



Hygiene Services Assessment Scheme

Assessment Report October 2007

Portiuncula Hospital, Ballinasloe

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1.0 Executive Summary

1.1 Introduction

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

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

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

Hygiene is defined as:

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

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

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

1.1.1 Standards Overview

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

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

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

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

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

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

Core Criteria:

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

In the Corporate Management standards, the core criteria cover:

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

In the Service Delivery standards, core criteria cover:

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

1.1.2 Rating Scale

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

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

A Compliant - Exceptional

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

B Compliant - Extensive

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

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

1.1.3 Assessment process components

The assessment process involves four distinct components:

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

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

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

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

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

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

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

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

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

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

- **Continuous Improvement**

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

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

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

² New York Department of Health and Mental Hygiene

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

⁴ Irish Acute Hospitals Cleaning Manual, HSE (2006)

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

1.2 Organisational Profile

Portiuncula operates as a constituent acute hospital the HSE West, Network 5. Portiuncula Hospital provides services to patients residing in the East Galway, Roscommon, Midlands and Midwestern areas. The current population served is just under 400 000 (Census 2002 Preliminary Report). There are currently 203 beds

Services provided

General Medicine, General Surgery, Paediatrics, ICU – CCU, Maternity, Special Care Baby Unit (SCBU), Administration and the hospital shop, A&E and Physiotherapy Departments, Out Patients, Radiology, Anaesthetics, Cardiology, Elderly Care, Gastroenterology, Gynaecology, Laboratory, Medicine, Obstetrics, Occupational Therapy, Oncology ,Palliative Care ,Pastoral Care Pathology, Social Work, Special Care Baby Unit and the Laboratory.

On site, although not linked to the main building, are: the Mortuary, Stores and Works, Waste Storage, Linen Supply, Cardiac Rehabilitation, Medical Records, the IT Department and the Medical Residence.

Physical structures

There is one negative pressure room in ICU/CCU.

There are a number of single rooms in all wards; each of these is fitted with hand washing facilities. However, the current arrangement of rooms does not allow for an antechamber.

The following assessment of Portiuncula Hospital took place between 5th and 6th June 2007.

1.3 Notable Practice

- Corporate and operational structures to address hygiene have been adopted from a multi-disciplinary team approach within the Medical, Care and Resource Directorate at the hospital.
- Quality Improvement Plans are identified to address structural deficits such as the planned Special Care Baby Unit refurbishment; cleaner store upgrading, sluice refurbishment and hand wash sink installation/upgrading.
- A Patient satisfaction survey process is in place.
- Quality Improvement Plans are in place to address human resource deficits which will commence with reconfiguration of rostering and roles of hygiene staff to separate catering and cleaning.
- There was a comprehensive approach to the facilities and resources for the management of waste and sharps.

1.4 Priority Quality Improvement Plan

- The overall system for managing hygiene must be addressed with the implementation of appropriate resources which comply with the Irish Acute Hospitals Cleaning Manual 2006
- Risk Management resources, such as the support of a dedicated Risk Management officer, is encouraged to develop comprehensive systems for the management of risks.
- It is recommended that a detailed cleaning schedule is developed for all existing and planned facilities.
- It is recommended that comprehensive contracts are prepared with appropriate Service Level Agreements to meet hygiene standards including the National Cleaning Manual 2006 requirements. Structures and processes for the delivery of education and training should be reviewed and consolidated in order to provide a comprehensive education programme for hygiene to address all grades of staff.
- Kitchen and related ward kitchens are strongly encouraged to become HACCP compliant.
- It is recommended that a process to evaluate outcomes for hygiene interventions is put in place.
- Policies and procedures should be developed and implemented to manage, maintain and handle linen and soft furnishings.

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 Portiuncula Hospital, Ballinasloe has achieved an overall score of:

Poor

Award Date: October 2007

1.6 Significant Risks

<p>CM 7.1 (Rating D) The organisation has a structure and related processes to identify, analyse, prioritise and eliminate or minimise risk related to the Hygiene Service</p> <p>Potential Adverse Event There is a potential for a serious accident or a food safety incident to occur. As there is no formal risk management structure, included updated safety statements and hazard analysis. This could result in suboptimal care with potential adverse outcomes for effects patients, clients staff and contractors</p> <p>Risks</p> <table><tr><td>Likelihood of Event</td><td>Rated: M (2)</td></tr><tr><td>Impact of Event</td><td>Rated: M (2)</td></tr><tr><td>Urgency of Action</td><td>Rated: M (2)</td></tr><tr><td>TOTAL</td><td>Total: 6</td></tr></table> <p>Recommendations The hospital should adopt an integrated approach to the management of all risk as there is currently no approach in place to identify, analyse, prioritise and eliminate or minimise risk related to the Hygiene Service.</p> <p>To support this process the hospital should consider the role of the Risk Advisor.</p>	Likelihood of Event	Rated: M (2)	Impact of Event	Rated: M (2)	Urgency of Action	Rated: M (2)	TOTAL	Total: 6
Likelihood of Event	Rated: M (2)							
Impact of Event	Rated: M (2)							
Urgency of Action	Rated: M (2)							
TOTAL	Total: 6							

