Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Hygiene Services Assessment Scheme

Assessment Report October 2007

Naas General Hospital

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1.0 Executive Summary

1.1 Introduction

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

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

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

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

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

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

1.1.1 Standards Overview

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

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

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

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

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

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

Core Criteria:

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

In the Corporate Management standards, the core criteria cover:

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

In the Service Delivery standards, core criteria cover:

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

1.1.2 Rating Scale

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

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

A Compliant - Exceptional

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

B Compliant - Extensive

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

C **Compliant - Broad**

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

D **Minor Compliance**

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

E **No Compliance**

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

N/A **Not Applicable**

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

1.1.3 Assessment process components

The assessment process involves four distinct components:

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

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

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

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

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

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

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

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

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

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

- **Continuous Improvement**

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

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

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

[2] New York Department of Health and Mental Hygiene

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

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

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

1.2 Organisational Profile

Naas General Hospital is one of 5 acute general hospitals in Hospital Network 9 in the Dublin/Mid Leinster Area of the HSE.
With capacity of 243 beds, the hospital serves the catchment area of Kildare and West Wicklow, an area with rapidly growing population of some 200,000 people.

It is located on the southern perimeter and within walking distance of the centre of Naas Town.

The hospital's catchment area is County Kildare excluding all areas north of Prosperous and also encompasses West Wicklow. The hospital provides acute emergency care for this region.

Services provided

Naas General Hospital provides acute secondary hospital care in Medicine and Surgery for all persons over the age of 14 years.

An important aspect of the hospital's role is the provision of a 24-hour Accident and Emergency (A/E) service.

The hospital has a full range of diagnostic services including Radiology and Pathology, Physiotherapy, Cardiology, Nutrition and Dietetics, Speech and Language, Occupational Therapy and Pharmacy.

Lakeview unit is a 30 bedded unit which is an acute psychiatric admission unit but it is funded separately by PCCC.

The Outpatient department is on level 2 and level 3. Clinics include medical, surgical, orthopaedic, fracture clinics, respiratory medicine, cardiology, care of the elderly, gastroenterology, psychiatry, anti-coagulation, pain management, Ante-natal clinic run by the Coombe Hospital, Dental surgeries run by community dental service.

Physical structures

The hospital currently has 243 in-patient beds which includes 13 day service places, an Intensive care unit, a Coronary care unit and 5 Oncology day places. It has an Out-patient department, an Emergency department, three theatre Operating departments, a modern X-ray and Imaging department, a sophisticated Laboratory Medicine department and a full range of physical medicine and therapeutic departments including Pharmacy.

The campus is a combination of both old and new buildings both accommodating inpatients. The newer part of the hospital was commissioned and opened on a phased programme during 2003 and 2004. The campus is still under development and will open a new HSSD in 2007.
Two in-patient wards, a day-case centre, and a replacement Physical Medicine department will be commissioned in late 2008 and replacement kitchens, dining hall and other support facilities will be opened in 2010.

The accommodation at present consists of:

- Wards (mostly 31-bedded):
    - Intensive Care Unit – Four Beds
    - Coronary Care Unit – Six Beds
    - Moate Ward – Respiratory and Cardiac Care.
    - Curragh Ward – Medical Care
    - Imaal Ward – Age related medical Care
    - Liffey Ward – Medical Care
    - Slaney Ward – Medical Care
    - Allen Ward – Surgical
    - Day services – 13 day services.
    - Oncology Day places
    - Day Hospital – Care of the older person

- The Out-patients department is on 2 floors and includes:
    - 19 Consulting rooms
    - 3 Treatment rooms
    - Clinical nurse specialists
    - Dieticians
    - Speech and Language Therapy
    - Cardiology department
    - Phlebotomy department
    - 2 Dental suites with integral X-ray room

- The Emergency Department includes:
    - 2 resuscitation bays
    - 1 Nurse Triage Station
    - 8 Examination cubicles
    - 2 Treatment rooms
    - 1 Assessment room
    - 8 Observation bays

The following assessment of Naas General Hospital took place between 17th and 18th July 2007.

1.3 Notable Practice

- The policy relating to the Catering Department having full control of the ward kitchens was to be commended.
- Staff commitment to the Hygiene Process was very evident throughout the hospital.
- Management of risk was found to be most satisfactory.
- The collection and extrapolation of data from patient satisfaction surveys was commended and will assist in driving the process forward in a positive manner into the future.

