Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Hygiene Services Assessment Scheme

Assessment Report October 2007

The Coombe Women's Hospital

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1.0 Executive Summary

1.1 Introduction

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

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

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

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

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

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

1.1.1 Standards Overview

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

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

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

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

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

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

Core Criteria:

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

In the Corporate Management standards, the core criteria cover:

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

In the Service Delivery standards, core criteria cover:

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

1.1.2 Rating Scale

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

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

A Compliant - Exceptional

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

B Compliant - Extensive

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

C Compliant - Broad

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

D Minor Compliance

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

E No Compliance

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

N/A Not Applicable

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

1.1.3 Assessment process components

The assessment process involves four distinct components:

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

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

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

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

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

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

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

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

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

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

- **Continuous Improvement**

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

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

[1] Boot, M and Cairncross, S "Actions Speak" Delft, The Netherlands, IRC and LSTHM, British Occupational Hygiene Society.

[2] New York Department of Health and Mental Hygiene

[3] The Columbia Electronic Encyclopaedia, Sixth Edition. Columbia University Press. 2003

[4] Irish Acute Hospitals Cleaning Manual, HSE (2006)

[5] Hygiene Services Assessment Scheme. Irish Health Services Accreditation Board (2006)

1.2 Organisational Profile

The Coombe Women's Hospital is the largest provider of obstetrical/midwifery, neonatal and gynaecology services in the State. It is a tertiary referral centre for high-risk mothers, babies and complex gynaecology, including gynaecology oncology. The hospital is the only maternity unit in Ireland that holds cancer trials for the investigation and treatment of cervical and ovarian cancer. In addition, the Coombe Women's Hospital is one of the few public hospitals in a position to accept patients for treatment under the National Treatment Purchase Fund.
The Coombe Women's Hospital is an academic teaching hospital, the School of Midwifery is linked with University College Dublin, and it is a national referral centre for women and babies. The hospital is a leader in foetal medicine services and the management of maternal disease in pregnancy.
The hospital's approved complement of beds/cots is 251, which includes 19 daycare/daycase treatment places.

Services provided

- Gynaecology
- Obstetrics
- Paediatrics

Physical Structures:

The Coombe Women's Hospital has no isolation rooms and no negative pressure rooms.

The following assessment of the Coombe Women's Hospital took place between 8th and 9th August 2007.

1.3 Notable Practice

- The organisation's hygiene culture and multi-disciplinary approach to hygiene was strong and is to be commended.
- The reporting/communication structure throughout in relation to the hygiene services was strong and is to be commended.
- Staff compliance to the hand jewellery policy is of a very high standard.
- Inclusion of patient/clients in the evaluation of the hygiene service is commendable.
- Governing body support for quality improvement activities and benchmarking processes within the organisation is to be commended.

1.4 Priority Quality Improvement Plan

- Progress the introduction of the flat mop system.
- Progress the Quality Improvement Plan (QIP) to establish access to a comprehensive Occupational Health Service.
- Segregate the dual cleaning/catering and cleaning/porter roles in the theatre and labour wards and establish a single cleaning role for these areas.

- Develop a cohesive management structure for all catering areas and transfer the supervision of ward catering under the auspices of the Catering Department.
- Develop an overall Corporate Induction Programme, which includes hand hygiene and infection control as a mandatory component.
- Perform a Hygiene Education Needs Assessment and implement recommendations.
- Secure and cover the special waste facility.

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 Coombe Women's Hospital has achieved an overall score of:

Fair

Award Date: October 2007

2.0 Standards for Corporate Management

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

PLANNING AND DEVELOPING HYGIENE SERVICES

CM 1.1 (B → B)

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

A comprehensive approach is used to assess hygiene needs which included the review of best practice guidelines, internal and external audits and reports, for example, EHO reports Health & Safety reports, Patient/Client Satisfaction Survey results and staff feedback submitted to the Hygiene Services Committee. A complete Occupational Health needs assessment was performed by an external partner. It was evident through the hospital board minutes that members of the public were consulted when assessing hygiene needs. A thorough analysis of the hygiene needs was performed and the information was utilised in the development of the Corporate Hygiene Strategic Plan.

Quality improvements to-date, based on needs assessment included: upgrade the environment (for example the Out-Patient Department (OPD) and the upgrade of furniture and equipment. It was evident that business proposals had been submitted to the HSE and communication had commenced with another hospital regarding the provision of a cross-site Occupational Health Service. There was limited evaluation of changes made as a result of the needs assessment and it is advised to formalise this process.

CM 1.2 (B ↑ A)

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

The corporate team had a very clear vision regarding the modifications and developments required to meet the health needs of the population. This included the development of a new hospital for which funding has been sought. It was evident that the organisation is committed to ongoing quality improvement, through the upgrading of the current Out-Patient Department and staff canteen, upgrading of patient/client bathrooms which is on-going, upgrading of patient/client equipment and furniture, the introduction of patient/client satisfaction surveys and hygiene rounds, and the submission of business cases to the HSE for funding. An example of this would be the flat mop system and the need for a training officer. It was evident that evaluation of the modifications was performed through risk management, the Environment Health Officer (EHO), hygiene round and patient/client satisfaction surveys. A summary of all reports was presented to the hospital board.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1 (B → B)

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

There are strong hygiene-related linkages with relevant external bodies including the Department of Health & Children, HSE, colleges and other hospitals. This was evident from business proposals, letters, e-mails and minutes of corporate meetings provided. Linkages with patients/clients and the public were robust with patient/client members of the hospital board in place. There was evidence of regular independent patient/client meetings with the Master regarding services and needs, including hygiene. Patient/client satisfaction surveys are also carried out. The security contractors were actively involved in reviewing the Draft Visitor's Policy at the time of the assessment.

