Infection prevention and control standards

For health and adult social care settings

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Healthcare Improvement Scotland | Evidence
Advice, guidance and intelligence

NHS SCOTLAND

We are committed to advancing equality, promoting diversity and championing human rights. These standards are intended to enhance improvements in health and social care for everyone, regardless of their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation, socioeconomic status or any other status. Suggested aspects to consider and recommended practice throughout these standards should be interpreted as being inclusive of everyone living in Scotland.

We carried out an equality impact assessment (EQIA) to help us consider if everyone accessing health and social care services will experience the intended benefits of these standards in a fair and equitable way. A copy of the EQIA is available on request.

Healthcare Improvement Scotland is committed to ensuring that our standards are up-to-date, fit for purpose and informed by high-quality evidence and best practice. We consistently assess the validity of our standards, working with partners across health and social care, the third sector and those with lived and living experience. We encourage you to contact the standards and indicators team at his.standardsandindicators@nhs.scot to notify us of any updates that the infection prevention and control standards project team may need to consider.

Contents

Introduction

Infection prevention and control (IPC) is critical to keeping people safe when they are receiving health and social care. Effective IPC can help reduce the risk of infection and ensure the safety of people receiving care, staff and visitors. IPC is integral to quality health and social care delivery because anyone is at risk of developing an infection in these settings. Factors that are known to increase this risk include extremes of age (for example being older or very young), the complexity of interventions that are part of a person's care and prolonged or inappropriate use of antimicrobials.[1]

Good IPC practice can help to reduce the prevalence of infections (including healthcare-associated infections - HAIs[2]) that are associated with the delivery of care in hospitals, long-term care facilities (including care homes) and other care settings (such as ambulances, prisons, hospices and independent healthcare facilities).

HAIs can occur as a direct or indirect result of healthcare and treatment including the environment or setting where care is delivered.[3] Some HAIs are acquired through medical or surgical treatment (for example catheter-associated urinary tract infections) or from exposure to a pathogen within a health or social care environment (for example spread of an influenza virus within a hospital ward or care home). Common examples of HAIs include respiratory, urinary tract and gastric infections.

HAIs range from minor infections that require minimal intervention to more significant infections which cause illness and can have serious emotional and medical consequences for people. These consequences have financial implications for the health and social care system in Scotland.[1, 4]

All health and social care staff have an important role to play in preventing the spread of infection by recognising that IPC is everybody's responsibility. Though, not all HAIs are preventable because of factors including a person's pre-existing conditions or the complexity of the treatment they are receiving.

Infection prevention and control standards

IPC standards are a key component in the drive to reduce the risk of infections in health and social care in Scotland. Standards support:

- organisations to quality assure their IPC practice and approaches, and
- the IPC principles set out in the National Infection Prevention and Control Manual.[2]

A single set of standards has been developed for use across health and adult social care. This will support the *Once for Scotland* approach and further integration of health and social care.

Standards underpin Healthcare Improvement Scotland's programme of inspection of the safety and cleanliness in acute and community hospitals.

The Care Inspectorate inspects services using self evaluation frameworks (which include IPC practice) that are informed by standards and the National Infection Prevention and Control Manual.[2, 5-7]

These standards are informed by current evidence, best practice and stakeholder recommendations and supersede Healthcare Improvement Scotland's HAI standards published in 2015. More information about the standards development process can be found at Appendix 1.

Policy context

Since March 2020, services across health and social care have responded to the significant challenges of the COVID-19 pandemic. The pandemic has reinforced the importance of a strategic organisational approach to IPC to ensure that people receiving health and social care, their representatives, staff and visitors experience safe, effective and person-centred care, including in the environment where care is delivered.

The health and care built environment where health and care is delivered can play a significant role in reducing the transmission of infection. In June 2021, NHS Scotland Assure was launched by NHS National Services Scotland. This new national body aims to strengthen IPC in the built environment through oversight of the design, construction and maintenance of major infrastructure developments within the NHS. NHS Scotland Assure will play a pivotal policy and guidance role in relation to incidents and outbreaks across NHSScotland.

In addition, the Care Inspectorate has developed guidance that sets out design, planning and construction considerations for new or converted care homes for adults.These standards align with and support the work of NHS Scotland Assure and the Care Inspectorate.[8]

IPC standards have been developed to complement the National Infection Prevention and Control Manual and Infection Prevention and Control Manual for older people and adult care homes.[2] **Please note: one reference to the National Infection Prevention and Control Manual (which includes the Infection Prevention and Control Manual for older people and adult care homes) has been cited in these standards. Organisations should apply the context specific elements of the manual to their area of practice.**

In addition to local guidance and standard operating procedures, the standards should be read alongside other relevant legislation, policies and guidance. In particular:

- National Infection Prevention and Control Manual[2]
- HAI Compendium: Guidance and resources[9]
- Health and Social Care Standards: my support, my life[10]
- National Health and Wellbeing Outcomes Framework[11]
- Queen Elizabeth University Hospital/NHS Greater Glasgow and Clyde Oversight Board: final report[12]
- Recover, Restore, Renew. Chief Medical Officer for Scotland Annual Report[13]
- Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011[14]
- Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011[15]
- Vale of Leven Hospital Inquiry[16]
- UK 5-year action plan for antimicrobial resistance 2019 to 2024[17]
- Patient Rights (Scotland) Act 2011[18]
- Scotland's public health priorities, and
- other applicable Healthcare Improvement Scotland guidance, including Scottish Intercollegiate Guidelines Network (SIGN) guidelines and Scottish Antimicrobial Prescribing Group (SAPG) guidance and Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) Scotland guidance.

IPC standards are intended to complement, not duplicate, existing standards and guidelines. Reference to appropriate and relevant documentation has been made throughout the standards to signpost organisations and staff to further information. These references are not an exhaustive list. Organisations, services and staff should continue to refer to appropriate and applicable professional guidance, policy and best practice appropriate to the setting where care is being delivered.

Scope of the standards

These standards were commissioned by the Chief Nursing Officer Directorate on behalf of the Scottish Government and co-produced with national and local stakeholders. They are based on current evidence and best practice and are considered to be a requisite of safe, high-quality care in all settings. As such, it is the Scottish Government's expectation that they will be adhered to across all health and social care settings including NHSScotland settings, independent healthcare and adult social care including care homes. The Care Inspectorate and Healthcare Improvement Scotland will take these into account during all relevant scrutiny and regulatory activities.

For more information about Healthcare Improvement Scotland's scrutiny work, see reporting on quality and safety of healthcare in Scotland (healthcareimprovementscotland.org) and for information about how Healthcare Improvement Scotland regulates the Independent Healthcare sector see Regulation of independent healthcare (Healthcareimprovementscotland.org). For more information on regulatory framework in social care settings see the Care Inspectorate's quality framework for care homes for adults and quality frameworks.

All other health (including independent healthcare) and adult social care organisations and settings (including adult day care) are encouraged to adopt the standards as good practice.

Where a principle or criterion applies to a specific setting this has been highlighted throughout the document. The standards should be reviewed pragmatically by service providers. Individual criteria will be applied by service providers in different ways in recognition of the breadth of services and support delivered across health and social care in Scotland.

While NHSScotland and older people and adult care home organisations and settings are expected to meet the standards, the detailed implementation of this document is for local determination.

The standards cover the following areas:

- leadership and governance
- education and training
- communication
- assurance and monitoring systems
- optimising antimicrobial use*
- infection prevention and control policies, procedures and guidance
- clean and safe care equipment
- the built environment, and
- acquisition and provision of equipment.

* including, but not limited to antibiotics.

Using the standards for self evaluation, assurance and improvement

All our standards follow the same format. Each standard includes:

- a statement of the level of performance to be achieved
- a rationale providing reasons why the standard is considered important
- a list of criteria describing the required structures, processes and outcomes
- what to expect if you are a person experiencing care
- what is expected if you are a member of staff, and
- what the standards mean for organisations, including examples of evidence of achievement.

These standards have been published to inform organisational internal quality improvement, self evaluation and improvement. Organisations and services, for example NHS boards or older people and adult care home providers are responsible for implementing and monitoring compliance against these standards.

