Draft infection prevention and control standards

For health and social care settings

October 2021
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, socio-economic status or any other status. Suggested aspects to consider and recommended practice throughout the 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 when the final standards are published.

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 stakeholders across health and social care, the third sector and those with lived 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.

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First published October 2021

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Introduction

Infection prevention and control (IPC) is critical to keeping people safe when they are receiving health and social care. 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 involved in a person’s care and prolonged or inappropriate use of antibiotics.¹

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

HAIs are defined as occurring as a direct or indirect result of health care and treatment including the environment where care is delivered. 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, as well as financial implications for the health and care system in Scotland.¹ ³ Not all HAIs are preventable because of factors including a person’s preexisting conditions or the complexity of the treatment they are receiving.

Health and social care staff have an important role to play to help prevent the spread of infection by recognising that IPC is everybody’s responsibility.

Infection prevention and control standards

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

- organisations and their approach to quality assurance of their IPC practice, and

Standards underpin Healthcare Improvement Scotland’s programme of inspection of the safety and cleanliness in acute and community hospitals. HAI standards published by Healthcare Improvement Scotland in 2015 informed the Care Inspectorate and Healthcare Improvement Scotland’s joint evaluation of IPC practice in care homes in response to the COVID-19 pandemic. Since June 2020, the Care Inspectorate has developed additional key questions on IPC as part of their updated inspection methodology and grading system.

IPC standards support the integration of health and social care and recognise that a Once for Scotland approach improves care and support for people who use services and their representatives.
This document supersedes Healthcare Improvement Scotland’s HAI standards from 2015. These standards are informed by current evidence, best practice and stakeholder recommendations. More information about the 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, staff and visitors experience safe, effective and person-centred care, that includes the environment where care is delivered.

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 crucial policy and guidance role in relation to incidents and outbreaks across health and social care. These standards align with and support the work of NHS Scotland Assure.

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. 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\(^4\)
- Health and Social Care Standards: my support, my life\(^5\)
- National Health and Wellbeing Outcomes Framework\(^6\)
- Queen Elizabeth University Hospital/NHS Greater Glasgow and Clyde Oversight Board: final report\(^7\)
- Recover, Restore, Renew. Chief Medical Officer for Scotland Annual Report\(^8\)
- The Vale of Leven Hospital Inquiry\(^9\)
- UK 5-year action plan for antimicrobial resistance 2019 to 2024\(^10\)
- Scotland public health priorities, and
- other applicable Healthcare Improvement Scotland guidance, including SIGN guidelines and Scottish Antimicrobial Prescribing Group guidance and Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) Scotland guidance.

IPC standards are intended to complement, not duplicate, existing standards and guidelines. References to appropriate and relevant documentation have been included throughout the standards to signpost organisations and staff. 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.

**Scope of the standards**

Healthcare Improvement Scotland committed to revising the 2015 HAI standards and developing new IPC standards for health and social care settings. These updated standards will ensure that there is a common and current benchmark of quality for organisations and services across health and social care as they work together to help prevent and manage the spread of infection.

The standards cover the following areas:

- leadership and governance
- education and training
- communication
- assurance, monitoring and response
- optimising antimicrobial use
- infection prevention and control policies, procedures and guidance
- decontamination of reusable medical devices and equipment
- the built environment, and
- equipment.

**Ongoing internal quality assurance against these standards is mandatory in all NHSScotland and adult care home settings. All other social care organisations are encouraged to adopt the standards as best practice.**

The standards apply across health and social care. 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: **not every criterion will apply to all settings or all service providers.**

**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 to 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 can increase the risk of poor quality care, 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.

**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.

Organisations and services, for example NHS boards or care home providers are responsible for implementing and monitoring compliance against these standards. Application of individual criteria is for local determination.

**Terminology**

Some sections of the standards document are technical, for example they outline specific aspects of care, and have been developed to support staff to ensure the highest standards of IPC wherever health and social care is delivered.

