Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Hygiene Services Assessment Scheme

Assessment Report October 2007

St. Michael's Hospital, Dun Laoghaire

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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.

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[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

St Michael's Hospital, Dun Laoghaire, is an acute hospital opened in 1876. The hospital has 122 beds including 13 day beds. The catchment area for St Michaels Hospital as part of St Vincent's Healthcare Group Ltd is South Dublin and Wicklow.

Services provided

In patient specialties:

- Respiratory department
- Diabetes
- Infection Control
- Wound Care
- Occupational Health
- Cardiology Unit
- Cancer care/palliative care
- Urology
- Pain Management
- Vascular
- Plastic Surgery
- Haemovigilance

Out Patient Clinics:

- Cardiac Rehabilitation
- Diabetes
- Respiratory
- Heart Failure Unit
- Vascular
- Paediatric Clinic
- Urology
- Gastroenterology
- ENT
- Gynaecology
- Phsychiatry
- Orthopaedics
- Plastics
- General Medical/Surgical

Physical structures

St Michaels have no designated Isolation rooms, the private single rooms in St Michaels are used for Isolation purposes; there are no negative pressure or positive pressure rooms.

The following assessment of St. Michael's Hospital, Dun Laoghaire took place between 15th and 16th August 2007.

1.3 Notable Practice

- Hand hygiene education and compliance was of a high standard.
- The Clinical Sink Replacement Programme which is underway.
- Waste management procedures and ongoing waste management plans are to be commended.
- Catering facilities were of a high standard.
- Risk management structures are to be commended.

1.4 Priority Quality Improvement Plan

- Complete an Aspergillus risk assessment in the new building.
- Implement a process to monitor contractors.

- Review hygiene services to consider the allocation of cleaning requirements at the hospital.
- Review internal signage for effectiveness.
- The hospital should reflect all areas in its refurbishment plans including non clinical areas.
- Ensure hygiene is represented on all necessary agendas and projects throughout the hospital.
- Particular attention should be paid to high dusting within the hospital.

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 St. Michael's Hospital, Dun Laoghaire has achieved an overall score of:

Poor

Award Date: October 2007

1.6 Significant Risks

CM 8.1 (Rating D)
The organisation has a process for establishing contracts, managing and monitoring contractors, their professional liability and their quality improvement processes in the areas of Hygiene Services.

Potential Adverse Event
Suboptimal service provided by the contract staff.

Risks

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

Recommendations
It is recommended that the organisation implement a process for establishing contracts, managing and monitoring contractors, their professional liability and their quality improvement processes in the areas of Hygiene Services.

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.

The hospital, through the Hygiene Service Management system regularly assesses and updates the current and future needs of the hygiene services at the hospital. This was observed in a variety of ways, for example: internal audit systems of both the infection control and the hygiene contractors, the development of the Infection Control Manual which includes changes to hygiene practice in line with national cleaning guidelines (including colour coding, linen procedures and waste management). The results of internal audits are available to the hygiene services committee, team and departmental heads. There is a Hygiene Strategic Plan and Service Plan in place. There are copies of best practice and legislation available in relation to cleaning and catering. The hospital carries out regular patient satisfaction surveys and is currently developing a new questionnaire to formally include hygiene.
There is no evidence of the completion of a formal needs assessment process for the hygiene services. It is recommended that the hospital formalise a documented processes for a needs assessment and evaluate it for effectiveness.

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.

There is evidence that the hospital has undertaken a number of quality initiatives in the last 12 months. During the assessment it was observed that a major clinical hand wash sink replacement programme is near completion, with some further work noted. Internal local hygiene audits have influenced a hand hygiene education programme and waste bins replacement programme. There are plans in place to review the cleaning specifications at the hospital in conjunction with a review of the hospital cleaning tender. It is recommended that the hospital develop evaluation criteria to ensure that modifications and developments have been effective.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1 (B ↓ C)

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

The hospital is a member of a larger group of hospitals. There are direct accountabilities and responsibilities to the Board of Directors of the Group, the Network Manager (HSE) and Department of Health. This was evidenced in minutes of meetings and correspondence presented. The hospital has formed linkages with the SARI programmes, infection control association, local general practitioners, nursing homes and the hospital's hygiene contractor, waste contractors, local council, and suppliers of hygiene equipment. These linkages should be formalised. Evidence of patient/ client satisfaction surveys was also available. It is recommended that the hospital should develop a process to evaluate the efficacy of its linkages and partnerships.

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.

There are clear roles and responsibilities identified. The hospital has developed the Hygiene Strategic Plan and the Hygiene Service Plan which outlines the goals, objectives and proposed outcomes of the annual plan in line with hygiene plans of the group of hospitals. There is a multidisciplinary Hygiene Committee and Team in place, which includes representation from the hygiene contractors. However, there is no patient representation on these committees. There was no evidence of communication of this plan throughout the hospital. It is recommended that the hospital evaluate its Strategic Plan against defined needs.

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 Hospital, through the Hospital Group, has a current and inclusive philosophy and code of ethics in line with its mission statement and Catholic ethos. Corporate responsibility for hygiene is identified in the office of the General Manager through the CEO of the Hospital Group. The terms of reference and membership of the Hygiene Services Committee identify accountabilities and responsibilities of members. A suite of Hospital Corporate Polices was observed. The hospital has recently developed a Hygiene Service Plan and completed a review and revision of the Infection Control Plan. It is recommended that evaluation of compliance and adherence to legislation and relevant national guidelines is carried out.

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.

