



Department of
**Health, Social Services
and Public Safety**

An Roinn
**Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí**

www.dhsspsni.gov.uk

**PROTECTING
PATIENTS AND STAFF-**

**A STRATEGY FOR
PREVENTION AND CONTROL OF
HEALTHCARE ASSOCIATED INFECTIONS
IN NORTHERN IRELAND
2005-2010**

June 2005

FOREWORD

Healthcare Associated Infections (HCAs) are very much a priority for the HPSS, and rightly so. HCAs can prolong a person's stay in hospital and, in some cases, can cause death. As Chief Medical Officer I am acutely aware that our hospitals should be a safe place for those undergoing treatment for their conditions, and for the staff looking after them.

The prevention and control of HCAs in our hospitals is a complex issue and one that needs a comprehensive strategic approach. While it is impossible to prevent all HCAs we can do better to reduce these infections to an absolute minimum. In September 2004 the then Health Minister, Angela Smith MP, announced the Department's intention to establish a group to develop a strategy for the prevention and control of HCAs. The group has identified a range of issues that need to be addressed in order to make our hospitals safer for patients, visitors and staff. Such issues include enhanced support for infection control professionals; mandatory training for staff; better awareness and information for patients, visitors & patient representatives; opportunities for the sharing of best practice throughout the Health Service and the strengthening of accountability procedures in Trusts.

I am pleased, however, that this strategy paper recognises the key principle that ***Infection Prevention and Control is Everyone's Business***. The challenge for healthcare workers is to change our thinking and culture so that we all recognise the role we have to play in tackling HCAs. It is no longer valid simply to say that this issue is solely the responsibility of the Infection Control Team.

Working in partnership with all hospital users is the key to minimising the risk of infection to patients and staff alike.

This strategy represents a major step forward in tackling the issue of HCAs and I would encourage you to share you views on this consultation document with us.

Dr Henrietta Campbell

Chief Medical Officer

June 2005

CONTENTS

Section	Title	Page
	Glossary of Terms	5
1	Introduction	9
2	Background and Information	12
3	Strategic Context	19
4	Strategic Aim and Objectives	26
5	Organisation and Culture of Healthcare Organisations	27
6	Education, Training and Practices	33
7	Governance, Accountability and Audit	36
8	Surveillance	41
9	Patient and Public Partnership	47
Appendix		
A	List of Circulars and Reports	51
B	Membership of Strategy Working Group	57
C	Specialist Infection Prevention & Control Teams	59
D	Composite List of Recommendations	61
E	Equality Issues	71

GLOSSARY OF TERMS

Acute hospitals

Hospitals that are staffed and equipped to deal with patients suffering from severe (or acute) illnesses. Acute hospitals would usually have such facilities as Accident and Emergency Departments and Intensive Care Units.

Antimicrobial resistance

Antimicrobial resistance describes the ability of a microorganism to resist the growth-suppressing or microbicidal effects of particular antimicrobial agents. This ability can reflect a naturally occurring property of an organism (e.g. having a thick cell-wall), or might develop through alteration of the organisms' genes. In some cases, genes conferring resistance to a particular antimicrobial can be transferred between different strains of microorganisms, the recipient organisms thus becoming resistant.

Emergence of antimicrobial resistance in infectious organisms at a population level is dependent on the survival and further spread of organisms with antimicrobial properties. The extensive use of antimicrobial agents probably helps this process along, by eliminating sensitive microorganisms, which in turn allows the resistant ones a greater opportunity to spread.

Antimicrobial resistance has emerged in some bacterial, viral and fungal species that cause disease in man. Undertaking laboratory susceptibility testing of organisms causing infections can play an important role in identifying the most effective treatment, depending on which organism are involved.

Bacteraemia

A condition in which bacteria are present in the bloodstream.

C. difficile (Clostridium difficile)

Clostridium difficile (so called because when it was first discovered it was difficult to grow in the laboratory) is a cause of diarrhoea, which is usually acquired in hospital. Although in most cases it causes a relatively mild illness, occasionally and particularly in elderly patients, it may result in serious illness and even death. The bacterium produces two toxins which are responsible for the diarrhoea and which damage the cells lining the bowel. However, not all strains of *C. difficile* produce toxin; these strains are unlikely to cause disease and patients colonised by them remain healthy. In addition, the bacterium can form spores which enable it to survive in the environment outside the body and which protect the organism against heat and chemical disinfectants.

Control Assurance Standards

The ways that the board checks that its policies are being carried out. This includes internal and external audit for financial matters, employment policies and all areas in which the organisation interacts with the public.

Governance

Assessment, control and monitoring, which ensures organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence will flourish. It is about making sure that there are systems in place to provide patients with high standards of care.

Healthcare associated infections (HCAI)

Healthcare-associated infections are those that arise as a result of healthcare interventions, either in patients undergoing these interventions or in healthcare workers involved in these interventions. A wide variety of organisms can be transmitted in healthcare settings, causing in turn a wide range of different diseases.

Infection Control Nursing

This is a specialised area of nursing dealing with the prevention and control of infections in hospitals or other healthcare settings.

MRSA (methicillin resistant *Staphylococcus aureus*)

MRSA stands for Methicillin-Resistant *Staphylococcus Aureus*. *Staphylococcus aureus* (SA) is a common type of bacteria that can cause illness. Methicillin is a powerful antibiotic drug. MRSA includes several strains (types) of the SA germ that are not killed by powerful antibiotics.

Around 40% of cases of SA in the UK are resistant to methicillin and other antibiotics. These are the ones called MRSA. These types of SA tend to be more common in hospital, because people are more susceptible to infections when they are already unwell.

Antibiotics aren't completely powerless against MRSA. The infection may simply require a much higher dose over a much longer period, or the use of an alternative antibiotic to which the germ has less resistance.

The long-term risk of SA is the chance that it may become resistant to all antibiotic drugs. For this reason it is important that antibiotics are only used

when necessary and the full course of a drug is taken when it has been prescribed.

Nosocomial Infection

A nosocomial infection is a localised or systemic condition arising from an adverse reaction to the presence of an infectious agent(s) or its toxin(s) in a patient admission and there is no evidence that it was present or incubating at the time of hospital admission unless the infection was related to a previous admission to that hospital. The infection must also meet recognised criteria for a specific infection site.

Patient episode

Patient episode refers to laboratory samples that have the detected presence of bacteria. If these are collected from the same patient more than 14 days apart then this should be considered as reflecting different episodes of infection.

S. aureus (Staphylococcus aureus)

Staphylococcus aureus is a very common cause of bacterial infections – boils, carbuncles, infected wounds, deep abscesses and bloodstream infection (bacteraemia). It was first described in the 1880s by Ogston, in Edinburgh, who found it was the most common cause of infected surgical wounds.

SARS (Severe Acute Respiratory Syndrome)

SARS first appeared in South East Asia in March 2003 and quickly spread to many countries around the world. Over 850 people died as a result of contracting SARS, many of which were healthcare workers involved with treating SARS patients in hospital settings.

Surgical site infections

After a patient has undergone an operation (i.e. surgery) the wound (surgical site) can sometimes become infected. This can lead to secondary illnesses and even death.

Trusts

Self-governing bodies that provide health and social care to the public. They can employ a wide range of health and social care staff.

Trust Board

A group of up to eleven people who are responsible for major strategy and policy discussions in each trust. Typically comprises of a lay chairman and five lay members, the trust chief executive and executive directors.

1 INTRODUCTION

- 1.1 The Department of Health, Social Services & Public Safety (DHSSPS) has identified healthcare associated infections (HCAI) as one of the key areas requiring a strategic approach to prevention and control. The issues that have prompted the development of the strategy for prevention and control of healthcare associated infections are highlighted in the strategic context of this document. It is envisaged that the publication of this strategy and the subsequent action plan will give prevention and control of healthcare associated infections the priority it needs and deserves in the work programme of the HPSS.
- 1.2 Based on current knowledge and best practice only a minority (15%) of HCAI can be prevented, however, there is scope for considerable improvement in certain situations with improved practice across all sectors of the HPSS in Northern Ireland. The report produced by the National Audit Office in July 2004 noted that there had been improvements in infection prevention and control since 2000 but implementation and compliance with the Public Accounts Committee's recommendations had been patchy. The report makes a number of recommendations for Departments of Health and Trusts, specifically in the areas of surveillance, infection prevention and control training, infection prevention and control systems and staffing.
- 1.3 While this strategy document concentrates primarily on preventing HCAI in acute hospitals, the principles apply across all settings in the HPSS including community and primary care.
- 1.4 Preventing and controlling infection and ensuring that as few patients as possible acquire an infection during their hospital stay is the responsibility of all those working in the HPSS. In other words “**protecting patients and**

staff from infection is everyone's responsibility". Recognising this key fact is crucial as ensuring that infection prevention and control is a top priority will require both a change in culture at every level in HPSS organisations and a clear identification of infection prevention control as both a clinical and corporate governance issue for HPSS organisations. Healthcare bodies need to have clear reporting lines, develop infection prevention and control programmes and report on infection rates openly and constructively. Accountability for infection prevention and control lies with the Chief Executive of the relevant healthcare organisation.

- 1.5 Although this document outlines the future strategic approach to preventing and controlling HCAI this is not the first initiative in this area. A list of all the key circulars and documents that have been issued in the province in relation to this issue is contained in Annexe A. In addition, the Department invested heavily in infection prevention control measures and training in Trusts in the light of the emergence of SARS in 2003. The HPSS Control Assurance Standards: Infection Control, issued to Trusts in April 2004, provide a framework against which robust approaches to controlling infection should be developed and monitored. These have resulted in positive developments in infection control in HPSS organisations and it is these that we need to build on as we further improve our approach in this area
- 1.6 The Clinical and Social Care Governance Agenda in the HPSS further highlights the need to deal with HCAI as a priority. It is a core issue for the risk management programme for organisations. There should be a common imperative to improve patient safety and minimise the infection risk associated with modern healthcare. This needs to be at the centre of the Clinical and Social Care Governance Agenda. DHSSPS is committed to ensuring that through this strategy evidence-based infection control mechanisms are introduced and implemented in order to minimise the risk to patient safety.

