Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Self-Assessment Tool for monitoring against the National Standards for the Prevention and Control of Healthcare-Associated Infections in Public Acute Hospitals

Date of issue:

PLEASE COMPLETE:

Hospital name:

Contents

About the self-assessment tool

- Under section 8(1)(c) of the Health Act 2007, the Health Information and Quality Authority (HIQA) has the remit and responsibility to monitor against the National Standards for the Prevention and Control of Healthcare Associated Infections.
- As part of a revised approach to monitoring against these standards, the following self assessment tool has been developed. All 49 acute public hospitals in Ireland are requested to complete and return this self-assessment tool to HIQA.
- The self-assessment tool has been adapted from the US Centers for Disease Control Infection Prevention and Control Assessment Tool for Acute Care Hospitals* to align with Irish national standards and guidelines.
- The self-assessment tool comprises a series of specific questions in relation to:
    - The hospital infection prevention and control programme
    - Training and implementation of related policies, procedures, protocols and guidelines
    - Systems to detect, prevent, and respond to healthcare-associated infections and multidrug-resistant organisms.
- It is the responsibility of the hospital Chief Executive Officer or General Manager to ensure that this self assessment tool is completed and returned with the documents requested to HIQA by 2pm on

* Reference: Infection Control Assessment Tool for Acute Care Hospitals. Centers for Disease Control and Prevention. U.S. Department of Health and Human Services. Version 1.3.2 September 2016. Available online from: https://www.cdc.gov/infectioncontrol/pdf/icar/hospital.pdf

Instructions for completing this self-assessment tool

1. This self-assessment tool is formatted as an interactive portable document which should be saved onto a desktop or laptop computer only. The self-assessment tool must only be completed electronically and not manually.
2. The lead respondent completing the self-assessment tool should first check that they can save and store this document using Adobe Reader only on the device they propose to use to complete this self-assessment tool. This will allow the self-assessment tool to be filled out in separate stages and at different times should this prove necessary. All entries in the self-assessment tool should be saved before closing the document to ensure that work is not inadvertently lost.
3. Please complete all sections by answering yes or no to each question. If necessary, please provide further information in the comment box at the end of each section. For example, if you do not accommodate mechanically ventilated inpatients in your hospital, please state so in the relevant comment box.
4. The hospital Chief Executive Officer/ General Manager **and** the Hospital Group Chief Executive Officer must sign the declaration included at the end of this self-assessment tool before submitting it to HIQA. This should be done to verify that the information provided accurately reflects the arrangements within the hospital.
5. Please ensure that the documents requested by HIQA are submitted at the same time as the completed self-assessment tool.
6. The completed self-assessment tool should be emailed to qualityandsafety@hiqa.ie for the attention of Joan Heffernan.

Lead respondent details

Please complete this section before proceeding to self-assessment questions:

Lead respondents name	
Lead respondents role title	
Lead respondents email address	
Lead respondents contact telephone number	

Section 1: Infection prevention and control programme			
1.1.1	The hospital has a formalised governance structure for infection prevention and control.	Yes ☐	No ☐
1.1.2	An annual infection prevention and control risk assessment is performed which takes into consideration potential risks for infection, contamination, and infection-related exposures in the hospital in addition to local and national antimicrobial resistance trends.	Yes ☐	No ☐
1.1.3	The hospital develops an annual infection prevention and control programme plan which includes priorities based on identified risks and the demographic profile of the population served by the hospital.	Yes ☐	No ☐
1.1.4	An annual infection prevention and control report is produced.	Yes ☐	No ☐
1.1.5	The hospital provides financial and human resource support for maintaining the infection prevention and control programme.	Yes ☐	No ☐
1.1.6	Written infection prevention and control policies, procedures and guidelines available in each clinical area are current, and are based on evidence-based best practice guidelines and national standards and safety alerts including those from the National Clinical Effectiveness Committee, the Health Protection Surveillance Centre, the Health Service Executive, HIQA and others as applicable.	Yes ☐	No ☐
1.1.7	The performance of the service in relation to the prevention and control of healthcare-associated infection is continuously monitored within the hospital. There is measurement of performance indicators and targets that are relevant to the service.	Yes ☐	No ☐
1.1.8	There is reporting in relation to prevention and control of healthcare-associated infection performance through formalised governance structures.	Yes ☐	No ☐
1.1.9	Written reports are prepared following significant outbreaks of infection to identify opportunities for improvement.	Yes ☐	No ☐
1.1.10	Information about infection prevention and control is provided to patients and their carers and or visitors.	Yes ☐	No ☐
Please insert additional comment or clarification below related to this section of the tool, with reference to the question number where relevant			

