

# Healthcare-associated infections

Quality standard

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This standard is based on PH36.

This standard should be read in conjunction with QS75, QS61, QS49, QS15, QS121, QS161 and QS168.

## Introduction

This quality standard covers organisational factors in preventing and controlling healthcare-associated infections in secondary care settings.

Organisational factors include management arrangements, policies, procedures, monitoring, evaluation, audit and accountability.

Secondary care settings include hospital buildings and grounds; inpatient, day case and outpatient facilities and services; elective and emergency care facilities; and hospital maternity units and services.

This quality standard should be read alongside [NICE quality standard 61](#), which is an overarching quality standard on infection prevention and control, and [NICE quality standard 49](#), which covers surgical site infection in all healthcare settings. Other related quality standards, including a quality standard on antimicrobial stewardship that is in production, are listed in [related NICE quality standards](#).

The quality statements that follow build upon the [code of practice](#) on the prevention and control of infections that applies to all providers of healthcare and adult social care under The Health and Social Care Act 2008.

Throughout this quality standard, the term 'hospital' is used for ease of reference to represent the organisation responsible for services provided in secondary care settings.

For more information see the [healthcare-associated infections topic overview](#).

### *Why this quality standard is needed*

Healthcare-associated infections are a serious risk to patients, staff and visitors. They can cause significant morbidity to those infected and significant costs for the NHS. As a result, infection prevention and control is a key priority for the NHS.

Healthcare-associated infections cover any infection contracted:

- as a direct result of treatment in, or contact with, a health or social care setting
- as a result of healthcare delivered in the community
- outside a healthcare setting (for example, in the community) and brought in by patients, staff or visitors and transmitted to others (for example, norovirus).

The most well-known healthcare-associated infections, for which mandatory reporting is currently required, include those caused by meticillin-resistant *Staphylococcus aureus* (MRSA), meticillin-sensitive *Staphylococcus aureus* (MSSA), *Clostridium difficile* (*C difficile*) and *Escherichia coli* (*E coli*). Other gram-negative bacteria (including antibiotic-resistant bacteria) and norovirus can also cause healthcare-associated infections.

The [English National Point Prevalence Survey](#) (Health Protection Agency 2012) identified that 6.4% of inpatients in acute care hospitals in 2011 had a healthcare-associated infection. The 6 most common types of healthcare-associated infections, which accounted for more than 80% of all healthcare-associated infections, were pneumonia and other respiratory infections (22.8%), urinary tract infections (17.2%), surgical site infections (15.7%), clinical sepsis (10.5%), gastrointestinal infections (8.8%), and bloodstream infections (7.3%).

The quality standard is expected to contribute to improvements in the following outcomes:

- hospital-acquired harm
- length of stay in acute care
- antimicrobial resistance
- avoidable morbidity
- avoidable mortality
- incidence of *C difficile* and MRSA
- patient experience
- avoidable hospital admissions
- accident and emergency department attendance.

## *How this quality standard supports delivery of outcome frameworks*

NICE quality standards are a concise set of prioritised statements designed to drive measurable improvements in the 3 dimensions of quality – patient safety, patient experience and clinical effectiveness – for a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 3 outcomes frameworks published by the Department of Health:

- [NHS Outcomes Framework 2015–16](#)
- [Adult Social Care Outcomes Framework 2015–16](#)
- [Public Health Outcomes Framework 2013–16](#).

Tables 1–3 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

**Table 1** [NHS Outcomes Framework 2015–16](#)

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	<p><i>Overarching indicators</i></p> <p>1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare</p> <p>i Adults ii Children and young people</p>

