Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Hygiene Services Assessment Scheme

Assessment Report October 2007

Mid Western Regional Maternity Hospital

Table of Contents

1.0 Executive Summary

1.1 Introduction

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

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

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

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

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

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

1.1.1 Standards Overview

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

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

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

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

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

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

Core Criteria:

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

In the Corporate Management standards, the core criteria cover:

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

In the Service Delivery standards, core criteria cover:

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

1.1.2 Rating Scale

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

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

A **Compliant - Exceptional**

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

B **Compliant - Extensive**

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

C Compliant - Broad

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

D Minor Compliance

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

E No Compliance

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

N/A Not Applicable

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

1.1.3 Assessment process components

The assessment process involves four distinct components:

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

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

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

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

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

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

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

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

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

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

- **Continuous Improvement**

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

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

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

[2] New York Department of Health and Mental Hygiene

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

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

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

1.2 Organisational Profile

The Mid West Regional Maternity Hospital, Limerick is a stand alone Maternity Hospital providing Obstetric and Neonatology services for Limerick, Clare and Tipperary North Riding. The hospital has 80 Obstetric beds and 19 Neonatal cots. The hospital has responsibility for the delivery of approx 4,700 babies annually and also caters for 900 admissions to our neonatal unit.

Services provided

The Mid Western Regional Maternity Hospital provides the following services:

- Colposcopy Services
- Obstetric services including antenatal care i.e. care of mother during pregnancy and prior to delivery
- Antenatal classes
- Counselling services
- Postnatal care i.e. parentcraft and breastfeeding support and other maternity services for the Mid-West Region
- It also has a (neo-natal) special care baby unit and has a school of midwifery.

Physical structures
The hospital is a single structure building and was opened in 1961. In-patient accommodation comprises of 3 main wards (2 postnatal with 1 ante-natal) with 30, 27, and 23 beds respectively. Each ward incorporates 5 private rooms en suite, 4 semi private rooms with bathroom and a number of 3 to 4-bedded public rooms with bathroom.

The following assessment of the Mid Western Regional Maternity Hospital took place between 2nd and 3rd July 2007.

1.3 Notable Practice

- The overall compliance to Hazard Analysis and Critical Control Point (HACCP) and commitment within the catering department to food safety is to be commended.
- The adherence to uniform policy was very evident across all disciplines during the assessment and is to be commended.
- The adherence to and knowledge of the colour-coding system across all disciplines was noted.
- Quality improvement plans which have been developed and implemented to date are to be commended.
- Clear linkages with partners, the Health Service Executive and others were evident.

1.4 Priority Quality Improvement Plan

- It was recommended that the organisation implement the Environmental Health Officer recommendations in relation to the shop.

- The organisation should perform a needs assessment of hygiene staffing level requirements to ensure staffing requirements are met.
- The organisation is encouraged to implement the proposed upgrade of hand wash basins throughout the hospital and replacement as soon as funding approval is received.
- It is recommended that the organisation focus on improving the clinical waste trail in the hospital to ensure minimum handling of waste.
- Improvement to the facilities of clinical areas and an improved cleaning schedule for these areas is recommended.
- The organisation is encouraged to develop and improve evaluation processes and action plans for all aspects of hygiene services.
- It is recommended that the organisation develop a formal process for needs assessment of the hygiene services and develop hygiene service plans based on this assessment.
- The organisation is encouraged to improve the presentation and availability of self-assessment evidence documentation for future hygiene assessments.

1.5 Hygiene Services Assessment Scheme Overall Score

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

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

The results of the two previous national hygiene audits (2005 and 2006) were utilised in the development of the corporate hygiene strategic plan (for example, upgrading of handwash sinks). A process had been developed regionally for the performance of a needs assessment of hygiene staffing requirements and a projects officer had been nominated to oversee this project. It was recommended that a formal hygiene needs assessment and evaluation process be developed and implemented.

CM 1.2 (A ↓ B)

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

Evidence was observed that the following modifications were made as a result of needs identified through hygiene audits and hygiene steering group action plans. Local hygiene service plans and a Hygiene Services Committee were developed. The refurbishment of the neonatal unit was in progress, hygiene audit meetings were introduced, furniture and equipment were upgraded (for example chairs, bed side lockers and curtains). Cleaning equipment was also upgraded (for example flat mop), and a colour-coding system was introduced. Cleaning frequencies were increased (for example in the physiotherapy department/ultrasound) from weekends to daily cleaning). Catering tea towels have been replaced with disposable towels and fridge temperature records were introduced. New alcohol hand rubs were also introduced. Some evaluations of new modifications were performed through hygiene audits. It was recommended that the organisation develop a formalised approach to the evaluation of the developments and modifications to the organisation's hygiene service in relation to meeting the user's needs.

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.

