Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Hygiene Services Assessment Scheme

Assessment Report October 2007

St. Luke's Hospital Rathgar

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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.

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[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 Hospital is a modern, technologically advanced cancer centre specialising in radiation oncology. It provides radiotherapy and other specialist oncology services to a population of more than 4 million. With a complement of 179 beds, the hospital has four in-patient wards (110 beds), a day unit (20 beds) and a five-day unit, 49-bed Oakland Lodge, which is viewed as 'home from home' and is not considered a 'clinical' area.

Services provided

St Luke's is a specialist oncology tertiary referral centre specialising in radiation oncology. The hospital operates a twenty-four hour service 365 days a year, and has at its disposal the following radiotherapy equipment:

- 6 linear accelerators
- a cobalt unit
- brachytherapy
- DXT/CXT
- Radioiodine

Physical structures
Included in the total bed numbers are four Isolation Rooms, and three specialist procedure rooms (2 Selectron rooms and 1 radioiodine room).

The following assessment of St. Luke's Hospital took place on June 11th and 12th 2007.

1.3 Notable Practice

- The hospital demonstrated an exceptional level of patient-focused care.
- Evidence of extensive hand hygiene training and compliance was observed.
- There was an obvious commitment to staff education and training in the organisation.
- The operating theatre was a controlled, calm and uncluttered area.
- A very comprehensive Hygiene Services Strategic Plan was developed by the Hygiene Services Committee which had been ratified by the Hospital Executive and the Board of Governors.
- The Hygiene Multi-Disciplinary Committee and Team were enthusiastic and committed to improving hygiene services in the hospital.

1.4 Priority Quality Improvement Plan

- It was recommended that the organisation focus on the management of processes in relation to the catering service and a review of the Hazard Analysis and Critical Control Point (HACCP) monitoring systems was required.
- Policies, for example, waste and laundry should be consolidated into a single document.

- The hospital should review and broaden the scope of the evaluation processes currently in place.
- Upgrading of the waste management facilities should be implemented in the near future as per the identified quality improvement plan.

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 Hospital Rathgar has achieved an overall score of:

Fair

Award Date: October 2007

2.0 Standards for Corporate Management

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

PLANNING AND DEVELOPING HYGIENE SERVICES

CM 1.1 (B ↑ A)

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

The hospital provided comprehensive evidence in relation to its Corporate Strategic, Service and Operational Hygiene plans, which included robust audit and evaluation processes. The hospital Board of Governors and the Executive Management Team regularly assessed hygiene issues in the hospital. Evidence of this was observed in minutes and resultant actions of meetings. A multi-disciplinary approach to the management of hygiene was observed in the hospital. The hygiene services committee included a patient advocate representative, which was to be commended. The hospital presented evidence of evaluation and action plans as a result of both continuing internal and external audits, and following both National Hygiene Audits (2005 and 2006). There were extensive audit reports from the Environmental Health Officers with resultant corrective actions taken and documented. In line with the recommendations of the National Cleaning Manual, resources had been provided to reflect the change in hygiene practices. The hospital completed a patient satisfaction survey in June 2007, which had a specific hygiene remit. The results demonstrated a high level of patient satisfaction with the hospital's hygiene services and processes. The hospital also has a defined pathway for the management of its quality improvement plan.

CM 1.2 (A → A)

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.

Evidence of extensive internal auditing of hygiene services, both by the hospital and the hygiene contractors, was observed during the assessment. Extensive documentary evidence, such as a wide range of internal departmental audits and history of audits, was presented to support the evaluation and resultant actions required. A continuous process was in place to ensure that the organisation continued to monitor, evaluate and modify their approach to hygiene. Best practice was continuously monitored and assessed to support the hygiene system.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1 (B → B)

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

The hospital had formal linkages with other Dublin hospitals through the Dublin Hospitals Forum. As a voluntary hospital, the hospital worked closely with the Department of Health and the Health Service Executive, while at the same time remained independently managed by a Board of Governors. The hospital was supported in a very tangible way by the Friends of St Luke's Hospital who contributed to the enhancement of the external environment by financing, planning and installing a patient putting green and a water garden. Evidence of strong interaction between the hospital and the contracted companies who serve the hospital was observed. Evaluation of the services had been carried out as part of the tendering process for contracted services. The hospital also benefited from a patient advocate representative on the Hygiene Services Committee.

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.

A comprehensive Strategic Corporate Hygiene Services plan, which encompassed the years from 2007 to 2011 was presented. The hospital will, as part of this plan, evaluate the corporate hygiene plan annually. The Board of Governors approved the funding to provide for upgrading of hygiene services in 2006/7.

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.

Very clear lines of accountability for hygiene purposes were observed. The Board of Governors of the hospital were very involved with the Hospital Hygiene Programme and accountability. Management accountability was delegated to the Chief Executive Officer through the Hospital Board. The board intended that hygiene would be a regular standing order on the reports that are submitted by the Chief Executive Officer. The Chief Executive Officer was the chairperson of the Hospital Hygiene Services Committee. Comprehensive corporate policies and procedures and a code of corporate ethics were also observed. Within the hospital there was strong support for the concept that hygiene is the responsibility of all staff. Specific inclusions in job

descriptions for hygiene purposes in all grades of staff were noted. This responsibility was also included in the induction programmes and as part of ongoing education for all staff, including contracted staff. Comprehensive staff manuals were available. It was recommended that, on revision of the manual, the organisation consider separating Infection Control and Hygiene. Further evaluation of this criterion was recommended.

