Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Hygiene Services Assessment Scheme

Assessment Report October 2007

Our Lady's Hospital for Sick Children, Crumlin

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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.

[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's Children's Hospital Crumlin is an acute paediatric teaching hospital with 248 beds, employing over 1600 staff. It is Ireland's largest paediatric hospital and is responsible for the provision of the majority of tertiary care services for children and medical research for childhood illnesses. It is the national centre in Ireland for children's childhood cancers, cardiac diseases, medical genetics and major burns.

The hospital provides a high standard of care to the children availing of its services. The services provided are underpinned by a commitment to medical and nurse education and to the development of the skills of staff generally. The hospital is built on a site of approximately 5 hectares which was provided by the Archbishop of Dublin. It first opened its doors in 1956.

The quality of research carried out at the centre is best recognised by its international reputation in paediatric medicine and in its publications. The research laboratories constitute a major component of the activities of the Children's Research Centre. Molecular and cellular biology facilities are provided in a well equipped laboratory complex. The services and specialist medicine provided at the hospital have been significantly developed over the years.

Services provided

In addition to the acute services that are provided on site at Our Lady's Hospital, the following diagnostic services are provided:

- Audiology
- Cardiac
- Neurology
- Respiratory

The following out-patient services are also provided:

- Cardiology
- Dental
- Dermatology
- Diabetes and Endocrinology
- ENT
- Gastroenterology
- Genetics
- General Medical and Surgical
- Haematology/Oncology
- Infectious Disease
- Neonatology
- Nephrology
- Neurology
- Ophthalmology
- Orthopaedics
- Plastics
- Psychiatry

St Louise's Unit provides an integrated assessment and treatment service for child sexual abuse.

The following assessment of Our Lady's Hospital for Sick Children, Crumlin took place between the 14th and 15th of June 2007.

1.3 Notable Practice

- The obvious commitment and support from all levels of staff.
- Very clear ownership of hygiene by every member of the Hospital staff at point of care is to be commended.
- The overall standard of hygiene and cleanliness was excellent.
- The hygiene 'train the trainer' programme for household/contract cleaning staff is to be commended.
- The Hygiene Service's cleaning service manual has been translated into several languages. This is to be commended.
- Innovation in waste reduction and recycling programmes was also observed.

1.4 Priority Quality Improvement Plan

- It is recommended that an evaluation of the interim report on laundry services, with resultant timeframes and actions, is carried out.
- A review of the HACCP plan and associated procedures is recommended.
- It is recommended that the Hospital devise a standardised approach to evaluation on an on-going basis of all processes and policies.
- Plans for a stand-alone waste compound should be expedited without delay.
- A standardised approach is required for the development of policies and procedures.

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; Our Lady's Hospital for Sick Children, Crumlin has achieved an overall score of:

Fair

Award Date: October 2007

2.0 Standards for Corporate Management

The following are the ratings for the Corporate Management standards, as validated by the Assessment team. The Corporate Management standards allow the organisation to assess and evaluate its activities in relation to Hygiene Services at an organisational level. There are fourteen Corporate Management standards, all of which are focused on four critical areas: leadership and partnerships, environment and facilities, human resources and information management. They include such subjects as corporate planning, allocating and managing resources, enhancing staff performance and contractual agreements. There are eight core criteria within these standards.

PLANNING AND DEVELOPING HYGIENE SERVICES

CM 1.1 (B → B)

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

Evidence showed that the Hospital Board and its Management Team review and approve the Hygiene Service Corporate Strategic Plan. The Hygiene Services Committee has responsibility for managing and developing the Hygiene Services. Clear roles, responsibilities and accountability for all members of the Committee and for all staff at the Hospital were identified. The Hospital reviews both internal and external audits and submissions, in line with the Hygiene Services Quality Improvement Plan, to identify needs in relation to Hygiene Services. The Hygiene Services Team participates in Hospital capital development, in line with implementation of the organisation's development control, and agreed service interventions.

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 Hospital development plan is identified in line with agreed service delivery plans, and plans the future roles and services of the Hospital. Evidence validated that the Hospital maintained and modified the Hygiene Services in line with both the needs of the population, and the implementation of the Hospital Service Plan. There was a comprehensive Corporate Hygiene Service Plan and an Organisational Plan, which reflected the service needs of the Organisation. The service needs of the population are evaluated in line with the Annual Service Plan for the Hospital. This looks at population needs and addresses services required based on that information, and in line with national strategies, for example, Cancer and Cardiac.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1 (B → B)

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

The Hospital links and works in partnership with the Health Services Executive, the National Hospitals Office and the Department of Health and Children. Evidence validated that the Organisation interacts with site and service contractors and with patients/clients in a very holistic manner. Staff are very committed to the Hygiene

Services Programme. Evidence validated the tangible commitment of all staff to the Hygiene Process. Representation of all grades of staff on the Hygiene Committee and Team was noted. The Head of the Portering staff was particularly impressive in his ability to lead the Change Management Programme among his staff.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 (B → B)

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

There was a very comprehensive corporate hygiene policy in place, which was influenced by the Hygiene Service Plan and the organisational plan. The plan was devised with the full co-operation, and in consultation with staff. This was evidenced by the minutes of the Hygiene Services Committee meetings, circulation lists, quality improvement plans and staff feedback. Communication of the plan to stakeholders is through staff representatives on the Hygiene Committee and team, departmental meetings. The hygiene plan and quality improvement plan are distributed through the Hospital's IT facilities.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.1 (B → B)

The Governing Body and its Executive Management Team have responsibility for the overall management and implementation of the Hygiene Service in line with corporate policies and procedures, current legislation, evidence based best practice and research.

