

# **Northern Health and Social Care Trust Healthcare Acquired Infection Assurance Framework**

Local (Principal) Objective	Current Position	Future State	Exec Lead	Time Scale	Current Risk	Measure of Success (Evidence of Assurance to Trust Board)	
1.0 Accountability for Healthcare associated infection (HCAI) is clearly defined and understood at all levels in the Trust.  RQIA IR 1 IR 2 IR 3 FR 10	NHSCT Infection Prevention and Control Accountability Structure approved.  Board level responsibility for IPC is clearly defined and there are clear lines of accountability for HCAI throughout the organisation leading to the board.	Strong visible leadership with respect to prevention of HCAI.  Trust HCAI accountability structure reflects robust reporting arrangements within directorates and across professional groups.	CEO	In place	Low	Sustained reduction in HCAI's in NHSCT. (evidenced by internal reporting mechanisms and external review, trends reviewed against PfA targets )  Clear accountability, responsibilities and objectives for prevention of HCAI's at Board and directorate levels.	
	Directors are currently developing accountability frameworks and detailed delivery plans with NDL's, managers and staff in directorates. (Building blocks for accountability frameworks currently in place.)	Multidisciplinary HCAI Review Panel holds individual officers to account for new cases of HCAI.	Directors lead HCAI prevention within individual directorates, report to Trust Board on key performance indicators, work tenaciously to drive down infection rates and drive up quality healthcare experience	DIPC	31 July 2009	Med	All staff understand personal responsibility and accountability for reduction in HCAI's. 100% compliance with evidence based policy demonstrated by all professional groups (evidenced in internal and external review processes)
		Individual directorate HCAI delivery plans dovetail into corporate HCAI delivery plan . Reporting structures clearly articulated, performance	Directors lead HCAI prevention within individual directorates, report to Trust Board on key performance indicators, work tenaciously to drive down infection rates and drive up quality healthcare experience	Directors	31 July 2009	Med	Directorate Accountability Framework for HCAI operationalised. HCAI standing agenda item at Directorate governance meetings. Service user satisfaction with care provided. (user experience questionnaires, patient narratives, reduction in number of complaints)  Weekly performance management report on directorate HCAI's to SMT. HCAI standing agenda item at monthly accountability reviews with CEO and Directors.

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	Reporting frequency agreed on a range of key performance indicators including: Cdifficile MRSA MSSA Hand Hygiene, HII's, Environmental cleanliness Antibiotic prescribing	management structures agreed and operationalised.				Monthly directorate performance management report on HCAI to GMB tabled, discussed and challenged DIPC provides a monthly HCAI and environmental hygiene report to GMB.	
		Dashboard of KPI's (both outcomes and processes) developed and implemented.	DSPMPM Directors	30 Sept 2009	Med	KPI's demonstrate consistent compliance with policy and procedure. Evidence based practice embedded in clinical practice. (evidenced by internal audit processes, peer review, quality assured by IPC nursing audits and external review bodies)	
		Datasets reviewed in Directorate meetings and by GMB and IPCEHC.					
		Dashboard for each clinical area displayed on IPC notice board for staff, patients, relatives and carers to review.	Directors	30 Sept 2009	Med	Action plans developed if KPI's not met and actions monitored. Openness and honesty with respect to HCAI performance. Full engagement with service users with respect to same.	
		Feedback to individual clinical areas within directorate where sustained reduction in HCAI demonstrated and compliance with policy and procedure sustained.	Directors	30 Sept 2009	Med	Staff aware of performance of individual clinical area with respect to HCAI. Staff fully engaged in HCAI prevention. Evidence based policy and procedure integrated into clinical practice, 100% compliance with same.	
Nominated Directorate Lead for prevention of HCAI's appointed within operational directorate (currently being reviewed following organisational restructuring).	Monthly IPC Scorecard issued at directorate governance management meeting, performance reviewed and individual officers held to account for performance	Directors	30 Sept 2009	Med	NDL reports monthly to Directors at directorate governance meetings re: progress against delivery plan. NDL 's report monthly to DIPC at IPCEHC on directorate performance. Evidence based practice embedded in		

