Health Information and Quality Authority

An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte

Hygiene Services Assessment Scheme

Assessment Report October 2007

Mayo 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

Mayo General Hospital is a busy acute general hospital providing for the health care needs of 123,000 people in County Mayo.

Services provided
Emergency Services
24-hour Consultant led service, which sees approximately 50,000 patients/clients per year. It is newly built and has seen the introduction of a new nurse management structure, with the appointment of 7 Clinical Nurse Managers.

Care Services
Department of Anaesthetics and Intensive Care led by 7 consultants providing routine and emergency anaesthesia and the supervision of an 8-bedded Intensive Care/Coronary Care Unit.

Department of Medicine
Led by 6 General Physicians with areas of special interest in:
Gastro-Intestinal
Elderly Medicine
Cardiac Care

Department of Obstetrics & Gynaecology
Led by 4 Consultant staff delivering maternity and gynaecology services.

Department of Paediatrics
Led by 4 Consultant Paediatricians with areas of special interest in:
Neonatology
Respiratory
Community & Disability
The service incorporates a 29 bedded Paediatric Unit and a 9 bedded Special Care Baby Unit.

Department of Surgery
Led by 3 General Surgeons. The department provides general, traumatic and emergency services.

Orthopaedic Department
Led by 3 Consultant Orthopaedic Surgeons and provides an elective and trauma service.

Palliative Care Services
A Consultant led service, shared with County Roscommon. This service is managed at regional level.   Support services are provided in partnership with Mayo/Roscommon Hospice.

Adult Mental Health Service
Medical Assessment Unit – The Unit has 9 beds and sees approximately 20 patients per day (Monday – Friday).

Day Surgery Unit

This is a constantly developing service showing increases in activity on an annual basis. It delivers a range of services to Medical, Surgical, Obstetric and Gynaecological services.

Oncology Department
This is a Consultant led regional service providing day treatment facilities to accommodate up to 2000 patients with 4 stations and out-patient services.

Renal Dialysis Unit

Physical structures
There is one isolation room in the organisation.

The following assessment of Mayo General Hospital took place between 7th and 8th June 2007.

1.3 Notable Practice

- The hospital was very clean, bright and well appointed.
- The staff were very committed to ensuring that there were high standards of hygiene and they were interested in promoting the continuous improvement of the hygiene service. Such commitment was viewed as a strength and is to be commended.
- The Catering function was identified as an area of strength in the organisation as well as the cleaning of equipment in direct and indirect patient contact.

1.4 Priority Quality Improvement Plan

The priority area for improvement was identified as the lack of documentation for hygiene services. This documentation, when fully implemented at corporate and service delivery levels, ensures that the necessary structures are in place to ensure high standards of hygiene into the future. The management of the process around linen requires review and policies need to be introduced to ensure controls are in place in the local laundry used by the hospital. The Hygiene agenda was primarily the responsibility of the Infection Control Team. A more multi-disciplinary approach is required.

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 Mayo 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   (B ↓ C)
The organisation regularly assesses and updates the organisation's current and future needs for Hygiene Services.
The Hospital Management Team assume strategic responsibility for Hygiene Services. They receive information from a variety of sources including the National Hospitals Office and national legalisation, Health and Safety, Public Health, Infection Control, Environmental Health Officer, Executive Management Team, internal and national hospital hygiene audits and local contractors' audits. There was no document control process in place, which would ensure that all recommendations from each source was reviewed and implemented. It is recommended that document controls are put in place. The hospital has commenced use of the national cleaning guidelines and recommendations to influence its decision making in relation to the Hygiene Services. It was difficult to understand the process of evaluation of information received, how it was processed and disseminated at the hospital. It is recommended that clearer and comprehensive processes for information received are implemented. The Team is encouraged to conduct an evaluation of the needs assessment process.

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 used the information received from all internal and external resources to influence its decision making process. The Team has begun to adapt the recommendations of the National Hygiene Cleaning manual to reflect its processes.
The hospital reviewed its cleaning structures in line with the service and equipment requirements of the hospital. No evaluation has been carried out on its effectiveness as a result of the change. Evaluation of the Complaints Process, Suggestions Box, and the HACCP plan has been carried out; however, no reports were available on the complaints feedback mechanism or the outcome of the results of the hospital suggestion box. While the above processes are in place, there was no evidence of evaluation or resultant action. It is recommended that the organisation continue to develop the processes in place and progress the development of practices for evaluation and continuous quality improvement. The Team is encouraged to conduct an evaluation of developments and modifications to its Hygiene Services in relation to meeting the service user's needs.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1 (B → B)
The organisation links and works in partnership with the Health Services Executive, various levels of Government and associated agencies, all staff, contract staff and patients/clients with regard to hygiene services.
The hospital had robust processes in place to link all the elements in this criterion. There are external contracts for Catering, Linen, Waste and Cleaning. Limited interaction with patient representation groups was observed. However there are a range of hygiene issues that have been disseminated through the local and national media, for example the hospital has run a hygiene awareness campaign through the local media. There are strong linkages with other healthcare organisations in the catchment area and network. The Hospital has provided education on hygiene to the public health team/community nurses/elderly care hospitals and local nursing homes, which is to be commended. There are no education records available however, and no evaluation of this criterion was carried out. It is recommended that the organisation commence a process to evaluate the efficacy of its linkages and partnerships in the near future.

