Dear Colleague

THE NHSSCOTLAND CODE OF PRACTICE FOR THE LOCAL MANAGEMENT OF HYGIENE AND HEALTHCARE ASSOCIATED INFECTION (HAI)

Prevention and control of HAI is a high-profile priority issue for NHSScotland. A major 3-year programme of work was laid out in the SEHD Ministerial Action Plan on HAI, now being actioned by the Scottish HAI Task Force, of which I am the Chair. One of the immediate priorities was to develop an NHSScotland Code of Practice for the management of hygiene and HAI.

My previous letter to you on this issue was to seek your views on a consultation document outlining the Code of Practice for the local management of hygiene and HAI across the NHS in Scotland. From September 2003, in the interim period before the Code of Practice was finalised, NHS bodies were asked to use the draft consultation document as interim guidance.

The enclosed final document (see http://www.scotland.gov.uk/publications/hai1), has been developed by an HAI Task Force multidisciplinary working group, chaired by Dr Liz Jordan, Medical Director of NHS Argyll and Clyde, and has taken account of all views expressed from the overwhelmingly positive consultation process.

This final document is to be implemented with immediate effect in NHS Boards across all clinical areas, and I ask that Chief Executives take steps to ensure all staff are aware of this groundbreaking Code of Practice, the first of its type in the UK (and possibly in Europe).

The Code of Practice defines local management powers and responsibilities for delivering safe clinical care through ensuring high standards of hygiene and related measures to tackle HAI in the healthcare environment. It prescribes guidance on the management of hygiene and HAI in all clinical settings, and also for support services, within NHSScotland. In addition,
the principles underpinning this Guidance can be applied across all healthcare settings, including beyond the NHS.

I would ask that NHS Board Chief Executives distribute copies of this letter and the attached document to:

- Divisional Chief Executives
- Medical and Nursing Directors
- Chairs of Risk Management committees (or equivalent)
- Chairs of Clinical Governance committees
- The Senior Infection Control Manager (per HDL 2001(10))
- Infection Control Teams (for further distribution to all clinical areas)
- Directors of Facilities
- Hotel Services Managers

Please accept my thanks for your assistance with this important initiative.

Yours sincerely

DR E M ARMSTRONG
THE NHSScotland Code of Practice for the Local Management of Hygiene and Healthcare Associated Infection

Healthcare Associated Infection Task Force
THE NHSSCOTLAND CODE OF PRACTICE FOR THE LOCAL MANAGEMENT OF HYGIENE AND HEALTHCARE ASSOCIATED INFECTION

HEALTHCARE ASSOCIATED INFECTION TASK FORCE

Scottish Executive
Edinburgh 2004
FOREWORD FROM THE MINISTER FOR HEALTH AND COMMUNITY CARE –
MR MALCOLM CHISHOLM

In 2003, I established the HAI Task Force under the chair of the Chief Medical Officer, Dr Mac Armstrong, as a result of my Healthcare Associated Infection (HAI) Action Plan “Preventing infections acquired while receiving healthcare to reduce the risk of HAI to patients, staff and visitors”. The approach taken by the HAI Task Force has involved:

- Promoting a coherent approach to the prevention and control of HAI across a very wide raft of initiatives;
- Co-ordinating new and existing programmes and activities to reduce duplication of effort throughout NHSScotland and to share examples of best practice;
- Promoting a multidisciplinary approach, importantly including members of the public in all areas of its work;
- Engaging with management to embed the principles of infection control within organisations, and to promote the message that infection control is good, safe practice and good resource management;
- Promoting the key message that infection control is not the domain of infection control experts - “infection control is everybody’s responsibility”.

My HAI Action Plan required as a priority the development of an NHSScotland Code of Practice for the Local Management of Hygiene and HAI, including defining local management powers and responsibilities for delivering safe clinical care. I launched the draft Code of Practice as interim guidance to NHSScotland in September 2003. Following extensive consultation, this final Code of Practice prescribes guidance for healthcare staff throughout organisations on staff education in HAI, the management of hygiene and HAI in clinical settings, the production of information on HAI for service users, and the monitoring required to ensure compliance with high standards for hygiene and HAI management. Although intended for NHSScotland, the principles within this Code of Practice apply across all healthcare settings.

We know that the philosophy of clean hands, clean healthcare environments and clean equipment has to be underpinned by training and education, by organisational support, and by clear systems and structures to monitor performance. All staff have leadership roles in preventing HAI through personal example. Effective implementation of this Code of Practice will be everybody's responsibility, with integration of best practice, such as effective hand hygiene, into routine activities. I am committed to reducing the burden of disease and avoidable illness caused by HAI, and requiring implementation of the Code of Practice is part of the process of getting the basics right.
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1. INTRODUCTION

Context

Healthcare Associated Infection (HAI) is a priority issue for NHSScotland and is equally important for healthcare services in the private, independent and voluntary sectors. For prevention and control of infection to work effectively, critical activities such as hand hygiene have to be embedded into everyday practice. All staff must transparently demonstrate good infection control and hygiene practice through ‘leadership by example’. There must be a culture of “Infection Control is everybody's business”, with integration of best practice into routine activities: simply an understanding and belief that "this is the way we do things round here".

