Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Hygiene Services Assessment Scheme

Assessment Report October 2007

Connolly Hospital, Blanchardstown

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1.0 Executive Summary

1.1 Introduction

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

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

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

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

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

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

1.1.1 Standards Overview

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

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

The six Service Delivery standards facilitate the assessment of performance at team level. The standards address the following areas:
- Evidence based best practice and new interventions
- Prevention and Health Promotion
- Integration and coordination of hygiene services
- Implementing safe, efficient and effective hygiene services
- Protection of patient/clients rights
- Assessing and Improving performance. [5]

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

Core Criteria:

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

In the Corporate Management standards, the core criteria cover:

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

In the Service Delivery standards, core criteria cover:

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

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

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

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

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

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

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

E **No Compliance**
- Only negligible compliance (less than 15%) with the criterion provisions is discernible.

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

1.1.3 Assessment process components

The assessment process involves four distinct components:

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

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

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

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

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

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

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

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

October 2007 all 51 acute care hospitals had received a copy of their individual report.

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

- **Continuous Improvement**

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

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

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[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

Connolly Hospital, Blanchardstown (CHB) is a major teaching hospital providing a wide range of services to a population of 290,000. The hospital's catchment area extends into west Dublin, Meath and Kildare. Emergency services are provided 24 hours a day, 365 days a year.

The hospital was founded in 1955 in response to the rise in the incidence of tuberculosis. In the early 1960s the introduction of effective antibiotics revolutionized the treatment of tuberculosis and there was no need for the hospital to continue in its original role. By this stage however, there was increasing urban development in the area around the hospital and it became a General Hospital in 1973. By the early 1980s, the increasing population of the catchment area, and pressures on other hospitals, resulted in its integration into the Accident and Emergency Service for north Dublin.

Services provided

The hospital provides the following services:

- Acute medical and surgical service
- General Acute psychiatry
- Long stay care
- Day care out-patient
- Diagnostic and support services

Speciality areas include:

- Anaesthesia and Intensive Care General Medicine Orthopaedics
- Acute Care of the Elderly, Rehab, General Surgery, Pathology
- Day Hospital/Extended Care
- Cardiology, Gynaecology, Plastic Surgery
- Dermatology, Haematology, Radiology
- Emergency Department, Intensive Therapy Respiratory Medicine
- Endocrinology, Microbiology, Rheumatology
- ENT, Neurology, Urology
- Gastroenterology, Oncology, Vascular Medicine
- General Adult Psychiatry, Ophthalmology
- Psychiatry of Old Age

The following assessment of Connolly Hospital, Blanchardstown took place between 19th and 21st June 2007.

1.3 Notable Practice

- The development of hygiene management structures within the organisation
- Visible progress with building development and the new posts have had direct impact and input in hygiene services.
- Refurbishment works have been completed in the main kitchen and ward kitchens to comply with the prerequisite programme of Irish Standard 340. Catering staff who were interviewed and observed displayed food safety training commensurate with their work.

- There was adherence to hand hygiene requirements throughout the organisation and adherence to the uniform policy.
- The cleaners rooms, equipment being utilised and staff's knowledge was impressive, all giving a clean environment outcome.
- There was a palpable culture to improve hygiene.

1.4 Priority Quality Improvement Plan

- Additional wash hand basins should be provided in food rooms, to comply with the Environmental Health Service report under food safety legislation. Hazard Analysis and Critical Point Control (HACCP) should be reviewed to take account of new food systems that have been introduced by the catering department.
- A pest specification should be drawn up to include a site map of all bait stations and the issuing of a report for every visit.
- The assessment processes need to be enhanced, and opportunities for improvement identified. No action plans or time frames for quality improvement plans are being identified. The organisation would benefit from further involvement of the Clinical Nurse Managers and the heads of department with the evaluation processes.
- In the Physiotherapy Department, the single use patient/client invasive probes for urology intervention were being rinsed in the hand sink and the water from the hot pack machine was being disposed of in the hand sink on the corridor. This is being addressed and an alternative practice is being identified. The organisation is encouraged to continue to progress this.
- All current contracts should be signed and outstanding contracts should be developed.
- Linen stored at ward/department level needs to be segregated.
- Greater use of IT needs to be developed for analysis, reports and communication to stakeholders.

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 Connolly Hospital, Blanchardstown 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   **(B ↓ C)**
The organisation regularly assesses and updates the organisation's current and future needs for Hygiene Services.
Detailed Corporate Strategic, Service and Operational plans are in place. To meet the requirements of hygiene services the Hygiene Standards Group was formed. Pertinent issues in relation to hygiene are addressed in a Hygiene Services Quality Improvement Plan. The establishment of the Patient/Client Council will enhance the needs assessment process, and impact directly with resultant actions and continuous quality improvement.

CM 1.2   **(A ↓ B)**
There is evidence that the organisation's Hygiene Services are maintained, modified and developed to meet the health needs of the population served based on the information collected.
A Population Needs Analysis was undertaken as part of the Hospital Strategic Plan, which has been reviewed this year, as part of continuous quality improvement. Involvement in the National Patient/Client Survey and Staff and Patient/Client Hygiene Perception Survey assists in maintaining, modifying and developing hygiene services. In promoting continuous quality improvement, education on hygiene assessment was delivered to a broad range of staff. Follow up is advised.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1   **(A ↓ B)**
The organisation links and works in partnership with the Health Services Executive, various levels of Government and associated agencies, all staff, contract staff and patients/clients with regard to hygiene services.
Specific links are in place with the HSE and the Department of Health and Children. The organisation works in conjunction with "shared services". Monthly meetings are attended by the Network Area Manager. The hospital has a programme for the relocation of clinical areas from the older buildings to the new hospital building. Ongoing refurbishment of the existing older building is being undertaken and further works are planned.
The hospital gave direct feedback on the National Cleaning Manual, and liaises with other healthcare institutions about hygiene services. Patient/client surveys and staff satisfaction questionnaires have been undertaken with evidence of very positive findings in both. Management structures, for both internal and contracted hygiene

services are compliant with legislation and national best practice guidelines. The development of a patient/client council is a work in progress. This is encouraging.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 (A ↓ B)
The organisation has a clear corporate strategic planning process for Hygiene Services that contributes to improving the outcomes of the organisation.
The Hygiene Corporate Strategic Plan has been developed in conjunction with the overall Hospital Strategic Plan. It had a clear multi-disciplinary approach and existing quality templates were utilised in its development. It incorporated the Hygiene Services and Operational Plans. The development of the plan included a SWOT analysis of hygiene requirements. The hospital has extended its mission statement to include hygiene. Internal communication is via email, post, posters and ward/area meetings from members of the Hygiene Standards Group. The Director of Allied Health Professions and Director of Nursing are senior representatives of the Executive Management on the Hygiene Standards Group. Membership allows for improved methods of communication on hygiene issues. Members of the Hygiene Standards Group include catering and environmental management and Household Services Management. It is recommended that this is addressed. The team is encouraged to evaluate the goals, objectives and priorities of the Hygiene Corporate Strategic Plan against defined needs.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.1 (A ↓ B)
The Governing Body and its Executive Management Team have responsibility for the overall management and implementation of the Hygiene Service in line with corporate policies and procedures, current legislation, evidence based best practice and research.
The hygiene service structure makes clear provision for accountability, responsibility and channels of communication. A code of corporate ethics is in place. Minutes viewed of the Hospital Executive, Integrated Safety & Quality Committee, Hygiene Standards Group, Infection Control Committee and team meetings demonstrated commitment to hygiene. The Corporate Hygiene Plan outlines the structures in place for the hygiene services. The linkage of health care assistants and nursing staff to nursing administration in the operational hygiene structure is not documented. The team is encouraged to evaluate adherence to legislation and relevant national guidelines.

CM 4.2 (B ↓ C)
The Governing Body and / or its Executive Management Team regularly receive useful, timely and accurate evidence or best practice information.
There is some evidence that information from a variety of sources, including legislation, best practice guidelines, infection control, form the basis for change in hygiene practices. Hygiene service issues are discussed at all meetings as outlined in CM 4.1. The quality improvement plans from evaluations undertaken, are yet to be completed. The results from the internal evaluation of the physiotherapy department revealed a score in the mid forties, with no continuous improvement plan instigated. Similar unfavourable hygiene issues were identified during HIQA assessment.

