



**Hygiene Services Assessment Scheme**  
**Assessment Report October 2007**  
**South Tipperary General Hospital**

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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

South Tipperary General Hospital is a 247 Bed hospital providing acute services for the South Tipperary population of 82,000 people (2006 census). South Tipperary General Hospital also provides services to the bordering areas of North Tipperary and West Waterford increasing the catchment area up to 135,000.

Until January 2007 Acute Hospital Services in South Tipperary were provided on two sites: South Tipperary General Hospital (STGH), Clonmel and Our Lady's Hospital (OLHC), Cashel. Acute hospital services in South Tipperary amalgamated in South Tipperary General Hospital, Clonmel on January 12<sup>th</sup> 2007 following a major capital development to facilitate the transfer of A&E, General Surgery and Oncology services from Our Lady's Hospital, Cashel to Clonmel (Cost €30m).

The Obstetric Department, South Tipperary General Hospital provides outreach clinics in both Thurles and Tipperary Town.

South Tipperary General Hospital signed a learning agreement with University College Cork in 2006 for the education of Medical Students; approval is awaited for teaching hospital status from the Department of Health and Children

### Services provided

South Tipperary General Hospital provides the following services:

- General Medicine
- Gynaecology (Day Care Ward)
- Obstetrics / Gynaecology
- Paediatrics
- Acute Psychiatry
- Special Baby Care
- Cardiac Diagnostics and Rehabilitation
- Coronary Care
- Diabetes
- Endoscopy (Day Care Unit)
- Medical Assessment
- Accident & Emergency
- General Surgical
- Intensive Care
- Oncology
- Physiotherapy
- Radiology and Laboratory Services
- Social Services
- Speech and Language Therapy
- Chaplaincy

### Physical structures

<b>Bed Complement under the following headings</b>				
<b>Speciality</b>	<b>Ward</b>	<b>Public</b>	<b>Private</b>	<b>Non-Designated</b>
Obstetrics	Maternity	20	6	
Gynaecology	Gynae	5	5	
Paediatrics including SCBU	Paediatric	14	2	5

General Medicine	Medical Wards	54	22	3 (CCU)
Psychiatry	St. Michael's	47	3	
Day Ward		13	3	
Surgical	Surgical Ward	35	4	
ICU				5
Oncology	Oncology Day Ward	4		
<b>Total Bed Complement - 247</b>				

The following assessment of South Tipperary General Hospital took place between 21<sup>st</sup> and 22<sup>nd</sup> June 2007.

### ***1.3 Notable Practice***

- Waste management was identified as an area of strength.
- The structural standards of the new building in comparison with the older building.
- The commitment to improvement observed by the assessment team is a strength, which can be built on to drive the process forward.

### ***1.4 Priority Quality Improvement Plan***

- A priority area for improvement is the development of a robust hygiene management structure, which is multidisciplinary in its composition and ensures that, through regular meetings and follow up on action plans, hygiene improvements take place. It is essential that a strong corporate culture is in place to support these improvements.
- A clearer definition of roles and responsibilities in relation to catering and laundry staff was also identified as an area requiring improvement. They currently report directly to another hospital on the campus, which should be reviewed.
- It is recommended that a standardised process be in place for the development and control of policies, procedures and guidelines. A review of the use of storage facilities is also recommended, to ensure maximum use of space and remove items that may no longer be required.

### ***1.5 Hygiene Services Assessment Scheme Overall Score***

The decision mechanism used to translate an organisation's criteria, risk ratings to a Hygiene Service Assessment Scheme score is based on a quantitative analysis of the assessment results which ensures consistency of application. The decision regarding a score is made by the Internal Review Committee of HIQA, based on the findings of the Assessment Team; the South Tipperary General Hospital has achieved an overall score of:

**Fair**

**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**

Clear goals and objectives for Hygiene Services will not be defined.

### **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 is recommended that the organisation develop a Hygiene Corporate Plan for the Hospital

## 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.**

There was a level 1 Business Plan for the Acute Hospital Services in the region and a level 11 Business Plan for the Hospital in place.

Information used to inform the needs of Hygiene Services included:

- Relevant legislation and guidelines, for example, Health and Safety Act 2005, National Cleaning Standards, Hazard Analysis and Critical Control Point (HACCP).
- Feedback from a range of in-house committees, for example, Hygiene, Infection Control, Environmental monitoring, Health and Safety, HACCP.
- National and Local Hygiene and Infection Control audits.
- Manpower planning for service developments.
- The Hospital Executive Management Committee.
- Consultation with relevant Staff Associations/Unions.
- Patient Partnership Service Users Group.