Strong multi-disciplinary hygiene-related linkages were evident internally through the minutes of the corporate and hygiene committee meetings and comprehensive communication between the Corporate Team and staff via e-mails, letters and notices was evident.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 (B ↓ C)

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, developed by the Executive Management Team, in consultation with the Hygiene Services Committee had clear goals and objectives. Needs as assessed were identified in the plan and related costings provided - for example the proposal for a training officer's post. It was evident that the plan was approved by the hospital board. It is recommended that the organisation progress the Quality Improvement Plan (QIP) for the review of the Hygiene Strategic Plan and ensure goals and objectives are achieved.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.1 (B → 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.

Corporate responsibility for the hygiene service was clearly defined. Department managers were responsible for the implementation of the organisation's corporate policies within their areas. Corporate policies were in place which reflected current legalisation and best practice guidelines. There was evidence, through the minutes of the Clinical Governance/Risk Management Committee and Hospital Board meetings, that the organisation adhered to corporate policies. Examples included Fire, Health & Safety and visiting policies.

It is recommended that the organisation formalise its commitment to hygiene in its Code of Corporate Ethics and progress the approval of the draft Complaints Policy.

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 was comprehensive evidence, through the minutes of the Clinical Governance/ Risk Management Committee, that the Executive Management Team received and evaluated hygiene performance. For example: hygiene audit results, risk incidents reports, patient/client hygiene satisfaction surveys. It was evident that a comprehensive range of current hygiene-related best practice information/guidelines were reviewed by experts in this area (for example Infection Control) and presented to the relevant committee and/or Executive Management as appropriate (for example National Hand Hygiene Guidelines and Hygiene Services Assessment Scheme Standards).

It is recommended that the QIP is progressed and the process for receiving and evaluating best practice information be formalised.

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.

There was comprehensive evidence to suggest best practice information. Hygiene-related policies/guidelines were referenced to current best practice guidelines. Policies and guidelines were also available in all clinical areas and departments visited. The display of diverse hygiene-related signs/posters is to be commended. It was evident that staff has access to library facilities and the intranet to obtain best practice information. A comprehensive range of hygiene initiatives based on best practice information, have been introduced, including the upgrading of bathroom facilities and water tanks, the development of incident reports and the introduction of hygiene-related surveys.

There was evidence of evaluation of best practice information in the areas of signage, posters, policies and library. It is recommended that the evaluation of best practice information be formalised.

CM 4.4 (B ↓ C)

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

A framework for developing and maintaining best practice policies, procedures and guidelines has recently been approved. A comprehensive list of policies/guidelines was available and policies were currently being updated. Hygiene-related information, in areas such as hand hygiene, sharps, waste etc, is in line with best practice guidelines.

It is advised to progress the updating and approval of all policies in line with the new policy development framework and to commence evaluation of the efficacy of the process.

CM 4.5 (B ↓ C)

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

It was evident that Executive Management represented the Hygiene Services Committee on the Capital Development Project Committee. Infection control members of the Hygiene Services Committee were active in the consultation of minor capital projects such as advising on positioning of hand wash sinks.

There was limited evidence of communication between the Hygiene Services Team and the Capital Development Project Committee Planning Groups. The organisation is recommended to formalise the communication process for consultation between these committees and evaluate the efficacy of the process.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

*Core Criterion

CM 5.1 (A → A)

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

It was evident that the roles, responsibility, authority and accountabilities throughout the hygiene services structure were defined. Communication between the Executive Management Team and staff in relation to achievements such as improvement in internal hygiene audit scores was evidenced.

The roles and responsibilities of each member of the Hygiene Services Team were provided and were included in job descriptions. An example of this was a job description for a Clinical Nurse Manger. Correct hygiene culture was evident throughout.

*Core Criterion

CM 5.2 (A → A)

The organisation has a multi-disciplinary Hygiene Services Committee.

An active multi-disciplinary Hygiene Services Committee was in place as was evident from the monthly committee minutes viewed. Terms of reference were in place and administrative support was available to the committee. Roles of committee members were clearly documented and outlined in the minutes. Job profiles were available for distribution to new team members. It was evident that outcomes of committee meetings are distributed to staff via the line management systems and communicated to ensure follow up.

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

*Core Criterion

CM 6.1 (A ↓ 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.

Strong evidence of a systematic approach to the allocation of resources was observed. It was evident that capital and minor capital funding was defined. Additional funding for hygiene is supported by the House and Finance Committee and hospital board. Allocation of funding for a new hospital was noted, both at HSE and corporate level.

It is recommended that the QIP be progressed to ensure it is reflective of the expenditure requirements in the Corporate Hygiene Strategic Plan.

CM 6.2 (A ↓ C)

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

It was evident that the Hygiene Service Committee is actively involved in the process of purchasing hygiene-related equipment/products. The committee was represented on the hospital's Procurement Committee by the Infection Control Nurse. Also, the Master represented the Hygiene Services Committee on the House and Finance Committee, which approved the allocation of funding within the organisation.

It was evident that the quality initiative to develop an Asset Register had commenced. This is to be commended. There was limited evidence of evaluation within the minutes of the Hygiene Services Committee in relation to the consultation process for the purchasing of hygiene-related equipment/products such as new bedside lockers.

