I'm not a robot

For patients and staff alike, the greatest threat to healthcare facilities is the failure to prevent and control infection risks. Infection control is a top priority for all clinical facilities across the country: so, let's review the basics of infection control. If you work in a healthcare setting, you understand better than most that infection control is paramount. Why? Prevention and control are critical to protecting the health and safety of your caregivers and patients. Talk to an expert about infection control and waste management today! 9 techniques to enhance infection control: 1 / Taking A Holistic Approach 2 / Create an Infection Control Policy 3 / Screen Patients and Isolate Contagion 4 / Education, Education, Education! 5 / Use PPE (Personal Protective Equipment) 6 / Avoid Cross Contamination 7 / Vaccinations 8 / Ventilation 9 / Protecting Medical and Healthcare Staff and Patients from Infection 1. Taking A Holistic Approach The entire healthcare facility is accountable for supporting an infection prevention program, not just infection preventionists. Every interaction across departments can increase or decrease cross-contamination and infection risks. The pandemic has put a spotlight on how previously innocuous interactions and events can contribute to increased infection risks. 2. Create an Infection Control Policy An infection control policy details which patients have the highest risks for contracting or passing along Healthcare Associated Infections (HAIs). The policy should include information for when patients should be placed on isolation precautions, or otherwise prevented from making contact with other patients and staff. 3. Screen Patients and Isolate contagious individuals Highly contagious patients, or patients with a contractable virus should be identified as early as possible. An example of this is testing for Clostridium Difficile, a bacterium which can be life-threatening. 4. Education, Education, Education! Education is key for infection control in healthcare settings. Your organization should provide continuous education and training to staff on infection control. Education should include training on bloodborne pathogens, which can be contracted via needlestick injuries. 5. Use PPE (Personal Protective Equipment) PPE has always been critical in healthcare settings, and the COVID-19 pandemic has underscored its importance. This includes but is not limited to masks and face shields, aprons, and gloves. Masks help prevent the spread of droplet-borne pathogens, and gloves are useful when coming into contact with blood or bodily fluids. There are four levels of PPE depending on the tasks preformed. Find out more about PPE for COVID-19 here. Isolation-appropriate protective equipment includes waterproof aprons, gloves, shoe covers, face shields and masks. If patients have a contagious illness, appropriate isolation equipment should be readily available for use. 6. Avoid Cross Contamination Utilize proper disposal techniques and containers to reduce risk of cross-contamination and spreading of bacteria. Between patients, rooms should be disinfected and sanitized. This will prevent transmission of infection between patients. Staff should properly sanitize & clean linens, and linens should not be left on patients' beds for extended periods. In addition to this, although it might seem simple, hand hygiene is still a major part of infection control. In the wake of COVID-19, handwashing was highly advised to help prevent the spread of the virus. Here are some tips from the CDC regarding hand washing techniques. 7. Vaccinations Infection preventionists note that medical staff themselves may sometimes be the cause of the spread of healthcare-associated infections due to their close contact with patients with different diseases. This means that medical practices should routinely administer recommended vaccinations to their staff. You can access the CDC recommendations for COVID-specific vaccinations here. It might be challenging to tell the difference between some post-vaccination signs and symptoms from signs and symptoms of COVID-19 or other infectious diseases. 8. Ventilation Improvements to building ventilation can reduce the spread of disease and lower the risk of exposure to HAIs. This method of infection control has been highlighted during the COVID-19 pandemic. 9. Protecting Medical and Healthcare Staff and Patients from Infection One of the driving factors behind stringent infection control is the waste management and protection of those who are in contact with biohazardous waste. Measures to protect the workers who generate and handle medical waste include: Fit-for-Purpose and non-contact bins for the collection of infectious waste Following OSHA guidelines for discarding regulated medical-waste items Employing waste handling practices that minimize the "touches" of infectious waste and its outer packaging Tamper-proof containment before collection, ensuring waste is sealed in leakproof packaging Waste Consolidation and readiness for storage and transport that minimizes risk of spillage and cross-contamination Refer to the CDC's guidelines for Environmental Infection Control in Health-Care Facilities to understand the regulations that govern medical waste generated in medical facilities and how to achieve best-practice. Daniels Health products, education, and resources provide valuable, sustainable, cost-effective, and most importantly, compliant protection and guidelines for healthcare facilities. With containers and services designed to minimize infection control risk and protect frontline healthcare workers in the generation, packaging and movement of infectious waste, Daniels Health is recognized as the national leader of clinically designed waste services. For more information on who we are and what we do, call us today. Chat with an expert Safety is central to our vision. We are committed to protecting people and minimizing risk through innovative solutions that demonstrably reduce needlestick injuries and infection transfer. Since its inception, Daniels Health has focused on the fundamental importance of environmental safety. All Daniels products and waste processing solutions are designed and engineered for minimum environmental impact. Streamlining the efficiencies of healthcare environments through intelligent mapping, process re-engineering and clinically designed products, Daniels solutions enable point-of-use disposal, and optimize costs, labor and serviceability. Understanding the complexities of local, regional and national regulations, Daniels Health positions itself as an astute partner in delivering reliable guidance and compliant waste segregation and management solutions. We understand that each person learns differently and no two healthcare settings are the same; our education solutions are designed as an interchangeable