Health Information and Quality Authority

An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte

Hygiene Services Assessment Scheme

Assessment Report October 2007

Letterkenny 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.

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

[2] New York Department of Health and Mental Hygiene

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

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

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

1.2 Organisational Profile

Letterkenny General Hospital is the only acute hospital in County Donegal serving a catchment area of approximately 137,000 people. The hospital has 312 beds (excluding psychiatry) and has been developed over the last 40–50 years.

Services provided

The services provided by the hospital include:
- Accident and Emergency
- Dental Surgery
- Dermatology
- Endocrinology
- General Medicine
- Maxillofacial
- Nephrology
- Ophthalmology
- Otolaryngology (ENT)
- Respiratory Medicine
- Rheumatology
- Warfarin Clinic
- Intensive Care Services
- Coronary Care Services
- General Medicine Services
- Geriatric Services
- Renal Dialysis Services
- General Surgical and Urology Services
- Obstetric & Gynaecology Services
- Paediatric Services (including Neo-Natal Unit Services)
- Orthopaedic Services
- Oncology and Haematology Services.

Physical structures

There are three negative/positive pressure isolation rooms in the hospital. Single rooms are also used for isolation purposes.

The following assessment of the Letterkenny general Hospital took place between 3rd and 4th September 2007.

1.3 Notable Practice

- Strong commitment from all grades to the improvement of hygiene services.
- Commitment of management to the development of corporate structures and governance.
- Recognising the difficulties presented, due to the poor hospital infrastructure, there was evidence of commitment to overcome these challenges so that a quality health service can be delivered.

1.4 Priority Quality Improvement Plan

- Implement new governance structures, audits, evaluation and Key Performance Indicators (KPI's).
- Progress with on-going structural improvements.
- Ensure relevant polices and procedures are available at ward level.
- Re-organisation of sluices and cleaning stores.
- Formalisation of induction programmers and comprehensive training records.

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 Letterkenny 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   **(C ↑ B)**
The organisation regularly assesses and updates the organisation's current and future needs for Hygiene Services.
Strong evidence was observed that current and future needs are assessed through comprehensive needs analysis reports. Evidence was observed that some of the needs identified were incorporated in the Hygiene Corporate Strategic Plan and the HSE Strategic Plan. Examples include the upgrading of facilities and hand wash sinks. Consultation with external partners was evident through areas such as the public and patient/client focus groups. It was evident that needs are assessed, based on best practice legislation and guidelines. Evaluation of the efficacy of the needs assessment process was performed, minutes of the Estates Committee were observed, with resultant actions and feedback such as the inclusion of patient/clients into the needs assessment process.

CM 1.2   **(C ↑ B)**
There is evidence that the organisation's Hygiene Services are maintained, modified and developed to meet the health needs of the population served based on the information collected.
It was evident that users' needs were addressed by results of patient/client satisfaction surveys. It is recommended that modifications to upgrading the environment, as outlined in the needs assessment, be performed.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1   **(B → B)**
The organisation links and works in partnership with the Health Services Executive, various levels of Government and associated agencies, all staff, contract staff and patients/clients with regard to hygiene services.
There was strong evidence the organisation works in partnership with the HSE, network managers, regional committees and other hospitals. Strong evidence of linkages with the public exist through the patient/client (consumer) focus group meetings, question/answer session and patient/client satisfaction surveys. Strong internal hygiene linkages exist through the development of the new corporate structure where all management teams report information to the Clinical Governance Committee and the Executive Management Board. It was evident that hygiene services had strong linkages with all multi-disciplinary groups. Some evaluation of the efficacy of the linkages was evident, for example the new corporate structure, and it

is recommended the evaluation of the efficacy of linkages and partnerships be formalised.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 (C → C)
The organisation has a clear corporate strategic planning process for Hygiene Services that contributes to improving the outcomes of the organisation.
The Hygiene Corporate Strategic Plan 2007-2010 has clear goals and objectives and was developed by the Corporate Management Team, in consultation with the Estate and Environment & Facilities Committee. Areas identified for priority include the upgrading on hand-wash facilities. Responsibilities are clearly outlined, and related costings are provided. It was evident that the plan was communicated to the multi-disciplinary Estate and Environmental & Facilities Committee. The organisation is encouraged to progress its Quality Improvement Plan for the evaluation of the Hygiene Corporate Strategic plans, goals and objectives against defined needs.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.1 (B → B)
The Governing Body and its Executive Management Team have responsibility for the overall management and implementation of the Hygiene Service in line with corporate policies and procedures, current legislation, evidence based best practice and research.
Roles and responsibilities for the hygiene services are clearly outlined and it was evident that the General Manger assumes corporate responsibility for this area. Corporate polices and procedures are in place. Ladder, uniform, food safety and Hazard Analysis and Critical Point Control (HACCP) policies were in line with legislation and best practice. A fire policy and patient charter were observed. The Code of Ethics was incorporated into some policies. There was evidence of evaluation of compliance to legislation and best practice guidelines. Feedback and continuous quality improvement was observed in areas such as fire regulations, uniform policy and food hygiene/HACCP.

CM 4.2 (B → B)
The Governing Body and/or its Executive Management Team regularly receive useful, timely and accurate evidence or best practice information.
There was evidence that the Executive Management Team (EMT) regularly receives useful, timely and accurate evidence or best practice information. Some best practice information reviewed at regional level was distributed with summary/actions reported to regional hospitals. Best practice information received locally is reviewed by the experts in the area, and presented at the relevant committee with recommendation/actions. Examples include: hand hygiene guidelines, incident report, hygiene audit, Heath & Safety, and Environmental Health Officer (EHO) reports.
Infection rates are also presented to the Infection Control Committee. Hygiene performance indicators reviewed included hygiene audit score results and infection rates. Evaluation of best practice information received was evident through relevant committee minutes. These included resultant actions and feedback. It is recommended that the organisation progress its QIP to formalise the evaluation of best practice information.

