Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Hygiene Services Assessment Scheme

Assessment Report October 2007

National Maternity Hospital, Holles Street

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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 National Maternity Hospital is the largest maternity hospital in Europe with approximately 8000 deliveries per year. The hospital was founded in 1894 and its purpose is to care for women prior to, during and after childbirth as well as providing a full range of gynaecological services. It is a university hospital for Midwives and Doctors and has a bed complement of 200.
The busy Gynaecological Unit is a national referral centre for Gynaecological Cancer. A one-year Higher Diploma in Neonatal Nursing is run in our Neonatal Intensive Care Unit. It is organised jointly with the Faculty of Nursing (RCSI) with the clinical component of the course based in our Neonatal Intensive Care Unit. The Laboratory service encompasses adult and perinatal microbiology.

Services provided

- Maternity
- Neonatology
- Obstetrics/Gynaecology
- Anaesthetics
- Diabetes Mellitus
- Endocrinology
- Haematology
- Neurology
- Paediatrics
- Psychiatry
- Respiratory Medicine

Physical structures

The following are used for isolation purposes:
13 isolation rooms with en-suite facilities (2 public, 11 private)
7 single rooms with hand-washing facilities
2 single rooms without hand-washing facilities
There are two Neonatal Intensive Care Units in the hospital and there is one isolation room in one of these units.

The following assessment of the National Maternity Hospital took place between 24th and 25th July 2007.

1.3 Notable Practice

- Waste management was of a high standard with documented evidence of policies, procedures and staff training. ISO Certification had been awarded in June 2007.
- There was good evidence of staff commitment to maintaining and improving standards of hygiene.
- As a result of a patient/client questionnaire, visiting times were reviewed and changed to enhance patient/client rest.
- Segregation of catering and household staff duties was commenced.
- Patient/client representation was included on the Patient/Client Forum Group.

- A Health and Safety Week was organised in 2006, which was open to all staff.

1.4 Priority Quality Improvement Plan

- It was recommended that there be infrastructural improvements in Theatre, Central Sterile Supply Department (CSSD) and neo–natal units to reflect current best practice.
- The upgrade of hand-wash sinks should be completed as soon as possible.
- It was recommended that the Hygiene services Committee should review all possible storage potential and explore delivery scheduling options.
- Review of the Hygiene services Team terms of reference, frequency of meetings, agenda setting and interaction with the Hygiene services Committee.
- Structured audit process is required for all hygiene-related areas, with clearly defined action plans and identified person responsible for those areas.
- Suboptimal hygiene standards and accident risk to patients/clients and staff, if staff cannot access surfaces for cleaning and if equipment is inappropriately stored.
- Risk of cross contamination due to suboptimal decontamination facilities. This is related to the fourth recommendation on the priority Quality Improvement Plan and should be relocated on the list and included after the upgrade of hand-wash sinks recommendation.

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 National Maternity Hospital, Holles Street has achieved an overall score of:

Fair

Award Date: October 2007

1.6 Significant Risks

CM 9.1 (Rating D)
The design and layout of the organisation's current physical environment is safe, meets all regulations and is in line with best practice.

Potential Adverse Event
Risk of cross contamination due to suboptimal decontamination facilities.

Risks

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

Recommendations
The organisation should ensure an integrated decontaminated service is available, ideally in a single location with full tractability for all sterile instruments. This should be supervised by a qualified Central Sterile Supply Department (CSSD) manager, who is currently being trained to ensure co-ordination and compliance with best practice.

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.

Documentation was observed which identified the needs of Hygiene services. These were based on the outcomes from previous assessments, including the previous National Hygiene Audits (2005 and 2006). These needs were rated according to priority and included infrastructural, equipment and additional human resources, to segregate catering and cleaning functions at ward level. They were identified as immediate, interim and long term and had been costed.

The Hygiene Corporate Strategic Plan, Hygiene Service Plan and Operational Plan were observed. However it was recommended that further attention be given to developing their terms of reference, in accordance with the Hygiene Services Assessment Scheme structure of the hygiene services.

Documented evidence of consultation with community partners and patient/clients was confined to one patient/client and one staff satisfaction surveys in 2006. Legislation and Best Practice Guidelines included Infection Control Guidelines, Hazard Analysis and Critical Control Point (HACCP) standards, National Acute Hospital Cleaning Manual and EU Directives for Waste Management. Other sources of information included Ward Manager meetings, a patient/client user and service forum and complaints etc.

There was limited evidence of the evaluation of the efficacy of the needs assessment process, other than some shortcomings of previous national audits being addressed.

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.