and customizable offering – delivering results through a tailored approach. The Infection Prevention and Control team work hard to ensure that patients receive the very highest standard of healthcare. Although the risk of getting an infection whilst in hospital is low, careful attention to infection prevention and control is a crucial part of keeping our patients safe. Although the Trust has a dedicated Infection Prevention and Control Team there are also infection prevention and control leads at Trust Board, divisional and ward levels. The Infection Prevention and Control Team comprises of consultant microbiologists, specialist nurses and antimicrobial pharmacist headed by the Director of Infection Prevention and Control. The Infection Prevention and Control Team is committed to preventing and minimising the spread of infection. This includes: Constantly improving practice to reduce the incidence of infections acquired in hospital Providing advice on the management of individual patients, or suspected outbreaks of infection Robust surveillance on targeted infections reporting all results back to the frontline staff Education and training of all staff via the Trust's Induction and mandatory training programme and locally at ward and department level Producing Infection Prevention & Control Policies in line with government guidelines, which are readily available to all staff via the Trust's intranet Audit of policies and guidelines to ensure that best practice is followed Supporting and reassuring patients and their families using our services You can read our Annual IPC report for 2017/18 here. Dr Ian Stanley - Director of Infection Prevention and Control Beverley Aspin - Lead Infection Prevention Matron Kirsty Holt - Infection Prevention Matron Marie Wright - Infection Prevention Matron John Mannion - Infection Prevention Matron Christine Jones - Infection Prevention Nurse Tina Cronshaw - Infection Prevention Nurse Claire Higham - Infection Prevention Nurse Fran Kerr - MRSA Specialist Nurse Michelle Jones - Infection Prevention Assistant Laura Moores - Infection Prevetion Secretary Contact by telephone on 01254 733156 Or by post; Infection Prevention Team Dept. of Clinical Laboratory Medicine Level 0 Royal Blackburn Hospital Haslingden Road Blackburn BB2 3HH MRSA and other hospital infections are usually passed on by human contact, often from the skin of the hands, which is why washing and cleaning hands is so vital reducing infection rates. Hand sanitiser dispensers are placed and entrances to all wards/departments and beside every bed. Everyone can help combat infections by following these simple hand hygiene steps: Always wash hands or use the hand sanitizer before/on entering and when leaving clinical areas (such as wards) It's a very simple process - just press the button on the dispenser and rub the sanitiser into your hand, taking care to cover both the palm and backs of your hands and the skin between your fingers. The sanitiser will dry in a few of seconds, and you are free to enter the ward. Always wash your hands after using the toilet, or before and after preparing food If you are a patient, try to limit the number of visitors you have at any one time. The more people on our wards, the more the chance of infection spreading Visitors please use the chairs on wards not the beds If you are concerned that staff are not cleaning their hands or adhering to infection control procedures, please remind them as they may have forgotten. They may also remind you in a friendly way! If soap or hand towels are not available, or if the bathroom and toilet facilities are not clean, please tell a member of staff Stay at home if you have a cold, infection or stomach upset and only visit if you have been free from symptoms for at least 48 hours Tell a staff member if you have any particular concerns about infection prevention and control If you are prescribed antibiotics, make sure you finish the full course, even if you feel better part way through, as otherwise not all the bacteria will be killed and those that do survive may develop a resistance to the drug Published on 19 September 2024 The National Infection Prevention and Control Manual (NIPCM) provides IPC guidance to all those involved in care provision and is considered best practice across all health and care settings in Scotland. It is evidence based and aims to provide care staff with easily accessible information and supporting tools for infection prevention and control. It also aims to reduce practice variation and reduce the risk of healthcare associated infection (HAI). The following chapters can be found within the NIPCM: Chapter one Standard Infection Control Precautions, describes the basic infection prevention and control measures necessary to reduce the risk of transmission of infectious agent from both recognised and unrecognised sources of infection. These should be used by all staff, in all care settings, at all times, for all patients whether infection is known to be present or not. Chapter two Transmission Based Precautions, describes additional precautions required to be used by staff when caring for patients with a known or suspected infection of colonisation. Chapter three Healthcare associated infection incidents, outbreaks & data exceedance, supports NHS Scotland boards in the early recognition of potential infection incidents. It also provides a guide for Incident Management Teams to help assess and investigate any outbreaks and incidents. Included within the chapter are outbreak assessment tools and details of the outbreak reporting processes. which enables a single channel of infection incident and outbreak assessment as well as information reporting, both internally within a NHS board area and externally to ARHAI and Scottish Government Health and Social Care Department (SGHSCD). The data is used to identify possible and emerging healthcare associated infection (HAI), infection prevention and control (IPC) and antimicrobial resistance (AMR) threats within Scotland, as well as informing learning for the wider IPC community. Chapter four Infection Control in the Built Environment and Decontamination. The healthcare built environment means the buildings and related infrastructure used for the provision of healthcare. This includes utilities such as water and ventilation. The healthcare built environment plays a critical role in the provision of safe patient care and protection to staff and visitors. Chapter 4 is informed by evidence-based literature reviews and best practice guidance tools and resources relating to IPC in the built environment. Care home Infection Prevention and Control Manual (CH IPCM) In order to support care homes successfully adopt and implement the National Infection Prevention and Control Manual (NIPCM), this context specific Care Home Infection Prevention and Control Manual (CH