



Hygiene Services Assessment Scheme

Assessment Report October 2007

Royal Victoria Eye & Ear Hospital

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1.0 Executive Summary

1.1 Introduction

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

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

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

Hygiene is defined as:

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

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

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

1.1.1 Standards Overview

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

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

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

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

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

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

Core Criteria:

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

In the Corporate Management standards, the core criteria cover:

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

In the Service Delivery standards, core criteria cover:

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

1.1.2 Rating Scale

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

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

- A Compliant - Exceptional**
 - There is evidence of exceptional compliance (greater than 85%) with the criterion provisions.
- B Compliant - Extensive**
 - There is evidence of extensive compliance (between 66% and 85%) with the criterion provisions.
- C Compliant - Broad**

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

1.1.3 Assessment process components

The assessment process involves four distinct components:

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

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

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

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

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

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

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

The Internal Review Committee of the HIQA reviewed all the reports to ensure consistency, and based on the quantifiable translation guidelines, awards were made. Only organisations 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

Royal Victoria Eye and Ear Hospital is located on Adelaide Road, Dublin 2. It was built in 1897 for the provision of ophthalmic; ear, nose & throat; head and neck services. The hospital has 80 beds, of which 20 are located in the hospital's Day Care Unit. 60 beds are designated in-patient. Ten of these beds accommodate children. Two thirds of the beds are designated ophthalmic beds and one third are designated to ear, nose & throat, head and neck. Both private and public patients are accommodated. There is a large Out-patient Unit accommodating circa 45,000 patient visits per annum and a separate X-Ray building and Accident & Emergency Unit accommodating circa 40,000 patient visits per annum.

Services provided

- Ophthalmology
- Otolaryngology (ENT).

Physical Structures:

Two designated isolation rooms with other single rooms being utilized for isolation as appropriate. There are no negative pressure rooms.

The following assessment of Royal Victoria Eye and Ear Hospital took place between 13th and 14th August 2007.

1.3 Notable Practice

Examples of notable Practice at the hospital include:

- Corporate Approach taken to the Hygiene Service Management Development.
- Documentation — Policies, procedures, guidelines (PPGs), minutes of meetings for Hygiene Services Committee
- Hygiene structures and audit report
- Service contracts
- Infection control processes

1.4 Priority Quality Improvement Plan

Areas for Improvement:

- Service user/patient/client involvement, including patient forum opportunities and patient satisfaction surveys
- General painting and decorating of the hospital (internal)
- Continued replacement of hand hygiene wash hand basin facilities
- Replacement and cleaning of waste bins
- Continuous attention to cleaning detail to detail in the grounds and service yards of the hospital.
- Develop and implement Aspergillus policy

- Upgrade of the clinical waste area.
- Improve high dusting.
- Development of new Central Sterile Supply Department (CSSD) area in line with capital development plans.
- Upgrade flooring, skirting and doors.

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 Royal Victoria Eye & Ear Hospital has achieved an overall score of:

Fair

Award Date: October 2007

2.0 Standards for Corporate Management

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

PLANNING AND DEVELOPING HYGIENE SERVICES

CM 1.1 (B → B)

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

The organisation comprised six directorates and each identified its own needs, based on legislation and best practice as well as internal/external hygiene audit reports. There was a Corporate Strategic Plan 2005–2009 in place, which included Hygiene Service improvements. The organisation does not currently have an annual Hygiene Service Plan. A Hygiene Operational Plan was in place. The organisation was recommended to consider ways of including regular input from patients and the public into the management of its Hygiene Services. Evaluation was based on hygiene audits and minutes of meetings. Hygiene was prominent on the agenda for all meetings within the organisation in accordance with a management decision to prioritise hygiene on the agenda of all its committees.

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.

A multi-disciplinary Hygiene Services Group was established. New hygiene equipment had been installed and this was a work-in-progress, with considerable upgrades in such areas as wash hand facilities and closed waste bins storage which were outstanding. There were increased cleaning frequencies, structured deep bed cleaning and curtain cleaning, along with increased training and education, including hand hygiene. Further improvements were identified, costed and requisitioned from the Health Services Executive (HSE).

There was evidence of on-going evaluation through hygiene meetings and audits.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1 (B ↓ C)

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

There was evidence of appropriate linkages with external agencies, including Network Manager and Peer Committees, and national/international conferences. There were no formal processes for patient/client input other than specific issues audits, the complaints process and compliments cards/letters. The organisation was considering ways of including patient input and were recommended to progress this in the form of a Quality Improvement Plan (QIP). Staff exit interviews were also used as a source of information on staff satisfaction within the organisation. The organisation was recommended to consider staff satisfaction evaluation.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 (A ↓ C)

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

The Hospital Corporate Plan 2005–2009 includes hygiene issues and each of the directorates identified hygiene services development issues for their specific areas. These were based on the needs identified on a regular basis by the front line staff in those areas. Communication to all stakeholders was achieved through minutes of meetings and their circulation via intranet.