Healthcare Improvement Scotland and the Care Inspectorate may use these standards in a range of assurance and inspection activities. They may be used to assess registration applications, where appropriate, and review the quality of health and social care services.

Healthcare Improvement Scotland Quality Management System

The Healthcare Improvement Scotland Quality Management System (QMS) describes the key components and functions of a common framework that can be applied across different settings to support delivery of high-quality care.

Within a QMS, services take a holistic and evidence-informed approach to plan for quality including assessing what needs to change; apply quality improvement approaches to measure that changes have delivered improvement; and establish quality control mechanisms to ensure that changes are embedded and sustained in the system. A learning system is the way services use knowledge, evidence and evaluation to keep improving, measure how they are meeting their aims, and to learn and share with others.

Health and social care services are facing considerable financial and workforce challenges. These pressures could lead to a reduction in the quality of care being delivered. This in turn increases the need for a consistent approach to the management of quality, built on evidence and best practice. More information about this framework is available on the Healthcare Improvement Scotland website.

Terminology

Wherever possible, we have incorporated generic terminology, written in plain English, that can be applied across all health and social care settings:

- 'healthcare organisations' refers to all services delivered by NHS boards and independent healthcare providers
- 'social care organisations' specifically refers to providers of adult social care, and
- 'staff' refers to health and social care staff, students and volunteers.

Some sections of the standards document are technical, for example they outline specific aspects of care. Where technical terms have been included, for example *invasive device* or *antimicrobial stewardship*, these are defined in the glossary in Appendix 3. Hyperlinks to these definitions have been included throughout the document.

Summary of standards

Standard 1:   **Leadership and governance**

The organisation demonstrates effective leadership and governance in IPC.

Standard 2:   **Education and training**

Staff are supported to undertake IPC education and training, appropriate to their role, responsibilities and workplace setting, to enable them to minimise infection risks in care settings.

Standard 3:   **Communication**

The organisation implements robust communication systems and processes to enable person-centred decision making, continuity of care and effective IPC throughout a person's care experience.

Standard 4:   **Assurance and monitoring systems**

The organisation uses robust assurance and monitoring systems to ensure there is a co-ordinated and rapid response to reduce the risk of infections and to drive continuous quality improvement in IPC.

Standard 5:   **Optimising antimicrobial use**

The organisation demonstrates reliable systems and processes for antimicrobial stewardship to support optimal antimicrobial use.

Standard 6:   **Infection prevention and control policies, procedures and guidance**

The organisation uses evidence-based IPC policies, procedures and guidance.

Standard 7:   **Clean and safe care equipment**

The organisation ensures that care equipment is cleaned, maintained and safe for use.

Standard 8:   **The built environment**

The organisation ensures that infection risks associated with the health and care built environment are minimised.

Standard 9:   **Acquisition and provision of equipment**

The organisation demonstrates the acquisition and provision of equipment that is safe for use in health and social care settings.

Standard 1: Leadership and governance

> **Standard statement**
>
> The organisation demonstrates effective leadership and governance in IPC.

Rationale

Leadership in IPC underpins an organisation's commitment, approach and mechanisms to reduce the risk of infection.[19]

Effective governance provides assurances that organisations have robust IPC measures in place. These measures include risk and adverse event management, escalation procedures and data monitoring and response.[12, 20] The organisation's governance arrangements adhere to, and support implementation of relevant statutory Duty of Candour regulations and responsibilities.[21]

A transparent IPC assurance and accountability framework, with clearly defined roles and responsibilities, is required to support strategic and operational decision making. It is important that staff are aware of their organisation's accountability and reporting structures, including which teams to contact for IPC leadership and expertise.

All staff working in health and social care have a responsibility to apply IPC measures. Effective IPC requires a strategic and co-ordinated approach and consistent action at all levels within an organisation. This is underpinned by high-quality role-specific education, training and support.

Assessment, monitoring and assurance of IPC is fundamental to reducing the risk of infection. Organisational commitment to a culture of quality improvement encourages teams to continuously assess their performance, identify areas for improvement and measure the results to achieve and maintain improvements.[22]

Criteria

1.1 Appropriate and responsive governance and accountability mechanisms are in place.

a Healthcare organisations have:

- an executive lead with accountability for IPC and responsibility for overseeing and providing assurances on IPC within their organisation
- an IPC manager with responsibility for leading local IPC teams and reporting IPC issues to the executive lead,[23] and
- local IPC and health protection teams (HPT) with the necessary expertise, leadership skills and resources to support their organisation.

b Social care organisations have:

- an appropriate management structure and/or system that sets out clear accountability and responsibility for IPC within the organisation
- an appropriately trained lead person to co-ordinate IPC within the organisation, and
- access to appropriate health and social care teams for IPC expertise, advice and support.

1.2   The organisation has an IPC assurance and accountability framework that specifies, as a minimum:

- defined roles and responsibilities
- quality monitoring and assurance arrangements
- reporting and escalation structures, and
- an IPC risk management strategy with clear lines of responsibility.

1.3   The organisation has clear systems in place to ensure that it takes a strategic and co-ordinated approach to IPC. This includes, as a minimum:

- compliance with IPC policies, procedures, guidance and standards[9] with appropriate follow-up action where there is non-compliance
- access to specialist IPC advice, guidance and support
- implementation of staff induction, role-specific education and training programmes
- ongoing and consistent data assurance and monitoring with improvement plans
- prompt identification of people who are colonised or are at risk of developing an infection
- accountability and responsibility arrangements for reporting adverse events, in line with the national adverse events framework and national reporting requirements,[24, 25] and
- adherence to Duty of Candour regulations and responsibilities.[21]

1.4   There are well-defined and locally agreed processes to enable:

- an effective multidisciplinary and multiagency approach to IPC
- cross-organisational support including access to specialist advice when indicated
- compliance with mandatory HAI reporting,[9] where required
- staff to implement, monitor and improve their compliance with IPC policies, procedures, guidance and standards[9]
- accurate and prompt communications and information exchange following consent (where applicable) from the individual and within, and between, services and settings, and
- communication and engagement with people that use services, staff, visitors and the public on matters related to IPC, including reducing specific risks.

1.5   The organisation demonstrates effective management of outbreaks, including:

- preparedness
- assessment of a person's care and safety
- reporting, and
- improvement plans.

1.6   The organisation communicates and engages with people/the public on matters related to IPC, including information on reducing specific infection-related risks.

1.7 The organisation communicates and uses information, data and learning from a variety of internal and external sources to support good practice and continuous quality improvement in IPC.

1.8 The organisation ensures that there is continuous engagement with staff, visitors and people that use services and their representatives to capture feedback and inform service improvements.

What does the standard mean for the person receiving care or visiting a health or social care setting?
People are confident that: • the organisation has effective leadership and governance, and is committed to continuously improving the quality of its IPC • staff work together to provide safe, effective and person-centred care • information about them and their care is shared with consent and in line with national guidance, as appropriate • the organisation communicates clearly and openly with them and their representatives, where appropriate • their feedback is used to improve services • the organisation has a system in place for learning, including where there has been an event that resulted in, or could have resulted in, harm.
What does the standard mean for staff?

Staff, in line with role, responsibilities and workplace setting:
• are fully informed about their organisation's assurance and accountability framework
• understand IPC policies, procedures, guidance and standards, and their role and responsibilities in IPC, including outbreak management
• are supported to undertake learning and reflection from adverse events and outbreaks, and
• have clear guidance on how to:
    o identify people at risk of infection
    o identify IPC-related risks, including those associated with the health and care built environment
    o report and escalate adverse events
    o adhere to organisational Duty of Candour regulations and responsibilities, and
    o share their feedback to inform service improvements.

What does the standard mean for organisations?
Organisations, in line with workplace setting: • demonstrate their commitment to IPC through effective leadership and governance • have a transparent and accessible IPC assurance and accountability framework • have clear systems in place to ensure that there is a co-ordinated and strategic approach to IPC • comply with Duty of Candour regulations and responsibilities • monitor data and use learning to support continuous quality improvement, and • take a multidisciplinary and multiagency approach to IPC.

