Health Protection Scotland

NHS National Services Scotland

A National Monitoring Framework to Support Safe and Clean Care Audit Programmes

An Organisational Approach to Prevention of Infection Auditing

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Contents

List of Acronyms

AHP	Allied Healthcare Professional
CDI	*Clostridium difficile* Infection
CNO	Chief Nursing Officer
CVC	Central Vascular Catheter
HAIPU	Healthcare Associated Infection Policy Unit
FMT	Facilities Monitoring Tool
HAI	Healthcare Associated Infection
HEI	Healthcare Environment Inspectorate
HIS	Health Improvement Scotland
HFS	Health Facilities Scotland
HPS	Health Protection Scotland
ICMs	Infection Control Managers
IPC	Infection Prevention and Control
IPCT	Infection Prevention and Control Team IPCT
MRSA	Meticillin-resistant *Staphylococcus aureus*
NHS	National Health Service
NICE	National Institute for Clinical Excellence
PVC	Peripheral Venous Catheter
RMD	Re-useable Medical Device
SCN	Senior Charge Nurse
SG	Scottish Government
SICPs	Standard Infection Control Precautions
SLWG	Short Life Working Group
TBPs	Transmission Based Precautions
QA	Quality Assurance
QI	Quality Improvement

1 Background

In 2015, the Chief Nursing Officer (CNO) asked that Health Protection Scotland (HPS) consider the need for a national monitoring system for equipment decontamination following a series of Healthcare Environment Inspectorate (HEI) inspections where suboptimal IPC practice was highlighted. It was requested that such a system affords the Senior Charge Nurses (SCNs) the relevant autonomy and accountability for prevention of infection audit within their area of responsibility.

In order to understand the current landscape of auditing within NHSScotland, HPS wrote to NHS board Infection Control Managers (ICMs) and requested their current Infection Prevention and Control (IPC) audit tools. A gap analysis was undertaken to assess their content in terms of methodology and approach as well as ascertain what IPC data fields are used across Scotland. Findings from this showed a consistent approach in terms of IPC audit content. However, there was variation in terms of methodology including scoring and weighting of scores; re-audit and none used a QI approach within the action planning process. Following discussion with Scottish Government (SG), it was agreed to alter the deliverable from development of a National IPC Monitoring Tool to a National Monitoring Framework.

The inception of external IPC scrutiny by Health Improvement Scotland (HIS) in 2009 resulted in further layers of auditing prevention of infection practice within healthcare. In most cases, these audits are not undertaken by IPC personnel; rather by senior management, or peer to peer, facilities and AHPs. This was also demonstrated in the HPS audit review 2017 with audits including:

- internal review using HEI Methodology;
- environmental audit;
- peer IPC audit;
- IPC practice audits - SICPs and TBPs;
- invasive devices - PVC, CVC and urinary catheters (part of Scottish Patient Safety work);
- isolation audits;
- Facilities Monitoring Tool.

This document encompasses all audits and refers to them as ***Safe and Clean Care*** Audits.

1.1 Scope of the Framework

- To promote a consistent approach to all Safe and Clean Care audits across NHSScotland.
- To develop an assurance framework to support organisations in developing their audit programme that will be applicable in both primary and secondary care settings.
- Incorporate a quality improvement approach within the methodology.

2 Objectives of the Framework

The National Monitoring Framework for Safe and Clean Care Audits is an agreed recommended minimum approach to auditing for all NHS boards.

The purpose of the framework is to:

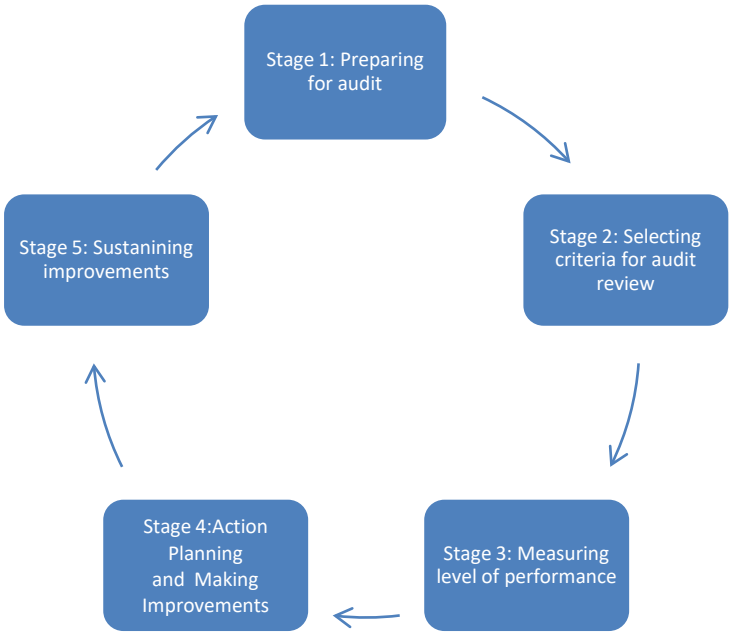
- Provide a set of principles which will provide an organisational quality assurance of all Safe and Clean Care auditing.
- Establish a framework for audit which adds value to the process and supports a QI approach.