1.7 The public, patients and visitors expect to have a safe stay and receive high quality care if admitted to hospital. Similarly our staff should also work in an environment where infection prevention and control is pivotal and infections are kept to an irreducible minimum. High standards of cleanliness and infection prevention and control are anticipated from hospital staff and patients do not expect to acquire a preventable but potential life threatening infection during their hospital stay. Similarly visitors to hospitals have a clear responsibility to comply with infection prevention advice and ensure they don't introduce infections from the community into hospitals filled with vulnerable patients. A key focus of this strategy is the need for cooperation and collaboration between the public, patients and health professionals in the prevention and control of HCAI.

Equality Issues

1.8 Under equality legislation (Northern Ireland Act 1998) the Department is required to consider the equality impact of all new strategies being developed. The strategy for the prevention and control of healthcare associated infections was assessed against the criteria contained in Section 75 of the Northern Ireland Act. An initial assessment of the strategy is that a full equality impact assessment (EQIA) is not required.

1.9 However, the Department is prepared to consider any alternative views on how this strategy might impact on equality issues and its decision not to subject the strategy to a full EQIA. Appendix E contains some questions that might assist in this process.

2 BACKGROUND INFORMATION

- 2.1 It is recognised that the United Kingdom has one of the highest levels of healthcare associated infection in Europe. The National Audit Office Report in July 2004 stated that approximately 5,000 patients died each year from HCAI but suggest that due to incomplete data the figure could be higher. It is estimated that HCAI costs the NHS around £1billion per year. In relation to HCAI in the UK the NAO Report states; “15% of HCAI could be prevented by better application of good practice, and releasing resources”. The Clinical Resource Efficiency Support Team (CREST) audits carried out in Northern Ireland in 1995 and 2001 showed improvements in infection prevention and control services.
- 2.2 Not all HCAI is preventable nor is it likely to become so in the foreseeable future. The very young and the very old, who have less efficient or immature immune systems, are particularly susceptible to hospital infections, as are patients undergoing treatments that suppress the immune system, such as transplant and chemotherapy patients. Often these patients can acquire an infection from organisms they are currently carrying on their skin, their airways or bowel. The length of stay in hospital is a risk factor, as are the severity of illness, the use of invasive procedures and the presence of medical devices such as urinary catheters and central venous catheters.

Current Position in Northern Ireland

- 2.3 Information on all HCAI rates in Northern Ireland is currently not available as there is an absence of comprehensive surveillance programmes. Some limited information is available from a number of targeted surveillance initiatives led by the Communicable Disease Surveillance Centre (Northern

Ireland) (CDSC (NI)) and the Healthcare-associated Infection Surveillance Centre (HISC) – see below.

2.4 However a considerable amount of work has already been done in the area of prevention and control of healthcare acquired infections in Northern Ireland and this includes:

a. CDSC (NI) was established in August 1999 following a major review of communicable disease control within the province. One of the key elements of service provided by CDSC (NI) is surveillance of communicable disease in line with national and regional priorities. It has led a number of mandatory regional programmes for surveillance of HCAs being taken forward in collaboration with acute Trusts. These mirror similar developments in the rest of the UK and include;

- *S. aureus* and MRSA bacteraemias (from April 2001)
- *C. difficile* (in faecal specimens) (from 1st January 2005)

There have been three annual reports on MRSA bloodstream (bacteraemia) infection rates (available from the CDSC (NI) website <http://www.cdscni.org.uk/>). These reports contain Trust specific trends and are considered to be the best available indicator of MRSA infection in hospitals. However, comparison between Trusts must be made with great caution as changes in patients' risk profile will influence susceptibility to MRSA bloodstream infection and therefore Trust rates. Nevertheless, it can enable Trusts to examine their own results and take action where there were areas for concern. Further reports have been produced and are available on the CDSC (NI) website.

CDSC (NI) is part of the Health Protection Agency (HPA) and has a direct link to the programme of work led by the HPA in relation to

HCAI. In addition CDSC (NI) has established links to the European Antimicrobial Resistance Surveillance Scheme (EARSS) with Northern Ireland laboratories now contributing data to Europe in a standardised format.

- b. The *Hospital Acquired Infection Sub-Committee* of the Regional Advisory Committee on Communicable Disease Control was established in October 1999. This Committee advises on infection prevention and control practice in hospitals and the surveillance of healthcare associated infection in relation to relevant organisms. The work of this committee included; (i) Development of draft regional standards for environmental cleanliness, (ii) Regional lead on Hand Hygiene Promotion and (iii) Contribution to the development of the Controls Assurance Standards on Infection Control issued by DHSSPS in April 2004.

- c. In September 2001 DHSSPS set up the Healthcare-associated Infection Surveillance Centre (HISC) to develop and improve surveillance methodology for HCAI within Northern Ireland. This was to be achieved by assisting hospitals to monitor HCAs including facilitating data collection, handling, analysis and feedback. To date HISC has developed regional surveillance for surgical site infection in elective orthopaedics and assisted local hospitals with surveillance for surgical site infections in other specialties. Training of staff in data collection, collation and analysis has also been facilitated. HISC is part of a national surveillance collaboration under the auspices of the Pan-Celtic surveillance group. Links have also been established to the Hospitals in Europe link for Nosocomial Infection (HELICS). HISC will also lead on the Northern Ireland participation in the National Prevalence survey of healthcare associated infections during 2005/06. A number of reports on the surveillance of surgical site infection have

been produced by HISC and can be viewed on the website at www.hisc.n-i.nhs.uk.

- d. In 2001/2002 DHSSPS commissioned a survey of all hospital Trusts in Northern Ireland with regard to the management and control of healthcare associated infections. The issues identified from this survey included improving the resourcing of infection control teams including an increase in the complement of infection control nurses, improving the computerisation of data collection systems, providing support for surveillance activities in Trust Hospital Microbiology Departments, and increasing the priority given to infection prevention and control at Trust Board level. Nevertheless, progress in further developing infection prevention and control was taking place and since an earlier survey in 1995 there had been an increase in the types and range of infection control policies at Trust level, increased infection control team contribution to clinical audit and increased infection control cover out-of-hours.

- e. Since 2002, DHSSPS has established a Healthcare Associated Infection Surveillance Group. This group has reviewed national HCAI surveillance initiatives and advised on their application to Northern Ireland. Under the auspices of that Group the surveillance of MRSA Bacteraemia has been made mandatory for all Trusts. Trusts have also been asked to undertake mandatory *C.difficile* from 1st January 2005.

- f. In April 2004, Controls Assurance Standards in Infection Control were produced and disseminated to all HPSS organisations. These are valuable standards that outline the key infection prevention and control criteria that Trusts must meet if they are to have appropriate

arrangements in place for infection prevention and control in their organisation.

- g. A high quality environment is essential for the delivery of health and social care services and needs to be supported by high standards of environmental cleanliness. A clean environment helps support best practice and optimum infection prevention and control standards. Whilst environmental cleanliness and infection prevention and control are strongly associated in public perceptions, preventing infections requires more than simple cleanliness. The key is to ensure that the highest possible standards of cleanliness are achieved within available resources and to satisfy service users that HPSS facilities are clean and kept clean. In support of this objective, the Department will be placing a renewed emphasis on environmental cleanliness with the development of a regional strategy for environmental cleanliness improvement that will be appropriately linked to infection prevention and control.
- h. DHSSPS, under the leadership of the Chief Nursing Officer, has developed a strategy for the future of Infection Control Nursing in the province. The Strategy has been consulted upon widely within and beyond the nursing profession. This consultation closed on 8th April 2005.

Approach taken in other countries

England, Scotland and Wales

2.5 Each of the countries of England, Scotland and Wales has developed strategic approaches to the prevention and control of HCAs that are at various stages of implementation. These strategic documents may be viewed at the websites of the respective health departments – England (www.dh.gov.uk) Scotland (<http://www.show.scot.nhs.uk/>) and Wales (<http://www.cmo.wales.gov.uk/content/publications/strategies/healthcare-associated-infections-e.pdf>). In each of these documents the priority given to infection prevention and control by the respective governments is clearly outlined. While each document contains required action relevant to the needs of that country there are a number of recurring themes as follows: the organisation, structure and culture of healthcare organisations needs to facilitate effective prevention and control practices, a clear governance and accountability framework is required, all staff require education and training, good surveillance is required to underpin and inform infection prevention and control practices and to monitor outcomes.

International

2.6 Internationally the need to reduce and control healthcare associated infections has received unprecedented attention from governments and healthcare leaders over the last number of years. Different approaches have been adopted around the world and include the ‘zero tolerance’ and ‘search and destroy’ approach to controlling MRSA in hospitals in the Netherlands which has resulted in the Dutch achieving very low rates of MRSA. However other factors also contribute to the success of this strategy including low bed occupancy rates. In the USA the Centers for Disease Control (CDC) lead on a range of strategies to reduce levels of HCAI and these may be viewed at

(<http://www.cdc.gov/ncidod/hip/>). A number of US states have also made regular and updated infection prevention training mandatory for all staff and a condition of registration that is required for employment. In the USA the Institute of Healthcare Improvement (www.ihp.org) is leading a nationwide campaign with US hospitals to reduce preventable patient deaths and save 100,000 patient lives in the USA by June 2006. Six key areas of preventable deaths are targeted as part of this campaign and, of these, three are related to the prevention of HCAI.

