



Hygiene Services Assessment Scheme

Assessment Report October 2007

Louth County Hospital, Dundalk

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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

Louth County Hospital has a complement of 142 beds (including a 20-bedded Day Services Unit) and serves a catchment area with a population of over 90,000. The hospital opened in 1959 and is one of two hospitals in the Louth Hospital Group.

Services provided

- Surgery and Medicine (including Coronary Care Unit) on both an in-patient / day case and out-patient basis.
- An extensive Day Services Unit provides Gynaecology, Urology and Respiratory Medicine. It also incorporates a Diabetic Day Centre, Cardiovascular Rehabilitation Unit, Cardiac Services and Dietician Services.

Physical structures

Included in the total bed numbers are two (2) Isolation Rooms. There are no negative pressure rooms in the organisation.

The following assessment of Louth County Hospital, Dundalk took place on 11th and 12th June 2007.

1.3 Notable Practice

- A stable and committed workforce dedicated to Hygiene Services was observed.
- Quality improvements have been noted since the 2005 and 2006 National Hygiene audits which include improvement in the specific area of bins and colour coding.
- New operating theatres have just been completed.
- The overall standard of cleanliness in the hospital was very good.
- There is an obvious commitment in the Hygiene Services Team to further develop the quality improvement culture, specifically regarding Hygiene Services.

1.4 Priority Quality Improvement Plan

- The Hygiene Management Committee would benefit from both general management support and a representative from the Medical Profession.
- Limited storage space was noted for patient clothing.
- Inadequate and inaccessible hand wash basins/splash backs were observed throughout the organisation.
- Physical environment restrictions were noted in the decontamination facilities.
- Upgrading of the physical environment is required including the kitchen and laundry.
- Risk management processes need to be embedded in the Hygiene Services processes.
- It is recommended that a process to evaluate outcomes for hygiene interventions is put in place.

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 Louth County Hospital, Dundalk has achieved an overall score of:

Fair

Award Date: October 2007

1.6 Significant Risks

CM 3.1 (Rating D)
The organisation has a clear corporate strategic planning process for Hygiene Services that contributes to improving the outcomes of the organisation.

Potential Adverse Event

Goals and objectives for Hygiene services will not be defined

Risks

Likelihood of Event	Rated: M (2)
Impact of Event	Rated: M (2)
Urgency of Action	Rated: M (2)
TOTAL	Total: 6

Recommendations

It is recommended that the organisation develop a Hygiene Corporate Plan for the Hospital.

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.

Louth Hospital, as part of the North East Health Service Region, does not have hospital specific corporate strategic plans. To date, no specific hygiene strategic plan has been developed. The latest service plan available for Louth Hospital is 2006. The needs assessment for 2007 was gathered through an estimates process with associated business cases. It is expected that needs assessment for 2008 and subsequent years will be gathered using new structures in accordance with the Teamwork Proposal for the Health Services Executive-North East. In addition, no hygiene operational plan was available. The recently established Hospital Hygiene Committee is tasked with responsibility for the development of a Corporate Hygiene Strategic Plan. The development of this plan is strongly recommended. HACCP, SARI and National Cleaning Guidelines were available. As yet, there is no evaluation of the needs assessment process and Continuous Quality Improvement records in this area. It is recommended that this is implemented in the future.

CM 1.2 (B ↓ C)

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.

Currents needs analysis is based on the outcome of the National Hygiene Audits in 2005 and 2006. Infection control and HACCP audits have also been completed. A number of developments have taken place in the organisation over the past two years. These include education and training in Health and Safety and HACCP, upgrades in relation to the environment and equipment have also taken place such as ward kitchens, hand wash facilities in clinical areas and repainting internally and externally. Other developments have occurred in the areas of waste management and water storage improvements and segregation of duties of household staff using a partnership approach. Two new modular theatres are currently being commissioned to replace one existing theatre and one minor procedures theatre. There is a very active Infection Prevention and Control Department providing training to all disciplines in hand hygiene, sharps and linen management. The hospital also organised an Infection Control Awareness Week in 2006. As yet, evaluation and continuous quality improvement are at a very elementary stage.

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.

