Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Hygiene Services Assessment Scheme

Assessment Report October 2007

Midland Regional Hospital Tullamore

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1.0 Executive Summary

1.1 Introduction

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

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

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

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

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

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

1.1.1 Standards Overview

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

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

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

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

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

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

Core Criteria:

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

In the Corporate Management standards, the core criteria cover:

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

In the Service Delivery standards, core criteria cover:

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

1.1.2 Rating Scale

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

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

A **Compliant - Exceptional**

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

B **Compliant - Extensive**

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

C Compliant - Broad

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

D Minor Compliance

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

E No Compliance

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

N/A Not Applicable

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

1.1.3 Assessment process components

The assessment process involves four distinct components:

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

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

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

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

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

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

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

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

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

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

- **Continuous Improvement**

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

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

[1] Boot, M and Cairncross, S "Actions Speak" Delft, The Netherlands, IRC and LSTHM, British Occupational Hygiene Society.
[2] New York Department of Health and Mental Hygiene
[3] The Columbia Electronic Encyclopaedia, Sixth Edition. Columbia University Press. 2003
[4] Irish Acute Hospitals Cleaning Manual, HSE (2006)
[5] Hygiene Services Assessment Scheme. Irish Health Services Accreditation Board (2006)

1.2 Organisational Profile

The Midland Regional Hospital at Tullamore is located in Tullamore, Co. Offaly. This hospital, with its complement of 227 beds, serves the population of the midlands comprising the counties Offaly, Laois, Westmeath and Longford. The hospital serves a population of circa 250,000.
The hospital building was designed by Michael Scott from 1934 to 1937 and is listed as a protected structure.
Services are provided in the main hospital building. Due to space constraints as a result of constantly increasing activities, many demountable structures are currently in use.

Services provided

The hospital provides the following services:

- General medicine, including Gastroenterology, Respiratory Medicine, Cardiology and geriatric medicine
- General surgery including vascular surgery
- Intensive care
- Coronary Care
- Accident & Emergency
- Orthopaedics
- ENT
- Oncology/Haematology
- Renal Dialysis.

Other services provided include:

- Echocardiography
- Cardiac Catheter Laboratory
- Radiology
- Physiotherapy
- Speech & Language
- Occupational Therapy
- Diet & Nutrition
- Audiology.

Pathology operates as a Joint Pathology Service and operates under a Joint Pathology Committee/Directorate. Pathology has rationalised services in the three midland hospitals. Services provided in the MRHT include Histopathology and Tumour Marking Testing.
Nurse managed Cardiac Rehabilitation, Heart Failure and Diabetic services are provided.
A joint replacement nurse provides an outreach service.

Physical structures

Isolation facilities are provided on a needs basis in single rooms.

The following assessment of the Midland Regional Hospital at Tullamore took place between 5th and 6th July 2007.

1.3 Notable Practice

- Establishment of Environment and Facilities Committee.
- On-site documentation presented for the Hygiene Assessment.
- Documented processes for policies procedures and guidelines, and standard operating policies development in the organisation.
- Multi-disciplinary in-house audit system/File-Maker database.
- Infection control policies and procedures.
- Improvements to hygiene facilities (such as flat mop system).
- Protected mealtime initiative.
- Patient satisfaction survey/informal feedback on daily ward cleaning.

1.4 Priority Quality Improvement Plan

- Ongoing assessment and improvement of performance through cross-checking, walkabouts, intersectoral collaboration across all levels of the organisation is recommended.
- Full roll-out of HACCP system.
- Increased awareness/implementation of hygiene policies by all frontline staff.
- Correlation of contractors' obligations and hospital standards in relation to hygiene services.
- Local ownership by all staff, and collective/individual responsibility.
- Appointment of Designated Waste Officer.
- That the hospital takes cognisance of the opportunity afforded to integrate hygiene facility sites (such as catering, in-house laundry/linen service and waste management) through the transfer of clinical services to the new facilities.

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 Midland Regional Hospital at Tullamore 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 hospital regularly assessed and updated the current and future needs through the use of internal and external audit process, its evaluation process and Quality Improvement Plans (QIPs) and resultant actions. The hospital had developed a Manpower management model to reflect the transfer to the new hospital and the hygiene staffing requirements. The hospital had developed a Strategic Service Plan and Annual Service Plan which identified its hygiene goals and objectives and action plans. The processes of internal and external audit had progressed hygiene actions plans to completion; for example, hand hygiene stations, hygiene services policies and colour-coding. There was no evidence of an evaluation of the needs assessment process during the assessment. There were comprehensive action plans, QIPs and resultant action taken. The Team was encouraged to evaluate the efficacy of the needs assessment process.

CM 1.2 (B → B)

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

The hospital was in the process of a major capital development project which will change the environment of the hospital to a modern multi-purpose hospital building. A full needs analysis had been carried out for both manpower and equipment for the new hospital in relation to Hygiene Services. However, all wards were still located in the old building. The results of the internal and external audits have influenced the decisions in relation to Hygiene Services. The Hospital had a comprehensive Strategic Hygiene services Plan, Service Plan and Operational Plans. There were 16 consumer panels in place. The hospital provided evidence of adherence to legislation and best practice (for waste and water, for example) and will process HACCP to completion. A range of Hygiene QIPs, actions Plans and resultant actions were evident. While the hospital carried out evaluation, it was recommended that the evaluation process be reviewed for effectiveness.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1 (A ↓ 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.

There was comprehensive evidence presented by the hospital of all the links and accountabilities with whom the hospital is involved e.g. Department of Health and Children, HIQA, Surveillance, Community. The hospital intrinsically is linked with the HSE and through the NHO. There are 16 consumer panels in place including E&F. Partnership is active within the hospital affording staff members an opportunity to discuss relevant issues. Partnership processes were evidenced with terms of reference and minutes during the assessment. Patient/Client surveys have been carried out both locally and nationally; evaluation of the results and action plans were evidenced. No evidence of evaluation of the efficacy of linkages and partnerships was evident.