IPCM) has been co-produced with national and local stakeholders. The content of the CH IPCM is completely aligned to the evidence based NIPCM. Skip to main content Skip to navigation Skip to mobile navigation Skip to accessibility tools Click for Accessibility Information Infection prevention and control (IPC) is essential in nursing practice to safeguard patient health and reduce healthcare-associated infections. This article explores IPC strategies, including hand hygiene, the use of personal protective equipment, environmental cleaning, safe injection practices, and antimicrobial stewardship. It discusses the implementation challenges and solutions, such as ensuring compliance through education, monitoring and strong leadership. IPC measures are crucial in preventing infections such as catheter-associated urinary tract infections, central line-associated bloodstream infections, surgical site infections, and ventilator-associated pneumonia. By integrating personalised IPC strategies into nursing practice, healthcare providers can significantly improve infection control outcomes and enhance overall patient safety and quality of care. Infection prevention and control (IPC) plays a crucial role in safeguarding patient health and mitigating the spread of healthcare-associated infections (HAIs) – and it is fundamental to nursing practice. Such infections, acquired during the course of receiving treatment for other conditions within a healthcare setting, impose a significant burden on healthcare systems, leading to severe complications, prolonged hospital stays, and increased healthcare costs (Loveday et al, 2014; Stewart et al, 2021)). Effective IPC practices are essential to mitigate the risk of HAIs and improve patient outcomes. These practices include regular hand hygiene, the use of personal protective equipment (PPE), environmental cleaning and disinfection, and adherence to protocols for invasive procedures. The importance of a collaborative approach to IPC across disciplines, to ensure comprehensive and consistent implementation of infection control practices, has also been emphasised (Hallam, 2021). This article explores key IPC strategies, highlighting their importance in nursing practice and offering practical guidance for implementation. Infections that patients acquire while receiving treatment for other conditions within a healthcare environment are known as HAIs. They can result from various pathogens, including bacteria, viruses and fungi, and are considered a key indicator of the quality of healthcare services provided. They are therefore a significant concern in clinical settings, impacting patient outcomes, healthcare costs, and overall quality of care. The pathogens responsible for HAIs can survive in healthcare environments and are often resistant to common disinfectants and antiseptics, antibiotics and antimicrobial medication. Common bacterial pathogens include Staphylococcus aureus, Escherichia coli, and Pseudomonas aeruginosa, while viruses such as norovirus and influenza, and fungi such as Candida species also contribute to HAIs (Magill et al, 2014). These pathogens are often transmitted through direct contact with contaminated surfaces, medical equipment or healthcare workers, highlighting the need for stringent infection control practices (Khan et al, 2017). Catheter-associated urinary tract infections (CAUTIs) are among the most common HAIs. They occur when bacteria or fungi enter the urinary tract via a urinary catheter, which is a tube inserted into the bladder to drain urine. CAUTIs can lead to complications such as kidney infections and sepsis. Prevention strategies include the use of aseptic techniques during catheter insertion, proper maintenance of the catheter, and timely removal when no longer necessary (Medina and Castillo-Pino, 2019; Centers for Disease Control and Prevention, 2024). Central line-associated bloodstream infections (CLABSIs) are another significant type of HAI. These infections occur when bacteria or viruses enter the bloodstream through a central venous catheter. CLABSIs can result in severe complications, including sepsis, prolonged hospital stays and increased mortality. Implementing central line insertion protocols and maintenance practices significantly reduces the incidence of CLABSIs. Key among theses are hand hygiene, the use of full barrier precautions during insertion, chlorhexidine skin antisepsis, and proper management of the central line (Buetti et al, 2022). Surgical site infections (SSIs) occur at the site of a surgical incision and are among the most common HAIs. These infections can be superficial, involving the skin or, in more severe cases, they may affect tissues under the skin, organs or implanted material. SSIs can lead to extended hospital stays, additional surgical procedures and increased healthcare costs. A systematic review by Ban et al (2017) indicated that the incidence of SSIs varies depending on the type of surgery and the patient's condition. Prevention strategies include proper surgical hand antisepsis, appropriate use of prophylactic antibiotics, and maintaining a sterile surgical environment (Ban et al, 2017). Ventilator-associated pneumonia (VAP) occurs in patients receiving mechanical ventilation, and it is associated with significant morbidity and mortality. VAP develops when pathogens enter the lower respiratory tract via the ventilator tube. The prevention of VAP involves multiple strategies, including maintaining proper hand hygiene, elevating the head of the bed, daily assessment of the patient's readiness to wean from the ventilator, and using subglottic secretion drainage (Gershonovitch et al, 2020). The implementation of care bundles that combine several preventive measures has been shown to reduce the incidence of VAP (Gershonovitch et al, 2020). Hand hygiene is universally recognised as the single most effective measure for preventing the spread of infections. Proper hand hygiene involves washing hands with soap and water or using alcohol-based hand sanitisers. It is essential to perform hand hygiene before and after patient contact, after contact with potentially contaminated surfaces, and before performing aseptic tasks (Loveday et al, 2014). Consistent hand hygiene practices can significantly reduce the transmission of pathogens in healthcare settings. Despite the simplicity of good hand hygiene practices, compliance with this remains a challenge, often due to workload, forgetfulness or insufficient facilities. Continuous education and monitoring can help improve adherence to hand hygiene protocols (NHS England, 2024). Personal protective equipment (PPE), such as gloves, gowns, masks and eye protection are crucial for protecting healthcare workers and patients from infectious agents. The appropriate selection and use of PPE depend on the nature of the patient interaction and the