Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Hygiene Services Assessment Scheme

Assessment Report October 2007

St. Mary's Orthopaedic 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 6th November 2006.

Hygiene is defined as:
"The practice that serves to keep people and environments clean and prevent infection. It involves the study of preserving one's health, preventing the spread of disease, and recognising, evaluating and controlling health hazards. In the healthcare setting it incorporates the following key areas: environment and facilities, hand hygiene, catering, management of laundry, waste and sharps, and equipment" [1-4]

More specifically, the Hygiene Services Assessment Scheme incorporates the following:

- Environment and Facilities: incorporates the condition of the building and all its fixtures, fittings and furnishings.
- Hand Hygiene: incorporates hand washing, antiseptic hand-rub and surgical hand antisepsis.
- Catering: incorporates kitchens (including ward kitchens) fixtures and fittings and food safety.
- Management of Laundry: incorporates management of linen and soft furnishings both in-house laundry and external facilities.
- Waste and Sharps: incorporates handling, segregation, storage and transportation.
- Equipment: incorporates patient, organisational, medical and cleaning equipment.

1.1.1 Standards Overview

The standards are divided into two sections: Corporate Management and Service Delivery. Each standard is divided into a number of criteria. These are specific steps, activities or decisions that must occur to achieve the standard.

The 14 Corporate Management standards facilitate the assessment of performance with respect to hygiene services provision to the organisation and patient clients at organisational management level. These standards commence at the planning stage and follow through to governing, implementation and evaluation. They incorporate four critical areas:

- Leadership and Partnerships
- Management of the Environment and Facilities
- Management of Human Resources
- Information Management.

The six Service Delivery standards facilitate the assessment of performance at team level. The standards address the following areas:

- Evidence based best practice and new interventions
- Prevention and Health Promotion
- Integration and coordination of hygiene services
- Implementing safe, efficient and effective hygiene services
- Protection of patient/clients rights
- Assessing and Improving performance. [5]

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

Core Criteria:

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

In the Corporate Management standards, the core criteria cover:

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

In the Service Delivery standards, core criteria cover:

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

1.1.2 Rating Scale

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

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

A Compliant - Exceptional

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

B Compliant - Extensive

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

C Compliant - Broad

- There is evidence of broad compliance (between 41% and 65%) with the criterion provisions.

D Minor Compliance

- There is evidence of only minor compliance (between 15% and 40%) with the criterion provisions.

E No Compliance

- Only negligible compliance (less than 15%) with the criterion provisions is discernible.

N/A Not Applicable

- The criterion does not apply to the areas covered by the Self Assessment Team. Rationale must be provided. This cannot be used for a core criterion.

1.1.3 Assessment process components

The assessment process involves four distinct components:

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

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

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

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

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

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

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

The Internal Review Committee of the HIQA reviewed all the reports to ensure consistency, and based on the quantifiable translation guidelines, awards were made. Only organisation's which received a "very good" score

were acknowledged with an award for the duration of one year. By the end of October 2007 all 51 acute care hospitals had received a copy of their individual report.

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

- **Continuous Improvement**

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

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

[1] Boot, M and Cairncross, S "Actions Speak" Delft, The Netherlands, IRC and LSTHM, British Occupational Hygiene Society.
[2] New York Department of Health and Mental Hygiene
[3] The Columbia Electronic Encyclopaedia, Sixth Edition. Columbia University Press. 2003
[4] Irish Acute Hospitals Cleaning Manual, HSE (2006)
[5] Hygiene Services Assessment Scheme. Irish Health Services Accreditation Board (2006)

1.2 Organisational Profile

St Mary's Orthopaedic Hospital was visited by the Hygiene Services Assessment Team on the 15th and 16th of August 2007. The staff are to be commended on their efforts to improve hygiene standards. Despite numerous requests at local and network level, this hospital did not submit an organisational profile or a self assessment for the Corporate Management Standards. This lack of compliance made it difficult for the assessment team to review their corporate services and is reflected in the ratings and the poor award allocated.