This structured framework provides evidence-based principles and consensus agreed by expert opinion from HPS, Health Facilities Scotland (HFS) and members of a Short Life Working Group (SLWG) (see appendix 1). This framework has been co-designed and co-produced by service experts throughout NHSScotland. It applies to all prevention of infection practice across primary and secondary care settings supporting a strategic approach to Safe and Clean Care auditing in line with the HIS HAI Standards.[1]

2.1 What is Audit?

Expert opinion denotes that audit is part of a quality assurance process as illustrated in the National Institute for Clinical Excellence (NICE) standard. Quality improvement processes should be present at different levels of the audit cycle until the audit loop is closed (see Figure 1). The purpose of audits is essentially to improve the quality of patient care and outcomes through systematic review of care against explicit criteria and the implementation of change as a result[2-5] correcting practice where it falls short, and re-auditing to confirm that standards are now met.

Figure 1: NICE Standard audit cycle[2]



Audit is used in healthcare by health professionals to assess and evaluate systems, process and practice in order to ensure safety for those in their care. Audit helps identify where practice is optimal as well as where improvements are required. However, in order to ensure that improvement is sustained, a quality improvement approach is required. This involves local teams working together to understand why the practices / process is not optimal, and what changes can be made to support improvement. This may require undertaking small tests of change known as PDSA – Plan Do Study Act – which are small, continual tests which will help refine the new process and support reliable change. Measuring the success of these changes is achieved by further small scale audit by local teams. Underpinning this is a culture of organisational leadership in which safety and quality improvement is front of mind.

Responsibility progression with audit action plans and closure of the audit loop lies with local teams and is underpinned by organisational governance structures which ensure strategic oversight; particularly where actions cannot be progressed by the responsible individuals.

3 Roles and Responsibilities

Chief Executive Officer

The HDL 2005(8)[6] clearly states the Chief Executive is central to ensuring successful prevention and control of infection throughout NHS Board areas with a legal responsibility to identify, assess and control risks of infection in the workplace.

HAI Executive Lead

In line with HDL(2001)10[7], the role of the HAI Executive Lead is around overall responsibility for risk assessment and management process relating to decontamination, infection prevention and control, medical device management and cleaning services.

Infection Control Manager (ICM)

The HDL 2005(8)[6] clearly states the ICM is designated as having overall responsibility for management processes and risk assessment relating to infection control. Therefore in terms of responsibility, for Board assessment of the framework and improving practice, the ICM would work collaboratively with all senior management personnel to establish best practice, accountable to the HAI Eexecutive Lead reporting to the Chief Executive.

Senior Nursing/Management Teams/Heads of Service

Support for individual audit as well as collective unit/directorate audit and progression of any actions should be provided to the SCN by Senior Departmental Management Teams. Where audit is undertaken by those out with the IPCT or SCN (self-audit) e.g. peer review, senior leadership; outputs and any actions from this should be fed back in real time to the area departmental manager e.g. dental lead, allied health professional (AHP), SCN for rectification as well as support where rectification is out with the control of the SCN. Outputs from these audits should be made available via local systems e.g. improvement dashboards to ensure organisational overview and to avoid repetition.

Facilities (including Domestics and Estates Departments)

As discussed above, any actions which pertain to facilities should be shared as part of the action plan. Ownership of these actions should be shared with the SCN, relevant AHPs and domestic/estates staff. This should include understanding of current systems; what are the failures and how can this be avoided going forward in order to provide reliability. Development of local action plans should be supported by these facilities teams; particularly where risk

assessment and implementation of control measures to mitigate these risks are required. These facilities teams should actively support regular review of these risks and the control measures.

Senior Charge Nurse (SCN)/Unit Lead

The HDL 2005(7)[8] clearly states SCNs are responsible for ensuring safe working conditions within their clinical areas. Chief Executive's should ensure that the SCN have the authority to request local cleaning services to act on any problems identified. This includes all aspects of environmental cleanliness. Therefore, in terms of co-ordinating the progression of any action plans which proceeds audit; the SCN should assume this role; assessing and testing system changes which will support reliable improvement. Progress with any actions as well as any concerns around completion should be raised through local governance structures to the relevant groups e.g. Senior Management, Facilities.

Infection Prevention and Control Team

The role of the IPCT in audit is to provide independent scrutiny and assurance and to support local stakeholders in terms of policy interpretation and risk assessment using their expert skills and knowledge. Local ownership around completion of any actions arising from audit is pivotal however the IPCT may be required to support actions where necessary. Any required system changes should be agreed with local teams and supported through their own management/governance structures.

4 Impact of audit

Measurement of the impact of audit should be considered alongside several influencing factors:

4.1 Measures

Process

Measurement of process is essential to ensure the system is operating appropriately. Knowledge and understanding of the principles of infection prevention and how to undertake these are pivotal to improving outcomes for patients. An example of this would be demonstration of IPC policy into practice such as correct application of hand hygiene – when to do it and how to do it and ensuring the correct hand hygiene facilities and products are available.

