



Hygiene Services Assessment Scheme

Assessment Report October 2007

Wexford 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

Wexford General Hospital serves a population of 131,615 people with 283 treatment beds. The coronary care unit, medical, paediatric, gynaecology and maternity units along with the laundry area were built in the 1970s, the two surgical wards, theatre, accident & emergency and out patients were built in the 1990s and opened in 1992.

Services provided

- General Medicine
- General Surgery
- Gynaecology
- Obstetrics
- Paediatrics
- Dental Surgery
- Dermatology
- Geriatric Medicine
- Oncology
- Ophthalmology
- Orthopaedics
- Palliative Medicine
- Respiratory Medicine

Physical structures

The hospital has 3 dedicated isolation and negative pressure rooms as well as 2 ventilation rooms.

The following assessment of Wexford General Hospital took place between 19th and 20th July 2007.

1.3 Notable Practice

- The management of sharps is commended.
- The organisation developed a specific location for the storage of clinical and non-clinical waste and all clinical waste bins were locked.
- The management of linen was identified as meeting best practice guidelines.
- The enthusiasm of staff in the hygiene programme was palpable and this should be encouraged in the organisation.

1.4 Priority Quality Improvement Plan

- The organisation is recommended to develop audit and evaluation processes and use this feedback to improve the services provided.
- The development of key performance indicators for the hygiene services team is recommended.
- The organisation is recommended to produce a 2007 annual report in consultation with staff and service users and ensure it is outcome focused.

- The management of external contractors in the organisation must be improved.
- The organisation should review the infrastructure in the catering and staff catering areas.
- The organisation is encouraged to implement a performance review for all hygiene staff and to ensure this is linked to the overall organisation training plan.
- The organisation is recommended to ensure that maintenance is provided in line with the needs of the service.
- It is recommended that the organisation review its provision of sanitary facilities.

1.5 Hygiene Services Assessment Scheme Overall Score

The decision mechanism used to translate an organisation's criteria, risk ratings to a Hygiene Service Assessment Scheme score is based on a quantitative analysis of the assessment results which ensures consistency of application. The decision regarding a score is made by the Internal Review Committee of HIQA, based on the findings of the Assessment Team; the Wexford General Hospital has achieved an overall score of:

Poor

Award Date: October 2007

1.6 Significant Risks

CM 7.1	(Rating D)
The organisation has a structure and related processes to identify, analyse, prioritise and eliminate or minimise risk related to the Hygiene Service	
Potential Adverse Event	
Exposure to blood borne infection of female service users.	
Risks	
Likelihood of Event	Rated: M (2)
Impact of Event	Rated: M (2)
Urgency of Action	Rated: M (2)
TOTAL	Total: 6
Recommendations	
It is recommended that the organisation would review its processes in place for the disposal of sanitary products and ensure these are discarded in line with national guidelines for the disposal of contaminated products.	

CM 8.1	(Rating D)
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.	
Potential Adverse Event	
Suboptimal service provided.	
Risks	
Likelihood of Event	Rated: M (2)
Impact of Event	Rated: M (2)
Urgency of Action	Rated: M (2)
TOTAL	Total: 6
Recommendations	
Implement a process for establishing contracts, managing and monitoring contractors, their professional liability and their quality improvement processes in the areas of Hygiene Services.	

CM 10.4 (Rating D)

There is evidence that the contractors manage contract staff effectively.

Potential Adverse Event

Suboptimal service provided by the contract staff.

Risks

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

Recommendations

The organisation should ensure contractors manage contract staff effectively.

2.0 Standards for Corporate Management

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

PLANNING AND DEVELOPING HYGIENE SERVICES

CM 1.1 (B ↓ C)

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

Evidence was presented of internal and external hygiene assessments. A hygiene management structure was in place. A documented needs assessment based on the SWOT (Strengths, Weakness, Opportunities and Threats) model for the hygiene services was observed. The Hospital Strategic Hygiene Plan and Hygiene Service and Operational Plan were noted. The minutes of the Partnership process and Patient partnership Forum included hygiene awareness, comments and actions. Minutes of risk management and patient complaints also noted hygiene and these comments influenced the Corporate Hygiene Plan and Service Plan, for example additional hygiene out-of-hours service. There was evidence of adherence to the principles of best practice and legislation, for example Health and Safety Act, HACCP, Waste Management and SARI.

