Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

# Hygiene Services Assessment Scheme

## Assessment Report October 2007

## St. Columcille's 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*

St. Colmcille's Hospital is an Acute Hospital with staffing for 133 beds. The total occupancy was 98% for 2006. The Hospital was built in the 1840s as a workhouse and is in need of major repair.

**Services provided**

- General Medicine
- Acute elderly assessment and rehabilitation
- Intensive/ Coronary care
- General Surgery
- Vascular Surgery
- Gynaecology
- Dental Surgery
- Urology
- Cardiology
- Endocrinology
- Nephrology
- Pathology
- Ophthalmology
- Respiratory Medical
- Psychiatry
- Gerontology
- Orthopaedics
- Anaesthetics
- Accident and Emergency

The following assessment of St Columcille's Hospital took place between the 12th and 13th of June 2007.

## *1.3 Notable Practice*

- The management of waste was considered a strength for the organisation.
- The commitment shown by the team to the process of continuous improvements in the overall standards of hygiene was commended.
- The documentation requirements were quite well established and with further refinement should also prove a useful tool in driving the process forward.

## *1.4 Priority Quality Improvement Plan*

- The main priority area of improvement was the refurbishment of the many structural deficiencies identified during the assessment and this was particularly evident in the ward structure of St. Brigid's and the toilet and washing facilities in the Lourdes ward.
- The organisation would benefit from reviewing the space in this ward area.
- It was recommended that the organisation consider the amalgamation of Endoscopy services into one centralised designated area.

- It is recommended that cleaning staff are not involved in the service of foods at ward level and that staff would cease to wear their uniforms to work and would use the changing facilities provided. This was not the practice observed during the site visit.

## *1.5 Hygiene Services Assessment Scheme Overall Score*

The decision mechanism used to translate an organisation's criteria, risk ratings to a Hygiene Service Assessment Scheme score is based on a quantitative analysis of the assessment results which ensures consistency of application. The decision regarding a score is made by the Internal Review Committee of HIQA, based on the findings of the Assessment Team; the St. Columcille's Hospital has achieved an overall score of:

**Fair**

**Award Date:** October 2007

## *1.6 Significant Risks*

**CM 9.1 (Rating D)**
**The design and layout of the organisation's current physical environment is safe, meets all regulations and is in line with best practice.**

**Potential Adverse Event**
Cross contamination/ risk of infection

**Risks**

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

**Recommendations**
Address structural changes in the ward and theatre areas to provide adequate hand washing facilities to comply with SARI guidelines in the sluice room of the Intensive Care Unit and the Accident and Emergency Department. Provide adequate space in the theatre area to perform endoscopic procedures and the decontamination process.

# 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 (C → C)**

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

Minutes of hygiene services committee were available. The organisation had developed service and operational plans and recently developed a Corporate Hygiene Strategic plan. There was evidence that funding is being sought to address hygiene services issues as identified through the service plan.

**CM 1.2 (C → C)**

**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.**

Audits were being undertaken by the Infection Prevention and Control Nurse and Household Services Manager in targeted areas. To further improve standards of hygiene for the organisation the auditing should be extended to the managers of all areas.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

**CM 2.1 (C ↑ 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.**

There were links especially through the Network Manager to the Health Service Executive (HSE) with respect to hygiene services issues and specific examples were seen during the site visit. Views of patients were sought through a recent patient satisfaction survey, results of which are yet to be collated. Feedback must assist in the improvement of hygiene services. Consideration could be given to the development of consumer/focus groups for both patients/staff and other stakeholders. Evaluatory mechanisms need to be built into all of these processes.

CORPORATE PLANNING FOR HYGIENE SERVICES

**CM 3.1 (C → C)**

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

It was noted during the assessment that the corporate strategic plan is being developed and that it should be progressed.

GOVERNING AND MANAGING HYGIENE SERVICES

**CM 4.1 (C → C)**

**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 responsibility for hygiene services in the organisation was managed through the Hygiene services team who liaise with the hygiene services committee and this process was commended. The organisational chart viewed in the documentation needed some adjustment to reflect this new structure.

**CM 4.2 (C ↑ B)**

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

The report from the Health and Safety Authority had assisted in the installation of hygiene stations throughout the organisation. It was observed that the Hygiene services team actively promote hygiene with suggestion for cleaning improvements, for example, the introduction of a bleep system at lunch time to cover hygiene issues arising.

**CM 4.3 (C → C)**

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

Very good evidence of current best practice and new innovations were demonstrated and include membership of the British Institute of Cleaning Services (BICS) and evidence of in-house training.