CM 4.3 (B → B)
The Governing Body and/or its Executive Management Team access and use research and best practice information to improve management practices of the Hygiene Service.

The organisation has a wide range of information sources available which includes a comprehensive library, which housed best practice journals and books. The internet/intranet are available to staff. Hygiene-related polices/procedures are current and referenced to best practice guidelines and are available at local level. Hygiene staff were informed of new best practice information though on-going in-service training. It is recommended that the organisation formalise the evaluation of related research and best practice available and ensures that all hygiene staff have easy access to best practice guidelines at local level.

CM 4.4 (B → B)
The organisation has a process for establishing and maintaining best practice policies, procedures and guidelines for Hygiene Services

Processes for the development of best practice policies and procedures are in place. The agreed templates and policies were current and referenced to best practice guidelines. A comprehensive list of hygiene services polices were available and included hand hygiene, waste, sharps, linen HACCP cleaning/disinfection of patient/client equipment/surfaces, environmental cleaning polices and uniform policies. Policies are monitored and approved through the Policy & Procedure Committee and other relevant expert committees such as Infection Control and Risk Management. Evidence was observed of informal evaluation of the policy development process through the Policy & Procedure Committee meeting minutes. It was evident that this had been established to develop formal processes for the evaluation of the efficacy of policy development. It is recommended that the organisation incorporate all cleaning into one overall policy and to develop a comprehensive laundry/linen policy to include the linen journey from the laundry to/from the wards.

CM 4.5 (C ↑ B)
The Hygiene Services Committee is involved in the organisation's capital development planning and implementation process.

It was determined that the process of consultation with Capital Development Planning is well established. It was evident that the Environment and Facilities Committee and users of the service were actively involved in capital development planning projects. The Infection Control Nurse sits on the Estates Committee, which is responsible for planning of refurbishment projects. The new building plans were also displayed in relevant areas of the hospital for user comment, prior to finalisation. Public consultation was also evident in the upgrade of current facilities (for example the cleaner rooms and sluice rooms). These included meetings with the Friends of Letterkenny, and MRSA Family Group. Evaluation of the efficacy of the consultation process was evident, which demonstrated the benefit of public consultation. It is recommended that the consultation and evaluation process of the Hygiene Services Committee involvement in the capital development projects be formalised.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

*Core Criterion
CM 5.1   (B ↑ A)
There are clear roles, authorities, responsibilities and accountabilities throughout the structure of the Hygiene Services.
The new corporate structure clearly outlined the roles and reporting structure for the hygiene service. It was determined that the General Manager assumes overall responsibility for hygiene services and, as a member of the Clinical Governance Committee, reports to the Hospital Management Board on hygiene issues. Roles and responsibilities for the hygiene services were evident in the General Manager, Nursing Director and Catering Manager's job descriptions. Members of the hygiene team report to the Environment & Facilities Committee and, through their representative/respective line managers, to the Clinical Governance Committee.

*Core Criterion
CM 5.2   (A → A)
The organisation has a multi-disciplinary Hygiene Services Committee.
An active multi-disciplinary Environment and Facilities Committee (Hygiene Services Committee), with senior representation from relevant disciplines, is in place. The committee had clear terms of references, administrative support and met regularly. Members' roles and responsibilities were outlined and they introduce themselves informally, as is practice within the hospital.

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

*Core Criterion
CM 6.1   (B → B)
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.
It was evident, through funding records supplied, that resources, including capital and minor capital funding, are allocated to hygiene services. This includes funding approval for new buildings and upgrading of current facilities and equipment such as the upgrading of hand-wash sinks, furnishing, and patient/client rooms/bathrooms. There was evidence of on-going funded projects for the hospital and this was reflected in the HSE Corporate Strategic Corporate Plan. There was evidence that human resources are allocated based on increased workload. An example would be increasing maintenance staffing levels for the installation new sinks, cleaning staff to cover shortfall for sick leave. Also, new Consultant Microbiologist, Infection Control and Surveillance Scientist posts were established and filled. There was evidence that human resources, including hygiene staff, were addressed in new building/facilities upgrade proposals and were included in the Hygiene Strategic Plan. A human resource needs assessment for cleaning was performed recently and at the time of assessment was awaiting review by the Executive Management Team.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion
CM 7.1 **(B → B)**
The organisation has a structure and related processes to identify, analyse, prioritise and eliminate or minimise risk related to the Hygiene Service
The organisation demonstrated that it utilised the STARS system for the identification and reporting of risk incidents. Analysed reports are reviewed and acted upon, on a weekly basis. There were no hygiene adverse events identified over the last two years. Other risk reports generated included Health & Safety, Fire Safety, and Environmental Health Officer (EHO) reports, which were reviewed and acted upon, with evidence of feedback provided.

CM 7.2 **(C → C)**
The organisation's Hygiene Services risk management practices are actively supported by the Governing Body and/or its Executive Management Team.
It was evident that Executive Management supports risk management practices by the appointment of a dedicated Risk Manager, the Facilities Manger and the development of a risk management framework. The Hygiene Services Team was involved/represented on the Clinical Governance/Risk Committee. The progression of the implementation of the Risk Management Framework and the inclusion of a hygiene team representative on the new Risk Management Committee is recommended.

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.
A process for the establishing, managing and monitoring contracts, and professional liability, in line with best practice national and Health Service Executive procurement process is in place. A reporting system was also outlined. It was demonstrated that contractors met with the Infection Control Team in relation to the required Aspergillus control measures, and its adherence to same.

CM 8.2 **(B → B)**
The organisation involves contracted services in its quality improvement activities.
Contracted services are involved in the organisations quality improvement activities. There was active involvement in discussions with relevant services such as Infection Control in respect of quality control measures, prior to commencing work. The organisation does not have any cleaning or catering contractors in place.