The Board of Governors has full responsibility for the Hygiene Services in the Hospital. The Chief Executive Officer is responsible for the enactment of the Hygiene Services Plan. Clearly defined roles for all hygiene structures in the Hospital were validated by the terms of reference for the Hygiene Services Committee and Team, minutes of meetings, job descriptions and the verbal commitment and understanding of the staff to the Hygiene Process in the Organisation.

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.

Evidence validated that the Board of Governors receives regular reports from the Chief Executive. The Board also receives all relevant data and information, to enable it to make informed decisions in relation to Hygiene Services. Some members of the Leadership and Partnership team are members of the Board and report all Hospital activities, including the management of Hygiene Services, directly to the Board in their respective reports. Minutes of Board meetings and copies of Functional Officers' reports were reviewed by the Assessment Team. In general, Hygiene issues are raised in the reports under 'Any Other Business'. The Board reviews internal and external audits and comments appropriately on the results. No formal evaluation of this criterion has been carried out by the Board, and there are no documented processes in place for Hygiene at Board level.

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 Organisation promotes research and best practice and provides many opportunities for education, training and research and is involved in many clinical international best practices and research project initiatives. However, research relating to hygiene is in its infancy at the Hospital. The Hospital is currently implementing the guidelines of the Irish Acute Hospitals Cleaning Manual, and adapting it to include recommendations in their hygiene practice. The organisation is commended on the translation of many of the hygiene policies and procedures into Polish and other languages. Multi-lingual staff leaflets on hygiene and hand hygiene are also available. The Hospital provides extensive library and internet facilities, and is committed to education and best practice. There is a strong programme of hygiene related training for all grades of staff. A very good "Train the Trainer" programme was observed within the household staff. It is recommended that formal evaluation of this criterion is progressed.

CM 4.4 (A ↓ C)

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

There is no documented process for the establishment, adoption, maintenance and evaluation of best practice guidelines for Hygiene Services. The Team is encouraged to progress this issue. To merit an 'A' rating there must be evidence of benchmarking in relation to the criterion.

CM 4.5 (A ↓ B)

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

The Hygiene Services Committee and the Infection Control Department are involved in the planning of all capital and new intervention projects. They are currently involved in the 'coffee shop project', and the 'catering project'. Evidence of their involvement, in the form of minutes of the capital project meetings was validated. However, no evaluation of the efficacy of their inclusion on these projects and no formal documentation to map the process were validated by the Assessment Team. It is recommended that this is progressed by the team.

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.

Comprehensive documentation was observed which outlined the roles, authorities, responsibilities and accountabilities for all household, professional and management staff. The Hospital Hygiene Services Committee and Team's Terms of Reference, Strategic Corporate Plan, Service Plan and Organisational Plan, clearly identify the commitment of the Hospital to its Hygiene Programme. Full responsibility and accountability for Hygiene is included in the job descriptions of all grades of staff, from household/hygiene staff to the Chief Executive. The Board of Governors, through its minutes, demonstrates that Hygiene is on the corporate agenda. It is not, however, included in the position specifications for a Board member.

*Core Criterion

CM 5.2 (A ↓ B)

The organisation has a multi-disciplinary Hygiene Services Committee.

Evidence validated that the Hospital has a multidisciplinary Hygiene Services Committee and a multidisciplinary approach to the management of Hygiene Services. However, the Organisation has not evaluated the efficacy of the team. It is recommended that the team should evaluate its attendance levels, and the efficacy of the process. This criterion should be cross referenced to SD3.1 for additional comments.

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

*Core Criterion

CM 6.1 (A → A)

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

The Hospital receives its annual budget from the National Hospitals Office in line with its Service Agreements. The Governing Body funds the Hygiene Programme in line with the internal Hospital Service Plan and new service submissions. The Governing Body can allocate resources to fund additional Hygiene Services and Human Resources if required. The appointment of the new Household Services Manager and additional Catering Officers provided evidence to validate this. New funding has also been allocated to implement the Quality Improvement Plans of the Hospital. The Hospital Hygiene Service Plan and Corporate Plan also influence the Board of Governors in their allocation of resources and funding.

CM 6.2 (B ↓ C)

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

The Hospital Hygiene Services Committee is involved in the purchasing of equipment/products. The Committee accepts written submissions from Hospital departments and managers, reviews hygiene submissions and makes recommendations to the Hygiene Services Team for the purchasing of both new and standard issue equipment/products. The committee has also devised a quality improvement plan in relation to hygiene, which includes staffing, replacement of hand washing facilities, review of policies and procedures and furniture replacement.

