Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Hygiene Services Assessment Scheme

Assessment Report October 2007

Mater Misericordiae University 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

The Mater Misericordiae University Hospital is a 600 bed charitable voluntary hospital and holds a unique place in the delivery of healthcare not only to the community of North Dublin but also to the rest of the country with its tertiary services. The hospital was established in 1861 under the auspices of Catherine McAuley and the Sisters of Mercy. The mission and ethos of the organisation are a reflection of Catherine McAuley's devotion to the sick and elderly in the Dublin of her time. This philosophy is effected through the Office of the Director of Mission Effectiveness whose principal remit is to ensure the widest possible promotion of the mission to hospital staff, patients and their relatives.

Services provided

The hospital has two national specialities, cardiothoracic surgery (including transplantation) and spinal injuries. Regional specialities include ophthalmology, dermatology, breast cancer screening and oncology. The hospital also provides services under a range of medical and surgical specialities, including cardiology, renal services, general and vascular surgery, urology and orthopaedics.
The Mater Hospital has an Emergency Department that is one of the busiest in the Country: over 50,000 patients attend the department every year. The Hospital also has an Ophthalmology Emergency Department for eye injuries.
Diagnostic services provided by the hospital include Radiology, Pathology, Bronchoscopy, Vascular Laboratory, Phlebotomy and Cardiovascular.

Out-patient services include medical and surgical out-patient clinics for all specialities.

Medical clinics include:
Cardiology, Medicine for the Older Person, Dermatology, Oncology, Haematology, Medicine & Therapeutics, Nephrology, Neurology, Neurophysiology, Endocrinology/Diabetology, Infectious Diseases, Psychiatry Adult, Psychiatry of Old Age, Rheumatology, Gastroenterology, Pulmonary Hypertension, Respiratory Medicine, Child and Family Psychiatry and Liver Disease Centre.

Surgical clinics include:
Colorectal Surgery, Breast/endocrine, Gynaecology, Orthopaedics, Fracture Clinics, Spinal Injury, Otolaryngology/Head and Neck (ENT), Plastic Surgery, Vascular Surgery, Cardiothoracic Surgery, Ophthalmology, Maxillo-Facial, Urology, Hepatobiliary and Pancreatic, and Heart and Lung Transplant.

Mater Misericordiae University Hospital also provides tertiary and supra-regional services as follows:

Tertiary
Cardiology, Medicine for the Older Person, Dermatology, Oncology, Haematology, Medicine & Therapeutics/Nephrology, Neurology, Neurophysiology, Endocrinology/Diabetology, Infectious Diseases, Psychiatry Adult, Psychiatry of Old Age, Rheumatology, Gastroenterology, Pulmonary Hypertension, Respiratory Medicine, Child & Family Psychiatry, Liver

Disease, Colorectal Surgery, Breast/Endocrine, Gynaecology, Orthopaedics, Spinal Injuries, Otolaryngology/Head and Neck (ENT), Plastic Surgery, Vascular Surgery, Cardiothoracic Surgery, Ophthalmology, Maxillo-Facial, Urology, Hepato-biliary and Pancreatic, Heart and Lung Transplant.

Supra-regional

Cardiothoracic Surgery, National Heart & Lung Transplant Programme, National Spinal Injuries Unit, Breast Check, National Pulmonary Hypertension Unit.

Physical Structures:

The Hospital has 44 isolation rooms and 9 negative pressure rooms.

The following assessment of the Mater Misericordiae Hospital took place between the 7th and 9th of August 2007.

1.3 Notable Practice

- The management's commitment to hygiene was very evident. Staff interviewed at ward level demonstrated an enthusiasm for the new initiatives being rolled out.
- The risk management process, and information technology innovations for on-going development, are to be commended.
- Announcements at the entrances were effective and clear.
- Hygiene signage and new initiatives such as the hand hygiene mat, which demonstrated the involvement of contractors in quality improvement initiatives, are to be commended.
- The strategic location of spill kits is also to be commended.

1.4 Priority Quality Improvement Plan

- Greater adherence to dating and signing of policies and procedures is recommended.
- Evaluation of the communication system at senior management level and departmental level needs to be implemented.
- The cleaning and maintenance of cleaning equipment and storage space should be reviewed.
- The location and management of sharps boxes in certain areas should also be reviewed.
- If the use of fans continues to be a requirement, a standard operating procedure should be implemented and maintained.
- Laundry facilities should comply with best practice in relation to location, access, storage, facilities and processes.
- Evaluation processes throughout the hygiene service should be reviewed.

