



## **Hygiene Services Assessment Scheme**

**Assessment Report October 2007**

**Mid Western Regional Hospital, Dooradoyle**

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

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

Hygiene is defined as:

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

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

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

### 1.1.1 Standards Overview

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

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

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

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

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

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

#### ***Core Criteria:***

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

In the Corporate Management standards, the core criteria cover:

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

In the Service Delivery standards, core criteria cover:

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

### **1.1.2 Rating Scale**

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

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

#### **A Compliant - Exceptional**

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

#### **B Compliant - Extensive**

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

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

### 1.1.3 Assessment process components

The assessment process involves four distinct components:

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

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

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

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

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

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

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

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

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

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

- **Continuous Improvement**

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

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

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

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

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

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

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

## **1.2 Organisational Profile**

The Mid-Western Regional Hospital was built in 1955 with a bed complement of 276. The site comprised of 28 acres in Dooradoyle on the road to Cork. The original building was constructed in reinforced concrete with a flat roof. The four-storey building made use of extensive windows and south facing sun-balconies to give a strong feeling of light to the ward areas. Patient accommodation was provided in a main spine comprising a surgical block with a four 28-bed units and a medical block with four 27-bed units.

Over the next 40 years many developments took place and presently the hospital has a bed complement of 426 in-patient beds including:

- 7 beds in Intensive Care Unit,
- 7 beds in Coronary Care Unit,
- 6 beds in High Dependency Unit.

The hospital has also 86 day places.

### **Services provided**

The specialities are as follows:

- A&E
- General Surgery
- Vascular Surgery
- General Medicine
- Renal Replacement Therapy
- Obstetrics/Gynaecology
- Trauma & Orthopaedics
- Paediatrics
- Radiology
- Nutrition and Dietetics
- Pharmacy
- Physiotherapy
- Social Work
- Anaesthetics, Intensive Care & High Dependency
- Pathology and Blood Transfusion Services
- Ophthalmology
- Oral/Maxillofacial Surgery & Dental Specialities
- Otorhinolaryngology
- Urology
- Acute Psychiatry
- STD
- Care of the elderly/Clinical Age Assessment
- Dermatology
- Rheumatology
- Breast Surgery
- Radiology/ specialties, MRI, CT Scanning, Nuclear Medicine
- Cancer Services including radiotherapy
- Medical Day Services/ Surgical/ Pulmonary Function/ Endoscopy/OPD etc.
- Cardiac Catheterisation Laboratory

The Mid-Western Regional Hospital is a regional referral centre for the Mid-West Region e.g. Renal, Endocrine, Maxillo-Facial, Cardiology, Clinical Age Assessment and Cancer services etc.

### **Physical structures**

There are no negative or positive pressure rooms in the hospital.

The following assessment of the Mid-Western Regional Hospital took place between 27<sup>th</sup> and 28<sup>th</sup> August 2007.

### **1.3 Notable Practice**

- The development of hygiene management structures within the organisation was noted.
- Upgrades to kitchens and below-par utility rooms in identified wards was noted.
- The use of hand gel at ward and department level was noted.
- Adherence to hand hygiene requirements, minimal wearing of jewellery and adherence to the uniform policy throughout the organisation was good.
- The palpable culture of desire to improve hygiene requirements was commendable.

### **1.4 Priority Quality Improvement Plan**

- Minor capital upgrade of clinical areas is recommended in many parts of the hospital.
- The removal of carpets from clinical areas should be expedited.
- The organisation is recommended to address storage facilities in the near future.
- The organisation should pay greater attention to specific areas of waste management, for example, sharps box assembly, written procedures for internal transportation of waste and auditing of the process to validate compliance with guidelines and best practice.
- The organisation should co-ordinate the roles and designation of duties for Contract and in-house staff.
- The involvement of patients/clients in hygiene issues should be progressed.
- Multidisciplinary auditing of each others areas utilising key staff within the organisation should be evaluated.
- Identification and monitoring of relevant key performance indicators for internal and contract staff should be progressed
- It is recommended that the organisation focus on disseminating and ensuring the integration of change to front line staff and the evaluation of same.

### ***1.5 Hygiene Services Assessment Scheme Overall Score***

The decision mechanism used to translate an organisation's criteria, risk ratings to a Hygiene Service Assessment Scheme score is based on a quantitative analysis of the assessment results which ensures consistency of application. The decision regarding a score is made by the Internal Review Committee of HIQA, based on the findings of the Assessment Team; the Mid Western Regional Hospital, Dooradoyle has achieved an overall score of:

**Fair**

**Award Date:** October 2007

## 2.0 Standards for Corporate Management

The following are the ratings for the Corporate Management standards, as validated by the Assessment team. The Corporate Management standards allow the organisation to assess and evaluate its activities in relation to Hygiene Services at an organisational level. There are fourteen Corporate Management standards, all of which are focused on four critical areas: leadership and partnerships, environment and facilities, human resources and information management. They include such subjects as corporate planning, allocating and managing resources, enhancing staff performance and contractual agreements. There are eight core criteria within these standards.

