National Infection Prevention and Control Manual

Compliance and Quality Improvement Data Collection Tool

Chapter 1 – Standard Infection Control Precautions (SICPs)
Chapter 2 – Transmission Based Precautions (TBPs)

Note:

This Standard Infection Control (SICPs) and Transmission Based Precautions (TBPs) Compliance and Quality Improvement Data Collection Tool has been developed to support implementation of Part 1 (SICPs) and Part 2 (TBPs) of the National Infection Prevention and Control Manual.

This Compliance and Quality Improvement Data Collection Tool has been designed for use by healthcare workers of all disciplines working in any healthcare environment to:

- Assess current compliance with each of the 10 SICPs.
- Assess current compliance with the Patient Placement Risk Assessment element of TBPs.
- Identify any missed critical elements that need to be improved and require process and/or system changes that will assure clinical teams of SICPs and TBPs Patient Placement Risk Assessment compliance in their care area.

The Healthcare Environment Inspectorate (HEI) requires evidence of compliance with SICPs and TBPs (where applicable) during Healthcare Associated Infection (HAI) inspections. Implementation of the National Infection Prevention and Control Manual and the Compliance and Quality Improvement Tool promotes consistency of practice and monitoring across NHS boards, and supports the HEI's HAI inspection process.

Support for implementation and quality improvement at a local level for the monitoring of compliance with SICPs and the patient placement risk assessment element of TBPs using the Compliance and Quality Improvement Data Collection Tool will be supported by Leading Better Care (LBC) in conjunction with boards' Infection Prevention and Control Teams (IPCTs) for nurses and midwives. Boards should also ensure they have systems in place so that all healthcare workers are aware and, where appropriate, measure compliance with SICPs and TBPs.

If boards have their own locally devised tools to monitor, evidence and improve compliance with SICPs and TBPs they can continue to use these. Boards should carry out an initial baseline assessment of compliance with the SICPs and TBPs, which will assist in informing how they determine the required frequency of compliance monitoring.

It is up to individual boards to determine the frequency of measurement of SICPs and TBPs compliance.

Boards are required to provide SICPs and TBPs compliance monitoring data to the Scottish Government. However, boards are expected to ensure they have robust systems and processes in place to assure themselves that areas for SICPs and TBPs improvement are identified and the necessary improvements are made.

SICPs and TBPs are not new practices within care settings, and boards are required to continue to demonstrate SICPs and TBPs compliance monitoring data as part of their Healthcare Environment Inspections.

This tool is divided into 2 parts; **Part 1** provides background information and guidance and **Part 2** discusses data collection

Part 1
Background Information and Guidance

Healthcare can present a serious risk to patient safety as patients may already be vulnerable to infection and healthcare procedures expose them to infection risks. Every patient needs to be confident that the care and treatment they receive is safe and meets the highest standard possible. Patients need to be assured that staff follow the correct procedures to reduce the risk of HAIs as a consequence of health care.

What are Standard Infection Control Precautions (SICPs)?

Standard Infection Control Precautions (SICPs) are intended for use **by all** staff, **in all** care settings **at all** times **for all** individuals whether infection is known to be present or not to ensure the safety of those being cared for as well as staff and visitors to the care environment. SICPs are the basic infection prevention and control measures necessary to reduce the risk of transmission of micro-organisms from recognised and unrecognised sources of infection. These sources of (potential) infection include blood and body fluid secretions or excretions (excluding sweat), non-intact skin or mucous membranes and any equipment or items in the care environment that are likely to become contaminated. The application of SICPs during care delivery is determined by the assessment of risk and includes the task/level of interaction and/or the anticipated level of exposure to blood or other body fluids.

There are ten elements of Standard Infection Control Precautions (SICPs):

- Patient Placement/Assessment for Infection risk.
- Hand Hygiene.
- Respiratory and Cough Hygiene.
- Personal Protective Equipment (PPE).
- Safe Management of the Care Equipment.
- Safe Control of the Care Environment.
- Safe Management of Linen.
- Safe Management of Blood and Body Fluid Spillages.
- Safe Disposal of Waste (including sharps).
- Occupational Safety: Prevention and Exposure Management (including sharps).

What are Transmission Based Precautions (TBPs)?