Developments and modifications to the hygiene services over the last two years included the introduction of flat mop and colour coding systems for cleaning and laundry, use of hand gel, trial segregation of cleaning and catering functions at ward level, waste segregation developments, upgrading of physical environment including sluice rooms and ward kitchens, laundry storage and installation of additional wash hand basins and a review of infection control guidelines. The implementation of the new visiting policy, which was based on the outcome of the Patient/Client Satisfaction Survey 2006, facilitated better opportunities for ward cleaning.

The National Hygiene Audit 2006 showed improvement, relative to the 2005 outcome. Extra funding had been allocated for further developments and its use was being considered by the Hygiene Services Committee at the time of assessment.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1 (B ↓ C)

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

The Organisation Executive Management Team linked through the Network Manager with the Health Services Executive and accordingly with the Department of Health and Children. Documented processes were observed to ensure that the organisation worked in partnership with contract staff. This included relevant department heads liaising with external contract cleaners, service suppliers, agencies etc. At the time of the assessment only one patient/client and staff satisfaction survey had been undertaken. There was no documented evidence observed to demonstrate the efficacy of linkages and partnerships, which is recommended.

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.

The Corporate Hygiene Strategic Plan was at an early stage of development and needed considerable work. There was no documented evidence to demonstrate who was involved in its development or what was the specific involvement of the Governing Body and Executive Management Team. It was recommended that the Hygiene Services Committee take responsibility for its progression, in accordance with the Hygiene Services Assessment Scheme standards. Communication was by way of minutes of meetings and work was in progress to improve the intranet database.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.1 (B ↓ C)

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

Overall responsibility here rested with the Board of Governors and the Executive Management Team. There was delegated responsibility to specific hygiene services and department heads. The Code of Corporate Ethics was reflected in a Mission, Vision and Values Statement. A Hygiene Services Team was established and standard operating procedures were in place for hygiene service delivery. Staff demonstrated appropriate knowledge of hygiene practices etc. However there were examples of non–compliance in a number of areas such as waste and soiled linen segregation, maintenance of cleaning equipment between use, hand hygiene technique etc. It is recommended that regular audits, across all aspects of hygiene services, be conducted, with feedback to the Hygiene Services Committee and continuous Quality Improvement Plan be progressed.

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.

There were a number of processes in place on the performance of the Hygiene Services Team in receiving and acting on information. These included National Hygiene audits, Infection Control Annual audits, Hazard Analysis and Critical Control Point (HACCP) and Environmental Health Officer (EHO) reports, waste audits, complaints, Medical Device reports, Patient/Client Service User views, and observations of the House Committee following their quarterly site visits. Good examples of networking between specific department staff and their colleagues in the larger Dublin teaching hospitals were cited at the team meeting. Use of information from international centres of excellence was accessed by the Engineering Department. This information was evaluated, with particular focus on its relevance to the end users. A good system of waste monitoring was observed. It is recommended that an evaluation process for the information received be implemented in the near future.

CM 4.3 (C → C)

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

The organisation had library and intranet facilities with a Quality Improvement (QIP), as a result of feedback from the staff satisfaction survey, to improve the content of the intranet database. A Health and Safety Awareness Week was arranged in 2006 and the organisation was awarded a Health Service Executive commendation for the content and communication methods used. Policies, procedures and guidelines were based on current research and best practice information in particular Health and Safety, Infection Control, Catering and Engineering. Sharing of information with hygiene services staff was through informal communication, committee meetings, intranet, e-mail etc. Induction and on-going education sessions on hygiene were provided.

CM 4.4 (B ↓ C)

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

There were processes in place for the development, approval, revision and control of policies, procedures and guidelines, including those relating to hygiene services. There was a comprehensive range of relevant policies but limited evidence of evaluation of the processes observed.

CM 4.5 (C → C)

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

There was evidence of consultation with hygiene services relating to pre-development of existing sites. However there were no documented processes and no evidence available to demonstrate their potency. The organisation is recommended to consider including documented processes for input into the re-development of existing sites and their evaluation in the terms of reference of the Hygiene Services Committee.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

*Core Criterion

CM 5.1 (B ↓ C)

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

Job descriptions had identified roles, responsibilities and reporting relationships within the existing line management structure. A number of relevant committees, which had a reporting relationship to the Executive Management Team, were in place. The hygiene service's management structures was poorly developed and the organisation was recommended to address this as a priority and ensure that all relevant stakeholders including service users, contractors and those leasing had representation.

*Core Criterion

CM 5.2 (B ↓ C)

The organisation has a multi-disciplinary Hygiene Services Committee.