All new products and current contracts are assessed in line with the National Procurement Policy. The contract manager and the household supervisor meet weekly to assess the requirements of the hygiene service from a purchasing perspective. Evidence of the process of the purchasing service was validated. The Team presented some evidence of pre-purchase assessment of products. It is recommended that post purchase evaluation of products after a defined period of time in use should be considered.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

CM 7.1 (A ↓ C)

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

No documented processes were in place to identify risk related to the Hygiene Service. There is an incident clinical risk reporting structure with the STARS programme, and a Safety and Quality Manager is in place. Annual reports and periodic reports are submitted to the Organisation from both the Infection Control department and Quality and Safety. The Hospital has recently appointed a Risk Manager who will take up the post in the near future. With the exception of the STARS results, little evidence of audit or evaluation in this area was observed. It is recommended that this issue is reviewed as a matter of urgency.

CM 7.2 (B ↓ C)

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

No documented processes are in place in relation to this criterion. The Governing Body supports the risk management structures and identified the need for a Risk Manager, who has recently been appointed. There was robust evidence of incident reporting, centralised collection, review and reporting. Risk management reports are disseminated throughout the Organisation through the STARS system of reporting and resultant actions are taken as appropriate. Unresolved issues at local level are referred to the Executive Management Team as appropriate. It is recommended that the HACCP and safety risk procedures are strengthened and that the organisation review its risk management structures in relation to Hygiene Services.

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.

The Hospital had a robust contracts department, with a Contracts Manager in place. The Hospital adheres to the National Procurement Policy for contracted services and goods. It is recommended that the Team review its evaluation processes before, during and after contracted periods.

CM 8.2 (B → B)

The organisation involves contracted services in its quality improvement activities.

The organisation's contracted Hygiene Services are represented on the Hospital Hygiene Committee. Contracted services are involved with new quality improvements, under the terms of the National Procurement Policy. A Contracts Manager is in place, whose brief includes the management of contractors, their services and their involvement in the quality initiatives in the Hospital. There are external contracts for waste and laundry at the Hospital; however, contractors were not represented on the Hygiene Services Committee or Team.

PHYSICAL ENVIRONMENT, FACILITIES AND RESOURCES

CM 9.1 (B → B)

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

The Hospital building dates back to the 1950's, with new additions in the intervening years. The Hospital Capital Committee and the Hospital Technical Services Department have processes in place to ensure that procedures are operative to provide a safe environment in line with the Hospital's actual structural constraints. A development control plan for the Organisation was observed, which prioritises the new building requirements for the Hospital. Hospital service delivery plans also identify new services.

*Core Criterion

CM 9.2 (A ↓ B)

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

The Hospital's Hygiene Services Committee, in partnership with its staff, plan and implement the Organisations Hygiene Services. The processes of internal/external audits influence the quality improvement plans and decisions in relation to hygiene. There are processes in place for the management of the catering (HACCP), waste and linen. It is recommended that the Hospital review some issues of practices in waste, kitchen and laundry to reflect best practice. Internal/external audits have been conducted, and influenced quality improvement plans; however, little overall evidence of evaluation was validated.

CM 9.3 (B ↓ C)

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

Some processes were in place to evaluate effectiveness and efficiency in relation to this criterion. Internal and external audit reports, risk management and complaints procedures and limited patient satisfaction surveys were validated. The hygiene contractors carry out weekly hygiene audits, which are presented to the Hygiene Service Committee and the Executive Management Team. The results of these audits are used to plan new interventions.

CM 9.4 (B ↓ C)

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

A pilot patient satisfaction survey has been conducted on St. Michael's ward. The evaluation of this survey was limited, and no quality improvement plan was put into place. A patient satisfaction survey was carried out on St John's ward on parent facilities; however, no evidence of evaluation of this survey was presented. As a result of service user feedback, the infection control leaflet was revised and updated.

It is recommended that Hospital-wide patient satisfaction surveys be conducted to evaluate users' satisfaction with the organisation's Hygiene Services facilities and environment. There is also a need for the Hospital to consider the inclusion of a service user representative on the Hygiene Service Committee.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 (B → B)

The organisation has a comprehensive process for selecting and recruiting human resources for Hygiene Services in accordance with best practice, current legislation and governmental guidelines.

The Hospital has a very comprehensive Human Resource Manual, which deals with employment law and responsibilities, contracts, terms and conditions of employment, human resource policies and procedures, recruitment, best practice, new trends and performance management. There is a defined household services human resource plan, which supports the employment and management of household staff. This includes recruitment, interviews, policies, induction and training. During the assessment, it was clear from household staff that they were fully conversant with the expected outcomes of their role, their continuous requirement for updating education and training and occupational health requirements. The Hospital subscribes to Equal Opportunities Employer and Health Services Executive terms and conditions of employment. Comprehensive staff records were available and four personnel records were checked during the assessment for validation purposes. The Hospital reported that it evaluates the Human Resource policies in line with best practice; however, no evaluation documentation was available during the assessment to validate this.

CM 10.2 (B → B)

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 formulated a Human Resource Plan, which identifies the Organisations' hygiene service human resource requirement. The Hospital receives annual whole time equivalent resources and funding, in accordance with the Hospital Corporate Service Plan. The Hospital employs staff on a planned basis as well as on an ad hoc basis according to service requirements. Additional staff are employed to deal with major outbreaks, for example MRSA. The Director of Finance and Senior Management Team, together with the Service Planning Team, allocate funds and resources. These include the employment of two additional catering officers, and a new position of Hygiene Services Manager was established and filled. Administrative resources have also been allocated to the Hygiene Services Committee and Team. This Committee and Team have evaluated the Hygiene Services resource requirements. While evidence of this was reviewed, no formal evaluation report was made available to the assessment Team.