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.

A Strategic Hygiene Service Plan and a Corporate Hospital Service Plan have been developed encompassing all service areas, including hygiene at the hospital. This corporate plan was submitted to the hospital's General Manager and to the Network Manager on an annual basis. All members of the Hygiene Team had input into the development of the process. No evaluation had been carried out of the Hospital Strategic Plan. However, action plans for Hygiene Services had been reviewed and updated. It was recommended that the Corporate Hospital Service Plans be reviewed against the defined needs.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.1 (A ↓ 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 Regional Management Structure ensured that resources were provided to the hygiene process in the hospital. The hospital management had invested the strategic management responsibility for Hygiene Services in the Environment and Facilities Committee. A Hygiene Leader had been appointed. The roles, responsibility and accountability were available through the terms of reference and job descriptions, but were not specifically noted in relation to individual team members. A full range of hospital policies, procedures, guidelines and Standard Operating Procedures (SOPs) was available in relation to the hygiene service, for example, risk management, waste, cleaning and hand hygiene. These were developed in line with best practice and national recommendations, for example, colour-coding and cleaning frequencies. The hospital through its mission statement and Health Service Executive (HSE) documentation had a corporate code of ethics. The organisation was encouraged to

evaluate the adherence to legislation. A range of action plans and Quality Improvement Plans (QIPs) was available.

CM 4.2 (B → B)

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

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

The management team at the hospital had access to and received information from a variety of sources including, national best practice guidelines, national hygiene results, national risk and safety alerts and safety data sheets. The Team also received internal information from risk management, infection control, internal hygiene audits, clinical audits, health and safety, Environmental Health Officer and water reports. The hospital has used the Infection Control Nurses Association (ICNA) audit tool to assess Hygiene Services. Annual reports for risk and hygiene were reviewed. The hospital provided no evidence of management team agendas or minutes of meetings. It was recommended that the governing body evaluate the information received.

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.

All members of staff had access to research and best practice information through a variety of in-house and regional methods, for example, the library services, email, internet and intranet facilities. The hospital provided comprehensive documentary evidence of best practice information, for example, national hygiene manual, national waste segregation, European standards for Legionella and Hazard Analysis and Critical Control Point (HACCP) legislation. These documents informed the Executive Management Team in their decisions and knowledge of current best practice. The Executive Management Team also had the support of the Regional Committees for Risk Management, Quality, Health and Safety. The hospital management had approved a suite of QIPs and policies, which supported the Hygiene Services team based on best practice, for example, colour-coding, flat mopping, composting of food waste and protected mealtimes. The Environment Management Team (EMT) supported education and training with a provision of education funding, protected study leave and provision of in-house training, education and seminars. The hospital provided evidence that evaluation of best practice was carried out in relation to development of policies but that the overall system has not been evaluated.

CM 4.4 (A ↓ B)

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

The hospital provided comprehensive documented process for the establishment, maintenance and evaluation of best practice policies, procedures and guidelines for the Hygiene Services. The hospital provided a comprehensive suite of infection control, hygiene and risk policies. This service was provided on a regional basis by the Regional Quality Facilitator. The hospital submitted a printed and collated list of all policies and procedures on the database. It was recommended that an evaluation of the process be completed and QIPs be identified and actioned.

CM 4.5 (A ↓ B)

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

The hospital was involved in a major capital development project, which was overseeing the transfer of the current hospital into the new premises. There was a full Capital Projects Team in place. Hygiene issues were represented by the Infection Control Department and the Environmental and Facilities Committee. There was extensive consultation throughout the capital project process. Examples of influence included: cleaning schedules, staffing and steam washers. The hospital did not provide formal evidence of evaluation of the efficacy of the inclusion of all staff in the capital development project. However, there was evidence through the minutes of the capital programme meetings which noted the inclusion of additional expertise as a result of the continuing work of the project team. The Assessment Team was encouraged to evaluate this process.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

*Core Criterion

CM 5.1 (A ↓ C)

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

The Hygiene Service structure was formalised in the hospital. A multi-disciplinary Hygiene Services Committee (Environmental and Facilities) has been set up. There were clear terms of reference, job descriptions which identified the roles, responsibilities and accountability of team members and all hospital staff. The organisational chart indicated reporting structures for the hospital. There was clear responsibility and accountability for heads of departments but not for the committee. There was no evidence of job descriptions for senior staff members/EMT.

*Core Criterion

CM 5.2 (A ↓ B)

The organisation has a multi-disciplinary Hygiene Services Committee.

The Hygiene Services were managed from a strategic perspective by the Environment and Facilities (E&F) Committee. This Committee included hygiene within its scope of interest. The team consisted of management, professional, and support grades from a wide multi-disciplinary background. The Team provided documentary evidence of team membership, agenda, minutes of meetings and action plans. The Environment and Facilities Committee did not provide any documented evidence of role awareness of the members of the team, but there were defined individual job descriptions for each of the Committee. Each member represented their own function as an individual or as a representative of the group. Evidence was observed that the E&F team had regular monthly meetings. The Committee had the services of clerical support. It was recommended that the Committee formally evaluate its efficacy and develop documented processes to ensure the role responsibility of every member.

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

*Core Criterion

CM 6.1 (B ↓ C)

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

The Hospital Hygiene Strategic Plan identified its hygiene resources requirements. The Annual Report of 2006 identified funding that was made available to the E&F Committee. The hospital was funded on an annual basis for agreed Hygiene Service levels and WTEs. The action plans identified resource requirement.

