



Hygiene Services Assessment Scheme

Assessment Report October 2007

Sligo General Hospital

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1.0 Executive Summary

1.1 Introduction

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

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

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

Hygiene is defined as:

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

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

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

1.1.1 Standards Overview

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

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

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

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

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

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

Core Criteria:

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

In the Corporate Management standards, the core criteria cover:

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

In the Service Delivery standards, core criteria cover:

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

1.1.2 Rating Scale

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

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

A Compliant - Exceptional

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

B Compliant - Extensive

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

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

1.1.3 Assessment process components

The assessment process involves four distinct components:

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

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

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

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

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

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

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

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

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

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

- **Continuous Improvement**

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

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

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

Sligo General Hospital is part of Network 4, Western Region of the Health Service Executive (HSE) and currently has a total of 323 in-patient beds and 36 day beds. The Hospital serves an area of 2,600 square miles with a population of 213,000 for the regional specialities and focuses in on the counties of Sligo, Leitrim, South Donegal and West Cavan (110,000) for its general acute service. In addition, some regional services are provided which include all of county Donegal which gives a population catchment of 213,000 for these services.

Services provided

The mainstream acute services provided are:

- Anaesthesia,
- Cardiology,
- Diabetology,
- Dermatology,
- Emergency Medicine,
- ENT,
- Gastroenterology,
- Geriatrics,
- Haematology,
- Medicine,
- Microbiology,
- Nephrology,
- Obstetrics/Gynaecology,
- Oncology,
- Ophthalmology,
- Orthopaedics,
- Oral and Maxillofacial,
- Orthodontics,
- Paediatrics,
- Palliative Medicine,
- Pathology,
- Radiology,
- Respiratory Medicine and Surgery.

Services which are structured on a regional basis with support provided to Letterkenny General Hospital include ENT, Ophthalmology and Dermatology Services. Out patient clinics are also provided at community hospitals. A regional Rheumatology service is based at Our Lady's Hospital, Manorhamilton.

Consultant Services in Immunology and Radiation Oncology are provided via University College Hospital, Galway with additional Consultant Radiation Oncology services provided from St. Luke's Hospital, Dublin.

Physical structures

Single rooms used as isolation rooms as required. There are a limited number of designated isolation rooms with Ante chamber for the storage of appropriate Personal Protective Equipment (PPE).

There is one isolation room in Intensive Care Unit with air conditioning but not maintained at negative pressure.
In addition, there are two isolation rooms in Renal Dialysis Unit.

The following assessment of Sligo General Hospital took place between 12th and 13th of September 2007.

1.3 Notable Practice

- The organisation is to be commended on its management of waste.
- Education and training within the Catering Department is to be commended.
- Hazard Analysis and Critical Control Point (HACCP) processes are well documented.
- Management commitment to the development of a hygiene-orientated culture is to be commended.
- Adherence to hand hygiene and uniform policy was of a high standard.
- The Accreditation Team are to be commended on their commitment to the development of processes in relation to hygiene assessment.

1.4 Priority Quality Improvement Plan

- It is recommended that the hospital prioritise the upgrading of the operating theatres, endoscopy, CSSD, linen receiving room and the air conditioning/storage in the neonatal unit.
- It is recommended that the organisation perform a human resource needs assessment as a matter of priority.
- It is recommended that the organisation review and update the systems for receiving, monitoring and evaluation of environment repairs and their completion.
- It is recommended that the organisation perform an evaluation of the appropriateness of the occupational services for their staff.
- It is recommended that all ceiling tiles and light shades are replaced and systems are introduced to replace same.

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 Sligo General 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.

A comprehensive multi-disciplinary approach in assessing and updating current and future hygiene needs is used. The multi-disciplinary Quality Circle (which includes consumers) is a sub group of the Environmental and Facilities Committee. Members of this circle assist with identification of structural, hygiene, human resource and other hygiene needs. There is a need to redefine hygiene staff duties and ongoing maintenance requirements are required. Needs are identified through hygiene related reports, survey results, review of best practice guidelines/legislation and information. An example would be the need to upgrade hand wash sinks and water tanks. There was evidence that the information collected was utilised in the development of the Corporate Hygiene Strategic Plan. Also evidence was provided on quarterly evaluation of the needs and progress in resolving issues identified.

CM 1.2 (A ↓ B)

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

The organisation has used a multi-disciplinary team approach to identify and review hygiene needs of the population served and have demonstrated a comprehensive list of improvements which include: development of business proposals such as refurbishment/development of neonatal and day assessment unit; redefining duties for catering, porter and housekeeping staff; purchasing of new furniture and equipment; development of an equipment replacement matrix; refurbishment of staff restaurant/ward kitchens; upgrading of hand wash facilities and showers; development of information leaflets/waste disposal handbook and the introduction mandatory hand hygiene training. Evaluation of development and modifications, in meeting the service user's needs, was observed through consumer committee minutes, staff, patient/client surveys and audit reports. Evidence was observed of resultant actions and feedback (for example development of painting programme and communication of quality improvement plans). It is recommended that the organisation review that painting programme and include defined timescales with estimated completion dates.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1 (A ↓ B)

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

Evidence was observed that the organisation has comprehensive hygiene-related linkages with relevant external and internal bodies including the Department of Health & Children and the Health Services Executive. The organisation has processes in place to work in partnership with staff, and patient/clients, as is evident from committee minutes viewed. Examples include: the Support Services Partnership Group, the Communications Group, and the Quality Circle Group.

A consumer and partnership representative is a member of the Quality Circle Group. Internal linkages were strengthened through the use of link persons within wards and departments. The comprehensive hospital newsletter, which is developed by the Communications Group, in partnership with the Health Promotion Group is commended.

Some evidence of evaluation of efficacy of linkages was observed in areas such as Support Services Partnership Group. It is recommended that the organisation formalise the process for evaluation of all its linkages and partnerships.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 (A → A)

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

Evidence was observed that the hospital Corporate Strategic Plan 2007-2010 was developed by the Executive Management Team, with input from multi-disciplinary groups and consumers. Goals and objectives, which cover all hygiene-related areas were clear, comprehensive action plans with responsibilities were developed, with time scales and cost implications included.

Evidence was observed that the plan was communicated to staff and the Consumer Group via e-mails and hard copies of the plans were observed at ward level. Staff interviewed was also aware of the location of the plan within their area. Evidence was observed that the progress on implementation of the actions was evaluated quarterly with feedback to the Hospital Management Team.