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.
Use of best practice information, Strategy for the control of Antimicrobial Resistance in Ireland (SARI) guidelines; British Institute of Cleaning Science (BICS); HSE cleaning manual; library and research facilities; education/training; expertise of multi-disciplinary team and development of internal auditing training are evident in the improvement of the hygiene services. There was documented evidence of ongoing induction and continuing hygiene related education. A number of new hygiene initiatives have been introduced over the last two years. Key personnel have been appointed with responsibility for hygiene as has a Clinical and Non Clinical Risk Co-ordinator; SARI pharmacist; an additional 0.5 Whole Time Equivalent Infection Control Nurse, Surveillance Scientist, an MPCE and Maintenance Manager. An evaluation of the information available in relation to hygiene services research and best practice is recommended.

CM 4.4   **(A ↓ C)**
The organisation has a process for establishing and maintaining best practice policies, procedures and guidelines for Hygiene Services.
A system is in place for the development, approval, revision and control of all policies, procedures and guidelines, including those relating to hygiene services. A standard template for all new and revised policies, procedures and guidelines, which reflects best practice, was at Draft 4 stage at the time of assessment.
A number of hygiene related policies already exist, based on this template.
A number of existing policies were not reviewed by the required date. Some procedures, such as internal transportation of waste, were not documented. It is recommended that this be addressed. Evaluation of the potency of the process for developing and maintaining the policies and procedures need to be incorporated into a Quality Improvement Plan.

CM 4.5   **(C → C)**
The Hygiene Services Committee is involved in the organisation's capital development planning and implementation process.
Terms of reference for the Hygiene Standards Group identified direct linkage to the Hospital Manager and Executive Committee. Members of the Hygiene Standards Group are on the Project Steering Group. Health & Safety, through the Risk Management Team, assess and review new projects and their impact.
There was evidence of the involvement of the Hygiene Standards Group in the recent and planned capital developments. The Hygiene Standards Group's involvement in minor capital works in the future is planned, through its new hygiene management structures. This will ensure comprehensive hygiene services input into all new developments. The evaluation of the potency of the consultation process is recommended.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

*Core Criterion
CM 5.1   **(B → B)**
There are clear roles, authorities, responsibilities and accountabilities throughout the structure of the Hygiene Services.
Details of the hygiene services structure were in place. The Hygiene Standards Group reports directly to the Hospital Manager. The reporting relationships and

responsibilities/ accountabilities for hygiene services were documented. The job description viewed of the Grade CNM11 included responsibility for hygiene within the ward area. Written job descriptions reviewed, of staff involved in hygiene services, included the responsibility for hygiene in their own area.

*Core Criterion
CM 5.2 (A ↓ C)
The organisation has a multi-disciplinary Hygiene Services Committee.
The organisation developed a Hygiene Standards Group with identified terms of reference and scheduled meetings weekly. Administrative support was provided by the Quality/Accreditation Office. The positions of Hygiene Service Coordinator and Senior Infection Control Nurse were being sought at the time of assessment. There was evidence of enhanced hygiene awareness since the development of the hygiene groups. The additional posts sought should enhance the Hygiene Standards Group and ensure this group is multidisciplinary.

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

*Core Criterion
CM 6.1 (B → B)
The Governing Body and/or its Executive/Management Team allocate resources for the Hygiene Service based on informed equitable decisions and in accordance with corporate and service plans.
Resources are allocated to hygiene services by the Executive Management Team, based on needs identified through the HSE: Pay for Purchase National Guidelines. General services had a plan for resources needed for hygiene services. A business case report is produced when new positions are being sought. There was evidence of on-going investment in hygiene service development and clinical area refurbishment/upgrades. There is a planned programme of capital works identified with 2008 estimates prepared.

CM 6.2 (C → C)
The Hygiene Committee is involved in the process of purchasing all equipment / products.
Members of the Hygiene Standards Group sit on the Hospital Executive and, in conjunction with the chairperson of the group reporting to the hospital manager, the members can bring hygiene issues directly to the Hospital Executive.
The Hygiene Standards Group has direct links to the purchasing and procurement group. A briefing paper for minor capital works for hygiene services, to the value of €400,000, had been developed. The Infection Control Services Team work closely with the Procurement Department and are involved in the purchase of specific hygiene-related equipment and products. The flat mopping system was identified as an example during the assessment. Evaluation of the potency of the consultation process between the Hygiene Services Committee and senior management is recommended.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion
CM 7.1   (B ↓ C)
The organisation has a structure and related processes to identify, analyse, prioritise and eliminate or minimise risk related to the Hygiene Service
The risk management structure has only been in existence for the last two years. Guidelines were developed and training was in progress. Issues identified in external reports from Health & Safety Authority (HAS) and the Environment Health Officer (EHO) had been addressed. As the organisational structure had changed, there was no risk management report available, but similar to the hygiene report this was a work in progress. No major adverse incidents were reported in the last two years. The STARS incident database system is used.
Records of completed risk assessments were reviewed. It is recommended that there is further use of the process to capture hygiene related issues/incidents. The team is encouraged to conduct audits in relation to hygiene services.

CM 7.2   (B → B)
The organisation's Hygiene Services risk management practices are actively supported by the Governing Body and/or its Executive Management Team.
Resources allocated to risk management over the last two years had been detailed. Representatives from risk management are on the Integrated Safety and Quality Committee (ISQC). Risk reports were reviewed and, where new developments or upgrades had been instigated, risk assessments were undertaken and reports and action plans fed back to ward/area managers. No major adverse hygiene service incidents were reported over the last two years. It is suggested that the organisation highlight to the ward and unit managers, the use of the risk incident forms to report adverse events in relation to hygiene services.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion
CM 8.1   (B ↓ C)
The organisation has a process for establishing contracts, managing and monitoring contractors, their professional liability and their quality improvement processes in the areas of Hygiene Services.
There was documented evidence in relation to establishing contracts, however the managing and monitoring of contracts needs to be improved. This was evident in relation to the management of linen, maintenance service contract and some shared services contracts. It is recommended that the organisation review and ensure all contracts related to hygiene services are up to date.

CM 8.2   (B → B)
The organisation involves contracted services in its quality improvement activities.
The contract cleaning company, who won the Irish Contract Cleaning Association for cleaning of Connolly Hospital in 2006, are involved in quality improvement plans such as the introduction of the flat moping system. The contracted linen agency has been involved in the development of segregation policies. Education and training have been provided by other contractors, for example waste, sharps and hand hygiene products. The inclusion of the Household Services Manager in the Hygiene

Standards Group would improve communication channels to the contractors, and assist in their involvement in quality improvement initiatives.

PHYSICAL ENVIORNMENT, FACILITIES AND RESOURCES

CM 9.1   **(B ↓ C)**
The design and layout of the organisation's current physical environment is safe, meets all regulations and is in line with best practice.
The new clinical delivery areas were evident of best practice and details of regulations and code of best practice were adhered to. An ongoing programme of moving patient care areas from the older buildings to the new build was in place. A development programme was evident addressing the requirement to place splash-backs behind all clinical wash hand basins. Some areas delivering clinical care from old "Porto-cabin" structures were very compromised in relation to the physical environment and facilities. It is recommended that the Team evaluate the safety of design, layout and the current environment and its adherence to regulations and best practice.

*Core Criterion
CM 9.2   **(B ↓ C)**
The organisation has a process to plan and manage its environment and facilities, equipment and devices, kitchens, waste and sharps and linen.
Processes are in place to manage the hospital environment and facilities, equipment and devices, kitchens, waste and sharps, and linen. However as detailed in CM 8.1, the contracts need to be evaluated and reviewed.
As many of the initiatives were relatively recent (within the last year) - for example the Expenditure and Procurement Committee, employment of Technical Services Manager and Medical Physics and Chemical Engineer (MPCE), these developments should be embedded.