1.3 Notable Practice

- Hand hygiene practice and training was noted.
- Colour coding in all areas was evident.
- Cleanliness of patient related equipment was commendable.
- Staff were very positive in their efforts to improve hygiene standards.
- The Patient information booklet was good.
- The availability of a cleaning manual in each clinical area visited is commendable.

1.4 Priority Quality Improvement Plan

- The Laundry Department requires attention.
- Cease using the 'Hubbard Tank' in the Physiotherapy Department until it can be utilised in line with best practice.
- The clinical hand washing facilities throughout the organisation require upgrading.
- The organisation should implement a process to ensure that contracts in place are appropriate to the needs of the organisation and that contractors manage contract staff effectively.
- Findings from hygiene audits from clinical areas, and reports from Catering need to be actioned in a timely manner through the Hygiene Services Committee.
- The production of an Annual Hygiene Report is recommended.
- An evaluation should be scheduled for the new initiatives and the effectiveness of the Hygiene Services Committee should be measured.

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 St. Mary's Orthopaedic Hospital has achieved an overall score of:

Poor

Award Date: October 2007

1.6 Significant Risks

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

Cross Contamination

Risks

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

Recommendations

The hospital should cease using the Hubbard tank in the Physiotherapy department until the appropriate people are consulted with to ensure it is utilised in line with best practice

CM 9.2 **(Rating D)**

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

Potential Adverse Event

Injury to staff.

Risks

Likelihood of Event	Rated: M (2)
Impact of Event	Rated: H (3)
Urgency of Action	Rated: M (2)
TOTAL	**Total: 7**

Recommendations

The organisation should undertake a thorough health & safety inspection of the use of the washing machines and their standard operation procedures. The use of more modern equipment is suggested.

CM 10.4 (Rating D)
There is evidence that the contractors manage contract staff effectively.

Potential Adverse Event
Suboptimal monitoring of the contractors could lead to breaches in appropriate duty of care

Risks

Likelihood of Event	Rated: M (2)
Impact of Event	Rated: M (2)
Urgency of Action	Rated: M (2)
TOTAL	**Total: 6**

Recommendations
It is recommended that the organisation develops its on-site monitoring processes of all contractors providing a service to the organisation.

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.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1 (N/A → N/A)

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

There is an existing "Friends of the Hospital" group. Membership of this group is inclusive of a retired member of staff and a family member of a patient who was cared for in the hospital. It is recommended that they be invited to extend their involvement with the hospital with specific reference to hygiene. In relation to auditing of patient care areas, their involvement would enhance the process and assist in continuous quality improvement. Patient Comment Cards from 2006 were utilised for a patient satisfaction survey with very positive results. Specific questions in relation to hygiene included the cleanliness of the hospital and the quality of food.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 (N/A → N/A)

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

At the hospital meeting with the members of the Hygiene Services Committee during the HIQA assessment, management indicated that a Hygiene Corporate Strategic plan was developed by CUH and was inclusive of the needs of St. Mary's Orthopaedic Hospital (SMOH). The Cork University hospital (CUH) Hygiene Corporate Strategic plan was not provided to the assessment team to verify this process. The CUH Orthopaedic Divisional Service Plan 2007 was viewed. Documented objectives and actions to achieve these objectives were inclusive of projects for SMOH. Multi-disciplinary involvement by the Hygiene Services Committee members was not apparent in this process and communication of the plan to all stakeholders did not appear to have been undertaken. The hospital should ensure the Hygiene Corporate Strategic plan for CUH is available on site for staff to access.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.4 (N/A → N/A)

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

St Mary's Orthopaedic hospital (SMOH) had its own policies and procedures committee but became subsumed into the processes of Cork University Hospital. CUH has a Policies and Procedures Guidelines (PPG) Committee and documented processes for their development, however, on review of documentation present, the policy on development of policies was not updated as it has a review date of December 2006. The organisation is encouraged to utilise the process to develop all new policies in SMOH.

CM 4.5 (N/A → N/A)

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

A documented process for consultation with Hygiene Services pre-development of existing sites did not appear to be evident within the organisation. Some communication between the Infection Control nursing staff and the Executive Management Team relating to capital development planning and implementation was highlighted during staff interviews and meetings.