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	NHSCT Strategy for IPC to be developed.	<p>against KPI's..</p> <p>NHSCT Strategy for IPC developed and launched.</p> <p>Annual programme for HCAI developed from strategy document and presented to GMB and Trust Board for approval. Evidence base for clinical practice evaluated against research. Trust performance benchmarked against comparable organisations. Excellence in practice celebrated.</p>	<p>DIPC EDON</p> <p>DIPC</p>	<p>30 Sept 2009</p> <p>30 Sept 2009</p>	<p><b>Med</b></p> <p><b>Med</b></p>	<p>clinical practice. (evidenced by internal audit processes, peer review, quality assured by IPC nursing audits and external review bodies)</p> <p>Strategy for IPC reflecting regional, national and international priorities and standards for excellence in practice developed involving key stakeholders both internal and external to the organisation.</p> <p>Annual programme of audit, research, education and training reported to Trust Board in June of each year. Monthly reports of progress against annual plan reported through to DIPC for review by IPCEHC.</p>

Risks: Low = green    Med = amber    High = red

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2.0 Trust has a zero tolerance approach to HCAI.  RQIA IR 18  RQIA FR 9 / FR 15	CEO has communicated to all staff that HCAI bacteraemia / infections are avoidable and that the Trust is adopting a zero tolerance approach to same.	Clear expectation for compliance with policy and procedures reinforced to all staff.	CEO	Low	In place	Demonstrable delivery of sustained improvement on reducing HCAI's. (Performance data, external reviews) Trust achieves agreed trajectory on MRSA reduction and C. Difficile infections.
	Addendum to all staff contracts.	Accountability and responsibility for HCAI prevention embraced at all levels of the organisation. <i>'Infection control is everybody's business'</i> is reflected as a core value within the organisation	CEO	Low	In place	
		Executive team walkabouts to review individual clinical areas performance data and encourage and support staff efforts. Infection prevention and control notice board to display performance and compliance data to staff patients and visitors.	Directors	Low	30 June 2009	Public and patient confidence in NHSCT is improved and there are good news stories in the media about the Trust and the HCAI progress which is being sustained. (Client / service user feedback, service user questionnaires, reduction in complaints relating to IPC and environmental cleanliness)
	Disciplinary procedure issued to all staff.	Consequences of non-cooperation and / poor practice understood and acted upon. HR processes of induction, training and disciplinary action used to encourage and embed evidence based practice in IPC. Disciplinary procedures initiated where evidence based policy	Directors	Low	30 June 2009	Staff undertake procedures correctly every time, for every patient in every healthcare setting across the organisation. (HII data, hand hygiene audits, environmental cleanliness scores.) Incident reporting forms completed if policy is breached.

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		<p>and procedure not consistently reflected in clinical practice.</p> <p>Clinical incident reporting used as a means of countering complacency, raising awareness and generating directorate based investigation and action.</p> <p>IPC nurses highly visible in clinical areas to reinforce best practice and provide targeted support.</p> <p>Link nurses and Link nursing auxiliaries are supported to embed best practice and empowered to challenge and act upon poor practice. Evaluation of the role commitments and support for link practitioners being undertaken.</p>	<p>Directors</p> <p>EDON</p>	<p>Low</p> <p>Low</p> <p>Med</p>	<p>30 Sept 2009</p> <p>In place</p> <p>30 Sept 2009</p>	<p>Learning culture fostered with development and ownership of directorate based actions with respect to HCAI prevention.</p> <p>Log of clinical activity maintained by IPC nurses. Culture of high challenge and high support nurtured.</p> <p>Best evidence embedded in clinical practice. (evidenced by internal audit processes, peer review, quality assured by IPC nursing audits and external review bodies) Regular supervision sessions and education and training updates for IPC link practitioners.</p>
3.0 Staff have access to evidence based policy and procedure and	Link to Regional IPC Policy Manual on Trust Intranet. Working group established to harmonise regional and local policies to ensure consistent IPC	Harmonisation of regional and local policies reflecting relevant legislation and evidence based guidance completed.	DIPC	Med	30 Sept 2009	Policies, procedures and guidelines for the prevention and control of infection are implemented in all clinical areas Performance reports demonstrate a sustained reduction in HCAI's.