3 STRATEGIC CONTEXT

- 3.1 Over the last number of years the prevention and control of healthcare associated infections has assumed high importance – with government, the health service, the public and the media. The Department recognises this area as a key public health priority and has been working consistently to improve approaches in this area. However, there have been a number of events that have highlighted the need to develop a more comprehensive strategic approach to healthcare associated infections in Northern Ireland hospitals.
- 3.2 Internationally the emergence of SARS and Avian Influenza have increased the sense of urgency in relation to ensuring that appropriate infection prevention and control arrangements are in place in hospitals, not only to protect patients but also to protect staff. The emergence of SARS prompted sustained work in Northern Ireland in the area of infection prevention and control and a number of key improvements, notably staff training materials, were developed in the context of SARS. These included elements of infection control training and have been widely distributed in the province and used for training healthcare professionals. In addition, further investment was made in infection control on the back of SARS planning.
- 3.3 However, there are a number of key issues that form the context against which this strategy has been developed. These are as follows:
1. Increasing concerns about MRSA and other antibiotic resistant organisms in hospital Trusts.
 2. Incidents of inadequate decontamination of endoscopes in Northern Ireland hospitals.

3. Enhanced focus on the surveillance of healthcare associated infections by the Health Protection Agency, Communicable Disease Surveillance Centre (NI) and the Healthcare-associated Infections Surveillance Centre (HISC), including making surveillance of a number of infections mandatory.
 4. Publications by the Chief Medical Officers' in England, Scotland and Wales of strategies to reduce healthcare associated infections.
 5. In the report by the National Audit Office 'Improving Patient Care by Reducing the Risk of Hospital Acquired Infection: A Progress Report – July 2004' a number of recommendations are made for improved national, regional and Trust approaches to infection prevention and control.
- 3.4 Healthcare associated infections are particularly important as adverse events in hospitals for a number of reasons. HCAs not only affect the individual patient but can be transmitted to others causing morbidity. In addition, outbreaks of infection may occur which are hard to control. This represents a significant public health problem. HCAs also have an impact on the delivery of health services. Patients who acquire an infection in hospital often have an increased length in stay that adversely affects the patient and is an additional cost for the service. HCAs are seen by the public as a reflection of poor hygiene, unclean environments, and poor practices among healthcare staff. This portrays a negative image of healthcare settings and also affects public expectations of the quality of care that they may receive in hospital. The principles underpinning the aims (see next section) of the strategy are the need to:
1. Minimise transmission of infection in healthcare settings
 2. Place infection prevention and control high on the agenda of Chief executives of HPSS organisations

3. Improve the general level of education and understanding of infection prevention and control principles and measures among professional staff, patients and the public.
4. Adopt a co-ordinated approach to surveillance, investigation, prevention and control of infection.
5. Ensure the accurate diagnosis and management of individual cases making efficient use of laboratory and clinical resources.
6. Ensure the appropriate management of adverse incidents, including outbreaks.

Strategic Outline

3.5 This strategy outlines action to be taken in a number of priority areas as follows:

1. Organisation and Culture
2. Education, Training and Practices
3. Governance, audit and accountability
4. Surveillance
5. Patient and Public Partnership

3.6 Information on the rationale for making these the priority areas for action in the strategy is included here. The key messages and recommendations are included in separate sections relating to each key area.

1. Organisation and Culture

This strategy highlights the need for strong leadership at the highest levels in HPSS organisations to prevent and control healthcare associated infections. A new approach is required to ensure uncompromising commitment from senior management to facilitate a culture of “**infection**

prevention and control is everyone's business". This culture must be supported at organisational level by making the issue integral to the management priorities and key performance indicators for the organisation.

For prevention and control of healthcare associated infection to work effectively, critical evidence of best practice must be embedded in everyday and routine activities: "that's how we do things round here". The HPSS workforce needs to be fully trained and supported to ensure they are enabled to implement good infection prevention and control practice.

Developing Better Services acknowledges the pressures faced by acute hospital services and the impact this may have on the quality and standard of care offered. Improvements in professional ways of working and service configuration are required to achieve the necessary standards in care. It is important that, in the efforts to improve productivity and throughput of patients, sight is not lost of the need to adhere to high standards of infection prevention and control at all times.

2. Education, Training and Practices

Each individual healthcare practitioner has a professional responsibility for safe practice including the prevention and control of infection. Professional practices are key to preventing and controlling healthcare acquired infections. At a very basic level they involve ensuring that all healthcare staff pay appropriate attention to infection prevention and control issues and that this is reflected in their daily practice. As such a key concern is achieving high levels of attendance by all healthcare staff at infection prevention and control training.

Changing certain aspects of professional practice is challenging and a key example is the issue of hand-hygiene. Appropriate and effective hand-

hygiene is seen as one of the most important factors in the prevention of transmission of healthcare associated infections.

3. Governance, Accountability and Audit

Important work is ongoing in relation to improving the quality standards and governance structures within the HPSS. Governance has been defined as “the system by which an organisation directs and controls its functions and relates to its stake holders”. Clinical Governance has been further defined as “a framework for improving quality and safeguarding high standards by creating an environment in which excellence will flourish”. Under current arrangements Chief Executives of Health and Social Services Organisations are now aware of their legal duties to identify, assess and reduce the risk of infection in the workplace. Approaches to infection prevention and control must be seen as part and parcel of quality and governance issues. Since 2003 the statutory duty of quality has been in place, and clinical and social care governance arrangements are being developed to support its implementation. From 1 April 2005 a new independent HPSS Regulation and Improvement Authority (HPSSRIA) assumed responsibility for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland and for encouraging improvements. The Clinical and Social Care Governance (CSCG) Support Team has been working with HPSS organisations to assist the development and implementation of good governance in the HPSS and sustaining longer-term cultural change and organisational development. As part of their CSCG arrangements HPSS organisations need to develop appropriate risk management systems which provide an environment in which users, staff and other stakeholders are protected and where safe, effective, efficient and high quality health and social care is provided. In addition, new high-level clinical and social care governance standards were issued for public consultation in April 2005. These quality standards will integrate key

elements of the quality and safety agenda and will provide a platform for the HPSSRIA to assess and report on the quality of care commissioned or provided by HPSS organisations.

In addition to strong leadership and management within organisations a clear accountability framework is required for infection prevention and control. Similarly all HPSS organisations must include activities in relation to infection prevention and control in the organisations regular programme of audit.

4. Surveillance

Surveillance is the collection, collation, analysis and interpretation of data regarding infection and timely dissemination of results so that appropriate action can be taken. The intention is to assess and, where necessary, improve the quality and effectiveness of care. Surveillance alone cannot protect health. It is the combination of surveillance with the action or response that follows which can reduce HCAI.

Surveillance data and information can be useful to: identify problems; ascertain risk factors; document trends; enable priorities to be set; target interventions; and monitor the effectiveness of action. It may also allow comparison with other geographical areas. HCAI surveillance is complex not least because of the many contributory factors associated with each patient. In the absence of specific, and often very expensive, surveys it is not possible to routinely have active surveillance for all HCAI. It is therefore necessary to prioritise and select organisms and infections for inclusion in routine surveillance. Surveillance programmes, if they are to be sustained, need dedicated resources to enable the appropriate data to be collected, collated, analysed, interpreted and disseminated to facilitate the desired action.

5. Patient and Public Partnership

Patients and members of the public have an important role to play in partnership with the HPSS to prevent and control healthcare acquired infections. There is much work to be done in restoring confidence in the HPSS in terms of HCAI. Appropriate, accessible and relevant information is required for patients and the public in order that they may appreciate and understand the issues around HCAI. **A key message is that not all HCAI is preventable but with a joined up effort infection rates could be kept to a minimum.** Information on infection rates and risk factors for acquisition needs to be in the public domain. Similarly information on how patients may reduce their risk of infection and how, in particular, visitors can contribute to this needs to be widely available. As in other areas of the HPSS patients need to share in the decision-making regarding infection prevention and control.

4 STRATEGIC AIM and OBJECTIVES

Aim

To minimise the occurrence of healthcare associated infections.

Objectives

1. To deliver the key message that “*infection prevention and control is everyone’s responsibility*”.
2. To make all healthcare settings a safe environment for patients, visitors and staff.
3. To ensure a robust accountability framework for prevention and control of healthcare associated infections (HCAI) is firmly embedded in clinical and corporate governance arrangements.
4. To develop and establish targeted surveillance programmes to enable defined action in infection prevention and control activities.
5. To work in partnership with patients and the public to prevent and control HCAs.

5 ORGANISATION AND CULTURE OF HEALTHCARE ORGANISATIONS

Organisation

Key Messages

- 5.1 Patients have the right to be treated in physical environments that minimise the risk of infection.
- 5.2 Effective action to reduce HCAI by improving the clinical environment and equipment depends on effective risk management and prioritisation of this issue by HSS Trusts and Boards.
- 5.3 Elements within the environment which facilitate effective infection prevention and control includes:
 - A clean environment;
 - Hospital building and equipment designed to facilitate ease of cleaning;
 - Safe water supplies and cooling systems;
 - Operating theatres with appropriate clean air systems;
 - Equipment and facilities for sterilisation and decontamination;
 - Isolation facilities with effective negative pressure (and, where appropriate, positive pressure) ventilation.
- 5.4 Factors such as high bed occupancy and throughput may adversely affect the incidence of HCAI. The increase in throughput of patients to meet performance targets has resulted in considerable pressure towards higher

bed occupancy, which is not always consistent with high quality care, good infection prevention and control and bed management practices. Due to pressures many trusts are operating with high bed occupancy levels which may adversely impact on their ability to prevent and control HCAI.