With regard to the minor capital projects for 2007; (Upgrading for theatre block to include X-Ray, CSSD, recovery and day procedure; refurbishment and upgrading of Blocks 1, 2, and 4 for specific projects; upgrading of bathrooms and ward kitchens and Non Consultant Hospital Doctors accommodation) the organisation is strongly encouraged to involve the Hygiene Services Committee and to enhance quality improvement by evaluating the efficacy of the consultation process.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

*Core Criterion

CM 5.1 (N/A → N/A)

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

The terms of reference for the Hygiene Services Committee were available and a quorum for convening a meeting was detailed.

The membership of the committee was not listed by name but areas were identified and representatives were to attend. Details of roles, responsibilities, accountabilities and job descriptions of Governing Body and/or Executive Management Team in relation to Hygiene Services was not available to the HIQA assessing team during the assessment. The reporting relationships of all members of the Hygiene Services Committee were not documented and the responsibility and accountability of ward/department managers for hygiene in their area needs to be part of all job descriptions. An algorithm of the Hygiene Services should be considered, to give clarity to the roles and the structure within the organisation and its linkage to Cork University Hospital.

*Core Criterion

CM 5.2 (N/A → N/A)

The organisation has a multi-disciplinary Hygiene Services Committee.

The Hygiene Services Committee meet at least monthly and as viewed in the minutes discusses hygiene issues and findings of audits undertaken on clinical areas. No evidence of administrative support available to the multi-disciplinary team was evident during the assessment.

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

*Core Criterion

CM 6.1 (N/A → N/A)

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

While a documented process for allocating resources on an informed equitable basis was not available, resource requirements were discussed at Hygiene Services Committee meetings. In the absence of a site specific hygiene services/hygiene operational plan, goals and objectives are not outlined for SMOH. To develop the SMOH Hygiene Service Plan the CUH Corporate Hygiene Strategic Plan will need to be available to the Hygiene Services Committee. The goals of the Hygiene Service Plan need to reflect the Hygiene Strategic Plan.

CM 6.2 (N/A → N/A)

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

It was reflected in the Hygiene Services Committee minutes that many products and equipment for purchase are discussed here. A product evaluation form was available within the organisation; however the effectiveness of the process had not been evaluated. The purchase of equipment which requires manual washing (for example commodes) should be reviewed as the dimension sizes purchased were not compatible with an automated washer. This issue highlighted deficiencies in the organisation's purchasing system. Discussion at the hospital hygiene assessment meeting highlighted the requirement for SMOH to have greater autonomy in specific product purchases as items sanctioned by CUH were not compatible with equipment on the SMOH site.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

CM 7.1 (N/A → N/A)

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

While the organisation were to be commended for the processes put in place locally in relation to risk management and the piloting of risk identification forms and safety statements specific to individual clinical areas, this needs to be extended to the risks identified in the Environmental Health Officer (EHO) reports for the catering department. The STARS national reporting system is utilised to document incidents.
Greater clarity on the involvement of CUH in relation to the overall risk management processes is required in the future, to ensure all healthcare workers in SMOH are aware of their roles and responsibilities. Risk management/health and safety annual reports were not produced by SMOH and clarity was not given as to whether these

areas specific to SMOH were addressed in the CUH documentation submitted to HIQA. Health & Safety and Fire Safety reports requested for the laundry area were not available to the HIQA assessment team. Information was given verbally to the assessment team that SMOH management were not responsible for the laundry services and that this was an ongoing issue for them with the HSE.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion

CM 8.1 (N/A → N/A)

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

A documented process for establishing contracts, managing and monitoring contractors and their professional liability in the area of Hygiene Services was not available on site in SMOH. A list of service contracts was viewed during the hygiene assessment. Written contracts for the provision of contracted hygiene services were with central contracts in CUH. Similar to purchasing difficulties already outlined, the Hygiene Services Committee members are not aware of the details of the contracts pertinent to their service delivery on site. This process should be further evaluated within the hospital.