Linkages with the Department of Health and Children and the Health Services Executive (North East) are through the Regional Management Team chaired by the Network Manager, which are then devolved to the hospital through the hospitals Executive Management structure. Representatives from both Nursing and General Management have attended national meetings and conferences aimed at raising awareness of hygiene related issues for example the Irish Patient Association Hygiene Summit (January 2006) and the Irish College of Physicians in Ireland public meeting on MRSA (January 2007). Louth Hospital is a small organisation and the Partnership process and informal systems are in place for the involvement of all relevant staff, especially in new developments such as the new modular operating theatres. The Hospital has no regular contract staff employed, however, it uses some contract services for equipment maintenance, pest control and water management, which are based on service specification and contract agreement. The hospital shop/cafeteria service is a contracted service. At present, patient input is through a patient comments system; however, a patient/staff satisfaction survey is scheduled and imminent. Comment cards were analysed in the previous years and the outcomes disseminated. The patients interviewed during the assessment were very positive in their comments regarding the hospital hygiene services. A partnership approach is used to decide staff responsibilities. To date, there is no medical representative on the Hospital Hygiene Committee. It is recommended that is addressed to ensure full multidisciplinary involvement and compliance with all relevant best practice aspects of hospital hygiene.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 (C ↓ D)

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

There are no documented processes for the development of the Corporate Hygiene Strategic Plan to date. A lack of clarity regarding the General Manager and Executive Management Team members' responsibility for developing the Hygiene Corporate Strategic Plan was noted during the assessment. To date, there is no multidisciplinary team involvement in this process. Once developed there is a requirement for the communication, evaluation and continuous quality improvement in relation to the Hygiene Corporate Plan. It is recommended that this is addressed in the near future.

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 authority for hygiene services provision rests with the Executive Management Board through the group General Manager and Director of Nursing. There are no details of corporate policies and procedures, or code of ethics pertaining to hygiene services observed during the assessment. To date, there is no evaluation of adherence to legislation and national guidelines and consequently no relevant continuous quality improvement plans. The recently appointed Hospital Hygiene Services Committee has demonstrated progress at local level in the area of Hygiene Services Standards and Provision. The committee expressed awareness of the need to progress to evaluation and continuous quality improvement.

CM 4.2 (B ↓ C)

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

There are no documented processes in place for receiving and acting on information on the performance of the Hygiene Services Team. However, there was considerable evidence that such information is available and communicated through meetings, line managers etc. The organisation is encouraged to formalise such processes. There is as yet no identified Hygiene Service Key Performance Indicators and consequently no monitoring, evaluation or continuous quality improvement plans in place. It is recommended that this area is addressed in the near future.

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 to current research and best practice information is available through a variety of sources for example intranet and library access and membership of a variety of regional and national groups including Infection Control, CSSD and Theatre Committees. The hospital Practice Development Committee, which is currently exclusive to the nursing discipline, engages in development of evidence based policies, procedures and guidelines. Consideration should be given to expanding this to a hospital wide multidisciplinary group. Initiatives related to hygiene services, which are based on research and best practice information, include HACCP, Cook /Chill, Hand Hygiene and Infection Control. A number of improvements in the environment/ facilities and cleaning processes have been implemented as a result of the National Hygiene Audits 2005/2006. The organisation has planned to make all research and best practice information regarding Hygiene Services available in a designated area in the library to encourage ease of access and usage. Evaluation is presently limited to Infection Prevention and Control audits. The planned increase in staff complement for this service from 0.5 to 1 whole time equivalent is expected to enhance the opportunity to implement evaluation. Improvements have been noted in the standard of hand hygiene and specific staff groups have been targeted for further training as a result of these audits.

CM 4.4 (B ↓ C)

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

The Nursing Practice Development Committee has undertaken to develop documented processes for the development, approval, revision and control of all clinical policies, procedures and guidelines for the hospital. It is recommended that these processes will also guide the development of policies, procedures and guidelines for Hygiene Services in future. Written organisational policies, procedures and guidelines for Hygiene Services are at an early stage of development. However, evidence was observed of induction/on-going training and good practice in relation to the delivery of Hygiene Services. Processes for evaluation and quality improvements are not in place. It is recommended that this is introduced in the near future and the organisation is encouraged to focus on this area.

CM 4.5 (B → B)

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

Evidence was noted of consultation with Hygiene Services during the development of the new theatre complex. Capital development needs are identified and communicated through the General Manager to the Executive Management Board for approval. There is, to date, no process to evaluate the efficacy of the communication process between the hospital and the Executive Management Board and, consequently, no quality improvement planning.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

*Core Criterion

CM 5.1 (B → B)

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

A Hygiene Services Structure is in place. Overall responsibility/accountability for Hygiene Services rests with the Executive Management Board. It is recommended that current job descriptions are reviewed to ensure explicit responsibility/accountability of all staff regarding hygiene issues is included.

*Core Criterion

CM 5.2 (A ↓ B)

The organisation has a multi-disciplinary Hygiene Services Committee.

