



## **Hygiene Services Assessment Scheme**

**Assessment Report October 2007**

**Our Lady's Hospital, Navan**

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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 6<sup>th</sup> 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”<sup>1-4</sup>*

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.<sup>5</sup>

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

#### ***Core Criteria:***

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

In the Corporate Management standards, the core criteria cover:

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

In the Service Delivery standards, core criteria cover:

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

### **1.1.2 Rating Scale**

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

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

#### **A Compliant - Exceptional**

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

#### **B Compliant - Extensive**

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

- C Compliant - Broad**
  - There is evidence of broad compliance (between 41% and 65%) with the criterion provisions.
- D Minor Compliance**
  - There is evidence of only minor compliance (between 15% and 40%) with the criterion provisions.
- E No Compliance**
  - Only negligible compliance (less than 15%) with the criterion provisions is discernible.
- N/A Not Applicable**
  - The criterion does not apply to the areas covered by the Self Assessment Team. Rationale must be provided. This cannot be used for a core criterion.

### 1.1.3 Assessment process components

The assessment process involves four distinct components:

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

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

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

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

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

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

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

The Internal Review Committee of the HIQA reviewed all the reports to ensure consistency, and based on the quantifiable translation guidelines, awards were made. Only organisation's which received a "very good" score were acknowledged with an award for the duration of one year. By the end of

October 2007 all 51 acute care hospitals had received a copy of their individual report.

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

- **Continuous Improvement**

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

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

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<sup>1</sup> Boot, M and Cairncross, S "Actions Speak" Delft, The Netherlands, IRC and LSTHM, British Occupational Hygiene Society.

<sup>2</sup> New York Department of Health and Mental Hygiene

<sup>3</sup> The Columbia Electronic Encyclopaedia, Sixth Edition. Columbia University Press. 2003

<sup>4</sup> Irish Acute Hospitals Cleaning Manual, HSE (2006)

<sup>5</sup> Hygiene Services Assessment Scheme. Irish Health Services Accreditation Board (2006)

## **1.2 Organisational Profile**

Our Lady's Hospital, Navan, is part of the Louth/Meath Hospital Group in Co. Meath serving a population of 162,621 and provides an elective Orthopaedic Service to the Health Services Executive, Dublin North East with a total bed capacity of 173.

### **Physical structures**

There are no dedicated isolation facilities within Our Lady's Hospital. The 19 private rooms are used for isolation purposes, as required.

### **Services provided**

Our Lady's Hospital, Navan, provides a range of acute services including:

General Medicine  
General Surgery  
Elective Orthopaedics  
Paediatrics (Out -patient services)  
Day Services  
Gynae Services  
Pathology Services  
Out-patient Services  
Orthodontic Out-patients  
ICU/CCU  
Physical Medicine Services

The following assessment of Our Lady's Hospital took place between 27<sup>th</sup> and 28<sup>th</sup> March 2007.

## **1.3 Notable Practice**

- In the area of hand hygiene the use and supply of gel was noted to be in accordance with the Strategy for the control of Antimicrobial Resistance in Ireland (SARI) guidelines.
- Both X-ray and Theatre Sterile Supplies Unit (TSSU) were found to have a high standard in relation to hygiene.
- The structure of the main kitchen was of a high standard.
- Linen control was generally good.
- A good interest and commitment to hygiene improvement was noted by the Hygiene Team.
- The auditing team encountered external consultants evaluating theatre issues on the day of audit. This indicated the positive commitment of the organisation to improving hygiene standards.

## **1.4 Priority Quality Improvement Plan**

- A corporate strategic plan is required.
- Appropriate separation of bathroom and sluice room on female surgical ward is necessary.
- The removal of the autoclave next to the theatre to be carried out

- Waste compound to be developed as a priority.
- Staff training to be carried out for all those involved with food production and waste management, which should be competency-based.

### ***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, Navan has achieved an overall score of:

**Poor**

**Award Date:** October 2007

## **1.6 Significant Risks**

**CM 3.1 (Rating D)**  
**The organisation has a clear corporate strategic planning process for Hygiene Services that contributes to improving the outcomes of the organisation.**

### **Potential Adverse Event**

Hygiene-related issues inclusive of financial and human resources may not have been receiving prioritisation as necessary for the organisation.

### **Risks**

Likelihood of Event	Rated: M (2)
Impact of Event	Rated: M (2)
Urgency of Action	Rated: M (2)
<b>TOTAL</b>	<b>Total: 6</b>

### **Recommendations**

It was recommended that a corporate strategic plan be developed.