Balancing

In terms of the unintended consequences of audit, we must look at its' effect on the other parts of the wider system. These effects may positively or negatively impact the outcome; however, it is important to be aware of their existence to allow for management of any associated risks as a result. For example, audit is often used for 'benchmarking' and as a result the final audit scores can be used for judgement rather than improvement. This can unintentionally provoke perverse behaviour where audit scores are overinflated. This can occur where self or peer audits, are in place and is often due to lack of knowledge of the audit process by the auditor. A robust quality assurance framework can support this; particularly where practice variation is not reported. It is a common perception or misconception that the goal is to achieve a positive or compliant score as a result of the audit (sometimes considered or articulated as a pass, a green result or a compliant result) when in fact the goal is to understand current practice and use these results to work with staff to improve quality of care for patients.

Outcome

Examining assessment of practice alongside other outcome measures, for example, observational practice identifying clean environment and equipment can often provide reflective indicators as part of observed practice. So in terms of impact of audit assessment, consideration of wider HAI outcomes should be examined. In some instances, reliable practice would be demonstrated through evidence of control in data points in surveillance, HAI prevalence rates, care bundle data results and not isolated audit findings. Also, where system changes are being tested, outputs from regular data collection can also support this.

4.2 Hawthorne Effect

During observational practice, modification of behaviour change, for example in hand hygiene monitoring, can often occur as a consequence of an awareness of being observed known as the "Hawthorne Effect."[9] In terms of results, these can often be overinflated, providing a false reassurance of practice. Observational practice should encompass a further process of quality assurance to understand where monitoring that is consistently inflated are a true reflection of good practice.

4.3 Canary Warnings

Impact of audit can be as a consequence of other intentional or non intentional failings. One of the prerequisites for tracking patient safety outcomes is the implementation of measures to capture clinically significant events in ways that are at once internally consistent and that draw on readily available data sets.[10] Nationally collected data sets such as staffing levels, complaints or bed pressures can be reflected within poor performance indicators such as patient falls or pressure ulcers. Infection rates are another indicator used to measure organisational performance. Therefore, reliability with prevention of infection practice as a measure of risk control should also link into quality dashboards in order to provide quality assurance and overall governance.

5 Approach

The framework comprises of 4 sections reflecting on key requirements that NHS boards should have in place to deliver an effective, efficient safe and clean care audit process.

1. Structure and Purpose -

- 1.1 Reporting and governance
- 1.2 Audit content
- 1.3 Risk based approach
- 1.4 Assurance

2. Resources

- 2.1 Consistency

3. Audit execution

- 3.1 Stakeholder engagement – planning and scheduling
- 3.2 Percentage of areas/activities audited
- 3.3 Feedback of audit findings
- 3.4 Ensuring local governance around requirement for immediate rectifications

4. Post Audit

- 4.1 Local reporting of audit findings
- 4.2 Scoring (including weighting of audit scores based on risk)
- 4.3 Re-audit and timescales
- 4.4 Action planning - QI approach including systems review to ensure sustained improvement
- 4.5 Completion of the audit loop

Section 1- Structure and Purpose

NHS Boards should have strategic oversight of collective Safe and Clean Care audit. These should be viewed in parallel with other adverse events/patient safety outcomes such as key performance indicators as part of quality dashboards. Internal audit service requires the appropriate structure and clarity of role to fulfil its professional remit through the following[11]:

1.1 Reporting and governance

Locally agreed internal reporting and governance structures should be in place to provide an assurance of performance and ensure identified risks are managed effectively. In doing so, this enables staff to understand the complex healthcare systems in order to support improvements; building both patient and stakeholder confidence providing a high quality environment and IPC practice where risk is mitigated/minimised.

Accountability, timescales, reporting mechanisms, review and feedback processes should all be clearly defined within the reporting and governance structure. In some instances, escalation may be necessary to Senior Management where serious risk is identified which may pose a threat to patient safety or where there is failure to take action to resolve issues requiring immediate rectification or progress actions in a timely manner.

The following are recommendations for inclusion within internal structure for audit, reporting and governance:

- Where practice or environment is sub optimal, any outcomes should be risk assessed, escalated with defined timeframes to nurse- in- charge or departmental manager.
- Aggregated scoring should identify risks e.g. where audit split into sections, each section can be easily reviewed on its own merit.
- Action planning should be undertaken in collaboration with local stakeholders using a QI approach (see section 4.4).
- Reflection of lessons learned.
- Sharing of good practice.

1.2 Audit content

Safe and Clean Care audit is undertaken to provide an assurance that organisations are following current IPC Policy as per National Infection Prevention and Control Manual (IPCM) http://www.nipcm.hps.scot.nhs.uk/ and meeting the HAI standards.[1] Local Board audit tools should encompass measurement of IPC policy knowledge, observation and checking of practice focusing on a minimum of 5 key areas:

1. **Decontamination**
   - This includes the environment and equipment (including Reusable Medical Devices (RMD)) ensuring they are clean, maintained and safe for use.
   - For completeness, this should also link to outcomes from other audits undertaken within the area such as facilities monitoring.
2. **SICPs and TBPs**
   - Demonstration of knowledge of national IPC policy into practice.
3. **Insertion and maintenance of invasive devices**
   - Systems and processes are in place to ensure the safe and effective use of invasive devices, for example, peripheral venous catheters, central venous catheters and urinary catheters.
4. **IPC education**
   - Staff can provide evidence of IPC education within their PDP.
5. **Communication**
   - Demonstrate the provision/recording of HAI information to healthcare teams, patients, their representatives and the public where applicable to the setting/service.