**CM 4.4 (C → C)**

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

The Infection Control nurse and Household Services manager were in the process of formulating policies on both infection control and cleaning duties and are encouraged to continue this process.

**CM 4.5 (C → C)**

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

A detailed pre-planned service plan demonstrated the involvement of the hygiene services committee in capital development planning. Evaluatory mechanisms were encouraged to assess efficacy of these processes.

ORGANISATIONAL STRUCTURE FOR HYGIENE SERVICES

*Core Criterion

**CM 5.1 (C → C)**

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

Clearly defined job descriptions were in place for the Household Assistant, Accident and Emergency Attendant, Office Cleaning Staff, Out of Hours and "3-11" Shift Staff. Evidence of compliance documented in self assessment related to the Clinical Nurse Managers being responsible for hygiene standards. During the assessment period it was not evident that ward/area auditing of hygiene standards was being undertaken by the Clinical Nurse Managers. It is recommended that Ward and Area Managers become more actively involved in this process and that roles are clearly defined.

*Core Criterion

**CM 5.2 (B → B)**

**The organisation has a multi-disciplinary Hygiene Services Committee.**

Membership of the Hygiene Services Committee was multidisciplinary. Minutes of meetings and terms of reference were viewed for this committee. Team members are aware of each others roles through the dissemination of job descriptions.

ALLOCATING AND MANAGING RESOURCES FOR HYGIENE SERVICES

*Core Criterion

**CM 6.1 (D ↑ C)**

**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.**

While a documented process for hygiene resources had not been developed, resources had been made available for training programmes, for example BICS and Hazard Analysis and Critical Control Point (HACCP). Specific cleaning processes and equipment had been allocated in accordance with need, for example, the cleaning of rooms being utilised for patients/clients in isolation.

**CM 6.2 (C → C)**

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

There was evidence of active involvement of the hygiene services committee in the purchase of equipment/products. Issues in relation to purchase of preferred bins for the disposal of healthcare risk and non-risk waste highlighted some difficulties posed to the organisation due to current HSE procurement policies and the organisation was encouraged to work with the HSE in this regard.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

**CM 7.1 (C → C)**

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

Processes were in place for risk management in the organisation with evidence of incidents driving changes and improving service delivery in the organisation, including change of waste bag type and increased cleaning schedules as a result of a norovirus outbreak.

**CM 7.2 (C → C)**

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

Risk management processes were evident during the site visit with some improvement in service delivery noted. However ongoing issues highlighted by staff included lack of structure and processes for health and safety risk management issues to be highlighted, resolved and the feedback loop completed and the need to streamline these. Some of the issues staff highlighted for improvement included the following, on St Bridget's and the Lourdes wards there was inappropriate bed spacing, inadequate space to accommodate hand hygiene facilities, insufficient bathing facilities, poor facilities for the isolation of patients and toilet facilities opening onto the main corridors.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion

**CM 8.1 (C → C)**

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

HSE Procurement system was utilised for some contractors. Further documentation is however required for processes to establish and manage contractors outside this system.

**CM 8.2 (N/A → C)**

**The organisation involves contracted services in its quality improvement activities.**

Contracted services were in use within the organisation which had lead to quality improvements including waste management, laundry, food hygiene training, hand gel products, hygiene station upgrades, maintenance contracts for equipment within catering and theatre. There was evidence of quality improvement activity by the laundry service dated March 2007 during the assessment. This could be rolled out to other contractors.

PHYSICAL ENVIORNMENT, FACILITIES AND RESOURCES

**CM 9.1 (D → D)**

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

The physical structure of the hospital and facilities for the delivery of patient/client care was challenging due to the age of the building. There was evidence during the assessment that very positive improvements were being made. Management and the hygiene committee were actively involved in seeking funding for improvements for both structural environmental improvements and equipment changes. The organistation had a Quality Improvement Plan (QIP) seeking funding for structural changes to ward and theatre areas. Other specific improvements required include, the provision of adequate space to perform patient care activities and that the Strategy for the control of Antimicrobial Resistance in Ireland (SARI) guidelines needed to be complied with, specifically wash hand basins in key locations such as sluice rooms.

Also the provision of adequate space in theatre to perform endoscopic procedures and carry out the entire decontamination processes in a controlled environment needed further attention.

*Core Criterion

**CM 9.2 (C → C)**

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

Processes were in place to manage waste, sharps and linen. Waste and sharps were very effectively managed and a high percentage of sharps bins complied with all requirements.