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 responsibility for the hygiene services at the hospital was clearly defined, with overall responsibility lying with the Hospital Management Committee, which is the most senior management team at the hospital. The responsibility for hygiene is devolved through the Hygiene Services Committee structure to the chairpersons of speciality management teams and subsequently to the ward/department and/or speciality manager. Direct links are maintained between the Hospital Management Committee and speciality management teams. A suite of corporate policies was

observed. Evidence that the Hygiene Services Team adhere to legislation and best practice, with resultant actions and feedback was observed.

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.

Current best practice information is used in developing corporate and hygiene-related policies and guidelines. All staff has access to a comprehensive library with teleconferencing/video conferencing facilities, the intranet, including catalogue databases. A list of best practice information was provided and was observed on the intranet. These included journals and corporate/hygiene related policies and guidelines. Quality initiatives, in relation to best practice information, included the use of corporate and hygiene-related policies on the intranet; the provision an online evaluation system; development of a risk management structure, introduction of a smoking cessation service; recycling initiatives and mandatory risk/hand hygiene training. Staff is informed of latest best practice information by e-mail; through ongoing education and through a comprehensive hospital newsletter issued at least three times a year. Support for educational activities relating to hygiene was observed and included food hygiene, Hazard and Critical Control Point (HACCP), FETAC. Evidence of evaluation of hygiene best practice information was observed and was in progress at the time of the assessment.

CM 4.4 (B ↓ C)

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

The organisation is in the process of introducing a computerised programme for managing the development, review date and distribution of all hospital policies, procedures and guidelines. Evidence was observed that a Policy and Procedure Committee was developed to oversee this project. An agreed policy template was utilised for the development of policies. Evidence was observed that current corporate policies and procedures are approved through the Hospital Management Operation Committee and plans are in progress to approve all policies/procedures through this committee. A system was observed for the management of hygiene-related infection control policies and all those observed were current and in line with best practice guidelines/legislation. Surface/equipment cleaning methods are included in the Infection Control Cleaning/Disinfection/Sterilisation Policy. It is recommended that the environmental/equipment cleaning policy is independent of the disinfection/sterilisation policy. The introduction of the computerised system for managing the development of all policies, procedures/guidelines, and developing a process for evaluation the efficacy of the process when in place, is encouraged.

CM 4.5 (B ↓ C)

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

The assessors were informed that the Hygiene Services Committee was involved in capital planning and refurbishment projects through their infection control representative and that the users of the services are involved in the consultation process. This was observed in the Refurbishment Project Report. It is recommended that the Hygiene Services Team and infection control/cleaning service are involved during all stages of capital planning and refurbishment projects. It is also recommended that the organisation develop formal planning processes, which

includes infection control/hygiene service involvement and the evaluation of the capital planning/refurbishment projects.

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.

The hygiene service structure is defined clearly in the organisational chart. Roles responsibilities and accountabilities for hygiene were clearly outlined in job descriptions. Reporting structure to the Environment & Facilities Committee is through the direct line management system and through each discipline representative. The deputy General Manager, who is chairman of both the Environment & Facilities and Hospital Management Operational Committees reports directly to the Hospital Management Committee on hygiene-related matters. The organisation has evaluated the current hygiene structure and has developed a new draft hygiene structure under the corporate quality improvement framework.

*Core Criterion

CM 5.2 (A → A)

The organisation has a multi-disciplinary Hygiene Services Committee.

Evidence was observed that the multi-disciplinary Environment & Facilities (hygiene service) Committee met on a two-monthly basis and that administrative support was provided. Terms of reference for the committee are in place and the role of each member is outlined. This committee reported through their representative to the Deputy General Manager and to the Hospital Management Operational Committee, via the Management Operational Committee to the Hospital Management Committee. The Hygiene Services Team, whose membership consists of representatives from each speciality management team, reports to the Environment & Facilities/Hygiene Committee through its representative. For example infection control, catering and hygiene services managers.

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

*Core Criterion

CM 6.1 (A → A)

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

A process was observed for the acquisition and allocation of resources to the hygiene services, which is based on the prioritisation. The Hygiene Strategic Plan, and relevant business proposals, are submitted to the network manager, who has responsibility for negotiating required funding for the projects. Needs, as outlined in the plan, are outlined in the HSE funding requirements at regional level. Capital and minor capital funding was allocated and defined for the hygiene service during the last two years. Evidence was observed that significant funding was made available on the basis of hygiene needs assessment as outlined in the Corporate Hygiene Strategic Plan. Examples include: the upgrade of three ward kitchens, purchase of fire retardant foot operated bins, upgrade of hand wash sinks, showers, replacement of water tanks and furnishing. It was evident that the organisation monitored expenditure on hygiene service activity on a monthly basis.

CM 6.2 (A ↓ C)**The Hygiene Committee is involved in the process of purchasing all equipment / products.**

The Health Service Executive's equipment/product procurement policy is in place. Evidence was observed that a hygiene team and Environment & Facilities Committee member is involved in the procurement process (for example glove review). Evidence was observed of communication between the Hospital Services Team and the governing body, relating to the purchase of equipment/products, through minutes of meetings observed. An example would be the development of an equipment replacement matrix. It is recommended that the organisation develop processes for the evaluation of the efficacy of the consultation process between the Hygiene Services Committee and the Governing Body.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

CM 7.1 (A → A)**The organisation has a structure and related processes to identify, analyse, prioritise and eliminate or minimise risk related to the Hygiene Service.**

A comprehensive Risk Management System is in place and included a multi-disciplinary patient/client safety/risk management committee. There was evidence that the organisation has appointed a Risk Advisor and administrative support. The health & safety statement was observed. A patient/client safety/risk strategy and committee is in place. Evidence was observed that the organisation has a current incident/near miss policy and sentinel/ high risk/adverse incident policy. A comprehensive incident reporting and analysis system was also in place. Verbal evidence was provided that incident reports are reviewed by the Hospital Management Team and issues identified addressed, followed up at department level. Verbal evidence that education on root cause analysis had commenced was also provided. Evidence was observed of internal risk management audits, fire assessment, internal hygiene audits and EHO reports with resultant actions. There were no major hygiene-related adverse events reported over the last two years.

