

Healthcare Associated Infection (HAI)

Standards

February 2015

 **Evidence**

Healthcare Improvement Scotland is committed to equality and diversity. We have assessed these standards for likely impact on the nine equality protected characteristics as stated in the Equality Act 2010 and defined by age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. A copy of the impact assessment is available upon request from the Healthcare Improvement Scotland Equality and Diversity Advisor.

© Healthcare Improvement Scotland 2015

First published February 2015

The publication is copyright to Healthcare Improvement Scotland. All or part of this publication may be reproduced, free of charge in any format or medium provided it is not for commercial gain. The text may not be changed and must be acknowledged as Healthcare Improvement Scotland copyright with the document's date and title specified.

www.healthcareimprovementscotland.org

Contents

Introduction	4
Development of the HAI standards	7
Standards for HAI	9
Standard 1: Leadership in the prevention and control of infection	9
Standard 2: Education to support the prevention and control of infection	13
Standard 3: Communication between organisations and with the patient or their representative	17
Standard 4: HAI surveillance	21
Standard 5: Antimicrobial stewardship	24
Standard 6: Infection prevention and control policies, procedures and guidance	29
Standard 7: Insertion and maintenance of invasive devices	33
Standard 8: Decontamination	37
Standard 9: Acquisition of equipment	41
References	44
Appendix 1 Membership of the standards for HAI short-life working group	49

Introduction

About Healthcare Improvement Scotland

We believe that every person in Scotland should receive the best healthcare possible every time they come into contact with their health service.

We have a key role in supporting healthcare providers to make sure that their services meet these expectations and continually improve the healthcare the people of Scotland receive.

We are a public body and have four principle functions:

- providing sound evidence for improved healthcare, through the Scottish Medicines Consortium, the Scottish Health Technologies Group, and the Scottish Intercollegiate Guidelines Network
- supporting the delivery of a safer health service and the reliable spread of best practice in quality improvement
- ensuring the effective participation of the public in the design and delivery of healthcare, principally through the Scottish Health Council, and
- scrutinising and quality assuring the provision of healthcare.

Our work programme supports the healthcare priorities of the Scottish Government, in particular those of NHSScotland's Healthcare Quality Strategy and the 2020 Vision.

For more information about our role, direction and priorities, please visit:
www.healthcareimprovementscotland.org/drivingimprovement.aspx¹.

Background to the revision of HAI standards

The prevention and control of infection is everybody's responsibility, with standards being one part of the drive towards a safer NHSScotland. In March 2008, NHS Quality Improvement Scotland published the *National Standards for Healthcare Associated Infection (HAI)*² emphasising the need for all NHS board staff to be involved in infection control initiatives, and since April 2009, the 2008 HAI standards have been applied in inspections of hospitals across NHSScotland. However, the standards were not developed explicitly for this inspection purpose.

The Scottish Government HAI Task Force National Policy Group tasked Healthcare Improvement Scotland with revising the 2008 standards, to ensure clarity around infection prevention and control of HAI, at the point of patient care. The 2015 standards are aligned to the *National Infection Prevention and Control Manual (2013)*³, with content supporting that of the manual, and together they are the key publications for all healthcare organisations to adhere to, to ensure robust HAI practice and policy across all healthcare and social care settings.

These 2015 standards supersede the NHSScotland Code of Practice for the Local Management of Hygiene and Healthcare Associated Infection and all previous HAI

standards produced by Healthcare Improvement Scotland's predecessor organisations.

Scope of the standards

The standards apply to all healthcare organisations and practitioners, including independent healthcare providers, and recognise the role of all patients, their representatives and the public. The standards should be reviewed pragmatically by service providers: ***not every criterion will apply to all settings or all service providers.***

Whilst the standards routinely make mention of specific infection-related policies, organisations should consider the clinically-appropriate policy or policies when implementing and demonstrating compliance to the standards.

The HAI standards have been reviewed against The Vale of Leven Hospital Inquiry Report⁴ published in November 2014, with criteria amended to reflect the recommendations, where appropriate. It should be noted that while the Vale of Leven report gives specific consideration to *Clostridium difficile*, the generic nature of the Healthcare Improvement Scotland HAI standards encompass all HAI infections.

These standards have been developed in recognition of the integration of health and social care services and the principles apply to both health and social care; standards are mandatory for healthcare settings (NHS boards), and considered best practice guidelines for social care settings. For social care settings, the standards should be read in conjunction with *The National Care Standards*⁵, produced by the Scottish Government, and regulated against by the Care Inspectorate.

The Healthcare Improvement Scotland standards for HAI cover the following areas:

- leadership
- education
- communication
- HAI surveillance
- antimicrobial stewardship
- infection prevention and control policies, procedures and guidance
- insertion and maintenance of invasive devices
- decontamination, and
- acquisition of equipment.

These 2015 standards incorporate key areas in line with existing policy and service objectives to allow for:

- ease of application at the point of care
- ease of transfer across all care settings
- the inspection of care settings in the prevention and control of infection, and
- continuous quality improvement.

Information for patients and members of the public

It should be noted that the standards document is a technical document, developed to support staff to ensure the highest standards of infection prevention and control wherever healthcare is delivered. Each standard details what patients, their representatives and the public can expect of healthcare services in Scotland following implementation.

Format of the standards

All our standards follow the same format. Each standard includes a statement of the level of performance to be achieved, a rationale providing reasons why the standard is considered important, and a list of criteria describing the required structures, processes and outcomes. Within these standards, all criteria are considered 'essential' or required in order to demonstrate the standard has been met. At the end of each standard is a list of examples of evidence of achievement (taking either **verbal** or **written** form) matched to specific criterion, which will enable service providers to demonstrate it has met the standard.

Terminology

Readers are advised that, wherever possible, Healthcare Improvement Scotland has incorporated generic terminology which can be applied across all healthcare and social care settings, those being NHS boards and independent healthcare providers. Examples include: infection control committee which should be read as infection control committee **or equivalent** throughout, and infection prevention and control team, which should be read as infection prevention and control team (**or team fulfilling this role**) throughout.

Development of the HAI standards

The development of the HAI standards builds on the current relevant evidence and two previous sets of national standards produced by Healthcare Improvement Scotland's predecessor organisations. Namely, the Clinical Standards Board for Scotland's standards for *Healthcare Associated Infection (HAI) Infection Control*⁶, and NHS Quality Improvement Scotland's standards for *Healthcare Associated Infection (HAI)*² published in 2001 and 2008, respectively.

A short-life working group, chaired by Dr Margaret McGuire (Director of Nursing, NHS Tayside) was convened in January 2014 to consider these and other documents, including the *Prevention and control of healthcare-associated infections: Quality improvement guide*⁷, a National Institute for Health and Clinical Excellence publication, to help identify key themes for standards development.

For information, membership of both the short-life working group and sub-groups is set out in Appendix 1.

To ensure each standard is underpinned with the views and expectations of both patients and the public in relation to HAI, information was gathered from a number of sources, including:

- patient complaints relating to infection control
- a focus group involving members of a public partnership forum, specific to HAI, and
- public partner feedback following inspections carried out by the Healthcare Environment Inspectorate.

This information was provided to each sub-group to inform the standards development process.

Consultation

We contacted professional bodies and independent healthcare organisations (such as The Faculty of Public Health Medicine and St. Columba's Hospice) and healthcare professionals involved in infection prevention and control, requesting feedback using a variety of media, including:

- the Healthcare Improvement Scotland website
- a feedback form provided with the distributed draft standards, and
- a public partnership forum.

Consultation feedback

Comments have been received from a variety of sources, including:

- 13 NHS boards
- the Association of Independent Healthcare Organisations
- the Care Inspectorate, and
- the Association of Antimicrobial Pharmacists Group.

A full consultation report is available from Healthcare Improvement Scotland.

Standards for HAI

Standard 1: Leadership in the prevention and control of infection

Standard statement

The organisation demonstrates leadership and commitment to infection prevention and control to ensure a culture of continuous quality improvement throughout the organisation.

Rationale

Robust leadership in infection prevention and control is essential for effective decision-making, efficient use of resources and ensuring the provision of high quality, safe, effective, person-centred care.

References: 4, 8, 9, 10, 11, 12

Criteria

- 1.1** Executive leaders and their teams have a working knowledge, appropriate to their role in the organisation, of the infection prevention and control policies and procedures as well as the national and local priorities that impact on care within their organisation.
- 1.2** There is an executive board member assigned to lead on infection prevention and control for the organisation.
- 1.3** There are local arrangements to ensure HAI issues are addressed by NHS board management.
- 1.4** There is an infection prevention and control team with the necessary expertise and leadership skills to support the organisation.
- 1.5** The organisation agrees and monitors key performance indicators for infection prevention and control, and executive leadership receives, reports and acts on these.
- 1.6** There is an infection prevention and control accountability framework, approved by executive leadership, which specifies the responsibilities, reporting structure and clinical governance of infection prevention and control risks at all levels in the organisation.
- 1.7** The organisation can demonstrate to patients, their representatives and staff:
 - (a) HAI risk assessments are undertaken to ensure continuity of safe patient care during periods of service planning and reorganisation, and
 - (b) effectiveness and improvement in maintaining a safe care environment.