Transmission Based Precautions (TBPs) are additional precautions to prevent transmission of specific infectious agents. SICPs must still be applied with these additional considerations.

TBPs should be applied when caring for:

- patients with symptoms of infection;
- asymptomatic patients who are suspected of incubating an infection; or

- patients colonised with an infectious agent.

There are five elements to Transmission Based Precautions (TBPs):

- Patient Placement/Assessment for Infection Risk.
- Safe Management of Patient Care Equipment in an Isolation Room/Cohort Area.
- Safe Management of the Care Environment.
- Personal Protective Equipment (PPE): Respiratory Protective Equipment (RPE).
- Infection Prevention and Control during Care of the Deceased.

Purpose of SICPs and TBPs Compliance and Quality Improvement Data Collection Tool

The SICPs and TBPs Compliance and Quality Improvement Data Collection Tool has been developed to support the identification of compliance and non-compliance in relation to SICPs and Patient Placement Risk Assessment element of TBPs in order to:

- Embed the importance of infection prevention and control into everyday practice.
- Reduce variation in infection prevention and control practice and standardise care processes.
- Determine what improvements need to made to achieve 100% compliance with SICPs and Patient Placement Risk Assessment elements of TBPs to reduce the risk of cross-infection.
- Improve the application of knowledge and skills in infection prevention and control.
- Help align practice, monitoring, quality improvement and scrutiny.

Who is the data collection tool designed for?

Whilst the Senior Charge Nurse/Midwife, Department Manager, Clinical Team Leaders etc are responsible for ensuring compliance monitoring takes place, the tool has been designed for use by healthcare staff from all disciplines working in any care environment.

How do I decide which SICPs to measure?

You need to review all 10 SICPs and agree which ones are applicable to your clinical area. This can be done in conjunction with your Infection Prevention and Control Team and Leading Better Care facilitator.

There is a SICP for Hand Hygiene- does this replace all other Hand Hygiene measures?

The compliance and quality improvement data collection for hand hygiene is a combined (**opportunity and technique**) tool that reflects the data measurement plans utilised by other national programmes, e.g. SPSP, and therefore where boards already have a tool to monitor and evidence compliance with hand hygiene they can continue to use it, ensuring the same level of detail included in the Compliance and Quality Improvement Data Collection Tool.

Collecting baseline data

To get a baseline of the current level of compliance you may wish to measure all 10 SICPs elements or those that are applicable to your area in the first instance, for example if all 10 SICPs apply in your area you may wish to take 2 SICPs elements per day over the course of a week/month and follow the instructions on each data collection sheet regarding completion. Thereafter you could focus your improvement efforts on the identified non–compliant SICPs ensuring that you identify and document the concept, system and process changes introduced that achieve increased compliance.. At present there is one element (Patient Placement Risk Assessment) of baseline data required for TBPs and this should be measured over the course of a week/month, following the same principle as SICPs data collection. TBP baseline data is only required if and when TBPs are implemented.

Why should you monitor SICPs and TBPs compliance?

The rationale behind measuring compliance with SICPs and the Patient Placement Risk Assessment element of TBPs is to provide assurance that critical elements of SICPs are integrated into everyday practice and that TBPs are integrated into practice when a need is identified. Measuring compliance with SICPs and the Patient Placement Risk Assessment element of TBPs will determine what improvements need to be made to achieve 100% compliance. There must therefore be an agreed plan within your organisation to ensure continuous monitoring, including a process to address and improve areas of non-compliance with SICPs and TBPs.

How often should I continue to collect data?

The data collection tool for SICPs has been designed to collect 5 samples per week/20 per month for each of the 10 SICPs (or those that are relevant to your area), however this does not mean that you need to measure every relevant SICP every month. You need to ensure you have a process in place to measure the SICPs you are not compliant with, and ensure ongoing improvements are made. Although the data collection tool for TBPs has been designed to collect 5 samples per week/ 20 per month, this can be adjusted to suit the requirements of the clinical area and should only be collected if TBPs are implemented.

How do I select the patients/clients/observations/members of staff I use?

They need to be randomly selected from all opportunities in your clinical area that meet the SICPs/TBPs criteria.

Who will/should see my compliance monitoring results?

