Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Hygiene Services Assessment Scheme

Assessment Report October 2007

St. John's Hospital, Limerick

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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 ensure 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

St. John's is an Acute General Public Voluntary Hospital, funded by the Health Service Executive.
St. John's Hospital is a registered charity under the Charities Acts and is administered and managed in accordance with a scheme of management approved by order of the High Court. The current scheme of management was approved in 1989. The property is vested in trustees.
The Hospital has a total of 103 beds—93 in-patient beds and 10 day care beds.

Services provided

- In-patient consultant services in breast surgery, general surgery, general medicine and gynaecology. The hospital has a 3-bedded combined intensive care/coronary care unit and also provides day care services in general surgery, general medicine, gynaecology, maxillo-facial surgery, gastroenterology and pain management.
- Accident & emergency services (including a minor injuries clinic) on an 8.00 a.m. to 8.00 p.m. basis from Monday to Friday each week.
- St. John's provides a range of in-patient and out-patient diagnostic services in pathology, radiology and endoscopy.
- There are out-patient clinics in general surgery, general medicine, gynaecology, E.N.T. and paediatrics.
- The support services provided are physiotherapy, clinical nurse specialist services in continence care, dietician, health promotion.

Physical Structures:
There are 3 negative pressure rooms in the hospital: 2 one-bedded and 1 two-bedded.

The following assessment of St John's Hospital Limerick took place between 8th and 9th August 2007.

1.3 Notable Practice

- The staff at the hospital demonstrated deep commitment to developing, delivering and maintaining high standards of hygiene throughout the hospital, this despite the difficult structural design and age of the hospital.
- The formal hygiene structures are well established and the hospital's inclusion in the Network Strategic Hygiene group is noted.
- The optimisation of existing storage spaces and the general level of cleanliness (which is very difficult to achieve) given the physical structures of the hospital.
- The hospital is to be commended for its very good waste recycling programme.
- The new HSSD, which is to be commissioned shortly, will provide a state of the art facility at the hospital.
- The hospital policy of separation of duties and responsibilities of the catering and hygiene staff is to be commended.
- Excellent team culture between all staff at ward and department level.

1.4 Priority Quality Improvement Plan

- It is recommended that the organisation further develop its evaluation processes for reviewing the hygiene standards for guidance.
- It is recommended that the organisation develops its documented processes in line with the hygiene standards.
- The PPG committee should develop a suite of hygiene PPG's with the hygiene contractor, taking guidance from the hygiene tender document and the National Cleaning Manual.
- It is recommended that the organisation develop a process for the further monitoring and evaluation of external contractors.
- The organisation should continue its upgrading of sinks, bathrooms and ward kitchen areas.
- The organisation should produce an Annual Hygiene Report.
- It is essential that the hospital address the required areas outlined in the assessment, for example, floor covering (carpets) in public areas, ventilation, and management of Aspergillosis during the current renovation.

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. St. John's Hospital has achieved an overall score of:

Fair

Award Date: October 2007

2.0 Standards for Corporate Management

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

PLANNING AND DEVELOPING HYGIENE SERVICES

CM 1.1 (A ↓ B)

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

The organisation does not have documented processes for completing a needs assessment regarding the requirements of hygiene services. However these needs were identified and there was evidence of improvements introduced based on the National Hygiene Reports 2005 and 2006 and the Irish Health Services Accreditation Board Peer Review Survey 2003. There was a Hygiene Corporate Strategic Plan, and Hygiene Operational Plan in place and these were of recent origin. Introduction of a patient focus group was in progress. The efficacy of the needs assessment process has yet to be evaluated.

CM 1.2 (A ↓ B)

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

There was evidence of on-going modification to the organisation's Hygiene Services over the last two years. Changes included reduction of the Intensive Care Unit bed complement, new Central Sterile Supply Department, upgrading of hand-washing facilities and some patient bathroom facilities. There was ventilation improvement work in progress at the time of the site visit in the Intensive Care Unit/Coronary Care Unit. New cleaning methods and colour coding systems had been introduced. Some of these developments had been informally evaluated but no formal evaluation of these developments had been carried out.

The organisation is recommended to introduce a process for the formal evaluation of all modifications to Hygiene Services.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1 (A ↓ B)

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

The organisation was a member of the Regional Steering Hygiene and Cleanliness Committee. The Contract Cleaning Supervisor was a member of the Hygiene Services Committee, which met regularly. Some patient/client satisfaction surveys were conducted. The organisation had concerns regarding the ability of current health services management structures to address their needs as a voluntary

organisation. The on-going indecision regarding the organisation's proposed major development plan was identified as a significant impediment, in particular for immediate and intermediate capital works. Other links and partnerships included external validation of the Central Sterile Supply Department equipment by an authorised person from a medical physics and bio-engineering department in a Band-I hospital. Also, infection control networking and participation in a joint prevalence survey of Healthcare Associated Infection in 2006 (which showed no HCAI for St. John's Hospital) was noted. There was no formal evaluation of the linkages and partnerships observed and this is recommended.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 (A ↓ B)

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

A Hygiene Corporate Strategic Plan was in place, which identified high level objectives. Overall responsibility for hygiene services is assumed by the Executive Management Team, who were responsible to a Board of Management. Relevant Hygiene Services Reports were issued to the Executive Team on a quarterly basis. The Hygiene Services Committee had an appropriate multi-disciplinary membership with a communication plan to all stakeholders other than the contracted shop manager. It is recommended that formal communications be initiated with the shop manager. The lifespan of the existing Hygiene Corporate Strategic Plan must be defined and its success measured and documented in the annual Hygiene Report.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.1 (A ↓ B)

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

The organisation had policies, procedures and guidelines relating to the delivery of hygiene services, which were based on legislation and best practice and signed off by senior management. There were also documented infection control procedures. The organisation's code of corporate ethics was reflected in the organisation's mission statement, which was clearly displayed throughout the organisation. The organisation was advised to ensure that there are evaluation processes in place to monitor compliance with all relevant legislation and best practice.