A Hygiene Services Multidisciplinary Committee has been established in recent months with agreed terms of reference with minutes of meetings available. The Committee however does not have Medical representation and this should be addressed. The roles of the various staff members need to be communicated to all staff within the organisation. Terms of reference have been developed and the Committee has secretarial support.

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.

Resources are assigned to each Hospital by the Network Manager. The hygiene committee then decide on the use of the resources within the hospital priorities. Formal processes for allocation of resources appear to be somewhat unclear. However, some financial resources were allocated in 2006 (€140,000) and again in 2007 (€30,000) for minor capital developments. Improvements to date include painting and the installations of wash hand basin/splash backs in priority areas. In addition, a new theatre complex comprising two fully resourced operation theatre suites are currently being commissioned. However there is no current Corporate Hygiene Services Strategic Plan or Hygiene Services Plan in place. The Hygiene Services Committee plans to develop an Annual Report by January 2008. It is recommended that they also develop a Service Plan.

CM 6.2 (C → C)

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

The terms of reference for the Hygiene Services Committee include the involvement of the Committee in the purchase of equipment and products. Previously, end users were not involved in the process of purchasing new equipment and products. Recently appropriate relevant line managers together with the Infection Prevention and Control department have become involved in pre-purchasing and evaluation of all new equipment. While this process is at an early stage of development, it is welcomed by line managers and is identified as a positive development driven by the Hygiene Services Assessment Scheme. Some concerns were expressed relating to the efficacy of the consultation process between the Hygiene Services Committee and Senior Management. However, the Hospital Group General Manager is a member of the Hygiene Services Committee, which was identified as a possible solution to this concern.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

CM 7.1 (A ↓ C)

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

The STARS risk management system is currently being introduced and training has just been completed for the analysis phase. No major adverse events relating to Hygiene Services have occurred within the last two years. Risk Management annual reports have been completed since 2004. A review of the Risk Assessment report was conducted recently by an Occupational Health Consultant to ensure appropriate controls were in place. The Development of Health and Safety Statements is in progress and, consequently, no annual report has been generated to date. Environmental health reports were available, however, little evidence of progress with regard to recommendations was observed. A decontamination review has recently been completed and has identified significant shortcomings in the CSSD, specifically in relation to the physical design which inhibits the appropriate processing of reusable products. These opportunities for improvement need to be addressed as a

matter of priority. Hygiene services audits are currently limited to Infection Prevention and Control and the completion a single HACCP audit to date. It is recommended that the evaluation process is developed within the organisation.

CM 7.2 (A ↓ C)

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

Hygiene Services, to date, are not represented on the Risk Management Committee. It is recommended that this is reviewed.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion

CM 8.1 (B → B)

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

The National Procurement Policy is adhered to, regarding contract processes. This includes specification for all relevant aspects, for example duration, liabilities, specifications and frequencies. The Hospital employs all in-house regular hygiene services staff. Some services are provided by external contractors. Some of these contracts are negotiated at Hospital Group Level including sterile technologies, hygiene, water systems and pest control, while others are negotiated at hospital level for example sanitary bins, window cleaning and grounds maintenance.

CM 8.2 (C → C)

The organisation involves contracted services in its quality improvement activities.

The contractors' involvement with the hospital relates only to the terms of their contract. It is recommended that the organisation consider developing its linkage/partnership with the lessee of the shop/cafeteria service, and others, to ensure hygiene best practice in Hygiene Services is maintained throughout the hospital.

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.

The design and layout of the organisations physical environment was varied in relation to safety and meeting best practice regulations. Some ward areas had been refurbished recently and had very good patient-focused design for example en-suite rooms. Some single rooms used for isolation were not en-suite; however, staff are to be commended on their optimisation of these facilities in the interests of hygiene. Storage facilities were limited in some areas, with staff making optimal use of the available resources. The existing operating theatres do not meet best practice standards; however two new theatres which are based on best practice are currently being commissioned. Extensive kitchen refurbishment is also required especially ventilation and the need for separate toilets for catering staff.

*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.

While limited documented processes were observed for the planning and managing of facilities including equipment, devices, kitchens, waste, sharps and linen, actual practices observed and communications with staff attested to staff knowledge and application. HACCP, SARI Guidelines, National Procurement Guidelines, and Guidelines for Management of Chemical Waste (2004), were all available. An initiative for bed cleaning is currently being considered to address and resolve the issue of bed hygiene. Implementation will be dependant on funding available.

CM 9.3 (B ↓ C)

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.

