Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Hygiene Services Assessment Scheme

Assessment Report October 2007

Cavan General Hospital

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1.0 Executive Summary

1.1 Introduction

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

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

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

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

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

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

1.1.1 Standards Overview

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

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

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

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

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

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

Core Criteria:

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

In the Corporate Management standards, the core criteria cover:

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

In the Service Delivery standards, core criteria cover:

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

1.1.2 Rating Scale

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

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

A Compliant - Exceptional

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

B Compliant - Extensive

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

C Compliant - Broad

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

D Minor Compliance

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

E No Compliance

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

N/A Not Applicable

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

1.1.3 Assessment process components

The assessment process involves four distinct components:

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

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

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

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

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

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

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

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

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

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

- **Continuous Improvement**

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

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

[1] Boot, M and Cairncross, S "Actions Speak" Delft, The Netherlands, IRC and LSTHM, British Occupational Hygiene Society.

[2] New York Department of Health and Mental Hygiene

[3] The Columbia Electronic Encyclopaedia, Sixth Edition. Columbia University Press. 2003

[4] Irish Acute Hospitals Cleaning Manual, HSE (2006)

[5] Hygiene Services Assessment Scheme. Irish Health Services Accreditation Board (2006)

1.2 Organisational Profile

Cavan General Hospital is part of the Cavan Monaghan Hospital Group and provides a general acute hospital service to the catchment area of Cavan and parts of surrounding counties. The hospital has 206 in-patient beds.

Services provided

The range of acute services is as follows:

- General Medicine
- General Surgery
- Obstetrics/Gynaecology including Midwifery Led Unit
- Paediatrics
- E.N.T. (Out-patient Services)
- Orthopaedics (Out-patient Services)
- Dermatology
- Acute Psychiatry
- Day Services
- Out-patient Services
- Renal Dialysis
- Pathology Services
- Radiology Services
- Physical Medicine Services
- ICU/CCU
- Oncology – outreach service from Mater Hospital Dublin.

Physical structures

There are 6 isolation rooms and no negative pressure rooms. Single rooms on wards are used as isolation rooms on a needs basis.

The following assessment of Cavan General Hospital took place between 3rd and 4th September 2007.

1.3 Best Practice

- The development of hygiene management structures within the organisation.
- The palpable culture of desire to improve hygiene requirements amongst all staff encountered.
- The General Manager's involvement at the local radio station informing of infection prevention and control precautions and utilisation of local radio and local papers to inform the public and local community of visiting times.
- Good adherence to personal hygiene practices by staff involved in food handling.
- Use of pictograms in isolation signs.
- The use of Personal Protective Equipment (PPE) and earplugs in the laundry, and adherence to best practice.
- The proposed inclusion for the requirement of privacy and confidentiality during cleaning services in the tender document for contract cleaners.

- Adherence to hand hygiene and absence of hand jewellery by staff involved in direct patient/client contact and hygiene services.

1.4 Priority Quality Improvement Plan

- Review the monitoring of the cleaning processes and schedules in all areas.
- More attention to training is recommended, with specific attention to food workers and all seasonal staff.
- A documented process for corrective actions and follow up, to issues identified during audit is recommended.

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 Cavan General Hospital 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 ↓ C)

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

Needs assessments were undertaken by a hygiene advisor, waste management consultant and Hazard Analysis and Critical Control Point (HACCP) consultant who identified needs in relation to cleaning, catering and waste services. It was recommended that a further needs assessment be undertaken, to clarify needs in relation to human resources in cleaning, for both contract and in-house staff who undertake cleaning duties and for key specific areas such as infection prevention and control. A needs assessment in relation to Information Technology (IT) facilities in recording and monitoring hygiene related issues and projects is recommended.

While evaluation of the needs assessment has been undertaken, by implementing recommendations from assessment reports, further evaluation of human and IT resources is required.

CM 1.2 (B ↑ 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.

Many commendable developments and modifications to hygiene services have been introduced over the last two years. Of note are:

- Education sessions monthly on infection control/hygiene.
- Introduction of pocket alcohol gels to staff.
- Introduction of recommended national visiting hours.
- Increase in cleaning hours at time of infection 'outbreaks', as recommended in national guidelines on Norovirus and MRSA.
- Removal of tea towels from kitchens and installation of disposable paper roll dispensers.
- Introduction of distinctive colour-coding of equipment and cleaning cloths in line with national guidelines.
- Introduction and/or redesign of dedicated cleaners' rooms to include hand wash facilities and adequate storage space.
- Introduction of dedicated storage facilities for waste awaiting collection from the wards.
- Installation/upgrading of hand-wash sinks in many areas including sluice rooms, kitchens and domestic services rooms.
- Colour-coded posters in cleaners' rooms and laminated pocket size colour-coded charts for staff.

- Labelling of waste bins for domestic and healthcare risk waste.
- Introduction of patient/client handbook, which includes a section on hygiene.
- Upgrade of ward kitchens and introduction of checklists to record temperature of fridges/freezers, and cleaning of microwave etc.
- Structured curtain change programme with check cards in linen rooms.
- Introduction of individual packs of hand hygiene wipes for patient/clients with information notice at each bed-side.
- Development of cleaning policy.
- Direct linkage between infection control, health and safety, risk management, clinical engineer, technical services and the capital planning team with regard to design layout, fixtures/fittings and cleaning of new/refurbished buildings.