**CM 9.3 (C → C)**

**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.**

Overall efficiency was observed with regard to this criterion. The organisation was encouraged to build in evaluation to all processes with appropriate loop closure.

**CM 9.4 (C → C)**

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

Complaints were dealt with in accordance with the HSE procedure. An information leaflet had been designed to include an evaluation sheet. This was a new development and feedback as yet has not been collated and will be of great value to the organisation and a significant QIP should be developed.

SELECTION AND RECRUITMENT OF HYGIENE STAFF

**CM 10.1 (C → C)**

**The organisation has a comprehensive process for selecting and recruiting human resources for Hygiene Services in accordance with best practice, current legislation and governmental guidelines.**

The Organisation utilised the HSE policy for recruitment. Job descriptions and general guidelines were available for attendants and household staff. No contract services were utilised within the organisation for direct cleaning duties at ward level. The organisation was encouraged to evaluate the process for selecting and recruiting staff for hygiene services and develop a QIP.

**CM 10.2 (C ↑ B)**

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

In line with organisational need hygiene services were extended to include a new shift "3-11". This extension of service had been evaluated and deemed to be very satisfactory. In addition to this service the procedures comprising specific tasks of cleaning bed spaces/rooms following the discharge of a patient with an infection or who had been in isolation had led to improvements within the service.

**CM 10.3 (B → B)**

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

The organisation was to be commended for its approach to hygiene services staff training. Members of staff had been trained to assessor level 1 of the Cleaning Operative Proficiency Certificate. Infection Control education is part of the induction programme and ongoing training and HACCP training is provided to staff. The organisation was encouraged to evaluate such training from all perspectives.

**CM 10.4 (N/A → C)**

**There is evidence that the contractors manage contract staff effectively.**

This was self rated by the organisation as not applicable. However during the site visit it became apparent that contract staff are involved in waste, linen and equipment maintenance. This process was being managed but needs to include documented processes for management of contract staff, including written contracts, reporting processes, details of training/orientation programmes. It was recommended that the organisation needed to evaluate its use of contract staff.

*Core Criterion

**CM 10.5 (D ↑ C)**

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

The Corporate Hygiene Services Strategic plan was under development, other developments required included service operational plans and an annual report. The Hygiene Services team had conducted a needs assessment process around the issue of separating cleaning/catering duties at ward level. The organisation was encouraged to reduce risk in this area and fully implement the QIP in this regard.

ENHANCING STAFF PERFORMANCE

*Core Criterion

**CM 11.1 (C → C)**

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

The organisation had implemented an induction training programme and had made hand hygiene training mandatory on an annual basis for all staff members. Records of training were available. It was suggested that Evaluation of all training programmes needed to occur.

**CM 11.2 (C → C)**

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

There was no Human Resources plan available, however there were some good initiatives in place including the following; return to learning skills to bring staff up to the standard of skill of the Voluntary Education Committee (VEC) scheme which was very well received by staff themselves. Protected time was provided to allow staff to attend training sessions. It was noted that evaluation, resultant action and continuous improvements are planned and these should be progressed.

**CM 11.3 (C → C)**

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

The cleaning operatives proficiency and the return to learning schemes had been evaluated as being very beneficial. Further documentation was required regarding the evaluation of training, the instigation of action plans to ensure continuous quality improvement.

**CM 11.4 (C → C)**

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

In-house staff involved in hygiene services were monitored locally by Ward Sisters and the Hygiene Services Team but it was suggested that a documented process to evaluate their performance and instigate resultant actions and feedback needed to be formulated to assist the organisation in continuous quality improvement. Consideration should be given to the needs of contract staff by the organisation and how this is managed by the agency but monitored by the organisation.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

**CM 12.1 (B ↓ C)**

**An occupational health service is available to all staff**

The occupational health service was provided by the HSE in an offsite facility. Details of the service were available, to date an evaluation had not been conducted and this is encouraged.

**CM 12.2 (C → C)**

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

The occupational health & well being of staff was monitored by the General Services Manager. Health and Safety guidelines were available to all staff members. It was recommended that staff satisfaction and evaluation of monitoring needed to be undertaken.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

**CM 13.1 (C → C)**

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

Data from in-house audits was collected manually. An Information Technology (IT) system would greatly enhance the evaluation process and assist in the formulation of resultant actions and feedback.

**CM 13.2 (C → C)**

**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.**

Infection control reports and audits were discussed at the Hygiene Services Team Meetings. Audit results were discussed with ward/area managers. It was recommended that a more formalised system for evaluation of data, user satisfaction with information and feedback is required from the organisation.

