Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Hygiene Services Assessment Scheme

Assessment Report October 2007

Kerry General 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

Kerry General Hospital is the second largest of the Health Service Executive – South's seven acute hospitals. The hospital provides acute general hospital services to the population of Co. Kerry (139,616) and additionally to a proportion of the populations of West Limerick and North Cork.
The hospital has 274 acute general beds; 50 Acute Psychiatric beds. 46-bed elderly continuing care beds and an Annual Budget of approximately €70m. The hospital treats over 20,000 inpatients per annum and approximately 41,000 patients attend the Outpatients Department. Accident & Emergency Department attendances are approximately 34,346 annually.

Services provided

The following services are provided at the Hospital:

- Emergency Medicine
- Ear, Nose & Throat Services
- General Medicine including Medicine of the Elderly &
- Endocrinology
- General Surgery
- Gynaecology
- Obstetrics
- Orthopaedics
- Paediatric including Special Baby Care Unit
- Pathology
- Psychiatry
- Radiography including C.T. Scanning Service.
- Renal Dialysis Satellite Unit
- Oncology Satellite Unit
- Palliative Care

Additional Specialist Out-Patient Services Provided by Visiting Consultants include:

- Dental
- Dermatology
- Nephrology
- Neurology
- Ophthalmology
- Plastic Surgery
- Rheumatology
- S.T.D.

Physical Structures:

Within a number of the wards there are isolation rooms as shown at table below
These rooms are generally used for Infection Control,

Ward	**Speciality**	**Bed Number**	**Number of Isolation/ Side Rooms**
Emly	SCBU/ Neonatal ITU Emly	10	4 Single Room

Ward	Speciality	Bed Number	Number of Isolation/ Side Rooms
Cashel	General Paediatrics	30	8 + 2 Private
Ardfert	Antenatal / delivery	12 antenatal / 1st stage	2 Private Located on Kells ward
Gallarus	Post Natal	22	4 (1 side + 3 private)
Clonfert	ENT, day surgery, general medical, palliative care	24	5 Private
Annagh	Gen surgical, lithotripsy day cases, day surgery, palliative care	29	3 private
Aghadoe	Gen surgery, day surgery, palliative care	30	3
Rathass	Orthopaedic in patient and day surgery	30	3
Muckross	Gen medical, palliative care	30	3 private
Sceilig	Cardiology	26	3
Ardagh	Rehabilitation, assessment, respite	13	1
Loher	Elderly continuing care, respite	29 + 1 respite	3
Dinish	Elderly continuing care, respite	15 + 1 respite	1
ITU	General ITU		1 isolation

The following assessment of Kerry General Hospital took place between 2nd and 3rd August 2007.

1.3 Notable Practice

- The Assessment Team found the documentation provided by the Hygiene Services Committee to be of an extremely high standard, comprehensive, well referenced and easily accessed. The policies, procedures and Standard Operating Procedures were a model for best practice.
- The Assessment Team noted the high standard of the refurbishment of the Clonfert Ward.
- The Hospital Hygiene Management Structures are to be commended.
- The standard of cleaning in clinical areas, surfaces and equipment were of a high standard.
- The Waste Management System was to be commended. The Assessment Team acknowledge the minor/major capital plan to construct a best practice waste compound in the near future.
- The Assessment Team noted the introduction of the Colour Coded systems.
- The Quality Improvement System based on self-assessment is commended.

1.4 Priority Quality Improvement Plan

- The organisation should cease using the cold room until the underlying problem is addressed.
- Supervision of cleaning in certain areas requires further attention.
- The hospital is encouraged to rollout their plans to upgrade surface cleaning of floors, work surfaces, crevices, equipment, trolley wheels. Corners/skirting areas in the main kitchen needs further attention to detail.
- The design of the theatre area and Central Sterile Supply Department (CSSD) is not compliant with current best practice but is managed so as to best use the existing facilities. It is recommended that these shortcomings, in terms of space and design, be addressed as quickly as possible.
- The cessation of the use of, and, removal of all sticky tape is recommended.
- The hospital is recommended to consider a review of the Hospital Smoking Policy in order that a more practical and effective delivery of this service is implemented in terms of segregation, into more appropriate locations, of patient/clients, medical staff, visitors etc.

