
- General Surgery
- Breast Surgery
- Neurosurgery
- Ophthalmology
- Chiropody
- Paediatrics
- Pain Relief
- Transplant Surgery
- Oncology Medical
- Neurology
- Detoxification
- Endocrinology
- Gastroenterologist
- General Medicine
- Geriatrics
- Haematology
- Nephrology
- Psychiatry
- Respiratory Medicine

- Rheumatology
- Infectious Diseases

Critical/Intensive care:
- Neuroscience's Intensive Care – 10 beds
- General Intensive Care – 10 beds
- Coronary Care – 12 beds

Emergency care:
The department delivers a twenty four hour three hundred and sixty five day per year care to its catchment area of 250,000 people.

Diagnostic services:
- Radiology – consists of 8 modalities including MRI scanner due to be installed by the end of 2007. The hospital has two CT Scanners with a third in St Joseph's hospital
- Neuro-interventional unit which provides the country's only neuroradiology-coiling service
- General angiography interventional room
- 2 Gamma cameras – nuclear medicine
- General/chest x-ray units
- X-Ray units in the Emergency Department
- Mobile Radiology units for patients unable to be transported to radiology e.g. ICU, Richmond ITU and theatre
- ERCP
- Ultrasound - 6 machines
- Vascular x-ray
- Digital mammography unit to support the new Symptomatic Breast Care Service

Outpatient services (clinical, dental, orthotics etc):
- Immunology
- Radiation Oncology
- Cardiology
- Pacemaker Clinic
- Orthopaedics
- Neurosurgery
- Geriatrics
- Urology
- Pain Relief
- Gastroenterology
- Cochlear Implantation
- Acoustic clinic
- Ophthalmology
- Orthotist
- Cervical Smear Clinical
- Colposcopy
- Orthopaedics
- Fracture Clinical Dermatology
- Allergy Patch Testing
- Nephrology
- Vascular Surgery

- General Surgery
- Respiratory
- Epilepsy
- Neurology
- TIA Clinic
- Rheumatology
- Breast Clinic
- Gynaecology
- Haematology
- Psychiatry
- Transplant
- Plastics
- Pituitary Clinic
- Endocrinology
- ENT
- Ophthalmology
- Oncology
- Maxillo-Facial
- Paediatric Spina Bifida Clinic
- Andrology Clinic
- Migraine Clinic

Physical structures
There are no negative pressure isolation rooms in the hospital. Single rooms are used for isolation purposes.

The following assessment of Beaumont hospital took place between 28th and 30th August 2007.

1.3 Notable Practice

- Patient/client and staff kitchen facilities are to be commended.
- The use of hand hygiene signage and alcohol gels was excellent.
- The innovative use of the hospital Hygiene Discharge Team, which cleans all rooms following the discharge of a patient/client, and the DECT hand-held direct phone line phone system, is to be commended.
- A positive hygiene culture is embedded at all levels.
- There is very strong communication structure in relation to hygiene.
- The involvement of patients/clients in the hygiene service is commendable.
- There is an extensive documentation system, which supports effective delivery of the hygiene services. Overall, the policies reflected the practices observed at ward level.

1.4 Priority Quality Improvement Plan

- The organisation is recommended to develop a cohesive management structure for all catering services.
- The refurbishment of the Accident and Emergency entrance should be prioritised.
- The organisation is encouraged to progress the development of the plan for the upgrade of the sluices, bathrooms and cleaners rooms.
- A process for the management of the ward-based washing machines and dryers should be developed.
- The organisation is recommended to further progress the planned implementation of the software package for training records.

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 Beaumont 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 (B → B)

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

There was strong evidence of this in the hospital's extensive internal processes, which include departmental audits, management weekly audits, infection control and health and safety audits. The hospital also audits and monitors its catering, purchasing and contractors services. Extensive evidence was observed that management of hygiene has been updated in recent years, following previous external audits and subsequent action plans, the establishment of a hygiene management system, and provision of funding to improve the hygiene services have all been implemented. The hospital engaged in a series of external visits to Ireland and Europe to assess and benchmark the management of standards in other hospitals. As a result a Discharge Hygiene Team was set up, which ensures that there is timely turnaround of the patient/client space upon discharge. This initiative is to be commended. A comprehensive quality improvement plan has been developed, which includes sink replacement, an internal painting programme and the upgrading of bathrooms and domestic services' rooms.

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.

These are continually audited and resultant actions are documented and reported to all management structures. There are excellent and documented linkages and continual assessment with the cleaning contractors in relation to audits and outcomes. Weekly cleaning contractor audits take place, as do task checklists and sign offs. Regular management meetings are held with the contractor to ensure continual high standards of cleanliness. The hospital communicates hygiene issues, changes of practice and audit results in variety of ways, for example: the implementation of its hygiene communication strategy, hospital newsletters, patient/client complaint procedures, risk management and suggestion boxes available since September.

