Health Information and Quality Authority

An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte

Hygiene Services Assessment Scheme

Assessment Report October 2007

Midland Regional Hospital at Portlaoise

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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

The Midland Regional Hospital at Portlaoise is a 202-bed hospital within Network 6 of the Health Service Executive.
The Midland Regional Hospital at Portlaoise is part of a network of hospitals, also including sites in Mullingar and Tullamore and within the overall system for healthcare, which aims to provide the range, quality and quantity of services, on a 24-hour basis, to meet the needs of the population.

Services provided

Services provided include:
- General Medicine
- General Surgery
- Obstetrics and Gynaecology
- Paediatrics

Regional specialties provided at Tullamore:
- Ear, Nose & Throat
- Orthopaedics
- Oncology
- Haematology

Ophthalmic Services are provided on an out-patient basis locally, with in-patient services provided at the Royal Victoria Eye and Ear Hospital, Dublin.

Physical structures

There is a 5-bed isolation bay in the Paediatric Ward; of these 2 isolation rooms are negative pressure rooms. In addition, there are 8 single/private rooms that are used for isolation purposes according to needs. 7 rooms have no en-suite facilities (Maternity) and 4 rooms have shared en-suite facilities per 2 rooms (Surgical). On the remaining wards, 18 single/private rooms are used for isolation purposes according to needs.

The following assessment of Midland Regional Hospital at Portlaoise took place between 20th and 21st August 2007.

1.3 Notable Practice

- The organisation's on-going commitment to hygiene services through the reporting structures is to be commended.
- The physical structures in the catering areas are to be commended.
- The waste compound is extremely well managed and developed.
- The risk management structures in place are evident and comprehensive.
- There was a comprehensive occupational health service.

1.4 Priority Quality Improvement Plan

- The organisation should apply a formalised approach to implementing opportunities identified in the hygiene audits and assessments.
- A review of the HACCP Manual format to ensure it reflects current and best practice is recommended.
- It is recommended that the organisation develop a cohesive system to maintain training records across the organisation.
- The organisation is recommended to develop a suite of key performance indicators for the hygiene services.
- A process to ensure local induction includes mandatory hand hygiene and infection control training should be implemented. The organisation should ensure this induction is provided on an on-going basis.
- A formalised process to complete hygiene audits and ensure the processes in place are audited is recommended.
- The organisation is encouraged to prioritise the up-grading of the labour ward, SCBU, laundry facilities and linen cupboards to ensure they meet best practice regulations and guidelines.
- A process to collate staff and patient feedback in relation to hygiene services should be developed and implemented.
- The organisation is recommended to provide storage and wash basins for cleaning staff.

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 Midland Regional Hospital at Portlaoise 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 (A ↓ B)
The organisation regularly assesses and updates the organisation's current and future needs for Hygiene Services.
Hygiene needs at the organisation are assessed through national and internal audit results, risk management reports, and the Environmental Health Officer's report. There is evidence that needs identified were used in the development of the Hygiene Strategic Plan and service plan (for example, human resource and infrastructural need). It is recommended that a formal needs assessment process is established for hygiene services.

CM 1.2 (A ↓ B)
There is evidence that the organisation's hygiene services are maintained, modified and developed to meet the health needs of the population served based on the information collected.
There was evidence that the following are some of the modifications that have taken place in the organisation: development of an Environment & Facilities Committee, up-grade of hand wash sinks, segregation of catering and cleaning in some areas, and introduction of colour-coding and up-grade of environmental facilities (Accident & Emergency and some ward kitchens and bathrooms in Maternity).
There was evidence of evaluation of new developments for example, the introduction of disposable curtains, which was performed regionally and included patient involvement at a local level.
It is recommended that the organisation develop a formalised approach to evaluate the efficacy of these modifications.

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.
There was strong evidence of linkages with the HSE, local authorities, regional Infection Control, regional Occupational Health, regional Risk Management, external education institutions (FETAC and SKILLS) and Professional Associations (ICNA). Environmental Health Officers (EHO's) are represented on the Environment & Facilities Committee. Linkages at a regional level were strong through a multi-disciplinary partnership committee which publishes a newsletter for staff including information on hygiene.

It is recommended to progress the development of patient involvement in the hygiene services and evaluation of the linkages for efficacy.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1   **(A ↓ B)**
The organisation has a clear corporate strategic planning process for hygiene services that contributes to improving the outcomes of the organisation.
There was evidence of both a regional and local Corporate Strategic Plan with clear objectives and targets with direction from the Network Manager and the Environment & Facilities Team and Regional Hygiene Committee, who were involved in its development. The objectives and targets as identified and achieved are communicated to staff through the Partnership Committee, who feed back to staff through line management and the Partnership Newsletter.
It is advised that the organisation formalise the strategic planning development process.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.1   **(A ↓ 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.
Evidence was observed that the Hospital Manger, who reports to the Regional Network Manager, assumes overall responsibility for Hygiene Services.
Corporate policies were noted, for example: health & safety, complaints, risk management, procurement, waste, hand hygiene, and data protection, which adhere to national guidelines and legalisation. Evidence of evaluation observed included EHO reports, risk management and health & safety reports, with actions taken and feedback to corporate management provided. Further attention is required to improving communication between senior management and hygiene services.

