

Infection control

NICE quality standard

Draft for consultation

November 2013

Introduction

This quality standard covers the prevention and control of infection for people receiving healthcare in primary, community and secondary care settings. For more information see the [topic overview](#).

Why this quality standard is needed

Healthcare-associated infections arise across a wide range of clinical conditions and can affect people of all ages. They can exacerbate existing or underlying conditions, delay recovery and adversely affect quality of life. Healthcare-associated infections can occur in otherwise healthy people, especially if invasive procedures or devices are used. Healthcare workers, family members and carers are also at risk of acquiring infections when caring for people.

It is estimated that 300,000 patients a year in England acquire a healthcare-associated infection as a result of care within the NHS, a prevalence rate of 8.2%. In 2007, methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infections and *Clostridium difficile* infections were recorded as the underlying cause of, or a contributory factor in, approximately 9000 deaths in hospital and primary care in England.

Healthcare-associated infections are estimated to cost the NHS approximately £1 billion a year. In addition to increased costs, each one of these infections means additional use of NHS resources, greater patient discomfort and a decrease in patient safety.

How this quality standard supports delivery of outcome frameworks

NICE quality standards are a concise set of prioritised statements designed to drive measurable quality improvements within 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 outcomes framework published by the Department of Health:

- [NHS Outcomes Framework 2013/14](#)

Table 1 show the outcomes, overarching indicators and improvement areas from the framework that the quality standard could contribute to achieving.

Table 1 [NHS Outcomes Framework 2013/14](#)

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	<p><i>Overarching indicator</i></p> <p>1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare</p> <p>1ai Adults</p> <p>1aii Children and young people</p>
5 Treating and caring for people in a safe environment and protect them from avoidable harm	<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>5.2i MRSA</p> <p>5.2ii C. difficile</p>

Coordinated services

The quality standard for infection control specifies that services should be commissioned from and coordinated across all relevant agencies. A person-centred, integrated approach that promotes multi-agency working is fundamental to preventing and controlling infection.

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 high-quality infection control 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 healthcare workers and social care and public health practitioners involved in infection control should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard.

Role of families and carers

Quality standards recognise the important role families and carers have in supporting infection control. If appropriate, healthcare workers and social care and public health practitioners should ensure that family members and carers are involved in the decision-making process about investigations, treatment and care.

List of quality statements

Statement 1. People are prescribed antibiotics in accordance with local antibiotic formularies as part of antimicrobial stewardship.

Statement 2. People receive healthcare from organisations in which leadership, multi-agency working and surveillance are part of a strategy for continuous improvement in infection prevention and control.

Statement 3. People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care.

Statement 4. People needing a long-term urinary catheter have their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the catheter.

Statement 5. People needing a vascular access device have their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the device.

Statement 6. People with long-term urinary catheters, vascular access devices or enteral feeds are educated about the safe management of their device or equipment, including techniques to prevent infection.

Questions for consultation

Questions about the quality standard

Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement?

Question 2 If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

Questions about the individual quality statements

Question 3 For draft quality statement 2: Does reference to an organisation's 'board' adequately apply to all organisations that deliver healthcare or can you suggest a more appropriate term?

Question 4 For draft quality statement 4: What are the specific components of the procedures defined that are the main areas for quality improvement?

Question 5 For draft quality statement 5: What are the specific components of the procedures defined that are the main areas for quality improvement?

Quality statement 1: Antimicrobial stewardship

Quality statement

People are prescribed antibiotics in accordance with local antibiotic formularies as part of antimicrobial stewardship.

Rationale

Antibiotic resistance poses a significant threat to public health, particularly because antibiotics underpin routine medical practice. To help prevent the development of resistance it is important to prescribe antibiotics according to the principles of antimicrobial stewardship, such as only prescribing antibiotics when they are needed (and not for self-limiting mild infections such as colds and most coughs, sinusitis, earache and sore throats), and reviewing treatment. Local formularies should indicate a range of drugs for general use, and permit use of other drugs only on the advice of the microbiologist or physician responsible for the control of infectious diseases.