1.3 Risk Based Approach

Scheduling of Safe and Clean Care audit should be assessed and risk prioritised. Clinical areas/departments have different levels of risk based on their patient profile. For example, an intensive care unit (ICU) would confer higher risk than a general outpatient department, health centre treatment room or care home.

Following audit, timeframes for rectifications should be based on inherent risk and systems review in the longer term in order to understand and standardise local processes by:

- Engaging the local stakeholders around audit results; discussing with them what process changes are required in order to achieve reliability.
- Synthesising audit actions and the outcome of audit into 3 categories – short, medium and long-term (see section 4.4). Prevention of infection leadership is pivotal in order to support frontline teams with completion of the audit loop; supporting improvement with prevention of infection practice and level of risk based on that assessment.

1.4 Assurance

Different levels of assurance are necessary to ensure that prevention of infection risks are monitored and mitigated. To provide local and organisational assurance, NHS Boards should ensure a co-ordinated approach is in place so that any actions arising from them are dealt with appropriately by the correct people within defined timeframes. In addition to this, there should be internal governance around Safe and Clean Care audit activity to ensure that risks are monitored and mitigated.

A process of internal governance around Safe and Clean Care audit activity should be linked with quality indicators e.g. quality dashboards or balanced score cards to ensure strategic oversight (see section 3.4).

Ward/Departmental visits

Locally, NHS Boards use scheduled/unscheduled ward/departmental visits either by Senior Management, IPC or dedicated staff as a means of providing an objective assessment to measure staff compliance with standards of infection prevention and control policy and guidance. Different types of assessment include commode audits, near patient equipment, staff knowledge of policy, observation and checking standard practice against HAI Standards. Results of these can be used to demonstrate a snapshot of prevention of infection practice in the clinical area. Local intelligence should be used for each Board to plan schedule/unscheduled prevention of infection visits in response to local needs. Feedback at the time of audit reporting on levels of performance outlining what went well as well as what could be improved is important as part of a quality improvement approach in order to achieve sustainable change.

Section 2- Resources

Staff undertaking Safe and Clean Care audit should have clearly defined roles and responsibilities. Support should be provided to demonstrate a shared understanding of audit outcome and reduce variation and subjectivity. This is particularly important when self or peer audit is undertaken by personnel other than the IPCT.[11]

2.1 Consistency

Limited studies have shown that when audit is undertaken by IPC staff, subjectivity is reduced.[12] However, this is likely due to the specialist knowledge that IPC staff hold. An example of staff who undertake Safe and Clean Care audit would be those who may have received a programme of shadowing with local guidance to support a consistent and objective approach. However if local systems in place include audit definitions, this may not be required. Support should include expectancy in terms of response to audit criteria, audit process, feedback, reporting and escalation. Locally, roles and responsibilities should be clearly defined.

Section 3: Audit Implementation

The method in which audit is undertaken is fundamental to the framework. NHS boards should review recommended processes against current practice to deliver an effective and efficient internal audit service.[11]

3.1 Stakeholder engagement – planning and scheduling

Audit requires expert leadership including joint working with frontline stakeholders. Involvement of key staff in all stages of the audit ensures a sense of ownership by those involved in making changes that will lead to improvement. Where appropriate, planning and scheduling of audit may be agreed between the auditor and the ward/department prior to undertaking the audit. Audit scheduling should be incumbent of risk and consistent with organisational priorities[13] taking the following into account:

- Ability to encompass reactive audit within planned schedule. For example, in response to outbreaks or incidents, surveillance exceedance or environmental concerns.
- Regular review of audit schedules to ensure they remain current.
- An agreed governance process for cascading of audit results and arising actions; supporting closure of the audit loop. This should include Senior Charge Nurse

(SCN), departmental lead, facilities (estates and domestic), nursing/department and general management.

3.2 Percentage of areas/activities audited

During audit, the number of areas reviewed should be proportionate to the size of the ward/unit/department as well as the risk in terms of patients occupying the area and/or activities undertaken within the area. It is not practical, or necessary to audit every area, piece of equipment or observe all practice during an audit, so a sample of each should be drawn in order reach a conclusion around infection prevention practice within that area.

Environmental audit room selection should take cognisance of date of recent clean stratifying down to equipment and environment with the room using a process of question, practice observation and visual checks. This will not be the same for every area. Sample size should be informed based on the associated risk and up to the discretion of the auditor.

The following are recommended core areas for inclusion:

- ward, bay or single rooms;
- other ancillary areas and facilities therein:
    - clean preparation area
    - equipment decontamination area
    - bathroom/shower Room
    - dirty utility/sluice area
    - linen
    - treatment room
    - clinical/treatment area (including physiotherapy/OT rooms or donating areas (SNBTS);
- re-useable patient related equipment; for example commodes, intravenous infusion stands;
- policy into practice – question, observe practice and visual check of equipment.

Audit of specialist areas should also include specialist rooms/equipment within that area. For example, maternity should include milk kitchens, birthing pools; theatres should include disposal room, anaesthetic room; ambulances; blood donating suites; encompassing patient related equipment relative to risk and speciality.

