



**Hygiene Services Assessment Scheme**  
**Assessment Report October 2007**  
**St. Vincent's University Hospital**

## Table of Contents

1.0 Executive Summary .....	3
1.1 Introduction.....	3
1.2 Organisational Profile .....	7
1.3 Best Practice .....	7
1.4 Priority Quality Improvement Plan .....	7
1.5 Hygiene Services Assessment Scheme Overall Score .....	9
2.0 Standards for Corporate Management.....	10
3.0 Standards for Service Delivery.....	21
4.0 Appendix A.....	25
4.1 Service Delivery Core Criterion .....	25
5.0 Appendix B.....	32
5.1 Ratings Summary .....	32
5.2 Ratings Details .....	32

# 1.0 Executive Summary

## 1.1 Introduction

This is the first National Hygiene Services Assessment Scheme (HSAS.) It is a mandatory scheme for all acute hospitals. The scheme aims to enhance cultural change in the area of hygiene services by not only focusing on the service delivery elements but also emphasising the importance of standards for corporate management. The HSAS is a patient-centred scheme which assists a hospital to prioritise the key areas in hygiene to be addressed. It is intended to promote a culture of best practice and continuous quality improvement.

The Irish Health Services Accreditation Board developed these, the first set of National Hygiene Assessment Standards in 2006. This development plan involved an extensive desktop review of national and international best practice literature, working groups and extensive consultation. The feedback from these development components formed the final draft Standards and Assessment Process, which were then piloted in a number of acute hospitals. *(The Irish Health Services Accreditation Board was subsumed into the Health Information and Quality Authority in May 2007.)*

**The Hygiene Services Assessment Scheme (HSAS) was launched by the Minister for Health Mary Harney on the 6<sup>th</sup> November 2006.**

Hygiene is defined as:

*“The practice that serves to keep people and environments clean and prevent infection. It involves the study of preserving one’s health, preventing the spread of disease, and recognising, evaluating and controlling health hazards. In the healthcare setting it incorporates the following key areas: environment and facilities, hand hygiene, catering, management of laundry, waste and sharps, and equipment”<sup>1-4</sup>*

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

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

### 1.1.1 Standards Overview

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

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

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

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

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

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

***Core Criteria:***

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

In the Corporate Management standards, the core criteria cover:

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

In the Service Delivery standards, core criteria cover:

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

### **1.1.2 Rating Scale**

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

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

**A Compliant - Exceptional**

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

**B Compliant - Extensive**

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

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

### 1.1.3 Assessment process components

The assessment process involves four distinct components:

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

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

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

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

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

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

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

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

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

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

- **Continuous Improvement**

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

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

---

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

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

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

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

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

## **1.2 Organisational Profile**

In March 2002, St Vincent's University Hospital Ltd, incorporating St Michael's Hospital in Dun Laoghaire was established, governed by a Board of Directors. Further changes in governance (to incorporate St Vincent's Private hospital) resulted in the formation of St Vincent's Healthcare Group Ltd. in January 2003. Each hospital has a separate management team and a Hospital Manager/CEO who reports to the Group CEO.

St Vincent's University Hospital is a major academic teaching hospital, with strong educational links to the Faculty of Medicine at University College Dublin at undergraduate and 'post-graduate levels'. St. Vincent's University Hospital is part of the Dublin Academic Teaching Hospitals (DATHs) group.

The hospital has in excess of 500 in-patient beds, incorporating 7-day, 5-day and day care options.

### **Services provided**

St Vincent's Healthcare Group (incorporating St Vincent's University Hospital, St Vincent's Private Hospital and St Michael's Hospital) provides acute general care serving the South East region of Dublin and surrounding areas. A tertiary referral service is also provided for patients both regionally and nationally, and there is an extensive range of general and specialist services including a number of centres of specialisation.

The assessment of St. Vincent's University Hospital took place between March 28<sup>th</sup> and 30<sup>th</sup> 2007.

## **1.3 Notable Practice**

- The involvement of senior management in hygiene services
- Hygiene is enjoying an increasingly high profile among the organisation's services and a clear culture of quality improvement was noted. This is attributed in particular to the newly created Hygiene Services Management structures, which are operating in a very complementary manner to provide comprehensive integration, communication development and evaluation of hygiene services. Informal assessments ("walkabouts") by Organisational Managers also occur regularly, which is commendable
- The hygiene management structures observed were of a high standard
- Considerable progress has been achieved in the past six to twelve months in particular in the areas of new capital development for clinical services, hand hygiene awareness and the overall organisation-wide enthusiasm for the development of hygiene services.