CM 10.3 (A → A)

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

All Hospital hygiene staff are employed at the Hospital using the comprehensive recruitment Human Resource Plan. Full orientation and training programmes were validated. This programme covers all aspects of the position that the employee will assume including manual handling, hygiene, equipment and occupational health. Evidence was observed of human resource records of employment, orientation, training and education and continuous on–going education and support. Four staff records were reviewed during the assessment. The external hygiene contractor has robust procedures in place for employment of hygiene staff, including full training and orientation. Full records were observed during the assessment. Job descriptions were available for all grades of Hospital staff, with specific reference to household staff, household supervisory and management staff, professional and management

staff. These job descriptions include qualifications and experience required for employment. Sample advertisements for Hygiene Services were reviewed.
A number of staff have also availed of the BICS training, which is to be commended.

CM 10.4 (B ↓ C)
There is evidence that the contractors manage contract staff effectively.
The Hospital hygiene contractors have robust procedures in place to effectively manage contract staff. These include orientation/induction programmes, performance management and communication with Heads of Departments. The hygiene contractors are also represented on the Hygiene Services Committee. To date, limited evaluation of other contractors has been carried out. It is recommended that a risk assessment on all contractor services is conducted, to evaluate the method of evaluation/monitoring of contractors.

*Core Criterion
CM 10.5 (A → A)
There is evidence that the identified human resource needs for Hygiene Services are met in accordance with Hygiene Corporate and Service plans.
The Hospital's Corporate Plan, Service Plan and Operational Plan and the Hygiene Services Resource Plan, identify, plan and implement staffing requirements to maintain adequate provision of Hygiene Services. The Team has reviewed its services in order to modify and extend the 'out of hours' janitorial service. The Hospital Hygiene Services Committee has evaluated both its service requirements and quality improvements plans, and has allocated resources in line with the agreed budget.

ENHANCING STAFF PERFORMANCE

*Core Criterion
CM 11.1 (A ↓ B)
There is a designated orientation/induction programme for all staff which includes education regarding hygiene
The Hospital provides an orientation and induction programme. This is departmentally driven, and the Hospital has itself identified the need for a corporate and composite approach to orientation and induction. Hygiene is a core component of the orientation and induction programme, under the remit of the Infection Control Department. The Hospital Hygiene Services trainers also train the staff in relation to the expected level of hygiene, and of the standards required by the Organisation. The hygiene contracted services have also included hygiene in their programme, and have developed hygiene-related information work sheets in a variety of languages, to reflect the cross cultural nature of their employees. Staff handbooks and staff training records were also reviewed.

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.
A continuous process is in place in the Organisation, to ensure the provision of education and training to all staff in hygiene and related issues. The Hospital supports protected time for staff to attend training and education, however, with the exception of the Department of Nursing and the Hygiene Contractors, no documented process was in place. The Hospital uses the services of its clinical

specialists, supervisors and management staff to provide training. The Hospital also trains Hygiene Services staff as trainers for the hygiene process. This process is very effective for the management of new equipment, cleaning products and hygiene staff. The trainers were very motivated and enthusiastic in their role. This is to be commended. The Human Resource Plan and the Executive Management Team ensure the provision of the resources to implement the training programmes at the Hospital. The Infection Control Department, the Human Resource department and the Department of Nursing have a documented process and guidelines, for the access to and the support of staff for training and education. It is recommended that the Organisation consider a composite overall documented approach to the process of training and education. No evidence of formal evaluation of the education processes was presented.

CM 11.3 (A ↓ B)

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

The Hospital provides comprehensive education and training, relating to hygiene, for all Hospital staff. The Hospital provides training to contracted Hygiene Services staff, who in turn audit and evaluate the service provided. A patient satisfaction survey on St. Michael's Ward demonstrated satisfaction from parents on the Hygiene Services provided. This was validated with a copy of the audit result and action plan. Whilst the attendance lists and dates, reflect very high attendance at the training sessions from all grades of staff, no evidence of staff satisfaction evaluations with the training programmes was presented. Also, no summary evaluations of training programmes were available to Assessors. Staff records are held by the training programme leaders. It is recommended that the Hospital consider a composite approach to the management of staff training records.

CM 11.4 (B ↓ C)

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

The Hospital has a formal performance management structure for nursing staff, which is competency driven. The performance tool currently in place is the Office of Health Management competency tool for Senior Nurse Managers, Clinical Nurse Manager 2 and Managers. The Hospital, with the agreement of the Unions, has commenced training in relation to the team-based approach to performance management for other grades of staff. The Hospital will use the services of an external Management Consultant to implement this training programme. The Hospital uses the national human resource "People in Management" system, to manage and assess staff in relation to disciplinary issues. No Evidence of evaluation was found in relation to this criterion.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (A ↓ C)

An occupational health service is available to all staff

A Hospital-based Occupational Health Service is available to all staff. It provides a regular weekly clinic, and a relevant occupational health vaccination service for staff. A record of attendance at the service was reviewed. Audits of attendances and vaccinations have been carried out; post accident/incident audits were also conducted. A range of relevant policies and procedures was also available. The information offered by the Hospital in relation to this criterion was validated by information available to staff at ward area, knowledge of the procedures in the event of an occupational incident and overall knowledge of the service. However, no

evaluation of the service was evident, and the annual report available was dated 2004. No evidence of Service Plans for the department was available to Assessors. It is recommended that a Service Plan is developed.