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; Kerry General Hospital has achieved an overall score of:

Fair

Award Date: October 2007

2.0 Standards for Corporate Management

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

PLANNING AND DEVELOPING HYGIENE SERVICES

CM 1.1 (C → C)

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

Documented processes are in place as was evidence of a strategic, services and operational plans for hygiene services. All comply with legislation, codes of best practice and national guidelines. The organisation is encouraged to increase the consultation with the relevant stake holders and evaluate the efficacy of the needs assessment process.

CM 1.2 (B → 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.

Improvements to the hygiene services have been made in order to meet the needs of the population served. These have been based on evaluations undertaken and include the establishment of new hygiene management structures and processes in accordance with the Terms and Key Concepts for Hygiene services as recommended in the Acute Hospitals Hygiene Assessment Scheme 2006, ward refurbishment in one area and plans for further refurbishment, improved hygiene information and facilities for patient/clients, staff and the public and the implementation of internal audit and evaluation.

The Hospital Outpatient/Visitor questionnaire for evaluation of hygiene services (which was devised using information from the Irish Society for Quality and Safety in Healthcare) has been adapted for the Out-patients Department (OPD) and is being evaluated. This will be extended to all of the OPD areas.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1 (C → C)

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

There was evidence that linkages and partnerships were in place, for example, the National Hospital Office through the network manager, Health Information Quality Authority (HIQA), Health and Safety Authority, Environmental Health Officer, Fire Safety Officer, Cleaning Contractor etc. The organisation is encouraged to evaluate the efficacy of its linkages and partnerships.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 (C → C)

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

A hygiene Corporate Strategic Plan is in place, which has defined goals and objectives. The Executive Management Team has overall responsibility for the development of the plan and is represented on the Hygiene Services Committee. This Committee is multi-disciplinary and comprises all necessary stakeholders, other than medical staff and patient/client representatives. The organisation is encouraged to include the latter two. It is recommended that the hygiene Corporate Strategic Plan, goals, objectives and priorities be evaluated on an annual basis, and relevant costs be identified.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.1 (C → C)

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

This is the case in the organisation. There is a strong organisational-wide approach to hygiene and a code of corporate ethics has been developed as is evident in the mission and vision statements. Evaluation of the efficacy of the Hygiene Services Team's adherence to legislation and best practice is encouraged, in order to ensure appropriate continuous Quality Improvement Plans are developed.

CM 4.2 (C → C)

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

Information is received from internal and external audits and from the Executive Management Team/Hygiene Services Committee/Hygiene Services Team and meetings with contract cleaning/domestic services staff. Terms of reference are defined for the Hygiene Services Committee and the Hygiene Services Team. The organisation is encouraged to develop a suite of Key Performance Indicators (KPIs) and ensure the Executive Management Team receive standardised and structured information.

CM 4.3 (C ↑ 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.

The Internet and 24-hour library facilities are available for staff. There was evidence to suggest this in the referencing of policies and procedures. A newsletter is in place and in-service training is planned and on-going. The department heads' meetings use this forum to discuss best practice. Minutes of meetings are circulated. Further evaluation of these practices is recommended.

CM 4.4 (C → C)

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

The process for establishing and maintaining best practice, policies, procedures and guidelines for hygiene services is in line with best practice. A comprehensive suite of policies, procedures and goals is available. A review system is established and all evidence-based policies and procedures are all signed off at senior management level and circulated to all areas. The assessment team recommends the implementation of the organisation Quality Improvement Plan (QIP) to evaluate the effectiveness of hygiene training to ensure that improvements are made and that they meet the needs of hygiene services staff.

CM 4.5 (C → C)

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

A process has been established to ensure the Hygiene Services Committee is involved in all capital development planning and implementation. This process was implemented in relation to the recent refurbishment of one ward and there was evidence of informal evaluation of the outcome in the planning for the next ward refurbishment. This consultation/involvement process needs to be documented and evaluated.

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.

An excellent hygiene structure is in place with clear roles, authority, responsibility and accountability to the Executive Management Team. Reporting relationships of all members of the Hygiene Services Team are identified. A Hygiene Services Co-ordinator has been assigned to the process on an interim basis and has been a significant asset. The ward/department managers carry overall responsibility for the standards of hygiene in their areas. The profile document identifies the support role of the Executive Management Team and Hygiene Services Committee for the Hygiene Services Team's delivery of its services. The Hygiene Services Committee is chaired by the General Manager and the Hygiene Services Team by the Hygiene Services Quality Co-ordinator.