1.4 Priority Quality Improvement Plan

- A more systematic approach to hygiene-related documentation was recommended.
- Further development of evaluation methods was required.
- The hospital was urged to review its internal arrangements relating to contract services – particularly those provided from shared services and other central procurement bodies, to ensure the hospital takes responsibility at local level.
- It was recommended that more regular, and unannounced 'walkabouts' be undertaken throughout the hospital. The personnel should be drawn from the Hygiene Services Committee and senior management with a variety of staff levels partaking.
- It was recommended that the adoption of the National Standard on colour-coding should be implemented as soon as possible.
- Greater visibility of Hand hygiene posters was recommended, particularly in public areas.
- The wearing of jewellery, particularly by contract cleaning staff, needed to be addressed

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; Naas General Hospital has achieved an overall score of:

Good

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 → B)

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

Comprehensive information was available to validate compliance, including the Hospital Service Plan and Annual Report and the HSE Network Plan for the area. Internal and external audits for hygiene, waste and catering were noted. Internal evaluation of the National Cleaning Guidelines, internal audits and their subsequent actions were reviewed. Needs assessments (for example audits), which had been carried out, were evaluated.

CM 1.2 (B → B)

There is evidence that the organisation's Hygiene Services are maintained, modified and developed to meet the health needs of the population served based on the information collected.

Evidence was noted in relation to the development of the Hygiene Committee, revised cleaning frequencies and quality hygiene initiatives. Patient satisfaction and risk management were well documented, and results influenced the changes in hygiene practices and procedures — for example extending out-of-hours service to cover 24 hours. The 24-hour cover has been evaluated on an ongoing basis, and this was validated in the minutes of meetings of the Hygiene Services Committee. It was recommended that an evaluation of developments and modifications to the Organisation's Hygiene Services in relation to meeting the service users' needs is implemented.

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.

Evidence of linkages and partnerships was available, including education, training, policies and the committee system. The hospital links and works closely with the Health Service Executive (HSE), the Department of Health and Children (DoHC), with other hospitals in the network and the community nursing homes. It was recommended that the organisation evaluate the efficacy of the linkages/partnerships.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 (B → B)

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

There was a Corporate Hygiene Strategic Plan and Hospital Service Plan with links through the reporting structures to all grades and management structures in the hospital. Documented processes were in place for the development of the plan through the terms of reference. The plan contained clear goals/objectives, with the Hygiene Services Committee responsible for its development. A consultation process for the development of the plan was in place through all services at the hospital. Continuous evaluation was carried out through internal audit processes to ensure compliance with the Hygiene Service Plan.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.3 (B → B)

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

The Executive Management Team received advice on best practice from a number of sources — infection control, national legislation and guidelines such as the Strategy for the control of Antimicrobial Resistance in Ireland (SARI), waste segregation and procurement policies. The hospital had also researched best practice in relation to buildings, equipment and human resources. The National Hospitals Office (NHO) National Cleaning Guidelines and the SARI guidelines reflected quality hygiene initiatives such as new capital building plans, colour-coding and alcohol gels. Pre-purchase evaluation was carried out for colour-coding, a flat mopping system and for alcohol gels.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

*Core Criterion

CM 5.1 (A ↓ B)

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

There was documented evidence that a Hygiene Services Committee and Hygiene Services Team were in place. This was validated by the committee and team minutes of meetings, terms of reference, multidisciplinary team members and committee action plans. The committee reported to senior management and worked closely with infection control and waste management committees. Members of the committee had, through their job descriptions, defined reporting relationships. The provision of Hygiene Services was both contracted and in house. There was evidence of minutes of meetings of the hospital management with the contract cleaners. The Corporate Hygiene Strategic Plan identified the roles, authorities, responsibilities and accountability for the Hygiene Services. It was very clear during the assessment that the hygiene at department/ward area was well managed and responsibility taken by ward/heads of department managers.

*Core Criterion

CM 5.2 (A ↓ B)

The organisation has a multi-disciplinary Hygiene Services Committee.

There was evidence that a multidisciplinary committee was in place. The Hygiene Committee was supported by clerical assistance from the Quality and Risk Office. Team memberships, terms of reference, reporting structures, and minutes of meetings, frequency of meetings, action plans and outcomes were all observed during the assessment. Specific documented processes were not available to identify awareness of the multiplicity of roles on the committee for all staff in the organisation, which was recommended. However, the terms of reference, which were drawn up by the Team, reflect the functions and roles of the members of the multidisciplinary team.

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

*Core Criterion

CM 6.1 (A → A)

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.

Evidence of the Hospital Service Plan, Corporate Hygiene Plan and Hygiene Services was noted. Resources were made available in relation to staff costs and capital spending for Hygiene Services. Documented processes were in place for the allocation of resources, through needs assessments. Additional financial resources were made available to extend cleaning contract hours and to pilot new interventions, for example, colour-coding and the continuing maintenance of the hospital.

CM 6.2 (B → B)

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

Management of the purchasing process was through a centralised process. There was a materials management process and policy. The hospital ascribed to the National Procurement Process. The Hygiene Committee was involved with new products and interventions, and the hospital was represented at network level in relation to hygiene purchases.