CM 9.3   **(B → B)**
There is evidence that the management of the organisation's environment and facilities, equipment and devices, kitchens, waste and sharps and linen is effective and efficient.
Evaluations of cleaning services included hygiene audits of household staff and contract cleaners. Patient/client perception and staff satisfaction surveys rated very high in terms of satisfaction with the management of hygiene services.
A list of improvements within the last two years was reviewed.
The process for segregation of linen at ward level needs to be reviewed, see section in service delivery 4.6 for specific issues.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1   **(A ↓ B)**
The organisation has a comprehensive process for selecting and recruiting human resources for Hygiene Services in accordance with best practice, current legislation and governmental guidelines.
The organisation adheres to the Code of Practice for Public Appointments 2006/Employment Control Framework 01/2006. Legislation is adhered to in relation to the tendering process for contractors. The Cleaning Services Contractor has its own documented processes for selection and recruitment of staff, based on legislation and current best practice. Job descriptions were available for staff and had

been updated to detail their responsibilities in relation to hygiene. The Human Resource Department maintains all recruitment and competition records. Evaluation of the process for selecting and recruiting human resources is recommended.

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.
Evidence of a review of changes in capacity and volume of work was validated. A needs assessment survey resulted in the use of agency staff for catering, additional contract cleaners and the appointment of .5 WTE Infection Control Nurse. A business case is put forward when it is identified that more staff are needed in hygiene services.
The appointment of a Hygiene Services Manager will significantly assist in ongoing quality improvement. It is recommended that an evaluation of work capacity and volume review process is undertaken.

CM 10.3 (A ↓ B)
The organisation ensures that all Hygiene Services staff, including contract staff, have the relevant and appropriate qualifications and training.
Induction and staff training programmes are in place for all new staff. Ongoing education and training is provided as required, and is specific to the area of employment, for example, catering, food hygiene, cleaning services.
Evaluation of the level of staff attending mandatory training on hand hygiene and chemical safety is recommended as a quality improvement plan. Education in relation to chemical safety was delivered to catering staff from product providers.

CM 10.4 (A ↓ B)
There is evidence that the contractors manage contract staff effectively.
The cleaning services company had a quality philosophy in place and a service contract with the organisation. The reporting structure of the contractors was identified on the Operational Hygiene Structure. Training and orientation was provided for the contracted staff. Evaluation of cleaning services from contractors was undertaken from a cost benefit analysis and a quality performance indication has very favourable outcomes. It is recommended that an evaluation of the appropriate use of contract staff is conducted.

*Core Criterion
CM 10.5 (B → B)
There is evidence that the identified human resource needs for Hygiene Services are met in accordance with Hygiene Corporate and Service plans.
There was evidence of the establishment of new hygiene services' posts as a result of a needs assessment having been undertaken. An analysis was undertaken to evaluate staffing requirements to facilitate hygiene services when the new building was opened. Corporate Strategic, Hygiene Service and Operational Plans were in place. The organisation is urged to progress its intent to formulate a hygiene services report for 2007.

ENHANCING STAFF PERFORMANCE

*Core Criterion
CM 11.1 (B → B)
There is a designated orientation / induction programme for all staff which includes education regarding hygiene
Induction/orientation is provided for staff. Ongoing hygiene awareness training is in place. Education is provided in relation to Health and Safety, Infection Control, Health Promotion and Occupational Health, Food Hygiene training and FETAC skills programme. The Risk Management Team were involved in specific training programmes. A database of attendants for risk management training was in use. The organisation is encouraged to provide additional training when it adapts its own policy for the management of complaints, in line with the HSE policy.

CM 11.3 (B ↓ C)
There is evidence that education and training regarding Hygiene Services is effective.
Training evaluation forms are used at end of training sessions and key performance indicators, to evaluate potency of training would improve feedback and assist in quality improvement. The team is encouraged to evaluate the attendance levels at education and training sessions.

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.
The Quality Philosophy Document used by the contractors included a performance review. A Cost Benefit Analysis and Quality of Cleaning Outcome were undertaken on the household and contract staff. The Employment Control Committee is reviewing the findings and the organisation is encouraged to progress these. The team is encouraged to evaluate the number of hygiene services staff who undergo performance evaluation.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (B ↓ C)
An occupational health service is available to all staff
Details of occupational health services and vaccinations were validated. An evaluation of the service provided by the Occupational Health Department had not been undertaken.
The Staff Satisfaction Survey did not have any specific questions pertinent to occupational health. Resultant actions and feedback were not available. The organisation is encouraged to implement a Quality Improvement Plan for occupational health to undertake a survey of the services they provide.

CM 12.2 (A ↓ B)
Hygiene Services staff satisfaction, occupational health and well-being is monitored by the organisation on an ongoing basis
A staff health needs assessment was undertaken in 2001 with a review in 2005. These assisted in the development of the HR strategy to provide a healthy work environment. External and internal "Sli na Slainte" routes have been developed for staff and patient/clients. Staff health fairs were held in both 2002 and 2006 – evaluations of both were undertaken. Stress management initiatives were instigated

as a result of evaluations. Staff was involved in the "Best Company to Work For" survey in 2005 and completed their own staff satisfaction survey this year. Quality improvements were reviewed during the assessment. Staff turnover rate is low. This can be utilised as a key performance indicator of staff satisfaction. The team is encouraged to evaluate mechanisms for monitoring staff satisfaction in relation to hygiene services.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.1 (B ↓ C)
The organisation has a process for collecting and providing access to quality Hygiene Services data and information that meets all legal and best practice requirements.
Currently data for hygiene services is collected manually. The organisation is encouraged to implement its Quality Improvement Plan to utilise the "Q-Pulse Audit Tool" for hygiene services monitoring. During the assessment, the manual system of record keeping arose on many occasions, particularly during the service delivery assessment. This has led to reduced efficiency in monitoring and evaluation of hygiene processes.
A need to implement an IT system, to enhance actions and feedback has been identified. It is recommended that this is progressed.

CM 13.2 (B ↓ C)
Data and information are reported by the organisation in a way that is timely, accurate, easily interpreted and based on the needs of the Hygiene Services.
Reports and quality improvement plans have been generated with a view to improving hygiene services. Annual hygiene service and risk management reports are in infancy stage. An evaluation of the data and information turnaround is recommended. This would be greatly assisted by more automated systems. Documented evaluation of user satisfaction in relation to the reporting of data was not evident. Managers expressed some dissatisfaction in the feedback loop to requests made in their departments. For example, staff had requested replacement of frayed couches in the Physiotherapy Department approximately two months prior to hospital assessment.

CM 13.3 (B → B)
The organisation evaluates the utilisation of data collection and information reporting by the Hygiene Services team.
The need for improvements in the scope and manner of relevant data collection needs reviewing. Hygiene issues identified during assessment need to be followed up. Evaluation of hours needed in specific areas was noted, and changes were made. This process should be reviewed for effectiveness.
It is recommended that an IT-based tracking of curtain change, use of a decontamination records for equipment be introduced. Similarly an assessment tool for household and contract cleaners which would be developed through the multi-disciplinary standards group and is inclusive of all ward/area managers.

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
There was a palpable culture of the desire to improve hygiene noticed during the assessment. Many management structures and new posts have been put in place within the last two years and extensive structural changes have been undertaken.
The management have been involved in many quality initiatives, as documented in minutes of meetings and seen during the assessment of the physical environment.

CM 14.2 (A ↓ C)
The organisation regularly evaluates the efficacy of its Hygiene Services quality improvement system, makes improvements as appropriate, benchmarks the results and communicates relevant findings internally and to applicable organisations.
A number of internal audits were undertaken. As a result a Hygiene Standards Group was developed. The identification of key personnel and their employment are indicators of the commitment to quality improvement. Additional senior infection control and Decontamination/Hygiene Coordinator posts were identified as necessary to assist in the improved delivery of hygiene services. It is anticipated that hygiene service performance indicators as well as increased evaluation and benchmarking can be achieved when these positions are up and running.
The further involvement of IT and use of software would assist in the evaluation of the quality improvement plans. The team is encouraged to progress this issue.

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 ↓ C)**
Best Practice guidelines are established, adopted, maintained and evaluated, by the team.
Guidelines and policies were evident, however the review and evaluation of some policies was not fully monitored. While it had been identified in the minutes of the meetings of the Infection Control Team that policies needed review, the process had not been undertaken. Evidence of protective time was not apparent for senior and supervisory staff. The organisation would benefit from ensuring protected time to ensure the continued development/ improvement of its hygiene services, with particular focus on evaluation and continuous quality improvement.

