Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Hygiene Services Assessment Scheme

Assessment Report October 2007

Mid Western Regional Hospital, Ennis

Table of Contents

1.0 Executive Summary

1.1 Introduction

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

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

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

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

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

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

1.1.1 Standards Overview

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

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

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

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

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

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

Core Criteria:

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

In the Corporate Management standards, the core criteria cover:

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

In the Service Delivery standards, core criteria cover:

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

1.1.2 Rating Scale

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

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

A Compliant - Exceptional

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

B Compliant - Extensive

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

C Compliant - Broad

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

D Minor Compliance

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

E No Compliance

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

N/A Not Applicable

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

1.1.3 Assessment process components

The assessment process involves four distinct components:

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

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

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

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

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

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

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

The Internal Review Committee of the HIQA reviewed all the reports to ensure consistency, and based on the quantifiable translation guidelines, awards were made. Only organisation's which received a "very good" score

were acknowledged with an award for the duration of one year. By the end of October 2007 all 51 acute care hospitals had received a copy of their individual report.

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

- **Continuous Improvement**

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

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

[1] Boot, M and Cairncross, S "Actions Speak" Delft, The Netherlands, IRC and LSTHM, British Occupational Hygiene Society.
[2] New York Department of Health and Mental Hygiene
[3] The Columbia Electronic Encyclopaedia, Sixth Edition. Columbia University Press. 2003
[4] Irish Acute Hospitals Cleaning Manual, HSE (2006)
[5] Hygiene Services Assessment Scheme. Irish Health Services Accreditation Board (2006)

1.2 Organisational Profile

The Mid Western Regional Hospital Ennis is an 88 bedded in-patient acute general hospital. It has a 6 bedded Day Care Unit.

The hospital was built in 1946, along with the "Nurses Home Building" and the Out-Patient Department.

During the 1990's the advancement of technology resulted in the Nurses Home Building being modified and this now contains the Hospital Library, Out-Patient Clinic Rooms and Administration Office for some of the Clinical Nurse Specialists, amongst others.

The Acute Psychiatric Unit was added to the main hospital building in 2003 but remains an independently managed unit with a separate entrance and reception.

Services provided

The Mid Western Regional Hospital Ennis provides the following services:

Clinical

- Accident and Emergency (24 hours)
- Male and Female Medical Wards (2)
- Surgical Ward (M & F) – separate areas
- Elderly Acute Care Unit
- Day Ward, Theatre & ICU
- Palliative Care Service
- Heart Failure
- Respiratory

Diagnostic

- Physiotherapy (in-patient and out-patient)
- Radiology Department (in-patient and out-patient)
- Laboratory
- CNS
- ECHO/ECG
- Cardiac Rehabilitation
- Out-Patient Department
- Out reach OPD clinics (rural)

Physical structures

There are no isolation or negative pressure units which comply with SARI guidelines. These are incorporated in the design plans of the new hospital development project. Currently isolation facilities are provided by the use of the single rooms (8) in the hospital. These rooms are provided with a patient wash hand basin. Alcohol hand rubs are available.

The following assessment of the Mid Western Regional Hospital, Ennis took place between 30th and 31st July 2007.

1.3 Notable Practice

- The organisation's commitment to and pride in the hospital is commended.
- There was strong leadership within the Catering and Waste Departments.
- Adherence to hand hygiene and uniform policy is commended.
- The hospital's commitment to upgrading facilities, including the replacement of the hand wash sink is commended despite the fact that services are provided in a 1940's building.
- The risk management system in place was robust and included communication between the Regional Risk Management Committee, Regional Hygiene Committee and staff.

1.4 Priority Quality Improvement Plan

- It is recommended that educational needs requirements for all hygiene staff be defined and that a formalised structure to facilitate the delivery of a corporate induction and on-going hygiene education programmes be defined.
- It is recommended that the organisation progress the workload review of clinical hygiene staff and the segregation of the catering and cleaning services in all clinical areas.
- It is recommended that the organisation establish formal staff satisfaction surveys for the hygiene and occupational health services.
- It is recommended that the organisation establish formal processes for the evaluation of hygiene staff performance.