Wherever possible, we have incorporated generic terminology, written in plain English, which can be applied across all health and social care settings. Where technical terms have been included, for example decontamination and invasive device, these are defined in the glossary in Appendix 3.
How to participate in the consultation process

We welcome feedback on the draft standards and will review every comment received. We have circulated the draft standards widely to relevant professional groups, healthcare service staff, social care staff, and voluntary sector organisations. To obtain feedback, we are using a range of methods including:

- an online survey, and
- tailored engagement with the public (including people who use services and carers), and
- tailored engagement with service providers (including staff at the point of care).

For more information, please contact:

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Submitting your comments

Responses to the draft standards should be submitted through our online survey. If you would like to submit your comments using a different format, please contact the project team using the email address above. The consultation closes on Tuesday 7 December 2021.

Consultation feedback

At the end of the consultation period, all comments will be collated and the IPC standards development group will respond to each comment received. The response will explain how the comments were taken into account in producing the final standards. Where the development group did not support a suggested amendment or inclusion, a detailed explanation will be provided in the report.

A summary of the responses to the consultation will be made available on the Healthcare Improvement Scotland website.

The IPC standards will be published in spring 2022.
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 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, monitoring and response
The organisation uses robust assurance and monitoring systems to ensure there is a coordinated 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: Decontamination of reusable medical devices and care equipment
The organisation ensures that reusable medical devices and care equipment are 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: Equipment
Equipment acquired for use in the health and care environment can be effectively decontaminated to minimise any infection risks.
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 activities to reduce the risk of infection. 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. Governance arrangements should adhere to the organisation’s statutory Duty of Candour responsibilities.

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 seek IPC leadership and expertise from.

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

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.

Criteria

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

(a) NHS boards have:

- an executive lead with accountability for IPC and responsibility for overseeing and providing assurances on IPC within their NHS board area
- an IPC manager with responsibility for leading local IPC teams and reporting IPC issues to the executive lead, and
- local IPC teams with the necessary expertise, leadership skills and resource to support the NHS board area.

(b) Social care organisations have:

- a registered service provider with accountability and responsibility for the overall management of IPC within the organisation
- an appropriately trained lead person to coordinate 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 which specifies, at 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 coordinated approach to IPC. This includes, at a minimum:

- compliance with IPC policies, procedures, guidance and standards
- 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
- adherence to Duty of Candour regulations and responsibilities, and
- continuous engagement with staff and people that use services and their representatives to capture feedback and inform service improvements.

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

- an effective multidisciplinary and multi-agency approach to IPC
- cross-organisational support including access to specialist advice when indicated
- compliance with mandatory HAI reporting
- staff to implement, monitor and improve their compliance with IPC policies, procedures, guidance and standards
- 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
- remedial improvement plans.

1.6 The organisation communicates and engages with the public on matters related to IPC, including information on reducing specific infection-related risks.
The organisation uses information, data and learning from a variety of internal and external sources to support good practice and continuous quality improvement in IPC.

### What does the standard mean for the person receiving care or visiting a health or social care setting?

People are confident that:
- the organisation demonstrates effective leadership and governance and is committed to continuous quality improvement in IPC
- staff work together to provide safe, effective and person-centred care
- the organisation communicates clearly and openly with them and their representatives, where appropriate
- their information is shared with consent, as appropriate
- their feedback is used to improve services
- there is an organisational system for learning, and
- the organisation commits to implementing learning from adverse events.

### What does the standard mean for staff?

Staff:
- 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
- have clear guidance on how to:
  - identify people at risk of infection
  - identify IPC-related risks, including those associated with the health and care built environment
  - report and escalate adverse events
  - adhere to organisational Duty of Candour regulations and responsibilities, and
  - share their feedback to inform service improvements
- are supported to undertake learning and reflection from adverse events and outbreaks.

### What does the standard mean for organisations?

Organisations:
- 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 coordinated 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 multi-agency approach to IPC.

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

**Practical examples: NHS boards 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.
- 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.
- Improvement work including improvement plans, data collection and review of data (for example feedback from people receiving care) and national benchmarking.
- Duty of Candour monitoring including evidence of organisational openness, honesty and supportiveness.

