Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

# Hygiene Services Assessment Scheme

## Assessment Report October 2007

## Children's University 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*

Founded in 1872, the Children's University Hospital, Temple Street is an Acute Paediatric Hospital serving Dublin North City and County and providing a secondary and tertiary referral and care service both regionally and nationally. It is the only inner city children's Hospital and as such, its catchment includes areas of the south inner city.
The hospital's Bed Stock/Patient Spaces as agreed with the HSE is made up as follows:

- ICU 9
- Neonatal HDU 7
- Day Beds 18
- Day Spaces 6
- In-Patient 5 day 10
- In-Patient Beds and Cots 95

The general bed and cots accommodation are organised on the basis of patient age with dedicated surgical and medical beds although the medical and surgical beds are used flexibly.

**Services provided**

- Accident and Emergency
- Anaesthetics
- Cardiology
- Clinical (Medical) Genetics
- Dental Surgery
- Dermatology
- Endocrinology
- General Surgery
- Gynaecology
- Haematology
- Infectious Diseases
- Maxillofacial
- Mental Handicap
- Metabolic Medicine
- Nephrology
- Neurology
- Neurosurgery
- Ophthalmology
- Orthopaedics
- Otolaryngology (ENT)
- Paediatrics
- Pathology
- Plastic Surgery
- Psychiatry
- Radiology
- Respiratory Medicine
- Rheumatology
- Urology

**Physical structures**

| WARD | ISOLATION FACILITIES | DESCRIPTION INFORMATION |
|---|---|---|
| St. Michaels C | 6 Single Cubicles | 2 of these are Transplant Cubicles |
| St. Michaels B | 12 Single Cubicles | |
| St. Michaels B HDU | 1 Single Cubicles | |
| St. Gabriel's | 2 Single Cubicles<br>2 Double Cubicles | |
| St. Patrick's | 4 Single Cubicles<br>1 Double Cubicles | |
| St. Brigid's | 5 Cubicles | |
| Top Flat Medical | 3 Single Cubicles in St. Josephs | |
| Top Flat Surgical | 1 Cubicle (Telemetry) | |
| Intensive Care Unit | 4 Single Cubicles<br>1 Double Cubicle | 1 Negative Pressure Room |

The following assessment of the Children's University Hospital took place between 24$^{th}$ and 25$^{th}$ July 2007.

## *1.3 Notable Practice*

- The hospital to be commended for its excellent management of sharps.
- The commitment, knowledge and management of Hand Hygiene are to be commended.
- The Sensor operated audio hand Hygiene poster is an excellent example of hand hygiene promotion to all service users/clients/visitors and staff at the hospital.
- There is a tangible ownership of the hygiene process throughout the hospital.
- There was evidence of commitment by the senior management of the hospital to the hygiene process.

## *1.4 Priority Quality Improvement Plan*

- The hospital should review its evaluation process in relation to the hygiene service in order to ensure opportunities for improvements identified following evaluation are completed.
- Provision of Waste Management services needs to be developed in line with best practice and the current and future needs of the hospital.
- Further attention to documented details will assist the organisation's compliance with HACCP.
- Adherence to monitoring and recording Fridge temperatures in ward based areas both kitchens and drug storage areas is required.
- The physical environment and facilities were mainly clean, however structural constraints continue to challenge staff in relation to storage of equipment, products and cleaning equipment.

## *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 Children's University Hospital has achieved an overall score of:

**Fair**

**Award Date:** October 2007

# 2.0 Standards for Corporate Management

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

PLANNING AND DEVELOPING HYGIENE SERVICES

**CM 1.1 (B → B)**

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

The organisation reviewed and documented a follow-up report on the previous two external hygiene audits. This was used to develop a hygiene service structure and action plan. The hygiene system is reviewed through internal audits, risk management and hygiene complaints reports as well as input from the Patient Care Committee. The hospital has developed a hygiene management structure in line with National Guidelines.

It is recommended that a formal hygiene needs assessment be carried out, in line with new services, and that potency of the service is evaluated. For example the new cleaning contract.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

**CM 2.1 (C ↑ B)**

**The organisation links and works in partnership with the Health Services Executive, various levels of Government and associated agencies, all staff, contract staff and patients/clients with regard to hygiene services.**

Strong links were in place with the Acute Hospital Programme through the Network Manager and associated network hospitals. The organisation is a member of the Dublin HSE Linkages Forum. The hospital's microbiologist holds a joint appointment with the National Disease Surveillance Centre. There are strong links developing through a new appointment at the Contracts Department and work has already commenced in reviewing contractors meeting, audits and action plans. There are links with the local community in relation to cultural diversity and in the Streetwise Programme. There is a very effective voice activated Hand Hygiene notice at the entrances and exits at the hospital. This initiative is commendable.

