



Hygiene Services Assessment Scheme

Assessment Report October 2007

Monaghan General Hospital

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1.0 Executive Summary

1.1 Introduction

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

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

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

Hygiene is defined as:

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

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

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

1.1.1 Standards Overview

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

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

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

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

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

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

Core Criteria:

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

In the Corporate Management standards, the core criteria cover:

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

In the Service Delivery standards, core criteria cover:

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

1.1.2 Rating Scale

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

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

A Compliant - Exceptional

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

B Compliant - Extensive

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

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

1.1.3 Assessment process components

The assessment process involves four distinct components:

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

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

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

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

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

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

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

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

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

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

- **Continuous Improvement**

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

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

¹ Boot, M and Cairncross, S "Actions Speak" Delft, The Netherlands, IRC and LSTHM, British Occupational Hygiene Society.

² New York Department of Health and Mental Hygiene

³ The Columbia Electronic Encyclopaedia, Sixth Edition. Columbia University Press. 2003

⁴ Irish Acute Hospitals Cleaning Manual, HSE (2006)

⁵ Hygiene Services Assessment Scheme. Irish Health Services Accreditation Board (2006)

1.2 Organisational Profile

Monaghan General Hospital site is part of the Cavan & Monaghan Hospital Group and provides a general acute hospital service to the catchment area of Monaghan. The hospital is a three storey hospital which opened in 1938 and contains the following buildings;

- Main hospital block with two small adjacent buildings on the hospital grounds
- Temporary off site, recently purposely refurbished OPD Department on the grounds of St. Davnet's Hospital.

As a result of the major current refurbishments of two Inpatient Wards, the Outpatients Department has been re-located off site to St Davnet's Hospital, and inpatient beds have been reorganised within the Hospital, the compliment of beds is currently as follows.

Medical Inpatient Beds	65 (includes 6 H.DU. beds)
Surgical Day beds	10
Day Ward Beds	<u>13</u>
	88

Services provided

- Acute General Medicine
- Medical Out-Patient Services, e.g. echo, stress, haemachromatosis,
- General Surgery (Day Services)
- Obstetrics/Gynaecology (Day Services)
- Paediatrics (out-patients)
- E.N.T (Outpatient Service)
- Endoscopy (Day Services)
- Pathology
- Radiology
- Physical Medicine
- Minor Injuries Unit
- Minor Injury Advanced Nurse Practitioner.
- Clinical Nurse Specialist Service Diabetes, Stoma, Tissue Viability, Smoking Cessation, Anticoagulation. Heart Failure, ICU/CCU
- Oncology (outreach service.)

Physical structures

Patients are accommodated in:

- Accident and Emergency Department which caters for medical emergencies and minor injuries
- Female Medical ward **29 in-patient beds**
- Medical 1 **12 in-patient beds** temporarily accommodated in purposely refurbished, disused children's ward.
- Medical 3 has **18 in-patient beds** temporarily accommodated in recently refurbished, disused Maternity Ward and side rooms off day ward.
- High Care Unit has **6 beds**
- Day Services has **10 beds on Day Ward**, and 13 beds/trolleys are temporarily accommodated in purposely refurbished out-patients department

Out-Patient Department is now temporarily located on the campus of St. Davnet's Hospital, in purposely refurbished temporary accommodation, in a disused Psychiatric Ward, to facilitate clinical day services.

There is one negative pressure isolation room in the Minor Injury/Minor Injuries Unit. There are no other dedicated isolation facilities; however, it is local policy to prioritise single rooms for isolation where possible.

The following assessment of Monaghan General Hospital took place between 2nd and 3rd July 2007.

1.3 Notable Practice

- A strong corporate approach to the management of hygiene services with strong organisational leadership was observed.
- Structures for the management/control of hygiene services observed were of a high standard.
- Quality improvement planning /action planning/responsibility identification and evaluation are carried out effectively.
- Audit and evaluation processes are implemented and supported within the organisation.
- The patient centred approach observed and the inclusion of patient advocacy input is to be commended.
- The commitment and knowledge of all staff to the improvement of hygiene services and the openness of the organisation to learn from this assessment is highly commendable

1.4 Priority Quality Improvement Plan

- A process for waste segregation at source is strongly encouraged.
- The completion of a training needs analysis is recommended.
- Responsibility for and evaluation of cleanliness of phones, computers and other office equipment across all areas should be identified.
- The elimination of tea towels from main kitchen is recommended.
- Completion of the structural work in non-risk waste compound is recommended in the near future.

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 Monaghan General Hospital has achieved an overall score of:

Fair

Award Date: October 2007

2.0 Standards for Corporate Management

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

PLANNING AND DEVELOPING HYGIENE SERVICES

CM 1.1 (B → B)

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

Documented processes for the management of hygiene services including identification of needs were observed in place. A very proactive approach including the identification of needs and their immediate resolution was observed through the General Manager's "walkabout" system. The services of an external consultant have been utilised to identify standards and current gaps in human resources needs. Information management systems are in place for the collection, assessment and dissemination of relevant information. Documented processes for health promotion are also in place, for example through the patient handbook. Information within the Hygiene Corporate Strategic Service Plan and Operational Plan is based on current legislation and best practice guidelines including the Hygiene Services Assessment Scheme Standards. Input from patients/clients and staff is collected through audit reports (internal & external), patient/client comments and staff satisfaction surveys.

