Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Hygiene Services Assessment Scheme

Assessment Report October 2007

Mallow 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.

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

[2] New York Department of Health and Mental Hygiene

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

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

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

1.2 Organisational Profile

Mallow General Hospital is an acute 76-bedded hospital situated in Cork. The hospital opened as a General Hospital in 1957 and presently serves the population of 85–90,000 people. It is part of the Cork University Hospital Group. The hospital is involved in teaching nursing, medical and paramedical students.

Services provided

Services provided at Mallow General Hospital include:

- General Surgery including Urology and ENT
- General Medicine including Cardiology and Gastroenterology
- Day Procedures Unit
- Accident and Emergency
- Intensive Care/Coronary Care
- Radiology

Additional services by visiting consultants (OPD)

- Orthopaedics
- Paediatrics
- Psychiatry

Specialities as Obstetrics, Paediatrics, ENT and Orthopaedics are centralised services from the Cork University Hospital.

Physical structures
Sun Room and Stress Room.

1.3 Notable Practice

- It was very evident that the primary objective of the hospital was to provide a focus on excellent patient/client care. This included all ancillary services such as hygiene, catering and communication.
- Introduction of a recycling process for cardboard and paper.
- An obvious emphasis on, and knowledge of, hand hygiene.
- The training and education of all staff is to be commended.

1.4 Priority Quality Improvement Plan

- It is recommended that a formal multi-disciplinary team approach to the management of hygiene be introduced.
- The organisation should formally evaluate its processes and procedures in line with the quality improvement cycle.
- All departments in the hospital should become involved in the hygiene process. For example the pharmacy requires urgent attention.
- The layout of the Central Sterile Supply Department, which is located within the Catering Department, requires review by the Hygiene Management Committee.

- It is recommended that further training on waste management be extended, with specific regard to general operative staff participating in waste handling duties. There is a need to further explore the reduction in the number of times clinical waste is being handled within the current system.

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 Mallow General Hospital has achieved an overall score of:

No Award

Award Date: October 2007

1.6 Significant Risks

CM 3.1 (Rating D)
The organisation has a clear corporate strategic planning process for Hygiene Services that contributes to improving the outcomes of the organisation.

Potential Adverse Event
Goals and objectives of the hygiene services will not be defined for the hygiene services.

Risks

Likelihood of Event	Rated: M (2)
Impact of Event	Rated: M (2)
Urgency of Action	Rated: M (2)
TOTAL	**Total: 6**

Recommendations
The hospital should develop a Corporate Strategic Hygiene Services plan.

CM 4.2 (Rating D)
The Governing Body and / or its Executive Management Team regularly receive useful, timely and accurate evidence or best practice information.

Potential Adverse Event
The hospital would not be kept informed of current best practice guidelines and information in relation to hygiene services.

Risks

Likelihood of Event	Rated: M (2)
Impact of Event	Rated: M (2)
Urgency of Action	Rated: M (2)
TOTAL	**Total: 6**

Recommendations
While it is recognised that hygiene services are managed at senior level, a more formalised executive management structure needs to be developed, where information is disseminated and acted upon.

CM 5.2 (Rating D)
The organisation has a multi-disciplinary Hygiene Services Committee.

Potential Adverse Event
Insufficient co-ordination of hygiene services across the organisation.

Risks

Likelihood of Event	Rated: L (1)
Impact of Event	Rated: M (2)
Urgency of Action	Rated: M (2)
TOTAL	**Total: 5**

Recommendations
A multi-disciplinary Hygiene Service Committee should be established.

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.

No formal committee is in place to oversee this. Leadership is assumed by the Director of Nursing, in collaboration with the catering and household manager, the assistant Directors of Nursing and departmental managers. The hospital regularly conducts audits, evidence of which was provided through informal audit notes and actions plans from 2005. The hospital holds regular Clinical Nurse Manager meetings with hygiene on the agenda and recorded minutes. The hospital liaises and receives relevant information such as isolation issues from the public health services.

CM 1.2 (B ↓ C)

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 hospital has reviewed its practices in line with the previous national hygiene audits (2005 and 2006). An action plan was devised as a result. Service level agreements with the Health Service Executive are in place and there are currently no new services planned. Policies and procedures are in place for Hazard Analysis and Critical Control Point (HACCP), cleaning, laundry and waste. An un-documented process of continuous self audit and informal evaluation is in place. It is recommended that this process be documented and strengthened.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1 (B ↓ 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.

Mallow General Hospital works in partnership with the Health Services Executive South, National Hospitals Office, Health and Safety Authority, Environmental Health Officers and Cork University Hospital. The hospital is considered part of the Cork University Hospital Group. The Hospital Manager reports to the deputy General Manager (CUH), and the Director of Nursing to the General Manager (CUH).

There are no formal management meetings in place with the Health Services Executive South. The hospital meets with the deputy General Manager on an informal basis. There are no documented minutes or agenda taken at these meetings. It is recommended that formal structures be developed.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 (E ↑ D)

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

No formal Executive Management Board is in place and there are no formal meetings between the Director of Nursing and the Hospital Manager. It is recommended that a Hygiene Services Committee be formed in the near future and a Corporate Hygiene Services Plan, Service or Organisational Plan for Hygiene Services be formulated and developed.

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.

