MRSA Action UK

Raising Public Awareness – Campaigning for Safer Standards
Supporting Victims and Dependants

RESPONSE TO DEPARTMENT OF HEALTH CONSULTATION ACTION ON HEALTH CARE ASSOCIATED INFECTIONS IN ENGLAND

We welcome the opportunity for the public to be involved in the consultation "Action on Health Care Associated Infections in England" and the "Partial Regulatory Impact Assessment".

Response to the "Partial Regulatory Impact Assessment"

1. We support Option 3 - Introduce new legislation to underpin the existing strategy, to encompass new legislation with the four principal elements:
   - A power for the Secretary of State to publish a new statutory Code of Practice (placing existing guidance on a statutory basis);
   - A duty on NHS bodies to comply, with a parallel duty on the part of the Healthcare Commission to assess compliance;
   - Power for the Healthcare Commission to issue an improvement notice; and
   - Enforcement action through use of **strengthened*** intervention powers.

*We believe the fourth principal should not be based on existing intervention powers alone, these need to be strengthened to include, in extreme cases of failure, criminal sanctions.

Response to "Action on Health Care Associated Infections in England"

Part 1 The Nature of the Problem

2. The effects of healthcare associated infection vary from discomfort for the patient to prolonged or permanent disability and even death. Not all such infections are preventable since the very old, the very young, those undergoing invasive procedures and those with suppressed immune systems are particularly susceptible.

3. However, procedures exist that can minimise the risk and prevent the acquisition and spread of healthcare associated infection (HAI), and it is our duty to ensure these procedures are implemented at every level in healthcare organisations.

4. The cost of HAI to the NHS is around £1 billion a year as patients with one or more infections can incur costs that are on average 2.8 times greater than uninfected patients. Source: National Audit Office

The commonest sites of healthcare associated infection are	
Urinary	23%
Lung	22%
Wound	9%
Blood	6%

Source: The second national prevalence survey of infection in hospitals 1996

5. Other research shows that surgical site infections (SSIs) account for 15-20% of healthcare associated infection. A consensus paper, developed by a number of leading healthcare experts in Europe indicates the scale of the problem caused by SSIs and the estimated financial impact on the health:

6. "Surgical site infections contribute significantly to the morbidity and mortality associated with surgical procedures, and continue to be one of the most serious complications that can occur in surgical patients. SSIs account for approximately 15–20 percent of all healthcare associated infections and data suggests that *Staphylococcus aureus* is the most common causative organism, accounting for some 30–40 percent of cases.

7. The cost [of SSIs] is threefold: the cost to the hospital, the community services, and the patient. The impact of an SSI to the individual patient is important in terms of the pain, suffering, longer lengths of stay in hospital and slow return to work, and social activities. As such, it is important that healthcare professionals do all they can to prevent these infections".
   Source: International Wound Journal, January 2005

8. The Department of Health Mandatory Surveillance scheme monitors bloodstream infections. Only 6% of healthcare associated infections are attributable to bloodstream infection. We believe surveillance should include a full breakdown of infection rates, and that the national target of a 50% reduction in MRSA bacteraemias in acute Trusts by March 2008 is not challenging enough. The aim should be to halve all significant[1] MRSA infection by 2008, in all healthcare situations, with an accurate baseline to be established by March 2006.

9. High quality surveillance systems need to be developed to establish an accurate baseline, and to enable the effectiveness of the Hygiene Code to be assessed. This includes recording and publishing deaths from MRSA and deaths where MRSA was a contributory factor.

10. The Health Protection Agency (HPA) have a significant role to play in the recording of MRSA, information for monitoring purposes can be derived from source, freeing up healthcare teams' time to get on with implementing infection control and prevention.

11. We therefore propose that the HPA collate and publish a more comprehensive view of infections from a properly funded and structured surveillance scheme with the results weighted by appropriate case mix, risk and actions to be taken. The system should be able to report "real-time" information to Trust Boards for quarterly monitoring, to ensure the outcomes of measures taken are effective.