Implementation of the Hospital Corporate Plan is reviewed on a regular basis by the directorates, Hospital Management Group and Hospital Council. It is recommended that the organisation regularly evaluates its goals for hygiene services against identified needs.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.1 (B → B)

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

The Hospital Council as the governing body for the hospital has formally adopted as policy and as a core strategic priority, the pursuit of excellence in Hygiene Services in the interest of patients, staff, the public and good governance. Delegated authority is vested in the Hospital Management Group and through them to the directorates. The organisation has a code of corporate ethics which are reflected in its Mission and Values Statement. Evaluation was based on the structures and checks/audits of compliance both internal and external. There was evidence of Continuous Quality Improvement (CQI).

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 documented policies, procedures and guidelines were evidence-based and reflected current legislation and best practice. A suite of key performance indicators pertaining to hygiene were reviewed regularly. Hygiene was an agenda item at all meetings and evaluation was based on regular review at meetings and internal/external audits. The organisation was recommended to develop trend analysis to further progress the audit report review process.

CM 4.3 (B → B)

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

Library facilities were available with intranet, internet and teleconferencing facilities, as well as subscription to a range of relevant journals. The organisation was also in the process of constructing a new education and library facility. Access to education and conferences is facilitated on rostered time. In-service education is supported with evidence-based documentation. The organisation was auditing/evaluating patient equipment and identifying suitable replacement products as a result — for example, mattresses and pillows.

CM 4.4 (B → B)

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

The organisation had a Nursing Policies and Procedures Committee. An extensive suite of policies and procedures were available and these adhered to a standard format, had introduction and review dates and were referenced. These were signed off by the Director of Nursing and General Manager.

Evaluation was based on the outcomes of regular audits which were reviewed by the Director of Nursing, Infection Control Nurse and Cleaning Contract Supervisor.

CM 4.5 (B ↓ C)

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

The Hospital Management Group is also the Hygiene Services Committee and consequently involved in the organisation's Capital Development Plan through its membership of the directorate structure. There were a number of committees within this small organisation and all had minutes of the meetings maintained, which were submitted to the Hospital Management Group. It is recommended that the organisation formally evaluate the efficacy of the consultation process in relation to hygiene services.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

*Core Criterion

CM 5.1 (A → A)

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

There was a very large Hygiene Services Team which comprised multi-disciplinary membership, chaired by the Director of Nursing. The organisation was recommended to review the membership of this group with a view to streamlining, in order to better reflect the size of the organisation. Documented responsibilities for each directorate were evident, as were terms of reference for the Hygiene Services Team. Reporting relationships for the Cleaning Contract Supervisor with each ward and department manager and the Director of Nursing were explicit. Each ward/department manager had overall responsibility for the hygiene standards in their own areas and each job description identified staff members responsibility for hygiene.

*Core Criterion

CM 5.2 (A ↓ B)

The organisation has a multi-disciplinary Hygiene Services Committee.

The Hospital Management Group, which also assumes the role of the Hygiene Services Committee, meets monthly and the Hygiene Services Team meet fortnightly. There are terms of reference and an identified chair and secretary for each of these teams. It is recommended that the hospital establish documented processes to ensure the team have an awareness of each others' roles and responsibilities.

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

*Core Criterion

CM 6.1 (A ↓ 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.

Allocation of resources is determined at Hospital Management Group level which has each of the directorate managers as members. Hygiene is a priority item on this group's agenda. The organisation received a once-off allocation of €150,000 for hygiene service developments in the last two years. There is still outstanding work in the area of wash hand basin upgrades, waste bin upgrades and refurbishment of clinical areas which were identified by the organisation as part of their QIP and the necessary funding identified to the Health Services Executive.

The organisation was recommended to establish an annual Hygiene Services Plan and complete a Hygiene Services Annual Report.

CM 6.2 (B → B)

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

Schedules of hygiene services requirements are completed annually with the involvement of staff across all areas and at all levels within the organisation. These are evaluated by the relevant directorate and recommendations made by the directorate to the Hospital Management Group. Evaluation of the efficacy of the process is considered at directorate level.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

CM 7.1 (A ↓ C)

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

The organisation had systems in place for risk identification, analysis, prioritisation, minimisation and elimination. The low hospital acquired infection rates were commendable. Risk and Health and Safety generate quarterly reports. The two adverse incidents which occurred during the last two years were assessed and resultant improvements introduced as a result. There was an established practice of internal/external audit reports including environmental health officer reports. The organisation was recommended to produce annual Risk and Health and Safety reports. There was no Aspergillus risk policy in place and there were external construction works in progress at the time of the assessor's visit. However, there was no evidence of internal dust present. Once this was highlighted and discussed with the microbiologist it was agreed that such a policy would be developed and adhered to in relation to future construction work.