The profile of prevention and control of HAIs has been transformed within the past few years. Significant milestones include:

- The Carey Report "Managing the risks of healthcare associated infections in NHSScotland" (August 2001);
- The NHS Quality Improvement Scotland (NHS QIS)/Clinical Standards Board for Scotland (CSBS) HAI Infection Control Standards (December 2001) and Cleaning Services Standards (June 2002);
- "A framework for national surveillance of healthcare associated infection in Scotland" (July 2001);
- The Antimicrobial Resistance Strategy and Scottish Action Plan (June 2002);
- The Ministerial HAI Action Plan "Preventing infections acquired while receiving healthcare (October 2002);
- The Audit Scotland review of cleaning services and the NHS QIS review of HAI infection control standards (both published January 2003);
- The "Champions" educational initiative (April 2002).

A major programme of work to improve the prevention and control of HAI across the NHS in Scotland was laid out in the Scottish Executive Health Department's Ministerial Action Plan on HAI. The Action Plan also detailed the formation of a Scottish HAI Task Force under the chair of the Chief Medical Officer.

One of the immediate priorities for the HAI Task Force was to develop an NHSScotland Code of Practice for the management of hygiene and HAI. An HAI Task Force working group was formed in 2003 to develop the Code of Practice. This multidisciplinary working group included representation from NHS clinical and support services, members of the public, the non-NHS care sector, including independent hospital representation and staff partners (full membership at Appendix 4).
The draft Code of Practice was issued for widespread consultation in 2003 and the final document takes account of the views expressed. In the interim period before the Code of Practice was finalised, NHSScotland was asked to implement this draft guidance. The Code of Practice is written to be applicable throughout Scotland wherever healthcare is being delivered (e.g. acute, primary care and independent contractor settings), within the NHS as well as in the private, independent and voluntary sectors. The importance of infection control in non-NHS sectors is reflected in The Regulation of Care (Requirement as to Care Services) (Scotland) Regulation 2002 No. 114 and the National Care Standards. The Code of Practice seeks to encourage compliance in all areas of healthcare provision in the interests of service users, staff and the public.

"Partnership for Care: Scotland's Health White Paper", issued in 2003, contained proposals for changes to the governance arrangements for local NHS systems. This included the dissolution of the remaining Trusts and the development of single-system working where this does not already exist. This is intended to improve service organisation and delivery throughout NHSScotland. Organisational terminology should be interpreted as appropriate to the new unified structures.

The Code of Practice

The Code of Practice defines local management powers and responsibilities for delivering safe clinical care through ensuring high standards of hygiene and HAI in the healthcare environment. It prescribes guidance on the management of hygiene and HAI in clinical settings, and also for support services, within NHSScotland. However, the principles underpinning this Guidance apply across all healthcare settings.

While the Code of Practice did not develop from specific legislation, it may attract a legal effect through its definition of specific accepted professional practice in this sphere of healthcare provision. Any radical departure from such accepted practice without clear justification might be regarded as a controversial decision within a legal setting.

The Scope of the Code of Practice

The scope of the Code of Practice was detailed in the Ministerial Action Plan. It embraces a range of issues, including:

- Maintenance of environmental and equipment standards;
- The responsibility of healthcare providers in informing service users about the risks of HAI and the measures being taken to reduce them;
- Avoiding inappropriate or over-frequent patient movement;
- The actions required to ensure compliance with hygiene and infection control standards, especially hand hygiene;
- Guidance on prevention and control of infection (e.g. managing patients with loose stools);
- Staff training in hygiene and infection control.

A list of topics underpinning these higher-level issues was identified. In constructing the Code of Practice, this list has been developed and organised into a series of six chapters within the Code, all presented in common format for ease of reference.

The Approach to the Code of Practice

The Code of Practice has been written to align with available guidance and documentation from a variety of other agencies and from HAI Task Force initiatives. There is some repetition in the Code of Practice in order to present the issues contained within each chapter as a complete entity. All the topics have been assessed on a risk management basis, and the Code of Practice aims to be relevant, realistic, rational and readable. In reaching its conclusions, the Working Group was conscious of the lack of robust evidence underlying the practice of prevention and control of infection, and so has adopted an expert opinion consensus methodology. The Working Group would seek to encourage future research activity focussed on augmenting the evidence base.

It is crucial that everybody is responsible for the effective implementation of the Code of Practice. While all organisations are well positioned to achieve ownership and effective activity, the NHS QIS/CSBS HAI infection control standards clearly outline the importance of the following at organisational level:

- Infection Control Team and Infection Control Committee;
- Risk Management Committee or structure;
- Designated senior manager with overall responsibility for risk assessment and management processes relating to decontamination, infection control, medical devices management and cleaning services (HDL(2001)10);
- Clinical Governance Committee.

The Impact of the Code of Practice

The prime intention of the HAI Code of Practice is to support action to reduce the risk of HAI for patients, staff, visitors and the wider public at local level. Success will be dependent on a change in culture where Infection Control is truly everybody's business with a clear focus on the importance of good hygiene, infection control practice and education as key to minimising HAI. It’s up to you to rise to the challenge and make a difference.
2. STAFF EDUCATION

2.1 The big issue

The education of staff involved in relevant Healthcare Associated Infection (HAI) issues is essential to ensuring that there is a managed environment that minimises the risk of infection to service users, staff and visitors.