CM 1.2 (B ↓ C)

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 range of quality initiatives were commenced following previous external audits. Actions Plans were noted for hygiene in conjunction with minutes of meetings of the Hygiene Committee and the Hygiene Team. A full service steam clean of all beds was completed in 2006. Hand hygiene gel/soap and hygiene training was implemented and noted in line with SARI recommendations. It is recommended that all developments and modifications as a result of internal changes to hygiene practice are formally evaluated.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1 (C → 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.

Evidence was presented of the hospital's linkages with National Hospital Office, Primary, Continuing and Community Care and National Surveillance Departments. The hospital also linked with Patient Partnership Forum. There was evidence of catering and hospital patient satisfaction surveys with some reports and evaluations

produced. The organisation is recommended to formally evaluate the efficacy of its linkages and partnerships

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 (B ↓ C)

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

Evidence was noted of a Corporate Strategic Hygiene Plan, which included goals, objectives relating to priorities, membership, terms of reference, and action plans. There was no evidence of associated costs. There was evidence that staff, clients and management have input through the committee system in the hospital and the partnership forum. There was evidence that hygiene communication is effective – communications being by email and hard copy. Minutes of the Hygiene Services Committee are available to all staff. A circulation list was noted. Documented evidence that the Hygiene Service Corporate Strategic Plan will be evaluated in November 2007 was observed. It is recommended that a formal process for the development of the Hygiene Strategic Plan be documented.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.1 (C → C)

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

The hospital has an Executive Management Team in place and hygiene is a standing order on the Hospital Management Agenda. The hospital management have responsibility to ensure that best practice guidelines, current legislation and research are utilised. This was evident in the areas of segregation of waste, the introduction of elements of the National Hygiene Manual and recruitment processes. The Infection Control SE Network Manual was available, but there was no evidence of a Hospital Manual for Corporate Policies, Procedures and Guidelines. The Code of Corporate Ethics for Procurement is incorporated in the National Procurement Policy to which the hospital subscribed. It is recommended that the organisation evaluate compliance of the Hygiene Services with current legislation and relevant national guidelines.

CM 4.2 (C → C)

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

The Hygiene Services committee reports to the Hospital Executive. The senior management team are members of the Hygiene Services Committee and receive minutes of meetings. The Risk Management Structure and the patient complaint process ensure that hygiene issues are identified. Members of the senior management team are involved in HACCP, Capital projects and other committees. The hospital management receive, through the HSE and other agencies, best practice guidelines. An Infection Control CNS is in place and provides information on best practice and hygiene audits. Internal and external audits are carried out, evaluated and action plans are developed.

CM 4.3 (B ↓ C)

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

Information such as SARI guidelines, National Cleaning Manual, and Segregation of Management of Waste is disseminated throughout the organisation. Email, internet and library facilities are available. Some initiatives have been implemented as a result of best practice guidelines, for example, single use soap cartridges and alcohol gels, flat mopping and colour-coding system. A programme of in house education is provided. An internal newsletter is available to all staff. Issues related to new interventions, best practice, and related areas including hygiene are included. Evidence was available of attendance at education sessions but there was no evidence of evaluation of the education programme. It is recommended that the organisation initiate an evaluation of its hygiene research and best practice data collection.

CM 4.4 (C → C)

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

The organisation presented evidence of corporate and operational policies procedures and guidelines, such as fire, environment cleaning, infection control and other related hygiene issues, laundry and waste. No documented evidence was available on policy development processes or evaluation of the policy documented process. The hospitals QIP identified this as an opportunity for improvement. It is recommended that the hospital develop a documented process for the development of policies, procedures and guidelines. It is recommended that the hospital evaluate this process when complete.

