

National Overview

Improving Clinical Care in Scotland

Healthcare Associated Infection (HAI); Infection Control



Clinical Standards Board for Scotland
(now part of NHS Quality Improvement Scotland)

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ISBN 1-84404-114-X

First published January 2003

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Introduction and Acknowledgements

The remit of the Clinical Standards Board for Scotland (CSBS) is to develop and run a national system of quality assurance of clinical services, with the aim of promoting public confidence in NHSScotland.

For each project, CSBS establishes a project group to:

- develop and consult on the standards and self-assessment framework;
- oversee the process of external peer review; and
- report the conclusions to the CSBS Board.

A wide range of conditions and services are already being addressed and details of these can be found on the CSBS website (www.clinicalstandards.org).

The Healthcare Associated Infection (HAI) Reference Group was established in June 2001, under the chairmanship of Dr David Old, Reader in Medical Microbiology and Consultant Clinical Scientist (retired). The Group was tasked with taking forward the Healthcare Associated Infection (HAI) standards of the report — *Managing the Risk of Healthcare Associated Infection*. Membership of the Group is given in Appendix 1.

CSBS issued *Standards for Healthcare Associated Infection (HAI) Infection Control* in December 2001 (ISBN: 1-903766-12-5) following extensive consultation. Copies of the standards are available on request from CSBS or on the CSBS website (www.clinicalstandards.org).

Prior to reviewing performance against the standards across Scotland, an interim report *Improving Clinical Care in Scotland: Healthcare Associated Infection (HAI); Infection Control Standards* (ISBN: 1-84404-062-3) was published in April 2002. This report, based on the self-assessment and evidence submitted by the Trusts¹, provided an update on progress and reported the initial findings of the Reference Group. Peer review visits to all NHS Board areas in Scotland, to assess performance against the standards and validate the self-assessments, were then carried out between April and October 2002.

This national overview reports on performance across Scotland against the standards, including examples of local initiatives. A local report on each visit to Trusts, including a detailed assessment of performance against each standard, has also been published and is available on the CSBS website or on request.

¹ For simplicity the term Trust is used throughout this document to refer to all NHS organisations included in this national review. Most of them (28), are Trusts. The exceptions are the three Island NHS Boards: Orkney, Shetland and the Western Isles; and the State Hospitals Board for Scotland and the Scottish Ambulance Service which are Special Health Boards.

CSBS gratefully acknowledges the work of the HAI Reference Group for their oversight of the project from its beginning to the publication of this report. In addition, the contribution made by every member of the peer review teams was crucial to the success of the programme. The CSBS Board would like to thank in particular the three Review Team Leaders: Dr David Old; Dr David Parratt and Miss Joan Sneddon; and the Review Team Advisors: Mrs Deirdre Anderson; Miss Mary Barr and Mrs Irene McKay.

This review has presented a challenge for Trusts and it was evident that there is a great deal of activity underway to comply with the standards. CSBS would like to acknowledge the efforts that the staff have made in rising to this challenge, in particular, the liaison co-ordinators, local review facilitators and lead clinicians in Trusts, who were responsible for preparing staff locally for peer review visits, as well as for the compilation of comprehensive self-assessment materials.

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Introduction

Each year, at least 33,000 patients in Scotland will develop one or more infections in hospital. The annual cost to NHSScotland is up to £186 million. Healthcare Associated Infection (HAI) is a major factor in an estimated 457 deaths per year and a contributory factor in a further 1,372. As a result of infection, admission and discharges may be delayed, wards closed and operations cancelled with 380,000 bed days lost each year. (Walker 2001).²

Because of the impact HAI has on the health service and those that use it, infection prevention and control needs to be right at the top of the Trust's risk management agenda. This is reflected in the overarching statement that underpins the infection control standards:

"There is a managed environment which minimises the risk of infection to patients, staff and visitors."

The main aim of the CSBS HAI infection control standards is to assess how well a Trust is managing this risk. Accordingly, they mainly relate to the organisational structures and processes needed to identify, assess and treat specified risks. Hand hygiene (hand washing) is directly related to clinical practice and was included as a key element of infection control due to the sound supporting evidence base.

The CSBS interim report on HAI: infection control, published in April 2002, was based on Trust self-assessment and provided Trusts with an opportunity to provide information and evidence on how they were performing against the standards. The evidence submitted was variable and suggested a lack of "coherent, co-ordinated organisational accountability arrangements" and limited support for the arrangements that were in place. Trusts were clearly working towards achieving compliance with the standards and the challenge for CSBS was to carry out peer review visits across the country to validate and flesh out the information provided in the self-assessment. This national overview of performance in NHSScotland against HAI infection control standards reports on the outcome of the review visits, which were carried out between April and October 2002.

² Walker A. Hospital-Acquired Infection: What is the Cost in Scotland? Glasgow: University of Glasgow. 2001.

What Was the Outcome of the Visits?

Infection control concerns all healthcare professionals, including doctors, surgeons, porters, nurses, domestic staff, electricians, managers and microbiologists. It also concerns patients, their families and friends. The standards set out the need for overall accountability and describe the arrangements that should be in place to make sure everyone knows what they should be looking for, when, where and how, and what they should do if they find any cause for concern. Arrangements for monitoring these systems should also be in place so that Trusts can learn from experience and share best practice. This summary is presented in four sections which link directly to the standards:

1. **Accountability** – does everyone know who is answerable for infection control and how to contact them? (Standards 1,2,3)
2. **Infrastructure** – how does the organisation support people to manage and prevent infection? (Standards 4,5,6,7,8,9,10,11,12)
3. **Monitoring, Review and Audit** – what systems are in place to monitor infection control, how are issues identified and what action is then taken? (Standards 13,14)
4. **Translating Process into Practice** – using hand hygiene as an example. (Standard 15)

1. Accountability (Standards 1,2,3)

Fewer than half the Trusts fully demonstrated clear lines of accountability in relation to infection control. This was usually because there was no link between infection control and risk management structures. Where links were strong, a Risk Manager/Director was usually employed. Most Trusts rely on an informal, ad hoc approach and this needs to be addressed to make sure that infection control is on the Trust's risk management agenda and that action is taken wherever issues are identified.

While Trusts generally have an Infection Control Committee in place, some areas have several such committees, with little evidence of a coherent approach, although many Trusts reported that they were moving towards a Trust-wide approach. The Infection Control Committees in most Trusts have not yet developed an infection control programme, setting out their protocols and procedures and their audit activities and as a result, cannot report easily on these activities. Communications from Infection Control Committees generally seemed to be ineffective, again made worse where multiple committees are in

place. Very few Trusts demonstrated senior management monitoring and review of infection control activities and at best, this was ad hoc and did not seem to have led to changes or improvements.

2. Infrastructure (Standards 4,5,6,7,8,9,10,11,12)

Team Approach

Most Trusts have Infection Control Teams that include Infection Control Nurses, Infection Control Doctors and a Consultant Microbiologist although the support in place for these teams is generally ad hoc. These teams are properly trained and infection control advice is available 24 hours a day. However, only one Trust had arrangements in place to make sure Infection Control Teams provided advice in relation to the purchase of medical devices and equipment, or to service developments such as building works or contracting for hotel services such as catering and cleaning. There were many examples of ad hoc activity but little evidence of any plans to develop comprehensive ways of providing infection control advice in key areas.

Infection Control Programmes

Very few Trusts have produced a formal infection control programme, and where this is in place, it has been developed without consultation with key stakeholders such as other health professionals, managers and patients. There are however many policies and procedures in place and the standard of these was good, and in some cases, excellent.

Microbiology Services

All but three Trusts have Clinical Pathology Accreditation (CPA) for their microbiology services and also reported access to, and effective communications with, these services with timely specialist support and test results.

Surveillance

While about half the Trusts provided evidence that surveillance (or keeping a close watch) of infection was in place, this was rarely Trust-wide and often reactive. Not all had arrangements in place for surgical areas and were still to identify resources to put this in place. The review teams were concerned that this did not appear to be a priority for Trusts and further, felt there was an opportunity to introduce surveillance into the healthcare culture, but one that had so far been missed. All staff should be encouraged to be aware of risks such as wound infections, respiratory infections and so on.

Infection Control Reports

Many Trusts produced reports on infection control but this was not usually based on an infection control programme and did not meet the elements outlined in the standards such as reviews of adverse incidents, education and training and audit results and associated action plans.

Access to Current Legislation and Guidance

All Trusts had access to this information by a number of routes, including library services, internet links and briefings.

Training, Education and Induction

Although infection control is included in most induction programmes, not all staff were included. In particular, the infection control content in induction for medical staff was minimal. Very few postgraduate programmes included topics such as antimicrobial prescribing of infection control.

3. Monitoring, Review and Audit (Standard 13,14)

Trust senior management does not generally carry out routine monitoring and review of the infection control arrangements in place. Less than a quarter of Trusts review accountability arrangements, the capability of the infection control system to perform effectively, and audit of the system and its outcomes and process. Where this was carried out, specific responsibility had been given to an individual or a group.

Risk Management Committees and Clinical Governance Committees are also not generally involved in monitoring the control of infection and the way in which it impacts on the quality of services, although many Trusts reported that they were addressing this.

The standards require that the Trust's Internal Auditor should carry out periodic audits to assure the infection control arrangements that are in place. Only five Trusts had completed an internal audit of their infection control systems and for most, this was their first independent infection control audit. Most other Trusts intended to carry this out over the next twelve months. Only one Trust had produced an assurance statement on infection control for their Chief Executive to sign-off.

4. Translating Process into Practice (Standard 15)

While the majority of Trusts have hand hygiene policies in place, few could demonstrate systematic review of compliance with these. Hand hygiene is included in induction and is mandatory although the time allocated to this topic for medical staff was often limited. Although it is challenging to ensure full compliance, Trusts have to find ways of checking that all staff are aware of the importance of hand hygiene and follow the policies in place.

Conclusion

These standards and the review of performance against them has been a significant challenge for Trusts. The activity and commitment seen across Scotland during visits confirms that NHSScotland is rising to this challenge, although there is still a long way to go.

Four key messages have emerged from this review:

- Trust Chief Executives have to accept responsibility for infection control. Communication upwards is often informal and ad hoc, making it hard to be sure that Trust management are aware of issues, supportive of actions and progress, and place infection control high on the Trust's risk management agenda.
- The infrastructure in place is complex and based on a management style that is very 'hands on'. This limits effective communication and co-ordination across, and between, Trusts.
- Communications are good at operational level – infection control nurses link well with ward staff and support and facilitate improvements. The challenge for these highly skilled staff is to pass the baton for operational infection control onto those directly involved in patient care and to concentrate on developing strong links with risk management.
- Practically, there is good evidence that effective hand hygiene reduces infection. Trusts need to make sure this is actually happening.

The real challenge for NHSScotland is to introduce a culture of surveillance and vigilance. We have all learned to be alert for suspicious packages and to take action if we are concerned. In the same way, we need to be alert for infection. This review has given us the evidence we need to drive forward with a prioritised agenda. It has given us an insight into the impact that effective infection control could have in terms of improving health, saving lives and reducing costs – money

which can then be put back into healthcare. Now that we have the tools, the focus must be on defusing a bomb that has been ticking for a long time, and on preventing future outbreaks. The standards that have been validated and evidenced in the report provide a sound starting point on which to focus. Our recommendations, if implemented, will go a long way towards establishing efficient infection control systems in all Trusts.

Key Recommendations

Accountability

- There should be clear accountability for infection control and prevention. While this is ultimately everyone's responsibility, there are designated staff in every Trust with specific roles, particularly the Infection Control Teams, the Risk Management and Clinical Governance Committees and senior management. **All staff should know who is responsible for which aspect of infection control and how to contact them.**

Infrastructure

- All Trusts should support their staff and patients in managing and preventing infection. This means having in place a streamlined structure which reports up and down, and having an infection control programme in place that has been developed in partnership with senior managers, patients and other healthcare staff. The infection control programme should set out aims and objectives for the coming year in areas such as surveillance, education and training, and audit. These objectives should link to the Trust's infection control priorities and there should be an annual report outlining progress. The infection control programme should be underpinned by policies and procedures, as detailed in the standards.
- All Trusts must make sure they meet the national deadlines for surgical site surveillance.
- Infection control should be an integral part of staff induction for all healthcare professionals, particularly medical staff. Regular updates should also be provided, and antimicrobial prescribing should be an essential topic on postgraduate medical and dental education programmes.

Monitoring, Review and Audit

- Once systems have been put in place, they must be regularly monitored and reviewed to make sure they are working effectively and that changes lead to improvements.

Translating Process into Practice: Hand Hygiene

- Education in hand hygiene (hand washing) should be mandatory for **all staff**.
- Regular (at least annual) hand washing awareness events should be held.
- Trusts must audit compliance with their hand hygiene policies.

Chapter 1

Setting the Scene

- NHSScotland Health Board Breakdown and Index of Visits
- The CSBS Approach to Assessment
- Introduction to Infection Control
- The Principle Aims of Infection Control
- The CSBS Standards and Your Care
- Useful Contacts
















1 Setting the Scene




































1.1 NHSScotland Health Board Breakdown and Index of Visits

1	Argyll & Clyde	10	Lanarkshire
2	Ayrshire & Arran	11	Lothian
3	Borders	12	Orkney
4	Dumfries & Galloway	13	Shetland
5	Fife	14	Tayside
6	Forth Valley	15	Western Isles
7	Grampian	16	The State Hospitals Board for Scotland
8	Greater Glasgow	17	Scottish Ambulance Service Board HQ
9	Highland		

The following Trusts were visited during April – October 2002. Local reports, containing findings of each individual peer review visit and assessments against the standards, are available on the CSBS website (www.clinicalstandards.org) or in print format from CSBS.