2.2 This is what it's all about

- Education is at the heart of a learning organisation. It is essential to enable staff to deliver the highest possible quality of care and this includes the issue of HAI.
- Within healthcare staff, there are 3 important groups to be considered in terms of HAI education:
  - management e.g. chief executives/directors/local managers
  - practice supervisors/trainers/educators
  - individual healthcare workers
- The organisation’s education effort in respect of HAI must allow for initial and continuing training and has to be comprehensive and targeted against risk. It should promote attendance through well-constructed, attractive programmes and through encouragement by management at all levels.

2.3 This is how to do it well

This section highlights areas of particular responsibility but it should be stressed that it is important to recognise that relevant education applies to **ALL** staff as HAI is *everybody's business*.

- **The Organisation will have:**
  - An explicit strategy for mandatory induction training in relation to HAI;
  - An explicit strategy for Continuing Professional Development (CPD) in relation to HAI;
  - Adequate resources identified to deliver the organisation's strategic plans for HAI education;
  - Recording and reporting structures in place specific to the HAI induction and CPD Strategies;
  - Impact evaluation integral to the organisation's HAI education strategies.
Practice Supervisors/Trainers/Educators will:

- Ensure their contribution to education and training is evidence-based where this evidence exists;
- Ensure their contribution to education and training in HAI fits with local and national strategies;
- Make connections between relevant bodies, e.g. NHS QIS/CSBS HAI infection control and cleaning services standards, and the organisation's education/training programme;
- Be able to demonstrate through their annual appraisal processes the maintenance of their own level of knowledge and skills in HAI.

Healthcare Workers i.e. Clinicians and Support Staff will:

- Within their annual personal development plan, identify specific objectives for CPD in HAI;
- Demonstrate an acceptable level of competence in the workplace relating to prevention and control of HAI;
- Act as a role model to others in the maintenance of a safe environment.
3. SERVICE USER & PUBLIC INFORMATION

3.1 The big issue

Service users, carers, relatives and the public have the right to receive high quality oral and written information on Healthcare Associated Infection (HAI). This will enable them to understand the issues and to be informed of the steps being taken to control the risks. It will also help them to ask informed questions and contribute to control.

3.2 This is what it's all about

- The general public is increasingly well-informed about health and healthcare. They expect their healthcare providers to provide them with accurate and accessible information.

- There is a professional obligation on all healthcare providers to communicate openly and clearly about the nature of healthcare associated infections and the measures to control them.

- There is a need for service users and the public to understand the risks of acquiring infections while receiving healthcare and to know what they and healthcare providers can do together to prevent HAI.

- It may be difficult to communicate information on risks. Different ways of presenting it may change how the public interprets it.

- It is necessary to have a programme for continuous improvement in the quality and quantity of HAI information provided for service users, their carers and relatives.

3.3 This is how to do it well

- In general, information provided to service users and the public should:
  - Inform, and ensure their confidence that healthcare services within the hospital and community are as safe and effective as practicable;
  - Raise awareness, knowledge and involvement of their expected roles and responsibilities in limiting the spread of infection;
  - Enable them to make informed choices about care and treatment.

- In preparing service user information on HAI, clear aims should be established. These should include:
  - Increasing knowledge and understanding;
  - Correcting misunderstandings;
• Raising awareness about the risk of HAI;
• Providing reassurance;
• Reducing anxiety;
• Giving instructions on how to reduce the risks from HAI;
• Giving information on what the staff/organisation should be doing about HAI;
• That written material should support verbal information given by healthcare professionals;

• Some service user information should be produced routinely as part of general information produced for service users. Other information should be produced when required. All service user information should be supported by evidence where this exists.

• A designated individual within the organisation's structure must be identified to be responsible for service user information. The responsibilities of the Infection Control Committee in this respect should be clearly defined.

• Information on HAI should be available both routinely as part of the general literature provided for service users and also periodically as necessary in other specific situations e.g. during outbreaks. The suite of information required should be identified against the needs of the organisation and the areas and services covered should know how to access this material. All HAI information should be supported by evidence where this exists.

• Service users, carers and the public must be involved in the development of service user information.

• Service user information must be easy to read and written in plain language. The format of the information should ensure all relevant information is included and is presented in a way that is easily accessible.

• The information must be provided in a range of forms to meet the needs of those with sensory or cognitive impairment, or for whom English is not their first language, dependent on the area covered and services provided.

• All service user information must have a plan for evaluation.

• All service user information must be dated and have a review date.

➢ Core service user information about HAI must address the following:
  • What is infection;
  • That there is a risk of acquiring infections and of passing them on;
● That there are a range of sources from which infection comes, including staff, visitors, other service users, service users’ own organisms, ‘brought-in’ food and the environment;

● That risk may be increased by, for example, radiotherapy, chemotherapy, steroids and inappropriate use of antibiotics and this may lead to increased susceptibility to infection and the emergence of antibiotic resistance;

● That infection is not inevitable;

● What is being done to monitor and prevent HAI;

● Explain that the very young, the very old and those with long-term health conditions are more likely than others to suffer from an HAI;

● Staff expectations of people as service users, carers or relatives;

● That the issue of food consumed in healthcare premises by service users, carers or relatives is a complex one, which should be addressed locally.