**CM 9.1 (Rating E)**

**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**

Ward area

This may have increased the risk of acquiring infections. A risk of suboptimal care was evident due to the increased risk of infection if patients had to access the toilets through the utility room, which needed attention.

Theatre

The positioning of the autoclave in the theatre was assessed is inappropriate as it may have lead to risk of cross contamination within the theatre environment.

**Risks**

Likelihood of Event	Rated: M (2)
Impact of Event	Rated: H (3)
Urgency of Action	Rated: H (3)
<b>TOTAL</b>	<b>Total: 8</b>

**Recommendations**

It was recommended that storage facilities for clean products and equipment for cleaning should be completely separate. The toilet and utility rooms should be redesigned in line with current best practice.

It was recommended that structural, process and equipment issues in the theatre should be addressed.

## 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 (C → C)

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

Documented risk assessments at ward level were being performed. However, when staff shortages resulted in the inadequate cleaning of equipment, the control measures for the hazard identified were not adequately addressed. National audit results and use of the Infection Control Nurses Association audit tool at ward level were being utilised to highlight hygiene issues at ward level. The organisation had not yet developed a Hygiene Corporate plan. However, it had implemented a Strategic Service and Operational Plan. The Hygiene Corporate Plan should have had input from relevant department heads. The organisation was recommended to utilise the Health Information and Quality Authority Hygiene Services Assessment Scheme as a driver for the ongoing development of hygiene services in the organisation.

#### 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.**

Following a needs analysis of the area delivering orthopaedic care, the area was refurbished, thereby addressing the structural issues and facilitating maintenance and cleaning. Documented evidence was observed of ongoing education delivered to staff in relation to Hygiene Issues. The purchasing of one system of floor cleaning was being introduced, but some discrepancies occurred in the use of floor cleaning equipment throughout the hospital.

### ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

#### CM 2.1 (C → 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.**

Specific linkages were in operation with Health Service Executive and the Department of Health and Children. Meetings were also held with the Area Network Manager. Documented processes in relation to the organisation's communications and meetings with all stakeholders were observed. The level of communication with

patients/clients/staff required some improvement. Information derived from client feedback forms acted as drivers for improvement of Hygiene Services.

## CORPORATE PLANNING FOR HYGIENE SERVICES

### **CM 3.1 (D → D)**

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

The organisation had a Strategic Service and Operational Plan. However, it had not yet developed a Corporate Strategic Plan. The organisation was advised to utilise the Health Information and Quality Authority Hygiene Services Assessment framework to develop this plan. It was recommended that the plan include clearly defined goals, priorities and related costs. The plan needed to be approved by the Executive Management Team of the organisation and to have input from and direct communication with all relevant multi-disciplinary team members.

## GOVERNING AND MANAGING HYGIENE SERVICES

### **CM 4.2 (C ↑ B)**

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

On discussion with senior staff during the assessment, further evidence regarding this criterion was available. Information from a variety of sources, including legislation, best practice guidelines and Infection Control formed the basis for change in hygiene practices. Evidence was observed that hygiene issues were discussed at all meetings such as Hygiene Services Team meetings, Hygiene Services Steering Group meetings, Catering Team meetings, Services Officer and Shop Steward meetings. Documentation of best practice reviewed and evaluation of information received by the organisation informed the development of the organisation's quality improvement action plan. Quality improvement plans observed included the upgrading of wash hand basins in line with SARI guidelines.

### **CM 4.4 (C → C)**

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

The organisation had a system in place on policy development, which was in line with the Health Service Executive Dublin North East system and with best practice. All ward areas and departments had policies and procedures relating to hygiene in place.

### **CM 4.5 (C ↑ B)**

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

Supporting evidence of the Hygiene Services Committee's involvement in ongoing developments was observed. Representatives from the Hygiene Services Team were involved in the planning and development of minor capital developments and refurbishments. This ongoing involvement ensured comprehensive Hygiene Service input into all new developments.

## 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.**

A documented hygiene service structure was in place. The Management of Our Lady's Hospital Navan assumed overall responsibility for hygiene services. The reporting relationships and responsibilities/accountabilities for hygiene services were documented. The ward managers/department managers were identified as being responsible for Hygiene Standards in their own areas. Risk assessments were performed at local level to identify hazards in relation to hygiene requirements.

\*Core Criterion

### **CM 5.2 (B → B)**

**The organisation has a multi-disciplinary Hygiene Services Committee.**

The Hygiene Services Committee and Hygiene Services teams were multidisciplinary, had clear terms of reference, meeting schedules and administrative support as recommended by the Hygiene Services Assessment Scheme standards. The Hygiene Services Committee had a mission statement outlining its aims and objectives and it has also outlined its structure and quorum for committee meetings. It was recommended that the mission statement should link with the Hygiene Corporate Strategic Plan when it is developed.