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.**

Evidence was observed that risk management practices are actively supported by the governing body, through the appointment of a Risk Advisor and the provision of risk management induction and on-going education. The Patient/Client Safety/Risk Management Committee is multi-disciplinary with representation from the Hygiene Services Committee (for example the deputy general manger). Clear processes are in place for risk identification, reporting, analysis minimisation and elimination. Evidence was observed that health & safety and EHO evaluations were acted upon and followed up.

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.

All large contracts are managed on a national and regional basis. Evidence was observed that the organisation managed and monitored local contracts, including professional liability, compliance to health & safety regulations and education, in line with best practice guidelines. Verbal evidence was provided that on-site contractors are monitored through the maintenance manager. Evidence was observed that infection control monitor the building contractors' compliance to dust control measures. Details of new contracts were observed.

CM 8.2 (B ↓ C)

The organisation involves contracted services in its quality improvement activities.

Evidence was observed that the organisation involves contractors in improvement activities such as the change of days/frequency in waste collection. The non-risk waste contractors are actively involved in the environment awareness days at the hospital and recycling representation attended the Green Team meetings on recycling initiatives. It is recommended that the organisation evaluate the efficacy of the initiatives completed.

PHYSICAL ENVIRONMENT, FACILITIES AND RESOURCES

CM 9.1 (B ↓ C)

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

The new building's design is in line with best practice design specifications. An example would be the Renal Dialysis Unit and Day Assessment Unit. Evidence of evaluation of the current building included health & safety and fire safety reports with follow up actions and feedback to the Patient Safety/Risk Management Committee. However, there were elements, within the current building, which is an older design, that require upgrading. Evidence of an ongoing painting programme was observed, however it recommended that timescales are defined. The upgrade of the operating theatres, neonatal unit (air condition/storage), endoscopy, HSSU and linen receiving room need to be addressed, to reflect best practice. Infrastructural issues in endoscopy and HSSU were highlighted during the decontamination audit and expressed during the assessment.

*Core Criterion

CM 9.2 (A ↓ C)

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

Evidence was observed that the hospital has a process in place for the management of its environment and facilities through the recognition of ongoing developments and upgrading of facilities. Ward kitchens and patient/client bathrooms are examples of this.

While documented processes were observed for the planning and managing of facilities including equipment, devices, kitchens, waste, sharps and linen, It was mentioned by many staff that there are a number of on going maintenance issues identified which have not been addressed, despite several requests being made. The maintenance personnel are currently completing repair work and providing maintenance to the hospital. No systematic approach for the prioritisation of maintenance work was observed and no documented evidence/records of work completed was observed. The operating theatre and endoscopy unit require maintenance work in the near future.

It is recommended that a comprehensive system is implemented to record, prioritise and assess repair works required/performed be developed and ensure regular evaluation of systems is performed. It is also recommended a human resource needs assessment be carried out to ensure that there are the necessary maintenance available to provide the services required. A painting programme was observed and the organisation is encouraged to include defined timescales for this.

CM 9.3 (A ↓ 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.

Evidence of this through hygiene audits results, EHO reports patient/client, staff satisfaction survey reports and comment card reports. Changes made to the environment included upgrade of the Day Assessment Unit, canteen, water tanks and ENT department. It is recommended that the organisation review processes for the provision of a timely environmental repair service and formalise the process for risk rating works/repairs requests. The monitoring/recording and evaluation of repair works must also occur.

CM 9.4 (A ↓ B)

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 actively encourages patient/client and staff feedback through the provision of comment cards, patient/client surveys and complaints procedure, all of which include a section on hygiene. An active consumer panel is in place, which provides feedback in relation the hygiene services and a representative sits on the Hygiene Services Committee. Evidence of evaluation of surveys/comment cards was observed. The organisation has demonstrated that it has implemented recommendations following receipt of feedback from both the consumer and staff. Examples include the upgrade of patient/client showers, hand wash sinks ward kitchens and staff canteen.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 (A ↓ B)

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

Evidence was observed that a comprehensive human resource recruitment process is in place, which is in line with current national legislation and best practice guidelines. Roles, authorities, responsibilities and accountabilities were clearly outlined in six job descriptions viewed. Contracts for contracted services such as

window cleaners outlined the reporting mechanism to the organisation. Evidence was observed that evaluation of the human resource process is performed.

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.

Evidence was observed that a review was performed of hygiene services human resources, which was based on work capacity and volume. Changes made as a result included the rostering of additional cleaning staff to the 4pm–12midnight shift and changes to cleaning roles of both the health care assistants and porter staff, through the partnership process. Evaluation of the effectiveness of the provision of additional evening services in these was observed. Evidence was observed that human resource needs (including cleaning staff needs) were incorporated into business proposals for new development/refurbishments. For example the Day Assessment Unit. It is recommended that the organisation extend the human needs assessment process to include an assessment of the maintenance needs, based on work capacity and volume. The organisation is encouraged to continue with evaluation of work capacity and volume of the cleaning service on a regular basis.

CM 10.3 (A ↓ B)

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

Educational and training needs of some staff are identified using the formalised human resources processes. A corporate induction is provided and evidence was observed of attendance by cleaning and catering staff at health & safety, fire, manual handling and infection control training. Evidence was observed that specialised training is provided for example in catering - Hazard Analysis and Critical Control Point (HACCP) and proficiency in the use of cleaning equipment. Evidence was provided that contracted services (for example window cleaners) were trained in areas such as health & safety.

CM 10.4 (B → B)

There is evidence that the contractors manage contract staff effectively.

The organisation has clear defined reporting structures for contracted services on site. Written contracts are established and it was evident that the organisation ensures that contractors are trained to the appropriate level in mandatory training for example Health & Safety. The development of a process to evaluate the training needs of all contracted services on site and ensure that they are met is recommended.

*Core Criterion

CM 10.5 (A ↓ B)

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

A review of the human resources needs for cleaning staff was carried out and additional cleaning hours were provided for the evening shift. Also hygiene human resources were included in business proposals for new developments/refurbishments in line with the Hygiene Corporate Strategic Plan. Details of hygiene staff cover were provided and a system is in place to provide holiday and sick leave cover. It is recommended that the organisation progress the appointment of the

Service Manager and endeavour to address absenteeism, as outlined in the Hygiene Corporate Strategic Plan.

