Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

# Hygiene Services Assessment Scheme

# Assessment Report October 2007

# Mid Western Regional Hospital (St. Joseph's General)

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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*

The Mid Western Regional Hospital, Nenagh, serves mainly the adult population of North Tipperary for acute medical and surgical conditions. The hospital has 75 in-patient beds and 6 day beds.

**Services provided**

In-patient:

- Medicine
- Surgery
- Geriatric Assessment
- Accident and Emergency
- Intensive Care Unit/ Critical Care Unit
- Day Surgery

Out-patient:

- Medicine
- Surgery
- Orthopaedics
- Ante-natal and Gynaecology
- Ear Nose and Throat
- Urology
- Paediatrics
- Psychiatry
- Ophthalmology

Specialities as Obstetrics, Paediatrics, ENT and Orthopaedics are centralised services from the Mid Western Regional Hospital Group in Limerick.

**Physical structures**
The organisation is managing hygiene services within an infrastructure which dates to 1936. Phased capital development is under way which is due to be completed by 2010. Single rooms are used for isolation purposes but are not specifically designed for isolation. There are no Negative Pressure rooms.

The following assessment of the Mid Western Regional Hospital, Nenagh, took place between 18th and 19th June 2007.

## *1.3 Notable Practice*

- The provision of a patient information folder.
- A new patient information leaflet.
- The provision of new hand wash facilities.
- The waste management system was of a very high standard.
- Infection Control processes were of a high standard.
- The new ward kitchen upgrade is to be commended.
- The staff are commended on their hard work in delivering hygiene services despite infrastructural shortcomings.
- The new Accident and Emergency facility is also to be commended.

## *1.4 Priority Quality Improvement Plan*

- The development of documented processes for cleaning is encouraged.
- Storage limitations, the physical layout and the upgrading of facilities should be addressed.
- Unnecessary and obsolete items of equipment should be removed from stairwells, landings and other inappropriate areas.
- Limited progress was observed in the development of corporate policies.
- Levels of cleaning of the physical environment were below standard and high level cleaning should be addressed.
- Risk/Health and Safety management also requires attention and should be improved.
- It is recommended a needs assessment is conducted and that work is commenced as soon as possible to develop Hygiene Services plan, Operational Plan and a Hygiene Annual Report.
- It is recommended that an evaluation of the safety of the design, layout and the current environment and its adherence to regulations and best practice is conducted.

## *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 Mid Western Regional Hospital (St. Joseph's General) has achieved an overall score of:

**Poor**

**Award Date:** October 2007

## *1.6 Significant Risks*

**CM 7.2 (Rating D)**
**The organisation's Hygiene Services risk management practices are actively supported by the Governing Body and/or its Executive Management Team.**

**Potential Adverse Event**
Potential or recurrence of adverse events resulting in provision of sub optimal Hygiene Services

**Risks**

| | |
|---|---|
| Likelihood of Event | Rated: M (2) |
| Impact of Event | Rated: M (2) |
| Urgency of Action | Rated: H (3) |
| TOTAL | **Total: 7** |

**Recommendations**
It is recommended that safe systems for Hygiene Services risk management practices are established as a matter of urgency. It is also recommended that a system is put in place to effectively address near misses, incident and accident reporting, and corrective measures introduced in consultation with staff.

**CM 9.1 (Rating D)**
**The design and layout of the organisation's current physical environment is safe, meets all regulations and is in line with best practice.**

**Potential Adverse Event**
A risk of cross contamination exists, as the entrance to the Operating Theatre is the same as the CSSD. There is also a risk of cross contamination in the CSSD as the structures does not allow for separating the flow of dirty, clean and sterilized instruments.

**Risks**

| | |
|---|---|
| Likelihood of Event | Rated: M (2) |
| Impact of Event | Rated: H (3) |
| Urgency of Action | Rated: H (3) |
| TOTAL | **Total: 8** |

**Recommendations**
It is recommended that an evaluation of the safety of the design, layout and the current environment and its adherence to regulations and best practice is conducted.

# 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.**

The Hygiene Corporate Strategic Plan, Service Plan and Operational Plans are currently a work in progress and were at an early stage of development at the time of the site visit. A Corporate Strategic Hygiene Services Committee has been established at regional level and minutes of these meetings were available. There is a high level Annual Service Plan for 2007/2008. Due to the current state of development of the structures for the overall management of hygiene services, no evaluation processes are in place as yet. There is no patient/client consultation process in place, and this is encouraged. There were no documented processes for completing a needs assessment regarding the requirements of hygiene services.

**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.**

A Regional Steering Group Network for hygiene and cleanliness for the 7 acute hospitals in network area had been established. This includes St. Joseph's Hospital, Nenagh. However, while a 'blueprint' for hygiene and cleanliness for the acute hospital network is in place, very little evidence of its further roll-out was observed to date. A hospital Hygiene Services Committee and Hospital Services Team were identified in the structures, the developments and modifications to the organisation's hygiene services have been mainly linked to the outcome of the two previous National Hygiene Audits. These developments include installation of new wash hand basins and splash backs in clinical areas that are in accordance with best practice. Foot operated bins for clinical and non–clinical waste have been provided, colour coding for linen and cleaning is in place, and stainless steel kitchen fittings have been installed. The division of responsibility for instrument decontamination has been outlined. Evaluation and feedback systems have yet to be developed, and this is encouraged.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

**CM 2.1 (B ↓ C)**

**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.**

Links with the Health Services Executive are through the Network structure. Links were in place with other network hospitals via the Regional Steering Group for hygiene and cleanliness. Due to the small size of the Organisation, no in-house structures for risk management and health and safety are in place. However, a regional risk management structure is in place. It was noted during the assessment that the documentation for health and safety and risk management was out of date. The Infection Control Nurse was a member of the Regional Infection Control Committee. An identified member of staff is currently assuming the role of Health and Safety representative. The only patient satisfaction survey available during the assessment was conducted in 2004. Development of the hygiene structures as identified in the Hygiene Services Assessment Scheme should facilitate meeting the gaps that currently exist. These relate to access to input, from the full range of expertise relevant to best practice in the planning, delivery, evaluation and continuous quality improvement across the spectrum of Hygiene Service delivery.