Assessment of the Organisation's needs for Hygiene Services has focussed mainly on the needs related to transfer of services/commissioning of new departments, and the outcomes of the National Hygiene Audits of 2005 and 2006.

As yet there was no Corporate Strategic Plan, Service Plan or Organisational Plan for Hygiene Services in place. Also there was no evaluation of the assessment process in place and consequently no feedback and no continuous quality improvement plan (QIP). It was recommended that the hospital progress the development of the above plans to ensure a robust framework for the management of its Hygiene Services.

#### 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.**

Developments and modifications to the Organisations Hygiene Services over the last two years included new information sheets for hygiene service delivery, infrastructural changes including taps, hoppers and furniture replacement, new cleaning systems, for example, flat mopping. A number of capital developments were commissioned including new theatre, ICU and Central Sterile Supply Department (CSSD).

Hygiene audits have commenced in some areas and the evaluation feedback and continuous quality improvement aspects need further development and a structure for frequencies.

## ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

### **CM 2.1 (B ↓ C)**

**The organisation links and works in partnership with the Health Services Executive, various levels of Government and associated agencies, all staff, contract staff and patients/clients with regard to hygiene services. The Hospital linked through the Network Management structure with the Department of Health and Children and the Health Services Executive for service delivery and capital developments. Business case process is in place for additional services. It also linked with the professional /regulatory bodies regarding professional development and training. This included the Further Education and Training Awards Council (FETAC) accreditation of staff in relation to extending the competency training of staff directly involved in the delivery of Hygiene Services. The organisation had a system for patient involvement through its service user's patient group. The most recent hospital wide patient satisfaction survey noted was 2003. Localised patient satisfaction surveys were planned and would be piloted in the A & E department. It was recommended that structures are put in place to extend this to all areas and ensure its inclusion in annual reports. The efficacy of linkages and partnerships had not been evaluated and there was no related continuous quality improvement plan.**

## CORPORATE PLANNING FOR HYGIENE SERVICES

### **CM 3.1 (C ↓ D)**

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

There were no documented processes developed at the time of the assessment for the development of the Hygiene Corporate Strategic Plan. It was recommended that the organisation prioritise this development and ensure it contained clearly defined goals, objectives and priorities relating to costings. It was envisaged that the Hygiene Services Assessment Scheme self-assessment and peer review assessment might help inform this development. There was a well-established Executive Management Team in place and it was recommended that this team would assume responsibility for the development of the Hygiene Corporate Strategic Plan. There were already a number of relevant Hygiene Services Committees in place whose expertise could be availed of to inform the plan including the Hygiene Committee, Infection Control Committee, Health and Safety Committee and HACCP Committee. Evaluation, feedback and continuous quality improvement should be integral components of this development.

## GOVERNING AND MANAGING HYGIENE SERVICES

### CM 4.1 (C → C)

**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 Executive Management Team held overall responsibility for Hygiene Service Delivery. The roll out of corporate policies and procedures was at an early stage of development. There were some policies observed that had been agreed /approved at corporate level, however, most had not been officially approved and were developed locally. The Quality and Risk Team might be an appropriate forum to progress the identification and progression of relevant corporate policies and procedures for Hygiene Services, based on an agreed Corporate Template.

A Code of Corporate Ethics was expressed in the Organisations Mission and Values, which were based on the outcome of a staff consultation process.

Evaluation of the Hygiene Services Team adherence to legislation and relevant national guidelines was confined to some specific Hygiene Services / Infection Control audits. The findings were reported to management however there was no evidence of their further development. These would have benefited from having action points, with allocated responsibilities for their implementation and follow-up audit to close the continuous quality improvement loop.

### CM 4.2 (C → C)

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

All relevant legislation and best practice information was available. It was disseminated to the relevant committee and line managers. Hygiene services performance indicators were confined to HACCP monitoring, cleaning check sheets and sharps audit. The organisation was commended on the development of the Quality and Risk group, however, it was recommended that evaluation of the information received and continuous quality improvement become an area of focus for the organisation.

### CM 4.3 (B ↓ C)

**The Governing Body and/or its Executive Management Team access and use research and best practice information to improve management practices of the Hygiene Service.**

The organisation had a library with internet facilities and regular supply of journals which are mainly targeted towards the clinical health care staff. The organisation was encouraged to consider establishing a dedicated area for relevant Hygiene reference material. The organisation had appointed a Clinical Risk Manager and training was now been provided for Department Heads.

While education and in-house training were provided responsibility rested with the line manager. It was recommended that attendance by staff at mandatory and all other relevant training was monitored.

