Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Hygiene Services Assessment Scheme

Assessment Report October 2007

Cappagh National Orthopaedic Hospital

Table of Contents

1.0 Executive Summary 3
1.1 Introduction 3
1.2 Organisational Profile 7
1.3 Best Practice 7
1.4 Priority Quality Improvement Plan 7
1.5 Hygiene Services Assessment Scheme Overall Score 8
2.0 Standards for Corporate Management 9
3.0 Standards for Service Delivery 15
4.0 Appendix A 20
4.1 Service Delivery Core Criterion 20
5.0 Appendix B 26
5.1 Ratings Summary 26
5.2 Ratings Details 26

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

Cappagh National Orthopaedic Hospital was founded in 1908; this is Ireland's major centre for elective orthopaedic surgery. The hospital has formal links with the RCSI, DCU and UCD for both undergraduate and postgraduate training. The hospital currently has 157 beds. Cappagh National Orthopaedic Hospital has a pleasant, calm environment. There are processes in place to ensure that hygiene is a core responsibility of all staff and sits actively at the highest level of the governing body. It is a clean hospital for today and there are processes in place to ensure a clean safe hospital for tomorrow.

Services provided
Cappagh National Orthopaedic Hospital is the only elective orthopaedic hospital in Ireland.

Physical structures
This organisation has an infection control unit (St Paul's ward) with 2 isolation rooms.

The following assessment of Cappagh National Orthopaedic Hospital took place on 29th and 30th March 2007.

1.3 Notable Practice

- Very robust corporate management structures are in place and senior management are involved in all aspects of hygiene service delivery.
- Very strong evidence of patient satisfaction with the services provided by this hospital was observed.
- An excellent system of waste management is in place.
- Strong evidence that health promotion and hand hygiene information is offered to patients, visitors and the community was observed.

1.4 Priority Quality Improvement Plan

- The Hazard Analysis and Critical Control Point (HACCP) system requires review and full implementation.
- It is recommended that agreements with external contractors are reviewed.
- It is recommended that hand wash sinks in all clinical areas comply with the Strategy for the Control of Antimicrobial Resistance in Ireland (SARI) guidelines.
- Continuous rollout of education and training in all areas of hygiene requires implementation. This needs to include contracted staff.

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 Cappagh National Orthopaedic 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 (A ↓ B)

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

This hospital is an elective admission hospital with systems in place to plan future needs in relation to hygiene services. Comprehensive details of the strategies employed are well documented within the Hygiene Corporate Strategic and Service Plans. The hospital has robust mechanisms to ensure that it is informed of the most up-to-date legislation, codes of practice and national guidelines. While there are informal mechanisms in place, it is recommended that a formal evaluation framework be adopted.

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.

This is an elective service hospital that, through its comprehensive service plans, accesses information required to provide a service that meets the health needs of the population it serves. The hospital evaluates, at both governance and operational level, the service that is currently offered and the opportunities available to extend its services.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1 (A → A)

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.

Self assessment rating as submitted.

Evidence of strong links as required in this standard provided.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 (A → A)

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

Very strong leadership was demonstrated, with clear documented evidence that the organisation ensures hygiene is managed at a corporate level. The governing body are informed of hygiene issues and/or risk issues ensuing from hygiene issues. One member of the governing body actively inspects the hospital randomly to ensure compliance to the hygiene standards.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.3 (A ↓ 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.

No evidence of specific research activities carried out by the hospital was noted.
However, evidence was observed that findings from the previous national hygiene audits (2005 and 2006) and internal hygiene audits are used to improve the hygiene services on an on-going basis. The hospital regularly carries out extensive internal hygiene audits.

CM 4.4 (A → A)

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

A robust system was in place to ensure policies, procedures and guidelines are implemented and reviewed as necessary. Operational documents noted throughout the assessment were at the correct revision number.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

*Core Criterion

CM 5.1 (A → A)

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

There are clear roles, responsibilities and accountabilities from corporate management throughout the entire organisation. All new job descriptions include hygiene as a core responsibility.

*Core Criterion

CM 5.2 (A → A)

The organisation has a multi-disciplinary Hygiene Services Committee.

The hospital has a very inclusive Hygiene Services Committee, which reflects both corporate and service level requirements. This committee is very active and is supported at corporate level.