<p>CM 8.1 (Rating D) 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.</p> <p>Potential Adverse Event In the event that there are service issues with contracted staff, there is a risk to the hospital including suboptimal service provision to patients/clients as contractors are not monitored/reviewed</p> <p>Risks</p> <table><tr><td>Likelihood of Event</td><td>Rated: M (2)</td></tr><tr><td>Impact of Event</td><td>Rated: M (2)</td></tr><tr><td>Urgency of Action</td><td>Rated: M (2)</td></tr><tr><td>TOTAL</td><td>Total: 6</td></tr></table> <p>Recommendations All hospital external contracts for both services and personnel should be reviewed.</p>	Likelihood of Event	Rated: M (2)	Impact of Event	Rated: M (2)	Urgency of Action	Rated: M (2)	TOTAL	Total: 6
Likelihood of Event	Rated: M (2)							
Impact of Event	Rated: M (2)							
Urgency of Action	Rated: M (2)							
TOTAL	Total: 6							

CM 10.4 (Rating D)
There is evidence that the contractors manage contract staff effectively.

Potential Adverse Event

High Risk of breaches of confidentiality, cross- infection and personal injury to both employee and patient.

Risks

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

Recommendations

A documented profile should be maintained on all contracted staff which should include qualification and training, orientation and occupational health needs. All information relating to contract staff is held with the contractors. There is no formal system of monitoring contractors. All contract staff should receive a formal orientation/induction programme.

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.

The hospital provided strong evidence that hygiene and hygiene issues are on the hospital agenda. There was evidence that hygiene issues are addressed at corporate level through the management meeting of the Directorates and the General Manager. Minutes of management and departmental meetings were observed, in which such issues were discussed, evaluated and progressed.

A draft Corporate Hygiene Strategic Plan was also available. It is recommended that evaluation of the efficacy of the process is strengthened.

CM 1.2 (B ↓ C)

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

The hospital has simple and informal mechanisms in place to ensure the hygiene services are maintained and modified to meet the hospital needs. No actual documented processes have been developed to modify hygiene services based on population needs and no evaluation currently takes place. However, the previous National Hygiene Audits (2005 and 2006) provided an impetus to formalise the management of hygiene services. It is recommended that this development is progressed and evaluation is commenced to ensure that population needs are met.

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.

The hospital operates as a single hospital site within Network 5.

The General Manager has direct links with the Network Manager and the offices of Corporate and Services Managers in the Health Service Executive. Internally hygiene issues are addressed through a number of channels including hospital hygiene structures, Ward and Department Management, the Hospital Executive and the Hygiene Services Team and Committee. It is recommended that the hospital begin to engage patient/clients in the hygiene services process. It is also recommended that

the efficacy of the linkages and partnerships is evaluated to ensure their effectiveness.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 (C → C)

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

The hospital has a Draft Hygiene Strategic Plan due for circulation before year end. The Hospital Management Team currently receives information on hygiene issues through the Clinical Directors, the Hygiene Services meetings and through Departmental meetings, all of which informs the development of the Hygiene Strategic Plan. It is planned that the Service Plan be circulated to all stakeholders in the hospital for comment. Following this process it is recommended that the plans, goals and objectives are evaluated to ensure that the Hygiene Services needs are met.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.1 (B ↓ C)

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

The Hospital Management team ensures that hygiene issues are presented to corporate management and there is an active approach to hygiene and the forward planning of this service. It is recommended that the hospital review its Hospital policies and procedures in line with current legislation and evidence-based practice. It is also recommended that the evaluation examine adherence to relevant legislation and national guidelines.

CM 4.2 (B ↓ C)

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

The Hospital Management Team receives information from the Hygiene Services Committee, Infection Control Team and audit process. With the exception of the Irish Acute Hospitals Cleaning Manual, further evidence is required that best practice information is available to staff. It is recommended that this is reviewed and evaluation of the information is commenced

CM 4.3 (B ↓ C)

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

The National Hygiene Guidelines have been used to influence local hygiene procedures and policies, for example hygiene policies in relation to flat mopping, colour coding and hand hygiene have been developed using these guidelines as a reference. While the hospital uses some best practices guidelines to influence its hygiene processes, no research is currently being carried out at the hospital relating to hygiene services. No hygiene journals or Information Technology software is available to provide staff access to hygiene information and knowledge. It is

recommended that methods for informing staff of current legislation and best practice information are improved and evaluation of current information available is commenced.