potential for exposure to blood, bodily fluids or infectious agents (Loveday et al, 2014). Proper donning and doffing techniques are essential to prevent self-contamination. Training healthcare workers on the correct use of PPE, ensuring adequate supplies and reinforcing the importance of PPE can mitigate the risk of infections (Barratt and Gilbert, 2021). Regular cleaning and disinfection of healthcare environments are vital for preventing the transmission of infections. This includes cleaning high-touch surfaces such as bed rails, doorknobs and medical equipment with appropriate disinfectants. Ensuring that cleaning staff are trained and adhere to standardised cleaning protocols is crucial for maintaining a safe environment (Loveday et al, 2014). The role of environmental cleaning extends beyond routine cleaning to include terminal cleaning of patient rooms after discharge, especially for those that had been occupied by patients with known infections. Innovations such as ultraviolet (UV) light disinfection and hydrogen peroxide vapour systems are increasingly used to enhance environmental cleaning (Royal College of Nursing (RCN), 2021). Safe injection practices prevent the transmission of bloodborne pathogens. This includes using aseptic technique, never reusing needles or syringes, and properly disposing of sharps in designated containers. Education and training of healthcare providers on safe injection practices are critical to preventing HAIs (NHS England, 2024). The implementation of needleless systems and single-use devices can further reduce the risk of infections. Continuous surveillance and audits of injection practices can identify areas for improvement and ensure compliance with safe injection protocols (Loveday et al, 2014). Antimicrobial stewardship involves the appropriate use of antibiotics to combat antimicrobial resistance. This includes prescribing antibiotics only when necessary, selecting the right antibiotic, and using the correct dose and duration of treatment. Nurses play a key role in monitoring patients for signs of infection and ensuring adherence to antimicrobial protocols. The overuse and misuse of antibiotics have led to the rise of multi-drug-resistant organisms, posing a significant challenge to infection control. Effective antimicrobial stewardship requires collaboration among healthcare providers, including infectious disease specialists, pharmacists, and microbiologists (RCN, 2021). Antimicrobial stewardship is essential in addressing resistance not only to antibiotics, but also to other antimicrobials, because fungal, viral and bacterial pathogens are becoming more resistant to treatment agents. It is crucial to include antifungals, antivirals and antiparasitic agents in stewardship efforts to ensure comprehensive strategies that limit resistance development and promote the appropriate use of all types of antimicrobials. This holistic approach may be key to safeguarding the effectiveness of these treatments across a wide range of infectious diseases. Implementing IPC measures effectively can be challenging due to factors such as staff shortages, lack of resources and varying levels of compliance. Overcoming these challenges requires a multifaceted approach. Education and training are paramount; regular training sessions and educational programmes can enhance staff knowledge and adherence to IPC protocols (NHS England, 2024). Continuous education keeps healthcare workers informed about the latest guidelines and best practices. Monitoring and feedback are also essential; continuous monitoring of IPC practices and providing feedback can improve compliance. This includes regular audits and feedback sessions (Loveday et al, 2014). Leadership and support from healthcare management are also crucial for the successful implementation of IPC measures. This will include providing adequate resources and fostering a culture of safety. Strong leadership can drive adherence to IPC protocols and address barriers to implementation. Hand hygiene compliance remains a persistent challenge in healthcare settings. Despite its simplicity, factors such as high workloads, skin irritation from frequent washing, and lack of access to hand hygiene facilities can hinder compliance. Strategies to improve compliance include installing hand hygiene stations at convenient locations, using hand sanitisers that are less irritating to the skin, and incorporating hand hygiene into the workflow. Regular hand hygiene audits and real-time feedback can also enhance compliance. Peer influence and role modelling by senior staff can encourage adherence to hand hygiene practices (Loveday et al, 2014; NHS England, 2024). The effective use of PPE requires proper training and adherence to protocols. Common challenges include improper donning and doffing techniques due to lack of training, which can lead to self-contamination, and the discomfort associated with prolonged use of PPE. Solutions include providing comprehensive training on the correct use of PPE, ensuring adequate supplies, and rotating tasks to minimise the need for prolonged use of PPE. Simulation exercises can help healthcare workers practise donning and doffing in a safe environment. Encouraging a supportive work environment where staff feel comfortable reporting PPE issues can also improve compliance (Loveday et al, 2014; NHS England, 2024). Maintaining high standards of environmental cleaning and disinfection is critical, but can be challenging due to factors such as staffing constraints and inconsistent cleaning practices. Training cleaning staff on standardised cleaning protocols and the importance of their role in infection prevention can enhance compliance. Using checklists and documentation to track cleaning activities ensures accountability. Implementing advanced disinfection technologies, such as UV light and hydrogen peroxide vapour systems, can supplement manual cleaning efforts. Regular environmental audits and feedback can help maintain high standards of cleanliness (Loveday et al, 2014). Clinical staff should also receive training in respect to the decontamination of the environment (and equipment) because they also have significant responsibility for maintaining a clean/safe clinical environment Safe injection practices are essential to preventing bloodborne infections, but it is imperative to ensure consistent adherence to protocols. Challenges include the lack of access to single-use devices and improper disposal of sharps. Addressing these issues involves educating healthcare workers on safe injection practices, ensuring the availability of single-use devices, and providing adequate sharps disposal containers. Monitoring injection practices through regular audits and providing feedback can improve adherence. Implementing policies that promote the use of needleless systems can also reduce the risk of infections (Loveday et al, 2014; NHS England, 2024). Antimicrobial stewardship is critical for preventing the spread of antibiotic-resistant infections. Challenges include overprescription of antibiotics, lack of awareness about antimicrobial resistance, and difficulty in changing prescribing habits. Solutions include implementing antimicrobial stewardship programmes that involve multidisciplinary teams, educating healthcare providers about the importance of appropriate antibiotic use, and monitoring antibiotic prescribing patterns. Providing decision support tools, such as guidelines and protocols, can assist healthcare providers in making informed prescribing decisions. Regular feedback on antibiotic use and resistance patterns can also promote adherence to stewardship principles. Continuous education and training are essential for effective IPC. Training programmes should be tailored to the needs of different healthcare workers and cover key IPC principles. Interactive training methods, such as simulations and workshops, can enhance learning and engagement. Providing training at regular intervals ensures that healthcare workers remain up to date with the latest guidelines and best practices. Encouraging healthcare workers to participate in IPC training as part of their professional development can also improve compliance (Loveday et al, 2014; NHS England, 2024). Monitoring IPC practices and providing feedback are crucial for maintaining high standards. Regular audits of hand hygiene, PPE use, environmental cleaning, and injection practices can identify areas for improvement. Providing real-time feedback to healthcare workers reinforces positive behaviours and addresses non-compliance. Using data from audits to track progress and identify trends can inform quality improvement initiatives (Loveday et al, 2014). Engaging healthcare workers in the monitoring process can foster a sense of ownership and accountability. Leadership and support from healthcare management are vital for the successful implementation of IPC measures. Healthcare leaders should prioritise IPC, allocate resources and support staff in adhering to protocols. Creating a culture of safety, where IPC is valued and prioritised, can drive compliance. Recognising and rewarding healthcare workers for their contributions to IPC can also motivate adherence. Engaging healthcare workers in decision-making processes related to IPC can enhance buy-in and support. Infection prevention and control is a fundamental aspect of nursing practice that protects patients and healthcare workers from HAIs. By adhering to key IPC strategies, such as hand hygiene, the use of PPE, environmental cleaning, safe injection practices and antimicrobial stewardship, nurses can significantly reduce the incidence of infections. Overcoming implementation challenges through education, monitoring and leadership support is essential to ensure the effectiveness of IPC measures in healthcare settings. The integration of personalised IPC strategies into standard nursing practice not only improves infection control outcomes, but also contributes to overall patient safety and quality of care. By adopting a holistic approach to IPC, nurses can significantly enhance their patients' overall health and the recovery process. This article underscores the importance of IPC in nursing practice and has provided a detailed guide on how nurses can effectively incorporate IPC strategies into patient care to achieve the best outcomes. Infection prevention and control (IPC) is essential in nursing practice to reduce healthcare-associated infections (HAIs) and safeguard patient health, ultimately improving patient outcomes Effective IPC practices include hand hygiene, personal protective equipment use, environmental cleaning, and adherence to invasive procedure protocols, involving multidisciplinary collaboration Common HAIs such as catheter-associated urinary tract infections, central line-associated bloodstream infections, surgical site infections and ventilator-associated pneumonia can be prevented by adhering to specific infection control measures Continuous education, monitoring, leadership support and antimicrobial stewardship are crucial to overcoming challenges in IPC implementation and ensuring compliance Consider infection prevention and control protocols in your place of work. How you could ensure that you consistently adhere to these protocols in your daily practice? Think about how you could contribute to the multidisciplinary approach to IPC in your clinical setting Reflect on how you have incorporated antimicrobial stewardship in your practice. In what way could you ensure that you remain up-to-date on the latest guidelines? What challenges have you encountered in maintaining high standards of hand hygiene. How can you address these in your future practice? We expect providers to be aware of and follow the following best practice guidance.Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (Department of Health and Social Care)Infection prevention and control (NICE Guidance [QS 61])Essential Practice for Infection Prevention and Control (Royal College of Nursing)HSE and Infection at Work (HSE)National infection prevention and control (NHS England)Healthcare-associated infections: prevention and control in primary and community care (NICE Guidance [CG139])Healthcare-associated infections: prevention and control (NICE Guidance [PH36])Cleanliness and hygiene (environment and equipment)National Standards of Healthcare Cleanliness 2021 (NHS England)(HTM 01-04) Decontamination of linen for health and social care (NHS England)(HTM 07-01) Management and disposal of healthcare waste (NHS England)Control of substances hazardous to health (HSE)Legionella and legionnaires' disease (HSE)Control of legionella in hot and cold water systems in care services / settings using temperature (HSE)Legionella disease - The control of legionella bacteria in water systems (HSE)Personal hygiene (staff and people who use services) Hand hygiene for all initiative: improving access and behaviour in health care facilities (World Health Organisation)PPECOVID-19: personal protective equipment use for non-aerosol generating procedures (UK Health Security Agency)COVID-19: personal protective equipment use for aerosol generating procedures (UK Health Security Agency) Personal protective equipment (PPE) at work (HSE)Natural rubber latex sensitisation in health and social care (HSE) Selecting latex gloves (HSE)VaccinationThe Green book: Immunisation against infectious disease (UK Health Security Agency)The Yellow Card scheme: guidance for healthcare professionals, patients and the public (Medicines and Healthcare products Regulatory Agency)A guide to the COVID-19 vaccination programme (UK Health Security Agency)Flu vaccination: who should have it and why (UK Health Security Agency)Outbreak managementLiving