



Hygiene Services Assessment Scheme
Assessment Report October 2007
Midland Regional Hospital at Mullingar

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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

Midland Regional Hospital Mullingar is a part of a network of hospitals, also working from sites in Portlaoise and Tullamore. With capacity of 215 beds (including 11 day beds and 6-bedded Medical Assessment Unit) the hospital provides an extensive range of services for the catchment area of Longford / Westmeath. The hospital has undergone major development since 1980s. The most recent development stage commenced in 2006 and is due for completion in 2007, which will lead to increasing bed number to 260.

Services provided

The following services are provided by the hospital:

- Accident & Emergency
- Child Psychiatry
- General Medical services with sub specialities in Respiratory, Cardiology and Care of the Elderly
- General Surgical
- Obstetrics and Gynaecology (including EPU, Colposcopy and Urodynamics)
- Ophthalmology
- Paediatrics (to include Special Baby Care Unit)
- Pathology
- Radiology

The hospital also provides out-patient services as well as full range of support services including Physiotherapy, Occupational Therapy, Speech and Language Therapy, Cardiac Services, Cardiac Rehabilitation, Pulmonary Function Laboratory and Respiratory.

Physical structures

Private rooms are used for isolation purposes as there are no designated isolation rooms or negative pressure rooms in the hospital.

The following assessment of Midland Regional Hospital Mullingar took place between 10th and 11th July 2007.

1.3 Notable Practice

- There was a robust system in place for internal audit and the action tool log was observed to be an effective means of monitoring corrective actions arising from the audit process.
- Waste management systems in place were of a high standard and are to be commended.
- The cleaning of direct patient contact equipment was of a high standard throughout the hospital.

1.4 Priority Quality Improvement Plan

- It is recommended that documented policies, procedures and guidelines are developed in line with the requirements of the Hygiene Service Assessment Scheme standards.
- The segregation of roles of catering and domestic staff is encouraged.
- Improved mechanisms to manage contracted services such as pest control and water monitoring are encouraged.
- Implementation of the National Visitors policy is encouraged.
- The hospital is encouraged to commence patient satisfaction surveys.

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 Midland Regional Hospital at Mullingar 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.

A hospital Hygiene Corporate Strategic and Hygiene Services Plan was observed. A hospital Environment and Facilities team is in place to manage hygiene services. Evidence of internal and external hygiene audits with resultant actions, reports and quality improvement plans were observed. Evidence of external HACCP, Environmental Health Officer, Waste Management and Population Census reports were provided as evidence of the needs assessment process. Evidence was also noted of hospital expenditure on hygiene services. Evidence of consultation with staff in relation to the hygiene service process and the management of hygiene services was noted. Best practice guidelines, legislation, National guidelines and codes of practice were all available for example, SARI and Food Safety. A needs assessment process was not observed, however, a staffing manpower assessment for hygiene services was noted for the new capital project services. There is no service user representative on the Environment and Facilities committee, which is recommended.

CM 1.2 (A ↓ B)

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

The hospital has modified its hygiene services in line with the results of previous national and internal hygiene audits. The hospital has established an Environment and Facilities committee to manage hygiene issues. This committee is multidisciplinary in nature and incorporates Risk Management, Fire Safety, and Environmental personnel. A full programme of quality improvement plans is in place and a number of new hygiene practices have been introduced for example, disposable curtains in the Accident and Emergency department, and hot trolleys in the catering department. New waste bags, recycling and colour coding have been introduced throughout the organisation. It is recommended that an evaluation of the modifications and developments undertaken is completed.

ESTABLISHING LINKAGES AND PARTNERSHIPS FOR HYGIENE SERVICES

CM 2.1 (A ↓ 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 management demonstrated structured links with the various Health Service Executive areas of responsibility, and both Primary Continuing and Community Care and the National Hospitals Office. An organisational chart was also evidenced. Documented minutes of meetings with these bodies were observed for example, Network Management, Human Resources, Microbiology, Environmental Health Officer and County Council meetings. The hospital has an active Partnership forum in place, which includes representatives from all grades of staff. Documented evidence of minutes of meetings and actions plans was evidenced. The hospital has previously been involved with the Irish Health Services Accreditation Board through its Acute Care Accreditation Scheme. The hospital also included staff in the hygiene product and equipment evaluation process. It is recommended that the hospital review its communication and monitoring processes with contractors of services. No evidence of evaluation of the efficacy of linkages and partnerships has been carried out, which is recommended.

CORPORATE PLANNING FOR HYGIENE SERVICES

CM 3.1 (B ↓ C)

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

The Midland Regional Hospital at Mullingar is a member of a group of three acute hospitals in the region. There was evidence of the Corporate Management structure from the Environment and Facilities group through the Hospital Management, to Regional Management and the Network Manager and National Hospitals Office. In their quality improvement plans, the hospital has identified a range of initiatives to strengthen the communication with the Corporate Management structure. The Hygiene Service Corporate and Service Plans have been developed and were observed and an organisational chart for the hospital indicating the management structure for the hospital was also noted. The hospital provided no evaluation of the Hygiene Strategic Plans goals, objectives and priorities to date, which is recommended.

