Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Hygiene Services Assessment Scheme

Assessment Report October 2007

Our Lady of Lourdes Hospital Drogheda

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

Our Lady of Lourdes Hospital is part of the Louth Meath Hospital Group and provides a general acute hospital service to the catchment area of Louth, Meath and North Dublin. In addition a number of regional services are based at Our Lady of Lourdes Hospital as follows:

- Regional Centre Symptomatic Breast Service
- Emergency Medicine – Trauma Centre
- Palliative Care.

The hospital has a complement of 340 beds, including 40 day beds.

Services provided

The range of acute services is as follows:

- General Medicine
- General Surgery
- Obstetrics/Gynaecology
- Paediatrics including Neonatal services
- E.N.T.
- Orthopaedics
- Oncology
- Urology
- Dermatology
- Day Services
- Out-patient Services
- Pathology Services
- Radiology Services
- Physical Medicine Services
- Speech and Language services
- Social work
- ICU/CCU

Physical structures

There is one negative pressure room in ICU.

The following assessment of Our Lady of Lourdes Hospital took place between 6th and 7th September 2007.

1.3 Best Practice

- Health promotion was of a high standard.
- Laundry services are to be commended.
- Hygiene services in high-risk areas, including ICU, NICU and Operation Theatres were of a high standard.
- The commitment and positive attitude of staff throughout the hospital towards hygiene requirements is to be commended.

1.4 Priority Quality Improvement Plan

- A reconfiguration of hygiene services to clarify management structure and role profiles is recommended.
- The organisation is recommended to develop a composite suite of Policies, Procedures and Guidelines (PPGs).
- The organisation is encouraged to carry out a Hospital Needs Assessment to identify hygiene related maintenance requirements.
- The continued replacement of the hand-hygiene sinks across the hospital is encouraged.
- The segregation of duties for catering staff from hygiene services is recommended across the entire hospital.
- Follow up to recent Environmental Health Officer's report regarding the temperature of dishwashers in kitchenettes is recommended.
- High dusting and general housekeeping require greater attention to detail
- The process of using yellow risk waste containers for non-risk or hazardous waste should be addressed
- A review of the membership of the Hygiene Services Team (HST) to include patient representatives and more front line staff is recommended.

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 Our Lady of Lourdes Hospital Drogheda has achieved an overall score of:

Poor

Award Date: October 2007

1.6 Significant Risks

CM 9.1 (Rating D)
The design and layout of the organisation's current physical environment is safe, meets all regulations and is in line with best practice.

Potential Adverse Event
Potential injury to staff

Risks

Likelihood of Event	Rated: M (2)
Impact of Event	Rated: H (3)
Urgency of Action	Rated: H (3)
TOTAL	**Total: 8**

Recommendations

Ensure a process is in place to manage the laundry collection, including cease using the current laundry chute.

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 → B)

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

The hospital has completed a limited Hygiene Needs Assessment (HNA) as a section to be included in Hospital Service Plans. The hospital currently has a draft Corporate Hygiene Plan for 2007-2010 and draft service/operational plan in place. These plans have yet to be approved by the Hospital Hygiene Committee or Hospital Executive Management Board. Evidence was observed that the hospital assesses current legislation, codes of best practice and national guidelines, for example, SARI, the National Cleaning Manual and National Laundry Guidelines. Limited evidence was available to support the consultation process for the development of The Hygiene Corporate and Service Plans and the needs assessment; however the hygiene service team is multidisciplinary in composition and these draft plans were developed through the membership of the Team. A range of Quality Improvement Plans (QIP's) were observed including completion of the corporate/service planning process, service user to be included on the team and improved evaluation. It is recommended that the hospital would complete an evaluation of the efficacy of the needs assessment process.

CM 1.2 (B → B)

There is evidence that the organisation's Hygiene Services are maintained, modified and developed to meet the health needs of the population served based on the information collected.

The organisation has evaluated the outcomes of the previous 2 two external hygiene audits, and has developed Quality improvement initiatives to address opportunities for improvement, for example, Colour coding, flat mopping and waste bins. The hospital has a process for continual internal hygiene audits, outcomes and resultant actions. The hospital hygiene service team and the Infection control department review, document and address hygiene issues. Additional resources have been allocated to address high dusting, windows and additional service cleaning as required on a daily basis. It is recommended that the hospital would complete an evaluation of the developments and modifications of the Hygiene Services in relation to the service users needs.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1 (B ↓ C)

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

The hospital, through the Network Manager reports to the HSE, it links with the Department of Health, other area hospitals, professional bodies, universities, regional SARI group, Regional Risk and safety groups. The hospital has joint policies for Risk, Health and Safety and Infection Control. The hospital receives hygiene information from national bodies. There are Customer Care comment cards available for customer feedback and some hygiene services have been highlighted and addressed, for example, toilet cleaning frequencies. It is recommended that the hospital strengthen its external linkages with the local healthcare groups and include a service user on the Hygiene Team.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 (C → C)

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

The hospital contributes to the overall Louth /Meath Hospital Corporate Strategic Plan, and hygiene is included in this overall plan. The hospital also contributes its hygiene service and operational plan to the regional plans. In line with the regional plan there is a funding estimate for hygiene current, capital and quality improvement plans for the hospital. The hospital has a multidisciplinary Hygiene Services Committee. Currently there is no representation from patients on the committee. It is recommended that the hospital review its Hygiene Services Committee and team to include appropriate staff and departmental representation and to include patient representation. It is also recommended that the hospital develop its internal documented processes for the management, planning and revision of its hygiene services.