<p>4 Ensuring that people have a positive experience of care</p>	<p><i>Overarching indicators</i></p> <p>4b Patient experience of hospital care</p> <p><i>Improvement areas</i></p> <p><i>Improving people's experience of outpatient care</i></p> <p>4.1 Patient experience of outpatient services</p> <p><i>Improving people's experience of accident and emergency services</i></p> <p>4.3 Patient experience of A&amp;E services</p> <p><i>Improving women and their families' experience of maternity services</i></p> <p>4.5 Women's experience of maternity services</p> <p><i>Improving children and young people's experience of healthcare</i></p> <p><i>4.8 Children and young people's experience of inpatient services</i></p> <p><i>Improving people's experience of integrated care</i></p> <p>4.9 <i>People's experience of integrated care*</i></p>
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<p>5 Treating and caring for people in a safe environment and protecting them from avoidable harm</p>	<p><i>Overarching indicators</i></p> <p><i>5a Deaths attributable to problems in healthcare</i></p> <p><i>5b Severe harm attributable to problems in healthcare</i></p> <p><i>Improvement areas</i></p> <p>Reducing the incidence of avoidable harm</p> <p>5.2 Incidence of healthcare-associated infection (HCAI)</p> <p>i MRSA</p> <p>ii C. difficile</p> <p>Improving the culture of safety reporting</p> <p>5.6 Patient safety incidents reported</p>
<p><b>Alignment with Adult Social Care Outcomes Framework and/or Public Health Outcomes Framework</b></p> <p>* Indicator is complementary</p> <p>Indicators in italics in development</p>	

**Table 2 The Adult Social Care Outcomes Framework 2015–16**

Domain	Overarching and outcome measures
<p>3 Ensuring that people have a positive experience of care and support</p>	<p><i>Overarching measure</i></p> <p>3A Overall satisfaction of people who use services with their care and support</p> <p>Placeholder 3E: The effectiveness of integrated care*</p>
<p><b>Aligning across the health and care system</b></p> <p>* Indicator complementary</p>	

**Table 3 Public health outcomes framework for England, 2013–16**

Domain	Objectives and indicators
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3 Health protection	<p><b>Objective</b></p> <p>The population's health is protected from major incidents and other threats, whilst reducing health inequalities</p> <p><b>Indicators</b></p> <p>3.7 Comprehensive, agreed inter-agency plans for responding to public health incidents</p>
4 Healthcare public health and preventing premature mortality	<p><b>Objective</b></p> <p>Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities</p> <p><b>Indicators</b></p> <p>4.3 Mortality rate from causes considered preventable*</p> <p>4.8 Mortality rate from communicable diseases</p>
<p><b>Alignment across the health and social care system</b></p> <p>* Indicator shared with the NHS Outcomes Framework</p>	

### *Patient experience and safety issues*

Ensuring that care is safe and that people have a positive experience of care is vital in a high-quality service. It is important to consider these factors when planning and delivering services that seek to prevent and control healthcare-associated infections.

### *Coordinated services*

The quality standard for healthcare-associated infections specifies that services should be commissioned from and coordinated across all relevant agencies. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care and preventing and controlling healthcare-associated infections in secondary care settings.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing a

high-quality services related to healthcare-associated infections are listed in [related quality standards](#).

## **Training and competencies**

The quality standard should be read in the context of national and local guidelines on training and competencies. All health, public health and social care practitioners involved in the prevention and control of healthcare-associated infections in secondary care settings should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard. Quality statements on staff training and competency are not usually included in quality standards. However, recommendations in the development source(s) on specific types of training for the topic that exceed standard professional training are considered during quality statement development.

## **Role of families and carers**

Quality standards recognise the important role families and carers have in supporting people with healthcare-associated infections in secondary care settings. If appropriate, healthcare professionals should ensure that family members and carers are involved in the decision-making process about investigations, treatment and care and are also provided with advice and guidance on hygiene and infection prevention and control.

## List of quality statements

Statement 1. Hospitals monitor healthcare-associated infections and other infections of local relevance to drive continuous quality improvement.

Statement 2. Hospitals work with local health and social care organisations to assess and manage the risk of infections in hospitals from community outbreaks and incidents.

Statement 3. Hospital staff have individual objectives and appraisals on infection prevention and control linked to board-level objectives and strategies.

Statement 4. Hospitals involve infection prevention and control teams in the building, refurbishment and maintenance of hospital facilities.

Statement 5. People admitted to, discharged from, or transferred between or within hospitals have information about any infections and associated treatments shared with health and social care staff to inform their care.

## Quality statement 1: Surveillance

### *Quality statement*

Hospitals monitor healthcare-associated infections and other infections of local relevance to drive continuous quality improvement.