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 Mater Misericordiae University Hospital has achieved an overall score of:

Fair

Award Date: October 2007

2.0 Standards for Corporate Management

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

PLANNING AND DEVELOPING HYGIENE SERVICES

CM 1.1 (A ↓ C)

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

Senior management, through budgeting and corporate planning, identify the financial requirements needed to meet the future needs of hygiene services. Regular audits also assist.

Training requirements of all staff are in the process of being identified. A Quality Improvement Plan will use the Kirkpatrick model for evaluating training.

Community consultation presentations have been delivered with specific reference to "maintaining high standard of hygiene and infection control".

A Structural Development Plan was not available.

Evaluation of the specific initiatives undertaken to assess and update current and future needs would add value to the initiatives taken.

There are many processes and initiatives in place to respond to the current and future needs, however, the organisation is encouraged to further develop and capture these in their Corporate Strategic and Services Plan.

CM 1.2 (A ↓ B)

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

Audit trails are undertaken by the cleaning contractor and used to evaluate Key Performance Indicators. Further attention to outcomes, and resultant actions, is needed.

Additional new facilities, such as transit and admission lounges, can be viewed as evidence of improving facilities.

The replacement scheme for wash-hand basins was 70% completed at the time of assessment. The evaluation of new initiatives should be undertaken. The organisation is commended for identifying hygiene needs and is encouraged to progress these, including clinical wash-hand basins and the bed cleaning process.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1 (A ↓ B)

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

On-going communication with Government agencies and HSE was evident. Internal communication has been improved, with greater usage of IT for all staff.

Evaluations have been undertaken during 2005 and 2006 both in out-patient and in-patient surveys. The organisation would benefit from including more comments on hygiene-related issues in future surveys. Evaluation of initiatives is recommended.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 (A ↓ C)

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

A corporate planning process is established and incorporates a multi-disciplinary approach. However the current hygiene services Corporate Strategic Plan should be reflective of desired outcomes. The Service Delivery Strategy for hygiene services, issued in January 2007 should be reviewed against the hygiene Corporate Strategic Plan's goals and objectives to ensure these can be achieved.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.1 (A ↓ B)

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

The Executive Management Team has overall responsibility with a designated Hygiene Services Co-ordinator recently appointed. The organisation is commended for having specific hygiene task force sub-groups, which ensure that best practices are used. Evaluation of task groups is recommended.

A Code of Corporate Ethics was not viewed during the hygiene assessment.

CM 4.2 (B ↓ C)

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

While the Executive Management Team receives timely information in relation to hygiene best practices there is no documented process to reflect this.

There was evidence that the Senior Management Team received information on hygiene services. This is reported to the Board of Directors on an annual basis. This information includes infection control, risk management and hygiene. The Hygiene Taskforce Committee receive information on hygiene services audits. It is recommenced that Key Performance Indicators are identified and reviewed on a regular basis for all elements of hospital hygiene.

CM 4.3 (A ↓ 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.

Responsibilities have been identified, and initiatives highlighted, in the self assessment, but evaluation of processes has not been undertaken.

CM 4.4 (B → B)

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

The process to establish and review policies and procedures is to be commended. While this process has been under review and new IT innovations will further enhance the system, evaluation and feedback is required.

CM 4.5 (A ↓ C)

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

There was evidence that the Hygiene Taskforce Committee were involved in capital development planning. The organisation should ensure that this process be documented and its efficacy evaluated.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

*Core Criterion

CM 5.1 (A → A)

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

The hygiene structure needs to be reflected in the overall organisational chart. The management team have identified hygiene as being part of everyone's job description and this has been agreed within the organisation. The ward/department managers demonstrated extensive responsibility and accountability for hygiene services.

*Core Criterion

CM 5.2 (A ↓ B)

The organisation has a multi-disciplinary Hygiene Services Committee.

Members are aware of each other's roles and responsibilities and terms of reference for the Hygiene Taskforce Committee were available but they were not dated. They did not indicate the quorum required, or frequency of meetings. This information should be documented as part of normal practice.

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

*Core Criterion

CM 6.1 (A ↓ 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.

Financial support and allocation of resources is based on service planning, national guidelines and population needs. The Corporate Hygiene Strategy and Hygiene Service Plan need to reflect the organisation's needs analysis and resources allocation.

CM 6.2 (B → B)

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

The Hygiene Taskforce Committee is involved here and the process is managed by the Procurement and Equipping Committee.
A procurement policies and procedures document gives guidance on the process for supplies and services but it is not dated.
The Procurement and Equipping Committee use a medical device evaluation form when testing and purchasing equipment. Evaluation of the purchasing process is recommended to ensure the needs of the Hygiene Services Team are met.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

CM 7.1 (A ↓ B)

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

There are documented policies for risk identification reporting, analysing and the management of risk. The terms of reference for the Corporate Risk Governance Group are present but not dated. IT innovations have been instigated, and hygiene issues included, for the risk reporting system. The electronic form was being piloted in two ward areas. *Risk Management and Health Safety* is a subsection of a 2005 Annual Report. External Reports, i.e. Environmental Health Officer's report were viewed and acted on. Details of hygiene service audits were available, however, a more multi-disciplinary approach and documented process are recommended. Evaluation of audits is necessary. No major adverse events were reported as having occurred over the last two years.