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demonstrate compliance.  RQIA FR 8 FR 15	practice across the Trust.	All staff have access to evidence based policy and protocols through intranet access or hard copy where intranet access not available.	Directors	Med	30 Sept 2009	Audit and regular local compliance monitoring ensure staff are consistently demonstrating safe, effective, evidence informed care. Staff demonstrate 100% compliance with policy and procedure to include Hand Hygiene, Uniform and Dress code policies, HII's.
	Clinical advisory role provided by IPC nursing team.	All policies, standards and guidelines are approved by IPCEHC and PSG (Trust policy review group) and disseminated to directorates by DIPC.	DIPC	Low	30 Sept 2009	Review of clinical activity monthly by Lead Nurse. IPC nurses role model proactive approach to prevention of HCAI's.
		Increased visibility of IPC nurses in all clinical areas. Frequency of visits dependant on risk rating of individual clinical areas. Development of risk rating tool for individual clinical areas and designation on the risk / confidence matrix dependant on performance and compliance with policy and procedure.	EDON	Low	In place	
	Multidisciplinary IPC audit programme being reviewed.	Rolling audit programme in place to measure compliance with key policies. Directorate compliance with key policies and procedures evidenced.	DIPC	Med	30 Sept 2009	Quality assurance of compliance with policy and procedures provided by unannounced observations of practice and IPS audits by IPC nurses.  Clinical staff held to account for re-designation on the risk / confidence matrix by directorate management team with reports through to IPCEHC.

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		Action plans to improve compliance developed and implemented by operational directorates with IPC nursing support. Monthly progress reports re: action plans and targeted support to IPCEHC.	Directors	Med	30 Sept 2009	by Directors to GMB quarterly  Best evidence embedded in clinical practice. (evidenced by internal audit processes, peer review, quality assured by IPC nursing audits and external review bodies)
4.0 High Impact Intervention Care Bundles become embedded in practice throughout the Trust.  RQIA FR 12	HII's not currently embedded across the Trust.	All relevant HII are embedded within clinical practice.  Risks associated with indwelling devices identified and mitigated through use of relevant HII.  Clinical ownership of HII's evident across the organisation.	EDON  Directors	Med  Med	31 Dec 2009  31 Dec 2009	All staff who care for patients with indwelling devices demonstrate 100% compliance with all care elements of HII care bundles as demonstrated by weekly audit data. Any non-compliance with HII's is documented, reported and immediate action taken to address poor practice.  Directors provide assurance to Trust Board that all relevant HII's have been implemented, that practice is embedded and that a system to monitor compliance and take action against poor performance is in place within their directorates (ie.KPI's). HII data presented monthly to IPCEHC and NET. Individual clinical teams are facilitated to identify the range of HII's relevant to the care setting and supported to incorporate same into clinical practice. IPC nurses continue to support staff and facilitate training for HII's.

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						IPC nurses audit clinical practice during unannounced visits to clinical areas and provide quality assurance re: robust nature of self assessment. Peer review of HII practice within and across operational directorates facilitated by Lead Nurses.
5.0 Surveillance of all alert organisms is enhanced by effective root cause analysis in all C difficile and MRSA / MSSA Bacteraemia cases.  <b>RQIA FR 13</b>	Alert organisms are reported regionally and monitored by Trust microbiologist.  Reported by exception to IPCEH.  Daily monitoring of cases of C Diff and weekly monitoring of MRSA / MSSA bacteraemia.  Pilot Root Cause Analysis process completed March 2009.	IPECH has full understanding of the role of surveillance of alert organisms and can recognise emerging problems at an early stage.  A formal root cause analysis process facilitated by staff trained in use of RCA is undertaken within specified timeframes.  RCA process facilitated by RCA lead with full engagement of	DIPC  DIPC	<b>Low</b>  <b>Med</b>	30 Sept 2009  31 Aug 2009	Annual IPC report demonstrates to Trust Board, surveillance activity. Quarterly reports to Trust Board report on trends in all alert organisms.  Sustained downward trend in cases of C Difficile and MRSA / MSSA bacteraemias (evidenced by internal reporting mechanisms and external review, trends reviewed against PfA targets )  RCA process embedded within the Trust process owned by clinical teams with