Practical examples of evidence of achievement *(NOTE: this list is not exhaustive)*

Practical examples: healthcare and social care organisations

- An organisational assurance and accountability framework describing lines of accountability, roles and responsibilities, and reporting and escalation structures.
- Implementation of an IPC risk management strategy with records demonstrating that risk registers are regularly reviewed and updated.
- Improvement plans, underpinned by quality improvement methodology, that demonstrate implementation of the IPC standards.
- Accessible documentation demonstrating evidence of staff and team performance, for example audit and improvement activity.
- Organisational responses to assurance visits with appropriate action taken, where required, which are accessible.
- Improvement work including improvement plans, data collection and review of data (for example feedback from people receiving care) and national benchmarking.
- Completion of Reporting of Incidents, Diseases and Dangerous Occurrences. Regulations (RIDDOR)[26] form, and notification to the Health and Safety Executive.
- Duty of Candour monitoring including evidence of organisational openness, honesty and supportiveness.
- Feedback from people receiving care and their representatives, and evidence of learning from complaints or feedback.

Practical examples: healthcare organisations

- Executive board reports or minutes.
- Infection control committee and internal clinical governance group reports Healthcare organisation use of risk assessment tools and risk registers.
- Quarterly reports on current and emerging issues being used for quality improvement.
- Outbreak management plans, including details of the incident management team, as instigated by the healthcare organisation.
- IPC key performance indicators.
- Healthcare Associated Infection Report Template (HAIRT).[2]

Practical examples: social care organisations

- Board reports or minutes.
- Minutes of staff meetings.
- Clinical and care governance group reports.
- Internal risk assessments.
- Quality assurance, risk and audit programme with improvement plans.
- Care Inspectorate notifications.[24]
- Communication and engagement with a person's representatives, for example a family member, in line with relevant governance arrangements and with consent.

Standard 2: Education and training

> **Standard statement**
>
> Staff are supported to undertake IPC education and training, appropriate to role, responsibilities and workplace setting, to enable them to minimise infection risks in care settings.

Rationale

All staff play a vital role in minimising the risk and spread of infection in health and social care settings. Accessible IPC education and training, as part of an organisation's training and development plan, enables staff to develop and maintain their knowledge, skills and competencies in line with national guidance.[2, 27-33] Access to role-specific resources is available to staff, as required. This supports staff to further develop in areas essential to their role, responsibilities and workplace setting.

Embedding positive working and learning environments across an organisation enables staff to continuously develop and improve their IPC knowledge, skills and confidence as part of their role. This includes evaluation of the effectiveness of the education and training programme and assessment of staff knowledge and competence, including how knowledge and skills are embedded into everyday practice.[34]

Empowering staff to act autonomously, confidently and skillfully within their professional and organisational codes, with opportunities to feed back on their experiences, underpins high-quality and person-centred health and social care.

Criteria

2.1   The organisation implements a comprehensive and accessible IPC education and training programme, in line with role, responsibilities and workplace setting, which includes:

- any local or national mandatory staff induction and training
- information on current IPC policies, procedures and guidance, including the National Infection Prevention and Control Manual[2]
- assessment of staff education and training requirements
- tailored education and training, for example infection-specific management and insertion and maintenance of invasive devices, where required
- allocation of dedicated time and resources for staff to access and undertake relevant IPC education and training, including refresher training
- learning and sharing of IPC best practice across settings and sectors
- application of quality improvement methodology for IPC, and
- evaluation of the provision, uptake and effectiveness of IPC training, including providing staff with opportunities to feedback on the education programme and training provided.

2.2 The organisation's training plan includes IPC education and training, in line with role, responsibility and workplace setting, to ensure that staff:

- are supported to maintain role-appropriate levels of skill, knowledge and competency in IPC
- have access to ongoing support, and
- have access to continuous professional development in IPC.

2.3 Staff, in line with role, responsibility and workplace setting have access to clear guidance and support:

- on their role and responsibilities in relation to IPC
- to identify and address their own ongoing continuous professional development, education and training needs
- on what to do when they experience barriers to implementing IPC measures
- on career frameworks and development opportunities in IPC, where relevant, and
- on infection-specific management, including outbreak management.

2.4 As part of educational monitoring across the organisation, organisations use local and national IPC-related data and information to:

- evaluate staff knowledge, skills, competency and confidence in IPC
- identify areas for improvement in relation to staff IPC practice, and
- improve staff IPC practice through further provision of education and training.

What does the standard mean for people receiving care or visiting a health or social care setting?
People are confident that: • staff are appropriately educated, trained and competent in IPC, in line with their role, responsibilities and workplace setting • staff have a clear understanding of their role and responsibilities in IPC, and • the care and support they receive is informed by evidence and best practice.
What does the standard mean for staff?
Staff, in line with role, responsibilities and workplace setting: • have knowledge and demonstrate skills, competence and confidence in IPC • use their learning to ensure that they provide safe, effective and person-centred care, and • can access and undertake relevant training to achieve, maintain and continuously improve their knowledge, skills and competencies including role-specific resources, where appropriate.
What does the standard mean for organisations?
Organisations, in line with workplace setting: • demonstrate a continuous quality improvement approach and learning culture to ensure that the knowledge and competency of staff in IPC, in line with role, responsibilities and workplace setting, is developed and maintained, and

- ensure that staff are supported to access and undertake training and education appropriate to their role, responsibilities and workplace setting.

Practical examples of evidence of achievement *(NOTE: this list is not exhaustive)*

Practical examples: healthcare and social care organisations

- Training and development plans and records, for example induction, e-learning, completion of competencies, safety briefs, conference or study-day attendance.[35, 36]
- Competency frameworks, appropriate to role and workplace setting.
- Where appropriate to role, responsibilities and workplace setting, staff access and participate in quality improvement methodology education and training, for example modules provided by NHS Education for Scotland.[37]
- Where appropriate to role and workplace setting, staff access national learning platforms and systems for health and social care staff, for example Turas Learn, LearnPro, Scottish Social Services Council (SSSC) Learning Zone.[36, 38-40]
- Availability of IPC-related information, which includes appropriate guidance, standards, manuals and audit tools and how they link to IPC practice.
- Where appropriate to role, demonstration of staff having access to regular supervision, appraisal and support to identify training needs.
- Dedicated learning time and support for staff included in the organisation's IPC education and training programme.
- IPC education and training that is easy to access and delivered in formats appropriate for staff learning styles and workplace setting.
- Use of adverse event reports to support training and education programmes.
- Evaluation of training needs and training programmes.
- Staff feedback being used to improve IPC education and training.

Practical examples: healthcare organisations

- Participation records in the organisation's IPC education and training programme, for example Scottish Ambulance Service Learning in Practice.

Practical examples: social care organisations

- Participation records for the NHS Education for Scotland Care Home Train the Trainer Programme.[41]
- Uptake of the Scottish Infection Prevention and Control Education Pathway.[30]
- Uptake of relevant SSSC learning resources.[38]

Standard 3: Communication

Standard statement

The organisation implements robust communication systems and processes to enable person-centred decision making, continuity of care and effective IPC throughout a person's care experience.

Rationale

Communication is fundamental to safe, effective and person-centred IPC. People receiving health and social care can be vulnerable to contracting infections and some present an infection risk to others, including staff and visitors. A person's care experience can involve multiple services and settings, which can increase infection risks. Continuity of care is underpinned by robust and reliable communication within, and between, health and social care organisations and providers.[16]

High-quality, accessible and timely IPC-related information underpins effective communication with the person receiving care, and their representatives where appropriate, and:

- enables informed choice
- supports person-centred decision making, and
- encourages people and their representatives to have meaningful discussions about their care, which can improve their care experience and personal outcomes.[42]

Criteria

3.1 All IPC-related communications with people, and their representatives where appropriate, are documented in the person's care record and used to inform their plan of care.

3.2 Staff are provided with clear, timely and responsive information and guidance on IPC to enable them to provide safe and effective care.

3.3 Staff, IPC teams and HPTs have effective and appropriate communication:

- when information and specialist advice for people receiving care is required
- when there is a known or suspected outbreak or incident, and
- throughout the outbreak management process.

3.4 Staff communicate and work collaboratively within, and between, health and social care settings. This is in line with relevant governance arrangements, including consent to share information, where applicable, to:

- support continuity of care, and
- minimise harm associated with infection, including when people are transferred between services.

