Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Hygiene Services Assessment Scheme

Assessment Report October 2007

Roscommon County 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

Roscommon County Hospital is an acute general hospital with a complement of 136 beds, serving Co. Roscommon which has a population of approximately 55,000. It also serves Counties Longford, Leitrim, Westmeath and east Galway.

Services provided

The following services and departments are provided at the Hospital:

- Acute surgical;
- Medical;
- Geriatric;
- 24 hour Accident & Emergency;
- X-Ray services, including ultrasound investigations;
- Laboratory services;
- Physiotherapy and Occupational therapy;
- Cardiac Rehabilitation;
- Dietetics;
- Out-patient clinics for both resident and visiting Consultant specialties are also provided as follows:
    - Medical;
    - Surgical;
    - Orthopaedics;
    - Paediatrics;
    - Urology;
    - Gynaecology;
    - ENT;
    - Dermatology;
    - Mental Health;
    - Medical;
    - Surgical;
    - Coeliac, etc.

Physical Structures:

There are no negative pressure rooms. Single en-suite rooms are used for patients who require isolation. Patients are also put in 2 bedded or other areas as appropriate. The planned CCU/ICU includes an isolation room.

The following assessment of Roscommon County Hospital took place between 31st July and 1st August 2007.

1.3 Notable Practice

- The development of the Hygiene Services Strategic Plan is to be commended.
- The development of the Hygiene Services Team and Committee with wide staff representation and linkages to services and committees within the organisation is noted.

- Staff evaluation following separation of the functions of hygiene and catering staff is noted as best practice.
- The template developed for pre-purchase evaluation of equipment/products, is to be commended.

1.4 Priority Quality Improvement Plan

- The priority areas for improvement are the implementation of an effective dust control programme as well as the provision of extra storage capacity to relieve clutter in the several areas.
- The documentation of local policies is encouraged. Currently, there is a reliance on national policies.
- Contracts should be established with contractors who manage key services such as waste, linen, shop and 'Sani-bins' and annual formal contract reviews should be undertaken.
- Further work is required in the area of auditing and all processes in relation to Hygiene Service delivery require evaluation.
- A centralised approach to the identification of training needs and the maintenance of training records is recommended.

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 Roscommon County Hospital has achieved an overall score of:

Poor

Award Date: October 2007

1.6 Significant Risks

CM 4.4 **(Rating D)**
The organisation has a process for establishing and maintaining best practice policies, procedures and guidelines for Hygiene Services

Potential Adverse Event
Suboptimal service to patients/clients or staff members.

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 hospital would develop a process for establishing policies, procedures and guidelines for the hygiene services and ensure all policies are developed in line with this.

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 services provided by contractors.

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 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 (C → C)

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

The organisation, through its Senior Management, Heads of Department and Hygiene Service Team, regularly assesses the hygiene needs of the hospital., This was noted in the minutes of meetings, audit reports and quality improvement initiatives; for example: wash hand basin replacement, hygiene trolleys and the provision of hand gels throughout the hospital. It was noted that the organisation had developed a Hygiene Strategic Plan (June 2007) and an Annual Report for 2006. Work is in progress for the development of a Hygiene Service and Operational Plan.
The organisation relies on national guideline documentation e.g. SARI, National Cleaning Manual, and National Safety Policy for Ladders as baseline information.
It is recommended that the hospital develop organisational and hygiene policies, procedures and guidelines and use the National guidelines as a reference for best practice. It is recommended that the hospital develop a needs assessment process and continuing audits and evaluation process in order to ensure compliance with national standards.

CM 1.2 (C → 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.

The organisation demonstrated measures undertaken to address the continuing evolvement of the hygiene process by the appointment of a Domestic Service Supervisor, Infection Control Nurses and Risk Manager during the last 12 months. The organisation has set up a Hygiene Services Team and Committee and an Equipment Purchasing group. There is wide staff representation on all groups and linkages to all services and committees in the organisation. A major wash hand basin replacement programme has been approved and work has commenced. No formal hygiene needs analysis has been carried out; however some internal hygiene audits have been carried but no evaluation or quality improvement plans were evident. The hygiene services at the hospital have been separated into hygiene and catering. Some staff evaluation of the process has been carried out and a report into the findings was noted. It is recommended that the organisation develop the needs assessment and evaluation processes in order to ensure that the hospital continues to develop its hygiene services based on appropriate information.

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.