➢ **Condition/Situation Specific Information on HAI** should be produced for the following situations:

● For service users isolated for the purposes of infection control.

● When a service user is colonised or infected with MRSA or some other "alert" organism.

● During outbreaks of infection:
  ○ What the service user has the right to expect;
  ○ What is the nature of the outbreak of infection;
  ○ If the outbreak has implications for the service user;
  ○ How the service user will be kept informed of any additional risks;
  ○ What is being done to monitor and prevent the spread of infection.
4. STANDARD HEALTHCARE EQUIPMENT

4.1 The big issue

Service users have the right to receive high quality care delivery using equipment (when necessary) that is provided and maintained in a way which minimises the risks of Healthcare Associated Infection (HAI) acquisition and transmission.

4.2 This is what it's all about

- Managing risk is at the heart of effective deployment of equipment. As this will vary from facility to facility, local assessment and decision making is essential.
- The range and quantity of equipment used in the delivery of healthcare is considerable.
- The focus of consideration in the Code of Practice is standard healthcare equipment as defined in Appendix 1.
- All equipment that service users will be exposed to must be cleaned between each different service user contact. Levels of basic equipment (e.g. hoists, slings, commodes) must be sufficient and be based on need as identified by local risk management. The purpose of these assessments is to reduce the communal use of such equipment and so reduce the risk of cross-contamination due to inadequate decontamination.
- The safe use of standard healthcare equipment is not merely related to availability, but depends upon the correct purchase, maintenance and training in the use of these resources, including cleaning/disinfection schedules.
- The principles in terms of evidence of infection risk, assessing infection risk, and management of infection risk apply to the equipment listed in the Code of Practice and to other healthcare equipment used in the range of healthcare delivery situations.
- There is evidence of HAI risk from:
  - Poorly designed and/or manufactured equipment that makes effective cleaning difficult or impossible;
  - Equipment transfer from one area to another resulting in difficulty in determining ownership of responsibility for condition and hygiene;
  - Equipment gifted or purchased outwith procurement procedures or infection control input as to its functional suitability;
  - Lack of clarity about who is responsible for cleaning particular items;
o Inadequate supplies of equipment resulting in sharing contaminated equipment;

o Inadequate cleaning schedules;

o Inadequate recording and monitoring of schedules and standards being achieved;

o Equipment contaminated as a result of poor personal hygiene e.g. hand hygiene of staff and service users;

o Staff using equipment without adequate and suitable training.

4.3 This is how to do it well

➢ Purchase procedure

● There must be a policy in place with input from appropriate specialist staff to ensure that infection risk is addressed at the purchasing stage in compliance with MDA DB9801, *Medical Equipment and Devices: Management for Hospital and Community based Organisations* and HDL(2001)10.

● Equipment purchase must take account of good design that allows easy decontamination and be constructed with durable materials that support easy cleaning and disinfection.

➢ Condition monitor

● The ongoing condition of the equipment needs to be monitored to ensure that infection risk can still be managed effectively and must be audited regularly.

● When the equipment condition has deteriorated to the extent that effective cleaning is no longer achieved easily, the equipment must be disposed of safely in accordance with the organisation's environmental management policy.

➢ Supplies

● There should always be available supplies of clean equipment to ensure that the re-use of potentially contaminated equipment does not happen.

➢ Scheduled cleaning

● Equipment will be subject to a cleaning schedule which will detail cleaning frequency and cleaning procedure, including cleaning agents to be used and the staff responsible.
• The schedule must be signed off at the end of each day certifying that it has been achieved, in line with the organisation's policy.

• Appendix 1 shows the normal cleaning schedule for standard healthcare equipment with an example of a daily monitoring record.

➤ Scheduled cleaning "plus"

• There are procedures common to all cleaning schedules, but certain items of equipment require particular actions (e.g. the finish or design of an item of equipment may require special attention to ensure that it is effectively cleaned).

➤ Training of staff

• Staff need to understand the importance of the measures in place to reduce the infection risk from standard healthcare equipment.

• Appropriate ongoing training must be provided to ensure that staff implement the measures required.

• Appropriate training must also be provided to all staff about the need for high standards of personal hygiene.

• The effectiveness of training should be monitored regularly as part of performance appraisal.

➤ Recorded audit

• Healthcare organisations need to exercise due diligence in their management of infection risk from standard healthcare equipment, and this requires them to ensure that their management measures are documented, implemented and recorded.

• Auditing of these measures is an ongoing requirement.

• Feedback, review and implementation of audit, corrective actions and observations are essential to ensure that risk management is being achieved.
MANAGEMENT OF INFECTION RISK FROM STANDARD HEALTHCARE EQUIPMENT

Measures to manage risk

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<td>26 Treatment Couches</td>
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<td>✓</td>
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<td>✓</td>
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</tr>
</tbody>
</table>

Measures to manage risk

**Purchase procedure**
There should be a policy in place with input from appropriate staff to ensure that infection risk issues are addressed at the purchasing stage. Purchasing equipment of good design, made from durable materials, and easy to clean is essential to managing infection risk.

**Design / material**
Good design and durable materials allow equipment to be easily cleaned.

**Supplies**
There should always be available appropriate supplies of clean equipment to ensure that the re-use of potentially contaminated equipment does not happen.