Local Report Area  Estimated Population  Area (square km)  Population (per square km)	Trust/Organisation Visited
1. Argyll & Clyde  423,500  7,531  56	Argyll & Clyde Acute Hospitals NHS Trust Lomond & Argyll Primary Care NHS Trust Renfrewshire & Inverclyde Primary Care NHS Trust
2. Ayrshire & Arran  373,400  3,338  112	Ayrshire & Arran Acute Hospitals NHS Trust Ayrshire & Arran Primary Care NHS Trust
3. Borders  106,900  4,734  22	Borders General Hospital NHS Trust Borders Primary Care NHS Trust
4. Dumfries & Galloway  145,800  6,439  23	Dumfries & Galloway Acute & Maternity Hospitals NHS Trust Dumfries & Galloway Primary Care NHS Trust

Local Report Area	Trust/Organisation Visited
<p>5. Fife</p> <p> 350,000</p> <p> 1,323</p> <p> 265</p>	<p>Fife Acute Hospitals NHS Trust</p> <p>Fife Primary Care NHS Trust</p>
<p>6. Forth Valley</p> <p> 278,000</p> <p> 2,652</p> <p> 105</p>	<p>Forth Valley Acute Hospitals NHS Trust</p> <p>Forth Valley Primary Care NHS Trust</p>
<p>7. Grampian</p> <p> 523,400</p> <p> 8,742</p> <p> 60</p>	<p>Grampian Primary Care NHS Trust</p> <p>Grampian University Hospitals NHS Trust</p>
<p>8. Greater Glasgow</p> <p> 911,200</p> <p> 560</p> <p> 1,627</p>	<p>Greater Glasgow Primary Care NHS Trust</p> <p>North Glasgow University Hospitals NHS Trust</p> <p>South Glasgow University Hospitals NHS Trust</p> <p>The Yorkhill NHS Trust</p>
<p>9. Highland</p> <p> 208,600</p> <p> 25,784</p> <p> 8</p>	<p>Highland Acute Hospitals NHS Trust</p> <p>Highland Primary Care NHS Trust</p>
<p>10. Lanarkshire</p> <p> 562,000</p> <p> 2,189</p> <p> 257</p>	<p>Lanarkshire Acute Hospitals NHS Trust</p> <p>Lanarkshire Primary Care NHS Trust</p>

Local Report Area	Trust/Organisation Visited
11. Lothian  778,500  1,721  452	Lothian University Hospitals NHS Trust Lothian Primary Care NHS Trust West Lothian Healthcare NHS Trust
12. NHS Orkney  19480  992  20	NHS Orkney
13. NHS Shetland  22,440  1,438  16	NHS Shetland
14. Tayside  385,500  7,558  51	Tayside Primary Care NHS Trust Tayside University Hospitals NHS Trust
15. NHS Western Isles  27,180  3,134  9	NHS Western Isles

NHSScotland Organisations

16. The State Hospitals Board for Scotland³

17. Scottish Ambulance Service Board HQ³

³ Minor adjustments were made to the criteria and the few that were applicable were excluded from the review of this national organisation. This is reflected in their local report.

1.2 The CSBS Approach to Assessment

CSBS has developed a methodology, which draws upon other quality assurance systems, to enable it, in partnership with healthcare professionals and members of the public, to develop standards for clinical services and to assess performance across NHSScotland against the standards.

Further information and definitions of the terms used in the standards and in the assessment of performance are contained in Appendix 2.

Assessment Categories

Each review team assesses performance using the categories ‘**met**’, ‘**not met**’ and ‘**not met (insufficient evidence)**’, as detailed below:

- ‘**Met**’ applies where the evidence demonstrates that the standard and/or criterion is being attained.
- ‘**Not met**’ applies where the evidence demonstrates that the standard and/or criterion is not being attained.
- ‘**Not met (insufficient evidence)**’ applies where no evidence is available for the review team, or where the evidence supplied was insufficient to allow an assessment to be made.

A final category of ‘**not applicable**’ is used where a standard and/or criterion does not apply to the Trust under review.

1.3 Introduction to Infection Control

Infection is one of the major causes of ill health in the general population. Healthcare associated infections are those acquired in hospital or in a healthcare setting. Despite the widespread use of antimicrobial agents, infection remains the most common postoperative complication in many forms of surgery and may even be the cause of the patient’s death. Its prevention wherever possible is therefore crucial.

Infection control and prevention is not a new concept. Throughout the centuries, action to prevent the transmission of infection has been documented: in biblical times lepers were isolated, and in the 14th century, at the time of the bubonic plague, doctors wore protective clothing and masks stuffed with herbs to shield themselves. However it was not until the development of true microbiology in the late 19th century, that the existence of bacteria and viruses and their role in infectious diseases was clarified.

In 1959 the first infection control nurse was appointed in the UK. Further appointments slowly followed but it was not until the late 1980s and into the 1990s that infection control nurses were to be found in most acute hospitals. Traditionally infection control has been perceived as primarily being a matter of concern for hospitals. This view is now changing. The move in recent years to appoint infection control nurses to public health Communicable Diseases Teams and Primary Care Trusts reflects the increasing awareness of infection as a major public health issue.

There are many reasons why people develop healthcare associated infections and the incidence of infection varies widely but it has been estimated that 9% of all patients entering UK hospitals develop an infection acquired during their time there, equivalent to at least 100,000 infections a year.

Patients now spend significantly less time in hospital, with early discharge and increased day case management. Caring for individuals at home has many advantages for the patient – including a reduced risk of cross-infection, but does pose other problems relating to infection control. Given the potential for the spread of infection from the community to hospital and vice versa, the actual setting in which any infection is acquired is less important than the type and nature of the infection itself. There is therefore a greater need to co-ordinate the management of infection across all healthcare sectors. There should be good communication and liaison between the hospital staff discharging the patient and the primary care team who will take over responsibility for the patient's care.

There is also a clear need to improve the general level of knowledge and understanding of infection control principles among healthcare staff working in the hospital and community. This will become increasingly important in order to ensure that patients are cared for in the most appropriate setting and to enable the most efficient use of health service resources.



1.4 The Principle Aims of Infection Control

The principle aims when managing infection should be to:

- adopt a co-ordinated approach to surveillance, investigation, control and prevention of infection, involving community and hospital-based healthcare staff, public health doctors, the residential care sector and other relevant individuals and agencies;
- improve the general level of education and understanding of infection control principles and measures;
- ensure the accurate diagnosis and management of individual cases, making efficient use of laboratory and clinical resources;
- minimise levels of persisting infection, carriage and further transmission of pathogenic organisms; and
- ensure the appropriate management of outbreaks/incidents by making effective use of health service and public health resources.

The previous sections are drawn directly from the Scottish Infection Manual, Edinburgh, Scottish Office (1998) and Nursing for Public Health, Chapter 9, Communicable Diseases.

1.5 The CSBS Standards and Your Care

Questions You Might Want to Ask

Hospital Care

- Is there any information I can read about infection and infection control in this hospital before I am admitted?
- Will I still be allowed visitors if I have an infection?

All Healthcare Settings

- What is the Trust doing about infection?
- Will the doctor tell me if I am at particular risk of getting an infection?
- If I have any questions about infection, who should I ask?
- Will I get tested for infection? If so, what kind of tests will I have?
- What kind of treatment am I likely to have if I do get an infection?
- Is there anything I can do to lower my risk of getting an infection?
- Will everyone treating and examining me wash their hands first?



1.6 Useful Contacts

The following organisations can provide information about healthcare associated infection. Named contacts are current at time of publication, but may be liable to change.

1. Association of Clinical Microbiologists

Dr Kenneth Liddell (Vice Chair)
Lanarkshire Acute Hospitals NHS Trust
Wishaw General Hospital
50 Nethererton Street
Wishaw
ML2 0DP

Tel: 01698 366406

Fax: 01698 366625

Email: ken.liddell@laht.scot.nhs.uk

2. Audit Scotland

110 George Street
Edinburgh
EH2 4LH

Tel: 0131 477 1234

Fax: 0131 477 4567

www.audit-scotland.gov.uk

3. Infection Control Nursing Association (ICNA)

Mrs Margaret McCowan
Co-ordinator of Infection Control Nursing Association (Scottish Group)
National Waiting Times Centre
Beardmoor Street
Clydebank
G81 4HS

Tel: 0141 951 5000

Fax: 0141 941 5006

www.icna.co.uk

4. Scottish Centre for Infection & Environmental Health (SCIEH)

Clifton House
Clifton Place
Glasgow
G3 7LN

Tel: 0141 300 1100

Fax: 0141 300 1170

www.show.scot.nhs.uk/scieh



5. Scottish Microbiology Association
Dr James McGavigan (Chair)
Forth Valley Acute Hospitals NHS Trust
Stirling Royal Infirmary
Livilands
Stirling
FK8 2AU
Tel: 01786 434000
Fax: 01786 447119
Email: james.mcgavigan@fvah.scot.nhs.uk



Chapter 2

National Performance Against the Standards

Quality
Improvement
Scotland

National Performance Against the Standards 2

The findings across Scotland in terms of performance against the standards are presented in this section. A number of examples of innovative local solutions and areas of good practice are described in boxes throughout the text. These examples are not exhaustive – indeed, individual review teams highlighted many innovative examples of good practice across Scotland. It is often the case that the example cited also exists in another location.

Although Trusts tried hard to meet the requests for information about services, what was provided was often incomplete. This explains some of the gaps in information provided throughout the reports, and where information was not available to support a response, this has been assessed as ‘not met (insufficient evidence)’.

This national overview offers a summary based on local reports for all relevant services. A total of 33 Trusts were reviewed to assess performance against the standards. It should be noted that this resulted in 31 local reports, as two NHS Board area-wide reports were produced, covering all the Trusts in each of these Board areas. The findings should be reviewed using the denominator of 31 reports.

Note: Scottish National Blood Transfusion Service

The Scottish National Blood Transfusion Service (SNBTS) arrangements for infection control were reviewed as part of their CSBS generic clinical governance visit, which took place in June 2002. This review found that SNBTS had a robust risk management strategy in place and had developed a number of standard operating procedures relating to infection control. These are audited by the Medicines Control Agency and SNBTS Risk Management Committee.

As a requirement of the Medicines Control Agency, key activities in both blood collection and component production are subject to a programme of environmental monitoring procedures, and the outcomes of these are overseen by the SNBTS Quality Directorate.

2.1 Standard 1: Accountability: Accountability Arrangements at Trust Level

Standard Statement

Responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters throughout the organisation.

Strengths

- Most Trusts have identified clearly the persons with delegated responsibility for infection control and have designated a senior manager as per HDL (2001) 10.
- Accountability for infection control is good where risk managers are in post.
- Some Trusts provided excellent examples of infection control programmes and infection control reports.
- In one Trust a definitive "Control of Infection Policy Statement" produced by the Trust Chief Executive was circulated to all staff.

Challenges

Trusts need to:

- document accountability structures in relation to infection control throughout the organisation;
- put in place risk management arrangements in respect of infection control;
- document formally the persons with delegated managerial authority in infection control and nominate a single senior manager responsible for all aspects of infection control as per HDL(2001)10;
- have senior manager on-call rotas in respect of infection control;
- develop infection control programmes and reports as core components of risk assessment in infection control; and
- develop credible mechanisms for reporting infection control issues to senior management.

Recommendations

Trusts should:

- Issue a "Control of Infection Policy Statement" endorsed by the Trust Chief Executive.
- Appoint risk managers/directors who are also members of the Infection Control Committee. In particular, this would improve bottom-up feedback from the Infection Control Team to senior management.
- Clearly define the lines of accountability and responsibility for all individuals, committees and groups involved in infection control in 'terms of reference' documents.
- Develop infection control programmes and annual, widely available reports on key targets. **This arrangement would form the cornerstone of risk assessment and resource prioritisation.**

Criterion 1.1

There are clear lines of accountability throughout the organisation which define the relationships between the Risk Management Committee/Group, Clinical Governance Committee, Infection Control Committee and Infection Control Team.

About one third of Trusts demonstrated clear lines of accountability in respect of risk management, clinical governance and infection control. Where this criterion was not met there was usually a link between the infection control and risk management structures. Links were strong when a Risk Management Director was in post. Some Trusts did not comply because the described link between clinical governance and infection control was not evident.

As a generalisation, many Trusts relied on ad hoc, personal contact links (ie personnel represented on several committees) rather than a formal, prescribed and fail-safe link mechanism between the Infection Control Team and the Risk Management and Clinical Governance Committees. The minutes of Committees and their terms of reference did not usually delineate the lines of accountability.

Many Trusts recognised these deficiencies and were actively discussing plans to address them.

Met = 9; not met (IE) = 5; not met = 17.

Criterion 1.2

The infection control programme is developed with the support and approval of the Trust Chief Executive.

Approximately two thirds of Trusts did not have an infection control programme or had a programme that was not supported by the Trust Chief Executive. Sometimes an 'action plan' or 'work plan' insufficiently detailed to be recognised as an infection control programme was available for infection control nurses, and these plans were occasionally approved by the Trust Chief Executive or a deputy.

Met = 11; not met (IE) = 2; not met = 18.

Criterion 1.3

The Trust Chief Executive and Risk Management Committee/Group receive the annual report on the infection control programme.

Receipt of an annual report on the infection control programme by the Trust Chief Executive and Risk Management Committee was uncommon. This was usually because the infection control report had not been prepared against a formal infection control programme. In some Trusts, annual reports were not reviewed by risk management because the risk management structure was not yet in place.

Met = 5; not met (IE) = 1; not met = 25.

Criterion 1.4

The Trust Chief Executive, or a deputy with authority to make appropriate decisions on the Chief Executive's behalf, works closely with the Infection Control Team.

Since the interim report, the issue of delegated responsibility has been addressed by most Trusts. Written guidance identifying the person with authority to act on behalf of the Trust Chief Executive in relation to infection control is now in place. This authority was usually delegated to the medical director or the director of nursing.

Met = 22; not met (IE) = 4; not met = 5.

Criterion 1.5

A senior manager as per HDL(2001)10 is designated as having overall responsibility for risk assessment and management processes related to infection control, decontamination and cleaning services.

More than three quarters of Trusts had designated a senior manager as per HDL(2001)10 with overall responsibility for the risk assessment and management processes relating to infection control, decontamination and cleaning services.

Six Trusts had delegated this responsibility to more than one individual. This contravenes the HDL instruction.

Met = 25; not met (IE) = 2; not met = 4.

Criterion 1.6

Senior management support is provided for infection control emergencies out-of-hours.

One third of Trusts provided no satisfactory evidence of an on-call rota for senior managers to deal with out-of-hours infection control problems. In some, the only evidence of such a role was found in the Trust's major outbreak and incidents plan.

Sometimes a list of names and telephone numbers was provided with an instruction to call through the list until someone was available.