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.

Hygiene-related risks are identified and investigated in accordance with the organisation's risk management structure and processes, and reports generated as appropriate, for example, an incident of fire was investigated and a report compiled. There was statistical evidence and classification in place pertaining to hygiene-related incidents on an annual basis. Recommendations from Environmental Health Officer (EHO) reports and other sources are acted upon. Issues of concern raised during the assessment visit were rectified immediately except the waste segregation issue and this was under consideration to identify a suitable option.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion

CM 8.1 (A ↓ B)

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.

There was evidence of good processes for the establishment of contracts. A number of contracts were in place and included clinical waste, cleaning, water maintenance and facilities management. An exception to this was the shop, where the contract was long-standing, monitoring being limited, with a poor hygiene status. However, this was identified by the organisation and the contract renewal was currently under consideration.

CM 8.2 (B → B)

The organisation involves contracted services in its quality improvement activities.

The organisation includes contractors in the area of quality improvement. The contract cleaning supervisor had documented processes for the evaluation of cleaning services. Independent evaluations were done by ward/department managers. Outcomes of the latter were discussed with the contract cleaning supervisor and infection control nurse. The internal hygiene audits were conducted on a quarterly basis and the outcomes reviewed by the infection control nurse and discussed with the relevant stakeholders. The organisation was encouraged to introduce trending to reinforce progress.

PHYSICAL ENVIRONMENT, FACILITIES AND RESOURCES

*Core Criterion

CM 9.2 (A ↓ B)

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

The organisation had relevant standard operating procedures in place for the management of its environment, facilities and equipment. These were evidence-based and reflected current legislation and best practice. The organisation should ensure full compliance in all areas, for example use of PPE at all times for waste handling and the creative use of space for waste segregation purposes.

CM 9.3 (B ↓ C)

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

The organisation was actively engaged in the continuous improvement of its Hygiene Services and had made considerable improvements in all aspects of its management and delivery, as well as infrastructural improvements. There was still considerable outstanding work in this latter area which was resource-related. Improvements to date were across all areas and were based on priorities identified. The organisation had a comprehensive long-term plan submitted to the Health Services Executive in 2006. It is recommended that the organisation continue to progress the provision of separate hand wash sinks in ward kitchens, develop a food safety policy for ward kitchens which takes account of night staff needs in relation to food preparation facilities for staff.

CM 9.4 (B ↓ C)

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

The organisation relied on voluntary feedback from patients and clients and the analysis of complaints to identify satisfaction with its services. The organisation was recommended to carry out patient and staff satisfaction surveys. Patients interviewed during the assessor's visit were positive in their views on the standards of hygiene experienced. It was also recommended to progress its Quality Improvement Plan (QIP) to include greater patient/client involvement in the evaluation of its Hygiene Services.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 (A → A)

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.

There were documented processes in place for the selection and recruitment of Hygiene Services staff in line with current legislation, with relevant job descriptions which identified each staff member's responsibility for hygiene. There was a small number of contract cleaning staff who had an on-site supervisor and the company was accredited to the ISO 9001:2000 quality management system. Human resource records for these staff (who work on this site only and function as regular hospital staff in all respects while on site) were forwarded to the organisation. The performance of contract staff was continuously supervised by the relevant ward/department manager and their supervisor. All other staffs performance was evaluated by the relevant ward/department manager.

CM 10.2 (A → A)

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.

Staff allocation and hours of service in specific areas was based on the British Institute of Cleaning Science (BICS) standards and the cleaning specification set out in the contract. Changes in the agreed arrangement were determined by the on-going assessments of the ward/department manager in conjunction with the contract cleaning supervisor as a result of the internal audit outcomes.

CM 10.3 (B → B)

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

Job descriptions identify any necessary pre-employment qualifications. Induction and on-going education are provided as necessary, for example Hazard Analysis and Critical Control Point (HACCP) infection control which includes hand hygiene, sharps, waste management and manual handling.

CM 10.4 (B → B)

There is evidence that the contractors manage contract staff effectively.

There were documented processes for the management of contract staff with identified reporting relationships. Their occupational needs, training and orientation were addressed through their supervisor, the infection control nurse and the occupational health service.

*Core Criterion

CM 10.5 (A ↓ C)

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

Hygiene Services needs were identified as a result of internal and external audit outcomes and through the evaluation of these by ward/department managers and contract cleaning supervisors — these needs being reflected in the contract for cleaning services. The organisation's Corporate Strategic Plan had been extended to include the Hygiene Corporate Strategic Plan. The organisation was recommended to develop a Hygiene Service Plan and produce an annual report.