The hospital has a system of internal audit mechanisms and outcomes are reported to the Hygiene Services Committee and Hospital Management Team. The Hygiene Contractor carries out internal audits and links with the infection control department and reports on its outcomes. The hospital receives best practice information (for example SARI and National Cleaning Guidelines through the HSE). No identified Key Performance Indicators are in place. However, evidence in the documentation provided demonstrated that the hospital receives internal audit outcomes, which with information on best practice are discussed at hygiene services management meetings. No trend analysis reports are available. It is recommended that the hospital develop documented process for the management of best practice information. It is also recommended that the hospital develop evaluation processes for this criterion.

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.

Staff have access to the facilities of the library where best practice information is available — for example, in the Infection Control National Cleaning Manual. There is limited access to the internet for research and information purposes. The hospital has the services of an infection control department, which advises on hygiene and infection control issues. The recently revised Infection Control Manual, which includes waste, linen and decontamination procedures is available for staff. The cleaning specifications are currently being revised. The hospital has instigated changes of practice as a result of research — for example colour coding, waste recycling, HACCP, and linen procedures. There is an active and well-documented hygiene education programme in place. There is evidence of attendance records and evaluation. There is a plan in place to include a section regarding hygiene in the hospital newsletter. It is recommended that this initiative is progressed. It is also recommended that the evaluation forms collected in the education programme are evaluated and outcomes recorded. A process to evaluate research and best practice information in line with a defined need should be implemented.

CM 4.4 (B ↓ C)

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

The Infection Control Manual was issued in August 2007 and this is a Hospital Group joint document. This policy reflects current best practice and guidelines and includes hygiene and clinical infection control management policies. No documented processes were observed for the development, approval and revision of Hygiene Services policies, procedures and guidelines. A suite of policies, procedures and guidelines for the Hygiene Services was observed. Hygiene contractors policies, procedures and guidelines were also noted. It is recommended that a process is developed and evaluated for effectiveness.

CM 4.5 (B ↓ C)

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

A capital project is underway to upgrade the fire doors and fire compartmentalisation at the hospital. There is no involvement of the hygiene team and limited involvement by the Infection Control Department in this project. The proposed operating theatre re-development project is due to commence shortly. Currently relevant clinical, management and support staff are involved in the committee for this project and it was indicated during the team meeting that the Hygiene Services Committee will be involved in the identification of hygiene issues. It is recommended that the hospital develop documented processes to ensure that the hygiene services are actively represented on all relevant hospital capital projects and evaluate the efficacy of the communication links in the capital development planning and implementation process, as suggested in this criterion, should be developed for future projects.

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.

Responsibility for the hygiene service at St. Michael's has been devolved to the General Manager. The Hygiene Management Structure at the hospital includes a multidisciplinary Team and Committee. The Committee is comprised of the Hospital Management Team and the Hygiene Services Team and reflects the interdepartmental areas of the hospital, including the hygiene contractor. There is evidence of terms of reference, membership list, communication circulation list and minutes of meetings, with identified action plans and persons responsible for the progression of actions. Clear organisational charts for hygiene services were observed and reporting structures were noted. Job descriptions for contract cleaning staff, site supervisor site manager and ward managers were observed with responsibility for hygiene and safety defined.

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

CM 6.2 (B ↓ C)

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

The hospital adheres to the principles of the National Procurement Policy and procedures. The Hospital Hygiene Committee has commenced discussions on hygiene purchasing requirements, for example, sink replacement. This process is undocumented and in its infancy. Informal communication between the Finance Manager and the Infection Control Officer facilitate purchasing. Some pre-purchase evaluation was noted, for example clinical equipment. However, a pre-purchase evaluation form has been developed. It is recommended that the hospital formalise its purchasing process for hygiene and issue documented procedures for this area. The hospital should channel all requests in relation to new items for purchase for the Hygiene Service through the Hygiene Services Committee.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

CM 7.1 (B ↓ C)

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

There is formal risk management programme and department at the hospital. There is comprehensive evidence of a risk policy, incident reporting mechanism, feedback, and follow-up action plans. Evidence of quarterly reports and trend analysis was also observed. Risk assessments have been carried out at the hospital for chemical, pregnancy, offices and health and safety risks. There is evidence of risk management meetings and education programmes. A risk was identified in relation to the management of Aspergillus during the current construction and re-grading Fire Prevention Construction works. This risk was addressed immediately and all construction work was deferred in consultation with the builder .The completion of an Aspergillus risk assessment in consultation with the Microbiologist and the Infection Control Team is recommended

CM 7.2 (B → B)

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

There is active support from senior management for the risk management process. This was evidenced in the annual risk report, quarterly reporting of identified risks, departmental structure, support for education and the establishment of a Risk Committee. A full and comprehensive list of safety/risk reports was noted. There was evidence of two hygiene risks issues in the previous two years. Full investigation, reports and outcomes were observed. The identified QIP for this criterion has been instigated, which is the establishment of a Risk Committee.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion

CM 8.1 (B ↓ D)

The organisation has a process for establishing contracts, managing and monitoring contractors, their professional liability and their quality improvement processes in the areas of Hygiene Services.

The current cleaning contract was agreed with an external contractor in 2001 and this has not been reviewed or re-issued. There have been informal modifications to the contract in the ensuing years for service requirements. The current contract cleaning specifications have not formally included changes of practice in line with best practice. There is no monitoring mechanism of the external contracts by hospital management. It is recommended that the hospital review its monitoring processes of external contractors providing services at the hospital.

CM 8.2 (B ↓ C)

The organisation involves contracted services in its quality improvement activities.

There is evidence, through the membership list of the Hygiene Services Team, that there is some involvement of the hygiene services contractor in QIPs. There has been an informal introduction of some national hygiene guidelines through the contractor, for example, colour coding and cleaning equipment trolleys. There is

evidence that the waste management external domestic waste contractor is involved in the recycling project at the hospital.