Section 2: Infection prevention and control training and implementation of policies, procedures, protocols and guidelines			
2.1: Standard and transmission-based precautions			
2.1.1	The hospital has an up to date hand hygiene policy that is in line with current national guidelines.	Yes ☐	No ☐
2.1.2	Hospital hand hygiene policy promotes preferential use of alcohol-based hand hygiene products over soap and water except when hands are visibly soiled or after caring for patients known or suspected to have *Clostridium difficile* infection.	Yes ☐	No ☐
2.1.3	Completion of hand hygiene training for healthcare workers is mandatory at least every two years and at induction.	Yes ☐	No ☐
2.1.4	Facilities and supplies necessary for implementation of standard and transmission-based precautions are made available and are accessible to personnel in clinical areas.	Yes ☐	No ☐
2.1.5	A multi-modal hand hygiene improvement strategy is followed in the hospital and the implementation of this is reviewed periodically.	Yes ☐	No ☐
2.1.6	The hospital regularly audits hand hygiene practices and feeds the results of any audits back to relevant personnel and senior management and reports hand hygiene performance in line with national reporting requirements. Audits are linked to an improvement programme as indicated.	Yes ☐	No ☐
2.1.7	Mandatory infection prevention and control training is provided to relevant personnel at induction and periodically in line with the national Core Infection Prevention and Control Knowledge and Skills framework document 2015.	Yes ☐	No ☐
2.1.8	Training is provided to all personnel who may need to use personal protective equipment (PPE) which includes 1) appropriate indications for specific PPE components, 2) proper donning, doffing, adjustment, and wear of PPE, and 3) disposal of PPE. This is provided at induction and periodically.	Yes ☐	No ☐

2.1.9	The hospital audits the implementation of national healthcare-associated infection guidelines and its own policies, procedures and guidelines. Audits are linked to an improvement programme as indicated.	Yes ☐	No ☐
Please insert additional comment or clarification below related to this section of the tool, with reference to the question number where relevant			

2.2: Prevention of catheter-associated urinary tract Infection (CAUTI)			
2.2.1	The hospital has a competency-based training program for all clinical personnel who **insert** urinary catheters.	Yes ☐	No ☐
2.2.2	The hospital regularly audits (monitors and documents) adherence to recommended practices for **insertion** of urinary catheters.	Yes ☐	No ☐
2.2.3	The hospital provides feedback from audits to personnel regarding their performance for **insertion** of urinary catheters.	Yes ☐	No ☐
2.2.4	Evidence-based urinary catheter care bundles have been implemented across the hospital.	Yes ☐	No ☐
2.2.5	The hospital regularly audits (monitors and documents) adherence to evidence-based urinary catheter care bundles.	Yes ☐	No ☐
2.2.6	The hospital provides feedback from audits to personnel regarding their adherence to evidence-based urinary catheter care bundles.	Yes ☐	No ☐
2.2.7	The hospital monitors CAUTI data and uses this information to direct prevention activities.	Yes ☐	No ☐
2.2.8	The hospital provides feedback of CAUTI data to frontline personnel.	Yes ☐	No ☐
Please insert additional comment or clarification below related to this section of the tool, with reference to the question number where relevant			