The Hygiene Services Team linked with centralised purchasing and senior management in relation to hygiene purchasing. This was evidenced through communication on products, signed approvals and minutes of meetings.

There was no evaluation of this criterion. There were Quality Improvement Plans (QIPs) in place to evaluate the efficacy of the management of the hygiene services process. The team was encouraged to progress that evaluation.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

CM 7.1 (A → A)

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

It was noted that there was a robust risk management system in place. The Risk Management Plan, annual report, incident report mechanisms, Health and Safety (H&S) statements, hazard analysis sheets with review dates and action plans were observed. There was also evidence of the complaints feedback mechanism and

analytical data reports of complaints. There was a limited number of environmental health reports for catering as there had been no regular Environmental Health Officer (EHO) visits. There had been no major adverse hygiene risk management events in the last two years. There were very comprehensive internal hygiene reports for all areas including audits, results, reports, and resultant actions.

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 had been approved to manage Hygiene Services Risk Management through the Quality and Risk Management Committee, which has cross representation from the Hygiene Services Committee, for example, waste management compound re-grading, provision of alcohol gels, and the establishment of an on-site occupational health service. Resources were provided for Health and Safety Training and Audit, development of the hospital's Health and Safety Statement and Hazard Identification, and it was stated that provision will be made to provide resources to review the Health and Safety Hazard Identification processes in late 2007. Resources were also made available to extend cleaning services over a 24-hour period. The Hygiene Services were represented on the Quality and Risk Management Committee. The Executive Management Team received annual reports of both Hygiene Services and Risk Management and on-going committee minutes and audit/risk reports. There was evidence that both patient complaints and risk management had documented evidence of continual evaluation of this criterion. Evaluation of the occurrence of Hygiene Services adverse events over the past two years was recommended.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion

CM 8.1 (A ↓ B)

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

There was evidence of the National Procurement Policy and Process, which sets the standards for procurement at the hospital.

The majority of contracted services were established with centrally located shared services departments of the HSE Eastern region. The current Hygiene Services contract was undergoing tender process. There had been inclusion from the Hygiene Service Committee and Household Service Management in this process.

There was no evidence onsite for establishing, managing and monitoring of contracts in relation to contracted services, for example IS340 compliance for the café or IS341 for the shop. It was recommended that a review of internal monitoring structures be conducted, in order to ensure that contracted services maintained approved standards and contract agreements.

CM 8.2 (B → B)

The organisation involves contracted services in its quality improvement activities.

Evidence was provided that the cleaning contractors were members of both the Hygiene Services Committee and Team.

The external contractors for the café were involved in the healthy eating promotion organised by the Health Promotion Department. The external laundry services in

conjunction with the hospital annually reviews its services. The external waste management companies were involved in the provision of best practice information, legislation and advice and were involved in the refurbishing of the external waste management compound.

PHYSICAL ENVIORNMENT, FACILITIES AND RESOURCES

CM 9.1 (A ↓ B)

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

The hospital was designed and constructed in accordance with all relevant Building, Fire and Construction regulations. This was enhanced through consultation with staff, user groups, Quality and Risk Office and other relevant groups, in addition to the statutory agencies. The Risk Identification Assessment and management strategy is in line with relevant Health and Safety regulations. Near misses, incident and accident reporting are recorded and corrective measures introduced where relevant, in consultation with staff. Enhanced security in the Accident and Emergency Department, car parking and staff identification was put in place, including 'Hospital Watch'. Positive patient perception surveys, patient environment audits, visitor staff complaints follow up procedures and catering surveys all pointed to a patient-friendly environment. There were two clinical areas, the kitchen and Central Sterile Supply Department (CSSD) located in the existing older hospital, both complying with the relevant regulations.

*Core Criterion

CM 9.2 (A ↓ B)

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

Policies, Procedures and Guidelines (PPG) in relation to linen, waste catering and hygiene were noted. Internal and external hygiene audits, EHO reports and patient satisfaction surveys were noted. The senior management and Hygiene Services Committee reflected hygiene as a core issue. A computer base information package to manage equipment at the hospital was introduced. The hospital used information on best practice to influence its hygiene decisions, for example selected issues from the National Cleaning Manual and from Waste Management National Policies.

CM 9.3 (A → A)

There is evidence that the management of the organisation's environment and facilities, equipment and devices, kitchens, waste and sharps and linen is effective and efficient.

The audits processes, risk management, complaints, and the management of the Hygiene Services at the Hospital ensure compliance to this criterion. The Team is to be commended on its practical approach to Hygiene and the commitment of staff is very evident. There was evidence of continuing process of Quality Improvement Plan's. The Team is encouraged to benchmark its Hygiene Services in relation to this criterion.