GOVERNING AND MANAGING HYGIENE SERVICES

CM 4.1 (B ↓ 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 hospital's Executive Management team (named the Hospital Consultative group) is comprised of the Hospital Manager, the Director of Nursing and 2 representatives from the Hospital Board. This team assumes overall responsibility for the operational management of the hospital. The Environment and Facilities Team at the hospital also has representation from Management on the team. While the Environment and Facilities team do not formally report to the Management team, a mechanism is in

place to address hygiene issues. It is recommended that formal communication channels, for example memos, letters and minutes circulation are established. Responsibility for the organisations is assumed by the Hospital Manager. The Environment and Facilities committee reports to the General Manager of the 3 Midland Hospitals. The General Manager reports to the Network Manager. There are formal meetings with each level of the management structure and a Code of Corporate Ethics was available. Hygiene issues are addressed through minor capital. It is recommended that Hygiene is introduced as a standing order on all management team meetings. No evidence of evaluation of adherence to relevant national guidelines or legislation was provided by the organisation. It is recommended that the hospital review the evaluation of its processes of governance in relation to hygiene services.

CM 4.2 (A ↓ C)

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

No formal mechanism was observed in place to ensure that the Executive Management Team receive information from the Environment and Facilities team. Evidence that national guidelines (for example, the Irish Acute Hospitals Cleaning Manual, SARI and Food Safety guidelines) were disseminated to the Management Team was observed. It is recommended that documented processes are put in place to ensure best practice information is received, implemented and reviewed on a regular basis. Details of internal and external audits were evidenced in the minutes of Executive Management Team meetings and the Regional Management meetings. It is recommended that a process to evaluate information received is developed and implemented in the future.

CM 4.3 (B ↓ 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.

Access to library facilities, internet and intranet facilities are provided for staff at the hospital. There was a range of policies, procedures and guidelines available for hygiene services located in the Infection Control section of the policies, procedures and guidelines. It is recommended that the policies, procedures and guidelines in relation to Hygiene are made available in user friendly format on the intranet. The hospital accesses research and best practice to influence changes made in relation to products, services and policies, procedures and guidelines (for example alcohol hand gels, the Irish Acute Hospitals Cleaning manual, Flat Mopping and the Management Structure of the hygiene services). Documented evidence was available in relation to the development of relevant policies, procedures and guidelines and the evaluation of new products, however, no reports on final evaluation outcomes were available.

CM 4.4 (B ↓ C)

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

The hospital provided a documented process (policy) for the development of policies, procedures and guidelines. It is recommended that the revision dates of policies, procedures and guidelines and the process to develop them is reviewed, to ensure that best practice is incorporated in the revision, and documented. A documented list of all hospital policies, procedures and guidelines are available on the intranet and in

hard copy. No documented evidence of evaluation of the efficacy of the process was presented, and this is recommended.

CM 4.5 (B → B)

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

A capital project is in place at present. A robust process is in place at the hospital to ensure that hygiene is included on the capital project agenda. The Environment and Facilities team is represented by Infection Control, and Hospital and Nursing Management on the capital projects team.

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.

The hospital provided comprehensive documentation of the management of the hygiene services structure for example terms of reference, agendas and members of the Hygiene Services Committee. A variety of departments and services at the hospital are represented on the committee. No evidence that the role of each member was documented was observed, with the exception of their function as representative of their specific service or head of department. It is recommended that the hospital clearly identify the roles, accountabilities and responsibilities of each team member. The resultant action plans following audits, which were observed, are identified as discipline/service specific. A range of job descriptions were noted, which included either a direct mention of hygiene responsibility or as a subset of Management of Risk and Health and Safety.

*Core Criterion

CM 5.2 (A ↓ B)

The organisation has a multi-disciplinary Hygiene Services Committee.

Evidence was observed that a multidisciplinary process for the management of Hygiene Services is in place in the hospital. The presence of a Hygiene Services Committee at local level, which links with the Regional Hygiene Committee for the three Midland Acute Hospitals, was noted. On-site documentation in relation to membership of the committee, agendas, minutes of meetings and terms of reference was observed. The committee assumed responsibility for the formation of the Hygiene Strategic Plan, Hospital Service Plan and Organisational Plan. An extensive range of actions plans and internal audits was observed. While internal audits of services with resultant quality improvement plans were available, no actual evaluation of the efficacy of the committee has been carried out, and this is encouraged.

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.

The funding and allocation of resources for hygiene is through a variety of sources from the Health Service Executive. The allocation of staff is based on the approval

level for whole time equivalents, with additional funding for contracted services of sanitary services, mats and pest control provided. Other funding is sourced through minor capital, planned maintenance and replacement programmes, clinical engineering and materials management. The Environment and Facilities Committee, through its quality improvement plans, identifies and sources funding through the Hospital Manager. Documented evidence of actual funding spent on hygiene services in 2006 was presented during the assessment (for example a financial coded spreadsheet which identified cost centres and product specific information). The Corporate Strategic Plan and the Hygiene Service Plan were available and the Annual report for 2006, which was observed, also identified funding sources and expenditure on hygiene services.