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

Evidence of a comprehensive orientation/induction programme was observed, which covered all risk areas including infection control, hand hygiene, waste, sharps and linens. Dedicated specialised training was provided to both cleaning and catering staff (for example proficiency in use of cleaning equipment and food hygiene training). A comprehensive staff handbook was provided. A sample of attendance records was provided, which included attendance by hygiene services staff. Verbal evidence was provided that attendance levels are monitored and used as a performance indicator. However, documented evidence of attendance levels was not available for review. It is recommended that systems to document and monitor hygiene staff attendance levels at induction be developed and to use the information as a hygiene key performance indicator.

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.

Evidence was observed of continuous ongoing education for hygiene staff, which included: mandatory hand hygiene waste, sharps, linen, food hygiene/HACCP, fire risk and FETAC training. Verbal evidence was provided that cleaning training was provided by an in-house certified trainer, but this post is currently vacant. On-site training is provided to staff within their own areas and the organisation is in the process of developing a modular training facility on site. Training records are maintained through the PPARS system and attendance levels are monitored at both local level and the person providing the education. Evidence of evaluation was observed with resultant actions and feedback (for example induction, infection control and hand hygiene). It is recommended that the organisation develop processes for the provision of protected time for staff to attend on-going education in relation to hygiene, including mandatory hand hygiene education. The organisation is also encouraged to progress their Quality Improvement Plan of formalising processes to monitor attendance levels electronically and the provision of a dedicated training facility.

CM 11.3 (B → B)

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

Evidence was observed that education attendance levels were utilised to evaluate the effectiveness of education and training. Verbal evidence was provided that most on-going education attendance levels were compiled manually. Effectiveness of education is also evaluated through the review of hygiene audit scores, incident reports and staff satisfaction rates. It is recommended that a process be developed to achieve agreed targets for attendance at mandatory education sessions.

CM 11.4 (C → C)

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

Performance evaluation has recently been introduced at the hospital and is being introduced through the line management system commencing at senior management level. Currently hygiene staff's performance is evaluated through the review of hygiene audit scores and during hygiene walkabouts. Daily review is performed by cleaning supervisors and in some cases the department managers. Contracted staff performance is monitored by the contractors and reviewed at the time of contract renewal. It is recommended that the organisation continue the process of introducing performance evaluation within an agreed timeframe, to include all hygiene staff.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (A ↓ C)

An occupational health service is available to all staff

The occupational health service is provided on a regional basis with evidence of provision of one hour protected session per week to the hospital. A comprehensive list of vaccinations and services was observed in the occupational handbook. Verbal evidence was provided that access to the occupational health service was supported and facilitated when required. It is recommended that the organisation evaluate the appropriateness of the occupational health service and establish if staff occupational health needs are met.

CM 12.2 (A ↓ B)

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

Evidence was observed that a survey of staff health needs and well-being was performed. Verbal evidence was provided that actions were taken based on the survey findings. These included: Health Fair held in 2006, the development of the corporate induction programme and the development of the hepatitis B booklet/occupational booklet, which were observed. Verbal evidence was provided that hepatitis B vaccination rates and referral levels were utilised as an occupational health performance indicator. It is recommended that the organisation establish a formal system for monitoring staff satisfaction, occupational health and well being on an on-going basis.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.1 (B → B)

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

Evidence of this was observed (for example the Freedom of Information/Data Protection Acts). Systems for the provision of access to data collected, such as the intranet system, comprehensive library containing evidence-based guidelines/journals, the hospital newsletter, reports and hard copies of best practice guidelines in clinical areas, were observed. Communication systems facilitate access to best practice information in areas such as infection control, relevant general/senior management correspondence such as minutes of meeting etc. It was evident that corporate management access and review best practice information as they formally agree/approve corporate best practice policies/guidelines. Evidence of evaluation of

the process for collection of data was observed for example EHO evaluation of HACCP and evaluation of HR data. Verbal evidence was provided that key statistical data is evaluated. It is recommended that the organisation extend the evaluation process to all hygiene data collected.

CM 13.2 (C ↑ B)

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

The organisation demonstrated how HACCP, infection rates, incident reports and annual reports data and information are reported. Evidence was observed that reports and best practice information generated were evaluated through a web-based staff survey and resultant actions included the development of tailor-made reports to meet needs the relevant staff groups within the hospital. This is to be commended. The organisation is encouraged to continue its progress in developing quality improvement plans.

CM 13.3 (C ↑ B)

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

There was evidence of this criteria at senior management level, examples include incident reports, Environmental Health Officer reports and comment cards. The utilisation of the comprehensive newsletter was reviewed and was considered very successful, which resulted in its production at least three times a year. This is to be commended. Evidence was observed that all intranet-based best practice guidelines were evaluated and processes have commenced to introduce systems to monitor and evaluate the management of this data. Evidence of changes made to data collection and reporting over the last two years included the introduction of the STARS reports and analysis of complaints by departments.

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

A culture of quality improvement was evident within the organisation. The establishment of a multi-disciplinary Quality Circle, which includes a partnership and consumer representative spearheaded the inclusion of all in quality improvement activities. A comprehensive number of quality improvements were initiated over the last two years and included the upgrading of ENT Department, ward kitchens, staff restaurant, hand-wash basins, the identification of secure locations for health care risk waste/soiled laundry in clinical areas, purchase of new equipment/furnishing, developing an equipment replacement matrix, and the reconfiguration and evaluation of the hygiene services structure within the organisation. Evidence was observed that the governing body is involved in quality improvement activities. The deputy General Manager chairs both the Environment & Facilities Committee and the Hospital Management Operational Committee. The Hospital Management Team provided financial resources for the hygiene quality improvements activities, approved/supported mandatory hand hygiene training, approved additional staff/hours to hygiene services and developed risk management and new hygiene services structures, which are currently being reviewed. Evidence that the hygiene services quality improvement activities are coordinated with other quality improvement

activities was evident. The Hygiene Quality Improvement Plan is incorporated into the overall hospital quality improvement strategy.

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.

Evidence of this included hygiene services structures developed during the last two years had recently been evaluated and new draft structure was observed. A comprehensive list of evaluations performed was supplied, evidence of improvements, made included the development of new incident plans, updating of fire policy/complaints policy/health & safety, development of a risk strategy and the Quality Circle. Communication of findings to internal staff, consumer representatives and network manager was evident through minutes of meetings and e-mails observed. Performance indicators reviewed included attendance levels at fire and hand hygiene training, incident reports, hygiene audit scores and MRSA and Clostridium Difficile rates. Internal benchmarking is performed. Evaluation of improved outcomes in hygiene service delivery was evident in the area of waste, risk management and catering. The organisation is encouraged to develop processes to benchmarking against other external organisations.