CM 7.2 (A ↓ B)

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

Resources have been allocated to the hygiene services Risk Management Committee whose representation is appropriate. Health and Safety Authority reports are adhered to. The replacement programme for clinical wash-hand basins is on-going with an end of year target. Evaluation of new IT innovations is required.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion

CM 8.1 (A ↓ C)

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.

A documented draft process for establishing contracts was evident. However, its focus is on the management of the contractors' legal requirements and their safety management. A documented process was not in place for managing all hygiene services contracts provided by external contractors. This needs greater attention and should specifically include duration, liabilities, conflict resolution, specifications, frequencies etc.

CM 8.2 (A → A)

The organisation involves contracted services in its quality improvement activities.

This takes place. Waste contractors provide on-going training to staff. The contractor providing alcohol hand gel and the contract cleaning company have sponsored a new floor mat, which promotes hand hygiene. This initiative is commendable.

PHYSICAL ENVORNMENT, 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.

Relevant regulation and codes of best practice are adhered to in the development of new buildings and structures. The physical structure of the older section poses a challenge to the staff on an on-going basis. Storage areas are compromised and clinical wash-hand basins cannot be provided in some areas due to lack of space. During the assessment, it was observed that the safety of the design and layout of the environment were evaluated in the Physiotherapy Department and Laundry. Management dealt effectively with the identified hygiene-related issues prior to the completion of the assessment. It is recommended that processes be implemented to ensure such issues are prevented in the future.

*Core Criterion

CM 9.2 (A ↓ B)

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

A plan is in place for future development of the Catering Department. Waste is being managed but the new developments for the Mater Hospital site will determine the waste compound facilities. A managed process is in place for linen. While access to information and legislative requirements is available to management via the Internet, the evidence provided to the assessors did not contain the most up-to-date legislation. It is recommended that all current legislation and best practice information be used.

CM 9.3 (A ↓ B)

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

Internal audits and surveys have been undertaken. While surveys have been evaluated, audits need to be reviewed and evaluated. As evaluation is not being undertaken in all hygiene areas, resultant actions are not captured. It is recommended that evaluation processes be developed and strengthened in the future.

CM 9.4 (B ↑ A)

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

Evaluation is being undertaken with patient/clients, staff and visitors through comment cards and through the management of complaints. A robust system is in place to address complaints. In keeping with the Quality Improvement Plan, the inclusion of a member of the Irish Patients' Association on the Hygiene Task Force Committee is commended.

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.

Job descriptions were available for hospital and contract staff. The Human Resources Reference Manual was dated 2001 and did not contain recent legislation, e.g. Child Care (Special Care) Regulations 2004 with specific reference to clearance from the Garda Siochana. The Ethics Policy was dated September 1998 and the Records Retention Policy was not dated. Evaluation of policies and documents within Human Resources, resultant actions and continuous quality improvement requires attention.

CM 10.2 (A ↓ 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 changes required to address the needs of hygiene services are identified at local level. They are managed through Human Resources and the hygiene services task subgroups. Documented processes are required in order to manage these needs and assist evaluation.

CM 10.3 (A ↓ B)

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

External contract providers and hospital staff have the required qualifications and are provided with on-going training. Documented processes are in place to ensure training is specific to sectors delivering hygiene services. An overall organisation-wide documented process is suggested.

CM 10.4 (B ↓ C)

There is evidence that the contractors manage contract staff effectively.

Evidence was available that contract staff are managed appropriately, have their occupational needs, training and orientation needs met as appropriate. The system should be evaluated. The Quality Improvement Plan to address language barriers is to be commended.

*Core Criterion

CM 10.5 (A ↓ B)

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

Human Resources were identified during the cleaning specification of 2005. On-going needs are requested through hygiene services taskforce subgroups. Hygiene services human resources requirements are addressed within new projects and development plans. The further development of the Corporate Strategic Plan and the Hygiene Service Operational Plan should outline human resource needs for hygiene services.

The organisation intends to produce a hygiene services annual report by the end of 2007. This is recommended.

ENHANCING STAFF PERFORMANCE

*Core Criterion

CM 11.1 (A ↓ B)

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

Training is delivered during the induction period with specific reference to hygiene. On-going education and training is provided and an evaluation system using the Kirkpatrick Model is soon to be tested. Attendance levels at training sessions were viewed, however some training records were not dated and the attendance breakdown was not available. It is recommended evaluation of this be implemented.