Evaluation of developments and modifications of structures and processes is undertaken by performing audit of areas. Resultant action from hygiene advisors' reports was evident.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1 (B ↓ C)

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

Details of direct linkages with the Health Service Executive (HSE), Department of Health and Children (DoHC) and network area were evident through minutes of meetings evaluated during assessment. Documented processes of linkages within the organisation and with external bodies were viewed, and minutes of meetings held, where hygiene-related issues were discussed, were evident. Patient/client satisfaction surveys have been carried out, with findings in relation to hygiene questions improving to 80% satisfaction. Staff satisfaction surveys were discussed and were recommended to be carried out. These should include satisfaction with service in relation to occupational health. Evaluation of the potency of the linkages and partnerships in existence should be undertaken.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 (B ↓ C)

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

A documented process was in place for the development of the Hygiene Corporate Strategic Plan. It contained goals and objectives but requires more specific information in relation to both human and IT resources. Responsibilities for the plan was detailed and its communication to all stakeholders evident. Evaluation of the plan's goals, objectives and priorities needs to be undertaken.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.1 (B ↓ C)

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

The organisation's hygiene services structure makes clear provision for accountability, responsibility and channels of communication. The patient/client charter is utilised as a template for corporate ethics. A quality initiative, to develop a corporate code of ethics for hygiene services, is in place. Minutes viewed of all senior management and related hygiene services meetings demonstrated commitment to hygiene. Full adherence to IS 340 was not evident during the assessment as reports from the Environment Health Officer (EHO) still had outstanding issues. Historical reasons for being unable to utilise specific areas for changing rooms, thus causing staff to travel to and from work in uniform (as allowed per hospital policy), were expressed by the management. It is recommended that a review of the uniform policy is carried out and approval sought from the Hygiene Services Committee.

CM 4.2 (C → C)

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

Documented processes are available within the organisation for receiving and acting on information in relation to hygiene services. Best practice is reviewed by key staff. Key performance indicators need to be further identified and utilised.

CM 4.3 (B → B)

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

Access is available to current research and best practice. Many quality initiatives, relating to hygiene services, and based on best practice and research, have been implemented. The Infection Control Team has provided regional education updates on best practice guidelines and key staff attend professional and national conferences with relevance to their specialty and hygiene issues. Ongoing educational sessions were evident in documentation viewed, informing staff of hygiene-related issues. It is planned to introduce a newsletter. Evaluation of the effectiveness of evidence-based hygiene quality initiatives has been documented during internal, external and national audits.

CM 4.4 (B ↓ C)

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

A process for the development of best practice guidelines is utilised. In the document Guidelines for Policy Making 2004, the process is set out in six key stages. The approach to policy development places a strong emphasis on encouraging a process for continuous improvement and review. Some documents and policies in use had exceeded their review date. It is recommended that the organisation use a computerised system to assist in control of documents and policies. Evaluation of current or suggested computerised system is necessary.

CM 4.5 (B ↓ C)

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

A robust process was evident for consultation with members of the Hygiene Services Committee prior to project developments. Communication between the Hygiene Services Committee/Team and hospital management, in relation to capital development, was evident during the assessment. The efficacy of the consultation process has not been formally undertaken and is recommended in the future. Evaluation of the process will ensure that all key areas are fully involved and aware of ongoing developments.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

*Core Criterion

CM 5.1 (C → C)

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

Details of the hygiene structure were available, with roles and responsibly documented. The reporting relationships for identified positions were evident, however, further details, specific to the Hygiene Services Team, need to be identified on the algorithm. Many job descriptions, including ward/department managers, were viewed with specific references made to hygiene and infection control issues. Whilst it is appreciated that the position of Project Officer/Hygiene Services Co-ordinator is a new initiative, the job description did not appear to be weighted proportionately between the dual roles. A needs analysis of the position and benchmarking with other organisations developing this role is recommended.

*Core Criterion

CM 5.2 (A → A)

The organisation has a multi-disciplinary Hygiene Services Committee.

Details of the Hygiene Services Committee, which is multi-disciplinary and works across the two hospital sites, were evident. The documented process to ensure team awareness of roles and responsibilities was observed. The terms of reference and details of administrative support and schedule of meetings were documented.

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

*Core Criterion

CM 6.1 (C → C)

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

A Corporate Hygiene Strategy and a Hygiene Service Plan have been developed. It is recommended that more details are provided in the plans in relation to human, financial, and IT resource needs.

CM 6.2 (B ↓ C)

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

The protocol for the introduction of new cleaning products/equipment and the use of a decontamination certificate is commended. Any equipment over €100 has to be approved by the Hygiene Services Committee and the General Manager. It is recommended that evaluation of this new process be implemented in the future.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

CM 7.1 (C → C)

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

A risk management programme is in place and a documented process is available to record risk incidents relating to hygiene. A report was formulated recording infection control incidents from January to November 2006. No major hygiene-related adverse events were reported to have occurred during the last two years. A health and safety report was produced in 2006. A risk management report was produced in 2004. Risks are identified during hygiene audits and management walkabouts.