CM 4.2   **(A ↓ B)**
The Governing Body and/or its Executive Management Team regularly receive useful, timely and accurate evidence or best practice information.
The Environment & Facilities Committee oversees all hygiene activities. Performance is monitored through hygiene audit reports, which are presented to both the Infection Control and Environment & Facilities Committees. Best practice information is reviewed by members of both of these committees, and incorporated into Standard Operational Procedures. This best practice information is used for improvements in the organisation, for example, the up-grade of hand wash sinks. It is recommended that the Governing Body develop hygiene-related Key Performance Indicators and ensure they receive and evaluate the efficacy of the information in relation to these.

CM 4.3   **(A ↓ B)**
The Governing Body and/or its Executive Management Team access and use research and best practice information to improve management practices of the Hygiene Service.
The organisation uses current research best practice information in developing hygiene related Standard Operational Procedures. Funding is provided for education and training for staff. Also, a process is in place for application for staff release to attend training and education sessions at a corporate level. The organisation is to be commended on progressing ward based education with the introduction of team-based performance training and the dissemination of information through the Partner Newsletter. Evaluation of best practice information is performed at both the Infection Control and Environment & Facilities Committees. The organisation is recommended to progress plans to implement team-based performance training to all areas within the organisation.

CM 4.4   **(A ↓ C)**
The organisation has a process for establishing and maintaining best practice policies, procedures and guidelines for hygiene services
A process is in place for the development and approval of all polices and procedures relating to hygiene services. Access to corporate policies and procedures is provided through the library service, intranet and hard copy at ward/department level.
The organisation is encouraged to continue to review the HACCP manual annually and ensure that SOP's are implemented in all areas of the hospital and are reflective of practice. There did not seem to be a cohesive approach to the management of policies (for example, waste, cleaning and linen policies). It is advised that all the information for to each policy be collated into one document (for example a single waste policy, a single cleaning policy) for use on the ward.

CM 4.5   **(A ↓ C)**
The Hygiene Services Committee is involved in the organisation's capital development planning and implementation process
It was evident that members of the Hygiene Committee were involved in the Planning process of the Accident and Emergency Department, for example, Infection Control and Hospital Management. Regular communication between planning and the Executive Management Team was noted. The organisation is advised to review processes with a view to involving all relevant stakeholders in future planning and equipment procurement projects and to evaluate the efficacy of the consultation process between the hygiene services team and senior management.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

*Core Criterion
CM 5.1   **(A → A)**
There are clear roles, authorities, responsibilities and accountabilities throughout the structure of the hygiene services.
The organisational hygiene services structure is clearly defined. Roles, authority, responsibilities and accountabilities for the hygiene services are outlined in job descriptions. Examples provided included staff nurses, clinical nurse managers, the catering manager and the new domestic services managers (posts recently advertised) who reports to the Director of Nursing. The Director of Nursing reports to the General Manger and both sit on the Regional Hygiene Services Committee.

*Core Criterion
CM 5.2 (A ↓ B)
The organisation has a multi-disciplinary Hygiene Services Committee.
There was evidence of a multi-disciplinary Environment & Facilities Committee which met on a regular basis (monthly) and administrative support was available to the committee. It is linked into the Regional Hygiene Services Committee, which ensure that the needs of hygiene services can be progressed. The minutes of both committees were observed and these committees have been a support to staff at local level (for example, providing information in relation to infection control and risk management). The organisation is encouraged to develop terms of reference for its committee as a matter of priority.

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 of funding allocation to hygiene services though the Network Management in the form of capital and minor capital funding as outlined in the hygiene services annual report. Additional funding approval was observed for capital projects (for example, the up-grade of Accident and Emergency, and the new Maternity ward). The organisation is encouraged to implement the Quality Improvement Plan to formalise processes for reporting on hygiene-related expenditure to the Environmental & Facilities Committee.

CM 6.2 (A ↓ B)
The Hygiene Committee is involved in the process of purchasing all equipment/products.
The organisation adheres to the national procurement policy. There was evidence that project groups were developed for the purchasing of equipment and products (for example, disposable curtains). Most equipment and product evaluation takes place at regional level, with involvement of the members of the regional Hygiene Services Committee. Infection Control was also represented on the Hospital Environment & Facilities Committee. The organisation is encouraged to evaluate the efficacy of the consultation process and to consult with staff at local level in purchasing equipment for their area.