Met = 20; not met (IE) = 1; not met = 10.

Criterion 1.7

The Trust Chief Executive and the Risk Management Committee/Group are informed of any serious problems or issues relating to infection control.

About half of Trusts had no formal mechanism to ensure that serious problems or issues relating to infection control were communicated to the Trust Chief Executive and the Risk Management Group. In some Trusts this was because risk management structures were still evolving, in others no documentation was available.

Some Trusts had a mechanism for direct reporting of acute problems from the infection control doctor to the Trust Chief Executive, but the outcome of these meetings was documented infrequently.

Met = 16; not met (IE) = 6; not met = 9.

2.2 Standard 2: Accountability: Infection Control Committee (ICC)

Standard Statement

There is an Infection Control Committee that endorses all infection control policies/procedures/guidelines. It also provides advice and support on their implementation and monitors the progress of the annual infection control programme.

Strengths

- Most Trusts have Infection Control Committees that liaise effectively with the Infection Control Teams to which they provide advice and support.
- Some Trusts provided excellent documentation relating, for example, to distribution lists for Infection Control Committees and the roles and responsibilities of Infection Control Committees and members.

Challenges

Trusts need to ensure that:

- the terms of reference, accountability arrangements and functions and responsibilities of **all** Infection Control Committees in their organisation are clearly documented;
- the membership of Infection Control Committees conforms to the components of the standard and fulfils the infection control needs of the organisation; and
- Infection Control Committees endorse the infection control programme.

Recommendations

Trusts should:

- Clearly define and formally document all components of the accountability structures for **all** Infection Control Committees in the organisation and for their constituent members.
- Ensure that terms of reference detail clearly the required functions of Infection Control Committees. These should include the endorsement of all policies, procedures and guidelines, involvement in all stages of development of the infection control programme in collaboration with the Infection Control Team, and the endorsement and monitoring of the progress of the programme.

- Where several Infection Control Committees exist, Trusts should review the respective operational and strategic roles expected of each Committee. Trusts should also develop a co-ordinated approach to infection control functions to consider whether they are optimally delivered by Infection Control Committees based at hospital, Trust, area or joint Board level.

Criterion 2.1

Membership of the Infection Control Committee includes:

- Chief Executive or a nominated senior manager with authority to represent him/her.
- Chief pharmacist or representative.
- Consultant in public health medicine (communicable diseases and environmental health) for the local NHS Board.
- Infection Control Team.
- Identified representatives, from, for example, sterile services department, estates department, facilities management, Trust risk management co-ordinator etc.
- Infectious disease physician (where there is one).
- Key representatives from other hospitals/areas covered by the Infection Control Committee eg general medical or dental practitioners.
- Nurse executive director or nominated representative(s).
- Other experts as required on an ad hoc basis eg environmental health officer.
- Representative of the occupational health service.
- Senior clinical medical staff representatives nominated by the medical director.
- Senior manager with overall responsibility for risk assessment and management processes relating to infection control/decontamination/cleaning services.

Slightly more than half of Trusts had an appropriately constituted Infection Control Committee (or another named committee carrying out this function). In many Trusts which met this criterion there had been recent review and approval of the Infection Control Committee membership to ensure that its representation was appropriate to the organisation. However, even then, the designation of the members and the capacity in which they served on the Infection Control Committees were not always readily determined.

Some Trusts had as many as four Infection Control Committees, operating at different sites in the organisation and with little evidence of a cohesive approach. With this multiplicity of Infection Control Committees it was especially difficult to assess the designation of the members and the capacity in which they served, even after scrutiny of relevant Committee minutes, constitutions and accountability arrangements/terms of reference.

Many Trusts were in the process of establishing a single Infection Control Committee that was Trust-wide. In two cases, Trusts had established a single Infection Control Committee at NHS Board level covering both Acute and Primary Care Trusts.

Met = 18; not met (IE) = 2; not met = 11.

Criterion 2.2

The Infection Control Committee agree terms of reference and accountability arrangements and meet at least four times a year.

Most Trusts provided satisfactory evidence through the Infection Control Committee minutes or terms of reference that there were four meetings per year.

Only eight Trusts produced comprehensive, up-to-date and approved terms of reference and accountability arrangements for Infection Control Committees. In the remainder, evidence was generally incomplete, out-of-date or satisfactory for only some of the Infection Control Committees in the organisation. However, it was encouraging that many Trusts had appreciated the need to develop revised terms of reference that reflected a new, co-ordinated approach that had been assessed as appropriate for the organisation.

Met = 8; not met (IE) = 7; not met = 16.

Criterion 2.3

Minutes of the Infection Control Committee are circulated to all clinical directors/managers and relevant committees, for example, Clinical Governance and Risk Management Committee/Group.

Only 11 Trusts provided a comprehensive list ensuring effective distribution of Infection Control Committee minutes to all senior medical and nursing staff, general managers and relevant committees, such as the Risk Management and Clinical Governance Committees.

Some Trusts did not have formal distribution lists, relying instead on department heads to distribute minutes further throughout the Trust. However, evidence that this informal mechanism resulted in full distribution of minutes was limited, and these Trusts were judged not to have met the criterion.

The difficulty in assessing this criterion was further complicated when several Infection Control Committees were in place in some Trusts.

Met = 11; not met (IE) = 4; not met = 16.

Criterion 2.4

The Infection Control Committee provides advice and support to the Infection Control Team.

About three quarters of Trusts met this criterion. Evidence that the Infection Control Committee supported and advised the Infection Control Team was obtained from minutes, approved terms of reference, and from discussions with Infection Control Teams and other Trust staff.

Met = 24; not met (IE) = 1; not met = 6.

Criterion 2.5

The Infection Control Committee endorses the annual infection control programme.

In the 13 Trusts meeting this criterion, there was either a formal effective mechanism in place to ensure that the Infection Control Committee endorsed the infection control programme, or the information was gleaned from scrutiny of Infection Control Committee minutes.

Met = 13; not met (IE) = 4; not met = 14.

Example of a Local Initiative

Renfrewshire & Inverclyde Primary Care NHS Trust

Practice development nurses sit on the Infection Control Committee in order to liaise and feed back to the Local Healthcare Co-operatives. Issues can be brought to the fore in relation to training, policy development, audit, practice issues, etc.

2.3 Standard 3: Accountability: Infection Control Team (ICT)

Standard Statement

There is an appropriately constituted and functioning Infection Control Team.

Strengths

- Most Trusts have an appropriately constituted Infection Control Team which has established good liaisons with colleagues in occupational health, public health medicine and environmental health.
- Infection control nurses are generally well-trained, undergo continuing professional development, and their responsibilities and accountability are well-defined.

Challenges

Trusts need to ensure that:

- dedicated secretarial support is provided for Infection Control Teams;
- infection control doctors, where they do not yet exist, are appointed; and
- the infection control sessions required from the infection control doctor are defined and contracted.

Recommendations

Trusts should:

- Employ an infection control doctor who should provide formally contracted sessions per week.
- Provide adequate and dedicated secretarial support to all Infection Control Teams.
- Ensure support for continuing professional development for all members of Infection Control Teams.

Criterion 3.1

The Infection Control Team includes: the infection control doctor(s); the infection control nurse(s); a consultant medical microbiologist if the infection control doctor is from another specialty.

About four fifths of Trusts have Infection Control Teams which include infection control nurses, an infection control doctor and a consultant medical microbiologist if the infection control doctor is from a different specialty. In Trusts which did not comply there was no designated infection control doctor.

Met = 25; not met (IE) = 0; not met = 6.

Criterion 3.2

The Infection Control Team is supported by: dedicated secretarial staff; IT staff; and audit staff.

Most Trusts did provide secretarial support, but this was usually available only on an ad hoc basis. Many Trusts reported that this was being addressed in their business plans.

Most Trusts provided audit and IT support for Infection Control Teams.

Met = 11; not met (IE) = 0; not met = 20.

Criterion 3.3

The responsibilities and accountability arrangements of each member of the Infection Control Team are clearly defined and the contracted sessions per week for the Infection Control Doctor are defined and agreed.

The responsibilities and accountability arrangements for infection control nurses were well documented in most Trusts. By contrast, this was not the case for infection control doctors, consultant medical microbiologists and clinical scientists. Trusts rarely defined and agreed the contracted sessions for infection control doctors. Where such sessions were defined, it applied mainly to newly appointed infection control doctors and ranged from 1-5 infection control sessions per week.

Met = 8; not met (IE) = 2; not met = 21.

Criterion 3.4

Members of the Infection Control Team have trained in infection control and can provide evidence of relevant continuing professional development (CPD).

In four fifths of Trusts the Infection Control Teams were properly trained and undertook relevant continuing professional development. In the exceptions, where training and continuing professional development was difficult for geographical reasons, this was acknowledged and was being addressed.

Met = 25; not met (IE) = 0; not met = 6.

Criterion 3.5

The Infection Control Team and the appropriate occupational health services liaise when dealing with infection control advice relating to the: health and safety of healthcare workers; transmission of infection between healthcare workers and other persons.

In all Trusts, liaison between Infection Control Teams and occupational health services was good in respect of meetings and the development of policies.

Met = 31; not met (IE) = 0; not met = 0.

Criterion 3.6

The Infection Control Team ensures that advice on infection control is available on a 24-hour basis.

Almost all Trusts ensured that infection control advice was available on a 24-hour basis, usually through the consultant medical microbiologist.

Met = 28; not met (IE) = 0; not met = 3.

Criterion 3.7

The Infection Control Team collaborates with the local consultant in public health medicine (communicable disease and environmental health) when dealing with: outbreaks or incidents within the acute and primary care settings; issues relating to infection within primary care settings; areas of work requiring the involvement of environmental health officers.

In the great majority of Trusts, collaboration between Infection Control Teams and public health specialists and, where relevant,

environmental health officers was strong. Where it was not, this was usually due to the lack of formal documentation.

Met = 28; not met (IE) = 0; not met = 2; not applicable = 1.

Examples of Local Initiatives

Grampian University Hospitals NHS Trust and Grampian Primary Care NHS Trust

The Infectious Diseases Group is chaired by the Consultant in Public Health Medicine and is a monthly exchange of reports and information with representatives from the Health Board, environmental health, laboratories, infection control staff from both NHS Grampian Trusts, veterinary services and the Communicable Diseases Team.

In addition, six-monthly open-day meetings are held with participants including colleagues from the Scottish Centre for Infection and Environmental Health (SCIEH) and the Shetland Isles.

Fife Primary Care NHS Trust

The role of the Joint Infection Control Team is to bring together all medical/scientific microbiologists and infection control nurses in Fife to discuss and agree common issues, such as audit, surveillance, the infection control manual, and relevant legislation and guidance. The Team meets monthly, and meetings are chaired by the Infection Control Doctor. The infection control nurses across Fife provide cover for each other during leave, sickness absence, and share out-of-hours duties. At the time of the visit, there were plans to strengthen this joint working by developing a single, integrated infection control service for Fife.

Forth Valley Primary Care NHS Trust

The Trust has developed a barbecue policy in consultation with infection control staff and environmental health officers. This enables adoption of inclusion of regular lifestyle activities for long-stay patients.

Greater Glasgow Primary Care NHS Trust

The infection control nurses contribute to the Health Board's monthly public health newsletter. The newsletter has a wide distribution, including general practices.

2.4 Standard 4: Processes: Planning and Development

Standard Statement

Prevention and control of infection are considered as part of all service development activity.

Strength

- There are good examples in many Trusts of informal mechanisms whereby Infection Control Teams have established effective liaison and good working relationships with other partners in the organisation in relation to all aspects of service development.

Challenge

- Trusts need to ensure that all service development activities in which the Infection Control Team are to be involved are co-ordinated and formalised by one organisation-wide strategic policy.

Recommendations

Trusts should:

- Produce and implement a 'planning and development policy' document.
- Provide effective infection control advice at every stage of **all** service developments, where this is relevant.

Criterion 4.1

There is a system in place which ensures that, where relevant, advice is sought from the Infection Control Team, particularly in relation to the following:

- **The development of policies/procedures/guidelines relating to engineering and building services and to the purchase of medical devices/equipment.**
- **Early stage planning for advice relating to engineering and building works and the purchase of medical devices/equipment.**
- **All stages of the contracting process for hotel and other services which have implications for infection control, eg cleaning, laundry, clinical waste, catering.**

Only one Trust had in place an organisation-wide strategy document which described mechanisms to ensure that the Infection Control Teams provide advice in relation to the purchase of medical

devices/equipment, and are involved in the early stages of all other service development activities as described in this criterion.

In a few Trusts, there was good evidence of effective communication between Infection Control Teams and estates and building departments in matters relating to engineering and building works, and in the contracting processes for hotel and other support services.

Some Trusts were developing action plans, produced in collaboration with risk management departments. Much of this work was based on current ad hoc activity.

Met = 1; not met (IE) = 2; not met = 28.

Examples of Local Initiatives

Grampian University Hospitals NHS Trust

The infection control nurses receive a weekly printout of building work taking place throughout the Trust.

Greater Glasgow Primary Care NHS Trust

A Trust-wide Procurement Group has been established with the aim to have all procurement on the intranet to standardise and rationalise throughout the Trust. The Group will seek core expertise, including infection control advice, for example when purchasing medical devices. The Chair of this Group sits on the Infection Control Committee, and the Group reports to the Chair of the Risk Management Advisory Group.

Argyll & Clyde Acute Hospitals NHS Trust and Lomond & Argyll Primary Care NHS Trust

Vale of Leven District General Hospital has formalised a policy which ensures that input and advice is sought from the infection control service prior to the Hospital Manager signing off maintenance, procurement, new build plans, etc.

Fife Acute Hospitals NHS Trust and Fife Primary Care NHS Trust

Both Trusts have taken a number of steps to integrate infection control into service development activity. The review team noted that the NHS Fife supplies service has established a wide range of focus groups and contract monitoring groups to ensure input from all relevant stakeholders. There is infection control nurse representation on the IV Therapy Care Products and Sharps Disposal Systems Focus Groups, and on the Patient Handling Equipment and Procedures Contract Monitoring Group.

2.5 Standard 5: Processes: Infection Control Programme (ICP)

Standard Statement

An organisation-wide annual infection control programme with clearly defined objectives is produced by the Infection Control Team.

