Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Hygiene Services Assessment Scheme

Assessment Report October 2007

St. Luke's General Hospital, Kilkenny

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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. Luke's General Hospital, Kilkenny is the Acute General Hospital for Counties Carlow and Kilkenny. Due to its location in the heart of the South East, St. Luke's General Hospital also provides services to its bordering counties: Tipperary North and South, Waterford, Wexford, Kildare and Laois. Most of these areas lie within a one hour commute of Kilkenny, which is of vital significance, particularly in emergency situations. The hospital has capacity of 317 beds, which includes 12 beds in day ward (6 general and 6 oncology).

Services provided

In addition to the acute services that are provided on site at St. Luke's, outreach services are also provided in Kilcreene, Carlow, Thomastown and Castlecomer. Lourdes Orthopaedic Hospital, Kilcreene provides regional elective orthopaedic services and is also the location for the Pre-Discharge Unit and other PCCC services.

Services provided by the hospital include:

- General Medical
- Surgical
- Obstetrics
- Gynaecology
- Paediatrics
- Psychiatry
- Cardiology
- Endocrinology
- Hepatology
- Gastroenterology
- Oncology
- Palliative Care
- Anaesthetic

Physical structures

St. Luke's General Hospital has 10 single rooms with clinical sink and en suite facilities designated for isolation. Additional single rooms with and without en suite facilities may be used for isolation purposes. There are no negative pressure rooms.

The following assessment of St. Luke's General Hospital, Kilkenny took place between on the 14th and 15th June 2007.

1.3 Notable Practice

- The approach to hygiene services management and delivery was considered an area of notable practice and is to be commended.
- The inclusion of patient/clients to plan and evaluate the service is welcomed and impressive.
- The hygiene services management structures and processes in place were excellent.

- Household staff awareness of hygiene systems was of a very high standard.
- The standard of operational hygiene in all areas of the kitchen and clinical areas was good.
- Internal audits were in place to evaluate the hygiene service. The computerised audit system is innovative and progressive.

1.4 Priority Quality Improvement Plan

- Due to the age of the hospital building, space for storage was limited in a number of areas.
- Facilities for the isolation of patient/clients and the physical layout of the older wards were not in line with best practice.
- It is recommended that the refurbishment and capital development roll out be continued as a priority.
- In some corporate areas, it is recommended that systems of evaluation be implemented.

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. Luke's General Hospital, Kilkenny has achieved an overall score of:

Good

Award Date: October 2007

2.0 Standards for Corporate Management

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

PLANNING AND DEVELOPING HYGIENE SERVICES

CM 1.1 (B → B)

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

Hygiene services are an integral component of the overall service delivery. The Hygiene Services Committee is responsible for planning, sustaining, evaluating and improving their delivery. A significant list of capital developments and service delivery reconfigurations have been completed and are in progress. This is in response to the health care needs of the population served by the hospital. Information used within the Hygiene Corporate Strategic Plan, Service Plan and Operational Plan was sourced from a variety of sources, both internal and external. The Health Service Executive Corporate Plan 2005-2008, the Health Service Executive South Business Plan Level 1 and St. Luke's Business Plan Level 2 outlined the plans for delivery of hygiene services.

To-date no evaluation of the efficacy of the needs assessment process has been carried out, and consequently, no resultant actions, feedback and continuous quality improvement plans were observed. It is recommended that a process of evaluation be implemented in the future.

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.

A Hygiene Services Annual Report 2006, Hygiene Services Strategic Plan 2007-2010 and Service and Operational Plan for 2007, were completed with identified actions, responsibilities and a reporting mechanism to the hospital's Executive Management Team. A number of developments and modifications had occurred within hygiene services (as outlined in the Service Delivery section of this report). These include developments across all aspects of hygiene services structures, processes and some evaluation in the area of hygiene service delivery.

To-date no formal evaluation of developments and modifications, in relation to meeting the service user's needs has taken place, and consequently, no resultant actions, feedback and quality improvement plans were observed. It is recommended that a process of evaluation be implemented in the future.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1 (A ↓ B)

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

St. Luke's Hospital links with the Health Service Executive's National Hospital Office through its Network Manager (minutes of meetings were observed) and a number of regular reports to the ESRI and the Department of Health and Children have been furnished. Hospital staff attend relevant national committee meetings relating to hygiene services. An Executive Management Board is in place, with a clinical directorate structure noted. There are close working relationships with tertiary referral hospitals, relevant community hospitals and primary care services. No contract staff are directly employed, however, contracts are in place for the provision of specific services such as waste collection, sani-bins and pest control. A Hygiene Service Team and Hygiene Services Committee are in place. The Hygiene Services Committee membership was fully representative of the multidisciplinary teams in the organisation and also had a Patient Partnership Forum representative. The organisation endeavours to work in partnership with regard to hygiene services. A Patient Partnership Forum is in place, and a Patient Satisfaction Survey on Food, which aims to involve patient/clients in developing this service, has been conducted. To-date, evaluation of the potency of linkages and partnerships has not been carried out, and consequently, no resultant actions, feedback and continuous quality improvement plans were observed. It is recommended that a process of evaluation be implemented in the future.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 (B → B)

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

Documented processes were observed for the development of the Hygiene Corporate Strategic Plan. Clearly defined goals, objectives and priorities have been established and a business case had been prepared for a number of the priorities. The Executive Management Team, in collaboration with the Hygiene Services Committee, assumes responsibility for the strategic direction and corporate plan for hygiene services. A strong teamwork approach, to ensure the operation of hygiene services is safe, efficient and effective, was identified. A communication system includes clearly documented structures for meetings (both discipline specific and project specific).

To-date, no process for the evaluation of the Hygiene Corporate Strategic plans' goals, objectives and priorities against needs has been developed and implemented, and consequently, no resultant actions, feedback and continuous quality improvement plans were observed. It is recommended that a process for evaluation be developed and implemented in the future.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.1 (B → B)

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

It was evident that the Executive Management Team and the Hygiene Services Committee have based their structures for the planning, delivery, evaluation and development of hygiene services on relevant current legislation, clinical, health and safety and other relevant guidelines. The Executive Management Team have developed a Business Plan Level 2, based on the Health Service Executive South Level 1 Business Plan, which was used to guide the Hygiene Services Corporate plan. A Code of Corporate Ethics was presented in a Mission and Values Statement. The Hygiene Services Team's adherence to legislation and relevant national guidelines is evaluated using internal audits in areas such as hygiene, waste management and infection control audits.