Excessive movement of patients, delayed discharges and boarding out of patients into other clinical areas makes surveillance of HCAI more complex and can increase the risk of transmission of infection.

Recommendations

- R1** HSS Trusts, supported by HSS Boards, need to have a clearly outlined and appropriately resourced strategic approach to prevention and control of HCAI. Elements of this approach must include:
- 'Infection Prevention and Control is everybody's business'
 - All healthcare staff facilitated and supported by directorate and senior management in applying high standard infection prevention and control practices in all areas of clinical work
 - Specialist Infection prevention and control teams in Trusts supported by senior management and appropriately resourced
 - Use of clinical guidelines, protocols, and standard audit toolkits
 - Effective risk management procedures involving all staff in the implementation and maintenance of relevant hygiene standards
 - Targeted and ongoing surveillance of HCAs
 - Production of an **Annual Infection Reduction Plan** by Trusts, which is agreed with the relevant HSS Board, and presented to DHSSPS
- R2** Trusts will comply with all Policies and Standards set by the Department of Health, Social Services and Public Safety. This will include standards on Waste Management, Nutrition and Catering, Cleanliness, Laundry,

Medical Devices Management, Decontamination and those relating to the premises and facilities in which services are provided or proposed.

- R3** Boards and Trusts should ensure that there is progress towards the appropriate provision of isolation facilities and the effective usage of single or specialist isolation rooms/anterooms as appropriate.
- R4** The standards applicable to space around the bed, the provision of single rooms in hospitals, and the Isolation Room Standards must be adhered to in new build and refurbishment schemes.
- R5** **Patient Journey**; Hospitals should establish a strategy to support better bed and patient management, to reduce the spread of infections. The movement of patients should be restricted as far as reasonably practical. Infection prevention & control teams should advise bed managers on appropriate policies to optimise bed use and minimise risk of infection.
- R6** The Trusts infection prevention and control team should be involved in the early design stage of new builds in order to maximise their input into the development process.
- R7** Trusts should have a policy in place regarding the wearing of uniforms by staff within and without Trust premises. All new build premises should have appropriate provision for staff changing facilities.

Culture of the Organisation

Key Messages

- 5.5 The minimisation of HCAI will require uncompromising commitment from management and leadership and a culture that emphasises the critical importance of care in a safe environment.
- 5.6 It is important that the HPSS workforce is 'fit for purpose' in terms of preventing and controlling the spread of healthcare associated infections. A clear focus of this is the need to ensure the culture of the organisation reflects the fact that infection prevention and control is everybody's business.
- 5.7 A key objective of this strategy is to introduce a *safety culture* throughout the organisation, where prevention and control of Infection are embedded as a core part of their organisation's Clinical and Social Care Governance, Risk Management framework and patient safety programmes.
- 5.8 For prevention and control of Infection and communicable disease to work effectively, critical activities have to be embedded in everyday practice: there must be a culture of "infection control is everyone's business" and integration of best practice into routine activities: "that's how we do things round here". Each individual healthcare practitioner has a professional responsibility for safe practice including the prevention and control of Infection. This must be associated with an audit or monitoring process to ensure infection prevention and control practices are in place and taking effect.

- 5.9 Embedded prevention and control of infection is best supported at organisational level by making the issue integral to the management priorities and key performance indicators for the organisation.
- 5.10 This strategy places strong emphasis on the need for all staff to understand and discharge their roles and responsibilities in relation to prevention and control of infection and expects clinical teams to confront their own issues guided and supported by the infection prevention and control team. This will best be delivered through the development of partnerships across the professional groups within the relevant Trust.

Recommendations

- R8** Prevention and control of infection must be embedded in Clinical and Social Care Governance and Risk Management agendas, ensuring everyone at all levels is involved in and prioritises prevention and control of infection measures.
- R9** Strong ***infection prevention and control leaders*** are needed at Trust Board level who will be the ‘face’ of infection prevention and control and provide leadership for training, prevention and control activities and communication.
- R10** Hospitals should strive to create a culture where hand hygiene is given a high profile for staff, patients and visitors. The appropriate and convenient location of hand hygiene facilities must be provided at the design and build stage to support the achievement of this goal.
- R11** Good practice in the area of infection prevention and control should be identified, acknowledged and disseminated to all staff. Mandatory training

and updates on infection prevention and control issues must be provided regularly for all staff.

- R12** All Trusts require the services and expertise of specialist **infection prevention and control professionals** who should work together as an Infection Prevention and Control Team (IPCT). The specialist role of the IPCT team (Appendix C) should be defined and communicated to all staff.
- R13** DHSSPS should implement the recommendations of the infection prevention and control nursing strategy in relation to building a specialist infection prevention and control workforce in the province that should support appropriate infection prevention and control policy, strategies, and training in healthcare organisations.
- R14** All Trusts should work towards the establishment of a 24-hour access to the Infection Prevention and Control Team in addition to existing medical cover.

6 Education, Training and Practices

Key Messages

- 6.1 The necessity to observe and implement high standard infection prevention and control practices needs to be instilled in all healthcare staff at a very early stage in professional training. This can only happen if infection prevention and control training is included as a core component of undergraduate training.
- 6.2 The provision of regular information and training to all healthcare staff on the prevention and control of healthcare associated infections is essential if staff are to be fully aware of the most appropriate practices to adopt. Training content needs to be appropriate to healthcare workers needs and based on the most up to date available evidence of good practice.
- 6.3 It is the experience of many Trusts that attendance at infection prevention and control training events is 'patchy' and many healthcare workers fail to recognise this as a priority in their training and continuing professional development needs. In some countries healthcare workers are not allowed to practice in clinical settings unless they have completed a recognised infection prevention and control training course and can demonstrate regular updating. The experience of some countries is that making infection prevention and control training mandatory for all healthcare staff is effective in ensuring that all staff are appropriately trained and updated.
- 6.4 Staff providing specialist infection prevention and control advice and services within the context of an Infection Prevention and Control Team require specialist training and support. There are a number of specialist

training events and courses run by UK and international bodies that could provide the training required by specialist staff in the HPSS.

Recommendations

- R15** An annual **Regional Infection Prevention & Control Symposium** should be held in order to bring together relevant healthcare workers and provide a platform for Trusts and Boards to share best practice, lessons learnt from critical incidents and outcomes of audit.
- R16** A regional **infection prevention and control manual** (where possible, linked to UK) should be developed to achieve standardisation in infection prevention and control practice across all Trusts.
- R17** A hand hygiene campaign targeted at healthcare staff and hospital visitors should be developed and implemented across the province. DHSSPS should consider the National Patient Safety Agency's hand hygiene campaign as a model of good practice.
- R18** The undergraduate curriculum for all health care professionals should include a core component on infection prevention and control.
- R19** Standard infection prevention and control training materials (where possible, linked to UK) should be commissioned or produced regionally. Where possible emphasis should be given to producing materials in an electronic format.
- R20** Infection prevention and control training should be made mandatory for all Trust staff and be clearly linked to appraisal, individual performance review and job planning processes.

- By end June 2006 Trusts should have undertaken a training needs assessment. This assessment is necessary to determine the type and frequency of training required by staff depending on job complexity and level of patient contact. For example staff working in high-risk environments such as oncology and ITU will require a higher level of training and more frequent updates. Trusts should develop an Infection Prevention and Control training plan which should be incorporated as part of the Trusts Annual Infection Reduction Plan.
- Trusts should aim to achieve 95% coverage for induction training for new staff by end December 2006 and for all existing staff by end December 2007. Data on training coverage must be included as part of the Trusts Infection Reduction Plan.

R21 Staff providing specialist infection prevention and control services should be appropriately trained and have a regular programme of Continual Professional Development.

R22 The agency staff used by healthcare organisations in the province should receive the same level of training and updating in infection prevention and control as permanent employees. Independent Healthcare agencies providing these staff need to be made aware of Trust requirements in this area.

7 Governance, Accountability and Audit

Key Messages

- 7.1 Over the last number of years HPSS organisations have adopted clear approaches to risk management within their organisations as part of their efforts to effect corporate and clinical governance arrangements. This has entailed applying risk management approaches to the entire spectrum of clinical care. Such an approach is urgently required for infection prevention and control in all HPSS organisations.
- 7.2 The appraisal arrangements in place for HPSS staff enable assessment of approaches and achievements in the area of patient care. Infection prevention and control is one such element of care.
- 7.3 DHSSPS has a key role to play in (i) setting infection prevention and control priorities and (ii) holding HPSS organisations accountable for minimising HCAI rates.
- 7.4 Arrangements are already in place to make organisations accountable to DHSSPS for the quality of patient care, generally through the Chief Executive. By placing infection prevention and control firmly on the quality and safety agenda it can become a key element to be addressed in the accountability arrangements for Boards and Trusts.
- 7.5 In order to ensure ownership of and commitment to the infection prevention and control agenda by all HPSS a robust accountability framework is required from the clinical directorate through to Departmental level.

7.6 Audit provides a method whereby the implementation of policies and the achievement of outcomes may be monitored.

Recommendations

R23 In addressing risk management in regard to HCAI each Trust should put in place an accountability structure in respect of infection prevention and control. This structure should be clearly documented in relation to all aspects of infection prevention and control throughout the Trust. The recommended accountability framework for Trusts is as follows.