## **1.4 Priority Quality Improvement Plan**

- Minor capital upgrade of clinical areas in the older part of the hospital is required
- It is recommended that the issues regarding storage facilities are addressed
- The organisation should aim to involve greater input from patients/clients in hygiene issues

- It is recommended that the organisation identify and monitor a relevant suite of Key Performance Indicators for hygiene services
- The organisation should focus on disseminating and ensuring the integration of change to front line staff and the evaluation of same.

### ***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. Vincent's University Hospital 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 (A → A)

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

Evidence of exceptional compliance was observed. Considerable progress in this regard is evident, especially in the past year. In addition to on-going internal audits, walkabouts and specific patient focus groups, the organisation arranged an independent external hygiene audit in 2006. The introduction of new structures relevant to hygiene services during that time, for example, the Hygiene Services Committee (chaired by the Chief Executive Officer) and the Hygiene Services Quality Improvement Group (chaired by the Director of Nursing) have increased the focus on hygiene across the organisation. The organisation has a Hygiene Corporate plan (2006-2010) and a Hygiene Service plan, which has input from relevant department heads. Compliance with all relevant national legislation and guidelines is addressed. There is also an operational plan, which is informed by Service plans, audit reports, and hospital hygiene quality improvement meetings. The Hygiene Services Assessment Scheme and Acute Care Accreditation Scheme appear to be drivers for these developments. The organisation's quality improvement plan to measure performance against key performance indicators quarterly and yearly, and to establish focus groups with patients, is to be commended.

#### 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.**

There is extensive evidence of quality improvement planning for hygiene services related to the Hygiene Services Assessment Scheme standards. Progress to date includes improvements in linen and clean utility room storage facilities at ward level; facilities for contaminated linen segregation; hand hygiene awareness for patients, staff and public; developments in the management and in-service training for cleaning staff and research based developments in the products used for cleaning. The new Clinical Services Building is evidence of incorporation of best practice in the context of its design and facilities. The organisation's Strategic Plan includes further developments, which will enhance its hygiene services, in the context of additional isolation facilities. The Hygiene Services Assessment Scheme standards are welcomed as a structure for the organisation to progress its hygiene development work and this is already evident in practice. Close liaison between the organisation's Infection Control department and the Hygiene Services department facilitates the provision of additional cleaning arrangements to deal with infection outbreaks. The

regular review of cleaning specifications, which is currently in progress, is commendable.

## 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.**

The organisation has recently realised the Capital Development plan for the introduction of the new Clinical Services block. A further Capital Development plan for the upgrading of the older ward areas has been communicated to the Department of Health and Children and the Health Services Executive and an application made for the relevant funding. The organisation's management structures for both internal and contracted hygiene services are compliant with legislation and national best practice guidelines. The hygiene services are evaluated; however, there is no formal evaluation of the linkages.

## CORPORATE PLANNING FOR HYGIENE SERVICES

### **CM 3.1 (A → A)**

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

The organisation has recently developed a Corporate Strategic plan for hygiene services (2006-2010) based on the Hygiene Services Assessment Scheme framework and the development plan for the St Vincent's Healthcare Group. The Strategic Plan contains clearly defined goals, priorities and related costs which are approved by the Executive Management Team and are input and communicated to the relevant multi-disciplinary team members. The Hygiene Services plan addresses issues identified in the self-assessment, internal and external audit results and feedback from quality improvement initiatives and feeds into the Corporate Strategic plan.

## GOVERNING AND MANAGING HYGIENE SERVICES

### **CM 4.1 (A → A)**

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

The recently revised hygiene management structures outline clear lines of accountability and responsibility for hygiene across all levels of the organisation including the Executive Management Board. A Code of Corporate Ethics is in place. Adherence to hospital hygiene policies, which are based on legislation and best practice guidelines, is being evaluated.

**CM 4.2 (A → A)**

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

Best practice information is reviewed and addressed at all meetings of the Hygiene Services Quality Improvement Group including service performance indicators and best practice information. This informs the continuous quality improvement plan. Information drawn from a variety of sources including legislation, best practice guidelines, infection control and hygiene audit results, patient focus groups, informal organisational assessments (“walkabouts”), are the basis for change.

**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.**

A continuous improvement ethos and broad base of expertise inputting through a variety of structures was evidenced. These included access to best practice information, library and research facilities, education/training, expertise of multidisciplinary team and internal/external audit reports. A number of new hygiene initiatives have been introduced recently, for example, the ‘Spirigel Initiative’, a new colour-coding system for cleaning cloths and mops. The Hygiene Services Co-ordinator is responsible for ensuring that the hospital’s Hygiene Services Quality Improvement group and the Hygiene Services Committee are aware of current best practice. There is on-going induction, continuing education and in-house training relevant to each staff discipline. The Cleaning Services Manager and the Cleaning Services Co-ordinator attend the weekly environment hygiene team meeting. This meeting is chaired by the General Services Manager, who has overall responsibility for hygiene services. Information is communicated through the internet, newsletters and minutes of meetings. Numerous examples of continuous quality improvement based on audit and best practice information were observed.