You are encouraged to share your results with your team and other relevant stakeholders and one beneficial way of doing this is to display your data in your clinical/care environment. As part of the Healthcare Environment Inspectorate visits you may be asked to discuss and demonstrate compliance with SICPs and when appropriate TBPs. Compliance monitoring results can support this.

What do I do if my results are below 100%?

You may identify a number of issues resulting in a non-compliance that can be managed and dealt with quickly and easily on a day to day basis at a local level, e.g. ensuring the correct equipment is available to immediately respond to a blood or body fluid spillage and every member of staff knows where this equipment is kept.

However, where there is a requirement to make more significant changes to the care system and/or processes, successful improvements will involve careful planning and testing. It is important that modifications are made as needed and tested to ensure any ideas to change systems and processes are sound before fully implementing across the care area.

The key questions to ask yourself and your team when making the improvements are:

- What are the issues and why are we not achieving compliance?
- What actions do we need to put in place?
- What are the results/changes/improvements needed?

The key with all improvements is to ensure that the changes/improvements you have made are documented and that you have a record of the work you have done.

The Model for Improvement is a simple yet powerful tool for accelerating improvement. You may need to seek some support within your organisation from Leading Better Care Facilitators, local improvement leads and teams to utilise the Model for Improvement if you have never used it before.

The model has two parts:

Part 1: The thinking part

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What changes can we make that will result in improvement?

Part 2: Plan-Do-Study-Act (PDSA) Cycle: The doing part

- Used to test out ideas that will improve systems and processes
- A structured approach for making small incremental changes to systems
- A full cycle for planning, implementing, testing and identifying further changes

The combination of **part 1** and **part 2** form the basis of the Model for Improvement

Ref: The improvement Guide; Landley G, Moen R, Nolan K, Nolan T, Norman C, Provost L, A Practical Approach to enhancing Organisational Performance.2nd Edition, 2009 pages 1-5

Situation Background Assessment Recommendations (SBAR) is another tool you can use

SBAR is an easy to remember mechanism that you can use to frame conversations, especially critical ones, requiring a clinician's immediate attention and action. It enables you to clarify what information should be communicated between members of the team, and how. It can also help to develop teamwork and foster a culture of patient safety.

The tool consists of standardised questions within four sections (Situation; Background; Assessment; Recommendations), to ensure that staff are sharing concise and focused information. It allows staff to communicate assertively and effectively, reducing the need for repetition.

Do SICPs and TBPs link with other National NHSScotland work streams?

The National Infection Prevention and Control Manual – Compliance & Quality Improvement Data Collection Tool has been developed and designed to support the work and delivery of the following:

- Leading Better Care - Delivering for Patients.
- Releasing Time to Care.
- National Tissue Viability Programme.
- Scottish Patient Safety Programme.
- Healthcare Environment Inspectorate (HEI) Inspection Programme.
- NHS Education for Scotland Cleanliness Champions Programme.

Compliance and Quality Improvement Data Collection Sheets

Chapter 1- Standard Infection Control Precautions

DATA COLLECTION SHEETS

Standard Infection Control Precautions (SICPs) Compliance & Quality Improvement Data Collection Sheet: No 1 Patient Placement					
Month:		**Data collected by:**		**Organisation:**	
Hospital /Site:			**Ward / Unit / Department:**		

Observe five patient placements per week in each clinical area [20/month]

Critical Element: Patient Placement	**Observations (Denominator)**	**All Critical Elements met (Yes or No) (Numerator)**	**Record unmet critical elements i.e.: 1 and/or 2**	**Record Quality Improvement Action taken/planned for all unmet critical elements**
1. The infection risks from patients are assessed pre patient placement in the care environment i.e.: - Patients who have symptoms / signs suggestive of an infection that could be transmitted from patient-to-patient are identified and isolated on arrival to the .care environment **2. Patient placement is continuously reviewed i.e.:** - Patients who develop symptoms / signs suggestive of an infection that could be transmitted from patient to patient then there is an isolation patient placement assessment, e.g. Patient A develops diarrhoea, 4 days after starting antibiotics, whilst a specimen result is awaited, the patient is isolated. - Patients who are isolated are assessed for isolation discontinuation based on results from the microbiology lab, current symptoms and discussions with the IPCN.	**1**			
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Monthly Compliance Rate is calculated by: Numerator (total Yes) ÷ Denominator (total number of observations i.e. 20) X 100			**Monthly Compliance Rate =**	