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.

Many best practice guidelines have been developed and implemented which are available manually and on hospital intranet. The process may become more standardised and effective when all documents (for example Infection Control Guidelines), which are currently approved through the Infection Control Committee, are processed through the Hospital Management Operational Team. To facilitate this process the hospital is actively planning to implement the computerised system. A cleaning and disinfection policy should be updated, independent of the sterilisation policy, and implemented to include recommendations from the National Hospital Cleaning Manual. Protected time for staff to consult with documentation remains a quality improvement area. There is no evidence available on the evaluation of the efficacy of the process used to develop best practice guidelines, which is recommended.

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

A significant number of hygiene services interventions which have been introduced, such as the location of dedicated departmental waste storage and flat mopping system, are based on needs analysis by members of the Hygiene Services Committee. Clear records of hygiene service interventions, which have been introduced, include upgrade of sinks process and strategic placing of hand hygiene stations throughout the hospital. It is recommended that a local procurement guideline be put in place, which includes a documented process to assess new hygiene interventions, and changes to existing ones, before their routine use.

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.

There is strong evidence to support health promotion activities that educate the community regarding hygiene. An innovative Health Fair, which included infection

control and hand hygiene stands with community and hospital stakeholders, was introduced as a direct result of staff and users needs analysis. The Catering Department have worked in partnership with Health Promotion to provide thematic days on food choices. A colourful hospital newsletter has been developed which is widely available to convey up-to-date hygiene information, for example what the hygiene assessment scheme entails and details of hygiene initiatives and capital plans. A selective range of information leaflets is widely available at ward and hospital entrances. Findings on waste initiatives have been presented to external stakeholders, including Sligo and Roscommon County Councils.

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 clear evidence that a very effective hygiene service is provided by a multi-disciplinary team with representation from Infection Control, Allied Health Professionals, Nursing Support Services, Catering, Patient/Client Safety Representative, Procurement and Maintenance, in collaboration with the Accreditation Team. Effective linkages have been formed with other committees such as the Quality Circle. Waste contractors (waste recycling) provide audit and feedback. Roles and responsibilities are documented in Terms of Reference observed for the following: the Hygiene Services Committee, the Infection Control Committee, the Hygiene Services Team, the Quality Circle and the Environment & Facilities Team. Records of committee meetings indicate that not all committees have met recently. The organisation is recommended to progress the current evaluation process in place, which is to amalgamate relevant committees and maximize efficiency of team work in relation to hygiene.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

SD 4.1 (B → B)

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

Cleaning in general is of a high standard in the majority of areas. Standardised cleaning specifications require implementation in all areas, which should include recommendations from the National Cleaning Manual. Hygiene services staff may benefit from a co-ordinated training programme. More attention is required in external areas with the collection of cigarette butts, upgrading/cleaning of signage and resurfacing of external paths. The standard of high dusting requires improvement and ceiling tiles, paintwork and floor covering requires replacement in many areas. It is recommended that the installation of wall protectors be extended throughout clinical areas in order to safeguard walls.

For further information see Appendix A

*Core Criterion

SD 4.2 (A → A)

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

The standard of cleaning equipment and medical devices is to be commended. The presence of cleaning schedules in place in some areas for equipment appears to be effective and should be extended to all areas. Equipment generally appears clean and a proposal to implement the flat mopping system may assist in more effective management of cleaning equipment. Telescopic poles with microfibre covers should be extended to all areas to achieve an improved standard of high dusting.

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.

Cleaning equipment in general was satisfactory and the availability of resources such as microfibre-covered telescopic poles varied in many areas. Storage deficits have resulted in some areas having difficulty correctly storing all equipment in the cleaner store. This issue may be resolved with the quality improvement initiative to implement flat mopping with designated trolleys. Consideration should be given to the view of hygiene advisers (for example the Infection Control Team) when locating appropriate areas for cleaner stores within high risk departments such as the Neo Natal Unit.

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.

Hazard Analysis and Critical Control Point (HACCP) is documented and well controlled in areas. Greater attention to temperature checking is recommended. Cleaning requires improvement in some areas. Induction Training was well documented and it is recommended that competency-based training is implemented. Control of storage, cooking, chilling and regeneration was very good and well documented. Main kitchen and ward kitchens had a good structure, except for the ceiling in the main kitchen, which needs replacement. Cleaning of ward kitchens was of a high standard.

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.

Handling, storage use and disposal of waste is to be commended. A significant number of staff has received in-house education on waste management, which was evident in their knowledge, and the practice of waste management procedures,

during the assessment. Current reconfiguration of porter roles should address the appointment and training of a designated Waste Officer.

For further information see Appendix A

*Core Criterion

SD 4.6 (A ↓ B)

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

Overall management of laundry practices observed on-site is of a high standard and is to be commended. However there was no evidence of evaluation of the external laundry service. Upgrading of hospital's laundry room is required which should include the provision of hand hygiene facilities.

For further information see Appendix A

*Core Criterion

SD 4.7 (A ↓ B)

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

Staff practices in hand hygiene observed was of a very good standard. It is recommended that the sink replacement schedule be completed. Alcohol gel in the dispenser nozzles must be addressed on a daily basis.

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.

The hospital has a robust documented system in place to manage risks and adverse events, which includes evaluation and feedback to departments and management. A Quality Improvement Plan to implement a suitable needle free system is at an advanced stage and this process should be completed. Response rates to events such as spillages are managed via a housekeeper bleep system. It is recommended that the hospital consider extending the role to ensure a rapid response to address hygiene issues is available overnight. Many disciplines of staff have been trained in root cause analysis to ensure effective management of incidents.

SD 4.9 (A ↓ B)

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

There is evidence that a very effective communication system is in place to ensure that the Consumer Panel, which represents, patient/clients, relatives and community, participates in improving hospital services including hygiene. Liaison from the hospital is via the Health Promotion Officer who consolidates the views of the Consumer Panel. Feedback from this group was provided on the hygiene strategy and there is consumer involvement in the publishing of innovative hospital newsletters to inform patient/clients and families of hospital plans and services. The chairperson of the Consumer Panel provides formal representation of patient/clients and families on the Hygiene Services Committee.