**CM 4.4 (A → A)**

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

The organisation has a system in place for the development, approval, revision and control of all policies, procedures and guidelines, including those relating to hygiene services. The organisation currently uses a standard template for all new and revised policies procedures and guidelines. This template has been agreed with the Hospitals Group Executive and reflects best practice. Some hygiene-related policies already exist based on this template and this work is on-going. All hygiene policies are available on the organisation’s intranet. Specifications for cleaning have been developed and key contractors maintain manuals for their staff.

**CM 4.5 (A ↓ B)**

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

Comprehensive evidence was observed of the involvement of the Hygiene Services Team in commissioning teams for the organisations recent and planned major capital developments. The involvement of the Hygiene Services Team in minor capital works in the future is planned, through its new hygiene management structures. This will ensure comprehensive hygiene service input into all new developments. The efficacy of the consultation process should be evaluated.

## 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.**

An excellent hygiene service structure is in place. A weekly environmental hygiene meeting is held, which is chaired by the General Services Manager. The reporting relationships and responsibilities/accountabilities for hygiene services are clearly documented. All ward/clinical department heads are responsible for hygiene standards in their own area. The Infection Control Team works closely with the Hygiene Services Contractors. Written job descriptions and contracts are in place for all staff. The implementation and application of policies, procedures, responsibilities and accountabilities for front line staff would benefit from on-going attention.

A nursing staff member, at ward/department level, should be appointed to a hygiene liaison role.

\*Core Criterion

### **CM 5.2 (A → A)**

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

The recently established Hygiene Services Committee and Hygiene Services Quality Improvement group have multidisciplinary representation, clear terms of reference, meeting schedules and administrative support as recommended by the Hygiene Services Assessment Scheme standards. The Hygiene Services Committee is chaired by the Chief Executive Officer and the Hygiene Quality Improvement group is chaired by the Director of Nursing, both of whom are members of the organisation's Executive Management Team. The Hygiene Services Co-ordinator and Hygiene Services Administration Assistant are represented on both teams. There is evidence of extensive, enhanced hygiene awareness and quality improvement since the establishment of these teams. It is recommended that this improvement is fully extended to frontline staff, and full compliance still needs to be addressed.

## 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.**

Resources are allocated to hygiene services by the Executive Management Team, which are based on needs identified by management through its budget allocation procedure and the provider plan process. Evidence of on-going investment in hygiene service development was observed, with clarity regarding resource implications of the clinical area refurbishment/upgrade and a plan/commitment to realise them within a defined time frame. There is a planned programme of capital works identified for 2007, for which the organisation has sought additional resources and which it is committed to achieving on time.

### **CM 6.2 (A ↓ B)**

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

Evidence to date is predominantly in relation to the organisation's major capital project, for example, the involvement of Infection Control and Microbiology staff in the

design of service areas such as operating theatres. The recently commissioned Central Sterile Supplies Department provided evidence of the efficacy of the consultation process. The Hygiene Services Committee also has a high level of involvement in the process. The Infection Control services work closely with the Procurement department and are involved in the purchase of specific patient equipment and infrastructural improvements. One example observed is the purchase of new mattresses based on a pressure sore prevalence audit. It is suggested that the Hygiene Services Committee are involved in the purchasing of both major and minor developments in the future.

## MANAGING RISK IN HYGIENE SERVICES

\*Core Criterion

### **CM 7.1 (A ↓ B)**

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

Risk management processes are in place in a number of key areas. Records exist of 14 risk assessments completed in 2006 and further work is in progress in the Pathology Department, where 14 chemical risk assessments are completed. Occupational health risk assessments are also underway. A Health and Safety report was completed for 2006 and a plan has been developed by the Health and Safety coordinator. This plan has been approved at executive level for 2007 and the organisation intends to continue this process on an annual basis. Nine up-to-date Safety Statements have been developed for all the key clinical areas and it is suggested that these are progressed to all areas. Weekly safety, quality and risk meetings are held and Risk Management provides monthly incident reports to the Occupational Health department and department heads. The Health and Safety Co-ordinator produced an end of year report for 2006. Infection Control staff conduct observational reviews of hygiene and the physical environment and liaise regularly with the Hygiene Services department. The Cleaning Services Contractor, Environmental Health and the Health and Safety Authority conduct their own audits in collaboration with the organisation; evidence of changes in practices and products used resulting from these audits was observed.

### **CM 7.2 (A → A)**

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

The review and continued implementation of safety statements is progressing in the organisation. A Complaints Management System is in place and monthly reports are issued to all department heads, resulting in the publication of an annual report. Health and Safety representatives are allocated a half day per week to fulfil their role.