A patient/client satisfaction survey has been carried out. It is recommended the potency of the linkages be evaluated.

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.**
It was noted that the Corporate Strategic Hygiene, Service and Organisational Plans had been developed in 2007 with defined goals, objectives, priorities, costings and membership development. There is access to financial expenditure through its minor capital and human resources, and contracted and procurement services' budgets. The development of corporate hygiene planning involved all stakeholders through the Hygiene committee and team, the latter also including a service user. Quality Improvement Plans have been developed so that there will be an annual review of the Corporate and Service Hygiene Plan. Quality Improvement Plans had on-going action plans, timeframes and identified personnel. It is recommended that a documented process for the development of the Corporate and Service Hygiene Plans and evaluation be undertaken to ensure the Corporate Strategic goals, objectives and priorities against identified needs taken place.

GOVERNING AND MANAGING HYGIENE SERVICES

**CM 4.1 (B → B)**
**The Governing Body and its Executive Management Team have responsibility for the overall management and implementation of the Hygiene Service in line with corporate policies and procedures, current legislation, evidence based best practice and research.**
The organisation provided evidence of department, committees and personnel reporting structures, following an external management consultation and evaluation process. The hygiene service is linked to the quality and accreditation management stream at the hospital, in conjunction with risk management and health and safety. There was evidence of the Governing Body's Memorandum and Articles of Association. Details of minutes of meeting and reports from the Chief Executive Officer (CEO) and Director of Nursing were available. The Board of Directors received hygiene information and delegation of authority has been invested in the CEO. A documented and agreed Corporate Code of Ethics was noted. It is recommended that documented evaluation processes be developed to ensure adherence to 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 Board of Directors receive regular written reports from the Hospital Executive Management, which include updates on hygiene audits, issues, risks and expenditure. The hygiene committee receive information from the Hygiene Services Team and heads of departments. Internal and external audits (including on-site cleaning contractors), hygiene, catering, waste and linen reports are forwarded to senior management. The organisation presented information on hygiene Key Performance Indicators (KPIs) in relation to waste management and infection Control rates. The Executive Management team and the Board of Directors receive risk management and complaints reports and the Board of Directors has established a Patient/Client Care Committee, which has strong service user representation. Minutes of these groups' meetings were noted and included issues related to

hygiene, catering and car parking. The organisation presented evidence of best practice and national guidelines. However no formal evaluation of the appropriateness of the information was evident.
It is recommended that an evaluation processes for this be developed to ensure that the information route/communication route was identified.

**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.**
It is recommended that the organisation would develop a documented evaluation process to ensure the potency of the research and best practice information on the ground.

**CM 4.4 (B ↓ C)**
**The organisation has a process for establishing and maintaining best practice policies, procedures and guidelines for Hygiene Services.**
This was noted and they are available at departmental level. Relevant standard operating policies in relation to flat mopping, colour-coding and frequencies have been developed, in conjunction with the cleaning contractor. A project to transfer all PPG's into an information management software programme will be available by the end of December this year. Quality initiatives, to include evaluation of this, were noted. It is recommended that these be progressed.

**CM 4.5 (B ↓ C)**
**The Hygiene Services Committee is involved in the organisation's capital development planning and implementation process.**
The organisation is in the planning and developing stage of a number of internal refurbishment projects including theatres, Transitional Care Unit and decontamination processes in the Out-patient Department. A number of defined minor capital projects such as the replacement of 100 clinical sinks have commenced, with an on-going project to complete all areas of the hospital by mid 2008. Evidence of the Strategic Projects Committee membership was available, as were project team minutes. Issues in relation hygiene are forwarded through the representation of a number of hospital personnel in areas such as infection control; Director of Nursing is on the Capital Project Team and both the Director of Nursing and the Accreditation Manager are on the Strategic Programmes Office. It is recommended that the organisation develop and evaluate documented processes for the management of the capital projects.

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.**
Designated overall responsibility for hygiene has been invested in the Chief Executive Officer who in turn reports to the Board of Directors. No job descriptions for the Governing Body were evidenced. There is a code of corporate governance, which outlines the roles and functions of the Board and its Directors. This was provided in the documentation during the assessment. There were clear job descriptions for hygiene staff, such as catering and healthcare assistants, porters and clinical nurse managers at ward level. The Hygiene Services Committee and

Team had clear and detailed roles, responsibilities, accountability, terms of reference, membership and designated areas of responsibility. The reporting relationships (including Hygiene) have been determined and are currently in progress and discussion. The Hygiene Services, Infection Control, Waste Management and the Facilities Engineering department's organisational charts and minutes of meetings were observed, as was a detailed organisational chart. It is recommended that job descriptions would include details of hygiene specific roles and responsibilities, both from a corporate and individual perspective.