CM 4.4 (B ↓ C)

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

A range of hospital policies and procedures have been developed, which are based on best practice. An information management system is in the process of being implemented to collate all policies and procedures. It is recommended that the hospital review its hygiene procedures documentation.

CM 4.5 (C → C)

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

Hygiene issues relating to capital projects are progressed through the Executive Management Team. The hospital should review this procedure. It would potentially benefit from the input of the Hygiene Services Committee at the earliest stage of the planning process. There was evidence that compliance with building works procedure and dust control measures were not in place during the assessment. It is recommended that this area is reviewed with the input of the Hygiene Services Committee.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

*Core Criterion

CM 5.1 (C → C)

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

The hospital had a Hygiene Services Committee in place. While members reflected their areas of responsibilities, no clear and formal roles, responsibilities and accountabilities of the function of the team members were in place. Hospital job descriptions are available for all Hygiene Services staff. However, the hospital should review job descriptions of all staff in order to ensure that hygiene is noted as a responsibility of all staff within the organisation.

*Core Criterion

CM 5.2 (B → B)

The organisation has a multi-disciplinary Hygiene Services Committee.

There is an active multidisciplinary Hygiene Services Committee at the hospital. This Committee has formulated terms of reference and has developed a Hygiene Services plan.

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

*Core Criterion

CM 6.1 (B → B)

The Governing Body and/or its Executive/Management Team allocate resources for the Hygiene Service based on informed equitable decisions and in accordance with corporate and service plans.

The hygiene issues identified by the Hygiene Services Committee are referred to the Executive Management Team, who allocate funding accordingly. Evidence presented demonstrated that Quality Improvement Plans have been identified by the committee

and have been forwarded to the Executive Management Team, who decides on funding for service provision. The General Manager seeks funding approval through the Network Manager. However, with the exception of the approved whole time equivalent funding, there is no annual allocated hygiene budget. A limited service plan for hygiene is in place. It is recommended that this is reviewed and developed to ensure adequate financial support and allocation for hygiene services.

CM 6.2 (B ↓ C)

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

There was some evidence that the hospital Hygiene Services Committee is involved in the purchasing of equipment through the Priority Equipment Group and has the ability to influence hygiene product procurement. The Hygiene Service Plan has identified required products. However, this service plan is limited and departmental purchasing still occurs. It is recommended that a protocol be developed for purchase of hygiene equipment and products

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

CM 7.1 (B ↓ D)

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

Currently, there is no risk advisor employed in the organisation. A Risk Management Committee is in place, which evaluates incidents. However serious breaches to HACCP were identified during the assessment, which could adversely affect patient health and safety for example HACCP cross infection and dust control during building works were observed during the assessment. It is recommended that Risk Monitoring processes are put in place (for example, HACCP and Health and Safety). It is also recommended that the Hospital update the Health and Safety Statement and the HACCP plan

CM 7.2 (B ↓ C)

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

Minutes of Risk Management team meetings were noted, which addressed hygiene issues when required. Hygiene services are a standing item on the Risk Management agenda. It is recommended that the organisation implement a process for evaluating major hygiene adverse events

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion

CM 8.1 (B ↓ D)

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.

Training records for contracted staff were not observed. No current contracts are in place for linen and cleaning services. It is recommended that contracted service processes are reviewed and ratified in accordance with best practice. Documented processes are required for establishing, managing and monitoring contractors in the

area of hygiene services. It is recommended that aspects of the pest control contract be updated. A formal evaluation of contracted services should be conducted to ensure quality service provision. The organisation should ensure that that service delivery and corporate management in the organisation is correlated and consistent to ensure the provision of quality contracted services.

CM 8.2 (B ↓ C)

The organisation involves contracted services in its quality improvement activities.

Contracted hygiene services are represented in the membership of the Hygiene Services Committee. No evidence was presented to support interaction with other contractors which supply services to the hospital. It is recommended that the involvement of contractors in quality improvement processes is reviewed.

PHYSICAL ENVIRONMENT, FACILITIES AND RESOURCES

CM 9.1 (B ↓ C)

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

A major refurbishment of the hospital is currently in progress. The hospital adheres to current building regulations in all new and refurbished areas. While there are Quality Improvement Plans in place, deficits were observed in hand washing facilities. A quality improvement plan has been developed for the replacement of sinks. It is recommended that further evaluation of the safety of the current environment is commenced to ensure its adherence to current legislation and best practice.

*Core Criterion

CM 9.2 (B ↓ C)

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

There are no written procedures which encompass an organisational approach to the management of the organisations environment and facilities, equipment and devices, kitchens, waste and sharps and linen. The current cleaning schedule does not fully address the hygiene services required in the hospital and it is recommended that this is reviewed.