### PLANNING AND DEVELOPING HYGIENE SERVICES

#### CM 1.1 (B ↓ C)

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

The organisation intends to undertake a Hygiene Services Needs Analysis by utilising a surgical ward to pilot a template developed. This pilot study had not been undertaken at the time of the hygiene assessment. The organisation has utilised the national cleaning standards in the development of its new tender document for its contract cleaning services. Clarity of roles and responsibilities in relation to hygiene services at ward and departmental level will assist when undertaking a needs analysis in relation to human resources required for the hygiene service. The Hygiene Corporate Strategic Plan is for the HSE Mid –West Acute Hospitals within network area 7 and not specifically for the Mid-West Regional Hospital, Limerick. The Hygiene Corporate Strategic Plan should be evaluated with regard to how the Executive Management Team address hygiene services health promotion, its human resource needs and information management processes. The Hygiene Service Plan is specific to the hospital and outlines the plans for the provision and management of services within the hospital. The Operational Plan was still in draft form at the time of hygiene assessment. It has an applicable algorithm outlining the hygiene services structure within the organisation. The involvement of the patients/clients would enhance the required evaluation of the needs assessment process and impact directly with resultant actions and continuous quality improvement.

#### CM 1.2 (C → 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.**

Additional areas have been allocated to the contract cleaning and funding for the extra hours was sanctioned. An in-depth analysis of the findings of the audits being undertaken at local level and by management during walkabouts should be performed to evaluate any modifications undertaken and highlight the current needs.

## ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

### **CM 2.1 (C → 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.**

Specific linkages are in operation with the HSE and the Department of Health and Children (DoHC). The organisation works in conjunction with other hospitals within network area 7. A Regional Steering Committee has been set up to manage Hygiene and Cleanliness. Within the hospital, a Hygiene Services Committee and local team have been established. Patient/Client satisfaction surveys have been undertaken on two occasions in relation to satisfaction with catering and served meals and also satisfaction with out patient visits. In keeping with the organisation's Quality Improvement Plan (QIP), evaluation of the efficacy of linkages and partnerships should be undertaken.

## CORPORATE PLANNING FOR HYGIENE SERVICES

### **CM 3.1 (C → C)**

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

While the Hygiene Corporate Strategic Plan for the network area hospitals contains clearly defined goals, objectives and priorities, the related costings are not indicated in the plan. The plan lists the multidisciplinary team members who had input into the plan. No patients were directly involved and their inclusion in the plan is recommended. Communication within the organisation is through emails, internal postal mail, ward/area meetings from members of the Hygiene Services Committee and team. Evaluation of the Hygiene Corporate Strategic plan will add value to the outcome of the entire process.

## GOVERNING AND MANAGING HYGIENE SERVICES

### **CM 4.1 (C → C)**

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

The organisation's hygiene services structure makes provision for accountability, responsibility and channels of communication. Minutes viewed of Hygiene Services Committee, Hygiene Services Team and Infection Control Committee meetings demonstrated commitment to hygiene and discussion of hygiene related issues.

The draft Hygiene Services Operational Plan outlines the structures in place for the hygiene services in an algorithm. In keeping with the organisation's QIP, audit of corporate policies and procedures in relation to hygiene and cleanliness will allow for evaluation of adherence to the policies.

**CM 4.2 (C → C)**

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

Evidence was seen of compilation of audit results for trend analysis. The utilisation of this information into a formalised action plan will improve the outcome of the hygiene services for the organisation. The development of Key Performance Indicators (KPI's) for internal and contract agencies in hygiene services is strongly recommended for the organisation.

**CM 4.3 (C → 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.**

Use of best practice information (for example SARI Guidelines, BICS, national cleaning manual), library, education/training and the expertise of regional and local multidisciplinary committees and teams, was evident in the improvement of the hygiene service. A number of new hygiene initiatives have been introduced over the last two years. Documented evidence was observed of ongoing induction and continuing hygiene related education. Information is communicated via emails, memos, hospital newsletter and minutes of regional and local meetings. Evaluation of both the household and contract services should be undertaken from the point of view of a quality of service and cost benefit analysis. Quality improvement plans were available and the organisation is encouraged to progress these.

**CM 4.4 (C → C)**

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

A documented process for the development approval, revision and control of all policies, procedures and guidelines including those relating to Hygiene Services was not evident during the hygiene assessment. A standard template for all new and revised policies procedures and guidelines, that reflects best practice, is required.

Some hygiene-related policies already exist and, which were in a structured format. Some standard operating procedures, such as internal transportation of laundry, have not been documented. Evaluation of the efficacy of the process for developing and maintaining the policies and procedures needs to be incorporated into a quality improvement plan.

**CM 4.5 (C → C)**

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

There was evidence of the involvement of the Hygiene Services Committee in the Organisations recent and planned capital developments. The Hygiene Services Committee and team involvement in minor capital works in the future is planned, through its hygiene management structures. This will ensure comprehensive Hygiene Service input into all new developments. The evaluation of the efficacy of the consultation process is recommended.

