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SCOTTISH EXECUTIVE

Health Department
Directorate of Performance Management and Finance

22nd November 2002

Addresses

For action

Chief Executives, NHS Trusts
Chief Executives, Health Boards
Chief Executive, NES
Chief Executive, PEF
General Manager, SCIEH
Chief Executive, CSBS
Chief Executive, State Hospital
Chief Executive, Scottish Ambulance Service

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Dear Colleague

MINISTERIAL ACTION PLAN ON HEALTHCARE ASSOCIATED INFECTION, WATT GROUP REPORT ON THE OUTBREAK OF SALMONELLA INFECTION AT VICTORIA INFIRMARY AND HAI & PATIENT CARE ENVIRONMENT QUESTIONNAIRE

Introduction

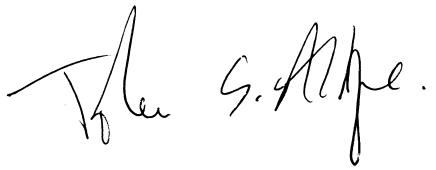
Infection control is an important issue for NHSScotland, both in terms of the safety and well-being of patients and of the efficiency and effectiveness of the service. I attach copies of two documents with important recommendations for the management of healthcare associated infection. Ministers have accepted these recommendations. Also enclosed is a questionnaire intended to help identify the extent of infection and related risk posed by the patient care environment in NHS hospitals and the work required to address the issue.

The Watt Group Report includes 47 recommendations for action by NHS Trusts/Boards and other bodies, including the Scottish Executive, to improve the efficiency and effectiveness of infection control arrangements and of hospital cleaning services. The Ministerial Action Plan, which incorporates the conclusions of the Watt report and a number of recommendations from the HAI convention held in Edinburgh at the end of June, sets out proposals for action by Trusts and other bodies. The implementation arrangements proposed in the Action Plan, in particular the formation of a Task Force to be led by the Chief Medical Officer are an important means of progressing effective action against HAI and of implementing the Watt Group's recommendations.

Conclusion

The first step is for you to take these reports to your Boards and assess how best to implement the recommendations that have been made. Full implementation will clearly take time and will involve action from the wide range of NHS bodies with an interest in HAI. The programme of work sketched out above and detailed in the Action Plan and the Watt Group report is clearly challenging and has implications for the commitment of NHS resources. But this is also an area which has to be tackled as a major and immediate priority. It is moreover an area where improvements in procedures cannot only benefit patients but can also reduce the cost burdens currently being borne by the NHS as a result of unnecessarily high levels of HAI.

Yours sincerely



JOHN ALDRIDGE
Director of Performance Management and Finance

NHS Boards and Trusts

It is important that NHSScotland takes action on the recommendations now. There are a number of recommendations on which Boards and Trusts can act without delay. **I would therefore be grateful if chief executives would arrange for**:

- the recommendations in the Watt Group report to be considered by your Board as a matter of urgency, and

- the Board to develop a plan for implementing those recommendations to the fullest extent possible in the light of your operational and financial circumstances and with due regard to the need to manage resources efficiently, effectively and to secure best value.

In particular the plan should set out immediate arrangements to respond to the following Watt Group recommendations – 2, 4, 6, 7, 9, 11 and 18 which deal with better arrangements for cleaning and infection control and recommendations 23, 24, 25, 31 and 32 which relate to arrangements for managing outbreaks including communications. (Annex B sets out the text of these recommendations.)

NHS Boards and Trusts should also consider the HAI Action Plan and provide the Department with a short report indicating how they plan to deliver it. In particular, the report should indicate how the Board/Trust will contribute to the implementation Task Force which CMO will lead. It should also set out how the Board/Trust will ensure that its documented policies and procedures are aligned with the objectives of the Action Plan and supportive of the overall objective of managing down the level of HAI. **This report should reach the Department by 31.01.03.**

The questionnaire below deals with assessing the scale of risks of HAI posed by the patient care environment and how best to reduce these risks through appropriate management action. (The cost of management action should be met within the increased overall allocations made available to NHS Boards this year and within indicative allocations for future years.) These are important issues for NHSScotland and the Department. Given the priority which Ministers attach to the issue of infection control and the potential costs of effective action, I would expect chief executives to take personal responsibility for ensuring completion of the attached questionnaire.