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.
There was no Hygiene Strategic Plan. The Management Team have primary responsibility for the strategic role in the Hospital and assume accountability for Hygiene Services. The minutes of the Management Team meetings reflect informal references to hygiene issues. It is recommended that the Hospital Management Team ensure that Hygiene is a weekly standing order on the Management agenda. It is recommended that a quality improvement plan is devised to develop a corporate strategic plan which should be communicated to all stakeholders.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.1 (B → B)
The Governing Body and its Executive Management Team have responsibility for the overall management and implementation of the Hygiene Service in line with corporate policies and procedures, current legislation, evidence based best practice and research.
The Hospital Management team has overall accountability for the management of the Hygiene Services. The Hospital Management Team receives hygiene related information from a number of sub groups in the hospital, for example the Environment Management, Risk Management and the Infection Control Teams. The Hospital subscribes to the Corporate Code of Ethics for the Health Service Executive and the National Procurement Policy. The National Hygiene Audit results are used to benchmark Hygiene Services. Internal audits have been carried out against the Infection Control Nurses Association audit tool to assess Hygiene, Waste and Hand Hygiene. Corporate Policies have been developed but have not been evaluated and updated. It is recommended that the evaluation of adherence to legislation and best practice is strengthened within the Organisation.

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.
The Hygiene Management Team receives verbal reports from the Environment Management Team as there is some cross over of membership of the two groups.
Evidence presented of minutes of the Hospital Management Team indicates that there is a formal structure in place for constant monitoring of Hygiene Services. The hospital was in receipt of all published best practice guidelines e.g. SARI, National Cleaning Manual, Dept of Health and HSE information on Hygiene Awareness. The Infection Control Department inform the Management of relevant issues in the Hospital, for example outbreaks of MRSA, Winter Vomiting and so on. The Hospital presented no evaluation of this criterion with the exception of the internal hygiene audits and the national hygiene audit results. It is recommended that evaluation processes or the information received is strengthened within the organisation.

CM 4.3   (B ↓ 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.
There is an on site library with 3 librarians. Access to the library is available for all staff; however, no specific cleaning or laundry journals were available. There are facilities in all departments for staff to access e-mails and the internet. There is a computer based 'shared drive' system for policies, procedures and protocols. However, no hygiene related policies have been included in the system to date. It is recommended that the system is updated to include all hygiene policies and procedures. The hospital staff are invited to attend relevant infection control conferences and seminars. Hospital staff also attend seminars and in-house education sessions. Records of attendance were observed and validated during the assessment. The National Cleaning Manual is available but has not been implemented as a benchmark for hygiene related issues. However, there was some merging of information from the National Cleaning Manual with the hospital procedures, for example colour coding, frequencies of cleaning and so on. It is recommended that this process is continued and an evaluation process implemented.

CM 4.4   (A ↓ C)
The organisation has a process for establishing and maintaining best practice policies, procedures and guidelines for Hygiene Services
Policies, procedures and guidelines were observed in the Organisation, however, there was no documented process for ensuring that the Organisation establish and maintain best practice policies, procedures and guidelines, and use these to improve the Hygiene Services. It is recommended that a process is established and evaluated to ensure all information is up-to-date.

CM 4.5   (B → B)
The Hygiene Services Committee is involved in the organisation's capital development planning and implementation process
The Environment Team have primary responsibility for influencing minor capital projects. To date, a flat mopping system and a colour coding system have been introduced by the Environment Management Team. These systems were evaluated prior to their implementation. Formal evaluations were not available during the assessment, however, numerous references to the introduction pathway were

observed in the minutes of the Environmental Management Team/Hygiene Committee meetings. Proposals from the Environment Management Team are considered and approved by the Hospital Minor Capital team on a weekly basis and are approved subject to resource availability. At present, there are no major capital projects in progress in the organisation.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

*Core Criterion
CM 5.1   **(A ↓ B)**
There are clear roles, authorities, responsibilities and accountabilities throughout the structure of the Hygiene Services.
The Hospital employs in-house cleaning staff and also uses external contractors for specialised areas. There are clear job descriptions for all grades of staff. Specific job descriptions are available for the Hygiene staff and hygiene supervisory staff. Management grades of staff and professional grades have specific reference to patient safety and maintaining a safe environment included in their job descriptions. This includes responsibility for hygiene. It is recommended that, as and when job descriptions are reviewed, they should include an overt reference to the responsibility for hygiene. There are clear terms of reference for the Hygiene Services Committee. It is recommended that these be further developed to include accountability and organisational structures.

*Core Criterion
CM 5.2   **(B → B)**
The organisation has a multi-disciplinary Hygiene Services Committee.
The structure for the management of the Hygiene services is through an already established pathway using the acute care accreditation framework. The overall strategic responsibility for hygiene (Committee) lies with the Hospital management team. This comprises: General Manager, Deputy General Manager, Director of Nursing, and Medical Consultants. The Hygiene Services team is aligned to the Environment Management Team and comprises a multidisciplinary cross section of management staff at the hospital. The team does not have representation from non-management grades; however, a representative from the hygiene contractors on site is included. This EMT team had 3 subgroups to include Hygiene and Audit.