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 Mid Western Regional Hospital, Ennis 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.

A comprehensive approach was used to assess and update current and future needs for the hygiene service. It was evident that information obtained was used in the development of the Regional Hygiene Corporate Plan and was reflected in the Organisation Service Plan. Quality improvement activities to-date included a plan for hospital upgrade, refurbishment of ward kitchen and replacement of worn equipment and furnishing. It is suggested that these are expedited and a more formal approach is adopted towards evaluation of future 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.

It was evident that the organisation linked and worked in partnership with the Health Service Executive through regular communication in respect of Capital Development projects. Hospital management are part of the Regional Corporate Hygiene Committee. There was also evidence of external linkages with other bodies, including the Environmental Health Department and the Infection Control Nurses Association.

Strong internal hygiene linkages were demonstrated through the representation of the Hygiene service Committee on other committees such as the Infection Control Committee and through minutes of nurse management meetings. Patients/clients provided feedback on the hygiene service informally and through formal satisfaction surveys.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 (B → B)

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

The Regional Hygiene Corporate Strategic Plan 2007-2009 was developed by a multi-disciplinary team, with representatives from all hospitals within the network and included in the future needs for the hospital. The plans, goals and objectives were clear. The organisation is encouraged to involve patients/clients and families in future corporate/service plan developments.

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.

Overall responsibility for the hygiene service lies with the General Manager, in line with corporate polices and procedures. Ethics were reflected in the Regional Procurement Policy. The organisation adheres to legalisation and relevant national best practice guidelines such as Hazard Analysis and Critical Control Point (HACCP) and waste management guidelines. Compliance to HACCP and the dress code policy is to be commended.

CM 4.2 (B ↓ C)

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

Hygiene performance was measured informally through reviews of hygiene audit results and incident reports at the relevant committee meetings.

The organisation is recommended to develop formal Hygiene Performance Indicators (HPI's) and to evaluate the efficacy to information recieved at both the Hygiene Corporate and Services Committees.

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.

It was evident that best practice information and progress on quality initiatives were communicated to staff through education sessions and attendance records at hand hygiene updates and food hygiene training. Information was also communicated informally through the nursing management structure.

It is recommended that the relevance of hygiene-related best practice information available to the hygiene team/committee be evaluated.

CM 4.4 **(B ↓ C)**

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

Hygiene-related policies/guidelines were comprehensive and included Risk Management, Occupational Health, and Infection Control areas such as hand hygiene, window cleaning policy, equipment cleaning policy, colour coding police, policy on cleaning frequencies, HACCP manual, linen and waste policies.

It is recommended that the Regional Policy process/template be applied to all hygiene-related polices and all hygiene cleaning policies be incorporated into one overall comprehensive cleaning policy. The organisation is also recommended to evaluate the efficacy of the process for developing and maintaining hygiene service Policies, Procedures and Guidelines.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

*Core Criterion

CM 5.1 **(B → B)**

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

There was evidence of clear roles and responsibilities for the hygiene service throughout the organisation and upwards to the Regional Hygiene Corporate Committee. It was clear from job descriptions reviewed that department mangers were responsible for hygiene in the areas and reported back into the Hygiene Service Committee via their direct line manager, who was a member of the Hygiene Service Committee.

*Core Criterion

CM 5.2 **(A → A)**

The organisation has a multi-disciplinary Hygiene Services Committee.

A comprehensive multi-disciplinary committee was in place and was representative of all departments. Its terms of reference were clear and concise. It was evident from minutes viewed that the committee met regularly, at a minimum, monthly. It was determined that secretarial support was made available. Hygiene issues discussed at committee level included audit results, Environmental Health Officer (EHO) reports and progress on refurbishment, to ensure corrective action be taken.

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

*Core Criterion

CM 6.1 **(B ↓ C)**

The Governing Body and/or its Executive/Management Team allocate resources for the Hygiene Service based on informed equitable decisions and in accordance with corporate and service plans.

There was evidence that capital and minor capital funding was defined. Additional funding was made available on the basis of hygiene need assessment, for example, kitchen refurbishment, equipment replacement and introduction of colour-coding. It is recommended that the organisation develop a systematic approach to allocation of funding.