CM 4.2 (B → B)

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

A number of relevant committees provide reports to the Executive Management Team. Regular monitoring of water sampling, infection control for MRSA, C. Difficile and ward fridge temperatures and internal auditing processes were in place. Logs are also maintained for tasks such as showerhead cleaning, hygiene and health and safety. Hygiene services best practice information is available through library facilities, which includes internet access, National and Regional Committee membership, and correspondence from the Department of Health and Children, the Health Service Executive, the Health and Safety Authority and relevant professional bodies. New information about hygiene services is discussed at line manager meetings. They assume responsibility for communicating this to all their local team. Evaluation of the information received through various internal audits mentioned, which produce resultant actions, feedback and continuous quality improvement plans is carried out.

CM 4.3 (B → B)

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

The Environment and Facilities and Risk Management Teams have developed Quality Improvement Plans based on research and best practice information. Following the previous national hygiene audits (2005 and 2006), a range of quality improvements have been introduced. These include funded time for hygiene staff to attend relevant education and training courses, the development of clinical policies, the provision of training and education on topics such as infection control, household, waste management, health and safety, the development of clinical risk management reports, the development of the induction programme, implementation of hygiene and clinical audits, the facilitation of regular household meetings and the revision of structures for hygiene management. Also, an ambitious major and minor capital works plan is in place, in addition to the on-going refurbishment and replacement of equipment and fittings. The plan to develop an Organisational Research Governance Strategy is to be commended. Evaluation of hygiene services-related research and

best practice information is through various internal audits. Resultant actions, feedback and Quality Improvement Plans were also observed in place.

CM 4.4 (C → C)

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

The hospital has established a Policy Development Committee. This committee aims to introduce standard processes for the development, approval, revision and control of all policies, procedures and guidelines, including those for hygiene services. A comprehensive suite of policies is currently in place for Health Service Executive procurement, household, waste management, infection control, hand hygiene, catering, curtain change and equipment servicing. It is recommended that the Policy Development Committee progress the introduction of the standardised processes as a matter of urgency to ensure consistency of processes across all aspects of services.

CM 4.5 (B → B)

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

A practice of including all relevant services, including hygiene services, in the pre-development consultation process of existing and future services has been developed. Evidence of this consultation was observed in the purchase of new autoclaves. Communication between the hygiene services and the Governing Body/ Executive Management Team can be seen at hygiene services committee meetings, weekly meetings between the General Manager and the Maintenance Manager, the Capital Projects Department's linkages with the Maintenance Manager and the Hygiene Services Committee, Multi-disciplinary Capital Projects Team meetings, linkages between the Nurse Planner and Household Staff and the role of the multi-disciplinary Aspergillus Committee in infection control issues pertaining to construction and environmental refurbishment.

A process for evaluating the efficacy of the consultation process between the Hygiene Services Team and Senior Management was not observed, and consequently no resultant actions, feedback and continuous Quality Improvement Plans have been developed. The team is encouraged to address this issue. However, a plan to develop a protocol for planned ward refurbishment regarding all aspects of the planning and work process is currently being developed and evaluation is intended. This is to be commended.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

*Core Criterion

CM 5.1 (A → A)

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

The role, authority, responsibility and accountability of the Executive Management Team in relation to hygiene services have been identified in the Clinical Directorate Structure, the Organisational Structure and the Hygiene Corporate Strategic Plan (2007-2010). Job descriptions for the Governing Body included roles, authority, responsibilities and accountabilities. Reporting relationships of all members of the Hygiene Services Team, through their relevant line managers to relevant senior hospital managers, are identified in job descriptions. Ward/Department managers assume responsibility and accountability for the overall standard of hygiene in their area and liaise with other relevant Hygiene Service Managers to ensure compliance.

A strong interdisciplinary approach for hygiene services delivery was observed, which is to be commended.

*Core Criterion

CM 5.2 (A → A)

The organisation has a multi-disciplinary Hygiene Services Committee.

The Hygiene Services Committee membership is reflective of the Hygiene Services Assessment Scheme recommended structure. A pre-existing awareness by team members of each other's roles and responsibilities, in the provision of all relevant services, through an integrated multi-disciplinary team culture, was noted.
Hygiene Services Committee Terms of Reference were in place, with administrative support provided to the committee. The Hygiene Services Committee meetings are held weekly, however a monthly schedule is planned.

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

*Core Criterion

CM 6.1 (A → A)

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

Allocation of resources is the responsibility of the Executive Management Team. Decisions are based on a Business Plan Level 2, which reflects national guidelines and the organisation's mission and values, Corporate Hygiene Strategic Plan and the Hygiene Service Plan. Identified new needs must be supported by a business case for consideration by the Equipment Procurement Committee or the relevant directorate, where necessary. The line manager, in accordance with the documented policy, can approve procurement of smaller items of equipment. The directorate prioritises needs before submission to the Executive Management Team.

CM 6.2 (B → B)

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

Minutes of Equipment Procurement Committee meetings provided evidence of the hygiene services committee members' involvement in the procurement processes.
There are on-going interactions between Hygiene Service Committee members and the Supplies Department. The General Manager is a member of the Hygiene Services Committee. Hygiene Services Committee members link through the Clinical Directorates with the Executive Management Team. There is, as yet, no formal evaluation of the efficacy of the consultation process between the Hygiene Services Team and senior management and consequently no resultant actions, feedback and continuous Quality Improvement Plan.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

CM 7.1 (A → A)

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

There was one Clinical Risk Manager with responsibility for all hospitals in Carlow/Kilkenny. This role involved the review and analysis of all incidents and near misses by clinical staff and the carrying out of root cause analysis. The Clinical Risk

Manager and the Regional Risk Manager participate in the Clinical Directorate and Clinical Governance meetings. The hospital, through its Environment, Risk and Facilities Management Team, was at an advanced stage in the development of a pro-active Risk Management Strategy. There had been no major adverse events in the last two years. Risk management and health and safety reports, hygiene services monitoring/recording and internal hygiene services audit systems are all in place. External Health and Safety Authority Reports, Environmental Health Reports and action plans are also in place. On-going internal Hygiene Services Audits of clinical areas commenced in March 2007 and were completed for 11 areas.