12. We welcome the introduction of a 2-hour screening test. Freeing up isolation facilities is one benefit. We also acknowledge this benefit is of particular importance where a patient may be awaiting discharge to a Hospice, Care Home or an Oncology Department where other patients with immunocompromised systems would be at risk if there were failures in identifying colonisation. The 2-hour test would also be useful for emergency admissions, enabling decisions on decontamination or isolation to be made quickly.

[1] By significant we mean the inclusion surgical site infection, catheters / other indwelling devices, infection acquired in birthing

Does the Code of Practice cover sufficiently broad a scope in respect of tackling healthcare associated infections and is there sufficient detail and clarity in the Code of Practice in what it requires of service providers?

13. The Partial Regulatory Impact Assessment recognises public concerns about the levels and dangers of healthcare associated infections.

14. The introduction of a statutory Code will go some way to provide reassurance. A more transparent way of publishing hospitals' performance against the Code will reinforce assurance that the government is serious about investing in systems to minimise healthcare associated infections. We propose a system that produces sufficient detail and clarity linking with *Saving Lives*, the Department of Health package launched in July 2005.

15. We welcome the regulation of the private, independent and voluntary sectors by the Healthcare Commission and the Commission for Social Care Inspection. We believe the Hygiene Code should apply to these sectors, and that information sharing protocols and screening must be established to prevent the transfer of infection between healthcare providers.

Are there any current measures that are unnecessary, or could be simplified, in the light of the introduction of these proposals?

16. The Department of Health MRSA performance indicator is not transparent as it only uses bloodstream infections in assessment. The special collection of data on the use of alcohol rub and its use in increasing hospitals' scores was also not in keeping with openness in the 2004/05 round of assessments.

17. This was a late data collection in March 2005. Hospitals where infection rates had fallen received an extra point for infection control, this score will also impact on Trusts ability the achieve Foundation status, where there will be less regulation and more freedoms. The reduced rates related to bloodstream infections only, therefore we feel this is not an accurate portrayal of improvement, particularly in the light of known information on the impact of SSIs and other infection sites such as catheter and urinary tract. Whist we welcome the implementation of near patient alcohol rub, we do not feel that this measure alone should be viewed as a panacea for effective infection control, and should not therefore be used in isolation to assess improvement and status.

18. We therefore propose a different approach to measuring the effectiveness of a new Hygiene Code by way of:
    - Publishing a comprehensive breakdown of all incidents of MRSA infection
    - Establishing a percentage score against a checklist of enforcement and good practice drawing on key areas of the *Saving Lives* package launched by the Department of Health in July 2005

19. We recognise that all hospitals and circumstances are different, but we do not feel that it should be a local management decision on how to comply with the Code. A national benchmark can be achieved if this approach is adopted. Resources and enforcement can then be targetted more effectively by the Healthcare Commission.

20. Compliance against a checklist of enforcement and good practice gives hospitals and other healthcare providers a clear focus on which to work. We attach our proposal for a checklist as Addendum A.

21. Lower re-admission rates should also be a positive outcome of reducing healthcare associated infections. Lower death rates and injury from the effects of MRSA are also positive outcomes. Performance indicators should be designed to measure these outcomes.

Part 2 Proposals for further action
The duty on NHS bodies to comply, with a parallel duty on the part of the Healthcare Commission to assess compliance

22. The Annual Healthcheck for the Assessment of Core Standards – Getting the Basics Right, has been set up by the Healthcare Commission to:

- bring together and rationalise existing requirements for the health service and
- describe a level of service which is acceptable and which is universal

23. The Core Standard C4a requires: "Health care organisations keep patients, staff and visitors safe by having systems to ensure that the risk of health care acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year-on-year reductions in MRSA"

24. The Developmental Standard D1 requires: "Health care organisations continuously and systematically review and improve all aspects of their activities that directly affect patient safety and apply best practice in assessing and managing risks to patients, staff and others, particularly when patients move from the care of one organisation to another"

25. We would urge the Healthcare Commission to consider responses to this consultation when making judgements on how it might best assess compliance with a new statutory Code, the Core Standard C4a, and the Developmental Standard D1.