*Core Criterion

CM 5.2 (A → A)

The organisation has a multi-disciplinary Hygiene Services Committee.

There is evidence that the Hygiene Services Committee is multi-disciplinary and its terms of reference have been established. The organisation is to be commended for providing the necessary administration support. The Hygiene Services Team links into the Hygiene Services Committee on a weekly basis, and through the Hygiene Services Committee, to the Executive Management Team. Some hygiene services groups, such as nurse managers, had representatives who reported back to their colleagues through the Clinical Nurse Manager meetings.

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

*Core Criterion

CM 6.1 (B ↓ C)

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.

To date, no dedicated budget for Hygiene Services has been made available to the hospital. The Hygiene Service Implementation plan was used by the Executive Management Team as the tool for informing and directing resource allocation in 2006 and early 2007. The hospital progresses hygiene service improvements through various channels e.g Capital programme, local budget etc. It is recommended that the Corporate Hygiene Strategic Plan identify costs and the dispersal of resources for hygiene services to ensure adequate financial support and allocation of resources for hygiene services. The organisation is to be commended on its process for cognisance of hygiene services implications in the development of all Statements of Need for capital projects.

CM 6.2 (C → C)

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

A Hygiene Committee is in place since January 2007. Its terms of reference encompass the process for involvement in pre-purchasing of equipment/products. Hygiene Service requirements are considered in all significant developments and procurements. This process needs to be formalised and evaluated.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

CM 7.1 (C ↑ B)

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

Processes are in place for risk incident identification reporting, analysis, minimisation and elimination, including hygiene risk incidents. There have been no adverse incidents in the past two years. There is no risk management annual report, however risks are identified and there was evidence of closure with root cause analysis completed. Overall responsibility for risk management rests with the deputy General Manager, who works in close association with a full-time Nursing Quality Assurance and Clinical Risk Facilitator. The organisation is encouraged to continue to seek a full-time Quality Risk Manager. A Health and Safety report for 2006 was noted, as were National Hygiene Audits for 2005 and 2006. Numerous internal audits have been completed, the findings of which are currently been implemented.

CM 7.2 (C ↑ B)

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

The Quality Assurance/ Nursing Quality Assurance and Clinical Risk Facilitator has been a key member of the multi-disciplinary Hygiene Audit Team since 2005 and has actively participated in the carrying out of local audits, as well as preparation of policies/procedures and undertaking of risk assessments. Evidence suggests that

risk management practices are actively supported by the Governing Body. Changes made following evaluation included a new incident reporting system.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion

CM 8.1 (B → B)

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

The contract cleaning company is supervised locally by the deputy General Manager in liaison with the Director of Nursing and Domestic Supervisor, with regular meetings involving the Contract Cleaning Supervisor occurring. Written contracts for all contract staff including, cleaning, water maintenance and waste management are maintained on site. The Ice Making contract has recently been established. This extensive process should be extended to the shop, to ensure there is training and compliance with the hygiene standards. This contract is currently managed and monitored on an informal basis.

CM 8.2 (B → B)

The organisation involves contracted services in its quality improvement activities.

There was extensive evidence of compliance by the contracted services in quality improvement initiatives. For example, the Contract Cleaning Supervisor is also a member of the Managerial Hygiene Audit Team.

PHYSICAL ENVORNMENT, FACILITIES AND RESOURCES

CM 9.1 (C → 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 hospital is 21 years old. The design in some areas is out-dated relative to current best practice. Evaluation of the structures has been completed and Capital Development Plans are in place to address some of the shortcomings, particularly on additional storage requirements. The refurbishment of Clonfert Ward is to be commended. The newly built Specialist Day Care Palliative Unit is also of a high standard. Other planned ward and theatre refurbishments also need to be progressed.

The design of the theatre area and Central Sterile Supply Department (CSSD) is not compliant with current best practice but is managed to best use the existing facilities. It is recommended that these shortcomings be addressed as quickly as possible. The organisation is encouraged to progress the role out of additional hand hygiene facilities such as sinks. The catering area in particular needs to be addressed and the use of the cold room should be ceased until the underlying problem of continuous surface ice at the entrance is addressed.

*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.

Comprehensive standard operating procedures for planning and managing the environment and facilities are evidenced-based and reflect current legislation and

best practice. The organisation is currently completing refurbishment programmes in the wards including the replacement of wash-hand basins.

CM 9.3 (C ↑ B)

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

The organisation has been proactive in implementing changes here, based on evaluation and audit.