*Core Criterion

**CM 5.2 (A ↓ B)**

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

The hospital has a comprehensive and inclusive multi-disciplinary committee. The 20 members include, senior management, human resources allied medical, finance, and clinical services. Terms of Reference and weekly frequencies of meetings were noted. The Hospital Hygiene Committee and Team have clerical support from the Quality and Accreditation Department. It is recommended that the hospital develop a documented process to ensure that all hygiene committee and team members have awareness of the role and responsibility of their roles.

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

*Core Criterion

**CM 6.1 (A ↓ 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.**

A Corporate Hygiene, Service and Organisational Plan outlined both financial and human resources required for hygiene services. The Chief Executive Officer, in liaison with the Board of Management, prepared monthly financial statements. The Executive Management Team allocated resources, with the HSE, in line with the National Service Plan. Training and education resources for induction, infection control and mandatory training in areas such as fire safety, hand hygiene and manual handling were allocated in conjunction with the education matrix for the hospital.
An annual National Service Plan template was in place. It is recommended that the hospital develop a documented process for the management and development of the corporate, strategic and annual hygiene services.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

**CM 7.1 (A ↓ B)**

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

The organisation had a robust Risk Management Committee, Strategy and Incident Reporting process. There was a risk register for hygiene. Risk management reports with trend analysis charts were available. There were reports on environmental health (HACCP), health and safety, water safety, infection control, decontamination and complaints. These identify relevant risks, on-going risk assessment and action plans. Internal hygiene audits of all clinical areas, waste, linen and hand hygiene have been completed. It is recommended that the organisation formally evaluate hygiene audits.

**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.**

Members of the Hygiene Services Committee are also members of the Risk Management Committee. Risk management is a standing order on the corporate agenda and would include hygiene risks as identified. A Quality Improvement Plan (QIP) for hygiene is in place and includes completing trend analysis of incidents and complaints. Financial resources were allocated to upgrade incident reporting software and to upgrade sinks in the hospital, in line with SARI guidelines.
To-date no major adverse event has occurred.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion

**CM 8.1 (B ↓ C)**

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

A Contracts Manager has been appointed. Robust procurement has commenced, in line with the National Procurement Policy. An example of this was the tendering process and appointment of a contract process for the External Cleaning Contract. Evidence was noted of review meetings with contracted services, auditing and internal monitoring by the hospital of the contractor. While some of the major contractors are involved in the monitoring processes at the hospital in areas such as waste, cleaning, catering and laundry, there was documented evidence that all contractors would be included in the review and monitoring process in the hospital within 12 months. Evidence was available of external contracted services. Contracts for pest control need to be reviewed, which should be done in the near future.

**CM 8.2 (C → C)**

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

The Hospital Hygiene Services Team includes representation from the external cleaning contractor, with a full participation and inclusion in the quality improvement initiatives devised by the hospital. It is recommended that the organisation would include other external contractors in the quality agenda.

PHYSICAL ENVIORNMENT, 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.**

This is a challenge to the provision of safe services. The hospital is 150 years old, has improved hygiene structural areas, but this is very limited in size. An example would be the domestic service rooms. It would appear all building and safety regulations are met. It is recommended that the hospital continue to review the waste management area and follow best practice guidelines.

*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.**
A suite of corporate, professional and service policies, procedures and guidelines were available for the management of the hygiene service. These include management of sharps, waste, linen, HACCP and cleaning. The hygiene structure, roles, responsibilities and reporting structures were noted. Details of legislation and best practice were note in areas such as SARI, Waste Legislation, Food Hygiene Safety and National Cleaning Manual. Appropriate job descriptions were available and hygiene committee system and internal audits have been completed. It is recommended that the internal audit and evaluation system be further developed to include internal peer review.

**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.**
Staff and patient/client surveys were being undertaken. Comment cards were evident for patient/clients, parents and visitors. There was an IT complaint report system in operation via the Risk Management Department. Central Sterile Supply Department (CSSD) user satisfaction surveys were available. A patient/client care committee involves service users who are also represented on the Hygiene Services Team. Development of all quality improvements is on-going and it is recommended that these and the comment cards be reviewed, dated and progressed.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

**CM 10.1 (A ↓ 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.**
A robust recruitment and selection process, which incorporates current legislation (Equal Status/Anti-Discrimination Disability policies) is in place. Guidelines for recruitment process on interview panels were noted. Human Resources' recruitment records were observed. The Human Resources Mission Statement identifies appropriate training and education in relation to the recruitment process. A range of hygiene-related job descriptions was observed. Agreements are in place for the employment of contract cleaner staff and agency nursing. It is recommended that the process of recruitment and selection of hygiene staff be evaluated.