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 that the Hospital Executive Management Team has overall responsibility was noted through job descriptions, terms of reference and minutes of meetings. The hospital Hygiene Services Committee reports to the Hospital Manager who is also a member of the Hygiene Committee. Through the provisions of job descriptions to all staff, hygiene has been identified as a part of everyone's role and responsibility at the hospital. A suite of policies and procedure in line with the National Hygiene Manual has been developed, and it will be extended further, for example colour coding. No evidence of a hospital code of corporate ethics was noted but code of ethics for procurement, professional and HSE was noted. The hospital has evidence of best practice and legislation that influence its hygiene decision making, for example, National waste management Guidelines, SARI and the National Cleaning Manual.

Through the internal hygiene audit process, the hospital has evaluated its compliance with national best practice and relevant legislation.

CM 4.2 (B → B)

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

The robust system of committee reporting and evidence of minutes of meetings were available. Information is communicated throughout the hospital through dissemination of minutes of meetings and the intranet. This also includes the dissemination of best practice guidelines and changes to policies and practices. The hospital has identified a suite of Key Performance Indicators (KPIs) for Hygiene Services. This is to be encouraged to fruition. It is recommended that the hospital formally evaluate the information it receives, to confirm its appropriateness.

CM 4.3 (B → 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 hospital has very strong access to research and best practice information through the management and dissimilation of national guidelines and recommendations, for example, SARI Hand Hygiene Recommendations, National Waste Management Guideline and the National Cleaning Manual – all of which have influenced local policies, practices, education and training. The hospital has introduced flat mopping, colour coding, blitz cleaning teams and has developed proposals for the re-configuration of household staff, upgrades of hand wash sinks and kitchenettes as a result of research and best practice information. Education and training has been influenced by the national guidelines available. It is recommended that the hospital evaluate its methods of research and best practice information to ensure it is fit for purpose in a hospital.

CM 4.4 (B → B)

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

The hospital has developed a policy for the management of all policies, procedures and guidelines at the hospital. A suite of relevant policies, procedures and guidelines was observed. It is recommended that these be further developed in line with the National Cleaning Manual. All changes to policies are reviewed and communicated to hygiene service staff through the line manager. Education sessions are also available for staff in order to implement changes to practice and procedure, for example O-infection control wipes and the introduction of the National Cleaning Manual. It is recommended that the hospital would evaluate the efficacy of the process of the development of the policies, procedures and guidelines (PPGs).

CM 4.5 (B → B)

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

There is a robust approach to the inclusion of hygiene and infection control representation on the capital development and implementation projects at the hospital. Evidence of this was noted on the project team meetings. Capital Planning procedures at the hospital were noted and evidence was available of the documented process for the management of major and minor capital projects. There

was evidence of evaluation of the efficacy of the consultation process between the Hygiene Services Team and Management.

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 are very clear hygiene roles and responsibilities at the hospital. The Hygiene Services are managed in accordance with the assigned departmental authorities and responsibilities. The Hygiene Services Committee reports to the Hospital Manager. Evidence of an organisational chart was noted. The job descriptions of all hygiene management and staff are specific to hygiene duties; heads of other departments have the provision of a safe environment as the authority for the management of the hygiene services. Clear reporting relationships were documented and noted.

*Core Criterion

CM 5.2 (A ↓ B)

The organisation has a multi-disciplinary Hygiene Services Committee.

The progress of the Hygiene Services Team has been extensive. However, the Hygiene Services Team and the Hygiene Services Committee should be separated. It is recommended that the Committee would prioritise finalising the strategic plan and open the draft for consultation with staff via the Hygiene Services Team. It is recommended that the members of the Hygiene Services Team exclude the Committee members until the process is complete. The Hygiene Services Team should recruit more front line staff, particularly medical staff and patient representatives.

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

*Core Criterion

CM 6.1 (C → C)

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

Improvement works have been carried out as a result of the two previous Desford audits. The development of a corporate hygiene strategic plan will improve the allocation of resources to hygiene services.

CM 6.2 (C → C)

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

The Hygiene Services Committee should become involved in the decision making for the purchase of equipment / products. It is recommended that the hospital consider establishing a Medical Equipment Procurement Group which may facilitate the development of templates for the purchase, servicing and maintenance of hygiene equipment. It is also recommended that an evaluation of the efficacy of the consultation process between the Hygiene Services Committee and senior management is conducted.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

CM 7.1 (A ↓ B)

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

The hospital has a Risk Management Policy which has been collated through a regional risk management department. This was available to staff in hard copy and on CD-Rom. Information leaflets for incident reporting were observed. Evidence was observed of incident reporting forms, hazard analysis forms and a range of risk policies, for example, incident reporting, local management of risk identified, near misses, complaints, health and safety authority notification, medical devises and modifiable diseases. There was strong evidence of management of Health and safety at the hospital; this was noted in PPG's; education, committee agendas, minutes, hazard analysis records, and safety statements. The risk management structure at the hospital also uses the results of the internal and external hygiene audits to review its management of hygiene risks.

CM 7.2 (A ↓ C)

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

The organisation actively supports risk management practices. The Risk Department links with the Health and Safety process at the hospital. The departments hold joint meetings. There is no Risk Management Committee at the hospital. The Risk Manager is a member of the Health and Safety Committee. The risk management department publish a composite risk register on an annual basis but does not prepare a formal annual report. A range of safety and risks reports were available for the Executive Team and are reviewed at management meetings on a regular basis. It is recommended that the hospital establish a Risk Management Committee. The Team is encouraged to evaluate the occurrence of Hygiene Services adverse events over the past two years.