CM 9.3 (B ↓ C)

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

Internal hygiene audits have been carried out in most areas of the hospital to evaluate organisational management. No specific evaluation processes are in place to address efficacy and efficiency. However, action plans following internal and external audits were observed as evidence of improvements to equipment and facilities. It is recommended that the evaluation process is developed.

CM 9.4 (B ↓ C)

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

Comprehensive Patient satisfaction surveys are conducted, however, evaluation and resultant actions of the surveys are not documented and loop closure is

recommended. During the site visit patients and visitors expressed their satisfaction with the hygiene services. A Quality Improvement Plan has been identified to include Service Users in the hospital hygiene process. It is recommended that further satisfaction surveys and the attendant quality improvement processes are conducted.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 (B → B)

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

The organisation adheres to the National Human Resource Recruitment Policy. It is recommended that job descriptions of all staff are reviewed to include hygiene as a core responsibility for all.

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 hygiene staff ratios are in line with whole time equivalent funding. There is a roster review in progress, which is looking at changes in staffing in line with service requirements. It is recommended that the hygiene service tender is reviewed following the roster restructuring of in house staff. It is also recommended that a comprehensive needs assessment for the human resource requirements for hygiene is completed.

CM 10.3 (C → C)

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

Hospital employees are recruited in line with the National Human Resource Recruitment Policy. Limited information in relation to qualification, training and recruitment processes regarding contract services was observed. It is recommended that evidence of contract staff (including supervisory staff) qualifications and training, be retained by the hospital.

CM 10.4 (B ↓ D)

There is evidence that the contractors manage contract staff effectively.

There was no evidence of any formal process to demonstrate that contractors have a system in place to manage staff. The management of contract staff was noted to be on an informal basis. No information was available on contractor's orientation /basic training for hygiene staff. It is recommended that a formal system of monitoring contractors is implemented in the near future, which includes the maintenance of a documented profile on all contracted staff including qualifications and training, orientation and occupational health needs.

*Core Criterion

CM 10.5 (B → B)

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

Hygiene Staff requirements are met through the whole time equivalent funding and project planning process. Annual service plans are in place. Staffing is provided on an annual basis with corresponding whole time equivalent requirements.

ENHANCING STAFF PERFORMANCE

*Core Criterion

CM 11.1 (B ↓ C)

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

An orientation /induction programme is available to all staff. Evidence of ongoing training in relation to hygiene was available from training records. The role of hospital hygiene requires further promotion in the orientation / induction programme. The role of medical staff in hygiene services also needs to be strengthened. It is recommended that compliance with hygiene policies is documented in the staff handbook.

CM 11.2 (C → C)

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

While there is evidence of continuing hygiene education for all grades of staff, the efficiency of the process is comprised due to its fragmented nature. Education records were available; however, they are not centrally collated. An information management system is currently being implemented which will address these issues. It is recommended that evaluation of the efficacy and processes of hygiene education is commenced in the near future.

CM 11.3 (C → C)

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

While hygiene education has been delivered, there are no easily identified records or system of recording education and training in place. The hospital has acknowledged this as an area for improvement and is encouraged in this endeavour.

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 is no formal national performance management system for the organisation to comply with. However, the hospital uses the People in Management Strategy to address staff issues in relation to performance. It is recommended that the hospital implement a formal staff performance evaluation and development structure in the future.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (A ↓ B)

An occupational health service is available to all staff

The Occupational Health department provides a comprehensive service to all staff. All staff questioned were aware of the services provided and how to access it. The department evaluates its service through staff surveys and education session feedback forms. There needs to be a formal system in place for collation of this evidence.

CM 12.2 (B ↓ C)

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

No evidence was observed to suggest that occupational health /well being is being monitored. It is recommended that a process of evaluation is implemented.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.1 (C → C)

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

This criterion is supported by the Clinical Directorate model and the reporting structures therein. The hospital Hygiene Services Committee submits relevant updates on the hygiene services to the Executive Management Team. The minutes of Hygiene Services Committee meetings are circulated through the members of the Committee, who include Senior Management. Internal and external audit reports are presented to the Executive Management Team, who subsequently sign off action plans.

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.

Hygiene issues are reported through the Clinical and Resource Directorates to the Executive Management Team. The General Manager in collaboration with the Network Manager discusses hygiene requirements for the hospital. Minutes of Hospital Hygiene Committee meetings are available locally in communication folders at ward and department levels. Local audit reports including action plans for the areas are available. It is recommended that evaluation of user satisfaction in relation to the reporting of data and information is commenced in the future.