CM 4.5 (B ↓ C)

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

The organisation has submitted a current design brief to the HSE/Department of Health for rebuilding the Maternity Unit, along with additional theatre and Accident and Emergency Department facilities. The Hygiene Services is represented on the project team by the Director of Nursing, Finance Manager and General Manager who reflect the issues related to hygiene. It is recommended that the Infection Control CNS be included on the project team. It is also recommended that the organisation evaluate the efficacy of the communications process between Hygiene Services and the capital project team and that appropriate QIP s are developed.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

*Core Criterion

CM 5.1 (B → B)

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

The organisation provided evidence of clear roles, authorities, responsibilities, accountabilities and reporting structures for the hygiene services. This was noted in a range of job descriptions, hygiene organisational structures and accountabilities from senior management. There were details of responsibility for hygiene implied in facilities improvement, clean and safe environment and risk management. It is recommended that the hospital explicitly includes responsibility for hygiene in all job descriptions which will be reviewed or developed.

*Core Criterion

CM 5.2 (A ↓ B)

The organisation has a multi-disciplinary Hygiene Services Committee.

Evidence was noted that the organisation had a Multidisciplinary Hygiene Team and Committee. A full range of departments and services are included. Terms of reference and frequency of meetings was noted. The committee was supported by the office of Quality and Risk for clerical support. There was no documented evidence of role awareness of the members of the team and committee. It is recommended that the organisation develop a documented process of team awareness of their roles and responsibilities.

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

*Core Criterion

CM 6.1 (B → B)

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

Resources for the Hygiene Services are allocated under pay/non pay and minor capital accounts. Details of this expenditure were observed. The hospital has no defined hygiene financial code for budgets and expenditure. The Corporate Strategic Plan and Hygiene Plan noted resource requirements. The equipment procurement group will identify and prioritise hygiene equipment procurement.

CM 6.2 (B ↓ C)

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

The organisation has a process for equipment procurement through the Equipment Procurement Group. There is multidisciplinary representation from all areas in the hospital on the group. Minutes, terms of reference and action plans were observed. The National Procurement Policy is the hospital policy for procurement. There is cross membership of the Equipment Procurement Group and the Hygiene Services Committee and Team. It is recommended that the organisation review its documented processes in relation to this criterion and evaluate the efficacy of the consultation process between the Hygiene Services and senior management.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

CM 7.1 (B ↓ D)

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

There is a well defined structure and related process that seeks to identify and eliminate risk relating to Hygiene Services. Training of Hygiene Services operatives is ongoing and comprehensive, such as checking of cleaning equipment and the use of alerts to be used during the cleaning process (BICs). There is an incident reporting form for completion and issues have been identified in relation to the premises. The organisational structure and process to respond to an adverse event such as NOROVIRUS is effective. The organisation is recommended to use the ICNA audit tool on a regular basis and give feedback to all staff. It is recommended that the organisation review its practice for the disposal of female sanitary products. The

current system of disposal is inappropriate, due to the health and safety risk to female service users.

CM 7.2 (C → C)

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

There is a defined funding system, as indicated in the Hygiene Services Annual Report. The membership of the Health and Safety committee is interdisciplinary. It is recommended that the process of approval of Policies, Procedures and Guidelines is amended. It is recommended that the hygiene services annual report and Quality Improvement Plans inform the service plan for the organisation.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion

CM 8.1 (E ↑ D)

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 limited evidence available in the organisation to ensure that there was a process for establishing, managing and monitoring contractors, their professional liability and Quality Improvement Plans. The hospital is guided in its contract process by the Regional Contracts Department in Kilkenny and there are some local contracts in place such as window cleaning and the internal hospital shop. A list of on-site and serviced contractors was observed. However, there was no formal monitoring at the hospital of the contractor for services offered. There was vocalised informal evidence of informal meetings with contractors but no documented evidence. It is recommended that the hospital develop a process for the monitoring and evaluation of contractors who provide services to the hospital. Informal discussion at present with those working in the shop needs to be formalised and extended to other contracted services.

CM 8.2 (B ↓ C)

The organisation involves contracted services in its quality improvement activities.