A very comprehensive site hygiene needs survey was completed and results observed. A number of initiatives, such as the Discharge Team, have taken place as a result of both external and internal audits. This service is being validated and it has been expanded on a trial basis to a ward janitorial service in some areas. This expansion is as a direct result of the evaluation of the efficacy of the Discharge Team's effectiveness. Other initiatives undertaken include the upgrading of the main kitchens and the appointment of Hygiene Co-ordinator and Waste Officer in the Out-

patient Department, and the purchasing of new beds and lockers. Extensive hygiene evaluation was observed in the form of internal and external audits, product evaluation, service evaluation and site needs analysis.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1 (B → B)

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

The hospital has strong linkages with all other Dublin academic teaching hospitals in relation to procurement, risk and waste management. Through its senior management team it has strong links with the Health Service Executive, National Hospitals Office, Primary and Continuing Community Care (PCCC) and Department of Health and Children. There are professional links and leadership by the hospital with national microbiology committees, universities and nursing homes. Hygiene education and training is provided to nursing homes and nursing and medical students from Dublin City University. A partnership and multi-disciplinary culture was evident throughout. The Patient/Client Council is actively involved in the hygiene process and carries out independent audits and its findings are reported to management. There is comprehensive evidence of extensive patient/client satisfaction surveys, both organisational and departmental, and input from the Patient/Client Council in relation to hygiene satisfaction. While there is evidence of internal and external evaluation of the management of hygiene, there is a need for the hospital to further evaluate the efficacy of linkages and partnerships.

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 terms of reference for the Hygiene Services Committee identified the development of a Corporate Strategic Plan. This has since been developed. The organisation has a Hospital Corporate Strategic Plan, which includes a hospital Hygiene Strategic Plan which identified hygiene goals, objectives, actions, plans and costs. There was a clear organisational chart of responsibility and accountability for the hygiene process from senior management. It had input from all service users. This was validated through emails, letters and minutes of meetings. The hospital Hygiene Communication Plan ensured that all service users were aware of the roles. It is evaluated on a continual basis through audits and outcomes, and will be reviewed annually.

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.

Regular, timely and accurate evidence or best practice information is received. The hospital has used international and national best practice guidelines; examples include the cleaning manual and the Strategy for the control of Antimicrobial

Resistance in Ireland (SARI) guidelines, to influence the management of hygiene services. Key Performance Indicators (KPI's) have been evaluated for hygiene training attendance, audit results and senior management reviews and have been adapted as a result.

CM 4.3 (B → B)

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

A sink replacement system, new alcohol gels, colour coding in catering and cleaning have been introduced, as has the flat mop system. There are comprehensive hygiene education and training programmes for all grades in the hospital. To date, 1,200 staff have received hand hygiene training. More intensive training for cleaning staff has been completed including standard precautions, equipment management and the British Institute of Cleaning Science (BICS) programme. An excellent hygiene services communication strategy includes a newsletter, audit reports and in-service training. Some evaluation of education and training, alcohol gels and flat mop systems has been carried out. However there has been no actual formal evaluation of the research and best practice information. It is recommended that the hospital evaluate this process in the future.

CM 4.4 (B ↓ C)

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

A documented policy was observed for the development, approval, revision, and control of all policies, procedures and guidelines, which includes the development of the hygiene policies. A comprehensive range was observed, as were policies for procurement, waste and audit. All of these are available on the intranet and in hard copy form at ward level. The cleaning contractor has a Staff Cleaning Manual. It is recommended the efficacy of the policy development and maintenance of a quality policy programme be evaluated.

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 organisation has a defined hygiene service structure. There is a multi-disciplinary senior Hygiene Steering Group (Hygiene Committee) and multi-disciplinary Environmental Task Group (Hygiene Team) at the hospital. Terms of reference, membership, roles, responsibilities and accountabilities were observed in the documentation/organisational charts provided. Job descriptions for members of both groups were available and observed, including CEO, Hygiene Co-ordinator, Ward/Departmental managers, hygiene staff and contract staff job descriptions. Evaluation of the efficacy of roles, authorities, responsibilities and accountabilities is recommended.

*Core Criterion

CM 5.2 (A ↓ B)

The organisation has a multi-disciplinary Hygiene Services Committee.

A Hygiene Steering Group, which reports to the Hygiene Service Committee, was in place. Documented processes for committee membership, terms of reference, frequency of meetings, organisational hygiene charts, job descriptions, and role awareness were observed. The Hygiene Service Committee is supported by the hygiene Services Co-ordinator who supports the hygiene committee. Evaluation of the efficacy of the Hygiene Services Committee is recommended.

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

*Core Criterion

CM 6.1 (A → A)

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.

There was strong evidence available and observed of the human, physical and financial resources allocated to the hygiene services. This was validated in the actions plans outlined for areas such as sink replacement, bathroom upgrades, proposed and planned painting programmes. In addition, changes to practices, for example in the establishment of the Discharge Cleaning Teams, have meant the allocation of additional human resources. Financial resources are forthcoming for new products, human resources and building projects. The Hospital Hygiene Strategic Plan and its costing indicate the commitment to the hygiene services.

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

There was a robust approach to the management of quality and risk. A dedicated Quality and Risk Department and Strategic Risk Plans were noted. This department actively engages in the process of risk identification, incident reporting and hazard analysis. All risks are followed up, reviewed, and corrective actions put in place.

The department also produces trend analysis charts for incident frequency. Information gathered from external reports (for example EHO and Health and Safety) is used continually to review risk minimisation. An integrated Quality and Safety Department flow chart identified the reporting structures and the linkages of the quality and risk system in the hospital.

All occupational risks are identified, reviewed and acted upon through both the Occupational Health Department and the Health and Safety Department. An example would be needle stick injuries. An annual report is issued from the Quality and Risk, Health and Safety and Occupational Health Departments, which is included in the generic hospital annual report, as witnessed in the 2005 report. It is recommended that the hospital consider benchmarking in this area.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion

CM 8.1 (A ↓ B)

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

The hospital has a robust procurement procedure in place. There is a Materials Management Department, which has a documented process in place for the development and management of procurement policies, procedures and guidelines. The hospital also supports, and is included in, region-wide purchasing of standard items. All relevant departments are involved in the pre-purchasing process and evaluation, including the hygiene services team, if appropriate. In general the hygiene team has not taken over the role of managing the purchase of all hygiene products. However, the Infection Control Department and the Health and Safety Management Teams are included in the pre-purchasing of products and equipment. There was strong evidence of waste, cleaning, ventilation, window cleaning, curtain exchange programme and hand hygiene gel contracts in place.