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.

Evidence was provided of National Codes of Practice for the Management of Recruitment and Employment Legislation. There was comprehensive information available on a range of Human Resources (HR) recruitment processes in line with National HR Guidelines, such as application forms and interview boards, interview training techniques, recruitment and selection booklets, and recruitment checklists. A full range of relevant hygiene job descriptions was available. No evidence was presented on the recruitment process or staff records for contracted cleaning staff. This was identified as a QIP by the team and had been included in the documentation on the new cleaning contract tender, which was at development stage. There was no evidence of evaluation of the recruitment and selection process. The Team was encouraged to evaluate the process for selecting and recruiting human resources.

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.

The organisation provided evidence of robust mechanisms to review staffing requirements for the Hygiene Services. There was a core complement of household staff in line with the Hygiene Services Plan. The hospital also employed contracted cleaning staff. As a result of patient satisfaction, risk management and new changes of practice, the hospital increased its cleaning service to a 24-hour service. Additional staff were allocated in the event of a major hygiene incident, for example a winter vomiting outbreak. It was recommended that the hospital would develop documented processes to review changes in workload measurement.

CM 10.3 (C → C)

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

The Human Resource guidelines for recruitment ensured that, through development and evaluation of the job description and qualifications required for the different functions and grades of staff, were appropriate. Job descriptions observed included relevant qualifications for appropriate grades. There was no evidence of contracted cleaning services, recruitment process or job descriptions. It was recommended that the organisation would review this criterion for contracted cleaning services.

*Core Criterion

CM 10.5 (A → A)

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

As part of the Hygiene Services Corporate Plan and Service Plan, hygiene staff were assigned to tasks based on Hygiene Services requirements. The capital plan for new areas of the hospital included a needs assessment for hygiene staff requirements. There was evidence of additional infection control and hygiene cleaning staff employed in 2006. The Hygiene Service Corporate Plan, Organisational Plans and the Annual Report for 2006 were reviewed.

ENHANCING STAFF PERFORMANCE

*Core Criterion

CM 11.1 (B →B)

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

There was a designated orientation/induction programme for staff. This was validated by the staff induction programme, staff handbook, HSE corporate staff handbook, education and training in relation to hand hygiene, management of waste and sharps and relevant training in relation to cleaning procedures. Evidence was presented of contractors' training programmes/orientation or induction for hygiene contract staff. There was mandatory ongoing training on an annual basis for relevant infection control and hygiene programmes. There was evidence of attendance levels at induction/training and evidence at ward/department level, with renewal dates noted. This data was also collated centrally in Nursing Administration in an information database.

CM 11.3 (B → B)

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

The risk management and complaints reporting process had determined through evaluation that incidents relating to hygiene had decreased. The internal audit process identified areas of good practice, and areas which required improvement. Staff satisfaction surveys in relation to hygiene education and training were noted, as were attendance levels and training sessions. It was recommended that the evaluation process be further developed.

CM 11.4 (C → C)

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

There were no formal performance management procedures, with the exception of new appointees. There was a mechanism during the probation period to deal with performance management. And there was a system for managing disciplinary procedures in relation to non-compliance in work practices. No evidence was presented by the cleaning contractor in relation to compliance with this criterion. It was recommended that the team introduces staff performance evaluation and development of all Hygiene Services staff.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (B → B)

An occupational health service is available to all staff

The organisation provided an occupational health service to its staff. This service was provided to the hospital from the Central Occupational Health Department at Dr Steeven's Hospital. Evidence was provided of procedures for the management of needle stick injuries and access was given to the Occupational Health Services in the staff induction packs. Services offered by the department included pre-employment medical assessment, self-referrals, vision screening and health promotion. A full range of occupational vaccinations were available. The service had been formally evaluated and there was evidence of resultant correspondence between the department and management in relation to identified issues, for example, availability of on-site service. An annual report for the occupational service was compiled and was observed for 2005.

CM 12.2 (B ↓ C)

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

The organisation monitored staff absenteeism through the Occupational Health Department. A staff survey was carried out to promote healthy eating (a Healthcare Food Award Initiative) for staff, and an action plan for 2007-08 was developed. The hospital promoted lifestyle changes though the Lifestyle Challenge and Pilates.

The hospital presented no evaluation of the mechanism for monitoring staff satisfaction. No staff satisfaction surveys in relation to hygiene staff had been carried out, which was 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.