Please note that we have arranged for a session at the chief executives' meeting on 28 November to discuss the results emerging from the survey. This will also provide an opportunity for chief executives to discuss more general HAI/infection control issues and in particular the Watt Group report and the Action Plan. The Minister will no doubt wish to cover similar issues at his meeting with NHS Chairs on 29 November.

NHS Boards and Trusts should develop a HAI leaflet and other information materials for patients informing them what their rights are in this respect and what information they can expect from NHS in Scotland about the risks to them from receiving a clinical procedure in a specific setting, with advice from HEBS and SCIEH as required.

Other NHS bodies

Addressing HAI will require a co-ordinated response by NHSScotland including those bodies such as the Scottish Ambulance Service. While the Action Plan and questionnaire have been drafted in consideration of the issues within the hospital setting, the same fundamental principles apply in whatever environment in which patient care is being provided. Bodies such as the SAS are therefore asked to carry out an assessment of the scale of the specific problems faced and to develop plans for securing better arrangements for cleaning and infection control and to submit these to the same timetable as NHS Boards and Trusts. A number of NHS organisations are specifically being called on to play their part with regard to education and training, patient information, raising standards, developing guidance on the built environment and other issues. Action in these areas will benefit from some further discussion and co-operation amongst the bodies involved. Proposals for particular bodies are set out below.

HAI is also an important issue for

NHS Education for Scotland (NES)

As an integral component of mandatory induction, NES should contribute to the establishment of education on HAI and hygiene for all clinical and non-clinical staff with revalidation of knowledge and skills at appropriate intervals.

In addition to the educational initiative to prepare 'clinical champions' that is already underway, NES should also develop for NHS staff groups an educational framework on risk assessment and management which will inform:

- standardised educational packages on HAI for all clinical and non-clinical staff;
- an HAI website with links to all relevant guidance and training materials; and
- liaison with universities and colleges on ensuring all receiving undergraduate education in clinical disciplines receive appropriate HAI-related education.

CSBS and NES to review the scope for joint working in setting standards and methodologies for monitoring Trusts' education and training programmes on HAI and hygiene.

NHS Scotland Property and Environmental Forum

PEF should review the current guidance on upgrading the physical environment for healthcare in old buildings. This would be with a view to ensuring it's accessibility for general managers and to strengthen associated good practice guidance.

Following the patient care environment audit and the stakeholder conference, PEF should conduct a healthcare environment audit of standards and technical requirements related to infection control and the built environment including the provision of staff washing, decontamination and changing facilities to guide new builds and refurbishment projects.

SCIEH

SCIEH should develop model infection control policies and procedures taking account of CSBS standards, including the management of outbreaks of HAI and guidance on staff screening during HAI outbreaks. SCIEH should also arrange to train public health and microbiology staff in the management of HAI outbreaks.

CSBS

CSBS should aim to work with NES to set standards and methodologies for monitoring Trusts' education and training programmes on HAI and hygiene.

CSBS should further develop their infection control standards particularly with regard to ensuring that Trusts have in place:

- systems for ensuring good practice in catheterisation and anti-microbial prescribing;
- infection control services, drawing on the SCIEH model on good practice as appropriate; and
- systems to monitor the level of resources invested in infection control .

Other Bodies

Arrangements are being made to carry forward recommendations applying to the Chief Scientist's Office (on research) to the Health Department (on communications) and on multi disciplinary prescribing teams in hospitals.

Background

The Scottish Health Plan, "Our National Health" made clear that tackling HAI was a major objective for the health service. As a result of the proposals set out there, the CSBS has developed standards for infection control and cleaning services which NHS Trusts are expected to meet. The CSBS and Audit Scotland will report on the performance of the health service against these standards in December this year. **Achieving the CSBS standards will continue to be the main yardstick by which the performance of the NHS will be judged in this context, and Trusts will be expected to address the areas for improvement identified in their individual reports.**

Since the last major HDL on HAI (Managing the risk of HAI in NHS Scotland HDL(2001)53) was issued in June 2001 there have been a number of developments including the holding of a Ministerial Convention on HAI, the commissioning of the Watt Group report and a higher profile for HSE's involvement in these issues. This has been accompanied by a generally increased concern about the quality of the patient care environment.