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.

There was an induction programme in place for all staff which included hygiene education. Records were maintained by department managers. The organisation was recommended to consider centralised records also. One member of staff in each area was trained to provide hand washing instruction to all staff in that particular area. On-going education included hygiene, infection control and risk management. Staff were facilitated to attend education/training during rostered time. A comprehensive staff handbook was in place and the organisation was recommended to include a section on hygiene in the next edition.

CM 11.2 (A ↓ 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 organisation had a Director of Education and Research in place. All relevant on-going education in relation to hygiene services was provided. Internal/external facilitators were availed of. Attendance was monitored by the hospital management group. The relevance of specific education and training was determined by the line managers and adjustments were made where necessary.

CM 11.3 (A ↓ B)

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

Performance indicators monitored included incidents, complaints and attendance levels at training/education sessions. The effectiveness of education and training was evaluated through increased awareness and resultant submissions for improvements in clinical/non-clinical areas, hygiene audit outcomes, incidents and complaints levels.

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.

There was evidence of extensive compliance with this criterion across all areas of Hygiene Services. There was also evidence of continuous quality improvements based on the outcomes of internal/external audit reports.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (B ↓ C)

An occupational health service is available to all staff

The organisation had a contract with an external company for the provision of occupational health services for all staff including contract staff. The service included the provision of necessary vaccinations. The organisation had an identified liaison arrangement with the company. The organisation was recommended to formally evaluate the service provided and include a staff satisfaction survey.

CM 12.2 (B ↓ C)

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

There was evidence that the organisation reviews relevant performance indicators, and make changes as necessary on an on-going basis. Staff satisfaction is based on complaints, attendance turnover and exit interviews. The organisation is recommended to implement staff satisfaction surveys.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.1 (B ↓ C)

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

The organisation collects information through the Health Services Executive, the professional regulatory bodies and other sources. This is disseminated through the hospital management group to the relevant departments and committees which are responsible for making recommendations to management for its local application, development of draft policies and procedures to ensure its implementation. Data collected internally includes reports from risk management, infection control, activity/budget statistics and attendance records. The organisation was recommended to establish processes for the evaluation of data reliability, accuracy and validity.

CM 13.2 (B → 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.

Reports generated included Infection control, waste management, health and safety, complaints and internal/external audits. Reports were presented in a manner which was user friendly and evaluated. They were discussed with the relevant line managers and action points agreed and progressed.

CM 13.3 (B ↓ C)

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

Developments introduced in the last two years included the establishment of a new incident reporting system, risk management department, internal audits and the use of computerised systems for communication with staff. A comprehensive series of reports were generated and circulated to management and staff. The organisation is recommended to evaluate data collection and information utilisation in relation to hygiene service provision in the context of establishing a continuous QIP.

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.

It was obvious that this organisation was committed to the delivery of a high standard of hygiene and to its continuous quality improvement. Hygiene was on the agenda of all hospital management group, directorate and all other relevant committee meetings. There was evidence of an organisation-wide approach to addressing the shortcomings in the current hospital infrastructure and fittings. Audit reports were considered and reviewed by all relevant committees across all levels of the organisation.

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 organisation made significant progress in the development of its hygiene services over the last two years. Of particular note was the organisation-wide commitment to continuous quality improvement and the inclusion of hygiene and the consideration of audit outcomes on the agenda of all management meetings. The whole approach to individual responsibility for hygiene and the knowledge of staff was noteworthy. The establishment of the Hygiene Services Team and its work to achieve the current state of physical and practice development were commendable. The outcomes of the internal audits were evidence of this progress. The organisation recognised the gaps that still existed in relation to the physical developments.

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.

There were comprehensive hospital policies, procedures and guidelines which have been adapted from the best practice guidelines of a number of areas, including cleaning protocols, cleaning of equipment, linen, and waste. The catering department complies with the ISO 340 standard.

Evidence was provided of best practice documentation which influenced the adaptation of local hospital policies, such as National Cleaning Manual, National Laundry Guidelines, Segregation of Waste, Department of Health and Children (DOHC) and ISO 340. The hospital supports the training and education of the staff when new policies are introduced by facilitating protected study time and there was documented evidence of training being available to support this criterion. While substantial audit activity is carried out in the hospital, including continuing evaluation, feedback and action plans, there has been no evaluation of this criterion. A documented process for the establishment of nursing and infection control policies was observed. It is recommended that this process is established for all hospital PPGs. It is recommended that the hospital would develop a documented process for the establishment, maintenance and evaluation of best practice guidelines.