This was in place. It was recommended that the membership be reviewed to ensure a full representation, with clear identification of roles and responsibilities and comprehensive terms of reference, meeting frequencies etc., thus enabling a robust integrated structure, for the development of Hygiene Corporate Strategic and Service and Operational planning and hygiene service delivery. It was also recommended that existing structures be reviewed to ensure that they are streamlined and any possible unnecessary overlaps are eliminated.

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.

There were identified budgets, relevant to current Hygiene Service provision, for human resources and consumables. Considerable additional resource requirements were identified and costed. As monies were made available by the HSE the Hygiene Services Committee met and agreed their dispersal. A strategic plan was in place for environmental developments, which reflected immediate, intermediate and long-term needs. The progression of the Corporate Hygiene Strategic and Hygiene Services Plans should further strengthen this process.

CM 6.2 (B ↓ C)

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

There were no documented processes for this existing practice. Processes for communication between the Hygiene Services Committee and the Governing Body and Executive Management Team, relating to the purchasing of equipment and products, were in place. Its efficacy was not formally evaluated and this is recommended, followed by the development of a documented process.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

CM 7.1 (B → B)

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

A Risk Management Strategy is in place since 2005 and a Risk Register in place for 2007. Accidents and near misses were recorded using an electronic incident database. Incidents investigated, action plans identified and specific feedback given/reports issued. They were classified and trended and an annual report produced. In 2006 there were 11 incidents of individual collisions with equipment stored in corridors and cramped spaces. The organisation is recommended to progress the culture of hygiene auditing by developing a strategy for structured internal audit, to include all aspects of the hygiene services and their inclusion in future annual reports. It is also recommended to review further possible ways of reducing the storage of equipment on corridors and ward overcrowding.

CM 7.2 (B → B)

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

A Quality Improvement Plan (QIP) 2005-2008 was developed with specific improvements for each year, based on the outcome of the first Acute Hospital Accreditation peer review outcome. This includes QIP in relation to hygiene issues.
The Hygiene Services Committee had representation on the Risk Management Committee.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion

CM 8.1 (A → A)

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.

This was in place and was based on legislation and best practice. The setting up and managing of contracts was the responsibility of Central Purchasing and the organisation had access to professional legal advisers. Current contracts included domestic, hazard and non–hazard clinical waste, linen, catering supplies, water maintenance, sanitary services, window cleaning, and pest control.

CM 8.2 (B → B)

The organisation involves contracted services in its quality improvement activities.

Contractors' involvement in quality improvement activities is organised directly through the relevant line manager and the contract company. There was evidence of quality improvement initiatives such as changes made to contracts as a result of regular meetings and the provision of a new degreaser in the Catering Department.

PHYSICAL ENVIORNMENT, FACILITIES AND RESOURCES

CM 9.1 (C ↓ D)

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

This hospital is an amalgamation of a number of interconnecting buildings dating from the early 1800s and two additions dating from the 1930s and 1960s. Very little development space is available. However interim development plans had been costed and submitted to the Health Services Executive, to address some of the present shortcomings. Decontamination of instruments was carried out in different locations and on different floors. The location of new wash-hand basins and associated hand gels, notices, waste bins etc. was compromised in some instances due to lack of suitable wall and floor space. There are limited isolation facilities in the hospital. Staff is to be commended on their creativity in the best use of the space that was available. The organisation recognises the limitations of the current physical environment and have interim design plans to build three operating theatres, a Central Sterile Supply Department (CSSD) and a neo-natal unit. The hospital is encouraged to review the design of the CSSD.

*Core Criterion

CM 9.2 (B ↓ C)

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

This is the case. However, as identified under CM9.1 the physical environment does not adhere to all relevant regulations and best practice. The recent Decontamination Audit is one example of non-compliance.

CM 9.3 (B → B)

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.

Evaluation methods used to determine the efficiency of the organisations environment and facilities included, internal audits, for example infection control, HACCP, waste management, linen, environmental audits, Health and Safety reports and external audits such as Environmental Health Officer reports. Patient/client and staff satisfaction surveys were still at an early stage of development. However, examples of quality improvements as a result of their findings included a revised patient/client visiting policy and the upgrading of intranet database to facilitate staff information. Other developments included the relocation of office space off-site to facilitate patient/client-related improvements. Examples of this include additional neo-natal space, improvisations to enhance ward storage, improvements to ward kitchens, sluice rooms, replacement of flooring, additional wash-hand basins, etc. The organisation was encouraged to establish a system of continual patient/client and staff satisfaction surveys and on-going internal hygiene audits to evaluate change and progress the culture of continuous quality improvement.

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.