HAI Action Plan

The Minister hosted the HAI convention on 28 June. The intention, which was widely publicised, was to use the event as the basis for developing an action plan covering further measures to tackle HAI. This has been done. A report summarising the convention proceedings has been produced to provide a record of the material presented, the issues discussed and the recommendations made by those who attended. The report underpins but is distinct from the Action Plan. The Plan incorporates proposals generated at the convention, by the Watt Group recommendations and through policy development within the Department.

The Action Plan focuses on making progress in three key areas and highlights the additional development activity required to tackle HAI more effectively. A summary of the Action Plan is set out in Annex C.

National Co-ordination

To take forward the Action Plan, SEHD will establish a multi-disciplinary Task Force led by the Chief Medical Officer with the remit to:

- co-ordinate the development and implementation of the HAI Action Plan;
- review progress across Scotland;
- monitor the levels of HAI and assess the impact of control measures;
- take forward amendments to the action plan and its component initiatives;
- report on progress to the Minister of Health and Community Care and annually through the CMO's report, to the public at large.

Phasing

Of the 17 initiatives listed in the Action Plan, the most important priorities are the development and implementation of:

- the Code of Practice for the local management of hygiene;
- mandatory hygiene and infection control induction training programmes and the other HAI related educational initiatives;
- technical requirements for cleaning processes.

These and the implementation of the 12 initiatives currently in train will form the core programmes of the HAI Action Plan in the first year of its operation. The HAI Task Force will decide the timing of other initiatives.

2. Watt Report

The Watt Group report was commissioned as a result of an outbreak of salmonella infection at the Victoria Infirmary, Glasgow, in December 2001 and January this year. The Watt Group was asked to draw conclusions and make recommendations to help reduce the risks of future outbreaks of infections of this kind and help improve management.

The report makes a large number of recommendations. Amongst its conclusions are that the following are required throughout the NHS In Scotland:

- A comprehensive implementation of Infection Control standards at ward/departmental level and the necessary resources to achieve this;
- A properly developed and funded infection control infrastructure:

- A culture change in hand washing, underpinned by hand washing audits for all staff;

- Implementation of a suggested Infection Control Outbreak/Episode Risk Matrix to allow consistent responses and communications across Scotland and

- Proper emphasis on all aspects of communications in infection control and in outbreaks, including a culture of openness.

The detailed recommendations of the group have been incorporated in the HAI Action Plan.

3. HAI & Patient Care Environment Questionnaire

Part of the solution to the problems posed by HAI lies in addressing the challenges of the patient care environment. Some of our hospitals are not ideally suited to delivering modern patient care while minimising risk of infection for patients, staff and visitors. The attached questionnaire has been drawn up to help assess the scale of the specific problems faced by the service and to help Trusts develop plans to address them. These plans should be realistic and reflect the resources available. The questionnaire has been prepared with the support of a NHS advisory group chaired by Richard Carey (chief executive Highland Acute Hospitals Trust). Its purpose is

- To allow each hospital site/Trust to rapidly assess its own situation in relation to the risks posed by the patient care environment and to identify potential action points; and
- To allow collation of information on the current situation across Scotland.

We are particularly interested in the position in high risk areas of hospitals. These have been identified as Intensive Care, High Dependency, neonatal wards, Special Care Baby Units, areas with patients with orthopaedic or surgical implants (including hip replacements, pins & plates, grafts), oncology/transplant units, haemodialysis units and burns units. The environmental issues we have identified relate to:

- handwashing facilities
- Sluice areas
- Patient handling equipment
- Furniture and fittings
- Storage of domestic services equipment
- Bed spacing
- Isolation facilities for infectious patients

There are also hospital wide issues which relate to:

- Staff changing facilities
- Staff washing/decontamination facilities
- Management of clinical waste

Information from this questionnaire will be used solely for the purposes of assessing the overall Scottish picture.

The questionnaire should be returned by **22 November 2002.** This will enable us to feed back initial results of the survey at the Chief Executives meeting on 28 November.