**CM 10.2 (C → C)**
**Human resources are assigned by the organisation based on changes in work capacity and volume, in accordance with accepted standards and legal requirements for Hygiene Services.**
The employed cleaning services have been established through an external contract. This contract has recently been awarded and new contactors are in place. The contract specifications include all component elements of training, education, recruitment, job specifications, audits, QIPs and evaluation. Staff for waste, internal linen and catering is employed directly. The cleaning specification has been reviewed, in line with the National Cleaning Manual. The hospital has also identified its resource implication in its strategic and service hygiene plans. It is recommended that documented process for the reviewing and changing of hygiene services

resources be developed, in line with changing services needs. It is recommended that the organisation would develop a process to evaluate its work capacity and volume.

**CM 10.3 (B → B)**

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

The hygiene service has been recently been awarded to a new company. Full tender documentation incorporated all the elements of appropriate recruitment and best practice. Hospital staff is recruited in line with national recruitment policies. Specific job descriptions, which included qualifications and training relevant to post, were observed. A number of training programmes were noted e.g. FETAC, HACCP, SKILLS, and mandatory infection control training.

**CM 10.4 (C ↑ B)**

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

There is robust procedure in place for the management of contract staff. The cleaning services contract was changed this year and a new company is now in place. Strong evidence of education, training and audit of the cleaning services has been carried out by the contractor. Review meetings are in place for contracted cleaning and laundry. An audit of linen services by the contractor and hospital has been carried out, and resultant actions were evidenced.

*Core Criterion

**CM 10.5 (C → C)**

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

Human resource needs are met in line with approved WTE and hospital budget. An external contractor is employed for janitorial duties and a mechanism is in place to identify staffing requirements in new and planned areas. A Hygiene Services Co-ordinator has been appointed and a new cleaning contract is in place, which included additional out of hours services.

ENHANCING STAFF PERFORMANCE

*Core Criterion

**CM 11.1 (A → A)**

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

This is in place for all staff including NCHD's and contract cleaning staff. The content of the programme was noted as was specialist training for catering (HACCP) and Healthcare Assistants (FETAC). New staff receives mandatory infection control and hand hygiene training as part of the initial induction programme. Attendance records and a staff induction handbook were noted, as was staff information on hospital Policies, Procedures and Guidelines (PPG's). Continuing education and training is in place following initial induction. It is recommended that the organisation evaluate the potency of the induction procedures and content.

**CM 11.2 (B ↓ C)**

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

This is in place for all staff, including specific training for hygiene staff on hygiene issues. Annual infection control and hand hygiene training is mandatory. Training records and matrix was available at ward/departmental level. All training is recorded centrally on a management information system in the office of the Director of Nursing and in the Human Resources Department.

**CM 11.3 (C → C)**

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

All training programmes are evaluated. These evaluations are centrally reviewed. Feedback and evaluation commentary is available for hand hygiene and waste.
It is recommended that the evaluation of education and training would be further developed in areas such as staff satisfaction and attendance rates at education sessions.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

**CM 12.1 (A ↓ C)**

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

This is in place and details are provided by means of staff information leaflets. Vaccination details are included. No evidence was available to support any evaluations of the service either by the organisation or by the department themselves. It is recommended that the appropriateness of the service be evaluated.

**CM 12.2 (A ↓ C)**

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

Performance indicators were outlined by the organisation in respect of occupational health, however they were not available. The QIPs are a work in progress.
The Occupational Health Department should be involved more in the hygiene process. Monitoring systems should be developed. It is recommended that performance indicators be developed, in line with national strategies and local projects. Evaluation of the service should be undertaken with feedback to service users and hospital management.

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.**

The hospital is involved in an extensive information audit process. They have the use of evolving IT systems. Patient/client and staff satisfaction surveys are undertaken. Reports from external contractors are available. All Quality Improvement Plans (QIPs) are work in progress. The organisation should complete the progress in relation to evaluation. The accuracy of the collected data will be enhanced by the proposed introduction of the Management Information System. The establishment of the Quality and Accreditation Committee will compliment this process.

**CM 13.2 (C → C)**

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

There is access to hygiene-related reports. No evidence was observed that internal evaluation of the presentation of the data is carried out. Neither is there evaluation available of user satisfaction regarding the reporting or presentation of data. Evaluation of the data in relation to accuracy, presentation and circulation within the organisation should be undertaken.

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 Board of Governors and Executive Management Team are committed to the quality agenda. This includes hygiene. Commitment to change management, provisions of resources and quality initiatives were noted. Examples include improvements in the provision of clinical hand wash sinks, provision of new waste, clinical and domestic bins throughout the hospital, and the purchase of new sharps bins with added internal safety mechanism.