PHYSICAL ENVIRONMENT, FACILITIES AND RESOURCES

CM 9.1   (B ↓ C)
The design and layout of the organisation's current physical environment is safe, meets all regulations and is in line with best practice.
A commitment to upgrade buildings, within the constraints presented, (they date from the 1960's), was provided. It was evident that plans for the new buildings are designed to meet current best practice and building regulations. The organisation is endeavouring to upgrade the facility to meet current regulation and best practice in areas such as the labour ward, sluices, bathrooms and a new day ward, and a five-year plan has been developed. It is recommended that the organisation prioritise the upgrade of the laundry facilities and some ward kitchens.

*Core Criterion
CM 9.2   (B ↓ C)
The organisation has a process to plan and manage its environment and facilities, equipment and devices, kitchens, waste and sharps and linen.
There was evidence of a number of policies in place such as catering, Hazard Analysis and Critical Control Point (HACCP), waste and sharps. There was an informal maintenance programme in place. It is recommended that a formalised and planned preventative maintenance programme, in respect of equipment such as ventilation systems, bedpan washers, be put in place.

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.
The organisation demonstrated that the management of facilities, equipment and devices, kitchens, sharps and linens was effective. Related audit EHO and infection control hygiene reports were viewed. The organisation is recommended to formalise the process for evaluating the efficacy of the management processes.

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.
It was evident that visitors and patient/clients were satisfied with the facilities. Patient/client satisfaction surveys such as the Irish Society for Quality and Safety in Healthcare (ISQSH) survey, in-house patient/client and customer catering surveys and letters from patient/clients were supplied. Comment cards are also used with resultant actions evident (for example the development of patient information booklet and upgrade of the bathrooms). It is recommended that the organisation develop processes for the performance of staff satisfaction surveys.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1   **(B ↓ 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.
A comprehensive Human Resource Policy was viewed and is in line with national guidelines. Recruitment process and job descriptions viewed were in line with the recruitment policy. The recruitment process for contract staff was in line with best practice. It is recommended that the process for selecting and recruitment of staff be evaluated.

CM 10.2   **(B ↓ C)**
Human resources are assigned by the organisation based on changes in work capacity and volume, in accordance with accepted standards and legal requirements for Hygiene Services.
Human resource needs were assigned based on changes in work capacity and volume. Additional staff was recruited to install the new hand-wash sinks; a microbiologist, a second infection control nurse and surveillance scientist were also recruited as were additional cleaning staff to cover the shortfall for sick leave. A comprehensive human resource needs assessment for the cleaning service had just been completed and was evident form the report viewed. It is recommended that the organisation formalise the process for performing hygiene staff human resource needs assessment and evaluate the process.

CM 10.3   **(B → B)**
The organisation ensures that all Hygiene Services staff, including contract staff, have the relevant and appropriate qualifications and training.
The organisation adheres to the national requirement for employment of hygiene staff, including the checking of qualifications. Training needs are reviewed on an individual basis and it was evident that appropriate training was provided. Examples included the use of cleaning equipment and hand washing, Health & Safety, manual handling, food hygiene and HACCP. There is a certified food hygiene trainer within the Catering Department, which is commended. It is recommended that the system for assessing on-going training needs be formulated to ensure that all hygiene staff receive the appropriate training. The organisation is encouraged to explore the use of an in-house certified cleaning trainer.

CM 10.4   **(N/A → C)**
There is evidence that the contractors manage contract staff effectively.
The organisation demonstrated that contractors on site manage their staff effectively. Training records were current. Contractors conformed to the organisation's requirements for dust control during building works and they attended the required education, provided by the hospital, regarding Aspergillus control prior to commencing the project. All contracts are reviewed annually to ensure all human resource requirements are met. On-site contractors report to the Maintenance Manager. It is recommended that the organisation review the reporting process for all contact staff and to ensure contractors also report into local area managers as appropriate. The organisation is also recommended to evaluate the appropriate use of contract staff.

*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.
Additional hygiene staff have been provided in areas they were required. A comprehensive human resource needs assessment for cleaning staff has just been completed and additional requirements in the current cleaning staffing levels were identified. However, the organisation confirmed that they are bound by the national restrictions on hospital staff recruitment. Staffing levels, as outlined in the Hygiene Service Plan, are in place. Staff are assigned to designated areas and cover is provided for annual and sick leave. The organisation is encouraged to formalise the human resource needs assessment process for hygiene staff, to develop a business case to the HSE to address the shortfall in current cleaning staffing levels, as outlined in the needs assessment.

ENHANCING STAFF PERFORMANCE

*Core Criterion
CM 11.1   (C → C)
There is a designated orientation/induction programme for all staff which includes education regarding hygiene
Evidence that all staff participate in induction at local and department level was noted from records viewed. Education and training, in relation to hygiene specific issues, takes place. A staff handbook is provided and this is currently being updated to include hygiene. Education records are maintained locally. Capturing attendance levels at local induction on a hospital-wide basis is its infancy. The organisation is currently reviewing a HSE document in relation to the formalisation of corporate induction within the region, details of which were viewed.
It is recommended that the organisation formalise corporate induction and that attendance be mandatory for all staff at the time of employment. Infection control and hand hygiene practice should be included in the induction programme. It is recommended that attendance levels at induction be noted and included as a Key Performance Indicator (KPI).

CM 11.2   (C → 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.
The organisation demonstrated attendance at formal ongoing hygiene-related education sessions. These are provided by experts in the relevant area. The Catering Manger is a certified food hygiene trainer. This is to be commended. Education is provided at local level to facilitate attendance. Evidence was observed that evaluation of the relevance of education is performed with resultant actions and feedback to staff. The capturing of hospital-wide ongoing education information is in its infancy and issued identified with the system used are being addressed. It is recommended that the organisation formalise on-going training for all staff involved in cleaning. The organisation is encouraged to consider the provision a certified cleaning trainer, to facilitate induction and on-going training. It is recommended the evaluation of the relevance of education be carried out.