- 1.8** The organisation can demonstrate effective management of outbreaks, including:
- (a) preparedness
 - (b) assessment of patient care and safety
 - (c) reporting, and
 - (d) remedial action plans.
- 1.9** The organisation has strategic, operational and quality assurance systems, with clinical governance oversight to demonstrate compliance with infection prevention and control policies.
- 1.10** The organisation demonstrates a culture of learning from positive reporting, and adverse events, including outbreaks and incidents, and seeks confirmation of system change to reduce risk, prevent recurrence and promote resilience.
- 1.11** The organisation uses data from a variety of internal and external sources to meet its objectives and to support learning and continuous improvement in infection prevention and control practice.

What does the standard mean for people receiving treatment or visiting a healthcare or social care setting?

- Patients and visitors have confidence that the organisation has effective leadership and governance and that it promotes an organisational culture committed to continuous improvement in infection prevention and control.

What does the standard mean for the organisation?

- The organisation is able to demonstrate achievements in continuous improvement in infection prevention and control practice.

What does the standard mean for the infection prevention and control team?

- The infection prevention and control team is able to provide a proactive infection prevention and control service, supported by executive leadership, with whom they communicate risks and recommend actions.
- The infection prevention and control team supports clinical, and other staff, with data, training, environmental assessments, risk assessments, practice audits and recommendations for practice that facilitate safe, effective patient care and service improvement.

What does the standard mean for staff?

- Support is provided by senior staff and the infection prevention and control team through the provision of resources, a suitable environment, a reporting structure, guidance, training and education, and data that facilitate the delivery of effective infection prevention and control.
- Staff, where appropriate to their role, use data to assess the quality of care or service provided and to improve practice.
- All staff are aware of their role in maintaining a safe care environment.

Examples of evidence of achievement (*NOTE: this list is not exhaustive.*)

The **executive team** can:

- i. describe organisational accountability and support for continuous quality improvement, specific to infection prevention and control.

The **infection prevention and control team** can:

- ii. demonstrate regular review of guidelines to optimise the provision of a proactive infection prevention and control service.
- iii. articulate their role in the strategic, operational and quality assurance systems that demonstrate compliance with infection prevention and control policies.
- iv. describe how learning from adverse events, including outbreaks and incidents, have reduced risk, prevented recurrence and promoted resilience.
- v. demonstrate how the organisation uses data to meet its objectives and support learning and continuous improvement in infection prevention and control.

Staff can:

- vi. describe organisational infection prevention and control priorities.
- vii. describe the data they use to influence practice to minimise infections and improve care processes.
- viii. explain their own role and responsibilities in the prevention and control of infection.
- ix. articulate the reporting structure and the process for reporting and escalating infection prevention and control risks or incidents, and make contact with the infection prevention and control team when necessary.
- x. demonstrate the availability of action plans to address any deficiencies.

Practical examples (*The numbers shown in brackets correspond to relevant criterion/a*)

1. A named designated HAI executive lead. (1.2)

2. An organisational chart that shows the management and accountability of infection prevention and control from executive level to the point of care. (1.2, 1.3)
3. Executive board reports or minutes. (1.1)
4. HAI improvement data. (1.6, 1.8, 1.9, 1.11)
5. Infection control committee reports (or equivalent). (1.1, 1.4, 1.5, 1.7, 1.8, 1.9, 1.11)
6. Infection prevention and control annual programme. (1.1, 1.5, 1.7, 1.8)
7. Infection prevention and control key performance indicators. (1.4, 1.7, 1.8, 1.10)
8. Outbreak management plans, including details of the internal investigation team, as instigated by the NHS board. (1.6, 1.7, 1.8, 1.9)
9. Patient involvement in learning from adverse events. (1.8, 1.9)
10. Patient safety / leadership walk rounds – timetable and inspections. (1.1, 1.6)
11. Patient satisfaction survey reports. (1.9)
12. Quarterly reports on current and emerging threats (1.10, 1.11)
13. Risk registers (or equivalent). (1.5, 1.7, 1.8, 1.10, 1.11)
14. Staff, patient and visitor feedback (1.10, 1.11)
15. Ward scorecards (or equivalent). (1.6, 1.9)

Standard 2: Education to support the prevention and control of infection

Standard statement

Education on infection prevention and control is provided and accessible to all healthcare teams to enable them to minimise infection risks that exist in care settings.

Rationale

To minimise the infection risks associated with healthcare, all staff are provided with the necessary knowledge and skills in infection prevention and control to confidently and competently demonstrate behaviours integral to safe, effective and person-centred care.

References: 3, 4, 8, 12, 13, 14, 15, 16, 17, 18

Criteria

- 2.1** The organisation assesses the education and training needs of all staff relating to infection prevention and control through performance management reviews.
- 2.2** All relevant staff within the organisation are provided with clear guidance on:
 - (a) roles and responsibilities in relation to infection prevention and control
 - (b) identifying and addressing education and training needs, and
 - (c) infection-specific management, including *Clostridium difficile* and loose stools policies.
- 2.3** Education and training needs of specialist practitioners are aligned to career and development frameworks appropriate to their role.
- 2.4** The organisation provides an education programme that meets the need of staff which includes:
 - (a) mandatory induction, training and updates on HAI guidance, policies and procedures commensurate with staff roles
 - (b) tailored HAI education to meet roles and responsibilities, and
 - (c) learning and sharing of HAI best practice, internally and externally.
- 2.5** The organisation evaluates the provision, quality and uptake of infection prevention and control training and responds to any unmet infection prevention and control education needs.
- 2.6** The organisation has multiple and integrated approaches to ensure the timely delivery of infection prevention and control education across all professions and disciplines.

- 2.7** National HAI-related intelligence and other data are utilised in the identification of education and training needs and the planned programme of education and training offered.

What does the standard mean for people receiving treatment or visiting a healthcare or social care setting?
People using the services are assured that staff delivering care are educated and trained in infection prevention and control, and use their learning to ensure care is safe, effective and person-centred.
What does the standard mean for the organisation?
The organisation can demonstrate a continuous quality improvement approach and a learning culture to ensure the knowledge and competency of staff involved in infection prevention and control is maintained.
What does the standard mean for the infection prevention and control team?
The infection prevention and control team supports the organisation to identify, provide and evaluate organisation-wide infection prevention and control education needs.
What does the standard mean for staff at the point of care?
Staff are: - able to demonstrate knowledge and competence in the delivery of care, and act as role models in the promotion of infection prevention and control. - responsible to the organisation for identifying issues relating to infection prevention and control. - able to effectively challenge and support colleagues to promote best infection prevention and control practices.
What does the standard mean for support services?
Support services staff (for example, domestic, estates and procurement) have the skills to practice safely and promote infection prevention and control.
Examples of evidence of achievement (<i>NOTE: this list is not exhaustive.</i>)
The executive team can: describe organisational accountability in supporting and maintaining the continuing professional development of staff, specific to infection prevention and control. The HAI education lead and the infection prevention and control team, where appropriate to role can:

- ii. describe the methods used in the provision of HAI training and education to healthcare teams.
- iii. describe the evaluation process used to address HAI training needs.
- iv. articulate the review process for the organisation's HAI training programme.

Staff can:

- v. describe types of training undertaken in relation to infection prevention and control processes and procedures.
- vi. describe systems and procedures to identify individual education and training needs.
- vii. explain escalation procedures for issues specific to infection prevention and control.

Practical examples *(The numbers shown in brackets correspond to relevant criterion/a)*

1. A range of training methods to give staff the opportunity to learn from each other's experiences in relation to infection prevention and control. (2.3)
2. Active organisational programmes for HAI education. (2.3)
3. Completion data and observation of implementation of national and local training programmes (assessment data, peer review, reflection). (2.1, 2.3, 2.4, 2.6, 2.7)
4. Evaluation processes to ensure that HAI training is appropriate, fit for purpose, quality assured and consistent with national guidance and standards. (2.4)
5. Inclusion of training issues and needs in significant event analysis relevant to HAI. (2.1, 2.3)
6. Alignment of roles to profession-specific competencies and frameworks (for example, Career Development Framework for IPC Nurses or Post Registration Career Development Framework for Nurses, Midwives and Allied Health Professionals in Scotland). (2.2, 2.3)
7. Performance indicators for staff performance management in infection prevention and control, which are checked on a regular basis. (2.1, 2.4, 2.7)
8. Recording and reporting structures for monitoring the uptake of training. (2.3, 2.4, 2.5, 2.6)
9. Reports of the proportion of staff undertaking mandatory infection prevention and control induction and update training. (2.1, 2.4)
10. Staff education and training requirements, in relation to infection prevention and control are included in organisational policies and procedures. (2.3, 2.5)
11. Staff feedback on their experiences on infection prevention and control, which inform learning activities. (2.4, 2.6)

12. Training and achievement records. (2.1, 2.2)
13. Training evaluations (individual and organisational). (2.4)
14. Training needs analysis informed by national initiatives, organisational strategy and local HAI outcomes. (2.6)

Standard 3: Communication between organisations and with the patient or their representative

Standard statement

The organisation has effective communication systems and processes in place to enable continuity of care and infection prevention and control throughout the patient's journey.