All relevant legislation and national best practice guidelines pertaining to all areas of hygiene services informed the organisations identified current and future hygiene needs. It is recommended that the efficacy of this process be evaluated in the future.

CM 1.2 (B → B)

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

Following the completion of a needs analysis, considerable progress has been made in relation to the development and modification of hygiene services. This progress includes development in management structures and processes, educational awareness, audit and evaluation, facilities and equipment. Excellent communications and feedback processes were observed. Quality Improvement Plans (QIPs) are in place and it is recommended that the organisation continue to progress its quality improvement plan in relation to this criterion.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1 (B → 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.

Monaghan General Hospital works in partnership with Cavan General Hospital for the provision of acute health services. Monaghan General Hospital is part of the Senior Management Team for the Cavan and Monaghan Group. There is an overall Network Manager for the region, who links with the Acute Hospital network. The organisation also has links with relevant contractors, for example the local council and the waste management company. Regional health and safety and infection control are represented on the Corporate Hygiene Team. Previously, the hospital has used a press release approach to communicate with the public. Documented processes are in place to ensure the organisation works in partnership with all staff, contract staff, and patients/clients. A patient satisfaction survey was completed in April 2007, and plans are in place to conduct further patient satisfaction surveys on a structured basis in the future. Resultant actions have been implemented but have not yet been documented. It is recommended that a process to evaluate the efficacy of these linkages and partnerships is developed and implemented in the near future.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 (B → B)

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

The Hygiene Corporate Strategic plan was developed in February 2007, with a review planned for December 2007. The organisation intends to develop this into a multi-year plan thereafter. The plan contains goals, objectives and priorities. The Senior Management Team members assume overall responsibility for the development of the Corporate Strategic Plan and were involved in the development of the Hygiene Corporate Strategic Plan. Input to the plan from the multi-disciplinary team was through relevant line managers. Suggestions from patient comment cards, patient satisfaction surveys and the patient advocate were all considered in the development of the plan. The plan is communicated throughout the organisation through all line managers. The evaluation has not yet been conducted. It is recommended that evaluation of the plans, goals, and objectives against defined organisational needs be completed. The process should be progressed as identified by the organisation and that relevant costings should be identified.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.1 (B → B)

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

The Senior Management Team has overall responsibility for the management and implementation of hygiene services. Responsibility is delegated throughout the organisation to each staff member, which is identified to staff during the induction programme. The governing body's corporate policies and procedures are clearly

identified, as are the terms of reference for the Hygiene Services Committee and Hygiene Services Team. The code of corporate ethics is identified in all relevant documentation, including the organisation's Mission Statement. Ongoing information sessions, leaflets and posters are in use to ensure patient/client and staff awareness of best practice. A corporate safety statement was observed and all safety statements are regularly updated in conjunction with service provision. Adherence to national guidelines is monitored and evaluated through internal audit processes and reports.

CM 4.2 (C ↑ B)

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

The organisation has processes in place to regularly receive useful, timely and accurate information. These were included in reports from external bodies for example the Irish Acute Hospitals Cleaning Manual, Infection Control, Health and Safety and Clinical Risk information. These processes are disseminated to relevant department heads and through the Corporate Hygiene management structures. Information utilised include HACCP compliance /Environmental Health Officer reports, hygiene audit reports and infection control reports. Local policies, procedures and guidelines were developed based on best practice information. Some evaluation in relation to infection control report, hygiene audits and Environmental Health Officer reports were observed and it is recommended that this is progressed.

CM 4.3 (B → B)

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

The organisation provides internet access and library facilities, which contains all relevant legislation and national guidelines. Relevant initiatives, based on best practice information, were evident across all aspects of the hygiene services. Staff are supported to attend all mandatory training and other relevant in-house training, education and seminars. A variety of methods are used to inform hygiene services staff of the latest research and best practices including in-service training, induction, notice boards, leaflets, e-mails and minutes of meetings. Updated information for hygiene services staff is made available at local level, for example colour coding, bin lid information and standing operating procedures. The results of internal audit and reports influence management decisions regarding hygiene services.

CM 4.4 (B → B)

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

Documented processes for the development and approval of hygiene services policies procedures and guidelines were observed. An excellent infection control manual, which requires updating, was available. An excellent cleaning manual was also developed in April 2007. It is recommended that the newly established Quality and Risk Committee assume responsibility for the introduction of standardised documented processes for the development, approval, revision and control of all policies, procedures and guidelines relating to hygiene services.