Evidence was provided that contractors have carried out work in relation to the hygiene services, including window cleaning, ventilation, clinical and domestic waste, flooring and painting. No evidence was noted of the involvement of contractors in the Hygiene Services Committee or management systems. It is recommended that the organisation implement a structure that all contractors at the hospital are included in the hospital's hygiene quality initiatives and processes. Informal discussion at present with those working in the shop needs to be formalised and extended to other contracted services,

PHYSICAL ENVIRONMENT, FACILITIES AND RESOURCES

CM 9.1 (B → B)

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

The hospital buildings and facilities adhere to all building regulations, fire safety regulations (fire certificate observed), radiological protection guidelines and maintenance.

*Core Criterion

CM 9.2 (B ↓ C)

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

Evidence was presented to support the Hygiene Services process to plan and manage its services. There is a Hygiene Services Committee and Team with terms of reference, needs assessment, corporate strategic plan and service plan for hygiene. There was a range of hygiene policies and procedures in relation to cleaning, waste and laundry. It is recommended that the organisation further develop these policies to include frequencies, audit and evaluation.

CM 9.3 (C → 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.

Limited internal hygiene and hand hygiene audits were noted. EHO reports were noted. Minutes of the Patient Partnership Forum were noted and there is real participation of consumers at the hygiene table which resulted in the development of internal signage and the Patient Information Booklet. It is recommended that the organisation develop further multidisciplinary approaches to the consistent audit and evaluation of this criterion.

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.

There is a very good system for gathering feedback from patients using the patient information booklet. The evaluation of satisfaction with the facilities and environment requires further development.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 (A ↓ C)

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

The organisation ascribes to the HSE procedures and policy on recruitment. There was evidence of all templates for the interview, selection and recruitment process. The Recruitment Code of Practice was noted. The annual national recruitment audit was also noted. There are no contract staff employed in the hospital. A full range of hygiene, hospital management and professional grades were noted. No evaluation of this criterion was noted.

It is recommended that the hospital should develop a process for evaluating the local recruitment programme.

CM 10.2 (B ↓ C)

Human resources are assigned by the organisation based on changes in work capacity and volume, in accordance with accepted standards and legal requirements for Hygiene Services.

A needs assessment matrix was noted for hygiene staff for allocation of duties. Staffing levels are adjusted informally to meet service requirements. It is recommended that documented processes are established to ensure that service adjustments are formally monitored.

CM 10.3 (B ↓ C)

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

The organisation has formal processes in place to ensure that all hygiene staff have relevant qualifications and training in accordance with the national grade job specifications. A range of relevant job descriptions were noted. All hygiene staff under go training with BICS (The British Institute of Cleaning Science). Full staff training records for this programme were noted. All catering staff have completed HACCP training and documented records are kept. It is recommended that internal hygiene-specific training is recorded in a systematic manner, including manual handling and hand hygiene training.

CM 10.4 (E ↑ D)

There is evidence that the contractors manage contract staff effectively.

The only contract staff employed in the hospital are in the shop and coffee dispensing unit. There is no evidence of any documented processes to monitor this contractor. The hospital does not employ external contractors for cleaning, catering, laundry or maintenance. A list of external contractors was evident for incidental contract work. It is recommended that the hospital develop monitoring processes to ensure that the contractor obligations under the terms of employment for contract staff are fulfilled

ENHANCING STAFF PERFORMANCE

CM 11.2 (B ↓ C)

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

A programme of in-service education is available for all staff in infection control and hygiene. Specialised training is available, relevant to catering and hygiene staff. A documented staff development process was evidenced. Records of staff training are available. All staff training records are held by each specific head of department.

CM 11.4 (E ↑ C)

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

The organisation does not evaluate staff performance and ascribes to the Human Resource policy on the probationary period, However, staff performance is managed through direct supervisory intervention and the National People Management.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (C → C)

An occupational health service is available to all staff

An occupational health service is available to all staff. There is no evidence that it is available to external contractors. There is a comprehensive list of vaccinations available to staff but there is no evidence that the levels of uptake by staff of any vaccination programme. There is also no evidence of any evaluation of the appropriateness of the service offered. It is recommended that the organisation evaluates its Occupational Health Service for staff.