CM 6.2

(A ↓ B)

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

The organisation complied with the standards of the National Procurement Policy. The hospital Environment and Facilities Committee manage the purchase of all hygiene equipment and products and have facilitated the introduction of new products and equipment. The terms of reference for the Environment and Facilities Committee at the hospital incorporate identified quality improvement plans, which include the replacement/introduction of quality initiatives for the hygiene service. Evidence to indicate that the hospital had a documented process (procedure) in place for the purchase of hygiene products and equipment was observed. Evidence that the introduction of new products and equipment was consultative in nature was noted and a full evaluation for a range of new products was available. This included Alcohol hand gels, floor cleaner, trigger spray for the cleaning of difficult areas, and flat mops. The Environment and Facilities Committee communicates with the Hospital Manager in its decisions regarding hygiene products and equipment. The Hospital Manager is also a member of the Committee and communication occurs through minutes of Environment and Facilities Committee meetings and purchase orders. No formal evidence of evaluation of the efficacy of the process of the communication between Senior Management and the Environment and Facilities Committee was observed, and this is encouraged.

MANAGING RISK IN HYGIENE SERVICES

*Core Criterion

CM 7.1

(A ↓ B)

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

The Risk Management structure for the hospital is provided by a Regional Risk Management office, which is managed through the Department of Corporate Fitness. This department also is the location for Clinical Audit, Freedom of Information, internal audit and communication. A comprehensive suite of policies, procedures and guidelines are available. Incident report forms, hazard identification and risk assessments were noted. The Risk Management department reports its incidents to the STARS national monitoring system and receives monthly reports, which are issued to the Hospital Manager and the Director of Nursing. For the period of January to June 2006, of 368 incidents reported, only 2 incidents of falls were attributed to hygiene issues (wet floor). A desk top incident review was carried out in 2005 with full documentary report and an Annual Risk Management report for 2006 was noted. The Regional Risk Management department issues a newsletter, which was also observed. On the day of the assessment, a fire risk in relation to a wall heater in the

Post Mortem Room was observed. This was identified to Management and prompt remedial action was taken, and resultant actions noted.

CM 7.2 (A → A)

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

The Corporate Structure of the Acute Network supports the role and function of the Risk Management process. There is a regional office for Risk Management, which supports the hospital. The hospital has representatives on the Quality and Safety Committee, Risk Management and Infection Control Committees. The hazard identification processes support the management of hygiene and have supported the needs analysis for training, changes to waste management, new equipment, and internal auditing. Hygiene services are represented on the Risk Management forum by the Hospital Manager and Director of Nursing. A comprehensive incident reporting process for 'hygiene adverse events' is in place. No major hygiene adverse events were recorded over the last 2 years. Comprehensive evidence of quality improvement plans in place, resultant actions and feedback were noted, which is to be commended.

CONTRACTUAL AGREEMENTS FOR HYGIENE SERVICES

*Core Criterion

CM 8.1 (A ↓ C)

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

The hospital adheres to the guidelines of the National Procurement policy. The hospital, through the regional contracts department, has contracted services for Linen, Waste, Pest Control, Sanitary bins, Mats and Catering. The Clinical Engineering Department manages clinical equipment in line with manufacturer's recommendations. The majority of external contracts are negotiated at Regional level for all three acute hospitals. It is recommended that the hospital implements a monitoring mechanism for contractors who provide services to the hospital to ensure compliance with the terms and conditions of contracts.

CM 8.2 (A ↓ C)

The organisation involves contracted services in its quality improvement activities.

It was noted that the hospital is involved in the evaluation of external contracts for all services prior to their use. New services/equipment are evaluated prior to their purchase. No formal report of the outcomes of the evaluations had been completed at the time of the assessment. Contracts for renewal are managed by Materials Management, Clinical Engineering and Maintenance departments prior to re-issue. The hospital has an identified quality improvement plan to include all equipment at the hospital into service agreements.

PHYSICAL ENVIRONMENT, FACILITIES AND RESOURCES

CM 9.1 (B ↓ C)

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

The hospital had a major capital project in place and a plan to transfer a range of services to the new buildings later this year is in place. The new capital project is built to current building regulation standards and meets the requirements of the SARI guidelines for hospitals. On observation, the current hospital requires renovation. Storage space was at premium and some corridors were cluttered. A Health and Safety Committee is in place. Documented minutes of meetings identify many safety issues relating to the environment. A security service is present at the hospital 24 hours per day and a Hospital Watch Committee is also in place. Internal and external audit processes, Risk Management and the Environment and Facilities Committee assume responsibility for the safety of the hospital environment. Blueprint plans of the current hospital and the new buildings were noted. No evidence of formal evaluation of these criteria was noted, and this is encouraged.

*Core Criterion

CM 9.2 (A → A)

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

The Environment and Facilities Committee assume responsibility for the planning and management of the organisations environment and facilities, equipment and devices, kitchens, waste and sharps and linen. The hospital has used extensive evaluation of the results of internal and external hygiene audits to reflect its management approach to hygiene. The Environment and Facilities Committee is representative of all the above departments and service areas. A Corporate Strategic and Hospital Hygiene Service Plan have been developed and evidence of best practice was observed, for example SARI, Food Safety and Waste Management.

CM 9.3 (A ↓ B)

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

Mechanisms are in place in the hospital to ensure that the management of hygiene, its environment and its service and equipment are effective and efficient. This is through extensive internal and external audits, action plans and feedback. The Risk Management process, the Health and Safety process and the complaints policy provided evidence that these areas are managed effectively and efficiently. The hospital is encouraged carry out regular patient satisfaction surveys to identify opportunities for improvement in these areas.

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.