2. ***That the cleaning specification in wards and departments should be set by the senior nurse responsible for the area and each ward/departmental manager in collaboration with the relevant Infection Control Team and Domestic Services Manager. Cleaning against this specification should be subject to rigorous monitoring and action to correct deficiencies. Failure to meet the specification should be subject to formal audit and review within each hospital and be subject to public disclosure.***

4. ***That Audit Scotland reports are reviewed carefully by the management of Trusts, and that appropriate action is taken to respond to them.***

6. ***That exposure of staff to faeces should be documented through the Incident Reporting Procedure as thoroughly as exposure to any other biological (body) fluids.***

7. ***That specific guidelines and facilities (washing, showering, cleaning uniforms) should be available in every hospital for the decontamination of staff who become grossly contaminated from body fluids (blood, urine, faeces and so on).***

9. ***That nursing notes/care plans should clearly reflect the need for enteric precautions in individuals suffering from loose stools /diarrhoea.***

11. ***That clear infection control guidance to all staff on how to nurse a patient with loose stools/diarrhoea should be provided within the infection control manual.***

18. ***That the Agency/Bank/Locum induction checklist should include explicit mention of Infection Control precautions in place.***

23. ***(a)*** ***That an OCT should always be chaired by someone with competence and authority in health care associated infection. The local Consultant in Public Health Medicine (CPHM) should chair OCTs for major outbreaks (see Appendix E for definition). This demonstrates that the Team is led by an individual external to the Trust, who has close links with the local NHS Board and with community surveillance. In the case of other hospital outbreaks the CPHM should be consulted regarding chairmanship of the team. In practice, this will usually be the ICD.***

(b) ***That there should be clear role definitions for the members of the OCT, with clear responsibilities documented.***

(c) ***That a clear Outbreak Control Plan should be agreed and implemented.***

24. ***That senior management (Executive Director level) of the Trust should be fully engaged from an early stage in managing outbreaks either as full and active members of the OCT or as a separate support team to the OCT. Senior management support should include a senior communications manager who can ensure that staff, relatives and the public are timeously informed of the outbreak and are given appropriate public health messages.***

25. ***That all OCT reports should provide sufficient details of key factors in the spread of infection to allow proper audit.***

31. ***That in any outbreak that is considered at any stage to be foodborne, the Scottish Executive is informed in addition to the Food Standards Agency.***

32. ***That Trusts and Boards ensure that there are sufficient resources to appoint adequate levels of communication professionals, but that "Press Office to Press Office" communication is additional to, not a substitute for, professional communication.***

HAI ACTION PLAN **ANNEX C**

The action plan covers three broad areas of activity.

(i) Promoting good infection control and hygiene practice in wards, other clinical settings and support services.

Good hygiene is an essential aspect of clinical care. The environments staff work in may not always be conducive to effective infection control but we need to ensure that their focus is always on hygiene. We shall encourage this by action under the following heads

The development and implementation of a **Scotland wide Code of Practice for the local management of hygiene** .

The Code will define local management powers and responsibilities for:

ensuring environmental and equipment standards are maintained;
informing patients about the risks of HAI and measures to reduce them;
managing inappropriate or over-frequent patient movement and overcrowding; and
ensuring compliance with hygiene and infection control standards especially hand hygiene.

It will include guidance on:

managing patients with loose stools;
setting requirements for basic equipment to reduce communal use especially in clinical settings ;
records on infection control measures and advice in patient notes and incidents of staff exposure to faeces or other body fluids;
decontaminating grossly contaminated staff;
policy and procedures on uniforms and changing;
training in hygiene and infection control, including food hygiene;
ensuring that agency nursing staff and other contracted non-NHS staff are competent in hygiene and infection control;
improving the quality of clinical information on laboratory request forms.

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The establishment of **mandatory induction training on HAI and hygiene for all clinical and non-clinical staff** with appropriate revalidation arrangements.

The introduction of **an HAI leaflet and other information for patients** setting out their rights and explaining the information to expect from NHS in Scotland about the risks of clinical procedures in specific settings.