PHYSICAL ENVIORNMENT, FACILITIES AND RESOURCES

CM 9.1 (N/A → 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 physical structure of the buildings in many areas was old and in need of refurbishment. The Physiotherapy Department has no wheelchair accessible toilet facilities and the radiator in the Baby Changing Area was very rusty rendering it very difficult to clean. The storage area for linen was used for many other inappropriate items. The storage area for crutches was previously a dirty utility room and has not been suitably refurbished as a storage area. A "Hubbard" tank used for hydrotherapy treatment was viewed during the hygiene assessment. This use of this tank was not in line with best practice. A standard operation procedure for cleaning of the tank and its many moving parts was not available. It is recommended that the hospital cease using the Hubbard tank until a qualified specialist and the consultant microbiology staff are consulted to ensure it is utilised in line with best practice. This should include its cleaning and temperature regulation, and the recording and maintenance of claibration certificates.

*Core Criterion

CM 9.2 (N/A → D)

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

Documented processes were in place for the management of the environment and facilities, equipment and devices, kitchens, waste and sharps throughout the organisation. The process of dealing with linen and laundry at ward level and its transportation within the hospital site is well managed; however, this should be documented. The lack of management structure for laundry staff and lines of responsibility were identified. Hygiene issues identified were discussed with the Laundry Manager and hospital management. An issue raised on Day one of the visit

in relation to uncontrolled steam from damaged pipe work was rectified by Day two of the hygiene assessment. The processes in place in the laundry are very old and should be reviewed. An interim measure of erecting hazard notification signs and verbal communication with staff with reading difficulties was discussed with the Laundry Manager. The organisation should undertake a thorough Health & Safety inspection of the use of the washing machines and their standard operation procedures.

CM 9.3 (N/A → N/A)

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.

Kitchen audits are undertaken by the Catering Manager. Clinical areas are audited by the Infection Control nurse. The audit tool first used was the ICNA tool. The organisation is to be commended for then moving to the HIQA assessment tool. It is recommended to continue with this and to roll out auditing to all areas. It is suggested to the organisation to commence multi-disciplinary auditing to best utilise the expertise within the organisation and to involve patient representatives. The utilisation of a Hygiene Services Standards Self Assessment form, adapted from CUH, is to be commended and the minor adjustments to the form discussed with the Infection Control Nurse should enhance feedback and quality improvement.

CM 9.4 (N/A → N/A)

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

Patients' satisfaction comment cards and letters sent to the organisation were viewed during the hygiene assessment. A process for the management of complaints had been in existence and has now been superseded by the HSE Guide to Complaints "Your Service, Your Say". No complaints were viewed during the visit.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.4 (N/A → D)

There is evidence that the contractors manage contract staff effectively.

No evidence of the management of contractors was available to the assessment team. The organisation should implement a process to ensure that contracts in place are appropriate to the needs of the organisation and that contractors manage their staff effectively.

*Core Criterion

CM 10.5 (N/A → N/A)

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

A Human Resources needs analysis was not available for the assessment team to view. However, on discussion with management at the hygiene assessment meeting the Hospital Manager detailed the series of administrative stages for a new post to be filled. The need for a second .5 position in Infection control was noted in the minutes of hospital hygiene meetings from 2005. In Light Of the Proposed Capital Development Plans and The Adoption of the HIQA Hygiene Assessment Scheme, human resources needs, for example, an Infection Control position and a Hospital Hygiene Co-ordinator, require further assessment.

ENHANCING STAFF PERFORMANCE

*Core Criterion

CM 11.1 (N/A → N/A)

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

Induction training is provided to nursing staff which is inclusive of hygiene issues and standard precautions and waste management. All staff are included in hand hygiene training sessions and the infection control nursing personnel have to be commended on the follow up assessment of knowledge and practical observation. Health care assistants undergo the FETAC training which includes follow up assessment of knowledge gained. It is recommended that Catering staff undergo Food Hygiene training.