3.5   People who are at risk of developing an infection, and their representatives where appropriate, are provided with high-quality and timely communication and information in a format that is right for them. This supports people to:

- understand the impact, consequences and risks of having an infection
- implement IPC precautions, where appropriate
- understand what actions they can take to minimise the risk of developing an infection
- understand what action the organisation is taking to minimise infection risks, and
- make informed decisions and ask questions about their care.

3.6   People that have become colonised or have developed an infection, and their representatives where appropriate, are:

- promptly notified of their infection
- provided with information in a language and format that is right for them
- signposted to support on IPC-related care and procedures
- informed about any impact their infection may have on their care
- given accessible and relevant information about minimising the infection risk to others, and
- provided with opportunities to ask questions about their care.

3.7   Where there is an IPC-related adverse event, the person, and their representatives where appropriate, are informed about this in line with organisational Duty of Candour[21] and professional codes of conduct.

3.8   There is continuous quality improvement of all IPC-related communication systems and processes. This includes:

- monitoring the effectiveness of communications, and
- evaluating and using feedback from staff, visitors and people receiving care and their representatives.

What does the standard mean for people receiving care or visiting a health or social care setting?
People: • receive information in a language and format that is right for them   • are listened to and involved in decisions, and   • are confident that the organisation or service that provides their care has processes in place to ensure that people have the right information at the right time.
What does the standard mean for staff?
Staff, in line with role, responsibilities and workplace setting: • ensure that people receive effective communication to help minimise infection risks   • regularly communicate within, and between, relevant teams for expert information and advice

- effectively communicate with people receiving care, and their representatives where appropriate, regarding the mitigation of risks to the person and other people in the health and social care setting, and
- are competent in communicating risks within, and between, health and social care settings, to enable continuity of care, and to mitigate risks to other people in the health and social care setting.

What does the standard mean for organisations?

Organisations, in line with workplace setting, have IPC-related communication systems or processes in place:

- to enable safe, effective and person-centred communications throughout a person's care experience
- to ensure the availability of appropriate and easily accessible information in a range of languages and formats
- to ensure that communication of infection-related information and guidance is clear and timely, and
- that support collaborative working within, and between, health and social care settings.

Organisations evaluate and respond to feedback on IPC-related communications taking appropriate actions to learn and improve communication.

Practical examples of evidence of achievement *(NOTE: this list is not exhaustive)*

Practical examples: healthcare and social care organisations

- Availability of information provided in alternative formats and languages.
- Timely communications and collaboration between health and social care settings detailing any infections, for example handovers, discharge summaries and admission letters.
- Mechanisms for communication regarding IPC issues within, and between, health and social care settings, for example electronic staff communication systems.
- Examples of person-centred communication with a person's representatives where a person has reduced capacity or is unable to make their own decisions.[43]
- Availability and use of information leaflets appropriate to individual need.[44]
- Duty of Candour monitoring.[21]
- Feedback from staff, visitors and people receiving care and their representatives, and evidence of learning from complaints or feedback.

Practical examples: healthcare organisations

- Enquiries and responses to and from the IPC team.
- Examples of completed care records/plans (anonymised) for communication between people receiving care and their representatives and healthcare staff about HAIs throughout a hospital episode. Examples include a person's methicillin-resistant *Staphylococcus aureus* (MRSA) status and cause of death.

Practical examples: social care organisations

- Enquiries and responses to, and from, the HPT.
- Minutes of relevant meetings.
- Care Inspectorate notifications.[24]
- Safety huddle and outbreak reporting tools.

- Setting-specific information, for example relative information leaflets and information provided through approved online platforms.
- Implementation of the Care Inspectorate's quality frameworks, for example 'A quality framework for adults'.[45]

Standard 4: Assurance and monitoring systems

Standard statement

The organisation uses robust assurance and monitoring systems to ensure there is a co-ordinated and rapid response to reduce the risk of infections and to drive continuous quality improvement in IPC.

Rationale

Robust assurance and monitoring systems support organisations to reduce infection risks and improve people's outcomes. The most effective systems enable organisations to:

- systematically collect, monitor, analyse and interpret data on an ongoing basis
- seek expertise that is proportionate to the complexity and seriousness of the incident, and
- act on the findings appropriately.

It is important that organisations understand the risk factors associated with the different groups of people they care for and support to ensure that the care and support is responsive to an individual's needs.

Monitoring results drives continuous quality improvement and reduces infection risks by enabling organisations to:

- inform, support and improve practice for clinical, care and support service staff
- analyse the effectiveness of responses
- monitor trends and identify areas for targeted improvement
- review the impact that responses and interventions have on reducing infections
- share learning across the organisation and with external partners, and
- report and communicate infection rates to people/the public.

Criteria

4.1 The organisation has robust assurance and monitoring systems and processes in place, with appropriate triggers:

- to carry out mandatory national and local surveillance of infections and alert organisms, in line with national guidance[2, 9]
- that enable access to multidisciplinary support from professionals and teams with specialist IPC knowledge and expertise, where required
- that enable prompt detection, response and ongoing monitoring of any variance from normal local infection limits, including incidents and outbreaks, in line with national guidance[2, 9]
- to respond to all infection-related incidents and outbreaks, in line with the National Infection Prevention and Control Manual,[2] and
- to help identify and plan areas for targeted learning and improvement.

4.2   The organisation reviews and evaluates assurance and monitoring activity to ensure that:

- information from assurance and monitoring systems is used to help reduce infection risks
- appropriate action is taken, where required, to further reduce infection risks, and
- learning can be shared across settings and sectors.

4.3   The organisation's assurance and monitoring system enables information and interpreted data to be communicated, in an accessible format, to:

- relevant health and social care teams, and
- people in receipt of care, and their representatives and visitors, as appropriate.

4.4   Staff that use assurance and monitoring systems:

- have their training needs assessed in line with career and development frameworks appropriate to their role, responsibilities and workplace setting, and
- undertake relevant and up-to-date training on the organisations system.

4.5   **Healthcare organisations** report performance against local and national measures:

- through internal reporting structures
- to external partners, for example ARHAI Scotland, and
- publicly at board meetings.

4.6   **Healthcare organisations** review and report assurance and monitoring system data, including new, emerging and re-emerging infection-related risks, in line with the National Infection Prevention and Control Manual.[2] This information is shared with external partners.

What does the standard mean for people receiving care or visiting a health or social care setting?
People: • can expect to be cared for in an environment where staff, teams and organisations work together to monitor, minimise and manage infection risks, and • can be confident that services are safe and effective.
What does the standard mean for staff?
Staff, in line with role, responsibilities and workplace setting: • understand how they support monitoring, reporting and responding to infection risks in line with the organisation's assurance and accountability framework as described in standard 1 – leadership and governance • participate in, and implement learning from, relevant education and training programmes as described in standard 2 – education and training • are empowered to report and escalate issues within the multiagency team • work collaboratively with multidisciplinary and multiagency teams to ensure that infection-related issues are understood and responded to as necessary to reduce infection-related risk

- know how to seek specialist support from relevant professionals and teams, where required, and
- use infection and IPC-related data and intelligence to drive improvements in care and support.

What does the standard mean for organisations?

Organisations, in line with workplace setting, can demonstrate that:

- assurance and monitoring systems are in place to support IPC practice and ensure that infection-related incidents are detected and responded to, and
- infection and IPC-related data are reviewed to ensure that assurance and monitoring activity is effective in reducing infection risks.

Practical examples of evidence of achievement *(NOTE: this list is not exhaustive)*

Practical examples: healthcare organisations and social care organisations

- Local and national reporting and escalation of infection surveillance, incidents and outbreaks.
- Access and uptake of quality improvement training for staff, where appropriate, in relation to assurance and monitoring systems.
- Audit and improvement plans.
- Staff understanding of organisational monitoring, for example local standard operating procedures and guidance documents, with detail on how they would escalate.
- Responses to trigger alerts with improvement plans.
- Availability of communications on assurance and monitoring information in staff and public areas, for example audit result charts and graphs.