It is recommended that the evaluation of the efficacy of the consultation process between the Hygiene Services Committee and Senior Management in relation to purchasing hygiene-related equipment/products be formalised.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

CM 7.1 (A ↓ B)

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

A robust risk management system is in place. The Master represents the Hygiene Services Committee on the multi-disciplinary Clinical Governance/Risk Management Committee and it was evident that the committee meets at least quarterly. Incident reporting processes are strong and it was evident that trend analyses are presented to the Clinical Governance/Risk Management Committee and Hospital Board. It was evident that risks identified were acted upon promptly and measures put in place to minimise reoccurrence. There was evidence of Risk Management, Infection Control, Health & Safety and EHO inspections performed, with feedback to staff and follow up to ensure corrective measures were taken. The hospital annual report contains Risk Management/Health & Safety outcomes.

It is recommended that the process for performing risk management audits and the development of independent Risk Management/Health and Safety reports be formalised.

CM 7.2 (A ↓ B)

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

Risk management practices were actively supported by the Governing Body. This was evident through the financial support for hygiene risk reduction initiatives such as the upgrade of hand wash sinks and introduction of alcohol based hand gels. A dedicated Risk Manger is in place and is supported by risk analysis IT systems. It was evident that identified risks are acted upon promptly and measures put in place to minimise reoccurrence and provide feedback.

The Master, who represented the Hygiene Services Committee on the Clinical Governance/Risk Management Committee, reviews all risk reports such as EHO and incident reports, before presenting them to the committee and hospital board. It was noted that the organisation works in partnership with another hospital in certain areas. The organisation is encouraged to formalise the performance of completing root cause analysis of all risks identified.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion

CM 8.1 (A ↓ 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 evidence that the establishment of contracts in areas like window cleaning, ground maintenance, recycling and water tank decontamination, was in line with national policy and legislation. Professional liability and reporting mechanisms from contract records were observed.

Monitoring of equipment validation contracts such as fridges, dishwashers, bedpan washers, air conditioning systems and ground maintenance on-site was evident. New contracts awarded are monitored by the Governing Body.

The organisation is recommended to formalise the process for managing and monitoring all contracts, including the catering contracted service within the on-site coffee shop.

CM 8.2 (A ↓ B)

The organisation involves contracted services in its quality improvement activities.

Some evidence that contracted services cooperated and complied with the organisation's quality improvement activities was observed. An example of this would be the use of alcohol gels and agreeing/moving window cleaning times each visit to suit area workload. Building contractors complied with dust control measures through infection control inspection audit reports. Contractors attended infection control education in respect to hand hygiene and dust containment measures.

It is recommended that the organisation formalise processes for involving contractors in its hygiene quality improvement activities.

PHYSICAL ENVORNMENT, FACILITIES AND RESOURCES

CM 9.1 (B → B)

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

It was evident from the capital development plans that the proposed design is in line with current specifications and regulations. The number/position of hand wash sinks were in line with National Hand Hygiene Guidelines and cleaners' rooms were included in the plans of clinical areas viewed. Specifications for sanitary appliances were in line with best practice guidelines such as HBN 95).

Processes were observed for the upgrading of the current facility in areas such as upgrading of patient/client bathroom, and hand wash sinks, in line with best practice design and regulations, and this was ongoing.

Evaluations of the safety of the design have been performed and findings have been utilised in the Quality Initiative Programmes. Examples of this would include the upgrade of patient/client bathrooms and hand wash sinks and replacement of fly screens on kitchen areas.

*Core Criterion

CM 9.2 (A ↓ B)

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

There was evidence that the organisation planned and managed its environment, equipment/devices, kitchens, sharps, linens and waste and other hygiene related risks in line with legislation and best practice guidelines. Plans are in place and funding has been sought for the new hospital. Planned on-going refurbishment and upgrade of the current environment was evident. There is an internal call-out repair system in place and turnaround times are monitored on a weekly basis.

The organisation is recommended to develop a cohesive approach to the management of all catering facilities, including the ward kitchens.

CM 9.3 (A ↓ C)

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

The organisation demonstrated that its management of the hospital environment and facilities, equipment/devices, kitchens, waste, sharps and linen is effective through the use of internal and external audits walkabouts, Health and Safety audits, Risk Incident Reports, internal kitchen/EHO audits, patient/client satisfaction surveys, comment cards and independent interviews with patient/clients. Changes made, as a result of audits, include the upgrading of hand wash sinks, upgrading of the staff canteen, the installation of new water tanks and the introduction of informal hygiene audit walkabouts.

The organisation is encouraged to progress the introduction of the flat mop system and the complete closure of the special waste storage facility. It is also recommended that the improvement of current cleaning equipment storage facilities and the extension of the hygiene audit walkabout to include the contracted catering facility are implemented.

CM 9.4 (A ↓ B)

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

Feedback from patients and visitors, through on-going patient/client satisfaction surveys, comment cards and complaint procedures is encouraged. Independent patients/clients have been interviewed following their discharge by the Master and hygiene-related issues discussed. External professional bodies including the HSE, An Bord Altranais and the Irish Council of Medical Training are involved in the review of staff training facilities. Hygiene-related complaints are promptly addressed and evidence of a reduction in such complaints was observed within the last two years.

Improvements as a result of feedback from patient/clients and external bodies were made to patients'/clients' bathrooms, the introduction of protected mealtimes and upgrading of training equipment. Processes for performing staff satisfaction surveys in relation to the hygiene services should be formalised.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 (A ↓ C)

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.

Both the organisation's and the contracted services' Human Resource selection and recruitment process were comprehensive and in accordance with best practice, current legislation and guidelines. Job descriptions viewed were in line with best practice and roles/responsibilities in relation to hygiene were outlined. Probationary period evaluations were in place. A pilot exit interview was noted in the documentation provided. It is recommended that the Human Resource selection and recruitment process be evaluated.

CM 10.2 (A ↓ C)

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

A comprehensive manpower planning policy was observed. Human Resource needs were considered during new developments such as upgrading of the OPD. On a daily basis rosters are reviewed and staff redeployed accordingly.