There is a robust, informal and formal, monitoring system in place for contractors and the provision of services. It is recommended that all hygiene products and equipment be approved by the hygiene team, prior to purchase.

CM 8.2 (A → A)

The organisation involves contracted services in its quality improvement activities.

There was evidence of their inclusion. The Environmental Task (Hygiene) Team included the cleaning contractors' on-site supervisor. There are audit procedures in place with the cleaning contractor, the results of which, in conjunction with the observance of international best practice, led to the concept of the Hygiene Discharge Team. Its configuration is adjusted according to service requirements. There is joint education and training available. The hospital has included the contractors of the Curtain Exchange Programme in the management of quality initiatives such as the Sink Replacement Programme and hand hygiene stations.

PHYSICAL ENVIRONMENT, FACILITIES AND RESOURCES

*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.

There was evidence that the hospital, through its Corporate Strategic Hygiene and Service Plans, have identified the resources and processes to ensure that the hospital is clean. There is a comprehensive suite of hospital policies and procedures, including corporate, HR, professional and hygiene. There were very robust internal hygiene audit mechanisms, complaints and risk management procedures, which supported the process of hygiene management. There are regular hygiene management meetings with staff, management and contractors.

There is strong evidence of external evaluation through health and safety inspections, Environmental Health Officer (EHO) and external hygiene audit reports. It is recommended that the organisation should establish a cohesive corporate reporting structure for catering areas and that it should progress the upgrading of the hand sinks as required.

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.

There was strong evidence that the internal audit process for hygiene, such as weekly audits, contractors' audits and daily checklists, ensured that the hygiene standards are effective. Furthermore trend analysis for risk identification and patient/client complaints show a downward trend in hygiene dissatisfaction, as does the external audit report of 2006. During the assessment, excellent processes were observed in the main kitchen in a bid to achieve a high standard in catering hygiene. It is recommended that a centralised management structure for all areas engaged in the catering process and the production of food, be considered.

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.

A Patient/Client Representative Department deals directly, and in a timely manner, with all patient/client complaints. There is a documented process for the management of these, with timeframes, reporting and feedback structures. The department also provides evidence of complaint trend analysis reports. Organisational, professional and departmental patient/client satisfaction surveys, in areas such as catering, services and day wards, are carried out. The Surgical Day Ward carries out a weekly telephone satisfaction survey on a selected number of patient/clients from the previous week. This approach is to be commended and it is recommended that the results be formally compiled. Ward management surveys took account of hygiene, and hygiene training satisfaction.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 (B → 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.

The hospital provided evidence of a recruitment and selection policy in line with Health Service Executive national guidelines and other national legislation such as the Employment Equality Act, 2004 and Terms of Employment, 1994.

All hygiene department staff are recruited in line with this policy.

A full range of job descriptions was observed, including the Hygiene Co-ordinator, Site Supervisor, and porter staff. The recruitment record was observed.

Copies of all hygiene contractor staff recruitment and training records are held. The Recruitment and Selection Policy for both the cleaning and the laundry contractor were observed, as were job descriptions for contract cleaning staff.

There was good evidence that evaluation of the recruitment process for contract staff was carried out through internal hygiene audits and the outcomes of these audits. Staff turnover rates are also used to measure the success of the recruitment and selection policies at the hospital.

CM 10.2 (B → B)

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

The hospital uses the internal mechanisms of hygiene audit to assign hygiene resources. Results of external hygiene audits, external focuses, national and international hospital visits and local professional knowledge has been taken into account so as to determine the appropriate resources required for quality hygiene services, in line with approved staffing levels and budgetary constraints. The Hygiene Discharge Team has been evaluated and adjustments have been made to its hours of service. A janitorial service pilot programme has begun in two wards.

CM 10.4 (A ↓ B)

There is evidence that the contractors manage contract staff effectively.

The standard specifications provided to the relevant hygiene contractors include monitoring of staff performance, standards of service required and management structures. Regular meetings with contractors are held, which was evidenced by the minutes of these meetings. Both contractor and hospital meet regularly with hygiene contract staff. The hospital reviews standards of service through internal audits, patient/client satisfaction, patient/client complaints and risk management procedures. There are procedures, including penalty clauses, in place for non-compliance with hospital standards. Following internal audits, changes were made by contractors, in areas such as supervision, frequencies, training, and hygiene management structure. It is recommended that the hospital complete evaluation of the suitability of the use of contract staff.

*Core Criterion

CM 10.5 (A → A)

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

The hospital, through its Hygiene Corporate and Service Plan, has identified its hygiene human resources for the hygiene service, in line with best practice and international peer review. The hospital cleaning contractor has identified the resources required to provide an appropriate hygiene staff level, in accordance with needs assessment carried out as part of the tendering process. The results of the internal audits, patient/client satisfaction and ward managers' surveys have been reflected in changes made to frequencies. The hospital prepared an annual hygiene report in 2006.