CM 4.2 (A ↓ B)

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

Some areas have performance indicators, which are reported on at regular intervals. The organisation is recommended through its Hygiene Services Committee to identify a comprehensive suite of Key Performance Indicators across all aspects of hygiene services, which will be reviewed regularly and used to benchmark service performance/developments. Evaluation of this criterion is recommenced.

CM 4.3 (A ↓ 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 had library, internet and intranet facilities. Hygiene Standard Operating Procedures were based on the National Cleaning Manual Guidelines. There was induction and on-going in service training pertaining to hygiene services in place for all staff on a structured basis. A new cleaning contract had commenced on 1st August and the contractor had committed to providing all cleaning staff with BICS level 1and 2 training by September 2007. Information sharing systems were in place and the evidence at site visit was indicative of its effectiveness. Formal evaluation is recommended.

CM 4.4 (A → A)

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

The organisation had documented processes for the development, approval, revision and control of all policies, procedures and guidelines. There were standard operational procedures in place for environmental and equipment cleaning. Staff interviewed during the assessment were knowledgeable regarding these processes. The efficacy of these processes was evaluated through the internal and external hygiene audits, infection control, hand hygiene, environmental health audits, risk management reports and so on.

CM 4.5 (A ↓ B)

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

There was evidence of compliance. Some members of the Hygiene Services Committee were also members of the Capital Development Project Team. The Infection Control Nurse in particular was actively involved in the consultation process around new initiatives. There was no formal evaluation process in place for the evaluation of the efficacy of the consultation process and this is recommended.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

*Core Criterion

CM 5.1 (A → A)

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

There were clear roles, authorities, responsibilities and accountabilities throughout the hygiene services structure and included the contract cleaning staff. It was acknowledged during the assessment that the Executive Management Team has overall responsibility for hygiene services. Some responsibility was delegated to specific senior managers, to whom hygiene services staff reported. Responsibility was also delegated by the Executive Management Team to the Hygiene Services Committee. Ward and Department Managers had overall responsibility for the standard of hygiene in their areas of responsibility, and were directly involved in the hygiene audits of their area using the HIQA mandatory compliance tool. They were also members of the Hygiene Services Committee and demonstrated a high level of commitment to all aspects of hygiene in their areas.

*Core Criterion

CM 5.2 (A → A)

The organisation has a multi-disciplinary Hygiene Services Committee.

There was a multi-disciplinary Hygiene Services Committee in place with identified terms of reference, roles and responsibilities. This Committee met on a quarterly basis. Minutes of meetings were compiled by a member of the group and circulated throughout the organisation.

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

*Core Criterion

CM 6.1 (A ↓ B)

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

The organisation allocated resources based on informed equitable decisions, for example, the recently allocated cleaning contract. The organisation made decisions at Hospital Executive Committee level, and had systems in place for ensuring financial input and had increased the non-pay budget allocation for hygiene services for cleaning and washing from 7% in 2005 to 8% in 2006.

It is recommended that the organisation ensure that developments are factored in to the corporate and service plans so that they may be addressed appropriately.

CM 6.2 (A ↓ B)

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

The chairperson of the Hygiene Services Committee attends meetings of the Executive Management Committee. There were processes in place for the inclusion of an Infection Control Nurse Specialist in the pre-purchasing of equipment/products etc. It is recommended that consideration be given to the inclusion of the Hygiene Services Committee in this process in the future. Evaluation of the efficacy of the consultation process is based on the developments approved by the Executive Management Team. Formal evaluation of these processes should also be considered to ensure the continuous quality improvement loop is closed in this regard.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

CM 7.1 (A ↓ B)

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

There is a risk management system in place and health and safety statements for each clinical and non-clinical area with associated hazard identification/risk assessment. Education and training programmes focussed on best practice hygiene/infection control standards safety and risk management were in place.

Hygiene related risks included trips and falls and these were noted, and a revised system of floor cleaning had been introduced to manage this risk. It was anticipated that the next quarterly risk management report would reflect a reduction in these incidents. Hygiene Services audits are carried out in all the clinical areas on a weekly basis. The organisation was recommended to increase the frequency to allow for corrective actions to take place between audits.

CM 7.2 (A ↓ B)

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

There is extensive evidence of Executive Management Team support for risk management including that associated with hygiene. This includes provision of additional human resource to address issues identified through the acute hospital accreditation scheme and national hygiene audits. The Team's support for risk management is also evident in the improved facilities, for example, the new Central Sterile Supply Department, Day Care facilities and the current upgrading of the Intensive Care Unit. The Risk Manager is a member of the Hygiene Services Committee. The organisation's Quality Improvement Plan to include this service in all areas of hygiene management is commendable, as some recent structural and flooring upgrades were a cause for concern and risk assessed during the hygiene assessment visit. The organisation had plans to upgrade theatre facilities and awaited funding approval for same. The assessment team strongly supports this development and commend the staff for their management of hygiene in the existing facility.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion

CM 8.1 (A ↓ B)

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 organisation was compliant in relation to the establishment of contracts, however the organisation needs to monitor and evaluate them on an on-going basis. The current cleaning contract commenced on 1st August 2007 and was based on a cleaning contract specification developed by the Hygiene Services Committee, and informed by the National Cleaning Manual.