CM 11.3   **(C → C)**
There is evidence that education and training regarding Hygiene Services is effective.
Performance indicators used to measure the effectiveness of training included hygiene audit scores, incident reports and infection rates. Informal evaluation is also performed, through monthly walkabouts by the Executive Management Team. The organisation demonstrated improvement in local hygiene audit scores and a reduction in Clostridium difficile rates This was attributed to increased hygiene awareness among staff as a result of ongoing hygiene education.

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 performance probationary assessment is in place as part of the human resource recruitment process. Evidence was observed that formal staff appraisals are performed in the Catering Department. Performance of other hygiene staff is assessed informally through local inspections, walkabouts and the assessment of hygiene audit scores. Contract staff performance is assessed by the contractor and by the organisation during the annual contract review. It is recommended that a systematic approach to hygiene staff performance evaluation be carried out.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1   **(B ↓ C)**
An occupational health service is available to all staff
The occupational health service is provided to the organisation at a regional level. Regional policies in place include pre-employment health assessment, an occupational health manual and staff information booklets. The occupational health service provided includes a staff vaccination programme. It was established that the level of occupational health human resources within the region, did not facilitate the provision of dedicated protected time for the service at the hospital. It is recommended the evaluation of the appropriateness of the occupational service at the hospital be prioritised and occupation health needs, required for the provision of a comprehensive service, be established.

CM 12.2   **(C → C)**
Hygiene Services staff satisfaction, occupational health and well-being is monitored by the organisation on an ongoing basis.
Individual staff satisfaction evaluation forms are completed at regional level by the Occupational Health Department. Completed forms were reviewed during the assessment. One staff survey has been performed on the psychological aspects of work. It was determined that staff well-being be monitored locally. Changes, made as a result of monitoring, included the introduction of stepladders and kick stools. It is recommended that the organisation progress it Quality Improvement Plan (QIP) to perform a staff satisfaction survey in relation to the occupational health services provided.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.1   (C → 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.
Freedom of Information and the Data Protection Policy in areas such as infection data and incident reports was noted. Processes are in place for the collection of quantitative infection data and reliability, accuracy and validity is checked by the Surveillance Scientist. Evaluation of the systems used to record infection data has resulted in the upgrading of the current system to more facilitated, timely and accurate collection and dissemination. Processes are also in place for the collection of qualitative data such as patient/client satisfaction surveys. It is recommended that the organisation formalise the processes for the evaluation of data reliability accuracy and the validity of quantitative data collected.

CM 13.2   (C ↑ B)
Data and information are reported by the organisation in a way that is timely, accurate, easily interpreted and based on the needs of the Hygiene Services.
Hygiene data and information are reported through several methods. Examples include infection, EHO, Health & Safety and incident reports along with an Infection Control Newsletter. Evaluation of reports such as incident reports and the timely production of infection data has occurred and the organisation is endeavouring to change systems to ensure they are generated in a timely and more user-friendly manner. Evaluation of user satisfaction was evident in information provided (for example education presentations, signage, notices and Infection Control Newsletter). Data viewed during the assessment was presented in a very user-friendly manner. Infection data is utilised to improve practice in the prevention and control of organism spread in areas such as hygiene awareness and mandatory hand hygiene education. It is recommended that the organisation formalise the evaluation of user satisfaction in this area.

CM 13.3   (C → C)
The organisation evaluates the utilisation of data collection and information reporting by the Hygiene Services team.
Infection data is used to improve practice in the prevention and control of organism spread (for example increased hygiene awareness and mandatory hand hygiene education). Data systems such as the Infection Control Newsletter, posters and hygiene-related notices are used to provide information. The organisation is currently in the process of changing the data systems for the collection and analysis of infection and incident data to ensure more timely and friendly report generation. Data and information generated is presented on the hospital's intranet system and is used to improve practices in hygiene and hand hygiene.
It is recommended that the evaluation of data and information utilisation and outcomes be formalised.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE
SERVICES

CM 14.1   (C ↑ B)
**The Governing Body and/or its Executive Management Team foster and
support a quality improvement culture throughout the organisation in
relation to Hygiene Services**
The Governing Body and Executive Management Team foster and support a quality
initiative culture through their support for hygiene education. Hygiene awareness
campaigns, a mandatory hand hygiene policy, the upgrading of bathroom and hand
wash sinks, the provision of resources to the hygiene services, and initiation of new
building projects to address the structural issues within the current facility have all
been carried out. Executive Management are also members of the Estates
Committee, Environment & Facilities Committee and support hygiene initiatives at the
Executive Management Committee and hospital board. The organisation also invited
patient/client involvement in the evaluation of the hygiene services.

CM 14.2   (C ↑ 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.**
This is done through a review of Key Performance Indicators (KPI's). Examples
include hygiene audit scores, MRSA and Clostridium difficile rates. Evidence of
communication to staff and the HSE in relation to relevant hygiene findings was
abundant. Changes made in the organisation's hygiene service quality improvement
systems included introduction of recycling, increase in staffing levels to cover sick
leave, introduction of hand hygiene gels, introduction of KPI's as outlined above, and
increasing hand hygiene awareness culture. It is recommended that hygiene service
KPI's be further developed.

3.0 Standards for Service Delivery

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

EVIDENCE BASED BEST PRACTICE AND NEW INTERVENTIONS IN HYGIENE SERVICES

SD 1.1   (C ↑ B)
Best Practice guidelines are established, adopted, maintained and evaluated, by the team.
An active Policy and Procedure Committee is established to review and evaluate national and international best practice guidelines such as the Strategy for the control of Antimicrobial Resistance in Ireland (SARI) and the Management of Clinical Waste in the Delivery of Health and Social Care in the Community policies. The hospital has adopted and incorporated best practice guidelines into local policies and processes. A multi-disciplinary Policy and Procedures Committee was recently established. Its function was to evaluate local guidelines and ensure adherence to current best practice information. A schedule was in place for the review of new best practice guidelines, policies and procedures. It is recommended that a formal protected time procedure be developed for staff/supervisors for the reviewing of guidelines, policies and procedures. Evaluation of the efficiency processes should also be developed to ensure guidelines, details of resultant actions, feedback and continuous improvement plans are set up.