CM 12.2 (B ↓ C)

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

The Hospital has not carried out a Staff Satisfaction Survey, however, staff retention figures and turnover figures at 10% indicated staff satisfaction. The Hospital conducts exit interviews and questionnaires. Absenteeism rates at the Hospital are monitored and managed, with resultant actions carried and documented in personnel files. The Executive Management structure, through their reporting departmental structures of human resources and professional groupings, reviews the welfare of the Hospital staff. The Occupational Health Department submits annual reports and composite reports on absenteeism and the vaccination programme to the Executive Management Team. It is recommended that Hygiene Services staff satisfaction, occupational health and well-being is monitored by the organisation on an ongoing basis.

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.

No documentation was presented specifically in relation to Hygiene Services. The Organisation is in the tendering stage of selecting a software system for clinical and non clinical audit. There are method statements from the contractors of Hygiene Services, which outline the frequencies, cleaning methods and sign off, of responsibilities of the contract cleaning staff. The Hospital uses the Irish Acute Hospitals Cleaning Manual to influence best practice, and HACCP audits are used to influence improvements in catering. To date, no evaluation on data and information processes have been carried out. It is recommended that a process is put in place to ensure legal and best practice requirements are met in relation to this criterion.

CM 13.3 (B ↓ C)

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

The Board of Governors, in its service deliberations, makes use of all hygiene related information as presented by the Hygiene Services Team members (who are also Board members). The Board utilises the results of the previous National Hygiene Audits, and on-going internal audits to inform its decisions. The Executive Management Team, through the leadership and partnership group, uses the information received through the internal and external audits, and through the Hospital's relevant committees, to influence its service deliberations. No formal evidence was presented to demonstrate that the Organisation has an actual evaluation process in place. It is recommended that a formal documented evaluation process is implemented in relation to this criterion.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

CM 14.1 (B → 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

A culture of quality improvement was observed throughout the Hospital in relation to Hygiene Services. The Quality and Safety Manager and the Accreditation Manager are members of both the Hospital Hygiene Services Team and the Leadership and Partnership team. An extensive quality improvement plan was in place which is not exclusive to hygiene issues. Rather, there is a Hospital-wide quality improvement plan in place. The Executive Management Team and the Board of Governors support quality initiatives, and have approved funding for a range of improvements, including the employment of additional staff, for example, a Hospital Hygiene Services Manager, in order to improve Hygiene Services.

CM 14.2 (B → B)

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 evaluates its Hygiene Services through various methods of audit. Internally, it uses the Infection Control Nurses Association (ICNA) audit tool, and the Hygiene Contractors audit their services on a weekly basis. The Hospital has carried out an organisation-wide audit of all departments using the HIQA mandatory compliance tool. The organisation also uses the information received through its risk management and complaints procedures. The Hospital benchmarks its Hygiene Services against the previous National Hygiene Audits. The Hospital has identified a quality improvement plan in relation to evaluation, and has gone to tender for a computerised system of audit. The Hospital produces a newsletter, which is distributed throughout the Organisation for all users of the Hospital service. Information is also disseminated to all staff through the Hygiene Services Committee system and the departmental methods of staff communication. Evaluation of improvements has been through internal audits and the reviews of quality improvement plans carried out by the Hygiene Services Committee.

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.

There is no documented process for the establishment, adoption, maintenance and evaluation of best practice guidelines. There was a comprehensive set of best practice guidelines available including the National Hospitals Office Cleaning Manual, Health and Safety and the Department of Health and Children's publication: Segregation, Packaging and Storage Guidelines for Healthcare Risk Waste. Information is available for staff via the internet and library facilities and training sessions are provided on any new guideline. Evaluation of the efficacy of the process is currently through the Health Services Executive audit scheme and quality improvement plans are in place to address deficiencies. The Organisation is encouraged to develop a standardised approach to the development of policies and procedures, which include appropriate document controls and review periods. It is recommended that processes for the evaluation of best practice are progressed.

SD 1.2 (B ↓ C)

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

No documented process is in place for assessing new Hygiene Services' interventions and changes to existing ones before their routine use. Requisitioning guidelines and procedures are in place for 2007. There is a specification template for products and services as part of the tendering process. Guidance for developing and evaluating tenders is in place as part of the national procurement process. This includes a specification sign off.

The development of an equipment group is currently being planned for the introduction and evaluation of all new equipment. It is recommended that a process for the introduction of new Hygiene Services interventions at local level is put in place. Focus for new Hygiene Services interventions over the last two years includes the review and development of cleaning schedules for many areas of the Hospital. Some of these have been evaluated by the contract cleaning company. It is recommended that an overall evaluation of the efficacy of the assessment process is carried out.

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.