CM 8.2 (A ↓ C)

The organisation involves contracted services in its quality improvement activities.

There was evidence that new contracts require contractor involvement in quality improvements. The new cleaning contract was an example of this practice and there was evidence of the contractor's involvement in feedback and awareness of hygiene audit outcomes. Cleaning contractors had committed to providing hygiene training for all cleaning staff within the first two months of the new contract, as practically all the staff were employed by the previous contractor. It is recommended that the involvement of contracted services in the organisation's quality improvement activities is developed and strengthened.

PHYSICAL ENVIRONMENT, FACILITIES AND RESOURCES

CM 9.1 (A ↓ 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 an old building and had significant limitations in terms of design, and patient and storage space. The staff were to be commended on the standard of cleanliness achieved despite these limitations. The organisation has engaged in a

process of refurbishment and new developments to address these shortcomings, in the upgrading of kitchens, bathrooms, toilets, sluice rooms, and hand wash basins. The new Central Sterile Supply Department reflects best practice, and this standard needs to be implemented throughout the hospital. The staff/storage facilities in the main operating theatre area are not up to standard, and the organisation's plan for additional space needs to be progressed as a matter of urgency. There is an infection risk associated with poor ventilation. While the organisation was in the process of addressing this issue in the Intensive Care Unit/Coronary Care Unit, it is urged to progress the upgrading of the ventilation systems in the other identified areas (Medical Assessment Unit, Day Ward, main kitchen) and eliminate the use of electric fans. It is recommended that the organisation should have a hygiene assessment carried out to ensure that the newly laid carpet-type corridor flooring (Central Sterile Supply Department, Medical Assessment Unit, Day Ward corridors) does not pose hygiene or infection risk. It is recommended that an evaluation is conducted to ensure the safety of design, lay out and current environment at all times including the implementation of changes to ensure adherence to regulations and best practice.

*Core Criterion

CM 9.2 (A → A)

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

The organisation had a process to plan and manage its environment and facilities. It also had a plan developed at the beginning of the decade for a major capital development, which would replace the existing hospital on the same campus, and this had been the subject of discussion with the Health Service Executive but no formal decisions are in place.

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.

The organisation had some evidence of documented patient satisfaction through a survey report and unsolicited feedback and the complaints mechanism. It is intended that the Patient Focus Group would submit a report to the Executive Team once it is established. The organisation had evidence of appropriate external and internal audit /inspection reports and there was evidence of changes made to reflect the implementation of recommendations and continuous improvements.

CM 9.4 (A ↓ 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 organisation had some evidence of documented patient satisfaction through a survey report and unsolicited feedback and the complaints mechanism. It is recommended that patient satisfaction surveys are conducted to evaluate satisfaction with Hygiene Services facilities and the Environment.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 (A ↓ B)

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.

There were processes in place for selection and recruitment of the organisation's staff in line with Human Resources policies. The cleaning contractor was also contractually required to adhere to these standards. Job descriptions were in place for all staff, and records were kept either by the organisation or the contractor as appropriate. The organisation was advised to evaluate the selection and recruitment processes in use.

CM 10.2 (A ↓ 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.

Evaluation of work capacity and volume had resulted in increased resource allocation to hygiene services including increased cleaning hours, janitorial services and increased cleaning supervision at weekends. Decisions were also made to allocate additional resources in specific circumstances for example infection outbreak etc. The organisation was advised to review its work capacity and volume, to review processes and to complete the CQI loop.

CM 10.3 (A ↓ B)

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

Job descriptions reflected the necessary qualifications for specific hygiene services roles. Where specific qualifications were not required the organisation had systems in place for the induction and training of new staff with identified mandatory hygiene training for all new staff and regular on-going training which was structured to ensure optimal access by staff.

CM 10.4 (A → A)

There is evidence that the contractors manage contract staff effectively.

There were documented processes for the management of contract staff with reporting relationships to the contract supervisor. There was an excellent team culture at ward/department level between all staff. Many of the contract cleaning staff had a long record of working for the organisation. The contract staffs' needs were met through the organisation's Occupational Health Department. The evaluation of the appropriate use of contract staff was based on informal evaluation, the use of communications books to flag gaps for the cleaning supervisor and staff who worked outside core hours, and the outcome of the internal/external audit processes.

*Core Criterion

CM 10.5 (A ↓ B)

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

The Cleaning contract identified the cleaning requirements and the Contractor then allocated the human resources to meet these requirements. There is ongoing supervision and liaison with the Hygiene Services Supervisor and Line Managers, to

ensure gaps are identified and standards are met. Specific arrangements are agreed to address specific cleaning needs. The internal and external Hygiene Audits were identified as evidence of the adequacy of Human resources. The organisation is encouraged to develop a Hygiene Annual Report.

ENHANCING STAFF PERFORMANCE

*Core Criterion

CM 11.1 (A → A)

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

The organisation had documented designated induction programmes in place for non-consultant hospital doctors and newly qualified staff nurses. These had mandatory training topics, which included sharps awareness and hand hygiene. A less formal system was in place for all other staff and included structured training availability on a regular basis. Training was structured on a full day basis, where possible, to facilitate attendance. All staff had the opportunity to attend within the first month. A questionnaire was used for catering staff to elicit their level of knowledge after training. Hygiene information leaflets and notices were available in the clinical and relevant hygiene areas. Information was also available on the intranet. Attendance levels were recorded centrally by the Human Resources Department and new staff were targeted for attendance at training sessions. No documented evidence was observed in relation to training in risk waste management and this is recommended.