CORPORATE PLANNING FOR HYGIENE SERVICES

**CM 3.1 (B ↓ C)**

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

The development of the Hygiene Corporate Strategic Plan is at a very early stage. It is recommended that the organisation progresses the development of this plan to ensure a comprehensive, informed system with goals, objectives and priorities and related costings is produced. A high level hospital annual service plan for 2007/2008 was observed. Two members of the Executive Management Team were represented on the Regional Steering Group network for the regional hospital group for hygiene and cleanliness. The interface between the hygiene services team, hygiene services committee and corporate hygiene committee should ensure a comprehensive hygiene service delivery for the hospital. Evaluation and continuous quality improvement have yet to be established, and this is encouraged.

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.**

Hygiene services are delivered by a team, which comprises cleaning, portering, catering and laundry staff. These staff reported to an Assistant Director of Nursing. The Clinical Nurse Manager II in clinical areas assumes responsibility for the standard of Hygiene Services in each area. Overall responsibility rests with the Executive Management Team. There were some corporate policies for the delivery of hygiene services in place. The code of Corporate Ethics was expressed in the organisation's mission statement. Evaluation of the Hygiene Services teams'

adherence to legislation and relevant national guidelines was confined to infection control audits, environmental health officer reports and HACCP reports. The Team is encouraged to evaluate its adherence to legislation and relevant national guidelines.

**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.**

The Hygiene services performance indicators were confined to infection control and haemovigilance audits. The Director of Nursing has responsibility for liaising on hygiene related matters at Executive Management Team level. Hygiene best practice information is reviewed by the Director of Nursing and disseminated to clinical nurse managers at monthly meetings. It is also reviewed and implemented as relevant by the infection control nurse. The information received feeds into infection control policies, procedures and guidelines. The infection control nurse also provides relevant education and training. A section of the identified Quality Improvement Plan relates to the introduction of a hygiene and cleanliness newsletter to report on achievements and Quality Improvement Plans for the future. It is recommended that the Organisation formulate an organised approach to improving Hygiene Standards across all aspects of their Hygiene Services and the evaluation and communication of same.

**CM 4.3 (B ↓ C)**

**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.**

Staff intranet access is available at ward level and the Organisation also subscribes to a number of journals. A staff notice board is available in the staff canteen. Monthly meetings are held with clinical nurse managers and it was noted that hygiene is a regular agenda item. A local nursing newsletter is being developed; this will cover relevant topics, including hygiene related matters. The new HSE regional newsletter "Working for Health Together" is also available. Staff are supported for further relevant education programmes, Records of attendance are maintained, however, no formal process for evaluating the benefits to the organisation has been developed. It is recommended that this is implemented in the future.

**CM 4.4 (B ↓ C)**

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

A system is in place for the development, approval, revision and control of policies, procedures and guidelines, and there was variance in the documentation structure observed. A suite of policies, procedures and guidelines were included in the infection control manual. Information notices for staff, patients and the public were evident and appropriately displayed. No evidence of evaluation was observed.

It is recommended that the organisation's Quality Improvement Plan for the development of a standardised policy template is progressed as a matter of priority. It is also recommended that existing policies, procedures and guidelines are updated, where necessary.

**CM 4.5 (B ↓ C)**

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

No documented processes were available for consultation with hygiene services. However, pre-development of existing sites included input from the infection control nurse. Also the General Manager had sought identification of priority items for inclusion in its equipment plan from the ward/department managers. No evaluation, resultant actions, feedback and continuous quality improvement were observed.

## ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

*Core Criterion

**CM 5.1 (B ↓ C)**

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

Hygiene Services staff in the clinical areas were accountable to the Director of Nursing through a reporting structure. The Hygiene Services Committee and Team are still in their infancy, and perceived as a support structure for Hygiene Services development. However, the size of the organisation was identified as a challenge to the number of committees that the Organisation could support without the constant repetition of membership on each committee. The Executive Management Team assumes overall responsibility for Hygiene Services. It is recommended that responsibility for hygiene services be made more explicit in job descriptions at all managerial levels. There is insufficient evidence to support a B rating.

*Core Criterion

**CM 5.2 (B ↓ C)**

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

The General Manager and Director of Nursing were members of the Regional Steering Committee on hygiene and cleanliness. Documented membership of the hospital hygiene steering committee was not available. The main focus of attention of the committee thus far, had been the completion of the self assessment documentation, which involved a number of key hygiene services and hospital management staff.

It is recommended that the Organisation assign the responsibility of the Hygiene Services Committee to the Executive Management Team as part of its remit, with an identified structure for regular input from the chairperson of the Hygiene Services Team. This would facilitate full communication between management loop and the regional corporate hygiene and cleanliness team.

## ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

*Core Criterion

**CM 6.1 (B ↓ 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.**

The allocation and management of resources is seen as a challenge for the Hospital. It was perpetually deemed to be insufficient for the provision of Hygiene Services. However, additional staffing in excess of the approved whole time equivalent had evolved over a number of years, based on service delivery changes. This was previously justified on the basis of regional structures, which no longer exist. The current Health Service Executive regional process for approval and acquisition of

new equipment and products was identified as cumbersome. The development of the Hygiene Corporate Strategic Plan should help in this regard.