CM 4.5**(B → B)****The Hygiene Services Committee is involved in the organisation's capital development planning and implementation process**

Documented evidence was observed that the hospital's Hygiene Services Committee is represented on the Capital Projects Team in the hospital. Capital project minutes were available and evidence that the Infection Control Officer monitored and recorded issues of concern was observed, for example, on-going correspondence and emails to the Commissioning Officer and the General Manager were noted. The infection control officer is also the link to the Hospital Administrator, who provides feedback to the Hygiene Services Committee. Evidence of input from all staff in the hospital in relation to new hospital projects was observed. New projects are highlighted to all staff, and opinions sought. There was a substantial building project in progress at the hospital at the time of the hygiene assessment. Two new wards were in the process of being built for occupation in autumn of 2007. The hospital was well protected in relation to the building works, dust control, site management and cleanliness. A range of environmental policies were available to manage new projects and their impact on the hospital during construction. A process to plan and manage the cleaning standards and frequencies for the newly constructed areas, when opened, was observed. This process is in line with the quality improvement plan submitted. No formal evaluation of the efficacy of the process was observed, which is recommended.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

*Core Criterion

CM 5.1**(B → B)****There are clear roles, authorities, responsibilities and accountabilities throughout the structure of the Hygiene Services.**

The hospital provided clear evidence and extensive documentation to identify that the roles, responsibilities and accountabilities of all staff at the hospital are clearly defined. There are clear terms of reference for the multidisciplinary Hygiene Services Committee and Team which identify each participant's role, responsibility, accountability and reporting relationships as a member of the team. The job descriptions of all direct hygiene and catering staff are clear, regarding the expected outcomes of their required duties. Management and professional staff job descriptions include responsibility for hygiene in relation to the provision of a safe environment for patients. Induction programmes include responsibility for hygiene for all grades of staff within the organisation.

*Core Criterion

CM 5.2**(B → B)****The organisation has a multi-disciplinary Hygiene Services Committee.**

The hospital has a proactive approach to the management of its hygiene services. There was a single multidisciplinary Hygiene Services Committee, incorporating both Cavan and Monaghan General Hospitals. There was evidence of representation from both hospitals at corporate level and its membership reflected all disciplines. Documented terms of reference, membership and minutes and meeting frequencies for the Hospital Hygiene Services Committee were all observed. Composite job descriptions were available for all members of the committee. The hygiene services committee is supported by some defined clerical support (0.5 whole time equivalent).

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

*Core Criterion

CM 6.1 (C ↑ 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.

Strong leadership and resources were observed in this area, which is to be commended. The hospital Hygiene Services Committee has produced a Corporate Hygiene Strategic Plan. The Hygiene Service Plan identifies the resources required in line with its operational plan. The General Manager has allocated both human and capital resources for hygiene in line with the hygiene service and the Corporate Strategic Plan. Resources have also been allocated in the annual budget for staffing, in line with whole time equivalents. Additional funding has been identified through the SARI programme (Strategy for Antimicrobial Resistance in Ireland) to deal with hand wash sinks and hand hygiene.

CM 6.2 (B → B)

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

The terms of reference for the Hygiene Services Committee clearly identify their responsibility for purchasing regarding hygiene services. The committee also links with Infection Control and Capital projects in relation to major hygiene expenditure in new buildings and products. Full documented evaluation of pre-purchased equipment was observed. The procurement policy is also used effectively. Ease of access to the General Manager for approval to purchase appropriate hygiene products was observed. No evaluation of this criterion was submitted, however, quality improvement plans are in place following internal and external audits.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

CM 7.1 (C ↑ B)

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

The processes in place and the documentation submitted for this area were of a high standard. A Quality and Risk Advisor is in place for the Cavan & Monaghan Hospitals. There are formal risk management meetings, policies and incident reporting mechanisms in place. The hospital has a Health and Safety Statement with hazard report sheets located in each area- these are reviewed quarterly. A Risk Management Annual Report is produced, which is submitted to the General Manager. The hospital also receives external hygiene reports and environmental reports. Extensive and comprehensive hospital hygiene reports and audits, with resultant action planning and some evaluation, were observed.

CM 7.2 (C ↑ B)

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

In conjunction with Cavan General Hospital, the services of a Quality and Risk Advisor are provided to the hospital. Their commitment to this organisation is 16 hours per week. A full suite of risk management policies and procedures are in place.

Incident reporting, evaluation and monthly reports are also issued. The Hospital Administrator represents the hospital on the Regional Risk Committee, which is chaired by the General Risk Manager. Here, issues in relation to hygiene are identified and reported to relevant committees and heads of departments. No major hygiene risk issue has been identified in the last 2 years.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion

CM 8.1 (C → 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.

The hospital, as part of the Cavan & Monaghan hospitals group, subscribe to the national procurement policy for contracted services. Local contracts for soft drinks/sweets have been arranged with the local Materials Management Department. The hospital is to be commended on the external contract for the management of its bed cleaning service. There are a range of external contractors for services and these are regional in management. The hospital has gone to tender for cleaning services and has included robust evaluation mechanisms as part of this contract proposal.

CM 8.2 (B → B)

The organisation involves contracted services in its quality improvement activities.

A representative from contracted hygiene services is present on the hospital's Hygiene Services Committee. Evidence of that member at attendance at meetings was observed from minutes and their involvement in quality improvement planning and the development of action plans was also noted. The hospital has a robust communication system with its providers of linen and waste. The hygiene contractors were actively involved in the hygiene needs analysis process and the hygiene review conducted by the external advisor.

PHYSICAL ENVIRONMENT, FACILITIES AND RESOURCES

CM 9.1 (B → B)

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

The hospital building is structurally old, however, it is clean and clutter free. A substantial re-building project is in progress and the capital planning procedure is very robust, with mechanisms in place to ensure that all current legislation is adhered to. The building site compound is very tidy with limited, but thorough hazard signage. The hospital has an Aspergillus policy, which was very well adhered to. A sink replacement programme has been in progress over the last 6 months to ensure the organisation conforms to HTM standards. A health and safety statement was observed, which has been reviewed and re-issued recently. An evaluation process, through the Health and Safety committee and the Project management committee, is also in place.