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	Process review conducted awaiting recommendations to develop action plan and embed process.	clinical teams. Further roll out of RCA training for front line clinical staff. Training needs analysis completed to identify staff requiring training to ensure confidence with process.				facilitation from IPC nurses and quality assurance provided by RCAL. Directorates produce evidence that RCA has been carried out within the specified timescale; reports generated by RCAL to NDL who will action practice improvements and drive practice change within the directorate. Delivery of training for front line clinical staff facilitated, evaluated and support given to facilitate integration into practice.
	Lack of ownership of RCA process in clinical areas.	Clinical engagement across operational directorates with clarity regarding roles and responsibilities and effective sharing of learning disseminated across the organisation by Governance department.	Directors	Med	31 Aug 2009	RCAL quality assures data, performs thematic analysis of RCA's and presents same to IPCEHC for debate and further analysis. Data forwarded to governance department to ensure opportunities for learning are disseminated across the trust.
	RCA data not used to hold individual clinical teams to account.	Multidisciplinary HCAI Review Panel holds individual officers to account for new cases of HCAI.	CEO DIPC DON	Med	31 July 2009	Staff held to account for performance of individual clinical area with respect to HCAI prevention. Zero tolerance principle actioned. Staff facilitated to reflect on impact of poor clinical practice on patient experience and patient outcome. Staff fully engaged in HCAI prevention. Evidence based policy and procedure integrated into clinical practice and 100% compliance with same.
	Successful application to GAIN to further refine RCA process.	Development of a regional RCA audit process.	DIPC	Low	31 March	Directorates will implement refined RCA process and support dissemination of

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					2010	learning throughout the Trust.

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6.0 All NHSCT staff are trained and obtain an annual update in IPC.  RQIA IR 8	NHSCT Training Strategy developed: <ul style="list-style-type: none"> <li>– induction for all staff</li> <li>– mandatory update for all clinical staff</li> <li>– mandatory update for nurses using different modalities</li> </ul> Directors currently implementing corporate reporting system to provide overview of uptake for staff groups. Uptake between staff groups varies from very low to very high.	Training delivery plan for nurses delivered by IPC nurses in collaboration with NEDC. Training delivery plan for other staff groups delivered in collaboration with Organisational Development Team.	EDON	Low	In place	Induction awareness training for new staff delivered as part of corporate induction process.  A programme of mandatory update for existing staff delivered annually. 95% clinical staff will have attended annual IPC update as evidenced by reports from corporate database.
	Directors currently implementing corporate reporting system to provide overview of uptake for staff groups. Uptake between staff groups varies from very low to very high.	Systems embedded in operational directorates to capture of IPC training statistics for all staff groups. Compliance with PfA target for annual training of 95% clinical staff. Directorate training statistics highlight where effort needs to be focused to comply with training requirements and action plans developed to ensure compliance is attained.	Directors	Med	30 June 2009	Process for gathering training statistics implemented within all directorates for all staff groups and forwarded to corporate centre for collation. Corporate database (Oncore) provides robust data with respect to training. Collated corporate training statistics demonstrate compliance with PfA target for IPC training. NDL reports re: directorate training statistics at directorate governance meetings and IPCEHC. Reports re: nurse training presented to NET. Corporate training figures reported to Trust Board quarterly.
	Low uptake of NHS e-learning programme in infection control.	Clinical staff are registered to use the e-learning package. Competency assessment sheets are available as evidence of completion of same.	Directors	Low	On-going	IPC Nurse seconded to NEDC to promote e-learning package and to engage clinical staff with same. Increased uptake of e-learning programme across the Trust.

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	<p>IPC is a key dimension for review in the appraisal process of all health care staff.</p> <p>Training tracker for medical staff being implemented in the Trust.</p>	<p>Clinical practice reflects best available evidence.</p> <p>Individual PDP reflect learning and development needs linked to HCAI prevention.</p> <p>Infection control integrated into consultant appraisals. Medical staff training records transferable across the region.</p>	<p>Directors</p> <p>DIPC</p>	<p>Low</p> <p>Low</p>	<p>On-going</p> <p>On-going</p>	<p>Reports from e-learning administration centre demonstrate sustained increase in level of uptake to projected annual levels required to comply with PFA targets.</p> <p>All staff understand personal responsibility and accountability for reduction in HCAI's. Staff committed to HCAI prevention. Evidence based policy and procedure integrated into clinical practice and 100% compliance with same.</p> <p>Transferability of robust training data for medical staff across region.</p>
7.0 The risk of transmission of infection is minimised through timely	GAIN Risk Assessment tool completed for all patient admissions / transfers	NHSCT continuously and systematically reviews, improves and applies best practice in assessment and management of risk to patients, staff and others when patients	DIPC	Low	In place	<p>Correct and timely placement of infective patients (suspected or proven) to control and minimise the risk of colonisation of other patients within the clinical area.</p> <p>Critical incident reporting initiated when</p>