## 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.**

The Organisation is compliant with Health Services Executive Procurement policy for 2006. The organisation is a member of the Hospital Services Procurement group (a

consortium of hospitals which have joined together formally, via an independent executive, for the purpose of combined purchasing) and are currently involved in the development of a specification for tender for the provision of scrub suit hire and a laundry service. The organisation also plans to progress a tender for hygiene services, including bed linen hire and laundry and curtain cleaning. St. Vincent's Health Care Group is in the process of publishing a European Union tender for the provision of management of non-hazardous waste. The clinical waste contract was undertaken by the Department of Health and Children in 2003 for a five-year period and provides improved management and monitoring structures. Evidence of close working relationships with relevant hygiene contractors was observed: the organisation's staff supervised and monitored hygiene services contractors' work and signed off on the quality of work executed. Several examples of product and process modification by contractors, in response to organisations requirements for quality improvement, were evident.

**CM 8.2 (A → A)**

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

A number of examples were noted where the Cleaning Services Contractor had introduced changes in structures and processes in response to the quality improvement initiatives in the organisation. The Cleaning Services Contractor has appointed a Cleaning Contract Manager for the organisation and an in-house on-site trainer to train hygiene services staff in accordance with the British Institute Cleaning Standards. The inclusion of the Hygiene Services Manager in the organisation's new hygiene services management structure is evidence of the collaborative/integrated approach present in the organisation.

**PHYSICAL ENVIRONMENT, FACILITIES AND RESOURCES**

**CM 9.1 (A ↓ 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 new clinical services capital development is evidence of best practice and details of regulations and codes adhered to are available. However, some of the older clinical areas have considerable shortcomings in respect of patient hygiene, isolation and storage facilities. There is a recognised need in the organisation to continue to carry out extensive physical upgrade/maintenance improvements in these areas. Staff are to be commended for the careful usage of these facilities in the best interest of patient care.

\*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.**

The organisation has a detailed policy to manage contractors when working on site, which covers a range of levels of work. There is a list of legislation and best practice, which is adhered to. The organisation has a Clinical Engineering department for the provision of a complete equipment management service across all the organisation's sites. Waste and linen management are in accordance with hospital waste and infection control policies.

**CM 9.4 (A ↓ B)**

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

The organisation participated in the National Patient Survey conducted by the Irish Society of Quality and Safety in Healthcare 2004. To date, the evidence is mainly informal and overall appears to be positive. This was confirmed through patient interviews during the assessment. Some specific patient focus groups exist. The organisation plans to develop further the involvement of its service users in the area of hygiene and it is recommended that a more formal approach is implemented in the future, in line with the organisation's quality improvement plan.

**SELECTION AND RECRUITMENT OF HYGIENE STAFF**

**CM 10.1 (A → A)**

**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.**

An organisational recruitment policy is in place for its entire staff, which is based on HSEEA and best practice guidelines. The Cleaning Services Contractor has its own documented processes for selection and recruitment of staff, which is also based on legislation and current best practice. Job descriptions are available for all staff including contract staff. Job descriptions for contract cleaning staff are competency based and are monitored/evaluated by their Human Resources department. Human Resource recruitment records are in place for hygiene services staff.

**CM 10.2 (A → A)**

**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 Cleaning Services Contractor is accredited to the ISO9001: 2000 quality management system. Their recruitment and selection processes are evaluated regularly through internal and external audits. Dedicated and more experienced staff are assigned to the more specialised hygiene services, for example, the cleaning of contaminated rooms. A system is in place for the identification and evaluation of competencies for the work to be done, with staff reassignment and the provision of additional training where necessary. The appointment of a Hygiene Services Manager and an on-site Training Co-ordinator for cleaning services has been identified as a significant quality improvement. Department heads are responsible for monitoring changes in work volume and using the service plan for the approval of additional resources. Theatre cleaning was added to the contract for hygiene services in 2006.

**CM 10.3 (A → A)**

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

Induction and staff training programmes are in place for all new staff. On-going education and training is provided as required, with input from relevant staff including Infection Control. Comprehensive selection, training and correspondence of competencies to job specification are conducted by the Cleaning Services Contractor. The Cleaning Services adhere to British Cleaning Service standards Level 1 and 2. A PDCA (Plan/Do/Check/Act) audit process is used and training

requirements are identified and addressed accordingly. Records of all training are maintained.