3.3 Feedback of audit findings

The use of feedback can be an effective QI strategy, although a multi-modal approach is necessary to elicit reliable change.[14] Evidence suggests that feedback provided more than once, in addition to education and measureable targets such as action plans, can lead to a greater impact[3]. Feedback is more effective when provided verbally during the audit and reiterated in writing as soon as possible (within the audit report/action plan).

Immediate feedback should be used as an education opportunity and be provided in a supportive way including the following:

- information around what went well/could be done better;
- information regarding the correct practice (if required) to support the individual going forward.

Details of these conversations should be included in the audit report and action plan (See section 4.4).

3.4 Ensuring local governance around requirement for immediate rectifications

There should be organisational governance to ensure that any infection risks are managed effectively. As well as this, the individual responsible for rectification should be specified by the person completing the actions and included within the audit action plan. Immediate rectifications should be communicated at the time of audit and actions put in place to mitigate the risk by the responsible person. Immediate rectifications are defined as risk that has implications for health and safety or HAI for people receiving care. An example of this would be the presence of blood and body fluids on patient related equipment where an immediate rectification would be to ensure that the equipment was appropriately decontaminated as soon as possible. As already stated; this should be identified within the action plan as short term actions and complete. It is important to understand why these issues arise, for example as described above, where there is contaminated equipment or environment these need to be addressed immediately to ensure patient safety. However, the ‘why’ is equally important – is there an issue with the local system which supported this deviation? Understanding the local system is vital to ensuring long term improvement.

There are many examples in both primary and secondary care where systems improvement work would be required:

Practice – Observed practice around hand hygiene technique is incorrect in 3 out of 5 observations. The immediate action would be to feed this back to the individual involved in a supportive way; pointing out correct practice during this. However, it is equally important to understand why this practice is unreliable. This will take longer and involve speaking with the local stakeholders, for understanding custom and practice within the ward/clinical area – are these educational requirements for staff, is there a requirement for extra equipment? System review can only be undertaken by those within the system working together for a common goal. Regular review of progress through data collection and feedback by the local teams will support progression to reliability. This will be discussed further in Section 4.

Section 4: Post Audit

4.1 Local reporting of audit findings

In order to achieve sustained, reliable IPC practice, it is likely that system changes will be required. Reporting processes should include the following:

- Feedback to SCN/departmental lead around general findings of the audit should include good practice as well as where it could be improved.
- Reporting of findings which require immediate action should be conveyed verbally to SCN/departmental lead or nurse/AHP in charge prior to leaving the area reporting and recording on the action plan as ‘short-term’.
- Auditor(s) will be responsible person (s) for audit report content.
- Local agreed governance process should be in place for reporting of audit results as well as escalation routes where necessary.

4.2 Scoring (including weighting of audit scores based on risk)

Consistency in application of scoring is essential to produce quality data and should be risk based and proportionate. Therefore the following should be in place:

- Audit definitions to assist with consistency in application.
- Scoring should be weighted based on risk.

Scoring alone does not improve practice by mere action of measurement. Therefore aggregated scores must identify risk enabling direction to focus on improvement methods and monitor

performance. Audit is timely; therefore scoring using such methods goes some way to minimising the burden for re-audit. Scoring should include:

- Summary of subtotals for audit sections.
- Scoring that identifies risk (where aggregate scoring is used, highest risk items are identified at a glance).
- Ability to audit individual sections where action is required whilst working with stakeholders to understand the system and system changes required. This would include testing and implementation of interventions which would support sustained, reliable change.

4.3 Re-audit and timescales

Risk based approach to re-audit planning is key to an improvement approach. Some areas use a red, amber, green (RAG) scoring system where the colours indicate data values based on whether the audit score is good (green) or poor (red). These colours will determine re-audit timescales. However, RAG scoring should be used with caution as it does not explain whether this result happened by chance or whether there is an ongoing issue.[15] Therefore, where RAG is used it should encompass the following definition indicators:

- Individual section compliance percentages and re-audit periods
    - re-audit risk based approach, for example re-audit section of risk.
- Action timescales for short, medium and long term actions
    - long term actions should be held in a local risk register for example, non compliant taps; Responsibilities for risk register reporting should be locally defined;
    - short term action require immediate rectification.

For Example:
Two areas are audited.
Area One is a healthcare facility in an old building where there are issues in terms of the environment, fixtures and fittings such as sinks and taps which do not conform to the appropriate Health Technical Memoranda. IPC practice within the area is optimal and there are control measures and risk assessments with regular review are in place around the issues within the environment. Their audit score is 84% and an **AMBER** rag score.

Area Two is a healthcare facility in new build where the environment, fixtures and fittings are optimal. However, IPC practice is sub-optimal – SICPs compliance poor and the auditor uncovered multiple pieces of equipment (commodes, pumps, drip stands) which are stained with blood and body fluids. Their audit score is 90% and a **GREEN** rag score.

In terms of risk, Area Two confers a higher IPC risk there, but more importantly because IPC practice is poor and therefore the potential risk of cross transmission is increased considerably

The above example indicates the importance of ensuring that although RAG status can be useful; where it is used there should also be structures in place which weights the risk associated and not necessarily concentrates on the percentage score. Regardless of the scoring system used, there should be the ability to track, measure progress, take corrective action and keep stakeholders informed of risk. These risks should be handled locally, via risk assessment with regular review of control measures and action where required.