There was evidence to suggest that the organisation works with a wide range of external partners in relation to the management of hygiene. This was evidenced through reports presented including: Health and Safety Authority reports, Environmental Health Officer reports, Waste management, Regional Infection Control, HSE, National Partnership Programme, Bio-engineering Department at University College Hospital Galway and others. However little evidence of staff and patient satisfaction surveys was noted. The hospital is encouraged to develop its formal documented and evaluation processes to ensure that linkages and partnerships are recognised and sustained by the hospital.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 (C → C)

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

The organisation has developed a Corporate Strategic Hygiene Plan which has been approved by the senior management team. The Hygiene Services Committee and team have terms of reference. The organisation has also developed an Equipment Purchasing Committee and Risk Management Committee in 2007. These two committees have met only once, and have agreed terms of reference and membership. There was evidence of minutes of meetings and action plans for the Hygiene Services Committee and Team. It is recommended that the hospital develop documented processes for the development of hygiene service, corporate and organisational plans and evaluate the efficacy of the Hygiene Service Corporate plans and objectives.

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 organisation's senior management team have responsibility for the management of hygiene in the hospital. The senior management team access and use national guidelines and legislation to influence hygiene decisions. The hospital management hygiene team has the authority to identify and revise hygiene procedures. The Hygiene Committee/Team has a dedicated budget for 2007 though no details were available. The hospital has established a risk and quality group. It is recommended that the hospital develop corporate policies and procedures, including a Code of Corporate Ethics, evaluation and continuous quality improvement mechanisms.

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.

There was evidence available to support this criterion through senior management and various hospital committee minutes and actions plans, education and training programmes, national guidelines and required legislation. There was ample evidence that the hospital availed of national guidelines e.g. SARI, Legionella, National Cleaning Manual, HR recruitment. It is recommended that the organisation review its documented processes, evaluation and performance indicators in relation to this criterion.

CM 4.3 (C → C)

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

The Organisation's management have access to best practice guidelines and these have been distributed throughout the hospital for staff information. There is an on-site library and internet access is available to all hospital staff. The hospital has introduced flat mopping, waste bins and sanitisers based on best practice information. A limited programme of education is available; however, hygiene and hand hygiene training is not mandatory, and this is encouraged.

Development of the organisation's communications process in relation to hygiene issues is recommended. The organisation should develop its evaluation and audit process for this criterion.

CM 4.4 (C ↓ D)

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

While the organisation has access to, and makes extensive use of the national best practice guidelines for hygiene services, there are no local policies, procedures and guidelines supporting the hygiene services with the exception of Catering (HACCP), Laboratory and Waste Management. The organisation is strongly encouraged to develop organisational and service policies, procedures and guidelines which reflect legislation and best practice in relation to the Hygiene services.

CM 4.5 (C → C)

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

A number of capital projects have taken place at the hospital including a new Accident and Emergency Department and Asbestos removal. Currently there is a capital development plan in place for the Coronary Care Unit and the Out-patient Department. The Hygiene Services Committee is represented at the capital projects team meeting by the General Manager and Director of Nursing. Evidence was noted of the Process Manual for Capital Development of the Out-patient's Department and continuing capital project team meetings for Accident and Emergency Department were noted. It is recommended that the organisation develop documented processes for consultation, audit and evaluation of the capital projects at the hospital.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

*Core Criterion

CM 5.1 (C → C)

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

Evidence was observed of a hygiene organisational chart, hygiene committee and team, terms of references and minutes of meetings. There was evidence of job descriptions and reporting relationships for catering and hygiene staff, hygiene supervisory staff and Heads of Department including ward managers. Senior management job descriptions were not observed.

*Core Criterion

CM 5.2 (C ↑ B)

The organisation has a multi-disciplinary Hygiene Services Committee.

There is a multi-disciplinary committee at the hospital. Evidence was observed of Membership, terms of reference, frequencies of meeting and action plans including procurement issues, for example wash hand basins. The hygiene service is supported through Nursing Administration for clerical support. The awareness of the roles of the team members was evident as this is a small hospital. The hospital is encouraged to document the related processes and procedures.

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

*Core Criterion

CM 6.1 (C → C)

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

The organisation presented evidence of the Corporate Strategic Hygiene Plan which documented resources required for the hygiene services including Human Resources, equipment and changes of practice. The Hygiene processes had defined allocated resources for wash hand basins, Sanitisers, waste management compound, and Flat Mopping. This was observed in a financial spreadsheet.

It is recommended that documented processes for the allocation of resources be developed.

CM 6.2 (C → C)

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

The organisation has established a Hospital Equipment Procurement Group which has representation from the Hygiene Committee and Team. Minutes of this group and terms of reference were noted. There was evidence of pre-purchasing evaluation of products on a defined template, and there was evidence that this process had been carried out for the operating theatre tables, curtains and flat mop system. The hospital is to be commended for the development of this initiative. It is recommended that the organisation continue to strengthen the purchasing process in line with the National Procurement Policy.