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.
Risk management processes were in place and were managed through the regional risk management structure. There was evidence of organisational incident reporting using the STARS system. Incidents are presented at the regional Risk Management Committee and reported back to the Regional General Manger. It was noted that incidents are followed up at local level by the General Manager. Clear processes are in place for risk identification, reporting and analysis, minimisation and elimination. There were no major adverse hygiene-related incidents reported over the last two

years. Risk audits are completed and outcomes of these are reported to line managers. Recent external risk assessments performed included: EHO (HACCP compliance), health & safety (accident & emergency department) and fire safety (operating theatre), with evidence of the implementation of recommendations observed. The organisation is encouraged to strengthen the linkages between Risk Management and the Environment & Facilities Team.

CM 7.2 (A ↓ B)
The organisation's hygiene services risk management practices are actively supported by the Governing Body and/or its Executive Management Team.
It was determined that Risk Management is supported in the organisation at a regional level through a Regional Risk Manager. Risk Management site visits occur three times weekly. The Regional Risk Manger is a member of the Regional Hygiene Services Committee. External risk reports are reviewed by the Regional Risk Management committee, with evidence of action taken observed. Incident reporting is well established at all levels within the organisation. The organisation is encouraged to formalise the risk incident follow up and feedback system at an organisational level.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion
CM 8.1 (A ↓ B)
The organisation has a process for establishing contracts, managing and monitoring contractors, their professional liability and their quality improvement processes in the areas of Hygiene Services.
There was evidence that contracts were managed and monitored, which included the monitoring of their professional liability (for example the window cleaning contract, vacuum service contract, pest control and sani-bins). Frequency of visits and reporting mechanisms were clearly outlined within the contracts (for example reporting and signing off work completed by each Department Manger).It is recommended that the organisation formalise the process to monitor their contractors regularly.

CM 8.2 (A ↓ B)
The organisation involves contracted services in its quality improvement activities.
Evidence that contractors are involved in hygiene improvement activities was observed though company audit reports issued to the Hygiene Services Committee (for example, an audit of sani-bin use and hygiene standards). At corporate level, it was determined that suppliers of alcohol hand rub were actively involved in the education and evaluation of staff satisfaction with product use. The organisation is encouraged to formalise the process of involving contractors in the hospitals quality improvement activities.

PHYSICAL ENVIRONMENT, FACILITIES AND RESOURCES

CM 9.1 (B ↓ 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 was evidence that new building design (for example the new Accident & Emergency Department) is in line with relevant regulations and codes of best practice. A programme of upgrade and refurbishment of the current structure (for example, medical and maternity) is on-going. There was evidence of evaluation of risk (fire) within the operating theatre and actions are currently being implemented.
The organisation is encouraged to progress the upgrade of the maternity unit, surgical units, the laundry, linen storage cupboards, and ICU sluice and to prioritise the up-grade of both the labour wards and special care baby units to current design regulations and codes of best practice.

*Core Criterion
CM 9.2 (A ↓ C)
The organisation has a process to plan and manage its environment and facilities, equipment and devices, kitchens, waste and sharps and linen.
There was evidence of a process to plan and manage the environment and facilities through on-going development and upgrade of the hospital facilities (for example, ward kitchens). A routine environmental repair/maintenance system is in place through the Technical Services Department. It is recommended that this system is formalised to ensure prioritisation of issues and evaluation of turn-around time.
Referenced policies and SOP's were observed in place for the management of sharps, linen waste and equipment, including the utilisation of an equipment asset system. The use of a computerised filing system which is under development will further assist this process. The upgrade of the HACCP Manual is on-going and this needs to be progressed as a matter of priority.

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.
The complaints process, through which hygiene complaints were addressed, is well established in the organisation. Comments cards are available within the organisation and patients interviewed reported satisfaction with the service.
It is recommended that the organisation develop a formal process for patients/clients, staff and visitors evaluation of the hygiene services.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 (A ↓ C)
The organisation has a comprehensive process for selecting and recruiting human resources for hygiene services in accordance with best practice, current legislation and governmental guidelines.
The corporate human resource processes were in line with current national legislation and codes of best practice. Roles, authorities, responsibilities and accountabilities were clearly outlined in five job descriptions reviewed during the assessment. Contract services (for example, window cleaners) are used and job descriptions outlined reporting mechanisms to the organisation. It was evident that the manpower planning process is utilised for determining human resource needs for

the organisation. It is recommended that the organisation evaluate the process for selecting and recruiting human resources.