It was advised that induction training for all staff should be mandatory and hygiene services staff should have hand hygiene training provided on the first day of employment. The A-Z decontamination of equipment programme should be an integral part of all hygiene services staff induction. All staff should be aware of these standards. The organisation was to be commended on its plans to provide induction

training for new medical staff, with a pilot in the A & E department. Ideally this should be evaluated and rolled out hospital wide.

**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 library with internet facilities and regular supply of journals which are mainly targeted towards the clinical health care staff. The organisation was encouraged to consider establishing a dedicated area for relevant Hygiene reference material. The organisation had appointed a Clinical Risk Manager and training was now been provided for Department Heads.

While education and in-house training were provided responsibility rested with the line manager. It was recommended that attendance by staff at mandatory and all other relevant training was monitored.

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**CM 4.5 (B → B)**

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

There was a capital development team in place and a projects manager on site, who was involved in the management of all major and minor capital developments. Consultation in relation to Hygiene matters was through the Infection Control Nurse, who was a member of that team.

An Aspergillosis policy had been developed in relation to new building and refurbishment works. There was a communication/consultation structure in place with the executive management team in relation to capital development and implementation. There was no formal evaluation of the efficacy of the consultation process between the Hygiene services and senior management in this regard

**ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES**

\*Core Criterion

**CM 5.1 (B ↓ C)**

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

There was a Hygiene Services Audit Committee in place and minutes of meetings were observed. The roles, authority, responsibility and accountability of the Executive Management team, while acknowledged, were not clearly documented. Reporting relationships were as follows: Nursing and Health Care Assistants reported to the Director of Nursing while cleaning staff reported to a Deputy General Manager and the Waste Manager reported to the Technical Services Manager. There was a lack of clarity in relation to the accountability of Catering and Laundry staff. Clarification of where their accountability should best be aligned, that is, Hospital Management or Primary Continuing and Community Care (PCCC) is recommended. The organisation should put in place a Hygiene Services Structure that has a Hygiene Services Team and Hygiene Services Committee consistent with the acute hospital Hygiene Services Management Structure. These ideally should have terms of reference, meeting frequencies, minutes, and a reporting system with the

Executive Management Team. Also they should have involvement in the development of the Annual Report.

\*Core Criterion

**CM 5.2 (C → C)**

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

It was recommended that the composition and terms of reference of the Hygiene Committee be revisited to ensure full multidisciplinary representation. The committee should have documented processes in place to ensure team awareness of each others roles and responsibilities, terms of reference, administrative support and frequency of meetings.

## 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.**

While they were no documented process for allocation of new resources, allocation of existing revenue was in accordance with the existing level of service and new developments. Additional Hygiene Services needs were identified by the specific department, prioritised, and the Executive Team responded as resources permitted. The development of a Hygiene Services Plan and a Corporate Strategic Plan for Hygiene Services based on the Strategic Plan would allow for best practice and greater transparency in the management of the Hygiene Services.

**CM 6.2 (B → B)**

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

There was a regional procurement structure in place and this committee had representation from each of the hospitals with involvement in pre-purchasing. Procurement of some specific equipment for the hospital included pre-purchasing evaluation and decision making. The input of the Hygiene Services Staff was co-ordinated through the Infection Control Nurse in the main. Evaluation of the efficacy of this process might be considered the responsibility of the Hygiene Services Committee in the future.

## MANAGING RISK IN HYGIENE SERVICES

\*Core Criterion

**CM 7.1 (C ↑ B)**

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

The organisation was encouraged to work on this area. There was a Risk Manager in place and documented process for risk incident identification, reporting, analysis, minimisation and elimination were observed. There were no major adverse events in the past two years. A Risk Management and Health and Safety Report were observed. Safety statements for all areas were completed for 2007 and risk assessments were carried out. The terms of reference for Health and Safety committee included a list of the organisation's Health and Safety Representatives who were elected for a fixed term. External reports, for example, Health and Safety

Authority and Environmental Health reports were available. Hygiene Services audits were at an early stage in terms of their evolution and usage and the organisation was encouraged in this regard.

**CM 7.2 (C ↑ B)**

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

The Risk Health and Safety Committees are multidisciplinary and regular reports including annual reports were generated. The Risk management system had been developed during the last two years. Other resources allocated to Hygiene Services included fixtures, fittings and equipment. The General Manager reviewed risk and Health and Safety Reports. There were no major Hygiene Services adverse events over the last two years.

**CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES**

\*Core Criterion

**CM 8.1 (C ↑ B)**

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

There were documented processes in place for establishing contracts, managing and monitoring contractors and their professional liability in relation to Hygiene Services. Contracts in place relate to specific services, for example, water maintenance, pest control and sani-bins.

**CM 8.2 (N/A → C)**

**The organisation involves contracted services in its quality improvement activities.**

The organisation had not self assessed this criterion. A need to involve representatives from contracted services in Hygiene Services related team meetings was identified. Organisations should develop robust communication systems with their providers of contracted services.

