Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Hygiene Services Assessment Scheme

Assessment Report October 2007

Waterford Regional Hospital

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1.0 Executive Summary

1.1 Introduction

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

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

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

Hygiene is defined as:
"The practice that serves to keep people and environments clean and prevent infection. It involves the study of preserving one's health, preventing the spread of disease, and recognising, evaluating and controlling health hazards. In the healthcare setting it incorporates the following key areas: environment and facilities, hand hygiene, catering, management of laundry, waste and sharps, and equipment" [1-4]

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

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

1.1.1 Standards Overview

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

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

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

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

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

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

Core Criteria:

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

In the Corporate Management standards, the core criteria cover:

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

In the Service Delivery standards, core criteria cover:

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

1.1.2 Rating Scale

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

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

A **Compliant - Exceptional**

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

B **Compliant - Extensive**

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

C Compliant - Broad

- There is evidence of broad compliance (between 41% and 65%) with the criterion provisions.

D Minor Compliance

- There is evidence of only minor compliance (between 15% and 40%) with the criterion provisions.

E No Compliance

- Only negligible compliance (less than 15%) with the criterion provisions is discernible.

N/A Not Applicable

- The criterion does not apply to the areas covered by the Self Assessment Team. Rationale must be provided. This cannot be used for a core criterion.

1.1.3 Assessment process components

The assessment process involves four distinct components:

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

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

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

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

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

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

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

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

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

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

- **Continuous Improvement**

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

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

[1] Boot, M and Cairncross, S "Actions Speak" Delft, The Netherlands, IRC and LSTHM, British Occupational Hygiene Society.
[2] New York Department of Health and Mental Hygiene
[3] The Columbia Electronic Encyclopaedia, Sixth Edition. Columbia University Press. 2003
[4] Irish Acute Hospitals Cleaning Manual, HSE (2006)
[5] Hygiene Services Assessment Scheme. Irish Health Services Accreditation Board (2006)

1.2 Organisational Profile

Waterford Regional Hospital is an acute hospital providing services to the population of Waterford City and County, and the HSE South – East Region. There are 474 in-patient beds and 71 day places (including 16 dialysis stations) in W.R.H.

W.R.H. is also a Teaching Hospital affiliated to Royal College of Surgeons of Ireland (RCSI). It also provides pre registration and post registration training for nurses in partnership with Waterford Institute of Technology (WIT). Waterford Regional Hospital also provides clinical placement for student midwifes in collaboration with the University of Limerick and the Regional Maternity Hospital in Limerick. Training is also supported for a range of other Groups e.g. Cardiac Technicians, Pharmacists and Health Care Attendant Personnel.

Out Patient Services are provided within W.R.H. and at other locations within the HSE SE, in respect of regional specialties.

Services provided

The hospital, which is the regional hospital for the south eastern region, provides in-patient, day cases, outpatient, and emergency medicine (including Medical Assessment Unit and Minor Injuries Unit).

Regional Services:	***Waterford City and County Services:***
• Ophthalmology, • Oncology, • Palliative Care, • ENT, • Neonatal, • Haematology, • Rheumatology, • Dermatology, • Nephrology • Orthopaedic Trauma. • Pathology	• General Medical, • General Surgical, • Paediatrics, • Acute Psychiatry • Obstetrics and Gynaecology

The services provided are supported by:

- Physiotherapy
- Occupational Therapy
- Nutrition and dietetics
- Endocrinology
- Cardiac Diagnostics
- Phlebotomy
- Endoscopy
- Services supported by dedicated Clinical Nurse Specialists include
    - Breast Care,
    - Cardiac Disease Management.
    - Cardiac Rehabilitation
    - Cardio-Pulmonary Resuscitation

- Chest Pain
- Colposcopy
- Cystic Fibrosis
- Dermatology
- Endocrinology
- Dialysis Nurse Coordinator
- Haematology / Oncology
- Haemovigilance
- Infection Control Nurse
- Occupational Health
- Oncology Liaison Nurse
- Oncology Research Nurse
- Pain Control
- Palliative Care
- Pre Operative Assessment
- Radiation Oncology
- Respiratory
- Rheumatology Nurse
- Stoma Care
- Tissue Viability
- Ultrasonography /midwifery
- Chronic Kidney Disease Nurse

Site Preparation currently underway for a further 2 Nr. Advanced Nurse Practitioners (Rheumatology and Midwifery)

Physical structures

W.R.H. is built on the site of the former Ardkeen Hospital. The new hospital was built between 1988 and early 1990s and is administered by the Health Service Executive South Eastern Area (HSE SE), formerly South Eastern Health Board (SEHB)

Waterford Regional Hospital (W.R.H.) consists of one main building and seven smaller buildings.

The main building contains all wards, pathology laboratory, diagnostic services, outpatient departments, pharmacy, catering, laundry, chapel and administration departments. It also houses the staff restaurant, visitor's restaurant one shop and one florist.
The seven smaller external buildings which were built in mid-1950s.

These seven smaller buildings house the maintenance department, ambulance department, administration department, some community clinics, the 'healing arts' offices, IT Department and some individual staff. The mortuary was built in 1991.

Of the 474 in-patient beds, 6 beds are located in the Intensive Care Unit and 6 beds are located in the Coronary Care Unit.

The ward structure consists of 4 no. 6-bed rooms (total 24 beds); one 3-bed room (semi-private) and four single rooms (private or for isolation purposes if required), total of 31 beds per ward.

Of the four single rooms in each ward, one is an isolation room with ante room.
There is one negative pressure room in ICU, which is currently being upgraded. Funding has been received for a further two negative pressure rooms which will be installed on the medical floor, by converting single rooms.

The following assessment of Waterford Regional Hospital took place between 16th and 17th July 2007.