CM 6.2 (C ↑ B)

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

There was a clear process for the involvement of the committee in this area. The Infection Control Nurse was involved in the review and approval of hygiene-related equipment/products. It was evident the regional procurement and evaluation processes, which are in line with National Procurement Policy, were used during the purchase of the new flat mop system and were discussed and approved for purchase by the Hygiene Service Committee.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

CM 7.1 (B → B)

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

A robust risk management system was in place, including a link risk management person, as was a process for the identification and analysis of risks on a monthly basis. Risk assessments had been performed in areas such as waste, ward kitchens and hand hygiene facilities, with resultant actions implemented. An example would be the replacement of hand-wash sinks. Hazard Analysis and Critical Control Point (HACCP) systems were well defined and evaluated by the Environmental Health Officer.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion

CM 8.1 (B ↓ C)

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

A regional tendering process was in place, in line with national policy and legislation. At an organisational level there was no cleaning or catering contracted staff in place. The clinical risk waste contract was regionally based and managed by the HSE. The local food waste collector contract had been submitted for tendering and was not available for viewing. It is recommended that monitoring of both local service contracts and the effectiveness of all contracted services be formalised.

PHYSICAL ENVIORNMENT, 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.

There were elements that required repair and upgrading. These included deficits in storage facilities. Health and safety, risk management and infection control reports have highlighted environmental deficits in the current building and action has been taken to rectify problems. It is recommended that a Space Utilisation Committee be set up to review present storage arrangements and to identify solutions to current storage problems.

*Core Criterion

CM 9.2 (B → B)

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

Evidence of this included: current food safety policies/HACCP plans, linen, current sharps, hand hygiene and waste policies. Cleaning specifications/policies were available, a procurement policy is used and a Legionnaire's Control Policy is in place, all of which are in line with best practice legalisation, regulations and guidelines.

CM 9.4 (B ↓ C)

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

A national patient/client satisfaction survey was performed during 2006 and a comment cards/complaints system was used to obtain feedback on the hygiene service. It is recommended that formal processes for regular evaluation of patient/client, staff, provider, visitor and community satisfaction with the hospital's facilities and environment be developed.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 (B → 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.

All recruitment is processed through the Human Resource Department in the HSE Mid West region. Job descriptions were in line with the recruitment policy and they outlined roles and responsibilities in relation to the hygiene service. There was evidence of external evaluation of the process.

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.

It is recommended that the review of hygiene staff workload, segregation of ward catering and cleaning service be progressed with a view to providing a single role hygiene service operative.

CM 10.4 (B ↓ C)

There is evidence that the contractors manage contract staff effectively.

This was demonstrated through the production of timely reports in areas such as pest control, bait trap and waste disposal reports. There was evidence that contractors complied with the policy for on-site infection control training in areas such as dust control and hand hygiene. The organisation is encouraged to formalise the reporting mechanism for all the contracted services and to evaluate the appropriateness of the use of contracted staff.

*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.

It was determined that a needs assessment is performed when a vacancy occurs and justification for filling the post is documented and processed by the HSE Human Resource Department.

Day to day HR needs are determined through a daily review of hygiene service rosters to ensure staff are appropriately allocated.

The organisation is encouraged to develop a human resource needs assessment and incorporate findings into the Hygiene Corporate and Service Plan.

ENHANCING STAFF PERFORMANCE

*Core Criterion

CM 11.1 (B ↓ C)

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

An informal induction programme is in place for all staff including non-consultant doctors. It covers all areas of risk including sharps management, waste segregation, basic cleaning and hand hygiene. A handbook was provided to all new staff, which included information on health and safety and infection control. The organisation is recommended to formalise the induction programme and to centralise the collection of induction training records.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (A ↓ B)

An occupational health service is available to all staff.

A comprehensive occupation health service was established at regional level, which provides a twice-weekly satellite service. A broad range of services is provided including comprehensive immunisation and counselling services and an injury follow up and referral programme. Out of hours services are provided by the Accident and Emergency Department, which has direct links with the Regional Occupational Health Department. It is recommended that the organisation develop systems to evaluate the appropriateness of the occupational services.