CM 7.2 (B → B)

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

There was an Environmental, Risk and Facilities Management Team in place, with documented terms of reference and minutes of meetings noted. Risk management make monthly reports to the Executive Management Team. Health and safety, Infection Control mandatory training records. Waste Management training and audits records were also observed. No major hygiene service adverse events have occurred in the past two years.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion

CM 8.1 (A → 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.

Documented processes are in place for establishing contracts, managing and monitoring contractors and their professional liability in the area of hygiene services. These are in accordance with the tendering process for supplies (the National /HSE Procurement Guidelines). There are contracts in place for provision of a range of hygiene services such as linen, pest control, sanitary bins, air conditioning and HEPA filters.

CM 8.2 (C → C)

The organisation involves contracted services in its quality improvement activities.

Relevant expertise is involved when drawing up contracts. A consultation process with contractors is in place. Product complaint forms are also in use. This area requires further development to ensure contractors' involvement in the area of QIP.

PHYSICAL ENVORNMENT, 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.

There were two different standards of design evident in clinical areas. The newer areas were of a high standard of design and well appointed. The older larger wards did not have adequate patient/client wardrobe, ward storage and hand wash facilities. Staff in these areas are to be commended for the optimisation of the resources that existed. There is a Capital Development Plan for the replacement of the older wards

and a business case has been developed for central storage of medical and nursing equipment and a separate plan developed for central storage of wheelchairs. The progression of these is recommended. Work is currently in progress to bring the standard of decontamination facilities in the Central Sterile Supply Department (CSSD) in line with current best practice guidelines. The team is encouraged to evaluate the safety of the design, layout and the current environment and its adherence to regulations and best practice.

*Core Criterion

CM 9.2 (A → A)

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

There are major and minor capital development programmes in place with a prioritisation mechanism for the more critical needs. There are processes for the management of environment and facilities, equipment and devices, kitchens, waste and sharps and linen, which include regular planned/preventive maintenance where relevant. Compliance was evident with relevant legislation and best practise in areas such as National Infection Control guidelines, Hazard Analysis and Critical Control Point (HACCP) and Waste Management guidelines.

CM 9.3 (B → B)

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

HACCP audits and meetings take place regularly, with waste management audits also in progress. Internal clinical audit reports were observed, with improvements noted in linen and cleaning systems in the past two years. A patient/client satisfaction survey has been planned for 2007. Outcome from the audits were noted in the Operational Plan for 2007.

CM 9.4 (B → B)

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

Comments cards are in use and a complaints process was also in place. Any issues are followed up in accordance with the complaints/risk management procedure. Patient/clients interviewed during the assessment were all very positive regarding hygiene services. Patient/client representation was noted on all relevant committees. There is a plan for patient/client forum representatives to participate in the internal hygiene process, once clarity as to how best they might be involved, is obtained. The complaint follow-up process is completed, with patient/client feedback provided.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 (A ↓ 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.

Documented processes were observed for staff selection and recruitment, which included hygiene services staff. These are in line with human resources policies and are based on current legislation and best practice. Job descriptions were reviewed for all staff. No contract staff is involved in general service delivery. Specific contracts are in place for areas such as waste management, cleaning (for high cleaning areas)

and pest control. There are recruitment records. The evaluation of the process of selecting and recruiting human resources had not yet commenced, however, the Human Resource Department are currently developing this.

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.

There was no documented process in place; however, a systematic approach was used to review changes in hygiene services' work capacity and volume. Within the last two years, an additional Infection Control Nurse and several household staff had been recruited to improve the hygiene service. No evaluation of this process is currently in place. The team is encouraged to develop documented processes to review changes in workload measurement and evaluate the process.

CM 10.3 (A ↓ B)

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

Documented processes included job descriptions, induction, on-going and mandatory training. An effective buddy system is in place for new household staff. It involved working in a supernumerary capacity with an experienced staff member for three days prior to the commencement of independent working. The allocation of hygiene staff to critical areas is influenced by experience and competence. It is recommended that Catering Management become trained and registered to carry out on-going hygiene training.

CM 10.4 (C ↑ B)

There is evidence that the contractors manage contract staff effectively.

Entire processes are not contracted out in any area of the organisation but structures are in place for the management of contracted services. There were regular no contract staff, with the exception of specific contracted services in the sani–bins and pest control areas. The tendering process identifies the standards required in these situations and this is the responsibility of the contractor. All hygiene services staff are in–house and their work is subjected to regular audit and evaluation.

*Core Criterion

CM 10.5 (A ↓ B)

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

Human resources identification of hygiene services' needs was based on professional judgement of the line managers. Internal audit outcomes assist in identifying key areas of needs. The low staff turnover rate was noted as a very positive area. Approval for additional staff is dependant on a business case submission. Hygiene services staff appeared sufficient to provide the necessary services, which is evaluated during the annual review. It is recommended that a hygiene services needs assessment be carried out.

ENHANCING STAFF PERFORMANCE

*Core Criterion

CM 11.1 (A → A)

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

A good induction handbook for kitchen staff was observed. This contained comprehensive and relevant information. Appropriate education and training provision for all new staff was evident. The Infection Control Education Team are informed of all new staff members. In the future, specialist registrars are to be included on the Hygiene Services Committee. The medical induction programme has a hygiene awareness component. Hand hygiene is a mandatory training requirement for all staff.The two Infection Control Nurses provide on-going education on a needs basis.

Records of attendance are maintained by Infection Control Nurses and circulated to ward managers to ensure compliance.

CM 11.2 (B → B)

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

This plan was being implemented. Processes are in place to ensure adequate facilities and protected time is afforded to staff to attend training.

CM 11.3 (B → B)

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

Staff questioned during assessment tours was all very competent in areas of hygiene services. Internal audits reflected this. Attendance levels at education and training sessions are recorded. A staff evaluation process is in place for training. Staff participates in gap analysis (an evaluation of staff's perception of gaps in the training provided, relative to what they needed).

CM 11.4 (A ↓ B)

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

The performance of all hygiene staff is monitored by audits and patient/clients' comments.