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.

The Governing Body received internal and external audit reports from a number of sources for example HACCP, Environmental Health Officer (EHO), National Hygiene and internal hospital audit results. The hospital used the Infection Control Nurses Association audit tool to internally audit the hospital, the results of which were evaluated. These reports were commented on by the board and referred to the Chief Executive Officer for subsequent action. The Board of Governors requested commentary on implementation of the actions identified following evaluation. The board also met with the Executive Management Team. The board of the hospital was presented with all relevant information on best practice by the Executive Management Team.

CM 4.3 (A → A)

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.

Education, training and research were core functions at the hospital. This supported the many facets of hospital services and recognised that financial support and systems were in place to facilitate education and research. The hospital had a library with access to computers and relevant software tools for all grades of staff. Internet access was available throughout the hospital. National hygiene, catering, and waste standards had been adopted. These programmes continued to be implemented throughout the organisation. Safety and quality issues were addressed following a review of accepted national standards. Hand hygiene had been addressed following the implementation of Strategy for the control of Antimicrobial Resistance in Ireland (SARI) guidelines. The hospital had evaluated and documented best practice and implemented resultant action following extensive research. The hospital had also reviewed its practices in line with best practice following the National Hygiene Audits (2005 and 2006). This area was extremely well managed and exceptional compliance was noted.

CM 4.4 (C ↑ B)

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

The hospital had the services of an Infection Control Team who, in conjunction with contracted services, risk management and the hospital, influenced the deliberations of the Hygiene Services Committee. All hygiene policies had been updated, reviewed, approved and re-issued by the Hygiene Services Committee. The cleaning

contractors had also reviewed and revised cleaning policies and procedures in line with national guidelines. Changes to practices had been made following the policies and procedures review and in line with the recommendations of the Hygiene Services Assessment Scheme. All hygiene policies had been evaluated and resultant actions had commenced. A planned programme of priorities with identified quality improvement plans had also been developed. A procedure for the evaluation of best practice guidelines for hygiene was in the process of being developed, through the sourcing of an audit tool to consolidate best practice.

CM 4.5 (B ↓ C)

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

Evidence of the capital project plan was in place. Members of the Hygiene Services Committee played an active role in capital planning projects at the hospital, for example, evidence of the Infection Control Team implementing and monitoring dust control measures during construction activity was observed. Documented evidence was observed of capital planning meetings for current projects. Previous major developments at the hospital site were carried out prior to the formation of the Hygiene Services Committee. The Hygiene Services Committee was involved in some minor building projects which were in place in the hospital, for example, the upgrade of the laundry washing machine area and the new treatment area. The committee had been directly involved in the planning and implementation of a €100,000 capital investment in hygiene issues involving linen/laundry, waste, hand hygiene and new products. The process of purchasing in line with all stakeholders and in line with the National Procurement Policy was evaluated. The recommendations of the committee were forwarded to the Executive Management Team. The hospital developed a documented process to identify the roles and responsibilities of key stakeholders during building work projects, as these were directed locally. This implementation of this process was scheduled to commence when proposed works were at the planning and design phase.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

*Core Criterion

CM 5.1 (A ↓ B)

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

There were very strong and robust processes in place that identified roles, responsibilities and duties of all grades of staff at the hospital. A well developed and published human resource strategy, as well as recruitment and retention policies was also observed. Hospital job descriptions were hygiene specific in relation to contractors and hospital support in that area. For professional and management grades, accountability for hygiene was included under the remit of a safe patient environment. Clear pathways of accountability for the hygiene process were noted. Some evaluation was carried out and resultant actions documented. It was recommended that further development of evaluation in this area be implemented in the future.

*Core Criterion

CM 5.2 (A → A)

The organisation has a multi-disciplinary Hygiene Services Committee.

A strong and robust multidisciplinary Hygiene Services Committee, which included active representation by the patient advocate representative and was chaired by the Chief Executive Officer (CEO), was in place. Terms of reference for the committee were also noted. At the time of assessment the committee had developed a comprehensive Strategic Corporate Plan, Service Plan and Organisational Plan and planned to develop an Annual Report in 2007. The committee had not implemented a process to evaluate their effectiveness. However, effectiveness of the committee was demonstrated through evidence such as how hygiene services were implemented and managed and how audit and procurement processes were managed.

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.

Extensive capital funding was provided to the Hygiene Services Team in 2007 to facilitate the implementation of the Corporate Hygiene Services Plan. The hygiene services budget was based on service requirements in line with the hospital allocation for services. A review of hygiene services had been completed for 2007, resulting in an adjustment to hygiene services. The annual budget for hygiene services increased from 2003 to 2006 (an increase of 32%). The Hospital Hygiene Strategic Plan had been used to guide the hygiene services development.

CM 6.2 (C → C)

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

The Hygiene Services Committee had commenced integration with the Hospital Purchasing Department in order to assess hygiene procurement issues. The Hospital Purchasing Officer was also a member of the Hygiene Services Committee. Further work was required to capitalise on all the expertise available for hygiene purchasing.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

CM 7.1 (B ↓ C)

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

Clear structures and accountability to manage risk at the hospital were observed during the assessment. Structures for clinical, health and safety and corporate risk were in place and hygiene risk was incorporated in all risk categories. Minutes, risk evaluations and reports of the risk management service were observed and this service documents all resultant actions. Incident reporting was robust and outcomes were monitored and documented. The control of patient safety was breached during the assessment period through the insufficient monitoring of product storage in the Catering Department. Effective corrective action procedures and management of the identified risk were not demonstrated completely. This issue was discussed with the Hospital Management Team during the assessment.