It is recommended that cleaning duties among catering and porters within the theatre/labour wards be segregated, with a view to providing a single role cleaning service operative, and the recruitment of a Hygiene Services Co-ordinator be progressed.

It is recommended that an evaluation of hygiene staff work capacity and volume be carried out and consideration given to placing the supervision of ward catering under the auspices of the catering department.

CM 10.3 (B ↓ C)

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

The organisation ensures that hygiene staff, including contract staff, have the relevant and appropriate qualifications/training as outlined in job specifications through the Human Resource recruitment processes. There was evidence that contractors such as window cleaners and waste firms were appropriately trained, in line with requirements. Additional training was provided by the organisation for example in Health & Safety, Infection Control, Sharps, Food Hygiene and SKILLS.

It is recommended that the QIP be progressed and a review of training needs for the hygiene services, including hygiene supervisory staff, be undertaken.

CM 10.4 (A ↓ B)

There is evidence that the contractors manage contract staff effectively.

This was demonstrated. Contractors receive on-site infection control education in relation to dust control and hand hygiene. The reporting process, as outlined in contract documents and service agreements, was adhered to. Contracts, including training records, are evaluated and monitored during the annual review process.

The organisation, in conjunction with the window cleaning contractors, introduced a new reporting mechanism for window cleaners on site. They report to the ward mangers and it was evident that this was effective.

It is recommended that the organisation formalise the evaluation of the appropriate use of all contract staff.

*Core Criterion

CM 10.5 (A ↓ C)

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

A comprehensive manpower planning policy was observed. Some human resource needs were provided such as additional staff in the refurbished Out-Patient Department and further staffing needs have been submitted to the HSE.

Staff census and employment reports were reviewed by the Corporate Management Team and Manpower Planning Committee and used in the development of the Hospital Corporate Strategic Plan. It is recommended that hygiene staffing levels/needs are incorporated into future Hygiene Corporate Strategic Plans.

ENHANCING STAFF PERFORMANCE

*Core Criterion

CM 11.1 (A ↓ C)

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

Staff induction is provided. It includes health and safety, occupational health, inoculation injury, sharps and waste training. Employee information packs are provided and include information on Hepatitis B. Attendance records were reviewed. Individual ward orientation packs are utilised and signed off at local level. Induction in specialised areas was evident (for example the main hospital Kitchen).

It is recommended that the current induction programmes be formalised to include the appropriate mandatory training to all staff (including environmental cleaning, hand hygiene and Infection Control) and the appointment of the Training Officer be progressed. Systems should be developed to formally procure induction attendance levels.

CM 11.2 (A ↓ C)

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

It was evident that a structured programme was in place for regular on-going risk and infection control training such as hand hygiene, waste, sharps, linen, catering, fire, health and safety and manual handling. Infection control and hand hygiene on-site training is provided to staff within their own areas. Informal training on cleaning methods is performed by the Infection Control Team. Attendance at SKILLS and VTAC training was evident. Manual attendance records are maintained. Evidence of evaluation of relevance of infection control education was demonstrated. The organisation is recommended to formalise ongoing education for cleaning staff and ensure that all staff receive the appropriate training in line with best practice guidelines.

CM 11.4 (B ↓ C)

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

There was no formal performance evaluation processes in place, however, the HSE, in conjunction with the hospital, have agreed to involvement in a pilot performance evaluation project for hygiene staff. This was in the very early stages of development by the HSE. Hygiene staff performance was measured informally through local review of cleaning/check sheets and formally through hygiene audit scores, patient/client satisfaction surveys, comment/suggestion sheets and monitoring of hygiene-related complaints. The organisation is encouraged to progress the Hygiene Performance Evaluation Project, in conjunction with the HSE.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (C ↑ B)

An occupational health service is available to all staff

There is evidence that an occupational service is provided to staff by an external provider and provisions are in place for out-of-hours emergency care, if required. A comprehensive vaccination programme is provided. Staff well-being is monitored locally (for example sick leave). A comprehensive occupational health needs assessment was performed and discussions have commenced with another hospital for the provision of a co-located Occupational Health Service.

CM 12.2 (B ↓ C)

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

Limited evidence of evaluation of staff satisfaction occupation health and well-being was noted. An example of this would be sick leave, occupational related injuries and retention rates. An external survey, performed this year, evaluated staff satisfaction and well-being. Discussions are taking place with another hospital for the provision of a co-located Occupational Health Service.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.1 (A ↓ 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.

Documented processes for data protection meet legal requirements and are managed in accordance with the Freedom of Information Act. These include safe storage of files and controlled computer access. There was evidence that patient/client confidentiality was maintained and that hygiene data analysed was reviewed at corporate level and at relevant committees. There was some evidence that information such as infection data was reviewed for reliability and accuracy. It is recommended that the organisation develop formal processes for evaluating the accuracy, reliability and validity of all data.

CM 13.2 (A ↓ B)

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

All reports and documentation were available for review and the organisation demonstrated how data and information is reported. These were easily interpreted and the graphics utilisation is commended. There was evidence of users' satisfaction with data presentation/reporting methods (for example infection control evaluations of presentations). There was also evidence that there were changes to information provided to users and it was determined that changes were communicated to staff.

It is recommended that the organisation progress its QIP to formalise the approach to the evaluation of users' satisfaction in relation to the reporting of data and information.