**CM 14.2 (C ↑ B)**

**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.**

Results of the previous two national audits were reviewed and there was documented evidence of the internal report and subsequent action plan. The organisation reviewed and benchmarked its performance in relation to other peer, and all other acute, hospitals. External Hazard Critical Control Point (HACCP), waste and linen audits were noted and reports available and hygiene services are continually audited. It is recommended that the hospital further develop the audit, evaluation and QIPs.

## 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 (A ↓ C)**

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

A documented process was in place for the establishment, adoption, maintenance and evaluation of best practice guidelines for hygiene services. An information management system to manage this is currently being tested. Input from patient/clients and parents, mainly comes through the patient/client care committee.
It was suggested to include a patient/client focus consultation group regarding a new breastfeeding policy being developed from international standards. The structural changes and adherence to hand hygiene and management of healthcare waste and laundry throughout the organisation were examples of the adoption of national guidelines into best practice. Protected time for supervisory staff to consult documentation is not standardised. Evaluation of this process needs to be undertaken.

**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.**

While evidence existed from minutes of hygiene services meetings that these are discussed and tested in the hospital, there is a need to develop a documented process to formalise this. The newly-established Cleaning Contractor Clinical Wash-hand Basin Replacement Programme, increased availability of alcohol gel, and management of sharps/waste and laundry were some of the listed service interventions that had a significant impact on improving the hygiene service.
The hospital is encouraged to formalise these processes.

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.**

Evidence observed was reviewed and discussed with staff during the assessment.
The hygiene initiatives undertaken, which specifically included the community, should be evaluated to determine their effectiveness.

INTEGRATING AND COORDINATING HYGIENE SERVICES

**SD 3.1 (A ↓ C)**

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

This is so. While members of the multi-disciplinary teams, through involvement at many committee levels, are aware of each other's role, the management structure of reporting and establishing/maintaining linkages/partnerships was still under review. This process will require evaluation to allow for continuous quality improvement.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

**SD 4.1 (B → B)**

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

They were mainly clean; however structural constraints continue to challenge staff in relation to storage of equipment and products. A fridge and microwave, which appeared to be for staff use, was in a storeroom. A specimen fridge was also in operation. This room should be designated for storage of patient/client related equipment only.

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.**

In general equipment and medical devices were deemed to be clean and managed satisfactorily, however the Intensive Care Unit and Accident and Emergency were identified as in need of greater attention to the management of the medical devices and equipment.

For further information see Appendix A

*Core Criterion

**SD 4.3 (A ↓ B)**

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

The cleaning equipment used in the hospital was relatively new, appeared clean and well managed. The structural facilities however did not appear to be of adequate size or have the facilities to manage hygiene requirements.

For further information see Appendix A

*Core Criterion

**SD 4.4 (B → B)**

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

The hospital main kitchen is not in full compliance with Hazard Analysis and Critical Control Point (HACCP) guidelines. It is due for review to take account of reheating of

food at ward level. Issues identified by the Environmental Health Officer (EHO) on the last visit were being addressed at time of assessment. Remedial action was taken for non-compliance to temperature requirements for salad items in the display/holding unit and inadequate management of cooking oil identified during assessment.

For further information see Appendix A

*Core Criterion

**SD 4.5 (A ↓ B)**

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

The commitment to the waste management process is evident. However, compliance with waste management, need to be reviewed. Areas identified and addressed during the assessment include access to the public, and staff, storage of electrical products, appropriate (Personal Protective Equipment (PPE) should be available, with staff training and evaluation. This should be assisted by an on-going audit. The management of waste, particularly sharps management, was in line with best practice.

For further information see Appendix A

*Core Criterion

**SD 4.6 (B → B)**

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

The contracted service to manage the organisation linen is managed effectively. A process needs to be developed for the on-site use of washing machines and tumble driers to comply with national standards.

For further information see Appendix A

*Core Criterion

**SD 4.7 (B ↑ A)**

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

Hand hygiene standards and facilities were noted to be very high. Training and education was effective. It is recommended that a process be put in place to ensure that all agency/locum staff employed in the hospital meet with hospital standards.

For further information see Appendix A

**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 specific educational system in place to educate parents and older patient/clients. Information leaflets were available and a review of these, with the involvement of the cultural diversity group, was underway.

The visitor policy was evident in many areas.

Patient/client satisfaction with the service has been undertaken. However this may be further enhanced, to ensure specific hygiene issues are addressed.

PATIENT'S/CLIENT'S RIGHTS

**SD 5.1 (B ↓ C)**
**Professional and organisational guidelines regarding the rights of patients/clients and families are respected by the team.**
Confidentiality and dignity is strived in hygiene services delivery. Isolation signs are designed to inform the public to seek further assistance prior to entering rooms. Training in standard precautions are delivered to staff involved in hygiene services, and the information received, affords staff to work in a safe manner and the patient/client to be cared for without violation of confidentiality. Evaluation is recommended.