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.

The Board of Governors and the Executive Management Team demonstrated, from both minutes and agendas of their meetings, that risk management is a standing item on their corporate agenda. The hospital has a risk manager in post, with a full suite of risk management policies and procedures in place. Three committees that dealt with risk were in operation; health and safety, clinical and corporate risk. There was strong evidence that the hospital evaluated risk management outcomes.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion

CM 8.1 (B ↓ C)

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

External contracts were in place for waste, cleaning and laundry services. A contract for the local laundry service for curtain cleaning required development. The cleaning contract was fully reviewed and, as a result, changes had been implemented. This allowed for the availability of Hygiene Services in the hospital on a daily basis and also included the provision of an evening service. Management responsibility had been identified to review external contracts. National guidelines on procurement of services were adhered to. Internal hospital audits identified any issues in relation to contract services. However, no evidence was observed of the evaluation or resultant action of the contracted services, with the exception of the contract cleaning service. There was some evidence that the hospital had an audit trail for waste to the final destruction site. It was recommended that the evaluation process in the organisation be developed and strengthened.

CM 8.2 (A ↓ B)

The organisation involves contracted services in its quality improvement activities.

Contract cleaning services were represented on the Hospital Hygiene Committee. However, no other external contractors were members of the Hygiene Team.

In order to meet the needs of St. Luke's Hospital, the contract cleaning service had developed the skills to train their staff in line with new interventions, for example, the cleaning contractor supervisor had been trained to train staff on the use of the new flat mopping system. There was a forum to communicate performance of contract cleaning staff following internal/external audits. It was recommended that this process be applied in other areas, for example, performance of laundry and waste management contractors. Contract cleaners had been afforded the opportunity to attend in-house education and training. It was recommended that this opportunity should be extended to other contract services.

PHYSICAL ENVORNMENT, FACILITIES AND RESOURCES

CM 9.1 (B → B)

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

The hospital is a modern, fit for purpose building adhering to all current building and safety regulations. The hospital adhered to the legislation governing health and safety, infection control, waste management and HACCP. It is recommended that the hospital ensure compliance with legislation and that this should be monitored.

*Core Criterion

CM 9.2 (A ↓ B)

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

Robust policies and procedures were in place in the hospital for in-house and contract hygiene services. The Hygiene Services Committee had been assigned the authority for planning and managing hygiene services. Extensive internal and external audits were carried out and evaluated. Changes were made to Hygiene Services based on the results of these audits. Risk management, infection control, patient satisfaction, patient advocacy and the complaints procedure all influenced the deliberations and decisions of the hospital in the management of its Hygiene Services. It is recommended that the organisation continues to review the above processes and develops its processes to manage its hygiene related services in line with continual changes in legislation and best practice.

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.

Extensive internal audits, evaluation and resultant actions for Hygiene Services at the hospital were observed. These included full audits of all areas using the Infection Control Nurses Association audit tool and internal HACCP audits. Extensive external

audits, evaluation and resultant actions for Hygiene Services at the hospital were also observed. These included previous National Hygiene Audits (2005 and 2006), Environmental Health Officer reports and water audits. Increased cleaning frequencies and the implementation of the flat mopping system were introduced as a result of these audits. Patient satisfaction surveys were also carried out and reviewed and recommendations were put in place in accordance with service management and finance.

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.

Patient satisfaction surveys had been conducted and their dates collated and evaluated. They indicated a very positive satisfaction rate with the hygiene services, facilities and the environment. A dozen patients were spoken to during the assessment, all of whom reported high levels of satisfaction with the hygiene processes in the hospital. Some staff were also consulted, who were very knowledgeable regarding the policies and procedures, occupational health, hygiene and hand washing. It was recommended that an evaluation of staff and other stakeholders' satisfaction with such services should be conducted.

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.

A very comprehensive and robust Human Resource Strategy and Policy was observed, which was reflective of relevant legislation and best practice. A range of job descriptions for all grades were observed, which incorporated responsibilities such as patient confidentially and safety, heath and hygiene. Human Resource (HR) staff satisfaction surveys were also carried out. With the exception of the staff survey, no evidence of evaluation was presented.

CM 10.2 (B → B)

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

The hospital assigned staff in accordance with defined whole time equivalents and assigned dedicated resources to the Hygiene Services Committee. The hospital had a defined workload and could assign staff in a planned manner. The hospital had reviewed the cleaning requirements and cleaning contract hours had been reviewed and modified to meet service needs. These reviews were carried out in line with the Hygiene Service Plan for 2007 and on a daily basis as needs dictated.

CM 10.3 (B → B)

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

Excellent evidence of training for all staff at the hospital, both in-house and contract was observed. Details of qualifications required for specific roles were in place. However, the current Waste Management Officer required training. Evaluation of training had been carried by the Infection Control Team and training programmes were also evaluated by participants. However, no evidence was presented of composite evaluation of the training programmes.

CM 10.4 (B → B)

There is evidence that the contractors manage contract staff effectively.

Robust processes were in place for contractors to manage staff on-site, which included training and documented records of all staff on-site. Strong policies and procedures for recruitment, education and audit of contracted staff were observed. Risk management monitoring of issues identified no major adverse hygiene incidents in the last two years. Little evidence was observed that external contractors for laundry and waste had reviewed their services or staff. It was recommended that this be implemented to ensure that a high quality service was provided.