PHYSICAL ENVIORNMENT, FACILITIES AND RESOURCES

CM 9.1 (B ↓ C)
The design and layout of the organisation's current physical environment is safe, meets all regulations and is in line with best practice.
The hospital is currently undergoing a major fire prevention structural programme, which will install a new fire alarm system and will compartmentalise the hospital for fire purposes. There are plans for the upgrading of the theatres and there is an annual painting programme in place. The hospital has a set of Health and Safety statements in place for all areas. Modifications to the building have been carried out and these reflect best practice at the time of the renovations. The hospital currently is a fit for purpose building, though it presents challenges for the hygiene services with its ducting systems, high ceilings and lack of storage. It is recommended that the hospital carry out a formal evaluation on this criterion.

*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.
The hospital has developed policies, procedures and guidelines to ensure that it plans and manages its hygiene and ancillary services. This includes HACCP, waste management, infection control, linen and decontamination. The external hygiene contractor has developed hygiene polices and procedures, check lists and mechanism of signing to comply with this criterion. The hospital has risk management and health and safety measures in place. Best practice information, which influences the hospital, was observed. It is recommended that the organisation addresses the storage needs.

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.
There are comprehensive internal audit processes in place in the hospital. The hospital and the external hygiene contractor carry out regular audits. While the frequencies of the audits are to be commended, it is recommended that the organisation develop a process to implement quality improvement plans as identified in the audits, prior to re-auditing. The latest Environmental Health Officer (EHO) report was viewed. Details of patient satisfaction surveys were noted. There were substantial changes made to hygiene services as a result of the external and internal hygiene audits, for example, the replacement of sinks and the upgrading of bathrooms, waste management and hand hygiene stations) and a QIP is in place.

CM 9.4 (A ↓ C)
There is evidence that patients/clients, staff, providers, visitors and the community are satisfied with the organisation's Hygiene Services facilities and environment.
There is visible evidence in the hospital of interaction with services users. For example, patient satisfaction comment cards, posters and 'Drop' boxes. A QIP has been identified for this criterion and a new patient satisfaction form will be designed

to specifically include hygiene. There is a risk management policy and a complaints policy, which also support provision of comments in relation to hygiene services. There was evidence of quarterly results of patient satisfaction, with very little patient comments regarding hygiene services noted. These reports are circulated for action throughout the hospital. It is recommended that the hospital finalise its QIP plan to include a hygiene section on the patient satisfaction surveys.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 (A ↓ C)
The organisation has a comprehensive process for selecting and recruiting human resources for Hygiene Services in accordance with best practice, current legislation and governmental guidelines.
The hospital has developed recruitment policies for all hospital employed staff. The hospital adheres to the HSE recruitment best practice guidelines. A range of job descriptions were noted. Cleaning staff are employed by the external contractor. The hospital has no mechanism to ensure that contracted staff meet all recruitment terms and conditions. Hygiene services recruitment and personnel records were not observed as they are centrally held at the contractor's off-site head office. With the exception of education records, no records are available to the hospital. It is recommended that the hospital seek appropriate copies of personnel records, in particular for long-term hygiene staff and evaluate its human resource process for hygiene services.

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.
Informal additional staff have been granted as required on an informal basis. Internal audits have influenced the employment of extended evening hours.
It is recommended that the hospital review its hygiene services in line with the recommended national cleaning and best practice guidelines and to establish this review using a needs assessment tool.

CM 10.3 (A ↓ C)
The organisation ensures that all Hygiene Services staff, including contract staff, have the relevant and appropriate qualifications and training.
There were processes in place, through the formal recruitment process, to ensure that hospital appointed staff have relevant and appropriate qualifications and training. The hygiene services cleaning staff are contracted to an external hygiene contractor. As part of the terms of the contract, the contractor is obliged to employ appropriate staff. However, the hospital has no copies of contracted staff's personnel records. Job descriptions for contracted hygiene staff were observed. It is recommended that the hospital ensures that the staff employed through the contractor have the appropriate training and qualifications as set out in the terms and conditions of the contract.

CM 10.4 (A ↓ B)
There is evidence that the contractors manage contract staff effectively.
There are strong internal mechanisms for the contractor to manage its hygiene staff through direct supervision and providing a training officer on site. The contractor conducts two weekly hygiene audits and conducts monthly hygiene audits in

conjunction with the infection control department. There is evidence of the audits, outcomes and resultant actions. The contractor has policies, procedures and a guideline manual which documents processes for the management of contract staff. There was evidence of contractor staff education records, training and orientation and occupational health requirements. It is recommended that the hospital review its management of the hygiene contract tender to specifically include areas that require further attention. It is recommended that new contract cleaning specifications for future cleaning tenders include current best practice guidelines.

*Core Criterion

CM 10.5 (A ↓ C)

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

A cleaning service contract is in place since 2001. Hygiene services are externally contracted. No formal review of contractor's levels of staff requirements has been carried out since 2001. This is completed on an informal basis. Additional staff have been employed to cover evening duties and to cover building projects. The cleaning staff rota was observed. There was a hospital Strategic Plan and Service Plan observed. No hygiene annual report was noted. However, the hospital Group Annual report has referred to hygiene, infection and financial commitments and resources for the hygiene process.

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.

There is a designated orientation and induction programme for all new staff at the hospital. This programme includes the principles of infection control and hygiene (including hand hygiene training). The infection control department offers information packs to all new staff and records of attendance are available. The hospital handbook is also given to all staff. Catering staff and nursing staff have discipline specific induction booklets. It is recommended that hygiene-related information is circulated to all new staff and that hand hygiene training be mandatory for all staff.