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

**SD 5.3 (A ↓ C)**
**Patient/Client complaints in relation to Hygiene Services are managed in line with organisational policy.**
Documented processes are in place for dealing with complaints. Records were viewed; however patient/client evaluation needs to be undertaken.

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.**
A parent representative from the Patient Care Committee is on the Hygiene Services Team. To be wholly inclusive it is suggested an invitation to participate in some of the internal audits to appropriate areas as designated by hospital management, be offered.

**SD 6.2 (B ↓ C)**
**The Hygiene Services team regularly monitors, evaluates and benchmarks the quality of its Hygiene Services and outcomes and uses this information to make improvements.**
One of the most specific changes within the last two years was the review and change of external contractors for cleaning services. Key Performance Indicators (KPIs) are established for this contractor. On-going audit is undertaken regularly.
It is recommended that the hospital would evaluate the contracted and in-house hygiene services.

**SD 6.3 (A ↓ C)**
**The multi-disciplinary team, in consultation with patients/clients, families, staff and service users, produce an Annual Report.**
This is done every two years. The 2004 report did not make specific reference to hygiene issues or risk management, but the hospital has identified the need to

include hygiene services in the next report. It should include consultation with patient/clients, families and service users.

# 4.0 Appendix A

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

## *4.1 Service Delivery Core Criterion*

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

(2) All high and low surfaces are free from dust, cobwebs and flaking paint.
**No -** Evidence of high dust was observed in clinical areas.

(3) Wall and floor tiles and paint should be in a good state of repair.
**No -** Tiles need replacing on stairs to wards.

(13) External areas including grounds, gardens, footpaths, ramps and car parks should be clean and well-maintained.
**No -** Evidence of litter in external grounds was observed.

(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 -** There was evidence of cigarette buts on the ground in the Staff designated smoking area.

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

(207) Bed frames must be clean and dust free
**No -** Ingrained dirt was observed in some areas noted.

(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 -** Evidence of curtain changing in the process for curtain change should be reviewed.

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

(34) Beds and Mattresses
**No -** Beds reviewed in Intensive Care Unit, St Philomena's and St Patrick's all had in-grained dirt under the mattress. Parents' mattresses were in need of repair in some wards.

(36) Lockers, Wardrobes and Drawers
**No -** While lockers and drawers appeared in the main to be clean, lack of storage space gave rise to excessive clutter of patient/client personal belongings and equipment.

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

(45) There is a facility for sanitary waste disposal.
**Yes -** None available in staff toilet at front hall.

(47) Bathrooms / Washrooms are clean and communal items are stored e.g. talc or creams.
**Yes -** Communal items were noted in some wards.

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

(58) Sluice rooms should be free from clutter and hand washing facilities should be available.
**No -** The dirty utility room in St Patrick's ward was extremely small and would be difficult to work in. Some waste was being stored in the clean utility room due to the lack of space in this area.

(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 -** A fridge and microwave which appeared to be for staff use was in the store room in St Patrick's ward. A specimen fridge was also in operation in this area. This room should be designated for storage patient related equipment only.

**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.
**Yes -** However dust noted on wheels of patient/client equipment in surgical ward. Dust noted on fan in St Patrick's ward.

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

(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.
**No -** Some areas visited had very good attention given to the cleaning of medical equipment, however high risk areas require greater attention to cleaning.

(67) Bedside oxygen and suction connectors.
**Yes -** However there was dust on nitric cylinders in Intensive Care Unit.

(68) Patient fans which are not recommended in clinical areas.
**Yes –** A fan observed in St Patrick's ward required further cleaning, however, this was not in use.

**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, emergency trolleys in two areas were dusty.

(74) Patient's personal items, e.g. suitcase which should be stored in an enclosed unit i.e. locker / press.
**Yes -** However some areas require wardrobes.

(76) Hand-wash dispenser holders and brackets should be free of product build-up around the nozzle.
**Yes -** In the majority, however, some hand soap dispenser in kitchen required attention.

(77) Loose items such as patient's clothing should be stored in the patient's locker or property bag.
**No -** Some areas require additional storage.

(80) All office equipment (e.g. telephones, computers, fax machines) should be clean and well-maintained.
**Yes -** However electrical lead management needs to be reviewed. Residual Selotape marks on some computer monitors.

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

(83) Mop heads are laundered daily and are stored according to local policy or are disposable i.e. single use.
**Yes -** However the area used for storage requires attention.