There was a very good range of health promotional activity undertaken to educate the community regarding hygiene including: a children's art competition (Beat the Bugs Competition), the provision of leaflets (particularly relating to Infection Control), staff demonstration of hand hygiene techniques to users and dedicated awareness days. The Hospital also actively communicates to the public in the event of an outbreak. Notices and leaflets are provided in the parents facilities, however, the Hospital would benefit from a more prominent display of hygiene information in public areas. It is recommended that other service providers are encouraged to participate in promotional activities, and the evaluation of efficacy of activities and resultant action plans should be progressed.

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.

Senior management support is given to the provision of Hygiene Services. A Hygiene Services Committee is in place, with representation from each department, and external services. This committee reports to the Hygiene Services Team, which is a sub team of the Leadership and Partnership team. Team roles and responsibilities are clearly defined. Established links are in place to other groups, departments and subgroups; and minutes of meetings were verified during the visit. Information is also shared with external agencies, for example the Department of Health and Children, the Health Services Executive and the Health Protection Surveillance Centre. It is recommended that the team take a more structured approach to action, planning and evaluation. Progression of action plans must also be addressed. It is recommended that an evaluation of the efficacy of the team structures is carried out.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

SD 4.1 (A → A)

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

Overall, the level of cleanliness and maintenance of the physical environment was excellent. Attention to detail in this regard was strongly evident. Additional detail as per mandatory check list.

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.

Overall, the medical devices and cleaning devices were managed and cleaned to a high standard. Additional detail as per mandatory check list.

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.
The management and cleanliness of cleaning equipment was excellent. Additional detail as per mandatory check list.

For further information see Appendix A.

*Core Criterion
SD 4.4 (A ↓ B)
The team ensures the organisation's kitchens (including ward/department kitchens) are managed and maintained in accordance with evidence based best practice and current legislation.
The overall HACCP plan was developed in 2003, and should be updated to reflect current legislation. Initially, there were many breaches of HACCP practices noted, for example traceability, recording of cook and cooling temperatures and sampling. The management of HACCP was also lacking with only one external audit carried out in January 2007, which was in the early stages of corrective action. The scope of HACCP requires review to include the diet kitchen and the formula room.
A major refurbishment was in progress during the assessment; however, the lack of a robust HACCP system would leave the Hospital in a very vulnerable position in the event of a food safety incident. Corrective action was swift on the part of the Hospital Catering Department, which resulted in the score being upgraded to a B rating.
It is recommended that the HACCP implementation plan is progressed immediately, and an appropriate monitoring system is adopted.

For further information see Appendix A.

*Core Criterion
SD 4.5 (A → A)
The team ensures the inventory, handling, storage, use and disposal of Hygiene Services hazardous materials, sharps and waste is in accordance with evidence based codes of best practice and current legislation.
Waste management inventory, handling, storage, use and disposal of Hygiene Services hazardous materials, sharps and waste met standards of best practice and current legislations. Plans are currently in progress to provide a designated waste compound. Of note was the innovation and commitment of the Portering Manager and staff employed in Waste Management, in relation to introduction of successful recycling initiative undertaken. Additional detail as per mandatory check list.

For further information see Appendix A.

*Core Criterion
SD 4.6 (A ↓ B)
The team ensures the Organisations linen supply and soft furnishings are managed and maintained
An interim report on the laundry service has been drawn up detailing new guidelines and policies. At ward level, the majority of linen bags were observed to be greater

than two-thirds full. No hand washing facilities were in place in the laundry department.
However, a replacement sink in the laundry department is part of current sink replacement process. Additional detail as per mandatory check list.

For further information see Appendix A.

*Core Criterion

SD 4.7 (A → A)

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 is well managed with evidence of significant prominence, education and training to ensure compliance with SARI guidelines. Additional detail as per mandatory check list.

For further information see Appendix A.

SD 4.8 (B ↓ C)

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

No documented process was observed for the minimisation of risk, when Hygiene Services are being provided. Some risk assessments have been carried out; however, this process needs to be extended to all areas, including contracted services. Incidents are reported via the STARRS system and these are evaluated and reported on. However, resultant action plans were not available. A draft Health and Safety statement has been developed, however, no minutes of meetings for the previous year were observed. There is a HACCP plan for 2003 which needs to be updated in line with current legislation. It is recommended that Health and Safety audits and HACCP audits are carried out at regularly defined periods.

SD 4.9 (B ↓ C)

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

No overall documented process was observed to encourage and help patients/clients and families understand and carry out their responsibilities regarding hygiene Services. The Hospital was in the process of introducing the National Visitor Policy in line with the paediatric services offered. A range of patient/client information leaflets and welcome packs are provided at admission. Both hand-wash stations and information are provided at the entrance to ward areas. Visitor cards are used during outbreaks, for example MRSA. Satisfaction surveys are at an early stage of development, and therefore, evaluation was not fully evident. It is recommended that a proactive approach to participation be investigated, for example dedicated hygiene responses in the event of a hygiene deficiency being noted on comment cards.

PATIENT'S/CLIENT'S RIGHTS

SD 5.1 (A ↓ B)

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

It was very evident that all activities were patient-focused and child-centred. Hygiene Services are delivered in consultation with clinical areas, in an effort to ensure patient care is not compromised, and that the dignity of the patient is maintained.