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 number of Hygiene Services contractors are operating on site. The informal and formal review of contractors should be recorded and evaluated on a regular basis. Review of the internal services provided by internal cleaning contractors should be reviewed and actions taken to address issues arising.

CM 8.2 (A ↓ C)

The organisation involves contracted services in its quality improvement activities.

There are limited contractor services at the hospital. There was evidence of the contract cleaners at the team meeting, but no formal evidence of other interaction.The hospital should formalise the process to ensure the hospital Contract

Manager and the Health Services Team meets with Contractors, particularly internal cleaning contractors, on a regular basis.

PHYSICAL ENVORNMENT, FACILITIES AND RESOURCES

CM 9.1 (B ↓ D)

The design and layout of the organisation's current physical environment is safe, meets all regulations and is in line with best practice.

The Hospital is housed in an old building, which is in need of general upgrading and significant refurbishment in general ward areas. The maternity hospital is a newer building. Areas of concern in relation to the laundry chute and the open stairwell were discussed with senior management and agreement was given that processes were put in place which will address the stairwell. It is recommended that an evaluation of the safety of the design, layout and the current environment and its adherence to regulations and best practice is undertaken.

*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.

The hospital has a suite of policies, procedures and guidelines in place to ensure compliance with both mandatory and best practice in relation to its management of its hygiene services for example, its HACCP plan, its waste management plan and cleaning equipment policies. The hospital has commenced a re-cycling waste project. The hospital through its minor capital plan has identified the replacement of wash hand basins and kitchen refurbishment as areas for improvement. These improvements have commenced. The hospital also has a hygiene education and training programme in place.

CM 9.3 (C ↑ B)

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

The hospital reviews internal and external hygiene audits and reflects the outcomes in its hygiene service and operational plan. The hospital also reviews hygiene related risk incident reports, patient satisfaction surveys and patient complaints and compliments in relation to its hygiene services. Changes to practices have included an out-of-hours hygiene team, and a major improvement in the waste management site. The organisation is encouraged to evaluate the methods utilised to determine the efficacy of its environment and facilities.

CM 9.4 (C ↑ B)

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

The patient liaison department evaluate patient's complaints and address issues raised. A comprehensive patient satisfaction survey was carried out in 2007 in relation to hygiene and composite results noted. Feedback in relation to all adverse and complimentary comments, incidents and complaints received are disseminated through the relevant department at the hospital.

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.

There was no documented evidence to verify best practice in place in relation to the recruitment of hygiene services staff. Many of the job descriptions are actually standard operation procedures for staff in areas. It is important to date all job descriptions and Standard Operation Procedures. It is recommended that an evaluation of the processes for selecting and recruiting staff is undertaken.

CM 10.2 (C → C)

Human resources are assigned by the organisation based on changes in work capacity and volume, in accordance with accepted standards and legal requirements for Hygiene Services.

The hospital has commenced changes in hygiene practice in line with the National Cleaning Manual, SARI recommendations and waste management legislation.
A consultant microbiologist is not available.
The non segregation of household and food workers in the ward kitchens is not in compliance with HACCP guidelines. It is recommended that this issue be addressed.

CM 10.3 (B ↓ C)

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

There has been an increase in the use of contracted services in the hygiene services area and it is recommended that training of these staff needs to be continuously monitored. It is recommended that all training records should contain the name of course attended; date of attendance and sign in sheets as evidence of compliance. No dates were evident on many of the training sheets in the catering department.

CM 10.4 (B ↓ C)

There is evidence that the contractors manage contract staff effectively.

There is some evidence of formal, documented meetings with contractors and actions for improvements in service. It is recommended that this process be formalised. The internal hygiene audit results are discussed with cleaning contractor and used to manage staff. An evaluation of the appropriate use of contract staff should be conducted.

*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.

There is no segregation of duties for household workers and food workers and it is recommended that this issue is addressed. There is no Consultant Microbiologist on site. The Hygiene Corporate Services Plan is in draft format and needs to be signed off at corporate level and disseminated to all staff.

ENHANCING STAFF PERFORMANCE

*Core Criterion

CM 11.1 (B → B)

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

The hospital provides orientation/induction programmes for all staff at the hospital including hygiene staff. Evidence of a staff employee handbook, staff orientation pack and training programmes including continuing hygiene, infection control and hand-hygiene available were noted. Records of training and induction training are held in the Human Resources Department. It is recommended that the hospital ensure that induction and orientation programmes be mandatory for all staff.

CM 11.2 (B → B)

Ongoing education, training and continuous professional development is implemented by the organisation for the Hygiene Services team in accordance with its Human Resource plan.

Continuing education and training is provided for all staff including hygiene staff at the hospital in accordance with the hospitals HSE North East Human Resources plan and hospital documented policy and procedure. Hospital training is carried out for specific household staff and in 2007 a programme of training and education was carried out specifically to roll out the principles of the National Cleaning Manual. Hygiene staff have also participated in the national SKILLS project. Training was also carried out into Sharps management, linen management, Hand Hygiene and Health and Safety. A full record of staff attendance was noted. Staff education facilities are available including library, internet and classrooms. Evaluation of training and education has been carried out in relation to actual courses provided. Staff are released from duty for attendance at education programmes. It is recommended that the hospital would conduct an evaluation of education provided to each staff member.