4.4 Action planning – QI approach including systems review to ensure sustained improvement

Audit reports are necessary to provide identified risk and evidence of agreed risk prioritisation recommendations that will enable progress towards the desired state. Investigatory management beyond the immediate rectification is essential to achieve sustainable change using a QI approach. This includes understanding of the local systems and processes and what local changes/interventions are required in order to achieve reliability.

Action plans should be outcome focussed – what do you want to achieve? Use of intelligence from local systems and processes will support progress towards reliability. In order to achieve

this, local agreement should identify risk priorities to provide timely resolution considering short, medium and long-term outcomes articulated within the action plan.

For Example

Audit findings show multiple failings in terms of equipment or environmental cleanliness.

Actions

Short term (immediate) – The equipment/environment should be correctly decontaminated with support from the IPCT/auditor where required. This information is obtained within the NIPCM http://www.nipcm.hps.scot.nhs.uk/

Medium term – Need to understand why equipment is not clean. It is essential to include the ward staff in this – they must see the need for change in order to support it. Actions could include a combination of training re cleaning (use of scenario based learning to support this), standardisation of cleaning equipment and how to use it, roles/responsibilities for cleaning. Data required for this – training sessions undertaken, number of staff trained etc.

Long term – Sustained compliance with cleaning, improved clinical practice

Risks around equipment or environment which are deemed to be unable to be resolved in short term such as incorrect sinks/taps, these may be documented within the audit action plan as long term actions. A local risk assessment is required to assess suitability for ongoing use as well as required control measures. This should be agreed with local stakeholders and documented with a clear action plan in place. Another example of this would be theatre position equipment where withdrawal of the piece of equipment would be detrimental to patient, procedure or system opposed to patient risk. They should be a process of regular and ongoing review and governance around these risks and current control measures within local or organisational risk registers.

There may be incidences where the environment is within a host organisation and therefore environmental improvements would be the responsibility of the host organisation. In these incidences, the responsible person must follow local procedures with the host organisation's to facilitate rectifications: taking consideration of the host organisation's governance procedures in addition to ensuring that their own organisations' reporting and governance procedures are followed.

Processes should be in place at local level and up to corporate level to ensure that the risk is managed. Good governance includes quality assurance follow up to assess that the risk is not re-occurring.

4.5 Completion of the audit loop

Essentially, completion of the audit loop means the process has been finalised with an action plan implemented, and the impact of the action plan determined. At this important final stage, new data is collected and compared again with the standard. The purpose is to establish whether the intervention led to quality improvement meeting the goal of the audit.

Successful completion of the audit loop is dependent upon:

- Local ownership of issues/risks with expert advisory support from IPCT where required.
- Defined responsibilities and realistic timeframes for all actions to provide timely resolution (short, medium, long-term). This should include system and process review.
- Local governance framework which includes a mechanism for continual review and supports stakeholders where risks are identified, assessed and control measures in place.
- Overarching regular QA of practice and process which is incorporated within local benchmarking systems such as data dashboards or balanced score card to ensure reliability. The inclusion of infection rates within these dashboards will also support early warning and diagnosis of inherent system failures.
- Sustainable change has been achieved.

Completion of the audit loop should occur when sustainable change has been achieved. From this point a form of monitoring should replace a full audit for example peer review or IPCN visits. Regular data collection will support achievement of reliable process.

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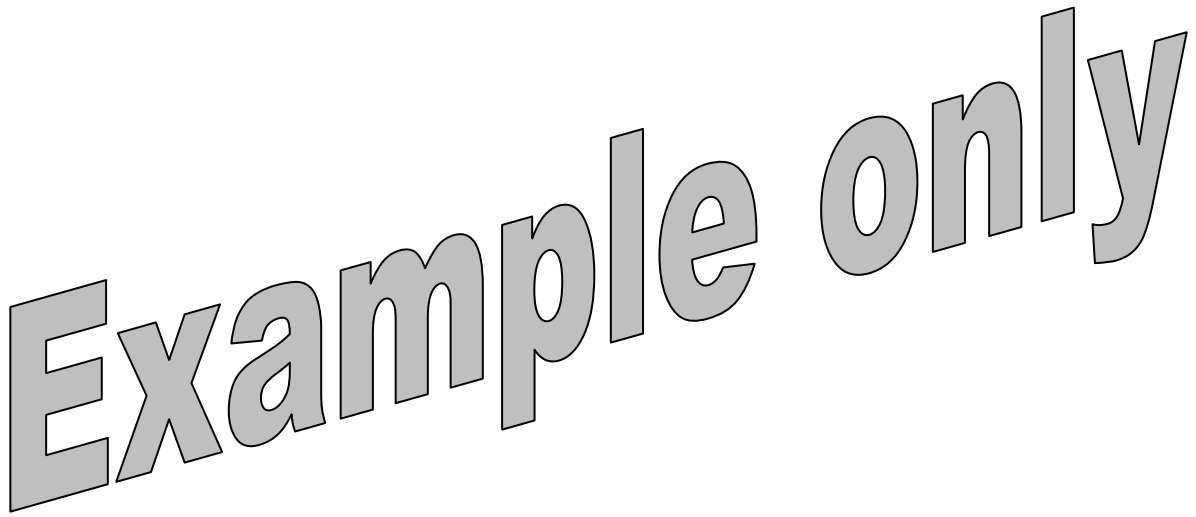
Appendix 1: Improvement Plan (Example)

In order to understand the landscape of local organisational audit, it is recommended that Boards complete an improvement plan using a multi-disciplinary approach; primarily led by senior management teams with input from IPC, nursing and other departmental staff. This will ensure good organisational governance as well as local ownership of audit. Appendix 1 is an example of this.