CM 11.3 (N/A → N/A)

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

Key Performance Indicators to evaluate the effectiveness of education and training were not available. No evidence of satisfaction rates on education and training was given. Evidence of attendance levels at education and training was viewed and staff interviewed during assessment could verify when they last attended hygiene training sessions.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (N/A → N/A)

An occupational health service is available to all staff.

An Occupational Health Service is available to staff and is provided from CUH. While staff interviewed were never asked to participate in a staff satisfaction survey in relation to the service provided, staff verbally expressed their complete satisfaction with the Occupational Health Department.

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.

There is a documented process in place for the establishment of best practice guidelines, for example, Colour coding for cleaning cloths/mops were in place and in use. However this process needs to be updated to ensure it is current. While there are regional documents (for example infection control) which were developed with input from St Mary's staff, they do not adhere to the documented process above. Protected time for staff to develop & review best practice guidelines was identified as a Quality Improvement Plan (QIP). The hospital should evaluate this process for effectiveness.

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.

There was a process for evaluation of all new products. Evidence was observed that products are discussed at the Hygiene Services Committee meetings. SMOH staff stated that all new hygiene products were evaluated by Cork University Hospital before being introduced to SMOH. The process of introducing new products needs to be reviewed so that the local needs and requirements are addressed more accurately.

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.

Leaflets regarding hygiene and health promotion are readily available to patients, and visitors on wards. The development of a "Friends" group is underway. The organisation is a member of the national Health Promotion Hospitals group. Membership of the Hospital watch scheme in conjunction with the Gardai was also noted. No evaluation of health promotion activities was noted and a Hygiene promotion day was identified as a QIP. The organisation is recommended to develop links with voluntary agencies, and the community (for example primary care and GP's). Greater linkages with external community organisations is also recommended.

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 was a multi-disciplinary Hygiene Services Committee with a defined membership and Terms of Reference. Minutes of meetings were available during the assessment. There was a formal process of linking with CUH as members of the committee (Director of Nursing and General Manager) have roles across both hospitals. No defined roles and responsibilities were available. In addition, evaluation of the effectiveness of the committee was not available, which is recommended.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

SD 4.1 (C ↑ A)

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

The odour control initiative in the toilets is to be commended. High dusting in many areas requires greater attention. Flaking paint was noted in Block 9, the Physiotherapy department and in the main kitchen. A documented process is in place in relation to flushing outlets, however, the organisation needs to evaluate whether or not this is in keeping with the process. Various grades of staff clean different parts of beds, with poor results noted. The use of wipes to clean large areas, for example, beds, needs to be evaluated. For further information see Appendix A

*Core Criterion

SD 4.2 (C ↑ A)

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

Overall the patient equipment was very clean. Pans from commodes are not compatible with bed pan washers. Therefore these are hand washed. There is a requirement to fit a different holder to the base of commodes to accommodate a pan that will be effectively decontaminated in a bed pan washer. For further information see Appendix A

*Core Criterion

SD 4.3 (C ↑ A)

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

Cleaning equipment over all was well maintained and clean. While the domestic services room is locked - the provision of lockable chemical cupboards should be considered. Equipment in Physiotherapy and some buffers in other areas need attention. There is no evidence of cleaning equipment being approved by the Hygiene Services Committee. For further information see Appendix A

*Core Criterion

SD 4.4 (C ↑ 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.

While the most recent EHO report April 2007 was available, all of the issues raised had not been addressed at time of assessment. The Catering Manager had detailed a risk management report, which should be progressed. To date, there has been no response. The hospital is encouraged to implement all aspects of HACCP and ensure that food is not prepared in any of the ward kitchens. For further information see Appendix A

*Core Criterion

SD 4.5 (C ↑ 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.

There are informal processes in place for the management of waste and these appear to be effective. The hospital should review these practices to ensure they are in line with current best practice, for example, recording tags numbers issued to each ward and ensuring Certificates of Destruction are linked to C1 forms. 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.