The hospital had a process for collecting and providing hygiene data through its internal audit processes, team meetings programme and hospital information databases for policies, procedures and guidelines. The hospital had a fully stocked library and training resources. It was recommended that the hospital access hygiene catering and laundry information and make this available through the library. The desktop computer facilities available included access to internet and intranet which were used to reflect updates in data, such as waste management. The internal audits had provided an abundance of information relevant to all services. No evaluation of the process for collecting information and adherence to best practice was noted. However, internal audits did note compliance with best practice information, policies and procedures. It was recommended that an evaluation of processes for the collection and assessment of information and adherence to legal and best practice requirements be conducted.

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.

Evidence was provided through the Hygiene Services Committee that internal reports were furnished to both senior management and relevant heads of departments with results and recommendations. The management of the audit process was commended for processes, reports and frequency of turnaround. A sample audit for one ward indicated an audit date of 24 May 2007 and results and recommendations were contemporarily written. It was recommended that results and audit reports be dated. There was no evidence of evaluation in respect to data turnaround, presentation methods or service user, which was subsequently recommended.

CM 13.3 (B → B)

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

The Complaints and Risk Management system had robust evaluation processes in place and mechanisms for reports and action plans. The hospital managed its internal hygiene audit process. Catering service user information was evaluated and comments were reflected in service changes. Evaluation of patient satisfaction surveys initiated changes in cleaning hours.

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

The HSE and the Executive Management Team at the hospital supported the quality agenda. There was a Quality and Risk Adviser in place. There was a Quality Plan in place, which had a statement of vision, performance goals, committee, priorities, reporting structures and risk reduction strategies. The hospital, though its hygiene improvement plan, had identified a number of quality initiatives, for example, refurbishment of the ward areas in the old hospital to include domestic services rooms with wash hand basin and locked cupboards, piloting of the colour-coding system and introduction of the flat mop system. Hygiene Services internal audits included waste, linen and other clinical areas such as Radiology, in addition to the wards, theatre, Out-patients Department and Accident and Emergency.

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.

There was extensive evidence of internal and external hygiene audits, waste management audits, annual EHO reports with resultant commentary and feedback to the individual hospital areas and to the Hygiene Services Committee. The committee fed back the outcomes of these reports to the Senior Management Team. The organisation had a Corporate Strategic Hygiene Plan and Service Plan. The organisation benchmarked against its continual internal audit system and the results of external audits, such as previous national audits. The risk management system also benchmarked issues related to hygiene and environment with resultant reports

and actions. On validation of these results there was a marked decrease in the number of issues reported which related to hygiene and environment over an 18-month period. It was recommended that the hospital continue to develop the quality cycle in relation to evaluation and efficacy of the process.

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 was no documented process for ensuring that best practice guidelines were established, adopted, maintained and evaluated by the team and such a policy was recommended. It was validated that the various disciplines within the hospital organisation such as infection control, catering, central sterile supplies, and cleaning were up-to-date with best practise and relevant literature was available. However, there was a library onsite, and it was recommended that a section should be dedicated to literature and journals which would support best practice in the area of hygiene, such as cleaning and food safety journals. Staff were members of professional institutes and attended seminars and conferences which contributed to the process of keeping up-to-date with best practice. An E learning tool had been introduced for Central Sterile Supplies operatives but there were challenges in ensuring staff had sufficient time to use this valuable resource and there was no protected time allocated. It was recommended that an evaluation of the efficacy of processes used to develop best practice guidelines by the Hygiene Services Team should be carried out.

SD 1.2 (B ↓ C)

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

The most recent pilot was an evaluation of colour-coding which was evaluated by the team and based on the results, colour-coding was not rolled out within the organisation. There was no documented policy for the assessment of new hygiene service interventions. The team was encouraged to address this issue. It was recommended that an evaluation of the efficacy of the assessment process for new/changed Hygiene Services interventions be conducted.

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.

An Infection Control awareness week was held in November 2006 to coincide with international awareness week. There was an unmanned stand in reception where visitors and patients could gain access to information on hand hygiene and on hospital acquired infection. Other activities during the week included education sessions which local GPs and nursing homes were invited to attend. The Infection Control team provided advice from the local community as requested. The local media was to be used in the advent of an outbreak of Norovirus. It was recommended that further linkages with the community be established.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1 (B → B)

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

A multidisciplinary Hygiene Service Team is in place. This team links in to the Hygiene Service Committee, which includes the manger of the contracted cleaning company. The terms of reference for both teams were available as were minutes of meetings and actions taken. Within the Hygiene Corporate Strategic Plan and the Hygiene Service Operational Plan, there was clear evidence of the roles of the teams and the linkages between teams. There was no overall evaluation of the efficacy of the team structure or evaluation of the attendance at these meetings and such evaluation methods were recommended. It was also recommended that an evaluation of the efficacy of the multidisciplinary team structure be conducted.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

SD 4.1 (A → A)

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

The physical environment and facilities were to a high standard of cleanliness.