CM 13.3 (A ↓ C)

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

Information collected in relation to hygiene services is utilised and evaluated and reported to the Clinical Governance/Risk Management Committee, Medical Board, Infection Control Committee and Procurement Committee meetings. Among the changes made to data reporting were the inclusion of hygiene reports to the Clinical Governance/Risk Management Committee and the Hospital Board, and the development of key hygiene performance indicators such as comparison of audit scores, incident reports and MRSA rates. The use of hygiene data is discussed at the Clinical Governance/Risk Management Committee. It is recommended that the hospital formalise its evaluation and information reporting process by the Hygiene Services Team.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

CM 14.2 (A ↓ B)

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

It was evident that key performance indicators are used in evaluation, so that internal/external performance can be benchmarked. Examples include: hygiene audits, risk incident reports and MRSA rates. External benchmarking was evident through the Clinical Governance/Risk Management Committee meetings. Information in relation to performance is communicated to staff via line management systems. Evaluation of improved outcomes in hygiene service delivery is continuous through regular audit, with data/reports generated and resultant actions implemented. It is recommended that external benchmarking be extended to other areas.

3.0 Standards for Service Delivery

The following are the ratings for the Service Delivery standards, as validated by the Assessment team. The service delivery standards allow an organisation to assess and evaluate its activities in relation to Hygiene Services at a team level. The Service Delivery standards relate directly to operational day-to-day work; 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.

There is strong evidence that many best practice guidelines have been developed and implemented. A standardised documented development process is in place on which all guidelines are based. Time is provided to staff to consult the documentation in relation to hygiene services. This process should be documented. There is no evidence of evaluation of the efficacy of the process used to develop best practice guidelines, which is recommended.

SD 1.2 (A ↓ C)

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

Hygiene services' interventions, which have been introduced and which are being actively sought, are based on needs analysis by the Hygiene Services Committee.

Clear records of new hygiene services initiatives were observed. Examples include hand hygiene stations strategically located around the hospital, upgrades to furniture, shower facilities and installation of wall protectors in corridor areas. A colour coding system for cleaning has been effectively implemented by the hygiene committee, which is part of the hospital's new hygiene manual.

A draft procurement policy was presented during the assessment. There is no documented process for the assessment of new hygiene service interventions, and changes to existing ones, before their routine use in line with national practice. It is recommended that be formally developed and added to the draft Procurement Policy prior to its implementation.

PREVENTION AND HEALTH PROMOTION

SD 2.1 (B ↓ 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.

A variety of colourful and informative hygiene service posters and leaflets are widely available in public areas and wards, many of which have been evaluated and are in the process of being transferred into the patient/client information booklet. Some of these leaflets are available in different languages to ensure effective communication with ethnic minorities in the community who attend the hospital.

There was no evidence available of health promotion activities for hygiene in the community and the Hygiene Committee should consider implementing hygiene/environmental awareness days.

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 is clear evidence that a very effective hygiene service is provided by a multi-disciplinary team with representation from clinical, nursing, infection control, allied health professionals, support service staff and maintenance. Links are in place with contractors and patient/client satisfaction surveys are also in place so that hygiene issues can be evaluated. The hospital, however, may benefit from a more formal structure of linkage i.e. membership of the Hygiene Committee.

Terms of Reference for the Hygiene Services Team, and descriptions of team members were provided, which outline hygiene roles and responsibilities. It is recommended that the organisation evaluate the efficacy of the multi-disciplinary team structure and progress the quality improvement plans identified.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

SD 4.1 (A ↓ B)

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

Strong evidence of this was observed. Funding has been sought for the new hospital building and on-going improvement to the current structure was evident. It is recommended that the upgrading of hand wash sinks, showers, and the sourcing of dedicated cleaner stores, be developed further, in line with best practice guidelines.

Closer supervision of contract cleaners is recommended to ensure areas such as high dusting are carried out more appropriately.

Cleaning schedules have been developed and should be signed off.

The role of a Health Care Assistant should be developed as a priority, to facilitate the introduction of dedicated trained cleaning staff.

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.

Very clear and concise cleaning schedules for equipment are in place and are followed, with some exceptions. The majority of close patient/client, medical and organisational equipment are clean and well maintained.

There was strong evidence of audit and walkabout in wards and departments. Greater attention to cleaning of nozzles of alcohol gels and fans is required.

For further information see Appendix A.

*Core Criterion

SD 4.3 (A ↓ C)

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

The lack of space for dedicated cleaners' rooms has impacted on the ability to correctly store and maintain cleaning equipment and products appropriately. Alternative storage areas should be sourced for cleaners. It is recommended that the Quality Improvement Plan (QIP) implement a flat mopping and dust control system. Cleaning schedules have been developed for the environment. These need to be signed off in all areas.

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.

Responsibility for ward kitchens is currently assumed by Household Services. It is recommended that the organisation develop a cohesive approach to the management of all catering areas by putting ward catering under the auspices of the Catering Department. Tea towels should be removed from ward kitchens and replaced with disposable paper towel and a comprehensive ward kitchen food hygiene policy should be developed. It is also recommended that the organisation review training needs of catering supervisory staff and implement a process to ensure this is completed.

Processes for the annual validation of ward kitchen dishwashers should also be developed.

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.

Clear documented processes and guidelines regarding the management of waste were observed. Upgrading of the Waste Compound is recommended as a priority. Education regarding waste is widely available and needs to be widened to all staff, in particular porter and clinical staff, with attendance monitored. A Dangerous Goods and Safety Advisor is now in place. The organisation is advised to identify and provide training to a designated person with responsibility for waste on site. The segregation of waste during disposal and transportation should be reviewed. This may include the placement of healthcare risk waste.

For further information see Appendix A.

*Core Criterion

SD 4.6 (A → A)

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

A very good system is in place for the management of linen, which is structured and co-ordinated. It is recommended that this process be extended to ensure clear documented processes are in place for the management of curtains, tea towels and white coats. Training on the filling of laundry bags should be repeated. The knowledge of colour coding policy and practices on segregation was excellent.