Patient/client, staff, visitors and the community's satisfaction with hygiene services are collected mainly through patient/client satisfaction surveys which are based on

patient/clients voluntarily taking a survey form from a range of convenient locations (the uptake is small); complaint analysis; input from the House Committee who are members of the Board of Governors, who do quarterly site visits and make recommendations to the board based on their findings. There was evidence, as already identified, of improvements as a result of such information.

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.

Documented processes for selection and recruitment for hygiene services staff in line with human resource policies, are in place, and reflect current legislation and best practice. Job descriptions were available for all staff disciplines and grades. A small number of contract staff were employed in Cleaning and Catering Departments and contracts existed for the provision of specific services in areas such as waste management, linen, sani-bin, pest control etc. Human resource recruitment records were maintained for all staff. There was no documented evidence of evaluation of the recruitment process and this is recommended.

CM 10.2 (B → 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.

Documented evidence identified additional human resource needs for hygiene services. Some additional human resources were provided, to enable the piloting of the segregation of cleaning and catering services at ward level. Additional resources have been identified to facilitate the expansion of this initiative across the entire organisation and also to provide 24/7 cover for cleaning. The organisation was encouraged to document its evaluation before expanding the practice.

CM 10.3 (B → B)

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

Where relevant, the necessary qualifications and training are identified in job descriptions and validated prior to employment. Staff not requiring prior qualifications are inducted on site. Certain aspects of hygiene training are mandatory and included in induction and on-going education and training. The timing of induction training should be reviewed to ensure this is delivered at the optimum time.

CM 10.4 (B → B)

There is evidence that the contractors manage contract staff effectively.

Documented processes were in place for this as were facilities for addressing the occupational needs, training and orientation for contract staff. Meetings with contractors allowed regular evaluation of the use of contract staff, and changes were made where necessary.

*Core Criterion

CM 10.5 (B → B)

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

Each department has an identified level of service requirement to meet its particular needs. Staff rosters reflect the necessary provision to meet identified service needs.

ENHANCING STAFF PERFORMANCE

*Core Criterion

CM 11.1 (A ↓ B)

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

Corporate induction is provided for all staff and includes training in hand hygiene, sharps, health and safety, waste management and infection control. There is on–going education and training which is structured to facilitate ease of access by staff. Staff are released from rostered duties to attend relevant education and training. Records were maintained for training attendance; however, there was no centralised record in place. The organisation is encouraged to progress its QIP to establish central record keeping for staff training/education and have it accessible to line managers.

CM 11.2 (B → 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.

There were systems in place to ensure relevant continual professional development for hygiene services staff. Department heads ensured staff release for training, which was provided in-house. Eleven members of staff were currently undertaking the SKILLS training. Evaluation of the relevance of training and education took place at a number of levels and included reviews of induction training by the Staff Training Committee, Risk Assessment analysis, Hazard Analysis and Critical Control Point (HACCP) compliance; specific training for housekeeping staff was assessed at monthly meetings.

CM 11.3 (B → B)

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

Performance indicators, used to evaluate the effectiveness of education and training, included cases of incidents and near misses, audit outcomes, staff satisfaction survey etc. it was recommended that a comprehensive suite of performance indicators be identified across all aspects of hygiene services and used as benchmarks against which to monitor progress.

CM 11.4 (B → B)

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

This was based on the probationary period assessment for new staff or otherwise through post probationary reviews, individual, management and team meetings and audit outcomes. There was no documented evidence of feedback and continuous Quality Improvement Plans observed. This is recommended.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (A ↓ B)

An occupational health service is available to all staff

This service included the provision of a range of staff support services such as Dignity At Work training, stress support, back care, manual handling training, a range of staff screening services, and relevant vaccinations. While it was identified that the Health Promotion Committee and the Occupational Health Department evaluated the appropriateness of services no documentation evaluation was observed during the site visit.

CM 12.2 (A ↓ B)

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

A staff satisfaction survey was conducted and evaluated within the last year. Uptake of vaccines was monitored as a Key Performance Indicator (KPI) by the Occupational Health Department. It was recommended that a comprehensive suite of Key Performance Indicators be identified, monitored and reported for this service through the annual report system. It was also recommended that staff satisfaction surveys be carried out on a regular structured basis to evaluate/ benchmark the appropriateness of support services provided for staff.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.1 (C → C)

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

This is achieved through access to national guidelines and current legislation, which was provided through relevant hygiene department managers, and the Executive Board. Policies, procedures, guidelines and practices were amended accordingly. Information was also generated through minutes of meetings, annual report, internal, and external audit reports. The organisation should consider developing a comprehensive suite of Key Performance Indicators (KPIs) across all aspects of hygiene services and ensure evaluation of patient/client's satisfaction takes place.