safely with respiratory infections, including COVID-19 (UK Health Security Agency)COVID-19 symptoms and what to do (NHS)How to avoid catching and spreading COVID-19 (NHS)People with symptoms of a respiratory infection including COVID-19 (UK Health Security Agency)COVID-19: information and advice for health and care professionals (UK Health Security Agency)COVID-19: guidance for people whose immune system means they are at higher risk (UK Health Security Agency and Department of Health and Social Care)Handling the deceased with suspected or confirmed COVID-19 (HSE)Food HygieneThe Food Safety Act 1990 – A guide for food businesses (Food Standards Agency)Food Standards Agency guidance Enjoy sharper detail, more accurate color, lifelike lighting, believable backgrounds, and more with our new model update. Your generated images will be more polished than ever.See What's NewExplore how consumers want to see climate stories told today, and what that means for your visuals.Download Our Latest VisualGPS ReportData-backed trends. Generative AI demos. Answers to your usage rights questions. Our original video podcast covers it all—now on demand.Watch NowEnjoy sharper detail, more accurate color, lifelike lighting, believable backgrounds, and more with our new model update. Your generated images will be more polished than ever.See What's NewExplore how consumers want to see climate stories told today, and what that means for your visuals.Download Our Latest VisualGPS ReportData-backed trends. Generative AI demos. Answers to your usage rights questions. Our original video podcast covers it all—now on demand.Watch NowEnjoy sharper detail, more accurate color, lifelike lighting, believable backgrounds, and more with our new model update. Your generated images will be more polished than ever.See What's NewExplore how consumers want to see climate stories told today, and what that means for your visuals.Download Our Latest VisualGPS ReportData-backed trends. Generative AI demos. Answers to your usage rights questions. Our original video podcast covers it all—now on demand.Watch Now We're here for youLearn More Rob Melling, Head of Community Development "I love working for the local population - I'm passionate about helping the people of Leicester, Leicestershire and Rutland." John Barnes, Charge Nurse, LD Short Breaks "I really enjoy the human interaction on a daily basis - with colleagues, patients, relatives. Good communication skills are key." Laiqaah Manjra, Corporate Affairs Administrator "I progressed from being an apprentice to a Corporate Affairs Administrator - the NHS really supports staff development." Ellie Pratt, Community Knowledge Officer "I like that I'm able to help both staff and service users. It's really rewarding." Liam Capel, Nursing Associate "I have developed so many new skills over the years working in the NHS, going from a healthcare assistant to a nursing associate." Daxa Mangia, Mental Health Nurse, The Willows "I really enjoy my job, helping people to recover - I cannot imagine doing anything else." Care to join our family? We're always looking for the best. Make a difference with a career at LPT. Work at LPT Autism Space Involving you Volunteering We have four core values: Compassion, Respect, Integrity, Trust. Our values This monthly award is about recognising members of staff who have gone the extra mile. Our values Infection Prevention is everyone's responsibility. Leicestershire Partnership NHS Trust staff are committed to providing effective prevention and control of Healthcare Associated Infections (HCAI) to ensure that our patients, carers and families are cared for in a safe, secure and clean environment. The minimum requirements of any healthcare organisation are: A culture of zero tolerance to Healthcare Associated Infections (HCAI) Recognition that HCAI is everyone's responsibility Robust assurance for HCAI A dynamic and visible Infection Prevention and Control Team The Infection Prevention and Control (IPC) team work in partnership with staff and our multi-agency partners to promote best practice in infection, prevention and control and requirements of the Health and Social Care Act (2015). The team is responsible for a number of functions, some of which are identified below: Providing advice on all aspects of infection prevention and control. Managing increased incidences and outbreaks of infection. Surveillance with regard to incidence of MRSA and Clostridium difficile. Developing and facilitating programmes of education. Operating and delivering an Infection Prevention and Control Link Programme. Undertaking audits in line with local and national standards. Reviewing and advising on building works and facilities. Key documents Contact us Amanda Hemsley Head of Infection Prevention and Control Tel: 0116 295 2320 Laura Brown Senior Infection Prevention and Control Nurse Tel: 0116 295 2320 Skip to main content NHS England published its updated National Infection Prevention and Control Manual on April 24, 2023. The new manual provides recommendations and ways to prevent and manage infections in healthcare settings, serving as a crucial resource for healthcare practitioners. The updated manual contains the most recent evidence-based practices and is in line with the changing healthcare landscape, with an emphasis on patient safety. In this Article, we will provide a summary of the key highlights and recommendations from the updated manual. Enhanced Hand Hygiene Protocols: The manual emphasises the crucial role that 'hand hygiene' practices have in preventing infections. It offers detailed guidance on how to wash your hands properly, how to use alcohol-based hand sanitizers, and when to practice good hand hygiene. These recommendations aim to lessen the spread of dangerous infections within healthcare settings. Improved Environmental Cleaning: The manual stresses the need of thorough environmental cleaning and disinfection to reduce the risk of infections. It provides detailed instructions for cleaning different tools, surfaces, and patient care facilities. The new guidelines also stress the importance of using the correct disinfectants and adhering to the recommended cleaning frequencies. Robust Personal Protective Equipment (PPE) Guidelines: The updated manual offers thorough instructions on the proper usage of PPE. It addresses a number of topics, such as appropriate donning and doffing practices, choosing PPE depending on particular processes and dangers, and properly disposing of contaminated items. These guidelines aim to improve safety precautions and lessen the chance of cross-contamination. Effective Management of Infectious Diseases: The management of infectious illnesses, particularly those brought on by emerging pathogens, is covered in the updated IPC Manual. It provides guidance on methods for isolation precaution, early identification and the