The organisation should undertake a thorough Health and Safety Inspection of the washing machines and their standard operating procedures. The use of more modern equipment is suggested. For further information see Appendix A

*Core Criterion

SD 4.7 (B ↑ A)

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

Hand hygiene training is to be commended. There is extensive compliance with the uniform policy in place. The organisation is in the process of upgrading the clinical wash hand basins to ensure they conform to HBN 95. This initiative should be completed. For further information see Appendix A

SD 4.9 (B → B)

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

Visiting times are clearly displayed on the wards. Problems were noted in some units regarding removing visitors at night. Patient information leaflets are available on wards – “Hand hygiene for parents” and “Hand hygiene for children”, were particularly user friendly. However, the Patient information leaflet/book has no reference to hygiene. Hygiene is mentioned on comment cards, which are part of elective admissions. Extending the patient information booklet and comment cards to Trauma was identified as a Quality Improvement Plan. A Satisfaction survey was completed in 2006. The organisation is recommended to develop and implement the

following suggestions to improve patient/client participation: 'Think Clean Day', 'Sharps Awareness Days', open days for MRSA prevention, involving patients in focus groups, and including a patient representative on relevant committees.

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.

Overall the organisation is patient-centred. Patients, when interviewed, provided feed back regarding hygiene. The Patient Information Booklet mentions "respect for privacy, dignity and cultural beliefs" and "details of conditions and treatments are confidential" and "rights of Hospital patients". A Patient's Charter is displayed on wards. Signage used in isolation facilities is generic. No evaluation was provided, and this is recommended.

SD 5.3 (C → C)

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

There was evidence that the HSE complaint form – "Your Service Your Say" is in operation. No complaints were viewed and there was evidence of compliments received. The hospital is encouraged to include consumers in reviewing the complaints on an annual basis.

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1 (N/A → C)

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

No patients/clients are involved in routine audits. Feedback from patients on hygiene services is available to the team from replies to comment cards. A Quality Improvement Plan (QIP) was in place to involve clients in evaluating the service by questionnaire.

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.

Routine audits are conducted in clinical areas by Infection Control Nurses using the HIQA assessment tool. A Catering officer conducts audits in main kitchen using the HIQA assessment tool. Sharps audits has been undertaken by an external supplier. Memos to staff detailing actions followings audits were noted. The evaluation of staff in the past year regarding hand hygiene practice and knowledge is commended.

SD 6.3 (D ↑ C)

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

In order to ensure that the organisation would be unable to assess at the Corporate Health Service Executive or Network level whether the service specification was achieved and if current requirements were met. They are encouraged to produce an annual report.

4.0 Appendix A

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

4.1 Service Delivery Core Criterion

Compliance Heading: 4. 1 .1 Clean Environment

(1) The environment is tidy, well-maintained, free of rust, blood or body substances, dust, dirt, debris and spillages.
Yes - In the majority, compliance was noted. However, the Physiotherapy unit & Block 9 need greater attention.

(2) All high and low surfaces are free from dust, cobwebs and flaking paint.
No - High dusting in many areas needs greater attention and flaking paint was noted in Block 9, Physiotherapy and in the main kitchen.

(4) Floors including edges, corners, under and behind beds are free of dust and grit.
Yes - In the majority, compliance was noted. However, the floors in Block 9 and in Physiotherapy require attention.

(6) Free from offensive odours and adequately ventilated.
Yes - The odour control initiative in the toilets is to be commended.

(7) Areas should be adequately ventilated with ventilation units cleaned and serviced accordingly and documentation available regarding service.
Yes - In the majority, compliance was noted. However, the X-ray air conditioning unit was broken and a fan was in use.

(14) Waste bins should be clean, in good repair and covered.
Yes – The cleaning of bins excellent.

(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 – A No Smoking area was noted.

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

(19) Ceilings
Yes - In the majority, compliance was noted. However, lint was noted on the Laundry ceiling.

(21) Internal and External Glass.
No - External glass requires further attention.

(25) Floors (including hard, soft and carpets).
Yes - In the majority, compliance was noted. However, the floors in Block 9 and in Physiotherapy require attention.