1.3 Notable Practice

- There was an excellent approach to the development and improvement of Hygiene Services.
- The Hygiene Services Assessment scheme Terms and Key Concepts for Hygiene services were implemented.
- The content and organisation of the documentation was to be commended.
- There was in-laid floor signage encouraging visitors to perform hand hygiene.
- The key performance indicators, which had been established for the contract cleaning company and were monitored by the hospital.
- The attention to equipment that is not in use was commendable.
- The standard of hygiene in high risk areas was very high, for example, Intensive Care Unit; the hospital Sterile Supply Department was commended.
- The hospital has introduced two negative pressure rooms which were of a high standard.

1.4 Priority Quality Improvement Plan

- Sticky tape residue needs to be removed from all surfaces.
- An in-house patient survey should be conducted to gather information regarding patient's satisfaction with hygiene services within the hospital.
- Sharps training needs to be updated for all staff working in clinical areas.
- A policy in relation to maintenance of patient dignity and privacy during the cleaning processes needs to be developed.
- A process for directly including patients and other service users in evaluation of hygiene services needs to be developed.
- The monitoring and feedback on level and quality of hand hygiene practices for staff should be increased following evaluation.
- The Hospital Information Booklet (with section in relation to patient and visitor responsibilities in relation to hygiene) should be rolled out be introduced.
- Review the hospital training needs, to ensure efficacy of training provided to all staff, for example Waste Segregation in the laboratory.
- The environment in the Laundry should be upgraded and a cleaning schedule developed for this location.
- Key Performance Indicators (KPIs) for hygiene services may be expanded.
- Separate hand wash sinks should be installed in all sluice rooms.

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 Waterford Regional Hospital has achieved an overall score of:

Fair

Award Date: October 2007

2.0 Standards for Corporate Management

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

PLANNING AND DEVELOPING HYGIENE SERVICES

CM 1.1 (B → B)

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

The organisation had documented processes for completing the needs assessment regarding the requirements for Hygiene Services. A Hygiene Corporate Strategic Plan 2007-2010, Hygiene Service Plan 2007 and Hygiene Operational Plan 2007 were developed based on information from a variety of sources, including hospital activity and specific Clinical Services, the National Hygiene Audits 2005 and 2006, the Patient Partnership Forum 2006, which included patient and the franchise representation for the cafeteria and the shop. There was also a Hygiene Improvement Plan 2006, which was still being rolled out as part of the on-going Quality Improvement Plan (QIP) following on from the first National Hygiene Audit.

Evaluation of the efficacy of the needs assessment process included the outcome of the second National Hygiene Audit which showed an improvement in rating from 62% (2005) to 86% (2006) and the introduction of frequent localised Clinical Hygiene Audits, the reports from which were reviewed at Hygiene Operational Team and Hospital Management Team (HMT) levels.

The organisation was commended on the progress made and it was recommended that the future planning and development of Hygiene Services continually takes account of the changing needs of the population served.

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 had been considerable developments and modifications to the organisation's Hygiene Services over the last two years. These included the introduction of new Hygiene Management Structures with clear terms of reference and involvement of all relevant stakeholders, review of the cleaning specification for Contract Cleaning Services, change of Cleaning Contractor, new Service Level agreement with additional hours of service related to reflect new department developments/expansions and financial penalty system related to internal cleaning audit outcomes. Waste Management Plans were developed for 2006 and 2007. Hygiene Services Improvement Plans were commenced in 2006 and were still a work in progress. Improvements included the replacement of taps in wash hand basins which was still on-going, introduction of new flat mop system, introduction of Hand Gel at all entrances, replacement of furniture and fittings, structural improvements to catering department, new autoclaves in the Central Sterile Supply Department (CSSD), and staff training in the use of new systems and products for Cleaning Staff.

The introduction of the new floor level Hand Hygiene signage merited particular commendation and the organisation's plan for its extension to all relevant entrances was encouraged. The introduction of weekly internal Hygiene Audits and regular Infection Control Nurses Association (ICNA) audits with outcomes presented to the Hospital Management Team (HMT) was commended. A Dangerous Goods Safety Audit was completed in 2006. It was recommended that the internal audit process be extended to include all clinical service areas (for example, In-patient, Out-patient services).

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1 (C → C)

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

The organisation linked and worked in partnership with the HSE and various levels of Government via the area Network Manager and the National Hospital Office (NHO). Other regular communications with associated agencies and bodies included the Head of Quality and Risk, the Strategy for the control of Antimicrobial Resistance in Ireland (SARI) and the Health Protection and Surveillance Centre (HPSC). The New Hygiene Management Structures provided for the inclusion of all relevant staff including Contract Cleaners, external Catering and Retail Units and Patients.

Patient/Client and Staff Satisfaction Surveys needed to be progressed. This should include hygiene services. Some patients interviewed were not completely satisfied with current standards of hygiene services. It was a strategic aim of the Organisation to deepen its linkages with its partners. It was recommended that this be progressed and that Patient Satisfaction Surveys be prioritised.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 (B → B)

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

The Organisation had a clear strategic planning process for Hygiene Services aimed at improving the outcomes of the Organisation. The Hygiene Corporate Strategic Plan 2007-2010 had clearly defined goals, objectives, priorities and related costings. Improvements planned for 2007 included the creation of more storage space, refurbishing nurses stations and ward pantries, continuing furniture replacement, structural upgrading of a variety of areas including theatre and other staff changing areas. At the time of the hygiene assessment work was in progress in Intensive Care to introduce negative pressure facilities for two of the six beds and an additional negative pressure room had already been completed at ward level. The Hospital Management Team (HMT) had overall responsibility for Hygiene Services with delegated authority from the General Manager (GM) to the Deputy General Manager (who chaired the Hygiene Services Committee), the Hospital Quality and Safety Committee and the Environmental Monitoring Committee. The Hygiene Services Committee had representation across the entire multidisciplinary team and was charged with monitoring the implementation of the Hygiene Services Plan for 2007 and the production of the Hygiene Services Annual Report for 2007 for which a framework had been developed. A Communication Plan had also been developed for the Annual Report which included presentation to the General Manager and HMT followed by dissemination to all relevant committees and line managers. All Hygiene Services Plans were circulated to all staff via the in house communication structure and discussed at the bi-monthly General Services Meeting, Nurse Management and other Departmental Meetings

Since the establishment of the Hygiene Corporate Strategic Plan had been a recent development, evaluation was through monthly reporting. The Annual report 2007 will also include a progress report on the Service Plan.