The introduction of **training packages on risk assessment and management** including;

- standardised packages in HAI for all clinical and non-clinical staff;
- an HAI website with links to guidance and training materials;
- arrangements to ensure undergraduate education in clinical disciplines includes an HAI-related element.

Holding a stakeholder conference to develop **guidance on upgrading the physical environment for healthcare in old buildings.**

Setting **technical requirements for cleaning processes and frequencies for service specifications for cleaning services**.

To guide new builds and refurbishment projects, a detailed **review of standards and technical requirements related to infection control and the built environment** including the provision of staff washing, decontamination and changing facilities.

(ii) Management arrangements to ensure that good hygiene and infection control practice is in place throughout healthcare organisations.

Most NHS organisations in Scotland are upgrading their management systems related to infection control. To further develop management systems we shall:

review the **training and support arrangements for those engaged in media handling**

develop **model infection control policies and procedures, including the management of outbreaks**

develop **guidance on staff screening during HAI outbreaks**

develop **guidance on multidisciplinary prescribing teams** in all NHS hospitals and primary care services to ensure that education and training on anti-microbial use takes place and practice is audited and

introduce training of public health and microbiology staff in **the management of outbreaks of HAI.**

(iii) Ensuring that the performance of healthcare organisations in Scotland is of sufficient quality and effectiveness to reduce the incidence of HAI.

To strengthen policy, performance management and accountability at national level, we shall:

Develop, for incorporation in the overall Performance Assessment Framework, **performance indicators for the risk management of HAI** (based on HAI surveillance and CSBS data) designed to demonstrate progress with risk reduction.

Develop a **Code of Practice on disclosure of adverse events**, including HAI rates, outbreaks and compliance with standards.

Commission research into:

the use of HAI surveillance data to alert Trusts to the development of outbreaks and incidents;

the impact of HAI on bed usage and resources;

the cost-effectiveness of different interventions to reduce HAI;

the development of a methodology to track the on-going impact of HAI including the cost of its control .

Institute joint working to **set standards and methodologies for monitoring Trusts' education and training programmes on HAI and hygiene**.

Encourage further development of infection control standards particularly with regard to ensuring that Trusts have in place:

systems for ensuring good practice in catheterisation and anti-microbial prescribing;

infection control services which take account of the recommendations of the SCIEH model on good practice;

systems to monitor the level of resources invested in infection control.

Review SEHD procedures for handling outbreaks, including streamlining arrangements for reporting and communications.

The full text of the guidance referred to below should be consulted for further details: copies should be available from the Property and Environment Forum if not available locally. The Property and Environment Forum has issued a helpful CD-ROM under the heading 'Decontamination Guidance' which contains details of guidance produced by PEF, the Scottish Executive, NHS Estates (England) the Medical Devices agency and others: it also covers topics such as ventilation in healthcare premises.

This audit questionnaire is being sent to all Acute Trusts, and should cover all hospital sites within the Trust. There are two purposes to this exercise:

- to allow each Trust to rapidly assess its own situation in relation to issues raised by the Victoria Infirmary investigations, and to identify potential action points; and
- to allow collation of summary information on the current situation across Scotland, and to feed back this summary information to Trusts.

There are a number of basic principles underlying the conduct of this survey and assessing its implications: it should be a learning opportunity which is risk-based, evidence based, practicable, affordable, predicated on impact on patient care, and built into systems which already exist. This particular survey relates only to current issues of specific concern, and forms part of the immediate activities outlined in the HAI Action Plan.

The questionnaire has two Sections, the first relating to specified high-risk areas and the second to the site in general. It may be easier (and more useful for Trusts) to complete a separate copy of the questionnaire for each ward, department or clinical area, and to collate the results within a single form for return to SEHD. If there are too many wards to cover by the return deadline, we suggest selection of sentinel or representative wards, with extrapolation of cost implications for the hospital. However, the exercise should be applied to all specified areas for the Trust's internal management purposes.

Where there are standards published by NHSScotland Property and Environment Forum, these are cited and briefly summarised in the Appendix. However, the complete documents should be referred to in the conduct of this exercise.

This questionnaire should be returned by 22nd November 2002 at the latest to allow collation of results by the end of November.

Information from this questionnaire will be used by the Department solely for the purposes of assessing the general situation in Scotland. However, we would expect that, where major deficiencies are detected, appropriate action is taken to remedy these.