Rationale

Patients are vulnerable to infections and some present an infection risk to other patients, visitors and staff. As a single patient journey can involve staff in multiple care settings, effective care provider communications are vital in infection prevention and control, and safe, effective and person-centred care.

Wherever possible, patients and their representatives must be assured of, and involved in, communications regarding their care.

References: 3, 4, 11, 18, 19, 20

Criteria

- 3.1** The organisation has systems that require an infection prevention and control risk assessment (to and from the patient) to be made and documented on patient admission and transfer.
- 3.2** Where infection risks **to the patient** are identified, appropriate actions are taken to minimise these risks. Both risks and actions are communicated with, and involve, the patient or their representatives.
- 3.3** Where infection risks **from the patient** are identified, appropriate actions are taken to minimise these risks. Both risks and actions are communicated with, and involve, the patient, their representatives and relevant healthcare teams.
- 3.4** Patients, or their representatives, are provided with information, in a format appropriate to their needs, on specific infection-related risks (including any longer term implications) if relevant, during their care stay, for example, leaflets on HAI, *Clostridium difficile*, norovirus.
- 3.5** Support and information about specific infection-related care issues and procedures are accessible to patients or their representatives from healthcare staff, including during visiting times.
- 3.6** All communication with patients or their representatives is recorded in their records and is used to inform the patient's care plan.
- 3.7** Staff communicate with a patient's representative, where cause of death is related to an HAI. This information is recorded in the patient's record.

- 3.8** Staff communicate with the infection prevention and control team
- (a) for advice and information regarding specialist infection prevention and control risks for individual patients. This information is recorded in a patient's record and care plan.
 - (b) when an outbreak is suspected.
- 3.9** There is continuous quality improvement of all HAI communication systems and processes, making use of feedback such as patient survey data, complaints data, and staff survey data.
- 3.10** The organisation communicates and engages with the public on matters related to infection prevention and control, including reducing specific risks.

What does the standard mean for people receiving treatment or visiting a healthcare or social care setting?

People receiving treatment in, or visiting one or more care settings can expect effective communication:

- on infection-related risks and to be involved in care decisions taken to mitigate these risks, and
- between care providers resulting in a seamless continuity of care to mitigate any infection risks.

What does the standard mean for the organisation?

The organisation:

- has systems in place to enable effective, safe, person-centred communications throughout the patient journey
- will monitor data and take appropriate actions to learn and improve communications
- has effective communication to enable wider public health issues to be acted on, and
- responds to any feedback on communications issues.

What does the standard mean for the infection prevention and control team?

The infection prevention and control team supports the organisation to attain its communication standard by:

- the delivery of HAI education, to include risk assessment and communications
- working with colleagues to devise and implement communication documentation, and

providing advice on the improvement of, wherever possible, tools used to optimise communication, which will enhance safe person-centred care.
What does the standard mean for staff?
Staff (where appropriate to their role): - are aware of their responsibilities, in ensuring patients, or their representatives, receive effective communications to minimise infection risks. - will effectively communicate with patients, or their representatives, regarding the mitigation of risks to themselves and other persons in the care settings. - will be competent in communicating risks, to enable the provision of continuity of care, and to mitigate risks to other persons in the care settings.
Examples of evidence of achievement (<i>NOTE: this list is not exhaustive.</i>)
The executive team can: i. describe organisational accountability and support for effective communication systems and processes. The infection prevention and control team can: ii. demonstrate the provision of HAI information to healthcare teams, patients, their representatives and the public. iii. provide action plans to address any deficiencies. iv. demonstrate the regular review of guidelines to optimise communication systems and processes. Staff can: v. confirm the infection prevention and control team lead (or equivalent) from whom specialist infection prevention and control advice can be sought, and how to contact them. vi. describe types of communications with patients, or their representatives and/or agencies to achieve continuity of care in relation to infection prevention and control. vii. describe systems and procedures to identify communication risks on admission, during treatment/patient stay and/or transfer. viii. explain how to access infection prevention and control resources, for example, leaflets. Practical examples (<i>The numbers shown in brackets correspond to relevant criterion/a</i>) - Audits of internal communication, and action plans. (3.1, 3.8, 3.9, 3.10)

2. Availability of easy to understand standardised information on HAIs, in a format appropriate to the needs of patients, their representatives and staff. (3.4)
3. Completion of RIDDOR (Reporting of incidents, diseases and dangerous occurrences regulations) form, and notification to the Health and Safety Executive (3.2, 3.3)
4. Evidence of enquiries and responses to and from the infection prevention and control team. (3.5)
5. Examples of communications between different health and social care providers, detailing any infections (for example, discharge summaries to GPs, admission letters from care homes and ambulance care records). (3.1, 3.2, 3.3, 3.5)
6. Examples of patient records/care plans (anonymised) for communication between the patient or their representative and healthcare staff about HAIs (for example, the patient's MRSA status, cause of death) throughout an hospital episode. (3.4, 3.6, 3.7, 3.8, 3.10)
7. Media releases. (3.9)
8. Minutes, reports, patient feedback and evidence of actions updating communication issues. (3.1, 3.2, 3.3, 3.8, 3.9)
9. Sample patient (or representative) feedback. (3.3, 3.8, 3.9)
10. The organisation's communication strategy (particular to the general public). (3.8, 3.9)
11. Written information accessible in clinical areas for staff. (3.8)

Standard 4: HAI surveillance

Standard statement

The organisation has a surveillance system to ensure a rapid response to HAI.

Rationale

HAI surveillance is the ongoing and systematic collection, analysis and interpretation of data, relating to HAI, which is used to reduce the risk of infection and improve patient outcomes.

References: 4, 15, 21, 22, 23

Criteria

- 4.1** The organisation has an annual surveillance programme that incorporates mandatory national and local surveillance of infections and alert organisms. This programme is developed by the infection prevention and control team and endorsed by the infection control committee.
- 4.2** The IT systems used within the organisation are simple to use and support real-time surveillance and response.
- 4.3** Triggers have been incorporated into surveillance systems that allow prompt detection and response to any variance from the normal limits, including outbreak.
- 4.4** The infection prevention and control team follow standard operating procedures that detail the response to surveillance triggers.
- 4.5** Surveillance outputs and interpreted data are communicated to the relevant healthcare teams, patients, their representatives and visitors in a format, appropriate to their needs.
- 4.6** The infection prevention and control team [review](#) surveillance data and produce a report detailing both adverse incidents and areas of low incidence. The report should also recognise new, emerging or re-emerging infection-related risks.

There is clinical governance oversight for this report through the organisation's reporting structure, to chief executive and NHS board level (or equivalent).
- 4.7** The infection prevention and control team produces a summary annual report of the effectiveness of surveillance activity which considers modifications to further reduce infection risks.

- 4.8** Users of HAI surveillance systems undertake up-to-date training with training needs assessed, and are aligned to career and development frameworks appropriate to their role.

What does the standard mean for people receiving treatment or visiting a healthcare or social care setting?
Patients, visitors and the public can expect to be cared for in an environment where the executive team, infection prevention and control team and clinical teams are effectively working together to monitor, minimise and manage infection risks.
What does the standard mean for the organisation?
The organisation can demonstrate that surveillance systems are in place to detect, respond to and reduce infection-related incidents.
What does the standard mean for the infection prevention and control team?
The infection prevention and control team: - will ensure the outputs from surveillance systems are reported in a clear and concise manner to the relevant healthcare teams. - will use surveillance outputs to focus infection prevention and control team resources for improvement and risk reduction activity.
What does the standard mean for staff at the point of care?
- Staff are engaged in using surveillance data to drive improvement. - Where surveillance data indicate there may be local infection-related issues, the clinical team engage with the infection prevention and control team to understand these issues and respond as necessary to reduce infection-related risks.
What does the standard mean for support services?
Support services staff will have assurance that their working environment is controlled and safe, where the risk of them being exposed to infectious agents is minimised.
Examples of evidence of achievement (<i>NOTE: this list is not exhaustive.</i>)
The executive team can: - describe organisational accountability and management processes for HAI surveillance. Clinical leads can: - describe what surveillance activity takes place within their clinical area. - interpret surveillance data generated from their clinical area.

- iv. describe the procedures to be followed when a trigger has been identified.

The **infection prevention and control team** can (where appropriate to role):

- v. articulate the reporting structure for risks identified.
- vi. describe the process for the development of action plans to address any deficiencies.
- vii. describe types of communications with healthcare teams, patients, their representatives and visitors in relation to surveillance data and outputs.

Staff can:

- viii. confirm the infection prevention and control team lead (or equivalent) from whom specialist infection prevention and control advice can be sought, and how to contact them.