**Scheduled cleaning**
Equipment will be subject to a cleaning schedule which will detail cleaning frequency, cleaning procedure including cleaning agents to be used and the staff group responsible. The schedule must be signed off at the end of each day certifying that it has been achieved.

**Scheduled cleaning plus**
In addition to the comments under scheduled cleaning some equipment requires special attention as detailed in the cleaning schedule below.

**Condition monitor**
Ongoing condition needs to be monitored to ensure that infection risk can still be effectively managed. When the equipment is in a condition when effective cleaning is no longer easily achieved the equipment must be disposed of.

**Recorded audit**
Implementation of recorded audits are essential to ensure that risk management is being achieved.
5. 'PREVENTION AND CONTROL OF INFECTION' GUIDANCE

5.1 The big issue

To create a healthcare environment that is safe for service users, staff and visitors, organisations must take a risk management approach (based on evidence and best practice) to infection control practice, including that related to gastro-intestinal infection.

5.2 This is what it's all about

● To identify the infection risks.

● To minimise the risk of cross-infection.

● To facilitate the appropriate management of the service user. This includes staff being cared for by the Occupational Health Department or other relevant specialists.

● The Code of Practice outlines the basic principles for the control of infection and should be used alongside relevant local policies and procedures.

5.3 This is how to do it well

➢ Principal good practice statements

● All service users must be assessed on admission and at a planned frequency thereafter, taking into account the service users’ environment and medical details for their ‘risk of infection', both susceptibility and risk of spread (e.g. the planned frequency of assessment may be greater in oncology compared with care of the elderly). These assessments must be documented in the service user care plan, but are not intended to replace assessment normally carried out as a result of a change in the clinical condition of the service user.

● The details of all incidents of infection, including the infection control advice given, must be documented in the relevant service users' care records. An example of a care plan for service users with gastroenteritis is at Appendix 2.

● Service users who are infected, or potentially infected, and considered to be a potential risk to others must only be moved after agreement between the clinical and infection control teams.

● All healthcare deliverers must perform hand hygiene appropriately before and after direct service user care, and when there is a risk of contamination from faeces, other body fluids, equipment or the environment.
● All healthcare deliverers must wear personal protective equipment whenever there is a likelihood of direct contact with faeces, other body fluids or potentially contaminated materials/equipment. This includes the risk of contact involving mucous membranes e.g. the eyes or mouth.

● All laundry, including staff uniforms, used during an outbreak or in the management of significant infection must be treated as 'infected' linen when a risk assessment identifies these as a possible mechanism of disease spread.

● In incidents where there has been a risk of spread of infection (e.g. contamination with faeces or other body fluids), spillage of waste must be appropriately reported on incident forms and in the service user record. This applies equally to gross contamination and to mucous membrane exposure.

● The following details must be documented on all laboratory request forms: name, date of birth, CHI/hospital number, ward/clinic/GP practice, consultant/GP name, requesting clinician and contact details, date of onset of symptoms, details of link to possible other cases, anti-microbial therapy, time and date specimen collected, nature of specimen, clinical details relevant to specimen including foreign travel and investigation required. Clearly identify 'high risk' samples with appropriate markings, e.g. faecal specimens where there is clinical suspicion of typhoid/paratyphoid or verotoxigenic *Escherichia coli* infection, or where contacts of cases of these infections are being screened.

● All waste must be segregated and disposed of into the correct waste stream. Dispose of waste generated during outbreaks or the management of a significant infection as clinical waste.

➢ **Audit**

● Practice only improves when it is assessed and the lessons learned put into practice.

● Organisations must establish relevant periodic audits across the range of good practice principles to test performance and improve delivery where necessary.

● The frequency of follow up audits must be based on the potential risk of infection.
6. CLEANING SERVICES

6.1 The big issue

Service users, staff and visitors have a right to, and expect, a safe physical healthcare environment. Key to ensuring this safety at all times is cleanliness of the facilities where healthcare is delivered.

6.2 This is what it's all about

- Poor cleanliness of the healthcare setting is a proven infection risk for service users and staff.

- Ensuring appropriate cleanliness protects against acquiring infections and reduces the risk of onward transmission of disease.

- Organisations have a responsibility to service users, staff and visitors for ensuring a safe, effective and clean physical environment of care in healthcare facilities.

- Service users, staff and visitors each have individual responsibilities to ensure a safe, effective and clean physical environment in healthcare facilities.

- Staff involvement and decision-making in achieving cleanliness must occur at the appropriate level within organisations and as close to the service user as possible.

- The views of service users, visitors and staff are essential in guiding cleanliness work and in assessing performance.

- The Code of Practice outlines the basic principles of best practice in cleaning services and should be used alongside relevant local policies and procedures.

This document draws on the current NHS QIS/CSBS HAI Cleaning Services Standards, and on the HAI Task Force National Cleaning Services Specification in everyday healthcare practice. This latter important resource will be available in its final form in 2004.

6.3 This is how to do it well

➢ Principal good practice statements

- Since they provide the basis for maintaining a safe environment for service users, staff and visitors, the cleaning standards set within any organisation must, as a minimum, always meet those laid down by NHS QIS or future equivalents.