For further information see Appendix A

*Core Criterion

SD 4.2 (A → A)

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

The organisation’s equipment, medical devices and cleaning devices were clean.

For further information see Appendix A

*Core Criterion

SD 4.3 (A → A)

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

The organisation's cleaning equipment was well managed and was clean.

For further information see Appendix A

*Core Criterion

SD 4.4 (A → 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.

The organisation's kitchens were maintained to a very high standard of cleanliness. Hazard Analysis and Critical Control Point (HACCP) was fully implemented in both the production kitchen and ward kitchens. The ward kitchens were under the responsibility of the catering manager and this practice was commended. Structurally, the kitchen was satisfactory but there were plans to relocate the main production kitchen by 2010, due to current space limitations. Some high temperatures were noted for self service display units in the staff restaurant and in a ward fridge and management were committed to effective corrective action to ensure these units would be more efficient in maintaining the correct temperatures.

For further information see Appendix A

*Core Criterion

SD 4.5 (A → A)

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

The management of both clinical and non-clinical waste was to a very high standard.

For further information see Appendix A

*Core Criterion

SD 4.6 (A → A)

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

The management and storage of the linen was commended. Hospital staff were aware of a deficiency in the quality of laundry bags supplied by the contractor and had actively pursued their replacement.

For further information see Appendix A

*Core Criterion

SD 4.7 (A → A)

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

The management of hand hygiene is to a very high standard and such high standards were commended.

For further information see Appendix A

SD 4.8 (B → B)

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

There was a Quality and Risk Management Committee in place as well as a Health and Safety committee. Departmental safety statements were in place and risk assessments were carried out in clinical and non-clinical areas. There was a system in place for the reporting of incidents and staff were trained in the appropriate reporting of incidents or near misses (which were then fully investigated and data was noted for 2006 and for 2007 at time of assessment). The Quality Plan referenced risk reduction strategies and a major accident plan was in place. There was a dedicated Risk Manager on site.

SD 4.9 (B → B)

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

There was a hospital hygiene information leaflet onsite. However, this leaflet did not include relevant information which would encourage patients and visitors to participate in improving the hygiene service. It was recommended that the hospital hygiene leaflet should be reviewed through the multidisciplinary team structures and should include information on such issues as flowers, luggage, patient food and not visiting when ill. The hospital operated a local visiting policy and planned to launch a visiting policy adapted from the National Visitors Policy which would educate the community with regard to same. A patient satisfaction survey was conducted in 2006 by the Irish Society for Quality and Safety in Healthcare and there were high levels of satisfaction with the cleanliness of the hospital environment at 94.3%. Internal satisfaction surveys were also conducted for the period September 2006 to February 2007, based on a sample of 16 patients. Areas for improvement were identified through these surveys. These included poor cleaning standards in toilets in the main concourse of the old hospital building and had been actioned through the provision of additional cleaning hours in that area.
Catering satisfaction surveys were carried out on a monthly basis and evaluations took place with results showing a very high level of satisfaction with all aspects of catering and food quality.

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.

Evidence that patient dignity and privacy is respected by the hospital team and is maintained during hygiene service delivery was observed during the assessment. Privacy was mentioned in the hospital information leaflet and a ‘quiet time’ was enforced from 12.00 to 2.00pm to facilitate meal times and doctors’ rounds. There

were family rooms at ward level and the confidentiality of patients with infectious disease was protected at ward level. The curtains in place around the sink units to protect patient dignity during washing and such practices were to be commended. There was a policy in relation to confidentiality of patient information and it was recommended that a policy be developed for maintaining patient privacy and dignity. Data derived from patient satisfaction surveys indicated that there was a high level of satisfaction (at 96.3%) with the maintenance of patient care and dignity. The X-ray Department had very strong measures in place to protect the patient's dignity.

SD 5.2 (B → B)

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

There was a hospital information leaflet and it was recommended that further information be included in relation to hygiene issues. There were also other leaflets available throughout the hospital such as a publication on Methicillin Resistant Staphylococcus Aureus (MRSA) and another on the Hygiene Services Assessment Scheme, 'Your Service, Your Say'. There were posters and signage in relation to hand hygiene and hand gels were available. However, it was recommended that there should be more extensive visibility of hand hygiene posters in public areas. Patient satisfaction surveys were carried out and evaluated and improvements had been made using the data from these surveys. The hospital produces a newsletter in which hygiene issues are included.

SD 5.3 (B ↑ A)

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

Complaints were managed in line with national policy and all complaints were logged onto an access database, which provided very comprehensive information in relation to all aspects of the complaint and the effective tracking of same. Complaint numbers in relation to Hygiene Service delivery were low with no complaints logged for 2006 and only one to date of assessment (which was a comment in relation to the process of bed cleaning from a visitor). Complaints, when they did occur, were fully investigated and followed on activities were clearly documented. Complaint trends were logged and evaluated and monthly reports were generated and issued to senior hospital management and discussed at meetings.