ENHANCING STAFF PERFORMANCE

*Core Criterion

CM 11.1 (A ↓ B)

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

A robust orientation and induction programme for all staff is in place. Evidence of this was provided from both a corporate perspective and a discipline-specific perspective. The management of hygiene issues (including hand hygiene, universal precautions and waste management) are an integral part of the programme since January 2007. A staff handbook has been revised and is in final draft form. It includes a specific section on hygiene. Attendance records were observed. Staff are provided with a training programme by the contractor, in line with contract specifications. This

includes the principles of hygiene, as recommended by the hospital, for all staff. Continual education and training programmes are available, including infection control, hand hygiene, waste management, British Institute of Cleaning Science (BICS), and supervisory training in hygiene and hygiene audit training.
The effectiveness of training programmes/induction/orientation is internally checked through the Hygiene Audit Programme. It is recommended that the hospital further the proposed system of centralised recording and monitoring of education and training.

CM 11.2 (B → B)

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

There are full documented processes in place for the management of education at the hospital. A wide range of education and training is available, including hygiene and waste and occupational health training for both hospital and contract staff. Extensive training records were observed at both at departmental and training provider levels. It is recommended that the hospital instigate a centralised approach to education records, which would provide formal monitoring of all programmes, feedback and actions required.

CM 11.4 (C → C)

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

There is limited formal performance management; however, team-based performance is monitored through internal hygiene audits, patient/client satisfaction and risk management procedures.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (A → A)

An occupational health service is available to all staff

Extensive evidence was available to support the management of occupational health. The department has strong policies, procedures, audit processes, counselling, information leaflets and services.
It is involved with induction and staff awareness programmes, ergonomic and staff risks assessments, travel questionnaires, and a detailed vaccination programme. Evaluation includes surveillance of healthcare workers with blood borne viruses, Flu vaccination uptake records, department attendance records and annual needle stick injuries analysis and trends. Resultant actions were noted and a continuous and updated quality improvement plan is in place.

CM 12.2 (B → B)

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

There was strong evidence that the hospital, through its HR and occupational health service, monitors staff satisfaction, and occupational health. In addition, attendance records are monitored and remedial actions (through the HR processes) are instigated. The department also provides critical incident stress management and counselling services for staff. Strong evaluation is carried out.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.2 (B → B)

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 a very comprehensive process to ensure that this takes place. This was evidenced in the internal audit mechanisms, the management of complaints and risks and infection control statistics. The use of a dedicated phone number for addressing immediate hygiene needs is to be commended. The proposal to have a dedicated email address for hygiene issues is laudable. The hygiene management structure ensures all relevant information is managed in a timely manner. Evaluation of these criteria is evidenced in internal hygiene audits, and feedback on the introduction of the cleaning manual. There are quality initiatives in place to ensure the progression of the quality agenda.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

CM 14.1 (B → B)

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

There was very strong evidence of the commitment to foster a culture of hygiene. This was evident from the level of board meetings, through executive management, and throughout all departments and grades of staff. The hospital has supported a Quality and Risk Department and has allocated resources to improve the hygiene agenda through cleaning specifications, contracts, education and training and a Quality Improvement Plan (QIP), which included sink replacements, internal painting and upgrades to facilities, including waste.

CM 14.2 (A → A)

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

The hospital is to be commended for its innovative approach to management of the first external hygiene audit in 2005. External site visits within Ireland and Europe were undertaken to examine how other hospitals manage their hygiene services. This was evidenced in the reports submitted by the hospital personnel who visited these hospitals. The appointment of the Hygiene Co-ordinator is an example of how best practice was adapted to the needs of the hospital. Internal audit processes and results are regularly reviewed and benchmarked against previous internal and external audits, including catering, waste, hand hygiene and cleaning. The hospital benchmarked itself against other similar sized hospitals in previous external hygiene audits. Information gathered from all these sources are used to progress and manage the hygiene services. All changes are communicated through the channels determined by the robust communication strategy and procedures at the hospital.

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 ↓ B)

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

There was strong evidence of this. Hazard Analysis and Critical Control Point (HACCP) was carried out in all catering areas, hand hygiene, cleaning, colour coding, sharps, linen and waste policies were available in all clinical wards/departments. A clear policy development process was in place. All internal and contract staff were informed when policies were updated and signature sheets were used to indicate when staff had read policies. Staff interviewed during the assessment (including contract cleaning staff), were aware of the location of the policies within their respective areas. It was evident that they are released from duties to attend on-going hygiene training in hand and linen hygiene, waste and sharps and British Institute of Cleaning Science training. Also, staff from various disciplines, including medical staff/students, demonstrated correct hand hygiene technique in line with best practice. The organisation is recommended to formalise the evaluation of the efficacy of the process used to develop best practice guidelines for the Hygiene Services Team.

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

The organisation has a comprehensive procurement policy, in line with best practice. Hygiene interventions are assessed in accordance with policy. Examples include the testing of the flat mop system and new alcohol gels. Many hygiene services' initiatives have been introduced over the last two years following needs assessments. They include increasing staff awareness/ownership of hygiene, agreeing times for waste pick up from clinical areas, the introduction of the discharge hygiene team, additional supervision of contract staff and a reduction in frequency of floor buffing. The introduction of other initiatives such as the upgrading of hand wash sinks and the floor replacement programme is ongoing. There was strong evidence of evaluation of changes made, for example:

- The efficacy of the Hygiene Discharge Team was analysed and the introduction of janitors on a trial basis in two areas is planned.
- The efficacy of use of new alcohol gels was reported at 89%.
- The results the evaluation of the flat mop system have led to the planned roll out of the system to all areas.