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

*Core Criterion
CM 6.1   **(B → B)**
The Governing Body and/or its Executive/Management Team allocate resources for the Hygiene Service based on informed equitable decisions and in accordance with corporate and service plans.
The Management Team allocates resources in accordance with the agreed Hospital Service Plan, the Hygiene Services Plan and the funding allocated for Human Resources. Funding is also allocated under minor capital for new hygiene interventions and for new and replacement hygiene equipment. Funding is also allocated for the provision of external contracts for Hygiene, Catering, Linen and Waste. The role of the Healthcare Assistant has been established at the hospital. Waste Management has been improved and funded.

CM 6.2   **(B ↓ C)**
The Hygiene Committee is involved in the process of purchasing all equipment/products.

The Committee evaluates using audits carried out in the hospital (for example using the Infection Control Nurses Association tool and catering audits) to make decisions on the purchasing of relevant hygiene products. Weekly results are also offered by the cleaning contractors–following audits of their services. All requirements for contractor equipment go through the contractor. Informal evaluation and corrective actions were also noted. Sample Hygiene data forms were observed before completion. Hospital cleaning equipment is purchased through Materials Management. Department heads have access to routine supplies at the hospital and new products are agreed with the Hospital Manager and relevant Department Heads. The Hygiene services committee is starting to get involved in the purchasing of equipment/products, and it is recommended that this is progressed.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion
CM 7.1   **(A ↓ B)**
The organisation has a structure and related processes to identify, analyse, prioritise and eliminate or minimise risk related to the Hygiene Service

The Hospital has a Risk Management Committee, a Clinical Risk Management Committee and a Risk Manager. A structure is in place for these committees to report to the General Manager and the Hospital Management Team. The work of these committees is in its infancy, and they continue to develop and progress. Incidents reported have been audited and evaluated. The overall hospital risk reporting template is used for the reporting of hygiene incidents. The hospital has active risk assessments completed in relation to clinical issues, the management of the de-toxification of patients and slips, trips and falls. The STARS web incident reporting system has been in use since January 2007. STARS data was available during the assessment and incidents are audited. The outcomes are evaluated and resultant actions are carried out, for example in cases of needle stick injuries. An incident reporting structure is also in place. No Hospital Risk Management Strategy was observed during the assessment. The hospital plans to adopt the National Framework Document in the near future, which is recommended.

CM 7.2   **(B ↓ C)**
The organisation's Hygiene Services risk management practices are actively supported by the Governing Body and/or its Executive Management Team.

Risk management composite reports and incidents of significance are reported and minuted at the Hospital Management meetings. Insufficient evidence was presented to merit a B rating. It is recommended that an evaluation of occurrence of Hygiene Services events is conducted.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion
CM 8.1   **(A ↓ C)**
The organisation has a process for establishing contracts, managing and monitoring contractors, their professional liability and their quality improvement processes in the areas of Hygiene Services.
The Hospital had a robust contracts department, which oversees the formation and implementation of external contracts. Contract tendering processes use the template of the national procurement policy, however, no evidence of the process or continuing evaluation was observed during the assessment. It is recommended that the hospital strengthen its auditing and evaluation process for the management of the contracted services. Local laundry procedures should also be reviewed by the hospital.

PHYSICAL ENVIRONMENT, FACILITIES AND RESOURCES

CM 9.1   **(A ↓ B)**
The design and layout of the organisation's current physical environment is safe, meets all regulations and is in line with best practice.
The present hospital was built between 1990 and 2001. The Hospital is built to conform to modern building standards. Updating of some areas is required for example, hand washing sinks. Some areas in the theatre also require attention, for example walls guards, scrub sink taps, and the floor covering in the cleaning room.
There is no evidence of on-going evaluation in relation to the current building; however, on-going maintenance programmes were in place. It is recommended that an evaluation process is implemented.

*Core Criterion
CM 9.2   **(A ↓ B)**
The organisation has a process to plan and manage its environment and facilities, equipment and devices, kitchens, waste and sharps and linen.
Processes are in place to plan and manage its environment and facilities, equipment and devices, kitchens, waste and sharps and linen. Hygiene, waste, linen and catering policies are all in place and audits are carried out in all areas. Hygiene reports and issues are discussed at the multi-disciplinary team meeting, either at department level or at the Hygiene Services Committee. It is recommended that evaluation of the processes is strengthened.

CM 9.3   **(B → B)**
There is evidence that the management of the organisation's environment and facilities, equipment and devices, kitchens, waste and sharps and linen is effective and efficient.
Regular internal hygiene audits are carried out by the contractors of Hygiene Services and the Infection Control Department. The kitchens are subject to the Environmental Health Office audit process. Risk Management reports reviewed, indicate very few reported issues in relation to these areas. Policies and Procedures have been updated in some areas; however, the hospital should consider a full review of hospital policies and procedures in the future.