Practical examples *(The numbers shown in brackets correspond to relevant criterion/a)*

1. Action plans from trigger incidences. (4.2, 4.3, 4.4, 4.5)
2. Alert organisms surveillance data. (4.1, 4.6)
3. Alignment of roles to profession-specific competencies and frameworks (4.8)
4. An annual surveillance programme developed by the infection prevention and control team (based on identified risks and priorities) approved by the infection control committee, and agreed by the executive board. (4.1, 4.2, 4.4)
5. Availability of charts and/or graphs within staff and patient areas. (4.5)
6. HAI reporting template. (4.3, 4.5, 4.6)
7. Inclusion of training issues and needs in significant event analysis relevant to HAI surveillance. (4.8)
8. Minutes of meetings, for example, infection control committee, clinical governance committee. (4.1, 4.6, 4.7)
9. Standard operating procedures for trigger alerts. (4.3, 4.4)
10. Surveillance annual report. (4.7)

Standard 5: Antimicrobial stewardship

Standard statement

The organisation demonstrates effective antimicrobial stewardship.

Rationale

Antimicrobial stewardship, in the form of a co-ordinated programme, has been shown to reduce inappropriate antimicrobial use, improve patient outcomes and reduce adverse consequences of antimicrobial use including, antimicrobial resistance, toxicity and unnecessary costs.

References: 4, 12, 24, 25, 26, 27

Criteria

- 5.1** There is senior management support (chief executive, medical director, HAI executive lead) for the antimicrobial management team or equivalent.
- 5.2** There is access to an antimicrobial management team, consisting of a minimum, a lead clinician, microbiologist and antimicrobial pharmacist, to support the development, communication, implementation and evaluation of antimicrobial stewardship.
- 5.3** There is continuous quality improvement of the organisation's antimicrobial stewardship through alignment with the work programmes of, for example, infection prevention and control team and antimicrobial management team, with consideration given to the work programmes of the public health, patient safety and clinical governance teams.
- 5.4** The antimicrobial management team produces and updates, at least every two years, the antimicrobial policies. These include empirical prescribing, surgical prophylaxis, gentamicin / vancomycin, and controls to manage the use of restricted antimicrobials, aligned to the Scottish Antimicrobial Prescribing Group and *Scottish Management of Antimicrobial resistance Action Plan (ScotMARAP2)*.
- 5.5** The antimicrobial management team's policies on antimicrobial stewardship are accessible to staff who prescribe, administer and supply antimicrobials.
- 5.6** The organisation readily communicates any changes in policy and guidance on antimicrobial practice to staff.

- 5.7** The antimicrobial management team monitors the quality of antimicrobial stewardship (including antimicrobial stewardship and antimicrobial resistant organisms), and unintended consequences, through an annual programme of audits and monitoring of antimicrobial consumption data. The intelligence is **fed back to** prescribers and lead clinicians and **fed forward to** the executive team, with an assessment of the risks and a summary of the actions being taken or planned.
- 5.8** The antimicrobial management team detects and responds to data which indicate poor antimicrobial stewardship with monitored action plans.
- 5.9** The antimicrobial management team has a planned programme of education on antimicrobial stewardship for all healthcare teams involved in the prescribing, supply and administering of antimicrobials.
- 5.10** The organisation provides information to the public, in a format appropriate to their needs, to raise awareness to the risks from unnecessary use of antibiotics and, to individuals receiving antimicrobials, about the need for antimicrobial course completion and instructions for use.

What does the standard mean for people receiving treatment or visiting a healthcare or social care setting?

Every patient will get the most appropriate antibiotic (type, dose, route and duration) in a timely fashion for their infection, according to local and national policy and/or guidelines:

- patients or their representatives are involved in discussions regarding the reason for antimicrobial treatment, the intended duration and any major potential adverse reactions
- for every patient receiving antimicrobial therapy: indication, duration or a review plan are documented in the patient's record according to local and national guidelines
- the need for parenteral antimicrobial treatment is reviewed daily, with a view to making decisions to continue, change or stop the administration route. This review and the rationale for the decision are documented in the patient's record
- staff demonstrate knowledge of local and national policies and guidance regarding antimicrobial prescribing that is relevant to their responsibilities and duties, and
- improvement plans are implemented if deficiencies in antimicrobial prescribing are highlighted by antimicrobial utilisation or prescribing indicator data review.

What does the standard mean for the organisation?
• The organisation is aware of the risks from poor antimicrobial stewardship and is assured that it has a programme in place to continuously improve antimicrobial stewardship and to detect and respond to data on poor prescribing and administration practices. The organisation must ensure there are resources and processes in place to: • provide executive leadership and governance for antimicrobial stewardship • provide a clinical microbiology service to support antimicrobial stewardship • provide expert advice on infection management and antimicrobial stewardship through an established antimicrobial management team • support the antimicrobial management team to utilise national education resources on antimicrobial stewardship for the public • provide an integrated approach to infection prevention, management and safety through team working, and • ensure an annual work plan is implemented and its effectiveness measured.
What does the standard mean for the antimicrobial management team and the infection, prevention and control team?
• The antimicrobial management team is supported in its efforts to continuously improve antimicrobial stewardship by the executive team and clinical colleagues. • The infection prevention and control team works in close collaboration with the antimicrobial management team and patient safety team.
What does the standard mean for staff at the point of care?
• All healthcare teams involved in the prescribing, supply and administering of antimicrobials are aware of the importance of, and their role in, optimising antimicrobial stewardship for the benefit of patients and the public, and can demonstrate this in practice. • All healthcare teams involved in the prescribing, supply and administering of antimicrobials should be able to demonstrate knowledge of common infections, microbiology investigations required and their antimicrobial management following the local guidelines. • Prescribing clinical staff will: - demonstrate basic competency in relation to prudent and safe antimicrobial prescribing for treatment and prophylaxis - know how to access local antibiotic policy and/or guidance

- participate in data collection about antimicrobial prescribing and feedback data in relation to the quality of prescribing, and - participate in education on prudent prescribing as part of their continuing professional development.
Examples of evidence of achievement (<i>NOTE: this list is not exhaustive.</i>)
The executive team can: i. describe the organisational accountability and support for antimicrobial stewardship. The antimicrobial management team (in partnership with the infection prevention and control team) can: ii. demonstrate that guideline reviews are completed every two years. iii. demonstrate regular antimicrobial stewardship audit and surveillance of antimicrobial use as per Scottish Antimicrobial Prescribing Group policy and guidance. iv. feedback data to all healthcare teams involved in the prescribing, supply and administering of antimicrobials and to the executive team. v. provide action plans to address any deficiencies. vi. demonstrate the provision of education to healthcare teams, patients, their representatives and public involved in the prescribing, supply and administering of antimicrobials. Staff can: vii. demonstrate awareness of how to access advice from local experts on management of infection and use of antimicrobials. viii. demonstrate awareness of antimicrobial guidelines relevant to their roles and responsibilities and can access them. Practical examples (<i>The numbers shown in brackets correspond to relevant criterion/a</i>) 1. Access to the <i>Clostridium difficile</i> infection decision aid developed in partnership between Scottish Antimicrobial Prescribing Group, the Care Inspectorate, Health Protection Scotland, NHS microbiology expertise in <i>Clostridium difficile</i> infection and Scottish care. (5.4, 5.5) 2. Access to the urinary tract infection decision aid for older people (developed in partnership between Scottish Antimicrobial Prescribing Group and the Care Inspectorate, Scottish Care and Health Protection Scotland). (5.4, 5.5) 3. Antimicrobial stewardship audits (including national Scottish Antimicrobial Prescribing Group required, local targeted and point prevalence), surveillance of antimicrobial use, reports and action plans. (5.7, 5.8, 5.10)

4. Antimicrobial stewardship policies are easily accessible and meet Scottish Antimicrobial Prescribing Group minimum requirements. (5.4, 5.5)
5. Evidence of communication of the above to staff at the point of care and the organisation's chief executive (or equivalent). (5.1, 5.6, 5.8, 5.10, 5.11)
6. Information received by patients, their representatives and the public, both verbal and written on antimicrobials. This will be provided in a format appropriate to their needs. (5.1110)
7. Membership, terms of reference, minutes, annual programme/plan of the antimicrobial management team. (5.2)
8. Planned programme of education and training records on antimicrobial stewardship for healthcare teams involved in the prescribing, supply and administration of antimicrobials. (5.3, 5.8, 5.10)
9. Review of individual treatment records to establish if the antimicrobial prescribed has indication documented, is compliant with local policy and all prescribed doses have been administered and appropriate documentation has been completed, as per local policy. (5.7, 5.8, 5.9)
10. Utilisation of national education resources on antimicrobial use for patients, their representatives and the public. (5.1110)

Standard 6: Infection prevention and control policies, procedures and guidance

Standard statement

The organisation demonstrates implementation of evidence-based infection prevention and control measures.

Rationale

The minimum standard of infection prevention and control to be practiced by all staff, in all care settings, for all care procedures is the application of standard infection control precautions, as detailed in chapter one, of the *National Infection Prevention and Control Manual*.

Standard infection control precautions are the most effective means to prevent cross-transmission and cross-infection with micro-organisms in care settings.