CM 11.3 (C → C)

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

The hospital has used the mechanisms of risk management, patient complaints and internal audits to review its hygiene services effectiveness. There has been a marked increase in incident reporting in relation to hygiene incidents and marked compliance with hand hygiene policies as noted by the improved hand hygiene audit results. Evaluation by staff is in place and it is planned that this will be rolled out for local courses. Attendance records are informally monitored in the nursing office but not formally evaluated. It is recommended that the hospital conduct an evaluation of education programmes and attendance records to ensure that all hygiene staff have appropriate training and education for hygiene roles.

CM 11.4 (C → C)

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

Performance review of hygiene staff is in line with policies and procedures of the Human Resource HSE policy. There is no formal performance review for permanent staff but is in place for temporary staff and for those completing a probationary period of permanent appointment. There is no evaluation of actual numbers undergoing

performance appraisals. It is recommended that the hospital conduct an evaluation of the number of Hygiene Service staff who undergo performance evaluation.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (B ↓ C)

An occupational health service is available to all staff

The Regional Occupational Health Service for the hospital is off-site. Needle-stick injuries are evaluated by the OH Department. There is little documented evidence of extensive Occupational Health service to staff. It is recommended that the hospital conduct an evaluation of the appropriateness of the service provided by Occupational Health for staff.

CM 12.2 (B ↓ C)

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

There is no evidence of regular monitoring of occupational health and well being.
Introduction of a needle-free system is commended as a pilot program. It is recommended that the hospital conduct an evaluation of mechanisms for monitoring staff satisfaction in relation to this criterion.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.1 (B ↓ C)

The organisation has a process for collecting and providing access to quality Hygiene Services data and information that meets all legal and best practice requirements.

There is good tracking of data in waste management, catering and risk management.
Infection control has a process for collection and providing information on their service and audits. The hospital is encouraged to further develop the evaluation of the processes in place for data collection. The further development of Key Performance Indicators in the delivery of hygiene services will be beneficial in assisting the hospital when disseminating information to the users. It is recommended that the hospital conduct an evaluation in relation to this criterion.

CM 13.2 (C → C)

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

Further development of the audit function will benefit the hospital hygiene services.
The development of Key Performance Indicators and distribution of results to staff will benefit the delivery of hygiene service delivery. It is recommended that the hospital would conduct an evaluation of user satisfaction in relation to the reporting of data and information.

CM 13.3 (C → C)

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

Further evaluation of the data collected needs to be commenced. Mechanisms in all areas of the hospital need to be developed. This is particularly relevant to the area of Risk Management. Documented processes of actions taken as a result of out of

range data needs to be developed for example, temperature readings on dishwashers and water quality results.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

CM 14.1 (C → C)

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

There was evidence that the governing body and/or its Executive Management Team foster and support a quality improvement culture throughout the organisation in relation to Hygiene Services. For example, there is improved communication to front line staff on refurbishments or remedial actions planned for hygiene services. Continued momentum has been established with the hand hygiene education campaign. Front line staff are involved in the development of a hygiene needs assessment. These processes need to be developed further as this will increase ownership of areas post refurbishment and increase staff commitment to the multidisciplinary delivery of hygiene services.

CM 14.2 (C → C)

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

The evaluation of patient/staff comment cards with documented actions following on from this action, will facilitate quality improvements in hygiene delivery. The hospital is encouraged to develop Key Performance Indicators for hygiene services delivery as this will facilitate the evaluation of quality improvement systems.

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.

The organisation ascribes to the continuing of the best practice guidelines for the Hygiene Services including SARI guidelines, waste guidelines and National Cleaning Manual. The hospital has adopted the National Cleaning Manual. However, it is recommended that the hospital review the National Cleaning Manual with a view to adapting this document with specific reference to the hospital. Best practice was evidenced by the laundry procedures, colour coding and flat mopping that were in place. It is recommended that the hospital develop documented processes for the establishment, adoption, maintenance and evaluation of hospital procedures.
It is recommended that the hospital evaluate the efficacy of the process to develop best practice guidelines and develop a Quality Improvement Plan for this process.

SD 1.2 (B → B)

There is a process for assessing new Hygiene Services interventions and changes to existing ones before their routine use in line with national policies

The hospital has a process for assessing new hygiene services through its formal procurement policy, infection control advice and Hygiene Services Team. There was evidence of the purchase consultations and evaluation of products for example cleaning agents and flat mops. Internal hygiene audits and risk assessments have identified outcomes and changes in hygiene standards. It is recommended that the organisation continue to evaluate its new hygiene services interventions. It is recommended that the organisation develop documented processes for the approval and introduction of new hygiene interventions.

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 Health Promotion Corner is extensive and has won many awards. The hospital is exceptional with regard to health promotion. There was extensive evidence of hand gel stations and hand hygiene leaflets in prominent display areas in the main reception area of the hospital and throughout the organisation. The hospital is a member of the Health Promoting Hospitals Network and a member of the European

and National Network for Smoke Free hospitals and has been awarded a silver medal. The hospital also supports participation by the Infection Control in the a number of areas for example, participation in national and regional committees-SARI, Regional Infection Control Committee and the Infection Control Nurses association. This enables the hospital to be aware of current trends and best practice. There was no evidence of external interaction or linkages with the community. It is recommended that the hospital evaluate the efficacy of its hygiene-related health promotion activities, with particular reference to its linkages with the community.

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.

The Hygiene Services Team is multidisciplinary. More participation by a patient/ client representative would be welcomed. The multidisciplinary team has demonstrated its effectiveness through the management and introduction of hand hygiene stations and gels, minor capital project identification for Wash hand basin replacement, and the introduction of the principles of the National Cleaning Manual.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

SD 4.1 (B ↓ C)

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

In general the hospital is striving to improve hygiene standards; however it is challenged by an older style hospital structure. Maintenance standards following routine repairs did not finish all surfaces to allow effective cleaning. Cleaning rules and responsibilities for in-house and external contractors should be clarified and records available at ward level to evaluate cleaning standards. More attention is recommended in areas such as the nurses' stations and general offices within medical areas.