26. In implementing the Annual Healthcheck to assess compliance with core standards, the Commission are reliant on self-assessment by Trusts, and independent validation through patients or carers who bring complaints and third party statements.

27. There is evidence to suggest complaints procedures are not effective at dealing with concerns of complainants, with the Health Service Ombudsman expressing concern over the numbers of complaints about MRSA (response to Assessment for Improvement – 18 February 2005). The Ombudsman is recommending a complete revision of the core standard for complaints and its implementation across the health service system. We support the Ombudsman recommendation, as this should enable a more structured assessment of how to improve where there have been failures to comply with the Core Standards.

28. The Healthcare Commission needs an effective and transparent way to assure compliance with the proposed Code of Practice. We believe our proposal for a checklist of enforcement and good practice, based on the guidance within the *Saving Lives* package will enable the Commission to assess whether Trusts and Bodies have indeed achieved a level of service which is acceptable and is universal.

29. The *Saving Lives* package is a robust mechanism for implementation of good infection control and prevention, and lends itself to clear audit.

Do the proposals apply sufficient pressure on health care organisations to bring about changes in approaches to tackling HCAI where these are needed?

30. If infection control measures have not been implemented in any number of incidents, and there is a proven systematic breakdown in the management systems in place, then sanctions must apply. Healthcare organisations have a statutory duty of care to patients and the public, if they fail to act on an improvement notice and patients continue to acquire Health Care Associated Infections such as MRSA, we believe criminal sanctions must apply.

Part 3 The Draft Code of Practice

31. We welcome the proposal for the introduction of a Code of Practice. We welcome the introduction of guidance on effective evidence based protocols to assist healthcare providers with meeting their duty to adhere to the Code.

32. The Code should be updated to reflect changes in practice and developments in knowledge. A score against a checklist of enforcement and good practice for Trusts and Bodies will allow updating without undue delay.

33. A statement giving top priority to research and development relevant to Department of Health, Health Protection Agency and Trusts' local priorities should be included in the Code of Practice.

34. The statement should include prioritisation and funding applications for the introduction of new technology or methods of working within the service.

35. All NHS bodies and the Private, Independent and Voluntary sectors need to comply with the Code, regulated by the Healthcare Commission and the Commission for Social Care Inspection.

36. We agree with the broad principles set out in the proposed Code of Practice and would wish to see additional measures included.

37. Reference points 2.1.1: The implementation of a Hygiene Code must not be viewed as a choice. Strong leadership through Corporate Governance is needed within Trusts to review and change approaches to prevention and control of infection. Senior management must engage in this process in order to secure the implementation of best practice. Intervention powers must be used where there are significant failings to improve poor practice.

38. All Trust employees and contractors must have a programme of education and training on the prevention and control of infection in order to understand their responsibility for infection control and the actions they must personally take. Time out for training and education is essential. More clinical care staff and more cleaners are needed.

39. Resources must be made available to appoint infection control leaders at every level in the organisation to ensure the promotion of good clinical practice and to challenge inappropriate behaviour.

40. Reference point 2.1.2: Healthcare services should be provided in environments that are well designed to support the prevention of infection, and well maintained to ensure continued effectiveness. For example "Clean Room" technology in theatre settings and isolation rooms.

41. Reference point 2.1.3: There should be effective communication in place between NHS healthcare Bodies to inform recipient Bodies when known or potentially infected or colonised patients are being transferred or discharged. We would therefore like to see guidance on keeping case record documentation and a minimum data set for MRSA positive patients. This can then be easily recognised and communicated to other healthcare teams.

42. All aspects of MRSA should be recorded in the case notes, care plans and drug prescription charts. Means of facilitating this would include the incorporation of a stamp or adhesive into the case records, including nursing checklists, integrated care pathways and multi-discipline team procedures.

43. Screening for infection colonisation should be carried out until all tests are clear. Health Protection Agency computerised records must be able to flag up tests that were previously positive and have not returned clear. The recently trialled 2 hour screening test is beneficial where patients need to transfer to another healthcare provider, for example nursing home, hospice or oncology ward. A flag on the cover of patient's case notes and medical records would ensure all other healthcare teams and other agencies would be aware of the patients' infection and colonisation, and the need for isolation nursing.