Strength

- Some Trusts produced excellent infection control programmes developed by the Infection Control Team in full consultation with members of broadly-based Infection Control Committees, other key stakeholders, and approved by the Trust Chief Executive/Management Team through the relevant risk management structure.

Challenges

Trusts need to ensure that:

- Infection Control Teams use a risk management approach to develop formal infection control programmes in full consultation with all other key professionals in their organisation;
- There is approval of the infection control programme by Trust Chief Executives and review through the risk management structures; and
- regular review and modification of the infection control programme leads to an annual report.

Recommendations

Trusts should:

- Ensure that infection control programmes are signed-off by the Trust Chief Executive.
- Review these programmes through the Trust's risk management structures.

Criterion 5.1

The Infection Control Team develops and produces an annual infection control programme in full consultation with relevant key stakeholders, including the Infection Control Committee, health professionals and senior managers.

About one quarter of Trusts have formal, prospective annual infection control programmes detailing the aims and objectives of audit, surveillance, education and other strategic infection control activities/plans. These have been developed by the Infection Control Team in full consultation with, and approval by, other relevant colleagues.

A few Trusts had prepared their first infection control programme for 2002-2003 in consultation with key stakeholders but, at the time of their review visit, had not yet received the approval of appropriate committees such as the Infection Control Committee. In some cases, claims that the infection control programme had been approved by the Infection Control Committee could not be verified from the Infection Control Committee minutes.

Some Trusts did not meet this criterion because their infection control programme had been developed by infection control nurses or teams without consultation with other stakeholders – such as other health professionals, senior managers and the Infection Control Committee. Other Trusts operating on several sites provided satisfactory infection control programmes for some, but not all, of these sites.

In several Trusts, the infection control programmes submitted comprised a set of written objectives for the senior infection control nurses or the Infection Control Team, often as part of their personal development programmes. Again, several documents submitted as infection control programmes were reports listing that year's infection control activities but without any evidence that the activity had been planned the year previously.

Met = 8; not met (IE) = 4; not met = 19.

Criterion 5.2

The programme is approved by the Trust Chief Executive and Management Team through the relevant risk management structure.

Only four Trusts demonstrated that the infection control programme had been approved both by the Trust Chief Executive and through the relevant risk management structure. In other cases, it seemed that, although the infection control programme had been received by the Chair of the Risk Management Committee, or by some senior manager who was a member of the Risk Management Committee, there was no evidence from Risk Management Committee minutes of discussion, review or approval of the infection control programme.

Several Trusts reported that, at the time of the peer review visit, formal risk management structures were not yet fully developed. Hence, formal mechanisms for approval of the infection control programme through the risk management structure did not exist.

Met = 4; not met (IE) = 2; not met = 25.

Criterion 5.3

Identified priorities arising from the infection control programme are incorporated within the relevant annual business plan(s).

About one quarter of Trusts had identified priorities from their infection control programme (whether or not that infection control programme had met criteria 5.1, 5.2) that had been incorporated in relevant annual business plans.

Met = 8; not met (IE) = 0; not met = 23.

Criterion 5.4

The programme is kept under regular review by the Infection Control Committee and Infection Control Team and modified as necessary.

Detailed scrutiny of documentary evidence, such as Infection Control Committee minutes and annual infection control reports, revealed very few examples to confirm that regular discussion, assessment and necessary modification of the infection control programme had occurred.

Met = 6; not met (IE) = 4; not met = 21.

Criterion 5.5

The programme includes reference to audit of the implementation of, and compliance with, selected infection control policies/procedures/guidelines.

In the few Trusts where infection control programmes had been formally approved, reference to the implementation of, and compliance with, audit of selected policies, procedures and guidelines in a planned manner was usually present.

Met = 10; not met (IE) = 2; not met = 19.

Criterion 5.6

The annual infection control report outlines the progress of the infection control programme.

The six annual infection control reports received, based on a previous year's prospective infection control programme, were comprehensive documents outlining clearly progress against the infection control programme.

Met = 6; not met (IE) = 0; not met = 25.

Examples of Local Initiatives

Tayside Primary Care NHS Trust

The Trust has integrated risk management of infection control within its existing organisational framework. Prioritised risk control plans for infection control and specific risk management action plans are developed. The Infection Control Committee includes a review of the infection control risk action plans at every meeting. This creates an accurate and dynamic method for monitoring the risks the Trust is exposed to in infection control. The risk control plan is also used to develop the infection control programme. Regular monitoring of the risks within the Trust ensures that the Infection Control Committee has a mechanism to follow the compliance of the Trust with the infection control programme.

Ayrshire & Arran Primary Care NHS Trust

The Infection Control Team has developed a process that ensures that all key stakeholders can input into the development of the infection control programme. All key stakeholders including the Trust Chief Executive, directors, clinical managers, senior clinical staff and support services managers are asked to identify issues that they wish included in the infection control programme. After the programme is drafted, all of the key stakeholders are then given an opportunity to comment on the programme before it is submitted to the Trust Control of Infection Committee, Risk Management Group and Trust Chief Executive for approval.

2.6 Standard 6: Processes: Policies, Procedures and Guidance

Standard Statement

Written policies/procedures/guidelines for the prevention and control of infection are implemented and reflect relevant legislation and published professional guidance.

Strength

- Most Trusts have a good complement of infection control policies and recognise the importance of producing up-to-date, quality guidance in policies and other documents – many are reviewing their procedural mechanisms for achieving this.

Challenges

- Trusts need to ensure control mechanisms for all aspects of their policies/procedures/guidelines.
- Trusts need to produce a review plan and timetable that is incorporated into the infection control programme, for their infection control policies/procedures and guidelines.

Recommendations

Trusts should:

- Review their mechanisms for distribution of infection control policies/procedures/guidelines so that their receipt by all users is guaranteed and acknowledged.
- Complete policies/procedures/guidelines 'sets' where omissions have been identified.
- Ensure that a timetable for review of policies/procedures/guidelines is included in the infection control programme.
- Ensure that all policies are dated, review-dated and signed-off appropriately.

Criterion 6.1

Policies/procedures/guidelines are approved by the Infection Control Committee.

In nine tenths of the Trusts, infection control policies/procedures/guidelines are approved by the Infection Control Committee. Trusts not meeting this requirement either did not provide sufficient evidence of the processes or had only recently taken action to correct the problem.

Met = 27; not met (IE) = 2; not met = 2.

Criterion 6.2

There is a system to ensure each directorate, department or service has a current copy of the approved policies/procedures/guidelines pertinent to its activities.

Two thirds of Trusts had mechanisms for the distribution and acknowledgement of receipt of policies and guidance documents. The remaining Trusts were generally taking steps to correct the problem, often as part of an over-arching change to all policy distributions in addition to infection control. It is also apparent that as Trust intranets develop, policies will be available by this medium.

Met = 20; not met (IE) = 3; not met = 8.

Criterion 6.3

Key policies/procedures/guidelines are in place, and where assessed as relevant, include:

- Antimicrobial prophylaxis and therapy prescribing.
- Control of Methicillin Resistant Staphylococcus Aureus (MRSA) and other antimicrobial resistant micro-organisms.
- Collection, packaging, handling, delivery and disposal of laboratory specimens.
- Control of tuberculosis, including multi-drug resistant tuberculosis.
- Control of viral haemorrhagic fevers.
- Decontamination and reprocessing of reusable medical devices.
- Food hygiene.
- Hand hygiene.
- Handling of medical devices in procedures carried out on known/suspect CJD (of any type) patients and on patients in risk categories for CJD as defined in the ACDP/SEAC guidance (including disposal/quarantining procedures).
- Insertion and maintenance of central venous catheters.
- Isolation of patients.
- Last offices.
- Laundry.
- Legionellae control.
- Management of occupational exposure to blood-borne viruses (BBVs) and post exposure prophylaxis.

- Outbreaks/incidents of communicable infections and ward/hospital closure.
- Occupational health policies for prevention and management of communicable infections in healthcare workers, including those infected with blood-borne viruses.
- Prevention of occupational exposure to blood-borne viruses, including prevention of sharps injuries.
- Safe handling and disposal of healthcare waste.
- Single use and single patient use devices and other healthcare products.
- Standard infection control precautions.
- Use of indwelling urethral catheters.

Nine tenths of Trusts did not produce evidence of a full set of completed, signed-off policies, procedures and guidelines. However, in most instances, there were only a few omissions per Trust and often draft documents were being considered. The standard of existing policies was good, and in some instances, excellent.

Met = 4; not met (IE) = 0; not met = 27.

Criterion 6.4

The annual programme includes a timetable stating which key infection control policies/procedures/guidelines are to be reviewed or written that year.

In two thirds of Trusts there was no programme and timetable for reviewing or writing infection control policies/procedures/guidelines. Where there was a programme, a timetable for completion was not always included.

Met = 10; not met (IE) = 2; not met = 19.

Criterion 6.5

All policies/procedures/guidelines are clearly marked with a review date.

Nine tenths of Trusts acknowledged that their policies were not marked with a review date, although in most cases steps were being taken to correct this; review dates in newer policies and recent revisions were more likely to be appropriately marked.

Met = 4; not met (IE) = 0; not met = 27.

Criterion 6.6

Relevant parts of key policies/procedures/guidelines are produced in abbreviated form and are accessible for routine use as aides-mémoire by operational staff.

All but one of the Trusts provided excellent examples of abbreviated aides-mémoire of their policies/procedures/guidelines, for which they are to be commended.

Met = 30; not met (IE) = 0; not met = 1.

Examples of Local Initiatives**Lanarkshire Acute Hospitals NHS Trust and Lanarkshire Primary Care NHS Trust**

The Lanarkshire control of infection manual is a consensus document endorsed by the Area Control of Communicable Diseases Committee and used by both Trusts in Lanarkshire. The manual is available on the NHS Lanarkshire website and in hard copy in all clinical and other relevant areas throughout the Trusts. It is an attempt to put national guidelines and local priorities together with practical advice, and is used daily by infection control nurses for both training and routine infection control interventions. This comprehensive and user-friendly manual is a model of good practice and has been adapted for use by several other Trusts and NHS Boards.

The State Hospitals Board for Scotland

The State Hospitals Board for Scotland has developed a range of food hygiene guidance. This includes hygiene guidelines on ordering takeaway meals and preparing food in therapeutic kitchens, and barbecue guidelines to be used in conjunction with a comprehensive barbecue risk assessment form.

Forth Valley Primary Care NHS Trust

Comments are invited and approval sought from the Local Health Council for posters to be used in the community, for example, a poster for waste management.

2.7 Standard 7: Processes: Policies, Procedures and Guidelines

Standard Statement

There is an annual programme for the audit of infection control policies/procedures/guidelines.

Challenge

- All Trusts need to have a risk assessment and prioritisation approach to the development of a programme to audit the implementation of infection control policies/procedures/guidelines.

Recommendation

- Trusts should plan, programme and timetable audit of infection control policies/procedures/guidelines.

Criterion 7.1

There is a written, agreed programme for the audit of infection control policies/procedures/guidelines.

One third of Trusts had formal programmes for planned infection control audit. In the remaining two thirds which did not meet this criterion, this was often because they did not have infection control programmes in place. However, this deficiency was recognised by most Trusts and they were actively considering methods to address the issue.

Met = 11; not met (IE) = 2; not met = 18.

Criterion 7.2

There is audit of the implementation of infection control policies/procedures/ guidelines.

Two thirds of Trusts carried out some form of infection control audits; often these were environmental audits. The latter incorporated many of the components of most policies, although they do not specifically address all aspects of any given policy. There was little evidence that audits were selected and actioned on a risk assessment basis.

Met = 20; not met (IE) = 1; not met = 10.

Criterion 7.3**Audit results are fed back to stakeholders and are included in the infection control annual report.**

In only seven Trusts were audit results fed back to stakeholders and included in the annual report. Local feedback was generally on an informal basis and its effectiveness was unclear.

The four fifths of Trusts which did not meet this criterion, either did not have annual infection control reports in which to include audit results or had annual reports but did not incorporate audit results in them.

Met = 7; not met (IE) = 1; not met = 23.

Criterion 7.4**Audit results are used to facilitate improved infection control practice.**

Where audit had been carried out, particularly in the case of environmental audits, it was usually clear that feedback of audit results had stimulated an implementation plan for improvements and this was sometimes timetabled.

Closing the audit loop was uncommon and, hence, improvements in infection control practice were generally poorly documented.

Met = 20; not met (IE) = 3; not met = 8.

Examples of Local Initiatives**The State Hospital Board for Scotland**

The Infection Control Nurse runs a comprehensive programme of environmental audit based on sound risk assessment principles. The audit tool used has been adapted from the West Midlands environmental audit tool, and incorporates a variety of infection control policies/procedures/guidelines. A comprehensive report on environmental audit findings is produced for the Infection Control Committee. The report contains a detailed action plan which specifies resource implications for the various actions, timescales for their completion, who is responsible for ensuring that they are carried out, and an indication of level of priority for each of the action points.

Forth Valley Primary Care NHS Trust

Audit results are fed back to stakeholders using coloured feedback forms (traffic light system) to indicate level of risk (high, medium, low) with an agreed date of one, three or six months for return to the infection control department.

Tayside University Hospitals NHS Trust

The Infection Control Team uses digital photography to enhance its environmental audit tool and generate visual feedback for staff. The camera is used to record any instances of inadequacies in relation to infection control, eg dangerous or inappropriate items sent to the laundry or poor segregation of waste during waste audit. This information is fed back immediately to the staff responsible. The infection control nurses keep the camera with them during daily visits.

Ayrshire & Arran Acute Hospitals NHS Trust

The infection control nurses purchased a digital camera to be used for supporting evidence during audits. The pictures taken can be e-mailed directly to the responsible persons or can be attached to environmental audits to demonstrate good practice and highlight deficiencies. The pictures can also be used to enhance educational presentations.

Ayrshire & Arran Primary Care NHS Trust

The Infection Control Nursing Advisor undertakes an extensive audit programme that examines both the physical environment and policy implementation. Reports are issued to the ward and service managers and, where applicable, copied to the estates department. Digital photography is used to good effect to visually highlight issues identified in the audit. Action plans are submitted to the Infection Control Nursing Advisor within two months by the ward manager. Annual summary reports of all audit activities are then tabled at the Infection Control Committee.