CM 12.2 (A ↓ C)

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

The Occupation Health Service monitors staff well-being through the provision of follow up on absenteeism, needle stick injury rate and stress levels.

The organisation is encouraged to develop mechanisms for monitoring satisfaction with the service.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.3 (B ↓ C)

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

It was determined that the regional Hygiene Service Committee were in discussions were the regional Patient/Client Advocacy Group in relation to the nomination of a patient/client representative to sit on local hygiene committees and were awaiting a reply. It is recommended that the involvement with patient/clients and the public in the promotion of a quality hygiene culture be progressed.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

CM 14.1 (A ↓ B)

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

It was determined that the regional Hygiene Service Committee were in discussions with the regional Patient/Client Advocacy Group in relation to the nomination of a patient/client representative to sit on local hygiene committees and were awaiting a reply. It is recommended that the involvement with patients/clients and the public in the promotion of a quality hygiene culture be progressed.

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 → B)

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

Best practice guidelines have been established, adopted, maintained and evaluated by the team in areas such as catering, risk management, health and safety and hygiene-related policies. There were systems and policies in place for colour coding, infection control, sharps, and waste and a decontamination policy for the cleaning of patient/client equipment. The Household Services Manager assumes responsibility for review of the manuals. There was evidence of the evaluation of the efficacy of the needs assessment process, for example the Environmental Health Officer report, and a review and upgrade of kitchens and transport trolleys.

PREVENTION AND HEALTH PROMOTION

SD 2.1 (A ↓ 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.

The hospital is a member of the Heath Promoting Hospitals Network. Infection Control Specialists provide on-going training. Hand hygiene notices were observed on staff and patient/client notice boards. Hand gels are available. Information leaflets are available, patient/client meal times are protected and visiting times are currently under review. There was evidence of the evaluation of the efficacy of the needs assessment process for example patient/client questionnaire, a review of comment cards with actions plans, an evaluation of Healthy Living Expo, and health promotion development for patients/clients, relatives and community.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1 (B → B)

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

A multi–disciplinary team, with clearly defined roles and responsibilities, is in place. All disciplines were represented, as was evident by attendance, minutes and action plans of regular meetings. The Organisational Structure Charts outline the reporting relationships and responsibility. There was evidence of the efficacy of the multi-disciplinary team structure in audits from the Environmental Health Officer, Infection

Control and Health and Safety. The Hygiene Service Team meet with department heads and minutes of meetings are available. It is recommended that the organisation consider including a service user representative on the team.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion
SD 4.1 (A ↓ B)
The team ensures the organisation's physical environment and facilities are clean.
Evidence of this was provided by staff education records, job descriptions, hygiene manuals, hospital policies and procedures, a sharps policy and infection control manuals. Some areas require further attention. Sinks need to be upgraded and provided in sluice areas. The cleaning of toilets needs to be looked at.

For further information see Appendix A.

*Core Criterion
SD 4.2 (A → A)
The team ensures the organisation's equipment, medical devices and cleaning devices are managed and clean.
The cleaning of the equipment is carried out in line with the National Cleaning Manual. Informal audits take place on a daily basis. It is recommended that the organisation formalise a weekly multi-disciplinary audit, with designated staff responsible for the development of action plans.

For further information see Appendix A.

*Core Criterion
SD 4.3 (A ↓ B)
The team ensures the organisation's cleaning equipment is managed and clean.
A flat mop system is in place, however, no designated storage area is identified for cleaning equipment.

For further information see Appendix A.

*Core Criterion
SD 4.4 (A → A)
The team ensures the organisation's kitchens (including ward/department kitchens) are managed and maintained in accordance with evidence based best practice and current legislation.
This is done in accordance with evidence-based best practice and current legislation. Hazard Analysis and Critical Control Point (HACCP), Environmental, Risk Management and Infection Control reports were available. All staff receive appropriate training. No separate hand sink facility or hand gel is available in ward kitchens. It is recommended that there be segregation of cleaning and catering functions at ward level.

For further information see Appendix A.