Quality measures

Structure

Evidence of local antibiotic formularies governing the use of antibiotics to ensure that people are prescribed antibiotics appropriately.

Data source: Local data collection.

Outcome

Antibiotic prescribing rates.

Data source: National prescribing comparator data available from the [Information Services Portal](#) hosted by the [Health and Social Care Information Centre](#), specifically the number of prescription items for antibacterial drugs ([British National Formulary \[BNF\], section 5.1](#)) per Specific Therapeutic Group Age-sex weightings Related Prescribing Unit (STAR-PU), and the number of prescription items for cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF, section 5.1).

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

Service providers ensure that they have antimicrobial stewardship initiatives in place, including local antibiotic formularies for antibiotic prescribing.

Healthcare professionals ensure that they prescribe antibiotics in accordance with local antibiotic formularies as part of antimicrobial stewardship.

Commissioners ensure that they commission services that have antimicrobial stewardship initiatives and in which people are prescribed antibiotics in accordance with local antibiotic formularies.

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

People are offered antibiotics according to local guidance about which ones are most suitable, including not being offered antibiotics that are not needed.

Source guidance

- Respiratory tract infections – antibiotic prescribing (NICE clinical guideline 69), [recommendations 1.3 and 1.4](#)
- Expert consensus

Definitions of terms used in this quality statement

Local antibiotic formularies

A local policy document produced by a multi-professional team, usually in a hospital trust or commissioning group, combining best evidence and clinical judgement (adapted from [NICE clinical guideline 74 – full version](#)).

Local formularies often limit the antibiotics that may be used to achieve reasonable economy consistent with adequate cover, and to reduce the development of resistant organisms. A policy may indicate a range of drugs for general use, and permit other drugs only on the advice of the microbiologist or physician responsible for the control of infectious diseases ([BNF, section 5.1](#)).

Antimicrobial stewardship

Antimicrobial stewardship is an organisational or healthcare-system-wide approach to promoting and monitoring judicious use of antimicrobial drugs to preserve their future effectiveness (adapted from [PHE and ARHAI Antimicrobial prescribing and stewardship competencies, 2013](#)). The approach recommended for secondary care is as follows:

- Do not start antibiotics without clinical evidence of bacterial infection.
- If there is evidence or suspicion of bacterial infection, use local guidelines to start prompt effective antibiotic treatment.
- Document the following on the drug chart and in the person's medical notes: clinical indication, duration or review date, route and dose.
- Obtain cultures first.
- Prescribe single-dose antibiotics for surgical prophylaxis if antibiotics have been shown to be effective.
- Review the clinical diagnosis and the continuing need for antibiotics by 48 hours and make a clear plan of action – the “Antimicrobial Prescribing Decision”. The five Antimicrobial Prescribing Decision options are: Stop, Switch IV (intravenous) to Oral, Change, Continue, and Outpatient Parenteral Antibiotic Therapy (OPAT).
- Clearly document the review and subsequent decision in the person's medical notes (adapted from [ARHAI Start Smart – Then Focus, 2011](#)).

The approach recommended for primary care is as follows:

- Prescribe an antibiotic only if there is likely to be a clear clinical benefit.
- Consider a no, or delayed, antibiotic strategy for acute self-limiting upper respiratory tract infections.
- Limit prescribing over the phone to exceptional cases.
- Use simple generic antibiotics if possible. Avoid broad-spectrum antibiotics (for example, co-amoxiclav, quinolones and cephalosporins) if narrow-spectrum antibiotics remain effective, because the former increase the risk of *Clostridium difficile*, methicillin-resistant *Staphylococcus aureus* (MRSA) and antibiotic-resistant urinary tract infections.

- Avoid widespread use of topical antibiotics (especially those that are also available as systemic preparations, such as fusidic acid) (adapted from [PHE Management of Infection Guidance for Primary Care, 2013](#)).

Quality statement 2: Organisational responsibility

Quality statement

People receive healthcare from organisations in which leadership, multi-agency working and surveillance are part of a strategy for continuous improvement in infection prevention and control.