For further information see Appendix A

*Core Criterion

SD 4.2 (B ↑ A)

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

Medical devices and cleaning devices were clean to a high standard. Generally, patient equipment was managed effectively and cleaned on a regular basis.

For further information see Appendix A

*Core Criterion

SD 4.3 (B → B)

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

Procedures for cleaning the cleaning equipment itself should be developed and implemented on a local basis. There was adequate storage available for cleaning equipment, but this could be organised better to facilitate these new procedures. It is recommended that attention to detail in relation to the cleaning of equipment is encouraged so that all equipment used for cleaning is itself clean, and kept in a well maintained condition.

For further information see Appendix A

*Core Criterion

SD 4.4 (B → B)

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

It is noted that the kitchen function is moving to temporary accommodation to facilitate refurbishment of the main kitchen. This is a welcome move. Management should proceed with the challenging task of segregation duties for food workers. The model developed for catering in the maternity unit is commended – this model could be extended throughout the hospital.

For further information see Appendix A

*Core Criterion

SD 4.5 (B → B)

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

Hospital-specific documentation for the storage and transport of waste has been developed. However yellow risk-waste containers and the contract waste company's wheelie bins are being used for the storage and transport of non-risk waste and hazardous waste in the hospital.

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

The laundry services provided in the hospital are excellent. There is plenty of storage for clean and dirty linen at ward level. The transport of linen to the laundry department should be reviewed. The standards of clean linen returned to wards are excellent.

For further information see Appendix A

*Core Criterion

SD 4.7 (B → B)

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

The hand hygiene training provided to all support staff and medical staff has been extensive and effective. The number of hand-washing sinks to a HTM standard should be addressed throughout the hospital. The Intensive Care Unit is currently the only high-risk area with the appropriate HTM sinks. A Quality Improvement Plan is in place to address this and the minor capital (Modernisation Programme) proposal was reviewed.

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.

Evidence was noted that documented and audit processes were available to ensure that patients were safe from accidents, injuries and adverse events in relation to the hygiene services. A suite of polices, procedures and guidelines adapted from the National Hospital Cleaning Manual was available. Safety signs during the cleaning process were noted. Education and training for new staff and continuing education and training for all staff is available for the management of cleaning, new products, risk management, incident reporting and managing complaints. All risk incident reports/complaints are dealt with in a timely manner with a documented process for consultation, trend analysis and action plans if required. Monitoring of the complaints system and the compilation of the incident reporting have resulted in changes to practice including, management by contract, of an out– of–hours cleaning team.

SD 4.9 (B → B)

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

The hospital is to be commended for its approach to encourage patient/clients and families to participate in hand hygiene procedures at the hospital. The Health Promotion Corner and hygiene stations in prominent areas of the hospital, as well as the range of patient/client/public information, are excellent. The management and use of the service user comment cards and management of risk incident reporting ensure that hygiene issues are identified and addressed. The National Visiting Policy was observed, with its outcomes and resultant actions. Hygiene issues with relation to toilets were noted. Evaluation of patients/clients and families' satisfaction with participation in service delivery is recommended.

PATIENT'S/CLIENT'S RIGHTS

SD 5.1 (B → B)

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

Patient Satisfaction Surveys were carried out and actions implemented. Patient/client dignity during the hygiene services was observed. As complaints arise, they are dealt with by line managers. Complaints generally relate to facilities rather than services provided.

SD 5.2 (B → B)

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

A range of Health Promotion clinical and support service leaflets is available. Hand Hygiene and management of MRSA leaflets and posters were noted. No patient information Booklet was available. The hospital has carried out a patient/client satisfaction survey in 2007 and has evaluated its results in a formal manner. A range of resultant actions has been formulated and these are progressing, for example in the introduction of the Blitz Cleaning Team. It is recommended that the hospital develop a Patient Information Pack which would be available on admission and which specifically includes the management of hygiene from the hospital and the patient/client's perspective.

SD 5.3 (A ↓ B)

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

The Patient Liaison department deals with patient/client complaints as they arise. The hospital complaints policy will be reviewed along with a new National Complaints Policy. The hospital has formally evaluated its complaints, and has reported complaints to senior management, relevant committees and to the Hygiene Services Committee if appropriate.

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1 (B ↓ C)

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

Currently there is no representation of patients/clients on the Hygiene Services team or committee. However, this has been identified as quality improvement initiative which will be progressed. Patient /clients have direct input through the complaints department and through the use of Customer Care comment cards. A patient satisfaction survey was carried out the public toilets in the main waiting area have been completed – this was a direct result of patient comments. Some outcomes of these procedures have included management changes. The maternity unit has been designated as a pilot area for involving service users in evaluation, and improvement of its service.

SD 6.2 (B → 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 hospital evaluates its hygiene services by utilisation of internal audit mechanism, incident reporting and patient complaints. The organisations continually benchmarks itself against previous external audits, previous internal audits and by review against other hospitals. A range of Health Service initiatives have been undertaken which included review of hygiene staff work practices, introduction of recommendations of the National Hygiene Audits and the introduction of National Visiting Policy.

It is recommended that the hospital evaluate results of previous evaluation outcomes and develop Quality Improvement Plans.