44. This is particularly important where patients are entering environments where other patients are severely immunocompromised.

45. We endorse a "seek and destroy" approach, which has been widely acclaimed as a key factor in reducing HAIs in the Netherlands – *The Secrets of MRSA Control in the Netherlands,* Margareet C Vos. Screening and decolonising patients and healthcare workers should become the norm in the UK.

The strategic cleaning plan

46. With reference to point [2.2.3] "A lead manager for cleaning services should be appointed with responsibility for ensuring their Body has a strategic cleaning plan, reviewed and approved by the board annually, through which sufficient and appropriate resources are deployed to maintain cleanliness and hygiene".

47. We believe the plan should include the monitoring and supervision of compliance with cleanliness and hygiene standards, to include environmental testing.

48. Healthcare associated infections are surviving on surfaces to spread illnesses that can be life-threatening. The Department of Health's claim that there is no correlation between lower rates of MRSA and hospital cleanliness gives weight to the case that environmental testing and the use of disinfectant should therefore be routine. Visible cleanliness is no longer an acceptable standard. Disinfectants that are environmentally friendly should be used in the battle against healthcare associated infections.

49. Cleaning contracts should be in-house to ensure the highest hygiene standards are implemented. Whether in-house or external, cleaners form an essential element of the infection control team and need to be trained and qualified to do the job. Corners should not be cut in this area, resources must be available to ensure the job is carried out thoroughly. Cleaning Teams are responsible for implementing the highest hygiene standards in environments that are required to be aseptically clean.

50. We particularly welcome the appointment of Directors of Infection Control with a direct line to the Chief Executive. The Director of Infection Control must be accountable for the Trusts' Cleaning Plan, the Lead Manager for Cleaning Services must report directly to the Director of Infection Control. External contracts for cleaning must be monitored closely by the Director of Infection Control.

51. Where cleaning specifications are external or part of a PFI/PPP Directors of Infection Control must be involved in the procurement of the contract and the contract monitoring process. We would expect Matrons to have jurisdiction to take instant action with externally contracted staff if work is unsatisfactory. Cleaning contractors must provide at least as a minimum:

- Details including curricula vitae of, and a statement of the technical and professional qualifications and current experience of all key professional, technical and supervisory staff who will be responsible for carrying out the contract requirements
- A statement of the firm's average workforce and the number of managerial staff, technicians, etc. which the contractor can call upon for carrying out the requirements of the contract; and
- A statement of the organisation's ability to perform the contract taking into account in particular its skills, efficiency, experience and reliability.
- The Key Members of the technical consultancy team must have professional qualifications in their field, including Infection Control
- Legal entities required to state the names and professional qualifications of the personnel responsible for execution of the contract

Patient care - Clinical care protocols

52. Reference [2.3.1]. Appropriate written policies should be in place where relevant for infection prevention and control in clinical settings. These should reflect national guidelines (where applicable) and evidence based practice and be monitored via the clinical governance system. There should be documented evidence of a rolling programme of audit, revision, and update.

53. We endorse the approach as set out in the consultation document. Particularly in relation to clinical procedures being carried out in a manner that maintains and promotes the principles of asepsis.

54. Education, training and assessment in the aseptic technique must be provided to all persons undertaking such procedures. The technique is standardised across the organisation and audit is undertaken to monitor compliance with aseptic technique.

55. Hands must be decontaminated immediately before each and every episode of direct patient contact/care and after any activity or contact that potentially results in hands becoming contaminated. Use optimum aseptic technique, including apron, facemask, gloves, and sterile drape in all invasive procedures (eg surgical, catheterisation/IV or wound dressings).

Hand Hygiene

56. All healthcare staff must wash their hands at every opportunity before direct patient contact and care. This is regarded as the most important factor in reducing the spread of healthcare associated infection. Non-compliance with hand-washing should not be tolerated, and appropriate action must be taken where audits reveal healthcare workers are not compliant.

57. Damaged sore skin, caused by harsh hand cleansing agents, has been cited as a reason why staff fail to decontaminate their hands (ICNA, 2002).