It is recommended that a formal evaluation of all patient/client and visitor satisfaction with hygiene services be conducted.

It is also recommended that the hygiene assessment tool developed by the organisation for outpatient areas is evaluated and introduced to all outpatient service areas as planned.

Environmental Health Officer inspection reports and HACCP compliance monitoring are in place in the catering services as are staff satisfaction survey of contract cleaning surveys and catering audits.

CM 9.4 (D ↑ C)

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

The organisation is to be commended on the work that has been achieved to date on seeking feedback from patient/clients and should progress with this in accordance with their Quality Improvement Plan.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 (B ↓ 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.

There was evidence of this. However, it is recommended that evaluation of effectiveness for selecting and recruiting human resources for hygiene services, in accordance with best practice, current legislation and governmental guidelines be carried out at an organisational level, with records maintained.

CM 10.2 (D ↑ 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.

Work practices are being reviewed. This includes the allocated hours and segregation of duties and housekeeping and catering duties at ward level. This is in infancy stage and the organisation is encouraged to progress this through its Quality Improvement Plan to develop documented processes for the evaluation of work capacity and volume.

CM 10.3 (C → C)

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

All qualifications are identified in job descriptions. Contract cleaning staff are trained to the British Institute of Cleaning Science standard. The formalisation of induction and mandatory training for all staff is recommended.

CM 10.4 (C → C)

There is evidence that the contractors manage contract staff effectively.

Written contracts are in place and Health and Safety requirements are defined for contractors. The organisation is encouraged to ensure that opportunities to include contractors in its quality improvement initiatives are fully optimised.

*Core Criterion

CM 10.5 (C → C)

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

These are evidenced in the Corporate Strategic, Service and Operational Plans. The operational plan outlines the proposal to carry out a needs assessment of the Human Resource requirements for Hygiene Services. They should be reviewed.

ENHANCING STAFF PERFORMANCE

*Core Criterion

CM 11.1 (C → C)

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

This has recently been rolled out to hygiene services staff, is monitored and further progress is recommended. A staff handbook has been provided. This needs to be evaluated.

CM 11.2 (C → 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.

There is protected time for staff to attend education sessions, and records of training were reviewed. It is recommended the processes be reviewed for effectiveness.

CM 11.3 (D ↑ C)

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

Self-assessments and training are now evaluated and attendance records are maintained. Key Performance Indicators should be developed for education and training. Opportunities for improvements, which arise from the evaluations, should be implemented.

CM 11.4 (D ↑ C)

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

A process of evaluating staff performance, to include a team performance evaluation in the Physiotherapy Department, has been undertaken. This is commendable and should be rolled out to all areas.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (C → C)

An occupational health service is available to all staff

The services of an Occupational Health Nurse and Employee Assistance Officer are used, as required. A visiting occupational health physician provides sessions on a regular basis.

CM 12.2 (D ↑ C)

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

Key Performance Indicators (KPIs) have been established for staff satisfaction, and should be expanded. The organisation is recommended to complete a staff satisfaction survey. The Occupational Health Department is to be commended for producing an annual report. Evaluation of the mechanism for monitoring staff satisfaction is recommended.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.1 (C → 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.

Processes to collate information are in place and this is passed on to staff as required. Policies and procedures are in place to support this process; however it is recommended that this data be evaluated for reliability.

CM 13.2 (C → C)

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

A process for producing hygiene services audit reports has begun. Minutes of meetings observed were to be commended. The email and newsletter are in place and data is provided in a user-friendly way. However, this should be evaluated.

CM 13.3 (C → C)

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

Processes for the collection and provision of access to hygiene-related information are noted within the Hygiene Service Team's and the Hygiene Committee terms of reference. Information on all aspects of the hygiene services should be co-ordinated and included in the annual hygiene services report. Progress, in relation to the Corporate Hygiene Plan, should be benchmarked on an annual basis. Access to data

is provided to the relevant staff via email, the Hygiene Services Assessment Scheme database, internal post, library and minutes of meetings.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

CM 14.1 (C → C)

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

There is a very obvious culture of hygiene services quality improvement. The Hygiene Services Committee and Executive Management Team are involved in progressing improvements and endorsing a range of quality improvement initiatives in cleaning processes, education and training, evaluation and environment. The Hygiene Services Committee is encouraged to ensure an integrated comprehensive approach to quality improvement is implemented for hygiene services.