It is further recommended that the efficacy of the process when developed be evaluated.

SD 1.2 (B → B)

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

There is a process for assessing new hygiene interventions and a documented process through the Hygiene Services Team and the hospital procurement policy and procedure. The procurement policy ensures that all changes to procurement practice is researched and pre-purchase evaluation is carried out with the service requesting change, such as hygiene services. Pre-purchase evaluation documentation was observed in a number of areas — alcohol hand rub, colour-coding of cleaning trolleys, buckets and cleaning agents. Departmental managers submit their requirements and these are discussed at the Hygiene Services Team meetings. This was evidenced in the minutes of the team meetings and in the procurement and contracts documentation submitted. Quality Improvement Plans (QIPs) for the hospital include the establishment of a procurement committee.

It is recommended that the hospital would continue to evaluate new hygiene service interventions and products post-purchase. It is recommended that the hospital evaluate the efficacy of the assessment process for new interventions.

PREVENTION AND HEALTH PROMOTION

SD 2.1 (A ↓ 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.

There were information leaflets available throughout the hospital on hand washing procedures for both staff and community. There was a comprehensive suite of patient infection control and clinical patient information leaflets. The hospital actively liaises with GPs and community nursing services in relation to infection control. The hospital developed a number of annual national conferences and educational programmes; hygiene and infection control are standing order topics during these conferences. This was evidenced in the conference agendas. There are QIPs in place which will continue to develop this criterion, such as additional information leaflets, expanding local linkages and hygiene awareness. It is recommended that the efficacy of the activities carried out are evaluated by the team.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1 (B → B)

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

There is a multi-disciplinary Hygiene Services Team which has clear terms of reference, membership and circulation list, accountability and documented responsibilities. This team reports to the Hygiene Services Committee and is involved with the recommendation for purchase and the pre-purchase programme for equipment. There are comprehensive QIP plans in place to continue to develop the team process, including expanded membership on a needs basis and continuing audit. It was recommended that the Hygiene Services Team would evaluate the efficacy of its team structure.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

SD 4.1 (A ↓ B)

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

The general environment in this criterion was good. There were good warning signs present, the brass door plates were gleaming and a very good process for curtain changing was in place. A number of areas need to be addressed, such as high dusting and general flaking of paint. Some floors were damaged and wooden floors were not intact. Some inappropriate carpets in some areas required attention. Some internal signage needed to be renewed. The general external environment required immediate attention at the time of the assessment and in the main this was addressed. However, attention to detail in the external areas was advised.

For further information see Appendix A.

*Core Criterion

SD 4.2 (A ↓ B)

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

In general the organisation's equipment, medical devices and cleaning devices were managed and clean. There were policies, procedures and guidelines which reflected the hospital policy and required practice for this criterion.

It is recommended that the hospital review its washbowl and patient belongings procedures to reflect best practice. It is also recommended that the hospital review its use of fans throughout the hospital and that it ensure that office equipment is managed and clean.

For further information see Appendix A.

*Core Criterion

SD 4.3 (A → A)

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

In general the standard of cleanliness for the organisation's management of its cleaning equipment is to a high standard. It is recommended that the hospital review its practice of joint sluice and domestic services storage.

For further information see Appendix A.

*Core Criterion

SD 4.4 (A → A)

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

The overall standard in this criterion is very good and complies in most areas. However, ward kitchens should not be used as staff areas. The organisation is addressing the recommendations from the EHO report of 2005 and the outcome of the 2007 report was awaited.

For further information see Appendix A.

*Core Criterion

SD 4.5 (A ↓ B)

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

A system of waste management was in place. However, there was further work to be done in relation to the management and storage of healthcare risk and special waste. The external store needs to be sub-divided into separate special waste areas and spill kits need to be available in this area. Training of the designated officer needs to be completed and development of the waste files should be considered.

For further information see Appendix A.

*Core Criterion

SD 4.6 (A → A)

The team ensures the organisation's linen supply and soft furnishings are managed and maintained.

The linen process was of a very good standard. Documentation of clean linen to wards from linen store area should be documented and recorded. Separate closed linen store for clean and dirty linen is recommended. A written policy is required for the internal hospital washing machine process.

For further information see Appendix A.

*Core Criterion

SD 4.7 (A ↓ B)

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

Hand hygiene techniques were observed and facilities and training are in place in the organisation. The hospital should review its quantity and location of waste bins. The hospital has a QIP for the upgrading of all wash hand facilities.

The hospital should strategically place hand hygiene posters near to hand hygiene alcohol and sink positions.

For further information see Appendix A.