### *Rationale*

Mandatory national and local surveillance of healthcare-associated infections (such as *Staphylococcus aureus* [MRSA] and *Clostridium difficile* [*C difficile*]) provides information that can be used to assess the infection risk of people in hospital and inform the response. However, mandatory monitoring only covers a small number of healthcare-associated infections. Identification and monitoring of other infections of local relevance, including resistant organisms, contributes to a fuller understanding of the risk of infection to people in hospital. The results of monitoring can be used by staff across the organisation to help inform practice, review the effectiveness of responses, and review how well strategies to reduce healthcare-associated infections are working.

### *Quality measures*

#### Structure

a) Evidence of local arrangements for hospitals to monitor healthcare-associated infections and other infections of local relevance.

**Data source:** Local data collection.

b) Evidence of local arrangements for the results of monitoring healthcare-associated infections and other infections of local relevance to be used across the organisation to inform and review objectives for quality improvement.

**Data source:** Local data collection.

#### Outcome

Incidence of healthcare-associated infections.

**Data source:** Local data collection and national data collection including 2015–16 NHS Outcomes Framework indicator 5.2 (MRSA and *C difficile*); 2015–16 Clinical Commissioning Group [CCG]

Outcome Indicator Set indicators 5.3 (MRSA) and 5.4 (*C difficile*). National data derived from the Mandatory Surveillance of MRSA, MSSA, E coli and C difficile published by Public Health England.

### *What the quality statement means for service providers, health and social care practitioners, and commissioners*

**Service providers** (hospitals) ensure that systems are in place to carry out mandatory monitoring of healthcare-associated infections and other infections of local relevance, including resistant organisms; and ensure that the results are shared across the organisation and used to drive continuous quality improvement.

**Health and social care practitioners in secondary care** (including hospital clinicians, nursing staff and allied healthcare professionals) report healthcare-associated infections, act on information provided to them about local infections to reduce infection risk, and adjust clinical practice for continuous improvement.

**Commissioners** (such as clinical commissioning groups) ensure that they commission services from hospitals that have systems to carry out mandatory monitoring of healthcare-associated infections and other infections of local relevance, including resistant organisms; and ensure that they share the results across the organisation to drive continuous quality improvement.

### *What the quality statement means for patients, service users and carers*

**People receiving treatment in, or visiting, hospitals** can expect the hospital to monitor infection levels across all service areas to help improve services and minimise future infection rates.

### *Source guidance*

- [Healthcare-associated infections: prevention and control](#) (2011) NICE guideline PH36; quality improvement statements 1 and 3

### *Definitions*

#### **Monitor healthcare-associated infections**

Monitoring includes mandatory monitoring of healthcare-associated infections and also other infections that are of local relevance, including resistant organisms, within the hospital setting. Monitoring should be through a surveillance system that detects organisms and infections, and promptly registers any abnormal trends. Data from multiple sources (epidemiological, clinical,

microbiological, surgical and pharmacy) need to be combined in real time, and should allow for timely recognition of incidents in different spaces (for example, wards, clinical teams, clinical areas and across the whole trust). Surveillance data in key areas should be regularly compared with other local and national data.

[Adapted from [Healthcare-associated infections: prevention and control](#) (NICE guideline PH36)]

## **Continuous quality improvement**

Improving the provision of services and practice by using a range of audit and statistical tools to assess the current situation, identify areas for improvement and measure the results.

[[Healthcare-associated infections: prevention and control](#) (NICE guideline PH36)]

## Quality statement 2: Collaborative action

### *Quality statement*

Hospitals work with local health and social care organisations to assess and manage the risk of infections in hospitals from community outbreaks and incidents.

### *Rationale*

Healthcare-associated infections are a serious risk to hospital patients, staff and visitors. Infections contracted outside a hospital setting can be brought into the hospital by patients, visitors and staff, and transmitted to others. By identifying and assessing potential risks from community outbreaks and incidents, hospitals can take action in collaboration with other local health and social care organisations, including public health services, to reduce the risk of infection.

### *Quality measures*

#### Structure

a) Evidence of local arrangements for hospitals to monitor the risk of healthcare-associated infections from incidents and outbreaks in the community.

**Data source:** Local data collection.

b) Evidence of local arrangements for collaborative working between hospitals and other local health and social care organisations to investigate and manage the risks of healthcare-associated infection from incidents and outbreaks in the community.

**Data source:** Local data collection.

#### Outcome

Incidence of healthcare-associated infections.