**Practical examples: NHS boards**
- Executive board reports or minutes.
- Infection control committee and internal clinical governance group reports.
- NHS board 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 NHS board.
- 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.
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. High quality IPC education and accessible training enables staff to develop and maintain their knowledge, skills and competencies in delivering safe, effective and person-centred care. Access to role-specific resources is available to staff, as required, to support staff to further develop in areas essential to their role and responsibilities.

Organisational promotion of positive working and learning environments supports staff to continuously develop and improve their IPC knowledge and skills 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.

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 health and social care.

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

- mandatory staff induction and training
- information on current IPC policies, procedures and guidance in line with and including the National Infection Prevention and Control Manual
- 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 appropriate time and resources for staff to access and undertake relevant IPC education and 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.
2.2 The organisation has a training plan in place to ensure that staff, in line with role, responsibility and workplace setting:

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

2.3 Staff 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 career frameworks and development opportunities in IPC, where relevant, and
- on infection-specific management, including outbreak management.

2.4 Organisations use local and national IPC-related data and information to:

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

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<th>What does the standard mean for people receiving care or visiting a health or social care setting?</th>
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<tr>
<td>People are confident that:</td>
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<td>- staff are appropriately educated, trained and competent in IPC, in line with their role,</td>
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<td>responsibilities and workplace setting</td>
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<td>- staff have a clear understanding of their role and responsibilities in IPC, and</td>
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<td>- the care and support they receive is informed by evidence and best practice.</td>
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<td>Staff, in line with role, responsibilities and workplace setting:</td>
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<tr>
<td>- demonstrate knowledge, skills and competence</td>
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<td>- use their learning to ensure that they provide safe, effective and person-centred care,</td>
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<td>and</td>
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<tr>
<td>- access and undertake relevant training to achieve, maintain and continuously improve</td>
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<td>their knowledge, skills and competencies.</td>
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<td>Organisations:</td>
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<tr>
<td>- demonstrate a continuous quality improvement approach and learning culture to ensure</td>
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<td>that the knowledge and competency of staff in IPC, in line with role, responsibilities and</td>
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<td>workplace setting, is developed and maintained, and</td>
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<tr>
<td>- ensure that staff are supported to access and undertake training and education</td>
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<td>appropriate to their role, responsibilities and workplace setting.</td>
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Practical examples of evidence of achievement *(NOTE: this list is not exhaustive)*

**Practical examples: NHS boards and social care organisations**

- Training and development plans and records, for example inductions, e-learning, completion of competencies, safety briefs, conference or study day attendance.
- Competency frameworks, appropriate to role and workplace setting.
- Where appropriate to role, staff access and participation in quality improvement methodology education and training, for example modules provided by NHS Education for Scotland.\(^{25}\)
- Where appropriate to role, demonstration of staff having access to regular supervision, appraisal and support to identify training needs.
- 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: NHS boards**

- 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.\(^{26}\)
- Uptake of the Scottish Infection Prevention and Control Education Pathway.\(^{20}\)
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
Effective communication underpins safe, effective and person-centred care. People receiving health and social care are 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. Robust communications within and between health and social care providers and with the person receiving care, and their representative where appropriate, is fundamental to effective IPC and continuity of care.\(^9\)

Communication of high quality, accessible and timely information regarding IPC supports informed choice, person-centred decision making and encourages people and their representatives to have meaningful discussions about their care which can enhance their care experience.\(^{27}\)

Criteria

3.1 All IPC-related communications with people, and/or 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 communicate with IPC and Health Protection Teams (HPT) as appropriate, including:
- 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 in line with relevant governance arrangements and with consent, 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/or 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 developed an infection, and/or their representatives where appropriate, are:

- promptly notified of their infection in a timely manner
- provided with information, in a format that is right for them, and provided with support on IPC-related care issues 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/or their representatives where appropriate, are informed about this in line with organisational Duty of Candour\(^\text{13}\)

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 people receiving care and/or their representative.