**PHYSICAL ENVIRONMENT, FACILITIES AND RESOURCES**

**CM 9.1 (B ↓ C)**

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

Design and layout varied according to the age of the building. Storage areas were an issue in all wards/departments and the organisation was recommended to review items stored and the locations used in order to de-clutter and optimally use storage facilities. It was recommended that consideration be given to the possibility of central storage facilities for equipment to alleviate this issue. Evaluation of the safety of the current environment and layout was recommended.

\*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.**

There was a Project Manager in place for the overseeing all major and minor capital development projects. Department of Health and Children (DOHC) guidelines were adhered to in this process. Management of equipment and devices was provided for through the A-Z decontamination guidelines for Hygiene Services. The national Cleaning Manual for Acute Hospital and National Infection Control Guidelines were used to inform practices. The CSSD service was operated in accordance with Best Practice decontamination standards with manual tracking processes in place. HACCP standards were also in place. There was an in-house BioMedical Department for Clinical equipment maintenance and contracts for cleaning equipment and ventilation maintenance were observed. Policies, procedures and guidelines should be developed in line with best practice and an internal process should be put in place for documentation management.

**CM 9.3 (C → 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.**

Evaluation methods utilised to determine the efficacy of the organisation's environment and facilities, equipment and devices equipment, waste, sharps and linen included the National Hygiene Reports in 2005 and 2006. The Decontamination Audit in 2006 and Environmental Health Audits results were also observed. Internal audits included hand hygiene and sharps safety. Internal audit processes were at an early stage. It was recommended that this should be developed further.

**CM 9.4 (C → C)**

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

There was very little development in the area of patient/ staff/visitor satisfaction with Hygiene services but this is part of the organisation quality improvement plan. There was a complaints management system in place. Few complaints in relation to Hygiene service were noted. Patients interviewed were positive in their comments about Hygiene Services. However an earlier audit in the Maternity Unit had identified the need for more bathroom facilities. The organisations quality improvement plan in this area was commendable, which included the identification for greater patient representation from this area.

**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.**

There were documented processes for the selection and recruitment of hygiene services staff in line with Human Resources policies. These policies were consistent with current best practice. Job descriptions were available and recruitment records were maintained. No evaluation of the process of recruitment was observed. It was recommended that this is developed

**CM 10.2 (B ↓ C)**

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

No documented processes were observed for reviewing changes in hygiene services work capacity and volume. Professional judgement was used to determine staffing numbers required – it was recommended that processes for reviewing work capacity and volume are developed. While segregation of duties between catering, health care assistant and cleaning staff was undertaken, the allocation of duties between hygiene services staff in the clinical area could be further streamlined to reflect best practice.

**CM 10.3 (B → B)**

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

Job descriptions identified qualifications necessary for specific hygiene assessment roles, for example, catering. Hygiene services staff who did not require prior qualifications for their role were provided with induction and a buddy system for orientation for their role. Mandatory aspects of this training needed to be identified and the provision needed to reflect best practice in Hygiene/Infection Control. Some hygiene staff were availing of the FETAC Health Care Assistant and SKILLS training programme, which is commendable.

\*Core Criterion

**CM 10.5 (B ↓ C)**

**There is evidence that the identified human resource needs for Hygiene Services are met in accordance with Hygiene Corporate and Service plans.**

There were no Hygiene Corporate Strategic, Hygiene Services and Operation plans in place. No Hygiene Services annual report has yet been developed. As already identified Hygiene Services human resource needs assessment was based on professional judgement and the provision of cover for necessary services and the organisation should review this situation.

**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**

There were no Hygiene Corporate Strategic, Hygiene Services and Operation plans in place. No Hygiene Services annual report has yet been developed. As already identified Hygiene Services human resource needs assessment was based on professional judgement and the provision of cover for necessary services and the organisation should review this situation.

**CM 11.2 (C → C)**

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

There was documented process identifying relevant training/professional development for all hygiene services staff. Training was available to staff relevant to

their roles and responsibilities. Appropriate training was provided for the safe cleaning and maintenance of new and existing equipment, medical and cleaning devices. The staff were facilitated to attend relevant training during working time. To date, there is no evaluation relevance of education/training to each staff member – it was recommended that this is implemented to identify the suitability and relevance of training provided.

**CM 11.3 (C → C)**

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

There was no utilisation of performance indicators to evaluate the effectiveness of education and training. There was no evaluation of staff satisfaction rates with education and training sessions but the organisation identified this in its QIP and had plans to initiate it shortly. Attendance records were maintained and staff compliance is managed by line Managers.