SD 1.2   (C → C)
There is a process for assessing new Hygiene Services interventions and changes to existing ones before their routine use in line with national policies
A documented process was not in place. The assessment of new interventions is completed through the attendance at procurement meetings, Environment and Facilities Standards Group, Point of Care Testing Group and participation in product trials. A Facilities Standard Advisory Committee has been established during renovation works, to assess suitability of equipment and building materials. Assessments of interventions were completed after the introduction of the lidded bins, dust mats, hand gel and endoscope washers.
Evaluation and efficacy of these and details of resultant actions, feedback and continuous improvement plans are recommended.

PREVENTION AND HEALTH PROMOTION

SD 2.1 (C → C)
The team in association with the organisation and other services providers participates in and supports health promotion activities that educate the community regarding hygiene.
Health promotion activities were evident through patient/client posters and leaflets. The hospital has a patient/client focus group where hygiene-related matters are discussed and links with the community were noted. This included a recent radio campaign regarding the introduction of the new visitors' procedure. The Health Promotion Committee was involved in this. Evidence was not provided of the involvement of other service providers. The evaluation and efficacy of health promotion activities, resultant actions and feedback is advised.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1 (C → C)
The Hygiene Service is provided by a multi- disciplinary team in cooperation with providers from other teams, programmes and organisations.
The Environment and Facilities Hygiene Services Committee is multi-disciplinary. A documented procedure was in place for its setting up, function and role. It would benefit from the establishment of linkages with other teams, programmes and organisations. It is advised that members be aware of each other's roles and responsibilities. The evaluation and the efficacy of the multi-disciplinary team structure has not been completed.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion
SD 4.1 (A ↓ B)
The team ensures the organisation's physical environment and facilities are clean.
The majority of physical environment and facilities were clean; however, further attention is required in non-clinical areas, high dusting, laundry and the Accident and Emergency department. The review and reorganisation of the sluice rooms is recommended, to allow access to hand washing sinks and waste bins. Lack of, and access to, waste bins contributes to poor segregation in some areas. It is noted that the hospital is currently evaluating the flat mopping system, which is encouraged. The ambulance sluice room, located adjacent to the Accident and Emergency department was in very poor condition. Hospital management undertook to raise these issues with the ambulance supervisor during the assessment.

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.
Strong evidence was provided that equipment, medical devices and cleaning devices were clean and well managed.

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.
Equipment appeared to be clean and well maintained.

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.
The catering department was managed and maintained in accordance with best practice and legislation. Further attention is required for temperature monitoring of ward kitchen fridges, sandwich production and the control of preparation in the Coffee Dock.

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.
Overall good systems were in place. A lack of, and access to, bins in a number of areas contributed to poor segregation. Unsecured sub-storage areas accessible to the general public were observed and brought to the attention of hospital management. A commitment was given that a review would take place to reduce the number of sub-storage areas, and arrangements be put in place to secure all these areas.

For further information see Appendix A

*Core Criterion
SD 4.6   (A → A)
The team ensures the Organisations linen supply and soft furnishings are managed and maintained
The hospital laundry has been in operation for a number of years and the current facilities require upgrading. This has also been identified as part of the hospital's Implementation plan for 2007.

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
With the exception of obstructions of hand sinks in sluice rooms, there was strong evidence of good hand washing practices and facilities. An on-going maintenance programme is in place to upgrade sinks and install splash backs.

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.
The hospital has a documented process in place for this. A Risk Manager has recently been appointed who, together with the Director of Nursing, evaluates and actions all adverse incidents. Documented evidence was available of completed incident reports and also the involvement of the Occupational Health Department as part of the STARS system. As part of the implementation plan for 2007, the hospital is currently formalising a Health and Safety structure and committee. This committee will enhance response rates and provide resultant actions, feedback and continuous quality improvement plans.

SD 4.9   (B → B)
Patients/Clients and families are encouraged to participate in improving Hygiene Services and providing a hygienic environment.
A documented process to inform patient/clients and families of their responsibilities regarding hygiene services is included as part of the Patient Information Booklet. Hygiene services information leaflets and posters are available for patient/client and families. Copies of the National Visitors Policy are posted at the entrance and in a number of wards. As part of the Patient/Client Focus Group meetings, the evaluation of patient/clients and family is completed, as are customer support evaluation forms. Resultant actions and improvements taken were evident. The hospital is encouraged to complete further evaluation and develop quality improvement plans to help improve patient/client and families participation.

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.
Confidentiality clauses are included in employment contracts and guidelines are provided on how staff should deal with patient/clients who have an infectious disease. The draft Patient Information Booklet will provide information on infection control and patient/client information leaflets and posters were on display throughout the hospital. A copy of the Patient/Client Charter is on display at the entrance to the hospital detailing the Code of Ethics. A complaints policy is also in place for patient/clients. They were reviewed and evaluated. The hospital has a framework in place to deal with family rights violations in relation to hygiene services, which is managed in line with the organisational policy. It is recommended that the hospital review their current procedures on dignity and isolation signage on rooms at ward level.