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 strong evidence of hygiene services participation and support of health promotion activities. This included promotional/awareness of hand hygiene for staff, patient/clients, visitors and the public during hand hygiene awareness weeks. A diverse range of hygiene-related posters/signage is to be commended. Staff hand-hygiene badges are worn and there is a hand-hygiene facility at the front door. There was a strong culture of promoting cleanliness amongst staff, patient/clients, families and visitors. The Patient/Client Representative Officer meets with patient/clients and families to distribute hygiene complaint policy/forms. The quarterly hygiene newsletter, which is used as a promotional tool, is available for staff, patients/clients and the public and is to be commended. The public are also invited to participate in hygiene quizzes. Members of the hygiene team provide hygiene-related education to community organisations, such as nursing homes, and at conferences. The hospital received the silver award from the European Network of Hospitals in 2006. There was evidence of evaluation and feedback to the public of hygiene audit results; of alcohol gel usage at entrances and of a reduction in hygiene related complaints through the hygiene newsletters.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1 (A → A)

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

There is a multi-disciplinary approach to hygiene. The Hygiene Task Group, with representatives from all disciplines, was observed to be very effective. The Hygiene Services Co-ordinator and chair of the task group facilitate effective communication between the Hygiene Steering Committee, Task Group Committee, Contract Cleaners and all departmental managers. Job descriptions were observed, which outlined team member's roles and responsibilities in relation to hygiene. Team awareness was well developed through the hygiene task group structure. Linkages with the Patient/Client Council are strong and patient/client satisfaction surveys are performed. Other linkages include external hospitals for example St James's, University College Hospital Galway and Groningen, from which ideas on hygiene services and a number of processes, such as the increase in cleaning hours and supervision, were adopted for use. Evaluation of efficacy of the multi-disciplinary team structure was evident and as a result the team were in the process of inviting a patient/client representative and a cleaning contractor to become members of the group.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

SD 4.1 (A → A)

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

There was strong evidence of organisational commitment to ensure the physical environment and facilities are clean, which is to be commended. The flowers, particularly around the main entrance, and the décor of the front hall were cheerful. There were clear, planned programmes of works in relation to painting, upgrading of hand-wash sinks and ceiling tile replacement, which was on-going. The contract cleaners are included as part of the ward/area staff and are committed to the cleaning ethos. Supervision and audit are tightly controlled and there was evidence of strong reporting relationships between contractors, ward managers and senior managers. The Hygiene Discharge Team enhances the cleaning of beds/rooms in all areas and it is advised to consider extending the team to areas using patient/client trolleys. It is also recommended to review the ventilation and use of fans and to progress the development of the plan for the up-grade of sluice and cleaners' rooms.

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 management of medical devices and cleaning devices is excellent. There was clear equipment cleaning standard operating procedures in place. The audit process is strong, with evidence of local and weekly corporate multi-disciplinary team audits, actions, feedback and follow up. A process for repairs was in place, which included the use of signed cleaning cards, which are attached to the equipment prior to removal from the area. Training records (FETAC) were available for Health Care Assistants, who have the responsibility for cleaning equipment which was in a good state of repair. Records of validation of electrical equipment and vacuum filter change were reviewed.

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.

The cleaning equipment supplied by the cleaning contractors was in a good state of repair and clean. There was evidence of validation of electrical equipment and vacuum filter change. A copy of standard operating procedures for cleaning equipment, colour coded system, product cleaning dilution charts and a ladder safety policy were in place. Mop heads are laundered daily. It is recommended that the development of a plan for the upgrading of cleaners' room facilities and systems be put in place, and cleaning equipment be approved through the Environmental Taskforce.

For further information see Appendix A.

*Core Criterion

SD 4.4 (A → 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 patient/client and staff new kitchen/canteen and the Hazard Analysis and Critical Control Point (HACCP) processes reviewed are to be commended. Deliveries to the patisserie and the availability of Personal Protective Equipment (PPE) for visitors to the public kitchen require review. Corporate responsibility was different for the patient/client, staff and public catering areas: the CEO was responsible for the patient/client and staff area, while the Financial Controller was responsible for the public catering areas. The organisation is recommended to establish a cohesive corporate reporting structure for catering areas.

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.

In general, the management of waste was observed to be in line with best practice. However, the hospital has recognised the need to reduce the double handling of waste and they are encouraged to prioritise this.

For further information see Appendix A.

*Core Criterion

SD 4.6 (A ↓ B)

The team ensures the Organisation's linen supply and soft furnishings are managed and maintained

A contract linen supply company is used in the hospital and standards observed were in line with best practice. However, the organisation is advised to review the management of the ward-based washing machines and dryers.

For further information see Appendix A.

*Core Criterion

SD 4.7 (A ↓ B)

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

The promotion of hand hygiene is strong, with evidence of induction/on-going staff training and public attendance at hand hygiene awareness sessions. A current hand hygiene policy is in place, in line with best practice and evidence of audit of compliance, actions and feedback was observed. Observation of multi-disciplinary staff adherence to hand jewellery/nail policy is commendable. The plan for the upgrade of hand wash sinks to conform to HBN 95 has commenced and is ongoing.

For further information see Appendix A.

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.

The Code of Ethics policy and all job descriptions contained a section on patient/client confidentiality. The need for privacy is maintained through protected time for rest and generic isolation signage is used. It was evident that confidentiality is included as part of the induction programme, including induction for contract cleaners. There was evidence of patient/client's rights evaluation though patient/client satisfaction surveys.