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.

A Code of Corporate Ethics is in place. A range of job descriptions were available which incorporate confidentiality. The hospital carried out a recent survey on patient/client hygiene which indicated an 82% satisfaction rate with maintenance of patient/client dignity.

It is recommended that the respect for the rights of patient/clients during hygiene activities be documented when updating the Cleaning Policy and included in the training of hygiene services staff. The Consumer Panel provides a forum for the hospital to receive suggestions and feedback on issues such as dignity. Recent minutes of this group addresses the need for more disabled parking and visiting policy.

SD 5.2 (A ↓ B)

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

Information is effectively disseminated through a plasma screen at front entrance of hospital, the newsletter and information leaflets/signage. Infection control and hand hygiene stands were provided at the innovative Health Fair. Consumer representation on the Hygiene Committee has further enhanced communication in relation to hygiene services. The consumer panel have been afforded the opportunity to review new documentation in relation to hygiene, including the current strategic plan.

SD 5.3 (B → B)

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

Clear documented processes are in place to address patient/clients complaints. Complaints and comment cards are evaluated and reports presented at speciality meetings. The Consumer Panel representative provides a forum to voice concerns at hygiene committee meetings.

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.

A patient/client hygiene survey was completed and analysed. A Quality Improvement Plan is in place to provide feedback. External contractors (recycling) have participated in hospital waste audits and were involved in evaluating housekeeping and catering. The Consumer Panel has participated in walkabouts where hygiene issues were evaluated. Comment cards are available to afford patient/clients the opportunity to express views in relation to hospital services. The hospital has begun upgrading the hand washing and patient/client bathrooms as a result of evaluation of patient/client surveys.

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.

Internal hygiene audits are carried out by the Infection Control Team, and action plans are forwarded to relevant stakeholders. An annual report has been completed to evaluate the 2006 hygiene service. Evaluation of patient/client and staff satisfaction with hygiene was collated and analysed using a questionnaire. Key performance indicators have been identified which include attendance at education (which is monitored on PPARS database), hygiene audit performance and Multiple Resistant Staphylococcus Aureus rates. Consumer panel participates in the evaluation of the hygiene strategy.

4.0 Appendix A

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

4.1 Service Delivery Core Criterion

Compliance Heading: 4.1.1 Clean Environment

(27) Local policies should be in place for guidance on all cleaning processes, colour coding, use of equipment, use of protective clothing and fluids and spillages.

No - Departments have National Cleaning Manual on wards but no local policy was noted at ward level. However when questioned, staff were using a colour code system, which is understood but not formally documented. Environmental Cleaning /Equipment Policy should be updated in line with National Hospital Cleaning manual and be independent of Cleaning /Disinfection/Sterilisation Policy.

(28) Before cleaning commences, a work route should be planned and when necessary, furniture and equipment should be removed from the area.

No - Staff were observed to be washing floors without a planned work route.

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

No - Dust and fluff found in the Physiotherapy, Paediatrics, external entrances, clean utility rooms, male locker room in Orthopaedics Theatre and Accident & Emergency Department.

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

Yes - In the majority of cases, however, a number of walls and floors are in need of repair around the hospital. Wall protectors may be useful in limiting damage to walls.

(5) Cleanable, well-maintained furniture, fixtures and fittings used.

No – There was Sticky tape residue on a significant number of work surfaces and many cupboards in need of repair.

(6) Free from offensive odours and adequately ventilated.

Yes - Majority of areas visited appeared to be adequately ventilated. Staff toilets in Accident & Emergency require temperature to be controlled. The Neo-natal Unit would benefit from air conditioning throughout.

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

Yes - In the majority, however, external signage requires more attention and updating.

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

Yes - In the majority, however, sticky tape was noticed on doors of some lifts.

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

Yes - In the majority, however, grounds require closer attention.

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

Yes - In the majority, however some bins require replacing, for example in the Accident & Emergency, Physiotherapy and Paediatric Departments.

(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 - External grounds, and in particular entrances, have a significant number of cigarette butts.

Compliance Heading: 4.1.2 The following building components should be clean:

(19) Ceilings

No - Ceiling tiles require replacing in a number of areas around the hospital.

(20) Doors

No – A Significant number of doors were damaged throughout the hospital.

(21) Internal and External Glass.

No - In the main hospital external glass was found to be unclean.

(24) Ventilation and Air Conditioning Units.

No - A significant number of vents in the kitchen, Accident and Emergency were found to be dusty and in some cases mould was evident.

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

Yes - Carpeted floor noted in Ophthalmology Unit.

Compliance Heading: 4.1.3 Organisational Buildings and Facilities (note: while list is not exhaustive, the following compliance is required):

(30) Fixtures: Fixtures (i.e. a piece of equipment or furniture which is fixed in position) should be clean. This includes all electrical fixtures e.g. all light fittings and pest control devices.

Yes - In the majority, however, covers of light fittings were missing in the main operating theatre which requires replacement.

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

No - Storage shelves in many linen cupboards, equipment stores and Central Sterile Supply Department (CSSD) bench tops require more attention when cleaning.

(207) Bed frames must be clean and dust free

Yes - Storage shelves in many linen cupboards, equipment stores and CSSD bench tops require more attention when cleaning.

(209) Air vents are clean and free from debris.

No - Air vents were found to be dusty and in some cases and mould was noted in a significant number of areas.

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

(35) Patient couches and trolleys

Yes - In the majority, however trolleys in some areas require closer attention in relation to cleaning. Replacement of the couch in the Female Surgical Ward is recommended. Wheel covers are damaged on trolleys in the Day Services.

(37) Tables and Bed-Tables

Yes - In the majority, however, A&E bed tables require further attention.

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

Yes – The Standard of bin cleaning was found to be very good.

Compliance Heading: 4. 1 .5 Sanitary Accommodation

(44) Hand hygiene facilities are available including soap and paper towels.

Yes - In the majority, however, the waste compounds require to have hand hygiene facilities installed.

(46) Bathrooms / Washrooms must be cleaned on a daily basis. When necessary, they must be disinfected. This must be monitored and recorded.

No - Records were available for cleaning in one area only.

(47) Bathrooms / Washrooms are clean and communal items are stored e.g. talc or creams.

Yes - In the majority, however some communal items were observed in shared bathrooms.