58. To minimise the risk of skin damage, hands should be wetted before applying any soap solution. Rinsing and drying the hands thoroughly will also help to protect the skin. Alcohol hand rubs with emollients are associated with less skin damage than soap and water (Pittet et al, 2000).

59. Cuts or abrasions should be covered by a waterproof plaster for clinical work, which should be renewed when it becomes wet. Anti-bacterial barrier hand creams should be applied regularly to the hands to protect against drying. Communal jars are not acceptable as the contents may become contaminated.

60. The increased use of gloves containing natural rubber latex (NRL), to comply with standard infection control precautions, has increased the incidence of latex sensitivity and irritant reactions. The risks relate to the proteins found in NRL, accelerators added during manufacture, and the addition of cornstarch powder. Therefore NRL gloves that are powder-free, with the lowest possible levels of extractable proteins and residual accelerators should be used (ICNA, 2002). Synthetic gloves should be made available for staff who are known to be sensitised to NRL proteins.

61. Any member of staff experiencing a skin problem should refer themselves to the Occupational Health Department, where a full history will be taken and a discussion will take place to agree a suitable care plan. Management may need to be informed of the outcome where changes in work practice are required, in line with health and safety requirements.

62. Alternatives to alcohol rub should be sought to alleviate healthcare workers problems with skin sensitivity, through the work of the Rapid Review Panel.

Strategic Estates Plan

63. Reference [2.4.1] All NHS Bodies should have written local policies, including a strategic estates plan, which reflect statutory requirements and national guidelines on the provision of a safe environment. The development of these policies should take account of infection control advice and will include but not be restricted to:
Building and refurbishment (including air handling systems)

64. We would wish to see clear guidelines and regulation within the Code of Practice on the provision of:

    - A clean environment;
    - Safe water supplies and cooling systems;
    - Operating theatres with appropriate clean air systems, including UVGI technology;

- Equipment for sterilisation and decontamination;
- Isolation facilities with effective negative pressure ventilation;
- Equipment and materials used in specifications, for example flooring, wash basins, foot operated taps;
- Bedspaces to be at least 3.6 metres apart

65. The range of technicians required in building contracting are vast and well regulated. Whether hospitals and healthcare facilities are new build or refurbishments it is essential to ensure high quality specifications. It is essential to get the correct infrastructure in place to ensure we do not leave a legacy of poor design for future generations. The Director of Infection Control must therefore be involved in every stage of planning and procurement.

66. The requirement for equipment specialists and clinical planning need to be taken into account. The range of required technical skills in building works required include, but are not restricted to

- architectural
- environmental engineering
- mechanical engineering
- electrical engineering
- quantity surveying
- civil and structural engineering
- acoustics
- information technology

67. We would expect contractors to supply the following as a minimum, and wish to see clear guidelines and regulation within the Code of Practice on the requirement to provide:

- Details including curricula vitae of, and a statement of the technical and professional qualifications and current experience in PFI/PPP projects of all key professional, technical and supervisory staff who will be responsible for carrying out the contract requirements;
- A statement of the firm's average workforce and the number of managerial staff, technicians, etc. which the contractor can call upon for carrying out the requirements of the contract; and
- A statement of the organisation's ability to perform the contract taking into account in particular its skills, efficiency, experience and reliability
- Conditions specific to service contracts

  Provision of the service is reserved to a specific profession:
  The Key Members of the technical consultancy team must have professional qualifications in their respective fields.
- Legal entities required to state the names and professional qualifications of the personnel responsible for execution of the contract

68. Reference [2.4.3] The strategic cleaning plan should detail:
Monitoring and environmental testing procedures

Training arrangements which ensure that cleaning staff are kept up-to-date with infection control procedures

69. We believe cleaning must be supervised and environmentally tested.
To recap, the Lead Manager for Cleaning Services must report directly to the Director of Infection Control, who must be responsible for supervision and environmental testing.

70. Reference [2.4.5]. Policies on provision of linen should be in line with national guidelines. These policies should include staff uniforms which should be clean, fit for purpose and project a professional image.