Mechanisms are in place to ensure that patients/clients (and other) concerns are addressed, for example, the patient complaints forum and the risk management system. There was comprehensive evidence of correlation reporting and action plans for complaints and risk management. To date, no patient satisfaction surveys

regarding hygiene have been carried out, and it is recommended that a survey process is implemented in the near future

SELECTION AND RECRUITMENT OF HYGIENE STAFF

CM 10.1 (A ↓ C)

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

Evidence that the hospital adheres to the National Codes of Practice for Recruitment in the Public Service, Official Languages Act (2003), Data Protection and Freedom of Information acts was observed. Evidence of job descriptions for a sample range of staff within the hygiene services was observed during the assessment. This included the Domestic Supervisor, Clinical Nurse Manager 2, Catering Manager, Catering Attendant, Laundry Attendant and Attendant. Comprehensive documented linkages to Occupational Health and Training and Corporate induction programmes are in place during the recruitment process. The Hospital has reviewed its job descriptions in line with national best practice for each specific grade of employee. With the exception of the contracted services for window cleaning and sanitary facilities, no contract cleaning staff are employed at the hospital. No evidence of evaluation of the Human Resource process was observed during the assessment. No evidence of completion of the identified quality improvement plans was noted and this is encouraged.

CM 10.2 (B ↓ C)

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

A Human Resources Manpower needs assessment was in progress at the time of the assessment, in order to identify staffing requirements for the new hospital area. Current staffing levels are directed by the whole time equivalent protocol. Additional staff have been identified on a needs basis and allocated to manage high dusting and window cleaning. In their quality improvement plan, the Environmental and Facilities Committee have identified the need to manage catering and cleaning staffing as two individual processes, and this is encouraged.

CM 10.3 (A ↓ B)

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

Evidence that the hospital had a range of job descriptions available for hygiene services was observed. With the exception of the contracted services for window cleaning and sanitary facilities, no contracted services for cleaning services are employed at the hospital. The hospital provides a range of training to all hygiene staff (for example Corporate induction, Fire Safety, Risk Management, Hand Hygiene, Infection Control and Equipment Management) and records of training were observed during the assessment. A comprehensive range of policies, protocols, procedures and guidelines supported the management of education and qualifications at the hospital. It is recommended that a documented process (procedure) to ensure that all hygiene staff have the appropriate qualifications and training is developed.

CM 10.4 (B ↓ C)

There is evidence that the contractors manage contract staff effectively.

The management of external contracts is regionally based. The Contractors are managed in accordance with the Terms and Conditions of the contract. The hospital acknowledges that no direct processes for the management of on-site or service contractors are in place and that this area requires attention.

*Core Criterion

CM 10.5 (A ↓ C)

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

The Corporate Strategic/Service plan identifies staffing requirements for hygiene services. The capital planning process, through its manpower model, identified the staffing requirements for the new area. It is recommended that an overall staff needs assessment be carried out in the current hospital to ensure human resource needs are met.

ENHANCING STAFF PERFORMANCE

*Core Criterion

CM 11.1 (A ↓ B)

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

Comprehensive details of the staff induction and orientation programmes were observed. Staff are provided with corporate and local service induction programmes. Details of the contents of the courses were provided, as were records of attendance. In its quality improvement plan, the hospital identified the need to include hygiene as core subject in initial corporate induction. This will be progressed through the national induction and orientation strategy, which is currently being formalised. This should be progressed. Training in relation to hygiene (for example hand hygiene and colour coding) is provided by the Infection Control department as part of their education programme and details of the programmes were observed. A comprehensive corporate staff handbook is available to all staff, which was also observed during the assessment.

CM 11.2 (B ↓ 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.

The hospital provides induction, orientation, moving and handling, infection control and fire safety training to all relevant staff. Course contents of education programmes were noted and evidence that protected time is provided for staff to attend appropriate training was observed. The hospital provides a comprehensive list of all education and training to all grades of staff in relation to Hygiene Services and Infection Control. It is recommended that a review of the management of training records is carried out and a centralised approach to record maintenance is considered. It is also recommended that an evaluation on the appropriateness of individual staff training is carried out and an overall annual education report compiled.

CM 11.3 (B ↓ C)

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

Extensive internal and external audits were noted. The organisation reviews Risk Management incident reporting and the complaints mechanism to monitor the effectiveness of education and training. The management of needle stick injuries and the low level of needle stick injuries reported were noted. It is recommended that the hospital review and evaluate attendance at education sessions and carry out staff satisfaction surveys regarding education and training in the future.

CM 11.4 (A ↓ B)

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

There was evidence that performance management of hygiene staff was carried out under the framework of the People in Management project. Through the Recruitment project, the Human Resources function ensures that mechanisms are in place to evaluate staff following appointment to a permanent position. A performance template form was observed, as was a personnel record of a completed appraisal. Performance appraisal can also be carried out under the disciplinary procedures in place at the hospital. There was no evidence of evaluation of the performance rates carried out at the hospital, and this is encouraged.