(49) Cleaning materials are available for staff to clean the bath / shower between use.

Yes - Cleaning materials are available, however it is recommended that that a notice be put in place to inform staff about using shower/bath and the correct cleaning procedure.

(50) The toilet, sink, handrails and surrounding area is clean and free from extraneous items.

Yes - In the majority, however, caution signs were stored in the A&E public toilets.

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

(53) Bidets and Slop Hoppers

Yes - In the majority, however, a slop hopper in a sluice room required closer attention to detail.

(54) Wash-Hand Basins

No - Sink water outlets requires greater attention to cleaning in a significant number of areas, especially the toilets throughout the main hospital.

(55) Sluices

Yes – Splash backs are recommended on sinks of sluice in the orthopaedic Ward.

(57) Clear method statements / policies should be in place for guidance on all cleaning including sanitary cleaning and maintenance processes.

No - A clear policy should be developed and implemented; training should also be implemented with clear signage displayed in key areas.

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

No - No evidence to validate was observed.

(210) Consumables should be readily available and stored in a suitable environment, e.g. liquid soap, paper towels, toilet paper. Clean and well maintained dispensers should be available for consumables.

Yes - In the majority, however waste compound requires hand hygiene facilities.

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

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

Yes - Cleaning in this area was found to be of a very good standard.

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

(70) Bedpans, urinals, potties are decontaminated between each patient.

Yes - Some plastic bed pans appeared stained but upon inspection were clean.

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

(71) Alcohol hand gel containers.

Yes - In the majority, however, some nozzles require more attention as there appears to be a persistent problem with clogging of hand gel containers.

(73) TV, radio, earpiece for bedside entertainment system and patient call bell.

Yes - In the majority, however, the radio in the main kitchen was very dusty.

(76) Hand-wash dispenser holders and brackets should be free of product build-up around the nozzle.

Yes - In the majority, however some areas require closer attention.

(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 - Wilted flowers and soiled water was noted in many general ward areas.

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

No - Many areas including the Accident & Emergency, Physiotherapy, Theatre, and Supplies Departments were found to have dusty office equipment with in them.

(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 - Back splashes are in the process of being replaced.

(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 - Back splashes are being replaced/provided in a significant number of areas.

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

(81) All cleaning equipment should be cleaned daily.

No – There is no local programme available. Some mop buckets had water in situ and were not washed out and inverted. Plans to introduce flat mopping may assist in managing these equipment items.

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

Yes - Vacuum filter contract is in place.

(83) Mop heads are laundered daily and are stored according to local policy or are disposable i.e. single use.

Yes – A system is in place for mops laundry processing.

(86) Information on the colour coding system is available to all hygiene staff (according to national guidelines).

No - Colour coding was displayed in some areas and this is not in line with National Guidelines which were available in most departments.

(88) All cleaning equipment should be left clean, dry and tidy in the storage area after use.

No - Many cleaning stores appeared to be inadequate to facilitate cleaning equipment and excess mop buckets were stored in sluices.

(89) Equipment with water reservoirs should be stored empty and dry.

No – It is not possible to invert buckets due to the lack of space in the cleaner stores.

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

Yes - In the majority, however, some storage areas require locked cupboards.

(93) Cleaning products and equipment should comply with the relevant colour coding policy.

Yes – The colour coding policy is well known with staff. It is recommended that the hospital introduce the National Cleaning Manual recommendations and implement a dedicated local cleaning/equipment policy.

(94) Health and Safety policies should be in place for the use of ladders/steps when cleaning.

No - No policy in place.

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

(212) Irish Standard 340: 2006 Hygiene in Food Service (Draft) of the National Standards Authority of Ireland (NSAI) specifies guidance to compliance with the

requirements of S.I. 369 of 2006 EC (Hygiene of Foodstuffs) Regulations and Regulation (EC) No. 852/2004 on Hygiene of Foodstuffs. This should be complied with.

Yes - Draft was available; it is recommended that the hospital receive a copy of the new 2007 standard.

(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 – The EHO report for 29/05/07 was available. It is advised that water testing is performed for 2007.

(214) The person in charge of catering shall develop, implement and maintain a permanent system based on the seven principles of HACCP. A standard HACCP Plan should be fully completed.

No - A HACCP system has been developed but it is not fully implemented at chill service areas. Internal audits are in place.

(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 - No ward kitchen food safety policy was noted in the HACCP manual or available at ward level.

(216) Documented processes for manual washing-up should be in place

Yes - Documented process for washing up is in place. All staff must be familiar with this.

Compliance Heading: 4. 4 .2 Facilities

(217) Access to the main kitchen and ward kitchens should be restricted to designated personnel i.e. food workers.

Yes - Restriction notice available on the relevant doors.

(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.

Yes - Personal Protective Equipment (PPE) was available, hand washing was well controlled.

(219) Ward kitchens are not designated as staff facilities

Yes - No staff items were noted in these areas.

(221) Staff clothing/uniforms/shoes personal belongings should not be stored in food rooms.

Yes - Protective clothing was stored with personal items. However, these two items should be stored in separate areas.

(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 - Facilities were provided, however, soap and towel holders need cleaning at outlet areas.

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

Yes - These were clean but ladies toilet floor need to be replaced.

(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 - Ventilation in the main kitchen was good. The ventilation in the Lake Isle kitchen needs to be improved.

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

Yes - Good stock control was noted.

(226) Containers used to store foods shall be made of food grade materials, be in good condition, easy to clean and disinfect.

Yes - In the majority, clean containers are in use.

(227) Flour, cereals, sugar etc shall be stored in a dry environment and when opened stored in covered containers.

Yes – The Dry goods store was clean and tidy.

Compliance Heading: 4. 4 .3 Waste Management

(229) Animal and pest control measures shall be in place in all waste handling and storage areas.

Yes – An external contract is in place.

(232) Waste storage containers shall be smooth, durable, easy to clean and disinfect, well maintained and closable.

Yes - Waste containers were clean.

Compliance Heading: 4. 4 .4 Pest Control

(235) A system of pest control developed by a competent person shall be in place.

Yes - A formalised contract is in place.

(236) Detailed inspections of food areas shall be carried out and recorded at least every three months for evidence of infestation by insects or rodents by a competent person.

Yes - Audit are completed in this area.

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

Yes – A map was posted on the wall to identify external and internal bait points.