- Each ward or specialty as appropriate should designate a member of staff as a 'link person' who links to the infection prevention and control team. Management should ensure that these link persons have dedicated protected time for their control of infection activities including regular meetings (monthly).
- Each Trust should develop infection prevention and control and education programmes as a core component of risk management in infection prevention and control.
- Infection prevention and control is an activity that should be practiced routinely by all staff. Trust management should encourage ownership of the infection prevention and control agenda by all staff.
- Each trust should undertake a baseline assessment as to how the Trust is currently meeting its infection and control responsibilities as defined by the DHSSPS Controls Assurance Standards. This will inform the development of the Trust's **Annual Infection Reduction Plan** as defined below.
- Trusts should require each division/directorate to submit an annual infection reduction plan based on local need but consistent with regional and national programmes/priorities. After due consideration

by the Trust Board the key aspects of these infection reduction plans should be included in the Trust's **Annual Infection Reduction Plan** presented to the DHSSPS by the Trust Chief Executive. The Trust Chief Executive will also be required to present an annual update on the Trust's infection reduction plan with evidence of progress over the previous 12 months. The infection reduction plan will contain measurable outcome targets reflecting the Trust's priorities for management and control of HCAs within the Trust.

R24 Each Trust should designate a named senior member of staff who is the Trust lead on and has a strategic and operational responsibility for infection prevention and control issues. This senior person, if not already a Board Member, should be invited to join the Trust Board and report to the Chief Executive for all infection prevention & control issues. This named person would also be a member of the Trust's Governance Committee.

R25 **Each division/directorate should designate a senior member of staff as its lead on infection prevention and control.** The role of this person is to ensure that infection prevention and control policies and practice are enabled throughout the division/directorate. They must also be members of the Trust's infection prevention and control committee.

R26 Boards and Trusts should review their management arrangements to ensure that clear lines of accountability have been established. An essential structural issue for both Boards and Trusts is the establishment of clearly delineated relationships and communications between the Chief Executive and the:

- Designated Trust Infection Prevention and Control lead
- Infection Prevention and Control Team

- Infection Prevention and Control Committee
- Risk Management Committee or structure
- Clinical Governance Committee or structure.

R27 HSS Boards should play an active role in assuring patient safety in relation to HCAI in Trusts. This should include:

- Designating a senior officer, who will be responsible for (i) Agreeing the data to be shared between Trusts and Boards, (ii) direct input to priority and target setting and the Trusts Infection Reduction Plan, (iii) establishing and implementing the monitoring arrangements between Boards and Trusts in relation to the Board priorities in infection prevention and control.
- Ensuring infection prevention and control are key considerations in the commissioning process.
- Establishing a forum for local stakeholders to meet regularly with the Board to agree local priorities and appropriate action on infection prevention and control.

R28 All Trusts must have an active programme of audit in the area of infection prevention and control. These audits should be multidisciplinary. Standardised tools should be adopted such as the “Infection Control Nurses Association – Audit Tools for Monitoring Infection Control Standards 2004” issued by the Department of Health. This audit tool offers a standardised and comparable method for monitoring both clinical practice and the environment.

R29 Each Trust should select one or two multidisciplinary audit areas as part of the Trust annual infection control plan. These multidisciplinary audits should be presented to the Trust Board, Commissioners, and should be

included as part of the accountability review between Trusts and DHSSPS.

R30 DHSSPS, through the Trust accountability process, should ensure that Trusts have developed and implemented an Infection Reduction Plan and this is leading to a demonstrable reduction in HCAI.

R31 HCAI reduction process targets for Trusts should be developed by DHSSPS as part of the strategy implementation process.

R32 A **Regional HCAI Collaborative Forum** should be developed which would facilitate sharing of good practice, surveillance methods and outcomes, lessons learned and enable piloting of surveillance and other initiatives. The forum could, for example, have an annual workshop at which Trusts present HCAI initiatives/interventions and results of infection reduction plans and local applied research.

8 Surveillance

Key Messages

- 8.1 It is not feasible to have ongoing active surveillance for all HCAI. It is therefore necessary to prioritise and select organisms and infections for inclusion in routine surveillance. It may also be necessary to develop specific surveillance programmes to detect infections in those recently discharged from hospital. The focus should be on issues of the greatest risk, greatest public health importance and where there is the greatest potential for health gain.
- 8.2 Individual Trust surveillance programmes should reflect regional and local priorities. Locally frontline staff should have ownership of these initiatives, as they will determine the effectiveness of the data collection and appropriate action.
- 8.3 Surveillance programmes, if they are to be sustained, need dedicated resources to enable the appropriate data to be collected, collated, analysed, interpreted and disseminated to facilitate action.
- 8.4 Regional and local surveillance programmes must be developed based on recognised methodology and case definitions. Each surveillance programme requires a specification documenting the surveillance objectives and the system attributes including standards, inputs/outputs, validation processes and resources required.
- 8.5 Rates of HCAI are influenced by a range of factors including case mix, patient age, underlying conditions and type of treatment. Appropriate and

standardised risk stratification must be used to allow meaningful comparisons across hospitals, Trusts, region and other countries.

- 8.6 Currently limited surveillance information is available to patients, the public or bodies representing the public interest. In addition, this information is often in a format that is difficult to interpret. In order to support informed discussion, patient choice and shared responsibility surveillance summaries, appropriate for a lay audience, should be produced and disseminated in a variety of formats.
- 8.7 It is important that surveillance programmes for HCAI are developed which will allow the identification of risk factors and hence enable interventions to be targeted.
- 8.8 Information from surveillance programmes, which is disseminated to all stakeholders in a timely manner, will enable appropriate action to be taken. This is essential for ownership and maintains motivation.
- 8.9 HCAI is an important quality issue for patient care and requires to be explicitly considered and included in the commissioning of healthcare services. Trusts will need to see surveillance for HCAs as a priority.

Recommendations

Regional Bodies

- R33** CDSC (NI) and HISC should work together to enhance their role in the surveillance of HCAs. Together they should provide a regional resource and specialist support to Trusts in, for example: surveillance methodologies; epidemiological investigation and control of HCAI clusters;

sourcing of evidence based guidelines and best professional practice; study design; and enabling/facilitating relevant training to Trust staff actively involved in surveillance processes.

- R34** CDSC (NI), HISC and DHSSPS should ensure that NI is kept abreast of developments throughout the UK and internationally by collaboration and representation on appropriate committees/fora.
- R35** New developments in HPSS IT systems, including those proposed for pathology, must enable surveillance of HCAI using routine data sources. Biological, clinical and epidemiological data should be linked at the patient level with the capability of linking information from the same individual over time.
- R36** Links with European, UK and other international surveillance networks should be strengthened and enhanced. This will aid developing a standardised approach to surveillance and collecting comparative data.

Health and Social Services Boards

- R37** Boards will require surveillance information and the action plans developed by Trusts to reduce HCAI.

Trusts

- R38** All Trusts should have targeted continuous surveillance programmes for HCAs.
- R39** Surveillance activities should reflect both regional and local priorities. Regional priorities will be determined by DHSSPS on the advice of the Regional HCAI Surveillance Committee. The Chief Executive and/or

Medical Director should be involved in the setting of priorities for the surveillance of HCAI within their Trust. This should be done in collaboration with the Trust lead on HCAI, the infection prevention and control team and frontline clinical staff.

R40 Surveillance activities within Trusts should:

- i. Be carried out using standard and accepted methodologies such as those developed by the US Centers for Disease Control and Prevention (http://www.cdc.gov/ncidod/hip/SURVEILL/About_NNIS.htm) and being developed within Europe (http://europa.eu.int/comm/health/ph_projects/1999/com_diseases/fp_commdis_1999_exs_29_en.pdf).
- ii. Be appropriately resourced. In this regard it is further recommended that Trusts designate a **surveillance coordinator(s)** for HCAI who should be a member of the Trusts infection prevention and control team. The surveillance coordinator would liaise with Divisional leads, link staff, other members of the infection prevention and control team and frontline clinical teams and facilitate the Trust's HCAI surveillance programme and should have access to appropriate IT and administrative support.

R41 Surveillance of and action on HCAs within Trusts should be clearly linked to the clinical governance process and integral to the management priorities and key performance indicators of the Trust. Details on HCAI surveillance activities and resulting action should be included in the Trust annual report and presented at an open Board meeting.

R42 Trusts should develop systems to ensure that there is timely access to appropriate and good quality information sources for managing infection within the Trust. This would include, for example, use of laboratory,

pharmacy and PAS systems and links that exist between information systems.

- R43** Ownership of HCAI surveillance programmes by clinical staff is crucial and Trusts should enable clinical teams to contribute to this process, for example, through reference in job plans and participation in multidisciplinary audit.

Infection Prevention and Control Teams

- R44** Appropriate training is required for IPCTs to enable them to be involved fully in all aspects of surveillance including basic data handling and analysis.
- R45** IPCTs should have adequate resources to enable them to support clinical staff in surveillance initiatives. This will include clerical support, a surveillance coordinator(s) (see above) and access to IT support.

Communication/collaboration

- R46** Feedback should be timely and relevant to all stakeholders including HSSCs, patients and the public. This should include information on specific HCAs and, where appropriate, relevant HCAI trends.
- R47** CDSC (NI) and HISC should provide feedback to Trusts on the regional HCAI surveillance initiatives and contribute to appropriate national and international surveillance programmes. Trusts should ensure there is an internal process mediated by the IPCT to feedback the outcome of these regional and intra Trust initiatives to frontline clinical staff and link this information to the annual HCAI Reduction Plan.

- R48** Reports will need to be in formats appropriate to each stakeholder group to ensure that health professionals, patients and the general public can interpret the surveillance data, understand the risks of HCAs and what action is being taken to reduce HCAI.

Outbreaks/incidents

- R49** A clear definition is needed of what constitutes an outbreak or serious untoward incident that needs reported regionally.
- R50** CCDCs at Boards should be notified by Trusts of outbreaks of HCAI. CCDCs should report these HCAI outbreaks to CDSC (NI) for regional surveillance purposes. The format and content of these reports (e.g. include impact on hospital) should then be agreed between CDSC (NI) and Board CCDCs. A process also needs to be developed to share and learn lessons from these outbreaks. One example would be through the HCAI collaborative forum.