Practical examples: healthcare organisations

- Completed Healthcare Infection Incident Assessment Tool (HIIAT) assessments, where required.[2]
- Minutes of meetings from internal governance groups, for example problem assessment groups, incident management teams, 'hot debriefs' and infection control and clinical governance committees.
- Submission of data for national audit and surveillance programmes.
- Incident Management Team meeting minutes with improvement plans, where required.

Practical examples: social care organisations

- Reporting to public health departments on infection-related incidents and notifiable infections.
- Minutes of board meetings and internal governance groups, for example clinical and care governance.
- Care Inspectorate notifications.[24]

Standard 5: Optimising antimicrobial use

Standard statement

The organisation demonstrates reliable systems and processes for antimicrobial stewardship to support optimal antimicrobial use.

Rationale

Antimicrobial resistance is a significant threat to public health.[46] Overuse and misuse of antimicrobials (including antibiotics) drives the development of drug resistant pathogens that can adapt and find ways to survive the effects of antimicrobials.[47, 48] A key element of optimising antimicrobial use is that people receive the most appropriate antibiotic (type, dose, route and duration) promptly for their infection, according to local and national policy and guidance. An organisational approach to optimising antimicrobial use, in the form of a co-ordinated antimicrobial stewardship programme, ensures that antimicrobial use is safe, clinically effective and person-centred.

Criteria

5.1   All organisations can access appropriate antimicrobial expertise.

    a **Healthcare organisations** have a core multiprofessional Antimicrobial Management Team, with defined roles and responsibilities, for the oversight and co-ordination of all aspects of antimicrobial use within the NHS board.

    b **Social care organisations** access antimicrobial expertise through the local NHS board to ensure that there is optimal antimicrobial use for people receiving care.

5.2   All organisations support optimal antimicrobial use.

    a **Healthcare organisations** implement and evaluate a planned programme of education for optimising antimicrobial use.[49] The programme is provided to all staff involved in the prescribing, supply and administering of antimicrobials.

    b **Social care organisations** support optimal antimicrobial use through**:**

- promoting awareness to all staff involved in prescribing, supplying and administering antimicrobials, and
- enabling all staff involved in prescribing, supplying and administering antimicrobials to access relevant education and training.

5.3   **Healthcare organisations** support optimal use of antimicrobials by ensuring that:

- local antimicrobial policies are produced and updated at least every three years, or when indicated, in line with current national policy, guidance and best practice
- local antimicrobial policies and guidance are accessible to all health and social care staff, and
- staff who prescribe, supply and administer antimicrobials are alerted to any changes in antimicrobial practice policy and guidance.

5.4   **Healthcare organisations**, through the Antimicrobial Management Team, maintain an annual programme for antimicrobial stewardship.[50] This programme includes:

- monitoring data, including all adverse events relating to antimicrobial use
- providing feedback on prescribing practice to clinical teams
- targeted quality improvement interventions to address poor clinical practice in the use of antimicrobials,[50, 51] and
- reporting findings, including risk assessments, and improvement plans where appropriate, through internal governance structures.

5.5   To ensure that the **healthcare organisation** optimises its antimicrobial use through a quality improvement approach, the Antimicrobial Management Team:

- works with the multidisciplinary team to support and promote antimicrobial stewardship across health and social care
- participates in the implementation of an antimicrobial stewardship programme of education for optimising antimicrobial use
- reviews antimicrobial prescribing and resistance data in line with the annual programme for local surveillance of antimicrobial use[50, 52]
- feeds back the main findings of the review to clinical and management teams, and
- responds to data that indicate poor antimicrobial stewardship with targeted improvement interventions.[53]

What does the standard mean for people receiving care or visiting a health or social care setting?
People are confident that: - they will receive the most appropriate antibiotic (type, dose, route and duration) promptly for their infection, according to local and national policy and guidance - they will be involved in discussions regarding the reason for antimicrobial treatment, the intended duration and any potential adverse reactions - their care plan is updated with all information relating to their antimicrobial treatment, and - staff, in line with role, responsibilities and workplace setting, are appropriately trained and demonstrate knowledge of local and national antimicrobial prescribing policies, procedures and guidance.
What does the standard mean for staff?
Staff, in line with role, responsibilities and workplace setting: - are aware of the importance of their role in optimising antimicrobial use for the benefit of people receiving care and the wider public, and can demonstrate this in practice - are aware of the risks associated with poor prescribing and support colleagues where poor practice is identified - participate in education and training on appropriate antibiotic use as part of their continuing professional development, and - can demonstrate knowledge, skills and competences on rationales for antibiotic use.

Staff that prescribe antimicrobials:

- can demonstrate their competencies in relation to safe and effective antimicrobial prescribing for the treatment and prophylaxis of infection
- are enabled to access local antimicrobial policy and guidance, and
- engage in interventions to optimise antimicrobial prescribing.

What does the standard mean for organisations?

Organisations, in line with workplace setting:

- recognise the risks of antimicrobial resistance from poor antimicrobial use
- are assured that they have a programme in place for antimicrobial stewardship, including evaluation of the delivery of the annual work plan, and
- are assured that systems are in place to detect and respond to data on poor prescribing and administering practices.

Practical examples of evidence of achievement *(NOTE: this list is not exhaustive)*

Practical examples: healthcare and social care organisations

- Availability of antimicrobial guidance, for example signposting to the Antimicrobial Companion[54] and Scottish Antimicrobial Prescribing Group guidance.
- Improvement plans to address areas for quality improvement and evidence of progress against improvement plans.
- Support for staff to access education and training on optimal antimicrobial use.
- Multidisciplinary working to support and promote antimicrobial stewardship.
- Processes in place to access advice from local experts on the use of antimicrobials.
- Audits on appropriate antimicrobial prescribing in line with current guidance and best practice with improvement plans.

Practical examples: healthcare organisations

- Local antimicrobial policies that are produced and updated at least every three years.
- Regular audit and surveillance, including improvement plans, of antimicrobial use in line with Scottish Antimicrobial Prescribing Group policy and guidance.
- Feedback from the Antimicrobial Management Team provided to all teams involved in the prescribing, supply and administering of antimicrobials.
- Antimicrobial stewardship reporting through internal governance structures.
- Availability of organism- and body-system-specific treatment decision making aids, for example urinary tract infection, respiratory tract infection and MRSA.
- Prescribing and resistance data have been used to inform continuous quality improvement.
- Information exchange with multidisciplinary teams, for example through email, electronic portals and regular reporting of antimicrobial data.
- Membership, terms of reference, minutes and annual programme/plan of the Antimicrobial Management Team.
- JRCALC (Joint Royal Colleges Ambulance Liaison Committee) app[55] for Scottish Ambulance Service staff.

Practical examples: social care organisations

- Education and training records.

- Availability of antimicrobial information and guidance, for example signposting to Scottish Antimicrobial Prescribing Group guidance.[48, 56]

Standard 6: Infection prevention and control policies, procedures and guidance

Standard statement

The organisation uses evidence-based IPC policies, procedures and guidance.

Rationale

Implementation of evidence-based and accessible IPC policies, procedures and guidance can help reduce the risk of infection and ensure the safety of people receiving care, staff and visitors. A consistent and evidence-based approach to IPC:

- enables staff to apply effective standard and transmission-based precautions
- can reduce unwarranted variation by reinforcing robust IPC practice, and
- helps to align IPC practice, monitoring, quality assurance and quality improvement.

Criteria

6.1 The organisation ensures that the National Infection Prevention and Control Manual[2] appropriate for the specific care setting is adopted, implemented and accessible to staff.

6.2 The organisation has, and implements, an annual IPC work programme in line with national requirements and the National Infection Prevention and Control Manual.[2, 57]

6.3 The organisation has systems and processes in place to ensure that:

- staff are alerted to any changes in IPC policy, procedures and guidance, including the National Infection Prevention and Control Manual,[2] that may impact practice
- risk assessments, with mitigating actions, are put in place and reviewed when staff are unable to adopt and implement the National Infection Prevention and Control Manual[2]
- audit data and information, including risks, are fed back to staff, leadership teams, the executive team and registered services, as appropriate
- when an audit programme is not undertaken within the agreed timescales the risks are discussed, agreed and recorded through internal governance structures
- an improvement plan with clearly defined responsibilities and evidence of review is developed in response to audit data
- data and themes emerging from audit(s) are used to inform staff education and training and drive improvement in IPC practice
- there is access to appropriate specialist clinical advice for IPC and the diagnosis, treatment and management of infections, and
- learning from instances where staff are unable to adopt and implement the National Infection Prevention Control Manual[2] is shared.