The Health Services Executive and National Hospital Office network assume overall responsibility for the management of Hygiene Services. However, this has not been structured or agreed with local management at Mallow General Hospital. Currently the Director of Nursing, who is accountable to the Network Manager, takes responsibility for hygiene. The hospital reviews its hygiene service against in-house audits and the previous national hygiene audits (2005 and 2006). Limited and informal evaluation has been carried out. No evidence of overall evaluation was presented. It is recommended that formal evaluation processes be implemented in the future.

CM 4.2 (N/A → D)

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

This was not rated by the hospital but best practice information is reviewed. No Executive Management Board or other composite management structure is in place. The Director of Nursing receives best practice information relating to hygiene from the National Hospital Office and Public Health Surveillance such as the Strategy for the control of Antimicrobial Resistance in Ireland (SARI) guidelines and Irish Acute Hospitals Cleaning Manual and endeavours to adapt local policy and procedure to reflect this.

CM 4.3 (C → C)

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.

Library and Internet facilities are available in the hospital. The hospital is guided by the Irish Acute Hospitals Cleaning Manual, SARI guidelines, Department of Health and Children (DOHC) Segregation, Packaging and Storage Guidelines for Health Care Risk Waste. Best practice information is disseminated through Clinical Nurse Manager meetings and through the Hygiene Manager to relevant groups.

CM 4.4 (C → C)

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

The library has journals and posters on infection control and other hygiene issues. The hospital self audits and informally evaluates results. A wide range of policies is in place, however, a process for their development/revision was not observed.

CM 4.5 (N/A → C)

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

This criterion was not rated by the organisation neither was there a capital project. No evidence was observed that hygiene services or Infection Control Team were represented on the previous Capital Planning Team for the CT scanner. The Director of Nursing was involved at a late stage of the above process and promoted hygiene issues.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

*Core Criterion

CM 5.1 (C → C)

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

Clear roles, responsibilities and accountabilities are in place through job descriptions and professional line management. This was particularly evident for nursing, support and catering staff. No job descriptions for the Governing body, which included responsibility for hygiene, were observed. There was no documented evidence of the accountability of general management and allied health professionals for hygiene services. It is recommended that responsibility for hygiene issues be identified as a core issue in all staff job descriptions.

*Core Criterion

CM 5.2 (N/A → D)

The organisation has a multi-disciplinary Hygiene Services Committee.

This was not rated by the organisation neither is there a formal multi-disciplinary Hygiene Services Committee in place. Hygiene services are managed through the Director of Nursing and thereafter through the household/catering manager. It is recommended that a Hygiene Services Committee, with clear terms of reference be formed in the near future.

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

*Core Criterion

CM 6.1 (C → 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.

The Hospital Manager allocates resources to hygiene services in line with approved budgets and whole time equivalents. Additional funding is requested based on the results of in-house audits, which are forwarded to the hospital manager.

To-date, no Corporate Service Plan has been developed. There was no documented evidence that Hygiene services issues, or requirements for project funding, were facilitated through the Corporate Management Team or Network Manager.

CM 6.2 (N/A → C)

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

This was not rated by the organisation. As there is no hospital Hygiene Services Committee in place, the purchasing of hygiene equipment and services is managed by the Director of Nursing and the Hospital Manager. Products are controlled by the Contract Department at Cork University Hospital. It is recommended that the review of the purchasing process be implemented to ensure compliance with terms of contracts for areas such as linen, waste, consumables and equipment. Evidence was observed that local informal evaluation was in place to assess local curtain management issues and the up-grading of waste bins. No formal documentation of these assessments was presented. It is recommended that the hygiene product purchase function be part of the terms of reference of the new committee.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

CM 7.1 (C → C)

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

The hospital benefits from collaboration with the Cork University Hospital Risk Management Department. An incident reporting system is in place, which is evaluated and reported on a quarterly basis. Advice is sought from Cork University Hospital if necessary. A Health and Safety statement, with departmental hazard identification, is in place. The hospital partakes in the national waste management programme and internal/external hygiene audits have taken place and have been reviewed. An Infection Control Committee is in place in conjunction with Cork University Hospital. Material safety data sheets were observed and an occupational health service is available to all staff. A regional health and safety annual report was available. It is recommended that a review of the Hazard Analysis and Critical Control Point (HACCP) system be completed in the near future.

CM 7.2 (N/A → C)

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

This was not rated by the organisation. Risk management processes at Cork University Hospital and Mallow General Hospital are supported by the Executive Management Team. Mallow General Hospital has a health and safety plan in place, which is supported by local management. Incident reporting, hazard findings, and outcomes are documented. No details of funding for risk management practices were observed. No representatives from hygiene services were present on the Risk Management Committee, which is recommended.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion

CM 8.1 (C → 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.

The Central Contract Department at Cork University Hospital purchases most items for Mallow Hospital. Service contracts are in place for kitchen appliances, floor mats, pest control, sanitary services and waste management. The hospital informs the Central Contract Department if any issues of non-compliance of contracts arise. No local evaluation of contracted services is carried out.

CM 8.2 (C → C)

The organisation involves contracted services in its quality improvement activities.

No evidence of this was observed. However, some evidence was presented to suggest that contractors are involved in relation to maintenance and repair contracts.