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.
The hospital took part in the ISQSH national patient satisfaction survey in 2004. It is intended that the hospital will re-apply to participate in this survey in 2007. Limited local patient satisfaction surveys have taken place and it is recommended that this process is progressed to evaluate patient satisfaction with Hygiene Services facilities and the environment. A complaints policy was available, which is monitored by the General Administration Department. An annual report issued based on these results. Contractors on site have carried out patient satisfaction surveys. These have been audited and evaluated; however, resultant actions were unclear. It is recommended that the evaluation process is progressed and resultant actions are developed.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1   **(A ↓ B)**
The organisation has a comprehensive process for selecting and recruiting human resources for Hygiene Services in accordance with best practice, current legislation and governmental guidelines.
Comprehensive job descriptions were available for all staff. Comprehensive recruitment procedures are in place for the hospital and the contractors. Evaluation of the recruitment process has not been carried out. It is recommended that an evaluation process is commenced.

CM 10.2   **(B ↓ 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 Hospital assigns staff according to the annual service agreement. There was some evidence that additional staff would be provided for Hygiene Services on an informal basis, based on infection control issues or workload fluctuations. However, no evidence was observed that the service was formally evaluated from a workload perspective. It is recommended that this is implemented.

CM 10.3   **(B → B)**
The organisation ensures that all Hygiene Services staff, including contract staff, have the relevant and appropriate qualifications and training.
The contractors have a robust method of staff assessment, qualification and education. The hospital provides education and training for all grades of hospital staff. Extensive documentation of education records was presented both by the Hospital and the cleaning contractor services. The Infection Control Department evaluate and maintain attendance records for each individual course following completion. No formal report has been developed from the evaluations submitted. It is recommended that this is developed in the future

CM 10.4   **(A ↓ C)**
There is evidence that the contractors manage contract staff effectively.
Policies, procedures and protocols for the management of contracted staff are in place. However no evidence was observed that formal evaluation of the services is carried out by contractors. It was noted that external linen and waste contractors have carried out audits and assessments.

*Core Criterion
CM 10.5   **(B ↓ C)**
There is evidence that the identified human resource needs for Hygiene Services are met in accordance with Hygiene Corporate and Service plans.
The organisation assigns staff in line with funded Whole Time Equivalents and agreed hospital service plans. To date, the hospital has not reviewed the services of the cleaning staff in line with the Hygiene services Plan. It is recommended that a review is carried out in the near future.

ENHANCING STAFF PERFORMANCE

*Core Criterion
CM 11.1   **(B → B)**
There is a designated orientation/induction programme for all staff which includes education regarding hygiene
An Induction and Orientation programme is available for all new hospital staff.
Records of this programme were observed during the assessment, however, no records for medical staff induction were observed. Contracted services have a template system in place for the orientation induction of their staff. This was validated by actual staff records. A full Kardex system is available for all contracted cleaning staff and indicates orientation, occupational health and training dates.

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.
This criterion was not self assessed by the organisation. The hospital has a very robust training and education programme for all staff at the hospital. The Hospital Infection Control Department was responsible for all infection control training, including hygiene related issues. Records of training, course contents, course evaluations by staff and a brief overall evaluation of the effectiveness of this training were all validated. The hygiene contractors at the hospital provided full documentation on their training and education and a number of staff records were observed and validated during the assessment. Training and education is provided both on site and off site with protected time afforded.

CM 11.3   **(C → C)**
There is evidence that education and training regarding Hygiene Services is effective.
An education and training programme is in place for all grades of staff. Additional hygiene training is provided as required by the contractors and the hospital for specific hygiene issues. The composite complaints department have only received 4 complaints in 2006/7. The risk management department have received no hygiene risk incident reports to date. It is recommended that further evaluation of the education and training programmes are carried out.

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.
No formal Health Service Executive staff performance appraisal agreement is currently in place. There are mechanisms to address performance issues through the

People Management Project under the HSE disciplinary procedure. Informal appraisal is carried out on daily basis by the department heads and hospital management. Contractors have a template for performance management and a sample template was observed during the assessment.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1   (B ↓ C)
An occupational health service is available to all staff.
There is an Occupational Health service on site. Clerical support is also provided to the service. The service is supported by the Occupational Health Physician in Galway University Hospital. The approach to Occupational Health in the organisation uses the "hub and spoke" model, that is, there is main service in Galway with limited on site service provided in Mayo. All staff questioned were very familiar with the service and reported having the opportunity to receive vaccinations and seek advice. No evidence of audits or evaluations of the department were noted. It is recommended that an evaluation of the appropriateness of the services provided by Occupational Health for staff is recommended.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.1   (B ↓ C)
The organisation has a process for collecting and providing access to quality Hygiene Services data and information that meets all legal and best practice requirements.
There was limited evidence to suggest that management receive quality hygiene services information. The evidence provided included minutes of meetings, letters of recommendation and actions taken. Little documented evidence was provided of the process of report management. It is recommended that this area is addressed in the future.

CM 13.2   (B ↓ C)
Data and information are reported by the organisation in a way that is timely, accurate, easily interpreted and based on the needs of the Hygiene Services.
Information available in the Organisation is simple and easy to understand. However hygiene information relating to Hygiene Services was limited. It is recommended that the amount of information available relating to hygiene services is increased.