CM 6.2 (B ↓ C)

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

There was evidence that the Environment and Facilities Committee was involved in the pre-purchasing evaluation, purchasing, and continuing evaluation of new and existing hygiene products, for example, hand gel, flat mop systems and new beds. There was a robust procurement policy in place. The E&F Committee was chaired by the Hospital Manager, who is part of the decision and approval mechanism for all hygiene products. There was no formal documented process other than the terms of reference of the committee to document the process. The organisation had evaluated the efficacy of the process of communication between the E&F group and senior management. It was recommended however, that organisation document the above process.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

CM 7.1 (A → A)

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

The risk management structure for the hospital was provided by the Regional Risk Management Department. The hospital had a Risk Adviser. There was a system for reporting all incidents in relation to risk. These were entered into the STARS System and quarterly reports were issued. These reports were circulated throughout the hospital. The issues which arose are addressed at hospital and regional level. There was a Risk Management Policy and risk management incident reporting form in place. There were documented processes for Risk Assessment Guidelines. There was an Annual Risk Management Report which was observed during the assessment. The hospital also has a Health and Safety (H&S) structure, to which health and safety risks were addressed and a suite of hazard identification guidelines. Relevant minutes of meetings, agendas and action plans were observed. Environmental Health Officer (EHO) reports were observed. The hospital had a formal internal hygiene audit process and audit reports were observed. QIPs and resultant action were reviewed.

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.

The corporate structure for the management of risk at the hospital was through the line manager, to the Risk Adviser and to the Regional Risk Management Department. The hospital management received quarterly reports and the Annual Report through the risk adviser. The Risk Advisor was a member of the Hygiene Services Committee. The Risk Management Committee had multidisciplinary team membership. There were no specific hygiene-coded risk categories. It was recommended that the hospital include hygiene as a unique code for the risk analysis process.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion

CM 8.1 (A ↓ C)

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

The hospital demonstrated how they complied with the National Procurement Policy. Procurement at the hospital was managed on a regional basis. There was evidence that consultation with user groups had been carried out. The hospital had not evaluated the contractors on site. It was recommended that the hospital would roll out its identified QIPs in these areas, and would review the area of interaction and continuing engagement with a contractor to ensure compliance with hospital hygiene standards.

CM 8.2 (A ↓ C)

The organisation involves contracted services in its quality improvement activities.

It was noted that the hospital reviewed external contracts in line with the procurement policy and had sought and received product advice on continuing best practice at point of issue with contractors. The E&F Committee did not formally engage with contactors in relation to quality improvement. It would be recommended that the E&F Committee would devise a process to engage contractors in the formal quality agenda.

PHYSICAL ENVIRONMENT, FACILITIES AND RESOURCES

CM 9.1 (C → 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 hospital was in a state of transition. There was a proposal in place to move services on a phased basis in 2007 to new facilities. The Renal Dialysis Department, OPD, Pharmacy, Main Kitchens, Staff Cafeteria, Mortuary and some allied services had moved. The clinical services were predominantly delivered in the older part of the hospital. There was a planned transfer of service in the autumn of 2007. The hospital area that offered new services had been built to current building standards and regulations, and had been finished to a high standard. These areas provided adequate bed space, light, sinks and storage areas in line with accepted design standards. The existing hospital, which received internal hospital patients, was in

need of major upgrade. However, this service was due to transfer to a purpose built new hospital in the autumn of 2007. The lack of a sufficient number of clinical wash hand basins in the old hospital building was an issue — however there was a sufficient supply of hand gel stations available.

*Core Criterion

CM 9.2 (B → B)

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

The hospital had a full range of policies, procedures and guidelines to manage its equipment, devices, waste, sharps and linen. The hospital had a system of internal and external audit to ensure compliance with the hospital structure and a method of identifying QIPs and implementing action plans. It was noted that copies of international and national guidelines were available, for example, in the management of waste.

CM 9.4 (B → B)

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

It was noted that patient satisfaction surveys had been carried out in relation to hygiene, general environment and catering. Evaluation of these surveys resulted in changes to the mealtimes at the hospital. There was an informal process in place which sought patients' feedback and satisfaction with their stay at the hospital on a daily basis. The hospital also evaluated its complaints, comment cards and risk incident reporting in relation to user satisfaction. The hospital implemented its QIP, and Actions Plan based on the results of these evaluations.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 (A ↓ 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 hospital subscribed to the National Code of Practice for recruitment. There was a range of templates which were developed to ensure that the code of practice was enforced, for example, application forms, recruitment boards and recruitment action time-frames. The hospital recruited its own staff and did not employ contract staff.

The hospital provided a range of job descriptions for all grades, including management, professional and support staff. The job descriptions for Household Services Manager, Linen/Waste Porter, Cleaning Attendant and Catering Assistant were designed to reflect the specific role and responsibility of hygiene. The Human Resource Strategy for 2000-2010 was observed. The hygiene strategy had outlined its human resource need, based on annual submission.

It was recommended that the hospital engage in the process of evaluation of its HR procedures in order to determine the efficacy of the recruitment and HR resources in line with the needs of the Hygiene Service. It was also recommended that job descriptions be revised to include hygiene awareness and responsibilities.

CM 10.2 (A ↓ B)

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 hospital had developed a human resource manpower model which had determined the staffing levels for all services in the new capital development programme. The Hygiene Services Strategic Plan and the Hygiene Services Plan identified hygiene requirements in the current year. The hospital received core funding and staff designated as whole time equivalents for Hygiene Services. Additional funding was approved for additional staff on a needs basis. It was recommended that the team conduct an evaluation of work capacity and volume review processes.

CM 10.3 (A ↓ B)

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

The hospital employed staff using the National Code of Practice for Recruitment. It did not have contract hygiene staff in place. The hospital provided both infection control and hygiene training to all relevant staff. There were robust orientation and induction programmes available, tailored to each discipline. The contents and attendance records of those courses were observed during the assessment. There was evidence that training records were available for all staff. It was recommended that the hospital consider a composite training record system, for example, a Standard Operating Procedure (SOP) to record in chronological/alphabetical order all training records for easy reference.

It was recommended that the organisation review the training records of external partners, for example, waste contractors or Rehab contractors.

While there was evidence that the hospital had carried out training evaluations on specific courses, this should have been extended to include composite training evaluations of all Hygiene Services staff.