GOVERNING AND MANAGING HYGIENE SERVICES

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.

Documented processes for receiving and acting on information on the performance of Hygiene Services included internal and external audits, for example National and on-going internal Hygiene Audits and Infection Control Nurses Association (ICNA) Audits Environmental Health Officer (EHO) reports, Dangerous Goods Audit and the imminent decontamination audit. To date the only identified Key Performance Indicators (KPIs) for Hygiene Services are the ICNA audit reports. It was recommended that the scope of KPI for Hygiene services be reviewed and expanded to give a comprehensive overview of the entire service. The input from a Consultant Microbiologist was sought before implementation/alteration of relevant legislation and guidelines. Since the inception of the new Hygiene Services Management Structure, all information received was evaluated at both the Hygiene Team and Hygiene Services Committee meetings as appropriate and action points and responsibilities identified. There was evidence of resultant actions and continuous quality improvements observed. The closing off of the quality improvement loop through re-audit and evaluation needed to be further integrated into the Hygiene Services Management Structure.

CM 4.3 (C ↑ 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.

Research and best practice information was available through hospital library and intranet facilities and included relevant legislation and best practice guidelines.

Quality initiatives included the introduction of Legionella and Aspergillus precautions, the introduction of new cleaning products and systems and alterations to kitchens in accordance with research/information from the Hazard Analysis and Critical Control Point (HACCP) Quality Manager. There was a Research Committee in place and a training budget allocated for training and research. Methods of informing Hygiene Staff of the latest research, legislation and best practice included the use of the internal communications structure, training sessions provided by Infection Prevention and Control Staff, Occupational Health Staff and HACCP Quality Manager. New information received was forwarded to the relevant committees for evaluation, recommendation and implementation. Infection Prevention and Control input was essential with no changes in Hygiene Practices introduced without the formal approval of a Consultant Microbiologist. Hygiene leaflets and posters were also observed throughout the organisation.

CM 4.4 (B → B)

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

All policies, procedures and guidelines conformed to a standard approach in their development, approval, revision and control and were observed to be user friendly and of a high standard. There was an extensive suite of policies, procedures and guidelines that were hygiene specific and included hospital cleaning specification, a range of infection control policies and precautions, standard operating procedures for laundry and catering, waste management and sharps policies, Health and Safety

statements and proactive risk management strategy. Evaluation of the efficacy of these policies was mainly through Internal Hygiene, Infection Control, HACCP, Occupational Health and Risk Surveillance audits. It was recommended that the scope of audits should be extended to include all aspects of the Hygiene Services with outcomes evaluated and a comprehensive quality improvement plan reflective of the full scope of hygiene services progressed.

CM 4.5 (A ↓ B)

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

The Hygiene Services Committee had representation from the Senior Management Team and was thus involved in the Capital Development planning and implementation process. There was no documented process for consultation with the Hygiene Services pre-development of existing sites but there was evidence that this happens in practice. An Aspergillus Precaution policy was in place and there was evidence of on-going liaison between Infection Prevention and Control and Contractors in relation to capital projects. It was recommended that documented processes be developed for consultation with Hygiene Services in relation to the pre-development of existing sites and the evaluation of the efficacy of the consultation process between Hygiene Services and Senior Management with actions and a continuous quality improvement plan.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

*Core Criterion

CM 5.1 (A ↓ B)

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

There were clear lines of responsibility and accountability for Hygiene Services staff in place. Roles, authority and responsibilities of the HMT for Hygiene Service Provision were also identified.

Reporting relationships of all members of the Hygiene Services team were identified in their job descriptions and there was a clear liaison and accountability for Contract Cleaning Services provision between the Contractor and the Organisation with a partnership approach to the internal Hygiene Audit process.

Ward and Department Managers were responsible and accountable for the standards of hygiene services in their areas. Levels of awareness of hygiene processes by front line staff and monitoring of same at department level were variable and it was recommended that this is identified as a QIP across all disciplines.

*Core Criterion

CM 5.2 (A → A)

The organisation has a multi-disciplinary Hygiene Services Committee.

There was a comprehensive multidisciplinary Hygiene Services Committee in place which met on a monthly basis and a hygiene corporate strategic plan, hygiene service plan and hygiene operational plan had been developed. There was evidence that this team were actively progressing the roll out of the hygiene agenda and had a framework for the development of the annual hygiene report. Administrative support was provided to these meetings and minutes circulated. Consideration should be given to making members specific responsibilities explicit in relation to this committee to ensure full comprehensive organisational input and feedback.

There was also a hygiene services team in place which worked in conjunction with the hygiene services committee and was operational in its focus. There were documented terms of reference for the Hygiene Services Team. Consideration

should be given to reviewing the composition of this team to ensure full representation of Hygiene Services frontline managers. The Hygiene Services Team met weekly and secretarial support was provided from within its membership.
The organisation was to be complimented on the progress made in relation to the development of its hygiene management structures.