PHYSICAL ENVIRONMENT, 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 structure dates from the 1940s. Few additional services have been added with the exception of the CT scanner. Refurbishment is on-going as funding is made available. No evidence of capital or minor capital projects was presented (for example minutes, evaluations or drawings). The layout has created restrictions in corridor size and ancillary service rooms, for example sluice, linen and storage. An absence of individualised or centralised staff facilities was observed. This facility was shared with the linen room at ward level. The hospital was serviced by one internal lift. The layout of the Central Sterile Supply Department (CSSD) was inappropriate as it led directly to the Catering Department. However, a re-location plan is in place.

*Core Criterion

CM 9.2 (C → C)

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

No hygiene organisational plan has been developed; however, an Infection Control Policy is in place. A review of policies on laundry and linen is recommended, with a view to merging these. Management of kitchen procedures also requires review to ensure all legal standards are adhered to.

CM 9.3 (C → 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 hospital has a system of in-house auditing with informal evaluation and resultant action planning. A complaints procedure is in place. Complaints are reviewed, investigated and corrective action taken if necessary.

CM 9.4 (C → C)

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

High scores were achieved in the 2005 and 2006 national hygiene audits. Complimentary cards are received from visitors and patient/clients. However, no evidence of these cards was provided. The complaints procedure has not identified any areas in relation to hygiene issues. Comment cards are currently not available for service users. This is recommended. A patient/client hygiene evaluation survey should also be undertaken.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 (C → 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.

The hospital ascribes to the Cork University Hospital Human Resources Recruitment Policy. Full job descriptions are available for hygiene staff. Records fulfilled the recruitment criteria. All staff undergo a performance review on completion of probation. Education and training is provided for all staff. Selection and recruitment processes are currently not evaluated, and this is recommended.

CM 10.2 (C → 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.

The area is staffed in agreement with the approved whole time equivalent staffing level identified in the Hospital Service Plan. Additional staff are contracted if required for example during an infection outbreak. Staff assessments of the service are carried out on a daily basis and, if required, redeployment occurs.

CM 10.3 (C → C)

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

Recruitment takes place in line with national best practice procedures. All hygiene staff receive orientation, induction, on-going education and training. Hygiene staff attend specific training on waste management, hand hygiene, sharps and manual handling. It is recommended that general operatives receive further training in the area of waste management. Additional Hazard Analysis and Critical Control Point (HACCP) training is recommended for kitchen/ward-kitchen staff and management.

CM 10.4 (C → C)

There is evidence that the contractors manage contract staff effectively.

No contract cleaning staff are employed. All contractors are appointed through the Central Contracts Department. Issues of non-compliance are referred to that department. No on-site training/orientation is provided. No contracts were observed as all are housed at the Central Contracts Department in Cork city.

*Core Criterion

CM 10.5 (N/A → C)

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

This is not rated by the organisation. The hospital has not formulated a Hygiene Corporate or Service Plans. However, human services needs are met within the hospital. It is recommended these plans be developed in the near future.

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

An orientation and induction programme is in place for all hygiene, nursing, allied health and medical staff. Continuing in-service training and education programmes are also in place. Lists of attendance at individual training were available; however, no composite database was available. No evidence of results of any evaluation of the programme was presented. This is recommended.

CM 11.2 (N/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.

On-going education, training and continuous professional development is occurring. The organisation is recommended to evaluate its relevance.

CM 11.3 (C → C)

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

No hygiene-related incidents have been reported. However no performance indicators or records of staff satisfaction with training were observed.

CM 11.4 (C → C)

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

A system of performance review is in place for all new staff. The hospital supports the disciplinary procedure (People in Management) system as a performance measurement. Attendance is monitored and evaluated; resultant actions are noted in individual files.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (B → B)

An occupational health service is available to all staff

Cork University Hospital provides an occupational health service for Mallow General Hospital. This service is provided at Cork University Hospital and on a monthly basis on the Mallow campus. The Occupational Health Department carries out a full range of screening, diagnosis and treatment programmes. Health promotion initiatives and training also occur but these are not evaluated. This is recommended.

CM 12.2 (C → C)

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

An Employee Assistance Programme is available through the Occupational Health Department at Cork University Hospital. There has been no staff satisfaction survey of this done to-date. The department's annual report was not observed.

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.

A library facility with Internet access is available. The Director of Nursing has regular meetings with Clinical Nurse Managers and is also in receipt of national guidelines and best practice information, which is circulated. The hospital also adheres to the principles of Hazard Analysis and Critical Control Point (HACCP) and national waste segregation policies.

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.

In-house audits are analysed and results circulated to all departments. The hospital notifies Public Health Authorities in relation to infectious diseases. Daily bed occupancy is monitored and data is sent to the Health Service Executive National Office.

CM 13.3 (C → C)

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

In-house audits are informally evaluated and circulated. The previous national hygiene audits (2005 and 2006) were formally analysed and a Quality Improvement Plan was put in place. The clinical nurse management meetings are used as a forum to evaluate hygiene audits and best practice documentation.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

CM 14.1 (N/A → 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

This was not rated, however, a continuous quality improvement culture, led by the Director of Nursing and the Catering and Household Manager, was evident. The hospital internal audits informally review and develop Quality Improvement Plans in line with service agreements. A long-standing cleaning manual, which was influenced and updated to reflect the Irish Acute Hospitals Cleaning Manual, is used. Hygiene quality improvement initiatives include cleaning frequencies, flat mopping and hand hygiene training. However, no evidence of the Executive Management Team's involvement in these improvements was observed.