PROVIDING A HEALTHY WORK ENVIRONMENT FOR STAFF

CM 12.1 (A ↓ C)

An occupational health service is available to all staff

An Occupational Health service is provided by the hospital for all staff. This service is a regionally based service and clinics are provided on the hospital site on a regular basis. The service provided at the hospital includes pre-employment screening, vaccinations, health promotion and vision screening. Evidence of a sample health questionnaire and records of vaccinations was provided. The Occupational Health department Mission Statement was also available. The department offers a risk assessment to each employee based on their job specifications at the hospital. No evidence was presented of audits of the Occupational Health service. A quality improvement plan was in place to carry out a review of health questionnaires, however, there was no evidence that the review had progressed. This should be progressed

CM 12.2 (A ↓ C)

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

The hospital has an Absenteeism policy, which informs management on issues in relation to staff well being. In 2002, the organisation introduced a "Quality of Life" programme. A 5-year action plan was devised and a staff survey was carried out in 2003, with a published report in 2004. All staff, including hygiene staff, were involved in the Quality of Life programme. Following the results of the survey the hospital commenced a programme of projects which included, improving communications, people management training for managers, implementing a handling strategy and work/life balance initiatives. 6 projects leaders were identified to implement the programme and the projects work is ongoing. With the exception of the original staff satisfaction survey in 2003, no evidence of evaluation of the process was observed. It is recommended that a process of evaluation is implemented in the near future.

COLLECTING AND REPORTING DATA AND INFORMATION FOR HYGIENE SERVICES

CM 13.1 (A ↓ C)

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

No documented process were observed in place to ensure that best practice and legal requirements are met at all times, however during the assessment it was noted that legal and best practices guidelines are available on-site and are adhered to. An intranet facility is provided on site for all staff and is centrally managed. The hospital has a hospital library and email communications processes. Comprehensive structures for the management of internal hygiene audits are in place. It is recommended that the hospital review its documented process and methods of evaluation processes in relation to hygiene services data and information.

CM 13.2 (A ↓ 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.

Internal and external audits are reviewed and resultant actions are documented. Data in relation to complaints and risk management incident reporting data were observed. It is recommended that the hospital establish a process for the evaluation of this criterion.

CM 13.3 (A ↓ B)

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

The Environment and Facilities Committee regularly evaluates its internal and external audits, compiles action plans and reviews their progress. The committee takes note of other areas such as Risk Management and complaints to improve its hygiene services. The Hospital Management team receives and reviews minutes of meetings, memos and other communication from all areas of the hospital. There was no evidence of processes to evaluate the utilisation of data collection and information reporting by the Hygiene Services team. The development and implementation of these processes is encouraged.

ASSESSING AND IMPROVING PERFORMANCE FOR HYGIENE SERVICES

CM 14.1 (A ↓ B)

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

The hospital has a very active quality agenda. Quality initiatives, such as internal audits, resultant actions and quality improvement plans, were observed in place. The hospital Accreditation Manager actively supports the Hygiene Services Assessment Scheme in collaboration with the Environment and Facilities Committee, the Hospital Management Team and all staff. The organisation ate encouraged to consider benchmarking in this area.

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.

The organisation reviews the efficacy of its hygiene services by auditing internal hygiene processes and standards and benchmarking against other internal and external audits. The hospital had a comprehensive mechanism for quality improvement planning and developing resultant actions. The hospital, through its committee and departmental systems, ensures that all staff are aware of the aims, objectives, audit processes and results of the hygiene quality improvement process. A staff notice-board to communicate information was also observed.

It is recommended that the hospital develop and strengthen its evaluation processes in relation to hygiene services in the organisation.

3.0 Standards for Service Delivery

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

EVIDENCE BASED BEST PRACTICE AND NEW INTERVENTIONS IN HYGIENE SERVICES

SD 1.1 (A ↓ B)

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

An intranet facility is available, which is managed centrally for the network and allows staff access to policies, procedures and guidelines. There is access to an education centre and library facilities, however, no documented protected time is currently allocated to staff. Documented processes for the adoption, evaluation and maintenance of best practice guidelines are recommended.

SD 1.2 (A ↓ B)

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

There was documentary evidence to suggest that the hospital has trialled and evaluated new products and/or services, for example, a flat mop system and disposable curtains in the Accident and Emergency department. Trials were discussed at the Environment and Facilities meetings and minutes taken. It is recommended that all new interventions are formally trialled and a full evaluation report is produced and presented to the committee, to facilitate the decision making process regarding implementation.

The organisation is encouraged to implement a documented process for the assessment of new hygiene interventions.

PREVENTION AND HEALTH PROMOTION

SD 2.1 (A ↓ B)

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

The hospital has developed a hospital information leaflet, which provides clear guidance on visiting times, hand hygiene and the organisation's flower policy. An Infection Control officer is present on site, with some responsibilities within the local community. For example, education sessions are provided on request for schools, crèches and for the home care team. The media has been utilised to inform the public regarding infectious outbreaks and the organisation plans to use this method again for the introduction of the National Visitors policy. Posters and signage were observed throughout the hospital environment in relation to hand hygiene and leaflets in relation to MRSA and other aspects of infectious diseases were also noted. An

Annual Infection Control day is held in the hospital and demonstrations of correct hand hygiene technique are conducted. It is recommended that a documented policy for Health Promotion is developed to clearly outline activities in this area and evaluate its efficacy.

INTEGRATING AND COORDINATING HYGIENE SERVICES

SD 3.1 (A ↓ B)

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

The Environment and Facilities management team assumes responsibility for coordinating the delivery of hygiene services within the hospital. This team is multidisciplinary in nature, with representatives from external organisations (for example the Environmental Health Officer and the local Laundry Manager). It is planned that the Fire Officer will join the team in the near future. This team meets on an irregular basis and minutes were noted. Each department has their own hygiene team and it is recommended that a hygiene team comprised of members of these departmental teams is formed and that a member of this hygiene team is represented on the Environment and Facilities management team. This will ensure that another mechanism in place for full participation at all levels of the organisation in hygiene service delivery. It is recommended that that a team comprised of members of each department is formed, which would link into the Environment and Facilities management team, as opposed to the current stand alone departmental teams. It is also recommended that regular dates are agreed in advance of Environment and Facilities management team meetings to encourage high attendance levels.