Rationale

It is essential that organisations and agencies work together to coordinate strategies for infection prevention and control across a local area. Equally important is the sharing of information across organisations in order to meet each organisation's responsibility for establishing the current position with regards to infection control, monitoring the impact of quality improvement initiatives and ongoing surveillance. Leadership underpins all infection prevention and control, and is vital to ensure that it remains a priority for the organisation as a whole and each person working within it.

Quality measures

Structure

- a) Evidence that the organisation's board is up to date with, and has a working knowledge and understanding of, infection prevention and control.
- b) Evidence of support for, and participation in, joint working initiatives beyond mandatory or contractual requirements, to reduce healthcare-associated infections locally.
- c) Evidence of an adequately resourced surveillance system with specific, locally defined objectives and priorities for preventing and managing healthcare-associated infections.

Data source: Local data collection.

Outcome

Incidence of healthcare-associated infection.

Data source: [2013/14 NHS Outcomes Framework](#) indicator 5.2 and [2013/14 CCG Outcome Indicator Set](#) indicators 5.3 and 5.4 measure incidence of methicillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile*. Data are derived from the [mandatory reporting of healthcare-associated infections](#) to [Public Health England](#), which are published by the [Health and Social Care Information Centre](#) through their [Indicator Portal](#).

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

Service providers ensure that a strategy is in place for continuous improvement in infection prevention and control that includes leadership, multi-agency working and surveillance.

Healthcare professionals ensure that they implement strategies for continuous improvement in infection prevention and control through leadership, multi-agency working and adhering to surveillance requirements.

Commissioners ensure that they commission services from organisations that have strategies for continuous improvement in infection prevention and control, which include leadership, multi-agency working and surveillance.

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

People receive healthcare from organisations that aim to continually improve the ways in which they prevent and control infections. These include working with other organisations, sharing information and monitoring rates of infection.

Source guidance

- Prevention and control of healthcare-associated infections (NICE public health guidance 36), quality improvement statements [1](#), [3](#) and [6](#).

Question for consultation

Does reference to an organisation's 'board' adequately apply to all organisations that deliver healthcare or can you suggest a more appropriate term?

Quality statement 3: Hand decontamination

Quality statement

People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care.

Rationale

Effective hand decontamination results in significant reductions in the carriage of potential pathogens on the hands and decreases the incidence of preventable healthcare-associated infections, leading in turn to a reduction in morbidity and mortality. Hand decontamination is considered to have a high impact on outcomes that are important to patients. Although hand hygiene has improved over recent years, remaining misconceptions about this standard principle of infection control are reported and good practice is still not universal.

Quality measures

Structure

Evidence of local arrangements to ensure that people receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care.

Data source: Local data collection.

Outcome

Incidence of healthcare-associated infection.

Data source: [2013/14 NHS Outcomes Framework](#), indicator 5.2.

What the quality statement means for service providers, healthcare workers, and commissioners

Service providers ensure that systems are in place so that healthcare workers decontaminate their hands immediately before and after every episode of direct contact or care.

Healthcare workers ensure that they decontaminate their hands immediately before and after every episode of direct contact or care.

Commissioners ensure that they commission services in which healthcare workers decontaminate their hands immediately before and after every episode of direct contact or care.

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

People receiving healthcare are looked after by healthcare workers who always clean their hands thoroughly both immediately before and after coming into contact with the person or carrying out care.

Source guidance

- Infection prevention and control of healthcare-associated infections in primary and community care (NICE clinical guideline 139), recommendation [1.1.2.1](#) (key priority for implementation)
- Pratt RJ et al. (2007) [epic2: National evidence-based guidelines for preventing healthcare-associated infections in NHS hospitals in England](#), recommendation SP6

Definitions of terms used in this quality statement

Hand decontamination

Hand decontamination is the use of handrub or handwashing to reduce the number of bacteria on the hands. The term is often interchangeable with 'hand hygiene' ([NICE clinical guideline 139](#)).

Direct contact or care

Direct contact or care refers to 'hands on' or face-to-face contact with patients, and any physical aspect of the healthcare of a patient, including treatments, self-care and administration of medication ([NICE clinical guideline 139](#)).