**CM 11.4 (C → C)**

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

To date, attendance records at training and absenteeism were the only methods of evaluating staff performance. It is recommended that a formal evaluation process is implemented. Renewal of contracts, for example, Waste Management is based on performance evaluation.

**PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF**

**CM 12.1 (B → B)**

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

An Occupational Health Service was in place, which offered the full range of Occupational Health support, including all relevant vaccinations. There was also an Employee Assistance Programme in place. Evaluation of the service had not taken place thus far and this is recommended.

**CM 12.2 (C → C)**

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

Evidence observed showed that the uptake of services was recorded and reported. No developments were noted as a result of staff satisfaction evaluation. The Organisations QIP to evaluate this service is encouraged.

**COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES**

**CM 13.1 (C → C)**

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

There was a process in place for collecting and providing access to data and information from both quantitative and qualitative sources. The responsibility for the dissemination of this information to relevant staff and committees was through the General Manager's office. Library facilities were also available for this purpose. The Organisation is encouraged to consider a designated area within the library for hygiene related reference material. There was a structure in place for the assimilation

of documentation to support the Acute Hospital Hygiene Assessment process; however this could have encompassed more of the relevant material that was available and required.

**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.**

Reports generated in relation to Hygiene Services included Service Provision records, HACCP compliance, Waste Management, Infection Control reports and Health and Safety reports. It was recommended that the organisation identify a process in its terms of reference for the establishment of a Hygiene Services Team and Hygiene Services Committee, who have a process of regular communication with the Executive Management Team and contribute to the generation of an annual report.

**CM 13.3 (C → C)**

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

**Minutes of meetings and audit reports were noted. The organisation would benefit from the development of a communications strategy to ensure that all such reports are disseminated to all relevant staff.**

**ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES**

**CM 14.1 (C → C)**

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

The Organisation recognised the Acute Hospital Hygiene Assessment Tool as a basis for the identification and progression of Hygiene Services quality improvement initiatives. The Executive Management team was committed to the ongoing development of all aspects of Hygiene Services delivery. No details of any quality initiatives involving the governing body were observed and this is recommended.

**CM 14.2 (B ↓ C)**

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

The Organisation introduced a Hygiene Audit Committee, which reviewed and developed quality initiatives following the national Hygiene Audits in 2005 and 2006. It was instrumental in the commissioning of new departments earlier in 2007. This group was also instrumental in preparing for the acute hospital Hygiene Assessment. Hygiene Auditing and Benchmarking against existing standards is at an early stage of development, however, there was evidence of further expansion identified at the time of the site visit. Evaluation is only at a very early stage.

### 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.**

Staff had access to library facilities and to seminars, which were held in the education centre. Library service personnel sourced journals and books when requested by staff, however, no documented processes were in place for the establishment of best practice or any method of evaluation. It was recommended that the library have a section dedicated to hygiene and this would hold all up to date journals in relation to aspects of the hygiene service such as cleaning, waste management, linen and catering.

##### SD 1.2 (C → 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 integrated processes are in place for the assessment and introduction of new hygiene service interventions. However, certain interventions have taken place and improvements have been made over the past few years such as the introduction of a new mopping system and computerised temperature monitoring in the laundry. No evaluation reports of these new interventions were observed. It was recommended that, when a multidisciplinary hygiene service committee is formed and is operational, new hygiene initiatives would be channelled through this committee and trialled and evaluated in a controlled manner before a decision is made to roll out the service.

#### PREVENTION AND HEALTH PROMOTION

##### SD 2.1 (B → B)

**The team in association with the organisation and other services providers participates in and supports health promotion activities that educate the community regarding Hygiene.**

Evidence was noted in relation to a hand hygiene day on September 2 2005 whereby 300 leaflets were distributed to the public. The infection control officer had visited local schools and General Practitioners (GPs) regarding education on infection control and related issues. The media was used to inform the public of the national visitors policy and infection outbreaks. It was recommended that, for the future, a process is put in place to continue and enhance linkages with the community and that evaluation of the efficacy of such linkages be undertaken.

## INTEGRATING AND COORDINATING HYGIENE SERVICES

### **SD 3.1** (C → C)

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

There were teams in place but there was no overall Hygiene Service Team. Such a team must be introduced as soon as possible, which should be multidisciplinary in nature. Terms of reference for the team are required as well as a process which would establish and develop linkages to other teams within the organisation. When such a team is operational evaluation processes on the efficacy of the team structure should be introduced.

## IMPLEMENTING HYGIENE SERVICES

\*Core Criterion

### **SD 4.1** (C ↑ B)

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

In general the physical environment was clean; however, attention to detail was required for the control of dust in both the old and new buildings. The external glass was not observed to be clean and there was evidence of a lot of flaking paint in the older part of the hospital. A lot of areas were deemed to be untidy and this was due to a lack of storage areas throughout the hospital environment.