CM 7.2 (C ↑ B)

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

The Risk and Health and Safety advisers have been in position since 2002. The Operational Services Manager represents the Hygiene Service Committee on the Health and Safety Committee. The health and safety reports, national and internal audits and external consultants' reports were utilised to allocate resources and make improvements to hygiene services. The review of the Current Incident Form, to include a specific area for hygiene issues, is recommended.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion

CM 8.1 (C → 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.

There is a documented process for establishing contracts and managing and monitoring contractors and their professional liability. New Service Level Agreements (SLAs) will form part of the tender processes. SLAs will include regular contract review meetings, penalty clauses, pricing reviews and issues at local and operational level to be dealt with on a weekly basis.

As contracts are held at regional level, the Assessment Team were unable to evaluate the details for specific contracted hygiene services.

During the hygiene meeting the importance of local level knowledge of contents of contracts was reiterated, even though they are held regionally.

CM 8.2 (B ↓ C)

The organisation involves contracted services in its quality improvement activities.

While evidence was given of cleaning contractors' involvement in the area of quality improvement activities, the organisation is recommended to extend the involvement to other contract agencies involved in hygiene services.

PHYSICAL ENVIRONMENT, 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.

Evidence of compliance with regard to design specifications, adherence to relevant regulations and codes of best practice in the design and layout of the physical environment was available. Areas of the physical environment were in need of refurbishment and these have been documented under capital projects i.e. refurbishment of main kitchen, updating of equipment in use in the laundry. The organisation have used their Infection Control Team, EHO, National Audit, HSA, Dangerous Goods Advisor and Hygiene Consultant, who reports to the hospital and the HSE, to evaluate the safety, design and layout of the current environment.

Recent projects, based on evaluation include renovation of dedicated cleaners' rooms, linen rooms, appropriate clinical waste storage and clinical wash hand basins (to conform to HTM 95). The introduction of knee-operated clinical wash hand basins in dirty utility rooms is to be commended. The positioning of one inside the door on one of the surgical wards may need to be revised.

*Core Criterion

CM 9.2 (B ↑ A)

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

Documented processes and adherence to legislation was evident in relation to the planning and management of its environment and facilities, equipment and devices, kitchens, waste and sharps and linen.

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.

Audits were viewed during the hygiene assessment. In relation to the EHO reports, completion of actions outlined needs to be timelier. Evidence of the changes undertaken within the last two years was notable. Just two of many identified include: the redesign of some storage areas for clean utility products and the designation of some dirty utility rooms for the temporary storage of laundry and waste. The quality improvement plans, identified from the completed audits, had commenced at the time of the hygiene assessment. The use of structured checklists for all audits, in order to collate findings and utilise them for feedback to ward and department managers, and for submission to annual hygiene reports, is recommended.

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.

The patient/client satisfaction survey has yielded very positive findings in relation to increasing satisfaction of hygiene services. The plan to undertake a staff satisfaction survey is encouraged and recommended.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 (C → C)

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.

Evidence of internal and contact staff recruitment, with details of relevant legislation and adherence to codes of practice, was evident. Samples of job descriptions were reviewed. Evaluation of the processes and a review of handbooks are to be undertaken. This is recommended.

CM 10.2 (C ↑ 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.

Human resources, both in relation to internal and contact staff, were increased as a result of reviewing changes and increasing areas to be cleaned (i.e. new modular buildings). Relevant standards were utilised in the review process. Increases in work capacity and volume were documented and reflected in the improved hygiene audit findings.

CM 10.3 (C → C)

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

Training records for the contract waste company were observed. Hazard Analysis and Critical Point (HACCP) training records were available. However, the length of time between refresher training, and training for seasonal staff require review.

CM 10.4 (C → C)

There is evidence that the contractors manage contract staff effectively.

Details and processes for the management of contract cleaning staff were evident. Training cards were available for the contract cleaning staff. It is recommended that monthly audits, to monitor cleaning standards, evaluate not only the outcome of work undertaken, but the process of cleaning. Some of the audits available as evidence of compliance were not dated and action plans were not completed.

*Core Criterion

CM 10.5 (C → C)

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

The needs assessment process undertaken by the contract cleaning company involved conducting a time-in-motion study to assess how long it takes to clean certain areas, which could then be used to predict human resource needs. The

national cleaning manual was used to gain increased hours for areas within the hospital and is being utilised for the development of the next contract cleaning tender. During the hygiene assessment meeting, the general manager said that internal human resources for direct cleaning duties are being addressed at regional and national level under the "3 C's" (cleaning, catering and care assistants). National decisions will also impact on local human resources. The Hygiene Corporate Strategic and Service Plans produced should specify human resource needs.
The hygiene report 2006 was produced and it lists the capital development projects and quality improvements, however, there is no reference to internal human resources, IT or costs/budgets, which is recommended.

ENHANCING STAFF PERFORMANCE

*Core Criterion

CM 11.1 (B ↓ C)

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

The details of education and training given to staff during their induction period, which includes specific education regarding hygiene and the ongoing education and training, was evident. A staff handbook and information pack is given on induction. Attendance levels at induction/orientation training were viewed. It is recommended that the induction programme be reviewed for effectiveness.