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

*Core Criterion
CM 6.1 (A → A)
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.
There were documented processes for the allocation of resources which included a risk assessment of all identified resource needs with associated costings. The Hygiene Capital Development Plan was costed at €3 million overall. €1 million was approved in 2006 and a further €1 million was approved for 2007 to fund the Waste Management Project with an outstanding gap of the final €1 million euro. A further €0.8 million was provided for the implementation of the Hygiene Services Quality Improvement Plan in 2006 and a further €0.25 million in 2007. These developments were in accordance with the Corporate Hygiene Strategic and Hygiene Service Plan.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion
CM 7.1 (B → B)
The organisation has a structure and related processes to identify, analyse, prioritise and eliminate or minimise risk related to the Hygiene Service
There were documented processes for Hygiene Service risk incident identification, reporting, analysis, minimisation and elimination observed. One major adverse event occurred over the last two years. This is being investigated by the organisation in conjunction with the National Hospital Office and a report is imminent. Corrective actions leading from this adverse event were immediately taken. Risk Management and Health and Safety Annual Reports were produced and circulated.
External reports included Hospital Accreditation, Environmental Health Officer (EHO) and Dangerous Goods Reports. The decontamination audit was imminent. Hygiene Service audits included National Hygiene Audits 2005 and 2006 and there were ongoing internal Hygiene Audits since 2005. These included Departmental Hygiene, HACCP, Infection Control and Quality and Risk Surveillance Audits. There was evidence of considerable progress over the last two years and it was recommended that the organisation continue to progress the scope of the internal Hygiene Audits to include all patient areas.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion
CM 8.1 (A → A)
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 complied with the National Financial Regulations and Procurement Policy in the establishment, management and monitoring of contractors. The Contract Cleaning Services worked in close partnership with the Organisation primarily through the Cleaning and Waste Management Co-ordinator and the Contractors Area and Site Managers. The Contractors were represented at all levels

of Hygiene Service Management and the Patient Forum. Other contracted services included Waste Removal, Pest Control and Sani-Bin service and there was evidence of on-going quality improvements in each of these areas which were negotiated through the Cleaning and Waste Management Co-ordinator. Other licensees were involved in service provision and include Cafeteria, Shop, Florist and Hairdresser and Snacks Dispenser Service.
The current Cleaning Contract was awarded within the last two years and was based on a service level agreement. Key performance indicators are monitored for the contractors. The organisation is to be complimented on this initiative to ensure cleaning standards are achieved and maintained.

CM 8.2 (A → A)
The organisation involves contracted services in its quality improvement activities.
The Organisation involved all contractors in its quality improvement activities. In addition to the Cleaning Contractor being actively involved in the quality improvement activities of the Hygiene Services Committee, the Cleaning and Waste Co-ordinator liaison external contractors, the Florist, Hairdresser and Shop facilities were given the template of the organisations standard operating procedures and were requested to develop appropriate standard operating procedures for their own services. There was a liaison process between all on-site contractors and the Infection Prevention and Control Team for the provision of relevant training and the notification of infection outbreaks. Discussions had taken place with the Snack Dispenser Company regarding the cleaning standards for the dispenser units. This was to complete the inclusion of all contracted services participation in the maintenance of hygiene standards in accordance with the Organisations requirements. The organisation was recommended to hold copies of these standard operating procedures, together with evidence of compliance.

PHYSICAL ENVORNMENT, FACILITIES AND RESOURCES

CM 9.1 (B → B)
The design and layout of the organisation's current physical environment is safe, meets all regulations and is in line with best practice.
The organisation took account of relevant legislation and best practice in the design and layout of the organisations physical environment. Evidence of recent developments included the upgrading of patient isolation facilities. Storage space was an issue and the organisation was actively involved in optimising the use of existing physical space to address same. Developments in this regard included creating cleaning equipment storage cupboards on corridors. The staff were to be commended for their regular elimination of all unnecessary equipment and the creative use of space. Other physical developments in the Catering Department, the Laundry and Waste compound were part of the Hygiene Services Quality Improvement plan and it was recommended that they should be progressed.

*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.
There were documented processes in place to plan and manage the environment and facilities, equipment and devices, kitchens, waste and sharps and linen throughout the organisation which reflected current legislation and best practice. These included planned preventive maintenance, monitoring and recording of performance for tracking purposes and ongoing improvements, for example, waste segregation with associated volume variance and cost savings which were monitored

and reviewed on a monthly basis. The trialling of a new hand gel dispenser system was also in progress with a view to addressing some of the unacceptable features of the existing system.

CM 9.3 (B → B)

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

There was evidence of significant progress over the last two years in the evaluation of the efficacy of the organisation's environment and facilities and equipment. These included internal and external reports already identified and the introduction of the Patient Partnership Forum and Hygiene Corporate Structures. It was recommended that the organisation introduce Patient/Client Satisfaction Surveys for Hygiene Services. Changes made to the organisation's environment and facilities over the past two years included developments across all aspects of Hygiene Services and included structural developments, additional storage areas, improvements to catering areas, segregation and recycling which included the composting of food waste. These are part of the ongoing implementation of the Hygiene Quality Improvement plan.

CM 9.4 (B ↓ C)

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

Evaluation of patient/client satisfaction is based on the input from the Patients Forum and Complaints. There were 250 complaints in 2006 and in excess of 10% of these related to Hygiene Services. A number of patients interviewed were not satisfied with aspects of the cleaning service .The Organisation should commence structured Patient Satisfaction Surveys with evaluation and QIP.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 (B ↓ 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.

There were documented processes in place for the selection and recruitment of Hygiene Services staff including those recruited to manage the Contract Cleaning Services. Job descriptions were observed. Contract Staff were utilised solely for the provision of cleaning services and supervision of these staff was of a high standard. Human resources records for Cleaning Staff were held off-site by the Contractor. All the human resources records for the organisation's other Hygiene Services staff were held by the organisation. There was no evidence of evaluation of the recruitment processes observed during the assessment. However the organisation identified that this was currently underway at regional level.

CM 10.2 (B → B)

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

The changes in Hygiene Services work, capacity and volume are discussed at the weekly Hygiene Services Team Meetings. Changes made included the provision of additional hours to meet the standards of service agreed with the Contractor where necessary.

CM 10.3 (A → A)

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

There were documented processes to ensure that all staff including Contract Hygiene Services Staff had the relevant and appropriate qualifications and training. Job descriptions identify if pre-employment qualifications were required and these were verified prior to selection interview offer. The Cleaning Specification stipulates the British Institute of Cleaning Science (BICS) level of training for Cleaning Operatives and Supervisors. Catering Staff are HACCP trained and this is evaluated on an ongoing basis. All staff have received induction and ongoing training in hygiene related issues.

CM 10.4 (B → B)

There is evidence that the contractors manage contract staff effectively.