For further information see Appendix A

\*Core Criterion

### **SD 4.2** (C → C)

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

The main area requiring attention was the cleaning of equipment as items such as resuscitation trolleys and drip stands required further attention.

For further information see Appendix A

\*Core Criterion

### **SD 4.3** (B ↓ C)

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

There was a lack of appropriate storage facilities for cleaning equipment and equipment was noted in the sluice areas. A review of cleaning facilities is required to ensure that equipment and chemicals can be kept in locked dedicated storage facilities.

For further information see Appendix A

\*Core Criterion

**SD 4.4 (B ↓ C)**

**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 Kitchen is a centralised kitchen, which catered for the whole campus, which includes St Luke's Hospital. The catering department reported to the management structure of St Luke's Hospital Psychiatric Unit. Many of the policies and procedures noted were developed for St Luke's Hospital and not for South Tipperary General Hospital. There was a lack of clarity in who assumed responsibility for the staff restaurant and for the ward kitchens. It was recommended that the reporting structures be reviewed and that a multidisciplinary stand alone HACCP team is set up for the hospital which would cover all aspects of food safety from delivery to service at ward level. Food safety systems in the central production kitchen were generally satisfactory but some exceptions were noted as outlined in the mandatory compliance checklist. Further implementation of HACCP is required in the restaurant and in the ward kitchens. Structurally, the older ward kitchens such as St Monica's Ward were poor compared to the very good structural standards in the new areas. The structural standard of the restaurant was poor and the restaurant is located in a portacabin. Household staff plate and serve food at ward level and this practice is not recommended. Excessive levels of jewellery were noted on staff in the ward kitchens and in the restaurant.

For further information see Appendix A

\*Core Criterion

**SD 4.5 (B ↑ 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.**

Overall, the management of waste was to a high standard; however there was no waste compound on site. This had been identified as a Quality Improvement Plan and the funding had been made available for this project. The Plans for the waste compound were noted during the assessment.

For further information see Appendix A

\*Core Criterion

**SD 4.6 (B → B)**

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

In general the management of linen and soft furnishings was to a high standard. A centralised facility supplies the campus and other areas within the network. The laundry was structurally poor and a high cleaning programme was required. All staff handling dirty linen were issued appropriate protective equipment; however, further enforcement in the use of same was required.

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**

There was extensive compliance in the effective management of hand hygiene. Posters and alcohol based hand gel were noted within the hospital environment, however, a lack of same were noted at the hospital entrance. There was no jewellery noted on clinical staff. Whilst hand hygiene education sessions were held, these were not mandatory. This is noted as an area for improvement.

For further information see Appendix A

**SD 4.8 (B → B)**

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

A corporate safety statement was on site, as were health and safety statements for all departments. Relevant legislation was on file and risk assessments had been carried out across clinical and non clinical areas, records of which were verified. There was a system in place for standard hazard identification reporting and training had been carried out in the correct use of this tool. An incident report is issued on a 6 monthly basis and records were verified. Resultant actions and feedback are required in the future.

**SD 4.9 (B → B)**

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

There was no documented process in place for the participation of patients and their families in the improvement programme for the environment. However, there were activities in place such as the use of a hospital information leaflet and the introduction of the national visiting guidelines. Patient representatives were on certain committees such as the accreditation and environmental committee. Hand hygiene posters were displayed throughout the hospital but visibility of such posters should be improved. A patient satisfaction survey was carried out in 2003. It is recommended that this be repeated in the near future and at regular intervals thereafter.

**PATIENT'S/CLIENT'S RIGHTS**

**SD 5.1 (B ↓ C)**

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

There was no documented process available to outline how the rights of the patients and their families were respected by the team. However it was noted during the assessment that such rights are protected at all stages of patient care. Ward charters are present at ward level and there was adequate bed spacing and the use of curtains when appropriate. Relative's rooms were available and staff sign a confidentiality clause included in contracts. There was no evaluation process 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.**

A Hospital information leaflet was available which gives patient and their families' information in relation to visiting times, flowers policy, and patient food policy. In many areas of the hospital, leaflets were available on many different aspects of hygiene, infectious disease and other healthcare matters.

Hand hygiene posters were available throughout the hospital. It is recommended that evaluation of patient satisfaction with and comprehension of the information provided is carried out.