Line and ward/department managers also evaluate performance through supervisory processes. To-date, no documented process for hygiene services' staff evaluation has been developed. It is recommended that this be carried out.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (A → A)

An occupational health service is available to all staff

A designated Occupational Health Department was in place with two full-time staff members. A comprehensive service is available to all staff, including relevant vaccinations. The service is evaluated through the circulation of a staff questionnaire.

CM 12.2 (A → A)

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

Based on evaluations, a number of improvements have been introduced in the last two years. These included the appointment of a physiotherapist/ergonomist, development of a Dignity at Work Policy and the introduction of inoculation injury and influenza vaccination. This department is impressive and demonstrated exceptional compliance.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.1 (A → A)

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.

Standards, policies and procedures are disseminated throughout the organisation.
This is achieved via internal committees, the directorate structure and executive team. Each department maintain the relevant data.
During the assessment meeting, the staff were very familiar with impending legislation, guidelines and their implications for the organisation. Internal/external audit reports provide qualitative information. Compliance with national key performance indicators, HIPE coding, the Strategy for the control of Antimicrobial Resistance (SARI) reporting and compliance with infectious diseases regulation provided relevant quantitative information. The relevant data was reviewed at committee level and by the Executive Management Team.

CM 13.2 (B → B)

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.

A computerised system (which is considered best practice) and an effective mechanism for creating auditing data, is currently in use.

The hygiene services annual report was comprehensive.
Information is disseminated throughout the organisation in a timely manner.
Staff found the system to be user-friendly and committee meetings are used to discuss outcomes. It was recommended that staff document the evaluation process.
The on–site documentation for the Acute Hospital Hygiene Assessment visit was excellent, both in content and organisation.

CM 13.3 (B → B)

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

Hygiene services planning is based on data generated by internal audits, and planned improvements were noted in the operational Hygiene Services Plan 2007.
Improvements in the system were noted from back-dated internal and external hygiene audits. This should be evaluated.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

CM 14.1 (B → B)

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

The Executive Management Team plays an integral part in the provision of Hygiene Services. Over the past two years there have been significant developments across the spectrum of hygiene services delivery. The Executive Management Team have representation on the Hygiene Services Committee. The Patient/Client Partnership Forum is well established and used effectively. Developments in the past two years included the work of the policy and procedure development committee, introduction of internal audit and environmental refurbishment and the risk and facilities management team. A pro-active risk management strategy is also in progress.

CM 14.2 (B → B)

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

Relevant linkages were observed. The organisation benchmarks against published best practice and used external audits for standards relating to the hygiene services. Findings are published in audit and department reports and information was used at relevant committee meetings, with minutes maintained. Plans are in progress for twice annual internal audits for all clinical areas.

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 (A ↓ B)

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

Guidelines have been established, adopted, and maintained by the team and compliance to these guidelines are evaluated, using audits in relation to hand hygiene, kitchen and all clinical areas. Time is allocated for staff to consult this documentation. Documented processes need to be established for the adoption, maintenance and evaluation of these guidelines. An evaluation is recommended to assess the efficacy of these processes.

SD 1.2 (B → B)

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

There was a process in place for assessing new hygiene services. The Hygiene Services Committee meeting evaluates the efficacy of changes. However, with the exception of the minutes of meetings, no continuous improvement plan is in place. The efficacy of this process must be evaluated and reports of new interventions produced to evaluate the changes made.

PREVENTION AND HEALTH PROMOTION

SD 2.1 (C ↑ B)

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

The team was found to support the local community in focused areas. A patient/client partnership forum was in place. The hospital is a member of the Health Promotional Hospitals' Network. A Hand Hygiene Awareness Week has taken place. There were good leaflets on hygiene. A part-time health promotion staff member is employed. The hospital liaises with the local HSE Health Promotion Unit. Liaison also takes place with primary care and community groups. The efficacy of these activities is not currently evaluated, which is recommended.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1 (B → B)

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

Roles and responsibilities of the team members are defined. Internal hygiene audits and minutes of the Hygiene Services Committee meeting are used to evaluate the efficacy of the system. No documented processes are in place to review linkages/partnerships with other teams/programmes. It is recommended that this be addressed. Regular meetings, audits and the Hygiene Corporate Strategic Plan for 2007 aim to ensure team awareness of roles. Very good evidence was observed at ward and departmental level of a multi-disciplinary team approach to the provision of hygiene services.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

SD 4.1 (A → A)

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

Internally and external audits are carried out. Daily cleaning checklists are in place at ward level and are up to date. Good management of the physical environment and facilities was demonstrated.

For further information see Appendix A

*Core Criterion

SD 4.2 (A → A)

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

The level of cleaning observed was good; however, it is recommended that some areas of dust control be addressed. Also, some patient/client personal items were stored inappropriately. This is due to insufficient patient/client storage space. This should be addressed.

For further information see Appendix A

*Core Criterion

SD 4.3 (A → A)

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

Cleaning equipment was well stored and clean. Staff, when questioned, were very aware of the cleaning procedures. Some storage areas were cramped but tidy.

For further information see Appendix A

*Core Criterion

SD 4.4 (A → A)

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

The overall standard of operational hygiene in the kitchen was very good. The management of the system demonstrated good control, especially at ward kitchen level. The Patient/Client Satisfaction Survey is used to improve the system.

For further information see Appendix A

*Core Criterion

SD 4.5 (A → A)

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

Management of risk, non-risk and hazardous waste was of a high standard. Full implementation of the Hospital Waste Management Plan 2006 should be continued, including training for all staff. All departments who discharge liquid waste should be included in the waste discharge license application.

For further information see Appendix A

*Core Criterion

SD 4.6 (A → A)

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

The supply of laundry was good. Areas requiring improvement were the laundry room floor and the ventilation system. All laundry inspected was clean and well stored. This service is contracted out to Waterford Regional Hospital.

For further information see Appendix A

*Core Criterion

SD 4.7 (A → A)

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

The presence of infection control specialists at the hygiene services meetings assists in achieving compliance with SARI guidelines. Most wash-hand basins were compliant with HBN Technical/SARI guidelines, and the remainder were in the process of being phased. The staff's hand hygiene practice was good and no excess jewellery was noted. Hand hygiene training sessions were documented and compliance with attendance was audited in November 2006.