Evidence of good overall compliance was observed. However, to date, limited internal audit processes or satisfaction surveys are in place. A number of improvements were introduced in the past two years including upgrading of waste bins, additional hand wash basins, the introduction of stainless steel units in ward utility rooms and storage systems, colour coding for linen and cleaning and a new dishwasher in the patient wash up area. There are further developments outlined in the organisations quality improvement plan, which include further wash hand basin installation and upgrading of the linen room shelving. This will be dependant on funding available. The organisation is encouraged to ensure that, as with any continuous quality improvement process, loop closure occurs.

CM 9.4 (C → C)

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

Evaluation to date is based on informal patient/client and visitor feedback and analysis of patient comment cards, the results of which are generally very positive. No formal complaints relating to hygiene services were identified. A quality improvement plan to undertake the first patient satisfaction survey has been outlined and is due to commence in the near future and this should be expanded to include staff satisfaction surveys.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 (B → B)

The organisation has a comprehensive process for selecting and recruiting human resources for Hygiene Services in accordance with best practice, current legislation and governmental guidelines.

There are documented policies and processes in place, through the human resource department, for the recruitment of all staff. These policies and processes are reflective of current legislation and best practice. Job descriptions are available for all staff disciplines and grades. There are no contract hygiene staff employed at the Hospital. Human resources recruitment records for all staff are held centrally by the Health Services Executive (North East) and evaluation and continuous quality improvement planning is more appropriate at that central level, However Human

Resources in Louth County Hospital need to ensure that its needs are adequately met.

CM 10.2 (C → 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.

To date, with the exception of professional judgement, no formal process is in place for the review of changes in hygiene services work capacity and volume. It is expected that the new “estimates process” may address this issue. Some guidance is provided by documents including SARI guidelines. There is no evaluation of work capacity and volume in place and continuous quality improvement is based on professional judgement. It is recommended that this is reviewed formally by the organisation.

CM 10.3 (B → B)

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

Job descriptions for all staff are available and, where relevant, identify the necessary qualifications and training. Professional staff grades are registered with their professional bodies and health care assistants undertake a FETAC approved training programme. Some Household Staff are currently undertaking the SKILLS Programme. The HSE Corporate Induction Programme is available to all staff. Local induction and in-service training is provided for staff who do not require formal qualification.

CM 10.4 (C → C)

There is evidence that the contractors manage contract staff effectively.

No direct contract staff are employed for hygiene services. Contracts are available for related services, which are subject to the contract process for service provision and evaluation through the National Procurement process.

*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.

There is no formal staffing requirements assessment process; however, staffing levels appear to be adequate to meet current needs. Recent segregation of responsibilities between catering, household and health care assistant staff has been a welcome development and has accommodated a comprehensive approach to the overall services provided. To date there is no Corporate Strategic Plan, Hygiene Services Plan, Operational Plan or Hygiene Services Annual report in place. It is recommended that the organisation addresses these issues.

ENHANCING STAFF PERFORMANCE

*Core Criterion

CM 11.1 (B → B)

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

There is a standard induction programme for all staff, including hygiene staff, which includes relevant hygiene training. On-going education and training, specifically regarding hygiene, is provided by the Infection Prevention and Control department and is structured to facilitate attendance by staff. A staff handbook is available and would benefit from greater emphasis on each staff members responsibility and accountability for compliance with best practice in the area of hygiene. Attendance at induction/orientation is currently recorded manually and the hospital plans to introduce an electronic recording system.

CM 11.2 (B → B)

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

To date, no documented processes are in place to ensure the continuing professional development of staff. However, ongoing training and development is provided, based on the advice of the Infection Control and Prevention line manager. Education and training is provided for line managers and relevant clinical staff in the areas of health and safety hazards, conducting risk assessments and the handling of client/patients complaints.

Infection control training is also provided for all staff. Education relating to safe cleaning and maintenance of new equipment, including medical devices and cleaning devices is provided for the relevant users. No documented processes are in place to ensure that staff have protected time to attend on-going education and training. Staff training records are maintained by line managers with records kept in the infection control manual. Evaluation of the education of staff and continuous quality improvement planning requires development.

CM 11.3 (B ↓ C)

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

Attendance levels are recorded and all staff are obliged to attend relevant hygiene education/training. No Key Performance Indicators have been identified for the evaluation of hygiene education and training. Staff satisfaction rates with training are not evaluated. It is recommended that this area is addressed in the future.

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.

To date, no documented processes are in place for the evaluation of Hygiene Staff performance and development. It is recommended that the organisation introduces a system of evaluation of staff performance to ensure staff are equipped to deliver best practice standards.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (A ↓ B)

An occupational health service is available to all staff

There is an occupational health service available, which offers the full range of occupational health services to staff. The service was evaluated by staff at Health Service Executive North East Regional level in 2004, which has resulted in the introduction of service improvements.