(85) Cleaning solutions should only be prepared in a well ventilated area and should never be mixed.
**No -** Janitors rooms were very small with inadequate ventilation.

(87) All cleaning equipment should be approved by the Hygiene Services Committee and ensure sufficient supply.
**No -** The Hygiene Services Committee, at time of assessment, did not review all cleaning equipment but the organisation was committing itself to this process.

(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 -** Ventilation not in place in most areas, limited sinks available.

(92) Cleaning products and consumables should be stored in shelves in locked cupboards.
**No -** It is recommended that the hospital would lock consumables in cupboard.

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

(212) Irish Standard 340: 2006 Hygiene in Food Service (Draft) of the National Standards Authority of Ireland (NSAI) specifies guidance to compliance with the requirements of S.I. 369 of 2006 EC (Hygiene of Foodstuffs) Regulations and Regulation (EC) No. 852/2004 on Hygiene of Foodstuffs. This should be complied with.
**No -** The HACCP system was not fully in compliance this was due for review.

(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 -** Issues raised on most recent report (June 07- 1 month prior to HIQA assessment) by EHO were being addressed.

(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 –** This should be signed off by appropriate management such as Catering and General Services. It should mention compliance with (EC) Regulation 852/2004 on the Hygiene of Foodstuffs. IS 343 is no longer in place as an NSAI Standard.

**Compliance Heading: 4. 4 .2 Facilities**

(217) Access to the main kitchen and ward kitchens should be restricted to designated personnel i.e. food workers.
**Yes -** Signage in place on entrance to main kitchen and ward pantries.

(221) Staff clothing/uniforms/shoes personal belongings should not be stored in food rooms.
**Yes -** However Intensive Care Unit staff facilities were being used to store personal items such as a rucksack.

(223) Separate toilets for food workers should be provided.
**Yes -** However greater attention to personal items within the designated area for catering staff should be addressed.

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

(226) Containers used to store foods shall be made of food grade materials, be in good condition, easy to clean and disinfect.
**No -** The container used to store cooking oil was not listed in the cleaning schedule. The storage area was deemed to require attention. Corrective action was requested during the time of the assessment. This system was ceased oil in drums were purchased and stored in an appropriate designated area. Greater use of food grade containers recommended.

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

(232) Waste storage containers shall be smooth, durable, easy to clean and disinfect, well maintained and closable.
**No -** One of the bins in use in the centre of the main food area did not have a closure mechanism in operation.

**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 –** This was not applicable as a cook-chill system is not in operation.

(242) Temperatures for Food in Fridges / Freezers and Displays should comply with I.S.340:2006 requirements.
**No -** The temperature in the cold storage display unit in the restaurant was not in compliance. Records for last two days also recorded elevated temperatures. The service engineer was contacted and was on site during the assessment. Corrective action put in place to deal with situation. It is recommended the process of monitoring and recording temperatures of all fridge units being used is revised.

(244) Temperature for food when cooked, held or reheated should comply with I.S. 340:2006 requirements.
**Yes -** Food tracked to ward level at dinner service was observed to comply with requirements before serving.

**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 he thickest point of the food and should be compliant with I.S. 340:2006
**Yes -** The process for checking the temperature was correct.

**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 -** No ice making machines were in operation.

(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 –** However, funding commitment has been given for the upgrade of equipment within catering areas.

(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 -** Specific temperature probes checked against documentation for verification of calibration and evidence were appropriate

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

(149) Inventory of Safety Data Sheets (SDS) is in place.
**Yes -** Available on intranet but not very easy to navigate.

(151) Waste is disposed of safely without risk of contamination or injury.
**No -** On initial inspection no personal protective equipment (PPE) is in place to protect staff in dealing with spillage. Remedial action taken during assessment and is now available.

(152) When required by the local authority the organization must possess a discharge to drain license.
**No –** The organisation is in the process of applying for one.

(253) Personal protective equipment is accessible to all staff involved in the generation, collection, transport and storage of waste.
**No -** - PPE management was undertaken during the assessment and access to appropriate items were being sourced, PPE risk assessment should be undertaken in conjunction with health & safety and infection control. Training for all staff should be available in relation to wearing and disposal of appropriate PPE.

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

(256) Mattress bags are available and are used for contaminated mattresses ready for disposal; mattresses are disinfected.
**Yes -** Commercial system of disposal of mattress in place, which complies with the criteria.

(158) Needles and syringes should be discarded as one unit and never re-sheathed, bent or broken.
**Yes -** evidence of re-capping of needles in – However evidence of re-capping of needles should be reviewed.

(159) Sharps boxes are correctly sealed, labelled and stored in a safe environment.
**Yes -** the hospital is to be commended for the actual sharps boxes very appropriate to service.