For further information see Appendix A

SD 4.8 (A → A)

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

Health and safety and risk management teams are in place. A flow chart has been developed for the identification of any potential risks to patient/clients. Control of

infectious diseases, including Legionella and MRSA is very good. Accident or near miss reporting is in place and evaluation of the process was observed to be good. Evaluation of incident rates is in place and planned improvements were noted in the Hygiene Corporate Strategic Plan for 2007.

SD 4.9 (B → B)

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

The HSE complaints policy is in place as is a visitor policy.
Numerous complimentary comments were noted from patient/clients. A Patient Satisfaction Survey and forum have been developed. Patient/clients, questioned with regard to hygiene services, were all complimentary. Comment cards are in use to evaluate the service. Patient/client representatives are present on all committees. Planned improvements were noted in this area for 2007. It is planned that the patient/client forum group will become part of the internal auditing team. Patient/client leaflets are available in the appropriate areas. It is recommended that an evaluation take place.

PATIENT'S/CLIENT'S RIGHTS

SD 5.1 (B → B)

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

A patient/client charter is in use. Confidentiality and privacy is protected in the Accident and Emergency department by the use of a separate room which is also used for patient/clients with special needs. Space limitations were noted in some areas, however when questioned, staff was very aware of the patient/client rights.
Patient/client dignity was protected at all times during ward tours and in all clinical areas. Feedback from the Patient/Client Partnership Forum and the complaints procedure are well managed, reviewed and acted upon. No violation of patient/client rights was noted.

SD 5.2 (B → B)

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

Good information leaflets are available and signage was excellent throughout. Patient/client information booklets are also in use. The Patient/Client Satisfaction Survey and forum are well utilised. It is recommended that the organisation include specific questions on the survey as to satisfaction in relation to information provided by the Hygiene Service Team.

SD 5.3 (B → B)

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

The HSE complaints policy “Your service your say” is in place for 2007. This is reviewed and action plans are developed. Summaries of any issues are noted to identify any repeat complaints. Action Plans are developed to deal with repeat complaints and thorough follow up is carried out. Evaluation is recommended.

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1 (B → B)

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

The Patient/Client Partnership Forum is used for this function. Comment cards are in use and are evaluated. Changes have been made to the service as a result of patient/client involvement. An evaluation of the extent to which patient/clients' families and other organisations are involved by the team when evaluating its hygiene services is recommended.

SD 6.2 (C ↑ B)

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

The hygiene team have completed 11 Internal Hygiene Audits since March 2007. A computerised system for this has been implemented. The organisation plans to complete an assessment of each area/department twice yearly with re-audits occurring where any serious issues are noted. Benchmarking takes place against national and international standards. The annual report details results of monitoring and evaluation activities.

SD 6.3 (B → B)

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

The Hygiene Services Annual Report for 2006 is very comprehensive and based on feedback from all of the service providers, staff and patient/clients. The Operational Service Plan for 2007 is comprehensive and includes all the relevant areas. A planned process was in place to communicate the report to all stakeholders.

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 - Most areas observed were of a high standard. However Medical Ward 1 had dust noted on the chart trolley and some equipment. Floors also require deep cleaning. The shower seats reviewed were rusty.

(2) All high and low surfaces are free from dust, cobwebs and flaking paint.
Yes - Most areas observed were good. Some flaking paint was noted in the Theatre and Intensive Care Unit; however, painting is scheduled in the near future. The dressing trolley in the Accident and Emergency Department was dusty.

(5) Cleanable, well-maintained furniture, fixtures and fittings used.
Yes - Staff chairs in the Operating Theatre rest rooms were covered in soft fabric and were dirty and torn. These are due for replacement in the near future. Patient/client areas observed were good.

(8) All entrances and exits and component parts should be clean and well maintained.
No - The main entrance requires upgrading and modernisation to reflect high service standards.

(9) Where present, main entrance matting and mat well should be clean and in good repair.
Yes - Mats observed were in a good state of repair. However, the Emergency Department entrance mat was in need of replacement.

(10) Internal and external signage should be clean, updated, well maintained and laminated to enable cleaning.
Yes - Signage was of a very high standard, laminated and clean.

(13) External areas including grounds, gardens, footpaths, ramps and car parks should be clean and well-maintained.
Yes - A designated grounds man is employed for this purpose.

(27) Local policies should be in place for guidance on all cleaning processes, colour coding, use of equipment, use of protective clothing and fluids and spillages.
Yes - Local policies were well documented.

(29) A warning sign “cleaning in progress” must always be used, position to be effective.
Yes - This was observed at ward level.

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

(21) Internal and External Glass.
Yes - External glass cleaning was observed.

(25) Floors (including hard, soft and carpets).
Yes - No carpets were observed.

(26) Nozzles of wall mounted alcohol gels and hand disinfectants must be cleaned daily.
Yes - Overall, compliance in this area was good; however, one gel nozzle in the Accident and Emergency Department required cleaning.

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

(207) Bed frames must be clean and dust free
Yes - Bed frames inspected were very good.

(208) There should be a process for the cleaning of curtains and blinds. Curtains should be changed after each known case of infected patient / client where required. Records should be maintained of curtain changing.
Yes - A weekly documented check sheet was observed in place.

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

(36) Lockers, Wardrobes and Drawers
Yes - However some patient/client areas did not have wardrobes.

Compliance Heading: 4. 1 .5 Sanitary Accommodation

(45) There is a facility for sanitary waste disposal.
Yes - This is provided by external contractors.

(46) Bathrooms / Washrooms must be cleaned on a daily basis. When necessary, they must be disinfected. This must be monitored and recorded.
Yes - Bathrooms/Washrooms are cleaned daily. Flushing records are used; however, the record sheet requires modification to specify cleaning.

(48) Floors including edges and corners are free of dust and grit.
No - Some patient/client bathrooms were in a poor state of repair and required cleaning, in particular Medical Area 1.

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

(55) Sluices
Yes - Sluice rooms were very clean.

(57) Clear method statements / policies should be in place for guidance on all cleaning including sanitary cleaning and maintenance processes.
Yes - Method statements/policies were well documented and posted in the appropriate areas.