References: 3, 4, 12, 19, 28, 29, 30, 31, 32

Criteria

- 6.1** The current version of the *National Infection Prevention and Control Manual* has been adopted by the organisation and is accessible by all staff.
- 6.2** Staff are supported by senior management and empowered to challenge colleagues who do not adhere to guidance set out in the *National Infection Prevention and Control Manual*.
- 6.3** There is a system in place to update staff on any changes in the content of the *National Infection Prevention and Control Manual*.
- 6.4** The infection prevention and control team responds to any data which suggest that *National Infection Prevention and Control Manual* implementation may not be optimal.
- 6.5** The organisation executes a systematic programme of audits, policies, procedures, including standard infection control precautions, and guidelines for all clinical areas and HAI-related infections. These will be reviewed, at least every two years, to assess compliance with the *National Infection Prevention and Control Manual* and to provide assurance for the organisation.
- 6.6** The organisation has a clinical microbiology service that provides best practice testing including laboratory processing and rapid diagnostics as available, and specialist clinical advice on individual patient treatment.

- 6.7** Where there is an outbreak, incident or where patients have an infection or alert organisms have been identified
- (a) an assessment is undertaken by staff, using a (hospital) infection incident assessment tool, and
 - (b) a care plan is actioned and reviewed following condition-specific guidance.
- 6.8** Where audit data suggest actions are needed there is a procedure followed to ensure remedial action plans are implemented.
- 6.9** Reports on all audits are **fed back to** clinical staff and **fed forward to** leadership teams and the executive team to provide assurance, drive improvement, and to communicate any residual risks.
- 6.10** When the agreed audit programme is not undertaken, this is communicated through the organisation's risk reporting system.
- 6.11** The healthcare team discusses and acts to improve *National Infection Prevention and Control Manual* compliance locally.

What does the standard mean for people receiving treatment or visiting a healthcare or social care setting?

- Every patient receives care in a safe place without unnecessary exposure to infection. Staff providing care demonstrate knowledge of infection prevention and control practices and provide appropriate information to patients, their representatives and visitors on how to prevent infection transmission.

What does the standard mean for the organisation?

The organisation is assured that infection risks are reduced through:

- availability of policies, procedures and guidance that support the application of safe care practices
- processes that assess adherence to the policies and procedures
- systems and resources being in place to enable a safe level of care to be practiced by staff for all patients and visitors
- effective systems to monitor, report and respond to implementation (process) and infection (outcome) data
- a culture which promotes the reporting of incidents and the improvement of care systems, and
- supporting the infection prevention and control team in its efforts to measure, identify and minimise risks through the monitoring and reporting of audit data.

What does the standard mean for the infection prevention and control team?

The infection prevention and control team:

- has a critical role in devising and reviewing systems that measure the implementation of policies, procedures and guidance based on the infection risks within individual clinical areas
- works in close collaboration with staff at the point of care and the patient safety team, and
- is able to demonstrate a process for developing or reviewing policies, procedures and guidance.

What does the standard mean for staff at the point of care?

Staff:

- are aware of relevant policies, procedures and guidance and are able to evidence the provision of a safe level of care in minimising infection risks, and
- know how to respond if they have insufficient resources or support to minimise infection risks.

What does the standard mean for support services?

- Support services staff are aware of their role and responsibilities in the prevention and control of infection, are competent to carry out this role.

Examples of evidence of achievement (NOTE: this list is not exhaustive.)

The **executive team** can:

- i. describe organisational accountability and support for infection prevention and control.

The **infection prevention and control team** can:

- ii. demonstrate feedback of data to clinical teams at the point of care and to the organisation's executive team.
- iii. provide action plans to address any deficiencies.
- iv. demonstrate the provision of education, information and awareness raising sessions to healthcare teams, patients, their representatives and public.

Staff can:

- v. demonstrate in their daily practice the application of the *National Infection Prevention and Control Manual* for all patient contacts in the care setting.
- vi. explain how to access infection control policies, procedures and guidance.

- vii. discuss their role in the prevention and control of infection (for example, recognising unsafe activities, intervening when breaches in infection control are identified).
- viii. describe practice changes (for example, any altered standard of care).
- ix. articulate the process of reporting incidents and infection risks.

Practical examples *(The numbers shown in brackets correspond to relevant criterion/a)*

1. Audit of microbiology services. (6.6)
2. Completed rapid event investigations into hospital healthcare acquired infections, for example, *Staphylococcus aureus* bacteraemias. (6.2, 6.6, 6.7)
3. Education programme and training records on infection prevention and control. (6.2, 6.3)
4. Environmental and equipment cleaning schedules. (6.5, 6.9)
5. Infection control annual programme and annual report of infection prevention and control. (6.3, 6.5, 6.9)
6. Memberships, terms of reference, minutes of the infection control committee. (6.1, 6.3, 6.5)
7. *National Infection Prevention and Control Manual* implementation and compliance audits, and improvement and action plans. (6.1, 6.3, 6.4, 6.5, 6.6, 6.7, 6.8, 6.9, 6.10, 6.11)
8. Provide examples of (anonymised) condition-specific care plans following an outbreak or incident. (6.7).

Standard 7: Insertion and maintenance of invasive devices

Standard statement

Systems and processes are in place to ensure the safe and effective use of invasive devices, for example, peripheral venous catheters, central venous catheters and urinary catheters.

Rationale

Invasive devices present a significant infection risk to patients. These risks can be minimised by:

- avoidance of device use where possible
- following evidence-based procedures for insertion and maintenance, and
- removing the device as soon as there is a clinical indication to do so.

References: 3, 4, 8, 33

Criteria

- 7.1 Staff are aware of the infection risks associated with invasive device use and, where appropriate, use non-invasive alternatives.
- 7.2 Staff inform patients, or their representatives, of risks associated with invasive device use and involve patients and representatives in the decision-making process and, where relevant, the care and monitoring of device use.
- 7.3 Staff follow key practice recommendations on how and when invasive devices are to be used, maintained, monitored and removed.
- 7.4 Staff have access to an appropriate selection of invasive devices enabling them to provide the safest device options for their patients.
- 7.5 Staff document:
 - (a) the decision-making for invasive device use
 - (b) specifics of the insertion procedure
 - (c) observations and maintenance of the device, and
 - (d) planning for removal.
- 7.6 Staff are supported by senior management and empowered to challenge colleagues who do not follow best practice on the use of invasive devices.

- 7.7** Staff respond to data that indicate the presence of infection risks with a commitment to improvement through investigations, actions and peer support.
- 7.8** Local clinical teams are supported to optimise their practice by the use of improvement and surveillance data, provision of training, accessibility to guidance and investigations into any device-related bloodstream infections.
- 7.9** Governance processes ensure the executive team and management explicitly consider infection risks associated with invasive device use and of any significant issues related to local or organisation-wide use of invasive devices.
- 7.10** The organisation has a planned programme of education for all healthcare teams involved in the insertion and maintenance of invasive devices.

What does the standard mean for people receiving treatment or visiting a healthcare or social care setting?

- Every individual with an invasive device is reassured that the staff in the clinical area are competent and committed to providing the safest possible decision-making and care, and display data showing evidence of that commitment.
- If a patient has an invasive device in situ, insertion and maintenance are clearly documented in the patient's record and includes date of insertion and reason for insertion.
- The patient, or their representative, understands the need for the device and how to care for it.

What does the standard mean for the organisation?

The organisation:

- is able to demonstrate the safety of the systems that enable staff to minimise infection risks from invasive device use, and detect and respond to device-related incidents.
- evidences, through governance processes, the organisational culture of continuous improvement to optimise care, by reporting errors and incidents.

What does the standard mean for the infection prevention and control team?

Infection prevention and control teams:

- are able to demonstrate how effectively they support clinical teams, for example, through direct engagement on invasive device use, the provision of training, guidance, data and practice audits.
- are able to provide, through governance processes, the executive board with assessments of the effectiveness and safety of device use, reports on invasive device incidents and recommendations to reduce risks.

What does the standard mean for staff at the point of care?

Staff:

- will be supported to practice safely and minimise infection risks through the availability of resources, guidance, data and training and a culture committed to optimising patient care related to device use.
- will show commitment to the safe use of devices by compliance with procedures, maintenance of personal skills, provision of peer support to colleagues, response to data and reporting of any identified device-related issues.
- are aware that patients with invasive devices are vulnerable to infection and escalate to senior colleagues if they have any concerns.

Examples of evidence of achievement (*NOTE: this list is not exhaustive.*)

The **executive team** can:

- i. describe organisational accountability and support for the procurement and management of invasive devices.

The **infection prevention and control team** can:

- ii. demonstrate the support provided to clinical teams for the management of invasive devices.
- iii. provide feedback data to the organisational executive on the management of invasive devices, including recommendations where risks have been identified.

Staff can:

- iv. explain how to access procedures and guidance for the insertion and maintenance of invasive devices.
- v. articulate the key elements of improvement tools, for example, care bundles relevant to their care area.
- vi. discuss their role in the prevention and control of infection related to invasive devices (for example, recognising unsafe activities, intervening when breaches in infection control are identified).