Standard Infection Control Precautions (SICPs) Compliance & Quality Improvement Data Collection Sheet: No 2 Hand Hygiene					
Month:		**Data collected by:**		**Organisation:**	
Hospital /Site:		**Ward / Unit / Department:**			

Observe five opportunities for hand hygiene per week in each clinical area [20/month]

Critical Element: Hand Hygiene **OPPORTUNITY** Hand hygiene should be carried out by clinical staff: 1. Before touching a patient 2. Before clean/aseptic procedures 3. After body fluid exposure risk 4. After touching a patient 5. After touching patient/immediate surroundings **PROCEDURE** In order to carry out effective hand hygiene (using soap & water) the following 5 components are required: 1. Exposed forearms; remove all jewellery 1. (a single, plain metal ring is permitted); finger nails must be clean and short and artificial nails or nail products must not be worn; all cuts/abrasions should be covered with a waterproof dressing. 2. Wet the hands prior to applying liquid soap 3. Ensure the soap & water covers all surfaces of the hands 4. Effectively rinse and dry hands using paper towels 5. Dispose of the paper towels without re-contaminating hands In order to carry out effective hand hygiene (using Alcohol Based Hand Rubs (ABHRs)) dispensers should be as near to the patient as possible & the following 3 components are required: 6. Exposed forearms; remove all jewellery – (a single, plain metal ring is permitted); finger nails must be clean and short and artificial nails or nail products must not be worn; all cuts/abrasions should be covered with a waterproof dressing. 7. Apply alcohol based hand rub 8. Rub the hands together until they are dry–ensure the alcohol rub covers all surfaces of the hands.	**Observations (Denominator)**	**Staff group 1. Nursing 2. Medical 3. AHPs 4. Other (please state)**	**Opportunity taken (Yes or No) (Numerator*)**	**Record unmet opportunity number i.e.: 1, 2, 3, 4 or 5**	**All critical elements met for hand hygiene procedure (Yes or No) (Numerator*)**	**Record unmet procedure number(s) i.e.: 1-5 or 6-8**	**Record Quality Improvement Action taken/planned for all unmet critical elements**
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Monthly Compliance Rate is calculated by: Numerator (total Yes) ÷ Denominator (total number of observations i.e. 20) X 100			**Monthly Compliance Rate =**				

*** Yes required in both opportunity and procedure to count as numerator score**

Standard Infection Control Precautions (SICPs) Compliance & Quality Improvement Data Collection Sheet: No 3 Respiratory Hygiene/Cough Etiquette					
Month:		**Data collected by:**		**Organisation:**	
Hospital /Site:		**Ward / Unit / Department:**			

Ask five staff members per week in each clinical area [20/month]

Critical Element: Respiratory Hygiene 1. Ensure disposable tissues and hand hygiene facilities available and accessible 2. Promote effective respiratory hygiene/cough etiquette with patients (persons) in care areas 3. Cover the nose and mouth with a disposable tissue when sneezing, coughing, wiping and blowing the nose 4. Dispose of all used tissues promptly into a waste bin 5. Wash hands with non-antimicrobial liquid soap and water after coughing, sneezing, using tissues, or after contact with respiratory secretions or objects contaminated by these secretions; and 6. Keep contaminated hands away from the mucous membranes of the eyes and nose	**Responders (Denominator)**	**Staff group** **1. Nursing** **2. Medical** **3. AHPs** **4. Other (please state)**	**All critical elements met for respiratory hygiene procedure (Yes or No) (Numerator)**	**Record unmet procedure Number(s) i.e.: 1, 2, 3, 4, 5 or 6**	**Record Quality Improvement Action taken/planned for all unmet critical elements**
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Monthly Compliance Rate is calculated by: Numerator (total Yes) ÷ Denominator (total number of observations i.e. 20) X 100			**Monthly Compliance Rate =**		

Standard Infection Control Precautions (SICPs) Compliance & Quality Improvement Data Collection Sheet: No 4 Personal Protective Equipment					
Month:		**Data collected by:**		**Organisation:**	
Hospital /Site:		**Ward / Unit / Department:**			

Observe five staff per week in each clinical area [20 / month]