Contract Cleaning Staff report through their Supervisors to the Contract Site Manager. Daily Supervisor audits are conducted and all operational issues are dealt with at this level. There was close liaison between the Contract Managers and the Hospital Cleaning and Waste Co-ordinator. Contract Staff have access to the Hospital Occupational Health Service and are required to have Hepatitis B vaccinations. Induction and ongoing training was provided and included input from the Infection and Control Nurses and Occupational Health Nurses. Evaluation was carried out by the Contract Site Manager and Regional Trainer. Training needs were identified and actioned. Issues of concern were also discussed at the weekly Hygiene Services Team Meetings.

*Core Criterion

CM 10.5 (B ↓ C)

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

The Organisation's Cleaning Specification was informed by its Corporate, Service and Operational Hygiene Services Plans. The contracted hours had increased to reflect service expansion. Cleaning hours per department were monitored on a monthly basis by the Cleaning and Waste Co-ordinator and reviewed in the context of the internal audit outcomes. Structures were in place for the production of a Hygiene Services Annual Report 2007.

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

There was a designated induction/orientation programme for all staff which included education regarding hygiene. Ongoing education and training specifically regarding hygiene included Sharps Training, Hand Hygiene, Health and Safety Training and Standard Precautions. The Education Programme was developed by the Infection Control Department for all staff (January 2007) and the BICS training for the Contract Cleaning Staff. Specific Hygiene Information leaflets and posters were observed throughout the organisation. Attendance records are maintained and available to Line Managers. The Organisation was encouraged to use the Staff Handbook and Job Descriptions to ensure that staff responsibility for Hygiene Standards is comprehensively communicated.

CM 11.2 (A ↓ B)

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

There were processes in place to ensure staff had the necessary ongoing hygiene related education and training. These included Health and Safety Training, Infection Control, Waste Management, Hand hygiene, handling complaints, decontamination of medical devices and equipment, management of blood spillages Risk Management and safety statements. Staff were facilitated in attending relevant training during their rostered time. Education/training was provided mainly by in-house staff, however, external facilitators were available where necessary. Documented evaluation of education/training was observed and outcomes used to inform change.

CM 11.3 (B → B)

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

Audit outcomes and incident/near miss reporting were the main indicators used to evaluate the effectiveness of education and training. A documented evaluation system was in place for all education/training days. Attendance levels were recorded. The provision of extra classes was the only QIP identified.

CM 11.4 (C ↑ B)

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

All Hygiene Staff Performance was evaluated at an operational level through the weekly completion of the ICNA audits, which covered all hygiene elements. Behavioural aspects of work performance were reported on separately. These audit outcomes were discussed at the Hygiene Team meetings and any performance issues /corrective actions identified were subsequently discussed with the relevant Line Manager. A Training and Development Officer had been appointed and any necessary training was facilitated.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (A ↓ B)

An occupational health service is available to all staff

The Area Occupational Health Service was located on the campus of Waterford Regional Hospital and was well resourced. An Employee Assistance Service was also provided. A comprehensive range of Occupational Health services were provided which included vaccinations. To date, the service was not subject to any formal feedback process, however the staff were open to such an initiative and some preparatory work had been done. It is recommended that a formal evaluation process with QIP be put in place.

CM 12.2 (C → C)

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

The key performance indicators maintained by this department to date other than a Staff Wellbeing at Work Survey which included all staff were training, absenteeism records, Employee Assistance Referrals and accident statistics. There was evidence of effective QIP in relation to inoculation injuries for Hygiene staff. The staff should identify a suite of appropriate key performance indicators which are monitored regularly, become a basis for QIP and reported in their Annual Report.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.1 (B → B)

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

Information, which was available through the various national agencies, was notified to the organisation and available either in hard copy or online. It was reviewed by the relevant committee and if it pertained to Hygiene Services, Hospital Management sought the advice of a Consultant Microbiologist before introducing any change. Policies, procedures and guidelines for Hygiene Services, which were evidence based and reflected current best practice, were reviewed on a regular schedule. Examples of other information collected included minutes of meetings, Audit results, Surveillance results and notification of communicable diseases. There was evidence of corrective actions observed.

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.

The organisation had a system in place whereby the regularly conducted ICNA audit outcomes were circulated to the relevant Line Managers/ Department Heads for information and action. Results were inputted into a database and trends analysed. They were discussed at Hospital Management Team level and subsequently at weekly Hygiene Team meetings. Corrective measures were instigated with timelines for completion. Risk Surveillance Reports were submitted to the Hospital Quality and Safety Team and the Hospital Management Team for review and action. The documentation available for the Hygiene Assessment was comprehensive and user friendly.

CM 13.3 (A ↓ B)

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

Mechanisms used to assess data collection and information reporting were the information presentations to the Hygiene Team and Hygiene Services Committee meetings, for example, hygiene audit outcomes, waste management audit outcomes, linen audit outcomes, HACCP monitoring, risk surveillance and health and safety reports, occupational health and infection control/ ICNA audit reports. The outcomes are evaluated at the relevant committee meeting, for example, risk surveillance and health and safety reports are reviewed by the hospital quality and safety team and laterally relevant hygiene reports are evaluated by the hygiene services committee and all reports thereafter submitted weekly to the hospital management team for their consideration. The internal hygiene audit system was introduced following the 2005 national hygiene audit to generate regular reports on hygiene performance and is the basis for ongoing quality improvements in the hygiene services. These audits were conducted weekly in the ward areas and corrective action taken immediately where possible.

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

Following the National Hygiene Audit of 2005 the Organisation embarked on a comprehensive approach to improving its Hygiene Service Standards. The Quality Improvement Plan already referred to was drawn up and included improvements in isolation facilities, storage, hand hygiene and environmental cleaning practices and products used, decontamination facilities, internal audit, and management structures with inclusion of service users. There was evidence of significant progress and a well established commitment to Continuous Quality Improvement (CQI) in relation to Hygiene standards.