CM 13.2 (C → C)

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

Information is collected through a series of internal hygiene services reports and more recently through patient/client and staff satisfaction surveys. An annual hygiene services report, based on the Hygiene Service Plan, compiled by the Hygiene Services Committee, which could be integrated into the overall annual report, is recommended.

CM 13.3 (C ↑ B)

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

Each of the specific hygiene service areas collected information through checklists of its own service, which is evaluated by department managers. The Quality

Improvement Plan included the introduction of a Waste Work Plan by the Waste Manager as a result of assessing waste data.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

CM 14.1 (A → A)

The Governing Body and/or its Executive Management Team foster and support a quality improvement culture throughout the organisation in relation to Hygiene Services.

There was strong evidence of involvement of the Board of Governors and the Executive Board in all hygiene services matters. A quality improvement culture was also promoted. The fact that the House Committee members, who were also members of the Board of Governors, visited all clinical areas quarterly was one example of support at the highest level within the management structure for hygiene and other patient/client and staff concerns about services. All reports from the Hygiene Services Committee, department managers, infection control and external audits were issued to the Executive Management Team and hygiene services quality improvement activities were based on these outcomes.

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.

There was considerable evidence of this. The organisation was encouraged to promote the practice of evaluation of new pilot initiatives before rolling them out to all areas and consider a more structured approach to on-going evaluation and benchmarking.

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.

From speaking to various staff members and from reviewing available literature, it was evident that best practice guidelines are in place and adhered to. It is recommended that a more structured approach be implemented so as to ensure that it is included in the terms of reference of the Hygiene Service Committee and included as an agenda item. The intranet allows staff to reference relevant policies and procedures in areas such as infection control, health and safety and this could be developed further by including information on other areas of the Hygiene Service Assessment Scheme such as catering or laundry as examples.

SD 1.2 (B ↓ C)

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

There was no documented policy for the assessing of new hygiene service interventions. Such a policy is recommended so as to ensure a structured and centralised approach, through the hygiene service committee, for all new hygiene service interventions, or changes to existing ones. Some recent trials and evaluations, such as the segregation of catering and household in the management of the ward kitchens, have taken place. It is recommended that this be rolled out to all areas.

PREVENTION AND HEALTH PROMOTION

SD 2.1 (B → B)

The team in association with the organisation and other services providers participates in and supports health promotion activities that educate the community regarding Hygiene.

The hospital is a member of the Health Promoting Hospitals Network and has a Health Promotion Committee on site. Hand hygiene awareness is promoted throughout the hospital and was conducted in August 2006. The hospital participated in the National Quality and Hygiene Week in 2006 and won an award. Hand hygiene is taught in ante-natal classes. There were activities in the hospital as part of National Infection Control Week in November 2006 and a quiz was held, which is good practice. It is recommended that when these activities are held their efficacy be

evaluated and reported to the Hygiene Service Committee, so that areas for continuous improvement can be identified and acted upon.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1 (B ↓ C)

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

A multi-disciplinary Hygiene Service Committee is linked to the Executive Management Team. A Hygiene Team reported to the Hygiene Service Committee. It is recommended that the terms of reference for these teams be more comprehensive and that agendas and schedules are set for these team meetings to ensure that meetings are held on a regular basis for continuing momentum in the area of hygiene service delivery. The committee structures and reporting lines are somewhat complex and it is recommended that, where possible, these be reviewed and streamlined.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

SD 4.1 (B → B)

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

Whilst the general hospital environment was clean, challenges exist in relation to storage. The Assessment Team recognised that the current infrastructure does not lend itself to having adequate storage solutions and that the Hospital Team have used space to the optimum.

For further information see Appendix A

*Core Criterion

SD 4.2 (C → C)

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

Due to space constrictions challenges exist in the storage of patient/client luggage and personal belongings. The Hospital Team is aware of this and is making improvements, including patient/clients being advised to bring less personal items with them. Dust was observed on equipment for direct patient/client care and it is recommended that further monitoring be undertaken on this issue.

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.

Due to space limitations, there are challenges in providing correct storage facilities for cleaning equipment within most areas of the hospital environment.

For further information see Appendix A

*Core Criterion

SD 4.4 (A ↓ B)

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

The hospital kitchen was clean and Hazard Analysis and Critical Control Point (HACCP) guidelines are implemented. However, further controls are required to ensure that the monitoring and recording of critical control points, such as cooling, demonstrate full compliance with the HACCP plan. Separate and locked toilets must be provided for catering staff and the segregation of catering and household in the management of ward kitchens is recommended for all areas.

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.