**CM 6.2 (B ↓ C)**

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

Input into the purchase of hygiene services equipment is mainly by the infection control nurse. The clinical nurse managers had been invited to identify their equipment needs, which were prioritised locally and communicated to the regional procurement department. Purchasing was carried out at regional level and storage was also at regional level. Delivery to St. Joseph's Hospital was based on a lead-time of ten-days, which was deemed to be unsatisfactory and impacted adversely on the storage facilities available at the hospital. It is recommended that there be an evaluation of the efficacy of the consultation process between the Hygiene Services Committee and Senior Management.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

**CM 7.1 (B ↓ C)**

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

Documented processes are in place for Hygiene Service risk incident identification, reporting, analysis, minimisation and elimination. No major adverse events were identified in the last two years, Environmental health reports, HACCP reports and infection control audits for a number of issues were reviewed, however, no risk management or health and safety annual report was available. It is recommended these annual reports are developed in the future.

**CM 7.2 (B ↓ D)**

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

No evidence of completed risk assessments in relation to Hygiene Services was noted. The health and safety statement reviewed was in draft form. It is recommended that the Health and Safety committee is reconvened, as it has not met for two years. The hospital has an identified health and safety representative. While reporting and follow-up of incidents and near misses is performed on an individual basis, no reporting of trend analysis of incidents and near misses is completed, due to the long term absence of the clinical risk manager. There is the potential for recurrence of adverse events resulting in provision of sub-optimal Hygiene Services It is recommended that safe systems for Hygiene Services risk management practices are re-established as a matter of urgency.

It is also encouraged that a system is put in place to effectively address near misses, incident and accident reporting, and corrective measures introduced in consultation with staff.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion

**CM 8.1 (B ↓ C)**

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

The documented processes for establishing contracts are developed at regional level. Technical services are responsible for compliance monitoring at local level. Linen, cleaning, portering and catering services are all provided by in-house hospital staff. Contracts for the transportation and destruction of waste and pest control were reviewed. No recent contracts relating to Hygiene Services have been established.

**CM 8.2 (B ↓ C)**

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

Contracted services include waste, water and pest control. No evidence of contractors' involvement in the area of quality improvement initiatives was observed. Evidence of adverse events was noted, with quality improvement activities being reactive rather than pro-active.

PHYSICAL ENVIORNMENT, FACILITIES AND RESOURCES

**CM 9.1 (B ↓ D)**

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

A number of deficiencies were observed in the physical environment. Disparities between the old and new areas were noted, with the physical layout of the new areas having considerable benefits in relation to space and quality of finish. The integrated CSSD/Theatre complex had significant inadequacies in relation to the separation of clean and dirty processes. The CSSD itself had no internal segregation of its' clean and dirty process areas, however, capital development plans were in place to correct this. Treatment was being provided in the physiotherapy department in the midst of extensive building work, without obvious dust control measures in place. Extensive corrective measures were implemented to address the issue prior to the completion of the Assessment. The older ward areas and corridors are in obvious need of refurbishment /replacement/repair. Despite these deficiencies, evidence of considerable improvements in facilities and resources following the previous national hygiene audits was observed, for example wash hand basins, splash backs and stainless steel ward kitchen fittings. It is recommended that an evaluation of the safety of the design, layout and the current environment and its adherence to regulations and best practice is conducted.

*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.**

The Executive Management Team has overall responsibility for the management of the Organisation and its' services. Some processes for the management of specific Hygiene Services have been developed, for example kitchens, sharps and waste. It is recommended that the development of these processes be co-ordinated under the

terms of reference of the Hygiene Services Committee and that processes are informed by relevant legislation and best practice guidelines.

**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.**

Evaluation processes are limited. Observed examples include: some infection control audits, HACCP and Environmental Health Office reports and the previous national hygiene audits. The most recent patient satisfaction survey was conducted in 2003, however, the organisation has imminent plans to conduct a further patient satisfaction survey. It is recommended that this is progressed in relation to satisfaction with Hygiene Services. See comment in CM 9.1 in relation to improvements in facilities and resources over the last two years.

**CM 9.4 (B ↓ 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 of patient/ client, staff, providers, visitors and the communities' satisfaction with Hygiene Services facilities and the environment is based on the outcome of reported complaints, few of which are regarding hygiene. The hospital has implemented the "Your Hospital Your Say" guidelines. Patients interviewed during the assessment were very complimentary about hygiene services. It is recommended that a patient satisfaction survey is conducted to evaluate satisfaction with Hygiene Services.

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.**

Documented processes were observed in place for the selection and recruitment of hygiene services staff, which were in line with human resource policies for the region and based on National Guidelines. Job descriptions existed for all staff disciplines and grades. No contract staff are involved in direct service delivery in the organisation. Human resources records are maintained at local level for temporary staff, and at regional level for permanent staff. No evaluation of the process of selection and recruitment is in place, and this is encouraged.

**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.**

No documented processes are available for reviewing changes in Hygiene Services work capacity and volume. Increases in hygiene services staff is based on increased area/facilities which required cleaning and on professional judgement. The Organisation had a budget for 44 whole time equivalent hygiene services staff. This compliment has been increased to 54 over recent years to facilitate the management of the Hygiene Services in new ward areas, for which no additional resources were allocated. This increase was justified and approved on the basis of capacity

elsewhere within the region at that time. It is recommended that an evaluation of work capacity and volume review processes is undertaken.

**CM 10.3 (B ↓ C)**

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

Where relevant, qualifications were identified in the job descriptions and verified through the human resources department. Training was provided for staff who are not required to have prior qualifications. Content of the orientation and training programme was not available, however, it was validated that it included relevant hygiene and Infection Control issues. A "buddy system" was in place, which involves new staff working with experienced staff for training in practical aspects of the role. The development of a staff induction handbook and a spreadsheet of successful induction and on-going training are recommended.