CM 11.2 (A ↓ B)

On-going education, training and continuous professional development is implemented by the organisation for the hygiene services team in accordance with its human resource plan.

Infection control information was available to all staff both electronically and in hard copy. Regular on-going education was provided to all staff according to needs identified through internal/external audits. Ward based training was provided on an experimental basis and evaluation of this approach was in progress. This training pertained to hygiene/and safety issues, and staff were facilitated to attend during work time. There were documented processes in relation to staff support for attendance at approved courses. The relevance of education and training to each staff member should be formally identified.

CM 11.3 (A ↓ B)

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

Attendance records are maintained for all training. Some training is evaluated and outcomes of national hygiene audits were used as an evaluation of training. It is recommended that documented processes are established for the evaluation of attendance levels at education and training sessions. It is recommended that a staff satisfaction survey is conducted to evaluate staff satisfaction with education and training.

CM 11.4 (A ↓ B)

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

Performance evaluation of hygiene services staff was through informal processes, for example, gap analysis, regular supervision, ward/department managers' feedback to the supervisor. Staff records included attendance, education and training. It is recommended that an evaluation of the number of hygiene services staff including contract/agency staff who undergo performance evaluation is undertaken.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (A ↓ B)

An occupational health service is available to all staff.

An Occupational Health Service was available to all staff and offered an extensive range of services including pre-employment screening, vaccinations and occupational health education. Evaluation of training is carried out but the appropriateness of the service for staff has not been formally evaluated. It is recommended that the organisation consider such an evaluation.

CM 12.2 (A ↓ B)

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

Performance indicators used to evaluate staff satisfaction, occupational health and well-being included absenteeism, staff turnover, staff accidents/incidents and exit interviews. It is recommended that an evaluation of the mechanisms for monitoring staff satisfaction is conducted.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.1 (A ↓ 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.

High quality information was available to staff through evidence based policies, procedures and guidelines, education and training sessions, membership of committees, circulated minutes of meetings, hygiene check lists and audit reports. Evaluation was based on outcomes of audits/line manager and supervisor inspections. The organisation is recommended to evaluate its processes for collecting information, and the quality of the information.

CM 13.2 (A ↓ 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.

Internal Hygiene audits are conducted on a weekly basis, benchmarked against the previous week's outcome and forwarded to the chair of the Hygiene Services Committee for consideration. Internal hygiene audit reports and minutes of Hygiene Committee meetings are available via the intranet The organisation is encouraged to review user satisfaction with the current process, including frequency of audit, with a view to allowing time for identified improvements between audits. The organisation is also advised to adopt a reporting system which would highlight trends in the context

of implementation of its Quality Improvement Plan. It is also recommended that the organisation circulate summary internal audit reports to all departments for benchmarking purposes. An evaluation of user satisfaction in relation to the reporting of data and information is conducted.

CM 13.3 (A ↓ B)

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

The internal audit outcomes were reviewed fortnightly at the Hygiene Team meetings and quarterly at the Hygiene Committee meetings. Feedback to frontline hygiene services staff was through their line manager or supervisor. It is recommended that data and information utilisation in relation to service provision and improvement is evaluated.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

CM 14.1 (A ↓ B)

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

The organisation had been actively involved in the development of Hygiene services management and delivery over the last two years. Improvements included the development of current hygiene services management structures in accordance with the Acute Hospital Hygiene Assessment Scheme, upgrading of the environment and facilities, and the introduction of new products and practices. The organisation is to be commended on what has been achieved. Due to the age of the hospital there still remained a significant outstanding refurbishment/capital development workload to be addressed. The organisation was very aware of this and was actively pursuing the necessary resources.

CM 14.2 (B ↓ C)

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

There have been changes and developments in the organisation's hygiene services quality improvement system over the last two years. Many of these changes are to be commended and demonstrate better systems for identification of work volume, integration of in-house and contract human resources, improved monitoring and supervision, introduction of internal audit, establishment of the hygiene management structures and processes. The organisation should identify a suite of Key Performance Indicators across all aspects of hygiene services for regular monitoring, and produce a hygiene annual report based on same. It is also recommended that the Hygiene Services Committee be involved in the pre-planning of all new environmental developments to ensure best practice input in relation to hygiene issues.

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.

The hospital has a documented process for the development of all policies, procedures and guidelines at the hospital. All policies are submitted for approval through the PPG committee. All policies are maintained in standard template and are referenced to best practice and relevant legislation. Currently the hygiene services contract has been awarded to a new contractor from 1st August 2007.The tender documents have included specifications for cleaning in line with national guidelines and a monitoring mechanism of actual cleaning processes and the monitoring of the contractor by the hospital. The hospital has implemented colour coding for cleaning and laundry and a flat mop system and has begun a sink replacement programme as well as sluice, bathroom and kitchen regarding. No evidence of staff protected time to consult documentation was noted. While there is evidence of national best practice guidelines available during the assessment SARI, National Linen Guidelines and the National Cleaning Manual, the organisation should adapt these guidelines into a suite of PPG's to reflect its own hygiene programme. It is recommended that the hospital evaluate the efficacy of the processes used to develop best practice guidelines for hygiene.

SD 1.2 (A ↓ 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.

There is a robust method of pre-purchase evaluation through the hygiene services team and the through the purchasing department. Informal evaluation has been carried out in relation to hand gels and flat mopping system but no formal documentation was available on the pre-purchase products. The new external hygiene contract was influenced by the recommendations in the national hygiene manual, results of patient satisfaction surveys and risk reports.