CM 11.2 (B ↓ C)

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

While it was evident that continual professional development is being undertaken by the Hygiene Services Team, a documented process for this was not evident. Details were available of education/training in key areas such as: health and safety hazards and conducting risk assessments; handling of patient/client complaints; infection control training; safe cleaning and maintenance of new and existing equipment and medical devices; and cleaning. There was no documented process for ensuring that staff are afforded protected time and freed from duties to attend ongoing education and training, which is recommended. The provision of appropriate facilitators and educators to support staff education and training was evident and a Professional Development Co-ordinator post was recently developed. This appeared to have a very positive impact on hygiene service education needs. Staff training records were viewed and the evaluation of hand hygiene and standard precautions training was noted. Evaluation of training needs requiring identification, evaluation, and outcomes to improve patient care as a result of training received, is in its early stages and is to be commended. The organisation are recommended to extend this to all staff, including seasonal staff and staff involved with food duties at ward kitchenettes.

CM 11.3 (B ↓ C)

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

Evaluation forms are being utilised at the completion of infection control study days, and Infection Control Nurses' Association (ICNA) audits undertaken, allow for some evaluation of outcome from training. However, an evaluation process would greatly enhance the monitoring of the effectiveness of training. A regional infection control evaluation had collated feedback from education delivered. However it is recommended that the format, showing how results are communicated, should include conclusions: this would be more reader-friendly, and allow for interpretation

of the findings to be documented. Structured evaluation of attendance at education and training sessions for all staff is also recommended.

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.

Formal, structured systems of evaluation for all staff involved in hygiene systems have not been developed. Internal and external audits have been utilised to evaluate the outcome of cleaning. However, it is recommended that the cleaning process be part of this. Knowledge of methodology (inclusive of health and safety issues and infection prevention and control issues) also needs to be evaluated. Evaluation is included in care assistants' FETAC training. It is recommended that this system be used as a benchmark for other grades of staff involved in cleaning, waste management and laundry services.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (B → B)

An occupational health service is available to all staff

Details of occupational health services available to staff at this site and other regional sites were available. The organisation plans to extend the availability of the services to provide an increased number of days on site. The Occupational Health Department commenced customer satisfaction surveys in 2003. They are recommended to formulate their results and include findings in the hygiene services' annual report.

CM 12.2 (B → B)

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

A Stress and Quality of Health at Work Survey was carried out for all staff and utilised to monitor staff satisfaction, occupational health and well-being. As a result of ongoing monitoring and evaluation the Occupational Health Service has relocated from a central base to facilitate hospital access two days per week.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.1 (B ↓ C)

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

Processes to collect and disseminate data, relevant to hygiene services, were available. To ensure these processes are in line with standards and best practice, it is recommended that they be formally evaluated.

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.

Guidelines, reports and quality improvement plans have been generated with a view to improving hygiene services. Health and safety and hygiene reports have been produced for 2006. The organisation is recommended to evaluate data and information turnaround in the near future. This process would be greatly assisted by

more automated systems of collection. Documented evaluation of user satisfaction in relation to the reporting of data was not evident. This is recommended.

CM 13.3 (C → C)

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

Data collection and information reporting is the responsibility of members of the Hygiene Services Committee and with the more recently established hygiene services team members. It is recommended that the evaluation and utilisation of the data in relation to the provision of hygiene services is formally undertaken in the future.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

CM 14.1 (B ↑ 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

The Management Team support a quality improvement culture, which was evident from documentation regarding education, hand hygiene facilities, the general environment, and specific areas such as kitchens, linen, sharps, patient equipment and waste management. The hospital management's commitment to hygiene was evident from minutes of meetings and through formal and informal interviews/meetings held during assessment. Walkabouts by managers are in place and involvement with local radio and newspapers, to highlight issues ranging from visiting hours policy to precautions necessary for the hospital to take during outbreak of gastric illnesses, are to be highly commended. Hygiene is given a high profile and a clear culture of quality improvement was noted amongst all staff. Results from patient/client satisfaction surveys reflect the improvements made over the last two years.

CM 14.2 (B ↓ C)

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

The organisation participated in the two national hygiene assessments and undertook a number of internal audits. A Hygiene Audit Committee has been in existence since 2005. In keeping with the HIQA-recommended hygiene management structures it formulated the Hygiene Services Committee and Team. It is based between two sites to ensure maximum utilisation of human resources and time management. The identification of key personnel and their employment are indications of the commitment to quality improvement. The organisation identified the Practice Development post and Project Officer/Hygiene Coordinator as necessary human resources to assist in the improved delivery of hygiene services. Further opportunities to undertake continual professional development and training, development of hygiene service performance indicators for all staff involved in hygiene services, increased evaluation and further benchmarking can all be achieved. The inclusion of the ward/department managers in the hygiene structures, and their identification as the person responsible for hygiene in their own area, provides clarity to roles, authorities and accountabilities in all areas. The further utilisation of IT and use of software would facilitate quality improvement.