proper use of antimicrobial drugs. It also emphasises the significance of efficient monitoring systems to keep track of and respond to outbreaks promptly. Focus on Antimicrobial Stewardship: Whilst recognising antimicrobial resistance as a global challenge, the updated Manual emphasises the responsible use of antimicrobial agents. It offers guidance to healthcare professionals on how to optimise antimicrobial prescribing procedures while encouraging responsible usage, and preventing the emergence of resistance. Care Business Associate Training's Infection Prevention Control Training: The release of NHS England's updated National IPC Manual, marks a significant milestone in reinforcing infection prevention strategies within healthcare settings. The Manual intends to improve patient safety and lower the risk of healthcare-associated infections by adopting evidence-based practises and addressing new concerns. To guarantee the best possible infection prevention and control, workers are urged to adopt the manual's recommendations into their routine procedures. To stay updated with the latest guidelines, best practices, and emerging threats in infection control, regular infection prevention training is crucial to all healthcare workers. For more information about CBAT's Virtual Infection Prevention Control Lead Training give CBAT a call on 01772 816 922, email sales@cba-training.co.uk. References: NHS England. (2023). National Infection Prevention and Control Manual for England. Retrieved from National infection prevention and control manual for England. HomeNational infection prevention and control manual (NIPCM) for England This is an evidence-based practice manual for use by all those involved in care provision in England. It should be adopted as mandatory guidance in NHS settings or settings where NHS services are delivered, and the principles should be applied in all care settings. Introduction The UK Antimicrobial five-year national action plan, published in January 2019 stated that the Scottish national infection prevention and control manual (NIPCM) will be adopted in England as national standards, to be measured by the regulators. The NIPCM has been adapted for use within England to support and facilitate healthcare providers to demonstrate compliance with the ten criteria of the 'Health and Social Care Act 2008, Code of practice on the prevention and control of infections and related guidance (hereafter referred to as The "Code of Practice"). Aims The NIPCM has been produced to: provide an evidence-based practice manual for use by all those involved in care provision in England and should be adopted as guidance in NHS settings or settings where NHS services are delivered and the principles should be applied in all care settings. ensure a consistent UK wide approach to infection prevention and control, however some operational and organisational details may differ across the nations. In all non-NHS care settings, to support with health and social care integration, the content of this manual is considered best practice. The manual aims to: make it easy for care staff to apply effective infection prevention and control precautions reduce variation and optimise infection prevention and control practices across care settings in England improve the application of knowledge and skills in infection prevention and control help reduce the risk of Healthcare Associated Infection (HCAI) help with alignment of practice, education, monitoring, quality improvement and scrutiny. Pathogen specific guidance is out of remit of the NIPCM, which is not pathogen-specific. Pathogen-specific guidance appropriate to England, is produced by other agencies, for example, UK Health Security Agency (UKHSA), and can be found in the A-Z of pathogens resource. The NIPCM outlines evidence-based standards and transmission-based infection and prevention mitigations. The literature reviews that underpin and inform the practical application of the NIPCM and highlight implications for research are available via the NIPCM Scotland website. Audience and target groups This manual is guidance for the NHS and as such should be applied by all NHS staff involved in patient care. Furthermore, the principles in this manual should be applied across all care settings (including acute, community and social care), complementing specific guidance produced for these settings. Scope Guidance contained within this manual relates to infection prevention and control practice with a primary focus on healthcare (NHS) settings, however, the principles set out are relevant to all settings where care is delivered. This manual is complemented by setting and organism specific guidance, produced by agencies such as UKHSA, and links to other relevant guidance and legislation are provided for reference. Responsibilities for the content of this manual NHS England will ensure that there is appropriate consultation with key stakeholders, to ensure that the NIPCM recommendations are appropriate to the system and aligned with the relevant pathogen specific guidance, legislation, and mandatory requirements for England. Responsibilities for adopting and implementing this manual All registered care providers must demonstrate compliance with the Health and Social Care Act 2008: Code of practice on the prevention and control of infections and related guidance which outlines ten criteria which care organisations must demonstrate compliance against. The National IPC Board Assurance Framework (BAF) is available to support organisations to effectively self-assess compliance with the code of practice and to provide assurance in NHS settings or settings where NHS services are delivered. The Standard Infection Control Precautions (SICPs) Monitoring Tool can be used by organisations to self-assess the application of the SICPs set out in this manual and support its implementation. Responsibilities of organisation by role Chief executives/executive board (or equivalent) are responsible for ensuring: systems and resources available to implement and monitor compliance with infection prevention and control (Criteria 1, Code of Practice) as specified in this guidance in all care areas; compliance monitoring includes all staff (permanent, agency and, where required, external contractors) there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone. This may entail local risk assessments based on the measures as prioritised in the hierarchy of controls in the context of managing infectious agents*. safe systems of work, including managing the risk associated with infectious agents through the completion of risk assessments (outlined in Control of Substances Hazardous to Health (COSSH) regulations) and approved through local governance procedures, for example integrated care system level. This is for the protection of all healthcare workers, patients, and visitors. This