Critical Element: Personal Protective Equipment	**Observations (Denominator)**	**Staff group 1. Nursing 2. Medical 3. AHPs 4. Other (please state)**	**All critical elements met with task/ procedure undertaken e.g. bed making / changing, venepuncture, wound dressing (state procedure / task) (Yes or No) (Numerator)**	**Record unmet critical elements in accordance with task/procedure observed i.e.: 1 - 14**	**Record Quality Improvement Action taken/planned for all unmet critical elements**
1. Select correct Personal Protective Equipment (PPE) for procedure or task 2. Safely put on and remove PPE **All PPE should be:** 3. Located close to the point of use 4. Stored to prevent contamination in a clean/dry area 5. Disposed of (decontaminated only if reusable between each use) following use. **Gloves must be:** 6. Worn when exposure to blood and/or body fluids may occur					
7. Changed immediately after each patient (person) and/or following completion of a procedure or task 8. Changed if a perforation or puncture is suspected 9. Appropriate for use, fit for purpose and well fitting to avoid excessive sweating and interference with dexterity **Aprons must be:** 10. Worn to protect uniform or clothes when contamination is likely 11. Changed between patients (persons) and/or following completion of a procedure or task **Eye/face protection (including full face visors) should be:** 12. Worn if there is a risk of blood and/or body fluid contamination to the eyes. (Regular corrective spectacles are not adequate eye protection) **Surgical face mask should be:** 13. Worn if a risk of splashing or spraying of blood, body fluids, secretions or excretions onto the respiratory mucosa is anticipated/likely **Footwear must be:** 14. Non-slip; clean and well maintained; and support and cover the entire foot to avoid contamination with blood or other body fluids or potential injury from sharps	**1**				
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Monthly Compliance Rate is calculated by: Numerator (total Yes) ÷ Denominator (total number of observations i.e. 20) X 100			**Monthly Compliance Rate =**		

Standard Infection Control Precautions (SICPs) Compliance & Quality Improvement Data Collection Sheet: No 5 Managing Patient Care Equipment					
Month:		**Data collected by:**		**Organisation:**	
Hospital /Site:		**Ward / Unit / Department:**			

Observe five staff per week in each clinical area [20 / month]

Critical Element: Reusable Patient Care Equipment	**Observations (Denominator)**	**Staff group 1. Nursing 2. Medical 3. AHPs 4. Other (please state)**	**All critical elements met? (Yes or No) (Numerator)**	**Record unmet critical elements in accordance with task/procedure observed i.e.: 1 & 2 / 3 - 5 / 6 - 8**	**Record Quality Improvement Action taken/planned for all unmet critical elements**
Between use: 1. Decontaminate equipment with disposable cloths/paper towel and a fresh solution of **general purpose detergent and water or detergent impregnated wipes**. 2. Follow manufacturers instructions for dilution, application and contact time **If equipment contaminated with blood:** 3. Immediately decontaminate equipment with disposable cloths/paper roll and a fresh solution of detergent, rinse, dry and follow with a disinfectant solution of **10,000 parts per million available chlorine (ppm av cl)** rinse and thoroughly dry; or 4. Use a combined detergent/chlorine releasing solution with a concentration of **10,000 ppm av**, rinse and thoroughly dry 5. Follow manufacturers instructions for dilution, application and contact time **If equipment contaminated with urine/vomit/faeces or used on a patient with a known or suspected colonisation/infection:** 6. Either decontaminate equipment with disposable cloths/paper roll and a fresh solution of detergent, rinse, dry and follow with a disinfectant solution of **1,000 parts per million available chlorine (ppm av cl)** rinse and thoroughly dry; or 7. Use a combined detergent/chlorine releasing solution with a concentration of **1,000 ppm av**, rinse and thoroughly dry 8. Follow manufacturers instructions for dilution, application and contact time	**1**				
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Monthly Compliance Rate is calculated by: Numerator (total Yes) ÷ Denominator (total number of observations i.e. 20) X 100			**Monthly Compliance Rate =**		

Standard Infection Control Precautions (SICPs) Compliance & Quality Improvement Data Collection Sheet: No 6 Control of the environment					
Month:		**Data collected by:**		**Organisation:**	
Hospital /Site:		**Ward / Unit / Department:**			