Healthcare Associated Infection and the Patient Care Environment:
interim risk assessment for hospitals

Audit questionnaire

Hospital……Trust…… ……

Date of completion……..

Person completing the questionnaire:……..

Designation and contact details:……...

……..

Information comes from: (tick)

Summary of survey of all appropriate wards ☐

Selected 'sentinel' wards only* ☐

** If incomplete results are submitted, please indicate that financial estimates have been extrapolated to cover implications for the whole hospital.*

Information from this questionnaire will be used solely for the purposes of assessing the general situation in Scotland, and individual Trusts or hospitals will **not** be identified in any reports or presentations.

Electronic copies of this form can be obtained from susan.roberts@scotland.gsi.gov.uk

Please return completed forms, preferably by email, to the address below by 22nd November 2002

Bill.Sim@Scotland.gsi.gov.uk Fax 0131 244 2051

W Sim
Performance Management Division
SEHD
St Andrews House
Edinburgh EH1 3DG

SECTION 1: infection control high risk areas

Questions in this Section relate to Intensive Care, High Dependency, neonatal wards, Special Care Baby Units (SCBU), areas hosting patients with orthopaedic or surgical implants (e.g. total hip replacements, pins & plates, grafts), oncology/transplant units, haemodialysis units and burns units.

Example of answer to questions:

1.6 Bed centres

Standard: Minimum of 2.7 metres between bed centres (see Appendix)

Is provision in high risk areas adequate? YES / <u>NO</u> *if NO, please complete table below*

Where and in what respect is provision inadequate?	*25% of bed centres are under 2.7m*
What steps are needed to remedy the situation, and are there plans to do this?	**Increase space between beds, principally in orthopaedics** **Plan: increase spacing in areas where space can be recovered from moveable equipment and furniture**
Estimate of costs required to rectify	**Would require construction of new 20-bed ward and rearrangement of many facilities: of the order of £x,000**
What would be the implications for service delivery if implemented?	Implementation now would create 5% loss in bed capacity for the Trust; effects on patient throughput
Are there non-financial obstacles to remedial action, and what are they?	*Limited space for building new ward(s); staff recruitment; disruption to service delivery*

SECTION 1: infection control high risk areas

1.1 Provision of handwashing facilities

Standard: adequate numbers and types of facilities available (see Appendix A)

Is provision in high risk areas adequate? YES / NO *if NO, please complete table below*

Where and in what respect is provision inadequate?	
What steps are needed to remedy the situation, and are there plans to do this?	
Estimate of costs required to rectify	
What would be the implications for service delivery if implemented?	
Are there non-financial obstacles to remedial action, and what are they?	

Comments:

SECTION 1: infection control high risk areas

1.2 Sluice areas

Suggested standard: Surfaces (floor, worktops, splashbacks) intact and easy to clean; adequate storage for essential equipment

Is provision in high risk areas adequate? YES / NO *if NO, please complete table below*

Where and in what respect is provision inadequate?	
What steps are needed to remedy the situation, and are there plans to do this?	
Estimate of costs required to rectify	
What would be the implications for service delivery if implemented?	
Are there non-financial obstacles to remedial action, and what are they?	

Comments:

SECTION 1: infection control high risk areas

1.3 Provision of patient handling equipment (hoists etc) **and commodes**

Suggested standard: sufficient equipment available to allow effective decontamination of fabric slings and/or non-removable surfaces between use for one patient and the next

Is provision in high risk areas adequate? YES / NO *if NO, please complete table below*

Where and in what respect is provision inadequate?	
What steps are needed to remedy the situation, and are there plans to do this?	
Estimate of costs required to rectify	
What would be the implications for service delivery if implemented?	
Are there non-financial obstacles to remedial action, and what are they?	

Comments:

SECTION 1: infection control high risk areas

1. 4 Furniture and fittings in clinical areas and day areas

Suggested standard: all furniture & fittings are in good repair, fit for use and capable of being cleaned (e.g. chairs, tables, lockers, beds, mattresses)

Is provision in high risk areas adequate? YES / NO *if NO, please complete table below*

Where and in what respect is provision inadequate?	
What steps are needed to remedy the situation, and are there plans to do this?	
Estimate of costs required to rectify	
What would be the implications for service delivery if implemented?	
Are there non-financial obstacles to remedial action, and what are they?	