It is recommended that an evaluation process is implemented as soon as is practicable.

SD 5.2 (B → B)

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

Welcome packs and Hospital information leaflets are provided at admission. An information notice board was also observed at the Hospital entrance. Hand wash notices are present at the entrance to each ward. An outbreak policy is available, which is communicated in the event of an outbreak of, for example, MRSA. Evaluation of patient/client family and visitor satisfaction had commenced and there are plans to extend to all areas of the Hospital. A quality improvement plan is in place to progress this process.

SD 5.3 (B → B)

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

Currently the Organisation is not implementing the new National Complaints Policy. The Hospital has an internal documented system for managing complaints. Letters of complaint are acknowledged within three days and reviewed within twenty-eight days. Over the past year, approximately four complaints relating to Hygiene Services were discussed at the Hygiene Services Committee meetings.

An annual summary of complaints is compiled, which is available to the Hospital Executive. A quality improvement plan has been developed to initiate the compilation of quarterly reports, with associated action plans in relation to Hygiene Services.

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.

A complaints procedure was observed to be in place. Some trial satisfaction surveys have been carried out on St. Michael's ward and some initial evaluation data of the survey was observed. A patient satisfaction survey has also been carried out on the parent facilities in St. John's Ward. No evidence of evaluation of this survey was presented. As a result of user surveys, the infection control leaflet has been reviewed and updated. It is recommended that patient/client satisfaction is extended throughout the Hospital and that external partners become involved. External audits have been carried out by the environmental health officer and HACCP consultants. It is recommended that the organisation should focus on resultant action plans. Consideration should also be given to evaluation processes such as family focus groups and comment cards.

SD 6.2 (A ↓ B)

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

Current evaluation of the quality of Hygiene Services includes infection control audits using the Infection Control Nurses Association tool. Cleaning audits are carried out by the contract cleaning company and a HACCP audit was conducted in January 2007. Other evaluation techniques devolve from the risk management incident evaluations and the complaints policy. A quality improvement plan has been developed to extend the audit process, using a software tool (which has gone to

tender). Current benchmarking is limited to the results of the Health Service Executive audit reports (2005 and 2006) and the HSAS scheme. It is recommended that internal local key performance indicators are developed, monitored and reported. There is a comprehensive list of hygiene initiatives (quality improvement plans) which are ongoing. It is recommended that the organisation focus on evaluation and benchmarking against similar organisations and the development of resultant actions in the future.

SD 6.3 (B ↓ C)

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

While there is no composite annual report for the organisation, annual reports from the infection control department, the contract cleaning company and the quality and safety department were reviewed. Currently there is no documented process for the compilation and communication of the Hygiene Services Annual Report. A plan has been developed for the implementation of a software package to facilitate on-going audits across the organisation. It is recommended that contracted services are also evaluated. In the absence of a Hygiene Services Annual Report, appropriate resources may not be identified/allocated. The Team is encouraged to progress the development of a Hygiene Services Annual Report.

4.0 Appendix A

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

4.1 Service Delivery Core Criterion

Compliance Heading: 4. 1 .1 Clean Environment

(27) Local policies should be in place for guidance on all cleaning processes, colour coding, use of equipment, use of protective clothing and fluids and spillages.
Yes - A hospital colour code policy is in place and adhered to, however, it does not conform to national guidelines.

(3) Wall and floor tiles and paint should be in a good state of repair.
No - Damage to a number of corridor walls, lift entrances and radiators was observed.

(12) Internal and external stairs, steps and lifts must be clean and well-maintained.
Yes - Lifts were clean, however they require re-painting.

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

(25) Floors (including hard, soft and carpets).
Yes - The floors which were observed were excellent.

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

(208) There should be a process for the cleaning of curtains and blinds. Curtains should be changed after each known case of infected patient/client where required. Records should be maintained of curtain changing.
Yes - A schedule of curtain laundry in place, however, validation is required.

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

(54) Wash-Hand Basins.
Yes - However, attention to the hand wash basin in the Intensive Care Unit is required. Drainage was also observed to be a problem.

(58) Sluice rooms should be free from clutter and hand washing facilities should be available.
No - However, a quality improvement plan is in place to address this. An active sink replacement programme is also in place.

(59) Where present shower curtains should be clean and in good repair with a process for laundering and replacement.
Yes - The organisation uses baths, not showers. This practice is based on children's preferences.

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

(272) Splashes of water or hand-wash gel should not be present on the wall, floor, bed or furniture, splash backs should be provided.
No - No splash trays were available, and splashes were noted to be discolouring the floor.

(74) Patients' personal items (e.g. suitcase) which should be stored in an enclosed unit i.e. locker / press.
No - Very limited storage space was available and suitcases/bags were noted in most areas.

(75) Vases.
Yes - There is a hospital policy regarding flowers.

(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 - Practices observed were controlled and in line with paediatric services offered.

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

(86) Information on the colour coding system is available to all hygiene staff (according to national guidelines).
Yes - A hospital specific colour coding system is in place. It is currently being updated to comply with National Cleaning Manual.

(91) Storage facilities for Cleaning Equipment should be clean and well maintained.
Yes - The catering sluice area requires upgrading.