- During outbreaks/incidents of infection, the level of cleaning services must reflect the needs of each specific incident and should be locally determined.
● Regular monitoring, audit and benchmarking must be used to assess the efficiency and effectiveness of cleaning services.

● All cleaning services staff must receive training and instruction on safe operating practices and cleaning of healthcare facilities. This will commence with induction and will include appropriate training commensurate with their duties. Subsequently, staff should be supervised until they reach an appropriate standard.

● All cleaning services staff must receive on-going training and instruction on the safe operating practices and cleaning of healthcare facilities which is commensurate with their duties.

● A cleaning schedule detailing the levels of cleaning services for each particular area must be agreed with the Infection Control Team, the appropriate manager of the clinical area and the Cleaning Services Manager.

● A risk management process is an integral part of managing healthcare cleaning services.
7. COMPLIANCE MANAGEMENT

7.1 The big issue

Compliance mechanisms are essential to provide assurance that there is a managed environment that minimises the risk of infection to service users, staff and visitors. This section does not set national standards of compliance. It provides advice to assist governance at local levels.

7.2 This is what it's all about

● Compliance is an integral component of all organisations’ risk management processes, by providing evidence that there is in place a mechanism of internal 'good practice' control, which in turn offers assurance that the aims are being achieved.

● The organisation's assurance statement regarding HAI should encourage all staff within the organisation to support its commitment to HAI control and reduction.

● Compliance is most effective when it is based on a combination of self-assessment within the organisation and independent audit, inspection and review by others.

● Compliance mechanisms, whether addressed formally or informally, have three common, key components or activities:

  o **Monitoring activity** of the systems of quality and risk management e.g. audit;

  o **The regulatory framework** (the 'rules') including policies, procedures and guidelines, and the organisation's own **internal** standards of 'good practice'; and

  o **The regulatory authority**, or source, of the above.

● The intention of this chapter is to clarify the existing internal mechanisms to be utilised to address compliance arrangements.

7.3 This is how to do it well

● How has the public been involved?

● Does the public have a significant role in compliance management and do they feel supported in this?

● Organisations introducing a compliance management framework need to consider the following questions:
o Do all staff **understand** why the compliance framework is being introduced and what it hopes thereby to achieve?

o Do all staff, managers and committees **accept** and **own** the compliance framework?

o Are there **resources** available to allow the Code of Practice to be followed?

o Does the organisation’s audit and monitoring provide **robust data** to assess achievement of compliance?

o Are the results of audit and monitoring used in **education/training** to promote and support a culture of awareness of, and compliance with, the Code of Practice?

o Are existing **complaints procedures and employment conduct policies** adequate to deal with persistent breaches of the Code of Practice?

- The organisation should produce a summary of information relating to compliance with the Code of Practice.

- The basis of the Code of Practice should be conveyed to all staff within the organisation.

- The Infection Control Committee (ICC) terms of reference should include responsibility for assessment of levels of compliance within the Code of Practice.

- Tool(s) for undertaking audit that should be controlled by the ICC should accompany each component of the Code of Practice.

- Line managers should be responsible for monitoring and reviewing levels of compliance through annual performance review and appraisal processes.

- The annual infection control and monitoring programme should include:
  
  o audit activity undertaken and proposed by the Infection Control Team;
  
  o self-audit activity of compliance with the Code of Practice undertaken at operational level, e.g. ward, department or clinical group.

- Identification of breaches of the Code of Practice should trigger adverse-incident, adverse-event or near-miss reports.

- All elements of the Code of Practice should be regularly assessed within each one-year period.
• Areas of deficiency identified through compliance monitoring must initiate a local remedial action plan.

• The Risk Management and/or Clinical Governance Committees should on a quarterly basis critically appraise the results of infection control audit and monitoring of the processes.

• Evidence should be provided at least annually by the ICC that activity relating to audit and monitoring:
  o is widely disseminated;
  o is used to assist training and education;
  o results in an increasing awareness of the Code of Practice within the organisation.

• Persistent failure to adhere to the Code of Practice by any member of staff should be reflected in the annual performance review and the significance for an organisation should be similar to this.

• There must be a clear pathway from a staff member’s persistent failure to adhere to the Code of Practice to the organisation's staff management process.
8. BIBLIOGRAPHY

General

8.1 A Clean Bill of Health? A review of domestic services in Scottish Hospitals (Audit Scotland 2000)
8.4 Clinical Standards Board for Scotland standards on HAI Infection Control (December 2001) and HAI Cleaning Services (June 2002)
8.5 A framework for national surveillance of healthcare associated infection in Scotland. NHSScotland (2001)
8.6 The Watt Group Report: A review of the outbreak of salmonella at the Victoria Infirmary, Glasgow, between December 2001 and January 2002 and lessons that may be learned by both the Victoria Infirmary and the wider NHS family in Scotland. NHS HDL(2002)
8.7 Antimicrobial Resistance Strategy & Scottish Action Plan (SEHD 2002)
8.8 Ministerial HAI Action Plan, "Preventing infections acquired while receiving health care" (SEHD 2002)
8.9 Audit Scotland review of cleaning services (Audit Scotland 2003)
8.10 NHSScotland review of Infection control standards (NHSScotland 2003)