**Data source:** Local data collection and national data collection including 2015–16 NHS Outcomes Framework indicator 5.2 (MRSA and *C difficile*); 2015–16 Clinical Commissioning Group [CCG] Outcome Indicator Set indicators 5.3 (MRSA) and 5.4 (*C difficile*). National data derived from the Mandatory Surveillance of MRSA, MSSA, E coli and *C difficile* published by Public Health England.



## *What the quality statement means for service providers, health and social care practitioners, and commissioners*

**Service providers** (hospitals) participate in joint working initiatives with other health, public health and social care organisations beyond mandatory requirements to share information on outbreaks and incidents in the community, and assess and minimise the risks. Joint working initiatives can include agreeing a governance structure and lines of accountability between organisations; joint development of strategy, policy, pathway and shared targets; sharing information from risk assessments; and investigating and managing outbreaks and incidents of healthcare-associated infections.

**Health and social care practitioners in secondary care** (including hospital clinicians, nursing staff and allied healthcare professionals) participate in joint working initiatives and implement measures introduced in response to community incidents and outbreaks to minimise the risk of infections in hospital.

**Commissioners** (such as clinical commissioning groups) ensure that they commission services from hospitals that can demonstrate that they work collaboratively with local health and social care organisations to assess and manage the risk of infections in hospitals from community outbreaks and incidents.

## *What the quality statement means for patients, service users and carers*

**People receiving treatment in, or visiting, hospitals** can expect the hospital to work with other local health and social care organisations to help prevent infections in the community spreading into the hospital. As a result of this work, hospitals may occasionally have to change the way that people receive treatment or visit hospitals. For example, a ward may be closed to visitors, or a person may be admitted to a single room to help prevent infections spreading.

## *Source guidance*

- [Healthcare-associated infections: prevention and control](#) (2011) NICE guideline PH36; quality improvement statements 3 and 6

## *Definitions*

### **Community outbreaks and incidents**

An outbreak is usually defined as 2 or more people experiencing a similar illness linked in place and time, or a single instance of a rare or particularly harmful organism. An outbreak is only declared following the identification, notification and investigation of an incident. For example, laboratory results may confirm that 2 illnesses are caused by the same organism or strain of an organism.

An incident includes events or situations needing investigation to see if action or management to reduce a risk is needed. An incident can also include a single case of a disease. In the context of this statement, an incident is taken to include any incident with the potential to expose people to infection risk.

[Expert opinion]

## Quality statement 3: Responsibilities of hospital staff

### *Quality statement*

Hospital staff have individual objectives and appraisals on infection prevention and control linked to board-level objectives and strategies.

### *Rationale*

Trust boards provide leadership in infection prevention and control, but all hospital staff have responsibility for, and are accountable for, infection prevention and control. Boards can help minimise the risk to patients and ensure continuous quality improvement by leading on and regularly reviewing all relevant infection prevention and control objectives, policies and procedures. A clear governance structure and accountability framework will allocate specific responsibilities to all staff. All staff having these responsibilities as clear objectives that are reviewed in appraisals and reflected in development plans will help ensure that board-level objectives are achieved and that the risk of healthcare-associated infection is minimised.

### *Quality measures*

#### **Structure**

a) Evidence of local arrangements to ensure all staff have clear objectives in relation to infection prevention and control that are linked to board-level objectives.

*Data source:* Local data collection.

b) Evidence of local arrangements to ensure all staff have an appraisal and development plan that cover infection prevention and control.

*Data source:* Local data collection.

#### **Process**

a) Proportion of hospital staff who have individual infection prevention and control objectives that are linked to board-level objectives.

Numerator – the number in the denominator who have individual infection prevention and control objectives that are linked to board-level objectives.

Denominator – the number of hospital staff.

*Data source:* Local data collection.

b) Proportion of hospital staff who have an appraisal of their infection prevention and control objectives.

Numerator – the number in the denominator who have an appraisal of their infection prevention and control objectives.

Denominator – the number of hospital staff.

*Data source:* Local data collection.

c) Proportion of hospital staff who have a development plan that includes infection prevention and control.

Numerator – the number in the denominator who have a development plan that addresses individual needs for knowledge, abilities and skills in infection prevention and control.

Denominator – the number of hospital staff.

*Data source:* Local data collection.