CM 13.3   (C → C)
The organisation evaluates the utilisation of data collection and information reporting by the Hygiene Services team.
While some evaluation processes are in place, particularly in the area of risk management, limited evidence was submitted to support the process of data and information evaluation in the hospital. This area was outlined and communicated to the organisation as an area for improvement during the assessment.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

CM 14.1   **(B ↓ 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
Initiatives relating to Hygiene Services observed during the assessment included the flat mopping system and some sink replacement. No Quality Manager is employed, however, the Organisation is currently in the process of recruiting one. Quality is on the nursing agenda through the nurse practice development unit and the risk management unit. The Executive Management Team involvement was pro-active and evidence of hygiene expenditure was observed. Hospital management acknowledge support for the quality agenda, however, little evidence was submitted demonstrate that it was on the Hospital Management agenda. It is recommended that quality relating to hygiene services become a standing order on the senior management agenda.

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.
Evidence of evaluation and auditing was available through the infection control department and through catering and the contracted cleaning services. Evaluation of risk management and complaints are carried out. These evaluations were validated during the assessment by on site records. There is no patient representation on any committees in the hospital. It is recommended that this is reviewed.

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   **(B ↓ C)**
Best Practice guidelines are established, adopted, maintained and evaluated, by the team.
Evidence that Best Practice guidelines are in place was validated, for example relevant codes of practise for food safety, SARI guidelines, Colour Coding, and the management of Legionella. Staff also have access to library and internet facilities. However, no documented process is available for ensuring that the Organisation keeps up to date with best practice to improve the hygiene service. It is recommended that a designated person assume responsibility for this area. It was also recommended that the library have hygiene related journals available for staff use. Processes for this area, when established, must include evaluation of the efficacy of the process.

SD 1.2   **(B ↓ 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
New hygiene service interventions, such as the flat mop system and the introduction of bulk regeneration trolleys, have been assessed by the Environment management team and were trialled before their introduction. However, a robust and documented system of evaluation of any new hygiene service intervention must be introduced.

PREVENTION AND HEALTH PROMOTION

SD 2.1   **(B → B)**
The team in association with the organisation and other services providers participates in and supports health promotion activities that educate the community regarding Hygiene.
Extensive evidence was available to demonstrate linkages between the Hospital and the community. Infection control teams visit local nursing homes/district hospitals and local community groups. Local media was used to promote the national hand hygiene initiative and to inform the public in relation to outbreaks of the Winter Vomiting Virus. Volunteers work in the play area of the paediatrics ward and displayed a very good knowledge of relevant cleaning and hygiene issues. The local Environmental Health Officer is a member of the infection control team. An infection control study day was held on 12th March 2007 and delegate evaluation forms were noted. However, no

overall evaluation of the results was observed. It is recommended that a structured evaluation processes in implemented in the future.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1   **(B ↓ C)**
The Hygiene Service is provided by a multi-disciplinary team in cooperation with providers from other teams, programmes and organisations.
The main team responsible for hygiene services was called the Environment Management Team and this team reported directly to the Hospital Management Team. There was some evidence submitted to show the exact membership of this team but this evidence dated back to 2002 and some documented members were no longer connected with the Organisation. There were no documented terms of reference for the team. Evidence that the composition of both the Hygiene Committee and Hygiene Team were multidisciplinary was validated. The Committee and Team included members of the contracted staff and the local Environmental Health Authority. Patients were not yet included on teams except in the development of clinical practice in male medical and renal areas. The most recent minutes of both the Environment Management Team and the Hygiene services team dated back to March 2007. Attendance levels were low at between 5 and 7 attendees. It was recommended that a schedule of meetings be prepared in advance to facilitate greater staff participation. It is also recommended that documented processes for the team members' roles and responsibilities, along with a process for the overall evaluation of the efficacy of the team structure on an annual basis, be developed.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion
SD 4.1   **(A → A)**
The team ensures the organisation's physical environment and facilities are clean.
The hospital was bright, clean and free from clutter. External areas were maintained to a high standard.

For further information see Appendix A.

*Core Criterion
SD 4.2   **(B ↑ A)**
The team ensures the organisation's equipment, medical devices and cleaning devices are managed and clean.
On the day of assessment the organisations equipment, medical devices, and cleaning devices were clean and well managed.

For further information see Appendix A.

*Core Criterion
SD 4.3   **(B ↓ C)**
The team ensures the organisation's cleaning equipment is managed and clean.
The management of the cleaning equipment should be reviewed and strengthened in line with the requirements of this criterion.

For further information see Appendix A.

*Core Criterion
SD 4.4   (A ↓ B)
The team ensures the organisation's kitchens (including ward/department kitchens) are managed and maintained in accordance with evidence based best practice and current legislation.
Standards of cleaning in the main production kitchen and in ward kitchens were high. Very good food safety controls were observed in place. It is recommended that full responsibility for the ward kitchens be given to catering staff. Fridges in ward kitchens do not operate consistently to the required temperatures. It is recommended that dishwashers on ward kitchens be fitted with digital readouts of temperatures, and all ward kitchens be fitted with hand wash sinks.

For further information see Appendix A.

*Core Criterion
SD 4.5   (B → 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.
Whilst a robust system for waste management is in place, the hospital would benefit from having a designated waste officer /Dangerous Goods Adviser.

For further information see Appendix A.