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.

Patient satisfaction questionnaires for in-patients and out-patients were in place and had been replaced by the National 'Your Service Your Say'. Data had been collected and evaluated from these sources. There was no patient representative on the Hygiene Service Committee and it was recommended that a service user should be included as a member of this committee.

SD 6.2 (B → B)

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

Internal audits were carried out and reports generated which detailed the audit trail, along with summaries of good practice and areas for improvement. Audits were

scored, which was considered good practice. It was recommended that the internal audit process be extended to include the non-core areas of the Hygiene Service Assessment Scheme. It was stated that results of internal audits were distributed and to facilitate this practice it was recommended that results be evaluated and graphed so that trends could easily be identified for each audit area.
The team produced a Hygiene Corporate Strategic Plan as well as a Hygiene Service and Operational Plan and within these plans goals were set to drive the process forward for the next three years. The goals as documented were qualitative in nature and it was recommended where possible that a quantitative element be included as this facilitated the measuring process. It was recommended that, as a method for driving the process of continuous improvement, there would be benchmarking between the hospital and other hospitals within the network.

SD 6.3 (B ↓ C)

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

There was an Annual Report generated for 2006, which clearly outlined the developments that took place in the various areas of the organisation. There was no documented policy for the compilation of the Annual Report and it was recommended that such a policy be introduced which would outline the inputs into the report and the channels for dissemination, as well as the methods being used to evaluate the Hygiene Service delivery and the results of these evaluations.

4.0 Appendix A

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

4.1 Service Delivery Core Criterion

Compliance Heading: 4. 1 .1 Clean Environment

(1) The environment is tidy, well-maintained, free of rust, blood or body substances, dust, dirt, debris and spillages.
Yes - In general all areas assessed were clean.

(14) Waste bins should be clean, in good repair and covered.
No - Waste bins in Accident and Emergency and in the Intensive care unit were in poor repair.

(27) Local policies should be in place for guidance on all cleaning processes, colour coding, use of equipment, use of protective clothing and fluids and spillages.
No - There is no colour coding policy in place.

(28) Before cleaning commences, a work route should be planned and when necessary, furniture and equipment should be removed from the area.
Yes - Work routes are planned.

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

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

(207) Bed frames must be clean and dust free
No – Dust was observed on the bed frames in the Curragh Ward.

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

(33) Chairs
Yes - There were chairs with soft fabrics noted in the Coronary Care Unit and in the general ward areas. It was recommended that chairs have a washable surface.

(34) Beds and Mattresses
Yes - The mattresses were in an excellent condition.

Compliance Heading: 4. 1 .5 Sanitary Accommodation

(46) Bathrooms / Washrooms must be cleaned on a daily basis. When necessary, they must be disinfected. This must be monitored and recorded.
Yes - Some washrooms were noted to have no check sheet. It was recommended that all washrooms should have a cleaning checklist.

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

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

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

(65) Commodes, weighing scales, manual handling equipment.
No - Wheels on commodes and on other items of patient equipment were dusty, and in some instances had rust on them.

(66) Medical equipment e.g. intravenous infusion pumps, drip stands and pulse oximeters, suction apparatus and tubing, cardiac monitors, blood pressure cuffs, blood gas machines.
Yes - The medical equipment observed during the assessment was clean.

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

(72) Trolleys, e.g. chart trolleys, drug trolleys, linen trolleys, shop trolleys, emergency trolleys, suction apparatus, resuscitation equipment i.e. ambubag and mask.
Yes - The trolleys observed during the assessment were clean.

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.
Yes - Some buffers observed were dusty.

(86) Information on the colour coding system is available to all hygiene staff (according to national guidelines).
No - There was no colour-coding system in place at ward level. The kitchen area had implemented a colour-coding system.

(87) All cleaning equipment should be approved by the Hygiene Services Committee and ensure sufficient supply.
No - The hospital adheres to the network procurement policy.

(93) Cleaning products and equipment should comply with the relevant colour coding policy.
Yes - There was a local policy in place.

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 was tested at regular intervals, and the results identified that water quality was very good.

(214) The person in charge of catering shall develop, implement and maintain a permanent system based on the seven principles of HACCP. A standard HACCP Plan should be fully completed.
Yes - The HACCP Plan required updating with respect to the referencing of revoked legislation.

(215) There should be a documented ward kitchen food safety policy which should be signed off by the person in charge of the ward kitchen and the hospital manager.
Yes - The food safety policy in the catering area has been reviewed and should be implemented.