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.
There was evidence that the manpower planning process is utilised in determining hygiene needs for the environment (for example, the Accident and Emergency Department). Changes to cleaning services have been implemented in the form of a division of roles in some areas and the organisation has identified the need to develop this throughout the hospital. It is recommended that the organisation evaluate the work capacity and volume on a regular basis.

CM 10.3 (C → C)
The organisation ensures that all Hygiene Services staff, including contract staff, have the relevant and appropriate qualifications and training.
Educational and training requirements are identified for some staff using the formalised human resources processes. A corporate induction programme is provided to staff followed by local induction. There was evidence of qualification of contracted services staff through the provision of relevant training certificates. Training of cleaning staff is provided in their local area by their supervisors and Infection Control staff. The organisation is encouraged to develop a formalised structure to ensure all staff have the appropriate training and qualifications, and staff at management level have the appropriate certified training.

*Core Criterion
CM 10.5 (C → C)
There is evidence that the identified human resource needs for hygiene services are met in accordance with Hygiene Corporate and Service plans.
The organisation has completed a needs assessment for human resources. A manpower plan has also been developed. Additional staffing hours have been allocated to areas such as the ICU to meet hygiene needs. Hygiene services staff cover is managed on a daily basis through a roster system and absenteeism is monitored. It is recommended that the organisation continue to review the hygiene services needs and ensure that these are incorporated into the Hygiene Services Corporate Strategic Plan and Operational Plans.

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.
There was evidence of a comprehensive regional corporate induction programme which is followed up by local induction. Content of the programme included health & safety, risk management, occupational health and fire prevention. A HSE staff handbook is provided to staff at induction. It is recommended that the organisation include hand hygiene, infection control and cleaning into a mandatory local induction programme and implement a formalised approach for the monitoring of the induction programme to ensure this is provided to all staff at the time of employment.

CM 11.2   (A ↓ C)
On-going education, training and continuous professional development is implemented by the organisation for the hygiene services team in accordance with its human resource plan.
There was an on-going comprehensive education programme provided at corporate level by the regional Learning and Development Unit, which included health & safety and risk management. There was evidence of on-going local infection control training in hand hygiene, waste, sharps, linen and cleaning on an *ad hoc* basis, with evidence of evaluation of this training observed. Team-based performance in the ICU and the organisation's willingness to release staff to attend training sessions is to be commended. On-going FETAC and SKILLS training is in place, with evidence of funding approval noted. It was determined that cleaning staff receive informal education on cleaning methods at local level from Infection Control.
It is recommended that the organisation develop an in-house education plan and implement the team-based performance education to other areas. The organisation is encouraged to implement a process to formally evaluate the relevance of the education provided.

CM 11.3   (B ↓ C)
There is evidence that education and training regarding hygiene services is effective.
The effectiveness of education provided to staff is evaluated through routine hygiene audits. The attendance levels at training are maintained, however, it is recommended that this is formalised. The organisation is encouraged to develop Key Performance Indicators to evaluate the effectiveness of education and training.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1   (A ↓ B)
An occupational health service is available to all staff.
There was evidence that a regional occupational service was provided to all staff, with a dedicated weekly service at Portlaoise Hospital. A comprehensive health screening programme includes: an immunisation programme, inoculation injury follow-up and a counselling service. A smoking cessation programme, illness absenteeism and stress management programmes are all established. It was determined that staff evaluate the services provided, however, it is recommended that this data be collated to validate the relevance of the service within Portlaoise Hospital.

CM 12.2   (B ↓ C)
Hygiene Services staff satisfaction, occupational health and well-being is monitored by the organisation on an on-going basis.
Staff well-being is monitored at a regional level through the Occupational Health Service. Staff feedback is collated at ward level by ward managers. It is recommended that the organisation establish a process to evaluate staff feedback in relation to hygiene service. The establishment of Key Performance Indicators will assist this process.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

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.
Data and information viewed was presented in a user friendly manner and the graphics utilised are to be commended (for example, the Infection Control presentations). The audit checklists that are utilised in the ward areas are easily interpreted by staff. The findings from the audit reports are discussed by the Environment & Facilities Team. It is recommended that a formalised approach to evaluate the user satisfaction with the reporting of data is introduced.

CM 13.3   (A ↓ C)
The organisation evaluates the utilisation of data collection and information reporting by the hygiene services team.
There was evidence that some hygiene services information is collected in the organisation (for example, the incident reports presented to Risk Management and the results of hygiene audits presented to the Environment & Facilities Team) which is progressed to the Hygiene Services Committee. It is recommended that all hygiene-related reports, including EHO reports and validation reports, are presented at the Hygiene Services Committee for review and discussion.