*Core Criterion

**CM 10.5 (B ↓ C)**

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

The hospital's Human resources requirements need assessment to ensure changes in hygiene services work capacity and volume does not occur. There is, as yet, no provision for human resources in the Corporate Strategic Plan. Hygiene Services Plans, Operational Plans and Hygiene Annual Reports have yet to be developed. Without these systems in place, there is the potential for the provision of sub-optimal Hygiene Services. It is recommended that a needs assessment is conducted and that work is commenced as soon as possible to develop Hygiene Services plans, Operational Plans and a Hygiene Annual Report.

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.**

Evidence validated that education and training is provided to all staff during their induction period by the Infection Control Nurse, including specific education regarding hygiene. Attendance levels at induction/orientation training are maintained. On-going education and training is also provided, for example training on the use of new products and equipment. It is recommended that the organisation develop a staff handbook. A review of the availability of all standard operating procedures is recommended to ensure they cover all aspects of Hygiene Services.

**CM 11.2 (B ↓ C)**

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

No documented processes were available to ensure the continual professional development of all hygiene services staff. However, there was evidence of education and training in key areas, for example, the attendance of the Infection Control Nurse at regional, national and international conferences. In addition, five members of the hygiene services staff having completed the FETAC course for Health Care

Assistants and ten of the hygiene services staff were undertaking the SKILLs course. Evaluation of the relevance of education to each staff member is determined prior to approval being given. It is recommended that Hygiene Services staff receive training in key areas including Health and Safety and conducting risk assessment. It is recommended that resultant actions and continuous quality improvement is progressed.

**CM 11.3 (B ↓ C)**

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

To date, no evaluation of the effectiveness of education and training is carried out, with the exception of one specific instance where the infection control training was followed up with post training effectiveness audit. There is the potential for the provision of sub-optimal training in relation to Hygiene Services. The Team is encouraged to conduct a staff satisfaction survey to evaluate satisfaction level with education and training provided. It is also recommended that Key Performance Indicators are developed for Hygiene Services.

**CM 11.4 (B ↓ C)**

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

There are, to date, no documented processes for Hygiene Staff performance and development in place. The Team is encouraged to progress this issue. It is recommended that this is incorporated into the Hygiene Services Plan. Work/training attendance records are kept; however, no Quality Improvement Plan in relation to performance has been developed.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

**CM 12.2 (B ↓ C)**

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

No Hygiene Services staff satisfaction monitoring in place. Evidence of occupational health and well being of staff being monitored was observed. However no details of changes initiated over the last year were observed. An evaluation of mechanisms for monitoring staff satisfaction is recommended. A Quality Improvement Plan for the rollout of the stress wellness programme for all staff is in place.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

**CM 13.1 (B ↓ C)**

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

The documentation for the Hygiene Services Assessment was located in different departments. An index of relevant legislation and best practice documents is recommended to ensure evaluation of compliance. The documentation observed must be standardised and collated, to ensure a comprehensive suite of policies and procedures exist. The ward manuals observed had exceeded their review date. The recommended standardised approach to the development of policies and procedures should prevent this occurring. No evaluation process, resultant actions or Quality Improvement Plans have been developed to date.

**CM 13.2 (B ↓ C)**

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

During the assessment, very little evidence of reports generated by Hygiene Services was observed. No documented structures for the dissemination of information were in place. Agendas and Minutes of meetings were observed for the Infection Control Committee meetings, Ward Manager meetings and Executive Board meetings. No mechanism for user evaluation was in place, and this is encouraged.

**CM 13.3 (B ↓ C)**

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

With the exception of complaints, near-miss reports and infection control audits, no mechanisms to assess data collection and information reporting were in place. The organisation has developed a Quality Improvement Plan to introduce protected time for scientific data analysis. It is recommended that the organisation considers the introduction of local audits relevant to Hygiene Services with resultant action plans and relevant feedback mechanisms.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

**CM 14.1 (B ↓ C)**

**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 equipment procurement process is quality assured. A regional Corporate Hygiene Services Committee with terms of reference has been established. The hospital is represented on this committee by the Executive Management Team.

Plans to develop Hygiene Services structures and processes for the management of hygiene services at hospital level have been formulated. However, they have been delayed due to a number of other external hospital assessments, which have recently been conducted.

**CM 14.2 (B ↓ C)**

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

Changes in Hygiene Services over the last 2 years were reflected predominantly in improvements to the environmental facilities, cleaning processes, use of notices and the role of infection control. Communication to staff and applicable organisations in relation to relevant hygiene services was primarily though the self-assessment documentation for this process. Performance indicators have yet to be established. Audit processes and evidence of bench marking were limited and the evaluation of improved outcomes in hygiene service delivery has yet to be undertaken. It is recommended that this process is implemented and strengthened in the future. The Team is encouraged to conduct an evaluation of improved outcomes in Hygiene Services delivery as a result of the quality improvement system.

# 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 to ensure best practice guidelines are established, adopted, maintained and evaluated was observed. There is a link with regional Infection Control committees and the hospital has an internal Infection Control committee, which disseminates information to staff. Staff have access to the intranet facilities; however, no protected time is afforded to access best practice guidelines. Best practice guidelines were noted in a number of areas for example catering and Infection Control, however, no comprehensive list or review mechanism has been established. It is recommended that a review of policies, procedures and guidelines be carried out. Ward based infection manuals observed during the assessment had exceeded their review date. Documentation relating to hygiene services needs to be collated and indexed according to the Hygiene Services Assessment Scheme process. It is recommended that the overall process, for the adoption of best policy guideline adoption, is included in the evaluation process.

**SD 1.2 (B ↓ C)**

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

No documented process for assessing new hygiene services interventions prior to use was observed. Informal evaluation of recent hygiene interventions at local level (such as the implementation of hand gel) is carried out; however, no evaluation reports were noted. Some evaluation was evident as part of the regional procurement process with regard to tendering, however, no evaluation reports were presented. It is recommended that a structured process is implemented to cover the following steps: initial assessment criteria, trial data, review and sign off. It is also recommended that evaluation of this process is considered to include recent hygiene interventions.