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isolation and cohorting of infective patients.  <b>RQIA</b> <b>IR 5</b> <b>IR 6</b> <b>IR 18</b> <b>FR 11</b>	Developed and introduced tool to risk assess and appropriately manage single room occupancy and to prioritise the need for isolation facilities at ward level.	move from the care of organisation to another.  Isolation risk assessment tool (IRAT) implemented in all departments across the Trust. Trigger list to support staff in decision-making re: placement of infective patients Decision making by clinical staff quality assured by IPC nurses. IRAT tool rolled out across all acute facilities in the organisation.	EDON	<b>Low</b>	On-going	risk assessment forms not completed. (audit data will identify areas where additional focus is required to ensure compliance)  Robust systems provide evidence that available isolation rooms are used appropriately and where isolation requirements exceed capacity that patients are appropriately cohorted.
	Harmonising existing legacy Trust Bed Management policies.	Bed Management policy implemented across the organisation. Effective coordination of bed management with IPC nursing input.	DAS	<b>Low</b>	30 Sept 2009	Timely patient isolation and cohorting (evidenced from SOLVER system) Evidence from IRAT data to support local decision making re use of isolation rooms and appropriate patient placement. Detailed handover reports between nursing staff when transferring patients from one clinical area to another to ensure timely isolation and cohorting of infected patients and to minimise the risk of transmission. (Review of clinical incident reports when process not managed appropriately).
	Isolation Ward operationalised in Antrim Hospital, with associated	Daily review of capacity of isolation rooms across Trust compiled by Patient Flow team.	DIPC	<b>Low</b>	In place	Isolation ward with associated Escalation policy remains operational. Compliance with local policy for isolation facilities

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	Escalation policy. Isolation policy in use.	Clinical incident reporting used to highlight the number of occasions on which it is not possible to isolate patients. Regular review and analysis of incident reports by Patient Flow team and IPC nurses.				subject to regular monitoring and audit by clinical and domestic staff and quality assurance provided by IPC nurses unannounced visits and IPS audits. 100% compliance with local policies for environmental cleaning, equipment decontamination, waste and linen management demonstrated by clinical and domestic staff.
	Demand for single rooms outweighs current capacity.	New estates will have full compliment of single room accommodation. Options for increasing single room capacity within existing NHSCT estate maximised. Report from Trust Isolation Room Project Group will be implemented.	Directors	Med	On-going	Successful implementation of recommendations from Trust Isolation Room Project group.
	Some patients report that they have not been informed that they have MRSA.	All patients who are colonised or infected with MRSA and when appropriate, their carers, receive clear information about their infective status.	Directors	Med	On-going	Reduction in complaints from patients, GP's and carers.
8.0 Antimicrobial prescribing is consistent with best practice.	Antimicrobial guidance issued and available on Intranet and on hard copy in all clinical areas.	Prudent antibiotic stewardship evidenced across the organisation.	Directors	Low	In place	Antimicrobial guidance is reviewed and updated when new evidence directs a change in practice.

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RQIA IR 4 IR 18 IR 30 IR 31 IR 33 IR 34 IR 35 FR 9	Compliance audited. Audit results sent to DIPC. Audit findings are acted on to ensure continuous improvement	Expert antimicrobial stewardship committee led by antimicrobial pharmacist review antimicrobial prescribing against recommendations in local formulary. Clinicians fully engaged – compliance results disseminated to clinical directors. Prescribing culture with daily review, de-escalation from IV to oral therapy and maximum duration for antimicrobial therapy embedded across the organisation.	Directors	Low	In place	Processes for measuring compliance with policy integrated into practice. Run charts of compliance with prescribing policy reported through to IPCEHC. Clear process to address consistent non-compliance with antimicrobial guidance actioned. Antimicrobial audit fully integrated into annual IPC multidisciplinary audit programme.
9.0 Environmental cleaning will reflect best practice.	Daily assurance record agreed and signed off by Ward Manager and Domestic Supervisor.	Thoroughly clean buildings across the NHSCT estate. High levels of hygiene and cleanliness maintained. Role of nurse-in –charge as responsible officer for ensuring cleanliness throughout each shift clarified and actioned.	Directors	Low	In place	Evidence of sustained reduction in HCAI. Public and patient confidence in NHSCT is improved and there are good news stories in the media about the Trust and the HCAI progress which is being sustained. (Client / service user feedback, service user questionnaires, reduction in complaints relating to HCAI and environmental cleanliness)
RQIA FR 14	Daily cleaning schedule of patient equipment established on each ward.	Daily cleaning schedule of patient equipment maintained in all clinical areas and	Directors	Low	30 Sept 2009	Monthly patient questionnaires demonstrate high levels of patient satisfaction with levels of cleanliness.