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

CM 6.2 (A ↓ B)

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

A comprehensive defined pathway for hygiene products procurement was observed. Further controls are required regarding the selection of food suppliers to ensure that delivery of out-of-date, high-risk food products does not re-occur.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

CM 7.1 (A ↓ B)

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

The risk assessment process is well defined and includes evaluation with subsequent action plans. However, it is recommended that a further robust risk assessment process be implemented regarding food safety.

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.

Contracted services are included in the service requirements of the hospital.
A process for the management of contractors was in place. The training and qualifications of staff supplied for contracted catering services requires attention.

CM 8.2 (A → A)

The organisation involves contracted services in its quality improvement activities.

An excellent example observed was the involvement of the waste management and linen contractors in the service of the hospital. This is to be commended.

PHYSICAL ENVORNMENT, FACILITIES AND RESOURCES

*Core Criterion

CM 9.2 (A ↓ C)

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

The main kitchens are not fully Hazard Analysis and Critical Control Point (HACCP) compliant and the monitoring of food requires further attention.

CM 9.3 (A ↓ C)

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

The main kitchens require attention, however, senior management was notified of the risk identified in the kitchen and corrective action was taken during the assessment.

Evidence provided of evaluation was limited and it is recommended that evaluation processes are developed and implemented in the future.

CM 9.4 (A ↓ B)

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

Evaluation of this criteria is carried out at both operational and governance level. Excellent verbal and written reports of patient/client visitors' satisfaction with the hospital hygiene services were observed. Patient/client satisfaction surveys are completed and results observed appeared very favourable. No staff satisfaction survey is currently carried out and it is recommended that a process is implemented in the future.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 (A → A)

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

Very strong policies and procedures are in place to ensure appropriate staff are selected and recruited. Evaluation of job descriptions, in line with hygiene responsibility, is carried out as each post is filled.

CM 10.3 (B ↓ C)

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

Hospital hygiene staff all receive appropriate training. Hygiene service staff do not require prerequisite qualifications prior to commencement of employment. No evidence of training and education records for contracted or agency staff was observed. It is recommended that this process is introduced and records are maintained.

CM 10.4 (B ↓ C)

There is evidence that the contractors manage contract staff effectively.

With the exception of waste and laundry services, limited evidence of this was observed. It is recommended that the management of all contract staff is reviewed.

*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 conducts regular needs assessments to identify staffing requirements. As this is an elective organisation, staffing levels are based on admission rates, which have not fluctuated in recent years and are in line with the Corporate Strategic Plan.

ENHANCING STAFF PERFORMANCE

*Core Criterion

CM 11.1 (A → A)

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

Strong orientation/induction programmes are provided for all grades of staff. Attendance sheets were observed and individual staff training records are completed. The Infection Control Department is responsible for the delivery of hygiene, hand hygiene and general infection control orientation. Hygiene-specific training in relation to work practices, equipment and competencies are delivered by the Contract Cleaning Supervisor and the Hospital Supervisor responsible for hygiene.

CM 11.2 (A ↓ 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.

A strong ethos of training was evident in the organisation, with the exception of the contracted catering staff. All records of training and continuing professional development are maintained and kept up to date. The Risk Management Team perform evaluations of hygiene training as required following incidents. No evidence of pro-active evaluation was observed. It is recommended that this area is addressed in the future.

CM 11.3 (A ↓ B)

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

Evaluation of education and training is carried out in line with risk assessment/incident reporting. These risk reports demonstrate that the hygiene services in the organisation are effective. There have been few incident reports requiring further action. A robust system to deal with corrective action is in place. An annual report on the potency of education and training was also available.

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 an informal performance appraisal process in place for staff employed by the hospital; however, this does not apply to contracted staff. It is recommended that this process is reviewed and formal processes put in place.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (A ↓ B)

An occupational health service is available to all staff

Staff questioned appeared very aware of how to access the Occupational Health Department and were familiar with the services provided. No evidence was submitted of evaluation of the service.

CM 12.2 (A ↓ C)

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

A well structured occupational health service was observed. No evidence of audits or outcomes was observed. No evidence of staff satisfaction with the service was also noted. It is recommended that a process for evaluation is implemented in the future.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.3 (B → B)

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

Hygiene issues are discussed at all levels of the organisation and a consensus approach is taken to the implementation of modifications. Evaluation of the service was evident from the Hygiene, Infection Control and Risk Management audits observed.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

CM 14.1 (A → A)

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

Very strong corporate leadership and support was observed during the assessment.
A full quality improvement plan was in place which reflected work carried out to date. On-going projects were also observed.