Compliance Heading: 4. 4 .2 Facilities

(226) Containers used to store foods shall be made of food grade materials, be in good condition, easy to clean and disinfect.
Yes - There were excellent standards in this area.

(227) Flour, cereals, sugar etc shall be stored in a dry environment and when opened stored in covered containers.
Yes - There were excellent standards in this area.

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

(240) A Hospital using a cook-chill system should comply with Guidance Note No. 15 Cook-Chill Systems in the Food Service Sector (Food Safety Authority of Ireland) The temperatures of fridges, freezers, cold rooms and chill cabinets shall be capable of maintaining the temperature of foodstuffs
Yes - A Cook Chill System is not in place. All foods are cooked fresh on a daily basis.

(241) Ice cream display units can operate at -12℃ as long as it can be demonstrated that the product has been held at this temperature for less than 7 days.
Yes – This was not applicable in this organisation.

(242) Temperatures for Food in Fridges / Freezers and Displays should comply with I.S.340:2006 requirements
No - It was noted that some temperatures were not compliant to this requirement. Management were made aware and were committed to implementing a corrective action.

Compliance Heading: 4. 4 .10 Plant & Equipment

(250) The dishwasher's minimum temperature for the disinfecting cycle should be compliant with I.S.340:2006 requirements and should be monitored regularly. There should be digital readouts on dishwashers.
Yes - Whilst digital readouts are not available on all dishwashers, there is a monthly programme of checking the rinse water by an outside contractor and all temperatures were satisfactory at >82c.

(251) All temperature probes shall be calibrated annually. Calibration may be carried out internally or externally (instrumentation firm). Documentation should be retained of the procedures used to control, calibrate and maintain inspection, measuring and test equipment used to demonstrate compliance with the HACCP Plan.
Yes - All probes were calibrated, however, it was recommended that probes be calibrated within their operating range of 0-5c.

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

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

(253) Personal protective equipment is accessible to all staff involved in the generation, collection, transport and storage of waste.
Yes - The use of Personal Protective Equipment was noted.

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 available for the disposal of normal mattresses (non mechanical).

Compliance Heading: 4. 5 .4 Transport

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

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

(175) Clean linen is free from stains.
Yes - No stains were noted on any linen observed during the assessment.

(261) Clean linen store is clean, free from dust and free from inappropriate items.
Yes - Very high standards were noted here.

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

(187) Nails should be kept short and nail varnish or false nails should not be worn by those working in a clinical setting.
Yes - However, there were some contracted cleaning staff wearing nail polish and jewellery.

(198) Hand hygiene posters and information leaflets should be available and displayed throughout the organization.
Yes – In the majority, however, it was recommended that additional posters be displayed in public areas.

(204) Hand wash sinks conform to HBN 95. They should not have plugs, overflows and the water jet must not flow directly into the plughole.
Yes - However, some sinks in non-clinical areas have no mixer tap facility for example in the laundry.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team			Assessor Team
	FREQ	%	FREQ	%
A	17	30.36	13	23.21
B	36	64.29	28	50.00
C	3	05.36	15	26.79
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	B	→
CM 1.2	B	B	→
CM 2.1	B	C	↓
CM 3.1	B	B	→
CM 4.1	B	B	→
CM 4.2	B	B	→
CM 4.3	B	B	→
CM 4.4	B	B	→
CM 4.5	B	B	→
CM 5.1	A	B	↓
CM 5.2	A	B	↓
CM 6.1	A	A	→
CM 6.2	B	B	→
CM 7.1	A	A	→
CM 7.2	B	B	→
CM 8.1	A	B	↓
CM 8.2	B	B	→
CM 9.1	A	B	↓
CM 9.2	A	B	↓
CM 9.3	A	A	→
CM 9.4	A	A	→
CM 10.1	B	C	↓
CM 10.2	B	C	↓
CM 10.3	C	C	→
CM 10.4	C	C	→
CM 10.5	A	A	→
CM 11.1	B	C	↓
CM 11.2	B	B	→
CM 11.3	B	B	→
CM 11.4	C	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	B	→
CM 14.1	B	B	→
CM 14.2	B	C	↓
SD 1.1	B	C	↓
SD 1.2	B	C	↓
SD 2.1	B	B	→
SD 3.1	B	B	→
SD 4.1	A	A	→
SD 4.2	A	A	→
SD 4.3	A	A	→
SD 4.4	A	A	→
SD 4.5	A	A	→
SD 4.6	A	A	→
SD 4.7	A	A	→
SD 4.8	B	B	→
SD 4.9	B	B	→
SD 5.1	B	B	→
SD 5.2	B	B	→
SD 5.3	B	A	↑
SD 6.1	B	C	↓
SD 6.2	B	B	→
SD 6.3	B	C	↓