(58) Sluice rooms should be free from clutter and hand washing facilities should be available.
Yes - Due to space constrictions, some basins were difficult to access. These are scheduled to be improved in the business plan for central storage.

(59) Where present shower curtains should be clean and in good repair with a process for laundering and replacement.
Yes - Compliance was noted in this area.

(60) All outlets (including shower outlets) should be flushed at a temperature in accordance with current legislation.
Yes - Flush records for showers and taps were observed.

(210) Consumables should be readily available and stored in a suitable environment, e.g. liquid soap, paper towels, toilet paper. Clean and well maintained dispensers should be available for consumables.
Yes - However, some items were stored on the floor due to space restrictions.

Compliance Heading: 4. 2 .1 Organizational Equipment and Medical Devices and Cleaning Devices (note: while list is not exhaustive, the following compliance is required):

(64) All equipment, including component parts, should be clean and well-maintained with no blood or body substances, rust, dust, dirt, debris and spillages.
Yes - Items inspected were good. However, some shower seats observed were rusty.

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

(65) Commodes, weighing scales, manual handling equipment.
Yes - An exception were the scales in the Accident and Emergency Department, which were dusty.

(66) Medical equipment e.g. intravenous infusion pumps, drip stands and pulse oximeters, suction apparatus and tubing, cardiac monitors, blood pressure cuffs, blood gas machines.
Yes - A good standard of hygiene was observed in this area.

(68) Patient fans which are not recommended in clinical areas.
Yes - No patient/client fans were observed.

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

(70) Bedpans, urinals, potties are decontaminated between each patient.
Yes - Bedpan washers are serviced twice annually. Temperatures on digital read outs displayed 82 degrees Celsius.

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

(71) Alcohol hand gel containers.
Yes - These were observed on beds and in all clinical areas.

(72) Trolleys, e.g. chart trolleys, drug trolleys, linen trolleys, shop trolleys, emergency trolleys, suction apparatus, resuscitation equipment i.e. ambubag and mask.
Yes - Soiled cleaning trolleys were observed in two medical wards and the maternity ward. One dirty chart trolley was also observed on Medical Ward 1. Emergency and resuscitation equipment was all very clean.

(74) Patient's personal items, e.g. suitcase which should be stored in an enclosed unit i.e. locker / press.
No - A considerable amount of patient/client property was observed on chairs and on the floor due to lack of storage space.

(75) Vases
Yes - No vases were observed in critical areas. Water was changed daily in vases in other areas.

(77) Loose items such as patient's clothing should be stored in the patient's locker or property bag.
No - Personal clothing was noted at ward level. Patient/client clothing was also observed in the clean linen storage cupboard in Surgical Ward 2.

(78) Personal food items, other than fruit, should only be brought in with the agreement and knowledge of the ward manager and should preferably be stored in an airtight container.
Yes - Patient/client fridges were clean. All items checked were clearly labelled.

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

(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 - Areas observed during the assessment demonstrated good compliance.

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.
Yes - This was observed. Compliance was noted in this area.

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

(83) Mop heads are laundered daily and are stored according to local policy or are disposable i.e. single use.
Yes - Good compliance was observed. The organisation plans to change to microfibre type.

(85) Cleaning solutions should only be prepared in a well ventilated area and should never be mixed.
Yes - Sluice rooms were ventilated.

(86) Information on the colour coding system is available to all hygiene staff (according to national guidelines).
Yes - Staff questioned was very aware of the colour coding system. Flash charts were available at each trolley.

(88) All cleaning equipment should be left clean, dry and tidy in the storage area after use.
Yes - However storage space was at a minimum.

(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 - Cleaning cupboards and sluice rooms are used for storage. It is recommended that the central storage facilities for cleaning equipment on each ward be used.

(91) Storage facilities for Cleaning Equipment should be clean and well maintained.
Yes - Storage facilities were clean and tidy, however, space was at a minimum.

(92) Cleaning products and consumables should be stored in shelves in locked cupboards.
Yes - All cupboards checked were locked.

(93) Cleaning products and equipment should comply with the relevant colour coding policy.
Yes - Compliance was noted in all areas.

(94) Health and Safety policies should be in place for the use of ladders/steps when cleaning.
Yes - A policy was in place for cleaning and maintenance staff. High level cleaning is contracted out.

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 - All relevant documentation was in place.

(213) Environmental Health Officer (Senior EHO/EHO) reports on food safety inspections including the completed summary stage of compliance with HACCP and annual water analysis reports should be retained on the Hospital Food Safety Manual. Action plans/ actions taken on foot of issues raised in the reports should be documented.
Yes - Corrective actions for all reports were documented. Weekly water tests were observed on file, with good results noted.

(214) The person in charge of catering shall develop, implement and maintain a permanent system based on the seven principles of HACCP. A standard HACCP Plan should be fully completed.
Yes - Corrective actions for all reports were documented. Weekly water tests were observed on file, with good results noted.

(215) There should be a documented ward kitchen food safety policy which should be signed off by the person in charge of the ward kitchen and the hospital manager.
Yes - A signed and dated policy is in place and adhered to.

(216) Documented processes for manual washing-up should be in place
Yes - A documented process in is place and posted in the appropriate areas.

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 - Good compliance was observed.

(218) Authorised visitors to the food areas should wear personal protective clothing (PPE) and wash hands on entering the food area during food preparation/serving times.
Yes - Coats, gloves and hats were all available at the entrance.

(219) Ward kitchens are not designated as staff facilities
Yes - No evidence was observed of staff items in these areas. However the locker room, however, was cramped and untidy.

(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 - Elbow operated sinks are in use.

(223) Separate toilets for food workers should be provided.
Yes - Separate toilets were provided and all were clean.

(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 - Good ventilation was provided and filters observed were 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.
Yes - Good compliance by staff was observed at ward kitchen level. The kitchen staff regularly monitor these areas and demonstrate good practice.

(227) Flour, cereals, sugar etc shall be stored in a dry environment and when opened stored in covered containers.
Yes - Good clean covered bins were in use.

Compliance Heading: 4. 4 .3 Waste Management

(229) Animal and pest control measures shall be in place in all waste handling and storage areas.
Yes - Records provided evidence of good practice.