**CM 13.3 (C → C)**

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

The organisation was encouraged to examine the area of data collection/evaluation of its needs.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

**CM 14.1 (C → C)**

**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 management team supported a quality improvement culture. Education and training had been extended to all grades of staff. It was noted that initiatives to improve service delivery were being trialled to include “lunch time cover” and “out of hours cover”. A dedicated person was available for cleaning rooms used for isolation purposes.

**CM 14.2 (C → 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.**

The Organisation participated in the two national hygiene audits and undertook a number of internal audits. In keeping with the HIQA recommended hygiene management structures it formulated a Hygiene Services Committee and a Hygiene Services Team to address its hygiene services requirements. The Hygiene Services Team had representation on the Hygiene Services Committee which in turn had representation on the Corporate Management Team.

The identification by the organisation of key personnel and the recruitment of these posts holders were seen as indications of the organisations commitment to quality improvement. The commitment of the General Support Services Manager and the Infection Control Nurse to the entire process was especially commendable.

It was recommended that the inclusion of the ward/department managers in the hygiene structures and their specific identification as the ultimate responsible person for hygiene in their own ward/department would add clarity to roles, authorities and accountabilities in all areas.

It was suggested that the further use of IT and appropriate software would assist in evaluation of processes and resultant service delivery improvement/outcomes.

# 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 (C → C)**

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

It was noted that key staff were members of professional organisations such as BICS and the Catering Managers Association. Best practice guidelines are kept up to date through newsletters and relevant websites. A copy of the most recent European Hygiene of Foodstuffs Regulation 852 of 2004 was not however on file. There was an in-house library with relevant books on order. Staff were able to access the internet but there was no protected time allocated to this. The organisation was encouraged to document a process for ensuring that best practice guidelines are established, adopted, maintained and evaluated by the team.

**SD 1.2 (C ↑ 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**

Recent Hygiene Service interventions such as the introduction of a cleaner specifically for the isolation areas and the introduction of extended hours cleaning had been evaluated and the results were noted. Trials were also conducted in the introduction of a menu cycle to two ward areas and evaluation of this showed a very high level of satisfaction and a reduction in waste. Trials were underway in the use of a “turtleskin glove” to protect against needle stick injuries. It was recommended that a process to assess new hygiene interventions is documented.

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.**

There was strong evidence of signage and posters which were clearly displayed for staff, patients/clients and visitors to encourage high standards of hand hygiene. The infection control officer interacted with the public on defined days to educate them on hand hygiene. Leaflets on Methicillin resistant Staphylococcus aureus (MRSA) as well as other aspects of infection control were available within the hospital. It was suggested that this process could be enhanced by further interaction with the public

by for example visiting community groups or using local media to deliver information on health promotion.

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.**

The structure of the teams were multidisciplinary and there were three teams involved in the delivery of the hygiene service with a list of members available for the Hygiene Service Delivery Team with an evaluation of attendance rates at meetings. There was no list available of the members of the Corporate Team and such a list was recommended along with clearly defined terms of reference for each team. There was a lack of clarity regarding the structures of the teams and this obviously could lead to some confusion within the organisation. Where contractors were involved in the delivery of the hygiene service their expertise could be harnessed in teams in order to improve hygiene services. It was suggested that a process of evaluation should be introduced to assess the efficacy of each team in terms of actions delivered.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

**SD 4.1 (B → B)**

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

Whilst the hospital is old and structurally poor in many areas, the team had worked hard to ensure that within these constraints the environment was in general clean with some exceptions as outlined in the compliance checklist.

For further information see Appendix A

*Core Criterion

**SD 4.2 (C ↑ B)**

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

The organisations equipment, medical devices and cleaning devices were generally clean and well maintained except for trolleys and office equipment. Areas of improvement were identified and were noted in the mandatory compliance checklist.

For further information see Appendix A

*Core Criterion

**SD 4.3 (B → B)**

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

Cleaning equipment was clean and well managed but the storage facilities for cleaning equipment required improvement in many areas.

For further information see Appendix A

*Core Criterion

**SD 4.4 (C ↑ B)**

**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 kitchens were of a poor structural standard and were in need of refurbishment. HACCP as a food safety tool was implemented with monitoring of Critical Control Points. However, records needed to be reviewed by management to ensure that any non-conformances logged are identified and corrective action was taken. This was not the case with regard to the temperature of refrigerated units in the dining room, which showed high temperatures over a period of time. Internal audits which are a means of verification of the HACCP system were not carried out as per the frequency of IS340.

Agency staff were utilised in the organisation and there was insufficient evidence available to demonstrate that any training was received by such staff.