SD 6.3 **(C → C)**

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

The organisation has not produced a hygiene annual report to date. This has been identified as a QIP by the Organisation. It is recommended that the organisation progress this initiative. The Infection Control department produces an annual report. Annual statistics report with commentary is produced by the risk department. Both of these were observed during the assessment. The HSE North East and the HSE produce an annual report to which the hospital contributes. Annual reports as published are available to all departments and are in the hospital library. Evaluation of hygiene resources has been carried out, for example staffing, equipment and products. It is recommended that the organisation develop documented processes for the audit of hygiene Policy Procedures and Guidelines.

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.
No - The environment is not well maintained, particularly in older areas of the hospital

(2) All high and low surfaces are free from dust, cobwebs and flaking paint.
No - High dust was observed.

(3) Wall and floor tiles and paint should be in a good state of repair.
No - Many areas required retiling.

(4) Floors including edges, corners, under and behind beds are free of dust and grit.
No - Areas behind beds and around curtains were dusty.

(6) Free from offensive odours and adequately ventilated.
Yes - Some areas of the hospital were very warm and had poor ventilation; male toilets were malodorous.

(7) Areas should be adequately ventilated with ventilation units cleaned and serviced accordingly and documentation available regarding service.
No - Documents for service of the ventilation units were not available.

(10) Internal and external signage should be clean, updated, well maintained and laminated to enable cleaning.
Yes - It is recommended that hospital will review the extent of internal signage and check that all signage is laminated.

(12) Internal and external stairs, steps and lifts must be clean and well-maintained.
No - The electrical light fittings in the lifts need to be covered.

(13) External areas including grounds, gardens, footpaths, ramps and car parks should be clean and well-maintained.
Yes - The Grounds were in good condition except for the Maintenance/Deliveries yard and back laundry.

(14) Waste bins should be clean, in good repair and covered.
Yes - A small number of pedal bins need to be replaced; it was noted that there was an uncovered bin in the coffee shop.

(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 - Many unofficial smoking areas were in use.

(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 - The National cleaning manual is available throughout the hospital however, this should be locally modified.

(28) Before cleaning commences, a work route should be planned and when necessary, furniture and equipment should be removed from the area.
Yes - A work route was observed during the assessment.

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

(18) Walls, including skirting boards.
No - Skirting boards and walls were in a state of disrepair throughout the hospital.

(19) Ceilings
No - Stained and chipping suspended ceiling panels were observed throughout the hospital.

(20) Doors
No - Doors were in a poor state of repair.

(21) Internal and External Glass.
Yes - A Contractor has been appointed.

(23) Radiators and Heaters
No - Dust was observed on radiators in patient rooms.

(24) Ventilation and Air Conditioning Units.
Yes - Documents (service records) were not available, although various contractors were appointed, and vents were found to be clean.

(25) Floors (including hard, soft and carpets).
No - A floor replacement programme is recommended.

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

(31) Furniture and fittings: Furniture and fittings in direct patient care environment must be clean and dust free i.e. cleaned on a daily basis. Horizontal surfaces (high and low) around the patient i.e. ledges, worktops, window ledges, flat surface suction apparatus, bed table, locker, curtain rail and chairs.
No - Curtain rails and high ledges were not clean.

(32) Shelves, benchtops, cupboards are clean inside and out and free of dust and spillage
Yes - In the majority, however, an exception noted was the surgical medical storeroom in ICU.

(207) Bed frames must be clean and dust free
No - All beds frames observed required further attention.

(208) There should be a process for the cleaning of curtains and blinds. Curtains should be changed after each known case of infected patient / client where required. Records should be maintained of curtain changing.
Yes - Curtains observed to be changed during assessment, however, no record was available to validate, except for ICU.

(209) Air vents are clean and free from debris.
No - All vents observed required further attention.

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

(34) Beds and Mattresses
No - All bed frames required further attention, however, mattresses were observed to be clean.

(35) Patient couches and trolleys
Yes - Paediatric patient couches in A&E should be replaced to conform with patient safety standard specifically, cot sides, washable surfaces and mattress.

(37) Tables and Bed-Tables
Yes - A number of wooden tables were observed in the hospital; it is recommended that they be replaced.

Compliance Heading: 4. 1 .5 Sanitary Accommodation

(46) Bathrooms / Washrooms must be cleaned on a daily basis. When necessary, they must be disinfected. This must be monitored and recorded.
No - Bathrooms were not observed to be clean during the assessment; there is no monitoring or checklist process in place.

(47) Bathrooms / Washrooms are clean and communal items are stored e.g. talc or creams.
No - These areas were not observed to be clean.

(48) Floors including edges and corners are free of dust and grit.
No - Floors were not observed to be clean.

(50) The toilet, sink, handrails and surrounding area is clean and free from extraneous items.
No - These areas were not observed to be clean.

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
No - These areas were not observed to be clean; baths were very old and in poor condition.

(53) Bidets and Slop Hoppers
Yes - No bidets in use in the hospital, slop hoppers were observed to be clean.

(54) Wash-Hand Basins
No - These areas were not observed to be clean.

(55) Sluices
Yes - These areas were observed to be clean during the assessment.

(56) All associated bathroom fittings including component parts e.g. tiles, taps, showerheads, dispensers, toilet brushes etc should be clean and well maintained.
No - Taps required further attention and some tiles were missing. Bathrooms noted also required further attention.

(57) Clear method statements / policies should be in place for guidance on all cleaning including sanitary cleaning and maintenance processes.
No - These were not observed to be in place.

(58) Sluice rooms should be free from clutter and hand washing facilities should be available.
No - No hand washing facilities were available.

(59) Where present shower curtains should be clean and in good repair with a process for laundering and replacement.
Yes - Generally, shower doors are fitted.