2.3: Prevention of intravascular catheter-related bloodstream infection			
2.3.1	The hospital has an up to date policy detailing measures to prevent intravascular catheter-related bloodstream infection that includes care bundle elements.	Yes ☐	No ☐
2.3.2	The hospital has a competency-based training program for all clinical personnel who **insert** intravascular catheters.	Yes ☐	No ☐
2.3.3	Training is provided to all personnel who are given responsibility for insertion of intravascular catheters.	Yes ☐	No ☐
2.3.4	Training is provided when new equipment or protocols are introduced for the management of intravascular catheters.	Yes ☐	No ☐
2.3.5	The infection prevention and control team are consulted before new equipment or protocols for the management of intravascular catheters are introduced.	Yes ☐	No ☐
2.3.6	The hospital regularly audits (monitors and documents) adherence to recommended practices for **insertion** of intravascular catheters.	Yes ☐	No ☐
2.3.7	The hospital provides feedback from audits to personnel regarding their performance for **insertion** of intravascular catheters.	Yes ☐	No ☐
2.3.8	Evidence-based intravascular catheter care bundles have been implemented across the hospital.	Yes ☐	No ☐
2.3.9	The hospital regularly audits (monitors and documents) adherence to evidence-based intravascular catheter care bundles.	Yes ☐	No ☐
2.3.10	The hospital provides feedback from audits to personnel regarding their adherence to evidence-based intravascular catheter care bundles.	Yes ☐	No ☐
2.3.11	The hospital monitors intravascular catheter-related infection and uses this information to direct prevention activities.	Yes ☐	No ☐

2.3.12	The hospital provides feedback of intravascular catheter-related infection data to frontline personnel.	Yes ☐	No ☐

Please insert additional comment or clarification below related to this section of the tool, with reference to the question number where relevant

2.4: Prevention of ventilator-associated pneumonia (Please leave this section blank if you do not manage mechanically ventilated inpatients in your hospital)			
2.4.1	The hospital has an up to date policy detailing measures to prevent ventilator-associated pneumonia that includes care bundle elements.	Yes ☐	No ☐
2.4.2	Regular training is provided to relevant clinical personnel in relation to the prevention of ventilator-associated pneumonia.	Yes ☐	No ☐
2.4.3	Evidence-based ventilator-associated pneumonia care bundles have been implemented in clinical areas accommodating ventilated patients.	Yes ☐	No ☐
2.4.4	The hospital regularly audits (monitors and documents) ventilator-associated pneumonia care bundle compliance.	Yes ☐	No ☐
2.4.5	The hospital provides feedback from audits to personnel regarding their compliance with ventilator-associated pneumonia care bundles.	Yes ☐	No ☐
2.4.6	The hospital performs ventilator-associated pneumonia infection surveillance and uses this information to direct prevention activities.	Yes ☐	No ☐
2.4.7	The hospital provides regular feedback of ventilator-associated pneumonia infection data to frontline personnel.	Yes ☐	No ☐
Please insert additional comment or clarification below related to this section of the tool, with reference to the question number where relevant			

2.5: Safe injection practice			
2.5.1	The hospital has competency-based training programs for multi-disciplinary personnel involved in the preparation and administration of parenteral medications (e.g. by intravenous, intramuscular and subcutaneous routes) outside of the pharmacy.	Yes ☐	No ☐
2.5.2	Training is provided on induction and prior to being allowed to prepare and/or administer injections and parenteral infusions.	Yes ☐	No ☐
2.5.3	Training is provided to relevant personnel when new equipment or protocols are introduced in relation to the preparation and administration of parenteral medications.	Yes ☐	No ☐
2.5.4	Personnel are required to demonstrate competency in the preparation and/or administration of injections and parenteral infusions following each training.	Yes ☐	No ☐
2.5.5	The hospital maintains current documentation of competency in preparation and/or administration procedures for all personnel who prepare and/or administer injections and parenteral infusions.	Yes ☐	No ☐
2.5.6	The hospital regularly audits (monitors and documents) adherence to safe injection practices.	Yes ☐	No ☐
2.5.7	The hospital provides feedback of safe injection practice audit findings to frontline personnel.	Yes ☐	No ☐
2.5.8	The hospital has up to date policies around the administration of medications by injection or infusion.	Yes ☐	No ☐
2.5.9	Multi use vials are avoided wherever possible.	Yes ☐	No ☐
2.5.10	Insulin multi-dose vials and insulin pens are designated single patient use.	Yes ☐	No ☐
2.5.11	Retractable lancets/needles used for capillary blood testing are single use only.	Yes ☐	No ☐