CM 11.2 (B ↓ 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 Hygiene Training Matrix, to include continuous professional development, is in draft form and will provide for hygiene services' educational needs. While staff interviewed at ward level indicated that they were able to attend educational sessions, protected time is not in place. The use of the Kirkpatrick Model for training will provide a corporate, departmental and individual focus. As with all innovations, this process should be evaluated.

CM 11.3 (B ↓ C)

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

Key Performance Indicators for education and training are needed. While practices in patient/client care areas gives some evaluation of the effectiveness of training, specific evaluation following induction and of on-going training is necessary.

CM 11.4 (B ↓ C)

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

Team-Based Performance Management (TBPM) has been piloted within the hospital with positive outcomes. Evaluation regarding cleaning and hygiene will be undertaken, which will assist with continuous quality improvement.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (A ↓ B)

An occupational health service is available to all staff.

This involves an occupational health doctor and nurse but at present there are two vacancies in the department. Evaluation has not been undertaken. However issues, such as lack of disabled access for staff, have been identified. Policies and procedures are place. A Service Plan was not available for 2007. The hospital plans to develop improved linkages between the Occupational Health Department and hygiene services. This is encouraged.

CM 12.2 (A ↓ B)

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

Key Performance Indicators need to be specified in relation to monitoring of hygiene staff satisfaction, occupational health and well-being. While evaluation of staff satisfaction has not been undertaken, the Human Resources Department have initiated this process. The Occupational Health Department, in conjunction with others, undertook an evaluation of stress in the Accident and Emergency Department. This was published in a peer review journal. Repeating it would be of value.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.1 (A ↓ 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.

While Hygiene Services Taskforce Committee members have adequate and appropriate access to data in relation to hygiene services, there is no documented process to support this, and no evaluation has been conducted. Documentation was not dated in many areas and did not reflect the use of current legal documentation (refer also to CM10.1).

CM 13.2 (B → B)

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

Reports were available in relation to external hygiene audits. The presentation of internal audits could be improved by using graphics. Internal hygiene audits should be part of a wider continuous improvement plan. Infection control surveillance is being undertaken and has been presented to the Infection Control Committee. The Catering Department regularly monitors their non-compliance in relation to Hazard Analysis and Critical Control Point guidelines (HACCP). However, the reports stay within the Catering Department. There may be an opportunity to link the information gathered through audits and non-compliance with the risk management system. This would give a robust hospital-wide information database. Evaluation has not been undertaken.

CM 13.3 (B ↓ C)

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

Evaluation is recommended and should be incorporated into the reporting system to be developed as part of the continuous quality improvement cycle.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

CM 14.1 (A ↓ B)

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

While there is evidence of many quality improvement initiatives in hygiene services, structural processes and human resources, these details are not captured in a structured format. Performance monitoring activities were available for some hygiene services, but need to be extended to all areas.

CM 14.2 (A ↓ B)

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

The organisation, having been involved in the Acute Care Accreditation Scheme, had management structures in place prior to the HIQA Hygiene Assessment Scheme. These management structures are being used to address hygiene services requirements. Communication is managed through attendance at meetings and minutes are circulated to key stakeholders. Board and department managers take responsibility for communicating information to their staff. Focus groups are linked directly with the Corporate Hygiene Task Force Committee and, information is related up to executive management level and board of managers through a documented reporting structure. Evaluation of improved outcomes from hygiene services needs to be undertaken.

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 → B)

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

The Hygiene Taskforce Committee meets monthly. There were no details provided in relation to protected time being available for staff to consult documentation.
Guidelines are based on HSE guidelines such as the Strategy for the control of Antomicrobial Resistance in Ireland (SARI). A process is in place to develop further guidelines. All members of the Taskforce liaise with their affiliated organisations for networking and updating on best practice. A library facility affiliated to University College Dublin is available for all staff as are intranet and Internet facilities. Audits are being undertaken by the contract cleaners and Hygiene Services Co-ordinator. However feedback would appear to be verbal and no action plans were available. It is recommended that a more formal structured approach, which would be beneficial to ensure that protected time is allocated for supervisory staff to consult documentation, be implemented. Evaluation of the current hygiene service should be undertaken.

SD 1.2 (A ↓ 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 evidence of this in the bed cleaning programme. Patient/client equipment cleaning is discussed at the Hygiene Taskforce Committee meetings. New interventions such as sharps boxes, alcohol gel dispensers, floor mats, wall washing and flat mopping project have been introduced over the last two years. A documented process for the introduction of these was not available. Neither were they formally evaluated. The Taskforce Committee minutes record discussions regarding the progress of such interventions at meetings. While a Medical Device Evaluation Form is available through the Procurement Committee this does not appear to be used with new hygiene interventions. It is recommended that this be done.