CM 10.4 (C → C)

There is evidence that the contractors manage contract staff effectively.

Contracted Services for the hospital were managed through the Material Management Department, using the National Procurement Policy as its tool. Hygiene contracted services included pest control, window cleaning, entrance matting, air systems and high cleaning. There were no records of training/evaluation of external contractors. There was a QIP in place to develop the evaluation of contractor services provided at the hospital.

ENHANCING STAFF PERFORMANCE

*Core Criterion

CM 11.1 (B → B)

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

The hospital provided evidence of a comprehensive orientation and induction programme. All staff received corporate induction provided on a regional basis. The Infection Control (IC) Department co-ordinated all hygiene and infection control-related training. Examples of course content, course presentations, staff evaluations, training records and attendances were observed. A copy of the induction handbook for hygiene and nursing staff was observed. Full records of hygiene training records

were observed. A copy of NCHD's training and induction was observed. It was recommended that the hospital consider a system of centralised record management, for example, SAP or other relevant system.

CM 11.2 (B → B)

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

The hospital had a Human Resource Plan, which identified the ongoing commitment to education and training, both mandatory and discipline specific. The hospital had access to all relevant training through the Regional Corporate and Learning Training Service. There was a documented process for the application and processing of staff for continuing education. The hospital presented data and information on funding costs for education. The hospital through its in-house expertise provided continuing development opportunities for hygiene staff, for example, manual handling, health and safety, infection control and specific cleaning and disinfectant methods training. Hygiene staff and hygiene managers attended available conferences, for example, the Cleaner Hospital Conference in September 2006. The organisation was encouraged to develop an education policy and extend the evaluation process to all education and training provided to the Hygiene Services Team in accordance with its Human Resource Plan.

CM 11.3 (B → B)

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

The hospital provided evidence through its internal and external audits of the effectiveness of its hygiene training programme. Results indicated that staff were complying with hospital policies and procedures. There was no one composite education and training policy which documented the processes for the management of education at the hospital. Staff and management indicated that study leave was available to attend hygiene training in protected time. Training was on-going in nature and a planned programme of training was evidenced in the education diary dates. Staff training records were available in a subject specific format. It was recommended that the organisation complete an evaluation of the Hygiene Services training provided, to ensure that the appropriate training was in place.

CM 11.4 (C → C)

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

The hospital has no formal staff appraisal system in place. The recruitment programme provided a mechanism for performance management after six months of permanent service. Household staff were appraised after an initial one month's service, in line with the HR Policy. The hospital evaluated the daily work sheets and equipment check lists to ensure that the duties of specific grades were adhered to. The hospital also reviewed incident report forms and complaints to determine staff performance. No evaluation of the performance procedures for staff had been carried out. It was recommended that the hospital consider reviewing the performance appraisal system.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (A ↓ B)

An occupational health service is available to all staff.

The hospital provided a comprehensive regional Occupational Health Service to the Midlands group of acute hospitals. This Service provided evidence of a mission statement, the services provided, hours and place of service. There was a full range of Occupational Health policies, procedures and guidelines available for the service, for example, vaccination programmes, Back to Work programme and occupational injuries. The service also provided counselling, pre-employment screening and vision screening. A range of templates for theses services was observed. It was recommended that the organisation evaluate the appropriateness of the service provided by the Occupational Health Departments.

CM 12.2 (A ↓ C)

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

The Occupational Health Service monitors and evaluates attendance levels and provides a Back to Work programme for employees who are returning to work. A Quality of Life survey was completed in 2003 and a report was issued in 2004. A range of recommendations was suggested, but no further evidence was offered on the implementation of these recommendations. Staff satisfaction surveys were carried out and the hospital took part in a National Staff Satisfaction Survey. There was evidence that the surveys were collated and evaluated, but no further information was available on long-term action plans and QIPs. It was recommended that the organisation develop a formalised approach to implement improvements identified in the surveys and assessments completed.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.1 (B → B)

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 provided a range of documents which reflected national/international local, legal and best practice, for example, the DOHC, Waste Management Guideline, National Hygiene Manual and HACCP. The hospital provided details of all Policies, Procedures and Guidelines. Infection control and hygiene manuals were observed. There was staff access to the library, Internet and intranet facilities, which

provided Hygiene Services information. The hospital provided evidence of the internal hygiene audit system and its collation system. It was recommended that the hospital evaluate its system of collection and provision of information.

CM 13.2 (A ↓ B)

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.

The hospital provided extensive evidence of internal hygiene audits, external hygiene audits, EHO reports, the Annual Hygiene Report 2006 and the Dangerous Goods Safety Adviser (DGSA) Annual Report. The hospital reviewed the data received from the reports, collated action plans, monitored the resultant actions and completed the quality improvement cycle. The Environment and Facilities (E&F) Team/Committee submitted a Corporate Strategic Hygiene Plan and had also produced a report incorporating the Hygiene Services Action Plans and Quality Improvement Plans. The hospital had a very active service user on the E&F Committee. The hospital had not evaluated the process of report writing (data presentation) nor had it included the service user in this process of review of data. Resultant actions and QIPs were observed in relation to the audit process.

CM 13.3 (B → B)

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

The hospital provided evidence of internal and external audits and resultant action plans. The role of the Accreditation Co-ordinator ensured that action plans and QIPs along with continuing internal audits were managed through this office. The hospital had developed the File-Maker system within the last two years to collate hygiene service audits, action plans, and QIPs and resultant actions. The hospital was commended on this database. The E&F group evaluated the action plans developed as a result of the audit process and in line with the team's strategic plan. It was noted that some information was available in the minutes of E&F Committee meetings on the actual relevance of the information provided.

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.