Section 1- Structure and Purpose

1.1 Reporting and governance

Statements of Good Practice	Board Assessment				Action
	Conforms	Partially conforms	Does not conform	N/A	
Locally, audit structure should define accountable persons, timescales, reporting mechanisms with a process of review and feedback.					
Escalation processes are sometimes necessary in some instances where serious risk is identified, for example: • Those that may pose a threat to health and safety resulting in patient harm; • Where there has been failure to take action to resolve issues requiring immediate rectification or progress actions in a timely manner.					
The following are suggested recommendations for inclusion within internal structure: • Where practice or environment is suboptimal outcomes should be risk assessed, escalated with defined timeframes to nurse/person in charge or departmental manager. • Aggregated scoring should identify risks with ability to view each individual section in its own merit to prevent a static view of data and flawed interpretation of data. • Action planning should be undertaken in collaboration with local stakeholders using a QI approach. • Reflection of lessons learned and sharing of good practice.					

1.2 Safe and Clean Care audit content

Statements of Good Practice	Board Assessment				Action
	Conforms	Partially conforms	Does not conform	N/A	
Decontamination • Environment and equipment (including RMD used) clean, maintained and safe for use • Links should be established to outcomes from other audits undertaken within the area such as facilities monitoring					
SICPs/TBPs Monitoring • Demonstration of knowledge of NIPCM policy into practice with targeted monitoring where gaps in practice identified e.g. TBPs					
Insertion and Maintenance of Invasive devices • Systems and processes are in place to ensure the safe and effective use of invasive devices, for example, peripheral venous catheters, central venous catheters and urinary catheters					
IPC Education • Staff can provided evidence of IPC education, this may be within their PDP					
Communication • Demonstrate the provision of HAI information to healthcare teams, patients, their representatives and the public (inc. Leaflets) where applicable to service/setting					

1.3 Risk based approach

Statements of Good Practice	Board Assessment				Action
	Conforms	Partially conforms	Does not conform	N/A	
Safe and Clean Care audit should be assessed and risk prioritised, this should include: • Audit scheduling determined by clinical/ departmental setting risk based on their patient profiles. • Incorporates review of processes by engaging with local stakeholders around results to achieve reliability. • Synthesis of audit actions and outcomes determined locally by risk categories with prevention of infection leadership to support frontline staff with completion of audit loop.					

1.4 Assurance

Statements of Good Practice	Board Assessment				Action
	Conforms	Partially conforms	Does not conform	N/A	
A co-ordinated approach should be in place to ensure: • Any actions arising from audits are dealt with appropriately by the correct people within locally defined timeframes. • Risks are monitored and mitigated.					
A process of internal governance around Safe and Clean Care audit activity should be linked with quality indicators for example, quality dashboards or balanced score cards to ensure strategic oversight.					
Local intelligence is used to provide other means of objective assessment for example, use of scheduled/ unscheduled ward/departmental visits.					

Section 2: Resources

2.1 Consistency

Statements of Good Practice	Board Assessment				Action
	Conforms	Partially conforms	Does not conform	N/A	
Roles and responsibilities should be clearly defined					
Support should be provided to demonstrate a shared understanding of audit outcome and reduce variation and subjectivity when not undertaken by IPCT, for example where self audit, peer audit undertaken by other personnel. Support should include: • expectancy in terms of response to audit criteria, and process; • feedback, reporting/ action plans and escalation.					

Section 3: Audit Implementation

3.1 Stakeholder engagement – planning and scheduling

Statements of Good Practice	Board Assessment				Action
	Conforms	Partially conforms	Does not conform	N/A	
Planned audit schedules should: • Be subject to regular review to ensure they remain current. • Have the ability to encompass reactive work within the planned schedule. For example, following outbreaks or incidents, surveillance exceedance or environmental concerns.					
Audit methodology should: • Encompass an agreed governance process for cascading of audit results and arising actions supporting closure of the audit loop.					

3.2 Percentage of areas/activities audited

Statements of Good Practice	Board Assessment				Action
	Conforms	Partially conforms	Does not conform	N/A	
During audit the following should be considered: • A sample size should be drawn with the number of areas reviewed proportionate to size of the area as well as the risk in terms of patients occupying the area/ and or activities undertaken with the area to reach a conclusion around infection prevention practice within the area; • Environmental audit room selection should take cognisance of date of recent clean stratifying down to equipment and environment with the room using a process of question, practice observation and visual checks. This will not be the same for every area; • Sample size should be informed based on the associated risk and up to the discretion of the auditor.					
Suggested core areas for inclusion in Safe and Clean Care audit: • Ward , bay or single rooms • Other ancillary areas and facilities therein: o Clean Preparation area; o Equipment decontamination area o Bathroom/Shower Room; o Dirty utility/Sluice Area; o Linen; o Treatment Room; o Clinical/treatment area (inc. Physiotherapy/OT rooms or donating areas (SNBTS) • Re-useable patient related equipment; for example commodes, intravenous infusion stands. • Policy into practice – question, observe practice and visual check of equipment. • Audit of specialist areas should also include specialist					

Statements of Good Practice	Board Assessment				Action
	Conforms	Partially conforms	Does not conform	N/A	
rooms/equipment within that area. For example, Maternity should include milk kitchens, birthing pools; theatres should include disposal room, anaesthetic room; ambulances; blood donating suites encompassing patient related equipment relative to risk and speciality.					