Waste management is of a high standard and the hospital was awarded the ISO 14001 award for environmental standards in 2007.

For further information see Appendix A

*Core Criterion

SD 4.6 (B → B)

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

Further controls are required in the management of linen so as to ensure that soiled linen is not left on a corridor awaiting collection and that bags are only two thirds full and are tied securely. The service lift, which is used for the collection and delivery of supplies from the contractor, was in need of attention and the adjoining stairs was in poor structural repair and needed attention.

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.

All sinks in the hospital environment must be upgraded to conform to best practise guidelines.

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.

Risk management guidelines, a Health and Safety Plan and a major emergency and contingency plan ensure this occurs. A health and safety committee is in place and

the minutes of these meetings were noted, along with an annual report for 2006. Incidents are reported and evaluated.

SD 4.9 (A ↓ B)

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

A hospital information leaflet provides guidance on important aspects of hygiene and signs, posters and hand gels encourage high standards of hand hygiene. Patient/clients are included on a Service Users' Forum and satisfaction surveys are carried out.

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.

Patient/client charters are in place at reception and ward level. Confidentiality is included in the staff induction booklet and household staff, and in particular male staff, is trained to ensure patient/client dignity is maintained during hygiene service delivery. It was evident that maintaining patient/client dignity can be challenging during periods of high demand. It is recommended that current practises are reviewed and built upon to see if improvements can be made at these critical times.

SD 5.2 (B → B)

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

The hospital information leaflet deals with hygiene-related issues such as hand hygiene, visitor's responsibilities and policies on visiting times and patient/client foods. Hand hygiene posters were displayed but it is recommended that further posters and signage be put in place around the general hospital environment.

SD 5.3 (B → B)

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

A new database is been used for the logging and tracking of the complaints from 2007 onwards. Comprehensive actions were being taken, and reported on, at the weekly clinical governance meetings. Whilst a process flow diagram was noted for the complaint process, it is recommended that a policy be approved and dated by the appropriate personnel. It is also recommended that overall complaint trends be evaluated and reported on by year and category.

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1 (B → B)

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

Patient/client satisfaction surveys are completed but the response rate is low. It is recommended that efforts are made to increase this and to ensure that comprehensive evaluation of the results takes place. A Patient/Client Service User Forum meets monthly. Its terms of reference, and comprehensive minutes of meetings were noted. It was very involved in the pilot and rolling out of the revised visiting policy, which is proving to be a success for both patient/clients and for delivery hygiene services such as cleaning and meals.

SD 6.2 (B ↓ C)

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

There was a structured approach in place for auditing within the environmental area and to a lesser extent for the infection control audits. It is recommended that an internal audit policy and schedule be documented and implemented, with full tracking of non-conformances as they arise, until they are fully closed off. This would cover all internal audits. It is also recommended that internal auditors be fully trained. It is also recommended that Key Performance Indicators, which are quantitative in nature, are set and measured, as this would prove a useful tool for continuous improvement programmes. It is also recommended that data, collected from patient/client satisfaction surveys, is evaluated and a report issued.

SD 6.3 (B → B)

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

The report for 2006, which is circulated to stakeholders, was noted. Whilst it made reference to elements of hygiene service delivery it is recommended that further detail be given which would be more quantitative in its nature.

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

(28) Before cleaning commences, a work route should be planned and when necessary, furniture and equipment should be removed from the area.
No - A full corridor being mopped was observed rather than using a work route which would ensure there was access on one side.

(1) The environment is tidy, well-maintained, free of rust, blood or body substances, dust, dirt, debris and spillages.
No - The general hospital environment could have been tidier, especially corridors.

(2) All high and low surfaces are free from dust, cobwebs and flaking paint.
Yes - Flaking paint was noted in a number of areas.

(3) Wall and floor tiles and paint should be in a good state of repair.
Yes - Flaking paint noted in a number of areas.

(5) Cleanable, well-maintained furniture, fixtures and fittings used.
Yes - In the X-Ray Department waiting area fabric chairs were noted.

(10) Internal and external signage should be clean, updated, well maintained and laminated to enable cleaning.
No - Not all signs were laminated and in good condition.

(13) External areas including grounds, gardens, footpaths, ramps and car parks should be clean and well-maintained.
No - Weeds noted in concreted areas and compactor area could have been cleaner.

(15) Where present a designated smoking area must comply with the national legislation on tobacco control and local organisational policies, a cigarette bin must be available and the floor area should be free of cigarette ends, matches etc.
No - The smoking area was not to a high standard of cleanliness.

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

(17) Switches, sockets and data points.
No - Many switches, sockets, and data points required greater attention.

(21) Internal and External Glass.
No - Internal glass panels on doors required greater attention.