Comments:

SECTION 1: infection control high risk areas

1.5 Storage of domestic services equipment

Suggested standard: Suitable storage space is available and is not used for other purposes (see Appendix B)

Is provision in high risk areas adequate? YES / NO *if NO, please complete table below*

Where and in what respect is provision inadequate?	
What steps are needed to remedy the situation, and are there plans to do this?	
Estimate of costs required to rectify	
What would be the implications for service delivery if implemented?	
Are there non-financial obstacles to remedial action, and what are they?	

Comments:

SECTION 1: infection control high risk areas

1.6 Bed centres

Standard: Minimum of 2.7 metres between bed centres (see Appendix C)

Is provision in high risk areas adequate? YES / NO *if NO, please complete table below*

Where and in what respect is provision inadequate?	
What steps are needed to remedy the situation, and are there plans to do this?	
Estimate of costs required to rectify	
What would be the implications for service delivery if implemented?	
Are there non-financial obstacles to remedial action, and what are they?	

Comments:

SECTION 1: infection control high risk areas

1.7 Provision of side room facilities (e.g. for isolation of infectious patients)

Standard: Each ward should have, or have access to, single rooms with en suite toilets (see Appendix D)

Is provision in high risk areas adequate? YES / NO *if NO, please complete table below*

Where and in what respect is provision inadequate?	
What steps are needed to remedy the situation, and are there plans to do this?	
Estimate of costs required to rectify	
What would be the implications for service delivery if implemented?	
Are there non-financial obstacles to remedial action, and what are they?	

Comments:

SECTION 2: hospital-wide issues

Questions in this Section relate to **all areas** within the hospital.

2.1 Provision of (uniformed) ward staff changing facilities

Standard: Staff should have dedicated, clean and secure changing facilities (see Appendix E)

Is provision within the hospital adequate? YES / NO *if NO, please complete table below*

Where and in what respect is provision inadequate?	
What steps are needed to remedy the situation, and are there plans to do this?	
Estimate of costs required to rectify	
What would be the implications for service delivery if implemented?	
Are there non-financial obstacles to remedial action, and what are they?	

Comments:

SECTION 2: hospital-wide issues

Questions in this Section relate to **all areas** within the hospital.

2.2 Provision of staff washing/decontamination facilities

Standard: Staff should have access to facilities for washing and changing following incidents involving gross contamination with body fluids & faeces (see Appendix E)

Is provision within the hospital adequate? YES / NO *if NO, please complete table below*

Where and in what respect is provision inadequate?	
What steps are needed to remedy the situation, and are there plans to do this?	
Estimate of costs required to rectify	
What would be the implications for service delivery if implemented?	
Are there non-financial obstacles to remedial action, and what are they?	

Comments:

SECTION 2: hospital-wide issues

Questions in this Section relate to all areas within the hospital.

2.3 Management of clinical waste

Suggested standard: There is a Trust policy for management of clinical waste which is effectively implemented (particularly re storage, accumulation and uplift of waste)

Is provision within the hospital adequate? YES / NO *if NO, please complete table below*

Where and in what respect is provision inadequate?	
What steps are needed to remedy the situation, and are there plans to do this?	
Estimate of costs required to rectify	
What would be the implications for service delivery if implemented?	
Are there non-financial obstacles to remedial action, and what are they?	

Comments:

APPENDIX

The full text of the guidance referred to below should be consulted for further details: copies should be available from the Property and Environment Forum if not available locally. The Property and Environment Forum has issued a helpful CD-ROM under the heading 'Decontamination Guidance' which contains details of guidance produced by PEF, the Scottish Executive, NHS Estates (England) the Medical Devices agency and others: it also covers topics such as ventilation in healthcare premises.

A. Standards for hand wash basins in the healthcare environment

References: SHPN 04 [In-patient accommodation: options for Choice]

SHPN 04 provides guidance on the planning and design of hospital accommodation for people with acute illness or immediately before or after an acute intervention. This document lists recommendations for the appropriate number of hand wash sinks in clinical areas as follows:-

- a minimum of one sink per single room and small ward areas [see also SHPN 35]
- one sink per six beds in a large multi-occupied room.