Practical examples (*The numbers shown in brackets correspond to relevant criterion/a*)

1. Compliance monitoring and improvement plans relating to invasive devices. (7.5, 7.6, 7.7, 7.8, 7.9)
2. Patient documentation is used for invasive device management. (7.4)
3. Patients know their invasive device is checked every day with patient (or their representative's) feedback sought. (7.2, 7.4, 7.5)

4. Quality improvement data are used to improve patient outcomes, for example, root cause analysis, care bundles. (7.5, 7.7, 7.8, 7.9)
5. Staff can describe and apply the principles of asepsis. (7.1, 7.3, 7.10)
6. Surveillance and audit data which demonstrates monitoring of practice to improve patient outcomes. (7.5, 7.7, 7.8, 7.9)

Standard 8: Decontamination

Standard statement

The environment and equipment (including reusable medical devices used) are clean, maintained and safe for use. Infection risks associated with the built environment are minimised.

Rationale

Effective decontamination is critical in the provision of a safe, clean environment and equipment. The built environment must be designed, planned, constructed, refurbished and maintained to minimise the risk of infection.

This standard covers the decontamination, management and maintenance of:

- reusable communal patient care equipment
- reusable medical devices, and
- the built environment.

References: 3, 4, 12, 17, 29, 30, 31, 34, 35, 36, 37, 38

Criteria

- 8.1** The organisation provides equipment and an environment that is safe and clean, minimising the risk of cross-infection.
- 8.2** The organisation has, and implements, decontamination policies, records and procedures in line with relevant national guidance and legislation.
- 8.3** There is continuous quality improvement and assurance in place to monitor and ensure the environment and equipment (including reusable medical devices) is clean and safe.
- 8.4** There are robust reporting and escalation procedures in place to deal with any identified issues regarding cleanliness and maintenance of equipment (including reusable medical devices) and the built environment.
- 8.5** Specialist infection prevention and control advice is sought and adhered to when additional cleaning or decontamination activity is identified as necessary, or existing activity is assessed as sub-standard.
- 8.6** Equipment (including reusable medical devices) and environmental cleanliness is assessed during and following an outbreak or incident. Findings are shared within the organisation and with external partners.
- 8.7** In an incident or outbreak involving reusable medical devices, all relevant stages of the decontamination process are assessed and reviewed. Findings are shared within the organisation and with external partners.

- 8.8** When audits or data (including patient, visitor and staff feedback) identify deficiencies in cleanliness or adherence to cleaning specifications, infection prevention and control teams liaise directly and promptly with relevant services, remedial action is taken, and unaddressed issues are escalated within the organisation.
- 8.9** The organisation actively seeks feedback from patients, staff and visitors for their view on the cleanliness of the care environment and equipment (including reusable medical devices).
- 8.10** The decontamination of reusable medical devices complies with relevant technical requirements.
- 8.11** The organisation carries out regular risk assessment and takes action if any part of the decontamination procedure cannot, or has not, been followed, or a near miss, failure or non conformance has been detected.
- 8.12** Where there is a decontamination-related incident or outbreak, an assessment is undertaken using a (hospital) infection incident assessment tool.

What does the standard mean for people receiving treatment or visiting a healthcare or social care setting?
• People using the services have confidence that they are being cared for in a clean, safe care environment and that all equipment (including reusable medical devices) used will be clean and free from contamination.
What does the standard mean for the organisation?
• The organisation has a quality assurance system in place which demonstrates the provision of a safe and clean environment and equipment (including reusable medical devices).
What does the standard mean for the infection prevention and control team?
The infection prevention and control team: • support quality improvement to provide assurance of environment and equipment (including reusable medical devices) decontamination. • is involved in all incident outbreaks relating to decontamination failure and proactively responds to reduce the risk of recurrence.
What does the standard mean for staff?
Staff (where appropriate to their role): • are assured that there are effective systems in place to provide them with a safe environment and equipment (including reusable medical devices). • have an understanding of their individual roles and responsibilities in the provision

of a safe, clean environment and equipment (including reusable medical devices).

Examples of evidence of achievement (*NOTE: this list is not exhaustive.*)

The **executive team** can:

- i. describe organisational accountability for the decontamination, management and maintenance of the environment and equipment (including reusable medical devices).

The **infection prevention and control team** can:

- ii. articulate the expertise and support provided to staff at the point of care for the delivery of effective environment and equipment (including reusable medical devices) decontamination, and
- iii. provide feedback data to the organisational executive on decontamination, including recommendations where deficiencies have been identified.

Staff can:

- iv. articulate their own roles and responsibilities relating to decontamination, equipment (including reusable medical devices) and environmental cleanliness.

Practical examples (*The numbers shown in brackets correspond to relevant criterion/a*)

1. A-Z of communal reusable patient equipment. (8.1, 8.3)
2. Bed space checklists. (8.1)
3. Completed and signed cleaning schedules and exception reports. (8.1, 8.2, 8.3, 8.4)
4. Discharge checklists. (8.1)
5. Education and training records. (All standard 8 criteria)
6. Environment and equipment is clean. (8.1, 8.2, 8.3, 8.4, 8.5, 8.6, 8.8, 8.9, 8.10, 8.11)
7. Evidence of compliance with National Cleaning Services Specification (or its revisions). (8.1, 8.2, 8.3, 8.4)
8. Evidence of the management of estates issues. (8.4)
9. Evidence that HAI system for controlling risk in the built environment is in place and used as an active document, with involvement of all relevant staff as appropriate. (8.2, 8.4, 8.6)
10. Evidence that estates staff and contractors are aware of, and use, the HAI system for controlling risk in the built environment process when planning repairs, refurbishments and new builds. (8.11, 8.12)

11. Individual written responses to complaints. (8.8, 8.9)
12. Local audits undertaken by staff (including: clinical, estates, domestic, infection prevention and control). (8.1, 8.2, 8.3, 8.4, 8.8)
13. Patient feedback reports. (8.8, 8.9)
14. Senior charge nurse weekly assurance checklists. (8.1, 8.2, 8.3)
15. The following audits for reusable medical devices (8.1, 8.2, 8.3, 8.4, 8.7, 8.8, 8.10):
 - surgical instruments – compliant decontamination unit notified body audits
 - endoscopes – endoscope decontamination unit Joint Advisory Group / Endoscopy Raising Standards and Effectiveness Programme audits
 - dental instruments – local decontamination unit board practice inspections, and
 - podiatry instruments – local decontamination unit audit reports.

Standard 9: Acquisition of equipment

Standard statement

All equipment acquired (this being equipment that is procured, loaned, donated, in-house manufactured, or for use within a trial or research) for the care environment is safe for use.

Rationale

The infection risk to patients is minimised by having an acquisition process in place that ensures all equipment (including reusable medical devices) is safe for its intended use. Safety refers to minimising the risk of transmission of infection.

References: 38, 39, 40, 41, 42

Criteria

- 9.1** The organisation has, and implements, policies and procedures for the acquisition of equipment (including reusable medical devices), in line with current national guidance and legislation, whilst recognising existing and emerging technologies.
- 9.2** All acquired reusable equipment (including reusable medical devices) is decontaminated in line with manufacturer's instructions and current national guidance.
- 9.3** All incidents and near misses associated with equipment (including reusable medical devices) are reported to the incident reporting investigation centre (or equivalent).
- 9.4** The infection prevention and control team and other key individuals are involved in all procurement decisions for new equipment (including reusable medical devices) prior to purchase.

What does the standard mean for people receiving treatment or visiting a healthcare and social care setting?

- Individuals will be confident that all medical devices and communal patient equipment (including reusable medical devices) being used by staff and/or in the healthcare and social care setting, meet the required level of safety, quality and performance.

What does the standard mean for the organisation?

- The organisation has a quality assurance system in place which demonstrates effective and efficient procurement of medical devices and communal patient equipment (including reusable medical devices) that are safe for use.

What does the standard mean for the infection prevention and control team?
The infection prevention and control team will be involved in all matters of procurement which impact on infection prevention and control.
What does the standard mean for staff at the point of care?
Staff have confidence in the safety, performance and quality of medical devices and communal patient equipment (including reusable medical devices).
What does the standard mean for support services?
Support services staff can demonstrate competency in the application of policies and procedures, within their role and responsibility, in relation to the procurement of equipment and medical devices.
Examples of evidence of achievement (<i>NOTE: this list is not exhaustive.</i>)
The executive team can: - describe organisational accountability and management for the procurement process for equipment (including reusable medical devices) impacting on infection prevention and control. The infection prevention and control team can: - describe their involvement in the procurement process for equipment (including reusable medical devices), and - articulate the reporting procedure to the organisational executive on the management of equipment (including reusable medical devices), including recommendations where risks have been identified. Staff are: - aware of the procurement process for equipment impacting on infection prevention and control, and - able to describe the procedure for reporting non-compatible equipment (including reusable medical devices). Practical examples (<i>The numbers shown in brackets correspond to relevant criterion/a</i>) - Evidence of assessment of compatibility of all equipment which impacts on infection prevention and control with existing decontamination processes. (9.2) - Evidence of implementation of procurement policy. (9.1) - Evidence of incidence reporting. (9.1, 9.2) - Evidence of involvement of relevant staff in the procurement process. (9.1, 9.4) - Evidence of the implementation of a 'loan' policy. (9.1)

- | |
|--|
| <p>6. Procurement policy, procedures and records related to the acquisition of equipment which impacts on infection prevention and control. (9.1, 9.2, 9.3, 9.4)</p> |
|--|