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

(41) Door handles and door plates
No - In certain areas door push plates required attention.

Compliance Heading: 4. 1 .5 Sanitary Accommodation

(44) Hand hygiene facilities are available including soap and paper towels.
Yes - However, paper towels were not always in dispensers.

(49) Cleaning materials are available for staff to clean the bath / shower between use.
Yes - It was noted that access to a patient/client shower was through a sluice room.

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

(55) Sluices
Yes - However, some sluices were used for the storage of cleaning trolleys.

(58) Sluice rooms should be free from clutter and hand washing facilities should be available.
No - Hand wash sinks were not accessible in all cases.

(60) All outlets (including shower outlets) should be flushed at a temperature in accordance with current legislation.
Yes - Checklists in local areas require review to ensure each shower outlet is signed off on an individual basis.

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

(66) Medical equipment e.g. intravenous infusion pumps, drip stands and pulse oximeters, suction apparatus and tubing, cardiac monitors, blood pressure cuffs, blood gas machines.
No - Some equipment observed in the Gynaecology Ward and in Out-patients Department was dusty.

(68) Patient fans which are not recommended in clinical areas.
No - Fans were observed and needed attention.

(70) Bedpans, urinals, potties are decontaminated between each patient.
No - Bedpans, which required attention, were noted in sluice rooms.

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.
No - Patient/client personal items were noted in clinical areas.

(75) Vases
No - Vases in some areas needed attention.

(77) Loose items such as patient's clothing should be stored in the patient's locker or property bag.
No - Patient/client personal items were noted in clinical 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 - Vases in some areas needed attention.

(80) All office equipment (e.g. telephones, computers, fax machines) should be clean and well-maintained.
No - Phones in general could have been cleaner as could some keyboards. No keyboard covers were observed.

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

(88) All cleaning equipment should be left clean, dry and tidy in the storage area after use.
No - Some reservoirs noted to have residual water during storage.

(89) Equipment with water reservoirs should be stored empty and dry.
No - Some reservoirs noted to have residual water during storage.

(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 - Standards varied, as cleaning equipment was stored in some sluice areas.

(91) Storage facilities for Cleaning Equipment should be clean and well maintained.
No - Storage arrangements varied as cleaning equipment was stored in some sluice areas and storage of cleaning equipment was noted on corridors.

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.
No - No report was presented on the microbiological quality of the water used in the catering operation. An issue raised in the EHO report, on the provision of a ventilated lobby on the toilet, close to the canteen, has not yet been fully acted upon. Plans were noted for this.

(214) The person in charge of catering shall develop, implement and maintain a permanent system based on the seven principles of HACCP. A standard HACCP Plan should be fully completed.
Yes - A HACCP Plan was on site but a staff member was not fully aware of what it was or where it was. However, this staff member was quite new and was not fully au fait with the system.

(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 - None was noted at ward level and, whilst there was one in the food safety manual, it was not posted in the kitchen area for staff to view.

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 - No restricted access to the ward kitchens.

(218) Authorised visitors to the food areas should wear personal protective clothing (PPE) and wash hands on entering the food area during food preparation/serving times.
No - Personnel noted in the ward kitchens with no protective clothing.

(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 - However, no paper towel in dispenser in Unit 7.

(223) Separate toilets for food workers should be provided.
No - Toilets for catering staff are not locked and could be used by other staff and in the case of male staff by visitors and patient/clients.

(224) The ventilation provided for all cooking and steam emitting equipment shall be sufficient to prevent condensation on walls, ceilings and overhead structures during normal operations.
Yes - However, some dust noted in main ventilation in the kitchen area.

(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 - Cereals are decanted into containers and there is no apparent traceability.

(226) Containers used to store foods shall be made of food grade materials, be in good condition, easy to clean and disinfect.
Yes - However, scoops were noted in flour bins.

Compliance Heading: 4. 4 .3 Waste Management

(233) In food preparation areas where lidded bins are provided they shall be foot pedal operated.
Yes - However, a damaged bin was noted in the ward kitchen of Unit 7.

Compliance Heading: 4. 4 .4 Pest Control

(239) Fly screens should be provided at windows in food rooms where appropriate.
Yes - However, the screen on the window in Unit 7 was not closed properly.

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

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

(242) Temperatures for Food in Fridges / Freezers and Displays should comply with I.S.340:2006 requirements
Yes - In the majority, however, some high temperatures noted.

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 - However, there were incomplete records noted.

Compliance Heading: 4. 4 .9 Food Cooling

(248) Cooling Times for Cooked Food should comply with I.S. 340:2006 requirements
No - Records for cooling did not demonstrate correct controls. Corrective action was taken.