An Accreditation and Quality Manager is in post at the hospital. The hospital had the support of the services of the regional offices of Risk Management, Clinical Audit and Policy Development. The hospital has invested in the E&F Committee, the function of which included ensuring quality standards of hygiene. The hospital had links with a myriad of external organisations which foster quality for example: HIQA, Environmental Protection Agency (EPA) and the Irish Society for Quality and Safety in Healthcare (ISQSH). The hospital had fostered the quality agenda through education, training, policies, procedures and committee structures. This was evidenced in agendas, minutes of meetings and education content.

CM 14.2 (B → 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.

The E&F Committee had responsibility for the Hygiene Services. This committee regularly evaluated hygiene audit results, completed trend analysis, reviewed action plans and instigated QIPs. The hospital QIP had developed over the last two years and included both the existing hospital requirements and the new hospital requirements. The hospital benchmarked itself against internal audits, national audits and infection control rates. The hospital presented a sample range of staff communication — posters, minutes of meetings and memos. It was noted that improvements had been made in line with the QIPs for the hospital, for example, -hand hygiene and flat mopping and the development of PPGs. Key Performance Indicators (KPIs) have been identified for the management of complaints and this resulted in a decline in the number of hygiene complaints.

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 ↓ B)

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

Documented processes for the establishment, adoption, maintenance and evaluation for best practice from providers, patients and clients were evident. Innovative schemes existed based on a completed patient/client survey. Colour-coding and a flat mop system had been introduced. Staff were facilitated with regard to time allocated for policy and procedure development. Evaluation and consequential resultant action was at an early stage and its progression was recommended. The Hygiene Assessment Team endorsed the Organisation's QIP for the distribution of Environment and Facilities minutes of meetings to all departments.

SD 1.2 (A ↓ 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.

Documentation reviews and processes were in place for assessing new hygiene interventions and changing existing ones. New processes and technology requirements for Hygiene Services were evaluated and recommended to the Environment and Facilities Committee (which was the umbrella committee for the management of Hygiene Services) for approval. Evaluation of the efficacy of the assessment process was at a very early stage — for example the very recently introduced 'protected mealtime programme' was to be evaluated six months from introduction. There was no apparent evidence of resultant actions and continuous quality improvement in relation to new Hygiene Service interventions.

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.

Details of Hygiene Services activities undertaken by the Infection Control Nurse in relation to PHN and nursing home staff in the region were validated. The hospital was part of the National Health Promoting Hospital Network.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1 (B ↓ C)

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

There was an in-house Hygiene Services Quality Improvement Team in place, and the organisation was represented on the Regional Hygiene Services Committee.
A more localised ownership/autonomy in these areas might well benefit the hospital.
No documented processes were observed to ensure team awareness of each other's roles and responsibilities. This was a recommendation by the Assessment Team. To date there had been no formal evaluation of the multidisciplinary team structure (Environment and Facilities) and this was recommended. There was evidence that this committee has been actively involved in hygiene developments which included acquiring the services of a DGSA, appointing a Hygiene Team Leader and a Hygiene Audit Team and acquiring Hygiene Audit Software. Evaluation of the efficacy of this team was based on the outcomes of the internal hygiene audits.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

SD 4.1 (A ↓ B)

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

The situation of the hospital, in a state of transition from an old existing hospital to a new hospital, with clinical services still predominately delivered in the existing (old) facilities, and Renal Dialysis and Out-patient services recently moved into the new facilities, posed a challenge for the Assessment Team because it was clear that the senior management of the hospital was focused predominantly on the new facilities that were to come on-stream.
The Assessment Team noted the Pharmacy, Mortuary and some allied health services, Staff Cafeteria and Main Kitchen were also operational in the new building. 'Snagging out' was still in progress, although the main contracting work was apparently complete. Also worthy of comment was the duality of the location of some services (for example: catering, where wash up was located in the old building with the kitchen in the new; with laundering of flat mops undertaken in the old building, while linen services were located in the new building) which made the co-ordination of some services more challenging in this interim phase.
It is also worthy of comment that the existing hospital suffered from a paucity of continuing maintenance/capital investment and this was evident during the hygiene assessment visit — notable in particular in relation to damage to plastered surfaces that remained unrepaired, unpainted areas and general debilitation and dilapidation in building surfaces in the existing buildings. Whereas this might well be seen as acceptable in the current situation of flux, the Assessment Team recommend that this be addressed immediately in the transition to the new hospital and that such practices would not be permitted to continue into the future.
Attention to detail was needed in relation to cleaning standards and this should have been more readily achievable once the services had been transferred to the new building.

For further information see Appendix A.

*Core Criterion

SD 4.2 (B → B)

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

The Audit Team found that the organisation's equipment, medical devices and cleaning devices were not managed and not as clean as would be anticipated in normal circumstances. However the assessment team were advised that this equipment was to be replaced imminently in the transfer to the new building. The wearing of jewellery should have complied with best practice.

For further information see Appendix A.

*Core Criterion

SD 4.3 (B → B)

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

There were processes for the management and cleaning of the organisation's cleaning equipment.

On site visitation showed lack of evidence of compliance in some areas, such as reservoirs in floor mop buckets containing residual water. Awareness of the correct procedures was queried by the Assessment Team and was found to be deficient (for example there was no apparent knowledge of the requirement to dry and up-end reservoirs on completions of task). This should have been addressed by the hospital.

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 new kitchen had recently been opened and commissioning work was still in progress. The Staff Canteen was also recently opened and the resolution of ventilation issues and other commissioning work was also still in progress. These activities were impacting on the normal operation and the management of these areas at the time of the assessment visit. The washing of patient crockery and cutlery was still located in the older part of the hospital, some distance from the new areas.

While the new facilities provided a pleasant environment and were designed for best practice in relation to the food journey, cleanable surfaces and HACCP compliance, the Assessment Team noted a number of issues in the kitchen areas, including but not exclusively:

- Absence of blue-coded cutlery (fish).
- Access to ward kitchens by non-authorised staff (notices, doors open to passers-by).
- Maintenance of food trolleys (for example, soup trolley in the main kitchen was not clean).
- General maintenance of equipment (such as cleaning and deep cleaning), rust on preparation table in preparation area and wheels and castors in new equipment) should be addressed.
- There was evidence of hot and cold food temperature readings checked during the site visit outside the recommended range. As commissioning was still in progress management were to follow up this issue to identify and resolve.