PREVENTION AND HEALTH PROMOTION

SD 2.1 (A ↓ B)

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

Information leaflets and posters are available for visitors, patients/clients and the public. The hospital website has reference to hygiene issues. There is a voice over at all entrances advising the public on hand hygiene and visiting times. Alcohol gel is available for use by staff, patients/clients and visitors. The Infection Control Team gives advice to external agencies such as public health groups and GP surgeries. Information evenings have been delivered to the community. Evaluation, by means of a questionnaire, is documented. Membership of the Patient/Client Council includes service providers. A patient's/client's information booklet ("Let's Talk") does not include references to hygiene services. This should be given consideration. It is recommended that the alcohol gel, which is available at the front entrance, could be more strategically placed and evident. Evaluation of community activities was not evident and a needs assessment, in conjunction with service providers and local external agencies, could be undertaken.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1 (B → B)

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

Communication takes place between various teams but there is no documented process available to show how these links are established and maintained.

Evaluation of the multi-disciplinary structure has been undertaken. However there is no documented process for decisions taken during this process.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

SD 4.1 (A → A)

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

In general hygiene services covering the physical environment and facilities appeared effective.

While some bed frames and trolleys required additional cleaning it was noted that a planned cleaning programme was in place, this is to be commended.

For further information see Appendix A.

*Core Criterion

SD 4.2 (A ↓ B)

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

In general the equipment was observed to be clean. However there were isolated concerns, which were highlighted during the visit. A Quality Improvement Plan for mechanical fans is required. This should include a review of cleaning, storage, use and maintenance. Further cleaning of computers is required.

For further information see Appendix A.

*Core Criterion

SD 4.3 (A ↓ C)

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

The organisation is encouraged to review the process in place for cleaning equipment (e.g. mops) to ensure best practice is met.

For further information see Appendix A.

*Core Criterion

SD 4.4 (A → A)

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

There is an on-going Hazard Analysis and Critical Control Point (HACCP) process in the Catering Department. This is well monitored. There appear to be good links with the Household Department in relation to food hygiene at ward level. The development of a Standard Operating Procedure for manual washing within the ward areas is required. Consideration needs to be given to whether this process is appropriate or whether an automated one should be considered. Pest control within the main kitchen appears to be well monitored. However the location map needs to be updated as changes are made. This also needs to be dated. A Quality Improvement Plan is required for the ward kitchens Food Safety Policy which needs to be signed by the Clinical Nurse Manager and CEO.

For further information see Appendix A.

*Core Criterion

SD 4.5 (A → A)

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

In general waste management was adequate. It is recommended that a review of the double handling procedure of non-risk waste be undertaken. The labelling of sharps boxes and their location (i.e. use of wall brackets) should be reviewed in line with best practice.

For further information see Appendix A.

*Core Criterion

SD 4.6 (A ↓ B)

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

Laundry facility needs should be reviewed and should comply with best practice in relation to location, access, storage, facilities and processes.

For further information see Appendix A.

*Core Criterion

SD 4.7 (A ↓ B)

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

Hand hygiene is well promoted. A hand hygiene clinical wash-hand basin replacement programme is in place and alcohol gel is used extensively. New interventions include a hand hygiene promotion mat and new dispensers for alcohol gel. However there appear to be inconsistencies in the available guidelines, specifically in relation to the wearing of jewellery. This needs to be addressed.

For further information see Appendix A.

SD 4.8 (A ↓ C)

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

A risk register, which was dated in 2005, is available. To-date hygiene-related risks appear to be responded to at local level and therefore response times are not being recorded. In addition no trends are being recorded. Non-compliance in relation to Hazard Analysis and Critical Control Point (HACCP) is addressed at local level. They are not identified and recorded within the risk management structures.

While a new process is being tested in two areas, it was evident from interviews held with staff that their use will require a significant culture change and extensive training. The organisation is encouraged to ensure that there is two-way communication with regard to hygiene issues and that front line staff and senior management are aware of their roles regarding hygiene issues.

SD 4.9 (A ↓ B)

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

Feedback from patient/clients is through a website, comment cards, satisfaction surveys and the Patient/Client Council. Information leaflets are supplied to patients/clients and visitors; public announcements are made at the hospital entrance, hand gel, hygiene-related posters and signage are available at strategic locations.

It is recommended that patient's/client's satisfaction with specific hygiene initiatives undertaken, be evaluated. A resultant action plan should then be developed in consultation with service users.