CM 14.2 (A ↓ B)

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

This organisation has made considerable progress over the last two years mainly through the structures it has put in place to plan, evaluate and improve its Hygiene Services. Of particular note is the inclusive approach to ensure all relevant stakeholders are involved and the numerous examples of QIP which were evident. The role of the Cleaning and Waste Co-ordinator was particularly noteworthy in ensuring that in-house and contract services worked in unison and that new initiatives were progressed and evaluated.

3.0 Standards for Service Delivery

The following are the ratings for the Service Delivery standards, as validated by the Assessment team. The service delivery standards allow an organisation to assess and evaluate its activities in relation to Hygiene Services at a team level. The Service Delivery standards relate directly to operational day-to-day work and responsibility for these standards lies primarily with the Hygiene Services Team in conjunction with Ward/Departmental Managers and the Hygiene Services Committee. There are six Service Delivery standards, which focus on such areas as prevention and health promotion, implementing hygiene services and patients / clients rights. There are seven core criteria within these standards.

EVIDENCE BASED BEST PRACTICE AND NEW INTERVENTIONS IN HYGIENE SERVICES

SD 1.1 (B → B)

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

Details of how guidelines are established, adopted and maintained were outlined in the Hygiene Service Plan. Best practice guidelines were widely used for example the HACCP system was in place, Waste Guidelines were implemented, SARI guidelines were implemented, and a colour-coding system was in operation. Supervisory staff had protected time for reviewing documentation. A documented process for evaluating the process for developing best practice guidelines is not in place. However, weekly audits were conducted (using the HIQA Hygiene Services Assessment checklist) to check if guidelines were being adhered to.

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 were reviewed by the Hygiene Services Team. The Finance Manager sits on both the Hygiene Service Committee and the Equipment Procurement Committee. The Infection Control Department have developed a checklist to be completed pre-purchase for any new equipment. Many cleaning products were procured by the contract cleaning company on a regional basis so there was no evidence available of the process used for selection of recently introduced cleaning products. An evaluation was carried out of any new products introduced. There was no evidence of a process to assess the efficacy of the assessment process. It was recommended that this be put in place.

PREVENTION AND HEALTH PROMOTION

SD 2.1 (C → C)

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

An Infection Control Week and a Quality and Risk Awareness Week were held. Regular meetings of the Patient Partnership Forum were held and hygiene related topics were discussed. Hand Hygiene posters and leaflets were available in public areas. It was recommended that Alcohol hand gel information leaflets could also be made available. Evaluation of these activities was limited to hand hygiene audits.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1 (B ↓ C)
The Hygiene Service is provided by a multi- disciplinary team in cooperation with providers from other teams, programmes and organisations.
There is a multidisciplinary Hygiene Service Team. This group is a sub-group of the Hygiene Service Committee and they have linkages with teams through the HSE. There were documented terms of reference for the HSE. There was no evidence of evaluation of the efficacy of this structure.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion
SD 4.1 (A ↓ B)
The team ensures the organisation's physical environment and facilities are clean.
High risk areas, for example, the Intensive Care Unit (ICU), the Hospital Sterile Services Department (HSSD) were very well maintained. The Out-patients Department (OPD) and Pathology were noted to be areas requiring further improvement and need a QIP. Sticky tape residue was a huge problem in all areas. It was recommended that a cleaning programme be put in place for radiators.

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.
Equipment and medical devices were generally clean. However, sticky tape residue was a problem on some equipment. Patient belongings needed to be managed more efficiently to enable effective cleaning. Alcohol gels in Physiotherapy and Radiology were found to be out of date (one expired in 2003). These were removed over the duration of the assessment.

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.
Most equipment was clean and in good repair. A colour-coding system was in place for products and equipment. Hand wash facilities were not currently available in the cleaners' rooms but it was indicated that a plan is being put in place to address this.

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 main kitchen was managed very well with a good HACCP system in place. However, staff changing facilities must be upgraded to comply with HACCP regulations and include separate toilets for kitchen staff. The Catering Manager and the HACCP Quality Manager had plans to address this.

For further information see Appendix A

*Core Criterion
SD 4.5 (A → A)
The team ensures the inventory, handling, storage, use and disposal of Hygiene Services hazardous materials, sharps and waste is in accordance with evidence based codes of best practice and current legislation.
The Waste Management system was largely compliant with waste guidelines. However, the Laboratory waste needed to be reviewed. It was recommended that a process for monitoring compliance with waste management guidelines be implemented in the Laboratory. It was recommended that mattress bags should be purchased for the disposal of contaminated mattresses. Sharps awareness training was recommended given the level of needle stick injuries to household staff.

For further information see Appendix A

*Core Criterion
SD 4.6 (A → A)
The team ensures the Organisations linen supply and soft furnishings are managed and maintained
The Laundry was well managed and there was a good system in place for transport of linen to and from the clinical areas. However, the environment in the Laundry needed to be upgraded and a cleaning schedule developed for this location. It was recommended that a programme be put in place to remove stained linen from the maternity unit. The Guidelines for the Use, Handling and Storage of Linen should be updated to include a section on the transportation of linen.

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 was inlaid floor signage encouraging visitors to perform hand hygiene. This seemed to be effective. However, there needed to be increased monitoring and feedback on level and quality of hand hygiene practices.

For further information see Appendix A

SD 4.8 (B ↓ C)
The team ensures all reasonable steps to keep patients/clients safe from accidents, injuries or adverse events.
There were documented processes for the minimisation of risk. Details of response rates to non routine incidents and incident reporting forms involving contract cleaning staff were not available as they were held at the head office of the contract cleaning company. A list of incidents was provided. It was recommended that evaluation of these incidents is carried out and action taken, for example, refresher training for all staff on sharps disposal.

SD 4.9 (A ↓ C)

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

There was a plan to introduce a Hospital Information Booklet. It was understood that it will include the patient and visitor role in relation to hospital hygiene. The aim of the booklet was to empower the public in relation to hygiene. Information leaflets were available to patients and visitors. The National Visitors Policy had been implemented. There was no recent patient satisfaction survey (last survey was carried out in 2004). Plans to conduct a survey in 2007 through the Irish Society for Quality and Safety in Healthcare (ISQSH) had been put on hold due to advice from the National Hospitals Office (NHO). Input from patients was received from the Patients Partnership Forum. The conduction of an in-house patient satisfaction survey was recommended before the end of 2007.