*Core Criterion

CM 9.2 (B → B)

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

The hospital had a very comprehensive approach to the management of its environment and facilities, equipment and devices, kitchens, waste and sharps and linen. A wide range of policies, procedures and guidelines, in line with legislation and best practice, were observed. The hospital Hygiene Service Committee reviews internal and external audits, identifies quality improvement plans and manages resultant actions.

CM 9.3 (B → 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.

The hospital evaluates all areas and specialities of the hospital on a regular basis using the Infection Control Nurses Association audit tool. Risk management and complaints processes are used to identify any hygiene issues and concerns. A patient satisfaction survey has been carried out, which reported a very positive response. HACCP audits identify areas regarding catering which require attention and water monitoring is also in place. A range of initiatives have been put in place as a result of the continuing audit process.

CM 9.4 (B → B)

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

The hospital conducted a patient satisfaction survey in April 2007. The returned questionnaires were evaluated, issued and circulated to all hospital staff. A meeting with the Hospital Administrator and a patient advocate was held, in which issues relating to hygiene were discussed, actions implemented and re-assessed. A further meeting is planned for autumn 2007. Complaints are dealt with through the Hospital Administrator and monthly reports are issued. Issues related to hygiene are correlated and communicated through the Hygiene Services Committee and relevant heads of departments for subsequent action.

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 Hospital subscribes to the Health Services Executive Recruitment (National Code of Practice) process and is currently implementing the standards as recruitment progresses. All appropriate documentation in template form was observed during the assessment. Contractor obligations for recruitment are clearly identified in the hospital recruitment policy, tender documents and evaluation sheets from supervisors. A range of job descriptions were also noted. The hospital has identified the need to review staff handbooks and incorporate hygiene as a core subject for inclusion. The hospital intends to develop an evaluation processes for this area.

CM 10.2 (C ↑ B)

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

The hospital has a defined whole time equivalent for hygiene services. This has been reviewed and additional external contract staff have been employed to address areas of deficit. Evidence of this was observed in the 2006 needs analysis. The hospital employed the services of an external advisor, one of whose roles was to examine the human resource requirements of the organisation. The hospital is actively engaged in the process of separating core hygiene staff into specific hygiene disciplines, for example catering and cleaning. The hospital has subscribed to the new National Framework for a Patient/Client approach to Workforce Planning. The hospital complies with all legislation in relation to HACCP and waste management. The hospital evaluates its hygiene service and has developed quality improvement plans which are on-going in their implementation.

CM 10.3 (B → B)

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

The hospital presented strong evidence of the recruitment process, training and education for all hygiene staff at the hospital. The terms of reference for the Hygiene Services Committee ensure that education and training are available to all grades of staff. Contractors also have a documented approach to training and education. The Occupational Health department and the hospital itself, provide training which is relevant to duties. Job descriptions have been developed to ensure that hygiene is included, where appropriate, to the duties required of the applicant staff.

CM 10.4 (C → C)

There is evidence that the contractors manage contract staff effectively.

Evidence that contractors evaluate the training needs of their staff was observed. Evaluation of contractors at the organisation is based on the corporate procurement process. Relevant contract staff attend multi-disciplinary meetings of the hygiene services. Pest control and waste management have documented processes for the services provided by the contractor. Hospital staff and the Infection Control Officer work closely with the Capital Projects Team.

*Core Criterion

CM 10.5 (C ↑ B)

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

Strong evidence that the human resource needs for hygiene services are met was observed. The hospital conducted a hygiene needs assessment in 2006 to identify hygiene services human and capital resource requirements. The Hospital Manager has approved additional staff in line with the recommendations of the analysis and additional hours were allocated both in and out of core hours. Internal audits carried out provide information on resources, deficits and competencies. The hospital employed an external hygiene advisor, who carried out a human resource needs assessment. This assessment was considered during the development of the hospitals Hygiene Service Plan for 2006 and 2007. The hospital demonstrated strong hygiene leadership and a well-developed hygiene profile. The Hygiene Services Committee and Team have developed a commendable Corporate Strategic Plan and

hygiene service and operational plan. An annual report was also available for 2006, which identifies continuing support for the hygiene services.

ENHANCING STAFF PERFORMANCE

*Core Criterion

CM 11.1 (B → B)

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

Evidence was observed that all staff at the hospital have received corporate induction at the Health Service Executive headquarters on commencement of duty. Hospital staff also receive induction training at the Occupational Health Department. This induction training includes hygiene and infection control issues. This training is cross site orientated (i.e. both Monaghan and Cavan hospitals). On commencement of duty at Monaghan Hospital, local orientation is given at ward and department level. This orientation includes information on hygiene, infection control and hand hygiene. A comprehensive system of recording and monitoring staff education, through the overall computerised staff payroll and attendance system is in place and was demonstrated during the assessment. Staff have also participated in the annual Hand Hygiene Awareness Week. A corporate staff handbook is available and the hospital staff handbook is currently under review.