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.
There was a culture of quality improvement in the organisation. A designated regional Quality Co-ordinator supports the local Quality Co-ordinator in improving the service. The needs of the hygiene services are identified in the Corporate Hygiene Strategic Plan and there was evidence of the Executive Management Team involvement in specific quality initiatives (for example, the up-grading of the environment and facilities). The Executive Manager, as chair of the Environment & Facilities Committee, demonstrated commitment to quality improvement and ensures the progression of opportunities for improvement. It is recommended that the organisation develop performance indicators to monitor quality improvement in the organisation.

CM 14.2   (B ↓ 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.
The organisation is commended for developing clear structures for hygiene services for example, the Environment & Facilities Committee. Continuous Quality improvement (CQI) is progressed through this committee. Changes within the organisation were viewed during the assessment. These included hand sink replacements and the introduction of disposable curtains in the Accident and Emergency Department. Changes and quality initiatives are communicated informally

through line mangers and formally through the partnership newsletter which has designated communication in relation to hygiene services. It is recommended that the organisation develop processes to evaluate the improvement in outcomes in hygiene services delivery that result from initiatives implemented.

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.
Documented processes for the establishment of cleaning procedures in relation to rooms, equipment, environment, sluice rooms and kitchenettes were evident.
Policies were also observed in relation to patient and visitor access to ward kitchens, uniform policy, and the use of ladders. These policies were for a defined period of two years. There was evidence that best practice guidelines utilised by the hygiene team are provided throughout the organisation e.g. hand hygiene posters, waste management posters and linen segregation. It is recommended that evaluation of the processes used to develop best practice guidelines is implemented.

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.
Evidence of a range of information posters was observed including hand hygiene, Norovirus and Patient Information leaflets in relation to hygiene.
It was noted that "Awareness" Training in relation to hand hygiene for the general public has been provided on several occasions. Evaluation from patients and staff was evident during the introduction of disposable curtains to specific areas in the hospital. It is recommended that health promotion activities are developed through linkages & partnerships with PCCC and other organisations. It is also recommended that evaluation of the efficacy of activities is undertaken.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1   **(A ↓ B)**
The Hygiene Service is provided by a multi-disciplinary team in cooperation with providers from other teams, programmes and organisations.
Details of the multi-disciplinary team were provided, namely the Environment & Facilities (E&F) Team. Members of the E&F team participate in regional Infection Control, the cleaning committee and hygiene committees. A partnership newsletter is produced on a regular basis which facilitates integration and communication between teams and programmes. During the assessment, job specifications and descriptions

were observed for the catering manager, domestic supervisor, staff nurses, and multi-task attendants. This facilitates the awareness of roles and responsibilities. A regional news letter between the three hospitals in the region is produced incorporating laboratory, infection control and antibiotic prescribing. It is recommended the evaluation of the efficacy of the E&F team structure is carried out to facilitate the integration and coordination of hygiene services delivery. It is also recommended that terms of reference be developed for the E&F committee.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion
SD 4.1 (A → A)
The team ensures the organisation's physical Environment & Facilities are clean.
The hospital is to be commended on the organisational commitment to ensuring the physical Environment and Facilities are clean. There are plans to complete the upgrading of the Accident and Emergency and Maternity Departments. The grounds of the hospital are generally well maintained and clean. It was noted that parts of the building are quite old with some resultant infrastructural deficits, for example old doors, walls and floors. Cleaning schedules and check sheets were observed in place, however it was noted that inconsistent sign off of check sheets took place.
Maintenance records provided evidence of service of hygiene equipment. It is recommended that the upgrading of hand washing facilities should be expedited. The provision and management of storage space should also be reviewed. It is recommended that a systematic audit process be implemented with appropriate feedback and follow up.

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.
Clear evidence of compliance with this criterion was demonstrated. Medical equipment was generally clean and decontamination systems are in place. Service contracts exist for medical and cleaning equipment. Infection control audits are evident and facilitate compliance with this criteria.

For further information see Appendix A.

*Core Criterion
SD 4.3 (A → A)
The team ensures the organisation's cleaning equipment is managed and clean.
A spacious dedicated cleaning equipment store is to be commended. A colour coding system is in place, in line with national guidelines. Service records were evident in respect of cleaning equipment. It is recommended that an evaluation is carried out to determine the efficiency and value for money of the current mopping system. It is further recommended that the cleaners' equipment store be further up-graded to include best practice guidelines including hand washing facilities and the installation of hooks to store the 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.
The organisation's kitchens and ancillary areas are to be commended. Evidence of meeting identified Critical Control Points is documented and recorded.

For further information see Appendix A.