CM 14.2 (C → C)

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

A number of quality improvement activities have been developed in the past two years. The communication process in relation to hygiene services has improved. A suite of Key Performance Indicators (KPIs) covering all aspects of hygiene services should be developed, as should the progression of a hygiene audit, evaluation processes and benchmarking should commence.

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 (C → C)

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

Broad compliance in relation to this criterion was observed. Documented processes for the establishment, adoption, and maintenance of best practice guidelines are in place. However, evaluation of policies, procedures and guidelines need to be more frequent and involve the users, and those who deliver the service.

SD 1.2 (C → 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

A project development programme is currently being undertaken with a view to completion in 2010, and there is a process to incorporate the Project Team and the Hygiene Services Team in the commissioning process and involve the end users, prior to the purchase of all equipment. There is evidence that the Hygiene Service Committee has been involved in the introduction of new Hygiene Services interventions such as the flat mop system. It is recommended that the Hygiene Services Committee be involved in the evaluation of all new interventions.

PREVENTION AND HEALTH PROMOTION

SD 2.1 (C → C)

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

In 2007 the community were informed of restricted visiting times during a Norovirus outbreak and the local florists were contacted and advised against sending flowers.
Considerable importance is placed on the overall health and well-being of the hospital's population.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1 (C ↑ B)

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

The multi-disciplinary hygiene committee at Kerry General Hospital work with internal and external organisations (e.g. Contract cleaning services). On occasion, centrally based staff at the HSE South in Cork also input into the Committee from time to time; These staff would have a network remit (e.g. Central contracts, EHO, Fire & Safety personnel etc). A lot of progress has been made in this area this year. The efficacy of the Hygiene Services Team has been evaluated. Multi-disciplinary work is evident. However, the induction programme could expand its scope to include external and internal service providers.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

SD 4.1 (C ↑ B)

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

Despite the environmental challenges, the Hygiene Services Team make every effort to ensure this takes place. The condition of the paintwork and timberwork in many areas has been reviewed. There is a Quality Improvement Plan in place to address these issues. In the interim, it is recommended that a more thorough and rigorous inspection and cleaning regime be introduced. Wall surfaces in the main kitchen, stores and allied areas need upgrading. Floors surfaces and coverings need replacement. Of particular note was the kitchen floor, it was assured during the assessment that a capital works plans was to be carried out immediately.

For further information see Appendix A

*Core Criterion

SD 4.2 (C ↑ A)

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

A rota is in place for attending to medical devices and cleaning devices and clearly defined responsibility for both is in place in the clinical areas visited. A little rust was seen on patient/client equipment. Close patient/client contact equipment was tidy and well maintained.

For further information see Appendix A

*Core Criterion

SD 4.3 (C ↑ A)

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

There is documented evidence of the staff’s responsibility for cleaning equipment in the clinical areas. This is shared by the Contract cleaning services and Kerry General Hospital domestic staff.

For further information see Appendix A

*Core Criterion

SD 4.4 (B ↑ A)

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

While there is broad evidence that the organisation is making every effort to ensure this, a permanent solution should be implemented for the problem of the ice on the floor and the challenge of the continually damp/wet floor tiles in the chilled areas.

For further information see Appendix A

*Core Criterion

SD 4.5 (C ↑ A)

The team ensures the inventory, handling, storage, use and disposal of Hygiene Services hazardous materials, sharps and waste is in accordance with evidence based codes of best practice and current legislation.

The storage of hazardous material is either in a closed/ locked cupboard or on a high shelf. Sharps and waste is managed effectively with staff in the clinical areas very clear about their role, and the pathway, for sharps and waste from the ward to the waste yard.

For further information see Appendix A

*Core Criterion

SD 4.6 (B ↑ A)

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

Extensive compliance was observed in relation to this criterion.

For further information see Appendix A

*Core Criterion

SD 4.7 (B → B)

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

There is documented evidence that the Executive Management Board and the Hygiene Services Team are involved in the management and evaluation of hand hygiene training. The hospital is encouraged to roll out its sink replacement programme.

For further information see Appendix A

SD 4.8 (C ↑ B)

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

The team have demonstrated compliance in this area, for example the review of the incident report, Safety Statement, Isolation Procedures, Drugs and Safety Committee, Clinical Risk Management and Health and Safety Committees. The team is evaluating incident reports on hygiene services issues. This was particularly obvious in the management of the Norovirus outbreak.