References

1. Healthcare Improvement Scotland. Driving Improvement in healthcare: Our strategy 2014-2020. 2014 [cited 2014 November 11]; Available from: www.healthcareimprovementscotland.org/drivingimprovement.aspx
2. NHS Quality Improvement Scotland. Healthcare Associated Infection (HAI) Standards. 2008 [cited 2014 January 29]; Available from: http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/hei_policies_and_procedures/hai_standards.aspx
3. Health Protection Scotland. National Infection prevention and Control Manual (v2.3). 2014 [cited 2014 January 29]; Available from: <http://www.documents.hps.scot.nhs.uk/hai/infection-control/ic-manual/ipcm-p-v2-3.pdf>
4. The Rt Hon Lord MacLean, Chairman. The Vale of Leven Hospital Inquiry Report. 2014 [cited 2014 December 3]; Available from: <http://www.valeoflevenhospitalinquiry.org/Report/j156505.pdf>
5. Scottish Government and Social Care and Social Work Improvement Scotland. The National Care Standards. [cited 2014 November 14]; Available from: <http://www.nationalcarestandards.org/52.html>
6. Clinical Standards Board for Scotland. Standards: Healthcare Associated Infection (HAI) Infection Control. 2001.
7. National Institute for Health and Clinical Excellence (NICE). Prevention and control of healthcare-associated infections: Quality improvement guide (NICE public health guidance 36). 2011 [cited 2014 January 29]; Available from: <https://www.nice.org.uk/guidance/PH36>
8. Scottish Government. The Healthcare Quality Strategy for NHSScotland. 2010 [cited 2014 June 02]; Available from: <http://www.scotland.gov.uk/Resource/Doc/311667/0098354.pdf>
9. Scottish Government. Healthcare Associated Infection Delivery Plan - April 2011. 2011 [cited 2014 June 02]; Available from: <http://www.scotland.gov.uk/Resource/0039/00398323.pdf>
10. The Scottish Government. NHS Performance Targets. 2014 [cited 2014 November 17]; Available from: <http://www.scotland.gov.uk/Topics/Health/Quality-Improvement-Performance/NHS-Performance-Targets>
11. Health Protection Scotland. Healthcare Associated Infection Annual Report. 2013 [cited 2014 November 18]; Available from: <http://www.documents.hps.scot.nhs.uk/hai/annual-report/healthcare-associated-infection-annual-report-2013.pdf>

12. Scottish Health Council, Healthcare Improvement Scotland. A Participation Standard for the NHS in Scotland. 2010 [cited 2014 October 28]; Available from: http://www.scottishhealthcouncil.org/patient_public_participation/participation_standard/participation_standard.aspx
13. Scottish Government. Everyone Matters: 2020 Workforce Vision. 2013 [cited 2014 June 02]; Available from: <http://www.scotland.gov.uk/Resource/0042/00424225.pdf>
14. NHS Education for Scotland. Career and Development Framework for Infection Prevention and Control Nurses. 2013 [cited 2014 October 29]; Available from: http://www.nes.scot.nhs.uk/media/2455602/nescd0183_ipc_nurses_framework2.pdf
15. NHS Education for Scotland. Post Registration Career Development Framework. [cited 2015 January 26]; Available from: http://www.careerframework.nes.scot.nhs.uk/media/32227/nescd0057_postregistrationcareerframework_f.pdf
16. Infection Prevention Society. Outcome Competences for Practitioners in Infection Prevention and Control. 2011 [cited 2014 October 27]; Available from: <http://bjj.sagepub.com/content/early/2011/02/07/1757177410395797.full.pdf>
17. NHS Education Scotland. HAI Education for Infection Prevention and Control. Cleanliness Champions Programme (v3.0). 2013 [cited 2014 November 3]; Available from: <http://www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/healthcare-associated-infections/educational-programmes/cleanliness-champions/introduction-to-cleanliness-champions.aspx>
18. Health and Safety Executive. RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations. 2013. [cited 2015 January 27]; Available from: <http://www.hse.gov.uk/riddor/>
19. Health Protection Scotland. Guidance on Prevention and Control of *Clostridium difficile* Infection (CDI) in Care Settings in Scotland. 2014 [cited 2015 January 6]; Available from: <http://www.documents.hps.scot.nhs.uk/about-hps/hpn/clostridium-difficile-infection-guidelines.pdf>
20. Health Protection Scotland. Communicating with the Public About Health Risks: Scottish Guidance. 2008 [cited 2014 November 12]; Available from: <http://www.documents.hps.scot.nhs.uk/about-hps/hpn/risk-communication.pdf>
21. NHS National Services Scotland. Protocol for the Scottish Mandatory Surveillance programme for *Staphylococcus aureus* bacteraemia (5th edition). 2012. [cited 2014 June 02]; Available from: <http://www.documents.hps.scot.nhs.uk/hai/sshaip/guidelines/s-aureus/s-aureus-bacteraemia-protocol-v5-2012-12.pdf>

22. Health Protection Scotland. Local Infection Surveillance of Alert Organisms and Alert Conditions: IPCT actions to prevent and detect outbreaks and to minimise infections following healthcare. 2014 [cited 2014 November 11]; Available from: <http://www.documents.hps.scot.nhs.uk/hai/infection-control/toolkits/local-infection-surveillance-2014-5.pdf>
23. Health Protection Scotland. Surveillance Systems. (Various) [cited 2014 November 14]; Available from: <http://www.hps.scot.nhs.uk/haic/ic/surveillancesystems.aspx>
24. Department of Health. UK Five Year Antimicrobial Resistance Strategy 2013 to 2018. 2013 [cited 2014 June 02]; Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/244058/20130902_UK_5_year_AMR_strategy.pdf
25. Scottish Government. The Scottish Management of Antimicrobial Resistance Action Plan [SCOTMARAP]. 2008 [cited 2014 June 02]; Available from: <http://www.scotland.gov.uk/Resource/Doc/215645/0057700.pdf>
26. Scottish Antimicrobial Prescribing Group, Scottish Medicines Consortium. Decision aid for diagnosis and management of suspected urinary tract infection (UTI) in older people. 2013 [cited 2014 October 30]; Available from: http://www.scottishmedicines.org.uk/files/sapg/SAPG_Ddecision_aid_for_UTI_in_older_people_-_May_2013.pdf
27. Scottish Antimicrobial Prescribing Group, Scottish Medicines Consortium and The Care Inspectorate. Aide Memoire for General Practitioners on Management of Care Home Resident(s) with Diarrhoea and *Clostridium difficile* infection (CDI). 2014 [cited 2014 November 11]; Available from: https://www.scottishmedicines.org.uk/files/sapg/Aide_Memoire.pdf
28. Department of Health. Water systems-Health Technical Memorandum 04-01: Addendum (Pseudomonas aeruginosa – advice for augmented care units). 2013 [cited 2014 June 02]; Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/140105/Health_Technical_Memorandum_04-01_Addendum.pdf
29. NHS National Services Scotland. The NHSScotland National Cleaning Services Specification. 2009 [cited 2014 June 02]; Available from: <http://www.hfs.scot.nhs.uk/publications/The%2BNHSScotland%2BNational%2BCleaning%2BServices%2BSpecification.pdf>
30. Health Facilities Scotland. Scottish Health Facilities Note 30 (Part A): Manual Information for Design Teams, Construction Teams, Estates & Facilities and Infection Prevention & Control Teams. 2014 [cited 2015 January 15]; Available from: <http://www.hfs.scot.nhs.uk/publications/1418138222-V4%20%20Manual%20final.pdf>

31. Health Facilities Scotland. Scottish Health Facilities Note 30 (Part B): HAI-SCRIBE Implementation strategy and assessment process. 2014 [cited 2015 January 15]; Available from: <http://www.hfs.scot.nhs.uk/publications/1418138351-V3%200%20Imp%20Strategy%20final.pdf>
32. The Scottish Government. Infection Control Standards for Adult Care Homes. 2005. [cited 2014 October 28]; Available from: <http://www.scotland.gov.uk/Publications/2005/03/19927/42771>
33. Scottish Government. CEL 19 (2013) Next Steps for Adult Safety – Patient Safety Essentials and Safety Priorities. 2013 [cited 2014 June 02]; Available from: http://www.sehd.scot.nhs.uk/mels/CEL2013_19.pdf
34. Scottish Government. Sterile Services Provision Review Group: First Report - The Glennie Framework. 2006 [cited 2014 November 17]; Available from: <http://www.scotland.gov.uk/Resource/Doc/158784/0043107.pdf>
35. Health Facilities Scotland. Requirements for Compliant Endoscope Decontamination Unit. 2014. [cited 2015 January 29]; Available from: <http://www.hfs.scot.nhs.uk/services/decontamination-services/guidance/>
36. Health Facilities Scotland. Compliant Dental Local Decontamination Units in Scotland (Primary Care). 2013 [cited 2014 November 18]; Available from: [http://www.hfs.scot.nhs.uk/publications/1369061800-Compliant%20Dental%20LDUs%20in%20Scotland%20\(Primary%20Care\)%20v1.pdf](http://www.hfs.scot.nhs.uk/publications/1369061800-Compliant%20Dental%20LDUs%20in%20Scotland%20(Primary%20Care)%20v1.pdf)
37. Health Facilities Scotland. Provision of Compliant Podiatry Instruments. 2014 [cited 2014 November 18]; Available from: <http://www.hfs.scot.nhs.uk/downloads/1415636153-v2.0%2BProvision%2Bof%2BCompliant%2BPodiatry%2BInstruments.pdf>
38. Medicines and Healthcare Products Regulatory Agency (MHRA). Managing Medical Devices. 2014 [cited 2014 November 18]; Available from: <http://www.mhra.gov.uk/home/groups/dts-bs/documents/publication/con2025143.pdf>
39. The Scottish Government. Key Procurement Principles (CEL 05 (2012)). 2012 [cited 2014 November 18]; Available from: http://www.sehd.scot.nhs.uk/mels/CEL2012_05.pdf
40. Safety Of Health, Social Care, Estates and Facilities Equipment: NHS Board and Local Authority Responsibilities (CEL 43). 2009 [cited 2014 November 17]; Available from: http://www.sehd.scot.nhs.uk/mels/CEL2009_43.pdf
41. Scottish Government. Safety of Health, Social Care, Estates and Facilities Equipment: NHS Board and Local Authority Responsibilities (CEL 43). 2009 [cited 2014 November 17]; Available from: http://www.sehd.scot.nhs.uk/mels/CEL2009_43.pdf