## 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.**

Resources are allocated based on needs identified by management through its service plans and pre-planned preventative maintenance programme. Evidence of on-going investment in hygiene service development through kitchen replacement and wash hand basin replacement was noted. The development of the Corporate Hygiene Strategic Plan has prioritised hygiene issues for the organisation.

## MANAGING RISK IN HYGIENE SERVICES

\*Core Criterion

### **CM 7.1 (C → C)**

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

Documented processes for risk management were evident within the organisation. The North East Health Board Incident Reporting policy was used to record adverse incidents and near misses in the organisation. Samples of adverse incidents were observed during the assessment. Risk assessments had identified that patient-related equipment in the cardiac area had not been adequately cleaned due to inadequate human resources. However, a corrective action plan following the risk assessment was not identified. Prompt corrective actions were necessary following adverse incidents and it was recommended that this process is strengthened in the near future. An annual report relating to incidents was compiled by the Risk Management

Department in the Health Service Executive Dublin North East. No Health and Safety Authority inspections were performed in recent years. Environmental Health Officer reports were available for both the kitchen and store areas.

## CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

\*Core Criterion

### **CM 8.1 (C → C)**

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

The organisation was compliant with Health Service Executives Central Procurement Policy. Documented evidence of the management and monitoring of contracts was available and observed during the assessment. The organisation planned to arrange contracts for the cleaning of air vents and ventilation equipment. A plan to negotiate a contract for a waste management compound was in place, which was recommended in order to greatly benefit the management of waste.

## PHYSICAL ENVIRONMENT, FACILITIES AND RESOURCES

### **CM 9.1 (C ↓ E)**

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

The organisation is aware of its limitations within the physical structure of the building and is endeavouring to adhere to all regulations and best practice. The design and layout of some clinical areas did not promote best practice. Some of the structural issues identified during the assessment include:

- The design of the utility room in the female surgical unit, which needed upgrading.
- Patients having to access toilet facilities through that utility room.
- The cleaner's store is adjacent to/part of the other, cleaner utility room.
- The design and layout of the general theatre: inappropriate positioning of the autoclave and the poor general condition of the surrounding area. Storage facilities within theatre department were also inadequate.

Prior to the commencement of the Hygiene Services Assessment Scheme, there was a recognised need within the organisation to continue to carry out extensive physical upgrading and maintenance improvements in these areas. The upgraded areas observed demonstrated evidence of best practice and adherence to regulations. Further improvements, including the upgrade of ward kitchens, were part of the organisation's quality improvement plans.

\*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.**

Policies were in place in the organisation for the management of its environment and facilities. Of note was a very commendable Infection Control Manual detailing safe handling and disposal of sharps and segregation, handling and storage of linen was observed. Specific issues requiring improvement within catering departments are described in detail in SD 4.4.

**CM 9.4 (B → B)**

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

Evidence was observed of written patient/client satisfaction feedback, which was mostly positive. Patients who were interviewed during the assessment were very positive about their experience in the hospital. A quality improvement plan to improve feedback to the members of staff in the organisation had also been developed. It was felt that the organisation would benefit from further involvement of its service users in the area of hygiene and a more formal approach was recommended in the future.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

**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.**

Increased requirements for cleaning services had been identified and documented in risk assessments. However, human resources were limited in the organisation. It was noted that the organisation quality improvement plan aimed, through the Corporate Strategic Plan for 2008, to increase financial and human resources. Within the last two years additional changes in work capacity and volumes were met within the existing resources due to imposed employment ceilings.

\*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.**

During the assessment, observations were made that staffing levels were not meeting the needs of the organisation's hygiene requirements. No Corporate Strategic Plan was in existence. However, the organisation planned to formulate it by the end of the year, which was recommended, thereby assisting in addressing this issue.

ENHANCING STAFF PERFORMANCE

\*Core Criterion

**CM 11.1 (C → C)**

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

Induction/orientation was provided for all new staff with input from all other relevant disciplines. Ongoing hygiene awareness training was also in place for all staff. Some core elements of the content of the programme included Health and Safety and Infection Control. Staff involved in food handling received basic food hygiene training. A staff handbook was also made available to all staff on appointment.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

**CM 12.1 (B ↓ C)**

**An occupational health service is available to all staff**

Details of the services provided by Occupational Health were available within the organisation. Vaccinations and review of immune status in relation to specific

infectious illnesses were available on a voluntary basis. No evaluation of the appropriateness of the service had been documented. It was suggested that staff questionnaires are utilised to evaluate the service provided.

## COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

### **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.**

No evaluation was undertaken on the method of presenting data to staff or how staff should interpret the information delivered. Methods of capturing information from staff were discussed during assessment interviews. For example, staff questionnaires regarding information relayed to front line staff from formal meetings and evaluation forms for training, incorporating a section on the level of satisfaction with the method of information delivery. The monthly Hygiene Services meeting, which commenced in June 2005, was a good forum for the regular review of feedback on audit action report results. All hygiene quality improvement initiatives could be reviewed at these meetings.

### **CM 13.3 (C → C)**

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

Reports were managed in a structured process. Incident reports were assessed and classified by the Assistant Hospital Administrator prior to their forwarding to the Risk Management Department in the HSE Dublin North East, Kells. External audits performed assisted in the upgrading of areas, thereby significantly improving hygiene services in these areas for example Theatre Sterile Supplies Unit (TSSU), Orthopaedic Unit, orthopaedic theatre, general theatre/endoscopy unit and catering facilities.

## ASSESSING AND IMPROVING PERFORMANCE FOR 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 organisation undertook a number of internal audits and participated in two national hygiene audits in 2006. The establishment of the Hygiene Services Assessment Scheme recommended hygiene management structures and communication pathways, along with the identification of the ward/department managers as the ultimate people responsible for hygiene in their own areas. These are some of the examples observed of the involvement of staff at all levels of the organisation (including the most senior managers) in its Hygiene Services. These pathways were being utilised to communicate information to staff at all levels. Significant structural improvements were noted as a result of audits and needs analysis undertaken, for example, in the orthopaedic theatre area, upgraded gas and electrical services, TSSU installation and the main kitchen upgrade. Improvement of facilities was also observed, for example wash-hand basins, the replacement of dishwashers, colour-coding of waste bins, the purchasing of linen presses and

colour-coded cleaning equipment. The provision of alcohol-based hand gels for staff, patients and visitors had also increased as a direct result of Hygiene Services improvements. The further development of the Corporate Strategic Plan was seen as benefitting the organisation by identifying its goals and priorities relating to the Hygiene Services.

### 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 (C → C)

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

Relevant guidelines were available, but had not been fully evaluated. The National Laundry Guidelines 2006, SARI guidelines, Healthcare Risk Waste Guidelines and IS340 Catering Guidelines were all observed. It was recommended that the guidelines be used to develop best practices and audited to ensure compliance. It was also recommended that any non-conformances be noted in a quality improvement plan.

#### PREVENTION AND HEALTH PROMOTION

##### SD 2.1 (C → C)

**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 promotion of hygiene requires improvement. Leaflets were available at the front door of the hospital, but none were available at the Out-patient Department. It was recommended that the client feedback forms should be used to promote areas outlined by clients as requiring improvement. It was also recommended that the organisation strive to involve the entire community to become involved in health promotion. This could be achieved through communication with local schools or community groups.

#### INTEGRATING AND COORDINATING HYGIENE SERVICES

##### SD 3.1 (B → B)

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

All staff in the areas of the hospital visited were aware of and involved with hygiene improvement activities. Team awareness was good, roles were defined at team and individual level, but it was recommended that they are clearly documented.

The organisation was also recommended to evaluate the efficacy of the team structure and to implement a continuous quality improvement plan. With the exception of the National Hygiene Audits in 2006, no documented processes were in place for the establishment and review of linkages with other teams, programmes or organisations.

## IMPLEMENTING HYGIENE SERVICES

\*Core Criterion

### **SD 4.1 (A ↓ B)**

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

A high standard was observed in the TSSU and Radiology. This criterion had been rated using the mandatory compliance criteria and comments had been included where appropriate, with areas requiring greater attention being noted.

For further information see Appendix A

\*Core Criterion

### **SD 4.2 (A ↓ B)**

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

This criterion was rated using the mandatory compliance criteria. Comments were included where appropriate, with areas requiring greater attention to cleaning noted.

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.**

The storage of equipment required further improvement. An improved mopping system also needed to be implemented as a priority.

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 structure and general cleaning of the main kitchen was of a high standard. Temperatures checked were within specification and food storage and separation practices observed were good. Some operational practices in the main kitchen required improvement, for example, the wearing of jewellery, the use of sanitisers and in-house freezing.

The Hazard Analysis and Critical Control Point (HACCP) system in use did not adequately control food safety from kitchen to the patient. The ward trolleys did not have a chill section. Hot food checked was not at 63 degrees Celsius when served. Some ward kitchens did not comply with the policies in respect of jewellery, temperature checks, cleaning checks and the storage of staff foods.