What does the standard mean for people receiving care or visiting a health or social care setting?
People are confident that:
• they receive care in a clean and well-maintained environment without unnecessary exposure to infection, and
• staff that provide their care have knowledge and can demonstrate competencies in IPC practices.

What does the standard mean for staff?
Staff, in line with role, responsibilities and workplace setting:
• are fully informed about where to access up-to-date and relevant IPC policies, procedures and guidance
• can access and implement relevant IPC policies, procedures and guidance, including the National Infection Prevention and Control Manual[2]
• are fully informed about their organisation's IPC work programme, including audit data and information
• can evidence their safe IPC practice
• know how to respond and escalate if they have insufficient resources or support to minimise infection risks, and
• can access specialist IPC advice and support to enable them to effectively implement guidance.

What does the standard mean for organisations?
Organisations, in line with workplace setting, ensure that:
• relevant policies, procedures and guidance are available and accessible for staff in line with role and responsibilities
• the current National Infection Prevention and Control Manual[2] is adopted, implemented and accessible for staff
• an annual IPC work programme is implemented, and
• effective systems are in place to monitor, report and respond to audit data and information.

Practical examples of evidence of achievement *(NOTE: this list is not exhaustive)*
Practical examples: healthcare and social care organisations
• IPC education programme and training records.
• Environmental and equipment cleaning schedules.
• Membership, terms of reference and minutes of internal governance groups.
• National Infection Prevention and Control Manual[2] compliance audits and improvement plans.
• Audits with improvement plans.
• Completed improvement plans following an outbreak or adverse event.
• Risk assessments.
• Accessible up-to-date policy information displayed to staff.
• Lessons learned document themes are shared with appropriate improvement plan.

Practical examples: healthcare organisations

- Completed care plans for people with an alert organism.
- Completed rapid event investigations into HAIs, for example *Staphylococcus aureus* bacteraemia.

Practical examples: social care organisations

- Feedback from people receiving care and their representatives is used for service improvement.
- Care Inspectorate inspection reports.

Standard 7: Clean and safe care equipment

Standard statement

The organisation ensures that care equipment is cleaned, maintained and safe for use.

Rationale

Care equipment can be easily contaminated with infectious agents that can transfer during care delivery.[2] The effective cleaning or decontamination of care equipment is essential to minimise the risk of transmission of infectious agents between people.[2, 58, 59]

Organisations must demonstrate ongoing compliance with statutory legislation and implement national guidance to ensure that all care equipment is clean, maintained, free from damage and safe for use.[2, 9, 60, 61]

Please note: the decontamination of reusable invasive equipment, for example surgical instruments and endoscopes, is not within the scope of these standards.

Criteria

7.1 The organisation has, and implements, cleaning and decontamination policies and procedures in line with current:

- statutory legislation,[60] and
- national guidance.[2, 9, 61]

7.2 The organisation has effective cleaning and decontamination systems and processes in place to ensure that:

- all care equipment is clean, maintained and safe for users at the point of use to minimise the risk of cross-infection
- all care equipment is stored, installed, serviced, maintained, repaired, decommissioned and appropriately disposed of in line with the manufacturer's instructions, where relevant
- cleaning and decontamination of care equipment is carried out in line with the manufacturer's instructions and current national guidance, where relevant
- reporting and escalation of any cleanliness and maintenance issues are routinely undertaken, including evidence that issues have been addressed
- there is specialist input and guidance where cleaning or decontamination issues are identified, or existing activity does not meet requirements
- safety notices for care equipment are responded to
- there is accurate record keeping and documentation, where relevant, and
- feedback from people receiving care, staff and visitors is sought on the cleanliness and maintenance of care equipment and acted upon, where appropriate.

7.3 The organisation carries out regular audit to inform risk assessment, with mitigating actions, where any part of the cleaning or decontamination process cannot or has not been followed.

7.4   Where there is an adverse event associated with the cleaning or decontamination of care equipment, the organisation:

- investigates the reason for the adverse event and reports this using the HIIAT tool,[2] where relevant
- reviews processes during and following the adverse event or near miss in line with the national adverse events framework,[25] and
- reports through national reporting mechanisms,[24, 62] where required.

What does the standard mean for people receiving care or visiting a health or social care setting?
People are confident that any equipment used in their care is safe, clean and free from contamination at the point when it is being used.
What does the standard mean for staff?
Staff in line with role, responsibilities and workplace setting: • can articulate their individual role and responsibilities in the cleaning and decontamination of care equipment, including when there is an incident or outbreak • are aware of their organisation's cleaning and decontamination systems and processes relevant to their area of work • report and escalate issues and incidents, and • are committed to implementing learning from cleaning and decontamination-related incidents to support continuous quality improvement.
What does the standard mean for organisations?
Organisations, in line with workplace setting: • are compliant with the relevant regulations, cleaning and decontamination guidance and technical requirements and local policies and procedures • have effective systems and processes in place to assure the provision of clean, maintained and safe reusable care equipment • implement risk assessment mitigating actions, and • communicate and work collaboratively with agencies to share learning.
Practical examples of evidence of achievement *(NOTE: this list is not exhaustive)*
Practical examples: healthcare and social care organisations • Compliance with legislation and national guidance. • Records of the adverse event with improvement plans and evidence of learning. • Completed and signed cleaning schedules and records. • Minutes of local governance meetings. • Circulation of safety action notices to appropriate teams. • Maintenance records. • Risk assessments. • Education and training records. • Audits of care equipment with improvement plans. • Records/minutes showing how risk assessments for care equipment are regularly reviewed. • Audit reports of decontamination processes with improvement plans.

Practical examples: healthcare organisations

- Completion of HIIAT tool, where relevant.[2]
- Facilities monitoring tool feedback being used to inform service improvements.
- National reporting to Incident Reporting and Investigation Centre (IRIC).

Practical examples: social care organisations

- Care Inspectorate inspection reports and outcomes/findings.
- Care Inspectorate notifications, where appropriate.[24]
- Audits in line with the safe management of care equipment with improvement plans.

Standard 8: The built environment

> **Standard statement**
>
> The organisation ensures that infection risks associated with the health and care built environment are minimised.

Rationale

The health and care built environment (the environment) where health and care is delivered can play a significant role in the transmission of infection.[63] It is important that infection risks associated with these environments, for example water and ventilation systems, are minimised and managed through a co-ordinated and multidisciplinary approach. Organisational compliance with legislation, regulations and guidance, for example HAI-SCRIBE and Scottish Health Technical Memoranda (SHTM), underpins this approach.[2, 8-10, 61, 64, 65]

High standards of environmental cleanliness, IPC practice and ongoing maintenance of the environment can minimise the risk of the transmission of infection.[2] It is essential that the organisation provides a clean, well-maintained and safe environment.

Criteria

8.1 The organisation has, and fully implements, current policies and procedures to minimise the risk of infection across all areas of the environment in line with:

- statutory legislation and regulations, and
- national guidance and processes.[2, 8, 9, 61, 64, 65]

8.2 There are clear and agreed channels of communication and prompt information exchange across all relevant organisations, teams and settings to enable early assessment of potential and existing IPC risks associated with the environment.

8.3 The organisation ensures that IPC risks associated with construction, renovation, maintenance and repair of the environment are minimised by demonstrating that:

- building, refurbishment and maintenance work follow agreed processes and are planned, appropriately risk assessed, authorised, documented and carried out in ways that minimise infection risks and disruption to staff, people receiving care and visitors[61, 65]
- risks and issues are identified and communicated through appropriate mechanisms at the planning stage of building, refurbishment and maintenance work; a formal risk assessment with mitigation is put in place and acted on appropriately with key staff and teams involved at relevant stages
- there is regular monitoring and audit of maintenance and repair services to ensure that this is carried out in line with an agreed schedule[61]
- there is robust reporting, with follow-up action, including associated documented decision making and derogations,[61] where the environment cannot be accessed for maintenance or repair
- there is robust reporting, escalation, follow-up action, sign off and documentation of any IPC-related issues associated with the environment, and
- records and reports relating to maintenance, repair and refurbishment of the environment are accessible and regularly updated and reviewed.