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

Yes - In the majority, however, the cleaning of fly screens need attention as some were dusty and cleaning of same should be added to the cleaning programme.

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 – These were well controlled as per Guidance Note No. 15.

(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 units are in place.

(242) Temperatures for Food in Fridges / Freezers and Displays should comply with I.S.340:2006 requirements

No - Validation of fridge temperatures should be undertaken on a regular basis and should be enhanced by using temperature probes.

(243) Preparation of High Risk Foods should comply with I.S. 340:2006 requirements

No - Sandwiches were being prepared on an inappropriate chopping board. It is recommended that staff would wear gloves while handling ready-to-eat foods. Competency-style training to assess staff knowledge should be carried out and internal audits should monitor actual practices that are in place to help control the preparation of foods.

(244) Temperature for food when cooked, held or reheated should comply with I.S. 340:2006 requirements

Yes - Cooking, hot holding and reheating of foods was well monitored and documented.

Compliance Heading: 4. 4 .6 Food Preparation

(245) Cleaned and disinfected work surfaces, equipment and utensils shall be provided for preparing ready to eat foods and foods to be cooked to prevent the risk of contamination. In addition to the HSE hospital colour coded system (see Appendix 6 Irish Acute Hospitals Cleaning Manual 2006), the food colour coding of work surfaces, equipment and utensils should be provided for (see I.S. 340:2006).

Yes - Generally there was good use of sanitisers, however there are areas that further attention, these were discussed during the assessment and are being addressed.

Compliance Heading: 4. 4 .8 Food Cooking

(247) All foods shall be cooked to a temperature to ensure that the products are safe for consumption. The core temperature of the food shall be assessed at the thickest point of the food and should be compliant with I.S. 340:2006

Yes - Records were reviewed.

Compliance Heading: 4. 4 .9 Food Cooling

(248) Cooling Times for Cooked Food should comply with I.S. 340:2006 requirements

Yes – This is well controlled and documented.

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.

No - Ice scoops in the delivery suite was stored in the unit. This must be stored separately.

(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 monitoring of rinse cycle temperatures. A review of training in this area is recommended.

(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 - Internal calibration recorded monthly, external calibration contract in place for twice-yearly checks.

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, one untagged bag was noted. This is being addressed.

(149) Inventory of Safety Data Sheets (SDS) is in place.

No - No records were in place.

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

Yes - In the majority, however, Personal Protective Equipment (PPE) is not accessible in compactors yard and in the clinical waste compound.

Compliance Heading: 4. 5 .3 Segregation

(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 - In the majority of cases, the management of suction waste was in line with best practice, however, in one ward an incorrect disposal method was noted. Further education is required.

Compliance Heading: 4. 5 .5 Storage

(169) Documented process(es) for the replacement of all bins and bin liners.

No - No documented evidence was available.

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

No - In the majority, however, one transport trolley requires wooden base to be replaced. The base of two waste collection trolleys was corroded.

Compliance Heading: 4. 5 .6 Training

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

No - No evidence of trained and designated Waste Officer

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

(173) Documented processes for the use of in-house and local laundry facilities.

No - Documented processes are not complete for local laundry facilities.

(175) Clean linen is free from stains.

Yes - The standard of clean linen was good.

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

Yes - However dedicated linen stores should be sourced in all clinical areas including Neo-Natal unit.

(263) Bags are less than 2/3 full and are capable of being secured.

No - Plastic laundry bags were overfilled in many instances.

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

Yes - None in use.

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

No - No hand wash resources were available in the receiving laundry room and a Quality Improvement Plan to relocate this facility is strongly recommended.

(270) If a washing machine is in use, a tumble drier is also in place which is externally exhausted. Documented processes for planned preventative maintenance of this equipment should be in place.

Yes - Not in use.

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

(188) Hand and wrist jewellery should be removed prior to performing all levels of hand hygiene with the exception of a plain wedding band.

Yes - Overall staff were compliant with hand hygiene.

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

No - However Quality Improvement Plans are in place to replace/install splash backs. This should be completed.

(191) Hand washing facilities i.e. sinks, taps and splash backs must be clean and intact.

No - Sink water outlets on a significant number of hand wash sinks requires further attention.

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

Yes - Improvement plan to be completed on mixer taps.

(194) Dispenser nozzles of liquid soap or alcohol based hand rubs must be visibly clean.

No - Nozzles of significant number of alcohol gel dispensers were clogged.

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

Yes - Very good signage observed.

(199) Alcohol based hand rub should be available at the bed side of each patient in Critical care units and in each patient room/clinical room.

Yes - Hand gels strategically placed appropriately.

(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 - Replacement programme on sinks should be completed.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team		Assessor Team	
	FREQ	%	FREQ	%
A	26	46.43	8	14.29
B	27	48.21	37	66.07
C	3	05.36	11	19.64
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	A	B	↓
CM 2.1	A	B	↓
CM 3.1	A	A	→
CM 4.1	B	B	→
CM 4.2	B	B	→
CM 4.3	B	B	→
CM 4.4	B	C	↓
CM 4.5	B	C	↓
CM 5.1	A	A	→
CM 5.2	A	A	→
CM 6.1	A	A	→
CM 6.2	A	C	↓
CM 7.1	A	A	→
CM 7.2	B	B	→
CM 8.1	A	B	↓
CM 8.2	B	C	↓
CM 9.1	B	C	↓
CM 9.2	A	C	↓
CM 9.3	A	C	↓
CM 9.4	A	B	↓
CM 10.1	A	B	↓
CM 10.2	B	B	→
CM 10.3	A	B	↓
CM 10.4	B	B	→
CM 10.5	A	B	↓
CM 11.1	A	B	↓
CM 11.2	B	B	→
CM 11.3	B	B	→
CM 11.4	C	C	→
CM 12.1	A	C	↓

CM 12.2	A	B	↓
CM 13.1	B	B	→
CM 13.2	C	B	↑
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	B	→
SD 4.1	B	B	→
SD 4.2	A	A	→
SD 4.3	B	B	→
SD 4.4	A	B	↓
SD 4.5	A	A	→
SD 4.6	A	B	↓
SD 4.7	A	B	↓
SD 4.8	B	B	→
SD 4.9	A	B	↓
SD 5.1	B	B	→
SD 5.2	A	B	↓
SD 5.3	B	B	→
SD 6.1	B	B	→
SD 6.2	B	B	→
SD 6.3	B	B	→