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<td><strong>People:</strong></td>
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<td>- receive effective communication on infection-related risks in a format that is right for them</td>
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<td>- are involved in care decisions taken to mitigate infection-related risks, where appropriate, and</td>
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<td>- are confident that care providers have robust communication systems or processes in place to enable continuity of care and mitigate infection-related risks.</td>
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<td><strong>Staff, in line with role, responsibilities and workplace setting:</strong></td>
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<tr>
<td>- ensure that people receive effective communication to help minimise infection risks</td>
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<tr>
<td>- regularly communicate within and between relevant teams for expert information and advice</td>
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• effectively communicate with people receiving care, and/or their representatives where appropriate, regarding the mitigation of risks to themselves 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 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 formats
- to ensure that communication of infection-related information and guidance is clear and timely, and
- that support robust communication and 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 communications.

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

**Practical examples: NHS boards and social care organisations**

- Availability of information provided in alternative formats and languages.
- Timely communications and collaboration between health and social care providers detailing any infections, for example discharge summaries and admission letters.
- An organisational IPC communication strategy.
- Completion of Reporting of Incidents, Diseases and Dangerous Occurrences Regulations (RIDDOR) form, and notification to the Health and Safety Executive.  
- Availability and use of information leaflets appropriate to individual need.
- Duty of Candour monitoring.
- Feedback from people receiving care and their representatives, and evidence of learning from complaints or feedback.

**Practical examples: NHS boards**

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

**Practical examples: social care organisations**

- Enquiries and responses to, and from, the HPT.
- Response to Care Inspectorate notifications.
- Safety huddle and outbreak reporting tools.
- Setting-specific information leaflets, for example relative information leaflets.
- Implementation of the Care Inspectorate’s quality frameworks, for example ‘A quality framework for care homes for older people’.
Standard 4: Assurance, monitoring and response

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

Rationale
Infection risks can be continually monitored and reduced and people’s outcomes can be improved when organisations:

- systematically collect, monitor, analyse and interpret data on an ongoing basis, 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 this response is appropriate to an individual’s needs. Organisations can drive continuous quality improvement and reduce infection risks using monitoring results to:

- inform and reinforce staff practice, for example, clinical, care and support service staff
- analyse the effectiveness of responses
- monitor trends and identify areas for target improvement
- review the impact that responses and interventions have on reducing infections
- share learning across the organisation and with partners, and
- report and communicate infection rates to 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,
- 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
- to respond to all infection-related incidents and outbreaks, in line with the National Infection Prevention and Control Manual, and
- to help identify and plan areas for focused 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, and
- appropriate action is taken, where required, to further reduce infection risks.
4.3 Assurance and monitoring information and interpreted data is communicated, in an accessible format, to:

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

4.4 Staff that use assurance and monitoring systems:

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

4.5 **NHS boards** report performance against local and national measures:

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

4.6 **NHS boards** review and report assurance and monitoring system data, including new, emerging and re-emerging infection-related risks.

---

### 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 relevant health and social care professionals use infection and IPC-related data to support the delivery of safe, effective and person-centred care and services.

### 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 multi-agency team
- work collaboratively with multidisciplinary and multi-agency teams to ensure that infection-related issues are understood and responded to as necessary to reduce infection-related risks
- know how to seek specialist support from relevant professionals and teams, where required, and
- are engaged in using infection and IPC-related data and intelligence to drive improvements in care and support.
**What does the standard mean for organisations?**

Organisations 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: NHS boards and social care organisations**

- Local and national reporting of infection surveillance, incidents and outbreaks.
- Access and uptake of quality improvement training for staff in relation to assurance and monitoring systems.
- Responses to trigger alerts with improvement plans.
- Availability of communications on assurance and monitoring information in staff and public areas, for example charts and/or graphs.

**Practical examples: NHS boards**

- 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.

**Practical examples: social care organisations**

- Reporting to public health departments on notifiable infections.
- HP Zone infection data.
- Minutes of meetings from internal governance groups, for example clinical and care governance.
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. Overuse and misuse of antimicrobials drives the development of drug resistant pathogens. An organisational approach to optimising antimicrobial use, in the form of a coordinated 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) NHS boards have a core multi-professional Antimicrobial Management Team, with defined roles and responsibilities, for the oversight and coordination of all aspects of antimicrobial use within the board.