It is recommended that the organisation develops formal documented process as outlined in this criterion and formalises pre- and post-purchase hygiene products and interventions.

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.

The organisation offers continuing health promotion posters in both clinical and hygiene subjects, for example, information on hand hygiene, winter vomiting and isolation procedures. The hospital organised a Hand Hygiene Awareness Week in the hospital. There is no involvement with the community on an external basis.

There has been no evaluation of the health promotion activities in relation to hygiene. It is recommended that the organisation review the opportunities this criterion affords, in order to strengthen the links with the community.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1 (A ↓ B)

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

The organisation demonstrated its commitment to the hygiene process by the development of the Hygiene Services Committee and Team. The hospital is also a member of the Network 7 Strategic Hygiene Committee and attends monthly. The Hygiene Services Team at the hospital is multi-disciplinary from all grades and departments at the hospital, and will include the hygiene contractor. There was evidence of terms of reference, minutes of meetings, role awareness and responsibilities. It is recommended that the team includes the shop and other contractor services in its membership. It is also recommended that the organisation should develop its evaluation and documentation processes in line with this criterion.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

SD 4.1 (A ↓ B)

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

In general the hospital's physical environment was very clean, it is recognised that the hospital structure was old and that this posed difficulties for cleaning. It was observed that the hospital had a general difficulty with high dusting, flaking paint on corridor walls and floor coverings that were not attached to the wall edges or contained under skirting boards. This has resulted in some areas being difficult to maintain to the required standard.

It was observed that in some internal ramped areas of the hospital, the floor covering was made of carpet. This is inappropriate in a high use area and is very difficult to maintain. It is recommended that the hospital source an alternative grade of floor covering to ensure compliance with hygiene standards.

For further information see Appendix A.

*Core Criterion

SD 4.2 (A ↓ B)

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

In general the hospital's equipment, medical devices and cleaning devices were clean; a number of trolleys throughout the hospital had grubby wheels, some cleaner's trolleys and hostess-type trolleys in catering require attention also.

It is recommended that the organisation review its hygiene management of office equipment as some areas were dirty.

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.

The hospital has mechanisms in place to ensure compliance with this criterion. This will be further strengthened with the on-going development of policies, procedures and guidelines in conjunction with the new external hygiene contractor.

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 hospital kitchen is located at ground level, and is constrained in size by the design of the building. The main kitchen adheres to the HACCP standards. There are some issues with dirty bins outside the kitchen. The catering toilet area, while designated, is outside the kitchen area. It was observed that catering staff at ward level did not wear catering hair nets nor was the kitchen lockable. It is recommended that the dishwashing facility is reviewed as there is no digital readout of temperatures in place—a manual method of temperature measurement is in use. Ventilation in the kitchen is poor and should be addressed as a priority.

For further information see Appendix A.

*Core Criterion

SD 4.5 (A ↓ B)

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

The hospital has a very good recycling system in place to include wood, steel, cardboard, oil and X-ray films; this is to be commended. The hospital has recently appointed a designated Waste Officer who will undergo training in September. It was observed during the assessment that all waste bins (clinical, domestic and recycling) were very dirty—remedial action was taken during the assessment. It is recommended that a documented process be developed for the management of the cleaning/replacement of waste bins. An education programme and training records for waste staff needs to be formalised. It is recommended the organisation review its monitoring processes of contractors providing waste services to the hospital.

For further information see Appendix A.

*Core Criterion

SD 4.6 (A ↓ C)

The team ensures the organisation's linen supply and soft furnishings are managed and maintained.

The linen/laundry services are provided to the hospital by a central HSE laundry. There are no wash hand basins in either clean or dirty central linen store area**.**
It is recommended that the hospital completes the documentation policy process for laundry/linen at the hospital, and ensures that contractors develop a suite of policies, procedures and guidelines for management of hygiene at the hospital, including washing of the flat mops and management of washing and drier machines.

For further information see Appendix A.

*Core Criterion

SD 4.7 (A ↓ B)

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

There is a deep commitment to hand hygiene and hygiene education and training at the hospital. There are a significant number of clinical hand wash sinks that do not meet the recommendations, but a Quality Improvement Plan is in place to replace all sinks. Waste bins at the hospital have been replaced in line with an identified Quality Improvement Plan.

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.

The hospital has a risk management department, risk manager and risk policy available and observed. There was a Health, Safety and Security Committee in place and Health and Safety Statements observed for all departments. There is a risk/incident reporting mechanism in place with quarterly reporting and trend analysis charts in place, these include, slips, trips, falls and needle stick injuries.
The hospital complies with the HACCP standards for the catering service.
The Hospital Key Performance Indicators for risk include falls on wet floors in relation to hygiene.
At the time of the assessment an area of concern in relation to building works was addressed. It is recommended that the organisation continue to develop its risk management portfolio.

SD 4.9 (A ↓ B)

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

The Hospital provided evidence of patient information leaflets for hygiene. Local visiting policy (adapted from national policy), hand hygiene stations, and some signage was observed. The organisation discussed with the interim Patient Focus partnership groups results of hygiene audits and patient satisfaction surveys. There is security at the hospital which managed the visiting policy. There was little evidence of visitors in the clinical areas of the hospital except in the Out-Patient Department

and Accident and Emergency. While patient satisfaction surveys are evaluated, it is recommended that there could be further inclusion of patients in hygiene service delivery and the evaluation process.

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.

There is an organisational policy developed and approved for patients' dignity in the clinical setting during cleaning. This policy is robust and is to be commended. There was evidence of job descriptions and professional codes of conduct which enforce the privacy, dignity and confidentiality of the patient. There are documented infection control processes for the management of standard precautions and patients at risk. A range of patient information leaflets was available, including hand hygiene and Norovirus.