There was strong evidence of linkages with the National Hospitals Office, regional Health Services Executive and regional committees (for example: hygiene steering committee, risk management committee, occupational health, communicable disease committee and capital planning project teams). The organisation is a member of Health Promotion in Hospitals network. Catering linkages included environmental health and a private company for HACCP control. Evidence of linkages with patients and the public included: hand hygiene awareness days, comment cards and 'Your Service Your Say'. The organisation expressed that its plans for the introduction of a consumer panel were at an advanced stage. Some evidence of evaluation of linkages with the regional infection committee was observed (through production of regional infection rates). It was recommended that the organisation form the consumer panel in the near future. It was also recommended that formal evaluation of the efficacy of the linkages and partnerships be introduced.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 (B ↓ C)

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

Evidence was observed that the hygiene corporate strategic plan was developed at regional level by the regional hygiene steering committee, utilising information as outlined in the organisation needs assessments. The hygiene corporate strategic plan was a two year plan, which had clear goals and objectives with prioritisation for the development of a dedicated hygiene budget for the hospital. The plan was developed using a multidisciplinary approach from relevant stakeholders within the region, including representatives from the local Hygiene Services Committee (for example, the Assistant Director of Midwifery Services and Infection Control) and those responsible for the implementation of the plan were also outlined. As the plan was developed in 2007 it had not been evaluated. It was recommended that the organisation review the current hygiene corporate strategic plan to include relevant costings and receive formal approval on the plan in the form of a signature.

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.

Evidence was observed that the organisation's Assistant Director of Midwifery and Nursing services assumed overall responsible for hygiene at the hospital and reported to the regional hygiene steering committee on hygiene-related issues. Clinical nurse managers and other managers were responsible for implementing and monitoring hygiene at local level and reported to the Director of Midwifery Nursing. Corporate policies available and reviewed included the dress code policy, the visitors'

policy, human resources recruitment policy, risk management polices and infection control polices (for example hand hygiene, linen sharps and waste). All policies were referenced to best practice guidelines and recommendations. The Irish Acute Hospitals Cleaning Manual had been adapted for use by the organisation and the use of the colour-coded systems was evident throughout the organisation. European/national food hygiene/HACCP and waste legislation had been adopted and were in use. Some evaluation of adherence to hand hygiene, linen, sharps and waste was evident, with resultant actions through internal hygiene audit reports. The organisation had identified a quality improvement plan to implement evaluation of other corporate polices and procedures by the end of December 2007 and the organisation was encouraged to progress the implementation of this plan.

CM 4.3 (A ↓ 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.

A reference library containing up-to-date best practice hygiene guidelines and internet facilities were available for all staff within the organisation, including cleaning staff. All hygiene-related polices/guidelines observed were referenced to up-to-date best practice guidelines and legislation. The national hygiene audit tool had been utilised for the evaluation of the hygiene standards at the hospital. Some of the quality initiatives implemented in relation to best practice included the purchase of new cleaning products (including flat mops, colour-coded cloths and alcohol based hand gels), the purchase of new safety ladders and the upgrade of the neonatal unit. Protected time was provided for staff to attend education sessions in both catering and clinical areas. Funding was provided for the education and training of staff (for example Further Education and Training Awards Council (FETAC) courses, SKILLS, food hygiene, and management courses) as was evident from manual attendance records viewed. Staff were informed of latest research and best practice through infection control education sessions, as was evident from presentations viewed and through informal communication via the line management system. It was recommended that the organisation formalise the development of hygiene-related performance indicators.

CM 4.4 (B ↓ C)

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

Evidence was observed that a new regional policy template was in place and was utilised for the development of policies at regional level. These were distributed for use to the hospitals within the region (for example waste and linen issued in 2007). It was determined that all future corporate policy/guideline development and review was to be performed at regional level. Local polices/guidelines reviewed (pre-2007) were developed and updated in line with best practice guidelines (for example hand hygiene, food hygiene polices and HACCP). Access to corporate policies and procedure were available through the library service, intranet and hard copy on ward/department level. It was recommended that the organisation formalise the process for the development of local polices, procedures and guidelines and to evaluate the efficacy of the process for development of both regional and local policies, procedures and guidelines. The organisation was also recommended to review the ward catering policy and the approval of same.

CM 4.5 (B ↓ C)

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

It was evident that the Hygiene Services Committee were represented on the Capital Development Committee by a member of the Executive Management Team (for example the Assistant Director of Midwifery and Nursing). Consultation between the Hygiene Services Team and Executive Management were noted during the planning process of the new neonatal unit. It was recommended that the organisation formalise the processes for Hygiene Service Committee consultation with the Capital Planning Committee at the early and all stages of the planning process for all new development/refurbishment projects and evaluate the efficacy of the consultation process. The organisation was also recommended to review the design of the neonatal unit refurbishment project to include a cleaner's facility, which was in line with best practice recommendations.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

*Core Criterion

CM 5.1 (B → B)

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

The organisation's Assistant Director of Midwifery and Nursing assumes overall responsibility for hygiene services at the hospital and reports to the Regional Steering Committee on hygiene issues. The Clinical Nurse Managers, who report to the Director of Midwifery and Nursing and other hygiene services managers, are responsible for implementing and monitoring hygiene at local level. Other hygiene service managers report to the Hygiene Services Committee. Two job descriptions were reviewed during the assessment, included outline roles and responsibilities regarding the environment and cleaning in relation to an Assistant Director of Nursing and a household attendant.

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.