SD 5.2 (B ↑ A)

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

It was evident that the organisation had a comprehensive system in place for the provision of hygiene related information to all service users, which included diverse and well displayed signs on smoking, fire exits, visiting hours, hand hygiene, contact details for discharge team in the event of spillages, waste posters and controlled entrance to kitchens. Leaflets and information are provided on cleaning hours, care of personal clothing/food, hand hygiene, MRSA and the complaints policy. During the assessment, information was provided over the intercom system in relation to the smoking policy and encouraging hand hygiene. It was determined that the patients are actively encouraged to make staff aware of hygiene deficits and complaints, with visual displays of contact details for the Patient Council representatives in the front hall. It was determined that patients were involved in building redesign/design projects, including wheelchair access. There was evidence of evaluation of information comprehension through the provision of hygiene related quizzes for all users, which patients and the public are encourage to participate in. Patient satisfaction surveys are also performed which contained a question on signage. Staff are encouraged to participate in hygiene improvement activities through the hygiene email address and the planned helpdesk number. There was evidence, through minutes of the patient council, that hygiene issues are actioned by Executive Management.

SD 5.3 (A → A)

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

The organisation has a comprehensive complaints system in place, which includes a Patients Representative Office clearly visible and easily accessible to all. Information on the complaints procedure is presented to patents on admission and a visual display in the front hall outlines the contact details of the Patient council. Complaints receive are analysed and trends presented to the executive management team as was evident from Executive Management meeting minutes. There was evidence of actions taken in relation to complaints (for example the refurbishment of the Accident & Emergency toilets and the introduction of protected meal time on a pilot basis).

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1 (A → A)

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

It was evident from the Patient Council Meeting minutes that patients are actively involved when evaluating the hygiene service. Evidence was observed through Patient Council meeting minutes that they performed their own hygiene informal assessments ("walkabouts") and reported back to the Executive Management Team. Feedback is also presented to the patient council in relation to progress on hygiene related projects. Changes made as a result of patient involvement included the refurbishment of the patients' toilets in the Accident & Emergency Department and the change in the patients' teapots. There was evidence of patient involvement in Design project Teams including the OPD refurbishment project in which wheelchair user patients advised on wheelchair access. They were also involved in reviewing procedures for patient catering. It was evident that a patient representative had been invited to sit on the Hygiene Task Force. Executive Management informed the assessors that patient involvement in hygiene and design projects was pivotal to the changes implemented.

SD 6.2 (A → A)

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

It was evident that a robust system is in place for monitoring performance indicators, which includes trends in hygiene audit scores, evaluation of EHO reports, complaints, incident reports and DECT phone response times. It was determined that the hospital is benchmarking itself against hospitals in Groningen, St James's and UCHG. Initiatives undertaken as a result of benchmarking include the introduction of the discharge team, an increase in hygiene awareness and staffing levels and the introduction of the flat mopping system. A comprehensive 2006 Hygiene Annual Report was viewed which detailed the achievements and activities performed. There was evidence of evaluation of the initiatives implemented, for example following an evaluation of the effectiveness of the discharge team; it is planned to trial a janitorial service on wards.

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 - However, the tops of vending machines require attention.

(3) Wall and floor tiles and paint should be in a good state of repair.
No - However, a five-year rolling programme, including a painting programme, is in place to upgrade the environment. The Accident and Emergency Department and some walls within the Neurology Intensive Care Unit (ICU) should be prioritised.

(4) Floors including edges, corners, under and behind beds are free of dust and grit.
Yes - However, attention is required to the corners of the Sterile Services Department.

(6) Free from offensive odours and adequately ventilated.
Yes - Odours were not detected during the assessment.

(7) Areas should be adequately ventilated with ventilation units cleaned and serviced accordingly and documentation available regarding service.
No - It was evident that the Operating Theatre ventilation systems were serviced regularly and all extractor vents viewed in toilets were clean. However, it is recommended that the organisation perform a ventilation needs assessment of clinical areas, including cleaners' rooms as fans were observed in most areas.

(10) Internal and external signage should be clean, updated, well maintained and laminated to enable cleaning.
Yes - However, internal signage within the Coronary Care Unit (CCU) requires reviewing.

(12) Internal and external stairs, steps and lifts must be clean and well-maintained.
Yes - However, lift light fittings require attention.

(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 - The six designated smoking areas viewed were clean.

(16) Hospitals are non smoking environments. However, cigarette bins should be available in external designated locations.
Yes - In 2006 the hospital received the silver medal from the European Network Smoke Free Hospitals Association.

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

(19) Ceilings
No - Ceiling tiles were missing in many areas visited and others were in need of replacement. However, the hospital has an ongoing tile replacement programme.

(20) Doors
Yes - However, damaged door frames were observed throughout clinical areas.

(23) Radiators and Heaters
Yes - All radiators and heaters viewed were clean and cobweb free.

(25) Floors (including hard, soft and carpets).
Yes - However, the corners in the Sterile Services Department requires attention.

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

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

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

(33) Chairs
No - Cloth chairs noted in the Operating Theatre and X-ray and some vinyl chairs in the Accident and Emergency Department are in need of replacement.

(35) Patient couches and trolleys
No - Patient/client trolleys in the Accident & Emergency Department require urgent attention. This was addressed immediately during the assessment.

(41) Door handles and door plates
Yes - However, doorframes were damaged in many clinical areas.

Compliance Heading: 4. 1 .5 Sanitary Accommodation

(44) Hand hygiene facilities are available including soap and paper towels.
Yes - Two patient/client bathrooms visited had no hand wash soap or drying facilities.

(46) Bathrooms / Washrooms must be cleaned on a daily basis. When necessary, they must be disinfected. This must be monitored and recorded.
Yes - However, one bath in the Care of Elderly Day Ward assessment area required 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 - An exception noted was the bath in the Care of Elderly Day Ward assessment area. All showers viewed were clean.