PATIENT'S/CLIENT'S RIGHTS

SD 5.1 (A ↓ B)

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

Isolation rooms are used for patient/clients with communicable and transmissible infections. Infection Control Committee guidelines guide hospital personnel on isolation policies. The Patient's/Client's Charter states their rights and is displayed throughout the hospital. A Patient/Client Care Committee and Patient/Client Council has been in place since 2004.Evaluation of patient/client's complaints, in relation to hygiene issues, is generally dealt with at local level, or by the Hygiene Services Co-ordinator.

A confidentiality policy is to be launched 2007. The draft policy reviewed does not specifically mention patients/clients in isolation or hygiene related issues.

An isolated breach in best practice in relation to dignity was noted during the assessment in the Emergency Department. Curtains were not being fully closed around patients/clients. No procedures for this were noted. It is acknowledged that the department was busy but it is recommended that the use of curtains within the department be reviewed. Evaluation of best practice processes in relation to dignity and confidentiality does not appear to have been undertaken. It is recommended that a process be implemented in the near future.

SD 5.2 (B → B)

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

Hygiene signage and an automated announcement which gave visiting times and hand hygiene advice were evident. Satisfaction surveys carried out in 2006 and 2007 were available. Comparisons with previous surveys were being undertaken. Information leaflets were available, however, they did not specifically refer to hygiene services. Satisfaction surveys undertaken within the organisation have some reference to hygiene services. Comment cards were not visible during the audit. There is involvement by patient/client liaison personnel with patients/clients through the complaints procedure and satisfaction surveys in relation to hygiene services.

SD 5.3 (A ↓ B)

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

There is a documented policy for this and a record of complaints was available. Documented comparisons of patient/client complaints were evident, but an evaluation of the process was not.

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1 (A ↓ B)

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

A Patient/Client Council Committee includes service users. Minutes record that hygiene initiatives, such as insufficient toilets in transit unit, were discussed. While this issue may have been addressed, there was no action plan.

Patient/Client Liaison Officers are involved closely with patient/clients.

External agencies and contractors are employed within the hospital.

Environmental issues are addressed in conjunction local health authorities and local community. Hygiene Taskforce involvement with patients/clients is evident. It is

recommended that the organisation further involve patient/client representatives in the development of hygiene services in areas such as the multi-disciplinary auditing team. Evaluation of innovative ideas for hygiene needs to be carried out.

SD 6.3 (B ↓ C)

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

The completion of this is on-going.

On consultation with the Hygiene Taskforce Team, it appears that resources, used for hygiene services, are being identified through individual cost centres. Although there is documented evidence of hygiene audits, there is no documented process for auditing within hygiene services. The team recommends that auditing should be reviewed, linked and a documented process be developed, implemented and evaluated. A formal record of meetings between external contractors and the organisation should be recorded. All issues should be resolved in a timely manner.

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.
Yes - However, bumpers are required to protect walls.

(3) Wall and floor tiles and paint should be in a good state of repair.
Yes - However, there is some evidence that floor tiles in the older part of the hospital are missing or broken.

(4) Floors including edges, corners, under and behind beds are free of dust and grit.
Yes - However, the use of a vacuum cleaner on a daily basis would be beneficial.

(6) Free from offensive odours and adequately ventilated.
Yes - In the majority, however in one area a new floor was being laid. There were obvious odours from the adhesive being used. This was identified and assessed.

(14) Waste bins should be clean, in good repair and covered.
Yes - In the majority, however there was evidence that some bins were not cleaned internally. Clean bags were being left in the bin for later use. Some bins were also in need of repair.

(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.
Yes - However, there was evidence of cigarette butts on the ground.

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

(17) Switches, sockets and data points.
Yes - However, there was evidence of old and broken sockets in the X-ray Department.

(18) Walls, including skirting boards.
Yes - In the majority, however, walls in X-ray had fluid on them.

(19) Ceilings.
Yes - However ceiling tiles missing in the A&E area. Ceiling tiles were also absent in main corridors while electrical upgrading was being done.

(20) Doors.
Yes - In the majority, however, cleaning of some doors is required.

(22) Mirrors
Yes - Additional cleaning required in some areas.

(23) Radiators and Heaters.
Yes - However paint damage on some old radiators noted.

(25) Floors (including hard, soft and carpets).
Yes - However some carpeted areas were noted near Intensive Care Unit and the Occupational Health Department. This is not recommended.

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

(207) Bed frames must be clean and dust free.
No - Some bed frames were noted to be dusty and X-ray trolleys require cleaning.

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

(35) Patient couches and trolleys.
No - Further care and consideration needs to be given to trolleys and the apparent excessive use of sticky plaster in the X-ray Department.