8.4 The organisation ensures that the environment is safe and clean by demonstrating that:

- environmental cleanliness is in line with national guidance[61, 64]
- there is robust monitoring and audit of cleaning, including an escalation plan, where required
- there is robust decision making and reporting with appropriate follow-up action and escalation where the environment cannot be accessed for cleaning
- records and reports relating to the cleanliness of the environment are accessible and regularly updated and reviewed, and
- there is active engagement with people receiving care, staff and visitors to obtain feedback on the cleanliness of the environment. This includes development of an improvement plan, as appropriate.

8.5 Staff have access to information, specialist guidance and support to minimise infection risks associated with the environment. This ensures that staff are clear on their roles and responsibilities when:

- IPC risks and issues are identified in the environment
- additional cleaning activity is identified as necessary
- there is planned refurbishment or maintenance work in the environment
- there is emergency building or repair work to be undertaken
- known or suspected outbreaks and incidents relating to the environment are identified
- there is an alteration in the function or purpose of an area
- there is a change of use to an area, and
- the area cannot be accessed.

8.6 Learning from incidents, outbreaks and building and maintenance projects is shared throughout the organisation and across sectors to support continuous quality improvement in IPC.

What does the standard mean for people receiving care or visiting a health or social care setting?
People are confident that the environment is clean, maintained and safe.
What does the standard mean for staff?
Staff, in line with their role, responsibilities and workplace setting: - can articulate their individual role and responsibilities in providing a clean, maintained and safe environment - understand the risks associated with the environment and how to mitigate them - are aware of the level of cleaning required for the area that they are working in - are assured that there are effective systems in place to ensure a clean, maintained and safe environment, and - know who to escalate IPC risks and issues to in the event of a known or suspected environment incident or outbreak.

What does the standard mean for organisations?

Organisations, in line with workplace setting:

- are compliant with legislation, guidance and technical requirements associated with the environment
- have effective systems and processes in place to assure the provision of a clean, maintained and safe environment
- have transparent decision making and governance processes in place where derogations are required
- ensure staff are provided with the education and training, in line with role, responsibilities and workplace setting, to manage environment incidents and outbreaks and mitigate associated risks, and
- have quality assurance measures in place, including audits, to ensure compliance with systems and processes to mitigate risk associated with the environment.

Practical examples of evidence of achievement *(NOTE: this list is not exhaustive)*

Practical examples: healthcare and social care organisations

- Compliance with legislation and national guidance, including the National Infection Prevention and Control Manual.[2]
- Evidence that learning has been shared within and across organisations.
- Assurance mechanisms and accreditation checks when working with external partners.
- Water safety policy.
- Water outlet monitoring records.
- Infection-related risk assessment, for example Legionella risk assessment.
- Inspection reports and improvement plans.
- IPC audits with improvement plans, for example audits in line with the Safe Management of the Care Environment.[61]
- Feedback from people receiving care and their representatives, and evidence of learning from complaints or feedback.

Practical examples: healthcare organisations

- National facilities monitoring tool.[61]
- Annual validation and verification of ventilation systems.
- IPC audits with improvement plans, for example Scottish Ambulance Service vehicle and station audits.
- Patient feedback, for example, Care Opinion reviews.
- Incident and outbreak data and reports.
- HAI-SCRIBE documentation.[61]
- IPC committee, water safety group, and ventilation and pressure systems management group minutes.
- Ventilation systems management records.
- Compliance with Scottish Capital Investment Manual including completion of NHS Scotland Design Assessment Process, where required.[65]
- Completion of key stage assurance reviews, where required, and improvement plans.
- National Infection Prevention and Control Manual compliance data.[2]

Practical examples: social care organisations

- Compliance with Building Better Care Homes for Adults.[8]
- Records of compliance with National Cleaning Services Specification[64] or equivalent.
- Completed cleaning schedules.
- Development/refurbishment plans.
- Quality assurance records with improvement plans.
- Maintenance logs and reports.
- Care Inspectorate reports and complaint findings.

Standard 9: Acquisition and provision of equipment

Standard statement

The organisation demonstrates the acquisition and provision of equipment that is safe for use in health and social care settings.

Rationale

In this context, equipment that is acquired and provided for use in health and social care settings relates to any equipment that is:

- procured
- donated
- loaned
- manufactured in house, and
- used within a trial or for research purposes.

Infection risks to people receiving care, staff and visitors can be minimised when there is an acquisition process in place to ensure that equipment is safe for its intended use and can be effectively cleaned or decontaminated in line with manufacturer's instructions.[59]

Please note: the scope of this standard does not apply to personal items/equipment that are brought into a health or social care setting for personal use.

Criteria

9.1 The organisation has, and implements, policies and procedures for acquiring equipment in line with current:

- statutory legislation and regulations,[66-68] and
- national guidance.[9, 58, 61, 69]

9.2 There is IPC consideration and multidisciplinary involvement in the acquisition process prior to procurement. This includes the acquisition of new equipment.

9.3 The organisation has systems and processes in place to ensure that:

- all acquired equipment is compatible with national guidance[2, 61]
- all acquired equipment that cannot be effectively cleaned or decontaminated is removed from use, and
- feedback is provided to relevant teams on equipment that cannot be effectively cleaned or decontaminated to support continuous quality improvement.

9.4 All adverse events associated with equipment are:

- reported through the organisations local adverse event system
- reported through national reporting mechanisms, where required,[24, 62] and
- managed in line with the organisation's adverse event policy and the national adverse events framework.[25]

What does the standard mean for people receiving care or visiting a health or social care setting?
People are confident that all equipment used by staff or used in health and care settings meets the required level of safety, quality and performance.

What does the standard mean for staff?
Staff, in line with role, responsibilities and workplace setting: • demonstrate competency, where appropriate, in applying policies and procedures in relation to the acquisition and provision of equipment • can describe their involvement in the acquisition process and how it impacts on IPC, where appropriate • are confident in the safety, quality and performance of all equipment, and • can describe the process for reporting non-compliant equipment.

What does the standard mean for organisations?
Organisations, in line with workplace setting, have systems and processes in place that demonstrate the effective and efficient acquisition and provision of equipment that is safe for use.

Practical examples of evidence of achievement *(NOTE: this list is not exhaustive)*

Practical examples: healthcare and social care organisations

• Compliance with statutory legislation, regulations and guidance.

• Assessment of compatibility of all equipment, which impacts on IPC, with existing cleaning or decontamination processes.

• Adverse event reporting, where indicated.

• The implementation of a loan policy.

• The implementation of a procurement policy.

Practical examples: healthcare organisations

• Multidisciplinary involvement in decision making on the acquisition of equipment, where required.

• Procurement policy, procedures and records related to the acquisition of care equipment that impacts IPC.

Practical examples: social care organisations

• A procurement process that demonstrates consideration of IPC and cleaning or decontamination requirements.

• Care Inspectorate notifications, where appropriate.[24]

Appendix 1: Development of IPC standards

The IPC standards have been informed by current evidence and best practice recommendations and developed by group consensus.

Evidence base

A systematic review of the literature was carried out using an explicit search strategy devised by an information scientist in Healthcare Improvement Scotland. Additional searching was done though citation chaining and identified websites, grey literature and stakeholder knowledge. Searches included Scottish Government, Public Health Scotland, NICE, SIGN, NHS Evidence and Department of Health websites. This evidence was also used to inform all relevant impact assessments.

Development activities

A standards development group, chaired by Professor Hazel Borland, Executive Nurse Director, NHS Ayrshire & Arran was convened in April 2021 to consider the evidence and to help identify key themes for standards development.

Membership of the development group is set out in Appendix 2.

To ensure each standard is underpinned with the views and expectations of service staff from across health and social care, independent and third sector representatives and people/the public in relation to IPC, information has been gathered from a number of activities, including:

- a three-week scoping engagement period, and
- six development group meetings between April and August 2021.

Draft IPC standards were published on 12 October 2021. An 8-week consultation period was held to capture stakeholder feedback on the draft standards.