*Core Criterion
SD 4.6   (A ↓ C)
The team ensures the Organisation's linen supply and soft furnishings are managed and maintained.
This area was reviewed with senior management at the closing meeting as an area requiring a quality improvement plan. Whilst the linen observed was clean, the documented processes around linen and the controls over the local laundry need to 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
Whilst hand hygiene is a high priority, not all hand wash sinks are meeting the required HBN95 standard. Attendance at mandatory hand hygiene training must also be improved.

For further information see Appendix A.

SD 4.8   **(B → B)**
The team ensures all reasonable steps to keep patients/clients safe from accidents, injuries or adverse events.
An incident evaluation was conducted for the years 2005 and 2006. In 2006, the number of adverse events had declined by 14%. There was a documented fire policy and a major incident plan, which were developed in 2003 with a review scheduled for 2004. No evidence was observed to demonstrate that these reviews took place and it is recommended that these procedures are reviewed as a matter of priority. The STARS reporting system has been in use since January and the quantity and quality of reporting had improved since its introduction.
There was no local risk management policy and the hospital plans to adopt the National framework in the near future. However, there was a risk management committee in place. To date, no risk assessments had been carried out on non-clinical areas. Evidence was observed of quality improvement plans in the area of risk management. The hospital employed a Risk Manger who concentrates mainly on clinical areas. It is recommended that other areas are included in the scope of the Risk Manager's responsibilities.

SD 4.9   **(C → C)**
Patients/Clients and families are encouraged to participate in improving Hygiene Services and providing a hygienic environment.
Patients were not participating in an extensive way in improving the hygiene services of the hospital. This was acknowledged by senior management and was identified as an area requiring quality improvement. Leaflets on MRSA were available in reception areas, and there was adequate signage throughout the Organisation in relation to hand hygiene. The National visitors' policy was in operation and local media campaigns were held to inform the public of this policy. Patient satisfaction surveys were not carried out, with the exception of food quality surveys. Data was noted from a patient perception survey carried out in 2004; however, no evaluation of the extensive data collated in this report has been carried out. It is recommended that a patient satisfaction survey is introduced in order to assess satisfaction with general cleanliness within the Hospital environment.

PATIENT'S/CLIENT'S RIGHTS

SD 5.1   **(B ↓ C)**
Professional and organisational guidelines regarding the rights of patients/clients and families are respected by the team.
Limited evidence was observed in relation to this criterion. During the assessment, Patient Charters were noted at ward level. Confidentiality clauses were included in job specifications and the hospital operates the National Visitors Policy.

SD 5.2   **(C → C)**
Patients/Clients, families, visitors and all users of the service are provided with relevant information regarding Hygiene Services.
Leaflets on MRSA and other healthcare issues were available at the main front entrance. Extensive signage, particularly in relation to the importance of hand hygiene, was noted throughout the Organisation. Visitors' responsibilities were also clearly posted at all wards. Whilst some patient information leaflets were in place, there was little hygiene related information included in them. It is recommended that this is reviewed. An electronic notice board was observed, however, this was not in use. This has the potential to become a useful tool in promoting a hygiene message to patients, staff and visitors and it is recommended that its use is reviewed. The Organisation is encouraged to evaluate patient/client family and visitor's

comprehension of, and satisfaction with, the information provided by the Hygiene Service Team.

SD 5.3   (C → C)
Patient/Client complaints in relation to Hygiene Services are managed in line with organisational policy.
Complaints are processed in accordance with the National Complaints Policy. There were 4 complaints for 2006 and 2007 to date which related to some aspect of the hygiene service. Detailed documentation was on file for each of these complaints demonstrating the investigations undertaken and the feedback to the complainant. The documented policy for this area currently dates to 2002 with a review date planned for 2004! It is recommended that the policy is reviewed in the near future. It is also recommended that an evaluation process is implemented in the near future.

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1   (C → C)
Patients/Clients, families and other external partners are involved by the Hygiene Services team when evaluating its service.
This area was identified by the management as an area requiring a quality improvement plan. No evidence of patient satisfaction surveys was observed, with the exception of the standard of catering provided. The results of this survey were positive and it is recommended that the involvement of patient/clients, families and other external partners in evaluation of the service is expanded and developed.

SD 6.2   (B ↓ 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.
The Catering Service is certified by the Hygiene Mark, which is to be commended. Assessments using the mandatory compliance tool have been carried out and records were observed. However, it is recommended that more detailed audits are carried out which would cover all aspects of the Hygiene Service Assessment Scheme. It is also recommended that staff who conduct assessments receive appropriate training. There was no evidence of Key Performance Indicators monitoring in place. It is recommended that this area is addressed in the future.

SD 6.3   (C → C)
The multi-disciplinary team, in consultation with patients/clients, families, staff and service users, produce an Annual Report.
There was no Hygiene Services Annual Report in place. In the absence of an Annual Report appropriate resources cannot be identified and allocated. It is recommended that this is reviewed and processes are put into place to produce an annual report for Hygiene Services.

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 - However, some light dust found was in clinical areas.

(2) All high and low surfaces are free from dust, cobwebs and flaking paint.
Yes - However, some light dust found was in clinical areas.