*Core Criterion

SD 4.5 (A → A)

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

Waste was managed in accordance with evidence-based codes of best practice and current legislation. It is recommended that the waste transport container have side access to facilitate the transfer of waste to the wheelie bins.

For further information see Appendix A.

*Core Criterion

SD 4.6 (A ↓ C)

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

Linen bags were observed, which were not tied off and secured when two-thirds full and soiled linen was spilling from the bags, however, these issues were addressed during the assessment.

For further information see Appendix A.

*Core Criterion

SD 4.7 (A ↓ B)

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

Hand hygiene was managed effectively and in accordance with SARI guidelines. Staff are provided with training by the Infection Control Specialist, as part of the informal induction programme. Regular refresher programmes and audits at local level are carried out. On-going upgrading of hand-wash facilities was noted.

For further information see Appendix A.

SD 4.9 (B → B)

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

This is done. A Healthy Living Expo Survey was performed in 2006. A comment box was observed in clinical areas. Infection control information leaflets are given to patient/clients on admission and are available hospital wide.

The Patient/Client Charter was noted in prominent places. The visiting times policy is currently under review. It is recommended that the process for evaluating patient/client satisfaction be developed and strengthened.

PATIENT'S/CLIENT'S RIGHTS

SD 5.1 (A ↓ B)

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

A confidentiality clause is included in staff contacts. The staff handbook provides information on Professional Codes of Practice and Conduct. Staff adhere to principles of the Patient/Client Charter. Evidence was observed of a robust complaints policy. If required, single rooms were available. A Patient/Client Satisfaction Survey was performed in 2006. It is recommended that a process of evaluation be developed.

SD 5.2 (B → B)

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

Patient/Clients, families, visitors and all users of the service are provided with relevant information regarding hygiene service. Information leaflets are given on admission. Information posters regarding hygiene issues such as hand washing were observed on notice boards. A Healthy Living survey is also carried out. It is recommended that the process for evaluating patient/client satisfaction with the service be developed and strengthened.

SD 5.3 (B → B)

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

There was a robust system for managing patient/client complaints.
Comments boxes were available in clinical areas. (Your Service – Your Say) and positive comments are retained in a central location.
Issues relating to hygiene are communicated to Hygiene Service Team. There was evidence that complaints were evaluated and staff designated for follow up.

ASSESSING AND IMPROVING PERFORMANCE

SD 6.2 (A ↓ B)

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

The Hygiene Service Team monitors and improves the quality of services through regular audits and action plans, with designated staff assuming responsibility for follow through. On-going training for staff in areas such as Hazard Analysis and Critical Control Point (HACCP), infection control, waste and management of linen services, is provided. The Infection Control Specialist is a member of the Irish Association of Infection Control Specialists. There was evidence of Environmental Health Officer (EHO) and departmental audits led by infection control specialists in areas such as the upgrade of kitchens, hand wash sinks and transport trolleys. It is recommended that regular audits take place across all aspects of hygiene service with action plans implemented.

SD 6.3 (B → B)

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

An annual hygiene report was produced for 2006. Information collected is used to develop the report which is available throughout the organisation.

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

(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 - However, some of policies require updating.

(2) All high and low surfaces are free from dust, cobwebs and flaking paint.
Yes - Some dust observed on presses in HSSU and behind some doors. Flaking paint observed in Day Ward.

(3) Wall and floor tiles and paint should be in a good state of repair.
Yes - However there were wooden floors in Care of Elderly, Day Ward and Female Surgery all of which were worn. Resealing, or replacement with washable surface is recommended.

(7) Areas should be adequately ventilated with ventilation units cleaned and serviced accordingly and documentation available regarding service.
Yes - However internal grid on extractor vent in HSSU was missing and replacement recommended.

(8) All entrances and exits and component parts should be clean and well maintained.
Yes - However cobwebs were observed in some areas.

(12) Internal and external stairs, steps and lifts must be clean and well-maintained.
Yes - However grids in lifts required additional cleaning.

(13) External areas including grounds, gardens, footpaths, ramps and car parks should be clean and well-maintained.
Yes - However glass panel at entrance ramp soiled.

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

(21) Internal and External Glass.
Yes - However some internal glass needs attention in Care of the Elderly and the office at bottom of main stairs.