CM 11.2 (N/A ↑ B)

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

This criterion was not rated by the organisation. Documented processes were in place for ensuring the professional development of all hygiene staff. This included staff contracted through the cleaning contractors for the provision of hygiene services. Comprehensive information, which included provision of an employee handbook, accident reporting, a health and safety handbook and a smoking policy, was in place. A comprehensive skills training and recording system for all new hygiene services staff was observed in place. Hospital policy prohibits staff approval for other forms of training until the mandatory training has been undertaken. Staff training is provided during work duties and relevant training is identified in accordance with the requisite competencies for hygiene staff. Responsibility for the provision of hygiene related staff education and training is predominantly assumed by the Clinical Nurse Manager 2 in Infection Control, with the support of the Occupational Health department. Training records are maintained using a computerised system and evaluation is mainly through informal assessments (walkabouts) by key staff and feedback from department heads. Further training and education is supplied when necessary. It is recommended that a more formalised approach to evaluation of the effectiveness of the training is implemented for example the introduction of a formal competency identification tool to identify the specific competencies of hygiene services staff. The training needs assessment, which the organisation had identified as part of their quality improvement plan is encouraged.

CM 11.3 (B → B)

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

During the assessment, the hospital provided a clean environment for all. Areas of concern, which were noted, were addressed immediately. The internal audits system has consistently shown improvements in score levels in all departments. External

audits demonstrated that there was significant improvement on the most recent re-audit of 2006. A Risk Management and Complaints Systems are in place to identify any areas, of concern in relation hygiene. However, the hospital has received very few letters or comments of complaint regarding hygiene services. A meeting relating to hygiene was also held between the hospital manager and a patient advocate. This meeting identified patient concerns, which have been addressed. The hospital has a programme of quality improvement and action planning in place. At the completion of training programmes, evaluation by staff is carried out. However, it is recommended that a composite staff evaluation report be compiled to identify opportunities for improvement.

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.

The hospital, through the Occupational Health Department and in line with local managers, reviews and manages attendance issues at the hospital. The hospital uses the Framework for People Management to deal both formally and informally with disciplinary issues. Internal and external audits are used to identify performance issues with staff; however no formal staff performance review processes are in place within the hospital. The hospital has no internal Hygiene Services Supervisor on site who could liaise at ward/departmental level with hygiene staff on immediate hygiene concerns and issues.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (B → B)

An occupational health service is available to all staff

In conjunction with Cavan General Hospital, the hospital provides a comprehensive Occupational Health Service for all staff. Prompt and easy access to the service is provided as required. The Occupational Health Service provides an on-site service twice a week with referral to Cavan general hospital at other times. A well managed protocol for staff regarding the management of needle stick injuries is in place, which was well articulated by all staff questioned. A well defined immunisation protocol was observed, which ensures that all grades of staff receive vaccinations relevant to their role. A very user friendly leaflet has been produced by the Occupational Health department, which provides information on the service to all staff. No overall evaluation of the Occupational Health service was provided, however, evidence of evaluation of individual issues was observed for example Hepatitis B and needle stick injuries.

CM 12.2 (C → C)

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

The hospital presented evidence of a robust Health Service Executive attendance management policy, which has been adopted by the hospital and its' Occupational health department, resultant action plans, quality improvement plans and a documented process to address attendance issues were all observed. The Occupational Health Department carried out a "Stress at work" audit in 2005. A full report was issued with analysis. However, no recommendations, action planning or continuing evaluation were observed. An Occupational Health customer satisfaction survey template was observed, however, no actual completed samples or results were noted. The Occupational Health Department was not represented at the team meeting to explore these issues, and their attendance is recommended for the future.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.1 (B → B)

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

The terms of reference for the Hygiene Service Committee provide extensive evidence of the roles and responsibilities of all members. This includes responsibility for the collection, transmission, correlation and dissemination of data and information to the whole hospital. The Hygiene Services Committee also reports all issues relating to hygiene at the hospital to the Executive Management Board. Evidence of close collaboration of all grades of staff in relation to hygiene at the hospital was observed for example, minutes of meetings, interest and knowledge of the processes by staff. A process to manage the updating of policies and procedures at the hospital and address national alerts issues on medical equipment was observed. While there are quality improvement plans in place, evaluation of this criterion addresses the issues. It is recommended that the process for collection and accessing information is evaluated in the future.

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.

The hospital presented comprehensive evidence that data and information are disseminated throughout the organisation in a timely and structured manner. The high quality processes and management of the Hygiene Services Committee, Infection Control department and the Capital management programme were strong positive indicators for this area, which was evidenced in minutes of meetings and cross- correspondence regarding a range of issues. Data and information was also disseminated through the ward managers and heads of service. Audit reports, management of risks and patient complaints are communicated to all relevant areas in the hospital. No formal evaluation was presented on this process, however, evaluation of issues was available and easily interpreted by all staff, for example hygiene audits, incident reporting and patient satisfaction.