There has been no formal evaluation of this criterion, which is recommended.

SD 5.2 (A ↓ B)

Patients/clients, families, visitors and all users of the service are provided with relevant information regarding hygiene services.

The organisation has provided hand hygiene information and hand gel stands throughout the hospital. The organisation provides information leaflets in all areas. Some patient satisfaction surveys have been carried out through the feedback service. Some internal evaluation has been carried out on these surveys. Samples of negative and positive comments and reports were observed. There was no identified documented change of practice as a result of the surveys.

It is recommended that the organisation continue to evaluate this criterion and would extend the quality improvement plans to complete the documented process.

SD 5.3 (A ↓ B)

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

There is a robust complaints policy in place. There was evidence of a complaints register and quarterly reporting of complaints. Complaints in relation to hygiene were presented to the Hygiene Services Committee and Team for discussion and action. This was evidenced in the minutes of committee and team meetings. These reports are also available to the Board of Governors through the Executive Management Team. It is recommended that the organisation continues to develop evaluation of the complaints process in relation to hygiene issues.

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1 (A ↓ B)

Patients/slients, families and other external partners are involved by the hygiene services team when evaluating its service.

The organisation has commenced the development of management and structures for a Patient Partnership Forum in line with acute service accreditation standards. This forum has terms of reference agreed and has completed external facilitation training and will commence its formal meetings in September 2007. There is a service user on the environment team and it is envisaged that this person will link with the Hygiene Service Team structure for hygiene consultation. The hospital also has a patient satisfaction feedback programme, patient satisfaction surveys, risk

management and a complaints procedure—all this contributes to influencing evaluation of the hygiene services. Following evaluation of the risk reports, a trend analysis was addressed in relation to slips, trips and falls in one area. Improvements (cleaning method) to the hygiene service was instigated and it is anticipated that a reduction in falls in the area will be evident in the next quarterly report.
It is recommended that while there is some evaluation available the organisation will continue to develop its evaluation of the criterion.

SD 6.2 (A ↓ 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 hospital has a system of weekly internal audits using the HIQA Hygiene Assessment Tool. These are carried out by the departmental heads and are informally reviewed with relevant service and actions plans progressed. However there is no formal evaluation or action plan in place. The hospital also reviewed the external national audits. The hospital, as part of the Network Hygiene Strategic Group, also benchmarks with the other acute hospitals in the network. This has resulted in changes in practice in matters such as flat mops, colour coding, waste management, hand gels and sink replacement. It is recommended that the hospital formally evaluate the internal hygiene audits and subsequent action plans. It is recommended that the hospital develop evaluation and benchmarking mechanisms in relation to this criterion.

SD 6.3 (A ↓ C)

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

A Hospital Annual Report is published. In the Annual Report of 2005 there was a section on the national hygiene audits of that year and the establishment of a cleaning standards committee was noted. The Hospital Annual Report for 2006 is in the process of formulation and the Chairperson of the Hygiene Services Committee will formulate a commentary for inclusion under a specific hygiene section. There is staff involvement in the process but no involvement from patients/clients. There is no departmental annual report for hygiene, health and safety or risk management. It is recommended that a hygiene service annual report is progressed as identified by the Team in their Quality Improvement Plan.

4.0 Appendix A

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

4.1 Service Delivery Core Criterion

Compliance Heading: 4. 1 .1 Clean Environment.

(2) All high and low surfaces are free from dust, cobwebs and flaking paint.
No - in high areas dust was observed. Flaking paint was observed on walls.

(3) Wall and floor tiles and paint should be in a good state of repair.
No - It was observed throughout the hospital that floor coverings, while clean and intact, were shrinking away from skirting boards and floor edges leaving an area difficult to maintain. There is a carpeted public walkway near the hospital's Sterile Services Department; it is recommended that this area is re-surfaced with an appropriate hard wearing and washable surface.

(4) Floors including edges, corners, under and behind beds are free of dust and grit.
No - Floor coverings were shrunken at edges.

(6) Free from offensive odours and adequately ventilated.
Yes - The main kitchen has no ventilation and is, therefore, very hot.

(7) Areas should be adequately ventilated with ventilation units cleaned and serviced accordingly and documentation available regarding service.
No - In general the hospital has no ventilation in place. It is recommended as the building is constricted, consideration is given to the installation of ventilation systems.

(8) All entrances and exits and component parts should be clean and well maintained.
Yes - A Quality Improvement Plan is in place.

(10) Internal and external signage should be clean, updated, well maintained and laminated to enable cleaning.
Yes - It is recommended that additional hygiene information is displayed.

(12) Internal and external stairs, steps and lifts must be clean and well-maintained.
Yes - It is recommended that regular cleaning of the service lift be carried out.

(14) Waste bins should be clean, in good repair and covered.
Yes - A number of internal waste bins need replacement.

(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 - Separate smoking areas are assigned for patients and staff.

(28) Before cleaning commences, a work route should be planned and when necessary, furniture and equipment should be removed from the area.
No - No evidence of a managed work route was observed. Cleaning was in progress at time of assessment.

(29) A warning sign “cleaning in progress” must always be used, position to be effective.
No – “Cleaning in progress” signs were available but not observed in use in all areas.

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

(18) Walls, including skirting boards.
No - Damaged surfaces on skirting boards and walls were observed.

(20) Doors.
No - Damaged door edges were observed.

(21) Internal and External Glass.
Yes - Catering Department windows were dirty.

(23) Radiators and Heaters.
No - A number of dirty radiators were observed and noted as difficult to access.

