NICE National Institute for Health and Care Excellence

NICE quality standard

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.

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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

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

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 NHS Outcomes Framework 2015 to 2016 indicator 5.2 (MRSA and C difficile); Clinical Commissioning Group [CCG] Outcome Indicator Set 2015 to 2016 indicators 5.3 (MRSA) and 5.4 (C difficile). National data derived from the Public Health England Mandatory Surveillance of MRSA, MSSA, E coli and C difficile.

What the quality statement means for different audiences

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 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.

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. NICE guideline PH36 (2011),

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 NICE's guideline on healthcare-associated infections: prevention and control]

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. [NICE's guideline on healthcare-associated infections: prevention and control]

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

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

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 NHS Outcomes Framework 2015 to 2016 indicator 5.2 (MRSA and C difficile); Clinical Commissioning Group [CCG] Outcome Indicator Set 2015 to 2016 indicators 5.3 (MRSA) and 5.4 (C difficile). National data derived from the Public Health England Mandatory Surveillance of MRSA, MSSA, E coli and C difficile.

What the quality statement means for different audiences

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 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.

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. NICE guideline PH36 (2011), 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

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

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 different

audiences

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 ensure that they commission services from secondary care providers that appraise and support their staff to achieve their objectives on infection prevention and control.

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. NICE guideline PH36 (2011), 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 NICE's guideline on healthcare-associated infections: prevention and control]

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

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

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 different audiences

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 Infection control in the built environment: Health Building Note 00-09 (Department of Health and Social Care, 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 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.

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. NICE guideline PH36 (2011), 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

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

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 different audiences

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 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.

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. NICE guideline PH36 (2011), 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 NICE's guideline on healthcare-associated infections: prevention and control].

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.

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, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about how NICE quality standards are developed is available from the NICE website.

See our webpage on quality standards advisory committees for details about our standing committees. Information about the topic experts invited to join the standing members is available from the webpage for this quality standard.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Diversity, equality and language

Equality issues were considered during development and equality assessments for this quality standard are available. Any specific issues identified during development of the

quality statements are highlighted in each statement.

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.

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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 (BAD)
- UK Clinical Pharmacy Association (UKCPA)
- MRSA Action UK
- College of General Dentistry