CM 12.2 (E ↑ C)

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

A Quality of Working Life Audit report was undertaken in 2003. The organisation reviews its absence rate through its departmental structures and the action plan for people management. It is recommended that the organisation evaluates hygiene service staff satisfaction.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.2 (C → C)

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

The data collection system in the organisation is good, using such information as Environmental Health Officers findings and HACCP recommendations. The hygiene services committee has access to timely information as is evident by the comprehensive minutes of the various working committees. The Hygiene Services Annual Report needs to be developed to incorporate all aspects of hygiene services and the information collected should inform the service development plan for the organisation. It is recommended that tools such as the SARI Hand Hygiene Audit Tool and the Infection Control Nurse Audit Tool are utilised on a more frequent basis by the organisation to provide timely and pertinent data.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

CM 14.2 (C → C)

The organisation regularly evaluates the efficacy of its Hygiene Services quality improvement system, makes improvements as appropriate, benchmarks the results and communicates relevant findings internally and to applicable organisations.

There is some evidence that there is compliance with these criteria. However, it is recommended that the organisation consider increasing the frequency of audits to ensure that it is continuously benchmarking and improving its hygiene service.

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 is some evidence of best practice utilised within the organisation for example, colour-coding, waste segregation, sharps, laundry and hand hygiene. However, there is no documented process of how policies are developed and evaluated. It is suggested that the organisation develop this process and allocate protected time for staff to consult the documentation. The organisation should implement a Quality Improvement Plan to address this.

SD 1.2 (B ↓ C)

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

There is a process for assessing new interventions and changes in procedures. Evidence was observed that the cleaning system was evaluated in 2007, but there was no evidence in place to verify that this process is effective. The organisation is encouraged to extend this process to include all new interventions and equipment, for example the special trolley for recycling.

PREVENTION AND HEALTH PROMOTION

SD 2.1 (C → C)

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

The organisation has been proactive in engaging the community in health promotion activities, using local radio to inform patients of the changes to the visitor policy. Through the involvement with the community, the organisation is aware of the needs of the Polish community and is taking steps to address the deficiency in relation to patient information. There is a very good system and evidence is provided in alerting the public and staff regarding the Norovirus outbreak. The Health and Safety week in 2006 was comprehensive. It is recommended that the organisation complete evaluations for 2006 and highlight the improvements that have been made since then. There are no hand washing/alcohol based hand gel signs in the waiting area, in the Emergency Department or in the new Out Patients Department, and there are long corridors with no alcohol based hand gels or reminders to staff about hand hygiene. Patient satisfaction with hygiene services needs to be included in the next

patient satisfaction survey. The hospital is encouraged to proceed with patient information in the waiting area and improved hand hygiene facilities/information for visitors.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1 (C → C)

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

There are very clear defined terms of reference for those responsible for corporate management of hygiene services. There are also comprehensive minutes of meetings from the Hygiene Services Committee, but a great effort is required to engage all staff at the front line and a visible evaluation of front line service delivery is required. There is a defined list of external contractors, but there is no evidence of contractual obligations relating to when the work is carried out. A progress report on the completion of ongoing maintenance is required. It is recommended that the organisation seek a more inclusive approach to the design of furnishings and their maintenance.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

SD 4.1 (B → B)

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

It is recommended that more attention to detail is given at the main entrance, which would further enhance the visual appearance of the organisation. It is recommended that management develop evaluation and recording procedures of the process in place to further enhance compliance in this area.

For further information see Appendix A

*Core Criterion

SD 4.2 (B → B)

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

The organisation is recommended to develop a process to ensure clinical equipment is cleaned regularly and this process should be reviewed for effectiveness.

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.

While there is a system in place to clean and store equipment, there are limited storage facilities available for this criterion. It is recommended that the organisation review the management of its cleaning facilities in line with best practice.

For further information see Appendix A

*Core Criterion

SD 4.4 (B ↑ A)

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

There is evidence to suggest that the ward kitchens are maintained in line with best practice, however, the infrastructure in the central kitchen needs to be reviewed. For example, the temperature in the wash up area, (this currently leads to the practice of leaving doors open onto a public corridor), the lack of facilities for cleaning equipment and the fact that cleaning buckets are washed in the wash up sinks are all areas which need to be addressed.