## 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.**

The reporting relationships and responsibilities/accountabilities for hygiene services has not been clear, however the algorithm in the draft hygiene operational plan gives clarity to relationships at local ward and area level. The organisation, in conjunction with the unions, is currently addressing specific hygiene tasks applicable to individual grades of staff. The organisation, during interview, suggested that national job descriptions for all grades would assist in removing ambiguity in relation to the responsibilities of different grades in relation to their roles in hygiene services.

\*Core Criterion

### **CM 5.2 (A ↓ B)**

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

A multi-disciplinary hygiene and cleanliness regional steering committee has been in existence since May 2005. In preparation for the hygiene assessment, the organisation developed two hospital specific groups; the Hygiene Services Committee and the Hygiene Services Team. The roles and responsibilities of the teams, quorum for meetings, schedule of meeting and administrative support was evident through documentation during the hygiene assessment.

Whilst the multi-disciplinary teams are inclusive of patient services it has not specifically documented the involvement of a patient representative group. Further representation from the medical staff would broaden the multi-disciplinary ethos of the committees. Evaluation of the effectiveness of the multidisciplinary groups is recommended.

## ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

### **CM 6.2 (B ↓ C)**

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

The Hygiene Services Committee and team are involved in product and equipment purchasing. They are also involved in all minor capital works. The Infection Control team work closely with the Purchasing/Procurement Department and are involved in the purchase of specific patient equipment and infrastructural improvements. The purchase of hand gels and waste bins are examples of involvement. A new equipment library is planned to ensure a multidisciplinary approach to equipment procurement and maintenance. Evaluation of the efficacy of the consultation process between the Hygiene Services Committee and senior management with resultant action, feedback is advocated.

## MANAGING RISK IN HYGIENE SERVICES

### **CM 7.2 (B → B)**

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

Resources allocated to risk management over the last two years had been detailed. Financial resources were made available to purchase alcohol hand gels, spill kits, and needle proof gloves to assist in hygiene services risk management over the last

two years. The Hygiene Services Team is represented on the Risk Steering Committee. No major adverse hygiene service incidents were reported over the last two years. The assessing team recommend that the organisation highlight to the ward and unit managers the use of the risk incident forms to report adverse hygiene events.

## 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 management of contracts is at regional and local level. As a result, comprehensively defined written contracts for the provision of contracted hygiene services (for example, linen, cleaning, water maintenance and waste management) specifying all relevant aspects (for example, duration, liabilities, conflict resolution, specifications and frequencies etc) are held at regional level. During interview, management verbalised their confidence in the process of contract management. This process should be formalised.

### **CM 8.2 (C → C)**

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

The Cleaning Services Contractor has appointed an onsite Cleaning Supervisor for the Organisation and provides training to its staff in accordance with the British Institute Cleaning Standards (BICS). The inclusion of the Cleaning Supervisor on the Hygiene Services Team is evidence of an integrated approach. Greater involvement of contractors in the area of quality improvement activities is recommended in keeping with the organisation's quality improvement plan.

## 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 new clinical delivery areas were evidence of best practice and details of regulations and codes were adhered to. A programme of moving patient care areas from the older areas to accommodate refurbishment was in place. A development programme was evident addressing the requirement to upgrade all clinical wash hand basins. It was noted that many structures were made of wood and did not facilitate ease of cleaning. Storage areas should be reviewed. It was evident that the external area used for storage of laundry facility needed major refurbishment. The use of external entrance areas for smoking by visitors and the associated litter created should be reviewed.

\*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 Organisation had processes in place to manage its environment and facilities, equipment and devices, kitchens, waste and sharps and linen, however all services

under contract were not viewed during the assessment. The organisation is encouraged to evaluate and review contracts and service contracts pertinent to their own organisation.

**CM 9.3 (C → 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.**

Evaluations of cleaning services included hygiene audits performed. Patient perception and satisfaction surveys that have been undertaken in outpatients rated very high in terms of satisfaction with the organisations management of hygiene services. Satisfaction surveys need to be expanded hospital-wide. A list of organisational achievements and improvements within the last year was available, evidence of which was viewed during the assessment. Waste management, both healthcare risk and non-risk waste needs to be reviewed.

**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.**

The organisation adheres to legislation and code of practice for public appointments. Legislation is adhered to in relation to the tendering process for contractors. The Cleaning Services Contractor has its own processes for selection and recruitment of staff. Job descriptions were being reviewed and updated to detail their responsibilities in relation to hygiene. Human Resources maintain all recruitment and competition records. Evidence of training on interview techniques was viewed during the hygiene assessment. There was no evidence viewed of evaluation of the process for selecting and recruiting human resources. This is suggested as a Quality Improvement Plan (QIP).