Research

- R51** High quality applied research proposals should be invited to address current key questions regarding HCAs.

9 Patient and Public Partnership

Key Messages

- 9.1 Patient and public involvement in infection prevention and control are vital if we are to work together to tackle the problem. Involvement must begin at an early stage in the development of any HCAI related strategies, policies or information material.
- 9.2 Information provided for the public on surveillance, compliance with standards and HCAI related performance management material must be accompanied by full information regarding background and context.
- 9.3 Written information material provided for the public should include:
- Details about the risk of HCAI associated with the treatment or care
 - What will be done to reduce that risk
 - Opportunity to discuss particular concerns with a clinician if necessary
 - What action to take if they have concerns about standards of cleanliness
 - Advice for visitors
 - Advice on hand washing
 - On bringing in food and drink
 - On bringing small children to visit
 - Avoiding visiting if unwell and the potential impact of bringing infections into hospitals

All information produced must have in place a mechanism for updating to ensure that it remains current and relevant.

- 9.4 When a patient is unable to receive visitors due to either their own infection or that of their visitors it is important that staff provide an alternative channel of communication regarding the patient's progress. This is most likely to be the telephone.
- 9.5 The Media constitute a principal source of public information and as such can have a positive role in raising public awareness and dispelling myths around HCAI. Positive, proactive media engagement can encourage balanced informed reporting. Handling information in the event of an outbreak is also easier if an ongoing open relationship has been established with the local media.

Recommendations

- R52** DHSSPS should develop a comprehensive strategy on the release of surveillance, compliance with standards and HCAI related performance management information with full information re: background and context.
- R53** DHSSPS, in conjunction with the Health Promotion Agency, should develop a generic hospital information leaflet to include clear, concise and comprehensible information regarding HCAI, for patients and visitors. This should be supported by posters and web based information.
- R54** DHSSPS Press Office, in conjunction with Trust PR Officers to develop a strategy to address communication with the media focussing on a proactive approach and providing central guidance on disclosure of information, in particular in cases of outbreaks.

- R55** HSS Boards should support an Annual “Bugwatch” survey involving the HSSC of all hospital environments with year on year demonstration of improvements in results.

- R56** Infection Prevention and Control Committees at Trust Level should be able to demonstrate how they ensure patient/public involvement in their work.

- R57** Trust level infection prevention and control training should incorporate the key principles of patient/public involvement and consider the use of patient perspectives in training material.

- R58** Trusts should consider how they can develop, or build upon existing mechanisms, to encourage patients and visitors to provide feedback regarding their hospital stay and prevention and control of infection (e.g. did staff wash their hands, was the environment clean?).

Appendix A

Department of Health (London) circulars and GB reports

Department of Health (2002) *Hepatitis C Infected Healthcare Workers* HSC 2002/010 Department of Health, London

[http://www.info.doh.gov.uk/doh/Coin4.nsf/12d101b4f7b73d020025693c005488a9/c3b2dac6862aabb880256c15002cf18e/\\$FILE/010hsc2002.PDF](http://www.info.doh.gov.uk/doh/Coin4.nsf/12d101b4f7b73d020025693c005488a9/c3b2dac6862aabb880256c15002cf18e/$FILE/010hsc2002.PDF)

House of Lords Select Committee on Science and Technology (2003) *Fighting Infection*. Session 2002-2003. 4th Report

<http://www.parliament.the-stationery-office.co.uk/pa/ld200203/ldselect/ldsctech/138/138.pdf>

National Institute for Clinical Excellence (2003) *Infection control: Prevention of healthcare associated infection in primary and community care*

http://www.nice.org.uk/pdf/Infection_control_fullguideline.pdf

NHS Estates (2001) *Guidelines on infection control and the built environment*. NHS Estates, Leeds

NHS Estates (1993) Health Technical Memorandum HTM 2040 *The control of legionellae in healthcare premises - a code of practice* NHS Estates, Leeds

NHS Estates (2003) *Standards of cleanliness in the NHS*. A Framework in which to measure performance outcomes. NHS Estates, Leeds

NHS Executive (1995) *Hospital Infection Control: Guidance on the control of Infection in hospitals prepared by the joint DH/PHLS Hospital Infection Working Group* HSG (95)10 1995 (Issued by CREST to HPSS in 1997)

DHSS/DHSSPS circulars

DHSS (1992) *Decontamination of Equipment, Linen and Other Surfaces Contaminated with Hepatitis B and/or Human Immunodeficiency Viruses*. HA 1/92

DHSS (1997) *Prevention and Control of Tuberculosis in Northern Ireland*. HSS(MD)13/97

DHSS (1997) *Guidance on the Management and Control of Viral Haemorrhagic Fevers*. HSS(MD)14/97

DHSS (1998) *Guidance for Clinical Health Care Workers: Protection against Infection with Blood-borne viruses*. HSS(MD)7/98

DHSS (1998) *Review of Communicable Disease Control in Northern Ireland: Report of the Project Board* HSS(MD)210/98

DHSS (1998) *Antimicrobial Resistance – “The Path of Least Resistance”* HSS(MD)22/98

DHSS (1998) *Guidance on the Management of AIDS/HIV Infected Health Care Workers and Patient Notification* HSS(MD)29/98

DHSS (1999) *Resistance to Antibiotics and other Antimicrobial agents* HSS(MD)8/99

DHSS (1999) *Variant Creutzfeldt-Jakob Disease (vCJD) : Minimising the Risk of Transmission*. HSS(MD)15/99

DHSS (1999) *Controls Assurance in Infection Control: Decontamination of Medical Devices*. HSS(MD)16/99

DHSS (2000) *The Management and Control of Hospital Infection: action by the HPSS for the Management and Control of Infection in Hospitals in Northern Ireland*. HSS(MD)9/2000

DHSS (2000) *Hepatitis B infected health care workers* HSS(MD)17/2000

DHSS (2000) – *HIV post-exposure prophylaxis: Expert Advisory Group on AIDS* HSS(MD)21/2000

DHSSPS (2001) *Decontamination of Reusable Medical Devices*. HSS(MD)4/01 2001

DHSSPS (2001) *Risk Assessment on the risk of vCJD Transmission via Surgical Instruments. Addendum 1*: HSS(MD)4/01

DHSSPS (2001) *Protocol for Local Decontamination of Surgical Instruments. Addendum 3*: HSS(MD)4/01

DHSSPS (2002) *Antimicrobial resistance Action Plan* HSS(MD)1/02

DHSSPS (2002) *Joint Tuberculosis Committee of the British Thoracic Society Guidelines* HSS(MD)8/02

DHSSPS (2002) *Antimicrobial resistance Action Plan Implementation*
HSS(MD)16/02

DHSSPS (2002) *Guidelines for Renal Dialysis/Transplantation Units: Prevention and Control of Blood-borne Virus Infection* HSS(MD)36/02

DHSSPS (2003) [Severe Acute Respiratory Syndrome\(SARS\)](#) HSS(MD) 18/03

DHSSPS (2003) [Severe Acute Respiratory Syndrome \(SARS\)](#) HSS(MD)21/03

DHSSPS (2003) *Transmissible Spongiform Encephalopathy Agents: Safe Working and the Prevention of Infection. Publication of revised guidance.*
HSS(MD)36/03

DHSSPS (2004) **Governance in HPSS, Controls Assurance Standards, Infection Control**
http://www.dhsspsni.gov.uk/hss/governance/assurance_standards.asp

Legislation

Statutory Rules of Northern Ireland *Control of Substances Hazardous to Health Regulations (Northern Ireland) 2003* (No. 34), The Stationery Office, Belfast

Statutory Rules of Northern Ireland *Personal Protective Equipment at Work Regulations (Northern Ireland) 1993* (No. 20), The Stationery Office, Belfast

ACDP

Advisory Committee on Dangerous Pathogens (2003) “*Transmissible Spongiform Encephalopathy Agents: Safe Working and the Prevention of Infection*”
<http://www.doh.gov.uk/cjd/tseguidance/index.htm>

Department of Health (2001) *The Management, design and operation of microbiological containment laboratories.* Advisory Committee on Dangerous Pathogens. Department of Health, London

Spongiform Encephalopathy Advisory Committee (1998) “*Transmissible Spongiform Encephalopathy Agents: Safe Working and the Prevention of Infection*” (Advisory Committee on Dangerous Pathogens (ACDP) Spongiform Encephalopathy Advisory Committee (SEAC)

Medical Devices

Medical Devices Agency *Sterilisation, Disinfection and Cleaning of Medical Equipment: Guidance on Decontamination from the Microbiology Advisory*

Committee to Department of Health. Medical Devices Agency (MAC Manual) Health

Estates, Northern Ireland Adverse Incident Centre (NIAIC) *Safe use and disposal of Sharps* SN(NI) 2001/28.

Health Estates, Northern Ireland Adverse Incident Centre (NIAIC), *Single use medical devices: Implications and Consequences of Reuse*. DB2000/04(NI), November 2000

Health Estates

Health and Safety Commission (Health Services Advisory Committee) (1999) *Safe disposal of clinical waste*

Health Estates (March 1999) *The Segregation Primary Packaging, Secondary Packaging and Storage of Clinical Waste*. HSS-E. PEL (99)9.

Health Estates, (2002) *The Management of Clinical Waste in the Delivery of Health and Social Care In the Community*. PEL (01)11

General standards

Standards Australia (1999) *Risk Management AS/NZS 4360:1999*.