Evidence was observed that both capital and minor capital funding was allocated to the Hygiene Services. The funding, which was controlled at regional level, is allocated to each hospital within the region on an annual basis. The minor capital funding allocation was outlined in the Operational Plan. With the exception of a new cleaner's supervisory post and one cleaner post, evidence was observed that all requests for funding for the organisation's hygiene needs, which were submitted to the regional office over the last two years, were approved. New cleaning products, safety equipment and furnishings had all been introduced and approval for the upgrade of the neonatal unit had been granted. The hospital's service plan outlined the need for a protected dedicated financial budget for the Hygiene Service and the organisation was encouraged to progress this.

CM 6.2 (A ↓ C)

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

It was determined that the Regional Procurement Committee should source, evaluate and approve all equipment/ products, including hygiene products for the region, with the involvement of members of the Hygiene Services Team (for example Infection control). The process utilised for the purchase of bedside lockers and bed tables in the labour ward was verbally outlined during the assessment and was in line with national and Health Services Executive procurement guidelines. It was recommended that the organisation obtain a copy of the regional procurement policy and summaries of regional product evaluations for equipment/goods used by the organisation, and maintain these on file for local reference. It was also recommended that the organisation evaluate the efficacy of the procurement evaluation process performed within the organisation.

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

Evidence was observed that a risk management process was in place through the regional risk management structure. Clear processes were in place for risk incident reporting and analysis, minimisation and elimination. There was evidence of incident reporting using the STARS web-based system. Incident reports observed included hygiene-related risks such as slips and sharps injuries and were evaluated and actioned by the Hospital Administrator. Evidence was also observed that internal hygiene and Environmental Health Officer reports are actioned and followed up. There was no major adverse hygiene-related incident reported over the last two years. Management reported that a designated risk manager was in place and that a regional risk management report was developed. It was recommended that the organisation strengthens its linkages with the regional Risk Management Committee and feed back outcomes of incident reports actioned. It is also recommended that the organisation obtain a copy of the regional annual report to keep on file.

CM 7.2 (A ↓ B)

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

A regional risk management service was provided to the organisation. Verbal evidence was offered that a designated risk manager was in place and the Hygiene Services Committee were represented on the Regional Risk Management Committee by the General Administrator. Evidence of risk reports was provided (for example Environmental Health Officers' (EHO) reports). Evidence of risk reduction improvements were observed, including the introduction of hand gels, spill kits, needle-proof gloves, disposable tea towels/cloths and colour-coded systems. An increase in cleaning frequencies and improvement in the National Hygiene Audit results were also observed. Incident reports were available and there was one hygiene-related incident documented within the last year, which was actioned and followed up. During the assessment, a risk was identified and acted on promptly by the Hospital Administrator and a process was put in place to prevent reoccurrence. It was recommended that the organisation formalise the processes for linkage of the Hygiene Services Committee with the Regional Risk Management Committee and to

feedback outcomes of incidents actioned to the Regional Risk Management Committee.

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.

Large contracts were processed at regional level (for example the healthcare risk waste disposal, pest control and window cleaning contracts). There were no contract cleaning or catering services in place at the organisation. Evidence was observed of a standard service agreement and a contract tendering template which included a section on liability and insurance and it was verbalised that these were utilised for local service agreements (for example the Hazard Analysis and Critical Control Point (HACCP) quality improvement adviser). It was recommended that the organisation formalise the local process for establishing service agreements and contracts and to obtain the regional contract procurement process for the hospital files.

CM 8.2 (B ↓ C)

The organisation involves contracted services in its quality improvement activities.

Documented evidence that the HACCP quality improvement adviser was actively involved in catering quality improvement initiatives for HACCP was observed. This included the performance of food sampling analysis and the documented education of staff in relation to food hygiene issues. It was recommended that the organisation involve other contractors on site in its quality improvement services (for example, the Hygiene Services Committee).

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.

The structure of the hospital dated from the 1960s. Many design deficits in respect to Hygiene Services were identified (for example the absence of designated cleaners' rooms and inadequate storage facilities). Infrastructure through the hospital and the externally-managed coffee shop was poor (for example, walls and paintwork were poor and furniture in the coffee shop was damaged). Hand hygiene sinks observed, including the sink in the coffee shop, did not meet HNB 95 standards. The need for sink replacement was identified by the organisation as an area for improvement. A programme of refurbishment had commenced in the neonatal unit, which included additional storage facilities. However, it was highlighted that a designated cleaner's room was not included in the new design. Hospital management were advised that designated cleaners' rooms (plus a cleaner's hopper and hand wash facilities) were required in line with best practice guidelines and it was recommended that the current design of the neonatal unit be reviewed to include this and that cleaners' rooms be incorporated into all new future design/refurbishment projects. The organisation was also recommended to identify locations (in or adjacent to all clinical areas) for dedicated cleaners' rooms. The progression of the business proposal for the replacement of hand wash sinks was recommended as a matter of priority and a programme for refurbishment of paintwork through the hospital and coffee shop

should be developed. It was also recommended that the organisation ensure that measures were put in place to address the poor furnishing/infrastructure within the coffee shop as identified in a recent Environmental Health Officer (EHO) report and that the recommendations be implemented.