The hospital should evaluate the efficacy of the consultation process between the hygiene services and senior management in relation to management of hygiene issues.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

CM 7.1 (C → C)

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

The organisation has a Risk and Quality Department and Manager in place since 2006. The STARS reporting and feedback system is used for incident reporting. No evaluation is currently undertaken. There is a Health and Safety statement for the Hospital with evidence of Risk Assessments and Health and Safety Authority Reports and subsequent correspondence. Environmental Health reports were also noted. Some limited internal hygiene audits have been carried out. It is recommended that the organisation develop its audit tools and reporting mechanisms to comprehensively reflect the hygiene agenda.

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 evidence that the organisation supports the risk agenda through the establishment of the Risk Management Department and the appointment of a Risk Manager. There is a Quality and Risk Management Committee and both the Director of Nursing and the General Manager are active members. There is Risk Committee and minutes of meetings (2007) and terms of references were observed.
It is recommended that the Risk Committee continues to establish the risk agenda at the hospital.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion

CM 8.1 (C ↓ 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 is no documented process for the management of the contract services at the hospital. There are informal (telephone) contacts if issues and difficulties arise. There are no planned meetings with contractors. However, there is a process in place to involve the undertakers for mortuary services. The hospital is encouraged to review the management of contracted services with immediate effect.

CM 8.2 (C → C)

The organisation involves contracted services in its quality improvement activities.

No evidence was observed to signify the involvement of contracted services in quality improvement activities. It was noted at the team meeting that the hospital does not include its contracted services in the Quality Improvement Plans but the hospital does liaise with contractors regarding some new products for example curtains and Sani-bins. It is recommended that contract services are included in the Quality agenda for the hygiene services at the hospital.

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 Hospital building is safe, meets all regulations and is in line with best practice. This was evidenced in the capital project plans, health and safety guidelines, fire safety and risk assessments for Accident and Emergency. New capital building projects are in line with current best practice for buildings for example, the Intensive Care Unit and Out-patients. A Quality Improvement Plan is in place to look at storage in the hospital. It is encouraged that an evaluation process for this criterion is developed.

*Core Criterion

CM 9.2 (C → C)

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

The organisation has a process to plan and manage its environment and facilities, equipment and devices, kitchens, waste, sharps and linen. This was evidenced in the minutes of the hygiene team and committee, national documentation, some hospital guidelines and limited audits. The hospital has HACCP, waste and risk procedures.
It is recommended that the hospital devise a documented process to ensure adherence in this area.

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.

Evidence was observed that there were some hygiene audits in place but no corrective actions or audit reports were noted. EHO, Health and Safety reports and a patient satisfaction survey (2006) were available and the organisation is encouraged to ensure loop closure with all recommendations.

CM 9.4 (D ↑ C)

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

Evidence of a patient satisfaction survey (2006) was observed, which was analysed and trend charts were developed. Valuable information was available but this was not recorded in a composite report. Currently there is a staff satisfaction survey in progress. This survey asks about the vision, mission and values of the organisation. There is a complaints policy and reporting system in place in line with the national "Your Service Your Say" policy. The implementation of the visiting policy has improved rest time for patients, and has eased access for the cleaning services at the hospital.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 (C → 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 has a comprehensive approach to recruitment at the hospital. The hospital subscribes to the national HSE recruitment protocols and adheres to best practice. There is no human resources policy. A full range of job descriptions for the hygiene services was available. The organisation is encouraged to evaluate the process for selecting and recruiting human resources.

CM 10.2 (C → 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.

The organisation assigns staff according to budget. The management of catering and cleaning staff at the hospital has been segregated, which is to be commended. Additional staff have been approved and include a Domestic Supervisor and Quality and Risk Manager. There has been an increase in core staff in 2005/6. It is recommended that the hospital develop a documented process for reviewing changes in hygiene needs and that evaluation of work capacity and volume review processes are developed.

CM 10.3 (C → C)

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

All hygiene staff are recruited in accordance with the National recruitment criteria which have specific qualifications and training required relevant to post. Additional hygiene training is offered on recruitment e.g. Hand Hygiene, Waste and Sharps management and HACCP training. There are clear job descriptions available for all hygiene-related posts**.** It is recommended that the hospital develop its hygiene training programmes.

CM 10.4 (N/A → D)

There is evidence that the contractors manage contract staff effectively.

The criterion was not rated by the organisation. There are no contracted hygiene services staff at the hospital. However there are hygiene related contract services providing waste management, linen management, sanitary management, food supplies and management of the hospital shop. There was no evidence that the hospital manages these contractors in line with best practice and the needs of the organisation.

*Core Criterion

CM 10.5 (C → C)

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

The Hospital Corporate Strategic Hygiene Plan identified resources required for the hygiene services. No needs assessment has been carried out for the hygiene service. Staff rosters were observed in relation to catering and cleaning. The hospital is encouraged to develop a needs assessment process.