\*Core Criterion

**CM 10.5 (A → A)**

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

As a result of the number of review processes undertaken by department heads and line managers, a range of recent additional posts relevant to hygiene services have been introduced. New post approval guidelines and approval processes are in place for new posts and changes required to the skills mix. The staffing for the new Clinical Services Building was identified using a needs analysis and operational policies exercised and considered by organisational management in conjunction with the organisational objectives. Contract hygiene services staff use a labour matrix for the schedule of hours per week for each department. The performance of hygiene services staff is monitored through a variety of methodologies. Hygiene Services also produce an annual report. Overall, the organisation's hygiene standards were observed to be of a very high standard.

## 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**

Induction/orientation is provided for all new staff with input from all other relevant disciplines and on-going hygiene awareness training is in place for all staff. The hygiene training content includes Health and Safety, Infection Control, Health promotion, Occupational Health and food handling. Staff receive basic food hygiene training. There is FETAC level 5 available for health care assistants, which includes a Hygiene module. The organisation's target uptake is 100% by 2008 for all 103 staff. Manual attendance records were in place until recently, however, a Human Resource Management Information system is now in use. Additional training is provided in conjunction with new legislation and work practices. A staff handbook is provided to all staff, a review of which is planned for the near future.

**CM 11.2 (A → A)**

**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.**

Evidence that education, training and continuous professional development covers the whole scope of hygiene services was observed, with specific specialist training for relevant areas and staff groups. Specific training is also provided in the use of new equipment. Staff attend all mandatory and other relevant training. A Continuing Education and Research Department is in place and a specific Training Co-ordinator for cleaning services training is provided by the contractor. Records are maintained for each training session.

**CM 11.3 (A ↓ B)**

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

Staff evaluation of training is in place using the Kirkpatrick method of evaluation. It is recommended that measured outcomes for a number of Key Performance Indicators in this regard are introduced and monitored.

**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 organisation is currently finalising its Training Strategy, which is informed by a comprehensive review of training across the organisation. The Cleaning Contractor, using a competency assessment tool, conducts an annual assessment of the cleaning operatives. The Cleaning Services Management staff participate in an annual appraisal process using a Personal Development Tool. This tool was revised in 2006 and the implementation of a new system is planned for late 2007.

**PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF**

**CM 12.1 (A ↓ B)**

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

A well resourced Occupational Health Department, with broad range of occupational health services is available in the organisation. Evidence of staff health awareness and integration into various organisational committees was noted. Vaccinations are available on a voluntary basis. Pregnancy Risk Assessment Audits and Working Back Programmes are in place. There is close liaison between the organisation's Risk Management department and the Occupational Health department. Annual reports of its activities are published by the Occupational Health department. No formal evaluation of the occupational health service is carried out; however, a quality improvement plan for the assessment of these initiatives is planned. It is recommended that this process is implemented in the near future.

**CM 12.2 (A → A)**

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

A Risk Management approach to staff well-being is used throughout the organisation. Systems of reporting, investigating, monitoring and analysing data regarding health incidents, accidents and claims are in place in Occupational Health, Health and Safety and Risk Management departments. The Occupational Health department uses a number of indicators including a staff survey, absenteeism data, activity data, complaints and industrial relations issues, all of which are reviewed annually to evaluate the effectiveness of its activities for all staff. A Pregnancy Risk Assessment audit and Working Backs Programme are currently in progress and the departments' other quality improvement plans have definite time-frames. Staff morale was observed to be very positive during the assessment.

## COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

### CM 13.1 (A ↓ 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.**

Through its Hygiene Services Management structures, and more recently with the support of the Hospital Hygiene Quality Improvement group, the organisation uses national and international evidence of best practice and current legislation to inform its practices. This is reflected in its policies, procedures and guidelines and evaluated through the variety of internal and external audits, which span the hygiene services. Quality improvement planning was evident across all aspects of the hygiene services. Further evaluation and quality improvement planning in this regard is recommended.

### CM 13.2 (A → A)

**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.**

The weekly hygiene services meeting is an excellent forum for the regular review of feedback to the Cleaning Services Contractor of audit action report results. All current hygiene quality improvement initiatives are reviewed at these meetings. Good examples were observed in relation to infection control and the response of technical services to maintenance problems.

### CM 13.3 (A ↓ B)

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

On-going improvements in the scope and manner of relevant data collection was noted. These included improved tracking of curtain changes, a decontamination record sheet and the introduction of an electronic audit tool by the Cleaning Contractors. Evidence was observed in relation to the hygiene contractors; however, opportunities exist for further development in other areas.

## 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**

Hygiene is enjoying an increasingly high profile among the organisation's services and a clear culture of quality improvement was noted. This is attributed in particular to the newly created Hygiene Services Management structures, which provide comprehensive integration, communication, development and evaluation of hygiene services. Informal assessments ("walkabouts") by Organisational Managers also occur regularly, which is commendable.