(3) Wall and floor tiles and paint should be in a good state of repair.
Yes - The cleaners' room in the operating theatre had a cement floor which required a washable floor covering. A washable floor surface is also recommended in dining areas.

(4) Floors including edges, corners, under and behind beds are free of dust and grit.
Yes - However, several stains were observed on the carpet in dining room.

(5) Cleanable, well-maintained furniture, fixtures and fittings used.
No - Fabric chairs and sofas in were observed in many areas of the hospital. This is not recommended.

(7) Areas should be adequately ventilated with ventilation units cleaned and serviced accordingly and documentation available regarding service.
Yes - Extensive compliance was noted in this area.

(8) All entrances and exits and component parts should be clean and well maintained.
No - The front hall floor was badly stained in a poor state of repair. Litter and cigarette butts were also noted at the front entrance.

(10) Internal and external signage should be clean, updated, well maintained and laminated to enable cleaning.
No - Signage observed was soiled and not laminated.

(12) Internal and external stairs, steps and lifts must be clean and well-maintained.
Yes - However, the ceiling in the Accident and Emergency lift was stuffed with papers. It is recommended that this is addressed immediately.

(14) Waste bins should be clean, in good repair and covered.
Yes - Extensive compliance was noted in this area.

(27) Local policies should be in place for guidance on all cleaning processes, colour coding, use of equipment, use of protective clothing and fluids and spillages.
Yes - Policies were in place. The organisation should ensure that there is a process for reviewing these policies and keeping them up to date.

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

(19) Ceilings.
No - Broken and cracked ceiling tiles were observed in many areas.

(21) Internal and External Glass.
No - Window glass observed was dirty in many areas, particularly on the front door and in corridors.

(25) Floors (including hard, soft and carpets).
Yes - However, a dirty carpet was observed in the bereavement room and in the dining hall.

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

(31) Furniture and fittings: Furniture and fittings in direct patient care environment must be clean and dust free i.e. cleaned on a daily basis. Horizontal surfaces (high and low) around the patient i.e. ledges, worktops, window ledges, flat surface suction apparatus, bed table, locker, curtain rail and chairs.
Yes - However, some light dust was noted in some areas.

(208) There should be a process for the cleaning of curtains and blinds. Curtains should be changed after each known case of infected patient/client where required. Records should be maintained of curtain changing.
Yes - A very robust process in place. This is to be commended.

(209) Air vents are clean and free from debris.
Yes - However, the paediatric ceiling vent was dirty.

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

(33) Chairs.
No - Fabric chairs were observed in all areas. These are not conducive to effective cleaning.

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 - Extensive compliance was noted in this area.

(47) Bathrooms/Washrooms are clean and communal items are stored e.g. talc or creams.
No - Patient's personal items were noted in bathrooms.

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

(55) Sluices.
Yes - Sluices observed were clean.

(57) Clear method statements/policies should be in place for guidance on all cleaning including sanitary cleaning and maintenance processes.
No - No maintenance processes were documented

(58) Sluice rooms should be free from clutter and hand washing facilities should be available.
Yes - Some exceptions were noted but adequate compliance against this requirement was observed.

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

(65) Commodes, weighing scales, manual handling equipment.
No - At the time of the assessment, the standard of cleaning of the commodes and manual handling equipment could have been higher.

(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 - Compliance was observed in this area.

(68) Patient fans which are not recommended in clinical areas.
Yes - Fan were noted in the Accident and Emergency for clerical use.

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

(72) Trolleys, e.g. chart trolleys, drug trolleys, linen trolleys, shop trolleys, emergency trolleys, suction apparatus, resuscitation equipment i.e. ambubag and mask.
Yes - Some trolleys are in poor structural repair, however, they were clean. Flaking paint was noted on ward kitchen trolleys.

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

(80) All office equipment (e.g. telephones, computers, fax machines) should be clean and well-maintained.
No - Office equipment in many areas was dusty.

(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 - However, some areas do not have splash backs.

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

(81) All cleaning equipment should be cleaned daily.
No - A weekly cleaning scheduled is in place. It is recommended that this is reviewed.

(82) Vacuum filters must be changed frequently in accordance with manufacturer's recommendations - evidence available of this.
No - No system is currently in place for changing of vacuum filters in accordance with recommendations.

(83) Mop heads are laundered daily and are stored according to local policy or are disposable i.e. single use.
Yes - A single use flat mop system is in place.

(85) Cleaning solutions should only be prepared in a well ventilated area and should never be mixed.
No - The cleaners' rooms have no ventilation. It is recommended that this is reviewed.

(87) All cleaning equipment should be approved by the Hygiene Services Committee and ensure sufficient supply.
Yes - It was stated verbally that this occurs, however, no documented approval process is in place.

(89) Equipment with water reservoirs should be stored empty and dry.
Yes - However, the cleaning trolley at main entrance was unattended and had water in the reservoir.

(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 - No ventilation or hand wash facilities were provided in many cleaning rooms.

(91) Storage facilities for Cleaning Equipment should be clean and well maintained.
Yes - However, these areas are very small in structure.

(92) Cleaning products and consumables should be stored in shelves in locked cupboards.
No - These were observed stored on open shelves in unlocked rooms. It is recommended that this is reviewed immediately.