Quality statement 4: Long-term urinary catheters

Quality statement

People needing a long-term urinary catheter have their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the catheter.

Rationale

Catheter-associated urinary tract infections comprise a large proportion of healthcare-associated infections. There is a strong association between duration of urinary catheterisation and risk of infection, and catheters can be inserted inappropriately or there is a delay in removing them. This risk is greatly reduced by complying with all parts of the process for safe catheter insertion and maintenance, which is important in terms of both infection prevention, and patient comfort and experience.

Quality measures

Structure

Evidence of local arrangements to ensure that people needing a long-term urinary catheter have their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the catheter.

Data source: Local data collection.

Process

Proportion of people with a long-term urinary catheter who have their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the catheter.

Numerator – the number of people in the denominator who have their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the catheter.

Denominator – the number of people with a long-term urinary catheter.

Data source: Local data collection. Elements contained in NICE clinical guideline 139 [audit support – catheter maintenance](#).

Outcome

- a) Incidence of healthcare-associated infection.
- b) Incidence of urinary tract infection.

Data source:

a) [2013/14 NHS Outcomes Framework](#) indicator 5.2 and [2013/14 CCG Outcome Indicator Set](#) indicators 5.3 and 5.4 measure incidence of methicillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium Difficile*. Data are derived from the [mandatory reporting of healthcare associated infections](#) to [Public Health England](#), which are published by the [Health and Social Care Information Centre](#) through their [Indicator Portal](#).

b) Local data collection.

What the quality statement means for service providers, healthcare workers, and commissioners

Service providers ensure that there are systems in place to enable the completion of specified procedures necessary for the safe insertion and maintenance of long-term urinary catheters.

Healthcare workers ensure that they complete specified procedures necessary for the safe insertion and maintenance of long-term urinary catheters, in order to minimise the risk of infection for people needing a catheter.

Commissioners ensure that they commission services in which specified procedures necessary for the safe insertion and maintenance of long-term urinary catheters are completed, in order to minimise the risk of infection for people needing a catheter.

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

People needing a long-term urinary catheter have their risk of infection minimised by healthcare workers and professionals carrying out specified procedures to make sure that the catheter is inserted and looked after correctly and safely. These include things like cleaning hands, using a lubricant, emptying the drainage bag when necessary and making sure the catheter is removed as soon as it is no longer needed.

Source guidance

- [Infection prevention and control of healthcare-associated infections in primary and community care](#) (NICE clinical guideline 139), recommendations [1.2.2.1–1.2.2.3](#), [1.2.3.4](#), [1.2.4.3](#), [1.2.4.4](#), [1.2.5.1–1.2.5.3](#), [1.2.5.5–1.2.5.7](#), [1.2.5.9](#)
- Pratt RJ et al. (2007) [epic2: National evidence-based guidelines for preventing healthcare-associated infections in NHS hospitals in England](#), recommendations UC1–UC5, UC7–UC13, UC14, UC17.

Definitions of terms used in this quality statement

Long-term urinary catheter

A long-term urinary catheter is an indwelling or intermittent urinary catheter that is used for a period greater than 28 days ([NICE clinical guideline 139 – full version](#)).

Specified procedures necessary for the safe insertion and maintenance of urinary catheters

The person's clinical need for catheterisation should be reviewed regularly and the urinary catheter removed as soon as possible. The need for catheterisation, as well as details about insertion, changes and care should be documented.

An appropriate lubricant from a single-use container should be used during catheter insertion to minimise urethral trauma. For urethral catheterisation, the meatus should be cleaned before the catheter is inserted, in accordance with local guidelines or policy (for example, with sterile normal saline).

Indwelling catheters should be connected to a sterile closed urinary drainage system or catheter valve. Healthcare workers should ensure that the connection between the catheter and the urinary drainage system is not broken, except for good clinical reasons (for example, changing the bag in line with the manufacturer's recommendations). Urinary drainage bags should be positioned below the level of the bladder, and should not be in contact with the floor. The urinary drainage bag should be emptied frequently enough to maintain urine flow and prevent reflux, and should be changed when clinically indicated. A separate and clean container should be used for each person, and contact between the urinary drainage tap and container avoided. Urine samples must be obtained from a sampling port using an aseptic technique.