CM 13.3 (B ↓ C)

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

Simple and informal evaluation is carried out. Assessments (“walkabouts”) by Hospital Management are conducted in order to observe hygiene standards. However, no reports produced from these were observed. Departmental hygiene audits are carried out in some areas. It is recommended that a structured process is implemented to aid further development. A formal evaluation process in relation to data and information utilisation should be implemented.

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

An Accreditation Manager is in place in the organisation, who is a member of the Hygiene Services team and a shared organiser of the documentation development and collation for the Hygiene Services Assessment Scheme. There is a Hygiene Manager whose role it is to oversee the implementation of the hygiene services processes and standards. Hygiene quality improvement plans are supported by the Executive Management Team and funding has been sourced and received to implement some of the identified Quality Improvement Plans.

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 evaluation and bench marking processes at the hospital are at an early stage. Hygiene audits are conducted and are informally evaluated by each individual department. These are communicated to staff in other departments. It is recommended that the documentation of processes and outcomes is commenced on a formal basis.

3.0 Standards for Service Delivery

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

EVIDENCE BASED BEST PRACTICE AND NEW INTERVENTIONS IN HYGIENE SERVICES

SD 1.1 (B ↓ C)

Best Practice guidelines are established, adopted, maintained and evaluated, by the team.

No overall documented process for the adoption, evaluation and maintenance of best practice guidelines was observed. Best practice guidelines have been established for the Infection Control Manual, however, no obvious mechanism was observed for the dissemination and subsequent evaluation of the information. Some key documents require updating to ensure they are in line with current legislation including HACCP and the Hospital Safety Statement. Intranet access is available; however, no evidence was presented which highlighted that hygiene related journals are available or accessed. It is recommended that protected time for supervisory staff to access and review documentation is provided.

SD 1.2 (B ↓ C)

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

No documented processes were observed in place for assessing new hygiene interventions or modifications to existing ones before their routine use. Some good examples of initiatives to implement equipment were evident, which included the formation of a Priority Equipment Group. This group needs to ensure that education, training and full roll out processes are in place for any new equipment or procedures introduced.

PREVENTION AND HEALTH PROMOTION

SD 2.1 (B ↓ 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 was some evidence to support Health Promotion activities that educate the community regarding hygiene. Some examples include:

- The provision of appropriately placed hand hygiene dispensers
- A hospital newsletter
- A hand wash poster at the hospital entrance

It is recommended that information such as patient leaflets and the hospital visiting policy is made more visible to staff, patients and the public. Notice boards could be utilised to greater effect and additional posters could be displayed around the

organisation. No evidence of formal links between the hospital and the community/ service providers in relation to health promotion activities were noted. However, a patient satisfaction survey had been completed and the information collated. The organisation is encouraged to complete the Continuous Quality Improvement (CQI) process in all instances throughout the organisation.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1 (B ↓ C)

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

A multidisciplinary Hygiene Services Team and Hygiene Services Committee are in place and minutes of meetings were noted. However there have been no formal meetings since March 2007. It is recommended that regular meetings are held with a timetable for future meetings. The multi-disciplinary team is still at an early stage of development and links to other teams and programmes need to be strengthened.

A process to evaluate the efficacy of the team should be implemented

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

SD 4.1 (B → B)

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

The overall detail of cleaning requires improvement.

For further information see Appendix A

*Core Criterion

SD 4.2 (B → B)

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

Equipment, medical devices and cleaning devices required additional cleaning.

For further information see Appendix A

*Core Criterion

SD 4.3 (B ↓ C)

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

Overall, the cleaning equipment required significant improvement.

For further information see Appendix A

*Core Criterion

SD 4.4 (B ↓ C)

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

There were significant areas where the HACCP system was not adhered to, this could adversely affect patient's health and increase the risk of a food safety incident.

Corrective action was put in place immediately in the organisation, which obviated the need for a risk assessment.

For further information see Appendix A

*Core Criterion

SD 4.5 (C → C)

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.

Aspects of waste management require improvement.

For further information see Appendix A

*Core Criterion

SD 4.6 (B ↓ C)

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

The control of linen, and in particular local linen, require additional improvement.

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

Hand hygiene facilities in the organisation require improvement.

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.

Departmental safety statements observed were dated 2004. It is recommended that these are reviewed and updated in line with current legislation. In 2006, some workplace risk assessments were carried out. These should be followed up and corrective action plans developed. It is also recommended that a risk assessment is completed for each service provider, for example the Cleaning Contractor, to determine level of risk posed by inadequate procedures. This would also highlight critical areas for control. (One example of this risk is where food service staff perform clinical cleaning duties at ward level).

Some major breaches of HACCP were noted within the catering function, which could lead to a major food safety incident. Examples included:

- high temperatures in main fridges, the salad bar, and ward kitchen fridges.
- no cooking records
- no cooling records
- no traceability system for cooked joints.