3.3 Feedback of audit findings

Statements of Good Practice	Board Assessment				Action
	Conforms	Partially conforms	Does not conform	N/A	
Feedback is provided verbally during the audit and reiterated in writing (within the audit report/action plan). Multi –modal approach is used to elicit reliable change.					
Immediate feedback should be used as an educational opportunity and provided in a supportive way including the following: • Information around what went well/could be done better. • Information regarding the corrective practice (if required) to support the individual going forward. Details of these conversation should be included in the audit report and action plan					

3.4 Ensuring local governance around requirement for immediate rectifications

Statements of Good Practice	Board Assessment				Action
	Conforms	Partially conforms	Does not conform	N/A	
Organisational governance is in place to ensure infection prevention risks are managed: • The individual responsible for rectification should be specified by the person completing the actions and included within the audit action plan; • Immediate rectifications should be communicated at the time of audit and actions put in place to mitigate the risk by the responsible person; • Immediate rectifications are defined as risk that has implications for health and safety resulting in patient harm or HAI. These should be clearly identified within the action plan as short term action and complete;					

Section 4: Post Audit

4.1 Local reporting of audit findings

Statements of Good Practice	Board Assessment				Action
	Conforms	Partially conforms	Does not conform	N/A	
Reporting processes should include: • Feedback to SCN/Departmental Lead around general findings of the audit should include good practice as well as where it could be improved; • Reporting of findings which require immediate action should be conveyed to SCN/Departmental Manager or designated nurse in charge prior to leaving the area reporting and recording on the action plan as 'short-term'; • Auditor(s) will be responsible person (s) for QA of all audit report content; • Local agreed governance process should be in place for reporting of audit results as well as escalation routes where necessary.					

4.2 Scoring (including weighting of audit scores based on risk)

Statements of Good Practice	Board Assessment				Action
	Conforms	Partially conforms	Does not conform	N/A	
Audit definitions should be in place to assist with consistency in application.					
Aggregated scores must identify individual scores within the total thus providing direction to focus on improvement methods and monitor performance. Audit is timely; therefore scoring using such methods goes some way to minimising the burden for re-audit					
Scoring should: • Be risk weighted based on relative risk; • Include a summary of subtotals for audit sections; • Identify risk (where aggregate scoring used highest risk is identified at a glance); • Include the ability to audit individual sections where actions required whilst working with stakeholders to understand the system and system changes required.					

4.3 Re-audit and timescales

Statements of Good Practice	Board Assessment				Action
	Conforms	Partially conforms	Does not conform	N/A	
Risk based approach to re-audit should be in place however, where RAG status used, Boards must encompass following definition indicators: • Individual section compliance percentages and re-audit periods; o Re-audit risk based approach for example re-audit section of risk patient; • Timely action timescales for short, medium and long term actions.					
Compliance percentages should: • Have the ability to track, measure progress, take corrective action and keep stakeholders informed of risk.					
Action timescales are defined for short, medium and long term actions: • Short term actions should include immediate rectifications for patient safety associated risk; • Long term actions should be held in a local risk register for example, non compliant taps					

4.4 Action planning –QI approach including systems review to ensure sustained improvement

Statements of Good Practice	Board Assessment				Action
	Conforms	Partially conforms	Does not conform	N/A	
Action Plans should include a process of written documentation and are outcome focused : • Include any identified system failures, risk prioritisation and agreed recommendations that will enable progress towards the desired state; • Include a process of investigatory management beyond the immediate rectification and includes process review to understand the local systems and processes and what local changes/interventions are required in order to achieve reliability; • Use of intelligence from local systems and processes will support progress towards reliability. In order to achieve this, local agreement should identify risk priorities considering short, medium and long-term outcomes articulated within the action plan;					

4.5 Completion of the audit loop

Statements of Good Practice	Board Assessment				Action
	Conforms	Partially conforms	Does not conform	N/A	
Completion of the audit loop should occur when the sustainable change has been achieved.					
Successful completion of the audit loop is dependent upon: • Local ownership of issues/risks with expert advisory support from IPCT where required; • Defined responsibilities and realistic timeframes for all actions (short, medium long-term). This should include system and process review; • Local governance framework which includes a mechanism for continual review and supports stakeholders where risks are identified, assessed and control measures in place; • Overarching regular QA of practice and process which is incorporated within local benchmarking systems such as data dashboards or balanced score card to ensure reliability. The inclusion of infection rates within these dashboards will also support early warning and diagnosis of inherent system failures; • Sustainable change has been achieved					

Appendix 2 – Members of the Short Life Working Group

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