SD 5.2   **(C ↑ B)**
Patients/Clients, families, visitors and all users of the service are provided with relevant information regarding Hygiene Services.
A strong commitment to providing patient/client information was noted. A draft copy of the Patient/Client Information Booklet is to be introduced, which will provide information on generic hygiene services. The Hygiene Standards Group has a patient/client representative on their committee. There is a very proactive Friends of Letterkenny Hospital organisation, with representatives from the public who are involved in all aspects of hospital activities, including hygiene services and infection control. The hospital is very proactive in involving the media, who provide information regarding visiting times. Completed patient satisfaction surveys are in place and the hospital is in the process of developing staff satisfaction surveys. The Infection Control Team has had a consultation process with the MRSA family group in relation to the visiting policy and other infection control matters. A Patient/Client Liaison Officer has recently been appointed. A patient/client representative is involved in Standards and Advisory Group.

SD 5.3   **(C → C)**
Patient/Client complaints in relation to Hygiene Services are managed in line with organisational policy.
The hospital is aware that a more pro-active approach to complaints/comments from the public is necessary. A Quality Improvement Plan is in place to address these issues.

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1   **(C ↑ B)**
Patient/Clients, families and other external partners are involved by the Hygiene Services team when evaluating its service.
Feedback from patient/client surveys has prompted the introduction of the Patient Information Booklet, which is to be formally evaluated by the patient/client representative.

SD 6.2   **(C → C)**
The Hygiene Services team regularly monitors, evaluates and benchmarks the quality of its Hygiene Services and outcomes and uses this information to make improvements.
The hospital demonstrated that, through the findings of the audits, they were able to evaluate and benchmark hygiene services. The findings of the National Hygiene Audit and internal audits were detailed as part of the annual report. The hospital has implemented a number of hygiene initiatives such as sink upgrading, hand gels and the new central catering processing area, which were monitored and evaluated. Further evaluation of the extent to which quality initiatives are being undertaken is recommended. The hospital benchmarks their internal audits, MRSA and C-Diff rates. It is recommended that further benchmarking and Key Performance Indicators are generated.

SD 6.3   **(C ↑ B)**
The multi-disciplinary team, in consultation with patients/clients, families, staff and service users, produce an Annual Report.
The Environment and Facilities Team published an annual report in 2006, which provided evaluation of the hygiene services. Its findings were communicated to senior management, the Quality Circle and circulated to the rest of the hospital as

part of the Acute Hospital Cleaning Manual. As a result of a review of the annual report and the Acute Hospital Cleaning Manual, a needs analysis of Domestic Services was completed and a planned review was agreed for the Catering and Maintenance Departments.

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.
No - In the majority, the level of cleaning was satisfactory at ward level however; attention to detail is required in non clinical areas, laundry and the Accident and Emergency department.

(2) All high and low surfaces are free from dust, cobwebs and flaking paint.
No - Dust was noted, in particular along high surfaces. Low surfaces were satisfactory.

(3) Wall and floor tiles and paint should be in a good state of repair.
No - Evidence of chipped surfaces on doors, behind bins and in sluice rooms was observed.

(6) Free from offensive odours and adequately ventilated.
No - A number of sluice rooms and en-suites were inadequately ventilated.

(7) Areas should be adequately ventilated with ventilation units cleaned and serviced accordingly and documentation available regarding service.
No - Sluice rooms, en-suites and kitchen regeneration rooms were inadequately ventilated.

(10) Internal and external signage should be clean, updated, well maintained and laminated to enable cleaning.
No - A high number of signage was not laminated and evidence of Sellotape residue was noted.

(27) Local policies should be in place for guidance on all cleaning processes, colour coding, use of equipment, use of protective clothing and fluids and spillages.
No - Local policies regarding guidance on cleaning processes were available in the supporting documentation for the assessment, however, they were not available at staff level, and staff were unaware of their existence.

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

(23) Radiators and Heaters
No - Evidence of dust and cobwebs was noted on all radiators inspected.

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

(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 - The procedure for curtain cleaning was not available at ward level.

Compliance Heading: 4. 1 .5 Sanitary Accommodation

(44) Hand hygiene facilities are available including soap and paper towels.
No - Hand hygiene facilities were good at ward level; however accessibility was poor in all sluice rooms inspected.

(45) There is a facility for sanitary waste disposal.
No - Sanitary waste disposal bins were available in the public toilets but not in the public rooms. The management have subsequently supplied documentation to confirm that additional sanitary bins are to be provided.

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

(51) Baths and Showers
No - Some bathrooms not in use required further cleaning and were used for storage and changing facilities.

(55) Sluices
No - Inappropriate items were noted in sluices inspected. Areas were congested due to space constrictions, resulting in areas being difficult to clean and leaving hand basins and waste bins inaccessible.

(57) Clear method statements / policies should be in place for guidance on all cleaning including sanitary cleaning and maintenance processes.
No - Cleaning polices were inspected as part of the documents submitted for review, however, these polices were not available at ward level and staff were unaware of their existence.

(58) Sluice rooms should be free from clutter and hand washing facilities should be available.
No - Sluice rooms were very cluttered and hand wash facilities were not accessible.

(59) Where present shower curtains should be clean and in good repair with a process for laundering and replacement.
Yes - Shower curtains were clean, however, no documented policy was evident.

(60) All outlets (including shower outlets) should be flushed at a temperature in accordance with current legislation.
No - No evidence was provided that infrequently used showerheads were regularly flushed and cleaning checklists were not completed in relation to flushing.

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

(70) Bedpans, urinals, potties are decontaminated between each patient.
Yes - However it is advised that urinals and measuring jugs should not be stored in bathrooms.

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

(77) Loose items such as patient's clothing should be stored in the patient's locker or property bag.
Yes - Patient/client's clothing was noted in sluice room and the Accident and Emergency department clean linen locker.

(272) Splashes of water or hand-wash gel should not be present on the wall, floor, bed or furniture, splash backs should be provided.
No - Splash backs were only available in a small number of areas. The ongoing maintenance programme includes the installation of splash backs.

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

(88) All cleaning equipment should be left clean, dry and tidy in the storage area after use.
Yes - The cleaning equipment was stored off the floor but the installation of storage hooks is recommended to aid cleaning and storage.