The standard of cleaning in the kitchen and associated areas was good.

There was a division of responsibility between Catering and Household staff in relation to the management of ward kitchens. It was recommended that Catering would assume full responsibility for the management of same or that at the least Cleaning staff did not have responsibility in relation to the service of foodstuffs.

HACCP was implemented at ward kitchen level, however further scrutiny was required with regard to records which showed a trend in high temperatures in the fridges. Food temperatures were checked when the food arrived at the ward kitchen and records indicated compliance with food safety requirements. It was recommended that the focus of checks should change to high risk meat containing items rather than the current emphasis on mashed potatoes and porridge. It was suggested that changing rooms and toilets for male staff members must be provided.

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.**

Waste management was maintained to a very high standard.

For further information see Appendix A

*Core Criterion

**SD 4.6 (B → B)**

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

The majority of the linen was externally contracted, the in-house laundry were responsible for curtains and doctors coats as well as other items. There was evidence during the assessment that soiled linen being collected by the contractor was not properly secured and staff members were noted carrying soiled linen to the laundry without using a trolley. It was recommended that this process should be reviewed to ensure there is extensive compliance with the requirements of the standard.

For further information see Appendix A

*Core Criterion

**SD 4.7 (B → B)**

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

Hand Hygiene practises were managed effectively. Not all clinical areas had the appropriate numbers of hand wash sinks and sinks did not meet SARI requirements in all cases. The Laundry were in the process of reviewing this at the time of assessment with new hand hygiene stations being installed in clinical areas.

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.**

Incident logging of adverse advents such as slips, trips and falls were on file. Risk assessments had not been carried out except for one in relation to obese patients admitted to the hospital. There was a major incident plan located at the main security area dated 2004 and it was noted that the person designated as the major incident coordinator was no longer in the employ of the hospital. It was recommended that this plan is reviewed and updated where necessary. There was no evidence presented of evaluation of incident rates and the organisation is encouraged in this regard.

**SD 4.9 (C → C)**

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

Patient satisfaction survey template had been drawn up and was included with the Hospital Information Booklet. It was suggested that the organisation should progress these and gather feedback. The HSE leaflet 'Your Service Your Stay' was available but none of these had been completed at the time of the assessment. Patients had not yet been included on any of the committees. The National Hospital visiting policy was in operation but in discussion with staff members during the site visit it became apparent that there were challenges present in implementing this. It was suggested that the use of local media in delivering this message could be considered.

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.**

There was no documented process available for maintaining patient dignity during hygiene service delivery but patient charters were noted at ward level which included references to maintaining the dignity of the patient at all times. Confidentiality clauses were included in job specifications. Patient satisfaction surveys had not yet been conducted so there was no evidence available to demonstrate patient satisfaction levels in this regard.

**SD 5.2 (C → C)**

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

There was sufficient evidence of hand wash gels, posters and signage throughout the organisation. There were patient information leaflets available which could include more detailed references to important aspects of hygiene such as hand hygiene. A separate hand hygiene leaflet is available in the hospital area. Patient Satisfaction surveys were included with the patient information leaflet but as yet there is no data available from this. The organisation is encouraged to progress these.

**SD 5.3 (C → C)**

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

There was evidence that complaints were managed in line with national policy guidelines. There were two complaints in 2006 in relation to an aspect of hygiene service delivery and none to date for 2007. The complaints for 2006 were reviewed and there was a large amount of documented evidence to show the investigation that took place and the feedback to the original complainant. It was recommended that a complaint log is maintained which would show at a glance the status of each complaint in the system and could prove to be a useful tool for evaluation.

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.**

As the processes for service delivery were very much in their infancy during the site visit there was little evidence available to support the involvement of patients, visitors, contractors etc in the overall evaluation of its service. However, there was evidence to support the evaluation of recent hygiene service interventions.

**SD 6.2 (C → C)**

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

Key staff members had engaged in certain activities in relation to infection control evaluations in some areas and plans were in place to commence an internal auditing programme in the organisation when the requirements of the Hygiene Services Assessment scheme were fully implemented. This was strongly recommended and in order to facilitate the conducting of effective audits certain staff members should be selected to attend auditor training. It was also recommended that Key Performance Indicators (KPIs) be set and measured against and that these would be drivers for continuous improvement. It was suggested that in setting KPIs quantifiable targets should be set where possible as this would facilitate the measuring process.

**SD 6.3 (C → C)**

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

An Annual Report for 2006 had been produced. A procedure was required for the completion of same which would include details of the inputs to the report as well as the mechanisms employed for the communication of the report to stakeholders within the organisation. It was suggested that there should also be documented processes for the methods used to evaluate the resources used by the Hygiene Service Teams.