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.**

The health promotion hospital coordinator assumes overall responsibility for the co-ordination of health promotion activities. Links have been established between the co-ordinator and, the community for example the traveller health care hygiene programme. The hospital is part of the national health promotion network which promotes and undertakes hygiene initiatives. Signage is provided throughout the hospital in relation to hand hygiene, the visitor policy and smoking policies. Information leaflets are also available to patients and the public on hygiene issues. There is also a facility for the public to suggest hygiene improvements in the “Your hospital Your Say” feedback form. It is recommended that the Team conduct an evaluation of the efficacy of activities undertaken in the community in relation to Hygiene.

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.**

An organisational structure was observed in place for hygiene and cleanliness of the acute hospitals network 7. A multidisciplinary team was also in place with terms of reference for the Hygiene Services Committee, which includes representatives from all disciplines. The development of the team is still at a very early stage. There were no recent minutes of meetings available. It is recommended that a review of linkages to partnerships, teams and external organisations is carried out to support the hygiene services committee. It is also recommended that an evaluation of the efficacy of the multi-disciplinary team structure is put in place, with robust systems to progress action planning.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

**SD 4.1 (B ↓ C)**

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

All fittings and furnishings in patient care areas were clean and intact. Bathrooms and washrooms were clean; however, they were used as store rooms in many wards. The environment outside the immediate ward areas required improvement. Floor coverings and skirting boards were in need of repair or replacement. Flaking paint was observed throughout the building. A lack of attention to detail in relation to the cleaning of radiators, lifts and stairs and high dusting was noted. Clutter was a dominant feature in all areas of the hospital. Staff areas in particular were poor.

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.**

Overall, the equipment observed was clean. No food was observed in patient lockers. Medical devices such as infusion pumps and drip stands were clean. Bedpans and urinals were clean; however, it is recommended that staff review the practice of discarding contents in the sluice before placing pans in the washer disinfector and consider an alternative solution.

For further information see Appendix A

*Core Criterion

**SD 4.3 (B ↓ C)**

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

A colour coding system was in place and staff were aware and using this policy appropriately. Products used for cleaning and disinfection comply with hospital policy. Poor hygiene standards were observed in relation to some of the cleaning trolleys. Staff were unsure of timeframes for the changing of suction machine filters.
Cleaning products were not stored in locked cupboards, and immediate rectification is encouraged. It is recommended that a health and safety policy on the use of ladders/step-ladders is developed.

For further information see Appendix A

*Core Criterion

**SD 4.4 (B → B)**

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

The main kitchen requires structural upgrading. Inadequacies were particularly noted on wall surfaces, ventilation and proofing. The rear storage areas are very exposed to outside areas as the two back doors were constantly open during the Assessment. This was used as a general walk through area. Restricted coded access is required for the catering toilet. There is a HACCP system in place; however, this requires updating to include batch traceability and sampling. With the exception of cooling, Critical Control Points were in operation. High level dusting and cleaning were inadequate and the area for waste oil storage also required cleaning. It is recommended that this process is progressed in the near future.

For further information see Appendix A

*Core Criterion

**SD 4.5 (B → 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.**

When questioned, staff were knowledgeable on waste segregation. Sharps containers complied with best practice. All waste bins (domestic and healthcare risk waste HCRW) were hands free, clean and displayed appropriate signage. Specialist areas (pharmacy and laboratory) had access to appropriate healthcare risk waste

containers. Documentation reviewed was satisfactory. It is recommended that a review of collection times for removal of waste at ward level is carried out, to avoid the cluttering of sluice rooms.

For further information see Appendix A

*Core Criterion

**SD 4.6 (B → B)**

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

Processes for the handling of used laundry require review. One member of laundry staff questioned had no training in hand hygiene. The physical structure and layout of the laundry area needs reviewing and updating in line with best practice. The temperature of machines does not reach required temperature as per the hospital policy of 90 degrees Celsius for mops. The ward linen cupboards were used for the storage of miscellaneous items. Clean linen was stored within the patient bay in one ward and bathrooms in staff facilities were used to store linen.

For further information see Appendix A

*Core Criterion

**SD 4.7 (B ↑ 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**

Resources have been invested in this area, with the installation of new sinks. Soap, paper towels and hand washing posters were observed at all sinks and alcohol based hand gel was available throughout the hospital. It is recommended that the organisation ensure that annual hand hygiene education in conjunction with standard precautions is mandatory, as recorded attendance for 2007 was minimal.

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.**

No overall documented processes for the minimisation of risk when hygiene services are being provided were observed. A health and safety statement dated 2003 was noted, as was a new draft statement which requires signage, approval and implementation. The Health and Safety Committee has not been active for a significant time and risk assessments both for clinical and non clinical areas was inadequate. Storage of chemicals requires review as they were stored without adequate controls (storage in an unlocked environment poses a risk to patient/client safety). A documented HACCP plan was observed in place, which requires updating to include batch traceability, sampling and documented controls for the cooling process. Incident reporting is carried out, investigated and reported using the STARS system. Evaluation and feedback reports to the Hygiene Services Committee need to be implemented. The Clinical Risk Manager was on leave and the deployment of this role requires review in the future. A traceability system is in place in CSSD, which is operating satisfactorily and evaluated weekly. During the assessment, the physiotherapy department was very dusty and operating in the midst of a building programme without adequate precautions.

**SD 4.9 (B ↓ C)**

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

No overall documented policy to encourage patients/clients and families to participate in improving hygiene services and providing a hygienic environment were observed. The "Your Hospital, Your Say" policy has been implemented and records were available. Patient/client leaflets are available and alcohol based hand gel is provided in strategic locations. A new patient information leaflet has also been drafted

A new visitor policy is in place; however, adherence must be monitored in line with the National Visitor Policy. A patient satisfaction survey was carried out in 2003, and the hospital plan to carry out a new survey over the coming months. The Team is encouraged to evaluate patient/client satisfaction with participation in service delivery.