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 ↓ C)

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

Information to indicate that evidence-based practice is used by the team to develop and improve its hygiene services includes the following:

- A Hazard Analysis and Critical Control Point (HACCP) plan is in place for the catering department, albeit it should be reviewed on a periodic basis to ensure that it is still valid.
- There is a proposal to restructure the kitchen.
- New cleaning specification is at an advanced stage and input from all relevant stakeholders is being sought.
- Plans are in place to develop a new waste compound, which will be compliant with waste legislation.
- Hand hygiene facilities have been upgraded and will be consistent with the Strategy for the control of Antimicrobial Resistance in Ireland (SARI) guidelines.
- The introduction of the Hygiene Operational Team is evidence of best practice used to improve hygiene services.

Evaluation of catering to assess compliance with relevant legislation and standards is undertaken by a Senior Environmental Health Officer on a periodic basis. A Hygiene Advisor was engaged within the past year. It is recommended that a Quality Improvement Plan, to establish a systematic user friendly process for updating/amending guidelines, be implemented.

SD 1.2 (B → B)

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

The proposed introduction of new hygiene products is explored and discussed at Hygiene Service Committee meetings, with agreed trial periods and outcomes evaluated prior to a final decision on the particular product. As a result the hospital has introduced a new soap dispensing system, wall mounting of sharp boxes, new hand wash sinks in many areas, a variety of posters pertaining to linen, waste, colour coding, standard precautions and labelling of bins for domestic and health care risk waste. Evaluation of efficacy of new interventions is reflected in a review of scores both in national hygiene audits and internal audits. Since January of this year new protocols have been implemented for cleaning products and equipment.

PREVENTION AND HEALTH PROMOTION

SD 2.1 (B ↓ C)

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

Evidence was observed that external agencies, including nursing home staff, use Standard Precautions/Hygiene Standards Training. The General Manager regularly speaks on local radio to advise/reassure the public regarding outbreaks of Norovirus and the importance of taking adequate infection control measures when visiting the hospital. This is also undertaken on a periodic basis to remind the public to support the hospital in their endeavours to maintain optimum hygiene standards. Feedback from the public has been positive in this regard. The local newspaper is also used to advertise hospital visiting hours and outbreaks of infectious disease, where they occur. An audio message is in use at the hospital entrance to advise visitors regarding the non-smoking policy and visiting hours. Notices at the entrance regarding visiting hours and standard precautions were observed. The organisation is recommended to evaluate these activities.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1 (B ↓ C)

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

Details of the multi-disciplinary team members were evident. However, it is recommended that the organisation include allied health professionals as representatives on the team. Team members are aware of each other's roles and responsibilities, which is written into the hospital's strategy and distributed to all members of the team. Linkages with external agencies, including the Senior Environmental Health Officer, the Health and Safety Authority and the Hygiene Advisor are in place. Members of the Hygiene Services Team are actively involved in a number of national organisations including the Infection Control Nurses' Association, the Irish Society of Linen Services and Laundry Managers. An invitation has been issued to a patient/client representative to become a member of the team. It is recommended that a process be put in place to evaluate the multi-disciplinary team structure.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

SD 4.1 (A ↓ B)

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

While overall the physical environment and facilities were clean, floor-cleaning methods require greater attention to detail. The reduction of buffing frequencies requires evaluation to establish its impact on overall cleaning standards. Corrective action in relation to the use of colour-coded cloths is recommended.

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.

New bed-pan washers are currently being installed. A cleaning programme is required for the cleaning of fans, if their use is in line with organisational policy.

For further information see Appendix A.

*Core Criterion

SD 4.3 (A ↓ B)

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

Facilities and equipment are available to hygiene services staff to manage cleaning equipment. However it is recommended that contractors ensure that protocols, listed in national guidelines, are adhered to. (Mopping units must be kept clean and dried after use and buckets inverted.) A method to record the servicing of all cleaning equipment is recommended.

For further information see Appendix A.

*Core Criterion

SD 4.4 (B → 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 HACCP plan was in place. It is recommended that the hospital ensure all corrective actions taken are documented. Adequate space is recommended for the hygienic performance of all operations. Cleaning Contractors currently do not clean the kitchen at the weekend it is done by the kitchen staff. A more concerted focus is recommended regarding the cleaning of the main kitchen, with particular reference to difficult areas to access, high-level surfaces and behind and underneath equipment. Staff personal hygiene was observed to be consistent with good hygiene practice. A planned preventative maintenance schedule should be developed for all catering equipment.

For further information see Appendix A.

*Core Criterion

SD 4.5 (A → A)

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

The management of waste throughout the hospital was of a high standard. It was noted that the sluice (with key pad lock) was used as the holding area for waste bags awaiting collection. There is a listed schedule of collection times for collection of waste. It is noted that the development of the waste compound is in progress.

For further information see Appendix A.

*Core Criterion

SD 4.6 (A → A)

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

A planned schedule for collection and delivery of laundry is in place. Training of laundry staff is well organised and documented. Facilities and Personal Protective Equipment (PPE) for laundry staff was excellent and was in use during the time of assessment.

For further information see Appendix A.