71. In order to protect patients and the public from cross infection, we believe that shower and changing facilities must be provided, and uniforms must not be worn off-site. The practice of surgeons visiting patients straight from theatre dressed in scrubs must be avoided.

72. The Department of Health also needs to recognise that if visitors to hospital and patients from Care Homes pose a risk in terms of bringing infection into hospital, then it is logical to assume that the wearing of uniforms in the public domain, for example on public transport, also presents a risk of bringing infection into the healthcare setting. The practice of wearing uniforms outside of the healthcare setting needs to cease.

73. We would also wish the recommendations outlined by the Health Protection Agency, formulated by The Rapid Review Panel implemented where products are seen to be of particular benefit in the prevention and control of healthcare associated infection.

74. Some examples recently tested include disposable cubicle curtains, which we view as particularly beneficial in ICUs and Isolation Facilities. Hygienic keyboard covers for nurses workstations and GPs consulting rooms, a particularly useful tool due to the reservoir of bacteria found in keyboards, and the potential for transfer to healthcare workers' hands.

75. Reference [2.5] Healthcare Workers
There should be protocols for staff to report incidents of concern regarding the implementation of infection control procedures, or any other practices that fall within The Public Interest Disclosure Act 1998. This must include access to an independent adjudicator.

This concludes the submission of MRSA Action UK to the Department of Health on *Action on Healthcare Acquired Infections in England*. The addendum to this submission is a proposal to the Healthcare Commission for the regulation of healthcare Bodies in the implementation of a Code of Practice.

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ADDENDUM A

HEALTHCARE COMMISSION ANNUAL HEALTH CHECK 2005/06
PROPOSAL FOR REVISED MRSA PERFORMANCE MEASURE

We are pleased to see that the practice adopted last year in terms of the late data collection of near patient alcohol rub by PEAT teams, will not be assessed in isolation, in terms of raising Trusts' score for infection control. We welcome revisions to the performance measures in relation to reducing methicillin-resistant *Staphylococcus aureas* (MRSA).

We note the proposal to use the NICE standard CG2 on Infection Control. We ask that the Healthcare Commission consider the proposed measures to assess outcomes from the implementation of other evolving good practice in the Department of Health package *Saving Lives*, which is broader than the NICE guidance and is currently being implemented by Trusts.

We propose a checklist of enforcement and good practice that draws on measures in *Saving Lives* incorporating good practice produced by other professional bodies. A checklist approach may be favoured by the Healthcare Commission, as it

- provides transparency in assessing how Trusts' work programmes and actions are likely to impact on performance towards the Government's target to halve MRSA by 2008
- brings together existing and evolving good practice and
- describes a level of service to the public that should be applied across all healthcare Bodies
- lends itself to continuous updating to keep up with developments in knowledge to reflect necessary changes in practice
- can be used to assess compliance with the proposed Department of Health Code of Practice on Healthcare Associated Infection in England

Construction of the indicator
The list of proposed actions underpinning good practice in the prevention and control healthcare associated infection, are included at "Appendix 1". These actions are considered particularly important by MRSA Action UK. If there were 40 questions and observations then the percentage score against the number of questions returning a positive response would be as follows:

Number of Questions returning a positive response	% score based on positive answers	Number of Questions returning a positive response	% score based on positive answers
1	**3%**	21	**53%**
2	**5%**	22	**55%**
3	**8%**	23	**58%**
4	**10%**	24	**60%**
5	**13%**	25	**63%**
6	**15%**	26	**65%**
7	**18%**	27	**68%**
8	**20%**	28	**70%**
9	**23%**	29	**73%**
10	**25%**	30	**75%**
11	**28%**	31	**78%**
12	**30%**	32	**80%**
13	**33%**	33	**83%**
14	**35%**	34	**85%**
15	**38%**	35	**88%**
16	**40%**	36	**90%**
17	**43%**	37	**93%**
18	**45%**	38	**95%**
19	**48%**	39	**98%**
20	**50%**	40	**100%**

If a Trust achieves 31 positive answers out of 40 the percentage score would be 78%

The percentage score should be published together with a rating for infection control, the rating could be based on the scale in the balanced scored within the *Saving Lives* toolkit, requiring differing levels of intervention dependant on the level of non-compliance:

100%	=	Full compliance
71% - 99%	=	Review required of actions 'not met' (including improvement notices on areas needing further attention)
Equal to or less than 70%	=	improvement notices and further intervention required

Audit of Proposed Performance Measure

Saving Lives is an action planning and self assessment tool therefore evidence will be readily available to assess overall governance of trusts and progress by the Healthcare Commission.