2.8 Standard 8: Processes: Microbiological Services

Standard Statement

Timely and effective specialist microbiological support is provided for the infection control service.

Strengths

- There was evidence of good practice and effective liaisons between infection control and microbiology staff and most of them reported regular meetings, at least daily, which were formal or informal.
- Trusts had good access to high-quality microbiological services and support on a 24-hour basis.

Challenge

- Trusts not meeting this standard must ensure that microbiological services are provided by Clinical Pathology Accreditation (CPA) accredited laboratory services.

Recommendation

- Trusts should ensure that microbiological services are provided by Clinical Pathology Accreditation accredited laboratory services.

Criterion 8.1

The microbiology laboratory is Clinical Pathology Accreditation (CPA) accredited and supports the infection control service via processing, data provision, surveillance and specialist testing.

It was agreed that this standard did not apply to the Scottish Ambulance Service.

All but four of the Trusts confirmed Clinical Pathology Accreditation (or conditional accreditation) for all their microbiology laboratory services, and provided relevant documentary evidence to confirm microbiological support for the infection control service by the measures specified in the criterion.

Met = 26; not met (IE) = 0; not met = 4; not applicable = 1.

Criterion 8.2

There is access to, and provision for, timely specialist microbiology support, including the interpretation of results either on-site, or via reference laboratories.

All but one of the Trusts confirmed access to, and provision of, timely specialist support by microbiology staff. All Trusts reported frequent and effective liaisons between microbiology and infection control staff and, in many cases, the clinical and infection control remit was clearly defined in the job descriptions of consultant medical microbiologists (who were usually infection control doctors) and clinical scientists.

One Trust did not meet this criterion because, while most of its microbiology support and specialist advice was satisfactorily obtained from a local laboratory, a minority of GP practices used a microbiology laboratory in another Trust, and in this relationship there was little evidence of effective reporting, support or liaison.

Met = 29; not met (IE) = 0; not met = 1; not applicable = 1.

Criterion 8.3

There is a written procedure for the reporting of results on each test.

The vast majority of Trusts provided evidence of satisfactory written procedures for reporting results of all tests.

Met = 28; not met (IE) = 1; not met = 1; not applicable = 1.

Criterion 8.4

The Infection Control Team has appropriate access to laboratory results via an effective computer system.

Almost all Trusts demonstrated that Infection Control Team members had appropriate access to laboratory results via an effective computer system.

Met = 29; not met (IE) = 0; not met = 1; not applicable = 1.

Criterion 8.5**Microbiology services are available on a 24-hour basis.**

All Trusts assured their microbiology services were available on a 24-hour basis, usually by provision of detailed on-call rotas for medical laboratory scientific officers, clinical scientists and microbiology consultant staff.

Met = 30; not met (IE) = 0; not met = 0; not applicable = 1.

Examples of Local Initiatives**Lanarkshire Acute Hospitals NHS Trust**

A Subgroup of the Lanarkshire Microbiology Committee has been established to look at standardisation of the methodology, working time arrangements and on-call service across the three sites in Lanarkshire Acute Hospitals NHS Trust. This is a long-term commitment, with the ultimate aim of producing a functionally integrated service delivered from the three separate sites.

North Glasgow University Hospitals NHS Trust

The microbiology department at Stobhill Hospital has produced a user manual to help users make the best use of services available from the microbiology department. This manual is available in all wards and departments, and an electronic version has been created.

2.9 Standard 9: Processes: Surveillance

Standard Statement

Surveillance of infection and audit of the results is carried out in accordance with national requirements, and to meet defined local priorities and objectives as specified in communications from the Scottish Executive Health Department and in the annual infection control programme.

Strength

- All Acute Trusts provided national **minimum** data sets to the Scottish Centre for Infection and Environmental Health (SCIEH) for MRSA bacteraemias.

Challenges

- All Trusts need to ensure that the objectives and priorities of local/national surveillance are targeted and conform with the requirements of the standard.
- Acute Trusts need to identify local resources which will enable them to meet national deadlines for surgical site surveillance.
- Trusts need to identify all the surveillance components of their routine activities and use the results, wherever possible, to improve patient care and professional practice.

Recommendation

- Trusts should have a detailed surveillance strategy encompassing all aspects of their surveillance activity whether this is local in origin or directed towards national objectives.

Criterion 9.1

National and local objectives and priorities for targeted surveillance of infection, developed by the Infection Control Team and endorsed by the Infection Control Committee are included in the infection control programme.

It was agreed that this standard did not apply to the Scottish Ambulance Service.

About half of the Trusts provided evidence of infection surveillance activity, with priorities formulated in respect of both local and national objectives. Sections describing planned surveillance activities were included in some infection control programmes.

In the remaining Trusts where surveillance was undertaken, this was not usually formally prioritised.

Some Trusts had appropriate surveillance activity in some, but not all of the sites for which they were responsible; others reported that surveillance was conducted only after identification of specific problems or in response to clinical needs. A few Trusts, in which surveillance did not currently have a high priority, reported plans to develop and implement surveillance programmes.

Met = 15; not met (IE) = 3; not met = 12; not applicable = 1.

Criterion 9.2

Trusts implement surveillance according to the standard national protocols and timetable and provide the national minimum data sets for collation by the Scottish Centre for Infection and Environmental Health (SCIEH).

The current Scottish Centre for Infection and Environmental Health-facilitated national surveillance requirements do not apply to Primary Care Trusts.

Of the remaining Trusts with acute beds, all provided minimum data sets for collation by the Scottish Centre for Infection and Environmental Health in respect of MRSA bacteraemias and, at the time of review visits, about half of them had implemented the requirements with regard to surgical site surveillance.

Met = 11; not met (IE) = 1; not met = 6; not applicable = 13.

Criterion 9.3

Methods of surveillance are defined and in place, which includes continuous 'alert organism', 'alert condition' and 'healthcare associated infection' surveillance covering the whole organisation to prevent and rapidly detect outbreaks and incidents of infection.

About half of the Trusts demonstrated continuous surveillance of alert organism, alert condition and healthcare associated infection intended to prevent and/or rapidly detect outbreaks/incidents of infection and 'near misses' throughout the organisation.

A few Trusts did not meet this criterion either because continuous surveillance was not in place at all sites in the organisation, or because active surveillance of one of the components (usually alert condition) specified in the criterion was missing.

Met = 18; not met (IE) = 4; not met = 8; not applicable = 1.

Criterion 9.4

The confidentiality of patients and staff is maintained at all times in accordance with current codes of practice.

All Trusts adhered to current codes of practice on confidentiality of personal health information.

Met = 31; not met (IE) = 0; not met = 0.

Criterion 9.5

Results of surveillance with interpretation and recommendations are routinely reported to the Infection Control Committee, clinicians, nurses, managers at all levels; surveillance data for inclusion in national data sets are reported to the Scottish Centre for Infection and Environmental Health.

Only seven Trusts had developed satisfactory measures for comprehensive, effective feedback of surveillance findings, along with convincing examples of interpretation and recommendations to all who need to know; this included the provision of data for inclusion in national data sets reported by the Scottish Centre for Infection and Environmental Health.

In general, documented examples of good practice relating to feedback of surveillance activity were rare.

Met = 7; not met (IE) = 4; not met = 19; not applicable = 1.

Criterion 9.6**Any appropriate action is agreed with the Infection Control Team.**

Just over half of the Trusts reported various mechanisms to prove satisfactory involvement of Infection Control Teams in decision making arising from surveillance findings.

Met = 18; not met (IE) = 2; not met = 10; not applicable = 1.

Examples of Local Initiatives**NHS Dumfries & Galloway**

Dumfries & Galloway were well ahead of the field in surgical site infection surveillance prior to the national directive, being jointly funded by the Health Board and the Acute Trust to progress this work. Funding from the Scottish Executive Health Department also enabled them to participate as one of the two pilot sites for orthopaedic surgical site infection surveillance. They began electronic transfer to the Scottish Centre for Infection and Environmental Health of the national data set in January 2002.

Lanarkshire Acute Hospitals NHS Trust

Wound surveillance reports, detailing monthly infection rates for clean effective surgery, are compiled within the Clinical Audit Department using data collected by the Wound Surveillance Nurse. These reports are distributed on a monthly basis to various groups of staff from theatres and surgical and orthopaedic wards. Meetings are held between infection control doctors and nurses and various members of clinical, managerial and clinical audit staff, to discuss suspected increases in the incidence of infection. Recommendations are made, action points agreed and follow-up meetings held to review implementation of the action plans.

2.10 Standard 10: Processes: Infection Control Report

Standard Statement

A comprehensive infection control report is produced by the Infection Control Team on an annual basis, reviewed by the Risk Management Committee/Group and presented to the Trust Chief Executive.

Strength

- A few Trusts have produced comprehensive infection control reports and have ensured their transmission through the risk management process.

Challenge

- All Trusts must ensure that the infection control reports reflect the progress of the infection control programme and highlight additional risks that occur randomly.

Recommendations

Trusts should:

- Produce an annual infection control report on all infection control matters/concerns, including the components listed in the standard.
- Ensure that the Trust Risk Management Committee fully reviews the annual infection control report and prioritises infection control issues for incorporation into business plans and other Trust strategy documents.

Criterion 10.1

The annual infection control report contains, as a minimum, information on the following:

- Any recommendations made on measures taken to prevent recurrence of incidents.
- A review of reported adverse incidents, including reports by external agencies, eg environmental health departments.
- Progress of the infection control programme.
- Results of audit and proposed action plans.
- Surveillance reports.
- Education and training undertaken.

Only five Trusts produced infection control reports based on an infection control programme and including the elements described in the standard. Many Trusts were, however, in mid-cycle and expected to produce and approve infection control reports in 2003.

Met = 5; not met (IE) = 0; not met = 26.

Criterion 10.2**The report is submitted to the Risk Management Committee/Group for review.**

Only six Trusts had annual infection control reports that were submitted for review to Risk Management Groups or Committees. On many occasions, there was no infection control report which could have been submitted.

Met = 6; not met (IE) = 1; not met = 24.

Criterion 10.3**The Risk Management Committee/Group brings any significant risks or other issues to the Trust Chief Executive's attention.**

Risk management systems are still evolving in many Trusts and, hence, proof of their involvement in bringing infection control issues to the Trust Chief Executive's attention was demonstrated in very few cases.

Met = 9; not met (IE) = 3; not met = 19.

2.11 Standard 11: Capability: Legislation & Guidance

Standard Statement

The Infection Control Committee and Infection Control Team have access to up-to-date legislation and guidance relevant to infection control.

Strength

- All Trusts confirmed access to appropriate supporting reference materials.

Challenge

- Trusts should continue to provide regular updates on infection control legislation and guidance and should ensure that all staff are aware of these.

Criterion 11.1

The Infection Control Committee and Infection Control Team have access to all current up-to-date legislation and guidance including the Scottish Infection Manual.

All Trusts provided satisfactory evidence that Infection Control Committees/Infection Control Teams have access to current up-to-date legislation and guidance by a wide variety of mechanisms.

Met = 31; not met (IE) = 0; not met = 0.

Criterion 11.2

As a minimum, the Infection Control Committee and Infection Control Team have access to the key references listed on the back pages of these standards.

All key references were readily accessible by Infection Control Teams and were comprehensively collated. Most Trusts reported effective mechanisms for Trust Chief Executives and medical and nursing directors to 'cascade' important information to infection control staff.

Met = 31; not met (IE) = 0; not met = 0.

2.12 Standard 12: Capability: Education

Standard Statement

Education in infection control is provided to all healthcare staff, including those employed in support services, where appropriate.

Strength

- Infection control is included in the induction programmes of most Trusts.

Challenges

Trusts should ensure that:

- all staff, especially medical staff, attend induction programmes which have an infection control content appropriate to different staff groups;
- in induction programmes the time allocated for infection control is adequate for all staff;
- infection control and antimicrobial prescribing are included in postgraduate medical and dental education programmes; and
- mechanisms are devised for ongoing infection control education for doctors and dentists in the primary care setting.

Recommendations

Trusts should:

- Allocate at least one hour during induction programmes to cover infection control issues including hand hygiene and sharps awareness, and should deal with other HAI issues such as resistant organisms, nosocomial pneumonias, Legionella, outbreak procedures etc.
- Ensure that updates on infection control and antimicrobial prescribing are essential topics for annual inclusion in postgraduate medical and dental education programmes. Trusts should ensure that at least one hour for **each** topic is undertaken by all junior grade and most senior grade doctors each year.
- Negotiate with general medical and dental practitioners to provide regular update sessions on infection control and antimicrobial prophylaxis.

Criterion 12.1

Infection control education corresponding to work activity is included in induction programmes for new staff, including support service staff.

About two thirds of Trusts had induction programmes which included infection control education, but mechanisms did not always ensure that **all** staff were included. Generally, infection control content, if present, was minimal in inductions for medical staff.

Met = 18; not met (IE) = 3; not met = 10.

Criterion 12.2

There is a programme of ongoing education for existing staff, including update of: policies/procedures/guidelines; risk assessment and incident management; feedback of audit results and the action needed to correct deficiencies.

A third of Trusts had programmes of ongoing education in infection control which included updates on policies/procedures/guidelines, risk assessment and incident management, audit results and actions to correct deficiencies. The other two thirds of Trusts had ad hoc arrangements which provided updates on a random basis to small groups of staff but had no formal programme.

Met = 10; not met (IE) = 2; not met = 19.

Criterion 12.3

Infection control and antimicrobial prescribing is part of the Trust's postgraduate medical and dental education programme.

Only nine Trusts included infection control and antimicrobial prescribing as topics for postgraduate medical and dental education programmes.

In Primary Care Trusts it was generally the case that no postgraduate programmes existed and Trusts found it difficult to influence primary care practitioners in infection control and antimicrobial prescribing education. Only rarely did practitioners request educational sessions.

Met = 9; not met (IE) = 0; not met = 21; not applicable = 1.

Criterion 12.4**Records are kept of attendance of all staff on infection control education programmes.**

Records of attendance at infection control educational sessions were well kept in most Trusts. Where deficiencies existed it was usually the result of partial record keeping rather than absence.

Met = 24; not met (IE) = 2; not met = 5.