SD 1.2   **(A ↓ B)**
There is a process for assessing new Hygiene Services interventions and changes to existing ones before their routine use in line with national policies
Some examples of assessment/evaluation of new products and policies were evident.
Improved physical infrastructure, review of hygiene services, and employment of new staff, with specific input to hygiene services were assisting in the improvement of hygiene. Local input into purchasing was evident.
However in relation to evaluation of the hygiene services, the process was not completed in all areas/ departments where deficiencies were noted - no corrective action plan, incorporating continuous quality improvement, was instigated.
Evaluations of hygiene services by contract cleaners and internal household staff was undertaken by the House hold Services Officer. Quality improvement plans are in place.

PREVENTION AND HEALTH PROMOTION

SD 2.1   **(A ↓ C)**
The team in association with the organisation and other services providers participates in and supports health promotion activities that educate the community regarding Hygiene.
There was evidence of health and hygiene promotion activities having been offered to the community and participation at national level at conferences. While there is a health promotion table within the hospital concourse, it is recommended that this area could be expanded, becoming more of a focus for those entering the hospital.

Greater poster display and locating of alcohol gels at the entrance would improve adherence to the hygiene standards. Quality improvement could be enhanced by capturing feedback from the general public during hand hygiene awareness campaigns. Evaluation of these is recommended.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1   **(A ↓ C)**
The Hygiene Service is provided by a multi- disciplinary team in cooperation with providers from other teams, programmes and organisations.
There was evidence of multi-disciplinary membership in the Hygiene Standards Group. While it was noted that significant efforts have been made in educating staff on evaluation at department and ward level, resultant actions have not yet been effectively instigated. The multi-disciplinary approach must be continued. An example of the breakdown of this was evident when evaluation of the assessment tool, used by household management, did not involve the area manager and an evaluation of the outcome of the cleaning process but did not evaluate the actual procedure itself. Documentation and audit tool formulation should be undertaken as a multi-disciplinary task. The team is encouraged to evaluate the efficacy of the multi-disciplinary team structure.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion
SD 4.1   **(A ↓ B)**
The team ensures the organisation's physical environment and facilities are clean.
The general environment was reasonably well maintained. However there was some evidence of dust, flaking paint, and furniture requiring repair e.g. Unit 6.
Some of the domestic waste bins were in need of repair and were being maintained with tape. The bins were also seen to be damaging the wall, for example in the ICU. Odours, especially in dirty utility rooms, were identified. This may have been contributed to by the practice of sluicing of bedpans prior to decontamination in the washer/disinfector.

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 equipment generally was in a good state of repair. However there was evidence that patient/client wash bowls were stored in a wet condition. There was extensive use of stickers and tape on equipment and commodes, and those observed were also soiled. Items awaiting repair were not accompanied by a decontamination certificate, which would be reflective of best practice. It is recommended that the team review this process for effectiveness and implement a quality improvement plan. In the Physiotherapy Department, the use of single-patient/client invasive probes, used for urology intervention, were being rinsed in the hand sink, and the water from the hot pack machine was being disposed of in the hand sink on the corridor. These practices were reviewed, ceased and alternative processes are being identified.

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.
There was evidence that equipment was being cleaned. With regard to the dirty utility rooms and the cleaner's rooms, ventilation was inadequate. At time of assessment a tendering process was being undertaken to include the changing of vacuum filters, in accordance with manufacturer's recommendations. However there was no documented evidence that filters were being changed. It is recommended that this issue is addressed.

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.
Some opportunities for improvement were identified in the main kitchen, order to be fully to compliance with Hazard Analysis and Critical Control Point (HACCP). It is recommended that the quality improvement plans identified are now progressed.

For further information see Appendix A

*Core Criterion
SD 4.5   **(A ↓ B)**
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.
Waste management documentation was available; however, it was not all accessible in one document. Permits were not available from all waste contractors and breaches were observed in segregation during internal waste transportation. It is recommended that this be addressed. During the assessment process the organisation suggested and requested it to be noted that future evaluation of waste management should be expanded to incorporate broader environmental aspects, and that consultation with waste experts should be considered.

For further information see Appendix A

*Core Criterion
SD 4.6   **(A ↓ B)**
The team ensures the Organisations linen supply and soft furnishings are managed and maintained.
While the laundry from the contractor was of very good quality, the linen storage areas in the older building require significant improvements to bring them up to best practice. Refer to SD 4.1.3 for further issues in relation to linen/laundry identified during the assessment. It is recommended that a computerised database be established to record the pre-planned curtain changing process, instead of the manual recording system in place.

For further information see Appendix A

*Core Criterion
SD 4.7   (A → A)
The team works with the Governing Body and/or its Executive Management team to manage hand hygiene effectively and in accordance with SARI guidelines
There was good evidence of hand hygiene practices and alcohol gel use was very evident. Although there was evidence of staff attendance at hand hygiene sessions, there was no evidence within the documentation or following discussion with staff, that attendance at the training was mandatory.

For further information see Appendix A

SD 4.8   (A ↓ C)
The team ensures all reasonable steps to keep patients/clients safe from accidents, injuries or adverse events.
Documented processes for risk minimisation were observed. There was no evidence of risk incident forms being used in relation to hygiene or specifically infection control issues. The organisation is encouraged to improve the integration between risk management and other stakeholders, such as Hygiene Standards Group and the Infection Control Team in the evaluation of incident rates.

SD 4.9   (A ↓ B)
Patients/Clients and families are encouraged to participate in improving Hygiene Services and providing a hygienic environment.
Hand hygiene facilities are available at the hospital entrance, but as this is a very large and open area, it is recommended that the facilities and the promotion of hygiene could be improved. A visiting policy was in place, and on discussion with staff it was working well, but there was no documented evidence of its evaluation of efficacy.
The Patient/Client Council was a work in progress, patient/client satisfaction surveys have been undertaken, and patient/client information leaflets are being updated. Patient/clients interviewed during the assessment stated their very high levels of satisfaction with the service provided and commented positively on the cleaning service.
Wider patient/client participation and evaluation, in regard to hospital hygiene matters is recommended.

PATIENT'S/CLIENT'S RIGHTS

SD 5.1   (A ↓ B)
Professional and organisational guidelines regarding the rights of patients/clients and families are respected by the team.
The patient/clients' dignity and confidentially requirements were documented. Single rooms are available. Isolation signage is colour coded, maintaining confidentially during hospitalisation.
A review of the use of hazard stickers on patient/client's samples when transporting them to the laboratory is recommended. This may infringe on patient/clients' confidentially and not adhere to standard precautions.
Patient leaflets were available.

SD 5.2 (A ↓ B)
Patients/Clients, families, visitors and all users of the service are provided with relevant information regarding Hygiene Services.
The Mission Statement was evident in the entrance concourse. However, the Hygiene Mission Statement was in a document format and was not on public display. It is recommended that it be situated the health and hygiene promotion area.
Patient/client information leaflets did not make any specific reference to hygiene services. It is recommended that this be modified. Specific patient/client surveys rated very high in relation to satisfaction with the service.

SD 5.3 (B → B)
Patient/Client complaints in relation to Hygiene Services are managed in line with organisational policy.
Documented process viewed during the audit. Data would be more effectively captured if risk forms were utilised when dealing with complaints pertaining to hygiene. This would assist in feedback and continuous quality improvement.

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1 (B ↓ C)
Patient/Clients, families and other external partners are involved by the Hygiene Services team when evaluating its service.
Documentation to support hand hygiene awareness days for the public was reviewed. Patient satisfaction surveys have been completed. It was noted that 90% of respondents were satisfied with their experience with the hospital. Recommendations from the evaluations need to be addressed.
As the Patient/Client Council is a work in progress, no specific involvement in hygiene services was available.