CM 14.2 (A ↓ B)

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

It is recommended that evaluation and defined outcomes in relation to hygiene are strengthened. It must be discussed at all levels in the organisation and be on the formal management agenda. Changes to services have been made in the last few years, due to evaluations and quality improvement plans. This includes the upgrading of sinks and the refurbishment of some ward areas on a phased basis to include hygiene services, store, linen room and waste disposal areas. The hospital also introduced hand hygiene stations at hospital, ward and departmental areas. The hospital has also refurbished its main waste disposal compound.

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.

The Executive Council and Management Team have processes in place to ensure best practice guidelines are identified. Colour coding is used throughout the delivery of waste and catering services. Evaluation is conducted through internal and external audits, as well as other mechanisms such as meetings. The organisation states that the kitchens are Hazard Analysis and Critical Control Point (HACCP) compliant; however this was not validated during the assessment.

SD 1.2 (A → A)

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

Strong evidence was observed that that the Hygiene Services Committee assess all new hygiene services prior to their implementation. This process is outlined in the Hygiene Corporate Strategic Plan and was discussed with senior management during the assessment.

PREVENTION AND HEALTH PROMOTION

SD 2.1 (A → A)

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

The hospital provides patient information booklets to all patients. These provide relevant information on important aspects, such as infection control and visiting times. Extensive signage was observed throughout the hospital regarding hand washing and other aspects of health promotion. Signage was noted in different languages, which is to be commended. Patient satisfaction surveys are carried out and comment cards are in use. These encourage service users to make comments regarding hygiene practice. The hospital supports the Health Service Executive's national campaigns on hygiene and hand washing. During the assessment, this area was identified as an area of excellence.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1 (A ↓ B)

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

Strong evidence was presented to support the existence of a multi-disciplinary team working together to achieve high levels of quality in the provision of hygiene services. This was validated through interviews of key personnel and observed in the corporate strategy. Many of the key personnel are members of several different committees. The multi-disciplinary team structure is effective as high attendances at monthly meetings were observed and actions arising from these meetings are documented and implemented. No formal evaluation of the team has been carried out. However, evidence that the management of hygiene at the hospital is effective was noted.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

SD 4.1 (A → A)

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

There was evidence to suggest that compliance to this criterion was achieved in over 85% of areas. The exceptions to this, which requires further attention, include the lift areas, curtain rails and the Central Sterile Supply Department.

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 self-assessment rating submitted was verified through the mandatory compliance assessment tool and validated compliance to this core criterion. More attention to detail is required for a small percentage of equipment, including television sets and patient wash bowls.

For further information see Appendix A

*Core Criterion

SD 4.3 (A → A)

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

Overall, good processes and practices are observed. It was noted that diluted cleaning solutions were not dated and therefore no evidence existed that they were discarded every 24 hours. A process should be documented to address this.

For further information see Appendix A

*Core Criterion

SD 4.4 (A ↓ B)

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

During the assessment, the kitchen was clean and well maintained. However issues were identified regarding the implementation of HACCP, particularly in relation to date controls on incoming high risk deliveries and in maintaining temperatures as per the requirements of IS 340:1994.

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.

The self-assessment rating submitted was verified through the mandatory compliance assessment tool. An excellent system of waste management was observed in the organisation.

For further information see Appendix A

*Core Criterion

SD 4.6 (A → A)

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

The self-assessment rating submitted was verified through the mandatory compliance assessment tool. The clean linen system is managed to a very high standard.

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 self-assessment rating submitted was verified through the mandatory compliance assessment tool. Procedures for education, training and awareness regarding hand hygiene are in place. Hand wash sinks do not comply with SARI standards in all cases; however, a quality improvement plan has been developed to address this issue.

For further information see Appendix A

SD 4.8 (A ↓ B)

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

The presence of out-of-date high-risk foods in a kitchen storage fridge could, if utilised, lead to an adverse event of food poisoning. When identified, a comprehensive process to address this issue was put in place.

SD 4.9 (A → A)

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

Extensive evidence of Patient/Clients and families' participation in improving hygiene services was noted. Patient/client satisfaction surveys are carried out and the feedback received is used in the development of quality improvement plans.

PATIENT'S/CLIENT'S RIGHTS

SD 5.1 (A → A)

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

Documented guidelines are available regarding patient/client's rights regarding hygiene services. Information regarding patient/client's rights is also listed in the patient/client information booklet. Patient/client satisfaction surveys demonstrate that no issues in relation to the violation of patient/clients rights have been identified. A system was in place for the reporting of incidents and adverse events, which also identified no problems in this area.