(25) Floors (including hard, soft and carpets).
No - Inappropriate use of carpet in a public corridor and some broken terrazza tiles were noted.

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

(32) Shelves, benchtops, cupboards are clean inside and out and free of dust and spillage.
Yes - Shelves in the shop were dirty.

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

(33) Chairs.
Yes - The fabric in the couch in reception is split. It must be replaced.

Compliance Heading: 4. 1 .5 Sanitary Accommodation.

(48) Floors including edges and corners are free of dust and grit.
Yes - Some floor coverings were shrunken.

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

(53) Bidets and Slop Hoppers.
Yes - No bidets in use. Some slop hoppers need more regular attention.

(55) Sluices.

Yes - Shared facility with domestic cleaning equipment.

(58) Sluice rooms should be free from clutter and hand washing facilities should be available.
Yes - Sluice rooms are very small and congested. Staff should be commended for optimising space.

(59) Where present shower curtains should be clean and in good repair with a process for laundering and replacement.
Yes - No shower curtains observed.

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 – Cleaners' trolleys were dirty, and black catering-style hostess trolleys were also dirty.

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

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

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

(72) Trolleys, e.g. chart trolleys, drug trolleys, linen trolleys, shop trolleys, emergency trolleys, suction apparatus, resuscitation equipment i.e. ambubag and mask.
Yes - Some residual sticky tape and some wheels require attention.

(75) Vases.
Yes - There is a no-flowers policy at the hospital.

(76) Hand-wash dispenser holders and brackets should be free of product build-up around the nozzle.
Yes - A few hand wash dispensers require attention.

(79) Flower vases where present should be clean with water changed minimum daily. Wilted flowers should be removed and disposed of accordingly. Note: flowers not recommended in high risk areas.
Yes - The hospital has implemented a no-flowers policy in 2007.

(80) All office equipment (e.g. telephones, computers, fax machines) should be clean and well-maintained.
No - External monthly cleaning contract are in place. Some office areas visited were dirty, for example, phones, computers and desks.

Compliance Heading: 4. 3 .1 Cleaning Equipment & Products (note: while list is not exhaustive, the following compliance is required):

(88) All cleaning equipment should be left clean, dry and tidy in the storage area after use.
Yes - One cleaning trolley was observed to be dirty.

(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 for cleaning equipment is shared with sluice facilities. No dedicated domestic services room observed.

(94) Health and Safety policies should be in place for the use of ladders/steps when cleaning.
Yes - A comprehensive Policies, Procedures and Guidelines document is in place.

Compliance Heading: 4. 4 .2 Facilities.

(217) Access to the main kitchen and ward kitchens should be restricted to designated personnel, i.e., food workers.
Yes - It is recommended that the ward kitchen doors have a keypad lock in order to restrict entry.

(221) Staff clothing/uniforms/shoes personal belongings should not be stored in food rooms.
Yes - It was observed that catering staff at ward level did not wear catering headwear, and were not adhering to uniform policy.

(223) Separate toilets for food workers should be provided.
Yes - Dedicated staff toilets are provided, but not adjacent to the main kitchen.

(224) The ventilation provided for all cooking and steam emitting equipment shall be sufficient to prevent condensation on walls, ceilings and overhead structures during normal operations.
No - No ventilation units provided in main kitchen. Ventilation is provided by open windows. The area is confined and very hot. It is recommended that the hospital consider the installation of air conditioning units in this area.

(227) Flour, cereals, sugar etc shall be stored in a dry environment and when opened stored in covered containers.
Yes - There is a very comprehensive dry goods area. Some residual flour spots on storage shelving were observed. A weekly cleaning routine is in place for this area.

Compliance Heading: 4. 4 .3 Waste Management.

(230) A supply of water should be available to clean down external waste storage areas.
Yes - An external tap is available and a 'Belfast Sink' is available outside the back door of the kitchen.

(232) Waste storage containers shall be smooth, durable, easy to clean and disinfect, well maintained and closable.
No - All waste bins are quite dirty in the external catering area.

(234) Where waste is stored in plastic bags these shall be removed frequently, closed securely and stored in a manner that does not pose any risk to the food business.
Yes - There is a Quality Improvement Plan in operation.

Compliance Heading: 4. 4 .4 Pest Control.

(239) Fly screens should be provided at windows in food rooms where appropriate.
No - Broken fly screens were observed in the main kitchen—these need to be replaced.

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

(243) Preparation of High Risk Foods should comply with I.S. 340:2006 requirements.
Yes - Separate food preparation areas were identified.

(244) Temperature for food when cooked, held or reheated should comply with I.S. 340:2006 requirements.
No - Food trolleys are not compliant with the temperature requirement—this is already subject to an EHO report. Temperature probes at ward level should be stored in a dedicated box.

Compliance Heading: 4. 4 .10 Plant & Equipment.

(250) The dishwasher's minimum temperature for the disinfecting cycle should be compliant with I.S.340:2006 requirements and should be monitored regularly. There should be digital readouts on dishwashers.
No - The dishwashers in the main kitchen have no minimum recording mechanism—this is done with a manual probe. It is recommended that this equipment is reviewed in order to comply with ISO340 standard.

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

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

(142) Healthcare risk waste should be tagged and secured before leaving the area of production.
Yes - One sharps bin observed in the waste compound was not tagged.

(145) A record is kept of tags used for each ward/department for at least 12 months.
Yes - A Record Book for 2006 and 2007 is kept in the Stores Department.

(149) Inventory of Safety Data Sheets (SDS) is in place.
No - Not observed though safety statement in the maintenance reflects this area.