Other recommendations to encourage good practice include:-

- High dependency setting e.g. ITU – one sink between two patients [see also SHPN 27]
- Acute, elderly and long-term care settings – one sink between four patients
- Low dependency settings e.g. mental health units – one sink between six patients
- Primary care settings, where clinical procedures or examination of a patients/clients is undertaken – a sink must be close to the procedure. [see also SHPN 35]

The types of taps required are also specified. See also SHFN 30 [Infection Control in the built environment: Design and planning]

B. Storage of domestic services equipment

Reference: SHFN 30 [Infection control in the built environment January 2002] and SHPN 04 [In-patient Accommodation]

Domestic cleaning equipment, laundry and clinical waste all need to be stored in separate purpose-built areas to prevent cross-contamination. The domestic services/cleaners room is the base from which domestic staff provide the immediate day-to-day cleaning service. A clinical wash-hand basin should be provided. It should include storage for cleaning materials and equipment in daily use and facilities for the routine servicing and cleaning of equipment. The room should be well lit and ventilated so that equipment can dry quickly; mechanical ventilation may be required. Bulky equipment has to be moved in and out of the room and this should be taken into account in its location. Cleaning materials should be stored in a secure cupboard.

C. Standards for spaces between beds

Reference: SHFN 30 [Infection control in the built environment January 2002]

This document makes reference to SHPN 04 and its guidance for the size and space of in-patient accommodation. Specifically, the bed centre spacing of 2.7m is the standard currently adopted by

HSE. A planning checklist is included in this document, which can be used throughout the design and planning process to ensure areas with infection control implications are not missed. The list is as follows: -

- Sufficient space should be maintained between beds to allow for activities to take place and to avoid transmission of organisms either by air or by contact with blood /body fluids.
- The exact space required between beds will vary according to numbers and activity of staff, type of patient, and environmental factors such as ventilation, humidity and overcrowding
- Bed centres should be at least 2.7m apart.
- Bed groupings should contain the smallest possible number of beds
- Single rooms can be used for isolating patients with communicable infections.
- Provision of single room accommodation with ventilation will help prevent the spread of organisms, especially those transferred by the airborne route, or easily disseminated into the immediate patient environment
- There is currently no definitive guidance on size, ventilation or the equipping of single rooms.
- Healthcare facilities must provide enough sanitary facilities and shower/bathrooms to ensure easy access, convenience and independence where possible.
- All WCs must have provision for hand washing and HBN4 recommends that toilet facilities should be no more than 12m from the bed area or dayroom.
- Storage is required for bulky items of equipment as well as the smaller items used in the clinical setting to protect them dust or contamination and the need for sufficient storage should not be underestimated.

SHPN 27 [Intensive Care Unit] deals specifically with the requirements for space around beds in that environment. Recommendations include:

- A bed space should be large enough to permit all clinical interventions, accommodate multi-parameter monitoring and life support systems.
- Each bed space will now be required to accommodate patient hoists and mobile X-ray machines
- Staff access around each bed space is essential and staff must be able to access all four sides of the bed without having to move it away from the wall.
- Each bed space must also have enough space to allow a clinical team to deal with the 'worst case' scenario.

D. Standards for provision of single room facilities

Reference: SHFN 30 [Infection control in the built environment January 2002], also SHPN 04 and SHPN 27.

There is no definitive guidance on the size, ventilation or the equipping of single rooms used for patient isolation.

E. Standards for staff changing facilities

Reference: SHPN 04. Guidance is supplemented in individual departmental guidance in the relevant SHPNs.

The term ‘uniform’ includes protective clothing such as white coats for medical staff.

F. Management of clinical waste

The Action Plan ‘Waste Management in NHSScotland Trusts’ issued in May 2002 (HDL(2002)43) contains a number of specific actions in this area, notably the appointment of a Waste Management Officer who should be able to supply the required information for this audit. This Action Plan also covers compliance with the revised SHTN 3 (Management & Disposal of Clinical Waste).