**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.**

The pilot study on the surgical ward to assess the resources required to meet the cleaning frequencies (as outlined in the acute hospital cleaning manual) had not yet been undertaken. The requirement is to segregate food handling staff from ward cleaning staff is in keeping with best practice and food safety standards. Changes in work capacity and volume in Hygiene Services over the past two years has included portering and contract staff. Evaluation of work capacity and volume should be reviewed and resultant action and feedback to service users undertaken as a continuous Quality Improvement Plan.

**CM 10.3 (C → C)**

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

Induction and staff training programmes are in place for all new staff. On –going education and training is provided as required and is specific to the area of employment (in Catering- food hygiene, and in Cleaning Services – BICS).

Evaluation of the level of staff attending mandatory training on hand hygiene and management of waste is suggested as a Quality Improvement Plan.

**CM 10.4 (B ↓ C)**

**There is evidence that the contractors manage contract staff effectively.**

The reporting structure of the contractors is identified on the operational hygiene structure. Training and orientation is provided for the contracted staff. Occupational needs for contractors involved in cleaning are managed on site by the hospital Occupational Health Department. The contractor for cleaning services has received ISO Accreditation. Documentation and certificates were produced during the assessment. It is recommended that evaluation of the appropriate use of all contract staff be undertaken as a continuous Quality Improvement Plan.

**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**

Induction/orientation is provided for staff. Ongoing hygiene awareness training is in place. Education delivered includes Health and Safety, Infection Control, Health promotion and Occupational Health, Food Hygiene training and FETAC skills programme. A database was viewed at local level indicating when training had been delivered to staff.

**CM 11.2 (A ↓ 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.**

There was documented evidence of education and training with specific specialists providing training for relevant areas and staff groups. Specific training is provided in the use of new equipment. While staff are facilitated to attend all mandatory and other relevant training, there was not a documented process for providing protected time for attendance. Records are maintained for each training session; however, evaluation of the relevance of education to each staff member was not in place. The organisation is encouraged to assess models such as the "Kirkpatrick Model" for learning and training evaluation.

**CM 11.3 (C → C)**

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

Evaluation of the induction programme has been undertaken and adaptations made in response to critical appraisal. Use of Key Performance Indicators (KPI's) to evaluate efficacy of training would improve resultant actions, feedback and assist in quality improvement. The 'Kirkpatrick method' of evaluation (or similar) could be considered in the future.

## PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

### **CM 12.1 (C → C)**

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

Details of the service and vaccinations were available during the assessment process. An evaluation of the service provided by occupational health had not been undertaken. This is recommended.

### **CM 12.2 (C → C)**

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

The organisation is a member of the health promotion hospitals network. A Risk Management approach to staff well-being is used throughout the organisation. Systems of reporting, investigating, monitoring and analysing data regarding health incidents and accidents are in place in Occupational Health, and Risk Management. The Occupational Health Department monitors sick leave records. A Pregnancy Risk Assessment, and risk assessment post specific injuries are currently undertaken through the Occupational Health Department. Documented evidence of evaluation of the monitoring mechanisms used by the occupational health department was not evident during the hygiene assessment and is recommended.

## 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.**

A documented process for collecting and providing access to data and information from both qualitative and quantitative sources was not available. This has been identified as a QIP. This development is recommended and once established its effectiveness should be evaluated. Internet and intranet facilities are utilised to access hygiene related data and assist in updating policies. Staff have access to journals and library facilities. Trend analysis of hygiene audits is being compiled; however, it was not evident how this information was being delivered to the service user. It is recommended that this is completed and formalised.

### **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.**

Reports and Quality Improvement Plans have been generated with a view to improving hygiene services. An annual Hygiene and Infection Control Service Plan report was evident, however, this was not signed off and it was not evident how this report was disseminated throughout the organisation. The evaluation of the data and information turnaround is recommended. Documented evaluation of user satisfaction in relation to the reporting of data was not evident, which is also recommended.

**CM 13.3 (B ↓ C)**

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

The details of changes in data collection and information reporting over the last two years were not evidenced during the hygiene assessment. The organisation should evaluate the methods of data collection in relation to service provision and improvement. Examples could include documented tracking of curtain change and the use of a checklist by contractors to monitor attention to hygiene requirements of equipment used.

**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**

During the assessment, there was a noticeable desire to improve hygiene services within the organisation. Many management structures and some new posts have been put in place within the last two years and structural changes have also been undertaken. The management secured funding for hygiene related projects in the past 12 months and capital development plans and refurbishment projects are planned.

**CM 14.2 (B ↓ C)**

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

The Organisation participated in the two national hygiene assessments and undertook a number of internal audits, they have identified the Corporate and Service delivery committee and team to address its hygiene services requirements.

The specific identification of the ward/department managers as the ultimate responsible person for hygiene in their own ward/department would give clarity to roles, authorities and accountabilities in all areas. It is recommended that the hospital would further develop Key Performance Indicators, increase evaluation of the hygiene services and the utilisation of benchmarking. The further involvement of IT and use of software would assist in the evaluation of improved outcomes.