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.

Internal and external audits are used to evaluate and benchmark cleaning processes. Following the first National Hygiene Audit (2005), the hospital received wide media coverage to reflect its first position on the league table.

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.

These are in place and have been influenced by the Irish Acute Hospitals Cleaning Manual, Strategy for the control of Antimicrobial Resistance in Ireland (SARI) guidelines and the Department of Health and Children's guide on Segregation Packaging and Storage Guidelines for Healthcare Risk Waste. To-date, HACCP guidelines have not been fully implemented. Evaluation and resultant actions were not evident and no Quality Improvement Plan has been developed. This is recommended.

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 number of hygiene initiatives such as the flat mopping system, machine scrubber system and the use of hand sanitisers, have recently been introduced and evaluated. However, no further assessment has been completed since their introduction. It is recommended this be carried out.

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.

An abundance of visible hand hygiene and infection control leaflets were observed. The hospital has taken part in the national "Clean Hands" campaign. Patient/clients are encouraged to become involved in paper and cardboard recycling. An annual "Critical Care" evening is hosted, during which advice on hand hygiene, infection control and food safety is given to the community. No evaluation of this takes place. It is recommended this be done.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1 (C → C)

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

A defined multi-disciplinary team was not in place. Hygiene services are steered mainly by the Director of Nursing and the Catering and Household Manager. There was no evidence of involvement from the allied health professional or heads of departments in physiotherapy, occupational therapy, speech and language therapy and dietetics. There was no clear pathway for hygiene issues at the Corporate Health Service Executive level. With the exception of laundry and waste management, hygiene contracted services are not used. It is recommended that a multi-disciplinary approach to hygiene be established.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

SD 4.1 (B → B)

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

Overall, this was the case. Buildings date from the 1940s, which presents a particular challenge to the management of hygiene services. There has been an obvious commitment in the hospital to the refurbishment of many areas and many Quality Improvement Plans for areas such as sinks, toilets, ward kitchens and the waste compound have been undertaken.

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.

The hospital has a very comprehensive hygiene services manual, which pre-dates the Irish Acute Hospitals Cleaning Manual. This is currently being reviewed, in line with national standards. The hospital has a robust system of in-house audit and informal evaluation and action planning in place.

For further information see Appendix A.

*Core Criterion

SD 4.3 (C ↑ B)

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

This is so. A hospital colour coding system is in place and being adhered to. Cleaning storerooms were found to be small but clean and orderly, however, they would benefit from further secure storage. The hospital has a Quality Improvement Plan in place for refurbishment and the installation of wash-hand basins in sluice rooms.

For further information see Appendix A.

*Core Criterion

SD 4.4 (B ↓ C)

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.

Overall, the main kitchen and ward kitchens were clean; however they were not fully compliant with Hazard Analysis and Critical Control Point (HACCP) and best practice guidelines. Further consideration should be given to the review and management of the current HACCP system. Additional training is advised for staff and management. The organisation is recommended to benchmark and use best practice in the Catering Department. This would be of great value.

For further information see Appendix A.

*Core Criterion

SD 4.5 (C ↑ 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.

A waste management system is in place and a recycling project is being progressed. There are development opportunities in the latter project such as the use of glass and food waste. It is recommended that waste management training procedures be developed, in line with legislation and guidelines, and procedures should be reviewed.

For further information see Appendix A.

*Core Criterion

SD 4.6 (B → B)

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

Overall, hospital linen was very clean and well managed. Concerns were raised about the controls in place during the transport and storage of clean and dirty linen. Due to the lack of space, the linen rooms are also used as staff locker rooms in each ward and department. The linen policy and practices differ; however, the practice is in line with the national guidelines. It is recommended that this be reviewed.

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

A high level of compliance was observed due to comprehensive hand hygiene training of staff. This was validated by demonstrations, questioning and training records. Adherence to jewellery control was evident at ward level. The phased upgrade of sinks, as recommended in the SARI guidelines, will continue.

For further information see Appendix A.

SD 4.8 (C → C)

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

An incident reporting system has been adopted from Cork University Hospital, as has the risk management procedure. Risk issues are evaluated and reports issued on a quarterly basis. The hospital does not directly include hygiene as an individual heading for incident reporting and evaluation. This should be an area for consideration. Health and safety and departmental safety statements are in place as are hazard and control sheets. It is recommended that a review of HACCP system be completed in the near future.

SD 4.9 (C → C)

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

Hygiene information leaflets and posters are widely available throughout and the national hospital visitor policy is in place. Clearly labelled waste bins and personal protective equipment (PPE) is available for visitors. No documented procedure is in place for the encouragement of patient/clients and families in helping to improve hygiene services. No patient/client satisfaction surveys or evaluation has been carried out. There was no patient/client representation or structured evaluation and resultant action planning process. This is recommended.

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 “Patient/Client Charter of Rights” was clearly visible for patients/clients and visitors. All professional staff subscribes to their own professional Code of Conduct. The hospital mission statement also protects the rights of the patient/client and each ward and department has a clearly visible philosophy of care. Patient/client information leaflets are available. Job descriptions, in line with the National Human Resource Strategy, which include confidentiality as a core competency, have been developed. Where available and appropriate, high-risk patients requiring isolation are placed in single rooms. There is no feedback procedure in place for evaluation of this. The hospital would benefit from the inclusion of patient/client confidentiality as a core competency in the hygiene services structure.