SD 4.9 (C → C)

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

Patients/clients are given an information leaflet on what is required of them regarding hygiene services, when they attend the hospital. One patient/client questioned during the assessment was well informed regarding what he expects from staff regarding hand hygiene.

PATIENT'S/CLIENT'S RIGHTS

SD 5.1 (C → C)

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

The dignity of the patient/client is upheld by all staff in the hospital mission statement and a patient/client's charter is in place. There are no documented episodes of breaches of confidentiality in the organisation.

SD 5.2 (C → C)

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

This is provided by literature available on admission, a visiting policy, leaflets and education sessions. It is recommended that the Hygiene Services Team evaluate the optimal use of patient/client education opportunities and increase the number, and location, of hand hygiene facilities. This should also be done for patient/client information leaflets.

SD 5.3 (C ↑ B)

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

These are evaluated and managed. There were no complaints for the previous two years.

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1 (C ↑ B)

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

The patient/client information leaflet is a very effective method of informing patient/clients and families. This is supported by a Digi Information System in the reception area, which enhances the overall patient/client and family information effectiveness for such issues as Visitor Policy and the Norovirus Outbreak. A survey, which asked outpatients about their satisfaction with aspects of hygiene services, had an 87% response. It is recommended that this survey be extended to all patients at the hospital.

SD 6.2 (C ↑ 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.

Extensive evidence of compliance with this criterion was observed. Audits using Infection Control Nurses Association (ICNA) as well as regular cleaning manual tools and results are used in the application of quality improvements.

It is recommended that the organisation perform combined and inter-disciplinary monitoring and perhaps having a member of the local community on the Hygiene Services Team.

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 – In the majority, however, the Accident and Emergency Department needs attention.

(2) All high and low surfaces are free from dust, cobwebs and flaking paint.
Yes - There was evidence of compliance in all areas visited, however flaking paint was noted in some areas.

(3) Wall and floor tiles and paint should be in a good state of repair.
No - The floor surface in the kitchen area needs to be replaced.

(4) Floors including edges, corners, under and behind beds are free of dust and grit.
Yes - Evidence of compliance was observed.

(5) Cleanable, well-maintained furniture, fixtures and fittings used.
Yes - There was evidence that chairs had been replaced and bed tables were in great condition.

(6) Free from offensive odours and adequately ventilated.
Yes - A new air condition unit was installed in the Endoscopy unit the day prior to the assessment.

(7) Areas should be adequately ventilated with ventilation units cleaned and serviced accordingly and documentation available regarding service.
Yes - A new air condition unit was installed in the Endoscopy unit the day prior to the assessment.

(8) All entrances and exits and component parts should be clean and well maintained.
No – The entrance and exit to the Accident and Emergency Department needs to be reviewed. Proliferation of cigarette butts was noted in certain areas.

(9) Where present, main entrance matting and mat well should be clean and in good repair.
Yes – Compliance was noted.

(10) Internal and external signage should be clean, updated, well maintained and laminated to enable cleaning.
Yes – In the majority, however, additional signage needed for hand hygiene.

(12) Internal and external stairs, steps and lifts must be clean and well-maintained.
No - Lifts were compliant, however, stairs were not compliant.

(13) External areas including grounds, gardens, footpaths, ramps and car parks should be clean and well-maintained.
No - The external area adjacent to the main entrance has cigarette ends that require more frequent cleaning.

(14) Waste bins should be clean, in good repair and covered.
Yes - Bins are new and segregated.

(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 - The organisation needs to revisit the smoking policy to ensure the provision of an area for staff, patient/clients and visitors, in line with legislation.

(16) Hospitals are non smoking environments. However, cigarette bins should be available in external designated locations.
Yes - No designated area was observed, however, bins are provided.

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

(17) Switches, sockets and data points.
Yes - Some switches in the staff areas required attention.

(18) Walls, including skirting boards.
No - Skirting boards in many areas need attention.

(19) Ceilings
Yes – Compliance was noted.

(20) Doors
No - The doors in general were damaged. These had been painted in some areas.

(21) Internal and External Glass.
No - The external glass and front entrances need more attention.

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

(30) Fixtures: Fixtures (i.e. a piece of equipment or furniture which is fixed in position) should be clean. This includes all electrical fixtures e.g. all light fittings and pest control devices.
Yes – In the majority, however, the built-in units in some ward areas are in need of replacement.

(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 - All areas observed were clean.