CM 13.3 (C ↑ B)

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

Extensive evidence of the quality of the both documentation and actions plans completed was provided. The hospital presented comprehensive details of external and internal hygiene audits, HACCP reports, water monitoring and waste monitoring. Accompanying evidence of informal evaluation and action plans through the mechanism of the Hospital Hygiene Services Committee and Team was also noted. The hospital presented comprehensive hospital hygiene, corporate and professional policies, procedures and guidelines, which were all in line with legislation and best practice in their relevant areas. A range of quality improvement initiatives are in place, which have been generated from the evaluation of the all the above components and are evident throughout the hospital for example new sinks, waste bins and training and education.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

CM 14.1 (B → 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

Evidence was observed that both the hospital management and corporate management structure of Cavan & Monaghan are actively involved in the quality agenda at the hospital. A full range of hygiene structures, objectives, goals and outcomes were available. The General Manager has been very supportive in improving the hygiene status at the hospital and has committed and provided additional human and capital resources to improving hospital hygiene services. Evidence of active education and training was observed. Up-dating and formulation of the hygiene and infection control policies were observed. The hospital is to be commended on the new cleaning and disinfection policy, which has been drawn up using the Irish Acute Hospital Cleaning Manual. The quality improvement plans, which are hygiene related, also incorporate HACCP, waste, infection control and water safety monitoring.

CM 14.2 (B → B)

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

A full list of all hygiene improvements carried out over the last 2 years was observed. These were based on the internal/external hygiene audits and environmental audits carried out and were in line with waste management and infection control policies. Many letters, notices and copies of e-mails from senior management were observed, which indicated active support of the hygiene services and standards expected and outcomes to be achieved. The hospital has benchmarked itself against the previous national hygiene audits (2005 and 2006) and internal audits. The organisation had employed an external hygiene advisor to audit and recommend future plans and all documentation in relation to this was available. The hospital has evaluated its outcomes, evidence of which was observed in continuing audits, outcomes and quality improvement plans.

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.

Documented processes for the establishment, adoption, maintenance and evaluation of best practice for hygiene services were observed, which had input from patients and clients. These were identified in the patient handbook, for example the smoking policy, rules for visitors, patient satisfaction survey, patient suggestions and the complaints procedure. Also included were instructions on recycling and segregation of waste. Colour coding systems are in place in accordance with HACCP guidelines and cleaning best practice guidelines and provision existed for supervisory staff to consult all relevant documentation. The first patient satisfaction survey was completed in April 2007, which included a section on accommodation and physical facility. Results displayed that 86.31% of the population surveyed were completely satisfied. An audit schedule has been developed for 2007, which identified areas to be audited, by whom, and the audit frequency. The implementation of this process with resultant action plans, feedback and quality improvement planning is strongly encouraged.

SD 1.2 (B → B)

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

A cleaning products implementation protocol had been developed and has been used to manage recent changes in cleaning product implementation. New introductions in relation to cleaning products included the flat mop system and new cleaning solutions. An example of a new intervention in the organisation includes the replacement of tea towels with disposable towels, in all areas except the main kitchen. Here they were still used for the handling of hot appliances. The installation of hand wash sinks with splash backs, which were fully compliant with best practice guidelines, in all clinical and non-clinical areas is to be commended. Bins, in line with best practice for segregation of risk and non-risk waste, have been introduced throughout the hospital. Recycling had been introduced and a further experimental initiative was in progress. Deep clean system for beds, using an external contractor, has been introduced and furniture and flooring were replaced where necessary to ensure all surfaces were washable. It is recommended that reusable tea towels be removed from the main kitchen.

PREVENTION AND HEALTH PROMOTION

SD 2.1 (B → B)

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

Hygiene services activities undertaken have involved links with General Practitioners. Information on hand hygiene has been made available and instructions are included in the patient information booklet. To date, one meeting has been held between the patient advocate and the Hospital Administrator to discuss hygiene related matters. A number of recommendations were made by the patient advocate, and these have been addressed. It is intended that these meetings will be scheduled on a structured basis with feedback and further suggested opportunities for improvement identified. An Infection Control Week was organised in 2006, which was open to the public and was well supported. Excellent posters and information leaflets pertaining to hygiene services were observed throughout the hospital and a specific dedicated hygiene services notice board is in place. This is to be commended. To date, the efficacy of these interventions has not been evaluated, and this is recommended.

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.

A hygiene services operational team is in place in the organisation, which is hospital specific. A corresponding team is in place in Cavan hospital. A corporate Hygiene Services Committee has also been formed, which comprises members from both Monaghan and Cavan Hospital. The Committee also has an identified list of additional relevant members to be included as required. Clear terms of reference, meeting frequencies, minutes of meetings and circulation lists were all observed. Team member's roles and responsibilities are all clearly identified. These structures had been introduced in February 2007, with a review date planned for December 2007. Evaluation to date is limited to a review of membership. It is recommended that the organisation evaluate the efficacy of this team.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

SD 4.1 (A → A)

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

Overall, the organisation's physical environment was clean and well maintained. This was evidenced in the compliance required criteria.

For further information see Appendix A

*Core Criterion

SD 4.2 (A → A)

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

There was evidence of documented processes for the cleaning of the organisation's equipment, medical devices and cleaning devices. Attention to detail is recommended in some areas.

For further information see Appendix A

*Core Criterion

SD 4.3 (A → A)

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

Evidence of documented processes and a high level of compliance in relation to the management and standard of cleanliness of cleaning equipment were observed. Attention was recommended in some areas, for example cleaning trolleys.