### 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.**

There is evidence of use of the Infection Control Nurses Association (ICNA) audit tool to monitor Hygiene services in Clinical areas and feedback with resultant actions via walkabout by management. This ensures that any areas of non compliance are evaluated and addressed immediately following the audit and by the appropriate staff member. Some issues identified during the hygiene assessment for example, dust in high areas and management of waste indicate that further evaluation of the adoption of best practices is required.

##### SD 1.2 (C → C)

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

Whilst a request has been submitted from the hygiene services committee for the creation of a maintenance report, a follow up structure has not yet been implemented.

#### PREVENTION AND HEALTH PROMOTION

##### SD 2.1 (C → C)

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

There is evidence of hand hygiene promotion for both patients and visitors. The organisation utilised the media in the event of an outbreak of Norovirus, to reduce the number of visitors and patients to the hospital. The organisation should include the service users in hygiene focus groups and committees.

## INTEGRATING AND COORDINATING HYGIENE SERVICES

### **SD 3.1 (C → C)**

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

There is evidence of good co-operation from the multi-disciplinary teams, including the allied health professionals. However, the medical team's involvement on the Hygiene Services Committee should be documented.

## IMPLEMENTING HYGIENE SERVICES

\*Core Criterion

### **SD 4.1 (B → B)**

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

The cleaning of the environment is the joint responsibility of the cleaning contract company and the in-house ward attendant staff. Some areas are to be commended, including the Physiotherapy and Out-patients departments, which were clean and had minimal clutter. The storage of clinical equipment on corridors and decommissioned equipment noted in many areas of the hospital should be addressed. High dusting should be addressed. Several clinical areas had floors covered in carpet, including the waiting areas, examination rooms and treatment rooms. These must be removed and replaced with a suitable and cleanable floor covering. There is a plan in place for this; however, it should be addressed in the near future. There was no documented evidence of a rota for the cleaning of the carpets in the clinical area. A Standard Operating Procedure for this should be developed with a rota for its implementation. Accountabilities should be clearly defined.

For further information see Appendix A

\*Core Criterion

### **SD 4.2 (B ↓ C)**

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

The standard of cleaning of equipment does not appear to be universal. Bed frames and bed trolleys in many areas were noted to be in need of attention. This included those that were in use and those that were on the corridor. Close patient equipment was also found to be dusty. The responsibility for the cleaning of patient equipment must be clearly defined, monitored and recorded on a regular basis.

For further information see Appendix A

\*Core Criterion

### **SD 4.3 (C → C)**

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

The cleaner's equipment store room was found to be requiring attention. It is recognised that storage facilities in the organisation are in short supply. However, whilst there was no hand wash sink in the room, there was alcohol gel available. The installation of a dedicated hand wash sink and vented dryer was recommended. In response to this finding during the assessment, the contract cleaning company

verified the ordering of a dryer by producing a copy of the purchase order form. A Protocol must be written for its management. There was no evidence of segregation of used cloths on some of the trolleys, which should be placed in a separate container in preparation for laundering. The storage of cleaning equipment in the Physiotherapy Department should be reviewed.

For further information see Appendix A

\*Core Criterion

**SD 4.4 (B ↑ A)**

**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.**

Best practices in the management of catering and catering operations are adhered to in many areas. The catering department is in the process of addressing the dual role undertaken by ward staff in both cleaning and catering. Evaluation of this dual role is to be encouraged. When questioned, patients complimented the standard of food presented to them.

For further information see Appendix A

\*Core Criterion

**SD 4.5 (C ↑ 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.**

The inappropriate temporary storage of healthcare risk waste bags outside the theatre was addressed by the organisation. The review of waste management documentation was complete; however, the appointment of a designated Waste Management Officer would be of benefit to the organisation. A review of waste segregation is recommended in the pathology department, thus minimising the use of Sharps bins where leak-proof bins would be sufficient and would be in accordance with best practice. The replacement of waste bins in the pathology department by hands free, silent closure bins is recommended. Healthcare non-risk wheeled bins at the compactor must be cleaned on a daily basis; or more frequently if required. Currently these bins are brought to the wards/departments to prevent secondary handling. It is recommended that the healthcare risk waste yard is enclosed to guarantee restricted access to it, especially by the public.

For further information see Appendix A

\*Core Criterion

**SD 4.6 (B ↑ A)**

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

The physical environment (a temporary building in need of significant refurbishment/replacement) where the Laundry/Linen is handled and stored, is sub-standard. Staff working there are to be commended for their dedication and management of a difficult environment.

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**

The education and training of staff includes an extensive section of hand hygiene techniques. The organisation has several quality improvement plans in place including the replacement of hand wash sinks to comply with HBN 95 and the replacement of taps in the clinical areas to hands free units. An increase in the number of Alcohol Gels in public areas is recommended to encourage use by the public at the entrances to the building. An increase in the number of hand hygiene posters and information on the correct usage of alcohol gels is recommended in both clinical and non clinical areas. The usage of alcohol gels by staff in all clinical areas is to be commended.