(32) Shelves, benchtops, cupboards are clean inside and out and free of dust and spillage
Yes - All areas observed were clean.

(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 - Disposable curtains were being tested in the theatre.

(209) Air vents are clean and free from debris.
Yes - All areas observed were clean.

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

(33) Chairs
Yes - All observed were clean.

(38) Dispensers (e.g. handwash dispensers), Holders and Brackets
Yes - All observed were clean.

(41) Door handles and door plates
No - Some areas need greater attention.

Compliance Heading: 4. 1 .5 Sanitary Accommodation

(47) Bathrooms / Washrooms are clean and communal items are stored e.g. talc or creams.
Yes – In the majority, those viewed were clean, however, the Care of the Elderly areas need to be addressed.

(48) Floors including edges and corners are free of dust and grit.
Yes - Shower areas in the hospital need review.

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

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 - All viewed were clean.

(52) Toilets and Urinals
Yes - All viewed were clean.

(53) Bidets and Slop Hoppers
Yes - All viewed were clean.

(54) Wash-Hand Basins
Yes - More wash hand basins are required, and it is recommended that the replacement programme, which has commenced, needs to be rolled out.

(55) Sluices
Yes - All viewed were clean.

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

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

(58) Sluice rooms should be free from clutter and hand washing facilities should be available.
Yes - All areas observed were tidy.

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 - All observed complied with requirements.

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

(65) Commodes, weighing scales, manual handling equipment.
Yes - All observed were clean.

(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 - All observed were clean.

(68) Patient fans which are not recommended in clinical areas.
No - Two fans were observed and these had dust on them.

(69) Patient washbowls should be decontaminated between each patient, and should be stored clean, dry and inverted. Damaged washbowls should be replaced.
Yes - All observed were clean.

(70) Bedpans, urinals, potties are decontaminated between each patient.
Yes - All observed were excellent.

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

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

(76) Hand-wash dispenser holders and brackets should be free of product build-up around the nozzle.
Yes - All observed were clean.

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

(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 - All observed were clean.

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

(81) All cleaning equipment should be cleaned daily.
Yes - Records are maintained and best practice was noted.

(85) Cleaning solutions should only be prepared in a well ventilated area and should never be mixed.
Yes – In the majority, however, evidence that not all of the rooms were adequately ventilated.

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

(89) Equipment with water reservoirs should be stored empty and dry.
Yes - All observed were dry.

(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 - The organisation optimises the facilities that are available. Future development plans should consider additional space. The Clonfert ward is a model of best practice.

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

(92) Cleaning products and consumables should be stored in shelves in locked cupboards.
Yes - However locked cupboards are not yet available in all areas.

(94) Health and Safety policies should be in place for the use of ladders/steps when cleaning.
Yes – A draft ladder policy is in place review and re-issue.

(95) When using electrical cleaning equipment, a circuit breaker should be used if appropriate and the equipment should be plugged in while switched off using dry hands.
Yes - All electrical equipment used by cleaning staff is less than 12 months old.

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

(215) There should be a documented ward kitchen food safety policy which should be signed off by the person in charge of the ward kitchen and the hospital manager.
Yes – Compliance was observed.

(216) Documented processes for manual washing-up should be in place
Yes - Documented processes are in place.

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 - Coded locks are in place.

(219) Ward kitchens are not designated as staff facilities
Yes - Some wards have a fridge to maintain staff lunches.

(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 - All processes are in place.

Compliance Heading: 4. 4 .3 Waste Management

(232) Waste storage containers shall be smooth, durable, easy to clean and disinfect, well maintained and closable.
Yes - However, it wasn't possible to lock all waste storage containers.

Compliance Heading: 4. 4 .4 Pest Control

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

(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 – Compliance was noted.

(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 - Compliance was noted.

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

(244) Temperature for food when cooked, held or reheated should comply with I.S. 340:2006 requirements
Yes - Compliance was noted.

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).
No - No compliance noted during the assessment.

Compliance Heading: 4. 4 .10 Plant & Equipment

(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 - These are replaced annually.

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 - There was evidence that this was adhered to.

(139) Documented evidence that waste collectors are permitted to collect the waste concerned by virtue of holding a valid waste collection permit.
Yes - Evidence of compliance was observed.

(140) Documented evidence that the treatment facility and final disposal or recovery facility is permitted or licensed.
Yes - Evidence of compliance was observed.