Evidence of Hand-Hygiene Compliance

Designated Infection Control Nurses can be utilised to observe hand hygiene opportunities and compliance and cleaning of equipment after patient contact. PEAT observations as carried out in the Bug Watch pilots are also useful for independent review. PEAT teams must be trained to recognise good and poor practice. Findings regarding compliance should be assessed by Trust Boards and in the public domain. Persistent non-compliance by individuals would be dealt with through the Trusts procedures on improving performance, including counselling and where necessary disciplinary action.

An additional simple measure of increased hand hygiene compliance, would be the level of spend on hand hygiene products. We can assume that if the demand for alcohol-rub and anti-bacterial products is increasing, then increased hand hygiene compliance is a reasonable conclusion. This could be weighted against bed occupancy indicators to enable comparisons between Trusts to be made.

Evidence of Training and Development

Learning logs should be kept for all staff (contracted or in-house). Other information on protected time for learning and keeping up-to-date with good practice can be assessed in the annual staff survey, with findings being assessed for all healthcare workers at every level in the trust.

Advantages of showing a percentage score for hospital trusts

In addition to being open and transparent, this system is also better for staff morale. Progress against actions for improvement can be reviewed on a quarterly basis with key milestones being published, and staff updated as part of the ongoing actions needed to make prevention and infection control conditional in everything they do.

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Appendix 1

Checklist proposed by MRSA Action UK **Based on *Saving Lives* and other good practice – To be fully resourced and enforceable by legislation**	**Outcome**
1. Does each clinical team demonstrate consistently high levels of compliance with hand washing and hand disinfection protocols through the implementation of the National Patient Safety Association *"Clean your hands campaign"*)?	**Achieving optimum hand hygiene**
2. Are gloves, masks and protective clothing of an approved standard used in every appropriate clinical care situation and properly disposed of after use? (*EPIC guidance*) 3. Are isolation nursing signs clearly available and displayed when appropriate (HASWA and COSHH Health Regulations 2002) 4. Are there clear and precise instructions for the procedures for isolation nursing? 5. Does the (*Acute*) Trust provide uniforms for all staff and students commensurate with the number of shifts worked? 6. Does the Trust provide adequate onsite changing facilities for all staff? 7. Does the Trust provide adequate and timely laundering arrangements for staff uniforms?	**Using personal protective equipment**
8. Does the Trust have a written policy on waste disposal providing guidance on all aspects of special waste? 9. Are all clinical teams trained and kept up-to-date with safe handling and disposal of clinical waste protocols? *(ICNA toolkit)*	**Safe handling and disposal of sharps clinical waste**
10. Are the EPIC guidelines for the prevention of Surgical Site Infection being followed?	**Preventing Surgical Site Infection**
11. Do clinical teams demonstrate consistently high standards of aseptic technique by ensuring that all appropriate sterile items are available, and that the setting is prepared and manipulation at the affected site is minimised? (*Saving Lives)*	**Achieving and maintaining a clean clinical environment**
12. Are all appropriate staff trained and competent in using strictly aseptic techniques, in inserting, manipulating or removing intravenous feeding lines and urinary catheters? *(EPIC guidance)* *Hands must be decontaminated immediately before each and every episode of direct patient contact/care and after any activity or contact that potentially results in hands becoming contaminated. Use optimum aseptic technique, including apron, facemask, gloves, and sterile drape.* 13. Do clinical teams routinely document the date of insertion (including tagging) and date of removal of indwelling devices in the clinical record?	**Appropriate use of indwelling devices**
14. Do clinical teams rigorously adopt standard precautions to minimise the transmission of all infections for	**Managing accidents**