*Core Criterion
SD 4.5   (A ↓ B)
The team ensures the inventory, handling, storage, use and disposal of Hygiene Services hazardous materials, sharps and waste is in accordance with evidence based codes of best practice and current legislation.
The organisation is to be commended for the waste compound and its compliance with best practice. There was evidence of recycling of a wide range of items including plastic, cardboard, food, cans, batteries and glass. Training of staff and managers in waste management is recommended and appropriate records should be maintained. The organisation is recommended to update its waste policy. The placement of ward based bins should be reviewed in terms of need, value for money and efficiency. Mattress bags were not evident, and it was not established that they were in place to aid the disposal of contaminated mattresses. The organisation should review the storage of sharps boxes.

For further information see Appendix A.

*Core Criterion
SD 4.6   (A → A)
The team ensures the Organisations linen supply and soft furnishings are managed and maintained
An efficient system operates in the management of linen. The hospital complies with the national colour coding system. The introduction of disposable curtains in designated areas is to be commended.

For further information see Appendix A.

*Core Criterion
SD 4.7   (A ↓ B)
The team works with the Governing Body and/or its Executive Management team to manage hand hygiene effectively and in accordance with SARI guidelines
Hand Hygiene Guidelines are in compliance with national guidelines. The Assessors noted the hand washing facilities in some areas complying with HBN 95; however, the remainder should be up-graded as soon as possible.
It is recommended that hand hygiene training become mandatory within the hospital and that appropriate training records are maintained in order to monitor attendance. Additional signage is also recommended throughout the hospital.

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.

There is a clear incident reporting system through the organisation's Risk Management structure. Meetings are held at senior management level to discuss any major incidents. There was evidence also of a clear focus on Health & Safety within the organisation. A small number of minor incidents were noted from the STARS system in respect of the environment. Some training is provided in relation to waste management. Signs are displayed when washing of floors is being undertaken. Safety statements were also noted.

SD 4.9   **(B ↓ C)**
Patients/clients and families are encouraged to participate in improving hygiene services and providing a hygienic environment.

The hospital promotes cooperation from patients and families through the placement of alcohol gels and hygiene posters at various locations throughout the hospital. Leaflets are evident at entrances and in ward areas. Comment cards are also available to enable feedback from patients and relatives. A visiting policy is in place to aid hygiene and infection control. A smoking shelter is provided to assist in the provision of a hygienic environment; however, this is not consistently used. It is recommended that patient/client representation is sought to obtain feedback and participation on a structured basis. It is also recommended that a systematic audit/evaluation process be implemented to assess satisfaction with their participation in service delivery.

PATIENT'S/CLIENT'S RIGHTS

SD 5.2   **(A ↓ C)**
Patients/clients, families, visitors and all users of the service are provided with relevant information regarding Hygiene Services.

Information is proved to patients/clients via information leaflets and notice boards at entrances and points throughout the hospital. Signage is also on display in relation to smoking, hand hygiene for the notification of infectious disease.

It was noted that awareness days on hand hygiene were provided during the last year. It is recommended that the organisation evaluate patient/client, family and visitor understanding of (and satisfaction with) information provided by the hygiene team. It is also recommended that the internet site be used more frequently for the purpose of providing relevant information regarding hygiene services.

SD 5.3   **(A ↓ C)**
Patient/client complaints in relation to hygiene services are managed in line with organisational policy.

There was a complaints procedure in place. The national complaints and risk policy is also in use ("Your Service, Your Say"). Notices were on display in the hospital outlining the complaints procedure. A small number of complaints in relation to hygiene were noted for 2006 and 2007. It is recommended that a systematic process of evaluating patient/client complaints be introduced and the feedback be provided to the Environment & Facilities Committee. It is also recommended that a system is developed to evaluate specific hygiene complaints.

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1   **(B ↓ C)**
Patients/clients, families and other external partners are involved by the hygiene services team when evaluating its service.
Limited evidence was observed of patient/client, family and other service user involvement in evaluating the hygiene services of the hospital. Some evaluation was carried out during Quality & Safety Week. Evaluation of silent closing bins and disposable curtains was also observed. The organisation is recommended to implement a process to involve patients/clients, families and other service users in a systematic way in evaluating the hygiene services.

SD 6.2   **(A ↓ 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.
Internal audits are conducted periodically. Completed checklists are reviewed. A small patient satisfaction survey was undertaken. Details of quality initiatives were noted including the introduction of disposable curtains and alcohol gels. Formal benchmarking was not evident although some informal benchmarking was indicated. An annual report was provided which outlined in summary detail activities undertaken but did not include results of monitoring and evaluation activities. It is recommended that the hospital evaluate the extent to which hygiene services are undertaken as a result of evaluation and benchmarking. It is also recommended that formal benchmarking be undertaken with external partners.

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, dust was identified in some areas including A&E and X-Ray.