Generally staff training, particularly at ward level, should have been competency-based as the practices observed did not reflect the policies in place. Food service staff also performed clinical cleaning duties and due to the potential risk, this practice was not recommended. Staff did, however, change aprons and gloves between duties, but separate staff for each function would be its best practice.

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.**

This criterion was rated using the mandatory compliance criteria and comments were included where appropriate.

For further information see Appendix A

\*Core Criterion

**SD 4.6 (C ↑ A)**

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

Policies were in place and the practice observed during the assessment was very good. However, not all staff had records of training. It was recommended that this area be addressed and all issues regarding training be identified.

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**

Good staff practice and awareness of hand hygiene was observed throughout the organisation during the assessment.

For further information see Appendix A

**SD 4.8 (C → C)**

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

The sluice room observed was very cluttered and was used for patient washing, both baths and showers. There could have been difficulty in using the bathroom facilities due to the fact that this area was used to store other items, for example wheelchairs. The potential risk of patients accessing a bathroom through a sluice room may also have caused a health risk.

Patients were observed smoking at the hospital entrance, an area which is not considered safe for this practice. Greater attention to the frequency and detail of cleaning of medical equipment was required.

**SD 4.9 (C → C)**

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

A comment questionnaire was available at the main entrance and in public areas. While good leaflets and posters were noted in areas, the Out-patient department required improvement in relation to the promotion of hygiene.

## PATIENT'S/CLIENT'S RIGHTS

### **SD 5.1 (C → C)**

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

Good isolation practices for patients with infections were observed. Information leaflets for the public were available at the entrance. A visitor protocol was not in place, but it was planned for development within the next month. No documented process for maintaining patients' dignity was available, which was recommended. It was recommended that the organisation follow up on resultant actions, when quality improvement plans are put in place.

### **SD 5.2 (C → C)**

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

Patient information leaflets were available at the front door, but none were available at the Out-patient Department. Poor signage was also observed at the Out-patient department and the organisation was recommended to improve the promotion of hygiene in this area. Laminated signage must be introduced in all areas to promote hygiene.

### **SD 5.3 (C ↑ B)**

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

Good documented processes were observed. It was recommended that this information (from client feedback forms), be used to improve the service provided. It was also recommended that information provided by the patients should be reviewed and acted upon where possible. This corrective action had to be highlighted to the patients to demonstrate the organisation's commitment to improving the service.

## ASSESSING AND IMPROVING PERFORMANCE

### **SD 6.1 (C → C)**

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

A patient satisfaction survey was in place. These results of this were reviewed and the organisation was recommended to implement a corrective action system to follow up on any issues identified.

### **SD 6.2 (C → C)**

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

Internal meetings currently had taken place and the most recent minutes observed during the assessment were for February 2007. Good corrective action was taken following the Environmental Health Officer's report in relation to kitchen areas. All areas had to be audited at a defined frequency to evaluate the service and plan improvements.

There was no evidence of the use of benchmarking in most areas. It was recommended that this assessment be used to implement further improvements, without replacing internal auditing.

**SD 6.3 (C → C)**

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

No annual report was observed to be in place. This was required to plan improvements for 2008 and to set targets to improve patient care.

## 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** - Visible dust was observed on many horizontal surfaces.

(2) All high and low surfaces are free from dust, cobwebs and flaking paint.

**No** - Cobwebs were observed in the clean utility room.

(3) Wall and floor tiles and paint should be in a good state of repair.

**No** - The splash back areas of the wash hand basins observed were in a poor state of repair. The dish wash room at the canteen was also in need of repair.

(4) Floors including edges, corners, under and behind beds are free of dust and grit.

**No** - Pipe work observed behind beds were dusty. This bed had been cleaned and was ready for a new patient.

(5) Cleanable, well-maintained furniture, fixtures and fittings used.

**No** - Chairs and stools at ward level were in a poor state of repair.

(7) Areas should be adequately ventilated with ventilation units cleaned and serviced accordingly and documentation available regarding service.

**No** - Shower vents were observed to be dusty.

(10) Internal and external signage should be clean, updated, well maintained and laminated to enable cleaning.

**No** - Signage observed was in poor condition and not all signage was laminated.

(12) Internal and external stairs, steps and lifts must be clean and well-maintained.

**No** - Lift cleaning was observed to be inadequate. The cleaning of stairs also required improvement. The lift was also used for the transportation of food, waste and linen. This was not best practice and had to be reviewed.

(14) Waste bins should be clean, in good repair and covered.

**No** - Bin cleaning was noted to be poor and required improvement.

(16) Hospitals are non smoking environments. However, cigarette bins should be available in external designated locations.