ENHANCING STAFF PERFORMANCE

*Core Criterion

CM 11.1 (C → C)

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

The provision of a corporate induction programme will commence with the introduction of the National Induction Programme. There was a local induction programme held in July 2006 with 12 members of staff. Evaluation of the process was conducted. Local NCHD training with attendance noted. Hygiene is a subject matter on all these programmes. It is recommended that the hospital continue to develop the orientation and induction programme and evaluate the programme to ensure the continuing development of the programme in line with best practice.

CM 11.2 (N/A → C)

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

The criterion was not rated by the organisation. There is a limited programme of education and training at the hospital. This needs to be developed with an education policy and a training matrix which will include hygiene and hand hygiene structured training programmes. It is recommended that the hospital consider the centralisation of all training records. It is also recommended that the hospital consider hygiene training as part of a mandatory training programme which could also include IV Therapy, Fire Safety and Manual Handling.

CM 11.3 (D ↑ C)

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

Hand Hygiene training was evidenced during the assessment as staff were able to demonstrate correct techniques. Education programmes need to be supported by comprehensive evaluation mechanisms.

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.

There was no evidence of formal staff appraisal at the hospital. There are mechanisms in place for the management of performance issues under the People Management Framework and under the provisions of recruitment contracts. The organisation is encouraged to develop a process in this regard.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (C → C)

An occupational health service is available to all staff.

An Occupational Physician is available at a Regional Level with on-site availability once per month. This is supported by a 0.5 WTE on-site Occupational Nurse.

Details of this service have been introduced to the new Staff Induction Programme; making staff aware of the scope of this service including vaccinations, absenteeism monitoring and health promotion activities. Evaluation of this service is recommended.

CM 12.2 (D ↑ C)

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

A Staff Wellness Day is proposed as a Quality Improvement Plan in this area. This initiative is welcomed which will enhance health promotion awareness for Hygiene Service Staff. Records of sickness and absenteeism of all staff disciplines should assist in the monitoring of this criterion. This is informally monitored in nursing and support services and the People in Management framework allows this issue to be formally addressed if required.

A Dignity in the Workplace Training Programme has been introduced within the hospital. There is evidence to suggest this has been delivered to a large number of staff which will assist in the monitoring of well being of staff.

The Occupational Health Department is encouraged to seek evaluation of its services from users.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.1 (C → C)

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

There is no formal process within the organisation to collect and provide access to data and information that meets all legal and best practice recommendations. There is evidence that some data is being collected through audits, complaints and patient satisfaction surveys. This process needs to be updated to include formal correlation and evaluation of this data in order to drive the continuous improvement of 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.

It is recommended that a formalised process be implemented to ensure all data is made available in a user friendly, standardised format. This information should be disseminated to all relevant staff in a timely fashion to ensure the needs of Hygiene Services are met.

CM 13.3 (C → C)

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

Some evidence was available to support the evaluation processes of any data collected relating to the Hygiene Service of the organisation. It is recommended that the evaluation processes throughout the hospital are reviewed and updated to ensure all data recommendations are captured accurately and actioned appropriately.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

CM 14.1 (C → C)

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

The multidisciplinary teams report to the hospital management team and this line of reporting was clearly noted in the organisational chart. Quality and Risk improvement activities are in place with the appointment of a Quality and Risk Manager, a domestic supervisor and biomedical engineer. Other improvements include a more robust process in relation to the reporting of complaints and incident reporting. The hospital reports all risks incidents under the STARS reporting system.

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.

Quality and Hygiene improvements are being identified and implemented. Multidisciplinary team meetings are an effective means of communication for all aspects of the hygiene services. Due to the small size of the hospital, informal communications are also facilitated and effective. Whilst the internal evaluation and audit process has commenced, it needs to be developed and a tool identified that will reflect all areas and services in the hospital.

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 (C → C)

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

No policy is in place and it is recommended that a formal policy is documented to ensure that best practice guidelines are established, adopted, maintained and evaluated by the team. It is also recommended that a best practice register is compiled for each area such as waste, linen, cleaning, maintenance and catering. This register would be reviewed by the Hygiene Services Committee and updated as necessary.

SD 1.2 (C → 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.

An evaluation report from the Hygiene Service Team was observed with regard to the evaluation and introduction of the flat mopping system, however, this report was not dated and it is recommended that all reports are signed and dated. There was no formal system in place for the assessment of new hygiene service interventions but this has been included in the terms of reference of a new team the 'Hospital Equipment Procurement Group. Members of the Hygiene Service Team are also members of this team thus ensuring connectivity. It is recommended that the efficacy of the assessment process is evaluated in the future.

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.

There were posters and signage around the hospital environment in relation to hand hygiene and the visiting policy. A media campaign was conducted at the time of the introduction of the new visiting policy in February 2007 and this campaign has proved successful in ensuring patients are given rest and quiet time during the day. The Infection Control Nurse also has informal linkages with nursing homes if a patient transfers from the hospital to a nursing home. There is also a Mortuary Committee which has issued guidelines to the local undertakers on infection control in relation to embalming. It is recommended that further activities are undertaken in relation to linking with and education of the community in relation to hygiene issues for example,

a hospital information leaflet which would clearly set out the hospital policies for key areas such as visiting, flowers, patient food and hand hygiene.