### *What the quality statement means for service providers, hospital staff, and commissioners*

**Service providers** (hospitals) in secondary care settings ensure that all staff have objectives in relation to infection prevention and control that are linked to the board's objectives and strategies, that these objectives are appraised and included in development plans, and that staff are supported to carry out these objectives.

**Hospital staff** (including hospital clinicians, nursing staff, allied healthcare professionals, administrative staff and catering staff) in secondary care settings follow working practices and tasks on infection prevention and control described in their personal objectives; have feedback on their performance against these objectives through an appraisal; and are supported to ensure that learning, training and other development needs on infection prevention and control set out in a development plan are met.

**Commissioners** (such as clinical commissioning groups) ensure that they commission services from secondary care providers that appraise and support their staff to achieve their objectives on infection prevention and control.

### *What the quality statement means for patients, service users and carers*

People receiving treatment in, or visiting, hospitals can expect that all hospital staff have the skills and knowledge needed to carry out infection prevention and control procedures in their area of work.

### *Source guidance*

- [Healthcare-associated infections: prevention and control](#) (2011) NICE guideline PH36; quality improvement statement 4

### *Definitions*

#### **Hospital staff**

All clinical and non-clinical staff, including support staff, volunteers, agency or locum staff and those employed by contractors.

[Adapted from [Healthcare-associated infections: prevention and control](#) (NICE guideline PH36)]

## Quality statement 4: Planning, design and management of hospital facilities

### *Quality statement*

Hospitals involve infection prevention and control teams in the building, refurbishment and maintenance of hospital facilities.

### *Rationale*

In a healthcare setting the built environment can play a significant role in the transmission of infection. The design of new buildings, as well as their refurbishment and ongoing maintenance, should allow good infection prevention and control practices. Involving infection prevention and control teams in the planning, design and maintenance of hospital facilities can ensure that needs are anticipated, planned for and met, and that the risk of healthcare-associated infections is minimised.

### *Quality measures*

#### **Structure**

a) Evidence of local arrangements for involving infection prevention and control teams in the building and refurbishment of facilities in the hospital. Examples of evidence may include protocols covering infection prevention and control in the built environment; estate department procedures to engage infection prevention and control teams in new build and refurbishment projects; building and refurbishment project plans and schedules of work that show the involvement of infection prevention and control teams; and records of completed building and refurbishment works that show whether infection prevention and control requirements have been met.

**Data source:** Local data collection.

b) Evidence of local arrangements for involving infection prevention and control teams in the maintenance of facilities in the hospital. Examples of evidence may include protocols covering infection prevention and control in the built environment; estate department procedures to engage infection prevention and control teams in maintenance works; maintenance plans and schedules that show the involvement of infection prevention and control teams; and records of completed maintenance works that show whether infection prevention and control requirements have been met.

*Data source:* Local data collection.

### *What the quality statement means for service providers, healthcare professionals and commissioners*

**Service providers** (hospitals) in secondary care settings ensure that infection prevention and control teams are involved in planning, design and maintenance of hospital facilities, as part of managing and maintaining the whole estate to minimise the risk from infection. Providers should follow best practice guidance where available, such as [Health Building Note 00-09](#) (Department of Health 2013), which identifies infection prevention and control issues and risks that need to be addressed at each stage of a new build or refurbishment project.

**Healthcare professionals** (including hospital clinicians and nursing staff) who are part of hospitals' infection and control teams are involved in the planning, design and maintenance of hospital facilities. This may include identifying design issues (such as provision of isolation facilities, decontamination facilities and hand hygiene facilities); agreeing the requirements for infection prevention and control; risk assessing the works to be undertaken and advising on the necessary measures to protect patients, visitors and staff; ensuring that control measures are implemented and adhered to; and attending estates and property project planning meetings.

**Commissioners** (such as clinical commissioning groups) ensure that they commission secondary care services from providers where infection prevention and control teams are involved in the planning, design and maintenance of hospital services and facilities.

### *What the quality statement means for patients, service users and carers*

**People receiving treatment in, or visiting, hospitals** can expect the hospitals, and their related buildings and grounds, to be designed and looked after in a way that minimises the risk of infection.

### *Source guidance*

- [Healthcare-associated infections: prevention and control](#) (2011) NICE guideline PH36; quality improvement statement 10

## Quality statement 5: Admission, discharge and transfer

### *Quality statement*

People admitted to, discharged from, or transferred between or within hospitals, have information about any infections and associated treatments shared with health and social care staff to inform their care.