IMPLEMENTING HYGIENE SERVICES

*Core Criterion

SD 4.1 (A ↓ B)

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

The hospital facilities were of a high standard of cleanliness, however, ongoing attention is required in relation to high and low dusting in all areas. The use of non-laminated signage in a number of areas requires attention. The need for minor repairs was also noted during the assessment, for example, flaking paint on walls and skirting boards. The use of sluice rooms for the storage of other equipment should be reviewed for effectiveness. For further information see Appendix A

*Core Criterion

SD 4.2 (A → A)

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

The hospital domestic service staff are responsible for the general cleaning of all equipment and medical devices. It is evident that the management of cleaning has been well established throughout the hospital; however, further attention is required for direct patient contact items, for example, overhead bed lights, bedside lockers, table bases and equipment trolleys. For further information see Appendix A

*Core Criterion

SD 4.3 (A ↓ B)

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

The cleaning equipment within the hospital is clean. The hospital is encouraged to review the ventilation and storage within the Domestic Storage Rooms (DSR). It is recommended that the draft policy for use of ladders is implemented. For further information see Appendix A

*Core Criterion

SD 4.4 (A ↓ 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.

A HACCP system has been implemented within the hospital. The processes in place for preparation, cooking, cooling and plating of foodstuffs is commended. At the time of assessment, domestic service staff who are engaged in other activities (such as cleaning at ward level) are also responsible for the collection, regeneration and distribution of foods. It is strongly recommended that the quality improvement plan for the separation of these functions is implemented. The Central production kitchen requires upgrading, particularly in relation to the floor and walls. It was noted that funding had been allocated for 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.

Overall, this is a very well-managed system within the hospital. The Waste Management Policy has been well implemented and is centrally managed on-site. There is excellent record keeping in relation to all waste, including waste identified as 'high risk'. This allows for traceability in the event of any queries. No inter-loan of tags between areas is permitted, which is in line with best practice. For further information see Appendix A

*Core Criterion

SD 4.6 (A ↓ B)

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

Linen and soft furnishings are well managed. It is recommended that the draft policy for Linen Management be finalised and include a process for the transportation of linen. A written policy for the use of the washing/drier machines in the Paediatric ward must be documented and made available to all staff within this designated area. This document should also include a preventative maintenance programme for these pieces of equipment. For further information see Appendix A

*Core Criterion

SD 4.7 (A → A)

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

Effective hand hygiene awareness and practice was evident during the assessment. The implementation of mandatory hand hygiene training was noted. It is recommended that these attendance records are centrally stored as part of the Corporate Training and Education plan. An audit of the effectiveness of this training is also recommended with annual comparative departmental reports provided to the Environment and Facilities Team. For further information see Appendix A

SD 4.8 (A ↓ B)

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

A Risk Management structure is in place and training is provided in relation to incident reporting and other aspects of Risk Management. Risk Management is managed on a regional basis; however, there is a Risk Management Committee in the hospital. Reporting of incidents is through the STARS systems and numbers are collated on a monthly basis and reported to the Committee. Each department has a safety statement and reviews are conducted on an annual basis. A Risk Management report was also included in the 2006 Annual report. It is recommended that all risks identified for hygiene are followed up.

SD 4.9 (B ↓ C)

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

A hospital information leaflet, extensive signage and posters and alcohol hand gels are available to encourage good hygiene practice. The National Visitors policy has yet to be implemented; however a draft policy was observed. The organisation planned to have fully implemented the policy within a few weeks of the date of the assessment. No hospital wide patient satisfaction surveys have been carried out; however, two departmental surveys have taken place in the laboratory and in the medical assessment unit, the results of which were noted. No section relating to standards of cleaning and hygiene was included in the patient's questionnaire and it is recommended that such questions are included in future surveys. It is also recommended that a hospital wide patient satisfaction survey is conducted and that, where possible, patients/clients are represented on the Committee.

PATIENT'S/CLIENT'S RIGHTS

SD 5.1 (B ↓ C)

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

A policy regarding privacy and confidentiality was observed. It is recommended that this policy is reviewed and approved in the near future. Confidentiality clauses are included within job specifications and patient charters were noted at ward level. No areas for concern were raised in the survey conducted in the medical assessment unit and it is recommended that an organisation wide evaluation process is implemented in the future.

SD 5.2 (B ↓ C)

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

A hospital hygiene information leaflet is available and extensive signage and posters in relation to hand hygiene were also observed. A leaflet regarding the Hygiene Services Assessment Scheme and an information leaflet for families who are involved in an incident were also available. It is recommended that the Team evaluate the information provided to patients.

SD 5.3 (A ↓ B)

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

The National policy in relation to complaints management has been implemented and extensive signage is in place to inform patients and visitors of this service. Comment boxes are located around the organisation under the 'Your Service Your Say' initiative. A complaints log was reviewed, however, no information regarding the nature of the complaint or comment is recorded. It is recommended that more detailed information regarding comments/complaints/queries is documented. There is an extensive complaints consultation and feedback mechanism in place. Complaints are reviewed on a monthly basis and there was evidence that this information is reported to hospital committees and used in the compilation of the Annual report. It is recommended that a process to evaluate all complaints is implemented, which identifies the types of complaints received and highlights any emerging trends.