PATIENT'S/CLIENT'S RIGHTS

**SD 5.1 (B ↓ C)**

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

A bedside patient information booklet was available which provides patients with information on professional services offered. A robust system is in place for complaints management. An infection control guideline on the management of infectious diseases was available to staff, however, there were limited isolation facilities available. The plans of the new Accident and Emergency department were observed, in which a single room was noted. There were adequate patient information leaflets regarding services and hygiene related matters available.

Due to the on going building works in the physiotherapy, privacy and dignity of patients could be compromised. While a visitor policy is in place, the organisation is encouraged to implement a more proactive approach to its implementation.

It is also recommended that evaluation processes are implemented.

**SD 5.2 (B ↓ C)**

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

A directory of patient information was observed at ward level. Information is given to patients at admission and verbally during their stay. A new patient information leaflet has been drafted and will be circulated shortly. Hand wash signage and gels are available at the hospital entrance and the hospital visitor policy is posted throughout the organisation. Satisfaction surveys from 2004 were available, however, no resultant Quality Improvement Plan was observed. It is recommended that the satisfaction survey process is progressed and completed.

**SD 5.3 (B → B)**

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

The hospital operates the 'Your Hospital, Your Say" policy for complaints management. Each complaint is acknowledged immediately and reviewed within 28 days. Complaints are investigated with the key people involved and each complaint is filed when closed off. Six-monthly analysis is compiled for the regional management review. A small proportion of the complaints observed relate to hygiene facilities in the female medical ward, for which there is a capital upgrade plan. A large proportion of the feedback forms relating to positive feedback, and suggestions for improvement were also observed. It is recommended that these suggestions are reported back to the Hygiene Services Committee and that they be assessed for progression.

ASSESSING AND IMPROVING PERFORMANCE

**SD 6.1 (B ↓ C)**

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

Overall, limited evidence of involvement of patients/clients/partners in the evaluation of services was observed. A satisfaction survey was conducted in 2003; however, no resultant Quality Improvement Plan has been developed. It is recommend that the survey is extended to consider the involvement of patients/clients/families and external partners. Some evaluation is also carried out as part of the 'Your Hospital Your Say' policy, however, this information needs to be collated and reviewed by the Hygiene Services Committee. Improvements implemented over the last 2 years include improved refreshment facilities, and improved patient hygiene facilities.

It is recommended that a patient/client representative is appointed to 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.**

The Hygiene Services Committee and team are in the early stages of development. Some auditing using the Infection Control Nurses Association tool has commenced, and plans to extend this to cross functional audits with regional resources have been developed. Benchmarking was limited to the results of the previous national hygiene audits. Consideration should be given to the development of in-house benchmarks, for example, at ward level. Initiatives over the last two years include the provision of new hand wash basins with thermostatic controlled water temperature and the introduction of single detergent. The benchmarking is at the developmental stage and, consequently, evaluation processes were not in place.

**SD 6.3 (C → C)**

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

No documented processes were observed for the compilation of the Hygiene Services Annual Report, and, therefore, no annual report has yet been developed. It is recommended that the Hygiene Services Committee develop an annual report, which could be part of the overall hospital annual report. Some audits have been carried out in infection control and the kitchen. This process should to be extended to all parts of the hospital.

Resultant action plans should be developed and progressed. It is also recommended that an evaluation of the resources utilised by the Hygiene Services Committee is carried out and forms part of the annual report. It is recommended that consideration be given to the consultation of patients/families/staff and service users in the future development of the Annual Report

# 4.0 Appendix A

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

## *4.1 Service Delivery Core Criterion*

**Compliance Heading: 4. 1 .1 Clean Environment**

(1) The environment is tidy, well-maintained, free of rust, blood or body substances, dust, dirt, debris and spillages.
**No -** Standards were poor in ward areas, considerable clutter was observed in rooms and corridors, in the stairwells and included some dusty and unnecessary equipment. Exceptions include the Accident and Emergency department, theatre, Coronary Care Unit and CCSD. These specific areas were found to be clean.

(2) All high and low surfaces are free from dust, cobwebs and flaking paint.
**No -** Considerable flaking of paint was observed and high level cleaning is required.

(3) Wall and floor tiles and paint should be in a good state of repair.
**No -** Wall and floor tiles and paint were not in a good state of repair in the older parts of the hospital.

(4) Floors including edges, corners, under and behind beds are free of dust and grit.
**No -** Patient areas were compliant; however, storage areas and corridors were very poor.

(7) Areas should be adequately ventilated with ventilation units cleaned and serviced accordingly and documentation available regarding service.
**Yes -** While there were no fans noted in use, except in the kitchen, there were numerous fans in storage areas.

(8) All entrances and exits and component parts should be clean and well maintained.
**No -** Entrances and exits require additional attention.

(9) Where present, main entrance matting and mat well should be clean and in good repair.
**Yes -** However, the placement of a mat at the services entrances is encouraged.

(12) Internal and external stairs, steps and lifts must be clean and well-maintained.
**No -** Stairs and lifts require additional cleaning.

(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.
**Yes -** However, cigarette ends were noted in several areas.

(28) Before cleaning commences, a work route should be planned and when necessary, furniture and equipment should be removed from the area.
**No -** No evidence of a planned cleaning work route was observed.

(29) A warning sign “cleaning in progress” must always be used, position to be effective.
**No -** While signs were in place, they were not in use.

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

(17) Switches, sockets and data points.
**No -** The surgical floor was very poor in this regard.

(18) Walls, including skirting boards.
**No -** Skirting boards were poor throughout and flaking paint was observed.