**No** - Bins were not available in the area where staff were observed smoking. This area was not formally designated as a staff smoking area. It was recommended that

a designated area and the necessary facilities be provided. Hand gel in this area would also be required.

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

(18) Walls, including skirting boards.

**No** - Wall/floor junctions were not observed to be clean.

(19) Ceilings

**No** - Some ceiling tiles were missing and others required replacement due to staining.

(21) Internal and External Glass.

**No** - The entrance door glass observed was dirty.

(24) Ventilation and Air Conditioning Units.

**Yes** - The units inspected were clean.

**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** - Bed table, foot stool and curtain rails observed were not considered clean.

(32) Shelves, benchtops, cupboards are clean inside and out and free of dust and spillage

**No** - The clinical room beside the nurses' station in the top floor female ward and sluice room cupboards observed were not clean.

(207) Bed frames must be clean and dust free

**No** - The lower bed frame observed was good but the metal base for the mattress was dusty.

(209) Air vents are clean and free from debris.

**Yes** - The air vents inspected were clean.

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

(37) Tables and Bed-Tables

**No** - Sticky tape was noted under some table tops.

(41) Door handles and door plates

**No** - Some areas observed were not adequately cleaned.

**Compliance Heading: 4. 1 .5 Sanitary Accommodation**

(47) Bathrooms / Washrooms are clean and communal items are stored e.g. talc or creams.

**No** - Deep cleaning of floors, vents and pipe work require attention.

(48) Floors including edges and corners are free of dust and grit.

**No** - One public toilet inspected post cleaning was not satisfactory. Areas of the entrance corridors observed needed attention.

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

(58) Sluice rooms should be free from clutter and hand washing facilities should be available.

**No** - No appropriate wash hand basin was available for staff in the female surgical sluice room. Patients also had to enter the bathroom facilities via the sluice room. This was not best practice and required attention.

**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.

**No** - Intravenous pumps, stands and monitors observed were not clean.

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

(65) Commodes, weighing scales, manual handling equipment.

**No** - Underneath some commodes observed were not clean and in need of repair.

(66) Medical equipment e.g. intravenous infusion pumps, drip stands and pulse oximeters, suction apparatus and tubing, cardiac monitors, blood pressure cuffs, blood gas machines.

**No** - Greater attention to the frequency and detail of cleaning of medical equipment is required.

(69) Patient washbowls should be decontaminated between each patient, and should be stored clean, dry and inverted. Damaged washbowls should be replaced.

**No** - The washbowls observed were stored clean but not inverted.

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

(72) Trolleys, e.g. chart trolleys, drug trolleys, linen trolleys, shop trolleys, emergency trolleys, suction apparatus, resuscitation equipment i.e. ambubag and mask.

**No** - Many suction, chart and resuscitation trolleys were in poor condition.

(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.

**Yes** - No flowers were noted during the assessment.

(80) All office equipment (e.g. telephones, computers, fax machines) should be clean and well-maintained.

**No** - All keyboard and monitors in nurses stations visited were not satisfactory. These are hand contact areas and had to be included in the cleaning programme.

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

(82) Vacuum filters must be changed frequently in accordance with manufacturer's recommendations - evidence available of this.

**Yes** - A good service contract was available and observed during the assessment.

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

**No** - No formal system was in place. With the exception of theatre, single use mops were not used. Mops were used for a three-day period. This was not considered best practice and had to be reviewed.

(85) Cleaning solutions should only be prepared in a well ventilated area and should never be mixed.

**No** - Ward stores were not adequately ventilated, and this required attention.

(86) Information on the colour coding system is available to all hygiene staff (according to national guidelines).

**Yes** - One yellow bucket was observed in use at a ward kitchen, however, practice otherwise was good and in accordance with the hospital's colour-coding policy.

(87) All cleaning equipment should be approved by the Hygiene Services Committee and ensure sufficient supply.

**Yes** - Infection control approves all cleaning equipment as part of the Hygiene Services Committee.

(89) Equipment with water reservoirs should be stored empty and dry.

**Yes** - One mop bucket contained soiled water at general theatre, however, practice overall was observed to be good.

(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** - Space limitations were noted in areas and inadequate storage was also noted. A lack of sinks and wash hand basins was observed throughout.

(91) Storage facilities for Cleaning Equipment should be clean and well maintained.

**No** - Some storage facilities for cleaning equipment observed were untidy and the main store structure was inadequate.

(92) Cleaning products and consumables should be stored in shelves in locked cupboards.

**Yes** - Good yellow cupboards were observed in use.

(95) When using electrical cleaning equipment, a circuit breaker should be used if appropriate and the equipment should be plugged in while switched off using dry hands.