SD 5.2 (C → C)

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

There is clear signage in relation to protected cleaning times. The hospital did not present evaluation of the efficacy of visiting times or patient/client information. This is recommended.

SD 5.3 (C → C)

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

The complaints policy was developed by Cork University Hospital. The procedure for the management of complaints was through the office of the Director of Nursing, and a complaint template is available. Complaints were dealt with on an individual basis, acknowledged and forwarded to the head of service for investigation. However, no composite evaluation of the reports had been carried out.

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1 (C → C)

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

No formal evidence of this was produced. No evidence of any changes to the hygiene service as a result of feedback was observed. The hospital has a complaints procedure; however, no hygiene complaints have been recorded. A patient/client user satisfaction survey should be undertaken. It is also recommended that resultant actions, feedback and continuous Quality Improvement Plans be completed.

SD 6.2 (C → C)

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

While the hospital did not have a multi-disciplinary committee, evidence of in-house audits for all departments and services was produced. Results are given to the Director of Nursing and the department managers. Informal reviews are documented on the audit sheets, and any actions required are identified. No composite evaluation or outcomes are formally completed. The previous national hygiene audits (2005 and 2006) have been evaluated and Quality Improvement Plans were documented.

SD 6.3 (E ↑ C)

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

No annual report or corporate annual report was produced in 2006. It is recommended that these are produced in the near future.

4.0 Appendix A

The following are the scores received for the Service Delivery core criteria compliance requirements. The organisation must provide evidence of exceptional compliance (greater than 85%) to achieve an 'A' rating. All 'core criteria' must have achieved an 'A' rating to receive a score of 'very good' and be acknowledged with an award.

4.1 Service Delivery Core Criterion

Compliance Heading: 4. 1 .1 Clean Environment

(1) The environment is tidy, well-maintained, free of rust, blood or body substances, dust, dirt, debris and spillages.
Yes - The overall level of cleaning at ward level and in public areas was satisfactory. However the pharmacy and basement storage areas require urgent attention.

(2) All high and low surfaces are free from dust, cobwebs and flaking paint.
No - A number of areas required attention in relation to high dusting. Flaking paint was noted on corridor walls, bathrooms and door entrances in most areas.

(3) Wall and floor tiles and paint should be in a good state of repair.
No - Flooring in the Accident and Emergency Department, public corridors and kitchen storage areas requires updating. Painting is also an issue which requires attention.

(5) Cleanable, well-maintained furniture, fixtures and fittings used.
Yes - Some of the male toilets need to be replaced. A Quality Improvement Plan is in place to address this issue.

(7) Areas should be adequately ventilated with ventilation units cleaned and serviced accordingly and documentation available regarding service.
Yes - Full service and validation processes were in place and records were validated.

(8) All entrances and exits and component parts should be clean and well maintained.
No - The entrance and exit areas were not well maintained. Inappropriate waste bins and seating areas were noted. The entrances would benefit from the introduction of a regular cleaning schedule.

(10) Internal and external signage should be clean, updated, well maintained and laminated to enable cleaning.
No - Internal signage requires a full review. Evidence of handwritten and non-laminated signs was noted throughout. Sticky tape residue was an issue in most areas.

(13) External areas including grounds, gardens, footpaths, ramps and car parks should be clean and well-maintained.
Yes – In the majority, however, the surface of the car park requires attention.

(14) Waste bins should be clean, in good repair and covered.
Yes - Bins are cleaned but are not fully closed. Upgrading is required.

(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 - A designated smoking area must be identified. Evidence of unauthorised smoking was observed in five separate areas.

(16) Hospitals are non smoking environments. However, cigarette bins should be available in external designated locations.
No - Specific smoking bins are required, as are designated smoking areas.

(29) A warning sign "cleaning in progress" must always be used, position to be effective.
Yes - Warning signage was available at ward level. However, one multi-task attendant was observed mopping the floor without a warning sign. The hygiene of warning signs also requires improvement.

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

(18) Walls, including skirting boards.
Yes - Walls and skirting boards were clean but require repainting.

(21) Internal and External Glass.
Yes - An annual contract for the cleaning of the hospital windows was in place. An external contractor has completed a full window clean of the hospital.

(23) Radiators and Heaters.
Yes - Overall, radiators observed were satisfactory. However attention is required for the radiators in the Out-Patient Department corridor and in St Ann's Ward.

(24) Ventilation and Air Conditioning Units.
Yes - Theatre was the only area observed with mechanical ventilation. Confirmation of its servicing and maintenance was observed.

(25) Floors (including hard, soft and carpets).
Yes - Overall, the level of floor cleaning hygiene was satisfactory. It is recommended that cleaning frequency be reviewed.

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

(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 - Procedures were in place and records were verified.

(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 - A number of overhead light fittings observed need attention. All fixtures were satisfactory.

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

(37) Tables and Bed-Tables.
No - A number of bed tables throughout the hospital required attention.

(38) Dispensers (e.g. handwash dispensers), Holders and Brackets.
Yes - However, a small number of toilets were not fitted with toilet roll dispensers.