**SD 5.3** (B ↓ C)

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

Information was given to patients on how to make a complaint within the hospital information leaflet. Complaints are logged on a computer data base and reports are issued as required. There were 80 complaints for the period 2005-2006 with only three of these relating to an aspect of hygiene service delivery. A recent complaint was reviewed and ample evidence was observed of the investigation process, which was undertaken. There was no documented process noted for the management of complaints and there was no evaluation process in place for assessing the efficacy of the complaints process. It is recommended that this is implemented in the future.

**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.**

The process of involving patients and their families in evaluating the service had commenced and patient satisfaction surveys had taken place in coronary care and in the maternity unit, displaying satisfactory results overall. It was recommended that the process of conducting patient satisfaction surveys should be channelled through the hygiene service committee so that a structured approach could be taken.

Suggestion boxes were in place; however, these had just been introduced so no data or reports were available. A designated person had the responsibility for the collection and analysis of the comment cards from these boxes.

**SD 6.2** (B ↓ 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.**

There was evidence in place, which showed that audits were carried out in the area of hygiene services, however, the approach was unstructured and there was little evidence of the corrective actions taken as a result of these audits. It was recommended that an audit plan is developed together with a documented audit process and appropriate auditor training. Audits conducted are scored and a league table was in place. This is good practice, which can be further built on as the process develops further.

There were no documented key performance indicators. It is recommended that such KPI'S are considered and measured as they would further drive continuous improvements.

**SD 6.3****(C → C)**

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

There was no evidence of an Annual Hygiene Report but there were stand alone reports observed which should be included in an annual report, when it is produced. A documented procedure is required to show how such a report would be produced in terms of the inputs to the report and of the dissemination channels of the completed 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**

(1) The environment is tidy, well-maintained, free of rust, blood or body substances, dust, dirt, debris and spillages.

**No** - Many areas observed were untidy and excessive dust was noted in many areas.

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

**No** - Flaking paint was noted in the old areas and in some newer areas also.

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

**No** - The painted surface in the older part of the building requires refurbishment.

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

**Yes** - However, some exceptions were noted for example the foot rests were torn on reclining chairs.

(6) Free from offensive odours and adequately ventilated.

**No** - Malodorous toilets were noted.

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

**No** - At the time of the assessment, the standard of cleaning on the internal stairs should have been higher.

(13) External areas including grounds, gardens, footpaths, ramps and car parks should be clean and well-maintained.

**Yes** - However, the internal courtyard required weeding.

(15) Where present a designated smoking area must comply with the national legislation on tobacco control and local organisational policies, a cigarette bin must be available and the floor area should be free of cigarette ends, matches etc.

**Yes** - Unofficial smoking areas were noted.

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

(18) Walls, including skirting boards.

**Yes** - Skirting boards in restaurant were in need of repair.

(20) Doors

**No** - Doors observed were in need of attention.

(21) Internal and External Glass.

**No** - The standard of glass cleaning needs to be improved.

(23) Radiators and Heaters

**Yes** - Radiators and heaters observed in St Monica's ward kitchen were in poor condition.

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

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

**Yes** - Cupboards in some areas required cleaning, in particular in the store rooms.

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

(41) Door handles and door plates

**No** - Door plates were in need of attention.

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

(46) Bathrooms / Washrooms must be cleaned on a daily basis. When necessary, they must be disinfected. This must be monitored and recorded.

**No** - No toilet checklists were noted.

**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** - Handwash sinks obstructed due to a large amount of equipment stored in the sluice areas.

**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** - Dust was noted on several pieces of equipment.

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

(68) Patient fans which are not recommended in clinical areas.

**No** - Fans noted in many areas, requiring attention.

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

**No** - Incorrect storage of washbowls.

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

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

**No** - Wardrobe space lacking in some areas.

(77) Loose items such as patient's clothing should be stored in the patient's locker or property bag.

**No** - Patients and staff clothing were inappropriately stored in many ward areas.

(79) Flower vases where present should be clean with water changed minimum daily. Wilted flowers should be removed and disposed of accordingly. Note: flowers not recommended in high risk areas.

**No** - No clear policy on water changing was available.

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

**No** - Office equipment required cleaning.

(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** - Splashes of hand wash gel were observed on many wall surfaces.

**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.

**No** - No evidence was submitted on vacuum filter changing.

(88) All cleaning equipment should be left clean, dry and tidy in the storage area after use.

**No** - Cleaning equipment was untidy in many areas including the main kitchen area.

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

**No** - Buckets stored with residual water in them.

(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** - Storage facilities were not available in all areas.

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

**No** - Storage facilities were not available in all areas.

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

**No** - Attention to storage of chemicals is required.

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

**No** - No documentation was available for older equipment.

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

(213) Environmental Health Officer (Senior EHO/EHO) reports on food safety inspections including the completed summary stage of compliance with HACCP and annual water analysis reports should be retained on the Hospital Food Safety Manual. Action plans/ actions taken on foot of issues raised in the reports should be documented.