(90) Storage facilities for Cleaning Equipment should be provided in each work area with adequate ventilation, a hot and cold water supply and hand-wash facilities.
No - Hand wash facilities were not provided in a number of cleaning rooms inspected. The ambulance/ Accident and Emergency department cleaning room was in need of additional cleaning.

(91) Storage facilities for Cleaning Equipment should be clean and well maintained.
No - Storage facilities were disorganised and untidy. These rooms require reorganisation.

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

(213) Environmental Health Officer (Senior EHO/EHO) reports on food safety inspections including the completed summary stage of compliance with HACCP and annual water analysis reports should be retained on the Hospital Food Safety Manual. Action plans/ actions taken on foot of issues raised in the reports should be documented.
Yes - Copies of environmental health reports were available and evidence of corrective action taken was noted. Water analysis is completed on behalf of the HSE, however, it is advised that water samples are taken from ice machines and food sinks in the catering departments.

(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 - The hospital has developed and implemented a permanent HACCP system. Critical Control Points are identified and monitored.

(215) There should be a documented ward kitchen food safety policy which should be signed off by the person in charge of the ward kitchen and the hospital manager.
Yes - A documented Food Safety Policy is in place. Copies of the Food Safety Policy were on display in the main and ward kitchens.

(216) Documented processes for manual washing-up should be in place
No - A documented process for manual washing was not in place. Staff are instructed on the correct procedure for manual washing up as part of the Primary Course of Food Hygiene.

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 - Access to the main kitchen was not restricted, with only signage in place. Two staff members were observed walking through the main kitchen without protective clothing. Visitors were asked to complete a signing in form. A copy of the visitor's policy was not on display at the entrances.

(218) Authorised visitors to the food areas should wear personal protective clothing (PPE) and wash hands on entering the food area during food preparation/serving times.
Yes - Protective clothing was available for visitors. Hand sinks were available at the staff and delivery entrance. A hand sink off the main corridor entrance is recommended. Staff were observed not wearing adequate hair covering. Staff must ensure all hair is fully enclosed in a hat and or hairnet.

(219) Ward kitchens are not designated as staff facilities
No - Access to ward kitchens were restricted to patient/clients and ward staff. Patient/clients' tea/coffee were made in the staff room during the evening. Staff facilities must not be used for patient/client food and drink.

(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 - Bottles of drinking water were noted in the main kitchen and coffee dock area. Evidence of staff food was noted in the ward kitchen fridges.

(221) Staff clothing/uniforms/shoes personal belongings should not be stored in food rooms.
Yes - Designated staff areas were identified for staff uniforms, shoes, clothing etc.

(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 - Wash hand basins were in place. The hand sink in the coffee dock was fitted with domestic taps and their replacement is recommended.

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

(224) The ventilation provided for all cooking and steam emitting equipment shall be sufficient to prevent condensation on walls, ceilings and overhead structures during normal operations.
Yes – In the majority, however, ventilation was adequate in the main kitchen, coffee dock and most ward kitchens. No ventilation was provided in the cooker room in Medical 1. The catering staff were aware of the issue and it had been raised by Environmental Health Officer.

(225) Staff in charge of Ward Kitchens shall ensure that product traceability is maintained while the product is in storage (Regulation (EC) 178/2002). Stock shall be rotated on a first in / first out basis taking into account the best before / use by dates as appropriate. Staff food should be stored separately and identifiable.
Yes - A comprehensive traceability system was in place.

(226) Containers used to store foods shall be made of food grade materials, be in good condition, easy to clean and disinfect.
Yes - Suitable food storage containers were in place. The organisation is recommended to ensure that during storage, food containers are inverted.

(227) Flour, cereals, sugar etc shall be stored in a dry environment and when opened stored in covered containers.
Yes - Covered containers were in place for dry ingredients. Food scoops must not be stored inside the container.

(228) Unopened canned foods shall be stored above and segregated to prevent cross contamination.
Yes - Satisfactory compliance was noted.

Compliance Heading: 4. 4 .3 Waste Management

(229) Animal and pest control measures shall be in place in all waste handling and storage areas.
Yes - Evidence of pest control was noted at waste handling and storage areas.

(231) All waste shall be removed from the operational areas frequently as necessary but at least daily.
Yes - Waste was adequately removed.

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

(233) In food preparation areas where lidded bins are provided they shall be foot pedal operated.
Yes - Foot operated lidded bins were in operation.

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

Compliance Heading: 4. 4 .4 Pest Control

(237) A location map should be available showing the location of each bait point.
Yes - A bait location map was available in the hospital pest folder.

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 cook chill system was in operation. Documented evidence was provided for each stage of the process.

(241) Ice cream display units can operate at -12°C as long as it can be demonstrated that the product has been held at this temperature for less than 7 days.
Yes - The hospital does not have an ice cream display counter.

(242) Temperatures for Food in Fridges / Freezers and Displays should comply with I.S.340:2006 requirements
No - Ready-to-eat sandwiches temperature checked at ward level were unacceptable. The catering manager took immediate action and the sandwiches were disposed off. The Catering Department has also introduced a blast chilling stage after make up to ensure the product temperature is below five degrees before transportation. The temperature monitoring of ward fridges were temperature checked by a dial reading. A variance between the dial reading and product temperature were noted during the assessment. Upon discussion, the Catering Department reviewed their monitoring procedure to include the use of calibrated probes.

(243) Preparation of High Risk Foods should comply with I.S. 340:2006 requirements
Yes - In the majority, the preparation of high-risk foods complied with I.S. 340. Due to space constrictions in the coffee dock, preparation of high-risk foods was difficult to control during busy periods. A review of the current coffee dock menu is advised, to reduce the amount of preparation.

(244) Temperature for food when cooked, held or reheated should comply with I.S. 340:2006 requirements
Yes - It was noted during the inspection that a chef did not record a temperature check after cooking. The chef was informed at the time and immediate action was taken. The temperature of all inspected foods was satisfactory. Completed temperature records were verified and were satisfactory.