SD 6.2 (A ↓ 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.
Documented evidence was reviewed in relation to internal hygiene assessment training. Approximately 60 staff have been trained in this process. However, although there was evidence of assessments being undertaken the process was not completed, as action plans had not yet been instigated or re-assessments performed. The Hygiene Services Annual Report is a work in progress. The organisation is encouraged to progress with its intent to formulate a hygiene services report for 2007.
It is recommended that the quality improvement plan to incorporate the Infection Control Nurses' Association (ICNA) tool with the Service Delivery Standards should incorporate members of the multi-disciplinary team.
While evaluation of the internal and external cleaning staff is being undertaken, the process does not include heads of departments at the auditing stage. Heads of departments and wards need to have greater involvement in the process. The team is urged to evaluate the extent to which hygiene services' quality initiatives are being undertaken by the Hygiene Services Team as a result of evaluation and benchmarking.

SD 6.3   **(C → C)**
The multi-disciplinary team, in consultation with patients/clients, families, staff and service users, produce an Annual Report.
As per SD 6.2 the annual report for the hygiene services is in its infancy stage. It should be inclusive of consultation with patient/clients, families and service users.

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

(1) The environment is tidy, well-maintained, free of rust, blood or body substances, dust, dirt, debris and spillages.
Yes - The general environment is well maintained. There was some evidence of dust behind the radiators in the old part of the hospital in unit 6.

(2) All high and low surfaces are free from dust, cobwebs and flaking paint.
Yes - Generally all surfaces were free from dust. However there was evidence of flaking paint especially in Unit 6. In dirty utility rooms there was evidence of paint damage to walls by the opening and closing of bins, for example, the Intensive Care Unit. In the Out-Patients Department (OPD) the environment was generally clean but evidence of paint damage was seen.

(3) Wall and floor tiles and paint should be in a good state of repair.
Yes - However, paint was damaged in dirty utility rooms (as above) and also in areas such as OPD and the Physiotherapy Department. The administration block was identified as requiring paint refurbishment.

(4) Floors including edges, corners, under and behind beds are free of dust and grit.
Yes - The general environment was well maintained.

(5) Cleanable, well-maintained furniture, fixtures and fittings used.
Yes - In most cases the furniture was well maintained. However there was significant evidence of furniture requiring repair (chairs and beds), for example the Physiotherapy Department, Maple Ward, Unit 6 and ICU.

(6) Free from offensive odours and adequately ventilated.
No - Odours were present in dirty utility rooms. The cleaners' rooms were not sufficiently ventilated especially the one in OPD.

(7) Areas should be adequately ventilated with ventilation units cleaned and serviced accordingly and documentation available regarding service.
No - Outpatient Department was not well ventilated. Staff relied on open windows to circulate air.

(8) All entrances and exits and component parts should be clean and well maintained.
Yes - Entrances were clean and well maintained. The administration block entrance would benefit from additional cleaning e.g. windows and doors.

(9) Where present, main entrance matting and mat well should be clean and in good repair.
Yes - In general the main entrance was clean.

(10) Internal and external signage should be clean, updated, well maintained and laminated to enable cleaning.
Yes - Lamination of signage was evident.

(12) Internal and external stairs, steps and lifts must be clean and well-maintained.
Yes - The area was clean and well maintained in the main hospital. The administration block would benefit from additional cleaning.

(13) External areas including grounds, gardens, footpaths, ramps and car parks should be clean and well-maintained.
No - Due to ongoing building works, there was evidence that maintenance in this area was not being achieved.

(14) Waste bins should be clean, in good repair and covered.
No - Waste bins were in general clean. However there was evidence of locks being broken and tape being used to secure these. The transport waste bins (household waste) would benefit from more frequent cleaning.

(15) Where present a designated smoking area must comply with the national legislation on tobacco control and local organisational policies, a cigarette bin must be available and the floor area should be free of cigarette ends, matches etc.
No - There was a smoking area provided, however, there was also unofficial smoking areas being used by staff at the side of the administration block. Cigarette ends were evident on the ground of the official areas.

(16) Hospitals are non smoking environments. However, cigarette bins should be available in external designated locations.
Yes - However, additional cigarette bins were not in place in the outside designated areas.

(27) Local policies should be in place for guidance on all cleaning processes, colour coding, use of equipment, use of protective clothing and fluids and spillages.
Yes - Policies were evident and staff demonstrated awareness of these procedures.

(28) Before cleaning commences, a work route should be planned and when necessary, furniture and equipment should be removed from the area.
Yes - This was observed in the ward area where a 4-bed room was being cleaned. Beds and furniture were moved prior to commencing.

(29) A warning sign "cleaning in progress" must always be used, position to be effective.
Yes - Warning signs were evident.

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

(17) Switches, sockets and data points.
Yes - These were observed as being clean.

(18) Walls, including skirting boards.
Yes - In general these were clean.

(19) Ceilings
Yes - Some ceiling tiles were missing, for example in the dirty utility in the ICU.

(21) Internal and External Glass.
Yes - In general glass was clean. Greater attention to the washing of windows in the administration block is recommended.

(22) Mirrors
Yes - In general the mirrors were clean.

(23) Radiators and Heaters
No - There was evidence of long-term dust behind radiators, especially in unit 6.

(24) Ventilation and Air Conditioning Units.
No - Janitorial services are being renewed.

(25) Floors (including hard, soft and carpets).
Yes - Evidence of clean floors was observed.

(26) Nozzles of wall mounted alcohol gels and hand disinfectants must be cleaned daily.
Yes - However, there was evidence of clogging of gel noted in some areas.

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.
No - Flies were noticed in many light fittings in the physiotherapy department.

(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.
Yes - In general these would appear to be clean. However, in storage area of Maple ward patient/client chairs are not being cleaned sufficiently.

(32) Shelves, benchtops, cupboards are clean inside and out and free of dust and spillage
Yes – These were observed to be clean.

(207) Bed frames must be clean and dust free
No - Bed frames observed to have selotape on them. Where some of this had been removed there was evidence of the mark remaining. As observed in the Maple and Oak, and Laurel Ward.

(208) There should be a process for the cleaning of curtains and blinds. Curtains should be changed after each known case of infected patient / client where required. Records should be maintained of curtain changing.
No - There is a process in place for the cleaning of curtains, but not for the blinds. During the assessment it was identified that the organisation did not have a service contract with the agency who were laundering their curtains. The documentation reviewed from the agency involved was not in compliance with HSG 95 (18). This situation was rectified at the end of the first day of assessment.

(209) Air vents are clean and free from debris.
No - Air vents in ICU require additional cleaning.

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

(33) Chairs
No - Some of the chairs were identified as requiring recovering. The organisation is unable to clean torn chairs satisfactorily. Chairs in Physiotherapy Department had ingrained dirt in wooden part. Staff chairs in Unit 6 were unclean.

(34) Beds and Mattresses
Yes - However one bed was identified in the ICU as requiring repair/ or removal. This was undertaken.

(35) Patient couches and trolleys
No - Trolleys in Physiotherapy Department were in need of repair.

(36) Lockers, Wardrobes and Drawers
Yes - These were identified as being clean.

(37) Tables and Bed-Tables
Yes - These were identified as being clean.

(38) Dispensers (e.g. handwash dispensers), Holders and Brackets
Yes - These were identified as being clean.

(39) Waste Receptacles (e.g. sani-bins, nappy bins, sharps bins, leak proof bins)
Yes - These were identified as being clean.

(40) Curtains and Blinds
Yes - These were identified as being clean.

(41) Door handles and door plates
Yes - However, the door plates/handles in the administration block require cleaning.

Compliance Heading: 4. 1 .5 Sanitary Accommodation

(44) Hand hygiene facilities are available including soap and paper towels.
Yes - These were available.

(45) There is a facility for sanitary waste disposal.
Yes - These were available.

(46) Bathrooms / Washrooms must be cleaned on a daily basis. When necessary, they must be disinfected. This must be monitored and recorded.
Yes - Written evidence observed. The ladies toilet in the administration block was highlighted as being in need of additional cleaning. This was addressed during assessment.

(47) Bathrooms / Washrooms are clean and communal items are stored e.g. talc or creams.
Yes - However, some evidence of communal items in the bathrooms. These were removed.

(48) Floors including edges and corners are free of dust and grit.
Yes - These were clean.

(49) Cleaning materials are available for staff to clean the bath / shower between uses.
Yes - These were available.

(50) The toilet, sink, handrails and surrounding area is clean and free from extraneous items.
Yes - These were clean and free from extraneous items.

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 - These were clean.

(52) Toilets and Urinals
Yes - These were clean..