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 - A copy of Regulation 852/2004 and related Codes of Practice were not available initially, however, they were subsequently presented.

(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 - EHO reports and action plans from 2005 were observed. Water analysis results were satisfactory.

(214) The person in charge of catering shall develop, implement and maintain a permanent system based on the seven principles of HACCP. A standard HACCP Plan should be fully completed.
No - The HACCP Plan observed was dated 2003 and needs to be updated immediately. The implementation of aspects of the plan was observed to be deficient. A HACCP Team needs to be formed to progress the HACCP system, as outlined in the HACCP report, dated January 2007.

(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 - This was not available on the wards visited during the assessment.

(216) Documented processes for manual washing-up should be in place.
No - This was not available.

Compliance Heading: 4. 4 .2 Facilities

(217) Access to the main kitchen and ward kitchens should be restricted to designated personnel i.e. food workers.
No - Access to the main kitchen was not restricted as the door locking mechanism was broken. While coded access was available at ward level, it was not restricted to catering staff.

(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.
Yes - Personal protective equipment was provided in the main kitchen. Consideration should be given to the provision of appropriate personal protective equipment at ward level.

(219) Ward kitchens are not designated as staff facilities.
Yes - However, staff fridges were observed in the ward kitchen. It is recommended that this issue is addressed.

(223) Separate toilets for food workers should be provided.
No - Separate toilets are provided in main kitchen, but not at ward level.

(225) Staff in charge of Ward Kitchens shall ensure that product traceability is maintained while the product is in storage (Regulation (EC) 178/2002). Stock shall be rotated on a first-in/first-out basis taking into account the best-before/use-by dates as appropriate. Staff food should be stored separately and identifiable.
No - While there was a labelling policy in place, it was not possible to trace back specific products through the CCPs to a batch number.

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 - However, external bait points were not noted and were not reflected on the bait map.

(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.
No - When viewed, the main compactor area was in a poor condition. The compactor was overflowing and the ground area required cleaning.

Compliance Heading: 4. 4 .4 Pest Control

(236) Detailed inspections of food areas shall be carried out and recorded at least every three months for evidence of infestation by insects or rodents by a competent person.
Yes - However, the inspection checklist observed was not up to date.

(237) A location map should be available showing the location of each bait point.
Yes - External baits, however, were not in place on the map.

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

(243) Preparation of High Risk Foods should comply with I.S. 340:2006 requirements.
No - Designated areas are required for food preparation activities.

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 - Dishwasher temperatures should be monitored regularly and temperatures must also be validated.

Compliance Heading: 4. 4 .7 Food Processing

(246) The thawing of food shall be carried out under appropriate conditions such as in a thawing unit, a fridge or a microwave oven with thawing cycle.
Yes - It was stated that thawing was not carried out. The HACCP plan must be updated to reflect this.

Compliance Heading: 4. 4 .8 Food Cooking

(247) All foods shall be cooked to a temperature to ensure that the products are safe for consumption. The core temperature of the food shall be assessed at the thickest point of the food and should be compliant with I.S. 340:2006
No - While temperatures are checked, they are not always recorded. Therefore, cooked temperatures for specifically selected products from chill could not be validated.

Compliance Heading: 4. 4 .9 Food Cooling

(248) Cooling Times for Cooked Food should comply with I.S. 340:2006 requirements
No - Cooling temperature records are not always recorded. This was checked for specific cooked products from chill.

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

(173) Documented processes for the use of in-house and local laundry facilities.
No - These are currently being produced; however, to date, they have not been fully completed.

(262) Linen is segregated into categories and in appropriate colour coded bags (i.e. clean/unused linen, dirty/used linen, dirty/contaminated linen).
Yes - A new colour code has been introduced, and an interim laundry report and working group are in situ.

(263) Bags are less than two-thirds full and are capable of being secured.
No - Laundry bags observed were very full and difficult to close.

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

(271) Hand washing facilities should be available in the laundry room.
No - No hand hygiene sink was present in the laundry.

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

(192) Taps should be hands free and should be mixer taps to allow temperature regulation.
Yes - With the exception of the out-patient department, all taps were compliant.

(193) Liquid soap is available at all hand washing sinks. Cartridge dispensers must be single use.
Yes - No liquid soap was available in the kitchen sink on the first visit; however, this was rectified when revisited on the second day of the assessment.

(195) Absorbent paper towels are available at all hand washing sinks. Air dryers should not be recommended.
Yes - With the exception of the kitchen, all areas were compliant.

(197) Wall mounted/Pump dispenser hand cream is available for use.
No - Only a limited supply of wall mounted/pump dispenser hand cream was observed in the Hospital - this should be addressed.

(198) Hand hygiene posters and information leaflets should be available and displayed throughout the organization.
Yes - The visibility of the hand hygiene posters at the main entrance and ward entrances requires improvement.

(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.
Yes - A quality improvement plan is in place to complete the conversion programme.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team		Assessor Team	
	FREQ	%	FREQ	%
A	23	41.07	9	16.07
B	33	58.93	29	51.79
C	0	00.00	18	32.14
D	0	00.00	0	00.00
E	0	00.00	0	00.00
N/A	0	00.00	0	00.00

5.2 Ratings Details

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

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