Checklist proposed by MRSA Action UK **Based on *Saving Lives* and other good practice – To be fully resourced and enforceable by legislation**	**Outcome**
management of accidents?	
15. Does the Trust have an information sharing protocol to ensure all departments and other agencies involved in the patients care have been advised that they have / or had contracted MRSA? 16. Does the Trust's information sharing protocol ensure that next of kin and / or carers and dependants are kept fully informed of what the healthcare associated infection is, including the risks and the proposed healthcare plan? 17. Does the Trust ensure that if any additional infection control precautions are necessary these are documented in patient's records? 18. Have all carers and visitors to patients been advised of the need to use alcohol rub and the precautions to be taken to prevent cross infection of other patients? 19. Does the Trust use appropriate and understandable guidance for all patients and visitors? (for example – the Wipe It Out information leaflet, and/or local 'personalised' leaflets and information)?	**Good communication – with other health care workers, patients and visitors**
20. Does the Trust deploy mandatory infection control training at the time of induction for all health and social care staff working in both the NHS and the independent sector? 21. Does the Trust ensure an annual update to infection control training, with protected study time to allow staff to attend (as defined by the Health & Safety at Work Act 1974/1990)? 22. Does Infection Control training feature in all healthcare workers' personal development plans, including cleaning teams? 23. Are personal development plans reviewed and discussed every six months, with actions taken for non-compliance? 24. Does the Trust's annual survey ask if staff feel they have been adequately trained and resourced to implement the fundamental hygiene and infection control measures? 25. Are findings of the survey published, showing responses by grade and post held?	**Well resourced and enforced training and education**
26. Does the Trust have a protocol for the screening of patients prior to admission and surgery (as prescribed by the National MRSA guidelines and clinical risk assessment)? 27. Does the Trust have controlled entry and exit systems to wards, optimising the use of alcohol rub for all visitors? 28. Does the Trust highlight and promote infection control measures to all visitors and healthcare workers in A&E departments?	**Preventing access of infection from external sources**

Checklist proposed by MRSA Action UK **Based on *Saving Lives* and other good practice – To be fully resourced and enforceable by legislation**	**Outcome**
29. Are all appropriate healthcare staff up to date with immunisations for hepatitis B, TB, influenza and chickenpox? 30. Does the Trusts occupational health department ensure that healthcare workers are given the necessary health assessment and advice so that those known to be infected with blood-borne viruses do not carry out procedures that pose a risk of infection to patients? 31. Are all healthcare workers regularly screened for blood-borne viruses and infection? 32. Are all appropriate healthcare workers trained in the use of facemasks in ALL invasive and aseptic procedures (eg surgical, catheterisation/IV or wound dressings)? *Hands must be decontaminated immediately before each and every episode of direct patient contact/care and after any activity or contact that potentially results in hands becoming contaminated. Use optimum aseptic technique, including apron, facemask, gloves, and sterile drape.*	
33. Does the Trust ensure Matrons, senior nurses, sisters/charge nurses or registered managers have the mandated power, authority and necessary protected time to ensure health care establishments are clean and decontaminated in line with UK standards? 34. Does the Trust deploy 24 hour cleaning teams in all acute health care facilities which are rapidly deployable by senior nursing staff?	**Achieving a safe hygienic environment**
35. Does the Trust implement *immediate* standard infection control protocols (precautions used in isolation nursing), for the care of patients who are being tested for a healthcare associated infection? 36. Does the Trust have a protocol for prevention and control of outbreaks of infection? 37. Does this protocol include provision for adequate isolation nursing for MRSA and other endemic illness? 38. Does the protocol include the provision of information and leaflets explaining to patients and relatives the change of emphasis in infection control, including the need for isolation?	**Preventing outbreaks of infection**
39. Does the Trust have a protocol for staff to report incidents of concern regarding the implementation of infection control procedures / clinical practice, or any other practices that fall within The Public Interest Disclosure Act 1998? 40. Does the protocol include access to an independent adjudicator?	**Whistlebowing**