(53) Bidets and Slop Hoppers
No - Sluicing of bed pans was evident prior to placing them in the washer/disinfector in most areas that were visited. This process meant faecal fluids remained in the slop hoppers, allowing odours to develop.

(54) Wash-Hand Basins
Yes – Compliance was noted.

(55) Sluices
Yes - In general these were clean. The sluice in Unit 6 requires upgrading.

(56) All associated bathroom fittings including component parts e.g. tiles, taps, showerheads, dispensers, toilet brushes etc should be clean and well maintained.
Yes - In general these were clean. The toilet brush in the female toilet in the administration block was removed as it was identified as requiring further cleaning.

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

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

(59) Where present shower curtains should be clean and in good repair with a process for laundering and replacement.
Yes - Shower curtains were not observed during assessment, however shower doors were clean.

(60) All outlets (including shower outlets) should be flushed at a temperature in accordance with current legislation.
Yes - However, a written Standard Operating Procedure / policy / guideline is required to validate this process.

(61) Hand gel containers / dispensers must be replaced when empty, it is not permissible to 'top-up' containers / dispensers.
Yes - Staff demonstrated their awareness of the policy.

(210) Consumables should be readily available and stored in a suitable environment, e.g. liquid soap, paper towels, toilet paper. Clean and well maintained dispensers should be available for consumables.
Yes - These were available.

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 - These would appear to be clean.

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

(65) Commodes, weighing scales, manual handling equipment.
No - Some commodes observed were stained, prior to being available for patient/client use. Slings in the Physiotherapy Department were not sent for laundering regularly. There was evidence of staining observed on one of the slings.

(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 - In general they were clean. However there was evidence of selotape and stickers being placed on pumps. Therefore they were not being cleaned to a satisfactory level. A decontamination certificate was not being used prior to sending for repair. Patient/client equipment should have proper tags to ensure they can be

identified. This could be done in conjunction with clinical engineering. The use of stickers on equipment should be avoided.

In the Physiotherapy Department the single use patient/client invasive probes used for urology intervention were being decontaminated in the hand sink. This was addressed during the assessment and the practice has since ceased.

(67) Bedside oxygen and suction connectors.
Yes - These were clean.

(68) Patient fans which are not recommended in clinical areas.
Yes - No fans were in use during assessment.

(69) Patient washbowls should be decontaminated between each patient, and should be stored clean, dry and inverted. Damaged washbowls should be replaced.
No - Wash bowls were cleaned, however they were being stored wet on many occasions.

(70) Bedpans, urinals, potties are decontaminated between each patient.
Yes - However sluicing of bed pans is taking place prior to them being placed in the washer/disinfector. This should be unnecessary if the equipment is fit for purpose.

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

(71) Alcohol hand gel containers.
Yes - These were clean.

(72) Trolleys, e.g. chart trolleys, drug trolleys, linen trolleys, shop trolleys, emergency trolleys, suction apparatus, resuscitation equipment i.e. ambubag and mask.
Yes - These were clean.

(73) TV, radio, earpiece for bedside entertainment system and patient call bell.
Yes - These were clean.

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

(75) Vases
Yes – These were stored clean.

(76) Hand-wash dispenser holders and brackets should be free of product build-up around the nozzle.
Yes - However a few dispensers of alcohol gel were clogged during the assessment.

(77) Loose items such as patient's clothing should be stored in the patient's locker or property bag.
Yes - These items were stored in the locker.

(78) Personal food items, other than fruit, should only be brought in with the agreement and knowledge of the ward manager and should preferably be stored in an airtight container.
Yes - No food/fruit was observed.

(79) Flower vases where present should be clean with water changed minimum daily. Wilted flowers should be removed and disposed of accordingly. Note: flowers not recommended in high risk areas.
Yes - Staff demonstrated their knowledge of the process. Water is changed daily by the Health Care Assistant.

(80) All office equipment (e.g. telephones, computers, fax machines) should be clean and well-maintained.
Yes - In general they were well maintained. However some areas in the administration block (e.g. the photocopying room) are in need of attention.

(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 - No splashes were noted.

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

(211) Personal Protective Equipment is available and appropriately used and disposed of.
Yes – This was available.

(81) All cleaning equipment should be cleaned daily.
Yes - Evidence of equipment being cleaned was observed.

(82) Vacuum filters must be changed frequently in accordance with manufacturer's recommendations - evidence available of this.
No - However tendering for contract had begun at time of assessment as per evidence provided.

(83) Mop heads are laundered daily and are stored according to local policy or are disposable i.e. single use.
Yes - Mops, used by the household staff, are laundered and this process is in compliance with HSG 9518. It is recommended that the organisation get the system, utilised by contractors, validated.

(84) Products used for cleaning and disinfection comply with policy and are used at the correct dilution. Diluted products are discarded after 24 hours.
Yes - Staff demonstrated their awareness of the process. Documentation was available in the cleaners' cupboard.

(85) Cleaning solutions should only be prepared in a well ventilated area and should never be mixed.
No - Cleaners rooms and dirty utilities are poorly ventilated.

(86) Information on the colour coding system is available to all hygiene staff (according to national guidelines).
Yes – This was available and evident in cleaners' room.

(87) All cleaning equipment should be approved by the Hygiene Services Committee and ensure sufficient supply.
Yes - Members of Hygiene Standards Committee, including Intensive Care Unit (ICU) are on procurement committee. Minutes of meetings were available.

(88) All cleaning equipment should be left clean, dry and tidy in the storage area after use.
Yes – Compliance was observed.

(90) Storage facilities for Cleaning Equipment should be provided in each work area with adequate ventilation, a hot and cold water supply and hand-wash facilities.
Yes - Compliance was observed.

(91) Storage facilities for Cleaning Equipment should be clean and well maintained.
Yes - Compliance was observed.

(92) Cleaning products and consumables should be stored in shelves in locked cupboards.
Yes – These are stored in locked rooms not cupboards. However the cleaner's room in ICU was not locked. This issue should be addressed.

(93) Cleaning products and equipment should comply with the relevant colour coding policy.
Yes - Compliance was observed.

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

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

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

(213) Environmental Health Officer (Senior EHO/EHO) reports on food safety inspections including the completed summary stage of compliance with HACCP and annual water analysis reports should be retained on the Hospital Food Safety Manual. Action plans/ actions taken on foot of issues raised in the reports should be documented.
Yes - Hospital: The latest Environmental Health Service report on food safety and water quality was on file dated May 2006. Refurbishment works have taken place since then to ensure compliance in pre-requisite programme (PRPs). Bacteriological water analysis reports for May 2007 were satisfactory for samples taken at kitchen and Unit 8. Togo Cafe: The Environmental Health Service report of 04/05/06 is now being complied with. There is evidence that water supply is from the rising mains (potable water).

(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 - Hospital: The HACCP system is now due for review, to take account of the following: Flow chart does not include food that is cooked, reheated and then regenerated at ward kitchen level in a microwave; new system for chilling foods and

holding at chilled temperature for four days i.e. puree meals. The packaging of these foodstuffs does not take place in the cold room (< +10 degrees C) unlike other foodstuffs which are packaged in a chilled state in the cold room and have to be used within two days. (Reference Critical Control Point (CCP 5). It is important to review the system and bring back the holding time of the meals to shorter time frame. Process is in place in the Togo Café to store high-risk foods.

Quality improvement plans were identified to address these issues. Cafe management will now put in place a safe holding time and incorporate this into the HACCP plan. These should be progressed.

(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.
No - There should be a Ward Kitchen Food Safety Policy and a Staff Kitchen Food Safety Policy signed off by appropriate management as appropriate (Catering and Clinical Nurse Managers). The policy should mention compliance with (EC) Regulation 852/2004 on the Hygiene of Foodstuffs. IS 343 is no longer in place as an NSAI Standard.

(216) Documented processes for manual washing-up should be in place
No - On visiting one of the wash up areas off the main kitchen, the dishwasher was out of use due to maintenance work on the day. Manual washing-up was taking place in a single deep sink. There was no evidence of a documented process for manual washing-up.

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 - There was adequate signage on doors.

(218) Authorised visitors to the food areas should wear personal protective clothing (PPC) and wash hands on entering the food area during food preparation/serving times.
Yes - All those within the food areas were observed to have PPC during food preparation / food service times.