Compliance Heading: 4. 1 .5 Sanitary Accommodation

(46) Bathrooms/Washrooms must be cleaned on a daily basis. When necessary, they must be disinfected. This must be monitored and recorded.
Yes - However cleaning was monitored and recorded in public areas only. The introduction of a cleaning checklist for all areas is advised.

(48) Floors including edges and corners are free of dust and grit.
Yes - However the floors are old and difficult to maintain. An upgrade in the toilets and the Accident and Emergency Department is recommended.

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

(52) Toilets and Urinals.
Yes - Overall, the toilets were clean, however, some units require replacement.

(53) Bidets and Slop Hoppers.
Yes - This was not applicable as no bidets are in place.

(54) Wash-Hand Basins.
No - However a Quality Improvement Plan is in place. The current replacement of hand sinks is in line with the HBN 95 Standard.

(55) Sluices.
Yes - Sluice rooms were small but tidy and clean.

(58) Sluice rooms should be free from clutter and hand washing facilities should be available.
No - A number sluice rooms did not have hand-washing sinks.

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

(65) Commodes, weighing scales, manual handling equipment.
Yes - However, the wheels on some commodes require attention.

(68) Patient fans which are not recommended in clinical areas.
No - Fans were observed in all areas.

(70) Bedpans, urinals, potties are decontaminated between each patient.
Yes – In the majority, however, the wheels of some commodes require further cleaning.

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

(73) TV, radio, earpiece for bedside entertainment system and patient call bell.
Yes – In the majority, however, some dust was observed on the top of the television in the Intensive Care Unit.

(74) Patients personal items (e.g. suitcase) which should be stored in an enclosed unit i.e. locker/press.
No - A number of suitcases were observed on the floor and window sills.

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

(86) Information on the colour coding system is available to all hygiene staff (according to national guidelines).
Yes - The hospital maintains its own colour-coding system, which is adhered to. It is recommended that the national colour-coding guidelines be implemented and followed.

(87) All cleaning equipment should be approved by the Hygiene Services Committee and ensure sufficient supply.
No - A Hygiene Services Committee is not in place. Cleaning equipment is ordered through ward and departmental managers.

(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 - Storage facilities were available; however, no hot water or hand-washing facilities were available.

(91) Storage facilities for Cleaning Equipment should be clean and well maintained.
Yes – In the majority, however, storage facilities in the Catering Department for multi-task attendants were in poor condition. There were unacceptable surfaces and dust levels.

(92) Cleaning products and consumables should be stored on shelves in locked cupboards.
No - A number of household store rooms/cleaners' rooms were not locked and cleaning products were stored on open shelves.

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.
No - Copies of current legislation were not on file. The IS 340 standard was available.

(213) Environmental Health Officer (Senior EHO/EHO) reports on food safety inspections including the completed summary stage of compliance with HACCP and annual water analysis reports should be retained on the Hospital Food Safety Manual. Action plans/actions taken on foot of issues raised in the reports should be documented.
Yes - Environmental Health Officer correspondence was observed on file. Details of corrective actions are recorded. Copies of recent water testing were also available and satisfactory.

(214) The person in charge of catering shall develop, implement and maintain a permanent system based on the seven principles of HACCP. A standard HACCP Plan should be fully completed.
No - The current HACCP system was not reflective of the practices/procedures completed at kitchen and ward level. A full review of the HACCP system must be completed and must incorporate the seven principles of HACCP. A flow diagram, HACCP team, HACCP records and HACCP verification controls were all missing. Critical limits used for cooking and cooling were inaccurate. The Catering Manager was made aware of the issues during the assessment and assurances were provided that all relevant actions would be fully completed.

(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 copy of the Food Safety Policy, issued in 2004, was not available in the main ward kitchen. Copies were not posted and staff not formally instructed on the policy. The current policy does not refer to current legislation. The hospital manager had not signed it.

(216) Documented processes for manual washing-up should be in place.
No - This is not so. The main kitchen does not have a dishwasher and disinfection does not take place after the detergent wash. Assurances were provided of future compliance.

<u>Compliance Heading: 4. 4 .2 Facilities</u>

(217) Access to the main kitchen and ward kitchens should be restricted to designated personnel i.e. food workers.
No - Access to the main kitchen and ward kitchens was not restricted. Staff were observed entering the kitchen area without protective clothing. Ward staff were also observed collecting patients'/clients' meals without protective clothing. A policy for kitchen and ward kitchen access is required. The Catering Manager was made aware of the issues and assurances were provided that restrictions to the main kitchen and personal hygiene practices would be implemented.

(218) Authorised visitors to the food areas should wear personal protective clothing (PPE) and wash hands on entering the food area during food preparation/serving times.
No - No policy was on display to inform visitors of the correct personal hygiene policy. Also, no hand-wash sink was available at the entrance to the main kitchen. One is recommended. The Catering Manager was made aware of the issues and assurances were provided that all relevant corrective actions would be fully completed.

(220) Staff must not consume food or beverages intended for patient use, food should not be consumed in the ward kitchen and no food is to be routinely prepared in the ward kitchen other than beverages and toast.
Yes - Evidence of staff consuming beverages in the kitchen and at ward level was noted. There were coffee and tea facilities in the kitchen. The Catering Manager was made aware of these issues and assurances were provided these practices would cease and the canteen would be used in future.