**CM 14.2****(A ↓ 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 organisation uses a number of audits, including the two previous hygiene audits, and an independent external audit in 2007, following which the Hygiene Services Quality Improvement group were established to implement its findings. It is recommended that a suite of relevant key performance indicators are identified to regularly measure hygiene services outcomes and to benchmark and communicate the findings.

### 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.**

While best practice guidelines exist, outstanding issues in the areas of adoption, maintenance and evaluation were noted. It is recommended that the organisation introduce protected time to ensure the continued development/improvement of its hygiene services, with particular focus on evaluation and continuous quality improvement.

##### SD 1.2 (A → A)

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

Several examples of assessment and evaluation of new products and policies were evident and the integration of these into the organisation was demonstrated. This was particularly evident in a new capital project. Evaluation of hygiene services is carried out by Contract Cleaners and Infection Control and a quality improvement plan were observed in use.

#### PREVENTION AND HEALTH PROMOTION

##### SD 2.1 (A ↓ B)

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

Evidence of health promotion activities used to promote hygiene in the community was noted. Greater focus on the evaluation of the efficacy of Health Promotion activities in relation to hygiene is recommended.

## 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.**

A very good organisation-wide multi-disciplinary approach to hygiene was observed, with the inclusion of relevant external contractors on the organisations Hygiene Service Committee. Roles and responsibilities are clearly defined and evidence of good collaboration was noted. Evaluation of efficacy was observed through the internal and external audits.

## IMPLEMENTING HYGIENE SERVICES

\*Core Criterion

### **SD 4.1 (A → A)**

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

While there is evidence of organisational commitment to ensuring the organisation's physical environment and facilities are clean, the infrastructure in the older areas of the hospital have significant shortcomings in the whole area of maintenance and physical development. Some improvements are already in place and quality improvement plans identified. The organisation's plan to upgrade these areas is strongly endorsed. It is recommended that patient fans be removed from all clinical areas.

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.**

Evidence of the organisation's medical and cleaning devices being managed and clean was noted, however, the physical space for the cleaning of devices at local level requires improvement. The organisation's quality improvement plan includes a new equipment library, which is in the process of being commissioned.

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.**

The organisations cleaning equipment is managed and clean. Cleaning facilities were limited due to space constrictions but operational practices noted were satisfactory.

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.**

There was considerable evidence available to suggest that the ward kitchens demonstrated best practice. The main kitchen, however, while adhering to the main core criteria, will benefit from ensuring full HACCP compliance and food traceability at all stages.

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.**

External facilities observed were excellent; however, improved co-ordination of waste management between Infection Control and Portering services is required. It is recommended that on-going training of all key staff reflects current best practice.

For further information see Appendix A.

\*Core Criterion

**SD 4.6 (A → A)**

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

Designated storage areas are available for linen; however, compliance with linen segregation requirements was not adhered to in some areas. The physical constraints in space prevented best practice in some aspects of storage.

For further information see Appendix A.

\*Core Criterion

**SD 4.7 (A ↓ B)**

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

Excellent practices in hand hygiene were evident. It is recommended that some hand basins be replaced.

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.**

Very good structures were observed in place. Records are available from Occupational Health and Risk Management. Safety Representatives are in place and are given dedicated time to fulfil this role. The organisation's plan to review the Risk Management and Governance structure is commendable.

**SD 4.9 (A ↓ B)**

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

Excellent hand hygiene facilities for the public are available at hospital entrance. Visitor/patient information is available and the organisation is in the process of updating the information provided. A hospital visiting policy was observed in place and some patient focus groups are also in place. A National Patient Satisfaction Survey was completed in 2004 and some relevant internal audit reports are in place. Wider patient participation in, and evaluation of, hospital hygiene matters is recommended.

PATIENT'S/CLIENT'S RIGHTS

**SD 5.2 (A ↓ B)**

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

Information is provided through notices and leaflets. Opportunities to promote relevant hygiene issues to patients, clients, families and visitors should be considered for inclusion in patient and visitor handbooks. Information provided will benefit from on-going evaluation as part of the organisation's quality improvement plan.

**SD 5.3 (A → A)**

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

A documented system is in place for dealing with all complaints, adverse incidents and near misses. Hygiene related matters are addressed as part of the overall organisation's complaints procedure, with analysis and structured feedback provided to department heads and management.

ASSESSING AND IMPROVING PERFORMANCE

**SD 6.1 (A ↓ B)**

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

Some Patient Focus Groups were observed in place and others are planned. It is recommended that a more formal structured approach to patient, client and family involvement in evaluation of hygiene services is implemented.

**SD 6.2 (A ↓ 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.**

Internal audits by Cleaning Services and Infection Control were observed, as were some external audits, for example, Environmental Health and an independent external audit in 2006. The identification of Key Performance Indicators for hygiene services and regular evaluation of same is recommended.