### *Rationale*

Potentially avoidable healthcare-associated infections can occur when people are admitted to, discharged from or transferred between or within hospitals. Sharing information on current infections, treatment and colonising organisms can result in better care and outcomes for people with, or at risk of, infections and can help to reduce the risk of infections being spread between care settings. A consistent approach to sharing information between health and social care practitioners involved in a patient's care pathway should ensure appropriate ongoing support, and minimise the risk of inappropriate management and transmission of infection. Information should be shared when arrangements are made for a person to move from the care of one organisation to another, or when arrangements are made to move a person within a hospital, while maintaining patient confidentiality and privacy.

### *Quality measures*

#### **Structure**

Evidence of local arrangements to ensure information about any infections and associated treatments for people admitted to, discharged from, or transferred between or within hospitals, is shared with the health and social care staff responsible for the ongoing care.

**Data source:** Local data collection.

#### **Process**

a) Proportion of admissions to hospital, including transfers of patients from other hospitals, where information on infections and associated treatments is received.

Numerator – the number in the denominator where information on infections and associated treatments is received.



Denominator – the number of admissions to hospital of people with infections.

*Data source:* Local data collection.

b) Proportion of discharges from hospital, including transfers of patients to other hospitals, where information on infections and associated treatments is provided to health and social care staff responsible for ongoing care.

Numerator – the number in the denominator where information on infections and associated treatments is provided.

Denominator – the number of discharges from hospital of people with infections.

*Data source:* Local data collection.

c) Proportion of transfers of patients within a hospital where information on infections and associated treatments is provided to health care staff responsible for ongoing care.

Numerator – the number in the denominator where information on infections and associated treatments is provided to health care staff responsible for ongoing care.

Denominator – the number of transfers of patients between wards within a hospital.

*Data source:* Local data collection.

### *What the quality statement means for service providers, health and social care practitioners, and commissioners*

**Service providers** (such as hospitals and social care providers) provide information about any infections, colonising organisms and associated treatments when they arrange for a person to be moved into or out of hospital, or between wards, to inform the ongoing care of that person and minimise the risk of transmission. If appropriate, information should also be shared with the providers of transport for a person moving into or out of hospital.

**Health and social care practitioners** (including hospital clinicians, nursing staff and practitioners in care homes) involved in hospital admission, discharge and transfer ensure that they share information with other healthcare professionals and social care practitioners to manage and support patients with an infection on an ongoing basis during admission, transfer and discharge.

**Commissioners** (such as clinical commissioning groups) ensure that they commission services from health and social care providers that have mechanisms in place to ensure that information about any infections, colonising organisms and associated treatments is shared as part of the transfer process and used to inform the ongoing care of patients admitted to, discharged from or transferred between or within hospitals.

### *What the quality statement means for patients, service users and carers*

People who are admitted to, discharged from, or transferred between or within hospitals have information about any infections they have and their treatment, and any treatments they are having that include a risk of infection, shared with the health and social care staff responsible for their care.

### *Source guidance*

- [Healthcare-associated infections: prevention and control](#) (2011) NICE guideline PH36; quality improvement statement 8

### *Definitions of terms used in this quality statement*

#### **Information about any infections and associated treatments**

This includes information sharing to manage and support patients with existing infections – for example, transfer and isolation arrangements for them – during hospital admission, transfer and discharge. Information on infections and treatments being given for existing infections should also be shared with the health and social care practitioners who will be giving the continuing care, along with information relating to the ongoing use of [medical devices](#) (such as catheters) where there is a risk of healthcare-associated infections.

[Adapted from [Healthcare-associated infections: prevention and control](#) (NICE guideline PH36)].

## Using the quality standard

### *Quality measures*

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of care in areas identified as needing quality improvement. They are not a new set of targets or mandatory indicators for performance management.

We have indicated if current national indicators exist that could be used to measure the quality statements. These include indicators developed by the Health and Social Care Information Centre through its [Indicators for Quality Improvement Programme](#). If there is no national indicator that could be used to measure a quality statement, the quality measure should form the basis for audit criteria developed and used locally.

See NICE's [what makes up a NICE quality standard?](#) for further information, including advice on using quality measures.