*Core Criterion

CM 10.5 (B → B)

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

The Corporate Strategic Plan clearly identified human resource requirements and the hospital was funded for hygiene services in accordance with this plan. An internal review of the cleaning service identified service gaps with a resultant action to ensure that services cover the entire week. A hospital-wide needs assessment was also 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 designated orientation/induction programme was available to all staff, including medical staff and contract staff. Attendance levels at the programme were monitored. Hygiene training was incorporated in the infection control module of the induction programme. A staff handbook was available to all staff. The principles of hygiene were clearly referenced in the infection control section of this handbook.

Good hygiene principles were also evident in the hospital uniform policy. The hospital confidentiality policy also included hygiene procedures and services. The cleaning contractors had a specific confidentiality clause for all hygiene staff (that is, a confidentiality statement in their acceptance of employment) which had to be signed.

Ease of access to health and safety, infection control and human resource manuals hospital policies, procedures and guidelines was noted. The staff induction and orientation programme was evaluated by the Human Resources Team.

CM 11.2 (C ↑ B)

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

Extensive on-going education was provided for all grades of staff. Extensive evidence of records, course contents, evaluation methods and resultant actions was provided. This training was influenced by the Hygiene Services Committee's goals and objectives and the relevance of training provided to staff was evaluated. No documented processes were observed for the provision of facilities and protected time for staff to attend training. It was recommended that this be reviewed in the future.

CM 11.3 (C ↑ B)

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

Very strong evidence was observed during the assessment that staff of all grades had an extensive knowledge of waste segregation practices and standard precautions. Evaluation of attendance at education sessions from all staff had been carried out and corrective actions had been identified to ensure all disciplines of staff received training.

CM 11.4 (C → C)

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

Limited evidence was observed of methods of performance monitoring for contract cleaning staff. The hospital used human resources procedures to identify and manage performance issues with staff. It was recommended that the organisation implement a process to evaluate the number of hygiene services staff who undergo performance evaluation.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (A ↓ B)

An occupational health service is available to all staff

The hospital provided an occupational service to all members of staff, through the services of a contracted occupational health company. The hospital had reviewed its services and, as a result, a 0.5 whole time equivalent Occupational Health Nurse provided an in-house service. The hospital has links with St Vincent's Hospital

Occupational Health Department (OHD) as required. However, it was anticipated that limited reliance on St Vincent's Hospital would be required when the Occupational Adviser had the necessary structures in place. It was being expected that an active and immediate service would have to be provided with the establishment of an on-site service. Human resource policies on sick leave and access to the occupational health service were noted, as were staff absentee rates. While some evidence of evaluation was noted (for example audits and evaluation of needle stick injuries), it was recommended that further evaluation of the service and staff satisfaction be implemented.

CM 12.2 (C → C)

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

The organisation had a process to review occupational health issues, for example, risk management, health and safety and attendance records. There was some audit and evaluation in place, for example, the organisation has established its own occupational service, based on audit results. For further information see criterion CM 12.1.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.1 (B → B)

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.

Internal and external audits were analysed and, where necessary, corrective actions were identified, for example, Environmental Health Officer and hygiene audit reports. Best practice guidelines were in place and continued to be developed in line with the strategic plan, on-going audits and resultant outcomes. Management meetings were regularly held by all disciplines, which facilitated information sharing on issues and concerns in relation to the Hygiene Service. The Hygiene Services Committee and Team were in place and were the driving forces to achieve the goals of the hygiene strategic, service and operational plans. Contractors provided a full audit of their services, but the quality of the data, along with its reliability, accuracy and validity were not formally evaluated. It was recommended that this be implemented.

CM 13.2 (B ↓ C)

Data and information are reported by the organisation in a way that is timely, accurate, easily interpreted and based on the needs of the Hygiene Services.

Reports were generated by Hygiene Services and data on all hygiene issues was presented to the Board of Governors and the Executive Management Team. Data required for national surveillance was reported to relevant external organisations in line with national reporting procedures. Internal data and information was

disseminated through the organisation by department heads, hospital committees and hospital management. It is recommended that the data available at the hospital is subject to internal evaluation processes as a complete body of work to ensure easy comprehension of the overall results. It is further recommended that a user satisfaction survey is carried out in relation to the reporting of data and information.

CM 13.3 (B → B)

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

Data collection was assessed by the management team and department heads.

These evaluations ensured that the hospital had a proactive system to manage effective Hygiene Services provisions.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

CM 14.1 (A → A)

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

A very strong quality culture was evident in the organisation. Leadership of hygiene was demonstrated at both Board of Governor and Executive Management Team levels. The Chief Executive Officer, who is the chairperson of the Hygiene Services Committee provided support to initiate the quality improvement agenda, as recommended by the structures of the Hygiene Services Teams. As demonstrated in the minutes and reports of the Chief Executive Officer to the Board of Governors, the commitment to quality Hygiene Services was a very live issue. Hygiene was also a standing order on the Executive Management Team and Board of Governors agenda and minutes, both of which were involved in specific quality improvement initiatives. The organisation was committed to and had carried out an audit and evaluation of the Hygiene Services. The organisation’s commitment to Hygiene Services, its Hygiene Services Committee, terms of reference, internal audits and resultant actions were all to be commended.