# 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 -** High dusting in Accident & Emergency and the Intensive Care Unit and in the Lourdes ward is required. Flaking paint was noted throughout.

(3) Wall and floor tiles and paint should be in a good state of repair.
**No -** Walls and floors were damaged in places for example in the kitchens.

(4) Floors including edges, corners, under and behind beds are free of dust and grit.
**Yes -** Some areas had a light film of dust but in general these areas were clean.

(6) Free from offensive odours and adequately ventilated.
**Yes -** Some areas had poor ventilation such as Accident & Emergency and the Intensive Care Unit.

(7) Areas should be adequately ventilated with ventilation units cleaned and serviced accordingly and documentation available regarding service.
**Yes -** Some areas had poor ventilation.

(10) Internal and external signage should be clean, updated, well maintained and laminated to enable cleaning.
**Yes -** In general laminated signs were in place with some exceptions noted.

(12) Internal and external stairs, steps and lifts must be clean and well-maintained.
**Yes -** Internal surface of lift door was in need of attention in the main lifts leading to wards.

(13) External areas including grounds, gardens, footpaths, ramps and car parks should be clean and well-maintained.
**No -** Grounds required sweeping and a lot of cigarette butts were noted.

(14) Waste bins should be clean, in good repair and covered.
**Yes -** Clinical waste bins in the Intensive Care Unit had paint lifting on lids otherwise bins were satisfactory.

(16) Hospitals are non smoking environments. However, cigarette bins should be available in external designated locations.
**Yes -** Two external smoking areas were provided with appropriate cigarette bins.

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

(18) Walls, including skirting boards.
**No -** Skirting boards were damaged and wall paint was chipped.

(19) Ceilings
**No -** Ceilings were old and damaged.

(20) Doors
**No -** Doors were in poor repair in many places.

(23) Radiators and Heaters
**No -** Chipped paint was noted on radiators.

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

(30) Fixtures: Fixtures (i.e. a piece of equipment or furniture which is fixed in position) should be clean. This includes all electrical fixtures e.g. all light fittings and pest control devices.
**No -** Light fittings required cleaning in many areas. The light on the salad bar in the dining room was in need of further attention.

(31) Furniture and fittings: Furniture and fittings in direct patient care environment must be clean and dust free i.e. cleaned on a daily basis. Horizontal surfaces (high and low) around the patient i.e. ledges, worktops, window ledges, flat surface suction apparatus, bed table, locker, curtain rail and chairs.
**No -** A work surface in need of attention was noted in Lourdes Clinical room. Equipment was stored on a window ledge that was not observed to be clean.

(32) Shelves, benchtops, cupboards are clean inside and out and free of dust and spillage
**Yes -** The Cupboard in the Accident & Emergency Department under the sink was noted to have spillage in it.

(207) Bed frames must be clean and dust free
**No -** Beds checked at ward level were in need of attention.

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

(33) Chairs
**Yes -** In the majority, however, further detailed cleaning was required on some chair seats.

(34) Beds and Mattresses
**No -** Some mattresses on trolleys in the Accident & Emergency department further detailed cleaning.

(41) Door handles and door plates
**Yes -** The door jam in the Accident & Emergency Department isolation room was badly damaged but in general the door handles and plates were clean.

**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 -** Slop hoppers noted during the assessment were clean.

(56) All associated bathroom fittings including component parts e.g. tiles, taps, showerheads, dispensers, toilet brushes etc should be clean and well maintained.
**Yes -** Bathrooms and their component parts noted during assessment were clean.

(58) Sluice rooms should be free from clutter and hand washing facilities should be available.
**No -** Sluice area in the Accident & Emergency department was cluttered and contained inappropriate sterile oral hygiene packs and wound swabs. There were no hand hygiene facilities in the sluice areas of the Accident & Emergency and Intensive Care Unit, it was recommended that this be addressed.

(60) All outlets (including shower outlets) should be flushed at a temperature in accordance with current legislation.
**Yes -** Process in place for flushing of infrequently used outlets such as in the Theatre and OPD. It was recommended that this process should extend to all outlets.

**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.
**Yes -** In the majority, however, some rust was noted under commodes and on a shower chair.

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

(65) Commodes, weighing scales, manual handling equipment.
**Yes -** Overall commodes were clean but further cleaning was required for some commodes in Accident & Emergency and the Intensive Care Unit.