Healthcare workers must decontaminate their hands and wear a new pair of clean, non-sterile gloves before manipulating a person's catheter, and must decontaminate their hands after removing gloves.

The meatus should be washed daily with soap and water as part of routine daily personal hygiene (adapted from [NICE clinical guideline 139](#) and [epic2: National evidence-based guidelines for preventing healthcare-associated infections in NHS hospitals in England](#)).

Question for consultation

What are the specific components of the procedures defined that are the main areas for quality improvement?

Quality statement 5: Vascular access devices

Quality statement

People needing a vascular access device have their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the device.

Rationale

Vascular access devices are one of the most important causes of healthcare-associated infections, and bloodstream infections associated with central venous catheter insertion are a major cause of morbidity. The risk of infection is greatly reduced by complying with all parts of the process for safe insertion and maintenance of the device.

Quality measures

Structure

Evidence of local arrangements to ensure that people needing a vascular access device have their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the device.

Data source: Local data collection.

Process

Proportion of people with a vascular access device who have their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the device.

Numerator – the number of people in the denominator who have their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the device.

Denominator – the number of people with a vascular access device.

Data source: Local data collection. Contained in NICE clinical guideline 139 [audit support – vascular access](#).

Outcome

Incidence of healthcare-associated infection.

Data source: [2013/14 NHS Outcomes Framework](#) indicator 5.2.

What the quality statement means for service providers, healthcare workers, and commissioners

Service providers ensure that there are systems in place to enable the completion of specified procedures necessary for the safe insertion and maintenance of vascular access devices.

Healthcare workers ensure that they complete specified procedures necessary for the safe insertion and maintenance of vascular access devices, in order to minimise the risk of infection for people needing this device.

Commissioners ensure that they commission services in which specified procedures necessary for the safe insertion and maintenance of vascular access devices are completed, in order to minimise the risk of infection for people needing this device.

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

People needing a vascular access device (tubing inserted into a main vein or artery, used primarily to administer fluids and medications, monitor pressures and collect blood) have their risk of infection minimised by healthcare workers and professionals carrying out specified procedures to make sure that the device is inserted and looked after correctly and safely. These include things like following sterile procedures when inserting the device, as well as using the correct antiseptics and dressings.

Source guidance

- [Infection prevention and control of healthcare-associated infections in primary and community care](#) (NICE clinical guideline 139), recommendations [1.4.2.1](#), [1.4.2.2](#), [1.4.3.1](#), [1.4.3.2](#), [1.4.4.1](#), [1.4.4.5](#), [1.4.4.6](#), [1.4.4.12–1.4.4.15](#)

- Pratt RJ et al. (2007) [epic2: National evidence-based guidelines for preventing healthcare-associated infections in NHS hospitals in England](#), recommendations CVAD3, CVAD4, CVAD7, CVAD10, CVAD12, CVAD14, CVAD15, CVAD19, CVAD24, CVAD33, CVAD38, CVAD45–CVAD47.

Definitions of terms used in this quality statement

Vascular access device

A vascular access device is an indwelling catheter, cannula, or other instrument used to obtain venous or arterial access.

Specified procedures necessary for the safe insertion and maintenance of vascular access devices

Unless medically contraindicated, the subclavian site should be used in preference to the jugular or femoral sites for placing a non-tunnelled catheter. Maximal sterile barriers, including a sterile gown, sterile gloves and a large sterile drape, should be used when inserting a central venous access device. An aseptic technique must be used for vascular access device catheter site care and when accessing the system.

The skin should be decontaminated at the insertion site with chlorhexidine gluconate in 70% alcohol before inserting a peripheral vascular access device or a peripherally inserted central catheter. The skin site should be decontaminated with a single-patient-use application of alcoholic chlorhexidine gluconate solution (preferably 2% chlorhexidine gluconate in 70% isopropyl alcohol) before inserting a central venous access device.

Before accessing or dressing a vascular access device, hands must be decontaminated either by washing with an antimicrobial liquid soap and water or by using an alcohol handrub.