(141) Documented procedures for the segregation, handling, transportation and storage of waste.
Yes – Documented processes are in place.

(142) Healthcare risk waste should be tagged and secured before leaving the area of production.
Yes - All ward areas have their own areas labelled. Traceability was excellent.

(147) Only UN approved containers and bags to be used for healthcare risk waste.
Yes - Waste bins changed.

(149) Inventory of Safety Data Sheets (SDS) is in place.
Yes – An inventory of Safety Data Sheets was viewed.

Compliance Heading: 4. 5 .3 Segregation

(156) Healthcare risk waste must be segregated from healthcare non risk waste.
Yes - Compliance was noted and continued monitoring is recommended.

(159) Sharps boxes are correctly sealed, labelled and stored in a safe environment.
Yes - Evidence of compliance was observed.

(255) Within Healthcare risk waste, all special wastes including drugs & cytotoxic drugs / materials are segregated.
Yes - These are segregated, however, more frequent cleaning of the area is recommended.

(256) Mattress bags are available and are used for contaminated mattresses ready for disposal; mattresses are disinfected.
No - Mattress bags were not available, some stored in the ward areas. Consideration should be given for central storage of mattresses.

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 – A waste management policy in place.

(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 - Regional support was noted.

(166) Drivers of vehicles transporting hazardous waste must be trained in accordance with the ADR Regulations.
Yes - Compliance was noted.

Compliance Heading: 4. 5 .6 Training

(259) There is a trained and designated waste officer.
Yes – An acting Waste Officer is in place.

(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 - Documented records were in place.

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 - Excellent linen management was observed within the organisation.

(173) Documented processes for the use of in-house and local laundry facilities.
Yes - Documented processes were observed in place.

(175) Clean linen is free from stains.
Yes - There was evidence that a quality control system is in place.

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

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

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

(189) Clinical hand wash sinks are required in all areas where clinical activities are performed. They should be centrally located and free from obstruction.
No – A plan is in place to address requirements for additional clinical hand wash sinks and some already been replaced.

(190) All sinks should be fitted with washable splash backs with all joints completely sealed.
No – This is a work in progress and all new sinks are compliant.

(191) Hand washing facilities i.e. sinks, taps and splash backs must be clean and intact.
No - Not all hand washing facilities are meeting the requirement.

(192) Taps should be hands free and should be mixer taps to allow temperature regulation.
No – The organisation is recommended to put hands-free facilities in place.

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

(198) Hand hygiene posters and information leaflets should be available and displayed throughout the organization.
No – The organisation is recommended to provide further information in the public areas. This is also required in the neonatal unit.

(203) Hand wash sinks are dedicated for that purpose, are free from used equipment and inappropriate items (e.g. nail brushes).
Yes – However, the organisation is using re-sterilised nail brushes. Disposable nail brushes are recommended.

(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 - All new ones hand wash sinks conform to the standard.

(205) General wards should have one sink per 4-6 beds and critical areas should have one sink per 1-3 beds.
Yes – Overall, the organisation was compliant.

(206) Documented records of mandatory attendance at hand hygiene education and practice is required for all staff members involved in clinical areas. This may be undertaken during hospital induction programme followed by annual updates.
Yes - All staff asked said that hand hygiene was part of their induction programme.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team		Assessor Team	
	FREQ	%	FREQ	%
A	1	01.79	6	10.71
B	10	17.86	15	26.79
C	40	71.43	35	62.50
D	5	08.93	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	C	C	→
CM 1.2	B	B	→
CM 2.1	C	C	→
CM 3.1	C	C	→
CM 4.1	C	C	→
CM 4.2	C	C	→
CM 4.3	C	B	↑
CM 4.4	C	C	→
CM 4.5	C	C	→
CM 5.1	B	B	→
CM 5.2	A	A	→
CM 6.1	B	C	↓
CM 6.2	C	C	→
CM 7.1	C	B	↑
CM 7.2	C	B	↑
CM 8.1	B	B	→
CM 8.2	B	B	→
CM 9.1	C	C	→
CM 9.2	B	C	↓
CM 9.3	C	B	↑
CM 9.4	D	C	↑
CM 10.1	B	C	↓
CM 10.2	D	C	↑
CM 10.3	C	C	→
CM 10.4	C	C	→
CM 10.5	C	C	→
CM 11.1	C	C	→
CM 11.2	C	C	→
CM 11.3	D	C	↑
CM 11.4	D	C	↑

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