CM 11.2 (A ↓ C)

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

Evidence of ongoing hygiene education in the hospital was observed. Records are observed for course content, attendance levels and course evaluation by staff in attendance. A classroom is available for training purposes and the library is available to all staff. A range of education programmes are observed, for example, hand hygiene, waste management, principles of infection control, staff development, risk management and manual handling. Contract hygiene staff have access and are included in attendance records at the education programmes at the hospital.

It is recommended that a full evaluation of all courses is undertaken to ensure attendance compliance with the mandatory requirement for continuing education and training.

CM 11.3 (A ↓ C)

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

Comprehensive internal audits are available, including audit results and action plans. External hygiene audits are also noted. Limited HACCP audits are noted. Patient satisfaction comments and risk management incidents are noted. Patients interviewed during the assessment voiced satisfaction with the hygiene services and responses to hygiene requests. There is comprehensive training evaluation by staff on completion of training, which indicates understanding of the hygiene issues.
It is recommended that the hospital develop a suite of Key Performance Indicators for Hygiene Services. It is also recommended that the hospital formally evaluate staff satisfaction with training programmes in a composite form.

CM 11.4 (A ↓ C)

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

The hospital conducts regular audits, the results of which are used to measure staff performance. The external contractor audits the hygiene services. There is no formal mechanism for staff appraisal, but team-based performance management has commenced. The HR policies and Framework for People Management are used to identify specific staff difficulties with performance.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (A ↓ C)

An occupational health service is available to all staff

An Occupational Health Service is available to all hospital employed staff and contract staff. There is pre-employment screening and a vaccination service available. There is little formal evidence available during the assessment of the service provided. However, there were some leaflets available on pre-employment screening, management referral forms and needle stick injury management. All appropriate Occupational Health vaccinations, including HEP B are available. There is no evidence of evaluation of the appropriateness of the OH service provided. QIP has been identified for the development of OH policies, procedures and guidelines, but this has not been progressed. It is recommended that an evaluation of the appropriateness of the Occupational Health Service is carried out.

CM 12.2 (A ↓ C)

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

An annual Occupational Health Report is published, but was not available during the assessment. A well-being programme is in place and a specific well-being day has taken place. Holistic services for staff are held on a monthly basis, for example, aromatherapy and stress management. No staff satisfaction surveys have been carried out. It is recommended that the hospital implement processes to monitor staff satisfaction.

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.

The infection control and the general management departments provide relevant information and data on legal and best practice requirements, for example SARI, Fire Safety, Waste Management and National Cleaning Guidelines. The hospital carries out regular internal audits and external hygiene, EHO and health and safety (fire) audits. Current Infection Control policies recently issued comply with best practice.
It is recommended that the hospital develop documented processes to evaluate, date for reliability, accuracy and validity.

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.

The hospital is to be commended on the support of management to the fostering of a quality culture. During the assessment the hospital carried out remedial actions in a timely manner and has agreed to continue to strive towards a world class hygiene service. The hospital has infection control, quality, risk, complaints and clinical departments to support the process. The establishment of the Hygiene Services Committee and team will continue to lead the hygiene agenda. It is recommended that the quality improvement initiatives encompass all areas of the hospital including clinical, allied medical and clerical /administration and service areas (for example, kitchen, maintenance, waste and supplies). It is noted that there is an emphasis on QIPs to date in the clinical area (for example sinks) and it is recommended that this is rolled out to all areas.

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 (A ↓ B)

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

Best practice guidelines are adopted and maintained in the organisation. A Cleaning Standard Manual is in existence, but has not been fully implemented and evaluated. A Manual for Infection Control and a Waste Management Manual have been developed. A Hand Hygiene Manual has also been developed and notices are displayed throughout the hospital in appropriate areas. There is documented evidence of ongoing training for implementation of national standards. Colour coding of cleaning equipment has changed within the last six months from the in-house system. Staff were aware of the change and there is clear signage in the appropriate areas. It is recommended that the hospital evaluate the process in place to develop best practice guidelines.

SD 1.2 (B ↓ C)

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

New hygiene service interventions have been implemented.

PREVENTION AND HEALTH PROMOTION

SD 2.1 (A ↓ C)

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

A community nurse link and liaison with the community GP is noted.

Infection control leaflets are available (and provided for patient/visitor information). The Patient Handbook is currently being developed and a draft copy is available. Community involvement is limited to volunteers selling from the mobile shop/trolley daily. No patient representative is included on the Hygiene Team and no evidence of a patient forum is noted. It is recommended that the organisation address these areas in the near future. Complaints/feedback forms are available throughout hospital and are reviewed fortnightly. Education of staff is ongoing and the infection control nurse has ultimate responsibility for this area. Limited documented evidence of evaluation of education and training courses is noted, which is recommended. An exception noted are the infection control courses, where extensive evidence of course quality and evaluation is observed.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1 (A ↓ C)

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

A Hygiene Services Team is in place in the organisation. The team is multidisciplinary in its composition, but limited documentation of meetings, agenda, action points are noted. There is documented evidence of education and training provided to a range of staff throughout the hospital, but this training has not been completed for all staff. No documented evidence of evaluation of training is carried out, which is recommended. An over reliance on informal oral communication was evident during the assessment. Limited documented evidence was observed of full partnership and participation from all stakeholders in terms of composition of the team and participation by other teams and organisations. A large number of individual contractors are employed for a range of different waste products. The organisation is recommended to identify an individual responsible for overall waste management. The hospital are encouraged to review the efficacy of the multidisciplinary team structure.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

SD 4.1 (A ↓ C)

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

A cleaning specification exists with a contract cleaning company, but their remit is limited. Clarity was not apparent with respect to specific areas, for example, high and low dusting and furniture cleaning. Routine maintenance was not in evidence, for example, window replacement and missing tiles. Attention to detail following building works is recommended, including plasterwork to ensure it can be easily cleaned. Floor surfaces were in poor condition in some areas. There has been some replacement of chairs with easily washable vinyl, but this was limited. Some exceptionally good areas were noted, in particular in the newly-built and renovated areas and the day ward in particular was 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.