A summary of all feedback received during the consultation process, and details of any changes made to the final standards as a result, can be found on the Healthcare Improvement Scotland website.

Quality assurance

All development group members were responsible for advising on the professional aspects of the standards. Clinical members of the development group were also responsible for advising on clinical aspects of the work. The chair had lead responsibility for providing formal clinical assurance and sign off on the technical and professional validity and acceptability of any reports or recommendations from the group.

All development group members made a declaration of interest at the beginning of the project. They also reviewed and agreed to the development group's terms of reference. More details are available from the Healthcare Improvement Scotland website.

Healthcare Improvement Scotland also reviewed the standards document as a final quality assurance check. This ensures that:

- the standards are developed according to agreed Healthcare Improvement Scotland methodologies
- the standards document addresses the areas to be covered within the agreed scope, and

- any risk of bias in the standards development process as a whole is minimised.

For more information about Healthcare Improvement Scotland's role, direction and priorities, please visit: www.healthcareimprovementscotland.org/

Appendix 2: Membership of the IPC standards development group

Hazel Borland (*Chair*)	Executive Nurse Director/Deputy Chief Executive, NHS Ayrshire & Arran (until April 2022)
Lara Allan	Policy Manager, Chief Nursing Officer's Directorate, Scottish Government
Linda Bagrade	Consultation Microbiologist and Infection Control Doctor, NHS Greater Glasgow and Clyde
Michael Cassells	Principal Architect, Health Facilities Scotland
Alison Cockburn	Lead Antimicrobial Pharmacist, NHS Lothian
Linda Dalrymple	Lead Infection Prevention and Control Nurse, NHS Tayside
Karen Davidson	Podiatrist, NHS Dumfries and Galloway
Lynda Davidson	Health Protection Nurse, NHS Highland
Jackie Dennis	Senior Improvement Advisor, Care Inspectorate
Sandra Devine	Acting Infection Control Manager, NHS Greater Glasgow and Clyde
Jane Douglas	Chief Nurse, Care Inspectorate (until September 2021) Transforming Workforce Lead Nursing, Scottish Care (from October 2021)
Kay Duncan	Senior Charge Nurse, NHS Grampian
Hazel Dunsmuir	Care Home Manager, Abbotsford Care Home
Sofie French	Principal Educator, NHS Education for Scotland
Rhona Gardiner	Head of Service, Cross Reach
Susan Grant	Principal Architect, Health Facilities Scotland
George Grindlay	Public representative
Lindsay Guthrie	Associate Nurse Director Infection Prevention and Control, NHS Lothian
Lynda Hamilton	Specialist Advisor – Infection Prevention and Control, ARHAI Scotland
Sulisti Holmes	Head of Decontamination and IRIC, Health Facilities Scotland
Jonathan Horwood	Infection Control Manager, NHS Forth Valley
Laura Imrie	Lead Consultant, ARHAI Scotland
Jacqueline Jowett	Inspector, Healthcare Improvement Scotland
Ann Kerr	Lead Surveillance Nurse, NHS Greater Glasgow and Clyde
Grace MacDonald	Learning and Development Advisor, Scottish Social Services Council
Vince McCluskey	Lead Infection Prevention and Control Advisor, Scottish Ambulance Service
Donna McConnell	Infection Prevention and Control Nurse Lead, NHS Greater Glasgow and Clyde
Justine McCuaig	Health Protection Nurse, NHS Dumfries and Galloway
Pauline McIntyre	Deputy Director of Care, Erskine
Marie McKerry	Chief Nurse, Care Inspectorate
Alex McMahon	Executive Director of Nursing, Midwifery and Allied Healthcare Professionals, NHS Lothian (until December 2021)
David McNeill	Principal Engineer, NHS National Services Scotland

Appendix 3: Glossary

adult social care organisations and settings	all organisations and settings that provide any form of personal and practical support for adults who need extra support including care homes, care at home, housing support services (for example sheltered housing services) and support services (for example adult day care).
adverse event	an event that resulted in, or could have resulted in, harm to people or groups of people. An event that could have resulted in harm is often referred to as a near miss.
alert organism(s)	an organism that is identified as being potentially significant for IPC practices. A full list of alert organisms is set out in the National Infection Prevention and Control Manual.[2]
antimicrobial	a term used to describe substances that kill micro-organisms or prevent them from growing. Antibiotics and disinfectants are examples of antimicrobials.
antimicrobial resistance	when pathogens adapt and find ways to survive the effects of an antimicrobial (including antibiotics) they become 'antimicrobial resistant'. The antimicrobial is no longer effective at treating infections.
antimicrobial stewardship	a co-ordinated programme that promotes the appropriate use of antimicrobials (including antibiotics). An organisational antimicrobial stewardship programme can help health and social care staff improve a person's outcomes and minimise harms. Improving the appropriate use antibiotic prescribing can decrease the spread of infections caused by micro-organisms that have become resistant to certain antibiotics.
assurance and monitoring systems	systems that enable organisations to monitor the outcomes of current practice and provide timely feedback to clinicians and care professionals to ensure practice improvement and better outcomes for people receiving care.
care equipment	within these standards the term care equipment refers to single individual use equipment (this can be reused by the same person, for example nebuliser equipment) and reusable non-invasive equipment (this can be reused on more than one person following cleaning or decontamination between each use, for example a commode or bath hoist. This is also referred to as 'communal equipment').
colonised/colonisation	the presence of micro-organisms on a person's body surface (such as the skin, mouth, intestines or airway) that do not cause disease in the person or signs of infection.
health and care built environment	this term covers all aspects of IPC associated with the construction and adaptation of health and care buildings,

	as well as the design and provision of care in these settings.
decontamination	the appropriate cleaning, disinfecting and sterilising of reusable medical devices, care equipment and the environment. Decontamination is essential to lower the number of cross-infections between people and also to prevent HAIs. Processes need to be in place within health and care settings to ensure the environment and equipment, for example a person's room or commode, is decontaminated properly.
derogation	the process of defining and applying a solution that is not fully in line with current guidance but the service can demonstrate the outcome would be of the same or a better standard than if the guidance been fully adhered to.
health protection team (HPT)	a team of healthcare professionals whose role it is to protect the health of the local population and limit the risk of them becoming exposed to infection and environmental dangers. Every NHS board has a HPT.
healthcare associated infection (HAI)	infections associated with the delivery of care in hospitals, long-terms care facilities, care homes and other care settings such as prison facilities. The term HAI covers a wide range of infections that are caused by pathogens such as bacteria, fungi or viruses.
Healthcare Infection Incident Assessment Tool (HIIAT)	used by the IPC team or HPT to assess every healthcare infection incident, that is all outbreaks and incidents including decontamination incidents or near misses in any healthcare setting (the NHS, independent contractors providing NHS Services and private providers of healthcare).
Healthcare Associated Infection System for Controlling Risk in the Built Environment (HAI-SCRIBE)	an online risk management tool that supports organisations to identify infection risks, and collaborate with others to manage or mitigate risks.
Infection Prevention and Control (IPC) team	a multidisciplinary team responsible for preventing, investigating and managing an infection incident or outbreak.
infectious agent(s)	a micro-organism which has the ability to cause disease.
invasive device(s)	a device which penetrates the body, either through a body cavity or through the surface of the body, for example a urinary catheter.
NHS board	NHSScotland consists of 14 regional NHS boards that are responsible for the protection and the improvement of their population's health and for the delivery of frontline healthcare services.
pathogen(s)	an organism that causes disease, for example bacteria, viruses and fungi.
representative(s)	any person an individual experiencing care choses to be involved in their care and support. This includes, but is not limited to, next of kin, a power of attorney,[70, 71] carers, family or an independent advocate.
reusable invasive equipment	equipment that is used once and then decontaminated eg surgical instruments and endoscopes.

social care	within these standards the term social care does not apply to children and young people's services. It refers to all forms of personal and practical care for adults who need extra support. It describes services and other types of help, including care homes and the support provided by unpaid carers. Social care services can be provided by local authorities, health and social care partnerships (HSCP), independent bodies and the voluntary sector to support people to live their lives as fully and as independently as possible.

The majority of the descriptions in this glossary have been taken directly from the National Infection Prevention and Control Manual.[2]

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