(2) All high and low surfaces are free from dust, cobwebs and flaking paint.
Yes - Dust was noted on the tops of vending machines.

(3) Wall and floor tiles and paint should be in a good state of repair.
No - Deficits were noted in the surgical, labour, maternity and child psychiatric areas.

(7) Areas should be adequately ventilated with ventilation units cleaned and serviced accordingly and documentation available regarding service.
Yes - Kitchen air conditioning vents were in need of attention.

(10) Internal and external signage should be clean, updated, well-maintained and laminated to enable cleaning.
Yes - However, evidence of Selotape usage was found in a number of areas of the campus.

(13) External areas including grounds, gardens, footpaths, ramps and car parks should be clean and well-maintained.
Yes - Grounds and gardens were well maintained with an abundance of shrubbery.

(15) Where present a designated smoking area must comply with the national legislation on tobacco control and local organisational policies, a cigarette bin must be available and the floor area should be free of cigarette ends, matches etc.
No - Cigarette ends were noted on the floor in the smoking shelter and the surrounding area. Smoking was noted in a variety of areas in close proximity to the main building.

(28) Before cleaning commences, a work route should be planned and when necessary, furniture and equipment should be removed from the area.
No - The areas behind furniture and equipment in the main kitchen, ward kitchen, and the public waiting area were in need of attention.

Compliance Heading: 4.1.2 The following building components should be clean:

(18) Walls, including skirting boards.
No - Some dust was observed in public areas and Child Psychiatry.

(24) Ventilation and Air Conditioning Units.
No - Ventilation units in the main kitchen and public waiting area were in need of attention. Desk fans at ward level were also in need of attention.

(25) Floors (including hard, soft and carpets).
Yes - In the majority, however, the floor in the Accident & Emergency and X-Ray and areas under bins in Child Psychiatry were in need of attention.

Compliance Heading: 4.1.3 Organisational Buildings and Facilities (note: while list is not exhaustive, the following compliance is required):

(209) Air vents are clean and free from debris.
No - No policy was observed to clean the air vents in bathrooms.

(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 - Some bait boxes in the main kitchen were in need of attention.

Compliance Heading: 4.1.5 Sanitary Accommodation.

(48) Floors including edges and corners are free of dust and grit.
No - X-ray and Accident & Emergency required further attention.

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 - However, the medical sluice room was cluttered.

(58) Sluice rooms should be free from clutter and hand washing facilities should be available.
Yes - Some rooms were cluttered, for example the sluice room on the medical ward.

(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 - Toilet rolls and hand towels were noted on top of toilets and on window sills.

Compliance Heading: 4.2.1 Organizational Equipment and Medical Devices and Cleaning Devices (note: while list is not exhaustive, the following compliance is required):

(64) All equipment, including component parts, should be clean and well-maintained with no blood or body substances, rust, dust, dirt, debris and spillages.
Yes - However, a hoist in a corridor was in need of attention.

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.
No - No procedure was observed in place for this area.

(80) All office equipment (e.g. telephones, computers, fax machines) should be clean and well-maintained.
Yes - Radios observed in catering areas were in need of attention.

Compliance Heading: 4.3.1 Cleaning Equipment & Products (note: while list is not exhaustive, the following compliance is required):

(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 wash hand basin was observed in the cleaning store.

Compliance Heading: 4.4.1 Kitchens, ward/department kitchens & kitchen fittings/appliances (note: while list is not exhaustive, the following compliance is required):

(212) Irish Standard 340: 2006 Hygiene in Food Service (Draft) of the National Standards Authority of Ireland (NSAI) specifies guidance to compliance with the requirements of S.I. 369 of 2006 EC (Hygiene of Foodstuffs) Regulations and Regulation (EC) No. 852/2004 on Hygiene of Foodstuffs. This should be complied with.
Yes - The HACCP manual, which was being updated, requires further review as discussed with management. However the practice in place does meet current best practice regulations.

(214) The person in charge of catering shall develop, implement and maintain a permanent system based on the seven principles of HACCP. A standard HACCP Plan should be fully completed.
No – The HACCP plan was being updated at the time of the assessment.

(215) There should be a documented ward kitchen food safety policy which should be signed off by the person in charge of the ward kitchen and the hospital manager.
No - A local policy is in place, however, this is not in line with national policy and has not been signed off by either person.

(216) Documented processes for manual washing-up should be in place.
No - No documented process is in place. There is no double sink in 'pot wash' if the machine requires repair.

Compliance Heading: 4.4.2 Facilities.

(218) Authorised visitors to the food areas should wear personal protective clothing (PPE) and wash hands on entering the food area during food preparation/serving times.
No - Personal Protective Equipment was provided, however, the assessor was not advised to wash his hands or complete a questionnaire. No evidence of questionnaires was provided.