(221) Staff clothing/uniforms/shoes personal belongings should not be stored in food rooms.
Yes - Staff lockers were provided for kitchen staff. However staff were observed wearing their uniform into work. No procedure was in place for the discarding of uniforms during toilet or smoke breaks.

(222) A wash hand basin should be provided at the ward kitchen, in addition to a sink, along with a liquid soap dispenser and hygienic hand drying (e.g. paper towels).
Yes - However, the hand-wash sink in the kitchen does not conform to the HBN 95 standard.

(223) Separate toilets for food workers should be provided.
Yes - A separate toilet was provided for catering staff. However, this facility was also shared by other female staff from the Central Sterile Supply Department (CSSD) and Pharmacy.

(224) The ventilation provided for all cooking and steam emitting equipment shall be sufficient to prevent condensation on walls, ceilings and overhead structures during normal operations.
Yes - Ventilation was adequate but additional cleaning is required at the fryer area as high grease build-up was noted.

(225) Staff in charge of Ward Kitchens shall ensure that product traceability is maintained while the product is in storage (Regulation (EC) 178/2002). Stock shall be rotated on a first-in/first-out basis taking into account the best-before/use-by dates as appropriate. Staff food should be stored separately and identifiable.
No - A traceability system was not in operation. A number of items were not labelled and insufficient information was recorded on the in-house labels to provide full traceability. Batch code details were not recorded on inward goods. The Catering Manager was made aware of the issues and assurances were provided that a system would be fully implemented.

(226) Containers used to store foods shall be made of food grade materials, be in good condition, easy to clean and disinfect.
Yes - Stainless steel containers were in use. The organisation should ensure that containers are inverted during storage.

Compliance Heading: 4. 4 .3 Waste Management

(231) All waste shall be removed from the operational areas frequently as necessary but at least daily.
Yes - However, a number of unnecessary items were noted in the yard/waste area. High levels of cobwebs and moth hibernation were noted at the basement back door area.

(232) Waste storage containers shall be smooth, durable, easy to clean and disinfect, well maintained and closable.
Yes - Waste containers were cleaned daily. Cleaning records are recommended.

Compliance Heading: 4. 4 .4 Pest Control

(238) Electric fly killer (EFK) units when used shall be located in an area free from draughts, away from natural light and not directly above an area where food or materials that come into contact with food are located. The EFK units shall be left on at all times and have shatter proof sleeves. The ultraviolet (uv) light tubes shall be replaced at least annually and records of replacement should be retained. The EFK shall be fitted with a catch tray and emptied as required.
No - An electric fly killer was located directly over the food preparation bench in the main kitchen. Electric fly killers were not present at the basement back door, inward goods entrance or in ward kitchens.

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

(242) Temperatures for Food in Fridges/Freezers and Displays should comply with I.S.340:2006 requirements.
No - A number of units were displaying unsatisfactory readings in the ward kitchens. High temperatures were recorded on the check sheets and no corrective action was noted. The Catering Manager was aware of the fridge temperature issues in the ward kitchen and assurances were provided by the hygiene committee that all relevant corrective actions would be fully completed.

(243) Preparation of High Risk Foods should comply with I.S. 340:2006 requirements.
No - Foods were prepared for the lunch service from 9.30am. Once the foods were cooked, they were placed in the hot trolleys and stored along the kitchen corridor until service at 11.30am. Temperatures for these items were either at or below 63 degrees Celsius. The length of time between end of cook and service was too long, resulting in a drop of temperature. It is recommended that the timing be reviewed. The Catering Manager was made aware of the issues and assurances were provided that all relevant actions would be fully completed.

(244) Temperature for food when cooked, held or reheated should comply with I.S. 340:2006 requirements.
No - The temperature of foods held in the hot trolleys ranged from 48.2 degrees Celsius to 63.5 degrees Celsius. They are serviced by the maintenance department but are not calibrated. A number of critical control point records for cooking, hot holding and reheating were not up-to-date. Hot foods are not temperature checked at ward level. The Catering Manager was made aware of the issues and assurances were provided that all relevant actions would be fully completed.

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 - As there is only one single sink in the main kitchen and the kitchen does not operate the double sink clean method, disinfection of equipment was not evident.

Disinfection/sanitisation was not completed after equipment was washed. No evidence of spray bottles with sanitiser was noted in the main kitchen. Assurances were provided that all relevant corrective actions would be fully completed.

Compliance Heading: 4. 4 .7 Food Processing

(246) The thawing of food shall be carried out under appropriate conditions such as in a thawing unit, a fridge or a microwave oven with thawing cycle.
No - High risk-foods are frozen from fresh and are thawed before use. A defined thawing procedure was not in place. Labelling of foods during freezing and defrosting is required. A thawing procedure would be developed and implemented.

Compliance Heading: 4. 4 .8 Food Cooking

(247) All foods shall be cooked to a temperature to ensure that the products are safe for consumption. The core temperature of the food shall be assessed at the thickest point of the food and should be compliant with I.S. 340:2006
Yes - Cooking temperatures are recorded after cooking. It is recommended that the cooking record indicate the name of the item cooked, original use-by date and the date and time.

Compliance Heading: 4. 4 .9 Food Cooling

(248) Cooling Times for Cooked Food should comply with I.S. 340:2006 requirements.
No - A cooling record was available; however, on the day of the assessment, a number of high-risk food items were cooked and cooled without temperature control. Assurances were provided that staff would complete Hazard Analysis and Critical Control Point (HACCP) documentation as set out in the HACCP plan.