CM 12.2 (B ↓ C)

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

No Key Performance Indicators are currently being monitored and consequently, no resultant changes have been implemented. The organisation is encouraged to develop appropriate processes in this regard.

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.

No documented processes are currently in place for collecting and providing access to data and information specific to hygiene services. The organisation needs to develop robust data collection and analysis systems to meet needs of hygiene services. Systems are in place for the provision of same through line managers, meetings, education sessions, intranet/library access, and regional/national group or committee involvement. A plan to provide hygiene related information in a specific area of the library, to facilitate ease of access, has been developed. All relevant legislation and best practice guidelines are available in the organisation. There is no evaluation system in place and no resultant continuous quality improvement planning.

CM 13.2 (C → 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.

To date, only internal reports have been generated by Hygiene Services, which include attendance records, leave, rosters and training. There is a need to evaluate data in terms of usability, user satisfaction etc.

CM 13.3 (C → C)

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

There is limited data collection in relation to Hygiene Services to date. It is recommended that the Hygiene Services Committee identify relevant data which the Hygiene Services should collect and evaluate. This information could be used in the development of the Hygiene Services Annual Report.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

CM 14.1 (B → B)

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

A considerable number of hygiene services quality improvements have been introduced over the past two years. These include: the introduction of colour coding for linen and cleaning services, the introduction of the Infection Prevention and Control Link Nurse Programme, the adoption of SARI Guidelines and compulsory hand hygiene education, on-going hand hygiene audits, the promotion of hand hygiene gels, the introduction of isolation signage, the adoption of an MRSA outbreak plan, the decontamination of patient equipment, the refurbishment of the intensive care unit and coronary care unit and the development of the new operating theatre complex.

CM 14.2 (C → 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 Hospital has introduced new structures for the corporate management of its Hygiene Services in accordance with the Hygiene Services Assessment Scheme recommendations. These new structures are credited with improved team working and appreciation of roles and responsibilities across the multidisciplinary team. There have been significant improvements in Hygiene Services delivery based on the national Hygiene Audits in 2005 and 2006. It is recommended that the Hygiene Services Committee focus on the development of documented processes for all aspects of the service and, consequently, evaluation processes and continuous quality improvement plans. Evidence of good initial development was observed and it is recommended that staff continue to work together to progress this work.

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.

No documented process for the adoption, evaluation and maintenance of best practice guidelines were observed. There were, however, best practice guidelines relating to infection control. This needs to be extended to all disciplines in the hospital. It is also recommended that a process for the dissemination of best practice information is put in place. It is also recommended that evaluation of the effectiveness of the process is carried out.

SD 1.2 (B ↓ C)

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

No evidence of formal documented processes for new hygiene interventions was observed. Work practices include a combination of working sub groups and the use of the procurement policy for new hygiene interventions. Guidelines were drafted to implement the new colour coding system, which are being observed and adhered to. Details of new hygiene interventions include detergent wipes, disinfectant wipes and alcohol wipes. No evaluation reports were presented on the efficacy of these new interventions despite there being an evaluation process in place.

PREVENTION AND HEALTH PROMOTION

SD 2.1 (B → B)

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

A health promotion officer is employed in the organisation. Hand hygiene awareness days were held in March 2007 and external talks were also given to colleges and hotels. There is a patient information leaflet available on guidelines for visiting the organisation during infection outbreaks, including community notices through both local papers and radio. No evidence was provided on links between the team and community groups and no evidence was observed of service provider's involvement in health promotion in the community. Further development of links with community providers to encourage health promotion is recommended. Evaluation needs to be inherent in all 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.

A hygiene services multidisciplinary committee and team are in place however, the composition and function of the hygiene services team requires review. Links need to be strengthened between hygiene services and other teams. It is recommended that a review of the action planning process is carried out to ensure resultant actions are progressed in a timely manner. It is also recommended that the efficacy of the team structure is evaluated.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

SD 4.1 (A → A)

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

All areas observed, with the exception of the Accident and Emergency department, were of a very high standard. Some areas require some attention.

For further information see Appendix A

*Core Criterion

SD 4.2 (B → B)

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

Patient equipment observed during the assessment was very clean. A new green tagging system is in operation and appeared to be very effective. A review is required for the use of fans. Also, adequate provision of additional storage for equipment and patient's property is required.

For further information see Appendix A

*Core Criterion

SD 4.3 (A → A)

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

Cleaning equipment observed was clean and well managed and cleaner's rooms observed were well maintained. Specific detail is contained in the mandatory checklist.