(60) All outlets (including shower outlets) should be flushed at a temperature in accordance with current legislation.
No - No records were available.

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 - The equipment is cleaned by nursing staff.

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

(74) Patient's personal items, e.g. suitcase which should be stored in an enclosed unit i.e. locker / press.
Yes - Patient's personal items were generally stored in bed lockers.

(77) Loose items such as patient's clothing should be stored in the patient's locker or property bag.
Yes - Items were stored in bed lockers or patients' suitcases.

(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 noticed.

(79) Flower vases where present should be clean with water changed minimum daily. Wilted flowers should be removed and disposed of accordingly. Note: flowers not recommended in high risk areas.
No - Water in flower vases was changed on an ad hoc basis.

(80) All office equipment (e.g. telephones, computers, fax machines) should be clean and well-maintained.
No - In general the computers and telephones in all areas were not clean.

(272) Splashes of water or hand-wash gel should not be present on the wall, floor, bed or furniture, splash backs should be provided.
Yes - No splash back panels were in place, but otherwise these areas were clean.

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

(81) All cleaning equipment should be cleaned daily.
No - The cleaning equipment is not cleaned daily and some areas required further attention.

(82) Vacuum filters must be changed frequently in accordance with manufacturer's recommendations - evidence available of this.
No - No evidence available with regard to vacuum filters being changed, and accurate information as to the frequency of exchanges was not available.

(83) Mop heads are laundered daily and are stored according to local policy or are disposable i.e. single use.
Yes - Mop heads are disposed of daily.

(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 - Single use spray containers are properly used.

(85) Cleaning solutions should only be prepared in a well ventilated area and should never be mixed.
Yes - Single use items are prepared properly and are not mixed.

(88) All cleaning equipment should be left clean, dry and tidy in the storage area after use.
No - Cleaning buckets were left in dirty condition.

(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 - In general cleaning equipment is stored in sluice rooms; it is recommended that the hospital consider dedicated domestic service rooms.

(91) Storage facilities for Cleaning Equipment should be clean and well maintained.
No - Large sluice rooms were disorganised rusty and required further cleaning. Also, plugholes in the sinks required further cleaning.

(92) Cleaning products and consumables should be stored in shelves in locked cupboards.
Yes - This was observed during the assessment.

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

(213) Environmental Health Officer (Senior EHO/EHO) reports on food safety inspections including the completed summary stage of compliance with HACCP and annual water analysis reports should be retained on the Hospital Food Safety Manual. Action plans/ actions taken on foot of issues raised in the reports should be documented.
Yes - The EHO issues raised are being addressed with the move to temporary accommodation for refurbishment of kitchen area.

(214) The person in charge of catering shall develop, implement and maintain a permanent system based on the seven principles of HACCP. A standard HACCP Plan should be fully completed.
Yes - A comprehensive HACCP plan is in place.

(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 - It is signed off.

(216) Documented processes for manual washing-up should be in place
Yes - There was evidence of such documentation.

Compliance Heading: 4. 4 .2 Facilities

(217) Access to the main kitchen and ward kitchens should be restricted to designated personnel i.e. food workers.
No - Food workers on most of ward kitchens are household staff with the exception of the maternity unit.

(219) Ward kitchens are not designated as staff facilities
No - Open access to the kitchens was available to staff.

(221) Staff clothing/uniforms/shoes personal belongings should not be stored in food rooms.
Yes - There are limited staff changing facilities in the hospital.

(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 - These are not available in all kitchenettes.

(223) Separate toilets for food workers should be provided.
No - Separate toilets were not available in kitchenettes.

Compliance Heading: 4. 4 .3 Waste Management

(229) Animal and pest control measures shall be in place in all waste handling and storage areas.
Yes - A good Ecolab folder were evident, with traceable records.

(232) Waste storage containers shall be smooth, durable, easy to clean and disinfect, well maintained and closable.
Yes - One bin was broken in Maternity kitchen - it did not close correctly.

(234) Where waste is stored in plastic bags these shall be removed frequently, closed securely and stored in a manner that does not pose any risk to the food business.
Yes - All bins were in good order.

Compliance Heading: 4. 4 .4 Pest Control

(239) Fly screens should be provided at windows in food rooms where appropriate.
No - Fly screens were not visible in all kitchenettes.

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

(242) Temperatures for Food in Fridges / Freezers and Displays should comply with I.S.340:2006 requirements
Yes - Good temperature control was evident on all fridges.

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 - Colour coding was visible in the kitchen food preparation areas.

Compliance Heading: 4. 4 .8 Food Cooking

(247) All foods shall be cooked to a temperature to ensure that the products are safe for consumption. The core temperature of the food shall be assessed at he thickest point of the food and should be compliant with I.S. 340:2006
Yes - Core temperature records for a sample day were inspected during the assessment.

Compliance Heading: 4. 4 .10 Plant & Equipment

(250) The dishwasher's minimum temperature for the disinfecting cycle should be compliant with I.S.340:2006 requirements and should be monitored regularly. There should be digital readouts on dishwashers.
No - A digital dishwasher was not evident. The EHO report (dated 2/1/07) highlighted non compliance with Dish Temperatures. These were identified to the hospital and a QIP is in place to address them.

(251) All temperature probes shall be calibrated annually. Calibration may be carried out internally or externally (instrumentation firm). Documentation should be retained of the procedures used to control, calibrate and maintain inspection, measuring and test equipment used to demonstrate compliance with the HACCP Plan.
Yes - Good detail was available on the probe. Calibration was evident.