For further information see Appendix A.

*Core Criterion

SD 4.7 (A ↓ B)

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

Hand hygiene guidelines are in line with best practice and have been effectively implemented. Observation of hand hygiene and jewellery practices was excellent.
More attention is required in the cleaning of sinks to ensure that outlets and overflow areas are maintained in a clean condition.
The upgrading of stand-alone hand wash sinks, to conform to HTM 95 is recommended.

For further information see Appendix A.

SD 4.8 (A ↓ B)

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

There is a clear incident reporting process for accidents, injuries and adverse events, which are dealt with via the risk management process. Resultant actions and feedbacks from these are reported at Senior Executive Meetings.
Education and training is provided at induction, with updates provided by Health and Safety and Infection Control to ensure all staff are trained in hand hygiene, management of waste, equipment, sharps and laundry.
There is a rapid response rate to identified risks, which was evident during the assessment. Best practice guidelines on hygiene are in place including an updated safety statement which is available in all wards and departments.
A 24 hour cleaning service should be included in the Quality Improvement Plan to ensure a rapid response to hygiene issues such as spillages.

SD 4.9 (B → B)

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

Patient/client leaflets and handbooks have been developed. It is recommended that this initiative be expanded to include all wards. Information on hand hygiene and hand hygiene stations have been strategically located in public areas and wards/departments. Strategic notices regarding the non-smoking policy and the provision of a suitable smoking zone were observed. Patient/client satisfaction surveys are completed frequently and they include evaluation of hygiene needs from the patient/client perspective. The hospital has a robust policy on visiting which includes dedicated rest periods.

PATIENT'S/CLIENT'S RIGHTS

SD 5.1 (A ↓ C)

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

The staff demonstrated that they strive to maintain the rights of patients/clients at all times through participation in patient/client surveys. Documented processes for maintenance of patient/client dignity when dealing with hygiene services delivery were not observed. It is recommended that these be produced.

SD 5.2 (B → B)

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

Informative leaflets regarding hygiene services are available to patients/clients and some wards had it in book form. Information on visiting times, non-smoking and hand hygiene policy is strategically placed on notice boards in public waiting areas and at entrances to wards/departments. Communication notices regarding outbreaks are displayed, when necessary, to convey information on restrictions and visitor precautions. It is recommended that the results of satisfaction surveys and actions taken be prominently displayed for visitors and patient/clients.

SD 5.3 (A ↓ C)

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

Patient/client hygiene complaints are documented by staff. There are processes in place to manage patient complaints. Examples include comment/suggestion sheets, written complaints to the hospital and patient/client satisfaction surveys. These are dealt with through the Corporate Hygiene Services Committee and the Master outlines these to the Executive Board. A documented system is in place to deal with adverse incidents and near misses. The draft Complaints Policy requires implementation, to ensure a formal complaints process, which can be evaluated effectively, is in place. It is recommended to progress the approval and implementation of the draft Complaints Policy and to evaluate the efficacy of the complaints process.

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1 (A ↓ B)

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

Involvement in hygiene services by patient/clients and families is evaluated by participation in the patient/client satisfaction survey, patient/client focus groups, the completion of the suggestion/comments and written complaint forms. This information is evaluated by the Hygiene Services Committee and relevant actions implemented, where appropriate.

Quality improvement plans to identify a patient/client advocate, and implementation of the current draft Complaints Policy for the hospital, will further strengthen this evaluation process.

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.

A number of initiatives have been adopted by the Hygiene Services Team to monitor, evaluate and benchmark the quality of its hygiene services such as:

- Analysis, evaluation and feedback of previous external hygiene audits.
- Internal audits by multi-disciplinary hygiene services teams e.g. sink audits, infection control audits, informal walkabouts with the Master and representation from the Corporate Hygiene Services Committee.
- In-patient/client focus groups.
- Hospital visits by board members.
- Patient/client satisfaction surveys, analysis and feedback.

SD 6.3 (A ↓ C)

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

Current best practice guidelines and policies are up-to-date and a process is in place to update guidelines. There is no documented process for the compilation of the independent hygiene annual report, however, a hygiene report will be included as a chapter in the hospital's annual clinical report for 2006, which will be published on 23 November 2007.

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.
No - The environment was free of spillages; however, there were structural deficits in a number of areas, including cracks in walls in the NICU and the back stairs by theatre. Floor damage was noted in the kitchen and other areas.

(2) All high and low surfaces are free from dust, cobwebs and flaking paint.
No - Deficits identified with high dusting in most areas. Low level surfaces, including dado rail and skirting boards were very dusty in the delivery room and Physiotherapy Department.

(3) Wall and floor tiles and paint should be in a good state of repair.
No - Chipped walls and paint removed were noted in many areas of the wards and toilets. Wall protectors have been located on corridors and are effective. It is recommended that these are extended to bed and trolley areas.

(8) All entrances and exits and component parts should be clean and well maintained.
Yes - However, the back entrance requires closer attention.

(12) Internal and external stairs, steps and lifts must be clean and well-maintained.
No - The back stairs, adjacent to theatre, had many structural deficits. Floors of main lifts were worn and would benefit from re-covering.

(13) External areas including grounds, gardens, footpaths, ramps and car parks should be clean and well-maintained.
No - Litter including cigarette butts was evident in many areas of the grounds. Shrubbery and plants are aesthetically pleasing.

(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 - Vast number of cigarette butts noted on floor of designated smoking area.

(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 - Local policies were in place, however, it is recommended that all information in relation to cleaning should be compiled into one overall cleaning policy.