(219) Ward kitchens are not designated as staff facilities
Yes - Separate facilities are provided except for the Intensive Care Unit kitchen.

(220) Staff must not consume food or beverages intended for patient use, food should not be consumed in the ward kitchen and no food is to be routinely prepared in the ward kitchen other than beverages and toast.
Yes - Staff do not consume food in the Ward Kitchens. There are separate staff facilities provided. However on visiting one staff food facility (Unit 6), the fridge/freezer and the room in general were in need of cleaning.

(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).
No - The Environmental Health Service report of 16/01/2006, point No 26 stated the following: A/E Department: Pantry/Kitchen; A wash hand basin serviced with a constant and instantaneous supply of hot and cold water, liquid bacteriological soap and disposable paper towels, must be provided in ward kitchen. The hygiene assessment of the ward kitchen found this to be still not complied with. However, Unit 6 Woodlands has been refurbished and a wash hand basin has been provided.

(223) Separate toilets for food workers should be provided.
Yes - Separate toilets are provided in the main kitchen area for food workers. At ward level, catering staff utilise designate hospital staff facilities.

(224) The ventilation provided for all cooking and steam emitting equipment shall be sufficient to prevent condensation on walls, ceilings and overhead structures during normal operations.
Yes - However, the frequencies of the cleaning of the main canopy/grease fillers should be increased as appropriate.

(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 - Foods brought in by visitors are immediately consumed and not stored. Meats (poultry and minced meats) had EC Approval Numbers and Veterinary Control Stamps.

(226) Containers used to store foods shall be made of food grade materials, be in good condition, easy to clean and disinfect.
Yes - Technical specification for sealing film and polypropylene trays used for food distribution are food safe as per technical specifications.

(227) Flour, cereals, sugar etc shall be stored in a dry environment and when opened stored in covered containers.
No - Porridge was observed being stored in main kitchen beside the door of the cold packaging room.

Compliance Heading: 4. 4 .3 Waste Management

(229) Animal and pest control measures shall be in place in all waste handling and storage areas.
No - Evidence of pest control measures was not available.

(234) Where waste is stored in plastic bags these shall be removed frequently, closed securely and stored in a manner that does not pose any risk to the food business.
Yes - Plastic bags were placed in a wheelie bin.

Compliance Heading: 4. 4 .4 Pest Control

(235) A system of pest control developed by a competent person shall be in place.
No - Hospital: No evidence of pest control records for 2007.

(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.
No - Hospital: There was no evidence of pest control records for 2007. A pest control survey was completed by a pest prevention firm on the 30/05/07. This showed no sign of any infestation. There was no evidence of infestation throughout areas visited.

(237) A location map should be available showing the location of each bait point.
No - There was no map available for bait points.

(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 - Lamps have been changed in 2007.

(239) Fly screens should be provided at windows in food rooms where appropriate.
No - This was a work in progress at the time of the assessment.

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 is not in place.

(242) Temperatures for Food in Fridges / Freezers and Displays should comply with I.S.340:2006 requirements
Yes - The records of the temperatures of the fridges in the ward kitchens and a manual check by assessor during the assessment of fridge in ward kitchen Unit 6 demonstrated compliance with IS 340.

(243) Preparation of High Risk Foods should comply with I.S. 340:2006 requirements
Yes - High Risk Foods (ready to eat foods) are prepared in separate area to raw foods to reduce the risk of cross-.contamination. Colour-coding is not fully operational, i.e. yellow for cooked and red for raw meat as per I.S. 340:2006 requirements.

Compliance Heading: 4. 4 .9 Food Cooling

(248) Cooling Times for Cooked Food should comply with I.S. 340:2006 requirements
Yes - A blast chiller is used to quickly reduce food temperatures.

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.
No - The ice scoop from the ice making machine at the Togo Café was not stored separately from the ice, which may lead to a risk of contamination from the handle of the ice scoop.

(250) The dishwasher's minimum temperature for the disinfecting cycle should be compliant with I.S.340:2006 requirements and should be monitored regularly. There should be digital readouts on dishwashers.
No - The disinfection cycle observed was compliant but is not being recorded as appropriate.

(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 - Probes checked are calibrated until 2008.

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

(138) Details of current legislation and codes of best practice adhered to in relation to all waste types.
Yes –Waste management information is available in many guidelines such as infection control, waste management poster and Health Care Assistant's manual. It may be beneficial to have one document available for all staff with all this information in it.

(139) Documented evidence that waste collectors are permitted to collect the waste concerned by virtue of holding a valid waste collection permit.
No - There was evidence of valid licences observed. Other waste contractor permits were requested during the assessment, however, some were not available.

(140) Documented evidence that the treatment facility and final disposal or recovery facility is permitted or licensed.
Yes - Documentation was available.

(141) Documented procedures for the segregation, handling, transportation and storage of waste.
Yes - This is available in the Infection Control guidelines and HCA guidelines. As recommended previously, the organisation should incorporate this into one waste management policy. Standard Operating Procedure/guidelines are required on the internal transport of waste within the hospital to the external waste yard.

(142) Healthcare risk waste should be tagged and secured before leaving the area of production.
Yes - Documented evidence was available.

(143) Healthcare risk waste bags should be removed when no more than two-thirds full or at the maximum indicated by the bag manufacturers.
Yes - There was evidence available to support this.

(144) Healthcare risk containers should only be filled up to the manufacturers' fill or line or maximum three quarters full.
Yes - Guidelines was available. Waste education was provided to staff.

(145) A record is kept of tags used for each ward/department for at least 12 months.
Yes – Compliance was noted.

(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 - Using the barcodes from Sterile Technologies Group (STG), an assessment of the waste was available live on the STG website; the Waste Manager undertakes this procedure.

(147) Only UN approved containers and bags to be used for healthcare risk waste.
Yes - Compliance was noted.

(148) Healthcare risk waste must not be compacted.
Yes - No compaction of health care risk waste was observed.

(149) Inventory of Safety Data Sheets (SDS) is in place.
No – The assessment team were informed that these were in electronic format, sent to risk management. There was no evidence that these were being updated during assessment to ensure they are being maintained.

(151) Waste is disposed of safely without risk of contamination or injury.
Yes - No risks were observed.

(152) When required by the local authority the organization must possess a discharge to drain license.
No - However this is being sought by shared services. It was not available during the assessment.

(253) Personal protective equipment is accessible to all staff involved in the generation, collection, transport and storage of waste.
Yes - Appropriate gloves are available for staff, however breaches in their use were observed. Use of a more appropriate glove is being looked at.

Compliance Heading: 4. 5 .2 Maintenance of Records

(254) Documented process(es) for the retention of waste traceability records, certificates of destruction, consignment notes (C1 forms) and trans Frontier Shipment (TFS) tracking forms for at least 12 months. These should be retained for all hazardous waste types
Yes - All documentation was available and this was logically presented.

Compliance Heading: 4. 5 .3 Segregation

(155) Waste segregation should adhere to national colour coding scheme.
Yes - Adherence was observed.

(156) Healthcare risk waste must be segregated from healthcare non risk waste.
No - Risk waste and household waste are transported in one trolley going to internal storage area. This process should be reviewed by the organisation.

(158) Needles and syringes should be discarded as one unit and never re-sheathed, bent or broken.
Yes - Sharps boxes were observed. There was good evidence of compliance demonstrated.

(159) Sharps boxes are correctly sealed, labelled and stored in a safe environment.
Yes - Compliance was demonstrated.

(160) Suction waste must be disposed of in a manner which prevents spillage e.g. canisters / liners are disposed of into rigid leak-proof containers or suction waste is solidified with a gelling agent.
Yes - Staff demonstrated their awareness of the disposal procedures.

(162) Hazardous wastes (chemical etc) must be segregated, stored and disposed of correctly.
Yes - Compliance was observed.

(255) Within Healthcare risk waste, all special wastes including drugs & cytotoxic drugs / materials are segregated.
Yes - No risk were identified.

(256) Mattress bags are available and are used for contaminated mattresses ready for disposal; mattresses are disinfected.
Yes - Contaminated mattresses are disposed of by the waste company – It was outlined that a bag is not required. This operation was not viewed during the assessment.