*Core Criterion

CM 9.2 (A ↓ C)

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

Evidence was observed that a robust system was in place for the management of the hospital kitchen and waste. For example, a quarterly Environmental Health Officer inspection/water analysis report was published and compliance with national waste legislation, including clinical waste disposal was fully met. Infection control polices/procedures were in place for the handling of linen in clinical areas and the cleaning of equipment/surfaces (collated in the infection control manual), all of which were referenced to best practice guidelines. Verbal evidence was provided that a faults/environmental reporting system was in place. Computerised lists of reported faults/deficits were generated three times daily, issues prioritised and addressed the same day, unless parts were required that needed to be ordered (as was evident from work sheets provided). On a weekly basis, outstanding issues were reviewed for prioritisation the following week and reasons for delays are evaluated. It was recommended that the organisation develop a comprehensive process for the transportation of linen to/from the laundry through to clinical areas, which should form part of the overall hospital linen policy. It was also recommended that maintenance work sheets be signed off to confirm that the work was complete. The organisation was also recommended to develop a documented process for the ongoing management of the environment/facilities.

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.

Monthly internal environmental audits (which included audits of the environment, facilities, equipment, waste, sharps, linens and ward kitchens) were carried out. Evidence of quarterly Environmental Health Officer audits of the main hospital kitchen and waste trail audits was also observed. The results of a patient satisfaction survey carried out did not relate any hygiene concerns. Examples of changes made to the environment included the upgrade of the neonatal unit, the introduction of new cleaning equipment and disposable tea towels. However, damaged paint work/surfaces were evident throughout the entire hospital, and no documented evidence of a planned paint refurbishment programme was observed, which was recommended. It was also recommended that hygiene be identified as a distinct question in patient survey questionnaires and comment cards.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 (B ↓ C)

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

The corporate human resources policy was in line with current national legislation and codes of best practice. Roles, responsibilities and accountabilities were clearly outlined in two job descriptions viewed. Management confirmed that competency-based interviews were not used during hygiene service staff interviews. No contract

staff were employed for the provision of cleaning or catering services and other contracts (for example pest control) were not available for review. It was recommended that the organisation introduce competency-based interviews for all hygiene services staff and evaluate the process for selecting and recruiting human resources.

CM 10.2 (A ↓ 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.

A plan to review changes in work capacity and volume for the Hygiene Services was highlighted by the organisation. Evidence of the progress of this plan was not observed. The need for additional staff for equipment cleaning and a cleaning supervisor were identified as areas of priority in the corporate plan. It was determined that the business case for the cleaning supervisor had been submitted to the Health Service Executive (HSE) for funding approval. It was recommended that the organisation prioritise a human resource needs assessment for cleaning in the operating theatres and provide protected time for cleaning of shelving and storage areas.

CM 10.3 (A ↓ B)

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

Educational requirements for some hygiene staff were identified using the formalised human resource recruitment process (for example infection control, maintenance staff and catering staff). Evidence was observed that processes were in place for the provision of additional training (for example hand hygiene, manual handling, fire safety, health and safety, food hygiene and HACCP). Also, evidence that the waste manager had received certified training was observed. Each ward/department manager maintained individual staff training records, which included dates for required retraining. Contractors were at regional level and qualifications records were not observed. It was recommended that the organisation formalise a structure to ensure that all cleaning staff (including relief staff), have the appropriate cleaning training to include cleaning methods, techniques and specialised training as appropriate (for example in the operating theatre). It was recommended that cleaning supervisory staff have appropriate certified cleaning training and that the organisation supported attendance at a certified 'training the trainer' course.

CM 10.4 (B ↓ C)

There is evidence that the contractors manage contract staff effectively.

All contracts were negotiated and managed at regional level. Contractors on site reported into the relevant department manager (for example technical services, waste and catering) and work performed was monitored through the completion of sign-off sheets (for example pest control bait check, waste certificates and repairs). Evidence was observed that building contractors received in house education in relation to dust control and hand hygiene. It was recommended that the organisation obtain confirmation of on-site contractors training and evaluate the appropriate use of contract staff on site.

*Core Criterion

CM 10.5 (B ↓ C)

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

A plan to perform a hygiene needs assessment was highlighted. Evidence of the progress of this plan was not observed. Evidence was observed that the need for additional hygiene staff had been identified and included in the regional Corporate Hygiene Strategic Plan (for example healthcare assistance to clean equipment and a cleaning supervisory post). It was verbalised that the submission for the cleaning supervisory post had been made to the Health Service Executive for funding. Hygiene staff cover was managed on a daily basis through a rostering system and absenteeism was monitored. It was recommended that the organisation perform a comprehensive human resources needs assessment for the cleaning service, based on work capacity and volume, which would include adequate numbers to provide sick and annual leave cover. It was recommended that these should be incorporated into the regional Corporate Hygiene Strategic Plan.

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 induction programme is provided at regional level on a monthly basis, which staff at the Mid Western Regional Maternity hospital attend. The content of the induction programme includes education on basic cleaning procedures, infection control, hand hygiene, waste and sharps, linen, health and safety and manual handling. Evidence was observed that food hygiene and HACCP training were proved to all new catering staff during specific catering induction, which was performed on site. The local staff handbook included references to local policy (for example infection control and related hygiene policies). Local induction and orientation was also observed, with individual records maintained within the organisation. It was recommended that the organisation develop a formal approach to monitoring attendance at regional induction programmes to ensure it these courses were provided to all staff and to utilise this information as a key hygiene performance indicator.