42. Scottish Government. Addendum to CEL 43(2009): Safety of Health, Social Care, Estates and Facilities Equipment: NHS Board and Local Authority Responsibilities. 2013 [cited 2014 November 17]; Available from: http://www.sehd.scot.nhs.uk/mels/CEL2009_43add.pdf

Further reading

43. Department of Health. The Health and Social Care Act 2008: Code of practice on the prevention and control of infections and related guidance. 2010 [cited 2014 June 02]; Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216227/dh_123923.pdf
44. Emma Burnett. Outcome competencies for practitioners in infection prevention control: Infection Prevention Society and Competency Steering Group. 2011; i/27
45. Isopharm. Scottish Health Technical Memorandum (SHTM). 2014 [cited 2014 June 02]; Available from: <http://www.isopharm.co.uk/validation-engineer/scottish-health-technical-memorandum>
46. Loveday HP, Wilson JA, Pratt RJ, Golsorkhi A, Tingle A, Bak A et al epic3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England. J Hosp Infect. 2014; 86: S1-S70
47. National Institute for Health and Care Excellence. Infection prevention and control: NICE quality standard 61. 2014 [cited 2014 May 29]; Available from: <http://publications.nice.org.uk/infection-prevention-and-control-qs61>
48. National Institute for Health and Clinical Excellence. Prevention and control of healthcare-associated infections in primary and community care (NICE clinical guideline 139). 2012 [cited 2014 January 29]; Available from: <http://www.nice.org.uk/nicemedia/live/13684/58656/58656.pdf>
49. NHS Institute for Innovation and Improvement. The Fifteen Steps Challenge: Quality from a patient's perspective. 2012 [cited 2014 May 29]; Available from: <http://www.institute.nhs.uk/productives/15stepschallenge/15stepschallenge.html>
50. Pratt RJ, Pellowe CM, Wilson JA, Loveday HP, Harper PJ, Jones SRLJ et al epic2: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England. J Hosp Infect. 2007; 65: S1-S64.

Appendix 1 Membership of the standards for HAI short-life working group

Name	Position	Organisation	Sub-group
Hazel Borland	Executive Nurse Director	NHS Dumfries & Galloway	Leadership, governance and accountability
Susan Brimelow	Chief Inspector	Healthcare Improvement Scotland / Healthcare Environment Inspectorate	
Alison Cockburn	Lead Antimicrobial Pharmacist	NHS Lothian	Infection prevention and control
Abigail Cork	Facilities Support Manager	Health Facilities Scotland	Decontamination / Acquisition of equipment
Evonne Curran	Nurse Consultant Infection Control	Health Protection Scotland	Communication
Lesley Davis	Regional Manager	Truvox International	Decontamination / Acquisition of equipment
Liz Dillon	Director of Nursing	Ross Hall Hospital / Scottish Independent Healthcare Advisory Service (until June 2014)	
Rose Gallagher	Nurse Advisor Infection Prevention Control	Royal College of Nursing	Leadership, governance and accountability
Pamela Harrison	Infection Control Manager	NHS Grampian	Leadership, governance and accountability
Sulisti Holmes	Head of Decontamination Services	Health Facilities Scotland	Decontamination / Acquisition of equipment
Jonathan Horwood	Infection Control Manager	NHS Forth Valley (until June 2014)	Communication
Ellen Hudson	Associate	Royal College of Nursing	

Name	Position	Organisation	Sub-group
	Director	Scotland	
Laura Imrie	Nurse Consultant Infection Control	Health Protection Scotland / Scottish Surveillance of HAI Programme	Surveillance
Pamela Joannidis	Nurse Consultant Infection Prevention and Control	NHS Greater Glasgow and Clyde	Decontamination / Acquisition of equipment
Paul Kelly	Clinical Governance Manager	Scottish Ambulance Service	Communication
Pia Kirkpatrick	Infection Control Nurse	Ross Hall Hospital / Scottish Independent Healthcare Advisory Service	
Al Leanord	Medical Advisor	Scottish Government	Surveillance
Penny Leggat	Public Partner	Healthcare Improvement Scotland	
Helen Macguire	Patient Representative	Healthcare Improvement Scotland	Communication
Annette McCafferty	Domestic Manager	NHS Greater Glasgow and Clyde	Decontamination / Acquisition of equipment
Alastair McGown	Senior Inspector	Healthcare Improvement Scotland / Healthcare Environment Inspectorate	Decontamination / Acquisition of equipment
Willie McGregor	Senior Charge Nurse	NHS Lothian	Education
Margaret McGuire (Chair)	Nurse Director	NHS Tayside	
Iain McNally	Head of Estates	NHS Ayrshire & Arran	Decontamination / Acquisition of equipment

Name	Position	Organisation	Sub-group
Daniel McQueen	Public Partner	Healthcare Improvement Scotland (until July 2014)	Surveillance
Wilma Morgan	Inspector Manager	Care Inspectorate	Communication
Keith Morris	Consultant Microbiologist and Infection Control Doctor	NHS Fife	Infection prevention and control
Abigail Mullings	HAI Professional Advisor	Scottish Government	Surveillance
Geraldine O'Brien	Research Manager	Health Facilities Scotland	Decontamination / Acquisition of equipment
Ann Paterson	Infection Control Manager	Scottish National Blood Transfusion Service	Infection prevention and control
Kathryn Paterson	Associate Improvement Advisor	Healthcare Improvement Scotland / Scottish Patient Safety Programme (until December 2014)	Infection prevention and control
Christine Peters	Consultant Microbiologist	NHS Ayrshire & Arran	Surveillance
Annette Rankin	Nurse Consultant Infection Control	Health Protection Scotland	Decontamination / Acquisition of equipment
Lisa Ritchie	Nurse Consultant Infection Control	Health Protection Scotland	Infection prevention and control
Susan Roberts	Project Lead	Healthcare Improvement Scotland / Scottish Antimicrobial Prescribing Group	Infection prevention and control
Evelyn Rodger	Director of Nursing and Midwifery	NHS Borders	

Name	Position	Organisation	Sub-group
Janice Rollo	Clinical Governance Co-ordinator	NHS Grampian	Decontamination / Acquisition of equipment
Jacqueline Sneddon	Project Lead	Healthcare Improvement Scotland / Scottish Antimicrobial Prescribing Group	
Margaret Tannahill	Consultant Nurse Infection Control	Care Inspectorate	Education
Gill Walker	Programme Director	NHS Education for Scotland	Education
Tom Walsh	Infection Control Manager	NHS Greater Glasgow and Clyde	Leadership, governance and accountability
Sam Whiting	Infection Control Manager	NHS Borders	
Susan Wilson	Infection Control Manager	Scottish Ambulance Service	Infection prevention and control
Adam Wood	Senior Infection Control Nurse	NHS Borders	Education
Christine Young	Infection Control Nurse Advisor	NHS Education for Scotland	Education
Liz Young	Surveillance Nurse	NHS Lanarkshire	Surveillance



www.healthcareimprovementscotland.org

Edinburgh Office: Gyle Square | 1 South Gyle Crescent | Edinburgh | EH12 9EB

Telephone: 0131 623 4300

Glasgow Office: Delta House | 50 West Nile Street | Glasgow | G1 2NP

Telephone: 0141 225 6999

The Healthcare Environment Inspectorate, the Scottish Health Council, the Scottish Health Technologies Group, the Scottish Intercollegiate Guidelines Network (SIGN) and the Scottish Medicines Consortium are part of our organisation.



You can read and download this document from our website. We are happy to consider requests for other languages or formats. Please contact our Equality and Diversity Advisor on **0141 225 6999** or email **contactpublicinvolvement.his@nhs.net**