For further information see Appendix A

*Core Criterion

SD 4.4 (A → A)

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

The organisation's kitchens, including ward and departmental kitchens, were well managed and maintained in accordance with evidence based best practice and current legislation. The organisation must ensure that all waste containers are covered and meet best practice standards. The use of cotton tea towels (laundering of cotton tea towels in washing machine and drying in tumble dryer in the wash up area) should be discontinued. Consideration should be given to recording temperatures in dishwashers in ward kitchens and in the main kitchen.

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.

The overall management of hygiene services hazardous materials and sharps was in accordance with evidence based best practice and current legislation. Segregation of clinical risk and non-risk waste at collection requires review. Despite evidence of extensive development in this regard, additional clinical non-risk bins were still needed. The location of clinical non-risk bins close to the staff hand wash facilities is recommended in a number of areas. Evidence of compliance in relation to the handling and disposal of sharps was excellent. The organisation's quality improvement plan for the development of the compound for non-risk waste, which had already commenced, should be progressed as quickly as possible.

For further information see Appendix A

*Core Criterion

SD 4.6 (A → A)

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

The organisation's management of linen supply and soft furnishings was of a very high standard. All laundry for the organisation, with the exception of flat mops and tea towels in the main kitchen, was carried out in the laundry department in Cavan Hospital. As the flat mop system was a recent development and a room had been adapted to accommodate an industrial washer and dryer, it is recommended that a more suitable location be identified in advance of the instillation of the second washer. The soiled linen storage system was well maintained.

For further information see Appendix A

*Core Criterion

SD 4.7 (A → A)

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

Documented processes were in place for the management of hand washing in accordance with SARI guidelines and hand hygiene audits are carried out. During the Infection Control Awareness Week, instruction in hand hygiene was available to the public with an opportunity to evaluate its effectiveness at that time.

For further information see Appendix A

SD 4.8 (B → B)

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

Documented processes are in place for cleaning, clinical risk management, sharps management and waste segregation and removal. Systems are in place for the management of Aspergillus risk in relation to the construction work that was in progress. This system was observed to be very effective. Systems were in place to deal with non-routine situations, for example body fluid/blood spillage. Incident reporting forms are available for incident and near miss reporting – these included hygiene services. The issue of incorrect waste segregation was identified and addressed at education sessions; however, this was observed as an ongoing issue during the assessment and requires further attention.

SD 4.9 (B → B)

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

Very good documented processes were observed to encourage and help patients, clients and families understand and carry out their responsibilities regarding hygiene services. These included notice boards, information leaflets, a hospital visiting policy and a patient satisfaction survey, which was completed in January 2007.

PATIENT'S/CLIENT'S RIGHTS

SD 5.1 (B ↑ A)

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

The employee handbook outlined the responsibility of all staff to treat patients and clients in a courteous and impartial manner. Documented processes were observed in place for the maintenance of patient/client dignity at all times. The patient information booklet also identified the patient's right to privacy. The isolation signage policy ensures that the reasons for isolation are confidential. A complaints and review mechanism in accordance with best practice guidelines is also in place. Monthly reports were produced and circulated and a continuous improvement plan is in place.

SD 5.2 (B ↑ A)

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

A hospital Mission Statement was observed and information is also provided through the patient's handbook, information leaflets, and interaction with staff. This included patients, visitors and service user's rights and responsibilities. A patient satisfaction survey was completed during the month of April 2007 with a response rate of fifty questionnaires. Action points were identified and corrective actions taken in relation to the responses. The corrective actions however, were not documented and it is recommended that this be addressed. Plans are in place for further patient satisfaction surveys to be carried out at regular intervals.

SD 5.3 (B → B)

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

Documented processes are in place to manage patient/client complaints. Monthly reports are issued to the team. No significant complaints were recorded in relation to hygiene services. A system for dealing with any issues, feedback and any other issues relating to hygiene services was also in place.

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1 (C → C)

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

Documented processes were observed to involve patients, clients and families understand and carry out their responsibilities regarding hygiene services. Evidence of evaluation to date is the patient satisfaction survey 2007.

SD 6.2 (B → B)

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

The Hygiene Services Team is to be commended on its approach to managing and improving the quality of hygiene services. There was a variety of evaluation mechanisms in place, which included, informal assessments ("walkabouts") by the General Manager, Clinical Nurse Manager 2 and the Infection Control Department. 'On the spot' identification of problems and resolution is possible using these methods. All staff are encouraged to identify areas requiring improvement and these are brought to the Hygiene Services Committee for resolution, if they have not

have been resolved otherwise. There were a number of internal audits in process in addition to the previous national audits (2005 and 2006). The organisation employs the services of an independent external facilitator to evaluate the service and make recommendations. The organisation acknowledged a dramatic change particularly within the last twelve months, which was attributed to the General Manager's role in raising awareness, the commitment of the Hygiene Services Committee and staff ownership for hygiene standards. Reports, action plans and responsible persons were identified as key drivers. The reports from the Hygiene Co-ordinator are integrated into the agenda for Corporate Management Committee with the circulation of minutes to all staff. A Hygiene Services Annual Report was available for 2006, which was identified as the responsibility of the Hygiene Management Team in the future. Best practice guidelines were in place in hygiene services delivery with identified quality improvement plans.