Please insert additional comment or clarification below related to this section of the tool, with reference to the question number where relevant

2.6: Prevention of Surgical Site Infection (SSI)			
2.6.1	The hospital has implemented national recommendations in relation to the prevention of surgical site infection.	Yes ☐	No ☐
2.6.2	The hospital has a surgical site infection prevention policy that reflects up to date evidence-based recommendations in relation to pre-operative, intra-operative and post-operative management of patients.	Yes ☐	No ☐
2.6.3	The hospital regularly audits (monitors and documents) implementation of recommended measures to prevent surgical site infection.	Yes ☐	No ☐
2.6.4	The hospital provides feedback from audits to personnel regarding their implementation of measures to prevent surgical site infection.	Yes ☐	No ☐
2.6.5	Patients and or their carers or other service providers are provided with advice in relation to post operative wound care.	Yes ☐	No ☐
2.6.6	The hospital monitors surgical site infection rates (in targeted patient groups) and antimicrobial resistance surveillance data and uses findings to direct prevention activities.	Yes ☐	No ☐
2.6.7	The hospital provides feedback of surgical site infection data to surgeons and other relevant clinical personnel.	Yes ☐	No ☐
2.6.8	The information collected and analysed from surgical site infection surveillance and audit is used to evaluate and support the activities and effectiveness of the programme to prevent and control surgical site infections. This is reported regularly to senior management.	Yes ☐	No ☐
Please insert additional comment or clarification below related to this section of the tool, with reference to the question number where relevant			

2.7: Prevention of *Clostridium difficile* infection (CDI)			
2.7.1	The hospital performs CDI surveillance and uses the information gathered to direct prevention activities.	Yes ☐	No ☐
2.7.2	The hospital has an up to date policy detailing measures to manage patients with CDI that includes care bundle elements.	Yes ☐	No ☐
2.7.3	The hospital reviews CDI data in conjunction with other relevant indicators at clinical area/directorate and hospital management level at least every four weeks and more often during an outbreak.	Yes ☐	No ☐
2.7.4	The hospital has a locally defined threshold incidence for CDI that triggers implementation of additional infection prevention and control precautions.	Yes ☐	No ☐
2.7.5	The hospital has specific antimicrobial stewardship strategies in place to reduce the incidence of *Clostridium difficile* infection.	Yes ☐	No ☐
2.7.6	At a minimum, systems analysis is performed for each episode of severe CDI and all cases of CDI associated with a cluster or an outbreak of infection.	Yes ☐	No ☐
2.7.7	The hospital provides feedback of CDI data to frontline personnel.	Yes ☐	No ☐
2.7.8	The hospital formally reviews management of CDI outbreaks/clusters in order to identify precipitating factors and necessary control measures.	Yes ☐	No ☐
2.7.9	It is hospital policy that patients with potentially infectious diarrhoea are promptly isolated in a single ensuite room until an infective cause is ruled out.	Yes ☐	No ☐

Please insert additional comment or clarification below related to this section of the tool, with reference to the question number where relevant