(28) Before cleaning commences, a work route should be planned and when necessary, furniture and equipment should be removed from the area.
No - work routes did not appear to be planned.

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

(17) Switches, sockets and data points.
Yes - Kitchen needs close attention.

(18) Walls, including skirting boards.
Yes – The Physiotherapy Department was quite dusty.

(20) Doors.
Yes - More frequent spot cleaning required for toilet areas.

(21) Internal and External Glass.
Yes - Overall satisfactory but with some exceptions for example door to left of stairs leading to Supplies area.

(22) Mirrors.
Yes - Dirty mirror in X Ray Department.

(23) Radiators and Heaters.
Yes - Generally acceptable but back of radiators in Physiotherapy Department need attention.

(25) Floors (including hard, soft and carpets).
Yes - Floors in Theatres 3 and 4 need replacement.

(26) Nozzles of wall mounted alcohol gels and hand disinfectants must be cleaned daily.
No - Nozzles in many public areas visited and also the Radiology Department were clogged with residue from alcohol gel.

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

(31) Furniture and fittings: Furniture and fittings in direct patient care environment must be clean and dust free i.e. cleaned on a daily basis. Horizontal surfaces (high and low) around the patient i.e. ledges, worktops, window ledges, flat surface suction apparatus, bed table, locker, curtain rail and chairs.
Yes - However, areas requiring closer attention include Gynaecological, Out-Patient Department and Our Lady's.

(32) Shelves, benchtops, cupboards are clean inside and out and free of dust and spillage
No - Internal cupboards were dusty in many areas including labour ward, Gynaecological, Out-Patient Department and toilet area.

(207) Bed frames must be clean and dust free.
No - Bed frames were observed to be dusty in many areas.

(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.
Yes - Process in place.

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

(34) Beds and Mattresses.
No - Mattresses were generally satisfactory however beds were dusty.

(38) Dispensers (e.g. handwash dispensers), Holders and Brackets.
Yes - However nozzles of alcohol gel holders require more attention.

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

(54) Wash-Hand Basins
No - Sinks require closer attention.

(58) Sluice rooms should be free from clutter and hand washing facilities should be available.
No - Inappropriate storage of cleaning equipment was observed in most sluice rooms.

(60) All outlets (including shower outlets) should be flushed at a temperature in accordance with current legislation.
No - No evidence to verify that shower heads were flushed weekly, which is recommended.

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

(64) All equipment, including component parts, should be clean and well-maintained with no blood or body substances, rust, dust, dirt, debris and spillages.
Yes - In the majority, however, some areas require attention.

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

(68) Patient fans which are not recommended in clinical areas.
No - All fans which were found to be in use were dusty. Fans are not recommended in clinical areas.

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

(72) Trolleys, e.g. chart trolleys, drug trolleys, linen trolleys, shop trolleys, emergency trolleys, suction apparatus, resuscitation equipment i.e. ambubag and mask.
Yes - One resus trolley requires more attention adjacent to Our Lady's ward.

(73) TV, radio, earpiece for bedside entertainment system and patient call bell.
Yes - However, wall mounted televisions were dusty.

(74) Patients' personal items (e.g. suitcase), which should be stored in an enclosed unit i.e. locker/press.
Yes - Outpatient department requires a facility for luggage.

(76) Hand-wash dispenser holders and brackets should be free of product build-up around the nozzle.
No - Grit was observed on a significant number of nozzles in public areas, physiotherapy and radiology.

(80) All office equipment (e.g. telephones, computers, fax machines) should be clean and well-maintained.
Yes - Fax in Neonatal Intensive Care Unit and photocopier require more 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 - In the majority, however, splashes were evident in a minority of areas.

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

(81) All cleaning equipment should be cleaned daily.
No - On completion of cleaning duties, equipment was found to have fluff and dust residue on hoover heads, scrubbing machine, brushes and dust control mops. Wet mops found in buckets.

(83) Mop heads are laundered daily and are stored according to local policy or are disposable i.e. single use.
No - Processes in place to discard mop heads needs to be reviewed.

(87) All cleaning equipment should be approved by the Hygiene Services Committee and ensure sufficient supply.
Yes - Dust control tools and flat mops have been approved by the Hygiene Services Committee and a proposal has been currently submitted for funding.

(88) All cleaning equipment should be left clean, dry and tidy in the storage area after use.
No - Hoover heads need attention.

(89) Equipment with water reservoirs should be stored empty and dry.
No - Buckets for water were not dry and inverted.

(90) Storage facilities for Cleaning Equipment should be provided in each work area with adequate ventilation, a hot and cold water supply and hand-wash facilities.
No - Sluices are used in most instances to store cleaning equipment.

(91) Storage facilities for Cleaning Equipment should be clean and well maintained.
No - Dedicated cleaners' rooms not available in majority of areas.

(94) Health and Safety policies should be in place for the use of ladders/steps when cleaning.
No - Policy for ladders and steps not 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 - All standards available in main kitchen office.

(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 and/or actions taken on foot of issues raised in the reports should be documented.
Yes - Environmental Health Officer (EHO) reports were available and it was evident that actions had been taken on foot of issues raised in a recent report.

(214) The person in charge of catering shall develop, implement and maintain a permanent system based on the seven principles of HACCP. A standard HACCP Plan should be fully completed.
No - HACCP has been implemented and HACCP records maintained, however there are no HACCP summary control sheets with limited documented processes.

(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 - A ward kitchen hygiene statement rather than a policy is required.

(216) Documented processes for manual washing-up should be in place.
No - There was no documented policy available.