Incidents, if they do occur, are classified according to risk and appropriate actions are taken.

SD 5.2 (B ↑ A)

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

Extensive compliance in this area was noted. All patient/clients are provided with a patient/client information booklet and extensive signage and leaflets was observed throughout the hospital for patient/clients and visitors alike. The hospital operates the National Visitor's Policy and interviews with patient/clients demonstrated that this is rigorously enforced. Patient/clients satisfaction surveys are completed and analysed, the results of which indicate a very high level of satisfaction with all aspects of hygiene service delivery.

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.

A Patient/Client Care Committee is in place and has met twice this year. Patient/client comment cards and surveys are analysed and, based on the information received, actions were taken. Evidence that hygiene services have been changed based on the results of patient feedback was observed. Evaluation of this criterion is an on-going process, implemented by the various representative committees in the hospital.

SD 6.2 (B → B)

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 organisation is recommended to continue development in this area of benchmarking and trend analysis.

SD 6.3 (A ↓ B)

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

One has not yet been produced. A quality improvement plan is in place to develop this by December 2007 and evidence that related data has been gathered, which will be used to create this report, was observed. The organisation also intends to invite input from all the service users in its development of this report.

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.
No - High and low level dust was noted, as were cobwebs.

(4) Floors including edges, corners, under and behind beds are free of dust and grit.
No - Not all floor edges and corners observed were free of dust and grit.

(12) Internal and external stairs, steps and lifts must be clean and well-maintained.
Yes - However, at the time of assessment, the standard of cleaning in the lift could have been higher.

(13) External areas including grounds, gardens, footpaths, ramps and car parks should be clean and well-maintained.
Yes - This was identified as area of excellence.

(14) Waste bins should be clean, in good repair and covered.
Yes - One exception noted was the Hospital Sterile Services Department (HSSD) washing area.

(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 - This was identified as area of excellence.

(28) Before cleaning commences, a work route should be planned and when necessary, furniture and equipment should be removed from the area.
No - This is in the process of being developed.

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

(18) Walls, including skirting boards.
Yes - However, some areas requiring improvement were noted.

(21) Internal and External Glass.
No - The windows required cleaning.

(25) Floors (including hard, soft and carpets).
No - Floors and edges require greater attention.

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

(31) Furniture and fittings: Furniture and fittings in direct patient care environment must be clean and dust free i.e. cleaned on a daily basis. Horizontal surfaces (high and low) around the patient i.e. ledges, worktops, window ledges, flat surface suction apparatus, bed table, locker, curtain rail and chairs.
No - Dust was noted on top of curtain rails and lockers.

(207) Bed frames must be clean and dust free
No - Residual dust was observed on the bed frames at foot of beds and carriages.

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

(33) Chairs
Yes - However, fabric covered chairs were noted in the X-Ray department. This is not recommended.

(34) Beds and Mattresses
No - Residual dust was observed on bed frames and the foot of beds and carriages.

(39) Waste Receptacles (e.g. sani-bins, nappy bins, sharps bins, leak proof bins
Yes - However, at the time of assessment, the standard of cleaning of the sani-bins could have been higher.

(40) Curtains and Blinds
Yes - Curtains were not hung correctly in all areas. Some stains were noted on curtains and curtain rails were dusty in places.

Compliance Heading: 4. 1 .5 Sanitary Accommodation

(47) Bathrooms / Washrooms are clean and communal items are stored e.g. talc or creams.
Yes - Staff areas were also of a very high standard - this is to be commended.

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

(52) Toilets and Urinals
Yes - However, toilet rims require greater attention.

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

(69) Patient washbowls should be decontaminated between each patient, and should be stored clean, dry and inverted. Damaged washbowls should be replaced.
Yes - However, some wash bowls were not inverted.

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

(73) TV, radio, earpiece for bedside entertainment system and patient call bell.
Yes - However, dust was noted on television stands

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

(84) Products used for cleaning and disinfection comply with policy and are used at the correct dilution. Diluted products are discarded after 24 hours.
No - Documented evidence of this was not observed. Bottles were not dated and no records are kept.

(91) Storage facilities for Cleaning Equipment should be clean and well maintained.
Yes - However, an exception noted was the theatre.

(92) Cleaning products and consumables should be stored in shelves in locked cupboards.
No - The cleaning store was not locked.