2.8: Environmental and patient equipment cleaning			
2.8.1	There is a designated person with delegated responsibility for the management of environmental and patient equipment hygiene in the hospital.	Yes ☐	No ☐
2.8.2	Training is provided to all personnel who clean and disinfect patient care areas and patient equipment. Personnel may include, but are not limited to, hospital cleaning staff, clinical staff, healthcare assistants, porters and ancillary staff.	Yes ☐	No ☐
2.8.3	Training is provided to personnel prior to being allowed to perform environmental and equipment cleaning.	Yes ☐	No ☐
2.8.4	Training is provided when new equipment or protocols are introduced for environmental and equipment cleaning.	Yes ☐	No ☐
2.8.5	If the hospital contracts environmental services, the contractor has a comparable staff training program.	Yes ☐	No ☐
2.8.6	The hospital has a cleaning specification or matrix that identifies elements to be cleaned, method of cleaning, frequency of cleaning and discipline responsible, in line with national cleaning guidelines.	Yes ☐	No ☐
2.8.7	The hospital provides the necessary resources and facilities for environmental and patient equipment cleaning.	Yes ☐	No ☐
2.8.8	The hospital has protocols to ensure that healthcare personnel can readily identify equipment that has been cleaned and disinfected and is ready for patient use (e.g. tagging system, placement in dedicated clean area).	Yes ☐	No ☐
2.8.9	The hospital regularly audits (monitors and documents) adherence to cleaning and disinfection procedures, including use of products in accordance with manufacturers' instructions (e.g., dilution, storage, shelf-life, contact time).	Yes ☐	No ☐
2.8.10	The hospital provides feedback from audits to personnel regarding their adherence to cleaning and disinfection procedures.	Yes ☐	No ☐
2.8.11	The hospital regularly audits (monitors and documents) the standard of environmental and patient equipment hygiene across the hospital. Audit findings are trended and linked to an improvement plan as indicated.	Yes ☐	No ☐

2.8.12	The standard of environmental and patient equipment hygiene is overseen and continuously monitored at senior management level in the hospital.	Yes ☐	No ☐

Please insert additional comment or clarification below related to this section of the tool, with reference to the question number where relevant

2.9: Device reprocessing

This section refers to all medical devices that may be reused in the hospital. Device categories include:

- Critical items (e.g. surgical instruments) are objects that enter sterile tissue or the vascular system and must be sterile prior to use.
- Semi-critical items (e.g. endoscopes for upper endoscopy and colonoscopy, laryngoscope blades, ultrasound probes) are objects that contact mucous membranes or non-intact skin and require, at a minimum, high-level disinfection prior to reuse.
- Non-critical items (e.g. blood pressure cuffs, point-of-care devices) are objects that may come in contact with intact skin but not mucous membranes and should undergo cleaning and low or intermediate-level disinfection depending on the nature and degree of contamination.

2.9.1	The hospital has a named decontamination co-ordinator with responsibility for reusable invasive medical device reprocessing.	Yes ☐	No ☐
2.9.2	Decontamination of medical devices at the hospital is overseen by a decontamination committee.	Yes ☐	No ☐
2.9.3	The hospital has an inventory of all **critical and semi-critical devices** used in the facility that identifies areas in the hospital and services provided by the hospital where such devices are used.	Yes ☐	No ☐
2.9.4	Decontamination of critical items and semi-critical items is performed in a designated decontamination area in line with best practice guidelines.	Yes ☐	No ☐
2.9.5	The hospital has up to date policies and procedures for the reprocessing of all reusable invasive medical devices used in and by the facility in line with relevant national guidelines.	Yes ☐	No ☐
2.9.6	The hospital has a competency-based training program for reprocessing of **critical and semi-critical** devices.	Yes ☐	No ☐
2.9.7	There is a continuing programme of training and education for personnel involved in device decontamination.	Yes ☐	No ☐
2.9.8	The hospital regularly audits (monitors and documents) adherence to reprocessing procedures for **critical and semi-critical** devices.	Yes ☐	No ☐