Examples of Local Initiatives**Forth Valley Acute Hospitals NHS Trust**

The Trust has an established infection control link nurse course delivered in conjunction with the University of Stirling.

Forth Valley Primary Care NHS Trust

The review team commended the locally developed Community Resource for Education, Audit, and Teamwork (CREATE) education system in Forth Valley. The CREATE programme enables protected time (half-day per month) of designated training sessions for clinicians in general practice. Sessions are prioritised by general practices and, as a result, are user-led, needs assessed and targeted. Antimicrobial prescribing training is incorporated into CREATE guidance.

South Glasgow University Hospitals NHS Trust

The Trust delivers a comprehensive range of infection control training. This includes education updates for all groups of staff, tailored to their needs and work schedule. Updates cover a set of core issues (hand washing, standard precautions, isolation, sharps management, MRSA and alert organisms), and the infection control nurses write to each department, asking them to identify any other topics they would like to be covered and the times that would suit them for the training to be delivered.

The Trust also provides an infection control training course for nursing auxiliaries. The course runs for one hour per week over six weeks and covers the following topics: basic bacteriology and modes of transmission; hand washing and protective clothing; cleaning, disinfection and sterilisation; general principles of infection control; food hygiene and isolation.

Yorkhill NHS Trust

Once a month, the Infection Control Team provides infection control training for general services staff. Both new starts and existing staff are given the opportunity to attend. The session lasts one hour and covers a broad range of topics in relation to the protection of both patients and staff. The review team noted that an adapted version of this training is offered to other groups, including volunteer workers and parents.

Shetland NHS Board

There is a wide-ranging one hour infection control session with senior house officers during induction. Topics covered include universal infection control precautions, hospital associated infection, surveillance, hand washing, clinical waste and sharps.

2.13 Standard 13: Monitoring & Review

Standard Statement

The system in place for control of infection is monitored and reviewed by management in order to make improvements to the system.

Strength

- Some Trusts have demonstrated good practice by recognising the need for major managerial reviews of the infection control system, and have started to address this need.

Challenge

- Trusts must define clear roles for Risk Management and Clinical Governance Committees in the monitoring and review of all aspects of their infection control system, and ensure that this management review of infection control is carried out regularly.

Recommendations

Trusts should:

- Integrate risk management systems into review of infection control systems.
- Ensure that Chairs of Infection Control Committees should be members of Risk Management Committees/Groups and Chairs of Risk Management Groups, or risk managers/directors should be members of the Infection Control Committee.
- Ensure there is a fail-safe mechanism whereby Infection Control Committee concerns, as reflected in minutes, become agenda items for Risk Management Groups and Clinical Governance Committees, this mechanism being independent of personalities.
- Ensure that management review does not stop at the Risk Management Group level — there must be full consideration of the infection control system at Trust Management Team level.

Criterion 13.1

Monitoring and review of the infection control system includes:

- **Accountability arrangements.**
- **Capability.**
- **Internal audit findings.**
- **Outcomes.**
- **Processes, including risk management arrangements.**

Less than a quarter of Trusts demonstrated senior management monitoring and review of infection control matters relating to accountability arrangements, capability of the infection control system to perform efficiently, audit of the system and its outcomes and process. In the few examples of good practice seen, identified persons or groups had been given specific responsibility for this activity.

In many Trusts, there was no attempt to review the infection control system; in others, periodic reviews of parts of the infection control service had been undertaken but had not apparently led to changes or improvements.

Met = 7; not met (IE) = 0; not met = 24.

Criterion 13.2

The Infection Control Committee reviews the detailed issues surrounding infection control.

A third of Trusts demonstrated a review by the Infection Control Committee of the outcome of a management review process.

In seven Trusts, action/business plans for the infection control system were being developed and, where this occurred, the Infection Control Committee was integrally involved.

Met = 11; not met (IE) = 0; not met = 20.

Criterion 13.3

The Risk Management Committee/Group plays a significant role in monitoring and reviewing all aspects of the system as a basis for establishing significant information that is presented to, and dealt with by the Trust management and the Chief Executive.

There were only four Trusts in which Risk Management Committees/Groups played a significant role in reviewing infection control matters. However, most Trusts had recognised the deficiency in this area and were working to set up suitable systems through the risk management process and, hence, to Trust management.

Met = 4; not met (IE) = 3; not met = 24.

Criterion 13.4

The Clinical Governance Committee plays a significant role in monitoring and reviewing control of infection as it impacts on the quality of clinical service provision.

There were only six Trusts in which the Clinical Governance Committee played a significant role in monitoring and reviewing control of infection as it impacted on the quality of service provision. However, much work was underway in many Trusts to correct this deficiency and it was clear that Clinical Governance Committee involvement sometimes occurred but was not documented.

Met = 6; not met (IE) = 1; not met = 24.

Criterion 13.5

Infection control audits and findings are reviewed by the relevant Trust committee.

Only three Trusts reviewed infection control audits; in these cases, it was by an Audit Committee or by the Clinical Governance Committee.

Met = 3; not met (IE) = 1; not met = 27.

2.14 Standard 14: Audit: Internal Audit

Standard Statement

The Trust Internal Auditor carries out periodic audits to provide assurance that a system of infection control which conforms to this standard is in place.

Challenge

- All Trusts need to carry out internal audit to provide assurance that the infection control system in their organisation and its internal control mechanisms are satisfactory.

Recommendation

- Trusts should undertake a baseline internal audit of their infection control systems as a matter of urgency, and repeat this audit regularly to ensure actions are addressed.

Criterion 14.1

The Trust Internal Auditor periodically verifies that a suitable and effective system of internal control exists with respect to infection control.

In only seven Trusts had the Internal Auditor/audit service completed a review of the organisation's infection control system and verified that effective internal control systems were in place.

In another four Trusts, recent internal audit of their infection control systems had been undertaken but was not yet reported on.

Met = 7; not met (IE) = 1; not met = 23.

Criterion 14.2

The level of independent audit is based on risk, which will be determined principally by reference to assurances given by the Infection Control Committee and Infection Control Team.

In those Trusts whose infection control system had been reviewed, the level of independent audit was based on risk, with the internal audit measured against either the English NHS Controls Assurance or CSBS infection control standards, and supported by assurances given by Infection Control Team, Infection Control Committee and risk management department.

Met = 7; not met (IE) = 0; not met = 24.

Criterion 14.3

Reports from audits are presented for consideration to the relevant Trust committee with responsibility for internal audit.

In four Trusts, internal audit infection control reports had been submitted for detailed review to the Trust Audit Committee and, in one case, to the Trust Management Team also.

Met = 4; not met (IE) = 0; not met = 27.

Criterion 14.4

The relevant Trust committee submits an annual assurance statement on audit findings for consideration and approval by the Trust. The Trust includes the assurance statement in its annual report.

One Trust had produced a satisfactory assurance statement on infection control for inclusion in its annual report and for signing-off by the Trust Chief Executive.

Met = 1; not met (IE) = 1; not met = 29.

2.15 Standard 15: Practice: Hand Hygiene

Standard Statement

A clear hand hygiene policy and mechanism to ensure effective implementation is in place.

Strength

- Every Trust has a hand hygiene policy and has procedures in place to support hand hygiene.

Challenges

Trusts need to:

- review hand hygiene policies and ensure they include all the components listed in the standard criterion (15.1);
- maintain proactively their support for promoting hand hygiene;
- ensure that induction programmes which include hand hygiene are available for all staff; and
- devise innovative means to assess staff compliance with hand hygiene policies/procedures/guidance.

Recommendations

Trusts should:

- Ensure that education in hand hygiene is mandatory for all staff, at induction and update sessions.
- Hold annual hand hygiene awareness events and provide periodic reminders, such as frequently distributed leaflets, to staff.
- Devise methods for regularly auditing hand hygiene compliance of all staff and should use the audited information (i) to inform their workforce; and (ii) as a basis for risk review/assessment in developing their plans for the infection control system.

Criterion 15.1

There is a hand hygiene policy/procedure/guidelines which reflects the principles of good practice and includes:

- **Hand decontamination immediately before and after every episode of direct patient contact/care or any activity that potentially results in hand contamination.**
- **Use of liquid soap and water for hands visibly soiled or potentially contaminated with dirt or organic material.**

- Use of alcohol-based hand rub or hand washing with liquid soap and water to decontaminate hands between different patients, or between different caring activities on same patient.
- Removal of all wrist and, ideally, hand jewellery at the beginning of each clinical shift before regular hand decontamination begins.
- Covering all cuts and abrasions with a waterproof dressing.
- Effective hand washing technique including: wetting hands under tepid running water before applying liquid soap or antimicrobial preparation; hand wash solution must come into contact with all surfaces of hands; vigorous rubbing of hands for minimum of 10-15 seconds with particular attention to tips of fingers, thumbs and between fingers; thorough rinsing; drying with good quality paper towels.
- Effective alcohol hand rub technique: use only on hands free of dirt and organic material; hand rub solution must come into contact with all surfaces of hands; vigorous rubbing of hands, with particular attention to tips of fingers, thumbs and between fingers, until the solution evaporates and hands are dry.
- Application of an emollient hand cream regularly to protect skin from drying effects of regular hand decontamination.
- Access to occupational health advice in the event of skin irritation caused by a particular soap, antimicrobial hand wash or alcohol product.

The majority of Trusts had hand hygiene policies/procedures/guidance in place, although in one third the policies did not include all of the components specified in this criterion. Exclusions from the policy were usually of minor components.

Met = 19; not met (IE) = 0; not met = 12.

Criterion 15.2**There are arrangements to support and promote hand hygiene by healthcare workers.**

Almost all Trusts had arrangements to support and promote hand hygiene by healthcare workers. Methods varied but included posters appropriately sited in clinical areas, awareness days/weeks, use of ultraviolet light boxes on wards, distribution of leaflets with payslips and special training sessions on new cleaning/disinfecting agents.

Met = 27; not met (IE) = 2; not met = 2.

Criterion 15.3**Induction programmes for all staff include the topic of hand hygiene.**

The topic of hand hygiene was included in induction programmes by most Trusts. However, the amount of time allocated to hand hygiene for medical staff was often limited.

Six Trusts either had no induction programme, relying on induction information packs, or had programmes which were informal and based on voluntary participation.

Met = 25; not met (IE) = 2; not met = 4.

Criterion 15.4**Compliance with hand hygiene policy/procedure/guidelines forms part of the systematic risk review by Trusts.**

Few Trusts could demonstrate systematic risk review of compliance with their hand hygiene policies/procedures/guidelines.

Where Trusts were achieving this standard, both review of hand washing facilities and staff compliance with practice were undertaken.

Met = 4; not met (IE) = 0; not met = 27.

Examples of Local Initiatives

Lanarkshire Acute Hospitals NHS Trust and Lanarkshire Primary Care NHS Trust

Both Trusts in Lanarkshire have implemented a hand hygiene improvement project, developed by a working group of the Area Control of Communicable Diseases Committee (ACCDC) in response to MEL(1999)39. The main objectives of the project are as follows:

- review and re-distribute the hand hygiene section of the control of infection manual;
- revise the in-service education programme;
- develop a hand washing information leaflet for patients;
- audit hand washing facilities;
- assess staff knowledge of hand hygiene issues; and
- monitor hand washing technique using an ultraviolet light box.

Chapter 3

Conclusions



This national overview, and the accompanying local reports, set out the performance of NHSScotland as a whole and of each Trust against the Healthcare Associated Infection (HAI) infection control standards published by CSBS in December 2001. A number of general themes have emerged which apply across the country:

First, without exception the three review teams were struck by the commitment, dedication and hard work of the staff involved in providing infection control services, frequently under great pressure. Wherever possible these services seek to be responsive to staff and patient needs and a number of innovative service developments were seen during visits. However, all too often the provision of these services depends on a very few enthusiastic individuals and these key staff spend too long covering too many clinical areas at operational level. The review teams concluded that the Trusts need to refocus on:

- directing the Trust's infection control programme, involving staff and patients in this;
- reporting on progress towards meeting key targets and objectives; and
- implementing audit-driven changes that will lead to improvements in the quality and effectiveness of infection control services.

Second, members of the public have been involved at every stage of the HAI infection control project. This has provided a valuable perspective to the work of the HAI Reference Group in setting standards and on review visits. It has also given members of the public a chance to contribute to all aspects of the review process, rather than just to receive a report, prepared without their input.

Third, it is clear that many policies and procedures have been developed. These are underpinned by easy reference guides and aides-mémoire for all staff. The review team concluded that a review of these policies and procedures is required in the wake of CSBS visits, to make sure they comply with the standards, they are in use and that all staff are aware of them, and that compliance is monitored.

Fourth, there is already evidence that, although time-consuming for all involved, the standards and self-assessment are being used as a tool locally to monitor progress, and in many sites, preparing for the visit has brought staff together. While Trusts are working on several infection control requirements at present, the development of the standards and review of performance is a core activity and a 'buzz' and enthusiasm was evident in many Trusts to work together to achieve changes and improvements.

It was not until the late 1980s and into the 1990s that infection control nurses were to be found in most acute hospitals. Since then, there has been a growing public and health professional awareness of the consequences of infections, particularly now that more is understood about diseases such as Bovine Spongiform Encephalopathy (BSE) and variant Creutzfeldt Jacob Disease (vCJD). One of the main aims of this review was to find out whether "*there is a managed environment which minimises the risk of infection to patients, staff and visitors*". The review teams concluded that there is much in place to ensure this. This report provides a road map, based on evidence, and provides direction for the next phase of work – vital if NHSScotland is to achieve effective infection prevention and control.

CSBS looks to each Trust, guided by its Clinical Governance Committee, to ensure that, in close collaboration with the staff responsible for providing the service, practice is reviewed in the light of the report's findings and recommendations and appropriate action is taken. Considerable momentum has built up, and it is important to use this enthusiasm to take forward the work on strengthening and improving infection control.

Each NHS Board is responsible for the performance of its local NHS services and is accountable to the Scottish Executive Health Department who will use the reports, and local responses to them, to monitor local and national performance. The public, both locally and nationally, also have an important role to play in ensuring that changes are made.

CSBS reserves the right to revisit a Trust where it considers there are serious issues that need further external monitoring and report. CSBS intends periodically to review and raise its standards, in light of the latest evidence about best practice and the performance of the service, and to conduct further national reviews so as to encourage continuing quality improvement.