(40) Curtains and Blinds.
Yes - In the majority, however, blinds in the Out-patient Department were quite dusty.

Compliance Heading: 4. 1 .5 Sanitary Accommodation.

(44) Hand hygiene facilities are available including soap and paper towels.
Yes - In certain areas such as St. Camillus' Ward there were hand dryers in place near the utility room. Hand hygiene facilities, such as alcohol gel, are required at the entrance/exit to the hydrotherapy pool.

(46) Bathrooms/Washrooms must be cleaned on a daily basis. When necessary, they must be disinfected. This must be monitored and recorded.
No - The bathroom in the Catering Department and Out-patients Department public toilet area was not recorded as having being cleaned during the weekend. A review of cleaning needs as provided by contractors, especially at weekends, is recommended.

(49) Cleaning materials are available for staff to clean the bath/shower between use.
No - Cleaning materials were not noted.

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

(54) Wash-Hand Basins.
Yes - In the majority, however some hand sinks did not comply with HBN 95. The use of Formica tops was observed in some areas such as X-ray, which is not in line with best practice. Hand sinks should generally be free standing with no storage surrounding them.

(55) Sluices.
Yes - However some cramped utility areas were noted. Restricted access to some was evident.

(58) Sluice rooms should be free from clutter and hand washing facilities should be available.
No - While the sluice rooms were in general free from clutter, no paper towels to facilitate hand drying were evident. Hand dryers were in use.

(60) All outlets (including shower outlets) should be flushed at a temperature in accordance with current legislation.
Yes - From discussions with staff, further education as to the relevance of outlet flushing and temperature monitoring of water is required to reduce the risk of Legionella. One shower in the ladies staff changing area in the catering area was not being used and was not being flushed.

(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 - However some items were stored under sinks.

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 - Dressing trolleys in X-ray and some beds had evidence of rust. Foam wedges used in X-ray were covered with either cling film or green plastic bags and secured with tape. They were generally not in good condition.

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

(65) Commodes, weighing scales, manual handling equipment.
Yes - More cleaning attention needed to the underneath of commodes.

(68) Patient fans which are not recommended in clinical areas.
No - There was extensive evidence of the use of patient/client fans in clinical areas. The Cardiac High Dependency Unit had three fans in operation during the audit. One fan not in use was observed to have dust on it.

(69) Patient washbowls should be decontaminated between each patient, and should be stored clean, dry and inverted. Damaged washbowls should be replaced.
No - Washbowls were not inverted. In St. Camillus' and Cecelia's Wards bowls were stacked in a press under the sluice hopper. In general all bowls were not being stacked appropriately.

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 consideration should be given to the replacement of some trolleys which were found to be broken and rusty in some areas including St. Cecelia's Ward and X-ray Department.

(80) All office equipment (e.g. telephones, computers, fax machines) should be clean and well-maintained.
No - Computer keyboards and handsets required attention.

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 buffers, mopping units, trolleys not in a very clean and dry condition, and were not stored inverted.

(83) Mop heads are laundered daily and are stored according to local policy or are disposable, i.e., single use.
No - Due to the breakdown of the dryer in the laundry area there was no automated drying facility for mops heads. A new dryer is on site and is waiting to be installed. The organisation was informed and corrective action was undertaken.

(84) Products used for cleaning and disinfection comply with policy and are used at the correct dilution. Diluted products are discarded after 24 hours.
No - Confusion regarding disinfectant dilution was evident on wards. Unlabelled spray bottles were being used and very few dilution charts were seen.

(85) Cleaning solutions should only be prepared in a well ventilated area and should never be mixed.
No - Cleaners' rooms were not well ventilated.

(87) All cleaning equipment should be approved by the Hygiene Services Committee and ensure sufficient supply.
Yes - The cleaning contractors supply most of the equipment, which is reviewed and approved by the Hygiene Services Committee.

(88) All cleaning equipment should be left clean, dry and tidy in the storage area after use.
No - Water left in buckets. Equipment and cleaning trolleys not well cleaned.

(91) Storage facilities for cleaning equipment should be clean and well maintained.
No - Some cleaning storerooms were not well maintained and required attention.

(92) Cleaning products and consumables should be stored on shelves in locked cupboards.
Yes - In the majority, however, the disinfectant used for environmental cleaning was not stored in a locked area.

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

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

(215) There should be a documented ward kitchen food safety policy which should be signed off by the person in charge of the ward kitchen and the hospital manager.
No - No individual ward kitchen policies were available. However, a documented kitchen Food Safety Policy was present in the main kitchen.

(216) Documented processes for manual washing-up should be in place.
No - The manual washing process should be reviewed in line with best practice. If temperatures, in line with an automated process, are not achievable, the use of chemicals should be considered.