SD 4.8 (B ↓ C)

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

The organisation has risk management policies, procedures, and incident reporting in place. Incident reports are dealt with in a timely manner. There are mechanism for management reports, trend analysis and outcomes and actions in place. There is an excellent Health and Safety Statement with hazard risk analysis. There is a suite of infection control, hygiene and HACCP linen and waste plans in place with internal and external audits, feedback and actions plans.

It is recommended that all areas which will be subject to construction should have an Aspergillus risk assessment.

SD 4.9 (B ↓ C)

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

Service user/patients are encouraged to participate in a clean hospital. Information available on the clinical hygiene issues for patients. Information on hand hygiene and adherence to visiting policy and the discouragement of flowers are all evidence that the hospital is encouraging patients to help improve hygiene services. There was no patient forum and there are no patient satisfaction surveys completed at the hospital for hygiene services.

It is recommended that the hospital commence the process and evaluation of patient satisfaction. It is also recommended that the hospital include a service user in the hygiene process who would be part of the Hygiene Services Team.

PATIENT'S/CLIENT'S RIGHTS

SD 5.1 (B ↓ C)

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

The hospital respects the rights and dignity of the service user through its adherence to the 'Trust in Care' policy and professional codes of conduct.

The hospital's code of ethics incorporates the rights, privacy and confidentiality of the patient/service user. The hospital's Patient Charter was being observed. Internal notices were observed in relation to privacy, dignity and confidentiality. A documented medical records agreement was in place in relation to the labelling of records for infection control purposes. Incident reporting procedures and disciplinary procedures were available to deal with breaches of confidentiality.

It was recommended that the hospital evaluate violation of confidentiality and evaluate the efficacy of the dignity process for patients.

SD 5.2 (B ↓ C)

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

There was hand hygiene signage throughout the hospital. It was recommended that the signage at hand hygiene alcohol rub stations be reviewed as a number of stations were without relevant information. A visitor policy was in place, displayed at the front entrance as was hand hygiene information. It was recommended that the hygiene information provided at entrances to the hospital is reviewed and strengthened. No patient satisfaction of the Hygiene Services was carried out at the time of assessment. The hospital had identified the need for a patient satisfaction survey as a QIP.

SD 5.3 (B → B)

Patient/client complaints in relation to hygiene services are managed in line with organisational policy.

There was a documented process in place for the management of patient complaints. This process ensured timely management, reporting and feedback on complaints received. A complaints register was in place. Complaints, outcomes and solutions were developed as was feedback to the hospital service/departmental head of the service involved. Complaint trends were analysed.

It was recommended that a more structured approach be adopted towards feedback and QIPs.

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1 (B ↓ C)

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

There was some evidence that the hospital council carried out inspections of the hygiene services on an infrequent basis, as ensuing comments were minuted in council meetings and inspection reports.

There was a complaints procedure in place, but no patient comment cards were in use. This was a QIP identified by the hospital.

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.

There were excellent and comprehensive systems of internal audit in the hospital. This was observed in the documentation which was presented. The hospital audited, evaluated and provided feedback in its reports to all departments. There was evidence of trend analysis charts and the hospital benchmarks itself internally with other departments and nationally against standards available. The hospital benchmarked itself against previous national hygiene audits (2005 and 2006). The hygiene contractors on site audited its services on a weekly basis and the results were presented to the Hygiene Services Team. The hygiene contractor was a member of the Hygiene Services Committee.

It was recommended that the Hygiene Services Team continue to complete evaluation and to ensure that the results of audits are placed on the agenda of annual reports.

SD 6.3 (B ↓ C)

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

There was annual hygiene services report available at the time of assessment. A hospital annual report was published which had input from staff, heads of department and the hospital governing board. There was no involvement from service users and this was recommended. It was recommended that the hospital would compile an annual hygiene services report in line with its documented processes when developed.

4.0 Appendix A

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

4.1 Service Delivery Core Criterion

Compliance Heading: 4.1.1 Clean Environment.

(1) The environment is tidy, well-maintained, free of rust, blood or body substances, dust, dirt, debris and spillages.

Yes - While there is no hospital-wide ventilation system, areas with ventilation such as Out-patient Department (OPD) were compliant with this criterion.

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

No - High dusting and flaking paint observed in a number of areas.

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

No - Floor tiles damaged and wooden flooring not intact. Some carpets areas inappropriate and need to be reviewed, such as Radiology and Day Ward.

(6) Free from offensive odours and adequately ventilated.

Yes - Toilet beside lecture theatre needed attention.

(7) Areas should be adequately ventilated with ventilation units cleaned and serviced accordingly and documentation available regarding service.

Yes - While there is no hospital-wide ventilation system, areas with ventilation such as Out-patient Department (OPD) were compliant with this criterion.

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

No - In general the entrance and exit areas to the hospital needed more attention.