ASSESSING AND IMPROVING PERFORMANCE

SD 6.1 (B ↓ C)

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

There was some evidence available that patients/clients been involved in evaluating the service, for example patient satisfaction surveys were conducted in the medical assessment unit and the laboratory. This area requires development to ensure the organisation meets the requirements of the Hygiene Services Assessment Scheme. A quality improvement plan has been identified by the hospital Management Team to address this. This should be implemented.

SD 6.2 (A ↓ B)

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

A process of internal auditing is in place and an audit schedule was noted. Results of audits are logged and trend analyses, with respect to the overall scores for each area, were noted. The current audit process is environment based and it is recommended that other requirements of the Hygiene Service Assessment Scheme in both corporate management and service delivery are included in the audit process.

SD 6.3 (B → B)

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

An Annual report for 2006 was produced. To ensure a process of continuous quality improvement, it is recommended that aspects of the Hygiene Service Assessment Scheme, not already included in the 2006 Annual report, form part of the 2007 Annual report.

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 - Dust on high surfaces and flaking paint was noted.

(3) Wall and floor tiles and paint should be in a good state of repair.

Yes - In the majority, however, some flaking paint was noted.

(5) Cleanable, well-maintained furniture, fixtures and fittings used.

Yes - In the majority, however, bed tables require attention in some ward areas.

(10) Internal and external signage should be clean, updated, well maintained and laminated to enable cleaning.

No - Internal signage in many areas of the hospital was in poor condition, particularly those that were not laminated.

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

(19) Ceilings

No - Ceiling tiles were missing, stained or broken in many areas.

(21) Internal and External Glass.

No - External glass was poor and internal windows also required attention.

(23) Radiators and Heaters

Yes - In the majority, however, cigarette papers were observed behind some radiators.

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

Yes - In the majority, however, some carpets in non-clinical areas were stained.

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 - Dust was noted on fire equipment, fuse boxes and other fittings.

(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 - Curtain rails high ledges and bed tables observed required further cleaning.

(32) Shelves, benchtops, cupboards are clean inside and out and free of dust and spillage

No - Dust was noted in several areas.

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

(35) Patient couches and trolleys

No - Trolleys observed in the Accident and Emergency department and in the Out Patient department were dusty.

(36) Lockers, Wardrobes and Drawers

Yes - Lockers, wardrobes and drawers observed were clean but some damage was noted.

(37) Tables and Bed-Tables

No - Bed tables observed required further cleaning with particular attention to the bases and wheels required.

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 - In the majority, however, the bath in the Accident and Emergency department was in a poor state of repair.

(53) Bidets and Slop Hoppers

Yes - No bidets were observed in place.

(56) All associated bathroom fittings including component parts e.g. tiles, taps, showerheads, dispensers, toilet brushes etc should be clean and well maintained.

Yes - In the majority, however, the showerhead in the Level 0 bathroom needs attention.

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

Yes - Method statements and policies were noted.

(58) Sluice rooms should be free from clutter and hand washing facilities should be available.

No - Some sluice rooms observed were without hand wash facilities and clutter was also noted.

Compliance Heading: 4. 2 .1 Organizational Equipment and Medical Devices and Cleaning Devices (note: while list is not exhaustive, the following compliance is required):

(64) All equipment, including component parts, should be clean and well-maintained with no blood or body substances, rust, dust, dirt, debris and spillages.

No - Dust was observed on equipment trolleys, with wheels requiring greater attention to cleaning. Rust was also noted on some metal components.

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

(66) Medical equipment e.g. intravenous infusion pumps, drip stands and pulse oximeters, suction apparatus and tubing, cardiac monitors, blood pressure cuffs, blood gas machines.

No - Greater attention to cleaning of trolleys and wheels is required. Rust was also observed on equipment in the Accident and Emergency department.

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

Yes - Fans are prohibited within clinical areas and a hospital policy regarding this was observed.

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

(73) TV, radio, earpiece for bedside entertainment system and patient call bell.

Yes - In the majority, however, the television in the Accident and Emergency department requires greater attention to dusting.

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

Yes - In the majority, however, some computer screens observed require attention.

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

(81) All cleaning equipment should be cleaned daily.

No - Cleaning equipment in some areas was not clean.

(85) Cleaning solutions should only be prepared in a well ventilated area and should never be mixed.

No - Cleaning Solutions were observed stored in non-ventilated areas, this was discussed with management.

(90) Storage facilities for Cleaning Equipment should be provided in each work area with adequate ventilation, a hot and cold water supply and hand-wash facilities.

No - Storage facilities are provided, however, no hand washing facilities were noted and adequate ventilation is required.

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

No - Cleaning products and consumables were observed stored in open shelves, with no locked cupboards noted.

(94) Health and Safety policies should be in place for the use of ladders/steps when cleaning.

No - A policy is currently being developed; however, final approval is required.

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.

No - Corrective action is recommended to address the opportunities for improvement identified in the most recent Environmental Health Officer report. The water analysis report should be available.

(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 - The catering policy should be displayed in the Central Production Kitchen and in the ward kitchens. An unsigned policy in was observed in the HACCP manual.

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 - Access to the kitchens should be controlled.