CM 11.2 (A ↓ B)

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

Comprehensive ongoing mandatory training was provided which included Health & Safety, fire training and manual handling. Evidence was observed of ongoing infection control education (for example hand hygiene, linens, waste and sharps). Ongoing food hygiene and HACCP training was also provided for catering staff. Evidence was observed that hospital management supported ongoing professional education for hygiene staff (for example the SKILLS project). The hospital had an annual training budget and evidence was observed that hygiene staff benefitted from this (for example cleaning staff). Evidence was observed that hygiene staff were released from duties to attend training and relevant hygiene education sessions. Internal training cards reviewed were up-to-date with proof of attendance at mandatory training within the previous year observed (for example manual handling). The chief facilitator for the provision of training was the infection control nurse and the majority was performed on site. Hygiene-related Information leaflets/posters were

provided for staff, patients and visitors and were available at the entrance and in all clinical areas (for example hand hygiene and MRSA leaflets). Also, education on hand hygiene (including practice) was provided to prospective mothers at antenatal classes. It was recommended that the organisation develop processes for the evaluation of the ongoing education being provided and that attendance levels should be formally monitored. It was also recommended that the organisation introduce formal cleaning training for environmental cleaning staff.

CM 11.3 (A ↓ C)

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

The effectiveness of the education provided to staff was evaluated through routine hygiene audits, local routine hygiene inspections and reviews of incident reporting. Internal kitchen audits were also performed. The attendance levels at ongoing training were maintained at local level. However, it was recommended that this be formalised. The organisation was encouraged to develop hygiene key performance indicators to evaluate the effectiveness of education and training.

CM 11.4 (B ↓ C)

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

The practice of formal staff performance evaluation was not policy within the Mid Western Health Services Executive at the time of assessment. However, at local level, performance was evaluated utilising the results of monthly internal hygiene audit reports, which showed ongoing improvements scores. Systems were also in place for monitoring performance through the utilisation of task checklists, which were monitored by the ward/department mangers. It was recommended that the organisation extend the use of hygiene audits to all areas (for example public areas and the grounds) for monitoring hygiene staff performance. It was recommended that the organisation implement a formal process to evaluate hygiene staff performance against hygiene policies and standard operational procedures.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (B ↓ C)

An occupational health service is available to all staff

There was evidence that a regional occupational health service was provided to all staff with a dedicated weekly service to the Mid West Regional Maternity Hospital, Limerick. Evidence was observed that a comprehensive health screening programme was in place (for example a vaccination programme, inoculation injury follow up and counselling service). Stress management services were also established. It was recommended that the organisation implement a process to evaluate the appropriateness of the service to staff within the hospital.

CM 12.2 (B ↓ C)

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

Staff well-being was monitored at a regional level through the Occupational Health Service. Evidence was observed that a staff satisfaction survey, which focused on the occupational health service, was performed in 2001. It was recommended that the organisation develop a process to evaluate staff satisfaction, occupational health and well-being on an ongoing basis.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.1 (B ↓ C)

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

Best practice guidelines were provided by the organisation (for example national food hygiene and HACCP guidelines/legislation). Communication systems were in place for hygiene staff to obtain best practice information from relevant experts (for example infection control and risk management). Infection rates were analysed at regional level and statistics were presented in graphic format to relevant hospitals within the region. It was recommended that the organisation evaluate the process of collecting hygiene-related information and the appropriateness, accuracy, reliability and validity of this data.

CM 13.3 (B ↓ C)

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

It was verbally communicated that data collected was reviewed by the executive management (for example incident/EHO reports were reviewed by the administrator and hygiene audit reports were reviewed by the Assistant Director of Midwifery Nursing and presented at meetings of the regional hygiene steering committee). Evidence was observed that data was utilised in the development of hygiene needs and in hygiene- relation education sessions provided. It was recommended that the organisation evaluate the utilisation of data collection and reporting by the Hygiene Service Team. It was also recommended that audit data and education records be collated on a hospital-wide basis and utilised as a key hygiene performance indicator. It was further recommended that all hygiene-related reports be presented to both the Executive Management Team and Regional Corporate Hygiene Steering Committee for discussion and review.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

CM 14.1 (A ↓ 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

Evidence of support provided by the Executive Management Team included the provision of funding for the purchase of new replacement furniture, cleaning equipment, spill kits and the refurbishment of the Neonatal Unit, which was in progress during the assessment. The regional corporate strategic committee included representatives from the hospitals within Network 7. The results of both previous national hygiene audits (2005 and 2006) were compared and presented to both staff and the public in poster format in the hospital entrance. During the assessment, evidence of a highly motivated hygiene oriented culture within the organisation with management commitment to continuous quality improvement was observed. Documented evidence of the Executive Management Teams' involvement in the development of the strategic and service plans was also observed. It was recommended that the organisation actively involve patients in its systems to improve the quality of the hygiene services.

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.