(224) The ventilation provided for all cooking and steam emitting equipment shall be sufficient to prevent condensation on walls, ceilings and overhead structures during normal operations.
Yes - However, both air conditioning units in the kitchen were in need of attention.

(227) Flour, cereals, sugar etc shall be stored in a dry environment and when opened stored in covered containers.
No - Opened items were not stored in sealed containers.

Compliance Heading: 4.4.5 Management of Chill Chain in a Hospital.

(240) A Hospital using a cook-chill system should comply with Guidance Note No. 15 Cook-Chill Systems in the Food Service Sector (Food Safety Authority of Ireland) The temperatures of fridges, freezers, cold rooms and chill cabinets shall be capable of maintaining the temperature of foodstuffs.
Yes - No chill chain is in operation. Blast chill takes place for joints of meat and this complies with requirements.

Compliance Heading: 4.4.10 Plant & Equipment.

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

Compliance Heading: 4.5.1 Waste including hazardous waste:

(152) When required by the local authority the organization must possess a discharge to drain licence.
Yes - Compliance was noted in this area.

(253) Personal protective equipment is accessible to all staff involved in the generation, collection, transport and storage of waste.
Yes - Gloves and clothing are available at the waste compound.

Compliance Heading: 4.5.3 Segregation.

(256) Mattress bags are available and are used for contaminated mattresses ready for disposal; mattresses are disinfected.
No - No evidence was submitted or produced when requested.

(159) Sharps boxes are correctly sealed, labelled and stored in a safe environment.
No - The organisation is encouraged to review the management and storage of sharps boxes.

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 - A healthcare risk waste policy is in place. It is recommended that the organisation develop a comprehensive waste policy to include all waste, and its transportation through the hospital.

(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 - There is access to a Dangerous Good Safety Advisor on a regional basis.

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

Compliance Heading: 4.5.5 Storage

(169) Documented process(es) for the replacement of all bins and bin liners.
No - No evidence was submitted or produced when requested.

(257) Adequate segregation facilities for the safe storage of healthcare risk waste are locked and inaccessible to the public. Appropriate warning signs restricting public access should be prominently displayed.
Yes - The waste compound was very well-maintained but sluice rooms were open in many ward areas.

Compliance Heading: 4.5.6 Training.

(259) There is a trained and designated waste officer.
No - There is a designated person, but no training has been provided to date.

(260) There are documented records of staff training on the handling, segregation, transport and storage of healthcare risk waste including the use of spill kits and personal protective equipment.
Yes - There is some evidence of training provided by the Infection Control staff.

Compliance Heading: 4.6.1 Management of Linen and Soft Furnishings (note: while list is not exhaustive, the following compliance is required):

(261) The clean linen store is clean, free from dust and free from inappropriate items.
Yes - In the majority, however, some personal items were found, including coats.

(264) Bags must not be stored in corridors prior to disposal.
Yes - In the majority, however, two bags were observed on a corridor. They were tied and half full.

(267) Documented process for the transportation of linen.
Yes - A more explicit process is recommended for transportation.

(271) Hand washing facilities should be available in the laundry room.
No - No sink was available, however, hand gel was in place.

Compliance Heading: 4.7.1 Management of hand hygiene (note: while list is not exhaustive, the following compliance is required):

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

(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 - The upgrading of hand wash sinks is on-going.

(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 the hospital induction programme followed by annual updates.
No - Infection Control carry out workshops three to four times per year which includes hand hygiene, however this needs to be made mandatory at induction.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team		Assessor Team	
	FREQ	%	FREQ	%
A	32	57.14	6	10.71
B	21	37.50	26	46.43
C	3	05.36	24	42.86
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	A	B	↓
CM 1.2	A	B	↓
CM 2.1	B	B	→
CM 3.1	A	B	↓
CM 4.1	A	B	↓
CM 4.2	A	B	↓
CM 4.3	A	B	↓
CM 4.4	A	C	↓
CM 4.5	A	C	↓
CM 5.1	A	A	→
CM 5.2	A	B	↓
CM 6.1	B	C	↓
CM 6.2	A	B	↓
CM 7.1	A	B	↓
CM 7.2	A	B	↓
CM 8.1	A	B	↓
CM 8.2	A	B	↓
CM 9.1	B	C	↓
CM 9.2	A	C	↓
CM 9.3	B	B	→
CM 9.4	B	C	↓
CM 10.1	A	C	↓
CM 10.2	B	C	↓
CM 10.3	C	C	→
CM 10.4	B	B	→
CM 10.5	C	C	→
CM 11.1	B	C	↓
CM 11.2	A	C	↓
CM 11.3	B	C	↓
CM 11.4	C	C	→
CM 12.1	A	B	↓

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