CM 14.2 (B → B)

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

The Executive Management Team and the Board of Governors regularly assessed the hygiene services audits, recommendations and best practice. Evidence of this was noted in the commentary of the minutes of meetings. The hospital benchmarked itself against previous National Hygiene Audits and was part of the Risk Management Dublin Hospital Forum. Data was communicated to all staff through their representatives on the Hygiene Services Committee and Team. The organisation

had a draft communication policy which was in development. The Hygiene Services Committee system ensured that hygiene was an issue on all agendas. The organisation also reported, as required, to national organisations.

3.0 Standards for Service Delivery

The following are the ratings for the Service Delivery standards, as validated by the Assessment team. The service delivery standards allow an organisation to assess and evaluate its activities in relation to Hygiene Services at a team level. The Service Delivery standards relate directly to operational day-to-day work and responsibility for these standards lies primarily with the Hygiene Services Team in conjunction with Ward/Departmental Managers and the Hygiene Services Committee. There are six Service Delivery standards, which focus on such areas as prevention and health promotion, implementing hygiene services and patients/clients rights. There are seven core criteria within these standards.

EVIDENCE BASED BEST PRACTICE AND NEW INTERVENTIONS IN HYGIENE SERVICES

SD 1.1 (B → B)

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

Best practice guidelines were available and in use within the hospital. Staff accessed guidelines through the use of the on-site library, internet facilities and information seminars. A clear process was evident through The Hygiene Committee for the adoption and maintenance of best practice guidelines. Staff and service providers were involved in the development and implementation of hospital specific best practice guidelines through the Hygiene Services Committee and Team. Evidence was observed that the terms of reference to establish, adopt and maintain best practice guidelines were functioning within The Hygiene Committee. Procedures for the evaluation of the best practice guidelines for hygiene (for example the National Hospital Cleaning Manual) were in the process of being developed through the sourcing of an audit tool which would consolidate the key best practice elements of hygiene. It was recommended that the organisation commence evaluation of the guideline development process.

SD 1.2 (B ↓ C)

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

Processes were in place for assessing and evaluating new hygiene interventions such as the microfarad duster. However, the introduction of a documented implementation protocol would enhance the management and implementation of all new service interventions. Evaluations had been conducted to assess the efficacy of new hygiene service interventions, for example, clinical cleaning audits, contract cleaners' evaluation reports and evaluation of staff education seminars. It was recommended that a process for the evaluation of the efficacy of the assessment process be implemented.

PREVENTION AND HEALTH PROMOTION

SD 2.1 **(B → B)**

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

Strong evidence was observed that hygiene was being promoted to visitors and the community, for example, the implementation of hand hygiene stations throughout the hospital. Oakland Lodge provided information on hygiene best practice to all those who used the facilities. No evidence that community groups participated in health promotion activities for hygiene was observed. Posters and leaflets were available, but these could be promoted further through the implementation of a Health Promotion Notice Board in key public areas, for example, the main hospital entrance. It was recommended that the organisation implement a process to evaluate health promotion activities which were being undertaken.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1 **(A → A)**

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

Evidence was observed that a multi-disciplinary team, in cooperation with providers from other teams, programmes and organisations, was in place. All hospital services, contracted services and patient advocate groups were represented on the Hygiene Services Committee. The Hygiene Strategic Plan detailed roles and responsibilities of the team members. Details of multidisciplinary team meetings were minuted at department and corporate level. These reflected quality improvement plans, evaluations and audit feedback. Documented job descriptions were in place ensuring team members were aware of each other’s roles. The efficacy of the multidisciplinary team was evaluated by the Chief Executive Officer and the Executive Management Team. It was recommended that further evaluation and benchmarking of the multi-disciplinary team’s activities be implemented.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

SD 4.1 **(A → A)**

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

Overall, the hospital appearance was bright, spacious and clean, both inside and out. The mandatory self-assessment checklist highlighted areas which required attention.

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.

On the whole equipment, medical and cleaning devices were well managed and clean. This process was enhanced by the introduction of cleaning schedules and the inclusion of clinical equipment with an identified person responsible.

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 managed and clean. A robust central system for the management of cleaning equipment was in place. New cleaning equipment and trolleys were introduced and maintained in a good condition. The storage of chemicals for hygiene purposes did not comply with regulations and required attention.

For further information see Appendix A.

*Core Criterion

SD 4.4 (A ↓ B)

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

A commitment to food safety was noted with the development of the Catering Department and ward kitchen food safety systems. However, the implementation and the execution of these policies were not adequately observed during the assessment. Issues regarding inadequate storage temperatures, cook-chill control and hot holding/service of patient meals were areas of concern and required immediate review and action. These issues were highlighted with the management team during the assessment meeting.

For further information see Appendix A.

*Core Criterion

SD 4.5 (A ↓ 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.

While systems were in place to manage waste, some elements required further development. The role of the waste officer required further development in the area of education and training. It was suggested that the waste management system would benefit from the services of a Dangerous Goods Safety Adviser, who was in the process of being appointed.

For further information see Appendix A.

*Core Criterion

SD 4.6 (A ↓ B)

The team ensures the Organisation's linen supply and soft furnishings are managed and maintained.

Overall, linen supply was well managed and maintained, however, a documented process regarding the transportation and laundering of curtains to local launderette facilities required development.

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.

An excellent system was in place for the management of hand hygiene and a quality improvement plan had been developed to address the up-grading of the remaining hand wash sinks.

For further information see Appendix A.