It is recommended that the HACCP system is reviewed and extended to the ward kitchens. Risk monitoring processes also need to be implemented. Corrective action on some of the highlighted issues was taken prior to completion of the site visit.

SD 4.9 (B → B)

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

A hand-hygiene station is available at the hospital entrance. Patient satisfaction surveys have been carried out and comment cards are available. Patient information leaflets are provided, however, these need to be updated to include hygiene-related information. A Visitor Policy is in place and it is recommended that conformance to this policy is evaluated. A patient/client representative should be part of the Hygiene Services Team.

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.

A comprehensive set of policies and procedures were in place to ensure the rights of patients/clients and families are respected. The hospital visitor policy was displayed throughout the hospital. In line with the National Visitor Policy, protected meal times should be adopted. It is recommended that evaluation of these policies takes place.

SD 5.2 (B ↓ C)

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

General information leaflets are available at the hospital entrance. A patient information leaflet is also available; however, this did not contain information on hygiene. Greater emphasis is required on the inclusion and promotion of hygiene related information on notice boards. Evaluation of patient/client satisfaction is required to assess the adequacy of information provision. Also, a questionnaire is required for external visitor's entry to the kitchen facilities. This would highlight and prevent/control conditions which could compromise the quality and safety of food products.

SD 5.3 (B ↓ C)

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

A policy for managing complaints and information leaflets is available. However, there was no evidence of formal evaluation and feedback of complaints. Improvements have been made based on feedback, for example, upgrade of the OPD. The implementation of the national complaints procedure is at an early stage. It is recommended that this is developed fully.

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/client satisfaction surveys and comment cards are in use. However, no surveys involving families or external partners have been carried out to date. A comment section on menu cards for patients is also available. The complaints procedure was in the early stages of implementation. No evaluation process of the satisfaction surveys is currently in place. A review of this process is encouraged.

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.

Evidence was observed that some internal hygiene audits have been carried out. It is recommended that focus on HACCP related audits in Catering and ward kitchens be improved. Corrective action mechanisms need to be put in place to complete internal and external audits, Environmental Health Officer reports, and Pest Control reports. A real opportunity exists to strengthen the auditing, monitoring, and benchmarking processes in the hospital. It is recommended that internal and external benchmarks are established.

SD 6.3 (B ↓ C)

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

There are no documented processes for the development of the Hygiene Services Annual Report. A Hygiene Services Annual Report was compiled for 2005-2006. However, this report was developed by the multidisciplinary team and did not involve external providers and patients. The process for compilation of the report should be broadened to include all stakeholders for the current year.

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 - Many areas require immediate attention in relation to rust, dust, and general maintenance.

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

No - Flaking paint and dusty surfaces were identified in many areas. Cleaning resources and cleaning schedules require review as many areas are not reaching an acceptable standard.

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

No - Wall tiles in many areas, including cleaner stores and sluices, are in a poor state of repair.

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

Yes - In the majority, however, The X-ray department requires greater attention.

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

Yes - In the majority, however, the Accident and Emergency department requires greater attention

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

Yes - Foot operated bins are required in some areas including the Accident and Emergency department and the X-ray departments.

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

No - A number of bins are available, however, compliance with usage of these needs to be addressed.

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

No - Little evidence of work route planning was observed.

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

(18) Walls, including skirting boards.

No - This area requires significant attention.

(19) Ceilings

No - A significant number of ceiling tiles are missing and stained. Some tiles were broken and require replacement. Ceiling vents also require greater attention.

(20) Doors

No - Doors (both internal and external) were unclean and had a significant amount of residual sticky tape. Use of 'wall tack' and laminated posters for all notices is recommended.

(21) Internal and External Glass.

No - Internal and external glass was in need of attention and covered with sticky tape residue.

(23) Radiators and Heaters

Yes - Areas behind some of the radiators requires greater attention.

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

(32) Shelves, benchtops, cupboards are clean inside and out and free of dust and spillage

No - Cupboards and work surfaces were covered with sticky tape residue in a number of areas. A significant number of cupboard doors were in need of attention and sticky tape residue was also observed.

(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 - No evidence of compliance with HSG 9518 (Hospital Laundry Arrangements for used and infected linen) was observed. For further guidance, refer to the Irish Acute Hospitals Cleaning Manual (2006).

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

(33) Chairs

Yes - In the majority, however, the backs of chairs were in need of attention in many areas. Fabric chairs should be replaced with washable surfaces in areas such as theatre and private consulting rooms, where patients are examined.

(40) Curtains and Blinds

Yes - Public areas require greater attention

(41) Door handles and door plates

No - A significant number of door handles and door plates were in need of attention.

Compliance Heading: 4. 1 .5 Sanitary Accommodation

(50) The toilet, sink, handrails and surrounding area is clean and free from extraneous items.