For further information see Appendix A

*Core Criterion

SD 4.4 (A ↓ B)

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

There is a HACCP system in place, which should be reviewed annually. As outlined in the Environmental Health Officers' reports, the main kitchen area is in need of

structural upgrade. Separate toilets are required for the catering staff at ward level and additional focus is required on HACCP audits.

For further information see Appendix A

*Core Criterion

SD 4.5 (A ↓ B)

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

Overall controls were observed to be in place and the system for collection was excellent. However, some clinical bins observed in the compound were left open.

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 process for the collection and storage of linen was excellent, however, laundry is in need of upgrade and some basic controls are required. Additional detail is contained in the mandatory checklist.

For further information see Appendix A

*Core Criterion

SD 4.7 (B → B)

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

As outlined in the mandatory checklist, additional hand-wash sinks are required and access to some hand washing units was restricted. Good evidence of hand wash practices was observed during the assessment. Additional detail is contained in the mandatory checklist.

For further information see Appendix A

SD 4.8 (B ↓ C)

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

Risk assessment training was in progress at the time of the assessment. Incident reporting is via the STARS system, which is supplemented by an excel database (which provides summary reports). While incidents are followed up, no summary reports are available. A draft Health and Safety Statement is in place. It is recommended that an implementation plan for the Health and Safety Statement is devised, which should include individual risk assessments. It is also recommended that risk assessments be extended to service providers. Finally a review of the HACCP manual is also required.

SD 4.9 (B ↓ C)**Patients/Clients and families are encouraged to participate in improving Hygiene Services and providing a hygienic environment.**

Activities to encourage participation of patients/clients and families in providing a hygienic environment include:

- introduction of signage on hand washing
- introduction of signage on isolation rooms
- introduction of hand hygiene education sessions
- introduction of an audio system to encourage staff and the public in hand washing on surgical wards
- provision and evaluation of comment cards throughout the organisation.

A patient information leaflet was observed, however, this needed to include hygiene information. The National Visitor Policy is posted in the hospital. It is recommended that adherence to the visitor policy is measured, reported and evaluated. Consideration should also be given to the introduction of protected meal times. It is recommended that patient/client and family satisfaction surveys are conducted.

PATIENT'S/CLIENT'S RIGHTS**SD 5.1 (B → B)****Professional and organisational guidelines regarding the rights of patients/clients and families are respected by the team.**

No documented processes or guidelines regarding the rights of patients /clients and families were observed. Some reference is made to the rights of patients /clients and families in the induction manual for household staff and in the employee handbook.

The national patient charter and a hospital complaints policy are both in place. Evidence was observed of practices to maintain confidentiality with respect to patients with a communicable infectious disease, for example, colour coded labels. On visits to wards, it was clear that patient dignity is a priority with hospital staff. Information leaflets on MRSA were in place for patients and visitors. It is recommended that an evaluation of the process is carried out and root cause analysis is carried out where incidents are identified.

SD 5.2 (B → B)**Patients/Clients, families, visitors and all users of the service are provided with relevant information regarding Hygiene Services.**

A patient information leaflet was available; however, this requires updating to include hygiene related information. Patients and families are verbally updated on hygiene issues regularly throughout their stay. It is recommended that evaluation of the satisfaction of patients/clients/and families on information provided is implemented in the future.

SD 5.3 (B ↓ C)**Patient/Client complaints in relation to Hygiene Services are managed in line with organisational policy.**

The National Health Service Executive complaints policy is in place. Hygiene related complaints are referred to the hygiene services committee, however, no evidence of follow-up was observed. Evaluation of the complaints received in relation to hygiene activities is recommended.

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1 (C → C)

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

No direct evidence of patient/client/families and external partners involvement in evaluating the hygiene service was observed. Comment cards are in use. Satisfaction surveys had not yet commenced and therefore, no evaluation process or resultant actions were evident. It is recommended that the organisation place greater emphasis on surveys and focus groups in the future. It is also recommended that external partners become involved in evaluating the service. There is also potential for the formation of sub-groups to evaluate hygiene services. It is further recommended that a patient/service user representative be included on the Hygiene Services Committee.

SD 6.2 (B ↓ 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.

Regular infection control audits are carried out. The results from the national hygiene audits are compared and used as external benchmarks. It is recommended that further internal and external benchmarks are identified, monitored and measured. Details of hygiene service interventions over the last 2 years were available and included colour coding and waste segregation.

SD 6.3 (C → C)

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

There is no documented process for the compilation of an Annual Report and there was no Annual Report available. Some infection control audits have taken place; however, the audit process must be extended to all areas and systems. It is also recommended that the evaluation of service providers be commenced.