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

5.2 All organisations support optimal antimicrobial use.

(a) NHS boards implement and evaluate a planned programme of education for optimising antimicrobial use. 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 education and training.

5.3 NHS boards 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 **NHS boards**, through the Antimicrobial Management Team, maintain an annual programme for antimicrobial stewardship.\(^3^4\) 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,\(^3^4,\) \(^3^5\) and
- reporting of findings, including risk assessments with improvement plans where appropriate, through internal governance structures.

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

- works in partnership with health and social care services to deliver the local antimicrobial stewardship work plan
- 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\(^3^4,\) \(^3^6\) and
- feeds back the main findings of the review to clinical and management teams, and
- responds to data which indicate poor antimicrobial stewardship with targeted improvement interventions.\(^3^7\)

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

The organisation:
- recognises the risks of antimicrobial resistance from poor antimicrobial use
- is assured that it has a programme in place for antimicrobial stewardship, including evaluation of the delivery of the annual work plan, and
- is 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: NHS boards and social care organisations
- Availability of antimicrobial guidance, for example, signposting to the Antimicrobial Companion.\(^3^8\)
- 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.
- 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: NHS boards
- 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](https://www.scottishhealthboards.org.uk/policies-and-guidance/antimicrobial-prescribing) 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 has 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 app\(^3^9\) for Scottish Ambulance Service staff.

#### Practical examples: social care organisations
- Response to Care Inspectorate notifications.
- Education and training records.
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 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\textsuperscript{2} appropriate for the specific care setting, is adopted, implemented and accessible for all 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\textsuperscript{2}, \textsuperscript{40}

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 that may impact practice, including the National Infection Prevention and Control Manual\textsuperscript{2}
- risk assessments, with mitigating actions, are put in place when staff are unable to adopt and implement the National Infection Prevention and Control Manual\textsuperscript{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 are used to inform staff education and training and drive improvement in IPC practice, and
- there is access to appropriate specialist clinical advice for IPC and the diagnosis, treatment and management of infections.
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 an clean and well maintained environment without unnecessary exposure to infection, and
- staff that provide their care demonstrate knowledge and competencies in IPC practices.

What does the standard mean for staff?

Staff, in line with role, responsibilities and workplace setting:
- can access and implement relevant IPC policies, procedures guidance including the National Infection Prevention and Control Manual
- 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 ensure that:
- relevant policies, procedures and guidance are available and accessible for staff
- the current National Infection Prevention and Control Manual 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: NHS boards 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.
- Completed care plans for people with an alert organism.
- Completed care plans following an outbreak or adverse event.
- Completed rapid event investigations into HAIs for example, *Staphylococcus aureus bacteraemia*.
- Risk assessments.
Standard 7: Decontamination of reusable medical devices and care equipment

**Standard statement**
The organisation ensures that reusable medical devices and care equipment are cleaned, maintained and safe for use.

**Rationale**
The effective decontamination of reusable medical devices and care equipment is essential to minimise the risk transmission of infectious agents between people. Organisations must demonstrate ongoing compliance with statutory legislation and implement national guidance and technical requirements to ensure that all reusable medical devices and care equipment are clean, maintained, free from damage and safe for use.

**Criteria**

* 7.1 The organisation has a nominated person with overall responsibility for the decontamination of reusable medical devices and care equipment in line with national guidance.

* 7.2 The organisation has, and implements decontamination policies and procedures in line with current:
  * statutory legislation, and
  * national guidance.
The organisation has effective decontamination systems and processes in place to ensure that:

- all reusable medical devices and care equipment are clean, maintained and safe for users at the point of use, to minimise the risk of cross-infection
- all reusable medical devices and care equipment are stored, installed, serviced, maintained, repaired, decommissioned and appropriately disposed in line with manufacturer’s instructions, where relevant
- decontamination of medical devices and care equipment is carried out in line with 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 decontamination issues are identified, or existing activity does not meet requirements
- safety notices for reusable medical devices and 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 of reusable medical devices and care equipment and acted upon, where appropriate.