Yes - The sinks in some toilets require greater attention.

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

(52) Toilets and Urinals

No - Closer attention is required in relation to the cleaning of toilets.

(54) Wash-Hand Basins

No - Plug holes in many hand wash sinks were in need of attention.

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

No - This should be included in the cleaning schedule for the forthcoming cleaning contract tender.

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

No - Hand wash facilities were insufficient and must be installed. Greater adequate facilities must be provided.

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

No - Appropriate storage facilities are required.

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 - Equipment in the Accident and Emergency department and X-ray department requires greater attention and sticky tape residue must be removed.

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

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

No - Some tops/undersides of commodes were in need of attention.

(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 - In the majority, however, sticky tape residue must be removed.

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 - In the majority, however, X-ray, Accident and Emergency equipment and paediatric trolleys all require greater attention.

(75) Vases

No - No procedure is in place for the maintenance of vases.

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

No - No procedure is in place for the maintenance of vases.

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

No - Dust and sticky tape residue were found on a significant amount of office equipment.

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

(211) Personal Protective Equipment is available and appropriately used and disposed of.

Yes - In the majority, however, some Doctors in the Accident and Emergency department were observed to be using gloves inappropriately.

(81) All cleaning equipment should be cleaned daily.

No - Cleaning equipment required additional cleaning.

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

No - A flat mopping system has not been fully implemented and hygiene staff were observed laundering mops incorrectly.

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

Yes - It was observed that practice and policy differed in most areas.

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

No - No process is in place to ensure that all equipment is approved by the Hygiene Services Committee. Upon questioning staff, it was stated that they liaised with the cleaning supervisor in relation to this.

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

No - Cleaning equipment was found to be dirty and vacuum cleaners, buffers, mops and mop heads were inappropriately stored in most areas.

(89) Equipment with water reservoirs should be stored empty and dry.

No - Used stagnant water was found stored in buckets. Wet mops were observed stored in many buckets.

(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 - Adequate facilities for storage, ventilation, water supply and hand washing were not observed.

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

No - Cleaners storage areas were found to be unclean and poorly maintained.

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

No - Cleaning products and consumables were stored on open shelves.

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

No - Cleaning cloths and equipment were observed in a number of areas and did not comply with the colour coding policy.

(94) Health and Safety policies should be in place for the use of ladders/steps when cleaning.

Yes - A safety data sheet was available.

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

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

Yes - IS 340 was observed on file.

(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 - Environmental Health Officer and water results were observed on file. Corrective action is required for issues highlighted on the Environmental Health Officer reports. Summary issues need to be reported to the HACCP Team and the Hygiene Services Team.

(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.

No - A HACCP plan was developed in 2004 and has not been reviewed since. Many aspects of this plan have not been implemented, for example cooking and cooling records.

(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 was no ward kitchen food safety policy in place. This is planned for the future

(216) Documented processes for manual washing-up should be in place

No - There was no documented manual washing-up procedures. This is planned for the future.

Compliance Heading: 4. 4 .2 Facilities

(217) Access to the main kitchen and ward kitchens should be restricted to designated personnel i.e. food workers.

No - Access to ward kitchens is not fully restricted. Signage and a coded lock system (similar to the main kitchen) is required

(218) Authorised visitors to the food areas should wear personal protective clothing (PPE) and wash hands on entering the food area during food preparation/serving times.

Yes - Personal protective equipment for visitors is provided.

(219) Ward kitchens are not designated as staff facilities

Yes - A review of staff facilities is required. Space restrictions were also noted.

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

No - Some evidence was noted to suggest ward kitchens may be used by staff for snacks, for example the paediatric ward contained coffee mugs and a portable grilling machine.

(221) Staff clothing/uniforms/shoes personal belongings should not be stored in food rooms.

Yes - No evidence of this was noted.

(222) A wash hand basin should be provided at the ward kitchen, in addition to a sink, along with a liquid soap dispenser and hygienic hand drying (e.g. paper towels).

No - There were no hand wash units in ward kitchens. A Quality Improvement Plan was in place to address this issue. This should be progressed.

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

No - There is only one toilet provided for staff in the main catering unit. An additional toilet is required (the requirement being one toilet to fifteen staff).

(224) The ventilation provided for all cooking and steam emitting equipment shall be sufficient to prevent condensation on walls, ceilings and overhead structures during normal operations.

No - Ventilation in the main wash up area was inadequate. The ventilation unit was not functioning.

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

No - There was no traceability system in operation

(227) Flour, cereals, sugar etc shall be stored in a dry environment and when opened stored in covered containers.

Yes - Traceability information is required, for example, best before dates should be displayed on bins.

Compliance Heading: 4. 4 .4 Pest Control

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

Yes - In the majority, however, the bait map required up-dating.

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 blast chill system is in place.