**No** - There was no Water Analysis Reports available showing the microbiological status of water.

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

**No** - The HACCP plan was not fully compliant with the principles of HACCP.

(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** - There were no food safety policies at ward level and the policy in the kitchen needs to be reviewed.

**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** - Review of access to ward kitchens is required.

(219) Ward kitchens are not designated as staff facilities

**No** - Staff clothing was noted in ward kitchens

(221) Staff clothing/uniforms/shoes personal belongings should not be stored in food rooms.

**No** - Personal clothing was noted in the stores of St Monica's Ward.

(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).

**Yes** - Wash hand sinks noted in the ward kitchens visited.

(223) Separate toilets for food workers should be provided.

**No** - Dedicated toilets were provided in the central kitchen area.

(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 ventilation canopies were not observed to be clean.

(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** - Stock rotation requires attention.

**Compliance Heading: 4. 4 .3 Waste Management**

(229) Animal and pest control measures shall be in place in all waste handling and storage areas.

**No** - Doors to the kitchen were open.

(232) Waste storage containers shall be smooth, durable, easy to clean and disinfect, well maintained and closable.

**No** - The waste and yard area require attention.

(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** - The waste area requires attention.

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

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

**No** - Non compliance with temperatures were noted.

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

**No** - Care needed to ensure all food is at the appropriate temperature.

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

**No** - Non compliance noted.

**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** - Not all dishwashers observed had digital readouts.

(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.

**No** - Calibration process to be reviewed.

**Compliance Heading: 4. 5 .3 Segregation**

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

**No** - No mattress bags were noted.

**Compliance Heading: 4. 5 .5 Storage**

(257) Adequate segregation facilities for the safe storage of healthcare risk waste are locked and inaccessible to the public. Appropriate warning signs restricting public access should be prominently displayed.

**No** - There is no waste compound on site. A Quality Improvement Plan has been identified.

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

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

**No** - The linen store at ward level was very small and in need of attention.

(264) Bags must not be stored in corridors prior to disposal.

**No** - No central clean linen store available in the hospital. This should be addressed.

(267) Documented process for the transportation of linen.

**No** - No evidence was observed of this.

**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** - Catering staff were noted wearing jewellery.

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

**No** - Splash backs were not present on all sinks.

(197) Wall mounted/Pump dispenser hand cream is available for use.

**No** - No hand creams were noted.

(198) Hand hygiene posters and information leaflets should be available and displayed throughout the organization.

**Yes** - is recommended that posters are displayed at the entrance.

(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** - Not all sinks conform to a HBN95.

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

**No** - Attendance at these education sessions is not mandatory.

## 5.0 Appendix B

### 5.1 Ratings Summary

	Self Assessor Team			Assessor Team
	FREQ	%	FREQ	%
A	0	00.00	1	01.79
B	25	44.64	16	28.57
C	30	53.57	38	67.86
D	0	00.00	1	01.79
E	0	00.00	0	00.00
N/A	1	01.79	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	B	C	↓
CM 3.1	C	D	↓
CM 4.1	C	C	→
CM 4.2	C	C	→
CM 4.3	B	C	↓
CM 4.4	C	C	→
CM 4.5	B	B	→
CM 5.1	B	C	↓
CM 5.2	C	C	→
CM 6.1	C	C	→
CM 6.2	B	B	→
CM 7.1	C	B	↑
CM 7.2	C	B	↑
CM 8.1	C	B	↑
CM 8.2	N/A	C	↑
CM 9.1	B	C	↓
CM 9.2	B	B	→
CM 9.3	C	C	→
CM 9.4	C	C	→
CM 10.1	B	B	→
CM 10.2	B	C	↓
CM 10.3	B	B	→
CM 10.4	C	C	→
CM 10.5	B	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	B	→
CM 12.2	C	C	→
CM 13.1	C	C	→
CM 13.2	C	C	→
CM 13.3	C	C	→
CM 14.1	C	C	→
CM 14.2	B	C	↓
SD 1.1	C	C	→
SD 1.2	C	C	→
SD 2.1	B	B	→
SD 3.1	C	C	→
SD 4.1	C	B	↑
SD 4.2	C	C	→
SD 4.3	B	C	↓
SD 4.4	B	C	↓
SD 4.5	B	A	↑
SD 4.6	B	B	→
SD 4.7	B	B	→
SD 4.8	B	B	→
SD 4.9	B	B	→
SD 5.1	B	C	↓
SD 5.2	C	C	→
SD 5.3	B	C	↓
SD 6.1	C	C	→
SD 6.2	B	C	↓
SD 6.3	C	C	→