Observe five areas per week in each clinical area [20/month]

Critical Element: Control of Environment **The Environment is:** 1. Free from clutter 2. Well maintained and in a good state of repair 3. Clean and routinely cleaned in accordance with the national cleaning specification	**Observations (Denominator)**	**Which parts of the clinical area were observed? E.g. patient rooms, toilets, treatment room, sluice**	**All critical elements met? (Yes or No) (Numerator)**	**Record unmet critical elements i.e.: 1,2 and/or 3**	**Record Quality Improvement Action taken/planned for all unmet critical elements**
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Monthly Compliance Rate is calculated by: Numerator (total Yes) ÷ Denominator (total number of observations i.e. 20) X 100			**Monthly Compliance Rate =**		

Standard Infection Control Precautions (SICPs) Compliance & Quality Improvement Data Collection Sheet: No 7 Safe Management of Linen					
Month:		**Data collected by:**		**Organisation:**	
Hospital /Site:		**Ward / Unit / Department:**			

Observe five linen procedures per week in each clinical area [20/month]

Critical Element: Management of Linen	**Observations (Denominator)**	**All Critical Elements met (Yes or No) (Numerator)**	**Record unmet critical elements i.e.: 1 - 6 or 1 & 7 - 10**	**Record Quality Improvement Action taken/planned for all unmet critical elements**
1. Minimise handling of used and infectious linen **For all used linen** **2.** A laundry receptacle is available as close as possible to the point of use for immediate linen disposal. Used linen is not: **3.** Rinsed/separated/shaken or sorted on removal from beds **4.** Placed on the floor or any other surfaces e.g. a locker/table top **5.** Re-handled once bagged **6.** Laundry receptacles are not overfilled **For all infectious linen i.e.:** **7.** Linen that has been used by a patient who is known or suspected to be infectious; and/or **8.** Linen that is contaminated with blood and/or other body fluids e.g. faeces which is not considered to be from an infectious patient: **9.** Placed directly into a water-soluble/alginate bag and secure; then place into a clear plastic bag and secure before placing in a laundry receptacle; or **10.** Dispose of as healthcare waste if the item(s) is heavily soiled and unlikely to be fit for reuse following laundering.	**1**			
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Monthly Compliance Rate is calculated by: Numerator (total Yes) ÷ Denominator (total number of observations i.e. 20) X 100			**Monthly Compliance Rate =**	

Standard Infection Control Precautions (SICPs) Compliance & Quality Improvement Data Collection Sheet: No 8 Management of Blood and Body Fluids spillages					
Month:		**Data collected by:**		**Organisation:**	
Hospital /Site:		**Ward / Unit / Department:**			

Ask five staff members per week in each clinical area [20 / month]

Critical Element: /blood & body fluid spillages	**Responders (Denominator)**	**Staff group 1. Nursing 2. Medical 3. AHPs 4. Other (please specify)**	**All critical elements correctly stated / described? (Yes or No) (Numerator)**	**Record unmet critical elements i.e.: 1-7 or 1&2 & 8-11**	**Record Quality Improvement Action taken/planned for all unmet critical elements**
Fluids spillages 1. Clean up all spillages immediately 2. Use correct equipment and follow correct procedure **Blood spillages:** 3. Apply chlorine releasing granules directly to the spill or place disposable paper towels over the spillage to absorb and contain it applying a solution of 10,000ppm available (av) chlorine to the towels) 4. Follow manufacturers instructions on contact time usually three minutes 5. Clear the area using disposable towels and discard as healthcare waste 6. Clean the area with disposable paper towels and a solution of general purpose neutral detergent 7. Rinse and dry **Non blood spills e.g urine/vomit/faecal spillages:** 8. Remove any gross contamination with disposable paper towels and dispose as healthcare waste 9. Disinfect the area with 1,000 ppm av chlorine 10. Clean the area with disposable paper towels and a solution of general purpose detergent 11. Rinse and dry	**1**				
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Monthly Compliance Rate is calculated by: Numerator (total Yes) ÷ Denominator (total number of observations i.e. 20) X 100			**Monthly Compliance Rate =**		

Standard Infection Control Precautions (SICPs) Compliance & Quality Improvement Data Collection Sheet: No 9 Safe disposal of waste					
Month:		**Data collected by:**		**Organisation:**	
Hospital /Site:		**Ward / Unit / Department:**			