(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 - Some domestic staff were observed without the appropriate hair protection. Also some staff were noted wearing jewellery.

(219) Ward kitchens are not designated as staff facilities

No - Personal items should not be stored in ward kitchens.

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

No - Facilities at the central production kitchen were satisfactory. Separate toilets for food workers should be available at ward level.

(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 - All Stock should be rotated on a first in/first out basis taking into account the best before/use by dates. Staff food should be stored separately and be identifiable.

Compliance Heading: 4. 4 .4 Pest Control

(238) Electric fly killer (EFK) units when used shall be located in an area free from draughts, away from natural light and not directly above an area where food or materials that come into contact with food are located. The EFK units shall be left on at all times and have shatter proof sleeves. The ultraviolet (UV) light tubes shall be replaced at least annually and records of replacement should be retained. The EFK shall be fitted with a catch tray and emptied as required.

Yes - One electric fly killer observed was not operational.

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 - This was not applicable in this organisation. The machine on site is not operational.

(250) The dishwasher's minimum temperature for the disinfecting cycle should be compliant with I.S.340:2006 requirements and should be monitored regularly. There should be digital readouts on dishwashers.

No - The dishwasher rinse cycle in Central production kitchen was not operating at the correct temperature. Crockery observed was stored while still wet, however when this issue was highlighted to Catering Management, it was rectified immediately.

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

(149) Inventory of Safety Data Sheets (SDS) is in place.

No - Documented evidence of this was not available.

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

Yes - This is not required by Westmeath County Council.

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 are not available for mattress disposal.

Compliance Heading: 4. 5 .4 Transport

(166) Drivers of vehicles transporting hazardous waste must be trained in accordance with the ADR Regulations.

Yes - Two in-house staff members have completed this training.

Compliance Heading: 4. 5 .5 Storage

(258) Waste receptacles should be sanitised, secure and in a good state of repair when used.

Yes - Some waste receptacles observed require attention.

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

(173) Documented processes for the use of in-house and local laundry facilities.

No - No documented processes for the use of in-house and local laundry facilities were observed.

(267) Documented process for the transportation of linen.

No - The draft Linen Management policy and National Colour Coding policy does not include a documented process for the transportation of linen.

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

Yes - Ward based washing machines are in use on the Paediatric ward only.

(269) A washing machine if used is situated in an appropriate designated area and a clear policy/written guidance is in place regarding its use e.g. water temperature etc.

No - No clear policy/written guidance is available.

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

Yes - Hand washing facilities are available in the clean laundry room; however none are provided in the used laundry storage facility.

(270) If a washing machine is in use, a tumble drier is also in place which is externally exhausted. Documented processes for planned preventative maintenance of this equipment should be in place.

No - This is not available.

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

(190) All sinks should be fitted with washable splash backs with all joints completely sealed.

No - Some sinks observed were not fitted with washable splash backs. The seals on some sinks observed required replacement.

(191) Hand washing facilities i.e. sinks, taps and splash backs must be clean and intact.

No - Some taps observed required cleaning at the sink joints.

(198) Hand hygiene posters and information leaflets should be available and displayed throughout the organization.

Yes - Hand hygiene awareness was very evident throughout the hospital.

(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.

Yes - Hand washing sinks were compliant in clinical areas; however, some sinks in support areas require upgrading.

5.0 Appendix B

5.1 Ratings Summary

	Self Assessor Team			Assessor Team
	FREQ	%	FREQ	%
A	39	69.64	6	10.71
B	17	30.36	26	46.43
C	0	00.00	24	42.86
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	A	B	↓
CM 2.1	A	C	↓
CM 3.1	B	C	↓
CM 4.1	B	C	↓
CM 4.2	A	C	↓
CM 4.3	B	C	↓
CM 4.4	B	C	↓
CM 4.5	B	B	→
CM 5.1	A	B	↓
CM 5.2	A	B	↓
CM 6.1	A	A	→
CM 6.2	A	B	↓
CM 7.1	A	B	↓
CM 7.2	A	A	→
CM 8.1	A	C	↓
CM 8.2	A	C	↓
CM 9.1	B	C	↓
CM 9.2	A	A	→
CM 9.3	A	B	↓
CM 9.4	B	C	↓
CM 10.1	A	C	↓
CM 10.2	B	C	↓
CM 10.3	A	B	↓
CM 10.4	B	C	↓
CM 10.5	A	C	↓
CM 11.1	A	B	↓
CM 11.2	B	C	↓
CM 11.3	B	C	↓
CM 11.4	A	B	↓

CM 12.1	A	C	↓
CM 12.2	A	C	↓
CM 13.1	A	C	↓
CM 13.2	A	C	↓
CM 13.3	A	B	↓
CM 14.1	A	B	↓
CM 14.2	A	B	↓
SD 1.1	A	B	↓
SD 1.2	A	B	↓
SD 2.1	A	B	↓
SD 3.1	A	B	↓
SD 4.1	A	B	↓
SD 4.2	A	A	→
SD 4.3	A	B	↓
SD 4.4	A	B	↓
SD 4.5	A	A	→
SD 4.6	A	B	↓
SD 4.7	A	A	→
SD 4.8	A	B	↓
SD 4.9	B	C	↓
SD 5.1	B	C	↓
SD 5.2	B	C	↓
SD 5.3	A	B	↓
SD 6.1	B	C	↓
SD 6.2	A	B	↓
SD 6.3	B	B	→