*Core Criterion

SD 4.7 (A → A)

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

The new hand hygiene wash hand basins being installed throughout are to be commended. It is recommended that the organisation provide increased attention to the nozzles of dispensing units to ensure that they are not blocked. It was noted that new gels are currently being tested.

For further information see Appendix A.

SD 4.8 (B → B)

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

Documented processes to ensure patient/client safety were evident. While the foil liners for the sharp trays were not observed, trays in use were clean. Some staff within the laboratories were not aware of the use of blood spill kits. This was brought to the attention of the manager, who put a plan in place to deal with this issue. While incident report forms are used, a documented rate of response to these events was not evident. Evaluation of incident rates has been undertaken and should be repeated at defined intervals.

SD 4.9 (B → B)

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

A process is in place to ensure ward managers actively encourage patient/clients and visitors to report hygiene complaints. This process is in its infancy. Generic signage in use throughout the ward areas is to be commended. The use of pictograms on posters to indicate the isolation room is a good example of this. The Hospital Visitor Policy was clearly displayed throughout. Swipe cards for access to ward areas are an example of controlling visitor access. The findings of the patient/client satisfaction surveys and HSE comment cards reflect the hospital's commitment to continuously improve the environment. It is recommended that patient/client information leaflets be more prominently displayed and a hygiene leaflet be specifically designed for children.

PATIENT'S/CLIENT'S RIGHTS

SD 5.1 (C → C)

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

The Confidentiality Clause and Dignity at Work requirement is included in the HSE document in relation to the Appointment to Positions on a Short-term Basis. Consultants and nurses discourage visiting during ward rounds, based on patient/client confidentiality reasons. The Dignity at Work Policy Statement and Confidentiality Clause in the HSE employee handbook were observed. Adherence to standard precautions in the Infection Control Manual was observed. Generic isolation signage on doors of Isolation Rooms was noted. Cavan Hospital orientation/induction programme for nurses refers to patient/client confidentiality and respect for cultural and religious beliefs as part of their nursing philosophy. The hospital plans to include a section in their cleaning contract document regarding patient/client and family confidentiality. This proposal is to be commended.

SD 5.2 (B ↓ C)

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

A public address system provides information to patient/clients, families and visitors on the no smoking policy and visiting hours. Signage was observed on the main entrance door for visitors advising them to refrain from visiting if they had had symptoms of diarrhoea and vomiting in the past 48 hours. The main kitchen and ward kitchens have signage restricting unauthorised access. Sluice rooms also have coded access. All waste bins are clearly labelled. Patient/client handbooks are available which contain a section on the hygiene. The organisation is encouraged to include questions on hygiene satisfaction.

SD 5.3 (B → B)

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

There is a procedure in place to manage all hygiene-related complaints through the National HSE Complaints Policy. Evidence of the procedure and action plans developed was observed. A communication book is in place a ward level which cleaning staff can view on a daily basis regarding any hygiene-related issues. It was noted that, in some ward areas, complaints are addressed locally and sometimes through an informal process. It is recommended that the organisation fully utilise the risk management process to ensure learning takes place within the hospital. Increased availability of comment card boxes is also recommended.

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1 (B → B)

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

The findings of the patient/client satisfaction surveys and HSE comment cards reflect a positive evaluation of the hygiene service. Reports, conducted by external advisers (for example hygiene consultants, waste adviser, EHO, Health and Safety) are being used to develop best hygiene practice. The development of the waste compound, and the proposed restructuring of the kitchen, is a good example of this initiative. Patient/client representative involvement in the hygiene services operational team is

being developed and the commitment to include patient/client representation was demonstrated. A meeting was specifically scheduled to facilitate a patient/client representative to meet with the assessment team. This process is to be commended and evaluation is recommended.

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.

There has been an increase in the routine cleaning hours in some areas. There is a proposal to increase cleaning hours, which is reflected in the draft cleaning specification, and is due to go for tendering process in the near future. A number of initiatives have been introduced over the past two years to include the following: the removal of tea towels from the kitchens and installation of paper towel dispensers, the introduction of a decontamination certificate for electro-medical equipment awaiting repair. Evaluation of re-education on the use of the flat mop system is recommended in the near future. The reduction of buffing frequencies should be evaluated in order concentrate on routine and increased cleaning standards.

SD 6.3 (C → C)

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

A hygiene report (2006) was produced and circulated to all the members of the Hygiene Services Committee. The Infection Control Nurses' Association audit tool is used to evaluate the implementation of hygiene-related policies and guidelines. A review process has been undertaken in relation to the national audit report and a hygiene consultant has been engaged to advise on standards and to evaluate future resources. The organisation has developed a plan to include feedback and comments obtained from the patient/client satisfaction survey, the HSE comment cards and the patient/client representative in the 2007 report.

4.0 Appendix A

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

4.1 Service Delivery Core Criterion

Compliance Heading: 4. 1 .1 Clean Environment

(1) The environment is tidy, well-maintained, free of rust, blood or body substances, dust, dirt, debris and spillages.
Yes - The environment is clean, however, the method used for floor cleaning needs to be reviewed.

(3) Wall and floor tiles and paint should be in a good state of repair.
Yes - Areas visited were found to be satisfactory.