### *Levels of achievement*

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, NICE recognises that this may not always be appropriate in practice, taking account of safety, choice and professional judgement, and therefore desired levels of achievement should be defined locally.

NICE's [quality standard service improvement template](#) helps providers to make an initial assessment of their service compared with a selection of quality statements. It includes assessing current practice, recording an action plan and monitoring quality improvement.

### *Using other national guidance and policy documents*

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered alongside the documents listed in [development sources](#).

## Diversity, equality and language

During the development of this quality standard, equality issues have been considered and [equality assessments](#) are available.

Good communication between health, public health and social care practitioners and people with healthcare-associated infections, and their carers (if appropriate), is essential. Treatment, care and support, and the information given about it, should be both age-appropriate and culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. People with healthcare-associated infections in hospitals, and their carers (if appropriate), should have access to an interpreter or advocate if needed.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

## Development sources

Further explanation of the methodology used can be found in the quality standards [process guide](#).

## *Evidence sources*

The documents below contain recommendations from NICE guidance or other NICE-accredited recommendations that were used by the Quality Standards Advisory Committee to develop the quality standard statements and measures.

- [Healthcare-associated infections: prevention and control](#) (2011) NICE guideline PH36

## *Policy context*

It is important that the quality standard is considered alongside current policy documents, including:

- Department of Health (2015) [The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance](#)
- Department of Health (2013) [Health Building Note 00-09: Infection control in the built environment](#)
- Health Protection Agency (2012) [Healthcare-associated infection: operational guidance and standards for health protection units](#)

## *Definitions and data sources for the quality measures*

- [NHS Outcomes Framework 2015–16](#)

## Related NICE quality standards

### *Published*

- [Neonatal infection](#) (2014) NICE quality standard 75
- [Infection prevention and control](#) (2014) NICE quality standard 61
- [Surgical site infection](#) (2013) NICE quality standard 49
- [Patient experience in adult NHS services](#) (2012) NICE quality standard 15

### *Future quality standards*

This quality standard has been developed in the context of all quality standards referred to NICE, including the following topics scheduled for future development:

- Effective antimicrobial stewardship
- Influenza
- Non-antibiotic clinical management of infectious diseases
- Norovirus
- Outbreak planning and control
- Sepsis

The full list of quality standard topics referred to NICE is available from the [quality standards topic library](#) on the NICE website.

## Quality Standards Advisory Committee and NICE project team

### *Quality Standards Advisory Committee*

This quality standard has been developed by Quality Standards Advisory Committee 4. Membership of this committee during the period the quality standard was produced included:

**Miss Alison Allam**

Lay member

**Dr Harry Allen**

Consultant Old Age Psychiatrist, Manchester Mental Health and Social Care Trust

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Director of Strategy, The Health Foundation

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Primary Care Pharmacist, NHS Bath and North East Somerset

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Information and Intelligence Business Partner, Essex County Council



**Mr John Walker**

Specialist Services Deputy Network Director, Greater Manchester West Mental Health NHS Foundation Trust

**Mr David Weaver**

Head of Quality and Safety, North Kent Clinical Commissioning Group

The following specialist members joined the committee to develop this quality standard:

**Dr Debra Adams**

Head of Infection Prevention and Control (Midlands and East), NHS Trust Development Authority

**Dr Eimear Brannigan**

Consultant Infectious Disease Physician, Clinical Lead for Infection Prevention and Control

**Dr Peter Jenks**

Consultant Microbiologist and Director of Infection Prevention and Control, Plymouth Hospitals NHS Trust

**Mr Gavin Maxwell**

Lay member

**Dr Bharat Patel**

Consultant Medical Microbiologist, Public Health England

***NICE project team***

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## About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

The methods and processes for developing NICE quality standards are described in the [quality standards process guide](#).

This quality standard has been incorporated into the NICE pathway on [prevention and control of healthcare-associated infections](#).

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

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### *Endorsing organisation*

This quality standard has been endorsed by Department of Health and Social Care, as required by the Health and Social Care Act (2012)

## *Supporting organisations*

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- [British Kidney Patient Association](#)
- [British Association of Dermatologists](#)
- [UK Clinical Pharmacy Association \(UKCPA\)](#)
- [MRSA Action UK](#)
- [Faculty of General Dental Practice](#)