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.

The Hygiene Service Committee is multi-disciplinary and links into the senior management team. The hygiene service team also links into the hygiene service committee and there is overlap of members due to the size of the hospital. These teams meet regularly and the minutes were verified as were the terms of reference. It is recommended that consideration be given to external stakeholder input such as an EHO, waste contractor, linen contractor etc. A process to evaluate the efficacy of the team structure should be undertaken.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

SD 4.1 (B → B)

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

The hospital environment was quite dusty and a high and low level dusting programme is recommended. The external appearance of the grounds was poor with weeds visible in non-concreted areas, and cigarette butts and bird droppings were also visible.

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.

There was extensive compliance in relation to the cleaning of the organisation’s equipment, however dust was noted on some equipment and trolleys and fans were noted in clinical areas.

For further information see Appendix A.

*Core Criterion

SD 4.3 (B ↓ C)

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

Cleaning rooms were located at ward areas but they did not have hand wash facilities installed—cleaning trolleys were in need of attention when first viewed but were subsequently cleaned. Chemicals were not kept in locked cupboards and it is recommended that this is addressed.

For further information see Appendix A.

*Core Criterion

SD 4.4 (B → B)

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

The standard of cleanliness within the main kitchen and the ward kitchens was high. There is segregation of cleaning and food service at ward kitchen level and this is to be commended. The staff facilities at the main kitchen are inadequate in terms of space and ventilation and this area is to be upgraded. Household staff engaged in food service at ward level should use toilet facilities which are dedicated for food workers only. Whilst food safety standards are high and HACCP is implemented, a documented HACCP plan was not available and this should be documented, verified and reviewed as per the seven principles of HACCP.

For further information see Appendix A.

*Core Criterion

SD 4.5 (B ↑ 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.

It was noted during the assessment that the organisation has recently introduced a comprehensive, documented waste management policy. To support this policy, specific training has also been introduced for all staff. A high level of compliance was observed during the site visit; however, attention should be given to the need for segregation of waste during transportation to the waste compound.

For further information see Appendix A.

*Core Criterion

SD 4.6 (B ↓ C)

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

A documented linen policy is required to describe the methods used in the delivery, transportation and storage of linen. Also where possible, the laundry contractor should be audited by hospital personnel and the laundry contractor should replace the existing linen skips as these are in need of attention. There is no internal storage facility for soiled linen and skips are kept in the yard awaiting collection.

For further information see Appendix A.

*Core Criterion

SD 4.7 (B → B)

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

Hand hygiene practices observed were satisfactory. The programme to upgrade all the hand wash sinks to the required standard was on-going at the time of the assessment.

For further information see Appendix A.

SD 4.8 (C → C)

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

A Quality and Risk Manger has been appointed since the latter part of 2006 and a quality and risk committee with clearly defined terms of reference is in place but has only met once. Some risk assessments have taken place and training is planned regarding conducting risk assessments. There are safety statements in place but these are outdated and reviews are now required. The STARS system for the reporting of incidents has been recently introduced and as the data is collected it will be evaluated and fed into the quality and risk committee. There have been no major adverse events in relation to the delivery of hygiene services in the last 2 years. It is recommended that the Quality and Risk Committee meet more frequently and that safety statements for each area are reviewed as a matter of priority.

SD 4.9 (B ↓ C)

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

A patient/client satisfaction survey was conducted in July 2006 and the results were analysed and graphically illustrated. In general the results in relation to cleanliness, food and privacy issues were positive with the majority of those surveyed either satisfied or very satisfied with these areas. It is recommended that an evaluation process be undertaken on the very valuable comments which were included from patients/clients, and where possible improvements introduced based on the patient feedback. Further surveys should be undertaken and include trend analysis and bench marking. A visitors' policy based on the national guidelines is in place and there was ample visitor signage throughout the hospital. However practice seemed to contravene the policy. It is recommended that further controls are in place to reduce the number of visitors so that patients have rest periods and staff can deliver hygiene services effectively and efficiently.

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 were no formal guidelines in place regarding the rights, privacy or dignity of the patient/client and the development of such guidelines is recommended. All job descriptions have clauses pertinent to confidentiality and respecting the privacy and dignity of patients/clients. On a practical note an evaluation of bed screen curtains was undertaken in July 2007 and one of the criteria for the selection of the curtains was the maintenance of patient privacy and dignity.

SD 5.2 (C → C)

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

There was signage and posters throughout the hospital in relation to hand hygiene and also leaflets on MRSA and the Visitor's Policy. A patient satisfaction survey was conducted in 2006. It is recommended that a hospital information leaflet is developed to provide information on the hospital hygiene services and policies. It is also recommended that the evaluation of patient satisfaction is strengthened and progressed in the future.