**SD 6.3 (A ↓ B)**

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

An annual report was produced, however, further consultation with patients, clients, families, staff and service users is recommended.

## 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** - The areas inspected were tidy well maintained, free of rust, blood, body substances, dust, dirt, debris and spillages. Some unnecessary cleaning items were stored in ward areas.

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

**Yes** - All surfaces were free from dust and cobwebs. However, flaking paint was evident in the older parts of the hospital.

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

**Yes** - Overall, compliance was observed. However, floor maintenance and walls were not compliant throughout the organisation.

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

**Yes** - Overall, compliance was observed, however, some exceptions were noted.

(8) All entrances and exits and component parts should be clean and well maintained.

**Yes** - Overall, compliance was observed, however, some door frames were damaged.

#### **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** - Overall, compliance was observed, however, paint was damaged on window ledges in some areas.

(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.

**No** - Quality improvement is currently in progress in this area. There is still a lack of clarity in some areas regarding the process, responsibility and tracking.

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

(36) Lockers, Wardrobes and Drawers

**Yes** - Overall, compliance was observed, however bed side wardrobes are not available in older wards. Corridor based wardrobes are available in the older wards and are used for storage on occasion.

**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/ washrooms are cleaned on a daily basis and disinfected as necessary. An insufficient quantity of wash/toilet facilities in older wards was noted. Closer monitoring of cleaning in this area is required.

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

**Yes** - Bathrooms/washrooms observed were clean, however due to inadequate storage facilities; some linen storage in bathrooms was noted.

**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

**Yes** - The sanitary fixtures observed were clean; however, an increased number of wash hand basins, toilets and showers are required. These are included in the upgrade plan for these areas.

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

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

**Yes** - Overall, compliance was observed. Disposable slings are used for isolated patients.

(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** - All equipment observed was clean; however, storage of equipment was an issue. The equipment library will benefit the organisation in this regard.

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

**No** - Patient fans were in very limited use and should be phased out.

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

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

**Yes** - All patients had bed side lockers for the storage of personal items. A lack of bedside wardrobes resulted in patients' property being stored on the floor in some areas of older wards.

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

**Yes** - Patients personal items are stored in lockers. Compliance was noted in new clinical areas, however, in the older wards patients' wardrobes are not located adjacent to bedside resulting in some personal clothing and luggage being stored on the floor area beside the bed.

(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** - No evidence of water/hand wash gel splashes was noted, however, splash backs were not present over sinks in some older wards.

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

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

**Yes** - A quarterly service of vacuum filters is completed.

(90) Storage facilities for Cleaning Equipment should be provided in each work area with adequate ventilation, a hot and cold water supply and hand-wash facilities.

**No** - Storage facilities are provided but not in each work area in older wards for example one area is shared between two wards.

(94) Health and Safety policies should be in place for the use of ladders/steps when cleaning.

**No** - A policy is in the process of being developed.

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

**Yes** - All equipment is less than ten years old.

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

(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 documented HACCP system is in place, however, some critical stages of the process were not included.

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

**No** - A food safety policy was available, however, it requires review and up-dating. The latest version was issued in 2003 and does not refer to the new legislation.

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

(217) Access to the main kitchen and ward kitchens should be restricted to designated personnel i.e. food workers.

**No** - There are three potential entry points into the main kitchen. Signage was available at the main entrance but was missing from the other doors. Access was possible to the kitchen areas, as a suitable means of restriction was not in place.

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

**Yes** – Visitors personal protective equipment was available. It is recommended that the visitors notice includes the need for hand washing.

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

**No** - Compliance was observed in ward kitchens. Evidence of staff beverage consumption in the main kitchen was noted. Tea/ coffee and soft drinks consumption must be restricted to an identified appropriate area outside of the main kitchen.

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

**No** - A number of staff members were observed wearing jewellery. Insufficient protective clothing was worn by some staff members. One person was observed with an opened white coat in the main kitchen resulting in potential contamination from their outdoor clothing.

(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** - The majority of hands sinks observed were acceptable. Some hand sink taps require replacement in ward and main kitchens.

(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** - Traceability of products at ward level was compliant. Traceability of raw product was not evident at intake in the main kitchen. Batch code details and use-by dates were not recorded for red meat and poultry. Dairy delivery checks were not completed for traceability/temperature at intake. Out of date foods were noted at the bakery section in the main kitchen. The Catering Manager was made aware of the issues and evidence was provided before the end of the assessment of the relevant action completed.

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

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

**Yes** - Overall, compliance was observed. Food waste is removed from the post wash area frequently. It is recommended that lidded washable sealed containers are used during the transportation of food waste through the service corridor to the yard.