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

(69) Patient washbowls should be decontaminated between each patient, and should be stored clean, dry and inverted. Damaged washbowls should be replaced.
**Yes -** No proper storage space available in St. Brigid's for washbowls, otherwise wash bowls were clean and decontaminated between use.

(70) Bedpans, urinals, potties are decontaminated between each patient.
**Yes -** Bedpan washers reached the required temperatures for decontamination.

**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.
**No -** Resuscitation trolleys and storage trolleys were not observed to be clean.

(74) Patient's personal items, e.g. suitcase which should be stored in an enclosed unit i.e. locker / press.
**No -** There was Inadequate storage facilities for patient's items. Bags were noted on top of beds.

(77) Loose items such as patient's clothing should be stored in the patient's locker or property bag.
**No -** There was Inadequate storage facilities for patient's items.

(78) Personal food items, other than fruit, should only be brought in with the agreement and knowledge of the ward manager and should preferably be stored in an airtight container.
**Yes -** No personal food items observed.

(80) All office equipment (e.g. telephones, computers, fax machines) should be clean and well-maintained.
**No -** Telephones and computer terminals were in need of further 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 hand gel were noted on many wall surfaces.

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

(85) Cleaning solutions should only be prepared in a well ventilated area and should never be mixed.
**No -** There was no ventilation in the A&E sluice area.

(87) All cleaning equipment should be approved by the Hygiene Services Committee and ensure sufficient supply.
**Yes -** Evidence was presented to support this process.

(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 -** Inadequate storage facilities for cleaning equipment was noted.

(91) Storage facilities for Cleaning Equipment should be clean and well maintained.
**No -** Floors are made of concrete and required further attention on ground floor areas.

(92) Cleaning products and consumables should be stored in shelves in locked cupboards.
**Yes -** However it was observed that shelves were made of wood in some areas.

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

(213) Environmental Health Officer (Senior EHO/EHO) reports on food safety inspections including the completed summary stage of compliance with HACCP and annual water analysis reports should be retained on the Hospital Food Safety Manual. Action plans/ actions taken on foot of issues raised in the reports should be documented.
**Yes -** The Environmental Health Officer Report from August 2006 was noted with evidence of actions taken.

(214) The person in charge of catering shall develop, implement and maintain a permanent system based on the seven principles of HACCP. A standard HACCP Plan should be fully completed.
**Yes -** The HACCP Plan was on file.

(215) There should be a documented ward kitchen food safety policy which should be signed off by the person in charge of the ward kitchen and the hospital manager.
**No -** There were no food safety policies noted in ward kitchens. A food safety policy document was noted in the Catering Managers office signed by the Catering Manager only. It was recommended that this should be posted so staff and visitors can view same.

**Compliance Heading: 4. 4 .2 Facilities**

(217) Access to the main kitchen and ward kitchens should be restricted to designated personnel i.e. food workers.
**No -** Food was transported to ward kitchens and served by household staff some of whom it was noted were involved in cleaning duties on the wards.

(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.
**No -** A staff member was observed not to wash their hands on entering the ward kitchen.

(219) Ward kitchens are not designated as staff facilities
**No -** It was observed that Staff ate in the ward kitchen located off the ICU.

(220) Staff must not consume food or beverages intended for patient use, food should not be consumed in the ward kitchen and no food is to be routinely prepared in the ward kitchen other than beverages and toast.
**No -** It was observed that Staff used the kitchen off the ICU for their personal use.

(221) Staff clothing/uniforms/shoes personal belongings should not be stored in food rooms.
**No -** Male catering staff were observed using the cleaning room located off the kitchen as a changing facility.

(223) Separate toilets for food workers should be provided.
**No -** It was noted that male catering staff do not have separate facilities.

(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 -** The Main Kitchen was inappropriately ventilated. Fans were in use and flaking paint was noticed on the ceilings.

(225) Staff in charge of Ward Kitchens shall ensure that product traceability is maintained while the product is in storage (Regulation (EC) 178/2002). Stock shall be rotated on a first in / first out basis taking into account the best before / use by dates as appropriate. Staff food should be stored separately and identifiable.
**No -** The organisation is mostly compliant but out of date Glucerna was noted and the organisation is encouraged to be vigilant in this regard.

**Compliance Heading: 4. 4 .3 Waste Management**

(234) Where waste is stored in plastic bags these shall be removed frequently, closed securely and stored in a manner that does not pose any risk to the food business.
**No -** Waste in plastic bags was noted in a caged area and the door was open leaving potential for access to rodents.

**Compliance Heading: 4. 4 .4 Pest Control**

(237) A location map should be available showing the location of each bait point.
**No -** A map could not be presented as evidence during the assessment.