Compliance Heading: 4. 4 .2 Facilities.

(223) Separate toilets for food workers should be provided.
Yes - Toilets in the main kitchen are communal but are segregated from other staff and there are separate staff changing facilities.

Compliance Heading: 4. 4 .3 Waste Management.

(234) Where waste is stored in plastic bags these shall be removed frequently, closed securely and stored in a manner that does not pose any risk to the food business.
No - Food waste is stored in an area which is not secure. The area requires cleaning.

Compliance Heading: 4. 4 .4 Pest Control.

(237) A location map should be available showing the location of each bait point.
Yes - However the map needs to be updated and dated as changes are made.

(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 - UV light changes are being documented.

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

(139) Documented evidence that waste collectors are permitted to collect the waste concerned by virtue of holding a valid waste collection permit.
Yes - Evidence was observed.

(149) Inventory of Safety Data Sheets (SDS) is in place.
Yes - Evidence was observed.

Compliance Heading: 4. 5 .3 Segregation

(155) Waste segregation should adhere to national colour coding scheme.
Yes - Brown, white and black bins are in use for healthcare non-risk waste. This may lead to confusion.

(156) Healthcare risk waste must be segregated from healthcare non risk waste.
Yes - However a broken plate was observed in a sharps bin.

(159) Sharps boxes are correctly sealed, labelled and stored in a safe environment.
No - In the Infection Control Unit sharps boxes were not assembled correctly. In X-ray the label was not completed for assembly or closure. Staff were unaware of this best practice. Sharps boxes were observed on the floor in Histology under work bench areas.

Compliance Heading: 4. 5 .5 Storage

(258) Waste receptacles should be sanitised, secure and in a good state of repair when used.
No - The silver transport trolleys for non-risk waste was in need of attention. They were overfilled on some occasions.

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

(173) Documented processes for the use of in-house and local laundry facilities.
No - There is in-house laundry in the old convent. No documented processes were available for use of machines within the laundry area. During the audit some documentation was developed for use by the hospital.

(174) Clean linen is stored in a designated area separate from used linen (not in sluice or bathroom).
Yes - In the majority, however in St. Camillius' Ward the clean linen is stored in a storeroom, not in a designated separate area. Patients'/clients' drink supplements were also evident in the room. The organisation was informed of this and of the need to relocate these items.

(175) Clean linen is free from stains.
Yes - In the majority, however, some dye stains were observed.

(262) Linen is segregated into categories and in appropriate colour coded bags (i.e. clean/unused linen, dirty/used linen, dirty/contaminated linen).
No - There are contradictory guidelines within the hospital regarding the segregation of used linen. Used laundry was being placed on some occasions into clear plastic bags (not water soluble).

(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.
Yes - A washing machine and dryer were newly installed in the Physiotherapy Department in close proximity to a hydrotherapy pool. The organisation was made aware of the inappropriate placement of laundry facilities in this department. Management dealt effectively this prior to the completion of the assessment.

(271) Hand washing facilities should be available in the laundry room.
Yes - There were adequate hand hygiene facilities in the designated laundry areas.

(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 - No documented processes available for the tumble dryer or planned preventative maintenance programme within the designated laundry department.

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

(188) Hand and wrist jewellery should be removed prior to performing all levels of hand hygiene with the exception of a plain wedding band.
No - There was evidence of healthcare staff wearing watches and rings within the clinical area.

(190) All sinks should be fitted with washable splash backs with all joints completely sealed.
Yes - In the majority, however, washable splash backs were not available at some sinks.

(191) Hand washing facilities i.e. sinks, taps and splash backs must be clean and intact.
Yes - Some taps required attention.

(192) Taps should be hands free and should be mixer taps to allow temperature regulation.
Yes - Not all taps are hands free. There is an on-going hand hygiene sink and tap replacement programme in place.

(195) Absorbent paper towels are available at all hand washing sinks. Air dryers should not be recommended.
No - Air dryers are evident in the hospital in close proximity to utility rooms.

(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 - Not all hand-wash sinks conform to HBN 95. Overflows were evident.

(206) Documented records of mandatory attendance at hand hygiene education and practice is required for all staff members involved in clinical areas. This may be undertaken during hospital induction programme followed by annual updates.
No - Attendance records were available which showed on-going hand hygiene education, however, hand hygiene should be made mandatory.

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 - This was not applicable as none were in use.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team		Assessor Team	
	FREQ	%	FREQ	%
A	40	71.43	6	10.71
B	16	28.57	31	55.36
C	0	00.00	19	33.93
D	0	00.00	0	00.00
E	0	00.00	0	00.00
N/A	0	00.00	0	00.00

5.2 Ratings Details

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

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