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.**

The clinical incident reporting forms do not directly relate to Hygiene Services, however, this issue is to be addressed by risk management within the organisation. The organisation has not yet completed their Quality Improvement Plan for the provision of an external audit on Health and Safety. Issues identified during the hygiene audit in relation to waste management indicate the importance of identifying waste issues through risk management.

**SD 4.9 (C → C)**

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

Patient/client leaflets are available regarding hand hygiene, MRSA and healthcare associated infections. There is a visitor's policy; however, there is no evidence of evaluation of its efficacy.

The Hygiene Services Committee does not include a member of the public. . It is recommended that a member of the patient group is invited to sit on the committee.

**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.**

The rights of patient are respected by the organisation. An example of this was the Isolation Room signage (this discreetly indicates 'No Entry' - and no reason is given). There is documented evidence in Hygiene Services Committee minutes that there is protected time for ward cleaning, thus ensuring that medical staff do not undertake ward rounds during cleaning times. This is commended.

**SD 5.2 (C → C)**

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

There is a patient information leaflet; however this does not pertain to Hygiene Services. There is no ongoing evaluation of hygiene services, which is recommended.

**SD 5.3 (C → C)**

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

There is a documented process for dealing with patient complaints in line with organisational policy, however there should be increased evaluation of the efficacy of this process.

**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.**

A patient satisfaction survey was undertaken by the Outpatient Department in January 2007, however there was only one question regarding Hygiene Services. This did not provide the patient/client the opportunity to give their opinion of the quality of hygiene that was delivered. It is recommended that a further patient/client satisfaction survey is undertaken specifically to evaluate the hygiene service within the organisation. It is also recommended that In-patients in the clinical area be included in this survey. This would give the organisation a true evaluation of the service provided. Greater representation of the external service contractors is recommended on the Hygiene Services Committee, which should include those that provide the Linen Service and the external catering company operating the cafeteria in public areas.

**SD 6.2 (C → C)**

**The Hygiene Services team regularly monitors, evaluates and benchmarks the quality of its Hygiene Services and outcomes and uses this information to make improvements.**

There is regular audit of clinical areas undertaken using the ICNA audit tool. Also, the organisation's management undertakes walkabouts with feedback to the appropriate ward/departmental manager and the Hygiene Services Committee.

Alcohol gels were introduced in the last 2 years in all areas to improve hand hygiene compliance.

**SD 6.3 (C → C)**

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

Whilst an annual report is produced, greater inclusion of the service users is recommended. It is recommended that a member of the patient association is invited to sit on the Hygiene Services Committee and to be included in the production of this document.

## 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** - Dirt and dust were noted in general areas including public access corridors. However, the Outpatients Department was clean and dust free.

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

**No** - In general walls were in poor condition with flaking paint; this is not ideal for effective cleaning.

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

**No** - In general wall and floor tiles were in poor condition.

(4) Floors including edges, corners, under and behind beds are free of dust and grit.

**No** - Floor edges were noted to be dusty in several areas, including behind beds.

(5) Cleanable, well-maintained furniture, fixtures and fittings used.

**No** - Skirting boards in the Emergency Department are not amenable to cleaning.

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

**No** - Vents were dusty and in need of attention in many areas. There was a lack of awareness of the responsible for their cleaning.

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

**No** - The entrance area was poorly maintained with paper and cigarette ends visible

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

**No** - The external areas of the Hospital were poorly maintained with dirt and paper debris throughout.

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

**Yes** - Some bins, both healthcare risk waste and non risk waste, were noted to be in need of attention inside and out. Exceptionally, the bins in the Physiotherapy Department were very clean.

(16) Hospitals are non smoking environments. However, cigarette bins should be available in external designated locations.

**Yes** - Cigarette bins were available; however the area around the bins was littered.

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

**Yes** - When questioned, staff were able to demonstrate the colour coding of cloths.

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

(18) Walls, including skirting boards.

**No** - Skirting boards in many areas including Accident and Emergency Department, and public corridors were noted to be dusty and in need of attention with the exception of the Kitchens.

(24) Ventilation and Air Conditioning Units.

**No** - Air Vents in the Accident and Emergency department were noted to be extremely dusty and in need of attention, both inside and out.

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

**No** - Carpets in the Outpatient Department and paediatric physiotherapy treatment rooms were noted to be in need of attention and stained. These are not suitable for Clinical Areas and must be replaced in both waiting areas and Examination rooms.

(26) Nozzles of wall mounted alcohol gels and hand disinfectants must be cleaned daily.

**Yes** - However, the responsibility for the cleaning of alcohol gel nozzles is not clearly identified.

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

(207) Bed frames must be clean and dust free

**No** - Bed frames were noted to be dusty.

(208) There should be a process for the cleaning of curtains and blinds. Curtains should be changed after each known case of infected patient / client where required. Records should be maintained of curtain changing.

**Yes** - There is a policy for changing of curtains of which the staff are aware and adhere to.

(209) Air vents are clean and free from debris.

**No** - Air vents in Accident and Emergency department were noted to be in a poor condition. There was no documented process for the regular maintenance and cleaning of air vents.