(53) Bidets and Slop Hoppers
No - Most sluice hoppers viewed required attention.

(55) Sluices
Yes - Most sluices were very small and cluttered. This has been acknowledged by hospital management. However they were clean.

(58) Sluice rooms should be free from clutter and hand washing facilities should be available.
No - Most sluices were very small and cluttered. Also many sluices had no hand-wash facilities. However, alcohol gel was available and these areas have been included in the hand-wash sink replacement programme.

(59) Where present shower curtains should be clean and in good repair with a process for laundering and replacement.
Yes - A shower curtain laundering process is in place.

(60) All outlets (including shower outlets) should be flushed at a temperature in accordance with current legislation.
Yes - It was evident that a comprehensive Legionnaires program is in place, including quarterly water testing and ensuring temperature is in accordance with best practice recommendations.

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 - However, attention is required to some drip stand feet and the under surfaces of drip stands.

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

(66) Medical equipment e.g. intravenous infusion pumps, drip stands and pulse oximeters, suction apparatus and tubing, cardiac monitors, blood pressure cuffs, blood gas machines.
Yes - However, as stated, attention is required to some drip stand feet and the under surfaces of drip stands.

(68) Patient fans which are not recommended in clinical areas.
No - Many fans viewed required cleaning.

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

(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 - The provision of drip trays for alcohol dispensers is to be commended.

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

(81) All cleaning equipment should be cleaned daily.
Yes - Cleaning equipment viewed was clean.

(82) Vacuum filters must be changed frequently in accordance with manufacturer's recommendations - evidence available of this.
Yes - Records indicated that cleaning equipment is validated and filters were changed last March.

(83) Mop heads are laundered daily and are stored according to local policy or are disposable i.e. single use.
Yes - Two types of mop systems were in use throughout the organisation. The flat mop system was recently introduced to some areas and a roll out of this system is advised in all areas.

(85) Cleaning solutions should only be prepared in a well ventilated area and should never be mixed.
No - Most cleaning rooms were non-ventilated internal rooms. Reference 4.1.1 (7).

(87) All cleaning equipment should be approved by the Hygiene Services Committee and ensure sufficient supply.
No - Historically this process was reviewed by Infection Control and Health and Safety, however, it is planned that in the future it is reviewed through the Hygiene Steering Committee.

(88) All cleaning equipment should be left clean, dry and tidy in the storage area after use.
Yes - However, the stored floor washer in the Catering Department was not dry and was addressed during the assessment.

(90) Storage facilities for Cleaning Equipment should be provided in each work area with adequate ventilation, a hot and cold water supply and hand-wash facilities.
No - Hospital Management has recognised this as an areas requiring improvement.

(91) Storage facilities for Cleaning Equipment should be clean and well maintained.
No - Many cleaning storage facilities observed were very cluttered.

(92) Cleaning products and consumables should be stored on shelves in locked cupboards.
No - Cleaning products were stored on open shelving in most areas viewed.

(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 - Circuit breakers were standard within the hospital's electrical system and were incorporated into all cleaning electrical equipment in use.

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

(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 or actions taken on foot of issues raised in the reports should be documented.
Yes - Water analysis reports and EHO reports were available for review for all catering facilities.

(216) Documented processes for manual washing-up should be in place
No - A manual washing up policy was not viewed at ward level.

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.
Yes - Clear control notices on the doors of all ward kitchens were in place.

(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 - Assessor was offered PPE such as disposable coats/hair nets in the main patient/client and staff kitchen, and aprons and hair nets in ward kitchens. However, it is advised to extend the provision of PPE for visitors to the public hospital kitchen.

(222) A wash hand basin should be provided at the ward kitchen, in addition to a sink, along with a liquid soap dispenser and hygienic hand drying (e.g. paper towels).
Yes - In one kitchen, the hand-wash sink was used inappropriately; however, this was addressed at the time of inspection. Hand-wash sinks should be used exclusively for hand-washing only.

(223) Separate toilets for food workers should be provided.
Yes - In all main food production areas in line with best practice guidelines.

(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 - Supplement patient/client feeds were stored in some ward kitchens and were under the responsibility of the ward mangers. However, in three kitchens viewed, stock rotation of these products was not performed. This was brought to the attention of nursing staff in the affected areas and the issue was rectified during the assessment.

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 - Comprehensive bait maps were provided in all areas, along with two-monthly inspection records, which is to be commended.

(232) Waste storage containers shall be smooth, durable, easy to clean and disinfect, well maintained and closable.
Yes - Waste storage containers were lined with disposable liners to protect bins from being soiled, which is to be commended.

(233) In food preparation areas where lidded bins are provided they shall be foot pedal operated.
Yes - Open bins used were complaint to ISO 340 2007.

Compliance Heading: 4. 4 .4 Pest Control

(235) A system of pest control developed by a competent person shall be in place.
Yes - The system for pest control is to be commended.

(236) Detailed inspections of food areas shall be carried out and recorded at least every three months for evidence of infestation by insects or rodents by a competent person.
Yes - Two monthly inspection records were available for review.

(237) A location map should be available showing the location of each bait point.
Yes - Maps were clear and the location of traps identifiable during inspections.

(239) Fly screens should be provided at windows in food rooms where appropriate.
Yes - The fly screens in the food area inspected were visibly clean.

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

(242) Temperatures for Food in Fridges / Freezers and Displays should comply with I.S.340:2006 requirements
Yes - All fridges and records inspected, including those in the shop, complied with IS 340, 2007. Validation records available in food outlets were the responsibility of hospital management. The display units in the contracted shop were in the process of being validated at the time of assessment. It is recommended that the service of the vending machines is effective.