(230) A supply of water should be available to clean down external waste storage areas.
Yes - Test results were observed on file.

(231) All waste shall be removed from the operational areas frequently as necessary but at least daily.
Yes - Good separation was observed and all bins were foot operated and lidded.

Compliance Heading: 4. 4 .4 Pest Control

(235) A system of pest control developed by a competent person shall be in place.
Yes - A contract manual was in place to subcontract this service to a competent person and a bait point map was in place to identify all the bait point locations throughout the site.

(236) Detailed inspections of food areas shall be carried out and recorded at least every three months for evidence of infestation by insects or rodents by a competent person.
Yes - Records were maintained and observed.

(238) Electric fly killer (EFK) units when used shall be located in an area free from draughts, away from natural light and not directly above an area where food or materials that come into contact with food are located. The EFK units shall be left on at all times and have shatter proof sleeves. The ultraviolet (UV) light tubes shall be replaced at least annually and records of replacement should be retained. The EFK shall be fitted with a catch tray and emptied as required.
No - One Electric fly killer in the kitchen was not operational. It is recommended that more units be purchased for use in the kitchen.

(239) Fly screens should be provided at windows in food rooms where appropriate.
Yes - Some fly screens were dusty and need more frequent cleaning. The fly screens in the bread room were not flush fitting; otherwise all fly screens were flush fitting.

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

(240) A Hospital using a cook-chill system should comply with Guidance Note No. 15 Cook-Chill Systems in the Food Service Sector (Food Safety Authority of Ireland) The temperatures of fridges, freezers, cold rooms and chill cabinets shall be capable of maintaining the temperature of foodstuffs
No - Backdated records showed that the 63 degrees C temperature for hot holding and the 30-minute rule for food to be placed in the blast chiller after cooking are not always maintained. This process should be reviewed in the near future.

(242) Temperatures for Food in Fridges / Freezers and Displays should comply with I.S.340:2006 requirements
No - Some display units observed were out of specifications in canteen and at ward level.

(243) Preparation of High Risk Foods should comply with I.S. 340:2006 requirements
No - Mince beef once opened from the vacuum packed should be given a one-day use-by date and not three days. All items frozen in-house must be re-dated to demonstrate supplier use-by date, date-frozen and new use-by date to maintain traceability. Zoning observed was not best practice. It is recommended that a fully separate area be provided to prepare raw meat and fish. The system in use was, however, well controlled.

Compliance Heading: 4. 4 .6 Food Preparation

(245) Cleaned and disinfected work surfaces, equipment and utensils shall be provided for preparing ready to eat foods and foods to be cooked to prevent the risk of contamination. In addition to the HSE hospital colour coded system (see Appendix 6 Irish Acute Hospitals Cleaning Manual 2006), the food colour coding of work surfaces, equipment and utensils should be provided for (see I.S. 340:2006).
Yes - A very high standard of cleaning was observed, however, more frequent use of sanitisers at ward and kitchen level is required.

Compliance Heading: 4. 4 .7 Food Processing

(246) The thawing of food shall be carried out under appropriate conditions such as in a thawing unit, a fridge or a microwave oven with thawing cycle
Yes - Good compliance was observed.

Compliance Heading: 4. 4 .8 Food Cooking

(247) All foods shall be cooked to a temperature to ensure that the products are safe for consumption. The core temperature of the food shall be assessed at he thickest point of the food and should be compliant with I.S. 340:2006
Yes - Food cooking was very well controlled. Laboratory samples demonstrate the efficacy of this system. All microbiological tests recorded excellent results.

Compliance Heading: 4. 4 .9 Food Cooling

(248) Cooling Times for Cooked Food should comply with I.S. 340:2006 requirements
Yes - Once food was placed in the blast chiller, the food was cooled in the target time.

Compliance Heading: 4. 4 .10 Plant & Equipment

(249) Machines should dispense ice but where ice-scoops are used, they should be stored separately from the ice-making machine and there should be a process for the appropriate decontamination of the ice scoops. The making of ice cubes other than in ice machines is prohibited.
Yes - None are in use.

(250) The dishwasher's minimum temperature for the disinfecting cycle should be compliant with I.S.340:2006 requirements and should be monitored regularly. There should be digital readouts on dishwashers.
Yes - Temperatures are monitored but not recorded. No temperatures were noted at over 82 degrees C during the assessment.

(251) All temperature probes shall be calibrated annually. Calibration may be carried out internally or externally (instrumentation firm). Documentation should be retained of the procedures used to control, calibrate and maintain inspection, measuring and test equipment used to demonstrate compliance with the HACCP Plan.
Yes - Temperature probes are calibrated annually externally and internally every six months.

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

(138) Details of current legislation and codes of best practice adhered to in relation to all waste types.
Yes - The 2006 Hospital Waste Management Plan was reviewed during the assessment and this was in line with all national guidelines.

(139) Documented evidence that waste collectors are permitted to collect the waste concerned by virtue of holding a valid waste collection permit.
Yes - Waste Collection Permits for all contractors were appropriate.

(140) Documented evidence that the treatment facility and final disposal or recovery facility is permitted or licensed.
Yes - Risk waste treatment and non-risk waste disposal licenses were available.

(141) Documented procedures for the segregation, handling, transportation and storage of waste.
Yes - Department of Health 2004 Guidelines and the 2006 Hospital Waste Plan were used by the organisation.

(142) Healthcare risk waste should be tagged and secured before leaving the area of production.
Yes - All Risk Waste bags/containers were tagged or labelled.

(143) Healthcare risk waste bags should be removed when no more than two-thirds full or at the maximum indicated by the bag manufacturers.
Yes - Waste was collected three times daily so bags do not over fill.

(144) Healthcare risk containers should only be filled up to the manufacturers' fill or line or maximum three quarters full.
Yes - No fill lines were present on bins designed to prevent over filling.

(145) A record is kept of tags used for each ward/department for at least 12 months.
Yes - These were observed in Supplies Department and wards/departments.

(146) A tracking system should be in place to trace all hazardous waste from generation to disposal and therefore an audit trail is available to trace waste to final disposal.
Yes - An audit trail was available for risk waste bag/container tags and labelling. C1 forms for transport and Certificates of Destruction for final disposal were available.