Continuous quality improvement is progressed thorough the Regional Hygiene Steering Committee and Executive Management Team. Changes within the organisation observed during the assessment included the upgrading of the neonatal unit, introduction of colour-coding, removal of tea towels from the ward kitchens and the development of a quality hygiene culture. Evidence was observed of communication of hygiene audit findings at local level and the results of the National Hygiene Audits (2005 and 2006) to both staff and the public. These scores have been utilised to internally benchmark the quality of the hygiene service. It was recommended that the organisation develop a suite of hygiene performance indicators and benchmark against other organisations of similar size. The organisation was also recommended to review the process of annual report development to include achievements and quality improvements from the previous year.

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.

The colour-coding system observed is in line with National Policy. The policies/guidelines observed were referenced to best practice guidelines. It was recommended that the organisation develop the environmental cleaning manual to include methods, techniques and frequency. It was also recommended that the organisation evaluate the efficacy of the process to develop local policies and guidelines.

SD 1.2 (B → B)

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

The process used to evaluate hygiene services intervention and change was verbalised and was in line with national procurement policy. New intervention brought into routine use over the last year included chairs (which were changed to washable chairs in clinical areas) and tea towels which were replaced with disposable towels. A colour-coding system was introduced in November 2006 and a flat mopping system was also implemented. Evaluation of the new changes was evident in hygiene audit reports (for example bedside lockers and colour-coding). It was recommended that the organisation formalise the process to evaluation the efficacy of the assessment process for new/changed hygiene services.

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 was observed that heath promotional activities were endorsed and supported, as the organisation is a member of the Health Promotion Hospitals Network.

The visiting policy has been launched and new hand hygiene posters have been displayed throughout the hospital. A hygiene chart was present in the front hall to alert the awareness of the public. All patients and visitors were provided with antenatal teaching to promote hygiene and hand hygiene. It was recommended that

the organisation develop processes to evaluate the efficacy of health promotional activities undertaken or participated in by the team in relation to hygiene.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1 (B → B)

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

Evidence that a multidisciplinary hygiene services team was in place was observed. Strong linkages were established (for example linkages with the Regional Steering Group membership on the Capitals project committee). The organisation's communications policy encouraged the use of verbal introduction and it was confirmed that this format was used for introducing team members to each other.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

SD 4.1 (B → B)

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

The areas visited during the assessment included antenatal M3 Ward and Postnatal M1 Ward Neonatal Unit, along with the outpatient labour ward theatre and all public areas, shop and catering department. Good compliance was observed in the Neonatal and Labour areas and places of weaker compliance included Out-patient and public areas. It was recommended that the organisation develop processes for the cleaning of high surfaces and floor edges and corners. It was also recommended that the organisation develop a plan for the refurbishment of environment surfaces throughout the hospital.

For further information see Appendix A

*Core Criterion

SD 4.2 (C ↑ A)

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

Medical equipment is cleaned and maintained to best practice standards and extensive compliance in this area was observed.

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 was maintained to a high standard in most areas. However, an exception noted was the Out-patient Department.

For further information see Appendix A

*Core Criterion

SD 4.4 (B ↑ A)

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

Regulations were very well maintained and adhered to in the main kitchen area. It was recommended that the organisation develop a food safety policy for the ward kitchens.

For further information see Appendix A

*Core Criterion

SD 4.5 (A → A)

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

With the exception of the storage of some clinical bags on corridors awaiting collection, compliance with waste management in the hospital was of a high standard.

For further information see Appendix A

*Core Criterion

SD 4.6 (A ↓ B)

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

The linen supply is managed within the hospital. There are washing machines available for baby blankets, towels and curtains. It was also recommended that a comprehensive laundry policy be developed to include the management of washing machines at local level and the transportation of linen to/from the laundry and wards, in line with best practice guidelines (for example National Health Services guidelines on ‘laundry in healthcare facilities’).

For further information see Appendix A

*Core Criterion

SD 4.7 (A ↓ 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

There is evidence of compliance with hand hygiene standards and best practices. However, there is a need to upgrade all sinks within the hospital.

For further information see Appendix A

SD 4.8 (B → B)

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

There was a sharps policy and all incidents were reported. There was a presence of spill kits in all areas. Evidence that incident rates were evaluated was observed, and generated reports were sent to the Hospital Administrator. It was understood that action on reports was taken and followed up.

SD 4.9 **(B → B)**

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

There was evidence of visitors' handbook. Hand hygiene posters were available in wards and verbal encouragement was given to visitors and patients regarding washing of hands at all times. There were feedback suggestion boxes for patients' and visitors' comments. However, no feedback had been received at the time of assessment.

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.

Dignity and privacy of patients was observed during the assessment. There was a programme of fundamental care in progress to look at patients' dignity and privacy, which incorporated in the Hygiene Services.

SD 5.2 **(B → B)**

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

Information booklet and Methicillin Resistant Staphylococcus Aureus (MRSA) leaflets were in place in the organisation. Verbal advice was given by midwives regarding hygiene at antenatal clinics. Posters displaying the results of previous hygiene audits were in place in the main entrance of the hospital, to ensure public awareness of the organisation's achievements.