Observe five healthcare waste receptacles per week in each clinical area [20 / month]

Critical Element	Observations (Denominator)	All Critical Elements met (Yes or No) (Numerator)	Record unmet critical elements i.e.: 1 - 7	Record Quality Improvement Action taken/planned for all unmet critical elements
1. Ensure correct healthcare (including clinical) waste disposal/segregation **Always dispose of waste:** 2. Immediately and as close to the point of use as possible; 3. Into the correct segregated colour coded UN 3291 approved waste bag (either orange/yellow for healthcare waste or black for domestic); or 4. Into approved sharps waste box which must be no more than ¾ full 5. Liquid waste e.g. blood, must be rendered safe by adding a self setting gel or compound before being placed in the sack or managed as a body fluid spill; 6. Bags must be no more than 3/4 full or more than 4kgs in weight; and 7. Using a ratchet tag (for healthcare waste bags only) with a 'swan neck' to close or label (for sharps waste boxes) with point of origin and date of closure.	**1**			
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Monthly Compliance Rate is calculated by: Numerator (total Yes) ÷ Denominator (total number of observations i.e. 20) X 100		**Monthly Compliance Rate =**	

Standard Infection Control Precautions (SICPs) Compliance & Quality Improvement Data Collection Sheet: No 10 Occupational Exposure Management					
Month:		**Data collected by:**		**Organisation:**	
Hospital /Site:		**Ward / Unit / Department:**			

Ask five staff members per week in each clinical area [20 / month]

Critical Element	**Responders (Denominator)**	**Staff group 1. Nursing 2. Medical 3. AHPs 4. Other (please specify)**	**All critical elements correctly stated / described? (Yes or No) (Numerator)**	**Record unmet procedure Number(s) i.e.: 1, 2, 3, 4, 5, 6 or 7**	**Record Quality Improvement Action taken/planned for all unmet critical elements**
1. Follow correct procedure when a significant occupational exposure incident occurs Immediate actions **Skin/tissue exposure**: 2. Encourage the injured area to bleed (do not suck) 3. Wash/irrigate with warm running water and soap (do not scrub the area) 4. Cover with a waterproof dressing **Eye/mouth exposure:** 5. Rinse/irrigate copiously with water (use eye/mouth wash kits if available) 6. If contact lenses are worn remove before irrigating the eye 7. Do not swallow water used for muco-cutaneous rinsing Report/document all incidents and take any corrective actions	**1**				
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Monthly Compliance Rate is calculated by: Numerator (total Yes) ÷ Denominator (total number of observations i.e. 20) X 100			**Monthly Compliance Rate =**		

Compliance and Quality Improvement Data Collection Sheet

Chapter 2 – Transmission Based Precautions

Transmission Based Precautions (TBPs) Compliance & Quality Improvement Data Collection Sheet: : Patient Placement Risk Assessment					
Month:		**Data collected by:**		**Organisation:**	
Hospital /Site:			**Ward / Unit / Department:**		

Review 5 patients per week in each clinical area [20/month]

Critical Element: Patient Placement Risk Assessment	**Observations (Denominator)**	**All Critical Elements met* (Yes or No) (Numerator)**	**Record unmet critical elements i.e.: 1,2,3,4 and 5**	**Record Quality Improvement Action taken/planned for all unmet critical elements**
1. Patients who are known or suspected to be infected with infectious agents/conditions spread by contact or droplet are placed in isolation suite/single room/cohort area (if multiple cases of the same infection). 2. Patients who are known or suspected to be infected with infectious agents/conditions spread by airborne route are assessed for specialised negative pressure room. 3. Patient placement decisions are documented in the patient records 4. The single room/cohort area door is closed unless contraindicated by risk assessment. 5. Personal Protective Equipment is available at the point of care and ready for use inclusive of Respiratory Protective Equipment (RPE) if appropriate.	**1**			
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	20			
Monthly Compliance Rate is calculated by: Numerator (total Yes) ÷ Denominator (total number of observations i.e. 20) X 100			**Monthly Compliance Rate =**	

*If any of the 5 critical elements are not met then evidence of risk assessment/deviations must be documented daily in patient records.