SD 5.3 (C → C)

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

A local procedure has been drawn up based on the national guidelines and training in the area of complaint reporting was scheduled for August 2007. The hospital plans to introduce 'Your Service, Your Say' once the training is complete. A complaint log is maintained with low numbers of complaints noted in the area of cleanliness. There was no overall evaluation regarding complaints management, frequency or trends. This is planned for the future and such a process is encouraged.

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1 (D ↑ C)

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

There was no patient/client representative on any of the hygiene teams and this is recommended. It is to be encouraged that external partners such as those from contracted services are used in the evaluation process. A patient satisfaction survey was conducted in July 2006 and it is recommended that further surveys are conducted regularly.

SD 6.2 (C → 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.

Minimal internal audits have been conducted to date, however loop closure has been poor. It is recommended that an internal audit schedule is documented and adhered to and that when audits take place that they are scored to facilitate trend analysis and benchmarking processes. Consideration should also be given to development of a suite of appropriate performance indicators.

SD 6.3 (D ↑ C)

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

A Hygiene Service Annual Report has been documented for 2006 which lists the main achievements for the year and the key priorities for 2007. It is recommended that there is a documented process for the compilation of the annual report and this report should avail of statistical data from the key areas within hygiene service delivery.

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

(2) All high and low surfaces are free from dust, cobwebs and flaking paint.
No - High and low dust was observed in all assessed areas. Flaking paint was observed in the Out Patient Department.

(3) Wall and floor tiles and paint should be in a good state of repair.
No - Wall tiles in shower areas were falling off walls. Paintwork throughout the hospital is in need of attention. This has been identified as a Quality Improvement Plan by the self assessment team but no progress has been made to date.

(7) Areas should be adequately ventilated with ventilation units cleaned and serviced accordingly and documentation available regarding service.
Yes - Service records were observed for ventilation units in designated clinical areas. Units observed during assessment were clean.

(8) All entrances and exits and component parts should be clean and well maintained.
No - Litter, cigarette butts, and a phone which was in need of attention at the hospital entrance were observed during the assessment.

(13) External areas including grounds, gardens, footpaths, ramps and car parks should be clean and well-maintained.
No - It was noted that external grounds are in need of extensive cleaning. The hospital is encouraged to establish a routine grounds maintenance programme.

(27) Local policies should be in place for guidance on all cleaning processes, colour coding, use of equipment, use of protective clothing and fluids and spillages.
Yes - It is recommended that local policies are developed based on National Guidelines where appropriate.

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

(18) Walls, including skirting boards.
No - Walls and Skirting Boards were observed to be in need of attention in many areas.

(21) Internal and External Glass.
No - Glass was in need of some attention.

(23) Radiators and Heaters.
Yes - However, a radiator in the Out Patient's Department was observed to be damaged and have flaky paint.

(24) Ventilation and Air Conditioning Units.
Yes - Ventilation Units observed were clean.

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 - However, a number of overhead patient lights were dusty.

(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.
No - A number of curtain rails were noted as dusty.

(32) Shelves, benchtops, cupboards are clean inside and out and free of dust and spillage.
No - Shelves and cupboards were noted in a number of areas to be dusty and required further cleaning.

(207) Bed frames must be clean and dust free.
No - Bed frames in all wards observed were dusty.

(208) There should be a process for the cleaning of curtains and blinds. Curtains should be changed after each known case of infected patient/client where required. Records should be maintained of curtain changing.
Yes - The recent introduction of disposable curtains is to be commended.

(209) Air vents are clean and free from debris.
Yes - Air Vents observed during the assessment were clean with the exception of a vent in a sluice room in St Teresa's Ward.

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

(33) Chairs.
No - Chairs on the corridor of St. Coman's ward were very dusty.

(34) Beds and Mattresses.
No - Beds were noted to be in need of attention—mattresses were intact.

(36) Lockers, Wardrobes and Drawers.
No - Dust and debris was noted in a number of areas.

(37) Tables and Bed-Tables.
No - Bed tables in a number of areas need replacement.

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

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

(58) Sluice rooms should be free from clutter and hand washing facilities should be available.
No - It was noted that some sluice rooms are also used for storage. Hand hygiene facilities are not available in all sluice rooms. This was documented by the organisation as a Quality Improvement Plan and a work in progress.

(60) All outlets (including shower outlets) should be flushed at a temperature in accordance with current legislation.
No - No evidence was observed of a flushing routine at ward or department level. Whilst water is disinfected to protect against Legionella it is recommended that water is tested for the presence of the Legionella species. The hospital stated that they will commence this testing as per recommendations.

(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 - Appropriate consumables were 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 - Dust was observed on equipment.