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

(138) Details of current legislation and codes of best practice adhered to in relation to all waste types.
Yes - The NEHB Waste Plan was observed (Reference DOH&C 2002 - Department of Health and Children Policy Document 2002).
(140) Documented evidence that the treatment facility and final disposal or recovery facility is permitted or licensed.
Yes - Evidence was observed during the assessment.

(141) Documented procedures for the segregation, handling, transportation and storage of waste.
No - The National policy is available in the hospital; this should be reflected in the local policy.

(143) Healthcare risk waste bags should be removed when no more than two-thirds full or at the maximum indicated by the bag manufacturers.
Yes - There is a collection four times a day.

(145) A record is kept of tags used for each ward/department for at least 12 months.
Yes - The stores department holds the record.

(146) A tracking system should be in place to trace all hazardous waste from generation to disposal and therefore an audit trail is available to trace waste to final disposal.
Yes - Audits of all contractors are carried out by the Maintenance Department.

(147) Only UN approved containers and bags to be used for healthcare risk waste.
No - Some general waste was observed in yellow 60-litre bins and the contract waste company's wheelie bins were used for cardboard – this is inappropriate use of these bins.

(152) When required by the local authority the organization must possess a discharge to drain license.
No - No license is required.

Compliance Heading: 4. 5 .3 Segregation

(159) Sharps boxes are correctly sealed, labelled and stored in a safe environment.
Yes - Sharps boxes are only labelled on closure, not assembly.

(162) Hazardous wastes (chemical etc) must be segregated, stored and disposed of correctly.
Yes - In general, the laboratory's chemicals are cleared out on an infrequent basis.

(256) Mattress bags are available and are used for contaminated mattresses ready for disposal; mattresses are disinfected.
Yes - Mattress bags are available from infection control.

Compliance Heading: 4. 5 .4 Transport

(163) Documented processes for the transportation of waste through the hospital which minimizes manual handling of waste (and ensures that segregation of healthcare risk waste from non-risk waste is maintained) are in place.
Yes - Contractor wheelie-bins are used to collect risk waste in the hospital. .

(166) Drivers of vehicles transporting hazardous waste must be trained in accordance with the ADR Regulations.
Yes - Audit reports indicate that this is the case.

Compliance Heading: 4. 5 .5 Storage

(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.
No - Facilities could be extended to allow extra capacity, signage, and locked after hours only.

Compliance Heading: 4. 5 .6 Training

(259) There is a trained and designated waste officer.
No - This is part of the duties of a Maintenance Manager and Secretary. The Health and Safety Department and Infection Control have previously audited and identified this deficit. The appointment of a full time waste officer to coordinate the entire hospital and contractors is recommended.

(260) There are documented records of staff training on the handling, segregation, transport and storage of healthcare risk waste including the use of spill kits and personal protective equipment.
No - Some training is carried out by Infection Control, however, this could be more extensive.

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

(174) Clean linen is stored in a designated area separate from used linen (not in sluice or bathroom).
Yes - Storage cupboards are available on wards – but with wooden shelves only. It is recommended that wooden shelving is replaced.

(266) Personal protective equipment must be accessible to and used by all staff members involved in handling contaminated linen.
Yes - Scrubs and gloves are used for sorting dirty linen.

(271) Hand washing facilities should be available in the laundry room.
Yes - A hand wash sink was observed in the area.

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

(189) Clinical hand wash sinks are required in all areas where clinical activities are performed. They should be centrally located and free from obstruction.
No - A Quality Improvement Plan is in place to comply with this.

(190) All sinks should be fitted with washable splash backs with all joints completely sealed.
No - Sinks throughout the hospital required further cleaning.

(191) Hand washing facilities i.e. sinks, taps and splash backs must be clean and intact.
No - A Quality Improvement Plan is in progress.

(192) Taps should be hands free and should be mixer taps to allow temperature regulation.
Yes - Taps are not hands free. There is a Quality Improvement Plan in progress to address this.

(195) Absorbent paper towels are available at all hand washing sinks. Air dryers should not be recommended.
Yes - Air dryers are used in the Maternity Unit only.

(204) Hand wash sinks conform to HBN 95. They should not have plugs, overflows and the water jet must not flow directly into the plughole.
No - A Quality Improvement Plan is in progress. The ICU was compliant.

(205) General wards should have one sink per 4-6 beds and critical areas should have one sink per 1-3 beds.
No - This is a work in progress.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team		Assessor Team	
	FREQ	%	FREQ	%
A	10	17.86	2	03.57
B	32	57.14	28	50.00
C	14	25.00	25	44.64
D	0	00.00	1	01.79
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	B	→
CM 1.2	B	B	→
CM 2.1	B	C	↓
CM 3.1	C	C	→
CM 4.1	A	B	↓
CM 4.2	B	B	→
CM 4.3	B	B	→
CM 4.4	B	B	→
CM 4.5	B	B	→
CM 5.1	B	B	→
CM 5.2	A	B	↓
CM 6.1	C	C	→
CM 6.2	C	C	→
CM 7.1	A	B	↓
CM 7.2	A	C	↓
CM 8.1	B	C	↓
CM 8.2	A	C	↓
CM 9.1	B	D	↓
CM 9.2	B	B	→
CM 9.3	C	B	↑
CM 9.4	C	B	↑
CM 10.1	A	C	↓
CM 10.2	C	C	→
CM 10.3	B	C	↓
CM 10.4	B	C	↓
CM 10.5	C	C	→
CM 11.1	B	B	→
CM 11.2	B	B	→
CM 11.3	C	C	→
CM 11.4	C	C	→

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