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

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

No - Flaking paint was noted in the ultrasound room, catering and some other areas.

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

Yes - Missing tiles were noted in some areas.

(6) Free from offensive odours and adequately ventilated.

Yes - However, electric fans were noted in some areas, particularly offices, wash up and some clinical areas, which is not recommended.

(13) External areas including grounds, gardens, footpaths, ramps and car parks should be clean and well-maintained.

No - Grounds were in need of maintenance and the waste area was visually in poor condition.

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

Yes - One uncovered bin was noted.

(15) Where present a designated smoking area must comply with the national legislation on tobacco control and local organisational policies, a cigarette bin must be available and the floor area should be free of cigarette ends, matches etc.

No - While there was a designated smoking area in place, poor compliance was noted.

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

(18) Walls, including skirting boards.

Yes - High dusting is required in the Accident and Emergency department.

(19) Ceilings

Yes - All ceilings viewed were clean.

(21) Internal and External Glass.

No - Internal glass required additional cleaning. Also, wash up screens require cleaning.

(25) Floors (including hard, soft and carpets).

Yes - The floors in the Accident and Emergency department would benefit from a different method of cleaning to remove discoloration.

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

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

Yes - All areas viewed were clean except the Accident and Emergency department, where improvement was required.

(207) Bed frames must be clean and dust free

Yes – However, an exception noted was the Accident and Emergency department.

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

(33) Chairs

Yes - No dirty chairs were noted during the assessment.

(34) Beds and Mattresses

Yes - No dirty beds or mattresses were observed. An excellent system was noted in the mattress room.

(35) Patient couches and trolleys

Yes - However, an exception noted was the Accident and Emergency department.

(36) Lockers, Wardrobes and Drawers

Yes – However, some wards did not have patient's wardrobes, and patients were required to send luggage home.

Compliance Heading: 4. 1 .5 Sanitary Accommodation

(44) Hand hygiene facilities are available including soap and paper towels.

Yes - Additional sinks are required and the size of sinks must conform to infection control legislation. The location of some hand wash units made access difficult, including the accessing of the hand washing requisites.

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

Yes - However, on one ward, some showers could not be used because of leakage onto the corridor.

(54) Wash-Hand Basins

Yes – However exceptions noted were the Accident and Emergency department and Out Patient departments.

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

No - Hygiene schedules were available; however, cleaning methods (BICS course) were not present.

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

Yes - However, space restrictions were noted.

(210) Consumables should be readily available and stored in a suitable environment, e.g. liquid soap, paper towels, toilet paper. Clean and well maintained dispensers should be available for consumables.

Yes - However, some were stored with other clean goods.

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

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

Yes - All patient equipment is cleaned by health care assistants.

(67) Bedside oxygen and suction connectors.

Yes - Bedside oxygen and suction connectors are cleaned by health care assistants.

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

No - Fans were observed in use in clinical areas during the assessment and this practice should be reviewed.

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

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

No - Limited storage areas were observed in ward areas for example, wardrobes were not always available. Some staff clothing was observed in ward areas (for example the linen cupboard and staff room).

(79) Flower vases where present should be clean with water changed minimum daily. Wilted flowers should be removed and disposed of accordingly. Note: flowers not recommended in high risk areas.

No - Informal procedures only were observed. A policy is required in this area.

(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 - Some sinks had no splash backs; however, this is an area being developed by the organisation.

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

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

No - The recording of vacuum filters is advised (Minimum weekly or as directed by the Infection Control department).

(87) All cleaning equipment should be approved by the Hygiene Services Committee and ensure sufficient supply.

Yes - This process has recently been put in place.

(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.

Yes - However, some space restrictions were noted.

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

Yes - Cleaning products are stored in a locked room.

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 - Regulation 852/2004 was not available.

(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.

No - Action plans were not available for the Environmental Health Officer reports and many repeat issues were highlighted during the assessment.

(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 - A review of the HACCP plan is required.

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 - Some ward kitchen access was not restricted. While there is a locked coded access facility, this was not always in use.

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

Yes - However, cereals and yogurts were also noted in fridges.

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

No - Catering staff at ward kitchens did not have a separate toilet facility.

(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 - Ventilation was not adequate in the main kitchen areas. A quality improvement plan is in progress as part of the capital plan.

Compliance Heading: 4. 4 .3 Waste Management

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

No - The compactor area, plastic storage container and general waste area required attention.

Compliance Heading: 4. 4 .4 Pest Control

(235) A system of pest control developed by a competent person shall be in place.

Yes - A pest guard contract was observed.

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

Yes - The checklist observed requires review and updating.

(237) A location map should be available showing the location of each bait point.