(22) Mirrors.
No - Splashes observed on most mirrors.

(23) Radiators and Heaters.
Yes - Cobwebs were present behind radiators on most corridors.

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

(30) Fixtures: Fixtures (i.e. a piece of equipment or furniture which is fixed in position) should be clean. This includes all electrical fixtures e.g. all light fittings and pest control devices.
Yes - However sticky residue on overhead lamp in female surgical ward and adhesive tape on wardrobe in same area.

(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 window ledges in Female and Male Medical Wards were dusty. Storage of some items on window ledges could be prohibited, which would allow a high standard of cleaning. Storage facilities were poor. Between the backs and seats of armchairs in Care of the Elderly and under the cushions of two of the pink armchairs were dusty.

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

(36) Lockers, Wardrobes and Drawers.
Yes - However lockers in Care of the Elderly had worn surfaces, exposing the plywood. It is recommended that these be replaced.

(37) Tables and Bed-Tables.
Yes - However a table with a worn surface was observed beside the staff changing area.

(38) Dispensers (e.g. handwash dispensers), Holders and Brackets.
Yes - It was difficult to distinguish between hand-wash and hand-cream dispensers in the organisation.

(40) Curtains and Blinds.
Yes - However some vertical blinds were in poor repair.

Compliance Heading: 4. 1 .5 Sanitary Accommodation

(44) Hand hygiene facilities are available including soap and paper towels.
No - There was a replacement plan to upgrade all sinks.

(46) Bathrooms/Washrooms must be cleaned on a daily basis. When necessary, they must be disinfected. This must be monitored and recorded.
No - No record of monitoring was available.

(48) Floors including edges and corners are free of dust and grit.
No - Cobwebs were observed behind some doors.

(50) The toilet, sink, handrails and surrounding area is clean and free from extraneous items.
No - Toilets not cleaned, and the under surfaces of hand-wash sinks required cleaning. This was addressed during the assessment.

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

(51) Baths and Showers.
Yes - However shower grids in Cardiac Rehab are not being lifted for cleaning.

(52) Toilets and Urinals.
No - Toilets not cleaned, however, this was addressed during the assessment.

(53) Bidets and Slop Hoppers.
No - No dedicated Slop Hoppers for cleaning.

(54) Wash-Hand Basins.
No - The under surfaces of hand-wash sinks required cleaning, however, this was addressed during the assessment.

(55) Sluices.
Yes - Sluices were clean, however, they were used for storing cleaning equipment and were cluttered.

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

(58) Sluice rooms should be free from clutter and hand washing facilities should be available.
No - Clutter was observed and no hand-wash facilities were available.

(210) Consumables should be readily available and stored in a suitable environment, e.g. liquid soap, paper towels, toilet paper. Clean and well maintained dispensers should be available for consumables.
No - Such items were observed in inappropriate areas such as Sluice Rooms and Cardiac Rehab.

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

(68) Patient fans which are not recommended in clinical areas.
No - However no documented process for cleaning of the fan in Cardiac Rehab. A fan is not recommended in this area. However, this was the only fan observed in the organisation.

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

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

(80) All office equipment (e.g. telephones, computers, fax machines) should be clean and well-maintained.
Yes - Ward offices were of a high standard.

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

(211) Personal Protective Equipment is available and appropriately used and disposed of.
Yes - Extensive colour coding of aprons was also noted.

(84) Products used for cleaning and disinfection comply with policy and are used at the correct dilution. Diluted products are discarded after 24 hours.
Yes - However solutions in use require labelling and expiry dates must be displayed more clearly on containers in ward kitchens.

(88) All cleaning equipment should be left clean, dry and tidy in the storage area after use.
Yes - However there was insufficient designated storage space for cleaning equipment.

(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 - Insufficient designated storage space for cleaning equipment was observed, however, plans are in place to provide this.

(91) Storage facilities for Cleaning Equipment should be clean and well maintained.
No - Insufficient designated storage space for cleaning equipment.

(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.
No - Plans to provide circuit breakers were observed in place.

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

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

(216) Documented processes for manual washing-up should be in place
No - No documented processes for manual washing-up were available.