(239) Fly screens should be provided at windows in food rooms where appropriate.
**Yes -** Fly screens were in situ but were not fully secure and flies were noted in the main kitchen area.

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

(240) A Hospital using a cook-chill system should comply with Guidance Note No. 15 Cook-Chill Systems in the Food Service Sector (Food Safety Authority of Ireland) The temperatures of fridges, freezers, cold rooms and chill cabinets shall be capable of maintaining the temperature of foodstuffs
**Yes -** A Cook chill system was observed not to be in use. Foods for modified consistency diet were chilled and the process for this was reviewed.

(242) Temperatures for Food in Fridges / Freezers and Displays should comply with I.S.340:2006 requirements
**No -** High temperatures were noted in some fridges and self service units and care is encouraged in this regard.

**Compliance Heading: 4. 5 .3 Segregation**

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

(156) Healthcare risk waste must be segregated from healthcare non risk waste.
**Yes -** However, some segregation issues were noted in trolleys awaiting collection from wards.

**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.
**No -** Transportation of waste throughout the hospital was not clearly defined in the waste management policy.

(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 -** There was access to the DGSA.

**Compliance Heading: 4. 5 .5 Storage**

(169) Documented process(es) for the replacement of all bins and bin liners.
**Yes -** A policy was noted in this area.

**Compliance Heading: 4. 5 .6 Training**

(259) There is a trained and designated waste officer.
**No -** Training of a designated waste officer was ongoing.

(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 -** Records were observed on file.

**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.
**Yes -** Procedures were in place, however it was recommended that these include the transportation of linen and be more detailed to ensure they are an aide memoir for all new and existing staff.

(173) Documented processes for the use of in-house and local laundry facilities.
**Yes -** Procedures could have been more detailed.

(261) Clean linen store is clean, free from dust and free from inappropriate items.
**No -** Structurally the Laundry could have been better and items were noted on window sills such as plastic flowers, a plant and a mug. At ward level linen was sometimes stored with other consumables such as sterile equipment.

(263) Bags are less than 2/3 full and are capable of being secured.
**No -** There was evidence that Bags in transit to the contract laundry were not secured and there was evidence of laundry coming out of the bags and of alginate bags not in red linen bags.

(264) Bags must not be stored in corridors prior to disposal.
**Yes -** In the majority, however one non-conformance was noted in the ICU area.

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

**Yes -** Staff were noted carrying soiled linen to the laundry but in general the correct policy was adhered to.

(266) Personal protective equipment must be accessible to and used by all staff members involved in handling contaminated linen.
**Yes -** A Staff member was noted carrying soiled linen with no gloves but in general the correct policy was adhered to.

(267) Documented process for the transportation of linen.
**No -** Procedures were not detailed enough in this regard.

(269) A washing machine if used is situated in an appropriate designated area and a clear policy/written guidance is in place regarding its use e.g. water temperature etc.
**Yes -** An issue was noted with regard to a washing machine not working at the correct temperature. This was documented as a QIP by the team.

(271) Hand washing facilities should be available in the laundry room.
**No -** The hand washing facility was located in an adjacent toilet.

**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.
**No -** There was a programme in place for the installation of clinical hand wash sinks and this was being rolled out at the time of the assessment.

(191) Hand washing facilities i.e. sinks, taps and splash backs must be clean and intact.
**Yes -** Hand wash facilities assessed were clean.

(192) Taps should be hands free and should be mixer taps to allow temperature regulation.
**Yes -** Some temperatures were high in the ICU and this is currently being reviewed by the organisation but in general temperatures were satisfactory.

(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 -** An installation programme was in place.

(205) General wards should have one sink per 4-6 beds and critical areas should have one sink per 1-3 beds.
**No -** St. Brigid's ward only had 1 sink for 18 patients.

(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 -** Training process had commenced and records were noted.

**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 -** Low temperatures were logged for some dishwasher rinse cycles during the assessment.

# 5.0 Appendix B

## *5.1 Ratings Summary*

| | Self Assessor Team | | Assessor Team | |
|---|---|---|---|---|
| | FREQ | % | FREQ | % |
| A | 1 | 01.79 | 1 | 01.79 |
| B | 9 | 16.07 | 12 | 21.43 |
| C | 41 | 73.21 | 42 | 75.00 |
| D | 3 | 05.36 | 1 | 01.79 |
| E | 0 | 00.00 | 0 | 00.00 |
| N/A | 2 | 03.57 | 0 | 00.00 |

## *5.2 Ratings Details*

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

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