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

(30) Fixtures: Fixtures (i.e. a piece of equipment or furniture which is fixed in position) should be clean. This includes all electrical fixtures e.g. all light fittings and pest control devices.
No - All external lights require further attention.

(207) Bed frames must be clean and dust free
No - Various staff grades clean different parts of bed with inconsistent results.

(208) There should be a process for the cleaning of curtains and blinds. Curtains should be changed after each known case of infected patient / client where required. Records should be maintained of curtain changing.
Yes - In the majority, however, no records of curtain changing are maintained in the Physiotherapy department.

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

(34) Beds and Mattresses
No - Various staff grades clean different parts of bed with inconsistent results.

(35) Patient couches and trolleys
No - Theatre trolleys were dusty.

Compliance Heading: 4. 1 .5 Sanitary Accommodation

(48) Floors including edges and corners are free of dust and grit.
Yes - In the majority, compliance was noted. However, Block 9 needs attention.

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

(60) All outlets (including shower outlets) should be flushed at a temperature in accordance with current legislation.
Yes - Documented processes are in place, however, the organisation is recommended to evaluate if the practice is in keeping with the process.

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

(65) Commodes, weighing scales, manual handling equipment.
Yes - Pans from commodes are not compatible with the bed pan washers. Therefore pans from commodes are hand washed. There is a need to fit different holder to the base of commodes to accommodate a pan that will be effectively decontaminated in a bed pan washer.

(68) Patient fans which are not recommended in clinical areas.
No - Fans were observed in use.

(69) Patient washbowls should be decontaminated between each patient, and should be stored clean, dry and inverted. Damaged washbowls should be replaced.
Yes - Each patient is given their own wash bowl.

(70) Bedpans, urinals, potties are decontaminated between each patient.
Yes - However, no records of service and validation of the bed pan washer were available.

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

(272) Splashes of water or hand-wash gel should not be present on the wall, floor, bed or furniture, splash backs should be provided.
Yes - In the majority, compliance was noted. However poor installation of splash backs was noted.

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

(81) All cleaning equipment should be cleaned daily.
No - Equipment in Physiotherapy and some buffers in other areas require greater attention to cleaning.

(87) All cleaning equipment should be approved by the Hygiene Services Committee and ensure sufficient supply.
No – No documented evidence to support this was observed.

(88) All cleaning equipment should be left clean, dry and tidy in the storage area after use.
Yes - In the majority, however, the Physiotherapy department requires attention in this regard.

(92) Cleaning products and consumables should be stored in shelves in locked cupboards.
Yes - While the domestic services rooms are locked, the provision of chemical cupboards should be considered.

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 - Compliance with the main requirements of IS 340, SI 369 and EC 852 was noted.

(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 - The EHO report dated April 2007 raised many issues to be addressed. The hospital is recommended to review these in a timely manner.

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.
Yes - It is suggested that visitors fill in a "Visitors Form" before entering the main kitchen.

(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 - Some food was prepared in some ward kitchens and is recommended that this be ceased.

(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 - Splash backs were missing in some wash hand basins in the main kitchen and in ward kitchens.

(223) Separate toilets for food workers should be provided.
Yes - In the majority, however, staff toilets need refurbishment and repair. One sink observed was cracked.

(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.
No - Cob-webs were noted on extractors over the main cooking area. The Catering Officer requests cleaning from maintenance every 3 months, however, this has yet to be instigated.

Compliance Heading: 4. 4 .3 Waste Management

(233) In food preparation areas where lidded bins are provided they shall be foot pedal operated.
Yes - In the majority, however, extra attention is required for the cleaning of foot operated bins.

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 - Temporary control measures are in place to ensure food is held at the correct temperature in fridges in the main kitchen. It is recommended that this process be documented and formalised.

(244) Temperature for food when cooked, held or reheated should comply with I.S. 340:2006 requirements.
No - The cold side of the trolleys transporting food to wards is not holding temperature. This was reported to Maintenance but remains an issue. Control measures are in place to address this.