2.9.9	The hospital provides feedback from audits to relevant personnel and hospital management regarding adherence to reprocessing procedures for **critical and semi-critical** devices.	Yes ☐	No ☐
2.9.10	Single-use devices (SUDs) labelled by the manufacturer for a single use are not reprocessed.	Yes ☐	No ☐
2.9.11	The hospital allows adequate time for reprocessing to ensure adherence to all steps recommended by the device manufacturer, including drying and proper storage.	Yes ☐	No ☐
2.9.12	The hospital has an adequate supply of instruments for the volume of procedures performed to allow sufficient time for all reprocessing steps.	Yes ☐	No ☐
2.9.13	The hospital has a service level agreement outlining governance and accountability arrangements with respect to external contractor's involvement in device handling and where decontamination services are outsourced.	Yes ☐	No ☐
2.9.14	The hospital has a standard operating procedure in place based on national guidelines if devices are loaned, borrowed or trialled to minimise the risk of infection to patients, personnel and others.	Yes ☐	No ☐
2.9.15	If chemicals used for high-level disinfection are not single use, routine testing for appropriate concentration is performed and replacement of chemicals is documented.	Yes ☐	No ☐
2.9.16	Each step of the decontamination cycle is recorded, including the identity of the person undertaking each step.	Yes ☐	No ☐
2.9.17	The infection prevention and control team is consulted whenever new devices or products are to be purchased or introduced to ensure implementation of appropriate reprocessing policies and procedures.	Yes ☐	No ☐
2.9.18	All reusable invasive medical device sets (e.g. surgical instrument sets) and endoscopes can be traced through the decontamination process to the patient.	Yes ☐	No ☐
2.9.19	The hospital has policies and procedures outlining hospital response (i.e. risk assessment and recall of device, look back) in the event of a reprocessing error or failure.	Yes ☐	No ☐

2.9.20	The hospital central decontamination unit operates a quality management system in line with EN ISO 13485.	Yes ☐	No ☐
2.9.21	Endoscope and local decontamination units operate a quality system in line with the key elements of EN ISO 13485.	Yes ☐	No ☐
2.9.22	Personnel trained in decontamination practice are available to reprocess reusable invasive medical devices for out of hours unplanned emergency procedures if there is a requirement to decontaminate the device immediately following use e.g. an endoscope.	Yes ☐	No ☐
2.9.23	The hospital has up to date policies and procedures to minimise the exposure of patients and employees to transmissible spongiform encephalopathies.	Yes ☐	No ☐
Please insert additional comment or clarification below related to this section of the tool, with reference to the question number where relevant			

Section 3: Systems to detect, prevent, and respond to healthcare-associated infections and multidrug-resistant organisms (MDROs)			
3.1.1	The hospital has systems in place for the early detection and management of potentially infectious persons **at initial points of entry to the hospital**, including rapid isolation as appropriate.	Yes ☐	No ☐
3.1.2	Admission to another hospital, travel and occupational history is included as part of a patient's admission and triage assessment.	Yes ☐	No ☐
3.1.3	The hospital has up to date policies detailing measures to prevent the transmission of infection in line with relevant national and international guidelines.	Yes ☐	No ☐
3.1.4	The hospital has systems in place for early detection and isolation of potentially infectious patients identified **during the hospital stay,** including rapid isolation of patients as appropriate.	Yes ☐	No ☐
3.1.5	The hospital has systems in place for **INTER-facility** communication of infectious status and isolation needs of patients **prior to admission from and transfer to** other facilities.	Yes ☐	No ☐
3.1.6	The hospital has systems in place for communication of infectious status and related future care needs of patients **prior to or upon transfer of care to** primary healthcare providers e.g. GP, public health nurse, or primary care team.	Yes ☐	No ☐
3.1.7	The hospital has a surveillance programme to monitor incidence of epidemiologically important organisms and targeted healthcare-associated infections.	Yes ☐	No ☐
3.1.8	The microbiological service has a system in place to rapidly report alert organisms to the treating healthcare professional and the infection prevention control team that is accompanied by expert advice.	Yes ☐	No ☐
3.1.9	The hospital uses surveillance data to implement corrective actions rapidly when transmission of epidemiologically important organisms or increased rates or persistently elevated rates of healthcare-associated infections are detected.	Yes ☐	No ☐
3.1.10	The hospital has systems in place to facilitate the prompt identification of suspected/confirmed outbreaks of infection.	Yes ☐	No ☐