A sterile transparent semipermeable membrane dressing should be used to cover the vascular access device insertion site. The insertion site and surrounding skin should be decontaminated during dressing changes using a chlorhexidine gluconate solution (preferably 2% chlorhexidine gluconate in 70% isopropyl alcohol), and allowed to air dry. A single-patient-use application of alcoholic chlorhexidine gluconate solution (preferably 2% chlorhexidine gluconate in 70% isopropyl alcohol)

should be used and allowed to dry when decontaminating the injection port or catheter hub before and after it has been used to access the system, unless contraindicated by the manufacturer's recommendations, in which case either aqueous chlorhexidine gluconate or aqueous povidone iodine should be used. Preferably, a sterile 0.9% sodium chloride injection should be used to flush and lock catheter lumens.

Administration sets for blood and blood components should be changed when the transfusion episode is complete or every 12 hours (whichever is sooner), or according to the manufacturer's recommendations. Administration sets used for total parenteral nutrition infusions should generally be changed every 24 hours. If the solution contains only glucose and amino acids, administration sets in continuous use do not need to be replaced more frequently than every 72 hours (adapted from [NICE clinical guideline 139](#) and [epic2: National evidence-based guidelines for preventing healthcare-associated infections in NHS hospitals in England](#)).

Question for consultation

What are the specific components of the procedures defined that are the main areas for quality improvement?

Quality statement 6: Educating people about infection control

Quality statement

People with long-term urinary catheters, vascular access devices or enteral feeds are educated about the safe management of their device or equipment, including techniques to prevent infection.

Rationale

Because many people with long-term urinary catheters, vascular access devices or enteral feeds manage their own devices or equipment, it is important that they and their carers are confident about, and proficient in, infection prevention practices and the safe management of their devices.

Quality measures

Structure

Evidence of local arrangements for people with long-term urinary catheters, vascular access devices or enteral feeds to be educated about the safe management of their device or equipment, including techniques to prevent infection.

Data source: Local data collection.

Process

Proportion of people with long-term urinary catheters, vascular access devices or enteral feeds who are educated about the safe management of their device or equipment, including techniques to prevent infection.

Numerator – the number of people in the denominator who are educated about the safe management of their device or equipment, including techniques to prevent infection.

Denominator – the number of people with long-term urinary catheters, vascular access devices or enteral feeds.

Data source: Local data collection.

Outcome

Incidence of healthcare-associated infection.

Data source: [2013/14 NHS Outcomes Framework](#) indicator 5.2 and [2013/14 CCG Outcome Indicator Set](#) indicators 5.3 and 5.4 measure incidence of methicillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile*. Data are derived from the [mandatory reporting of healthcare associated infections](#) to [Public Health England](#), which are published by the [Health and Social Care Information Centre](#) through their [Indicator Portal](#).

What the quality statement means for service providers, healthcare workers, and commissioners

Service providers ensure that there are systems in place for people with long-term urinary catheters, vascular access devices or enteral feeds to be educated about the safe management of their device or equipment, including techniques to prevent infection.

Healthcare workers ensure that they educate people with long-term urinary catheters, vascular access devices or enteral feeds about the safe management of their device or equipment, including techniques to prevent infection.

Commissioners ensure that they commission services in which people with long-term urinary catheters, vascular access devices or enteral feeds are educated about the safe management of their device or equipment, including techniques to prevent infection.

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

People who have a long-term urinary catheter, a vascular access device or who need enteral feeding, or their families or carers, are given information and advice about how to look after the equipment safely, including how to prevent infection.

Source guidance

- Infection prevention and control of healthcare-associated infections in primary and community care (NICE clinical guideline 139), recommendations [1.2.1.1](#), [1.3.1.1](#) and [1.4.1.1](#) (key priority for implementation).
- Pratt RJ et al. (2007) [epic2: National evidence-based guidelines for preventing healthcare-associated infections in NHS hospitals in England](#), recommendations UC20 and CVAD2.