PATIENT'S/CLIENT'S RIGHTS

SD 5.1 (C → C)

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

The team were aware of best practice guidelines in relation to patient privacy but there was no evidence of a document process specifically referring to maintenance of patient dignity and privacy during the cleaning process. There was no evidence of a documented process for dealing with special needs for privacy. There was no specific leaflet relating to patient dignity/privacy. A policy in relation to maintenance of patient dignity and privacy during the cleaning processes needs to be developed.

SD 5.2 (C → C)

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

There were plans to introduce a Hospital Information Booklet for patients. This booklet was in draft form but the draft was not provided during the assessment. Hand hygiene booklets were available on entering the hospital. There was an announcement encouraging visitors to use the alcohol gels provided. However, instruction leaflets on how to use the gel were not provided. Patients were not surveyed on their satisfaction with the information provided but information in relation to patients' satisfaction was gathered via the Patient Partnership Forum.

SD 5.3 (B ↓ C)

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

The national complaints guidelines "Your Service Your Say" had been implemented and the complaints process is coordinated by the Patient Services Officer. Records of complaints received in relation to hygiene were available and responses are sent to patients through the Patient Services Officer. Statistics on comments, compliments and complaints are presented at the Quality and Safety Committee Meetings. Complaints specifically relating to the cleaning carried out by the contract cleaning company were forwarded on to them for comment. However, there was no evidence of resultant actions or a QIP.

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1 (C → C)

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

Patients and other service users were not directly involved in evaluating the hygiene services. However, feedback was received from patients via the Patient Partnership Forum. Refurbishment of some of the public toilets was carried out as a direct result of patient feedback.

SD 6.2 (B → B)

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

Weekly Internal Audits were carried out using the Infection Control Nurse's audit tool. The National Hygiene Audit report was used to prioritise the needs of the hygiene services. Key Performance Indicators for hygiene services needed to be expanded. There was no evidence of active benchmarking against external organisations. A Hygiene Services Annual Report for 2006 was available. It included summary data on internal audits conducted during the year.

SD 6.3 (B ↓ C)

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

There was no evidence of a documented process for the compilation of the Hygiene Services Annual Report but there was a template available for the contents. The report was circulated to all heads of department. The policies, procedures and guidelines were due to be reviewed by the Hygiene Services Committee in 2007.

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 - High risk areas were well maintained but non clinical areas were generally poor, with dust and debris noted.

(2) All high and low surfaces are free from dust, cobwebs and flaking paint.
Yes - Some flaking paintwork was noted in the OPD sluice areas.

(3) Wall and floor tiles and paint should be in a good state of repair.
No - Damage to walls was noted in some areas. Some additional floor tiles were needed in the bathrooms.

(4) Floors including edges, corners, under and behind beds are free of dust and grit.
Yes - In the majority, however, improvement is required in the OPD as dust was noted in corners of clinical rooms and sluice rooms.

(5) Cleanable, well-maintained furniture, fixtures and fittings used.
Yes - Sticky tape residue was noted in many areas.

(6) Free from offensive odours and adequately ventilated.
Yes - In the majority, however, an exception noted was some patient wash room facilities.

(8) All entrances and exits and component parts should be clean and well maintained.
No – The main entrance needs to be better maintained.

(9) Where present, main entrance matting and mat well should be clean and in good repair.
No – The main entrance mat required attention.

(10) Internal and external signage should be clean, updated, well maintained and laminated to enable cleaning.
Yes - Most signage observed was lamintated. Staff were aware of the remaining deficits and there was a plan to address the deficits.

(14) Waste bins should be clean, in good repair and covered.
Yes - Bins in the laboratory were not compliant, however, all other areas were compliant.

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

(20) Doors
Yes - All of the Catering Department doors need attention, however, all other areas were compliant.

(21) Internal and External Glass.
No - External glass required attention.

(23) Radiators and Heaters
No - Attention to detail behind many radiators was required.

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 – In the majority, however, sticky tape residue needs to be addressed.

(207) Bed frames must be clean and dust free
No - Dust was noted on many bed frames in the Emergency Department.

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

(37) Tables and Bed-Tables
Yes - One locker observed had with items belonging to previous patient.

(38) Dispensers (e.g. handwash dispensers), Holders and Brackets
Yes – In the majority, however, some exceptions were noted.

(39) Waste Receptacles (e.g. sani-bins, nappy bins, sharps bins, leak proof bins
Yes - Waste receptacles were clean, with the exception of those in the Laboratory, where many required attention.

(41) Door handles and door plates
No - Many door handles and door plates need further attention.

Compliance Heading: 4. 1 .5 Sanitary Accommodation

(45) There is a facility for sanitary waste disposal.
Yes - Some of the sani -bins were not clean.

(49) Cleaning materials are available for staff to clean the bath / shower between use.
Yes – These were not visible, however, staff expressed that they had access to these items as needed.

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
Yes - Showers clean but some showers had mould. This was being addressed.

(58) Sluice rooms should be free from clutter and hand washing facilities should be available.
No - Separate hand washing facilities were not available in all sluices.

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

(65) Commodes, weighing scales, manual handling equipment.
Yes - In the majority, however, some bedpans need attention.

(68) Patient fans which are not recommended in clinical areas.
Yes - None were observed in patient areas.

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

(71) Alcohol hand gel containers.
Yes - Some observed were not clean. Some out of date alcohol gels in out patient service areas were noted.

(72) Trolleys, e.g. chart trolleys, drug trolleys, linen trolleys, shop trolleys, emergency trolleys, suction apparatus, resuscitation equipment i.e. ambubag and mask.
Yes - Sticky tape was on some chart trolleys.

(74) Patient's personal items, e.g. suitcase which should be stored in an enclosed unit i.e. locker / press.
No - Patient personal items on the floor in many wards, when they should have been stored in an enclosed unit.