DFP (2001) *Corporate Governance: Statement on Internal Control* Circular DAO (DFP) 5/2001

DHSSPS (2002) *Corporate Governance: Statement on Internal Control* Circular HSS (PPM) 3/2002

DHSSPS (2002) *AS/NZS 4360: 1999 – Risk Management* Circular HSS (PPM) 6/2002

DHSSPS (2002) *Risk Management in the Health and Personal Social Services* Circular HSS (PPM) 8/2002

DHSSPS (2002) *Best Practice – Best Care: A framework for setting standards, delivering services and improving monitoring and regulation in the HPSS*.

The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 SI 2003/431 (NI 9)

DHSSPS (2002) *Governance in the HPSS: Clinical and Social Care Governance - Guidance on Implementation*. Circular HSS (PPM) 10/2002

DHSSPS (2002) *Governance in the HPSS – Risk Management* Circular HSS (PPM) 13/2002

DHSSPS (2003) *Governance in the HPSS – Risk Management and Controls Assurance* Circular HSS (PPM) 5/2003

DHSSPS (2003) – *Statement on Internal Control: Transitional statement* Circular HSS (FAU) 19/2003

DFP(2003) – *Statement of Internal Control* Circular DAO (DFP) 25/2003

NHS Executive (1995) *NHS Internal Audit Manual 1995*. NHS Executive, London.

Appendix B

Membership of the Working Group which Produced the Strategy for Prevention and Control of Healthcare Associated Infections

Dr Henrietta Campbell (Chief Medical Officer, DHSSPS) – **Chairperson**

Mrs Deborah Crudden (DHSSPS)

Mrs Stella Cunningham (SHSSC)

Mr Peter Deazley (DHSSPS)

Dr Lorraine Doherty (DHSSPS)

Dr Philip Donaghy (EHSSB)

Dr Tony Howard (NPHS Wales)

Dr Angela Jordan (Institute of Public Health)

Dr Paddy Kearney (United Hospitals Trust)

Mrs Isobel King (Ulster Community Hospitals Trust)

Mr Joe Magee (DHSSPS)

Ms Nicki Patterson (DHSSPS)

Mrs Elizabeth Qua (DHSSPS)

Dr Brian Smyth (CDSC (NI))

Dr Edward Smyth (HISC and Royal Group of Hospitals Trust)

Mr Mark Anderson (DHSSPS) - **Secretary**

Appendix C

Specialist Infection Prevention and Control Teams

Role of the Infection Prevention and Control Lead/Designated Board

Member or Manager

This person is either a Board member or is directly accountable to a Board member, i.e. has direct access to the Chief Executive. This person is designated as:

- having overall responsibility for management processes and risk assessment relating to infection prevention and control (including the issue of antibiotic resistant infections and antimicrobial prescribing)
- responsible for receiving and ensuring the circulation of relevant advice on these matters and working with DHSSPS, Boards and other agencies on improving practice

It is expected that this senior manager will report directly to the Chief Executive and the Board, and be an integral member of the organisation's Infection Prevention and Control, Clinical Governance and Risk Management Committees. He / she will be responsible for:

- co-ordination of prevention and control of infection throughout the Board area
- delivery of the Board approved Infection prevention and Control Programme in conjunction with the Infection Prevention and Control Committee and the IPCT

Infection Prevention and Control Team (IPCT)

The role of the IPCT is to implement the annual infection control programme and to be responsible for providing advice to the Trust personnel on a 24-hour basis. This is achieved with the support of the Chief Executive, Trust Board and the Infection Prevention and Control Committee.

The team is responsible for:

- Advising on and co-ordinating the surveillance of infections and monitoring methods of control;

- Rapid identification and investigation of outbreaks or potentially hazardous procedures;
- Providing advice on isolation of infected patients and on hazardous or ineffective procedures;
- Giving advice, making day-to-day decisions and liaising with staff in all areas where potential risks of infection exists;
- Providing, monitoring and evaluating policies for the prevention of infection and its spread;
- Auditing of infection prevention and control procedures as appropriate;
- Supporting clinical teams with audit and research initiatives;
- Establishing a staff education programme in collaboration with managers and clinical teams which provides information to staff on evidence based measures of infection prevention and control;
- Preparing the annual infection prevention control programme and reporting to the Infection Prevention and Control Committee, Chief Executive and Trust Board on a regular basis.

Appendix D

List of Recommendations Contained in Report

- R1** HSS Trusts, supported by HSS Boards, need to have a clearly outlined and appropriately resourced strategic approach to prevention and control of HCAI. Elements of this approach must include:
- 'Infection Prevention and Control is everybody's business'
 - All healthcare staff facilitated and supported by directorate and senior management in applying high standard infection prevention and control practices in all areas of clinical work
 - Specialist Infection prevention and control teams in Trusts supported by senior management and appropriately resourced
 - Use of clinical guidelines, protocols, and standard audit toolkits
 - Effective risk management procedures involving all staff in the implementation and maintenance of relevant hygiene standards
 - Targeted and ongoing surveillance of HCAs
 - Production of an **Annual Infection Reduction Plan** by Trusts, which is agreed with the relevant HSS Board, and presented to DHSSPS
- R2** Trusts will comply with all Policies and Standards set by the Department of Health, Social Services and Public Safety. This will include standards on Waste Management, Nutrition and Catering, Cleanliness, Laundry, Medical Devices Management, Decontamination and those relating to the premises and facilities in which services are provided or proposed.
- R3** Boards and Trusts should ensure that there is progress towards the appropriate provision of isolation facilities and the effective usage of single or specialist isolation rooms/anterooms as appropriate.
- R4** The standards applicable to space around the bed, the provision of single rooms in hospitals, and the Isolation Room Standards must be adhered to in new build and refurbishment schemes.
- R5** **Patient Journey**; Hospitals should establish a strategy to support better bed and patient management, to reduce the spread of infections. The movement of patients should be restricted as far as reasonably practical. Infection prevention & control teams should advise bed managers on appropriate policies to optimise bed use and minimise risk of infection.

- R6** The Trusts infection prevention and control team should be involved in the early design stage of new builds in order to maximise their input into the development process.
- R7** Trusts should have a policy in place regarding the wearing of uniforms by staff within and without Trust premises. All new build premises should have appropriate provision for staff changing facilities.
- R8** Prevention and control of infection must be embedded in Clinical and Social Care Governance and Risk Management agendas, ensuring everyone at all levels is involved in and prioritises prevention and control of infection measures.
- R9** Strong ***infection prevention and control leaders*** are needed at Trust Board level who will be the ‘face’ of infection prevention and control and provide leadership for training, prevention and control activities and communication.
- R10** Hospitals should strive to create a culture where hand hygiene is given a high profile for staff, patients and visitors. The appropriate and convenient location of hand hygiene facilities must be provided at the design and build stage to support the achievement of this goal.
- R11** Good practice in the area of infection prevention and control should be identified, acknowledged and disseminated to all staff. Mandatory training and updates on infection prevention and control issues must be provided regularly for all staff.
- R12** All Trusts require the services and expertise of specialist **infection prevention and control professionals** who should work together as an Infection Prevention and Control Team (IPCT). The specialist role of the IPCT team (Appendix C) should be defined and communicated to all staff.
- R13** DHSSPS should implement the recommendations of the infection prevention and control nursing strategy in relation to building a specialist infection prevention and control workforce in the province that should support appropriate infection prevention and control policy, strategies, and training in healthcare organisations.
- R14** All Trusts should work towards the establishment of a 24-hour access to the Infection Prevention and Control Team in addition to existing medical cover.
- R15** An annual **Regional Infection Prevention & Control Symposium** should be held in order to bring together relevant healthcare workers and provide

- a platform for Trusts and Boards to share best practice, lessons learnt from critical incidents and outcomes of audit.
- R16** A regional **infection prevention and control manual** (where possible, linked to UK) should be developed to achieve standardisation in infection prevention and control practice across all Trusts.
- R17** A hand hygiene campaign targeted at healthcare staff and hospital visitors should be developed and implemented across the province. DHSSPS should consider the National Patient Safety Agency's hand hygiene campaign as a model of good practice.
- R18** The undergraduate curriculum for all health care professionals should include a core component on infection prevention and control.
- R19** Standard infection prevention and control training materials (where possible, linked to UK) should be commissioned or produced regionally. Where possible emphasis should be given to producing materials in an electronic format.
- R20** Infection prevention and control training should be made mandatory for all Trust staff and be clearly linked to appraisal, individual performance review and job planning processes.
- By end June 2006 Trusts should have undertaken a training needs assessment. This assessment is necessary to determine the type and frequency of training required by staff depending on job complexity and level of patient contact. For example staff working in high-risk environments such as oncology and ITU will require a higher level of training and more frequent updates. Trusts should develop an Infection Prevention and Control training plan which should be incorporated as part of the Trusts Annual Infection Reduction Plan.
 - Trusts should aim to achieve 95% coverage for induction training for new staff by end December 2006 and for all existing staff by end December 2007. Data on training coverage must be included as part of the Trusts Infection Reduction Plan.
- R21** Staff providing specialist infection prevention and control services should be appropriately trained and have a regular programme of Continual Professional Development.
- R22** The agency staff used by healthcare organisations in the province should receive the same level of training and updating in infection prevention and control as permanent employees. Independent Healthcare agencies providing these staff need to be made aware of Trust requirements in this area.

R23 In addressing risk management in regard to HCAI each Trust should put in place an accountability structure in respect of infection prevention and control. This structure should be clearly documented in relation to all aspects of infection prevention and control throughout the Trust. The recommended accountability framework for Trusts is as follows.