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.

General compliance was noted. It was recommended that attention to detail be given greater focus in the future in relation to compliance with waste segregation and cleanliness of bulk containers.

For further information see Appendix A.

*Core Criterion

SD 4.6 (B ↑ A)

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

The standard of linen care was noted to be good. Laundry was conducted centrally for the region. The flat mop heads were laundered on site but the Team noted that the condition of receptacles for transporting laundry did not meet best practice and the organisation were advised that this should be addressed immediately. This practice was ceased. Consideration should be given to relocating the laundry room for flat mop washing to ensure appropriate environment/hand wash facilities, once space becomes available following the transfer of clinical services to the new building.

For further information see Appendix A.

*Core Criterion

SD 4.7 (B → B)

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

There was poor compliance in the older part of the hospital in relation to best practice in the area of wash hand basins. It was anticipated that the move to the new building will address this shortcoming. Wearing of jewellery by staff should have been addressed.

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 risk management system in place, reportage, follow-up on non-routine occurrences. Site specific safety statements were in place. Signage, spill kits etc were available. There was an in-house Health and Safety Committee with designated representatives. Evidence of robust infection control procedures was noted. Annual Health and Safety/Risk Management reports were available. It was noted in the assessors' visits that corrective action was rapidly taken on issues that were identified. The organisation should have ensured full compliance with the provision of hand gel in ICU and continue to implement improvements in provision of wash hand basins in line with best practice guidelines. It was anticipated that this issue would have been resolved on the transfer of clinical services to the new building. Alcohol-

based hand rub should be available at the bedside of each patient in critical care units and in each patient room/clinical room, however, the ICU was not compliant.

PATIENT'S/CLIENT'S RIGHTS

SD 5.1 (B → B)

Professional and organisational guidelines regarding the rights of patients/clients and families are respected by the team.

The rights of patients, clients and families were respected and understood, however, the physical constraints of some of the older areas of the hospital were less than ideal in regard to affording patient privacy. Single rooms were used for isolation purposes. Patient/client information leaflets were available. A "Comments, Enquiries, Complaints and Appeals" system was in place. Risk Management had a system in place for reporting, investigation and analysis of incidents and near misses and worked to a "Spot it, Sort it, Can't Sort it, Report it" philosophy. Hygiene-related issues were dealt with in accordance with this philosophy. Cleaning times had been revised and realigned in specific areas to coincide with low activity in the interest of greater safety and better cleaning outcomes.

SD 5.2 (B → B)

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

Patient and visitor information leaflets were available on admission. Easily accessible notice boards for updating information were available in the new hospital areas, and appropriate notices were displayed throughout the hospital for patient/visitor information on relevant hygiene issues. Waste bins carried clear instructions for their specific use. Evaluation included consumer representative input based on walkabouts and observation of hygiene practices and the use of consumer panels for specific issues. Informal daily questioning of patients as to their satisfaction with cleaning standards by cleaning staff, and the use of the Comments, Enquiries, Complaints and Appeals (CECA) process, which related to all aspects of the service, including hygiene-related issues. The organisation was encouraged to evaluate formally patient/client, family and visitor comprehension of, and satisfaction with, the information provided by the Hygiene Service Team.

SD 5.3 (A ↓ C)

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

There was a risk management system in place and complaints management was the responsibility of the Deputy Hospital Manager. Annual records/analysis of complaints were observed for 2001-2003. There was evidence of quality improvements to patient services as a result of information received through the Comment, Enquiries, Complaints and Appeals System. It was recommended that the organisation ensure that there be a system of regular analysis/reporting of information gathered, with findings submitted to management and relevant line managers, and that completion of the quality management loop be effected. The hospital has a system in place for prompt resolution of complaints at the point of complaint based on "Spot it, Sort it, Can't Sort it, Report it" philosophy, which staff claimed resolved quite a number of issues. It is recommended that an evaluation of patient/client complaints relating to the Team's activities be undertaken.

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1 (B ↓ C)

Patients/Clients, families and other external partners are involved by the Hygiene Services team when evaluating its service.

There is patient representation on the Environment and Facilities Committee. Focus groups were established for specific issues. Patient and family involvement in evaluating services is a work in progress and evaluation is outstanding. The most notable advance was the introduction of the patient information leaflets and the Protected Mealtimes Policy. It was recommended that the extent to which patients/clients and other organisations are involved by the Team when assessing its Hygiene Services be evaluated.

SD 6.2 (B → B)

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

Satisfactory evidence of relevant reports identified a need for a Hygiene Leader. One was appointed to oversee hygiene auditing, identify action plans and responsible persons and evaluate outcomes. Hygiene cleaning audit scores were undertaken on a regular basis in 2005/2006. This was encouraged on a scheduled basis as shown in the documentation (Hospital Hygiene Audit Schedule). An independent evaluation was recommended.

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

(27) Local policies should be in place for guidance on all cleaning processes, colour coding, use of equipment, use of protective clothing and fluids and spillages.
Yes - Local policies were not observed for all cleaning processes. Awareness/compliance by front line staff could have been better. In relation to existing processes examples of non-compliance included flower vases, telephones, and computers.

(28) Before cleaning commences, a work route should be planned and when necessary, furniture and equipment should be removed from the area.
No - This was not possible due to physical constraints.

(1) The environment is tidy, well-maintained, free of rust, blood or body substances, dust, dirt, debris and spillages.
No - Dust, debris, rust was evident in older areas.

(2) All high and low surfaces are free from dust, cobwebs and flaking paint.
No - Skirting boards and lower walls were in need of attention, some doors were damaged.

(3) Wall and floor tiles and paint should be in a good state of repair.
No - Some attention to painting was required.