SD 4.8 (B ↓ C)

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

A documented process was observed to ensure the minimisation of risk when Hygiene Services were provided. This process was through the corporate, health, safety and clinical risk management systems. Minutes of meetings, risk evaluations, reports and documented resultant actions of the risk management service were observed. Incident reports were robust, with outcomes documented and evaluated. Incident reporting forms were in place and completed forms were verified. It is recommended that the hospital review the structures in place for effectiveness.

SD 4.9 (B → B)

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

Various interventions were in place to inform patients, clients and families of the standards and services available within the hospital. For example patient information booklets, a local visitors policy and a patient comment box. Patients had been invited to express their opinions of the services provided through a patient questionnaire, which had been collated and evaluated. The patient information booklet contained documented processes, which outlined patient responsibilities regarding Hygiene Services. This intervention was evaluated and a Quality Improvement Plan (QIP), which was near completion, aimed to consolidate information for both in and out-patients at the hospital. It was recommended that further evaluation be carried out to ensure patient/client satisfaction with their participation in the Hygiene Service.

PATIENT'S/CLIENT'S RIGHTS

SD 5.1 (C ↑ B)

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

Guidelines regarding the rights of patients/clients and families were provided to staff through job descriptions, professional codes of practice, the staff handbook and patient booklets. Both the contract cleaning service and the Radiotherapy Department had a documented staff policy for patient dignity and respect during the performance of Hygiene Services. Despite the completion of some patient surveys, it was recommended that further evaluation of patient dignity should be implemented.

SD 5.2 (B ↓ C)

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

Patients/clients, families and visitors were provided with information regarding Hygiene Services through the patient information booklets and a local visitors policy. Hygiene services posters, leaflets and signage were posted at the reception desk. A patient questionnaire was completed, which evaluated patient comprehension of and satisfaction with the Hygiene Services information provided. However, it was recommended that further evaluation of this criteria could be developed to facilitate the involvement of clients, families and visitors.

SD 5.3 (B → B)

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

A formal complaints policy and procedure was in place within the hospital. All complaints are evaluated, monitored and reported to the Executive Management Team and the Board of Governors. Individual departments were notified of complaints relevant to them and resultant quality improvement plans were developed.

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1 **(C → C)**

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

A patient advocate was a member of the Hygiene Services Committee, which was to be commended. Links were provided with the contract cleaning service in relation to the Hygiene Services provided and patient satisfaction surveys were carried out and evaluated. It was urged that further development of critical equipment breakdown procedures with relevant service providers should be urgently addressed.

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.

The Hygiene Services Committee had a documented audit trail, and minutes of team meetings were available. The results from the National Hygiene Audits (2005 and 2006) were used as a means of evaluation. Hygiene initiatives resulting from internal and external audit results included the implementation of the microfibre system and hand gel stations. The completion of the Hygiene Services Annual Report was planned for 2007, which would provide evaluation and resultant actions on the Hygiene Services provided.

SD 6.3 **(C → C)**

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

The Hygiene Services Committee had scheduled their Hygiene Services Annual Audit Report for completion in 2007. The multidisciplinary team benefitted from the input of the patient advocacy representatives in this process.

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 - A cleaning schedule for the clinical waste compound required development.

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

Yes - Some areas required attention to high dusting, including the waste compound and internal and external laundry carts.

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

No - Some tiles on walls were observed with holes and repainting was required in a significant number of areas. It was recommended that the use of wall/door protectors in areas where trolleys are in high usage be considered.

(9) Where present, main entrance matting and mat well should be clean and in good repair.

Yes - The front hall carpet was clean; however, carpets were stained in some areas.

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

Yes - However, it was advised to deep clean the main internal stairwell.

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

Yes - However, some bins require labels.

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

(18) Walls, including skirting boards.

Yes - However, skirting boards behind some radiators observed were dusty. The overall majority of skirting boards were clean; however, repainting was required.

(23) Radiators and Heaters.

Yes - In the majority, however, consideration should be given to the repainting of some radiators.

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

(31) Furniture and fittings: Furniture and fittings in direct patient care environment must be clean and dust free i.e. cleaned on a daily basis. Horizontal surfaces (high and low) around the patient i.e. ledges, worktops, window ledges, flat surface suction apparatus, bed table, locker, curtain rail and chairs.

Yes - In the majority, however, socket panels above patient beds required greater attention.

(207) Bed frames must be clean and dust free.

No - A significant number of beds observed were dusty.

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

(34) Beds and Mattresses.

No - Greater attention to the cleaning of beds is required.

(37) Tables and Bed-Tables.

No - Many bed-tables observed were in poor condition.

Compliance Heading: 4. 1 .5 Sanitary Accommodation

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

No - Bathrooms and washrooms were cleaned; however, monitoring was not recorded.

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

Yes - However, shampoo was observed in the showers on one ward.

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

(54) Wash-Hand Basins.

No - Greater attention to the cleaning of plughole outlets is required.

(57) Clear method statements/policies should be in place for guidance on all cleaning including sanitary cleaning and maintenance processes.

Yes - However, the organisation should facilitate greater accessibility to these documents for contract staff.

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

No - Hand wash sinks were not available in many sluices.

(60) All outlets (including shower outlets) should be flushed at a temperature in accordance with current legislation.

No - Hand wash sinks did not conform to HBN 95 and, therefore, were not flushed in accordance with current legislation.

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 - In the majority, however, the replacement of some trolley castors was required.