SD 5.3 **(B → B)**

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

The HSE complaints policy 'Your Service - Your Say' was in place and had been launched within the organisation. At the time of assessment there had been no feedback of any complaints.

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.

Evidence that a consumer panel was to be set up in September 2007 was presented and the organisation was recommended to progress the development of this panel and encourage their involvement in the Hygiene Services in the near future.

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 - The environment required improvements, particularly in relation to paintwork, floor and dusting.

(2) All high and low surfaces are free from dust, cobwebs and flaking paint.
No - High ledges /surfaces were found to be dusty and cobwebs were present at ceiling level in the back hall and floor level in the public toilets in the Out-patients Department. There was paint flaking from the milk kitchen and in the Neonatal units. There was also a presence of chipped paint throughout the hospital.

(3) Wall and floor tiles and paint should be in a good state of repair.
No – Broken floor tiles were observed in some areas.

(4) Floors including edges, corners, under and behind beds are free of dust and grit.
No - There was dust behind furniture in the Out-patients Department and the floors at both main and back entrances were not clean .The carpeted area in the back corridor by the school of nursing was threadbare and needing replacement.

(5) Cleanable, well-maintained furniture, fixtures and fittings used.
Yes - In the majority of cases there was a number of couches and seats in the Out-patients Department damaged. And the stools in the coffee shop area were torn. This area was managed privately.

(8) All entrances and exits and component parts should be clean and well maintained.
No - Entrances were not clean and had flaking paint.

(9) Where present, main entrance matting and mat well should be clean and in good repair.
No - All mats at all entrances were in need of replacement and underneath mats needed immediate attention.

(12) Internal and external stairs, steps and lifts must be clean and well-maintained.
No - The back stairs was not satisfactory, including the rails of the stairs which were extremely dusty with cobwebs present.

(13) External areas including grounds, gardens, footpaths, ramps and car parks should be clean and well-maintained.
Yes - The grounds were fully in line with satisfactory assessment levels.

(14) Waste bins should be clean, in good repair and covered.
Yes - In the Out-patients Department there were some bins with no signage and others had Selotape marks.

(15) Where present a designated smoking area must comply with the national legislation on tobacco control and local organisational policies, a cigarette bin must be available and the floor area should be free of cigarette ends, matches etc.
Yes - The gazebos could have benefited from signage.

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

(18) Walls, including skirting boards.
Yes - All areas were clean except the Out-patient Department.

(19) Ceilings
Yes - All areas clean except in the back hall.

(21) Internal and External Glass.
No - External windows needed cleaning and internal windows were in need of urgent attention.

(25) Floors (including hard, soft and carpets).
No - There was dust behind furniture in the Out-patients Departments and the floors at both main and back entrances were not clean .The carpeted area in the back corridor by the school of nursing is threadbare and needing replacement.

(26) Nozzles of wall mounted alcohol gels and hand disinfectants must be cleaned daily.
Yes - These seemed to be managed well.

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

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

(32) Shelves, benchtops, cupboards are clean inside and out and free of dust and spillage
No - The internal surfaces of some cupboards were dusty.

(207) Bed frames must be clean and dust free
Yes - In the majority, however, bed frames in the Labour Ward were dusty.

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

(33) Chairs
Yes - The chairs were clean.

(34) Beds and Mattresses
Yes - The mattresses inspected were found to be clean.

(35) Patient couches and trolleys
No - There was a number of trolleys in the Labour Ward and Out-patients department which required greater cleaning.

(36) Lockers, Wardrobes and Drawers
Yes - Lockers were replaced.

Compliance Heading: 4. 1 .5 Sanitary Accommodation

(48) Floors including edges and corners are free of dust and grit.
Yes - There was some presence of dust in the public toilets in the Out-patients Department and at the main entrance.

(50) The toilet, sink, handrails and surrounding area is clean and free from extraneous items.
No - The base of some toilets were not clean. Some staining existed in the inside of the bowls. A number of sinks were found not to be maintained to standard.

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

(51) Baths and Showers
Yes - Showers in staff changing room were not cleaned.

(52) Toilets and Urinals
No - The base of some toilets were not clean. There was also some staining existing in the inside of the bowls.

(54) Wash-Hand Basins
No - A number of sinks were found not to be maintained to standard.

(57) Clear method statements / policies should be in place for guidance on all cleaning including sanitary cleaning and maintenance processes.
No - There is no process in place, which should be developed in the near future.

(58) Sluice rooms should be free from clutter and hand washing facilities should be available.
No - There was inappropriate storage of cleaning equipment and a presence of unused sharps boxes.

(59) Where present shower curtains should be clean and in good repair with a process for laundering and replacement.
Yes - Disposable shower curtains were used.

(60) All outlets (including shower outlets) should be flushed at a temperature in accordance with current legislation.
No - There were a number of non-clinical area showers being used as storage. As the rooms are solely used for storage, it was recommended that the showers and sanitary facilities be removed.

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 - The majority of equipment was maintained to standard, except in the Out-patients Department.

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

(74) Patient's personal items, e.g. suitcase which should be stored in an enclosed unit i.e. locker / press.
Yes - These are stored in linen press in the Labour Ward.