(5) Cleanable, well-maintained furniture, fixtures and fittings used.
Yes - There were exceptions in the Day Ward, and chairs in the waiting room which were not clean.

(10) Internal and external signage should be clean, updated, well maintained and laminated to enable cleaning.
No - Selotape residue was noted in many areas. Not all posters were laminated; some were in very poor condition.

(13) External areas including grounds, gardens, footpaths, ramps and car parks should be clean and well-maintained.
Yes - Waste bins in some areas needed attention.

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

(18) Walls, including skirting boards.
No - There was room for improvement in this area.

(20) Doors.
Yes - - Some damaged doors were noted in older parts of the building.

(21) Internal and External Glass.
No - Excessive posters were noted and Selotape residue was noted on the internal glass.

(23) Radiators and Heaters.
Yes - Chipped paint was noted on the radiators in the older parts of the building.

(25) Floors (including hard, soft and carpets).
Yes - Some floor areas displayed build up of grime in corners, especially at door architraves.

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 - Clutter was observed in older parts of the building with items on ledges noted in some areas.

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

(35) Patient couches and trolleys.
Yes - Some A&E trolleys were temporarily stored in the oil boiler house under the Theatre. It was recommended that these should to be stored in a clean location.

Compliance Heading: 4. 1 .5 Sanitary Accommodation

(44) Hand hygiene facilities are available including soap and paper towels.
Yes - A staff toilet was noted that did not have a wash hand basin (Day Ward area).

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

(53) Bidets and Slop Hoppers.
Yes - No bidets were observed in use.

(55) Sluices.
No – Multi-purpose use of the sluices was observed - some sluices did not have bedpan washers, or wash hand basin. It was indicated that this would be resolved in the transfer to the new building

(57) Clear method statements and policies should be in place for guidance on all cleaning including sanitary cleaning and maintenance processes.
Yes - Same needed to be displayed in all cleaners' rooms and presses.

(58) Sluice rooms should be free from clutter and hand washing facilities should be available.
No - These were used as multi-purpose rooms in the main in the older hospital areas.

(59) Where present, shower curtains should be clean and in good repair with a process for laundering and replacement.
Yes - Clarification was required on the shower curtain laundering process - for example there was a lack of clarity regarding the laundering of the shower curtain in the staff changing facility in main (new) kitchen.

(60) All outlets (including shower outlets) should be flushed at a temperature in accordance with current legislation.
Yes - Daily flushing was observed with local notices attached to all fittings.

(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.
Yes - Storage of consumables was noted as an issue. Additional non clinical waste bins were required in some areas, for example, in the main kitchen.

Compliance Heading: 4. 2 .1 Organizational Equipment and Medical Devices and Cleaning Devices (note: while list is not exhaustive, the following compliance is required):

(64) All equipment, including component parts, should be clean and well-maintained with no blood or body substances, rust, dust, dirt, debris and spillages.
No - The bases and wheels of several items were in need of further cleaning, rust was noted in some areas.

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

(65) Commodes, weighing scales, manual handling equipment.
No - The bases and wheels of some equipment were noted to be rusty and in need of further cleaning in some areas.

(67) Bedside oxygen and suction connectors.
Yes - Portable oxygen and suction was in place.

(68) Patient fans which are not recommended in clinical areas.
No - Fans were available in most areas despite the policy to the contrary.

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

(72) Trolleys, e.g. chart trolleys, drug trolleys, linen trolleys, shop trolleys, emergency trolleys, suction apparatus, resuscitation equipment i.e. ambubag and mask.
Yes - The wheels of much of this equipment needed further attention in some areas.

(79) Flower vases where present should be clean with water changed minimum daily. Wilted flowers should be removed and disposed of accordingly. Note: flowers not recommended in high risk areas.
No - There was no policy on washing flower vases available – the practice differed between different members of staff.

(80) All office equipment (e.g. telephones, computers, fax machines) should be clean and well-maintained.
No - In some areas there was a lack of clarity as to whose responsibility this is.

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

(81) All cleaning equipment should be cleaned daily.
No - Evidence to the contrary was observed.

(89) Equipment with water reservoirs should be stored empty and dry.
No - Reservoirs had residual water in many instances during the assessment.

(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 - Significant shortcomings were noted with regard to storage facilities in older clinical areas.

(94) Health and Safety policies should be in place for the use of ladders/steps when cleaning.
Yes - Several staff were unaware of the policy in this regard.

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 - This area was a work in progress – a recent partial transfer to the new kitchen was underway. It was indicated that there were plans to roll-out new systems for the new kitchen facility.

(214) The person in charge of catering shall develop, implement and maintain a permanent system based on the seven principles of HACCP. A standard HACCP Plan should be fully completed.
No - This area was a work in progress — full implementation of colour-coding compliance was required and compliance recording needed to be fully comprehensive.

(216) Documented processes for manual washing-up should be in place.
No - Not evident during the assessment.

Compliance Heading: 4. 4 .2 Facilities

(217) Access to the main kitchen and ward kitchens should be restricted to designated personnel, i.e., food workers.
No - An open door was noted in a ward kitchen. There were no evident notices advising access was for staff only.

(222) A wash hand basin should be provided at the ward kitchen, in addition to a sink, along with a liquid soap dispenser and hygienic hand drying (e.g. paper towels).
Yes - Additional waste bins for discarded paper towels were required.

(225) Staff in charge of Ward Kitchens shall ensure that product traceability is maintained while the product is in storage (Regulation (EC) 178/2002). Stock shall be rotated on a first-in/first-out basis taking into account the best-before/use-by dates as appropriate. Staff food should be stored separately and identifiable.
No - A date rotating system with corrective action procedures in accordance with best practice was recommended. No evidence of out-of-date food was observed.

Compliance Heading: 4. 4 .3 Waste Management

(233) In food preparation areas where lidded bins are provided they shall be foot pedal operated.
Yes - It was noted that not all lidded bins had foot pedals.

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 - The Cook Chill system was not in use. Food was observed to be prepared from fresh ingredients.