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.

The organisation is to be commended on their management and disposal of sharps. The designated facility for storage of waste is an asset to the organisation. There is evidence that recycling is encouraged in the organisation. There should be encouragement to provide training to the designated waste officer and other relevant staff to ensure continuous improvement in the management of waste.

For further information see Appendix A

*Core Criterion

SD 4.6 (A → A)

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

The services are of an exceptionally high standard with comprehensive policies in place to ensure a risk-free service is provided in line with best practice.

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

The process in place in relation to hand hygiene suggests that there is education of the staff and compliance was evident at the ward level. The organisation is encouraged to further develop the process of audit and evaluation in relation to hand hygiene and to implement a quality improvement plan to address opportunities for improvement, as this process is in its infancy stage.

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 hospital is required to display patient information in public areas, as well as hand hygiene facilities at all exits and entrances to the building. During the assessment it was evident that the “cleaning in progress” signs were being used. Infection control alerts and notices were available at ward level. There was evidence to suggest that the organisation in consultation with the public, clients and staff responds to risk and reduces adverse events, keeping patients safe, for example, during the Norovirus outbreak. The hygiene services complaints need to be identified as a risk management issue. It is recommended that all clinical areas should receive reports of patient complaints, such as risks on hygiene services, to ensure that opportunities for improvement identified are addressed.

SD 4.9 (C → C)**Patients/Clients and families are encouraged to participate in improving Hygiene Services and providing a hygienic environment.**

The organisation has developed and distributed an information booklet for patients, which is very informative. It encourages patients to comment on aspects of care during their stay in hospital, including facilities. It is noted that this booklet is due for review in 2007. The organisation is encouraged to seek specific feedback in relation to hygiene services and to use this information to improve service.

PATIENT'S/CLIENT'S RIGHTS**SD 5.1 (C → C)****Professional and organisational guidelines regarding the rights of patients/clients and families are respected by the team.**

There was exceptional evidence of the rights of patients being promoted due to the two shower curtains in place in the bathrooms. Patient who was interviewed as part of the hygiene service assessment scheme were very complementary of this area of the hospital and stated that they observed staff washing their hands. It is recommended that the organisation establish a process to ensure that the public are aware of their responsibility regarding hygiene services at all entrances and waiting areas of the hospital.

SD 5.3 (B ↓ C)**Patient/Client complaints in relation to Hygiene Services are managed in line with organisational policy.**

There is a very comprehensive patient complaints policy in place. It is recommended that the organisation seek feedback from patients in relation to hygiene services and use this to improve the services provided.

ASSESSING AND IMPROVING PERFORMANCE**SD 6.1 (C → C)****Patient/Clients, families and other external partners are involved by the Hygiene Services team when evaluating its service.**

There are processes in place, for example, the management of patient complaints and risk management policies to facilitate Patient/Clients and families involved in hygiene services. The organisation is encouraged to implement a systematic approach to evaluating its hygiene services.

SD 6.2 (B ↓ C)

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

The organisation has demonstrated the beginning of quality improvement activities in relation to hygiene services with their establishment of the quality improvement plans. However, it is recommended that Key Performance Indicators be established for the Hygiene Services Team, which are monitored to ensure the outcomes determined can be achieved.

SD 6.3 (B ↓ C)

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

There is evidence of an annual report for the hygiene services team, but the information provided in this plan is rudimentary. The organisation is encouraged to develop a service plan in consultation with service users in the future.

4.0 Appendix A

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

4.1 Service Delivery Core Criterion

Compliance Heading: 4.1.1 Clean Environment

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

Yes - In the majority, however, more attention to detail to the general cleaning of the main entrance would enhance the overall impression of the hospital.

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

No - There was evidence of dust, cobwebs and flaking paint.

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

No - The integrity of the walls is damaged in a number of areas.

(4) Floors including edges, corners, under and behind beds are free of dust and grit.

Yes - The integrity of the floor in the clinical areas is good. However, the Catering Department required attention.

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

No - More attention to detail at the exits and entrances is required.

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

No - The organisation is recommended to implement a quality improvement plan to upgrade the signage in the hospital. Linkage with patient partnership forum is in place for this project.