(149) Inventory of Safety Data Sheets (SDS) is in place.
Yes - SDS were noted in Departmental Safety Statements.

(151) Waste is disposed of safely without risk of contamination or injury.
Yes - Near miss or actual injuries reported were very low. Follow up was documented in all cases. Needle Free Systems are introduced in high-risk areas.

(152) When required by the local authority the organization must possess a discharge to drain license.
Yes - Waste Water Discharge License application being prepared. The organisation is recommended to ensure all departments, which discharge liquid waste, should be included in the waste discharge license application.

(253) Personal protective equipment is accessible to all staff involved in the generation, collection, transport and storage of waste.
Yes - Anti-sharps injury gloves and other PPE was available.

Compliance Heading: 4. 5 .3 Segregation

(255) Within Healthcare risk waste, all special wastes including drugs & cytotoxic drugs / materials are segregated.
Yes - Exceptions noted included risk waste storage in pharmacy, oncology, and the waste compound.

(156) Healthcare risk waste must be segregated from healthcare non risk waste.
Yes - Appropriate segregation was observed in all areas.

(162) Hazardous wastes (chemical etc) must be segregated, stored and disposed of correctly.
Yes - Hazardous Waste Storage was observed in the Waste Compound.

Compliance Heading: 4. 5 .4 Transport

(164) A consignment note (C1 form) must be completed for each shipment of hazardous waste and copies of these forms must be kept for at least 12 months. This should be linked with certificates of destruction and TFS where applicable.
Yes - A C1 form was observed.

(165) There is a designated person trained as a Dangerous Good Safety Advisor (DGSA) or the services of a DGSA are available to the hospital.
Yes - A DGSA consultant has been appointed, however, no records of qualifications were observed on file.

(166) Drivers of vehicles transporting hazardous waste must be trained in accordance with the ADR Regulations.
No - No evidence of driver training with regards to ADR (Transport of Dangerous Goods by Road) Regulations were observed.

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.
Yes - Waste storage on wards and at the waste compound were restricted to staff only.

Compliance Heading: 4. 5 .6 Training

(259) There is a trained and designated waste officer.
Yes - Full time designation of a Waste Co-ordinator is recommended to implement the Hospital Waste Management Plan 2006 in full.

(260) There are documented records of staff training on the handling, segregation, transport and storage of healthcare risk waste including the use of spill kits and personal protective equipment.
Yes - Documented training records were available. On-going training and induction training for all staff is recommended.

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

(172) Documented processes for the management, maintenance and safe handling of linen and soft furnishings throughout the organisation.
Yes - A laundry folder is in place, which contains the housekeeping guidelines.
An Infection Control Policy is also in place.

(173) Documented processes for the use of in-house and local laundry facilities.
Yes - No in-house laundry service is provided. However all services are provided externally.

(174) Clean linen is stored in a designated area separate from used linen (not in sluice or bathroom).
Yes - Adequate space was provided, however, the floor surface was poor and ventilation was inadequate. It is recommended that a fly door be used at both doors here to allow for air flow.

(175) Clean linen is free from stains.
Yes - Items viewed were very clean.

(261) Clean linen store is clean, free from dust and free from inappropriate items.
No - However shelf covers are ordered, which will aid dust control. At ward level, cupboards were small and some contained patient property.

(262) Linen is segregated into categories and in appropriate colour coded bags (i.e. clean/unused linen, dirty/used linen, dirty/contaminated linen).
Yes - Good segregation practices were observed and staff very aware of these practices.

(263) Bags are less than 2/3 full and are capable of being secured.
No - Some bags observed were overflowing and not all bags had draw string ties, which are recommended.

(265) Linen skips and bags must be used when collecting linen and taking it to the designated area. Soiled linen must not be left on the floor or carried by staff.
Yes - Good spring-loaded skips were available. These are cleaned daily.

(266) Personal protective equipment must be accessible to and used by all staff members involved in handling contaminated linen.
Yes - PPE was available and well utilised.

(267) Documented process for the transportation of linen.
Yes - A linen transport policy was in place.

(268) Ward based washing machines are used only with the agreement of the Hygiene Services Committee.
Yes - No ward-based washing machines are in place.

(269) A washing machine if used is situated in an appropriate designated area and a clear policy/written guidance is in place regarding its use e.g. water temperature etc.
Yes - This was not applicable.

(271) Hand washing facilities should be available in the laundry room.
Yes - Good hand washing facilities were available in the laundry room.

(270) If a washing machine is in use, a tumble drier is also in place which is externally exhausted. Documented processes for planned preventative maintenance of this equipment should be in place.
Yes - This was not applicable.

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.
Yes - This was included in minutes of meeting and good compliance was observed in clinical areas.

(189) Clinical hand wash sinks are required in all areas where clinical activities are performed. They should be centrally located and free from obstruction.
Yes - However, one clinical hand wash sink in the Accident and Emergency Department was obstructed by furniture.

(195) Absorbent paper towels are available at all hand washing sinks. Air dryers should not be recommended.
Yes - However, one towel holder in the Accident and Emergency Department was soiled at the outlet.

(198) Hand hygiene posters and information leaflets should be available and displayed throughout the organization.
Yes - Good compliance in this area was noted.

(203) Hand wash sinks are dedicated for that purpose, are free from used equipment and inappropriate items (e.g. nail brushes).
Yes - Good use of the wash-hand basins was observed and only disposable type nailbrushes were used in Theatre.

(204) Hand wash sinks conform to HBN 95. They should not have plugs, overflows and the water jet must not flow directly into the plughole.
Yes - The hand-wash sink in Surgical 1 treatment room requires replacement, which is planned.

(205) General wards should have one sink per 4-6 beds and critical areas should have one sink per 1-3 beds.
No - Larger wards were not all compliant with this requirement. This is noted as an area requiring attention in the improvement plan for 2007.

(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 - Not all staff were noted on the attendance sheet.

5.0 Appendix B

5.1 Ratings Summary

		Self Assessor Team		Assessor Team
	FREQ	%	FREQ	%
A	24	42.86	18	32.14
B	27	48.21	34	60.71
C	5	08.93	4	07.14
D	0	00.00	0	00.00
E	0	00.00	0	00.00
N/A	0	00.00	0	00.00

5.2 Ratings Details

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

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