Compliance Heading: 4. 4 .6 Food Preparation

(245) Cleaned and disinfected work surfaces, equipment and utensils shall be provided for preparing ready to eat foods and foods to be cooked to prevent the risk of contamination. In addition to the HSE hospital colour coded system (see Appendix 6 Irish Acute Hospitals Cleaning Manual 2006), the food colour coding of work surfaces, equipment and utensils should be provided for (see I.S. 340:2006).
Yes - Adequate cleaning procedures and facilities were in place. A colour-coded system was operational. Cleaning cloths were laundered but evidence of fraying was noted. It is suggested that a more suitable cleaning cloth is used.

Compliance Heading: 4. 4 .7 Food Processing

(246) The thawing of food shall be carried out under appropriate conditions such as in a thawing unit, a fridge or a microwave oven with thawing cycle
Yes - Frozen foods were thawed under refrigerated conditions. Fillet steak defrosted on Friday was noted in the red meat cold room (assessment was completed on Monday). The organisation is recommended to ensure foods once defrosted are used within 24 hours. It is suggested that a thawing sheet is introduced.

Compliance Heading: 4. 4 .8 Food Cooking

(247) All foods shall be cooked to a temperature to ensure that the products are safe for consumption. The core temperature of the food shall be assessed at he thickest point of the food and should be compliant with I.S. 340:2006
Yes - Cooking checks and records were in place.

Compliance Heading: 4. 4 .9 Food Cooling

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

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 - Ice making facilities were satisfactory. Ice scoops were stored in a clean container.

(250) The dishwasher's minimum temperature for the disinfecting cycle should be compliant with I.S.340:2006 requirements and should be monitored regularly. There should be digital readouts on dishwashers.
No - Dishwasher temperature checks are not verified by a calibrated probe. A number of dishwashers did not have a dial read out. A method for temperature checking the dishwasher is required.

(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 - Twice yearly external calibration checks are in place. Calibration certificates were verified and were satisfactory.

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

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

Compliance Heading: 4. 5 .3 Segregation

(156) Healthcare risk waste must be segregated from healthcare non risk waste.
No - Obstructed access to bins in sluice areas resulted in non healthcare risk waste being placed in yellow risk waste bins. The General Manager said sluices would be re-organised through the installation of shelving, to allow access to waste bins. A commitment to provide further education in relation to segregation was also given.

(256) Mattress bags are available and are used for contaminated mattresses ready for disposal; mattresses are disinfected.
No - Mattress bags were not available.

Compliance Heading: 4. 5 .5 Storage

(257) Adequate segregation facilities for the safe storage of healthcare risk waste are locked and inaccessible to the public. Appropriate warning signs restricting public access should be prominently displayed.
No - A number of areas used for the holding of risk waste were open to the public. It was confirmed that a review would take place to reduce the number of sub-storage areas and put in place arrangements to secure them. Even though the waste areas were open to the public, all bins were locked during audit and review audit on second day.

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

(172) Documented processes for the management, maintenance and safe handling of linen and soft furnishings throughout the organisation.
Yes - A documented process for the management, maintenance and safe handling of linen was available, however, this requires updating to include all areas of the organisation. Copies should be made available at all relevant areas.

(173) Documented processes for the use of in-house and local laundry facilities.
Yes - Documented instructions were available at the in-house laundry; however it is advised that more detail is provided for training purposes.

(261) Clean linen store is clean, free from dust and free from inappropriate items.
No - A number of linen stores contained inappropriate items such as patient/client's private property, equipment and supplies.

(264) Bags must not be stored in corridors prior to disposal.
Yes - However, linen bags were obstructing bins and hand sinks in some sluice rooms.

(267) Documented process for the transportation of linen.
No - A documented procedure for the transportation of linen is recommended.

(268) Ward based washing machines are used only with the agreement of the Hygiene Services Committee.
Yes - This is not applicable in this organisation.

(271) Hand washing facilities should be available in the laundry room.
Yes - Hand sinks were available. It is recommended that mixer taps are replaced.

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

(188) Hand and wrist jewellery should be removed prior to performing all levels of hand hygiene with the exception of a plain wedding band.
Yes - A small number of multi-disciplinary clinical/catering staff were observed wearing watches.

(190) All sinks should be fitted with washable splash backs with all joints completely sealed.
No - An ongoing maintenance programme was in place to upgrade and install splash backs.

(198) Hand hygiene posters and information leaflets should be available and displayed throughout the organization.
Yes - Hand hygiene posters were available but some observed were not laminated and Sellotape residue was noted.

(206) Documented records of mandatory attendance at hand hygiene education and practice is required for all staff members involved in clinical areas. This may be undertaken during hospital induction programme followed by annual updates.
Yes - Evidence of extensive on going hand hygiene training was noted. This now must become mandatory at induction and annual updates.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team		Assessor Team	
	FREQ	%	FREQ	%
A	9	16.07	8	14.29
B	19	33.93	25	44.64
C	27	48.21	23	41.07
D	0	00.00	0	00.00
E	0	00.00	0	00.00
N/A	1	01.79	0	00.00

5.2 Ratings Details

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

CM 12.1	B	C	↓
CM 12.2	C	C	→
CM 13.1	C	C	→
CM 13.2	C	B	↑
CM 13.3	C	C	→
CM 14.1	C	B	↑
CM 14.2	C	B	↑
SD 1.1	C	B	↑
SD 1.2	C	C	→
SD 2.1	C	C	→
SD 3.1	C	C	→
SD 4.1	A	B	↓
SD 4.2	A	A	→
SD 4.3	A	A	→
SD 4.4	A	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	C	B	↑
SD 5.3	C	C	→
SD 6.1	C	B	↑
SD 6.2	C	C	→
SD 6.3	C	B	↑