Appendices



Healthcare Associated Infection Reference Group Members

Chair

Dr David Old

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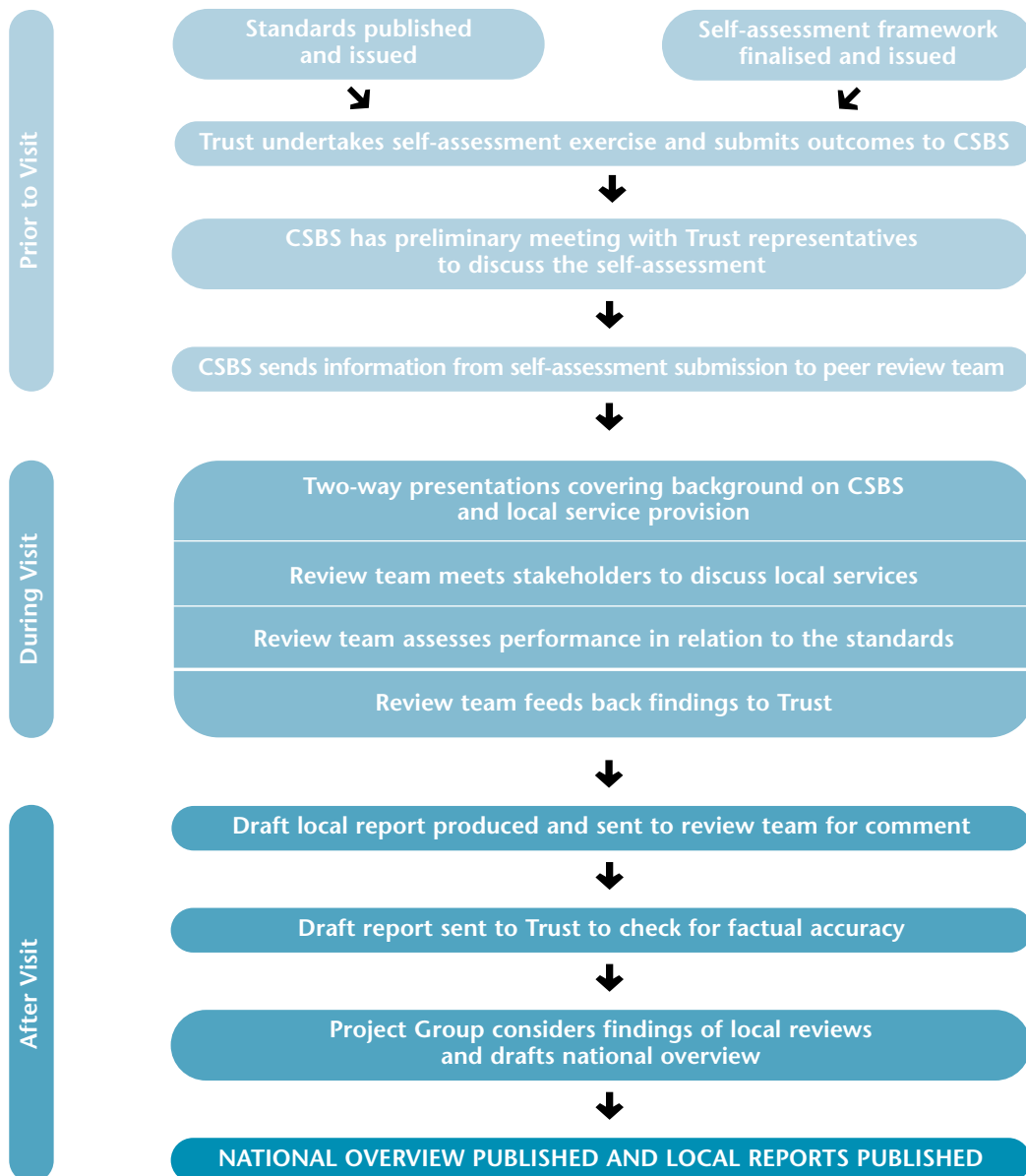
Dr Iain Wallace

Medical Director, Greater Glasgow Primary Care Trust

The CSBS Board member specifically working with the HAI Reference Group was **Mr Gordon Jamieson**.

Dr David Steel (Chief Executive), **Mr Sean Doherty** (Review Team Manager), **Ms Clare Echlin** (Senior Project Officer), **Miss Jan Nicolson** (Project Officer), **Miss Joanne Storrar** (Project Officer) and **Miss Alison Stout** (Project Officer) provided support from CSBS.

CSBS Quality Assurance: The Approach Used in this Review



Standards

All standards set by CSBS comprise a standard statement and related criteria.

Standard Statement

Describes the agreed performance for the specific area, determined by those who are involved in the delivery/receipt of the service.

Criteria

State exactly what must be done for the standard to be reached.

Some criteria are essential as it is expected that they will be met wherever a service is provided. Others are desirable/aspirational in that they will promote continuous quality improvement as they are being met in some parts of the service and demonstrate levels of quality which other providers of a similar service should strive to achieve. Each project group is responsible for determining which criteria are essential and which are desirable. In the case of the infection control standards, the HAI Reference Group considered all criteria were essential.

Self-Assessment

Each set of standards has an accompanying self-assessment framework developed by CSBS. This framework gives guidance about the type of evidence required to demonstrate performance against the standards. It is completed and submitted to CSBS prior to a peer review visit, together with extensive additional documentation. The evidence obtained from this self-assessment exercise comprises the main source of written evidence considered by each peer review team.

Peer Review

Peer review is the process by which a multidisciplinary review team carries out a review visit to validate the information submitted through self-assessment. Each review team is comprised of healthcare professionals and members of the public. All CSBS reviewers complete reviewer training designed and delivered by CSBS executive directors and management/training consultants.

Three review teams, led by a Review Team Leader and Advisor, were established to conduct the extensive programme of 33 infection control review visits across Scotland. During each visit, the Review Team Leader and Advisor guided the team to ensure a consensual agreement was reached and to provide necessary expert advice when dealing with complex infection control issues. At the conclusion of the visit, the review team provided feedback to the Trust giving a broad overview of their findings which was based on the written self-assessment and the evidence obtained during the review visit.

To enhance the consistency of the process, a CSBS manager and designated Project Officer accompanied each visit; and in addition provided the secretariat and developmental support for the project group during the standard-setting phase of the project. A non-executive member of CSBS also attended as an observer on a number of visits in order to provide progress reports to the CSBS Board.

The schedule for a HAI external peer review visit included:

- pre-visit meeting with key personnel responsible for the service under review to discuss the visit and self-assessment framework;
- table-top discussions with clinicians, audit staff and managers based on the written evidence;
- scrutiny of documentation;
- interviews with staff members at ward/departmental areas;
- regular team briefings throughout the day to assess progress and to compile the local report; and
- feedback to Trust representatives on conclusion of the visit.

The review team for each peer review visit comprised of different infection control personnel including infection control nurses and infection control doctors. Although this presents challenges in achieving consistency of process, it promotes sharing of good practice and ensures that each review team assesses the performance of a particular Trust against the standards, not by comparing one Trust with another.

In order to determine whether a particular criterion is 'met' or 'not met', each review team requires to identify evidence on a variety of levels. For example, to demonstrate that a particular issue is addressed in a local protocol, evidence is sought during the peer review process as follows:

- description of the issue and how it should be managed in a local written protocol (submitted as part of the self-assessment);
- confirmation of awareness of the location and content of the protocol through staff interviews;
- evidence of a process in place for the protocol to be regularly updated; and
- collection of data through an integrated care pathway/audit sheet, leading to provision of collated audit data confirming compliance with the local protocol.

The responsibility of CSBS is to report whether the services provided by NHSScotland – nationally and locally – meet agreed standards, but not to review individual cases or the work of individual healthcare professionals. In achieving this aim, variations in practice (and potentially quality) within a service will be encountered. Where such variation exists between hospitals (eg between hospitals within a Trust, this will be stated; treatment variations will also be reported but will not identify individual patients or healthcare professionals.

Reports

A local written report was drafted at the time of each visit by CSBS. The draft report was then circulated to the review team for comment, and to the Trust concerned to allow a check for factual accuracy. As this was the first review of Trusts against the infection control standards, some aspects of the process were refined during the course of the peer review programme. Where these refinements had implications for the assessment process, they had to be retrospectively applied to ensure consistency and equity of application across all visits.

Key Developments: Healthcare Associated Infection 1995-2003

Date	Key Developments	Health Department Letters (HDLs)/Reports
1995	SEHD Advisory Group on Infection established by the Chief Medical Officer to assist in the provision of professional advice.	Scottish Infection Manual, 1998.
1999	SEHD Working Group established to examine decontamination services throughout the NHS in Scotland, in response to concerns about the transmission of vCJD. Commissioned a pilot review of 15 hospital and primary care sites, which highlighted serious shortcomings in relation to decontamination services.	Report on " <i>The Decontamination of Surgical Instruments and Re-usable Medical Devices</i> ", February 2001. HDL(2001)10
1999	Cleaning services reviewed by Audit Scotland.	" <i>A Clean Bill of Health? A Review of Domestic Services in Scottish Hospitals</i> ", April 2000.
November 2000	Carey Group established to "address and make recommendations for a comprehensive framework for managing risk in healthcare settings with respect to infection control, decontamination and cleaning services". Recommended that NHSScotland adopt a standard approach to risk management in relation to healthcare associated infection and set out draft standards for infection control, cleaning services and decontamination.	Carey Report, " <i>Managing the Risk of Healthcare Associated Infection in NHSScotland</i> ", August 2001. HDL(2001)53
December 2000	Glennie Group established to "consider NHSScotland sterile services provision". Report included risk categorisation in relation to vCJD. Interim technical requirements (to be put in place by June 2002) and full technical requirements (to be put in place by March 2004) for each category of risk were specified.	" <i>NHSScotland: Sterile Services Provision Review Group: 1st Report – The Glennie Framework</i> ". HDL(2001)66
June 2001	SCIEH commissioned by SEHD to carry out baseline assessment of decontamination processes in all Acute Trusts and Island Health Boards.	
June 2001	CSBS Healthcare Associated Infection Reference Group established.	Published standards on Infection Control (December 2001) and Cleaning Services, June 2002.
July 2001	Subgroup of SEHD's Advisory Group on Infection established to "advise on the development of a national framework for surveillance in Scotland". Recommended that Acute Trusts and Island Health Boards should: <ul style="list-style-type: none"> • Report data on MRSA bloodstream infections by April 2002. • Implement surveillance of surgical site infections in relation to at least two surgical procedures (one of which should be orthopaedic) and report by April 2003. • Plan for surveillance of neurosurgery in four relevant Trusts. 	" <i>A Framework for National Surveillance of Healthcare Associated Infection in Scotland</i> ", July 2001. HDL(2001)57
August 2001	In response to the Framework, SCIEH established a multidisciplinary Scottish Surveillance of Healthcare Associated Infection Programme (SSHAIP) team, to facilitate the collection of standardised surveillance data by Trusts, for national reporting. National Healthcare Associated Infection Surveillance Steering Group set up to monitor and advise SEHD on the progress of SSHAIP.	

continued overleaf

Date	Key Developments	Health Department Letters (HDLs)/Reports
March-May 2002	Follow-up review of cleaning services by Audit Scotland, including a review of performance against CSBS cleaning services standards.	Audit Scotland report due January 2003.
April-October 2002	First round of national review of performance against CSBS infection control standards.	
May 2002	Watt Group established to "review the circumstances surrounding the onset of the outbreak of salmonella infection at the Victoria Infirmary, Glasgow, in December 2001 and January 2002 and identify the likely causal factors". The " <i>Watt Group Report</i> " was published along with the Scottish Executive's action plan to reduce the risk to patients, staff and visitors from healthcare associated infection, and an HAI and patient care environment questionnaire.	Action Plan, " <i>Preventing Infections Acquired While Receiving Health Care</i> ", November 2002. The " <i>Watt Group Report</i> ", November 2002. HDL(2002)82
August 2002	Tannahill Group formed to develop draft national standards for control of infection in the non-NHS adult care sector, for appropriate inclusion in the monitoring of care providers by the Scottish Regulation of Care Commission.	Draft standards launched November 2002.
2003	HDL(2002)82 specified the establishment of an HAI Task Force, to be chaired by the Chief Medical Officer. The Task force is due to have its first meeting in January 2003, and is a major 3-year project which has been charged with overseeing development and implementation of a wide range of policies and strategies for control of HAI, including issues raised by the Watt Report and the Ministerial Convention on HAI (June 2002). Many areas of work are already in progress. The aim is to produce an integrated approach to the problem through multidisciplinary working and by building directly on achievements already in place.	

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Glossary of Terms

accountability	Answerability. Responsibility to someone for an activity or service performed.
accreditation	A process, based on a system of external peer review using written standards, designed to assess the quality of an activity, service or organisation.
ACDP	Advisory Committee on Dangerous Pathogens.
acute sector	Hospital-based health services which are provided on an in-patient or out-patient basis.
adverse event	An unfavourable incident or situation, which occurs in a particular place during a particular interval of time.
AHP	See allied health professions.
alert organisms	Key indicators of infection control.
allied health professions (AHP)	Healthcare professionals directly involved in the provision of primary and secondary healthcare. Includes several groups such as physiotherapists, occupational therapists, dieticians, etc. Formerly known as professions allied to medicine (PAM).
antimicrobial	An agent that kills micro-organisms.
aseptic technique	A method of carrying out sterile procedures so that there is the minimum risk of introducing infection.
assessment	The process of measuring patients' needs and/or the quality of an activity, service or organisation.
assurance statement	A written declaration of confidence in an organisation.
audit	Systematic review of the procedures used for diagnosis, care, treatment and rehabilitation, examining how associated resources are used and investigating the effect care has on the outcome and quality of life for the patient.