**Yes** - All electrical cleaning equipment was replaced in the last two years and hence did not need a circuit breaker. A maintenance contract was in place for these machines. These units were serviced four times per year.

**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 the standard for 1994 was observed in the manual. Compliance with EC 852 of 2004 Hygiene of foodstuffs had to be maintained.

(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** - An Environmental Health Officer report for 2006 had a corrective action report drawn up. Extensive water testing was carried out in August 2006 and the results complied with current legislation.

(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** - This system had been developed but not implemented at ward kitchen level. No temperature checks of food were carried out once it left the kitchen. The coffee shop, however, had a HACCP system that was implemented and understood by staff.

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

**Yes** - A policy was observed, however it has not been implemented.

(216) Documented processes for manual washing-up should be in place

**Yes** - The policy was observed but staff questioned were not aware of same.

**Compliance Heading: 4. 4 .2 Facilities**

(220) Staff must not consume food or beverages intended for patient use, food should not be consumed in the ward kitchen and no food is to be routinely prepared in the ward kitchen other than beverages and toast.

**No** - In the day ward, a press identified 'staff food only' was observed

(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** - The female surgical ward kitchen had no separate wash hand basin available.

(224) The ventilation provided for all cooking and steam emitting equipment shall be sufficient to prevent condensation on walls, ceilings and overhead structures during normal operations.

**Yes** - However, the cooking vent observed was very dusty.

(227) Flour, cereals, sugar etc shall be stored in a dry environment and when opened stored in covered containers.

**No** - Some containers at ward level had no covers to protect opened products. Dried foods were stored with chemicals at the main store. It was recommended that these items should be separated.

**Compliance Heading: 4. 4 .4 Pest Control**

(238) Electric fly killer (EFK) units when used shall be located in an area free from draughts, away from natural light and not directly above an area where food or materials that come into contact with food are located. The EFK units shall be left on at all times and have shatter proof sleeves. The ultraviolet (UV) light tubes shall be replaced at least annually and records of replacement should be retained. The EFK shall be fitted with a catch tray and emptied as required.

**Yes** - Only one observed was not operational in the canteen preparation kitchen.

(239) Fly screens should be provided at windows in food rooms where appropriate.

**Yes** - However, some observed were dusty and required further cleaning.

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

(240) A Hospital using a cook-chill system should comply with Guidance Note No. 15 Cook-Chill Systems in the Food Service Sector (Food Safety Authority of Ireland) The temperatures of fridges, freezers, cold rooms and chill cabinets shall be capable of maintaining the temperature of foodstuffs

**Yes** - However, the system was not in general use. Controls were in place for cooked meats at the main kitchen.

(241) Ice cream display units can operate at -12°C as long as it can be demonstrated that the product has been held at this temperature for less than 7 days.

**Yes** - This was noted to be kept in the main freezer at -18 degrees Celsius.

(242) Temperatures for Food in Fridges / Freezers and Displays should comply with I.S.340:2006 requirements

**No** - The female surgical fridge recorded a temperature of 6-10 degrees Celsius with no corrective action noted. The service display at the canteen was observed at 9 degrees Celsius and staff training was required here.

(243) Preparation of High Risk Foods should comply with I.S. 340:2006 requirements

**No** - Records for chilling and cleaning were not always complete at kitchen and ward level. However, two internal audits for 2006 were noted on file.

(244) Temperature for food when cooked, held or reheated should comply with I.S. 340:2006 requirements

**No** - No formal control over reheating or hot holding at wards was observed. Foods probed were recorded between 56-59 degrees Celsius. The minimum required temperature here was 63 degrees Celsius.

#### **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).

**No** - The use of sanitiser was noted to be very poor. No sanitiser spray bottles were used during a tour of the kitchen. Spray bottles were not labelled. Staff stated they used detergents to clean; however, a sanitiser should have been used on a food contact area.

#### **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

**Yes** - Good cooking controls in line with IS:340 were noted.

#### **Compliance Heading: 4. 4 .9 Food Cooling**

(248) Cooling Times for Cooked Food should comply with I.S. 340:2006 requirements

**Yes** - Practice observed was generally good. However, one product was not recorded at less than 10 degrees Celsius after 150 minutes. Final chill temperatures should have been recorded.

#### **Compliance Heading: 4. 4 .10 Plant & Equipment**

(249) Machines should dispense ice but where ice-scoops are used, they should be stored separately from the ice-making machine and there should be a process for the appropriate decontamination of the ice scoops. The making of ice cubes other than in ice machines is prohibited.