Definitions of terms used in this quality statement

Long-term urinary catheter

A long-term urinary catheter is an indwelling or intermittent urinary catheter that is used for a period greater than 28 days ([NICE clinical guideline 139 – full version](#)).

Vascular access device

A vascular access device is an indwelling catheter, cannula, or other instrument used to obtain venous or arterial access.

Enteral feeds

Enteral feeding is feeding via a tube that can include any method of providing nutrition via the gastrointestinal tract ([NICE clinical guideline 139 – full version](#)).

Equality and diversity considerations

People with a lack of mobility or cognitive impairment may require additional support to undertake hand decontamination and other techniques to prevent infection.

Language barriers should not be a reason for non-provision of advice.

If religious beliefs are a source of concern in relation to the use of alcohol handrubs for hand decontamination, then patients could be made aware of the official stand of religious bodies about the product. Where information is available, patients should be directed to these sources.

Status of this quality standard

This is the draft quality standard released for consultation from 19 November to 17 December 2013. It is not NICE's final quality standard on infection control. The statements and measures presented in this document are provisional and may change after consultation with stakeholders.

Comments on the content of the draft standard must be submitted by 5pm on 17 December 2013. All eligible comments received during consultation will be reviewed by the Quality Standards Advisory Committee and the quality statements and measures will be refined in line with the Quality Standards Advisory Committee's considerations. The final quality standard will be available on the [NICE website](#) from April 2014.

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.

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 by commissioners, providers, healthcare workers and professionals and social care and public health practitioners, patients, service users and carers 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 healthcare workers and social care and public health practitioners is essential. Treatment, care and support, and the information given about it, should be 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 receiving healthcare 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](#) on the NICE website.

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.

- [Infection control](#). NICE clinical guideline 139 (2012).
- [Prevention and control of healthcare-associated infections](#). NICE public health guidance 36 (2011).
- [Respiratory tract infections – antibiotic prescribing](#). NICE clinical guideline 69 (2008)
- Pratt RJ et al. [epic2: National evidence-based guidelines for preventing healthcare-associated infections in NHS hospitals in England](#). Journal of Hospital Infection 65 (supplement 1): S1–64 (2007).

Policy context

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

- Department of Health (2013) [UK five year antimicrobial resistance strategy 2013 to 2018](#).
- Department of Health Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) (2011) [Antimicrobial stewardship ‘Start smart – then focus’: guidance for antimicrobial stewardship in hospitals \(England\)](#).
- Care Quality Commission (2010) [Essential standards of quality and safety](#).
- Department of Health (2010) [High impact intervention: central venous catheter care bundle](#).
- Department of Health (2010) [High impact intervention: urinary catheter care bundle](#).
- Department of Health (2010) [The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance](#).
- National Audit Office (2009) [Reducing healthcare associated infections in hospitals in England](#).

Definitions and data sources for the quality measures

- *To be completed*

Related NICE quality standards

Published

- [Surgical site infection](#). NICE quality standard 49 (2013).
- [Patient experience in adult NHS services](#). NICE quality standard 15 (2012).
- [Service user experience in adult mental health](#). NICE quality standard 14 (2011).

Future quality standards

This quality standard has been developed in the context of all quality standards referred to NICE.

Quality Standards Advisory Committee and NICE project team

Quality Standards Advisory Committee

This quality standard has been developed by Quality Standards Advisory Committee 3.

Membership of this committee is as follows:

Dr Hugh McIntyre (Chair)

Consultant Physician, East Sussex Healthcare Trust

Mrs Alison Raw (Acting Chair at prioritisation meeting)

Head of Integrated Health and Care, Lewisham

Dr Jim Stephenson (Vice Chair)

Secondary care provider, Consultant Medical Microbiologist, Epsom and St Helier NHS Trust

Dr Alastair Bradley

Primary care provider, General Medical Practitioner, Tramways Medical Centre/Academic Unit of Primary Medical Care, University of Sheffield

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Public health expert, Public Health Nutrition Lead & Registered Dietician, Manchester City Council

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Ms Ann Nevinson

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Commissioner, Strategic Commissioning Manager, Sheffield City Council

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

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Mr Gavin Maxwell

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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](#).

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