(152) When required by the local authority the organization must possess a discharge to drain license.
Yes - This is not requested by the local authority.

(253) Personal protective equipment is accessible to all staff involved in the generation, collection, transport and storage of waste.
Yes - Personal Protective Equipment is available throughout the hospital.

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 - The contracted waste company use a bar code system when collecting all healthcare risk waste bins.

Compliance Heading: 4. 5 .3 Segregation.

(255) Within Healthcare risk waste, all special wastes including drugs & cytotoxic drugs/materials are segregated.
Yes - Some inappropriate items were stored in this area.

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

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 - A designated trolley is available for the carriage of general and healthcare risk 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 - An Independent Private Consultant is retained by the organisation.

Compliance Heading: 4. 5 .5 Storage

(169) Documented process(es) for the replacement of all bins and bin liners.
No - Bins are owned by the relevant company and will be replaced as required—no documented process is in place.

(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.
No - Healthcare Risk Waste bins observed were all locked and in a locked area waiting for collection. Some non clinical waste bins were not in an enclosed area, and the public could access this area.

(258) Waste receptacles should be sanitised, secure and in a good state of repair when used.
No - All bins observed were dirty. Bins should be washed weekly. No evidence of this was presented.

Compliance Heading: 4. 5 .6 Training.

(259) There is a trained and designated waste officer.
No - The Risk Manager at the hospital is a designated person. Specific environmental management training has been approved for the post holder who will commence training in September 2006.

(260) There are documented records of staff training on the handling, segregation, transport and storage of healthcare risk waste including the use of spill kits and personal protective equipment.
No - No training records available—these were requested but not received.

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

(172) Documented processes for the management, maintenance and safe handling of linen and soft furnishings throughout the organisation.
No - A draft hospital policy is available in line with national linen recommendations. It is recommended that this policy is signed off and implemented as soon as possible.

(173) Documented processes for the use of in-house and local laundry facilities.
Yes – There is an on-site laundry for mops, and this is part of the external hygiene service contract.

(174) Clean linen is stored in a designated area separate from used linen (not in sluice or bathroom).
No - Due to the very limited storage space at the hospital, clean linen is stored at ward and departmental level in a multi-purpose store room in addition to medical and surgical supplies.

(261) Clean linen store is clean, free from dust and free from inappropriate items.
Yes - The hospital is to be commended that the multi-purpose store rooms are so clean and tidy given the limited space available. Best use of these areas was observed.

(267) Documented process for the transportation of linen.
No - A draft hospital policy is available in line with national linen recommendations. It is recommended that this policy is signed off and implemented as soon as possible.

(268) Ward based washing machines are used only with the agreement of the Hygiene Services Committee.
Yes - Ward Based washing machines are not in use at the hospital.

(269) A washing machine if used is situated in an appropriate designated area and a clear policy/written guidance is in place regarding its use e.g. water temperature etc.
No – A washing machine was based in the hygiene contractor's area and used to wash flat mop heads. No written instructions were available, however staff have had instruction and manufacturer's instructions were available. The Hygiene Contractor commenced on site on 1st August 07

(271) Hand washing facilities should be available in the laundry room.
No - No hand wash sink was available in the clean central storage area or dirty central storage area which had direct access for deliveries and collection of laundry.

(270) If a washing machine is in use, a tumble drier is also in place which is externally exhausted. Documented processes for planned preventative maintenance of this equipment should be in place.
No - Tumble drier in place—see (269) for further comment. No planned preventative maintenance programme in place.

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

(189) Clinical hand wash sinks are required in all areas where clinical activities are performed. They should be centrally located and free from obstruction.
Yes - It is recommended that further sinks are installed in clinical areas.

(190) All sinks should be fitted with washable splash backs with all joints completely sealed.
No - A number of hand wash sinks were without splash backs. It was observed that a number of sinks had a gap between the splash back tiles and the sink unit.

(191) Hand washing facilities i.e. sinks, taps and splash backs must be clean and intact.
Yes - A number of sinks observed were intact.

(192) Taps should be hands free and should be mixer taps to allow temperature regulation.
Yes - The organisation has a Quality Improvement Plan in place to replace all taps, with some non clinical and ancillary areas requiring replacement.

(194) Dispenser nozzles of liquid soap of alcohol based hand rubs must be visibly clean.
Yes - A cleaning programme for this criterion should include all clinical and non clinical areas, for example maintenance department.

(196) Waste bins should be hands free.
No - During the assessment a number of bins were observed to be not compliant. The organisation has purchased a number of new hands free bins; it is recommended that hands free bins are installed throughout the hospital.

(198) Hand hygiene posters and information leaflets should be available and displayed throughout the organization.
No - While some hand hygiene signage was observed, it is recommended that additional hand hygiene signs are displayed more prominently, and at all hand wash sinks.

(201) For antiseptic hand hygiene, an antiseptic hand wash agent or an alcohol hand rub product should be used for a minimum of 15 seconds (on visibly clean hands).
Yes - It is recommended that the organisation would review its usage of antiseptic hand wash agent, as there is excessive use of this product.

(204) Hand wash sinks conform to HBN 95. They should not have plugs, overflows and the water jet must not flow directly into the plughole.
No - A Quality Improvement Plan is in place for the continuing replacement of sinks.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team		Assessor Team	
	FREQ	%	FREQ	%
A	55	98.21	8	14.29
B	1	01.79	42	75.00
C	0	00.00	6	10.71
D	0	00.00	0	00.00
E	0	00.00	0	00.00
N/A	0	00.00	0	00.00

5.2 Ratings Details

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

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