Compliance Management


Service User & Public Information


Standard Healthcare Equipment

8.15 MDA Bulletin 9801 (January 1998)

Prevention & Control of Infection Guidance

9. RESOURCES

General

Scottish Health on the Web (SHOW) http://www.show.scot.nhs.uk/

Department of Health (DoH) http://www.doh.gov.uk/

Scottish Centre for Infection and Environmental Health (SCIEH) http://www.show.scot.nhs.uk/scieh/


Infection Control Nurses Association (ICNA) http://www.icna.co.uk/

NHS Education Scotland (NES) http://www.nes-hai.info/

Service User & Public Information

Patient Information Forum (PIF)
28 Queensbury Street
London
N1 3AD
Tel: 020 7688 9208
Fax: 020 7704 9697
Website: http://www.soi.city.ac.uk/

Plain English Campaign
PO Box 3, New Mills
High Peak SK22 4QP
Tel: 01663 744409
Fax: 01663 747038
Website: http://www.plainenglishcampaign.com/

National Resource Centre for Ethnic Minority Health
Clifton House
Clifton Place
Sauchiehall Street
Glasgow G3 7LS
Tel: 0141 300 1050/1043
Website: http://www.phis.org.uk/

NHS Quality Improvement Scotland
Elliot House
8-10 Hillside Crescent
Edinburgh
EH7 5EA
Website: http://www.nhshealthquality.org/
## 10. APPENDIX 1: CLEANING SCHEDULE

<table>
<thead>
<tr>
<th>Equipment Item</th>
<th>Between service users</th>
<th>After soiling</th>
<th>Daily</th>
<th>Weekly</th>
<th>Monthly or other</th>
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<td>✓</td>
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<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
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<td></td>
<td>✓</td>
<td>3 monthly²</td>
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<tr>
<td>18 Mobile X-Ray/Apron</td>
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</tbody>
</table>

### Note
1. Appropriate cleaning of specialist bed according to manufacturer instructions
2. Appropriate cleaning requires input from estates personnel
3. After use in isolation situation

### Cleaning Schedule Daily Monitor

<table>
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<tr>
<th>Frequency</th>
<th>Schedule completed</th>
<th>Comments/Remedial Action</th>
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<tr>
<td>Between service users</td>
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<tr>
<td>After soiling</td>
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<td></td>
</tr>
<tr>
<td>Daily</td>
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<td>Monthly</td>
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<tr>
<td>3 monthly</td>
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<td></td>
</tr>
<tr>
<td>Other</td>
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<td></td>
</tr>
</tbody>
</table>

Refer to cleaning schedule. Equipment requires to be adequately cleaned either between service users, after soiling, daily, weekly, monthly or at other stipulated frequencies. The schedule must be adhered to. Correct cleaning agents to be used.
11. APPENDIX 2: EQUIPMENT FLOW DIAGRAM

Notes
- **Purchasing**: equipment should be durable, and able to be decontaminated
- **Cleaning Schedule**: detail cleaning frequency, cleaning agent, who does it?
- **Certify**: cleaning schedule has been completed
- **Condition monitor**: equipment condition to allow effective cleaning
- **Audit**: independent monitor of equipment condition and hygiene as part of due diligence
- **Disposal**: equipment which can no longer be maintained to hygiene standard is disposed of

* Refer to organisation policy
12. APPENDIX 3: A SAMPLE CARE PLAN FOR A CASE OF GASTROENTERITIS

Risk Reduction for Enteric Incident

**Patient**
- Patients should be educated on hand hygiene after eliminating and before meals
- Written policy on enteric precautions should be available in all clinical areas
- Adequate ICN support

**Management**
- All equipment should be decontaminated after use

**Staff**
- Staff should be aware of isolation precautions, ie:
  - gloves
  - aprons
  - decontamination
- Staff have a responsibility to wear those PPE and to inform manager of shortage of equipment
- Ensure patient isolated or cohort
- Decontaminate room as per local policy

**Equipment**
- Adequate PPE
- Domestic staff should be informed of decontamination requirements

**Environment**
- Shower facilities should be available
-写了政策 on enteric precautions should be available in all clinical areas
- Written policy on enteric precautions should be available in all clinical areas

**Staff involved in direct patient care**
- Patients should be informed of purpose of precautions
- Written policy on enteric precautions should be available in all clinical areas

**Staff contaminated with faecal matter**
- Uniforms should be sent to laundry in alginate bag or incinerate
- Shower
- Hand hygiene
- New uniform/Greens or disposable uniform

**Education/Information**
- Patients should be educated on hand hygiene after eliminating and before meals
- Written policy on enteric precautions should be available in all clinical areas

**Report Incident**
- Observe for new cases - inform Occupational Health of staff who have been heavily contaminated
## APPENDIX 4: MEMBERSHIP OF WORKING GROUP