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

Where there is an adverse event associated with the decontamination of reusable medical devices and care equipment, the organisation:

- uses the HIIAT tool, where appropriate
- reviews decontamination processes during and following the adverse event or near miss in line with the national adverse events framework, and
- reports to the Incident Reporting Investigation Centre (IRIC) and external agencies, where appropriate.

What does the standard mean for people receiving care or visiting a health or social care setting?

People are confident that any reusable medical devices and equipment used in their care is safe, clean and free from contamination at the point it is being used.

What does the standard mean for staff?

Staff in line with role, responsibilities and workplace setting:

- know who is their organisational lead for decontamination
- can articulate their individual role and responsibilities in the decontamination of reusable medical devices and care equipment, including when there is an incident or outbreak
- are aware of their organisation’s decontamination systems and processes
- report and escalate issues and incidents, and
- are committed to implementing learning from decontamination-related incidents to support continuous quality improvement.
### What does the standard mean for organisations?

**Organisations:**
- have a nominated person with responsibility for the decontamination of reusable medical devices and care equipment
- are compliant with the relevant regulations, decontamination guidance and technical requirements and local policies and procedures
- have effective decontamination systems and processes in place to assure the provision of clean, maintained and safe reusable medical devices and 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: NHS boards 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 for reusable medical devices and 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: NHS boards**
- Completion of HIIAT tool, for example, following an adverse event associated with the use of an endoscope.\(^2\)
- Facilities monitoring tool feedback being used to inform service improvements.
- National reporting to IRIC.
# Standard 8: The built environment

<table>
<thead>
<tr>
<th><strong>Standard statement</strong></th>
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<tr>
<td>The organisation ensures that infection risks associated with the health and care built environment are minimised.</td>
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## Rationale

The health and care built environment, the environment, can play a significant role in the transmission of infection.\(^{48}\) It is important that infection risks associated with the environment, for example water and ventilation systems, are minimised and managed through a coordinated and multidisciplinary approach. Organisational compliance with legislation, regulations and guidance, for example, HAI-SCRIBE and Scottish Health Technical Memoranda (SHTM), underpins this approach.\(^{2, 4, 49-51}\) 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

<table>
<thead>
<tr>
<th>8.1</th>
<th>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:</th>
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<tbody>
<tr>
<td></td>
<td>• statutory legislation and regulations, and</td>
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<td></td>
<td>• national guidance, including SHTM and HAI-SCRIBE.(^2, 4, 49-51)</td>
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| 8.2 | There are clear and agreed channels of communication and prompt information exchange across all relevant 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 is planned, appropriately risk assessed, authorised, documented and carried out in ways that minimise infection risks and disruption to staff, people receiving care and visitors\(^\text{49, 52}\)
- risks and issues are identified and communicated 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\(^\text{49, 52}\)
- there is robust reporting, with follow up where the environment cannot be accessed, for maintenance or repair, including associated documented decision making and derogations\(^\text{49, 52}\)
- 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 the National Cleaning Services Specification\(^\text{51}\)
- there is robust monitoring and audit of cleaning including an escalation plan, where required
- there is robust reporting, including decision making, with appropriate follow up 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 for feedback on the cleanliness of the environment with 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.