3.1.11	Outbreaks of infection are managed in line with local policies and procedures and national guidelines.	Yes ☐	No ☐
3.1.12	There is oversight of outbreak management at executive management level at the hospital.	Yes ☐	No ☐
3.1.13	Findings from outbreak investigations are used to improve the services provided.	Yes ☐	No ☐
3.1.14	The hospital has an antimicrobial stewardship programme in place in line with national guidelines.	Yes ☐	No ☐
3.1.15	The hospital screens patients for multi-drug resistant organisms in line with current national guidelines for Meticillin resistant *Staphylococcus aureus* (MRSA), multi-drug resistant organisms excluding MRSA and resistant enterobacteriaceae.	Yes ☐	No ☐
3.1.16	Patients with a history of admission to another Irish hospital are screened for Carbapenemase resistant Enterobacteriaceae, as necessary, after consideration of the source hospital history and the unit/s into which the patient will be admitted, in line with current national guidelines.	Yes ☐	No ☐
3.1.17	Patients with suspected or confirmed multi-drug resistant organism colonisation or infection are isolated in line with current national guidelines.	Yes ☐	No ☐
3.1.18	The hospital has an occupational health programme that has policies regarding the management of personnel with potentially transmissible conditions and the management of personnel that have been exposed to transmissible infection.	Yes ☐	No ☐
3.1.19	The hospital offers immunisation to healthcare personnel in line with the recommendations of the National Immunisation Advisory Committee.	Yes ☐	No ☐
3.1.20	The hospital is compliant with mandatory reporting requirements for notifiable diseases, healthcare-associated infections (as appropriate), and potential and confirmed outbreaks.	Yes ☐	No ☐
3.1.21	The Infection Prevention and Control Team are involved in discussions around planned construction and or demolition of and renovation and repairs to hospital buildings.	Yes ☐	No ☐

3.1.22	The hospital implements control measures relevant to construction, renovation, demolition and repairs including the performance of an infection control risk assessment before work commencement.	Yes ☐	No ☐
3.1.23	The Infection Prevention and Control Team are involved in the planning of new facilities, procurement of new equipment and the provision of new services at the hospital in relation to infection prevention and control implications.	Yes ☐	No ☐
3.1.24	The hospital implements preventative measures relevant to water-borne infection including the performance and annual review of risk assessment in line with national guidelines. Risks identified are addressed within recommended timeframes.	Yes ☐	No ☐
3.1.25	The hospital has implemented additional control measures in relation to water borne infection in augmented care units including intensive care units, neonatal high dependency units, burns units and transplant units.	Yes ☐	No ☐
Please insert additional comment or clarification below related to this section of the tool, with reference to the question number where relevant			

Declaration to be completed by the hospital Chief Executive Officer/General Manager and by the hospital group Chief Executive Officer

I declare, that to the best of my knowledge and belief, all of the information that I have given in connection with this self-assessment, is full and correct. I am aware that under the Health Act 2007 it is an offence to provide false or misleading information.

For Chief Executive Officer/General Manager

Name:

Signed:

Date:

For Hospital Group Chief Executive Officer

Name:

Signed:

Date:

Please note that this form can be signed electronically if the user has a previously existing digital signature. However if the user does not have an existing digital signature, or does not wish to create one, then please print, physically sign and scan page 18 of this document and return it as an extra attachment with this tool.