(19) Ceilings
**Yes -** However, an exception was the doctors’ residence.

(20) Doors
**No -** Doors were in poor condition with splashes/dust and poor paintwork.

(21) Internal and External Glass.
**No -** External and internal glass observed was poor throughout the Hospital.

(22) Mirrors
**No -** These required further attention.

(23) Radiators and Heaters
**No -** Behind the radiators were poor and were being used for storage.

(24) Ventilation and Air Conditioning Units.
**No -** This is dependent on the Technical Services department.

(25) Floors (including hard, soft and carpets).
**No -** Floor covering was damaged in many areas and attention to the skirting boards behind doors was poor and requires attention.

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

(30) Fixtures: Fixtures (i.e. a piece of equipment or furniture which is fixed in position) should be clean. This includes all electrical fixtures e.g. all light fittings and pest control devices.
**Yes -** Attention is required for fluorescent covers.

(209) Air vents are clean and free from debris.
**No -** Not all vents observed were clean.

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

(36) Lockers, Wardrobes and Drawers
**Yes -** Only a small amount of wardrobes were in use.

**Compliance Heading: 4. 1 .5 Sanitary Accommodation**

(47) Bathrooms / Washrooms are clean and communal items are stored e.g. talc or creams.
**No -** Bathrooms are being used for storage of miscellaneous items, and items are being shared inappropriately.

(48) Floors including edges and corners are free of dust and grit.
**No -** Floor edges, particularly in staff areas, were poor.

**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 -** While they were clean, access was a problem due to clutter.

(53) Bidets and Slop Hoppers
**Yes -** Bidets were not in use.

(57) Clear method statements / policies should be in place for guidance on all cleaning including sanitary cleaning and maintenance processes.
**No -** No documented cleaning methods were observed.

(58) Sluice rooms should be free from clutter and hand washing facilities should be available.
**No -** Sluice rooms were not free from clutter. Clean items were also being stored here.

(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.
**No -** Consumables are stored in a variety of areas including sluice areas and the linen cupboard.

**Compliance Heading: 4. 2 .1 Organizational Equipment and Medical Devices and Cleaning Devices (note: while list is not exhaustive, the following compliance is required):**

(64) All equipment, including component parts, should be clean and well-maintained with no blood or body substances, rust, dust, dirt, debris and spillages.
**No -** Cleaning trolleys and linen trolleys were in need of attention.

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

(68) Patient fans which are not recommended in clinical areas.
**Yes -** With the exception of the kitchen, fans were not in use. However, they were in storage at ward department level throughout the hospital.

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

(72) Trolleys, e.g. chart trolleys, drug trolleys, linen trolleys, shop trolleys, emergency trolleys, suction apparatus, resuscitation equipment i.e. ambubag and mask.
**No -** Linen and drug trolleys required attention. Many items of equipment observed had sticky residue present.

(74) Patient's personal items, e.g. suitcase which should be stored in an enclosed unit i.e. locker / press.
**No -** Many personal items were stored on the floor due to limited storage.

(75) Vases
**Yes -** However, an exception noted was the stairwell area.

(77) Loose items such as patient's clothing should be stored in the patient's locker or property bag.
**No -** Due to limited storage, many personal items were stored on the floor.

(80) All office equipment (e.g. telephones, computers, fax machines) should be clean and well-maintained.
**No -** No responsibility is assigned for this task.

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

(81) All cleaning equipment should be cleaned daily.
**No -** Cleaning trolleys need further attention.

(82) Vacuum filters must be changed frequently in accordance with manufacturer's recommendations - evidence available of this.
**No -** When questioned, staff did not know how often filters should be changed.

(87) All cleaning equipment should be approved by the Hygiene Services Committee and ensure sufficient supply.
**No -** The Hygiene Services Committee is relatively new and compliance in this area will take some time.

(88) All cleaning equipment should be left clean, dry and tidy in the storage area after use.
**No -** Some trolleys and buckets observed needed attention.

(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 -** Limited dedicated storage facilities were available. Also, the sluice area was the primary area where solutions are mixed and disposed of.

(91) Storage facilities for Cleaning Equipment should be clean and well maintained.
**No -** Cleaning equipment was stored in a variety of locations.

(92) Cleaning products and consumables should be stored in shelves in locked cupboards.
**No -** These were stored on open shelves adjacent to patient care areas.

(94) Health and Safety policies should be in place for the use of ladders/steps when cleaning.
**No -** These policies were not available.

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

(212) Irish Standard 340: 2006 Hygiene in Food Service (Draft) of the National Standards Authority of Ireland (NSAI) specifies guidance to compliance with the requirements of S.I. 369 of 2006 EC (Hygiene of Foodstuffs) Regulations and Regulation (EC) No. 852/2004 on Hygiene of Foodstuffs. This should be complied with.
**Yes -** Current legislation is in place.

(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 -** The action items on the Environmental Health Officer reports need to be expedited.

(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 -** However, the food safety manual, HACCP flow charts and the HACCP plan need to be updated to the new IS340 standards.

(216) Documented processes for manual washing-up should be in place
**Yes -** No manual washing-up is carried out.

**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 -** Rear kitchen access observed was inadequate. The two access doors were left open, which poses a risk as freezers are stored in this area. The staff toilet needs restricted code access for catering staff only. The rear doors were also in a poor state of repair.

(218) Authorised visitors to the food areas should wear personal protective clothing (PPE) and wash hands on entering the food area during food preparation/serving times.
**Yes -** Personal protective equipment is worn; however, a jewellery policy must be enforced. Hair nets must also be worn correctly.

(223) Separate toilets for food workers should be provided.
**No -** Separate toilets are provided in the main kitchen but not at ward level. Locked access is also required for the catering toilet.

(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 in the main kitchen needs to be addressed.