<table>
<thead>
<tr>
<th>Name</th>
<th>Membership Representation</th>
<th>Title</th>
<th>Organisation</th>
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<tbody>
<tr>
<td>Liz Jordan</td>
<td>Chair</td>
<td>Medical Director</td>
<td>NHS Argyll &amp; Clyde</td>
</tr>
<tr>
<td>Sue Blair</td>
<td>Consultants in Occupational Medicine</td>
<td>Consultant in Occupational Medicine</td>
<td>Occupational Health and Safety Advisory Service</td>
</tr>
<tr>
<td>Oliver Blatchford</td>
<td>Consultants in Public Health Medicine</td>
<td>Consultant in Public Health Medicine</td>
<td>NHS Argyll &amp; Clyde</td>
</tr>
<tr>
<td>Alan Boyter</td>
<td>Human Resources</td>
<td>Director of Human Resources</td>
<td>North Glasgow University Hospitals NHS Trust</td>
</tr>
<tr>
<td>Angela Brown</td>
<td>Hotel/Domestic Services</td>
<td>Area Domestic Manager</td>
<td>Dumfries &amp; Galloway NHS Board</td>
</tr>
<tr>
<td>John Callaghan</td>
<td>Human Resources Forum</td>
<td>Non Executive NHS Board Member</td>
<td>Ayrshire &amp; Arran NHS Board</td>
</tr>
<tr>
<td>James Dalziel</td>
<td>Public Interest Representative</td>
<td></td>
<td></td>
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<tr>
<td>Margaret Duffy</td>
<td>Chief Executives</td>
<td>Interim Chief Executive</td>
<td>Forth Valley Acute Hospitals NHS Trust</td>
</tr>
<tr>
<td>Marie Farrell</td>
<td>Local Health Care Co-operatives</td>
<td>General Manager</td>
<td>Govanhill Health Centre, Glasgow Primary Care NHS Trust</td>
</tr>
<tr>
<td>Carol Fraser</td>
<td>Scottish Ambulance Service</td>
<td>Nurse Consultant in Health Protection</td>
<td>Lothian NHS Board</td>
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<tr>
<td>Liz Gillies</td>
<td>NHS Education for Scotland</td>
<td>Director of HAI Initiative</td>
<td>NHS Education for Scotland</td>
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<tr>
<td>Mary Hanson</td>
<td>Consultant Microbiologists</td>
<td>Clinical Lead</td>
<td>Lothian University Hospitals NHS Trust</td>
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<tr>
<td>Maureen Henderson</td>
<td>Directors of Nursing</td>
<td>Nursing Director</td>
<td>South Glasgow University Hospitals NHS Trust</td>
</tr>
<tr>
<td>Mary Henry</td>
<td>Scottish Centre for Infection and Environmental Health</td>
<td>Consultant Nurse Epidemiologist</td>
<td>Scottish Centre for Infection and Environmental Health</td>
</tr>
<tr>
<td>Ann Kerr</td>
<td>NHS Health Scotland</td>
<td>Programme Manager, Health Service</td>
<td>NHS Health Scotland</td>
</tr>
<tr>
<td>Heather Knox</td>
<td>Group 7 Link</td>
<td>Director of Facilities</td>
<td>Ayrshire &amp; Arran Primary Care NHS Trust</td>
</tr>
<tr>
<td>Beth Martin</td>
<td>Independent Healthcare Association</td>
<td>Matron/Manager</td>
<td>Abbey King’s Park Hospital</td>
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<tr>
<td>Craig Martin</td>
<td>Care Commission</td>
<td>Care Commission Officer</td>
<td>Care Commission</td>
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<tr>
<td>Bob Masterton</td>
<td>Medical Directors</td>
<td>Medical Director</td>
<td>Ayrshire &amp; Arran Acute Hospitals NHS Trust</td>
</tr>
<tr>
<td>Maggie McCowan</td>
<td>Infection Control Nurses’ Association</td>
<td>Senior Manager Infection Control</td>
<td>Golden Jubilee National Hospital</td>
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<tr>
<td>Ian McLuckie</td>
<td>Property and Environment Forum Executive</td>
<td>Chief Executive</td>
<td>Property &amp; Environment Forum Executive</td>
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<tr>
<td>Dilip Nathwani</td>
<td>Scottish Joint Consultants Committee</td>
<td>Consultant Physician</td>
<td>Infectious Disease Unit, Tayside University Hospitals NHS Trust</td>
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<tr>
<td>David Old</td>
<td>NHS Quality Improvement Scotland</td>
<td>Retired Consultant Clinical Scientist</td>
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<tr>
<td>Carole Reed</td>
<td>Infection Control Nurses’ Association</td>
<td>Clinical Nurse Specialist</td>
<td>NHS Argyll &amp; Clyde</td>
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<tr>
<td>Ralph Roberts</td>
<td>Support Services</td>
<td>Director of Integrated Care</td>
<td>Borders NHS Board</td>
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<tr>
<td>Janet Smart</td>
<td>Allied Health Professions</td>
<td>Lead Therapist</td>
<td>Shared Rehabilitation, Lothian University Hospitals NHS Trust</td>
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<tr>
<td>Joan Sneddon</td>
<td>Scottish Centre for Infection and Environmental Health</td>
<td>Nurse Consultant Infection Control</td>
<td>Scottish Centre for Infection and Environmental Health</td>
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<tr>
<td>Tom Steele</td>
<td>Group 7 Link</td>
<td>Assistant Director of Facilities</td>
<td>Ayrshire &amp; Arran Primary Care NHS Trust</td>
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<tr>
<td>Kenneth Stewart</td>
<td>Property and Environment Forum Executive</td>
<td>Managing Consultant</td>
<td>Stewart Consulting</td>
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<tr>
<td>Patricia Weir</td>
<td>Public Interest Representative</td>
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