<table>
<thead>
<tr>
<th>What does the standard mean for people receiving care or visiting a health or social care setting?</th>
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<tbody>
<tr>
<td>People are confident that the environment is clean, maintained and safe.</td>
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<tr>
<th>What does the standard mean for staff?</th>
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<tbody>
<tr>
<td>Staff, in line with their role, responsibilities and workplace setting:</td>
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<tr>
<td>• can articulate their individual role and responsibilities in providing a clean, maintained and safe environment</td>
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<tr>
<td>• understand the risks associated with the environment and how to mitigate them</td>
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<tr>
<td>• are aware of the level of cleaning required for the area that they are working in</td>
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<tr>
<td>• are assured that there are effective systems in place to provide them with a safe environment, and</td>
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<tr>
<td>• know who to escalate IPC risks and issues to in the event of a known or suspected environment incident or outbreak.</td>
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<tr>
<th>What does the standard mean for organisations?</th>
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<tbody>
<tr>
<td>The organisation:</td>
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<tr>
<td>• is compliant with legislation, guidance and technical requirements associated with the environment</td>
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<tr>
<td>• has effective systems and processes in place to assure the provision of a clean, maintained and safe environment</td>
</tr>
<tr>
<td>• has transparent decision making and governance processes in place where derogations are required</td>
</tr>
<tr>
<td>• ensures 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</td>
</tr>
<tr>
<td>• has quality assurance measures in place, including audits, to ensure compliance with systems and processes to mitigate risk associated with the environment.</td>
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<table>
<thead>
<tr>
<th>Practical examples of evidence of achievement (NOTE: this list is not exhaustive)</th>
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<tbody>
<tr>
<td><strong>Practical examples: NHS boards and social care organisations</strong></td>
</tr>
<tr>
<td>• Compliance with legislation and national guidance.</td>
</tr>
<tr>
<td>• Evidence that learning has been shared within and across organisations.</td>
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<tr>
<td>• Assurance mechanisms and accreditation checks where external partners are used.</td>
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<tr>
<td>• Water safety policy.</td>
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<tr>
<td>• Water outlet monitoring records.</td>
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<tr>
<td>• Legionella risk assessment.</td>
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<tr>
<td>• Inspection reports and improvement plans.</td>
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</tbody>
</table>

| **Practical examples: NHS boards** | |
|-----------------------------------| |
| • National facilities monitoring tool. | |
| • 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.\textsuperscript{49}
- IPC committee and water safety group minutes.
- Completion of key stage assurance reviews and improvement plans.

**Practical examples: social care organisations**

- Compliance with Building Better Care Homes for Adults.\textsuperscript{50}
- IPC audits with improvement plans
- Records of compliance with National Cleaning Services Specification.\textsuperscript{51}
Standard 9: Equipment

Standard statement
Equipment acquired for use in the health and care environment can be effectively decontaminated to minimise any infection risks.

Rationale
Equipment (which includes reusable medical devices) for use in the health and care environment relates to all 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 equipment is effectively decontaminated in line with manufacturer's instructions.42

Criteria

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

- statutory legislation and regulations, and53-55
- national guidance.4, 41, 56

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

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

- all acquired equipment is compatible with national guidance2, 51
- all acquired equipment that cannot be effectively decontaminated is removed from use, and
- feedback is provided to relevant teams on equipment that cannot be effectively decontaminated to support continuous quality improvement.

9.4 All adverse events associated with equipment:

- are reported through the organisations local adverse event system
- are reported to IRIC, where required,47 and
- are managed in line with the organisation’s adverse event policy and the national adverse events framework.16
What does the standard mean for people receiving care or visiting a health or social care setting?

People are confident that all equipment being used by staff or being used in the health and care environment, 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 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?

The organisation has systems and processes in place which demonstrate the effective and efficient acquisition of equipment which is safe for use.

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

Practical examples: NHS boards and social care organisations
- Compliance with statutory legislation, regulations and guidance.
- Assessment of compatibility of all equipment which impacts on IPC with existing decontamination processes.
- Adverse event reporting, where indicated.
- The implementation of a loan policy.
- The implementation of a procurement policy.

Practical examples: NHS boards
- IPC team involvement in decision making on the acquisition of equipment.
- Procurement policy, procedures and records related to the acquisition of equipment which impacts on IPC.

Practical examples: social care organisations
- A procurement process that demonstrates consideration of IPC and decontamination requirements.
Appendix 1: Development of IPC standards

The IPC standards have been informed by current evidence, 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 through 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**

To ensure each standard is underpinned with the views and expectations of service staff from across health and social care, third sector representatives, and 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.

A standards development group, chaired by Professor Hazel Borland, Interim Chief Executive, 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.

**Consultation feedback and finalisation of standards**

Following consultation, the standards development group will reconvene to review all comments received and to make final decisions and changes relating to the standards content. More information will be available on the Healthcare Improvement Scotland website following publication of the final standards.