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

Yes - Remedial action was taken during assessment.

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

Yes - There was evidence that these were clean.

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

Yes - There was evidence that these were clean.

(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 - There are a number of illegal smoking areas in the hospital. People are throwing cigarette butts into plastic containers; this was noted and discussed with hospital management.

(16) Hospitals are non smoking environments. However, cigarette bins should be available in external designated locations.

No - There are unauthorised areas for smoking and closer monitoring of the bins to include cigarette bins is essential.

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

(18) Walls, including skirting boards.

No - The integrity of the walls is damaged and paint is chipped.

(19) Ceilings

Yes - In the majority of cases, however, some tiles are missing.

(23) Radiators and Heaters

Yes - In the majority of cases, however, stand alone radiators are in the process of being removed.

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

Yes - In the majority of cases, the integrity of the floors is very good. However, the cafeteria floor requires attention.

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

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

Yes - Attention to high dusting in some areas is required and the removal of all non vinyl-covered chairs from the clinical areas is recommended.

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

Yes - These are clean, however, the handles of cupboards are difficult to clean. This should be reviewed.

(207) Bed frames must be clean and dust free

Yes - A very high standard was noted in this area.

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

(33) Chairs

No - A number of the chairs need attention to detail when being cleaned, for example, the joins of the chair.

(36) Lockers, Wardrobes and Drawers

Yes - In the majority, however, wardrobes are not available in all wards.

(37) Tables and Bed-Tables

Yes - In the majority, however, all should be cleaned and consideration be given to replacing chipped tables.

(39) Waste Receptacles (e.g. sani-bins, nappy bins, sharps bins, leak proof bins)
Yes - In the majority of cases, however, it is recommended that the organisation review the sanibin procedure.

(40) Curtains and Blinds

Yes - There is a documented process for curtain change, however, records for same are required, especially in the clinical areas.

(41) Door handles and door plates

Yes – The organisation do not have handle plates on the fire doors.

Compliance Heading: 4. 1 .5 Sanitary Accommodation

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

Yes – Compliance was noted.

(45) There is a facility for sanitary waste disposal.

No - The facility for sanitary waste is suboptimal and the organisation needs to look at providing an alternative system for sanitary waste disposal.

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

Yes - In the majority, however, the organisation needs to improve the recording of the service provided.

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 - The grouting in some showers needs to be replaced.

(53) Bidets and Slop Hoppers

Yes - In the majority, however, the stainless steel finish on the sluice waste needs attention.

(54) Wash-Hand Basins

Yes - The integrity of the wash hand basins in a majority of the clinical areas is good, however, the sink units in the maternity ward area require urgent attention in relation to the wooden surrounds.

(55) Sluices

Yes - Stainless steel was dull and not shining as required.

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

No – This needs continual development.

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

Yes - Compliance was observed.

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

Yes - The organisation was noted to have best practice in relation to shower curtains for extra privacy.

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

Yes - This process was in place, however, no record of completion of this process was in place.

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

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

No - There were many trolleys that were unclean and contained rust on them.

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

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

Yes - During the assessment there was evidence that a planned programme for replacement of these items is in place.

(66) Medical equipment e.g. intravenous infusion pumps, drip stands and pulse oximeters, suction apparatus and tubing, cardiac monitors, blood pressure cuffs, blood gas machines.

No - All areas, and in particular the wheels and basis of this equipment requires attention.

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

No - There appears to be no systematic process to manage wash bowls. These were found on window sills and other areas of the ward while not in use.

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

(72) Trolleys, e.g. chart trolleys, drug trolleys, linen trolleys, shop trolleys, emergency trolleys, suction apparatus, resuscitation equipment i.e. ambubag and mask.

Yes – However, linen storage in the day care needs to be in a covered storage unit.

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

Yes - In the majority of cases, however, high dusting is a difficulty for the hospital.

(74) Patient's personal items, e.g. suitcase which should be stored in an enclosed unit i.e. locker / press.

No - During the assessment it was observed that a number of patients had their personal items on the floor in the bed area.