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

(65) Commodes, weighing scales, manual handling equipment.
Yes - Equipment checked such as commodes, weighing scales were observed and were clean.

(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.
Yes - However, the mobile X-ray unit was dusty.

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

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.
No - Wheels on trolleys in many instances were in need of attention and trolleys observed on corridors were dusty.

(74) Patients' personal items (e.g. suitcase), which should be stored in an enclosed unit i.e. locker/press.
Yes - Only one piece of luggage was observed on the floor next to a patient rather than in a locker.

(78) Personal food items, other than fruit, should only be brought in with the agreement and knowledge of the ward manager and should preferably be stored in an airtight container.
Yes - There were no personal food items observed.

(80) All office equipment (e.g. telephones, computers, fax machines) should be clean and well-maintained.
No - The telephones and computers in a number of areas were dusty.

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 - Some cleaning trolleys observed were in need of attention.

(82) Vacuum filters must be changed frequently in accordance with manufacturer's recommendations; evidence available of this.
No - There was no documented policy in place.

(83) Mop heads are laundered daily and are stored according to local policy or are disposable i.e. single use.
Yes - National guidelines are in place. It is recommended that a local policy is documented.

(85) Cleaning solutions should only be prepared in a well ventilated area and should never be mixed.
No - Cleaning solutions are prepared on the trolley in a corridor.

(87) All cleaning equipment should be approved by the Hygiene Services Committee and ensure sufficient supply.
Yes - Evidence was shown that the new mopping system had been approved by the Hygiene Service Committee.

(88) All cleaning equipment should be left clean, dry and tidy in the storage area after use.
No - Cleaning equipment was in need of attention, however, when the organisation was informed, the equipment was cleaned.

(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 - There is a planned programme in place for the installation of hand wash basins.

(91) Storage facilities for cleaning equipment should be clean and well maintained.
No - The Utility room in St Teresa's was cluttered and there was no light in the cleaning room in St Coman's Ward.

(92) Cleaning products and consumables should be stored in shelves in locked cupboards.
No - Storage areas for cleaning products were not locked.

(94) Health and Safety policies should be in place for the use of ladders/steps when cleaning.
Yes - However, it is recommended that a specific local policy is documented.

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

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

(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 - There was no standard HACCP plan present. Process flow should note which steps are the critical control points with critical control points numbered. Revision of the document is recommended.

(216) Documented processes for manual washing-up should be in place.
Yes - There was a process in place for manual washing up.

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 - Access to kitchens at ward level and to the main kitchen is restricted.

(221) Staff clothing/uniforms/shoes personal belongings should not be stored in food rooms.
Yes - There were inadequate changing facilities and there are plans to up-grade the kitchen and staff areas; however no clothing was found in food rooms.

(223) Separate toilets for food workers should be provided.
No - There was only one cubicle present for greater than 15 staff. At ward level there were no designated toilet facilities for the ward kitchen attendants.

(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 - No condensation or excessive steam was observed during the assessment.

(225) Staff in charge of Ward Kitchens shall ensure that product traceability is maintained while the product is in storage (Regulation (EC) 178/2002). Stock shall be rotated on a first-in/first-out basis taking into account the best-before/use-by dates as appropriate. Staff food should be stored separately and identifiable.
No - Frozen fish was noted in the freezers in main kitchen with no traceability to original supply date. No date was present on frozen sausage rolls, and there was no 'Frozen on' date applied to bacon. Overall, traceability was good. These issues were exceptions to an otherwise good system.

Compliance Heading: 4. 4 .3 Waste Management

(230) A supply of water should be available to clean down external waste storage areas.
No - There was no external water source observed in the yard where food waste is stored.

(233) In food preparation areas where lidded bins are provided they shall be foot pedal operated.
Yes - Lidded bins are used in this area.

Compliance Heading: 4. 4 .4 Pest Control

(237) A location map should be available showing the location of each bait point.
No - There was a bait location map in the pest control folder in the kitchen area.

(238) Electric fly killer (EFK) units when used shall be located in an area free from draughts, away from natural light and not directly above an area where food or materials that come into contact with food are located. The EFK units shall be left on at all times and have shatter proof sleeves. The ultraviolet (uv) light tubes shall be replaced at least annually and records of replacement should be retained. The EFK shall be fitted with a catch tray and emptied as required.
Yes - An EFK was noted in the main kitchen.

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

(242) Temperatures for Food in Fridges/Freezers and Displays should comply with I.S.340:2006 requirements.
No - Fridge temperatures in ward kitchens assessed were high .It is recommended that all fridges are in the temperature range of 0-5℃.

(243) Preparation of High Risk Foods should comply with I.S. 340:2006 requirements.
Yes - Colour coding was in place but there were no dedicated zones except for vegetable preparation.

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 - More attention to detail is required in the cleaning of the meat slicer.