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 - This process is not documented, however, staff were observed completing this and it would appear that they are generally compliant.

(164) A consignment note (C1 form) must be completed for each shipment of hazardous waste and copies of these forms must be kept for at least 12 months. This should be linked with certificates of destruction and TFS where applicable.
Yes - This was available and observed during the assessment.

(165) There is a designated person trained as a Dangerous Good Safety Advisor (DGSA) or the services of a DGSA are available to the hospital.
Yes - The service was available and a staff member is identified.

(166) Drivers of vehicles transporting hazardous waste must be trained in accordance with the ADR Regulations.
No - No evidence is available in relation to external agency drivers.

Compliance Heading: 4. 5 .5 Storage

(169) Documented process(es) for the replacement of all bins and bin liners.
Yes - In conjunction with the Waste Manager, heads of departments order appropriate bins as required. The organisation is currently changing the bin company they use.

(257) Adequate segregation facilities for the safe storage of healthcare risk waste are locked and inaccessible to the public. Appropriate warning signs restricting public access should be prominently displayed.
Yes - These are available.

(258) Waste receptacles should be sanitised, secure and in a good state of repair when used.
No - The household transport bins were observed and these were dirty internally. There is a process to ensure STG clean their own bins. The household waste containers should be cleaned more frequently as the facility is available in the waste yard.

Compliance Heading: 4. 5 .6 Training

(259) There is a trained and designated waste officer.
Yes - This individual had an appropriate academic background and showed evidence of on-going professional development.

(260) There are documented records of staff training on the handling, segregation, transport and storage of healthcare risk waste including the use of spill kits and personal protective equipment.
Yes - The Waste Manager and Infection Control Team work together to provide training.

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

(172) Documented processes for the management, maintenance and safe handling of linen and soft furnishings throughout the organisation.
Yes - Documents were evident.

(173) Documented processes for the use of in-house and local laundry facilities.
Yes - There was evidence of documented processes in place in these areas.

(174) Clean linen is stored in a designated area separate from used linen (not in sluice or bathroom).
No - Clean linen is stored at ward level separate from used linen; however this is not segregated from other stored items. In the Physiotherapy Department the clean and dirty linen were stored in the same area.

(175) Clean linen is free from stains.
Yes - Linen viewed was free from stains.

(261) Clean linen store is clean, free from dust and free from inappropriate items.
No - In the new hospital area the linen store was free from dust and inappropriate items, However in the older building the store contained inappropriate items for example two open bags of cement. This was highlighted at time of inspection on day one as a significant risk. On day two this situation was rectified and the area was clean.

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

(263) Bags are less than 2/3 full and are capable of being secured.
Yes - Bags were less than 2/3 full.

(264) Bags must not be stored in corridors prior to disposal.
Yes - Bags were stored in the correct area.

(265) Linen skips and bags must be used when collecting linen and taking it to the designated area. Soiled linen must not be left on the floor or carried by staff.
Yes - Linen skips and bags were used to take linen to designated areas.

(266) Personal protective equipment must be accessible to and used by all staff members involved in handling contaminated linen.
Yes - Staff adhere to use of PPEs when they are handling linen.

(267) Documented process for the transportation of linen.
Yes - Documented processes are in place.

(268) Ward based washing machines are used only with the agreement of the Hygiene Services Committee.
Yes - Ward-based washing machines in use are in agreement with the Hygiene Services Committee.

(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 - The washing machine is in a designated area but written guidance on its use was not in place.

(271) Hand washing facilities should be available in the laundry room.
No - Hand hygiene facilities are not available within the three areas designated for laundry services.

(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.
Yes - The tumble drier is externally exhausted and the maintenance contract in place is through the shared services.

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

(187) Nails should be kept short and nail varnish or false nails should not be worn by those working in a clinical setting.
Yes - No nail varnish / false nails were observed.

(188) Hand and wrist jewellery should be removed prior to performing all levels of hand hygiene with the exception of a plain wedding band.
Yes - The organisation is compliant; however there was evidence of staff that are not involved in direct patient care, wearing additional rings and bracelets. It is noted that there was very good compliance by staff observed in relation to wearing uniforms-only at work.

(189) Clinical hand wash sinks are required in all areas where clinical activities are performed. They should be centrally located and free from obstruction.
Yes – Compliance was observed.

(190) All sinks should be fitted with washable splash backs with all joints completely sealed.
No - No splash backs were in place.

(191) Hand washing facilities i.e. sinks, taps and splash backs must be clean and intact.
Yes - In general the organisation is compliant, however taps in Physiotherapy Department had a spray nozzle which needs to be removed and appropriate taps should be installed.

(192) Taps should be hands free and should be mixer taps to allow temperature regulation.
Yes - There was evidence that taps were hands free and mixer taps were in place in clinical areas.

(193) Liquid soap is available at all hand washing sinks. Cartridge dispensers must be single use.
Yes - Cartridge dispensers were observed to be correct.

(194) Dispenser nozzles of liquid soap of alcohol based hand rubs must be visibly clean.
Yes - These were observed and were clean.

(195) Absorbent paper towels are available at all hand washing sinks. Air dryers should not be recommended.
Yes - Absorbent paper towels are available at all hand washing sinks.

(197) Wall mounted/Pump dispenser hand cream is available for use.
Yes - This was available.

(198) Hand hygiene posters and information leaflets should be available and displayed throughout the organization.
Yes - Hand hygiene posters were displayed well throughout the clinical areas.

(199) Alcohol based hand rub should be available at the bed side of each patient in Critical care units and in each patient room/clinical room.
Yes - Alcohol hand rubs were available.

(200) For social hand hygiene, plain soap and warm water or an alcohol hand rub product should be used (on visibly clean hands).
Yes - Staff demonstrated they would consider that hand washing is more appropriate than the use of alcohol gel.

(201) For antiseptic hand hygiene, an antiseptic hand wash agent or an alcohol hand rub product should be used for a minimum of 15 seconds (on visibly clean hands).
Yes - Alcohol hand rub is available.

(202) For surgical hand hygiene, an antiseptic scrub or an alcohol based hand rub (60-70%) should be used.
Yes - Antiseptic scrub is used.

(203) Hand wash sinks are dedicated for that purpose, are free from used equipment and inappropriate items (e.g. nail brushes).
Yes - In most areas visited the hand wash sinks were dedicated for that purpose. The water from the hot pack machine was being disposed of in the hand sink on the corridor. This issue should be addressed.

(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.
Yes – Compliance was observed.

(205) General wards should have one sink per 4-6 beds and critical areas should have one sink per 1-3 beds.
Yes - Generally compliant in the new building. In Unit 6 the sinks were on the corridor, which is not in keeping with best practice or SARI guidelines.

(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.
No - Hand hygiene education is available to staff. This was given by the Infection Control Team. There was some evidence of staff attendance. However some staff stated that it was between two months and two years since education had taken place. A Quality Improvement Plan (QIP) should include providing mandatory annual hand hygiene programmes for all staff. Records of this should be maintained centrally and time should be given to staff to attend. This would be in line with the SARI 2005 guidelines.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team		Assessor Team	
	FREQ	%	FREQ	%
A	29	51.79	3	05.36
B	23	41.07	31	55.36
C	4	07.14	22	39.29
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	C	↓
CM 1.2	A	B	↓
CM 2.1	A	B	↓
CM 3.1	A	B	↓
CM 4.1	A	B	↓
CM 4.2	B	C	↓
CM 4.3	A	B	↓
CM 4.4	A	C	↓
CM 4.5	C	C	→
CM 5.1	B	B	→
CM 5.2	A	C	↓
CM 6.1	B	B	→
CM 6.2	C	C	→
CM 7.1	B	C	↓
CM 7.2	B	B	→
CM 8.1	B	C	↓
CM 8.2	B	B	→
CM 9.1	B	C	↓
CM 9.2	B	C	↓
CM 9.3	B	B	→
CM 9.4	B	B	→
CM 10.1	A	B	↓
CM 10.2	B	B	→
CM 10.3	A	B	↓
CM 10.4	A	B	↓
CM 10.5	B	B	→
CM 11.1	B	B	→
CM 11.2	B	B	→
CM 11.3	B	C	↓
CM 11.4	C	C	→

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