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

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

No - Several commodes required more detailed cleaning and, in some cases, replacements had been ordered.

(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 - However, sticky tape residue should be removed from some medical equipment.

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

No - Several dusty fans were in use in clinical areas.

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

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

Yes - In the majority, however, chart trolleys required greater attention.

(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 - However, staff drinks were observed in some ward kitchen fridges.

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

Yes - However, some computers observed were dusty.

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 - However, buffers required greater attention. Also, the washing of buffers at ward level was not recommended.

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

Yes - The majority of cleaning equipment observed was clean and dry. However, two wet buffing pads were observed in the cleaner stores and two buffing machines were found to be dusty.

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

Yes - However, one bucket was observed with residual water. Wet buffing pads were also observed in the cleaner's store.

(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 - Hand sinks were not provided in cleaning stores. A QIP was in place to correct this deficit.

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

No - Cleaning chemicals were not stored in locked storage areas/containers as required.

(93) Cleaning products and equipment should comply with the relevant colour coding policy.

Yes - However, contract cleaners on one ward were observed using disinfectant to clean general ward surfaces.

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 - Copies of the legislation were observed on file. It was recommended that a copy of SI 852/2004 be made available for reference.

(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 - Copies of health board correspondence were on file and corrective actions taken were recorded. Water testing was in place. It was recommended that microbiological testing be completed on finished products for verification purposes.

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

No - A HACCP system was in place. However, additional focus was required on current systems to ensure adequate control measures were in place for each of the Critical Control Points, that is Critical Control Point 2 Storage. The Catering Manager was made aware of the issue and assurances were provided that all relevant actions would be fully completed.

(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 documented food safety policy is in place. The revised food safety policy should have been included in the kitchen food safety manual.

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

No - A documented manual washing up procedure was available, however when questioned, staff were unaware of the policy and copies of the policy were not posted in the area. The Catering Manager was made aware of the issues and assurances were provided that all staff would be trained in the relevant procedure.

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 - Access to main kitchen areas were restricted by signage. Ward kitchen doors were also adequately labelled, however, upon inspection, doors were open.

(218) Authorised visitors to the food areas should wear personal protective clothing (PPE) and wash hands on entering the food area during food preparation/serving times.

Yes - Personal protective equipment, visitor policies and hand wash facilities were provided for visitors.

(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.

Yes - Evidence of staff drinks were noted in the ward kitchen fridge. Clear signage was on display on the fridge. Further control of this policy was required.

(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 - During the assessment, the water temperature at the hand sink at goods inwards was reading 18 degrees Celsius. The organisation should ensure that hand sink water temperatures are maintained at 45-55 degrees.

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

Yes - Separate toilets for food workers were provided.

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

Yes - However, the ventilation canopy over the pressure cooker was very dusty. Opened food containers were stored in the same area.

(225) Staff in charge of Ward Kitchens shall ensure that product traceability is maintained while the product is in storage (Regulation (EC) 178/2002). Stock shall be

rotated on a first-in/first-out basis taking into account the best-before/use-by dates as appropriate. Staff food should be stored separately and identifiable.

No - Product traceability and batch codes/original use-by dates transference to internal date labels to aid traceability needed to be given greater consideration by the organisation. Such concerns were highlighted to the organisation and a system to ensure compliance needed to be put in place.

(226) Containers used to store foods shall be made of food grade materials, be in good condition, easy to clean and disinfect.

Yes - However, a great deal of label residue was observed on all food containers. Old date labels had not been removed from other containers.

Compliance Heading: 4. 4 .3 Waste Management

(230) A supply of water should be available to clean down external waste storage areas.

No - A direct water supply was not provided at the bin area. Also, documented evidence of yard cleaning was not available.

(234) Where waste is stored in plastic bags these shall be removed frequently, closed securely and stored in a manner that does not pose any risk to the food business.

No - A new cage system had been installed for the storage of waste food bags. The cage was open and required the wheelie bin lid to remain open to allow for access. This created a high risk for potential pest activity and required review.

Compliance Heading: 4. 4 .4 Pest Control

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

Yes - No electric fly killer was located at the back door leading to the bin area. An electric fly killer should be installed there.

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

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

Yes - This was not applicable in this organisation.

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

Yes - This was not applicable in this organisation.

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

No - A full review of the unit's temperature control capacity was required during the site visit. A full maintenance review of the kitchen's refrigeration system was completed by the hospital's refrigeration contractor. Evidence of work completed was available and upon re-inspection all temperatures were satisfactory and the organisation needed to put a system in place to ensure compliance in the future.

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

No - High risk foods were not maintained at the correct temperatures during hot holding and service. The catering team agreed to complete a full review of the temperature control and monitoring procedures and assurances were provided that all relevant actions would be fully completed.

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 - However, the use of large joints of meat should be reviewed. It is recommended that the size of joints be reduced to less than 2.5kg. Thawing procedures are also in place.

Compliance Heading: 4. 4 .9 Food Cooling

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

No - Foods removed from the blast chiller and stored in the walk-in cold room were all greater than the required critical limit. Staff during the visit did not follow the correct chilling procedure. The Catering Manager was made aware of the issues and assurances were provided that staff would complete HACCP documentation as set out in the Hospital HACCP plan.

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

(253) Personal protective equipment is accessible to all staff involved in the generation, collection, transport and storage of waste.

No - Aprons and gloves were not available at the central waste compound. Anti-needle stick gloves should be offered to staff involved in the collection and transportation of healthcare risk waste.