Office areas within clinical settings require a policy regarding the routine cleaning of computer keyboards, telephones and fax machines.

Although a written policy for the cleaning of soap and gel dispensers for hand hygiene was in place, little evidence of compliance at ward level and in the general hospital area is observed. Patient fans are widely available in use without any SOP for regular cleaning and maintenance. This should be addressed in the future. The cleaning procedures in the day ward are to be commended.

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.
A policy is in place for the cleaning of equipment but little evidence of adherence to this is noted. Most of the cleaning equipment is stored in one area. The security of this area needs to be addressed. Most of the buckets and mops are stored in this area with the resultant inappropriate cross-use. Processes are in place for cleaning cloths and mop heads, however, this process is not clearly documented. The hand wash sink is obscured in this area by cleaning equipment. No clear documented process has been developed for changing filters in vacuum cleaners, which is recommended. Staff in general were pleasant and well trained and were managing well in a situation where lack of space is an issue. The provision of lockable cupboards to segregate and store the cleaning equipment apart from clinical and catering areas would assist this process.

For further information see Appendix A

*Core Criterion
SD 4.4 (B ↑ A)
The team ensures the organisation's kitchens (including ward/department kitchens) are managed and maintained in accordance with evidence based best practice and current legislation.
Overall, kitchen areas and food hygiene is of a very high standard and is compliant in both documentation and in practice. The condition of the floor in the main kitchen needs to be addressed in the near future by the catering manager and should ensure all EHO recommendations are completed.
Food deliveries directly to the kitchen area should be resumed as soon as possible as delivery through the main hospital entrance is not ideal.
The kitchen delivery area should be considered when a plan for a new waste area nearby is being developed. A number of laminated signs in large print should be placed around areas in the kitchen that constitute a Critical Control Point according to the HACCP procedures and in addition signage regarding the colour coding of chopping boards should also be put in place in the relevant areas.
Repainting is required in the canteen, opposite the main kitchen. Staff training is being carried out, but this needs to be clearly documented to include the nature/title of training course attended. A list of staff and their training history should be brought up to date in the near future.

For further information see Appendix A

*Core Criterion
SD 4.5 (A ↓ B)
The team ensures the inventory, handling, storage, use and disposal of Hygiene Services hazardous materials, sharps and waste is in accordance with evidence based codes of best practice and current legislation.
Waste segregation, collection and transportation is excellent. Infection Control waste-related training is also excellent. Co-ordination of Hazardous Waste Management Contractors and documentation could be improved. DGSA Reports, Waste Discharge License and Hazardous Waste C1 Forms are not available. All waste-related documents should be stored together in a central location.

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.

Linen supply is located in a portakabin building with external access from other locations. This should be reviewed for effectiveness.

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.

Extensive evidence of up-to-date training in infection control and hand hygiene was observed. Documented evidence of attendance and evaluation of courses is provided. Infection control procedures are based on SARI guidelines. This is commended.

For further information see Appendix A

SD 4.8 (A ↓ B)

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

A health and safety manual is available. Material safety data sheets (MSDS) for cleaning agents and chemicals sheets are available in cleaning areas and in the Kitchen. Training courses are in place for contract cleaning staff and other staff. Appropriate usage of 'cleaning in progress' signage are provided. Documented evidence of training records are also available, as are incident reporting forms.
Fortnightly hygiene audits are carried out, which are documented and reports produced.

SD 4.9 (A ↓ C)

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

There is no representation of patients or families on the Hospital Hygiene Committee and there was no evidence of wider community communication.
Patient surveys are completed, on an informal basis. There is no policy for routine patient surveys (hygiene, catering, general satisfaction) or information sessions for patients/families in place. Draft versions only of hygiene services information leaflets and a patient information leaflet are available. Comments sheets were made available recently which seek patient feedback regarding hygiene. The organisation is recommended to formalise its methods of communication with patients/clients/families in the near future.

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.

Patient dignity and privacy are not included in any hygiene services documents observed. Privacy and dignity is afforded to patients through the provision of private rooms. This was noted in the Hospital Mission Statement and this is communicated

to patients through the draft Patient Information leaflet. Evaluation of complaints from patients is followed through. Families and patients can fill in evaluation cards which are reported back to the Hygiene Services Committee on a quarterly basis. Patient complaints which are reported to the Hygiene Services Committee are all followed through. More personal patient interaction on an ongoing basis with the Hygiene Services Committee would be welcomed.

SD 5.2 (A ↓ C)

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

A Hygiene Services Information Leaflet is available for patients, but this is currently in draft form and comments are encouraged. Patients should be clear about the standards which should be met by Hygiene Services and it is recommended that the information leaflet be completed as soon as possible. In addition it is recommended that a patient/member of the public be included in the hygiene team.

SD 5.3 (A ↓ B)

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

Complaints from patients are few and satisfaction appears to be good.
Any complaints are followed through in full by discussing complaints with appropriate managers.

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1 (B ↓ C)

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

Patient evaluations are processed through complaints and satisfaction surveys. Results of satisfaction surveys are communicated to the Hygiene Services Committee on a quarterly basis. Patients or members of the public representing former patients do not participate personally in the Hygiene Services Committee and it is recommended that this situation be reviewed.

SD 6.2 (B ↓ C)

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

Assessments are undertaken by the Infection Control Team and in consultation with the cleaning contractor. Documentation in the form of minutes and action points relating to these assessments are available. Many opportunities for improvement are identified following assessments and it is recommended that these are implemented as part of the overall QIP plan for the Hygiene Services.