Compliance Heading: 4. 4 .10 Plant & Equipment

(250) The dishwasher's minimum temperature for the disinfecting cycle should be compliant with I.S.340:2006 requirements and should be monitored regularly. There should be digital readouts on dishwashers.
No - Dishwasher in the main- and ward-kitchens do not have a digital display.

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

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

(149) Inventory of Safety Data Sheets (SDS) is in place.
No - These were not observed during assessment.

(151) Waste is disposed of safely without risk of contamination or injury.
No - Segregation of waste during transportation needs to be improved. It was noted that current practice does not allow for segregation of clinical and non-clinical waste during transportation to the waste compound as the bags are transported in the same trolley. It is recommended that a waste collection system is introduced to ensure segregation during the transport process.

(152) When required by the local authority the organisation must possess a discharge to drain license.
Yes - This is non applicable in the organisation as it is not required.

Compliance Heading: 4. 5 .3 Segregation

(256) Mattress bags are available and are used for contaminated mattresses ready for disposal; mattresses are disinfected.
No - No mattress bags were available.

Compliance Heading: 4. 5 .4 Transport

(163) Documented processes for the transportation of waste through the hospital which minimizes manual handling of waste (and ensures that segregation of healthcare risk waste from non-risk waste is maintained) are in place.
Yes - Documented process was implemented in May 2007.

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

Compliance Heading: 4. 5 .5 Storage

(169) Documented process(es) for the replacement of all bins and bin liners.
No - There is no documented process currently in place but the purchasing process of the hospital allows for the replacement of such items.

(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 - Healthcare Risk Waste is stored in a locked compound.

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

(172) Documented processes for the management, maintenance and safe handling of linen and soft furnishings throughout the organisation.
No - There was no documented process in place, and it is recommended that processes are developed in the future.

(173) Documented processes for the use of in-house and local laundry facilities.
No - There was no documented processes in place and it is recommended that processes are developed in the future.

(261) Clean linen store is clean, free from dust and free from inappropriate items.
Yes - In the day ward, clean linen was stored alongside clinical consumables and policy folders.

(262) Linen is segregated into categories and in appropriate colour coded bags (i.e. clean/unused linen, dirty/used linen, dirty/contaminated linen).
Yes - Linen was appropriately segregated.

(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.
No - Linen skips are used but there were in very poor condition and were in need of attention. Clean linen was also observed being transported on a wheelchair.

(267) Documented process for the transportation of linen.
No - No policy was in place and it is recommended that a process be developed in the future.

(268) Ward based washing machines are used only with the agreement of the Hygiene Services Committee.
Yes - A washing machine is in use for the cleaning of the flat mops.

(269) A washing machine if used is situated in an appropriate designated area and a clear policy/written guidance is in place regarding its use e.g. water temperature etc.
No - There was a washing machine in place in the kitchen but there was no written policy for its use.

(271) Hand washing facilities should be available in the laundry room.
No - Hand wash was present in the room where the flat mops are washed and dried but there was no hand wash station in the Portacabin used as a linen store.

(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.
No - The tumble drier in the kitchen was not externally exhausted nor was the drier for the flat mops.

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

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

(190) All sinks should be fitted with washable splash backs with all joints completely sealed.
No - The installation of hand wash sinks is a work in progress.

(192) Taps should be hands free and should be mixer taps to allow temperature regulation.
No - The installation of hand wash sinks is a work in progress.

(196) Waste bins should be hands free.
Yes - However a small number of bins were damaged.

(198) Hand hygiene posters and information leaflets should be available and displayed throughout the organization.
Yes - However some new sink areas require posters.

(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 - Compliance was noted in this area.

(204) Hand wash sinks conform to HBN 95. They should not have plugs, overflows and the water jet must not flow directly into the plughole.
No - The installation of sinks to the HBN 95 standard is a work in progress.

(205) General wards should have one sink per 4-6 beds and critical areas should have one sink per 1-3 beds.
No - The Critical Care Area has four beds but only one sink.

(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 - Limited training records were available. It is recommended that a centralised approach to training is adopted and that records be held centrally.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team		Assessor Team	
	FREQ	%	FREQ	%
A	0	00.00	1	01.79
B	9	16.07	5	08.93
C	40	71.43	47	83.93
D	5	08.93	3	05.36
E	0	00.00	0	00.00
N/A	2	03.57	0	00.00

5.2 Ratings Details

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

CM 12.2	D	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	C	C	→
SD 1.2	C	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	C	↓
SD 4.4	B	B	→
SD 4.5	B	A	↑
SD 4.6	B	C	↓
SD 4.7	B	B	→
SD 4.8	C	C	→
SD 4.9	B	C	↓
SD 5.1	C	C	→
SD 5.2	C	C	→
SD 5.3	C	C	→
SD 6.1	D	C	↑
SD 6.2	C	C	→
SD 6.3	D	C	↑