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

(81) All cleaning equipment should be cleaned daily.
Yes - All cleaning equipment was maintained to standard except in the Out-patients Department.

(82) Vacuum filters must be changed frequently in accordance with manufacturer's recommendations - evidence available of this.
Yes - This is carried out weekly.

(84) Products used for cleaning and disinfection comply with policy and are used at the correct dilution. Diluted products are discarded after 24 hours.
Yes - Compliance was observed.

(86) Information on the colour coding system is available to all hygiene staff (according to national guidelines).
Yes - This information was visible in all clinical areas.

(87) All cleaning equipment should be approved by the Hygiene Services Committee and ensure sufficient supply.
Yes - There was a process in place.

(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 - There were no cleaning rooms available in any area and the equipment was stored in corridors under stairs and sluices room. There was a need for dedicated cleaners, which should become a priority within the hospital.

(91) Storage facilities for Cleaning Equipment should be clean and well maintained.
No - There were no cleaning rooms available in any area.

(92) Cleaning products and consumables should be stored in shelves in locked cupboards.
No - These products were stored on open shelves, which is not recommended.

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

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

(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 - The policy has not been signed off by management.

Compliance Heading: 4. 4 .4 Pest Control

(238) Electric fly killer (EFK) units when used shall be located in an area free from draughts, away from natural light and not directly above an area where food or materials that come into contact with food are located. The EFK units shall be left on at all times and have shatter proof sleeves. The ultraviolet (UV) light tubes shall be replaced at least annually and records of replacement should be retained. The EFK shall be fitted with a catch tray and emptied as required.
Yes - There is an electric fly killer in main kitchen area.

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

(240) A Hospital using a cook-chill system should comply with Guidance Note No. 15 Cook-Chill Systems in the Food Service Sector (Food Safety Authority of Ireland) The temperatures of fridges, freezers, cold rooms and chill cabinets shall be capable of maintaining the temperature of foodstuffs
Yes - This is not applicable in this hospital.

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

(145) A record is kept of tags used for each ward/department for at least 12 months.
Yes - Records are not kept for Out-patient Department and this was mentioned to Waste Officer.

(149) Inventory of Safety Data Sheets (SDS) is in place.
No - These sheets were not present in the various areas.

(253) Personal protective equipment is accessible to all staff involved in the generation, collection, transport and storage of waste.
Yes - The incorrect personal protective equipment was used. This was addressed with management during the assessment.

Compliance Heading: 4. 5 .3 Segregation

(256) Mattress bags are available and are used for contaminated mattresses ready for disposal; mattresses are disinfected.
No - There were no bags available.

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 - There was a huge incidence of manual handling of clinical waste. Also the clinical waste was left on corridors in some areas, while awaiting collection. The organisation was informed and this issue was being addressed.

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.
Yes - In short-term clinical waste is stored on corridors awaiting collection.

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

(261) Clean linen store is clean, free from dust and free from inappropriate items.
No - There is inappropriate storage of items in linen rooms in some areas such as patients' luggage and monitors.

(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 written policy was in operation.

(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 - There was no documented evidence of preventative maintenance.

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

(190) All sinks should be fitted with washable splash backs with all joints completely sealed.
No - This problem was in all areas. A process was in place to upgrade all sink areas.

(192) Taps should be hands free and should be mixer taps to allow temperature regulation.
No - There was a process in place to upgrade all sinks with mixer taps.

(194) Dispenser nozzles of liquid soap of alcohol based hand rubs must be visibly clean.
Yes - In the majority of cases. However an exception noted was the OPD.

(195) Absorbent paper towels are available at all hand washing sinks. Air dryers should not be recommended.
Yes - There was a process in place to upgrade the paper towel system in use.

(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 - There was is programme in place to upgrade all clinical sinks to conform to HBN 95.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team		Assessor Team	
	FREQ	%	FREQ	%
A	15	26.79	3	05.36
B	38	67.86	25	44.64
C	3	05.36	28	50.00
D	0	00.00	0	00.00
E	0	00.00	0	00.00
N/A	0	00.00	0	00.00

5.2 Ratings Details

Criteria	Self Assessment	Assessor	Difference
CM 1.1	B	C	↓
CM 1.2	A	B	↓
CM 2.1	B	C	↓
CM 3.1	B	C	↓
CM 4.1	B	B	→
CM 4.2	B	B	→
CM 4.3	A	B	↓
CM 4.4	B	C	↓
CM 4.5	B	C	↓
CM 5.1	B	B	→
CM 5.2	B	B	→
CM 6.1	B	B	→
CM 6.2	A	C	↓
CM 7.1	A	B	↓
CM 7.2	A	B	↓
CM 8.1	B	C	↓
CM 8.2	B	C	↓
CM 9.1	B	C	↓
CM 9.2	A	C	↓
CM 9.3	B	C	↓
CM 9.4	B	B	→
CM 10.1	B	C	↓
CM 10.2	A	C	↓
CM 10.3	A	B	↓
CM 10.4	B	C	↓
CM 10.5	B	C	↓
CM 11.1	B	C	↓
CM 11.2	A	B	↓
CM 11.3	A	C	↓
CM 11.4	B	C	↓
CM 12.1	B	C	↓

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