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

(34) Beds and Mattresses

**No** - Many bed frames were noted to be dusty and in need of attention.

(35) Patient couches and trolleys

**No** - Patient trolleys in the Accident and Emergency department and on the corridor outside Theatre require attention.

(36) Lockers, Wardrobes and Drawers

**No** - Tops of wardrobes were noted to be very dusty.

(38) Dispensers (e.g. handwash dispensers), Holders and Brackets

**No** - Hand wash dispensers were noted to be dusty especially in the Pathology department.

(40) Curtains and Blinds

**Yes** - Some staining was noted on the curtains in the Accident and Emergency Department.

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

(48) Floors including edges and corners are free of dust and grit.

**No** - Floor edges in the public toilets in the Accident and Emergency Department and Main Hall were noted to be in need of attention.

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

(55) Sluices

**Yes** - Items were stored at floor level in some below-par utility rooms.

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

**No** - Separate hand wash sinks were not available in the many below-par utility rooms.

(60) All outlets (including shower outlets) should be flushed at a temperature in accordance with current legislation.

**Yes** - A Tap Flushing policy is in place and record of compliance was viewed.

**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** - Patient beds and trolleys were noted to be in need of attention and some were dusty.

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

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

**No** - Patient fans were in use and observed to be dusty.

(69) Patient washbowls should be decontaminated between each patient, and should be stored clean, dry and inverted. Damaged washbowls should be replaced.

**No** - In the absence of washer/disinfectors in sluice rooms an SOP for manual disinfection of measuring jugs is required.

(70) Bedpans, urinals, potties are decontaminated between each patient.

**Yes** - Paper made disposable products were in use in all areas.

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

(71) Alcohol hand gel containers.

**Yes** - Alcohol gels were in use with all close patient contact equipment.

(72) Trolleys, e.g. chart trolleys, drug trolleys, linen trolleys, shop trolleys, emergency trolleys, suction apparatus, resuscitation equipment i.e. ambubag and mask.

**No** - Some wheels and feet of Intravenous drip stands were noted to be dusty. Emergency trolleys were also dusty.

(75) Vases

**Yes** - Flower vases are not in use.

(76) Hand-wash dispenser holders and brackets should be free of product build-up around the nozzle.

**No** - Alcohol gel nozzles blocked in many areas. No splashes seen on walls floor or furniture.

(80) All office equipment (e.g. telephones, computers, fax machines) should be clean and well-maintained.

**No** - Computer keyboards in most areas were noted to be dusty and in need of attention. Keyboard covers were not in use.

**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 equipment was found not to be clean, on discussion with the contract cleaner's supervisor and area manager it was recommended to them to devise a checklist for their staff to include the cleaning of equipment used.

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

**No** - The contract cleaning company intend to implement and record the changing of vacuum filters in accordance with manufacturers' instructions.

(83) Mop heads are laundered daily and are stored according to local policy or are disposable i.e. single use.

**No** - Whilst mop heads were washed on a daily basis they were not dried prior to storage. Evidence of purchase order for industrial dryer was observed prior to completion of assessment.

(85) Cleaning solutions should only be prepared in a well ventilated area and should never be mixed.

**No** - The rooms used for the preparation of cleaning solution were not well ventilated.

(86) Information on the colour coding system is available to all hygiene staff (according to national guidelines).

**Yes** - Whilst information regarding colour coding was evident, some operatives were observed on occasions as being non-compliant in its use. That is using the wrong colour cloth for cleaning an area.

(88) All cleaning equipment should be left clean, dry and tidy in the storage area after use.

**No** - Cleaning equipment including cleaning trolleys and buffers were found to be in need of attention. The trolleys used by Ward attendants were observed to be clean on areas visited.

(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** - No hot water supply was found in the Contract Cleaners Store room and no structural hand hygiene facilities were available. Alcohol gel was available to staff in this area. The cleaning equipment in the Physiotherapy Department was inappropriately stored in the Store room.

(91) Storage facilities for Cleaning Equipment should be clean and well maintained.

**No** - The contract cleaners store room was found to be cluttered, and in need of attention with inappropriate items including personal items and tea making facilities.

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

**Yes** - In many areas cleaning products were not stored in locked cupboards. The cleaning contractors have a separate room for the storage of chemicals.

(93) Cleaning products and equipment should comply with the relevant colour coding policy.

**Yes** - Cloths comply with colour coding policy however some staff did not appear to comply in their use.

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

**Yes** - All new cleaning equipment brought into the organisation when the contractors were awarded the contract, is compliant.

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

(213) Environmental Health Officer (Senior EHO/EHO) reports on food safety inspections including the completed summary stage of compliance with HACCP and annual water analysis reports should be retained on the Hospital Food Safety Manual. Action plans/ actions taken on foot of issues raised in the reports should be documented.