#### **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** - A limited cook chill system is in operation and controlled.

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

**No** - It is recommended that colour coded posters are displayed for staff. Correct colour coded knives are required in some areas. A member of staff was observed using the wrong coloured knife during the visit. When questioned, the staff member was unsure of the correct procedure.

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

**No** - Items are temperature controlled. Further control is required for joints of meat which are cooked, hot held, portioned, reheated and served. Temperature checks were not available for the hot holding and reheating stages. The Catering Manager was made aware of the issues and evidence was provided before the end of the assessment of the relevant action completed.

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

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

**Yes** - The organisation was compliant with this criterion. Internal calibration checks are completed quarterly and annually. Care must be taken to ensure probes stored internally in cold rooms are calibrated annually.

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

(139) Documented evidence that waste collectors are permitted to collect the waste concerned by virtue of holding a valid waste collection permit.

**Yes** - The organisation was compliant.

(140) Documented evidence that the treatment facility and final disposal or recovery facility is permitted or licensed.

**Yes** - The organisation was compliant, with the exception of hazardous waste.

(146) A tracking system should be in place to trace all hazardous waste from generation to disposal and therefore an audit trail is available to trace waste to final disposal.

**No** - No C1 forms were available for hazardous waste.

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

**No** - The implementation of safety statements is still in progress across the organisation.

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

**No** - The organisation was unable to verify a discharge to drain licence. Hazardous discharge to drain was witnessed.

#### **Compliance Heading: 4. 5 .2 Maintenance of Records**

(254) Documented process(es) for the retention of waste traceability records, certificates of destruction, consignment notes (C1 forms) and Trans Frontier Shipment (TFS) tracking forms for at least 12 months. These should be retained for all hazardous waste types.

**No** - Documented processes are in place for the retention of waste traceability records. Traceability records were not available for all hazardous waste.

#### **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 forms where applicable.

**No** - C1 forms were not available for all hazardous waste.

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

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

**Yes** - A designated Waste Officer is in place. The Waste Officer is recommended to liaise with the Regional Health Service Executive Waste Advisor to ensure continuous best practice.

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

(174) Clean linen is stored in a designated area separate from used linen (not in sluice or bathroom).

**Yes** - Designated storage areas for clean linen are available, however due to space constraints, some linen storage in bathrooms in the older wards was observed.

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

**No** - A colour coding system is in place; however, compliance observed was variable.

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

**No** - Due to space constraints, evidence of laundry bags stored in corridors was noted.

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

(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** - Overall, compliance was observed. It is recommended that more clinical hand wash sinks and their best location be considered during ward upgrading.

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

**No** - This has been identified in the ward upgrade programme.

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

**Yes** - This has been identified in the ward upgrade programme.

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

**No** - This has been identified in the ward upgrade programme.

(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** - This has been identified in the ward upgrade programme. Priority should be given to this issue.

## 5.0 Appendix B

### 5.1 Ratings Summary

	Self Assessor Team		Assessor Team	
	FREQ	%	FREQ	%
A	56	100.00	34	60.71
B	0	00.00	22	39.29
C	0	00.00	0	00.00
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	A	A	→
CM 1.2	A	A	→
CM 2.1	A	B	↓
CM 3.1	A	A	→
CM 4.1	A	A	→
CM 4.2	A	A	→
CM 4.3	A	A	→
CM 4.4	A	A	→
CM 4.5	A	B	↓
CM 5.1	A	A	→
CM 5.2	A	A	→
CM 6.1	A	A	→
CM 6.2	A	B	↓
CM 7.1	A	B	↓
CM 7.2	A	A	→
CM 8.1	A	A	→
CM 8.2	A	A	→
CM 9.1	A	B	↓
CM 9.2	A	A	→
CM 9.3	A	A	→
CM 9.4	A	B	↓
CM 10.1	A	A	→
CM 10.2	A	A	→
CM 10.3	A	A	→
CM 10.4	A	A	→
CM 10.5	A	A	→
CM 11.1	A	A	→
CM 11.2	A	A	→
CM 11.3	A	B	↓
CM 11.4	A	B	↓
CM 12.1	A	B	↓

CM 12.2	A	A	→
CM 13.1	A	B	↓
CM 13.2	A	A	→
CM 13.3	A	B	↓
CM 14.1	A	A	→
CM 14.2	A	B	↓
SD 1.1	A	B	↓
SD 1.2	A	A	→
SD 2.1	A	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	A	→
SD 4.7	A	B	↓
SD 4.8	A	A	→
SD 4.9	A	B	↓
SD 5.1	A	A	→
SD 5.2	A	B	↓
SD 5.3	A	A	→
SD 6.1	A	B	↓
SD 6.2	A	B	↓
SD 6.3	A	B	↓