**Yes** - Ice scoops were not in use.

(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** - At all areas observed, only the wash temperature was recorded. The final rinse temperature must be at least 82 degrees Celsius, as per the HACCP plan. Staff were not aware of rinse temperatures; however, a service contract was in place for preventative maintenance on the dishwasher.

(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** - The calibration status was available on each probe in use; however, moist wipes had to be available beside each probe to adequately clean the probe before and after each use.

#### **Compliance Heading: 4.5.1 Waste including hazardous waste:**

(141) Documented procedures for the segregation, handling, transportation and storage of waste.

**No** - A documented procedure for segregation was available, however, procedures were not available for handling and storage.

(142) Healthcare risk waste should be tagged and secured before leaving the area of production.

**No** - Sharps bins observed at the exterior of the hospital were not closed properly and some were not tagged.

(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** - A DVD was presented as evidence of this tracking system.

(151) Waste is disposed of safely without risk of contamination or injury.

**No** - Staff were observed to carry bags of waste chest high with no personal protective equipment.

#### **Compliance Heading: 4.5.3 Segregation**

(159) Sharps boxes are correctly sealed, labelled and stored in a safe environment.

**No** - Some observed were not closed internally and were not externally controlled, not in a wheelie bin.

(256) Mattress bags are available and are used for contaminated mattresses ready for disposal; mattresses are disinfected.

**Yes** - Bags available for pressure relieving mattresses were used and disinfected.

#### **Compliance Heading: 4.5.4 Transport**

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

**No** - No documented processes were in place and the practice observed was not in line with best practice. This had to be reviewed.

(165) There is a designated person trained as a Dangerous Good Safety Advisor (DGSA) or the services of a DGSA are available to the hospital.

**Yes** - External services were used in this organisation.

#### **Compliance Heading: 4.5.5 Storage**

(169) Documented process(es) for the replacement of all bins and bin liners.

**Yes** - A policy is in place for the replacement of all bins and liners which was in line with current best practice.

(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** - No warning signs to restrict public access were observed.

(258) Waste receptacles should be sanitised, secure and in a good state of repair when used.

**No** - Waste receptacles observed were opened and in a poor state of repair.

**Compliance Heading: 4. 5 .6 Training**

(259) There is a trained and designated waste officer.

**No** - The maintenance manager controlled waste. Training was required there.

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

(172) Documented processes for the management, maintenance and safe handling of linen and soft furnishings throughout the organisation.

**Yes** - A linen policy was put in place in February 2006.

(173) Documented processes for the use of in-house and local laundry facilities.

**Yes** - External laundry facilities were in use.

(261) Clean linen store is clean, free from dust and free from inappropriate items.

**No** - Bags on the floor in linen store were inadequate due to storage space. Inappropriate storage was also observed at the female surgical ward.

(262) Linen is segregated into categories and in appropriate colour coded bags (i.e. clean/unused linen, dirty/used linen, dirty/contaminated linen).

**Yes** - Shortage of red bags could have caused problems in this area, however, no problems were noted during assessment. It was recommended that the purchase of new trolleys should not facilitate the transport of clean and used laundry.

(263) Bags are less than 2/3 full and are capable of being secured.

**Yes** - However, the posters displayed showed yellow bags which were not used at this facility. This may have caused confusion.

(265) Linen skips and bags must be used when collecting linen and taking it to the designated area. Soiled linen must not be left on the floor or carried by staff.

**Yes** - Clean blue skips were noted to be available.

(266) Personal protective equipment must be accessible to and used by all staff members involved in handling contaminated linen.

**Yes** - Colour-coded aprons and gloves were available. Some confusion was noted over colours of aprons after the change in the system. This may be due to some old signage in place. Staff had been trained in the change over of colours in line with the National policy; however, some staff members were using the old colour-coded system.

(267) Documented process for the transportation of linen.

**Yes** - Documented processes were observed.

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

(188) Hand and wrist jewellery should be removed prior to performing all levels of hand hygiene with the exception of a plain wedding band.

**No** - Rings and watches were noted on staff in numerous areas.

(190) All sinks should be fitted with washable splash backs with all joints completely sealed.

**No** - Splashback seals observed were poor in areas.

(192) Taps should be hands free and should be mixer taps to allow temperature regulation.

**Yes** - All sinks and taps observed were hands free.

(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** - Plugs and overflow did not conform to new standard. A review was recommended.

## 5.0 Appendix B

### 5.1 Ratings Summary

	Self Assessor Team			Assessor Team
	FREQ	%	FREQ	%
A	3	05.36	1	01.79
B	13	23.21	18	32.14
C	39	69.64	35	62.50
D	1	01.79	1	01.79
E	0	00.00	1	01.79
N/A	0	00.00	0	00.00

### 5.2 Ratings Details

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

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