**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 was assigned 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 stages of the project. They also reviewed and agreed to the development group’s terms of reference. More details are available on request from: his.standardsandindicators@nhs.scot

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
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<tbody>
<tr>
<td>Hazel Borland</td>
<td>Executive Nurse Director (until July 2021)/Interim Chief Executive (from July 2021), NHS Ayrshire &amp; Arran</td>
</tr>
<tr>
<td>Lara Allan</td>
<td>Policy Manager, Chief Nursing Officer’s Directorate, Scottish Government</td>
</tr>
<tr>
<td>Linda Bagrade</td>
<td>Consultation Microbiologist and Infection Control Doctor, NHS Greater Glasgow and Clyde</td>
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We would like to thank Helen Buchanan, former Executive Nurse Director, NHS Fife, and chair of the IPC standards scoping group, for all of her input and support.

The standards development group was supported by the following members of Healthcare Improvement Scotland’s Standards and Indicators Team:

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</table>
## Appendix 3: Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>adverse event</td>
<td>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.</td>
</tr>
<tr>
<td>alert organisms</td>
<td>an organism that is identified as being potentially significant for IPC practices. Examples of alert organisms include MRSA, Clostridioides difficile (C.diff) and Group A Streptococcus.</td>
</tr>
<tr>
<td>antimicrobial</td>
<td>a term used to describe substances that kill microorganisms, or prevents them from growing. Antibiotics and disinfectants are examples of antimicrobials.</td>
</tr>
<tr>
<td>antimicrobial stewardship</td>
<td>a coordinated programme that promotes the appropriate use of antimicrobials.</td>
</tr>
<tr>
<td>assurance and monitoring systems</td>
<td>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.</td>
</tr>
<tr>
<td>colonised/colonisation</td>
<td>the presence of microorganisms 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.</td>
</tr>
<tr>
<td>health and care built environment</td>
<td>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 environments.</td>
</tr>
<tr>
<td>decontamination</td>
<td>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.</td>
</tr>
<tr>
<td>derogation</td>
<td>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.</td>
</tr>
<tr>
<td>health protection team</td>
<td>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 health protection team.</td>
</tr>
<tr>
<td>healthcare associated infection</td>
<td>infections associated with the delivery of care in hospitals, long-term 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.</td>
</tr>
<tr>
<td><strong>HIIAT</strong></td>
<td>used by the infection prevention and control team or health protection team to assess every healthcare infection incident i.e. all outbreaks and incidents including decontamination incidents or near misses in any healthcare setting (that is the NHS, independent contractors providing NHS Services and private providers of healthcare).</td>
</tr>
<tr>
<td><strong>Healthcare Associated Infection System for Controlling Risk in the Built Environment (HAI-SCRIBE)</strong></td>
<td>an online risk management tool that supports organisations to identify infection risks, and collaborate with others to manage or mitigate risks.</td>
</tr>
<tr>
<td><strong>infection prevention and control team</strong></td>
<td>a multidisciplinary team responsible for preventing, investigating and managing an infection incident or outbreak.</td>
</tr>
<tr>
<td><strong>invasive device</strong></td>
<td>a device which penetrates the body, either through a body cavity or through the surface of the body, for example a urinary catheter.</td>
</tr>
<tr>
<td><strong>NHS board</strong></td>
<td>NHSScotland consists of 14 regional NHS boards which are responsible for the protection and the improvement of their population’s health and for the delivery of frontline healthcare services.</td>
</tr>
<tr>
<td><strong>representative</strong></td>
<td>any person an individual receiving care wishes to be involved in their care and support. This includes, but is not limited to, someone who has a parental responsibility for a child or young person, an attorney, carers, family, or an independent advocate.</td>
</tr>
<tr>
<td><strong>reusable medical devices</strong></td>
<td>devices that are used for diagnostic and/or treatment purposes for the same person or multiple people. They are intended by the device manufacturer to be reprocessed and reused. Examples of reusable medical devices include surgical forceps and endoscopes.</td>
</tr>
<tr>
<td><strong>social care</strong></td>
<td>refers to all forms of personal and practical support for children, young people and adults who need additional support. It describes a range of services, for example care homes, and other types of support including unpaid carers.</td>
</tr>
</tbody>
</table>

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