Compliance Heading: 4. 4 .9 Food Cooling

(248) Cooling Times for Cooked Food should comply with I.S. 340:2006 requirements.
No - The Blast chiller temperatures and size were identified and discussed during the assessment. These issues are in the process of being addressed.

Compliance Heading: 4. 4 .10 Plant & Equipment

(250) The dishwasher's minimum temperature for the disinfecting cycle should be compliant with I.S.340:2006 requirements and should be monitored regularly. There should be digital readouts on dishwashers.
Yes - No digital read out is completed on dish washer in the main kitchen but records were viewed of temperatures checked by the contract company bi annually.

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

(145) A record is kept of tags used for each ward/department for at least 12 months.
No - The hospital manages the traceability of waste through a manual system, however, it does not record tags numbers issued to each ward. They do however mark individual bags and rigid containers for risk waste with the individual department name. The hospital should consider keeping a record of tags for 12 months.

(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.
No - C1 forms are used by the hospital. Certificates of destruction are not linked with the C1 forms. Therefore the audit trail is not complete. This should be reviewed.

(152) When required by the local authority the organization must possess a discharge to drain license.
No - Staff did not have knowledge of the license requirement.

(253) Personal protective equipment is accessible to all staff involved in the generation, collection, transport and storage of waste.
No - Staff were using the PPE's available to them. There are no PPE's available in the main storage area. These are stored in the Waste Managers office some distance away.

Compliance Heading: 4. 5 .2 Maintenance of Records

(254) Documented process(es) for the retention of waste traceability records, certificates of destruction, consignment notes (C1 forms) and trans Frontier Shipment (TFS) tracking forms for at least 12 months. These should be retained for all hazardous waste types.
No - While there are CI forms and Certificates of Destruction in place - it was not possible to determine if all were in place for 12 months. The management of these should 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 - While there are CI forms and Certificates of Destruction in place - it was not possible to determine if all were in place for 12 months. The management of these should be reviewed.

Compliance Heading: 4. 5 .4 Transport

(163) Documented processes for the transportation of waste through the hospital which minimizes manual handling of waste (and ensures that segregation of healthcare risk waste from non-risk waste is maintained) are in place.
Yes - While the duties of the Technical Services staff revealed a process for transportation of waste, there was no other supporting documentation.

(166) Drivers of vehicles transporting hazardous waste must be trained in accordance with the ADR Regulations.
No - The hospital does not know if drivers are trained in accordance with regulations.

Compliance Heading: 4. 5 .5 Storage

(169) Documented process(es) for the replacement of all bins and bin liners.
No - No processes were found to be in place.

(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 - The inner gates in the waste compound are locked. There are outer gates on the area where waste is stored and these are only locked in the evening. The facility is secured by staff, however, the hospital could consider extending the hours for locking the gates for security reasons.

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

(173) Documented processes for the use of in-house and local laundry facilities.
No – There was documentation for the transportation of linen supplied. No documented process were in place for the local laundry.

(261) Clean linen store is clean, free from dust and free from inappropriate items.
Yes - The Physiotherapy department linen press had inappropriate items stored.

(266) Personal protective equipment must be accessible to and used by all staff members involved in handling contaminated linen.
No - No PPE was noted in the laundry facility.

(267) Documented process for the transportation of linen.
No - No documented process for transportation of linen was noted.

(268) Ward based washing machines are used only with the agreement of the Hygiene Services Committee.
Yes – No ward based washing machines were seen.

(271) Hand washing facilities should be available in the laundry room.
No - No hand wash sink was noted in the laundry facility.

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

(190) All sinks should be fitted with washable splash backs with all joints completely sealed.
No – The majority of hand wash sinks viewed did not have a splash back.

(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 – Of the areas visited, only out-patients hand wash sinks were noted to meet the standard. The hospital are in the process of addressing this deficit.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team		Assessor Team	
	FREQ	%	FREQ	%
A	0	00.00	4	07.14
B	3	05.36	4	07.14
C	14	25.00	11	19.64
D	1	01.79	2	03.57
E	0	00.00	1	01.79
N/A	38	67.86	34	60.71

5.2 Ratings Details

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

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