SD 6.3 (B ↓ C)

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

There is no evidence of an individual Hygiene Services Annual Report, but the Group Annual Report 2006 makes reference to infection control and isolation needs. Other relevant annual reports observed included Risk Management, Health and Safety and Complaints. With the exception of leaflets and patient complaint forms, no evidence of initiatives to include patients, families and service users as stakeholders in the hygiene services is observed, which is recommended.

4.0 Appendix A

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

4.1 Service Delivery Core Criterion

Compliance Heading: 4. 1 .1 Clean Environment

(1) The environment is tidy, well-maintained, free of rust, blood or body substances, dust, dirt, debris and spillages.
No - Dust was observed at high level was noted for example curtain rails, window sills and lockers.

(2) All high and low surfaces are free from dust, cobwebs and flaking paint.
No - High dusting was observed to be poor. Flaking paint was observed in many areas. Floor quality, especially tiling, which was cracked and chipped requires upgrading.

(3) Wall and floor tiles and paint should be in a good state of repair.
No - The Accident and Emergency department, isolation rooms, corridors, toilets and sluice room in the day ward require upgrading.

(4) Floors including edges, corners, under and behind beds are free of dust and grit.
No - Stairs and bathrooms floors in general require attention particularly, the floors in the Intensive Care Unit.

(5) Cleanable, well-maintained furniture, fixtures and fittings used.
No - Old and poorly maintained wooden surfaces were observed. Legs and wheels of furniture are not sufficiently well maintained to allow effective cleaning.

(7) Areas should be adequately ventilated with ventilation units cleaned and serviced accordingly and documentation available regarding service.
Yes – This is only applicable in the operating theatre as air conditioning was only observed in operating theatre and was up to standard. Fans and open windows are used for ventilation throughout hospital with no standard cleaning routine for these items.

(10) Internal and external signage should be clean, updated, well maintained and laminated to enable cleaning.
No - Residual sticky tape marks were noted on some areas. Some signage print was too small to read.

(12) Internal and external stairs, steps and lifts must be clean and well-maintained.
No - Dust was observed in many locations, especially behind pipes and radiators. Peeling paint and chipping was also observed.

(13) External areas including grounds, gardens, footpaths, ramps and car parks should be clean and well-maintained.
No - The area around the waste compound and at the back of the kitchen needs resurfacing following recent drainage works. A QIP is in place.

(14) Waste bins should be clean, in good repair and covered.
Yes - However, the organisation is recommended to ensure that if bins are being replaced they are colour-coded with the front opening to allow cleaning inside bins.

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

(17) Switches, sockets and data points.
No - Dust and grease was observed on many switches. The day ward was good overall.

(18) Walls, including skirting boards.
No - Excluding ongoing refurbishment works, peeling paint was evident and plasterwork and paintwork was cracked and chipped.

(21) Internal and External Glass.
No - Ongoing off-site construction works pose a significant problem. No window cleaning records were available for inspection.

(23) Radiators and Heaters
No - Radiator covers in some areas prevent effective cleaning. Dust build up was observed in many cases.

(24) Ventilation and Air Conditioning Units.
Yes - A high standard was observed in theatre, along with good documentation. However, most ventilation is through open windows and desktop fans, with no cleaning protocols in place for these items.

(25) Floors (including hard, soft and carpets).
No - Broken and chipped floor tiles were observed in high risk areas.

(26) Nozzles of wall mounted alcohol gels and hand disinfectants must be cleaned daily.
No - Some exceptions were noted.

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

(30) Fixtures: Fixtures (i.e. a piece of equipment or furniture which is fixed in position) should be clean. This includes all electrical fixtures e.g. all light fittings and pest control devices.
Yes - However, particular attention should be paid to high dusting of curtain rails and window ledges.

(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 - Particular attention should be paid to high dusting curtain rails, window ledges etc.

(32) Shelves, benchtops, cupboards are clean inside and out and free of dust and spillage.
No - Shelves and tops of lockers are used for storage and were dusty.

(207) Bed frames must be clean and dust free.
No - High risk areas are particularly dusty. This was brought to the attention of the Hygiene Team and it was addressed during the assessment. Other exceptions of good standard were noted, in particular the day ward and areas that have been recently upgraded.

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

(33) Chairs
No - Many chairs are in poor repair. Leather padded chairs had foam visible in some cases. Some chairs in waiting areas and clinical areas require attention.

(34) Beds and Mattresses
No - A number of beds in all areas visited were dusty. Mattresses observed were generally clean and in good condition.

(35) Patient couches and trolleys
Yes – In the majority, however, one exception was noted.

(38) Dispensers (e.g. handwash dispensers), Holders and Brackets
No - Nozzles observed were clogged and holders and brackets were not clean.

(39) Waste Receptacles (e.g. sani-bins, nappy bins, sharps bins, leak proof bins
Yes - Sani bins require deep cleaning.

(40) Curtains and Blinds
Yes - Some curtains require re-hanging and replacement hooks. Overall, they were observed to be clean.

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 - Some exceptions were noted, for example the Physiotherapy and x ray departments. A cleaning policy for baths after each patient use must be developed.

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

(51) Baths and Showers
No - There is a need to implement a process to ensure these are maintained. Tiles were also observed falling off the walls.

(55) Sluices
No - Clutter from equipment was observed and cleaning agents were not locked away.

(56) All associated bathroom fittings including component parts e.g. tiles, taps, showerheads, dispensers, toilet brushes etc should be clean and well maintained.
Yes - A protocol for flushing against Legionella was not evident in some areas. The organisation currently updating the protocols and documentation found that areas such as water tanks were recently tested and cleaned. It is recommended that a protocol be implemented for weekly purging of all hot water outlets taps and showers.