(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 was not applicable in this organisation.

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

No - High temperatures were noted in several fridges, for example, the cooked meat cold room, ward fridges and the rice hot hold unit.

(244) Temperature for food when cooked, held or reheated should comply with I.S. 340:2006 requirements

No - Hot - hold temperatures were in correct

Compliance Heading: 4. 4 .7 Food Processing

(246) The thawing of food shall be carried out under appropriate conditions such as in a thawing unit, a fridge or a microwave oven with thawing cycle

No - No thawing controls were in place at the time of the assessment and frozen product was noted in the freezer.

Compliance Heading: 4. 4 .8 Food Cooking

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

No - No cook records are maintained.

Compliance Heading: 4. 4 .9 Food Cooling

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

No - No blast chill records are maintained.

Compliance Heading: 4. 4 .10 Plant & Equipment

(249) Machines should dispense ice but where ice-scoops are used, they should be stored separately from the ice-making machine and there should be a process for the appropriate decontamination of the ice scoops. The making of ice cubes other than in ice machines is prohibited.

Yes - This was not applicable in this organisation.

(250) The dishwasher's minimum temperature for the disinfecting cycle should be compliant with I.S.340:2006 requirements and should be monitored regularly. There should be digital readouts on dishwashers.

No - Rinse temperature was recorded at 71 degrees Celsius. This should be greater than 82 degrees Celsius and rectification is encouraged.

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

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

No - A documented procedure was available for collection times only.

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

No - Bags are secured with metal ties, which are not coded. The sticker which is used on the bags is not traceable.

(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.

No - A complete audit trail is not carried out.

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

No - This documentation was not available.

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

No - A discharge to drain license is being applied for from Galway County Council.

Compliance Heading: 4. 5 .3 Segregation

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

No - However, the Hygiene Services Committee have stated they are actively seeking mattress bags.

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 - No documented processes were evident.

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

No - There is no Dangerous Goods Advisor in the organisation.

Compliance Heading: 4. 5 .5 Storage

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

No - No documented processes were observed.

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

No - No Clinical Waste sign is in place.

Compliance Heading: 4. 5 .6 Training

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

No - There is no designated Waste Officer in the organisation

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

No - The maintenance of comprehensive records requires further development.

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

(172) Documented processes for the management, maintenance and safe handling of linen and soft furnishings throughout the organisation.

No - Policies and procedures are not in place to manage, maintain and handle linen and soft furnishings.

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

No - No documentation on the processes for the use of in-house and local laundry facilities was available.

(262) Linen is segregated into categories and in appropriate colour coded bags (i.e. clean/unused linen, dirty/used linen, dirty/contaminated linen).

Yes - The plastic bags currently in use are not suitable. It is recommended that bags are introduced which are in line with the Irish Acute Hospitals Cleaning Manual recommendations.

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

No - In many areas, bags were observed stored on corridors prior to collection

(267) Documented process for the transportation of linen.

No - No documented process for the transportation of linen were available

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

No - A washing machine is located in a toilet area and no written policy or guidelines are in place.

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

No - No hand washing facilities are available in the clean and dirty linen segregation areas.

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

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

No - A Quality Improvement Plan is in place to address deficiencies.

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

No - Some splash backs observed were damaged.

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

No - Plug hole outlets require greater attention.

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

No - A Quality Improvement Plan is in place to address deficiencies.

(196) Waste bins should be hands free.

Yes - Some areas contain unsuitable bins, and these require replacement.

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

No - A Quality Improvement Plan is in place to address deficiencies. .

(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 - A Quality Improvement Plan is in place to address deficiencies.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team			Assessor Team
	FREQ	%	FREQ	%
A	1	01.79	0	00.00
B	45	80.36	12	21.43
C	10	17.86	41	73.21
D	0	00.00	3	05.36
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	C	↓
CM 2.1	B	C	↓
CM 3.1	C	C	→
CM 4.1	B	C	↓
CM 4.2	B	C	↓
CM 4.3	B	C	↓
CM 4.4	B	C	↓
CM 4.5	C	C	→
CM 5.1	C	C	→
CM 5.2	B	B	→
CM 6.1	B	B	→
CM 6.2	B	C	↓
CM 7.1	B	D	↓
CM 7.2	B	C	↓
CM 8.1	B	D	↓
CM 8.2	B	C	↓
CM 9.1	B	C	↓
CM 9.2	B	C	↓
CM 9.3	B	C	↓
CM 9.4	B	C	↓
CM 10.1	B	B	→
CM 10.2	B	C	↓
CM 10.3	C	C	→
CM 10.4	B	D	↓
CM 10.5	B	B	→
CM 11.1	B	C	↓
CM 11.2	C	C	→
CM 11.3	C	C	→
CM 11.4	C	C	→

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