(94) Health and Safety policies should be in place for the use of ladders/steps when cleaning.
No - No policies were noted for this requirement.

(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 - N/A All equipment is under 5 years old and the hospital is a new building.

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

(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.
No - No recent evidence was presented for water potability checks.

(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.
Yes - However, the HACCP Plan needs to include the full cook-chill system. Transportation and checking of temperatures in ward kitchens is currently not included.

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.
No - Non food workers have access to ward kitchens. It is recommended that this is reviewed.

(222) A wash hand basin should be provided at the ward kitchen, in addition to a sink, along with a liquid soap dispenser and hygienic hand drying (e.g. paper towels).
No - Three ward kitchens do not have hand wash sinks. It is recommended that this is addressed.

(223) Separate toilets for food workers should be provided.
Yes - Separate toilets are provided for food workers

Compliance Heading: 4. 4 .3 Waste Management

(232) Waste storage containers shall be smooth, durable, easy to clean and disinfect, well maintained and closable.
No - The waste skip is in poor condition.

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 - No record of bulb changes were available.

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
Yes - However, some out of specification temperatures were noted for some ward kitchen fridges.

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.
No - No readouts were observed on dishwashers in ward kitchens.

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

(142) Healthcare risk waste should be tagged and secured before leaving the area of production.
Yes - All healthcare risk waste is tagged and secured.

(146) A tracking system should be in place to trace all hazardous waste from generation to disposal and therefore an audit trail is available to trace waste to final disposal.
Yes - This was conducted in 2006.

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

(152) When required by the local authority the organization must possess a discharge to drain license.
Yes - Mayo County Council do not require this.

Compliance Heading: 4. 5 .3 Segregation

(158) Needles and syringes should be discarded as one unit and never re-sheathed, bent or broken.
Yes - Compliance was observed in this area.

(160) Suction waste must be disposed of in a manner which prevents spillage e.g. canisters / liners are disposed of into rigid leak-proof containers or suction waste is solidified with a gelling agent.
Yes - Compliance was observed in this area.

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

Compliance Heading: 4. 5 .4 Transport

(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 - The services of the DGSA come from Galway.

(166) Drivers of vehicles transporting hazardous waste must be trained in accordance with the ADR Regulations.
No - No evidence was submitted for this criterion.

Compliance Heading: 4. 5 .5 Storage

(169) Documented process(es) for the replacement of all bins and bin liners.
No - No evidence was submitted for this criterion.

Compliance Heading: 4. 5 .6 Training

(259) There is a trained and designated waste officer.
No - No Waste officer is employed on site.

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

(172) Documented processes for the management, maintenance and safe handling of linen and soft furnishings throughout the organisation.
No - A documented process was observed, however, it was due for revision in 2004.

(173) Documented processes for the use of in-house and local laundry facilities.
No - No documented processes for the use of local laundry facilities used by the hospital were observed.

(261) Clean linen store is clean, free from dust and free from inappropriate items.
No - Some extraneous items were noted.

(267) Documented process for the transportation of linen.
No - No documented process for the transportation of linen was observed.

(268) Ward based washing machines are used only with the agreement of the Hygiene Services Committee.
No - No evidence of an agreement was presented during the assessment.

(269) A washing machine if used is situated in an appropriate designated area and a clear policy/written guidance is in place regarding its use e.g. water temperature etc.
No - No written policy was observed.

(271) Hand washing facilities should be available in the laundry room.
No - Hand washing facilities were not available in the laundry room. The hand wash facilities in the toilet are being used.

(270) If a washing machine is in use, a tumble drier is also in place which is externally exhausted. Documented processes for planned preventative maintenance of this equipment should be in place.
No - The tumble drier was not externally exhausted and no maintenance policy was noted.

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.
Yes - Compliance was observed in this area.

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

(192) Taps should be hands free and should be mixer taps to allow temperature regulation.
No - Not all taps are hands free. The scrub taps in the theatre need attention. Some rust and corrosion was also noted.

(196) Waste bins should be hands free.
Yes - Compliance was observed in this area.

(197) Wall mounted/Pump dispenser hand cream is available for use.
Yes - Wall mounted/pump dispenser hand creams were present. However, their quantity and visibility in the organisation should be reviewed to ensure use.

(202) For surgical hand hygiene, an antiseptic scrub or an alcohol based hand rub (60-70%) should be used.
Yes - However, it should be noted that extensive and overuse of Hibiscrub at hand wash sinks was observed in many hospital departments and wards.

(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 hand wash sink replacement. Currently, not all sinks meet the required standards.

(205) General wards should have one sink per 4-6 beds and critical areas should have one sink per 1-3 beds.
Yes - Compliance was observed in this area.

(206) Documented records of mandatory attendance at hand hygiene education and practice is required for all staff members involved in clinical areas. This may be undertaken during hospital induction programme followed by annual updates.
No - Education sessions do take place on a regular basis and records are available, however, this training is not mandatory.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team		Assessor Team	
	FREQ	%	FREQ	%
A	11	19.64	2	03.57
B	31	55.36	19	33.93
C	13	23.21	35	62.50
D	0	00.00	0	00.00
E	0	00.00	0	00.00
N/A	1	01.79	0	00.00

5.2 Ratings Details

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

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