(58) Sluice rooms should be free from clutter and hand washing facilities should be available.
No - Sluice rooms were very cluttered and inaccessible. Kitchen and clinical mop holders and brushes are stored in the main cleaner's area. This practice should cease and separation of the cleaning equipment for catering and clinical areas should take place.

(60) All outlets (including shower outlets) should be flushed at a temperature in accordance with current legislation.
No - A policy is in place, but no evidence of compliance at ward level was observed.

(61) Hand gel containers / dispensers must be replaced when empty, it is not permissible to 'top-up' containers / dispensers.
No - Some evidence of topping up of containers was observed. Containers should be replaced in all cases.

(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 - Medical/ surgical supplies should be stored separately.

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

(68) Patient fans which are not recommended in clinical areas.
No - Fans were observed in every location. No cleaning procedure was in place, but this procedure should be developed.

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

(71) Alcohol hand gel containers.
Yes - There were alcohol hand gel containers present and topping up practises had ceased.

(72) Trolleys, e.g. chart trolleys, drug trolleys, linen trolleys, shop trolleys, emergency trolleys, suction apparatus, resuscitation equipment i.e. ambubag and mask.
Yes - In the majority, however, the food trolleys/drug trolleys require thorough cleaning and in some cases should be replaced as they are in poor condition.

(74) Patient's personal items, e.g. suitcase which should be stored in an enclosed unit i.e. locker / press.
No - Patients belongings were observed on floors around beds, especially in the surgical wards.

(76) Hand-wash dispenser holders and brackets should be free of product build-up around the nozzle.
No - Product build up was observed around nozzles.

(77) Loose items such as patient's clothing should be stored in the patient's locker or property bag.
No - Patients' belongings were observed on the floor.

(80) All office equipment (e.g. telephones, computers, fax machines) should be clean and well-maintained.
No - In general it was unclear who is responsible for this task. This was a particular problem at the nurses' station within clinical areas. Some exceptions were noted, in particular the day ward where a protocol for cleaning these areas was in place.

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 - This process needs to be reviewed.

(82) Vacuum filters must be changed frequently in accordance with manufacturer's recommendations - evidence available of this.
No - No evidence of filter changing on vacuum cleaners.

(87) All cleaning equipment should be approved by the Hygiene Services Committee and ensure sufficient supply.
No - This is in its infancy in the hospital, so not all cleaning equipment has been assessed, for example removing filters from vacuum cleaners.

(88) All cleaning equipment should be left clean, dry and tidy in the storage area after use.
No - The storage area was very untidy and cluttered.

(89) Equipment with water reservoirs should be stored empty and dry.
Yes - This was not applicable in the organisation.

(90) Storage facilities for Cleaning Equipment should be provided in each work area with adequate ventilation, a hot and cold water supply and hand-wash facilities.
No - Storage facilities were not specifically designated for storage. The security of this facility should be reviewed.

(91) Storage facilities for Cleaning Equipment should be clean and well maintained.
Yes - Cluttered storage was observed.

(92) Cleaning products and consumables should be stored in shelves in locked cupboards.
No - The security of this facility should be reviewed.

(93) Cleaning products and equipment should comply with the relevant colour coding policy.
Yes - Compliance with colour coding was observed.

(94) Health and Safety policies should be in place for the use of ladders/steps when cleaning.
No - No policy was available at the time of the assessment, but a draft policy is being prepared.

(95) When using electrical cleaning equipment, a circuit breaker should be used if appropriate and the equipment should be plugged in while switched off using dry hands.
Yes - All equipment observed was less than five years old.

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

(212) Irish Standard 340: 2006 Hygiene in Food Service (Draft) of the National Standards Authority of Ireland (NSAI) specifies guidance to compliance with the requirements of S.I. 369 of 2006 EC (Hygiene of Foodstuffs) Regulations and Regulation (EC) No. 852/2004 on Hygiene of Foodstuffs. This should be complied with.
Yes – The last EHO visit was in March 2004. QIP's have been implemented on the findings of this report. This needs to be documented.

(213) Environmental Health Officer (Senior EHO/EHO) reports on food safety inspections including the completed summary stage of compliance with HACCP and annual water analysis reports should be retained on the Hospital Food Safety Manual. Action plans/ actions taken on foot of issues raised in the reports should be documented.
Yes - The last EHO visit was in March 2004. A new cold room for meat and dairy has been installed but works have not been completed on floor exposed concrete strip remaining. Corrective action plans have not been documented.

(214) The person in charge of catering shall develop, implement and maintain a permanent system based on the seven principles of HACCP. A standard HACCP Plan should be fully completed.
Yes – The organisation is recommended to improve on HACCP signage in specific areas, for example CCP notice on cold rooms, dry storage areas and wash-up area.

Compliance Heading: 4. 4 .2 Facilities

(217) Access to the main kitchen and ward kitchens should be restricted to designated personnel i.e. food workers.
No - Food is delivered through the main hospital entrance door at present due to ongoing works in the delivery area.

(223) Separate toilets for food workers should be provided.
No - This is feasible for main kitchen but not at ward level. Toilets are shared with other staff but not with the general public. This issue is being addressed.

Compliance Heading: 4. 4 .6 Food Preparation

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

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

(138) Details of current legislation and codes of best practice adhered to in relation to all waste types.
Yes – The waste policy and procedures are based on Department of Health and Children Waste Guidelines.

(139) Documented evidence that waste collectors are permitted to collect the waste concerned by virtue of holding a valid waste collection permit.
Yes - Contract Companies Waste Collection Permits were noted. A number of Hazardous Waste Contractors were used over 2006/07. It is recommended that the number of contractors be reduced.