(244) Temperature for food when cooked, held or reheated should comply with I.S. 340:2006 requirements
Yes - Temperature records, which were supplied and requested at random, were compliant with I.S. 340:2007.

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).
Yes - It was evident from documentation provided and practice observed that surfaces were cleaned and disinfected appropriately. A colour coding system is in use for chopping boards, however, the use of colour-coded knives was not evident.

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 applicable, as no food thawing takes place.

Compliance Heading: 4. 4 .8 Food Cooking

(247) All foods shall be cooked to a temperature to ensure that the products are safe for consumption. The core temperature of the food shall be assessed at the thickest point of the food and should be compliant with I.S. 340:2006
Yes - All food temperatures checked complied with I.S. 340:2007.

Compliance Heading: 4. 4 .10 Plant & Equipment

(249) Machines should dispense ice but where ice-scoops are used, they should be stored separately from the ice-making machine and there should be a process for the appropriate decontamination of the ice scoops. The making of ice cubes other than in ice machines is prohibited.
Yes - All ice machines inspected had a policy available and scoops were stored in closed containers.

(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.
Yes - Temperature strips are in use in all catering departments and it planned to extend their use to the ward areas.

(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 - Up-to-date external validation records were supplied.

Compliance Heading: 4. 5 .3 Segregation

(156) Healthcare risk waste must be segregated from healthcare non risk waste.
Yes - However one sharps bin was in use by a building contractor. This was brought to the attention of Technical Services who will address this issue.

(162) Hazardous wastes (chemical etc) must be segregated, stored and disposed of correctly.
Yes - An unlabelled drum was noted in waste chemical storage area. However, this was resolved and labelled before end of the assessment.

(256) Mattress bags are available and are used for contaminated mattresses ready for disposal; mattresses are disinfected.
Yes - The Waste Officer indicated that mattress bags are now available.

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 - Double handling of waste is being reviewed and a new system is to be implemented. Yellow bins are to be left inside hospitals and exchanged with empties.

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

(268) Ward based washing machines are used only with the agreement of the Hygiene Services Committee.
No - A number of washing machines and dryers were observed in use in wards and the Physiotherapy Department for patient/client items. These were not agreed with the Hygiene Services Committee. During the assessment, information was supplied regarding the recent availability of patient/client itemised laundering by the external contractor. This is under review and washing machines may be decommissioned.

(269) A washing machine if used is situated in an appropriate designated area and a clear policy/written guidance is in place regarding its use e.g. water temperature etc.
No - No procedure in place for use of washing machines and dryers in ward areas.

(271) Hand washing facilities should be available in the laundry room.
No - None were available in the contract cleaners' room used to wash mops, however, plans are in place to install a hand-washing basin.

(270) If a washing machine is in use, a tumble drier is also in place which is externally exhausted. Documented processes for planned preventative maintenance of this equipment should be in place.
No - There isn't service/planned maintenance is in place for washing machines and dryers in ward areas.

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 - A planned programme for back splash installation was in place and in progress at the time of the assessment.

(191) Hand washing facilities i.e. sinks, taps and splash backs must be clean and intact.
Yes - Some sink outlets require attention. These were brought to the attention of relevant area manger during the assessment.

(192) Taps should be hands free and should be mixer taps to allow temperature regulation.
No - A planned programme for the upgrade of all hand-wash sinks was in progress at the time of the assessment.

(193) Liquid soap is available at all hand washing sinks. Cartridge dispensers must be single use.
Yes - However some hand wash antiseptics were not wall mounted.

(198) Hand hygiene posters and information leaflets should be available and displayed throughout the organization.
Yes - The supply and diversity of hand hygiene posters throughout the organisation is to be commended.

(203) Hand wash sinks are dedicated for that purpose, are free from used equipment and inappropriate items (e.g. nail brushes).
Yes - Inappropriate use of one catering hand-hygiene sink was addressed at the time of the assessment, and immediate action taken by the Catering Supervisor.

(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 - Many hand-wash sinks view had plugs and overflows. However, a planned programme for the upgrade of all hand-wash sinks was in progress at the time of the assessment.

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

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team		Assessor Team	
	FREQ	%	FREQ	%
A	27	48.21	16	28.57
B	28	50.00	38	67.86
C	1	01.79	2	03.57
D	0	00.00	0	00.00
E	0	00.00	0	00.00
N/A	0	00.00	0	00.00

5.2 Ratings Details

Criteria	Self Assessment	Assessor	Difference
CM 1.1	B	B	→
CM 1.2	A	A	→
CM 2.1	B	B	→
CM 3.1	B	B	→
CM 4.1	B	B	→
CM 4.2	B	B	→
CM 4.3	B	B	→
CM 4.4	B	C	↓
CM 4.5	B	B	→
CM 5.1	A	B	↓
CM 5.2	A	B	↓
CM 6.1	A	A	→
CM 6.2	B	B	→
CM 7.1	A	B	↓
CM 7.2	B	B	→
CM 8.1	A	B	↓
CM 8.2	A	A	→
CM 9.1	B	B	→
CM 9.2	A	B	↓
CM 9.3	A	B	↓
CM 9.4	B	B	→
CM 10.1	B	B	→
CM 10.2	B	B	→
CM 10.3	B	B	→
CM 10.4	A	B	↓
CM 10.5	A	A	→
CM 11.1	A	B	↓
CM 11.2	B	B	→
CM 11.3	B	B	→
CM 11.4	C	C	→
CM 12.1	A	A	→

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