SD 6.3

(B → B)

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

A structured approach had been developed for the Hygiene Services Annual Report. The report was available to all relevant stakeholders. Hygiene services policies, procedures and guidelines were in place and there was evidence of review and update. A quality and risk management structure has recently been established. It is recommended that this committee take responsibility for ensuring the identification of all necessary policies, procedures and guidelines and documented processes for the development, approval, revision and control of all policies, procedures and guidelines relating to hygiene services in conjunction with the Hygiene Services Committee.

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

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

Yes - Work route processes were evident.

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

Yes - However, high dusting throughout the hospital required attention. Some rusty trolleys and bins were also noted.

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

No - Cobwebs and flaking paint were noted. Also, high dusting was observed as an issue throughout the hospital.

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

Yes - The main entrance was excellent. However, the old Accident and Emergency Department entrance requires attention.

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

Yes - Overall stairs, steps and lifts were observed to be clean and well maintained.

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

Yes - Overall, the grounds and car parks were of an acceptable standard.

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

No - Some open top bins were observed in the main kitchen. Despite the provision of a significant number of waste bins, more are still required. Some transportation waste bins were visibly in need of attention.

(15) Where present a designated smoking area must comply with the national legislation on tobacco control and local organisational policies, a cigarette bin must be available and the floor area should be free of cigarette ends, matches etc.

Yes - No designated smoking areas are provided on site due to the regional policy.

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

(21) Internal and External Glass.

No - Ground floor windows observed require cleaning in some areas.

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

No - Attention to floor corners is required throughout the hospital, especially on corridors.

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 - It was observed that pest control devices require some attention.

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

Yes - However, some curtain rails are in need of attention.

Compliance Heading: 4. 1 .5 Sanitary Accommodation

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

Yes - Bathrooms and washrooms observed were clean, however, no evidence of monitoring or recording as per local policy was noted.

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

(55) Sluices

Yes - Sluices were well-maintained; however, no sluice was available in the Intensive Care Unit.

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

Yes - Evidence was observed that the required standards are met.

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 - A considerable level of compliance was noted, however, some trolleys and stands were visibly rusty, and in need of attention.

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

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

Yes - Only one fan was observed in a clinical area.

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 - Chart trolleys require more attention to detail.

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

No - No evidence was observed that office equipment, telephones and personal computers are cleaned or who is responsible for their cleaning. Generally, equipment was dusty and visibly in need of attention, especially telephones in most areas.

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

Yes - Overall, the organisation was compliant in this area.

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 - A number of cleaner's trolleys were visibly in need of attention

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

No - A number of items of cleaning equipment were in need of attention,

(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.

Yes - While the majority of areas comply, a few areas did not meet the required standard.

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

Yes - However, one cupboard observed was visibly rusted.

Compliance Heading: 4. 4 .2 Facilities

(218) Authorised visitors to the food areas should wear personal protective clothing (PPE) and wash hands on entering the food area during food preparation/serving times.

Yes - Food is currently taken through food supply doorway in closed containers for the 'meals on wheels' service. This process conflicts with best practice.

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

Yes - The provision of a paper towel disposal adjacent to wash hand basin is recommended.

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

Yes - The commissioning of a new staff shower facility is recommended.

Compliance Heading: 4. 4 .3 Waste Management

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

Yes - Pest control devices should be cleaned.

(233) In food preparation areas where lidded bins are provided they shall be foot pedal operated.

No - Some open top bins remain in use in the main kitchen.

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

(240) A Hospital using a cook-chill system should comply with Guidance Note No. 15 Cook-Chill Systems in the Food Service Sector (Food Safety Authority of Ireland) The temperatures of fridges, freezers, cold rooms and chill cabinets shall be capable of maintaining the temperature of foodstuffs

Yes - A cook-chill system not in use. Food is cooked daily. However, all appropriate temperatures are recorded.

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

Yes - No ice cream display units are in operation in the hospital.

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 - Items were observed that required replacement, for example the food processor observed was chipped. A small number of baking tins also need replacement.

Compliance Heading: 4. 4 .7 Food Processing

(246) The thawing of food shall be carried out under appropriate conditions such as in a thawing unit, a fridge or a microwave oven with thawing cycle

Yes - The thawing of food is carried out in a refrigerated system.

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.

Yes - However, it is suggested that records of such temperatures are maintained.

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

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

Yes - A discharge to drain license is not requested by the local authority and consequently was not available.

Compliance Heading: 4. 5 .3 Segregation

(156) Healthcare risk waste must be segregated from healthcare non risk waste.

No - Compliance in this area was generally poor, although containers were available. Extensive evidence of misappropriation of risk waste and non risk waste was observed.

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

No - Mattress bags were not in use for mattresses awaiting disposal/decontamination.

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

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

Yes - The use of ward based washing machines is prohibited by local policy.

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

Yes - A new hand washing sink is in situ in the laundry room – this was identified in the organisation's quality improvement plan.

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

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

Yes - Overall, it was observed that nozzles of soap and alcohol gel dispensers complied with the required standard.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team		Assessor Team	
	FREQ	%	FREQ	%
A	7	12.50	9	16.07
B	35	62.50	41	73.21
C	13	23.21	6	10.71
D	0	00.00	0	00.00
E	0	00.00	0	00.00
N/A	1	01.79	0	00.00

5.2 Ratings Details

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

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