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 - Dishwasher temperatures are recorded at ward kitchens. However, it is not possible to record the rinse cycle temperature due to the unit's design. A more suitable and accurate means of temperature recording is required. The Catering Manager agreed to investigate this.

(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 - Temperature probes are externally calibrated twice a year. Copies of certificates are held in Cork University Hospital. It is recommended that copies also be held at Mallow Hospital.

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

(141) Documented procedures for the segregation, handling, transportation and storage of waste.

Yes - The hospital would benefit from a composite waste management procedure, which outlines the trail of waste from point of generation to storage in the waste compound.

(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 - An audit trail was not available.

(152) When required by the local authority the organization must possess a discharge to drain license.
Yes - The local authority have not requested this.

Compliance Heading: 4. 5 .3 Segregation

(156) Healthcare risk waste must be segregated from healthcare non risk waste.
Yes - Recycled glass is not separated. All other items are segregated. It is recommended that this be carried out.

(162) Hazardous wastes (chemical etc) must be segregated, stored and disposed of correctly.
No - A system is required for the management of toxic chemicals and mercury thermometers, which are currently being stored within the Pharmacy Department.

(255) Within Healthcare risk waste, all special wastes including drugs & cytotoxic drugs/materials are segregated.
Yes - However, the hospital procedure for the segregation of special waste in the Pharmacy Department was not being adhered to.

(256) Mattress bags are available and are used for contaminated mattresses ready for disposal; mattresses are disinfected.
No - Mattress bags were not available.

Compliance Heading: 4. 5 .4 Transport

(163) Documented processes for the transportation of waste through the hospital which minimizes manual handling of waste (and ensures that segregation of healthcare risk waste from non-risk waste is maintained) are in place.
Yes - It is recommended that the organisation explore options to reduce the number of times clinical waste is being handled.

(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.
No - Services of the Dangerous Goods Safety Adviser are required to meet health and safety legislation.

(166) Drivers of vehicles transporting hazardous waste must be trained in accordance with the ADR Regulations.
No - No evidence of training was available. ADR driver training is also required.

Compliance Heading: 4. 5 .5 Storage

(169) Documented process(es) for the replacement of all bins and bin liners.

Yes - It is suggested that a documented procedure is included in the composite Waste Management Policy.

Compliance Heading: 4. 5 .6 Training

(259) There is a trained and designated waste officer.
Yes - A designated Waste Officer was on site and had completed some relevant training. However, the Waste Officer would benefit from further training.

(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 - Evidence of staff training was on file. Further staff training is required, in particular for waste management duties.

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 - A documented policy was in place, however, the policy must be reviewed due to the difference between practice and policy.

(174) Clean linen is stored in a designated area separate from used linen (not in sluice or bathroom).
Yes - However, clean and dirty linen was observed stored on the same table in the basement area.

(261) Clean linen store is clean, free from dust and free from inappropriate items.
No - Clean linen was stored with staff facilities in most areas.

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

(264) Bags must not be stored in corridors prior to disposal.
No - Linen was stored in green bins on the corridors

(267) Documented process for the transportation of linen.
No – No documented process was evident. The collection van used to transport both clean and dirty linen was inappropriate.

(270) Hand washing facilities should be available in the laundry room.
No - No hand-washing facility was observed at the central linen facility.

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

(188) Hand and wrist jewellery should be removed prior to performing all levels of hand hygiene with the exception of a plain wedding band.
Yes - Jewellery was noted in the Catering Department. All ward areas observed were satisfactory.

(190) All sinks should be fitted with washable splash backs with all joints completely sealed.
No – Not all joints observed were sealed.

(191) Hand washing facilities i.e. sinks, taps and splash backs must be clean and intact.
Yes - However, discs were missing on a number of screw handle taps.

(192) Taps should be hands free and should be mixer taps to allow temperature regulation.
No - However a sink replacement programme is in place.

(196) Waste bins should be hands free.
Yes - However, waste bins must be enclosed and fire resistant.

(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 - A Quality Improvement Plan is in place for the replacement of sinks.

(205) General wards should have one sink per 4-6 beds and critical areas should have one sink per 1-3 beds.
No - Multi-bedded rooms do not achieve this standard. It is recommended that this be addressed.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team		Assessor Team	
	FREQ	%	FREQ	%
A	0	00.00	1	01.79
B	7	12.50	6	10.71
C	39	69.64	46	82.14
D	0	00.00	3	05.36
E	2	03.57	0	00.00
N/A	8	14.29	0	00.00

5.2 Ratings Details

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

CM 12.2	C	C	→
CM 13.1	C	C	→
CM 13.2	C	C	→
CM 13.3	C	C	→
CM 14.1	N/A	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	C	→
SD 4.1	B	B	→
SD 4.2	C	A	↑
SD 4.3	C	B	↑
SD 4.4	B	C	↓
SD 4.5	C	B	↑
SD 4.6	B	B	→
SD 4.7	B	B	→
SD 4.8	C	C	→
SD 4.9	C	C	→
SD 5.1	C	C	→
SD 5.2	C	C	→
SD 5.3	C	C	→
SD 6.1	C	C	→
SD 6.2	C	C	→
SD 6.3	E	C	↑