(77) Loose items such as patient's clothing should be stored in the patient's locker or property bag.

No - A number of patients had their personal items on the floor in the bed area during the assessment.

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

Yes - In the majority, however, sticky tape was evident on the computers. It is suggested there was insufficient evidence of a cleaning policy.

(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 - During the assessment no splashes were observed but some stains were observed without residual products.

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 - This is changed on an ad hoc basis this should be formalised.

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

No - Ventilation in this room should be reviewed.

(87) All cleaning equipment should be approved by the Hygiene Services Committee and ensure sufficient supply.

No - There was insufficient evidence that this process was in place.

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

No - Trolleys require attention.

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

No - There was water in reservoirs in a number of areas.

(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 hand wash gel was observed in some areas.

(91) Storage facilities for Cleaning Equipment should be clean and well maintained.

Yes - During the assessment the area was observed to be cleaned and well maintained.

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

Yes - There was evidence that this room was locked.

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

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

No - The organisation should address the opportunities for improvement identified in the Environmental Health Officer report.

(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 - This should be developed by the organisation.

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 - This is a restricted area; however, the ventilation should be reviewed.

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

Yes - In the majority of cases, however, there was a maintenance jacket found in the weigh and check in area.

(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 - In the majority of cases, however, there was evidence of steam in the changing room corridor.

Compliance Heading: 4. 4 .3 Waste Management

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

Yes - In the majority of cases, however, two bins in the kitchen had residual water in them.

Compliance Heading: 4. 4 .4 Pest Control

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

Yes - - In the majority of cases, however, there was evidence that one of these was broken on 18/7/07 and this had been reported to maintenance.

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 - It was observed that the blue and red chopping boards were stored in the same stand. The organisation is recommended to review the area where fruit salad is prepared.

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 - These are not in use except in the staff canteen.

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

(140) Documented evidence that the treatment facility and final disposal or recovery facility is permitted or licensed.

No - There was evidence that these licenses are due for renewal in 2007. The organisation should review this.

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

Yes – This is not required by the Local Authority.

Compliance Heading: 4. 5 .3 Segregation

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

Yes - There was evidence that all clinical waste bins were locked. This is in line with best practice.

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

No - There are no mattress bags available in the hospital.

Compliance Heading: 4. 5 .4 Transport

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

Yes - There is regional access to the services of a Dangerous Good Safety Advisor.

Compliance Heading: 4. 5 .5 Storage

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

No - There is a need to implement a process to ensure all bins and bin liners are replaced in line with best practice.

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

Yes - During the assessment, tag no 186790 was found outside, however, the organisation traceability process supported this process in tracking this back to source.

Compliance Heading: 4. 5 .6 Training

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

No - The organisation needs to designate and train a waste officer.

(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.

No - There was insufficient evidence of staff training records on the handling, storage and transport of healthcare risk waste.

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.

Yes - There are no onsite laundry facilities.

(265) Linen skips and bags must be used when collecting linen and taking it to the designated area. Soiled linen must not be left on the floor or carried by staff.

Yes - Linen skips in the Coronary Care Unit needs to be replaced.

(267) Documented process for the transportation of linen.

Yes - This is in place.

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

(189) Clinical hand wash sinks are required in all areas where clinical activities are performed. They should be centrally located and free from obstruction.

Yes - In the majority of cases, however, some domestic services rooms and sluices require wash hand basins.

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

Yes - Sinks and taps are cleaned to an exceptional level.

(196) Waste bins should be hands free.

Yes - Compliance was observed.

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

No – This was not observed in all areas of the hospital.

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

No - This requires improvement.

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

No – The organisation was observed to be non compliant in this regard.

(206) Documented records of mandatory attendance at hand hygiene education and practice is required for all staff members involved in clinical areas. This may be undertaken during hospital induction programme followed by annual updates.

Yes - Compliance was observed.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team		Assessor Team	
	FREQ	%	FREQ	%
A	5	08.93	2	03.57
B	26	46.43	9	16.07
C	21	37.50	42	75.00
D	0	00.00	3	05.36
E	4	07.14	0	00.00
N/A	0	00.00	0	00.00

5.2 Ratings Details

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

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