(241) Ice cream display units can operate at -12°C as long as it can be demonstrated that the product has been held at this temperature for less than 7 days.
Yes – None are in use.

(243) Preparation of High Risk Foods should comply with I.S. 340:2006 requirements.
Yes - No blue coded (fish) cutlery was available and it is recommended that this be addressed.

(244) Temperature for food when cooked, held or reheated should comply with I.S. 340:2006 requirements.
No - There was a discrepancy noted in cold temperatures.

Compliance Heading: 4. 4 .7 Food Processing

(246) The thawing of food shall be carried out under appropriate conditions such as in a thawing unit, a fridge or a microwave oven with thawing cycle.
Yes - Thawing was observed to be carried out in the fridge.

Compliance Heading: 4. 4 .8 Food Cooking

(247) All foods shall be cooked to a temperature to ensure that the products are safe for consumption. The core temperature of the food shall be assessed at the thickest point of the food and should be compliant with I.S. 340:2006.
No - Food temperature was assessed at the thickest point of the food. Food temperatures for two food items were observed to be outside recommended limits on day one of the assessment visit.

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 - The system did not require scoops as the ice was dispensed directly into the containers.

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

(146) A tracking system should be in place to trace all hazardous waste from generation to disposal and therefore an audit trail is available to trace waste to final disposal.
Yes - Inappropriate segregation of hazardous waste containers was discovered in one yellow bin in a locked compound. This was addressed during the hygiene assessment visit.

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

Compliance Heading: 4. 5 .3 Segregation

Suction waste must be disposed of in a manner which prevents spillage e.g. canisters/liners are disposed of into rigid leak-proof containers or suction waste is solidified with a gelling agent.
No - Suction waste was disposed of in yellow (soft) bags in the ICU instead of rigid boxes. It is strongly recommended that his practice cease immediately.

(162) Hazardous wastes (chemical etc) must be segregated, stored and disposed of correctly.
Yes - There was a general lack of co-ordination of the information in relation to the relative location of certain hazardous waste receptacles and storage areas.
On observation, the Assessment team observed ‘dip sticks’ in a green waste bin base. The bin was also dirty.

(255) Within Healthcare risk waste, all special wastes including drugs and cytotoxic drugs/materials are segregated.
Yes - One bin observed did not comply with the recommendations—mixed risk waste boxes were noted in a single container. This non-compliance was resolved once it was brought to the attention of the appropriate senior staff.

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.
Yes – However, it was strongly advised that this policy be revisited urgently in light of the anomalies observed during the assessment.

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

(166) Drivers of vehicles transporting hazardous waste must be trained in accordance with the ADR Regulations.
Yes - Compliance for internal Hospital Drivers was also recommended, as they were involved in the movement of waste from one area to another on the campus

Compliance Heading: 4. 5 .5 Storage

(258) Waste receptacles should be sanitised, secure and in a good state of repair when used.
Yes - Some yellow clinical waste bins were observed to be damp/wet internally prior to their use.

Compliance Heading: 4. 5 .6 Training

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

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

(261) Clean linen store is clean, free from dust and free from inappropriate items.
Yes - Untreated timber storage shelving was evident in the new building which is difficult to clean.

(268) Ward based washing machines are used only with the agreement of the Hygiene Services Committee.
Yes - None are in use.

(271) Hand washing facilities should be available in the laundry room.
No - The design of the area where flat mop laundering takes place does not permit positioning of a wash hand basin. A wash hand basin was available in a locked toilet adjacent to the laundry. There was hand gel available and the toilet wash hand basin was exclusive to the staff of this room.

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

(188) Hand and wrist jewellery should be removed prior to performing all levels of hand hygiene with the exception of a plain wedding band.
No - Jewellery was observed extensively in certain areas. It was recommended that this should be addressed.

(189) Clinical hand wash sinks are required in all areas where clinical activities are performed. They should be centrally located and free from obstruction.
Yes - Clinical hand wash sinks were not always appropriately located for ease of access.

(190) All sinks should be fitted with washable splash backs with all joints completely sealed.
No - Older areas of the building were not found to be compliant.

(192) Taps should be hands free and should be mixer taps to allow temperature regulation.
No - Some areas of the older building were not found to be compliant.

(198) Hand hygiene posters and information leaflets should be available and displayed throughout the organization.
Yes - It was recommended that the number and location of posters be increased and reviewed.

(199) Alcohol based hand rub should be available at the bed side of each patient in Critical care units and in each patient room/clinical room.
Yes - All areas were found to be compliant other than the ICU which was not compliant, and this was recommended to be addressed.

(204) Hand wash sinks conform to HBN 95. They should not have plugs, overflows and the water jet must not flow directly into the plughole.
No - The new Renal Unit was found to be compliant but clinical areas in the older parts of the building were not always compliant.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team		Assessor Team	
	FREQ	%	FREQ	%
A	23	41.07	3	05.36
B	28	50.00	37	66.07
C	5	08.93	16	28.57
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	A	B	↓
CM 3.1	C	C	→
CM 4.1	A	B	↓
CM 4.2	B	B	→
CM 4.3	A	B	↓
CM 4.4	A	B	↓
CM 4.5	A	B	↓
CM 5.1	A	C	↓
CM 5.2	A	B	↓
CM 6.1	B	C	↓
CM 6.2	B	C	↓
CM 7.1	A	A	→
CM 7.2	A	B	↓
CM 8.1	A	C	↓
CM 8.2	A	C	↓
CM 9.1	C	C	→
CM 9.2	B	B	→
CM 9.3	B	B	→
CM 9.4	B	B	→
CM 10.1	A	C	↓
CM 10.2	A	B	↓
CM 10.3	A	B	↓
CM 10.4	C	C	→
CM 10.5	B	B	→
CM 11.1	B	B	→
CM 11.2	B	B	→
CM 11.3	B	B	→
CM 11.4	C	C	→
CM 12.1	A	B	↓

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