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RQIA IR 18	Programme for deep cleaning in high and low risk areas established.	departments trust wide. Cleaning manuals available Trust wide and reviewed annually.  Deep cleaning programme maintained and evaluated.	Directors	Low	In place	Clutter free clinical areas as demonstrated by environmental cleanliness audits, IPC audits and unannounced inspections by external agencies.
	Monthly cleanliness matters audit results disseminated ward to board.	Monthly cleanliness matters audits maintained Trust wide with compliance > 85%.	Directors	Low	In place	Infection Prevention and Control notice boards at entrance to each ward demonstrating hand hygiene and environmental audit scores updated weekly. Audit of data available conducted by Lead Nurses and IPC nurses. Facilities management provide updates on environmental cleaning to ICC from EHC.
	Systems available to adapt the increased demands of environmental cleaning.	Flexibility demonstrated in responding to increased demands of environmental cleaning. Agreed process for introduction and monitoring of new cleaning products.	DSPMPM	Low	On-going	Responsive, flexible domestic services system to deliver on the increased demands of environmental cleaning. Comprehensive guidance re: approval and review of cleaning products.
	Rapid Response team in place – Causeway Hospital.	Rapid Response team established Trust wide.				Rapid Response Team maintained to meet the increased demands of environmental cleaning Trust wide.

**ASSURANCE FRAMEWORK - DEFINITIONS**

HCAI Corporate Objective: To achieve / exceed the PfA target for HCAI in the Northern Trust  
(C difficile – 10.5; MRSA 3.5; MSSA 2.5)

Local Sub Objective	Current Position	Future State	Exec Lead	Current Risk	Time Scale	Measure of Success (Evidence of Assurance to Trust Board )
The objectives / goals which will deliver the corporate objective of the organisation	Identify how things are now	What does the future look like? What is different because of the action(s)? Fully articulate the future state so the reader understands what success looks like.	Which executive is responsible for ensuring this objective is fulfilled?  Who reports to the Board?	What is the current risk of this objective not being delivered?  How business critical is it?  Risk rating		How is success going to be measured?  What is the acceptable behaviour?  What should happen in this organisation?  How is success being monitored and evidenced?

## GLOSSARY

AD – Assistant Director  
 CD – Clinical Director  
 C Diff – Clostridium Difficile  
 CEO – Chief Executive Officer  
 Cons – Consultants  
 DAS – Director of Acute Services  
 DD – Deputy Director of Nursing  
 DGM – Directorate Governance Managers  
 DIPC – Director of Infection Prevention Control  
 DOH – Department of Health  
 DON – Director of Nursing  
 DS – Domestic Supervisor  
 DSPMPM – Director of Strategic Planning, Modernisation and Performance Management  
 FR – Final Report  
 GAIN – Guidelines and Audit Implementation Network  
 GM – General Manager  
 GMB – Governance Management Board  
 HCAI – Healthcare Acquired Infection  
 HII – High Impact Interventions  
 HoD – Head of Department  
 HoG – Head of Governance and Patient Safety  
 HoP – Head of Pharmacy  
 HR – Human Resources  
 IPCEHC – Infection Prevention Control and Environmental Hygiene Committee  
 IPC – Infection Prevention Control  
 IPCD – Infection Prevention Control Doctor  
 IR – Interim Report  
 IRAT – Isolation Risk Assessment Tool  
 JD – Job description  
 KPI – Key Performance Indicator  
 LIPCN – Lead Infection Prevention Control Nurse  
 LN – Lead Nurse  
 MIPC – Multidisciplinary Infection Prevention Control Team  
 MRSA – Methicillin Resistant Staphylococcus Aureus  
 MSSA – Methicillin Sensitive Staphylococcus Aureus

NDL – Nominated Directorate Lead  
NET – Nursing Executive Team  
NEDC – Nursing Education and Development Consortium  
NHSCT – Northern Health and Social Care Trust  
OD - Organisational Development  
PfA – Priorities for Action  
PFM – Patient Flow Manager  
RCA – Root Cause Analysis  
RCAL – Root Cause Analysis Lead  
RQIA – Regulation Quality Improvement Authority  
SMT - Senior Management Team  
SSI – Surgical Site Infections  
TGM – Trust Governance Manager  
TPM - Trust Performance Manager  
VRE – Vancomycin Resistant Enterococcus  
WM - Ward Manager

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