Audit Scotland	Audit Scotland was set up on 1 April 2000 to provide services to the Accounts Commission and the Auditor General for Scotland. Together they help to ensure that the Scottish Executive and public sector bodies in Scotland are held to account for the proper, efficient and effective use of public funds.
bacteraemia	When bacteria are present in the bloodstream.
benchmarking	Use of a standard or point of reference for the purpose of comparison, usually in the context of improving performance.
BSE	Bovine Spongiform Encephalopathy.
CA	See controls assurance.
carer	A person who looks after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid.
catheterisation	The insertion of a hollow tube (a catheter) into an organ of the body – for example the bladder, either for investigational purposes or to give some form of treatment. Performed under strict sterile conditions.
CJD	Creutzfeldt-Jakob Disease.
cleaning	A process which physically removes contamination but does not necessarily destroy micro-organisms. Current routines do not typically quantify the reduction of microbial contamination, which depends upon many factors, including the efficiency of the cleaning process. Cleaning removes micro-organisms and the organic material on which they thrive. It is a necessary pre-requisite of effective disinfection or sterilisation.
clinical governance	A framework through which NHS organisations are accountable for both continuously improving the quality of their services, and safeguarding high standards of care, by creating an environment in which excellence in clinical care will flourish.

Clinical Negligence and Other Risks Indemnity Scheme (CNORIS)	New financial risk sharing arrangements for both clinical and non-clinical risks. Introduced from 1 April 2000 and outlined in MEL(1999)86, issued in December 1999. More detailed information on the Scheme's coverage and operation is set out in MEL(2000)18, which was issued in April 2000. Website address is: www.cnoris.com/
Clinical Pathology Accreditation (CPA)	UK-based company created to set standards for laboratories. It enables an external audit of the ability to provide a service by declaring a defined standard of practice, which is confirmed by peer review.
Clinical Standards Board for Scotland (CSBS)	The Clinical Standards Board for Scotland was a statutory body, established as a Special Health Board in April 1999. Its role, in line with the Scottish Executive's commitment to quality, openness and public accountability, was to "promote public confidence that the services provided by the NHS are safe and that they meet nationally agreed standards, and to demonstrate that, within the resources available, the NHS is delivering the highest possible standards of care".
CNORIS	See Clinical Negligence and Other Risks Indemnity Scheme.
college	In the UK, the term college, when used relating to healthcare, as for example in "The Royal College of...", refers to organisations which usually combine an education role with promotion of professional standards.
controls assurance (CA)	The system of management of risk which is used in NHS (England) based on best governance practice and Internal Control. It exists to inform NHS (England) boards about significant risks within the organisation for which they are responsible. It is intended to assist staff to identify risks, to help them to determine unacceptable levels of risk, and to decide on where best to direct resources to eliminate or reduce those risks. The use of self-assessment techniques is fundamental to the process in ensuring that objectives are met and risks are properly controlled.
cost	Cost of activities, both direct and indirect, involving any negative impact, including money, time, labour, disruption, goodwill, political and intangible loss.

CPA	See Clinical Pathology Accreditation.
criterion(s)/ criteria(pl)	Provide the more detailed and practical information on how to achieve the standard, and relate to structure, process or outcome factors.
CSBS	See Clinical Standards Board for Scotland.
data set	A list of required and specific information.
data source	The source of evidence to demonstrate whether a standard or criterion is being met.
decontamination	A process which removes or destroys contamination and thereby prevents micro-organisms or other contaminants reaching a susceptible site in sufficient quantities to initiate infection or any other harmful response. Three processes of decontamination are commonly used; cleaning, disinfection and sterilisation.
desirable (criterion/criteria)	Good practice that is being achieved in some parts of the service and demonstrates levels of quality to which other providers of a similar service should strive.
diagnosis	Identification of an illness or health problem by means of its signs and symptoms. This involves ruling out other illnesses and causal factors for the symptoms.
discharge	A discharge marks the end of an episode of care. Types of discharge include in-patient discharge, day-case discharge, day-patient discharge, out-patient discharge and allied health professions (see AHP) discharge.
disinfection	A process used to reduce the number of viable micro-organisms but which may not necessarily inactivate some microbial agents, such as certain viruses and bacterial spores. Disinfection may not achieve the same reduction in microbial contamination levels as sterilisation.
essential (criterion/criteria)	A criterion that should be met wherever a service is provided.
evaluation	The study of the performance of a service (or element of treatment and care) with the aim of identifying successful and problem areas of activity.

evidence-based medicine	Evidence-based clinical practice is an approach to decision making in which the clinician uses the best evidence available, in consultation with the patient, to decide upon the option which suits that patient best.
generic standards	Standards that apply to most, if not all, clinical services.
GP	General Practitioner.
guidelines	Statements which help in deciding how to treat particular conditions.
HAI	See healthcare associated infection
hand hygiene	Hand hygiene is a term used to encompass all methods of hand decontamination. It includes hand washing using water and soap or a detergent-based cleanser, with or without antimicrobial activity, or an alcohol-based hand disinfectant.
HDL	See Health Department Letter.
Health Council	Each NHS Board area has a Health Council, an organisation whose aim is to promote public consultation and participation in health-related matters. Sometimes referred to as a Local Health Council.
Health Department Letter (HDL)	Health Department Letter (formerly known as Management Executive Letter – MEL), formal communications from the Scottish Executive Health Department to NHSScotland.
healthcare associated infection (HAI)	Infection acquired in the hospital or other healthcare setting.
healthcare professional	A person qualified in a health discipline.
ICC	Infection Control Committee.
ICD	Infection Control Doctor.
ICN	Infection Control Nurse.
ICP	Infection Control Programme.
ICT	Infection Control Team.
IE	See insufficient evidence.

incidence (of infection)	Rate at which new cases occur.
induction programme	Learning activities designed to enable newly appointed staff to function effectively in their new job.
infection	The entry into the body of a micro-organism (eg bacteria, virus, parasite) and its establishment and growth in the tissues, causing harm.
Information and Statistics Division (ISD)	The Information and Statistics Division is part of the Common Services Agency, National Health Service in Scotland. Health service activity, manpower and finance data are collected, validated, interpreted and disseminated by the division. These data are received from NHS Boards, NHS Trusts and general practices. Website address: www.show.scot.nhs.uk/isd/index.htm
insufficient evidence (IE)	Where an organisation under review has been unable to present evidence, the review team is able to class certain standard criteria as being neither 'met' nor 'not met', and records a note of 'insufficient evidence'.
intraocular	Within the eye.
ISD	See Information and Statistics Division.
Island NHS Board	Island NHS Boards do the work of both NHS Boards and Trusts, in that they have a strategic and operational role. There are three Island NHS Boards, covering Shetland, Orkney, and the Western Isles.
IT	Information Technology.
LHCC	See Local Health Care Co-operative.
likelihood	Used as a qualitative description of probability or frequency.
Local Health Care Co-operative (LHCC)	A grouping of general medical practices.
loss	Any negative consequence, financial or otherwise.
Managed Clinical Network	A formally organised network of clinicians. The main function is to audit performance on the basis of standards and guidelines, with the aim of improving healthcare across a wide geographic area, or for specific conditions.

Management Executive Letter (MEL)	Formal communications from the Scottish Executive Health Department to NHSScotland, now known as Health Department Letters (HDLs).
mandatory (guidance)	Compulsory (guidance) but not required by law.
MEL	See Management Executive Letter.
microbial	Relating to micro-organisms or germs.
microbiologist	Someone who specialises in the science of microbiology. See microbiology.
microbiology	The science of micro-organisms. Microbiology in relation to medicine is concerned mainly with the isolation and identification of the micro-organisms that cause disease.
micro-organism	Microscopic organisms of medical interest including bacteria, viruses, algae, fungi and protozoa.
monitoring	The systematic process of collecting information on clinical and non-clinical performance. Monitoring may be intermittent or continuous. It may also be undertaken in relation to specific incidents of concern or to check key performance areas.
multidisciplinary	A multidisciplinary team is a group of people from different disciplines (both healthcare and non-healthcare) who work together to provide care for patients with a particular condition. The composition of multidisciplinary teams will vary according to many factors. These include: the specific condition, the scale of the service being provided, and geographical/socio-economic factors in the local area.
NHS	National Health Service.
NHS Board	NHS Boards replaced the separate board structures of Health Boards and NHS Trusts. The NHS Boards cover the same geographical area as the old Health Boards. The overall purpose of NHS Boards is to ensure the efficient, effective and accountable governance of the local NHS system, and to provide strategic leadership and direction for the system as a whole, focusing on agreed outcomes.

NHS priorities	The three national clinical priorities are mental health; coronary heart disease and stroke; and cancer.
NHSScotland	The National Health Service in Scotland.
pathogenic	Capable of causing disease.
pathology	The study of disease processes with the aim of understanding their nature and causes. This is achieved by observing samples of blood, urine, faeces, and diseased tissue obtained from the living patient or at autopsy, by the use of X-rays, and by many other techniques.
patient	A person who is receiving care or medical treatment. A person who is registered with a doctor, dentist, or other healthcare professional, and is treated by him/her when necessary. Sometimes referred to as a user.
patient journey	The pathway through the health services taken by the patient (the person who is receiving treatment), and as viewed by the patient.
PCT	Primary Care Trust. See Trust and Primary Care.
peer review	Review of a service by those with expertise and experience in that service, either as a provider, user or carer, but who are not involved in its provision in the area under review. In the CSBS approach, all members of a review team are equal.
Performance Assessment Framework	The method used within NHSScotland to measure performance of Trusts and Health Boards (NHS Unified Boards) against agreed indicators.
physician	A specialist in medicine.
policy	An operational statement of intent in a given situation.
primary care	The conventional first point of contact between a patient and the NHS. This is the component of care delivered to patients outside hospitals and is typically, though by no means exclusively, delivered through general practices. Primary care services are the most frequently used of all services provided by the NHS. Primary care encompasses a range of family health services provided by family doctors, dentists, pharmacists, optometrists and ophthalmic medical practitioners.

probability	Probability is the chance or likelihood of a specific event or outcome measured by the ratio of specific events or outcomes to the total number of possible events or outcomes. Probabilities may vary in value from 0 (no chance) to 1 (certain). It is sometimes expressed as a percentage.
professions allied to medicine (PAM)	Healthcare professionals directly involved in the provision of primary and secondary healthcare. Includes several groups such as physiotherapists, occupational therapists, dieticians, etc. Now called allied health professionals (AHPs). See allied health professions.
protocol	A policy or strategy which defines appropriate action in specific circumstances, such as hand washing or assessment. These may be national, or agreed locally to take into account local requirements.
quality assurance (QA)	Improving performance and preventing problems through planned and systematic activities including documentation, training and review.
Quality Assurance Manual	Document outlining the methods and procedures to be used in setting standards and reviewing services.
rationale	Scientific/objective reason for taking specific action.
referral	The process whereby a patient is transferred from one professional to another, usually for specialist advice and/or treatment.
review	See peer review.
risk	The chance of something happening that will have an impact (good or bad) upon objectives. Risk is measured in terms of its consequences and likelihood.
risk factor	A clearly defined occurrence or characteristic that has been associated with the increased rate of a subsequently occurring disease or health problem. Risk factors include aspects of personal behaviour, lifestyle, environmental exposure, or inborn or inherited characteristics, which are known to be associated with the disease.

risk management	A systematic approach to the management of risk, staff and patient/client/user safety, to reducing loss of life, financial loss, loss of staff availability, loss of availability of buildings or equipment, or loss of reputation.
risk management process	The systematic application of management policies, procedures and practices to the tasks of establishing the context, identifying, analysing, evaluating, treating, monitoring and communicating risk.
risk reduction	A selective application of appropriate techniques and management principles to reduce either likelihood or an occurrence or its consequences, or both.
SCIEH	Scottish Centre for Infection and Environmental Health.
Scottish Executive Health Department (SEHD)	The Scottish Executive Health Department is responsible for health policy and the administration of NHSScotland. Website address: www.show.scot.nhs.uk/sehd/
Scottish Intercollegiate Guidelines Network (SIGN)	SIGN was established in 1993 by the Academy of Royal Colleges and Faculties in Scotland, to sponsor and support the development of evidence-based clinical guidelines for NHSScotland. Where a SIGN guideline exists for a specialty or service for which standards are being set, it will be referenced. For further information relating to SIGN guidelines or the methodology by which SIGN guidelines are developed, contact: SIGN Executive, Royal College of Physicians, 9 Queen Street, Edinburgh EH2 1JQ. Website address: www.sign.ac.uk/
SEAC	Spongiform Encephalopathy Advisory Committee.
secondary care	Care provided in an acute sector setting. See acute sector.
SEHD	See Scottish Executive Health Department.
self-assessment	Assessment of performance against standards by individual/clinical team/Trust providing the service to which the standards are related.
sharps	Medical items such as hypodermic needles, scalpels, and broken bottles, which can present a risk of skin puncture and infection, and so require proper handling and disposal.

SIGN	See Scottish Intercollegiate Guidelines Network.
SIGN guideline	Scottish Intercollegiate Guidelines Network guideline.
Special Health Board	The name is given to Health Boards with a national remit. These boards are focused on specific areas - eg, NHS Education for Scotland, or NHS Quality Improvement Scotland. Special Health Boards match regional NHS Boards in terms of administrative grading.
stakeholders	Those people and organisations who may affect, be affected by or perceive themselves to be affected by a decision or activity.
standard	Required level of quality.
standard statement	An overall statement of desired performance.
statutory	Enacted by statute; depending on statute for its authority as a statutory provision. Required by law.
sterilisation	A process used to render an object free from viable micro-organisms including viruses and bacterial spores.
surveillance	The ongoing systematic collection, analysis and interpretation of health data essential to the planning, implementation, and evaluation of public health practice, closely integrated with the timely dissemination of these data to those who need to know.
Trust	A Trust is an NHS organisation responsible for providing a group of healthcare services for the local population. An acute hospital Trust provides hospital services. A Primary Care Trust delivers primary care/community health services. Mental health services (both hospital and community based) are now usually provided by Primary Care Trusts.
unified Board	See NHS Board.
vCJD	Variant Creutzfeldt-Jakob Disease.
verification	Checking or confirmation of the truth or accuracy of something (eg self-assessment).

Our Commitment

We will:

- involve patients and the public in all parts of our work;
- work with and support NHS staff in improving standards;
- assist NHSScotland in delivering the highest quality of NHS care to each patient;
- base conclusions and recommendations on the best evidence available;
- be open and transparent in all our work through wide circulation of reports written in language that can be understood by all and is jargon free;
- seek to avoid duplication of effort through working closely with other national organisations involved in improving the quality of care within the NHS; and
- ensure our own work is subject to quality assurance and evaluation.



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