(149) Inventory of Safety Data Sheets (SDS) is in place.

No - An inventory of Safety Data Sheets was not in place.

(152) When required by the local authority the organization must possess a discharge to drain licence.

No - However, a quality improvement plan to seek a discharge to drain licence was in place.

Compliance Heading: 4. 5 .3 Segregation

(158) Needles and syringes should be discarded as one unit and never re-sheathed, bent or broken.

Yes - However, one clinician, when questioned stated that needles are separated from syringes during disposal.

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

No - Mattress bags are not available.

Compliance Heading: 4. 5 .4 Transport

(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.

No - However, the funding for a DGSA Adviser has been approved and the hospital management team was in the process of arranging this position.

Compliance Heading: 4. 5 .5 Storage

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

No - Bins were replaced at ward/department level as required. A number of bins on wards and within the Radiotherapy Department were identified which required replacing during hygiene assessment at the hospital.

(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 - However, special waste required high security locking within the compound.

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

Yes - However, it was recommended that empty bins be separated from full ones within the waste compound.

Compliance Heading: 4. 5 .6 Training

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

No - The identified designated waste officer is the Head Porter, however, there was no evidence that he has received training for this role.

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 - The development of a service level agreement for the external laundry contractor was required.

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

Yes - Washing machines and driers required more specific instructions for operation. Step-by-step instructions to operate the washer/dryer in cleaners' laundry room were also required.

(267) Documented process for the transportation of linen.

No - No documented evidence to meet the current practice of transporting linen and laundry was observed. Laundry carts require replacement by the contractor. All laundry trolleys also require replacement.

(268) Ward based washing machines are used only with the agreement of the Hygiene Services Committee.

Yes - The Hygiene Services Committee had identified the need to maintain ward-based washing machines and had developed a quality improvement plan to relocate this service.

(269) A washing machine if used is situated in an appropriate designated area and a clear policy/written guidance is in place regarding its use e.g. water temperature etc.

No - A quality improvement plan, informed by management, has been developed to relocate washing machines.

(271) Hand washing facilities should be available in the laundry room.

No - The laundry room for mops did not have hand washing facilities.

(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 - Driers were not vented externally, however, condensers are fitted.

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

(187) Nails should be kept short and nail varnish or false nails should not be worn by those working in a clinical setting.

Yes - However, one staff member was observed wearing nail varnish whilst working in a clinical setting.

(189) Clinical hand wash sinks are required in all areas where clinical activities are performed. They should be centrally located and free from obstruction.

No - A QIP was in place for the upgrading of clinical hand wash sinks.

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

Yes - However, the replacement of seals around sink outlets was required in some areas.

(191) Hand washing facilities i.e. sinks, taps and splash backs must be clean and intact.

Yes - However, some unclean sink outlets were observed.

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

Yes - The majority of sink taps conformed to this standard. A QIP was in place for the replacement of the remaining taps.

(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 - However, a QIP was in place.

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 - Ward kitchen ice machines were no longer in use in the organisation.

(250) The dishwasher's minimum temperature for the disinfecting cycle should be compliant with I.S.340:2006 requirements and should be monitored regularly. There should be digital readouts on dishwashers.

No - The dishwasher temperatures were verified by the dial temperature displays only. Independent temperature dials were in the process of being installed.

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

No - Temperature probes are calibrated externally and internally. The temperature unit and three probes at goods intake were out of calibration since April 2007.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team		Assessor Team	
	FREQ	%	FREQ	%
A	19	33.93	12	21.43
B	27	48.21	31	55.36
C	10	17.86	13	23.21
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	A	↑
CM 1.2	A	A	→
CM 2.1	B	B	→
CM 3.1	B	B	→
CM 4.1	B	B	→
CM 4.2	B	B	→
CM 4.3	A	A	→
CM 4.4	C	B	↑
CM 4.5	B	C	↓
CM 5.1	A	B	↓
CM 5.2	A	A	→
CM 6.1	A	A	→
CM 6.2	C	C	→
CM 7.1	B	C	↓
CM 7.2	B	B	→
CM 8.1	B	C	↓
CM 8.2	A	B	↓
CM 9.1	B	B	→

CM 9.2	A	B	↓
CM 9.3	B	B	→
CM 9.4	B	B	→
CM 10.1	A	B	↓
CM 10.2	B	B	→
CM 10.3	B	B	→
CM 10.4	B	B	→
CM 10.5	B	B	→
CM 11.1	A	A	→
CM 11.2	C	B	↑
CM 11.3	C	B	↑
CM 11.4	C	C	→
CM 12.1	A	B	↓
CM 12.2	C	C	→
CM 13.1	B	B	→
CM 13.2	B	C	↓
CM 13.3	B	B	→
CM 14.1	A	A	→
CM 14.2	B	B	→
SD 1.1	B	B	→
SD 1.2	B	C	↓
SD 2.1	B	B	→
SD 3.1	A	A	→
SD 4.1	A	A	→
SD 4.2	A	A	→
SD 4.3	A	A	→
SD 4.4	A	B	↓
SD 4.5	A	B	↓
SD 4.6	A	B	↓
SD 4.7	A	A	→
SD 4.8	B	C	↓
SD 4.9	B	B	→
SD 5.1	C	B	↑
SD 5.2	B	C	↓
SD 5.3	B	B	→
SD 6.1	C	C	→

SD 6.2	C	C	→
SD 6.3	C	C	→