- Each ward or specialty as appropriate should designate a member of staff as a 'link person' who links to the infection prevention and control team. Management should ensure that these link persons have dedicated protected time for their control of infection activities including regular meetings (monthly).
- Each Trust should develop infection prevention and control and education programmes as a core component of risk management in infection prevention and control.
- Infection prevention and control is an activity that should be practiced routinely by all staff. Trust management should encourage ownership of the infection prevention and control agenda by all staff.
- Each trust should undertake a baseline assessment as to how the Trust is currently meeting its infection and control responsibilities as defined by the DHSSPS Controls Assurance Standards. This will inform the development of the Trust's **Annual Infection Reduction Plan** as defined below.
- Trusts should require each division/directorate to submit an annual infection reduction plan based on local need but consistent with regional and national programmes/priorities. After due consideration by the Trust Board the key aspects of these infection reduction plans should be included in the Trust's **Annual Infection Reduction Plan** presented to the DHSSPS by the Trust Chief Executive. The Trust Chief Executive will also be required to present an annual update on the Trust's infection reduction plan with evidence of progress over the previous 12 months. The infection reduction plan will contain measurable outcome targets reflecting the Trust's priorities for management and control of HCAs within the Trust.

R24 Each Trust should designate a named senior member of staff who is the Trust lead on and has a strategic and operational responsibility for infection prevention and control issues. This senior person, if not already a Board Member, should be invited to join the Trust Board and report to the Chief Executive for all infection prevention & control issues. This named person would also be a member of the Trust's Governance Committee.

R25 **Each division/directorate should designate a senior member of staff as its lead on infection prevention and control.** The role of this person is to ensure that infection prevention and control policies and practice are

enabled throughout the division/directorate. They must also be members of the Trust's infection prevention and control committee.

R26 Boards and Trusts should review their management arrangements to ensure that clear lines of accountability have been established. An essential structural issue for both Boards and Trusts is the establishment of clearly delineated relationships and communications between the Chief Executive and the:

- Designated Trust Infection Prevention and Control lead
- Infection Prevention and Control Team
- Infection Prevention and Control Committee
- Risk Management Committee or structure
- Clinical Governance Committee or structure

R27 HSS Boards should play an active role in assuring patient safety in relation to HCAI in Trusts. This should include:

- Designating a senior officer, who will be responsible for (i) Agreeing the data to be shared between Trusts and Boards, (ii) direct input to priority and target setting and the Trusts Infection Reduction Plan, (iii) establishing and implementing the monitoring arrangements between Boards and Trusts in relation to the Board priorities in infection prevention and control.
- Ensuring infection prevention and control are key considerations in the commissioning process.
- Establishing a forum for local stakeholders to meet regularly with the Board to agree local priorities and appropriate action on infection prevention and control.

R28 All Trusts must have an active programme of audit in the area of infection prevention and control. These audits should be multidisciplinary. Standardised tools should be adopted such as the "Infection Control Nurses Association – Audit Tools for Monitoring Infection Control Standards 2004" issued by the Department of Health. This audit tool offers a standardised and comparable method for monitoring both clinical practice and the environment.

R29 Each Trust should select one or two multidisciplinary audit areas as part of the Trust annual infection control plan. These multidisciplinary audits should be presented to the Trust Board, Commissioners, and should be included as part of the accountability review between Trusts and DHSSPS.

- R30** DHSSPS, through the Trust accountability process, should ensure that Trusts have developed and implemented an Infection Reduction Plan and this is leading to a demonstrable reduction in HCAI.
- R31** HCAI reduction process targets for Trusts should be developed by DHSSPS as part of the strategy implementation process.
- R32** A **Regional HCAI Collaborative Forum** should be developed which would facilitate sharing of good practice, surveillance methods and outcomes, lessons learned and enable piloting of surveillance and other initiatives. The forum could, for example, have an annual workshop at which Trusts present HCAI initiatives/interventions and results of infection reduction plans and local applied research.
- R33** CDSC (NI) and HISC should work together to enhance their role in the surveillance of HCAs. Together they should provide a regional resource and specialist support to Trusts in, for example: surveillance methodologies; epidemiological investigation and control of HCAI clusters; sourcing of evidence based guidelines and best professional practice; study design; and enabling/facilitating relevant training to Trust staff actively involved in surveillance processes.
- R34** CDSC (NI), HISC and DHSSPS should ensure that NI is kept abreast of developments throughout the UK and internationally by collaboration and representation on appropriate committees/fora.
- R35** New developments in HPSS IT systems, including those proposed for pathology, must enable surveillance of HCAI using routine data sources. Biological, clinical and epidemiological data should be linked at the patient level with the capability of linking information from the same individual over time.
- R36** Links with European, UK and other international surveillance networks should be strengthened and enhanced. This will aid developing a standardised approach to surveillance and collecting comparative data.
- R37** Boards will require surveillance information and the action plans developed by Trusts to reduce HCAI.
- R38** All Trusts should have targeted continuous surveillance programmes for HCAs.
- R39** Surveillance activities should reflect both regional and local priorities. Regional priorities will be determined by DHSSPS on the advice of the Regional HCAI Surveillance Committee. The Chief Executive and/or Medical Director should be involved in the setting of priorities for the

surveillance of HCAI within their Trust. This should be done in collaboration with the Trust lead on HCAI, the infection prevention and control team and frontline clinical staff.

- R40** Surveillance activities within Trusts should:
- i. Be carried out using standard and accepted methodologies such as those developed by the US Centres for Disease Control and Prevention (http://www.cdc.gov/ncidod/hip/SURVEILL/About_NNIS.htm) and being developed within Europe (http://europa.eu.int/comm/health/ph_projects/1999/com_diseases/fp_commdis_1999_exs_29_en.pdf).
 - ii. Be appropriately resourced. In this regard it is further recommended that Trusts designate a **surveillance coordinator(s)** for HCAI who should be a member of the Trusts infection prevention and control team. The surveillance coordinator would liaise with Divisional leads, link staff, other members of the infection prevention and control team and frontline clinical teams and facilitate the Trust's HCAI surveillance programme and should have access to appropriate IT and administrative support.
- R41** Surveillance of and action on HCAs within Trusts should be clearly linked to the clinical governance process and integral to the management priorities and key performance indicators of the Trust. Details on HCAI surveillance activities and resulting action should be included in the Trust annual report and presented at an open Board meeting.
- R42** Trusts should develop systems to ensure that there is timely access to appropriate and good quality information sources for managing infection within the Trust. This would include, for example, use of laboratory, pharmacy and PAS systems and links which exist between information systems.
- R43** Ownership of HCAI surveillance programmes by clinical staff is crucial and Trusts should enable clinical teams to contribute to this process, for example, through reference in job plans and participation in multidisciplinary audit.
- R44** Appropriate training is required for IPCTs to enable them to be involved fully in all aspects of surveillance including basic data handling and analysis.

- R45** IPCTs should have adequate resources to enable them to support clinical staff in surveillance initiatives. This will include clerical support, a surveillance coordinator(s) (see above) and access to IT support.
- R46** Feedback should be timely and relevant to all stakeholders including HSSCs, patients and the public. This should include information on specific HCAs and, where appropriate, relevant HCAI trends.
- R47** CDSC (NI) and HISC should provide feedback to Trusts on the regional HCAI surveillance initiatives and contribute to appropriate national and international surveillance programmes. Trusts should ensure there is an internal process mediated by the IPCT to feedback the outcome of these regional and intra Trust initiatives to frontline clinical staff and link this information to the annual HCAI Reduction Plan.
- R48** Reports will need to be in formats appropriate to each stakeholder group to ensure that health professionals, patients and the general public can interpret the surveillance data, understand the risks of HCAs and what action is being taken to reduce HCAI.
- R49** A clear definition is needed of what constitutes an outbreak or serious untoward incident that needs reported regionally.
- R50** CCDCs at Boards should be notified by Trusts of outbreaks of HCAI. CCDCs should report these HCAI outbreaks to CDSC (NI) for regional surveillance purposes. The format and content of these reports (e.g. include impact on hospital) should then be agreed between CDSC (NI) and Board CCDCs. A process also needs to be developed to share and learn lessons from these outbreaks. One example would be through the HCAI collaborative forum.
- R51** High quality applied research proposals should be invited to address current key questions regarding HCAs.
- R52** DHSSPS should develop a comprehensive strategy on the release of surveillance, compliance with standards and HCAI related performance management information with full information re: background and context.
- R53** DHSSPS, in conjunction with the Health Promotion Agency, should develop a generic hospital information leaflet to include clear, concise and comprehensible information regarding HCAI, for patients and visitors. This should be supported by posters and web based information.
- R54** DHSSPS Press Office, in conjunction with Trust PR Officers to develop a strategy to address communication with the media focussing on a

- proactive approach and providing central guidance on disclosure of information, in particular in cases of outbreaks.
- R55** HSS Boards should support an Annual “Bugwatch” survey involving the HSSC of all hospital environments with year on year demonstration of improvements in results.
- R56** Infection Prevention and Control Committees at Trust Level should be able to demonstrate how they ensure patient/public involvement in their work.
- R57** Trust level infection prevention and control training should incorporate the key principles of patient/public involvement and consider the use of patient perspectives in training material.
- R58** Trusts should consider how they can develop, or build upon existing mechanisms, to encourage patients and visitors to provide feedback regarding their hospital stay and prevention and control of infection (e.g. did staff wash their hands, was the environment clean?).

Appendix E

Equality Issues

The Department is inviting comments on the following questions in relation to its decision to screen-out this strategy from a full Equality Impact Assessment:

- a. Are the different needs of the different Section 75 groups of people adequately addressed?
- b. Are you aware of any evidence - qualitative or quantitative - that the Infection control strategy may have an adverse impact on equality of opportunity or on good relations? If so, please provide details. Can you suggest any ways of reducing or eradicating such adverse impact?
- c. Could the infection control strategy better promote equality of opportunity or good relations? If so, how?
- d. Are you aware of any other equality implications likely to arise from the infection control strategy?