(76) Hand-wash dispenser holders and brackets should be free of product build-up around the nozzle.
Yes - A large number of dispensers in the Emergency Department had product build up on the nozzle.

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

(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.
No – A policy was in place, this should be complied.

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

(272) Splashes of water or hand-wash gel should not be present on the wall, floor, bed or furniture, splash backs should be provided.
No - Splashes of alcohol gel was noted on many walls.

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.
Yes – However, the buffer in Accident and Emergency department requires attention.

(90) Storage facilities for Cleaning Equipment should be provided in each work area with adequate ventilation, a hot and cold water supply and hand-wash facilities.
No – Storage was not available in many work areas but rather located close by. Most do not have hand wash facilities in the storage area, however, facilities were available nearby in clinical areas and these were being used.

(91) Storage facilities for Cleaning Equipment should be clean and well maintained.
Yes - In the majority, however, Accident and Emergency storage area needs to be addressed.

(92) Cleaning products and consumables should be stored in shelves in locked cupboards.
Yes - The storage of cleaning products should be reviewed.

Compliance Heading: 4. 4 .2 Facilities

(218) Authorised visitors to the food areas should wear personal protective clothing (PPE) and wash hands on entering the food area during food preparation/serving times.
Yes - It is recommended that the process to ensure all visitors to the catering areas comply with hand washing guidelines is reviewed.

(222) A wash hand basin should be provided at the ward kitchen, in addition to a sink, along with a liquid soap dispenser and hygienic hand drying (e.g. paper towels).
Yes – However, no soap was observed in the Accident and Emergency kitchenette. This was addressed during the duration of the assessment.

(223) Separate toilets for food workers should be provided.
No - The toilets used by the Catering Department were also used by various other grades of staff and it is recommended that this practice be reviewed.

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

(241) Ice cream display units can operate at -12°C as long as it can be demonstrated that the product has been held at this temperature for less than 7 days.
Yes - Current practice was observed to be compliant. However, the hospital is moving towards best practice and providing single serving portions.

Compliance Heading: 4. 4 .10 Plant & Equipment

(249) Machines should dispense ice but where ice-scoops are used, they should be stored separately from the ice-making machine and there should be a process for the appropriate decontamination of the ice scoops. The making of ice cubes other than in ice machines is prohibited.
Yes - None were observed.

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

(147) Only UN approved containers and bags to be used for healthcare risk waste.
Yes - In the majority, however, the laboratory did not use approved containers.

(151) Waste is disposed of safely without risk of contamination or injury.
Yes - In the majority, however, it was noted that one batch on risk waste was not transferred from the clinical area to the waste compound in a lockable secondary container as per the guidelines. This was addressed during the assessment.

Compliance Heading: 4. 5 .3 Segregation

(156) Healthcare risk waste must be segregated from healthcare non risk waste.
Yes - Poor segregation of waste in the laboratory was observed.

(159) Sharps boxes are correctly sealed, labelled and stored in a safe environment.
Yes - In the majority, however, the laboratory required attention.

(256) Mattress bags are available and are used for contaminated mattresses ready for disposal; mattresses are disinfected.
No – These were not available.

Compliance Heading: 4. 5 .5 Storage

(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 - Primary storage areas observed were not all locked and could potentially be accessed by the public.

(258) Waste receptacles should be sanitised, secure and in a good state of repair when used.
Yes - Some receptacles were not sanitised or secured.

Compliance Heading: 4. 5 .6 Training

(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 - Training records were available. It is recommended that these are collated on one system for easier access to the numbers of personnel who have been trained.

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

(175) Clean linen is free from stains.
No - Linen was clean, however it was stained on many beds in the hospital. This linen needed to be removed from the stock.

(261) Clean linen store is clean, free from dust and free from inappropriate items.
Yes - The OPD linen stores had various other items stored in them.

(267) Documented process for the transportation of linen.
No - No reference to the transportation of soiled linen in the laundry processes and procedures documents was observed.

(271) Hand washing facilities should be available in the laundry room.
Yes - In the majority, however, the area around hand washing facilities is in need of repair.

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

(188) Hand and wrist jewellery should be removed prior to performing all levels of hand hygiene with the exception of a plain wedding band.
No - Wrist jewellery was not removed to demonstrate hand washing procedures in a number of cases. It is recommended that this be addressed.

(189) Clinical hand wash sinks are required in all areas where clinical activities are performed. They should be centrally located and free from obstruction.
No - More clinical hand wash sinks were required.

(192) Taps should be hands free and should be mixer taps to allow temperature regulation.
No - Work was ongoing to improve this.

(198) Hand hygiene posters and information leaflets should be available and displayed throughout the organization.
Yes - It is recommended that posters are located in the hospital where they are more visible.

(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 - Attendance sheets for mandatory hand hygiene sessions were available. However, an overall tracking system highlighting those who have or have not attended was not available. Therefore, it is recommended that this is completed.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team		Assessor Team	
	FREQ	%	FREQ	%
A	25	44.64	12	21.43
B	23	41.07	29	51.79
C	8	14.29	15	26.79
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	B	B	→
CM 1.2	B	B	→
CM 2.1	C	C	→
CM 3.1	B	B	→
CM 4.1	B	B	→
CM 4.2	A	B	↓
CM 4.3	C	B	↑
CM 4.4	B	B	→
CM 4.5	A	B	↓
CM 5.1	A	B	↓
CM 5.2	A	A	→
CM 6.1	A	A	→
CM 6.2	B	B	→
CM 7.1	B	B	→
CM 7.2	A	A	→
CM 8.1	A	A	→
CM 8.2	A	A	→
CM 9.1	B	B	→
CM 9.2	A	A	→
CM 9.3	B	B	→
CM 9.4	B	C	↓
CM 10.1	B	C	↓
CM 10.2	B	B	→
CM 10.3	A	A	→
CM 10.4	B	B	→
CM 10.5	B	C	↓
CM 11.1	A	A	→
CM 11.2	A	B	↓
CM 11.3	B	B	→
CM 11.4	C	B	↑
CM 12.1	A	B	↓

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