**Yes** - Water report results were reviewed and found to be compliant.

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

**No** - There is no evidence of compliance; however a draft is in existence and is to be implemented shortly.

**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.

**Yes** - Signs were observed on entrance doors and keypad locks indicated restricted access.

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

(240) A Hospital using a cook-chill system should comply with Guidance Note No. 15 Cook-Chill Systems in the Food Service Sector (Food Safety Authority of Ireland) The temperatures of fridges, freezers, cold rooms and chill cabinets shall be capable of maintaining the temperature of foodstuffs

**Yes** –a 'freshly-prepared food system' is in operation.

(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** - This is not applicable as no ice cream display cabinets were evident.

**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** - An ice making machine was examined in one ward exclusively for patients with throat difficulties – a service contract is in place.

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

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

**No** - While staff could verbally outline the method, there was no documented process for the transportation of waste within the hospital.

(143) Healthcare risk waste bags should be removed when no more than two-thirds full or at the maximum indicated by the bag manufacturers.

**No** - Healthcare risk waste bags were left inappropriately on the staircase. This issue was resolved during the assessment.

(144) Healthcare risk containers should only be filled up to the manufacturers' fill or line or maximum three quarters full.

**Yes** - Some healthcare risk waste bags were noted to be more than 2/3 full.

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

**Yes** - A documented audit trail from generation to disposal was undertaken in January 2006.

(147) Only UN approved containers and bags to be used for healthcare risk waste.

**No** - The healthcare risk waste bin outside the Renal unit was lined with a green property bag. The use of sharps bins for the disposal of non sharp microbiological

waste should be reviewed. Sharps bins were in use in the cleaning contractors' room for the storage of cloths.

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

**No** - Health care risk waste bags were left inappropriately at a fire exit and in the Pharmacy IV fluid storage area. These issues were addressed by the organisation during the hygiene assessment.

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

**No** - The discharge to drain licence has been applied for.

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

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

**Yes** - C1 and Trans-Frontier shipment forms 2005, 2006 and 2007 were reviewed.

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

(255) Within Healthcare risk waste, all special wastes including drugs & cytotoxic drugs / materials are segregated.

**Yes** - Whilst cytotoxic waste is segregated within the waste compound, it is suggested that it is segregated at source to discourage secondary waste handling.

(256) Mattress bags are available and are used for contaminated mattresses ready for disposal; mattresses are disinfected.

**No** – These were not available.

(156) Healthcare risk waste must be segregated from healthcare non risk waste.

**Yes** - Some inappropriate segregation of waste was noted, including the disposal of gloves and paper towels in sharps bins.

(159) Sharps boxes are correctly sealed, labelled and stored in a safe environment.

**No** - Some Cytotoxic sharps bins were noted to be incorrectly assembled within the waste management compound. Most sharps bins were signed and dated at assembly.

#### **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 staff could verbally outline the method utilised, there was no documented process for the transport of waste through the hospital, thereby reducing the risk of manual handling of waste.

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

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

**No** - There is no documented process for the replacement of bins and bin liners.

(257) Adequate segregation facilities for the safe storage of healthcare risk waste are locked and inaccessible to the public. Appropriate warning signs restricting public access should be prominently displayed.

**Yes** - Whilst the waste management compound is locked it is not completely inaccessible to the public as it is not covered.

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

**No** - Non-Risk waste bins were found to be in need of attention both inside and out.

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

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

**No** - There is no designated Waste Management 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.

**Yes** - Education records were reviewed for the training of staff in Waste Management.

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

(261) Clean linen store is clean, free from dust and free from inappropriate items.

**Yes** - The building containing the linen store is sub-optimal but clean.

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

**Yes** - Bags of soiled linen are stored in a designated 'corridor' which is exclusive to the Linen /Laundry area.

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

**Yes** – This was not applicable as no ward based washing machines were observed.

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

(188) Hand and wrist jewellery should be removed prior to performing all levels of hand hygiene with the exception of a plain wedding band.

**No** - Wrist watches were worn by members of the healthcare staff in the clinical area.

(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** - Access to hand wash sinks was obstructed in several locations.

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

**No** - Not all taps in the clinical setting were hands free. A programme of replacement to elbow operated taps was in place.

(194) Dispenser nozzles of liquid soap or alcohol based hand rubs must be visibly clean.

**No** - The nozzles of alcohol gels were noted to be clogged in numerous locations.

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

**Yes** - Air dryers were in use in the public toilets only.

(198) Hand hygiene posters and information leaflets should be available and displayed throughout the organization.

**No** - There were insufficient posters for the instruction on hand hygiene technique. This included both hand wash at each sink and instruction in the use of alcohol hand gels.

(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** - The organisation has a Quality improvement plan in place for the replacement of hand wash sinks that comply with HBN 95.

## 5.0 Appendix B

### 5.1 Ratings Summary

	Self Assessor Team			Assessor Team
	FREQ	%	FREQ	%
A	2	03.57	2	03.57
B	26	46.43	12	21.43
C	28	50.00	42	75.00
D	0	00.00	0	00.00
E	0	00.00	0	00.00
N/A	0	00.00	0	00.00

### 5.2 Ratings Details

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

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