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

(166) Drivers of vehicles transporting hazardous waste must be trained in accordance with the ADR Regulations.
**Yes -** Compliant.

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

(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 -** There were inadequate segregation facilities and the area was accessible to the public. There were insufficient warning signs in relation to public access, and traffic management in this area needs to be reviewed. During the audit remedial action was taken in relation to signage and discussions regarding the security arrangements of waste were being commenced.

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

(259) There is a trained and designated waste officer.
**Yes -** There is a designated waste officer. However there was no evidence available in relation to training.

(260) There are documented records of staff training on the handling, segregation, transport and storage of healthcare risk waste including the use of spill kits and personal protective equipment.
**No -** No evidence seen in relation to specific training for waste porters. Evidence available for laboratory staff,

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

(173) Documented processes for the use of in-house and local laundry facilities.
**No -** No documented processes for a validated system for washing of mop heads.

(174) Clean linen is stored in a designated area separate from used linen (not in sluice or bathroom).
**Yes -** While the linen is stored in a designated area these areas are also being used to store other items. Shelving should be of a cleanable - not wood. This is not in keeping with best practice.

(175) Clean linen is free from stains.
**Yes –** A returns policy with the contractor is in place.

(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 -** No documentation was available from the cleaning company during the audit.

(271) Hand washing facilities should be available in the laundry room.
**Yes -** Hand hygiene facility available but as evident during assessment it is not used appropriately as it was full of extraneous items.

(270) If a washing machine is in use, a tumble drier is also in place which is externally exhausted. Documented processes for planned preventative maintenance of this equipment should be in place.
**No –** A service contract was in place, however, there was no document process in place for planned preventative maintenance.

**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 nail varnish was noted on one member of agency nursing staff.

(190) All sinks should be fitted with washable splash backs with all joints completely sealed.
**Yes -** However no splash backs in one area. On-going replacement programme in place.

(192) Taps should be hands free and should be mixer taps to allow temperature regulation.
**Yes -** There is evidence of replacement and those that have been changed comply with HBN 95.

(193) Liquid soap is available at all hand washing sinks. Cartridge dispensers must be single use.
**Yes -** However the use of liquid soap, alcohol gel and antiseptic solutions at the clinical wash-hand basins may give rise to confusion as to which product to use. It is recommended that a review is undertaken.

(194) Dispenser nozzles of liquid soap of alcohol based hand rubs must be visibly clean.
**Yes –** In the majority, however, one exception noted was the kitchen.

(198) Hand hygiene posters and information leaflets should be available and displayed throughout the organization.
**Yes –** A sensor-operated information hand hygiene voice-over was noted.

(203) Hand wash sinks are dedicated for that purpose, are free from used equipment and inappropriate items (e.g. nail brushes).
**Yes -** With the exception of laundry facility where the washing machine is. Nail brushes observed in Catering Department.

(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 -** 100 sinks have been replaced and continual replacement programme in progress.

(206) Documented records of mandatory attendance at hand hygiene education and practice is required for all staff members involved in clinical areas. This may be undertaken during hospital induction programme followed by annual updates.
**Yes -** Evidence of staff training was observed.

# 5.0 Appendix B

## *5.1 Ratings Summary*

| | Self Assessor Team | | Assessor Team | |
|---|---|---|---|---|
| | FREQ | % | FREQ | % |
| A | 16 | 28.57 | 3 | 05.36 |
| B | 27 | 48.21 | 24 | 42.86 |
| C | 13 | 23.21 | 29 | 51.79 |
| 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 | C | B | ↑ |
| CM 3.1 | C | C | → |
| CM 4.1 | B | B | → |
| CM 4.2 | B | C | ↓ |
| CM 4.3 | B | B | → |
| CM 4.4 | B | C | ↓ |
| CM 4.5 | B | C | ↓ |
| CM 5.1 | A | B | ↓ |
| CM 5.2 | A | B | ↓ |
| CM 6.1 | A | B | ↓ |
| CM 6.2 | C | C | → |
| CM 7.1 | A | B | ↓ |
| CM 7.2 | B | C | ↓ |
| CM 8.1 | B | C | ↓ |
| CM 8.2 | C | C | → |
| CM 9.1 | B | C | ↓ |
| CM 9.2 | A | B | ↓ |
| CM 9.3 | B | B | → |
| CM 9.4 | B | C | ↓ |
| CM 10.1 | A | B | ↓ |
| CM 10.2 | C | C | → |
| CM 10.3 | B | B | → |
| CM 10.4 | C | B | ↑ |
| CM 10.5 | C | C | → |
| CM 11.1 | A | A | → |
| CM 11.2 | B | C | ↓ |
| CM 11.3 | C | C | → |
| CM 11.4 | C | C | → |
| CM 12.1 | A | C | ↓ |

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