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

(214) The person in charge of catering shall develop, implement and maintain a permanent system based on the seven principles of HACCP. A standard HACCP Plan should be fully completed.
No - The current plan is not fully compliant.

(215) There should be a documented ward kitchen food safety policy which should be signed off by the person in charge of the ward kitchen and the hospital manager.
Yes - The food safety policy contained references out-of-date legislation (for example SI 165 OF 2000)

Compliance Heading: 4. 4 .2 Facilities

(218) Authorised visitors to the food areas should wear personal protective clothing (PPE) and wash hands on entering the food area during food preparation/serving times.
Yes - Evidence of personal protective clothing requirements was very visible.

(225) Staff in charge of Ward Kitchens shall ensure that product traceability is maintained while the product is in storage (Regulation (EC) 178/2002). Stock shall be rotated on a first in / first out basis taking into account the best before / use by dates as appropriate. Staff food should be stored separately and identifiable.
No - cooked chicken out of date -2nd March 2007 Extensive corrective action was taken and documented

Compliance Heading: 4. 4 .3 Waste Management

(232) Waste storage containers shall be smooth, durable, easy to clean and disinfect, well maintained and closable.
No - Two empty waste containers were observed in kitchen yard area, which were dirty.

Compliance Heading: 4. 4 .4 Pest Control

(238) Electric fly killer (EFK) units when used shall be located in an area free from draughts, away from natural light and not directly above an area where food or materials that come into contact with food are located. The EFK units shall be left on at all times and have shatter proof sleeves. The ultraviolet (UV) light tubes shall be replaced at least annually and records of replacement should be retained. The EFK shall be fitted with a catch tray and emptied as required.
Yes - In the majority of cases; however, the electric fly killer in the cleaning room was not working.

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 - A Cook/Chill system was not in use in the hospital.

(242) Temperatures for Food in Fridges / Freezers and Displays should comply with I.S.340:2006 requirements
Yes - However, a high temperature of 7 degrees Celsius was noted in ward kitchen fridge.

(243) Preparation of High Risk Foods should comply with I.S. 340:2006 requirements
No - All cooked food must comply with I.S. 340:2006 requirements.

(244) Temperature for food when cooked, held or reheated should comply with I.S. 340:2006 requirements
No - Food temperature observed at ward level was low at 57 degrees Celsius.

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
No - The core temperature after thawing was not being checked in all cases

Compliance Heading: 4. 4 .9 Food Cooling

(248) Cooling Times for Cooked Food should comply with I.S. 340:2006 requirements
No - On the date of assessment, no evidence was observed of cooling record for cooked brown rice.

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 - No ice machines were observed in the catering area.

(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 - This is not monitored at ward level.

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

(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.
Yes - An excellent tracking system is in operation - this is to be commended.

(151) Waste is disposed of safely without risk of contamination or injury.
Yes - A good hands-free system is in place.

Compliance Heading: 4. 5 .3 Segregation

(256) Mattress bags are available and are used for contaminated mattresses ready for disposal; mattresses are disinfected.
No - Mattress bags were not available; however, a suitable alternative method is in use.

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.
Yes - However, no in-house laundry provided.

(174) Clean linen is stored in a designated area separate from used linen (not in sluice or bathroom).
Yes - The clean linen system in operation was excellent

(262) Linen is segregated into categories and in appropriate colour coded bags (i.e. clean/unused linen, dirty/used linen, dirty/contaminated linen).
No - On the day of assessment, internal mop heads were not transported as per local policy.

(266) Personal protective equipment must be accessible to and used by all staff members involved in handling contaminated linen.
No - Aprons or gloves were not used by the linen operative. However, corrective action was taken with immediate effect.

(268) Ward based washing machines are used only with the agreement of the Hygiene Services Committee.
Yes - No ward-based facilities are provided.

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

(192) Taps should be hands free and should be mixer taps to allow temperature regulation.
No - The replacement of sinks is required in certain areas to comply with SARI standards.

(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 - However, a quality improvement plan is in place.

(205) General wards should have one sink per 4-6 beds and critical areas should have one sink per 1-3 beds.
No - The proportion of sinks to beds was not is compliance with SARI standards.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team		Assessor Team	
	FREQ	%	FREQ	%
A	46	82.14	28	50.00
B	10	17.86	22	39.29
C	0	00.00	6	10.71
D	0	00.00	0	00.00
E	0	00.00	0	00.00
N/A	0	00.00	0	00.00

5.2 Ratings Details

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

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