(4) Floors including edges, corners, under and behind beds are free of dust and grit.
Yes - In the majority of cases, however, greater attention needs to be paid to vacuuming in some areas.

(7) Areas should be adequately ventilated with ventilation units cleaned and serviced accordingly and documentation available regarding service.
No - Ventilation is required over the baking oven and behind the counter at the canteen service area in the main kitchen. This is being addressed in the context of the plans to upgrade the kitchen and documentation was viewed to this effect. Most vents in patient/client and public areas were observed to be dusty and required further cleaning.

(12) Internal and external stairs, steps and lifts must be clean and well-maintained.
Yes - While the internal and external stairs were clean, the grids of the lifts were not, as they are only being cleaned on a quarterly basis. The frequency of cleaning or the system of cleaning should be reviewed.

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

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

(19) Ceilings.
Yes - In the majority of cases, however, some ceiling tiles need refitting/repair.

(21) Internal and External Glass.
No - Consideration should be given to the frequency with which window cleaning is carried out. Building work is in progress, which has impacted on this.

(23) Radiators and Heaters.
No - Radiators observed were of a design that is difficult to clean – another type should be considered.

(24) Ventilation and Air Conditioning Units.
No - While in some areas the easily accessible parts of ventilation grids were clean the internal sections were visibly dusty.

(25) Floors (including hard, soft and carpets).
No - Poor floor cleaning methods were observed both in patient/client and catering areas.

(26) Nozzles of wall mounted alcohol gels and hand disinfectants must be cleaned daily.
No - Some nozzles were clogged, indicating inadequate cleaning.

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

(30) Fixtures: Fixtures (i.e. a piece of equipment or furniture which is fixed in position) should be clean. This includes all electrical fixtures e.g. all light fittings and pest control devices.
No - Some fly screens were found to require further attention. Equipment (e.g. pot washer, dish washers and food trolleys) in the kitchen requires more detailed cleaning.

(209) Air vents are clean and free from debris.
No - Most vents in patient/client and public areas were observed to be dusty.

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

(34) Beds and Mattresses.
Yes - Some chairs in physiotherapy waiting area need to be re-covered.

(38) Dispensers (e.g. handwash dispensers), Holders and Brackets.
Yes - Some need more attention or replacing.

Compliance Heading: 4. 1 .5 Sanitary Accommodation

(47) Bathrooms/Washrooms are clean and communal items are stored, e.g., talc or creams.
Yes - In the majority of cases, however, some communal items noted in physiotherapy staff changing facility and also in maternity unit bathrooms were not. All other areas were clean.

(48) Floors including edges and corners are free of dust and grit.
No - More attention to detailed vacuuming is required, particularly in relation to the corners and edges of floor areas in patient/client areas. The wall/floor area behind and underneath equipment in the main kitchen also requires attention.

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

(52) Toilets and Urinals.
No - The underneath surface of toilet seats in most areas require further attention.

(56) All associated bathroom fittings including component parts e.g. tiles, taps, showerheads, dispensers, toilet brushes etc. should be clean and well maintained.
Yes - Areas observed during the visit were clean.

(57) Clear method statements/policies should be in place for guidance on all cleaning including sanitary cleaning and maintenance processes.
Yes - It was noted that the new cleaning specification was at an advanced stage of development.

(60) All outlets (including shower outlets) should be flushed at a temperature in accordance with current legislation.
Yes - The document entitled "Legionella Control/Water Management Control Programme" was reviewed.

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

(68) Patient fans which are not recommended in clinical areas.
No - Fans noted in some clinical areas were not clean. A cleaning programme needs to be implemented for their cleaning if deemed appropriate by the hospital.

(70) Bedpans, urinals and potties are decontaminated between each patient.
Yes - New bed-pan washers have been installed.

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 of cases, however, greater attention to the surface areas on the back of cardiac arrest trolleys is required.

(74) Patient's personal items (e.g. suitcase), which should be stored in an enclosed unit i.e. locker / press.
No - A lot of personal items were found on the floor in the maternity unit.

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

(81) All cleaning equipment should be cleaned daily.
No - Mopping units and some trolleys were not cleaned daily, which is recommended.

(82) Vacuum filters must be changed frequently in accordance with manufacturer's recommendations - evidence available of this.
No - Records of filter change were not observed in place.

(88) All cleaning equipment should be left clean, dry and tidy in the storage area after use.
Yes - In the majority of cases, however, water in buckets had not dried out in some areas.

(92) Cleaning products and consumables should be stored on shelves in locked cupboards.
No - Locks not available on all domestic service rooms, which is recommended.

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.
No - Further compliance in this area 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.
Yes - Further compliance with HACCP is recommended. This should be verified and reviewed on a periodic basis.

Compliance Heading: 4. 4 .2 Facilities

(221) Staff clothing/uniforms/shoes personal belongings should not be stored in food rooms.
Yes - In the majority, food areas complied with the non-storage of personal belongings. However it was noted that the Thermal Protection Safety Jackets provided for use in cold areas (freezers, plating area - Cook Chill) were stored in the main kitchen; this needs attention.