(140) Documented evidence that the treatment facility and final disposal or recovery facility is permitted or licensed.
Yes - EPA licences for Contract Companies and a number of Hazardous Waste Contractors were noted.

(141) Documented procedures for the segregation, handling, transportation and storage of waste.
Yes - Waste Procedures are based on Department of Health and Children Guidelines.

(142) Healthcare risk waste should be tagged and secured before leaving the area of production.
Yes – A traceability process is in place.

(143) Healthcare risk waste bags should be removed when no more than two-thirds full or at the maximum indicated by the bag manufacturers.
Yes - Regular removal of bags and sharps containers occur as required.

(144) Healthcare risk containers should only be filled up to the manufacturers' fill or line or maximum three quarters full.
Yes - No overfilled containers were observed.

(145) A record is kept of tags used for each ward/department for at least 12 months.
Yes – The Stores Department records tags as distributed to Departments.

(146) A tracking system should be in place to trace all hazardous waste from generation to disposal and therefore an audit trail is available to trace waste to final disposal.
No - C1 Forms for florescent tubes batteries were noted. Chemical waste forms were not available. However, various EPA licensed companies are employed.

(149) Inventory of Safety Data Sheets (SDS) is in place.
Yes - Various Safety Data Sheets were available.

(151) Waste is disposed of safely without risk of contamination or injury.
Yes - Incidents are recorded and closed out as they arise.

(152) When required by the local authority the organization must possess a discharge to drain license.
No - A copy of the County Council waste discharge licence and audit reports were verbalised but they were not available.

(253) Personal protective equipment is accessible to all staff involved in the generation, collection, transport and storage of waste.
Yes - Gloves and aprons are worn by porters.

Compliance Heading: 4. 5 .2 Maintenance of Records

(254) Documented process(es) for the retention of waste traceability records, certificates of destruction, consignment notes (C1 forms) and trans Frontier Shipment (TFS) tracking forms for at least 12 months. These should be retained for all hazardous waste types
Yes - These were observed for risk waste/ clinical waste.

Compliance Heading: 4. 5 .3 Segregation

(256) Mattress bags are available and are used for contaminated mattresses ready for disposal; mattresses are disinfected.
No - Clear procedures for mattress disposal or mattress bags were not available.

(156) Healthcare risk waste must be segregated from healthcare non risk waste.
Yes – Increased numbers of A3 posters regarding the Department of Health and Children Risk Waste Segregation over the bins is recommended.

(159) Sharps boxes are correctly sealed, labelled and stored in a safe environment.
Yes – Compliance was observed in all departments.

(162) Hazardous wastes (chemical etc) must be segregated, stored and disposed of correctly.
Yes - Laboratory chemicals are disposed of as required. The external chemical store for post mortum chemicals could be used for redundant chemicals from other departments, prior to disposal.

Compliance Heading: 4. 5 .4 Transport

(163) Documented processes for the transportation of waste through the hospital which minimizes manual handling of waste (and ensures that segregation of healthcare risk waste from non-risk waste is maintained) are in place.
Yes - Trolleys are used and separate collection of risk and non-risk waste was observed.

(164) A consignment note (C1 form) must be completed for each shipment of hazardous waste and copies of these forms must be kept for at least 12 months. This should be linked with certificates of destruction and TFS where applicable.
No – This was not available for hazardous waste.

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

(166) Drivers of vehicles transporting hazardous waste must be trained in accordance with the ADR Regulations.
Yes – The Contact Companies drivers were compliant.

Compliance Heading: 4. 5 .5 Storage

(169) Documented process(es) for the replacement of all bins and bin liners.
Yes - Replacement of bins are allowed through annual hygiene budgets. Colour coded & front opening.

(257) Adequate segregation facilities for the safe storage of healthcare risk waste are locked and inaccessible to the public. Appropriate warning signs restricting public access should be prominently displayed.
Yes - Adequate but further upgrade of Waste Compound is planned.

Compliance Heading: 4. 5 .6 Training

(259) There is a trained and designated waste officer.
No - A number of managers have input into waste management. However, overall co-ordination and management of contractors could be improved if a waste officer is appointed.

(260) There are documented records of staff training on the handling, segregation, transport and storage of healthcare risk waste including the use of spill kits and personal protective equipment.
Yes - Spill kits are available.

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

(173) Documented processes for the use of in-house and local laundry facilities.
Yes - Mop heads for clinical and kitchen use have documented laundry processes.

(174) Clean linen is stored in a designated area separate from used linen (not in sluice or bathroom).
Yes - Storage facilities for linen need to be reviewed.

(261) Clean linen store is clean, free from dust and free from inappropriate items.
No - Flooring requires replacement, specifically in external area from main hospital.

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

(267) Documented process for the transportation of linen.
No – No documented process was observed.

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

(190) All sinks should be fitted with washable splash backs with all joints completely sealed.
No – The resealing of sink splash backs in some areas needs to extend to all areas.

(194) Dispenser nozzles of liquid soap of alcohol based hand rubs must be visibly clean.
No - Product build-up was evident on many dispenser nozzles.

(197) Wall mounted/Pump dispenser hand cream is available for use.
Yes – Hand cream observed was not always wall mounted.

(206) Documented records of mandatory attendance at hand hygiene education and practice is required for all staff members involved in clinical areas. This may be undertaken during hospital induction programme followed by annual updates.
Yes - Evidence was observed of training given as part of infection control standard precautions.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team		Assessor Team	
	FREQ	%	FREQ	%
A	29	51.79	3	05.36
B	26	46.43	22	39.29
C	1	01.79	30	53.57
D	0	00.00	1	01.79
E	0	00.00	0	00.00
N/A	0	00.00	0	00.00

5.2 Ratings Details

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

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