(9) Where present, main entrance matting and mat well should be clean and in good repair.

No - Mat at front door requires attention.

(10) Internal and external signage should be clean, updated, well maintained and laminated to enable cleaning.

No - Internal signage in a number of areas requires renewal and lamination.

(12) Internal and external stairs, steps and lifts must be clean and well-maintained.

Yes - Clean but some damaged areas.

(13) External areas including grounds, gardens, footpaths, ramps and car parks should be clean and well-maintained.

No - The external areas of the hospital, including specimen bottles, needed further attention. This issue was addressed on the first day of the assessment.

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

No - A number of bins needed further attention.

(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 needed attention.

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

(18) Walls, including skirting boards.

Yes - Wall clean but in need of painting.

(19) Ceilings.

Yes - Some flaking paint observed.

(20) Doors.

Yes - Clean but damaged and in need of paint.

(21) Internal and External Glass.

No - External glass needed greater attention. In the main, internal glass was clean but some sticky tape residue was observed.

(23) Radiators and Heaters,

Yes - Clean but in need of painting,

(25) Floors (including hard, soft and carpets).

Yes - It is not recommended that carpets are used in public or clinical areas. This is being addressed on a phased basis.

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

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

Yes - Clean, but there were a few exceptions. Some wooden shelving in use should be reviewed.

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

(34) Beds and Mattresses.

Yes - One dirty mattress was found after a bed had been vacated and cleaned.

(35) Patient couches and trolleys.

Yes - It is recommended that all wooden examination couches are replaced.

(39) Waste Receptacles (e.g. sani-bins, nappy bins, sharps bins, leak proof bins)

No - A number of bins were observed to be not fully compliant.

(41) Door handles and door plates.

Yes - The hospital is to be commended on its shiny brass door plates.

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

(51) Baths and Showers.

Yes - Mould was observed in the shower in the male toilets beside the lecture theatre. The old shower in this area needs to be removed.

(54) Wash-Hand Basins.

Yes - Clean but not all compliant.

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

No - Many sluice rooms were small and cluttered.

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

Yes - No shower curtains observed.

(60) All outlets (including shower outlets) should be flushed at a temperature in accordance with current legislation.

Yes – There is a policy in place, however, this should include all areas.

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

(64) All equipment, including component parts, should be clean and well-maintained with no blood or body substances, rust, dust, dirt, debris and spillages.

Yes - Some drip stands in the Accident and Emergency Department needed attention.

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

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

Yes - An old but clean weighing scales was in limited use.

(68) Patient fans, which are not recommended in clinical areas.

No - Patient fans observed in A&E, and OPD. It was recommended that these be removed.

(69) Patient washbowls should be decontaminated between each patient, and should be stored clean, dry and inverted. Damaged washbowls should be replaced.

No - Patient washbowls should be dry and inverted when not in use.

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 - Patients personal items including suitcases stored in an enclosed unit such as a locker/press.

(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.

Yes - Flowers vases were not observed to be in use.

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

No - A number of departments observed needed a cleaning programme for these items.

(272) Splashes of water or hand-wash gel should not be present on the wall, floor, bed or furniture, splash backs should be provided.

Yes - Splash backs were recommended.

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

(82) Vacuum filters must be changed frequently in accordance with manufacturer's recommendations — evidence available of this.

Yes - New machines in use.

(85) Cleaning solutions should only be prepared in a well ventilated area and should never be mixed.

Yes - Mixed for general use in a centralised area.

(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 - No dedicated domestic store area which fulfils this criterion.

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

No - Consumables in locked room but on open shelves.

(95) When using electrical cleaning equipment, a circuit breaker should be used if appropriate and the equipment should be plugged in while switched off using dry hands.

Yes - All cleaning equipment new.

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

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

Yes - The EHO reports available was 2005 and issues were being addressed. The 2007 report was awaiting.

Compliance Heading: 4. 4 .2 Facilities

(219) Ward kitchens are not designated as staff facilities.

No – They are used as a staff facility at night.

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

No - Night staff prepared food in the ward kitchen. It is recommended that an alternative arrangement is put in place for provision of night staff meals.

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

No - QIP in place and at time of assessment two ward kitchens complied and two wards were in need of upgrading.

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

Yes - Separate toilet areas were observed.

Compliance Heading: 4. 4 .4 Pest Control

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

Yes - This was observed on file.

(239) Fly screens should be provided at windows in food rooms where appropriate.

Yes - All clean and intact.

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 - Fresh food operation was in place.

(241) Ice cream display units can operate at -12°C as long as it can be demonstrated that the product has been held at this temperature for less than 7 days.

Yes - No ice cream display unit was observed, ice cream was stored in a freezer which is compliant with the required -12°C

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 - No frozen food supplied.