Compliance Heading: 4. 4 .10 Plant & Equipment

(250) The dishwasher's minimum temperature for the disinfecting cycle should be compliant with I.S.340:2006 requirements and should be monitored regularly. There should be digital readouts on dishwashers.
No - No records available for ward kitchens areas.

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

(142) Healthcare risk waste should be tagged and secured before leaving the area of production.
Yes - In the majority, however, the organisation should consider reviewing its tagging practices for sharps boxes.

Compliance Heading: 4. 5 .3 Segregation

(156) Healthcare risk waste must be segregated from healthcare non risk waste.
No - The organisation should consider reviewing its waste segregation practices.

(158) Needles and syringes should be discarded as one unit and never re-sheathed, bent or broken.
Yes - Single use syringes used for Colposcopy were discarded in inappropriate sharps container.

(160) 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.
Yes - However, some exceptions were noted.

(256) Mattress bags are available and are used for contaminated mattresses ready for disposal; mattresses are disinfected.
No - Mattress bags are not used in the hospital.

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 - Locked facility and appropriate signs observed.

(258) Waste receptacles should be sanitised, secure and in a good state of repair when used.
Yes - Some exceptions observed e.g. new bins not locking.

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

(172) Documented processes for the management, maintenance and safe handling of linen and soft furnishings throughout the organisation.
Yes - A linen policy was noted in the submitted evidence but laundry supervisor was not aware of its existence.

(173) Documented processes for the use of in-house and local laundry facilities.
Yes - Linen is subcontracted to an external company and information was available on the contract.

(174) Clean linen is stored in a designated area separate from used linen (not in sluice or bathroom).
Yes - However, some soiled theatre scrubs were noted in an open bag, close to clean linen in the main storage area.

(261) Clean linen store is clean, free from dust and free from inappropriate items.
No - Linen store in Unit 3 was dusty and other items such as cots, pods, stands etc were noted in this area.

(263) Bags are less than 2/3 full and are capable of being secured.
No - Linen bags noted which were full and were not fully secured.

(264) Bags must not be stored in corridors prior to disposal.
No - Bags of soiled linen noted in corridors awaiting collection.

(267) Documented process for the transportation of linen.
No - The policy did not include transportation of linen. An operator was noted with soiled linen in main lift rather than service lift.

(271) Hand washing facilities should be available in the laundry room.
No - No hand-wash facilities in the laundry store. Toilet facilities would have to be used.

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

(189) Clinical hand wash sinks are required in all areas where clinical activities are performed. They should be centrally located and free from obstruction.
No - Work is in progress.

(190) All sinks should be fitted with washable splash backs with all joints completely sealed.
No - New sinks were observed to be compliant, however, old sinks were not.

(192) Taps should be hands free and should be mixer taps to allow temperature regulation.
No - Not all sinks observed were compliant.

(198) Hand hygiene posters and information leaflets should be available and displayed throughout the organization.
Yes – However, further posters are needed in all areas of the hospital. Poster visibility in the Out-patients Department as information was located on a cluttered notice board.

(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 - Several sinks were non compliant with this standard.

(206) Documented records of mandatory attendance at hand hygiene education and practice is required for all staff members involved in clinical areas. This may be undertaken during hospital induction programme followed by annual updates.
No - Hand hygiene training should be mandatory before commencement of work. At present mandatory training can occur 6-8 weeks from commencement of work.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team		Assessor Team	
	FREQ	%	FREQ	%
A	9	16.07	3	05.36
B	40	71.43	33	58.93
C	7	12.50	19	33.93
D	0	00.00	1	01.79
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	B	B	→
CM 2.1	B	C	↓
CM 3.1	B	C	↓
CM 4.1	B	C	↓
CM 4.2	B	B	→
CM 4.3	C	C	→
CM 4.4	B	C	↓
CM 4.5	C	C	→
CM 5.1	B	C	↓
CM 5.2	B	C	↓
CM 6.1	B	B	→
CM 6.2	B	C	↓
CM 7.1	B	B	→
CM 7.2	B	B	→
CM 8.1	A	A	→
CM 8.2	B	B	→
CM 9.1	C	D	↓
CM 9.2	B	C	↓
CM 9.3	B	B	→
CM 9.4	B	B	→
CM 10.1	A	C	↓
CM 10.2	B	B	→
CM 10.3	B	B	→
CM 10.4	B	B	→
CM 10.5	B	B	→
CM 11.1	A	B	↓
CM 11.2	B	B	→
CM 11.3	B	B	→
CM 11.4	B	B	→
CM 12.1	A	B	↓

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