Yes - However, this needs to be signed and dated appropriately.

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

(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 - No display units were observed.

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

Yes - The control of salad products in dining room requires review as some high temperatures were noted. Gaps were also noted in temperature recording at ward level.

Compliance Heading: 4. 4 .10 Plant & Equipment

(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 - Monitoring of dish wash temperatures was not observed in the main kitchen or at ward level.

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

(141) Documented procedures for the segregation, handling, transportation and storage of waste.

Yes - A formal process of documentation is required.

(145) A record is kept of tags used for each ward/department for at least 12 months.

No - Tags are not maintained for review. A traceability audit is required.

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

No - The collation of Safety Data Sheets is required. Appropriate training is also required.

(151) Waste is disposed of safely without risk of contamination or injury.

Yes – In the majority, however, one member of staff was observed not wearing the correct personal protective equipment.

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

No - No discharge to drain license was observed.

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.

Yes - More formal documented process is required.

Compliance Heading: 4. 5 .5 Storage

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

No - No documented process was noted.

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

No - Bin lids were observed to be open in the clinical waste area.

Compliance Heading: 4. 5 .6 Training

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

No - The organisation should consider the provision of a designated and appropriately trained waste officer.

(260) There are documented records of staff training on the handling, segregation, transport and storage of healthcare risk waste including the use of spill kits and personal protective equipment.

No - No specific training records were in place.

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 – In the majority, however, more formal documented process are required, including the cleaning of cages, delivery vans and mechanisms of evaluation.

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

Yes - All laundry is managed in-house.

(263) Bags are less than 2/3 full and are capable of being secured.

Yes - Smaller bags are currently on order.

(267) Documented process for the transportation of linen.

Yes - More detail is required regarding the transportation and segregation and cleaning policies.

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

Yes - This is not applicable in the organisation as no ward based washing machine was observed.

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

Yes - However, processes are required for temperature monitoring and recording.

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

Yes - A number of sinks are in place and, while equipped for hand washing, some were observed being used for other purposes. It is recommended that at least one sink is reserved and appropriately labelled for hand washing only.

(270) If a washing machine is in use, a tumble drier is also in place which is externally exhausted. Documented processes for planned preventative maintenance of this equipment should be in place.

No - No planned preventative maintenance process is in place.

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

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

No - Despite some developments, insufficient numbers of hand wash sinks was still an issue. Access to hand wash sinks was restricted in some areas.

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

No - Washable splash backs were not present at all sinks. However, the newly installed sinks observed were all compliant with best practice and this should be rolled out to the entire organisation.

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

No - Some sinks observed were stained and marked.

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

No - Some sinks observed were without mixer taps and were not hands free.

(195) Absorbent paper towels are available at all hand washing sinks. Air dryers should not be recommended.

Yes – In the majority, however, some air dryers are still in use.

;(196) Waste bins should be hands free.

Yes - Overall, the organisation was compliant, however, hand operated lids still require replacement. The new hands free variety observed are commendable.

(203) Hand wash sinks are dedicated for that purpose, are free from used equipment and inappropriate items (e.g. nail brushes).

Yes – In the majority, however, an exception noted was the presence of tea bags, which were observed in a ward kitchen hand sink.

(204) Hand wash sinks conform to HBN 95. They should not have plugs, overflows and the water jet must not flow directly into the plughole.

No - Some hand wash sinks observed were not compliant.

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

No - Additional sinks are required. This should be identified on a ward by ward basis.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team			Assessor Team
	FREQ	%	FREQ	%
A	9	16.07	3	05.36
B	32	57.14	19	33.93
C	15	26.79	33	58.93
D	0	00.00	1	01.79
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	C	↓
CM 2.1	B	B	→
CM 3.1	C	D	↓
CM 4.1	B	C	↓
CM 4.2	B	C	↓
CM 4.3	B	B	→
CM 4.4	B	C	↓
CM 4.5	B	B	→
CM 5.1	B	B	→
CM 5.2	A	B	↓
CM 6.1	C	C	→
CM 6.2	C	C	→
CM 7.1	A	C	↓
CM 7.2	A	C	↓
CM 8.1	B	B	→
CM 8.2	C	C	→
CM 9.1	B	C	↓
CM 9.2	B	C	↓
CM 9.3	B	C	↓
CM 9.4	C	C	→
CM 10.1	B	B	→
CM 10.2	C	C	→
CM 10.3	B	B	→
CM 10.4	C	C	→
CM 10.5	C	C	→
CM 11.1	B	B	→
CM 11.2	B	B	→
CM 11.3	B	C	↓
CM 11.4	C	C	→

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