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.

No - Audit trail not completed by the hospital.

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

Yes - Not required by Dublin City Council.

(253) Personal protective equipment is accessible to all staff involved in the generation, collection, transport and storage of waste.

No - Protective equipment not used/none used in waste compound. This was addressed during the site visit.

Compliance Heading: 4. 5 .2 Maintenance of Records

(254) Documented process(es) for the retention of waste traceability records, certificates of destruction, consignment notes (C1 forms) and trans Frontier Shipment (TFS) tracking forms for at least 12 months. These should be retained for all hazardous waste types.

Yes - TRS forms not available on site.

Compliance Heading: 4. 5 .3 Segregation

(255) Within healthcare risk waste, all special wastes including drugs & cytotoxic drugs/materials are segregated.

Yes - This area needs further consideration.

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

No - This was not observed.

(158) Needles and syringes should be discarded as one unit and never re-sheathed, bent or broken.

Yes - Sharps containers require further training in their use.

(162) Hazardous wastes (chemical etc) must be segregated, stored and disposed of correctly.

No - Further attention to segregation required.

Compliance Heading: 4. 5 .4 Transport

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

No - Hospital unaware of drivers' training levels.

Compliance Heading: 4. 5 .5 Storage

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

No - No appropriate warning signs were displayed.

(258) Waste receptacles should be sanitised, secure and in a good state of repair when used.

No - A policy was in place, but bins need further attention.

Compliance Heading: 4. 5 .6 Training

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

No - As no designated person was in place it was recommended that waste management training should be provided.

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

Yes - Documented records were observed. Records were also kept in personnel file and staff information computer system.

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

(174) Clean linen is stored in a designated area separate from used linen (not in sluice or bathroom).

Yes - It is recommended that the wooden storage for linen is replaced.

(261) Clean linen store is clean, free from dust and free from inappropriate items.

No - Shared storage with general ward stores.

(268) Ward based washing machines are used only with the agreement of the Hygiene Services Committee.

Yes – The washing machine was in use for mops and used by hygiene contractors.

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

Yes - Shared service with stores. It is recommended that a central line store is created.

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

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

No - There was an absence of splash backs on a large number of sinks, but there was a QIP in place and this project was on-going.

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

No - Not all taps were hand free or of mixer type. A QIP was in place and work was on-going.

(196) Waste bins should be hands free.

No - Not all bins were foot operated. Some bins were open. It was recommended that all bins should be hands free and closed.

(197) Wall mounted/pump dispenser hand cream is available for use.

No - Hand cream was available but this should have been wall mounted.

(198) Hand hygiene posters and information leaflets should be available and displayed throughout the organisation.

Yes - Hand hygiene posters were available.

(204) Hand wash sinks conform to HBN 95. They should not have plugs, overflows and the water jet must not flow directly into the plughole.

No - A QIP was in place.

(205) General wards should have one sink per 4-6 beds and critical areas should have one sink per 1-3 beds.

No - A QIP was in place.

Compliance Heading: 4. 4 .10 Plant & Equipment

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

Yes - No ice machine was in use at the hospital.

(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 – There was no digital readout on the main kitchen dishwashers. There were new dishwashers in some wards which had digital readouts. It was recommended that a mechanism of validation is implemented in line with HACCP recommendations.

(251) All temperature probes shall be calibrated annually. Calibration may be carried out internally or externally (instrumentation firm). Documentation should be retained of the procedures used to control, calibrate and maintain inspection, measuring and test equipment used to demonstrate compliance with the HACCP Plan.

Yes - Annual calibration records retained.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team		Assessor Team	
	FREQ	%	FREQ	%
A	23	41.07	7	12.50
B	33	58.93	30	53.57
C	0	00.00	19	33.93
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	B	C	↓
CM 3.1	A	C	↓
CM 4.1	B	B	→
CM 4.2	B	B	→
CM 4.3	B	B	→
CM 4.4	B	B	→
CM 4.5	B	C	↓
CM 5.1	A	A	→
CM 5.2	A	B	↓
CM 6.1	A	C	↓
CM 6.2	B	B	→
CM 7.1	A	C	↓
CM 7.2	A	B	↓
CM 8.1	A	B	↓
CM 8.2	B	B	→
CM 9.1	B	B	→
CM 9.2	A	B	↓
CM 9.3	B	C	↓
CM 9.4	B	C	↓
CM 10.1	A	A	→
CM 10.2	A	A	→
CM 10.3	B	B	→
CM 10.4	B	B	→
CM 10.5	A	C	↓
CM 11.1	A	B	↓
CM 11.2	A	B	↓
CM 11.3	A	B	↓
CM 11.4	B	B	→
CM 12.1	B	C	↓

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