(225) Staff in charge of Ward Kitchens shall ensure that product traceability is maintained while the product is in storage (Regulation (EC) 178/2002). Stock shall be rotated on a first in / first out basis taking into account the best before / use by dates as appropriate. Staff food should be stored separately and identifiable.
**No -** Best before dates of stock should be monitored more carefully.

(227) Flour, cereals, sugar etc shall be stored in a dry environment and when opened stored in covered containers.
**Yes -** However, the best before dates of ingredients should be displayed on the exterior of the bin.

(228) Unopened canned foods shall be stored above and segregated to prevent cross contamination.
**Yes -** Canned food observed was satisfactory.

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

(229) Animal and pest control measures shall be in place in all waste handling and storage areas.
**No -** Fly screens are required at the rear door and main kitchen windows to control flies.

(230) A supply of water should be available to clean down external waste storage areas.
**No -** This was not available.

(234) Where waste is stored in plastic bags these shall be removed frequently, closed securely and stored in a manner that does not pose any risk to the food business.
**No -** The rear waste area was in need of attention when viewed.

**Compliance Heading: 4. 4 .4 Pest Control**

(239) Fly screens should be provided at windows in food rooms where appropriate.
**No -** As outlined in the Pest Contractors report, fly screens and general proofing are required.

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

(242) Temperatures for Food in Fridges / Freezers and Displays should comply with I.S.340:2006 requirements
**Yes -** Temperatures are monitored daily. Corrective action is required for the high temperatures recorded.

**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 -** Most food is cooked from fresh.

**Compliance Heading: 4. 4 .9 Food Cooling**

(248) Cooling Times for Cooked Food should comply with I.S. 340:2006 requirements
**No -** No blast chill records were in place.

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

(249) Machines should dispense ice but where ice-scoops are used, they should be stored separately from the ice-making machine and there should be a process for the appropriate decontamination of the ice scoops. The making of ice cubes other than in ice machines is prohibited.
**Yes -** This is not applicable in this organisation.

(250) The dishwasher's minimum temperature for the disinfecting cycle should be compliant with I.S.340:2006 requirements and should be monitored regularly. There should be digital readouts on dishwashers.
**No -** Rinse temperatures do not comply with requirements for example, not reaching over 82 degrees Celsius.

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

(149) Inventory of Safety Data Sheets (SDS) is in place.
**No -** These were not available.

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

**Compliance Heading: 4. 5 .3 Segregation**

(256) Mattress bags are available and are used for contaminated mattresses ready for disposal; mattresses are disinfected.
**No -** No mattress bags were in place.

**Compliance Heading: 4. 5 .4 Transport**

(163) Documented processes for the transportation of waste through the hospital which minimizes manual handling of waste (and ensures that segregation of healthcare risk waste from non-risk waste is maintained) are in place.
**No -** While there were documented process in place, staff were not aware of the processes.

(165) There is a designated person trained as a Dangerous Good Safety Advisor (DGSA) or the services of a DGSA are available to the hospital.
**No -** No designated person is trained as a dangerous goods safety advisor.

(166) Drivers of vehicles transporting hazardous waste must be trained in accordance with the ADR Regulations.
**No -** No validation checks are carried out on drivers.

**Compliance Heading: 4. 5 .5 Storage**

(169) Documented process(es) for the replacement of all bins and bin liners.
**No -** No documented processes are in place for the replacement of bins and liners.

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

(173) Documented processes for the use of in-house and local laundry facilities.
**No -** No documented processes are in use for in-house laundry.

(174) Clean linen is stored in a designated area separate from used linen (not in sluice or bathroom).
**No -** Inappropriate storage of items in linen cupboards was observed and clean linen was stored in other inappropriate areas, for example, the sluice area.

(261) Clean linen store is clean, free from dust and free from inappropriate items.
**No -** Fans and other equipment were noted in linen cupboards.

(271) Hand washing facilities should be available in the laundry room.
**No -** No appropriate hand wash facilities were observed.

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

(197) Wall mounted/Pump dispenser hand cream is available for use.
**No -** No hand cream was noted in clinical areas.

(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.
**No -** This has not been carried out for 2007.

# 5.0 Appendix B

## *5.1 Ratings Summary*

| | Self Assessor Team | | Assessor Team | |
|---|---|---|---|---|
| | FREQ | % | FREQ | % |
| A | 0 | 00.00 | 1 | 01.79 |
| B | 54 | 96.43 | 9 | 16.07 |
| C | 2 | 03.57 | 44 | 78.57 |
| D | 0 | 00.00 | 2 | 03.57 |
| 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 | C | ↓ |
| CM 3.1 | B | C | ↓ |
| CM 4.1 | B | B | → |
| CM 4.2 | B | C | ↓ |
| CM 4.3 | B | C | ↓ |
| CM 4.4 | B | C | ↓ |
| CM 4.5 | B | C | ↓ |
| CM 5.1 | B | C | ↓ |
| CM 5.2 | B | C | ↓ |
| CM 6.1 | B | C | ↓ |
| CM 6.2 | B | C | ↓ |
| CM 7.1 | B | C | ↓ |
| CM 7.2 | B | D | ↓ |
| CM 8.1 | B | C | ↓ |
| CM 8.2 | B | C | ↓ |
| CM 9.1 | B | D | ↓ |
| CM 9.2 | B | C | ↓ |
| CM 9.3 | B | C | ↓ |
| CM 9.4 | B | C | ↓ |
| CM 10.1 | B | C | ↓ |
| CM 10.2 | B | C | ↓ |
| CM 10.3 | B | C | ↓ |
| CM 10.4 | C | C | → |
| CM 10.5 | B | C | ↓ |
| CM 11.1 | B | B | → |
| CM 11.2 | B | C | ↓ |
| CM 11.3 | B | C | ↓ |
| CM 11.4 | B | C | ↓ |

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