(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 - Knee operated wash hand basins 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.
No - Mechanical extract ventilation to be provided over baking oven and mechanical intake ventilation to be provided behind the counter at the canteen service area.
The hospital is addressing this in the context of overall improvement plans for the kitchen.

Compliance Heading: 4. 4 .3 Waste Management

(229) Animal and pest control measures shall be in place in all waste handling and storage areas.
No - The rear external door, which is adjacent to the main kitchen entrance, had gaps and spaces.

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.
No - The UV light bulbs of the EFK units in the main kitchen area need to be replaced.

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

(240) A Hospital using a cook-chill system should comply with Guidance Note No. 15 Cook-Chill Systems in the Food Service Sector (Food Safety Authority of Ireland) The temperatures of fridges, freezers, cold rooms and chill cabinets shall be capable of maintaining the temperature of foodstuffs.
No - The air temperature of the portioning/assembly area was greater than recommended temperatures. Corrective action procedures were in the process of being put in place to address this. This should be progressed.

(242) Temperatures for Food in Fridges/Freezers and Displays should comply with I.S.340:2006 requirements.
No - The seal of this cold room door was in need of replacement.

(243) Preparation of High Risk Foods should comply with I.S. 340:2006 requirements.
Yes - However the organisation should strive to use individual portions of ice cream instead of multi use blocks.

Compliance Heading: 4. 4 .9 Food Cooling

(248) Cooling Times for Cooked Food should comply with I.S. 340:2006 requirements.
Yes - Blast Chillers are provided.

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 – The ice making machine in the Physiotherapy Department is for treatment purposes only.

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

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

(152) When required by the local authority the organization must possess a discharge to drain license.
Yes – This is not yet required by the local authority.

Compliance Heading: 4. 5 .3 Segregation

(256) Mattress bags are available and are used for contaminated mattresses ready for disposal; mattresses are disinfected.
No - The Environmental Cleaning and Disinfection Policy does not give a documented process for the disposal of contaminated mattresses.

Compliance Heading: 4. 5 .4 Transport

(163) Documented processes for the transportation of waste through the hospital which minimizes manual handling of waste (and ensures that segregation of healthcare risk waste from non-risk waste is maintained) are in place.
No - There is no documented process in place, but there is a timetable for collection of all waste.

(165) There is a designated person trained as a Dangerous Good Safety Advisor (DGSA) or the services of a DGSA are available to the hospital.
Yes - The services of a DGSA are available to the hospital.

Compliance Heading: 4. 5 .5 Storage

(169) Documented process(es) for the replacement of all bins and bin liners.
Yes – Compliance was noted.

(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 - There are adequate segregation facilities for the safe storage of healthcare risk waste, which is locked and inaccessible to the public. Appropriate warning signs restricting public access should be prominently displayed. There is a plan in place to develop a new waste compound. Proposed development plans were viewed.

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

(261) Clean linen store is clean, free from dust and free from inappropriate items.
Yes - Linen storage areas were clean, a new shelving system is being incorporated in some areas.

(267) Documented process for the transportation of linen.
No – This was not evident in the documentation provided.

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

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

(191) Hand washing facilities i.e. sinks, taps and splash backs must be clean and intact.
Yes - In the majority of cases, however, re-grouting of tiles in some public toilets could be considered.

(198) Hand hygiene posters and information leaflets should be available and displayed throughout the organization.
No - To promote public awareness of hand hygiene, more effective posters should be provided at all entrances to the hospital. Information leaflets in relation to hygiene were not freely available.

(204) Hand wash sinks conform to HBN 95. They should not have plugs, overflows and the water jet must not flow directly into the plughole.
Yes - Programme in place to upgrade hand wash sinks.

(205) General wards should have one sink per 4-6 beds and critical areas should have one sink per 1-3 beds.
Yes - Compliance was noted.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team		Assessor Team	
	FREQ	%	FREQ	%
A	7	12.50	8	14.29
B	33	58.93	16	28.57
C	16	28.57	32	57.14
D	0	00.00	0	00.00
E	0	00.00	0	00.00
N/A	0	00.00	0	00.00

5.2 Ratings Details

Criteria	Self Assessment	Assessor	Difference
CM 1.1	B	C	↓
CM 1.2	B	A	↑
CM 2.1	B	C	↓
CM 3.1	B	C	↓
CM 4.1	B	C	↓
CM 4.2	C	C	→
CM 4.3	B	B	→
CM 4.4	B	C	↓
CM 4.5	B	C	↓
CM 5.1	C	C	→
CM 5.2	A	A	→
CM 6.1	C	C	→
CM 6.2	B	C	↓
CM 7.1	C	C	→
CM 7.2	C	B	↑
CM 8.1	C	C	→
CM 8.2	B	C	↓
CM 9.1	B	B	→
CM 9.2	B	A	↑
CM 9.3	B	B	→
CM 9.4	B	B	→
CM 10.1	C	C	→
CM 10.2	C	B	↑
CM 10.3	C	C	→
CM 10.4	C	C	→
CM 10.5	C	C	→
CM 11.1	B	C	↓
CM 11.2	B	C	↓
CM 11.3	B	C	↓
CM 11.4	C	C	→
CM 12.1	B	B	→

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