Compliance Heading: 4. 4 .2 Facilities

(217) Access to the main kitchen and ward kitchens should be restricted to designated personnel i.e. food workers.
Yes - Doors were open. No keypad was observed.

(219) Ward kitchens are not designated as staff facilities.
Yes - Staff has access to kitchens at night due to lack of catering facilities.

(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 - Hand wash sinks available in some ward kitchens only.

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

(244) Temperature for food when cooked, held or reheated should comply with I.S. 340:2006 requirements.
Yes - However the upgrading of food transport trolleys is required to ensure correct temperatures. No temperature check performed on arrival at patient/client area. The organisation was recommended to discuss this issue with the Environmental Health Officer for advice.

Compliance Heading: 4. 4 .6 Food Preparation.

(245) Cleaned and disinfected work surfaces, equipment and utensils shall be provided for preparing ready to eat foods and foods to be cooked to prevent the risk of contamination. In addition to the HSE hospital colour coded system (see Appendix 6 Irish Acute Hospitals Cleaning Manual 2006), the food colour coding of work surfaces, equipment and utensils should be provided for (see I.S. 340:2006).
Yes - However, utensils are not colour coded.

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

(151) Waste is disposed of safely without risk of contamination or injury.
Yes - Clinical waste is taken manually from transport container by staff and placed in wheelie bin. It is recommended that the transport trolleys have side access to facilitate transfer of waste, however, when the organisation was informed of this, processes had commenced to address this issue.

(152) When required by the local authority the organization must possess a discharge to drain license.
No – The hospital has applied for one.

Compliance Heading: 4. 5 .3 Segregation

(256) Mattress bags are available and are used for contaminated mattresses ready for disposal; mattresses are disinfected.
No - None were 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.
No - Clinical waste is taken manually from transport container by staff and placed in wheelie bin, however, when the organisation was informed of this, processes had commenced to address this issue.

(165) There is a designated person trained as a Dangerous Good Safety Advisor (DGSA) or the services of a DGSA are available to the hospital.
Yes - The Hospital Manager and Technical Services Officer are Dangerous Goods Safety Advisers and have received training.

Compliance Heading: 4. 5 .5 Storage

(169) Documented process(es) for the replacement of all bins and bin liners.
No - The current arrangement is an informal one.

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 - Signed but not dated.

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

(261) Clean linen store is clean, free from dust and free from inappropriate items.
No - Due to storage restrictions, various items were stored in linen presses.

(263) Bags are less than 2/3 full and are capable of being secured.
No - In the majority, however, some alginate and linen bags were left open with items spilling out.

(267) Documented process for the transportation of linen.
No – The linen policy was available but no documented process for the transportation through the hospital was available. However, when the organisation was made aware of this, the issue was addressed and processes were put in place.

(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 documented policy was observed.

(270) Hand washing facilities should be available in the laundry room.
Yes - Hand-washing facilities were in place.

(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 - No documented maintenance processes were observed.

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 - However two sinks observed had restricted access.

(190) All sinks should be fitted with washable splash backs with all joints completely sealed.
No - A planned programme of upgrading had commenced.

(191) Hand washing facilities i.e. sinks, taps and splash backs must be clean and intact.
No - A planned programme for upgrading had commenced.

(197) Wall mounted/Pump dispenser hand cream is available for use.
Yes - However, there was a difficulty in distinguishing soap and hand cream.

(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 planned programme of upgrading had commenced.

(205) General wards should have one sink per 4-6 beds and critical areas should have one sink per 1-3 beds.
No - A planned programme of upgrading had commenced.

(206) Documented records of mandatory attendance at hand hygiene education and practice is required for all staff members involved in clinical areas. This may be undertaken during hospital induction programme followed by annual updates.
Yes - However, it is recommended that records be maintained locally.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team		Assessor Team	
	FREQ	%	FREQ	%
A	15	26.79	5	08.93
B	32	57.14	30	53.57
C	9	16.07	21	37.50
D	0	00.00	0	00.00
E	0	00.00	0	00.00
N/A	0	00.00	0	00.00

5.2 Ratings Details

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

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