Compliance Heading: 4. 4 .2 Facilities

(219) Ward kitchens are not designated as staff facilities.
No - It was noted during the assessment that equipment was stored in the ward kitchens.

Compliance Heading: 4. 4 .3 Waste Management

(230) A supply of water should be available to clean down external waste storage areas.
No - This was not compliant.

(232) Waste storage containers shall be smooth, durable, easy to clean and disinfect, well maintained and closable.
No - This was not compliant.

Compliance Heading: 4. 4 .4 Pest Control

(235) A system of pest control developed by a competent person shall be in place.
Yes - External contractors provide this service every 2 months.

(236) Detailed inspections of food areas shall be carried out and recorded at least every three months for evidence of infestation by insects or rodents by a competent person.
Yes - Most recent inspection was carried out on 3/8/07.

(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 - EFK units were replaced on 3/8/07 by external contractors.

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 - All temperatures in the cook chill system have been checked and validated.

Compliance Heading: 4. 4 .6 Food Preparation

(245) Cleaned and disinfected work surfaces, equipment and utensils shall be provided for preparing ready to eat foods and foods to be cooked to prevent the risk of contamination. In addition to the HSE hospital colour coded system (see Appendix 6 Irish Acute Hospitals Cleaning Manual 2006), the food colour coding of work surfaces, equipment and utensils should be provided for (see I.S. 340:2006).
Yes - Colour coded system of work surfaces in place.

Compliance Heading: 4. 4 .7 Food Processing

(246) The thawing of food shall be carried out under appropriate conditions such as in a thawing unit, a fridge or a microwave oven with thawing cycle.
Yes - No thawing carried out locally.

Compliance Heading: 4. 4 .10 Plant & Equipment

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

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

(145) A record is kept of tags used for each ward/department for at least 12 months.
No - Records for 12 months not available.

(146) A tracking system should be in place to trace all hazardous waste from generation to disposal and therefore an audit trail is available to trace waste to final disposal.
No - A system was in place to trace all hazardous waste from generation to disposal within the organisation through the use of tagging system. However it is advised that the organisation complete an audit trail to final disposal.

(151) Waste is disposed of safely without risk of contamination or injury.
No - Personal protective equipment should be provided to staff for disposal of waste.

(152) When required by the local authority the organization must possess a discharge to drain license.
No - Evidence was not available.

(253) Personal protective equipment is accessible to all staff involved in the generation, collection, transport and storage of waste.
Yes - PPE was not evident in waste compound.

Compliance Heading: 4. 5 .3 Segregation

(256) Mattress bags are available and are used for contaminated mattresses ready for disposal; mattresses are disinfected.
No - No evidence available.

(156) Healthcare risk waste must be segregated from healthcare non risk waste.
Yes - Policy on waste segregation in place. There were an extensive number of clinical waste bins located throughout the hospital including public OPD waiting area and beside hand wash sink. It is recommended that a needs assessment is performed to determine the need and strategic location of healthcare risk waste bins.

(158) Needles and syringes should be discarded as one unit and never re-sheathed, bent or broken.
Yes - Compliance noted.

(159) Sharps boxes are correctly sealed, labelled and stored in a safe environment.
Yes - In the majority, however, exceptions were observed where sharps boxes were in open position in two areas.

(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 - All observed were in containers. Further education is recommended in this area.

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.
Yes - Documented process in place however, policy should be reflective in practice.

(166) Drivers of vehicles transporting hazardous waste must be trained in accordance with the ADR Regulations.
Yes - Evidence on file.

Compliance Heading: 4. 5 .5 Storage

(169) Documented process(es) for the replacement of all bins and bin liners.
No - No documentation process was available

(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.
No - Waste signage and storage should be given consideration.

Compliance Heading: 4. 5 .6 Training

(259) There is a trained and designated waste officer.
No - there is no designated Waste Officer- no Job Description available.

(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.
No - records were not observed.

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.
No - Documented process in place for the handling of linens and soft furnishing but items such as white coats, tea towels and curtains were not included.

(173) Documented processes for the use of in-house and local laundry facilities.
No - No documented process available for local facility, which launders white coats, tea towels and all curtains.

(267) Documented process for the transportation of linen.
Yes - Documented processes were in place for the transportation of linen off-site, this should include curtains and tea towels which go to a local launderette.

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

(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.
Yes - Not applicable. Washing machines are currently not used at the Coombe Hospital.

(271) Hand washing facilities should be available in the laundry room.
Yes - Requires to be upgraded to conform to HTM 95.

(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 - Not applicable.

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

(191) Hand washing facilities i.e. sinks, taps and splash backs must be clean and intact.
No - All sink outlets require greater attention to cleaning, particularly in the areas of non-clinical rooms. Sinks in staff rooms and public toilet sinks require attention.

(192) Taps should be hands free and should be mixer taps to allow temperature regulation.
No - Upgrading of a large number of sinks required to include mixer taps.

(194) Dispenser nozzles of liquid soap of alcohol based hand rubs must be visibly clean.
No - A significant number of dispenser nozzles for alcohol gels require attention.

(195) Absorbent paper towels are available at all hand washing sinks. Air dryers should not be recommended.
Yes - The organisation is recommended to implement the use of single towel sheets as opposed to paper rolls.

(204) Hand wash sinks conform to HBN 95. They should not have plugs, overflows and the water jet must not flow directly into the plughole.
No - Quality Improvement Plan to upgrade sinks should be progressed.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team		Assessor Team	
	FREQ	%	FREQ	%
A	39	69.64	6	10.71
B	16	28.57	25	44.64
C	1	01.79	25	44.64
D	0	00.00	0	00.00
E	0	00.00	0	00.00
N/A	0	00.00	0	00.00

5.2 Ratings Details

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

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