national guidance outlines the recommended principles to support local decision making within individual organisations. *Guidance on the hierarchy of controls (HoC) is under development using the defined NIPCM methodology and will be included in the NIPCM content as a priority. Setting-specific risk assessment tools are available to support organisations in applying the HoC. Chief Operating Officers (COOs) are responsible for: directing the conduct of operational activities in relation to this guidance providing leadership, support, direction and assistance. Directors of infection prevention and control (DIPC) are responsible for ensuring: adoption and implementation of this guidance in accordance with local governance processes a workforce that is competent in infection prevention and control practice; (Criteria 6, Health and Social Care Act Code of Practice). Managers/employers of all services must ensure that staff: are aware of and have access to this guidance, including the measures required to protect themselves and their employees from infection risk have had instruction/education on infection prevention and control by attending events and/or completing training; (Criteria 1 and 9, Health and Social Care Act Code of Practice) have adequate support and resources to implement, monitor and take corrective action to comply with this guidance; and a risk assessment is undertaken and approved through local governance procedures who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment who have had an occupational exposure are referred promptly to the relevant agency, eg GP, occupational health or accident and emergency, and understand immediate actions eg first aid, following an occupational exposure including process for reporting (refer to section 1.10) have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs); (Criteria 10, Health and Social Care Act Code of Practice) include infection prevention and control as an objective in their personal development plans (or equivalent) (Criteria 6, Health and Social Care Act Code of Practice) refer to infection prevention and control in all job descriptions. Staff providing care must: show their understanding by applying the infection prevention and control principles in this guidance maintain competence, skills and knowledge in infection prevention and control by attending education events and/or completing training communicate the infection prevention and control practices to be carried out by colleagues, those being cared for, relatives and visitors, without breaching confidentiality have up-to-date occupational immunisations, health checks and clearance requirements as appropriate report to line managers, document and action any deficits in knowledge, resources, equipment and facilities or incidents that may result in transmitting infection including near misses, eg PPE failures apply the principles of good practice for uniform and workwear as set out in the NHS England uniforms and workwear guidance, eg, bare below the elbow not provide care while at risk of transmitting infectious agents to others; if in doubt, they must consult their line manager, occupational health department, and or their infection prevention and control team (IPCT) inform the IPCT and local UKHSA health protection team of any outbreaks or serious incident relating to an outbreak in a timely manner and in accordance with local policies and procedures. Infection prevention and control teams must: engage with staff to develop systems and processes that lead to sustainable and reliable improvements in applying infection prevention and control practices have suitably qualified infection prevention and control staff who can provide expert advice on applying infection prevention and control in all care settings and on individual risk assessments, ensuring action is taken as required must maintain competence, knowledge and skills in infection prevention and control practices have epidemiological/surveillance systems capable of distinguishing patient case(s) requiring investigation and control. When an organisation eg, an NHS trust, uses products or adopts practices that differ from those stated in this manual, it is responsible for ensuring safe systems of work, including the completion of a risk assessment approved through local governance procedures. Good infection prevention and control (IPC), including cleanliness, is essential to ensure that people who use health and adult social care services receive safe and effective care. This description of all activities related to infection prevention and control (including cleanliness) (IPC) was adopted in response to the consultation on the revision of the code of practice in 2015 to make it clear to non-specialists that cleanliness is an integral part of IPC. Throughout the document 'infection prevention and control (including cleanliness)' should be interpreted as including cleanliness. Effective prevention and control of infection must be part of everyday practice and be applied consistently by everyone. Good management and organisational processes are crucial to make sure that high standards of IPC (including cleanliness) are developed and maintained. This document sets out the code of practice (the code) on the prevention and control of infections under the Health and Social Care Act 2008 (H&SCA 2008). This act sets out the overall framework for the regulation of health and adult social care activities by the Care Quality Commission (CQC). It will apply to registered providers of all health and adult social care in England. Because of the wide range of services provided by all registered providers, the code will be applied in a proportionate way. Part 2 of the code sets out the 10 criteria against which the CQC will judge a registered provider on how it complies with the IPC (including cleanliness) requirements, which are set out in the regulations. To ensure that consistently high levels of IPC (including cleanliness) are developed and maintained, it is essential that all providers of health and social care read and consider the whole document and its application in the appropriate sector and not just selective parts. Parts 3 and 4 of this document will help registered providers interpret the criteria and develop their own risk assessments. The appendices provide examples of how a proportionate approach could be applied to the criteria in all sectors and it is important to read the examples given in the appendices, alongside the guidance under each criterion in part 3 of this document. The bibliography lists a range of supporting national guidance. This publication replaces the previous Health and Social Care Act 2008: Code of Practice document for health and adult social care on the prevention and control of infections and related guidance. The code applies to NHS bodies and providers of independent healthcare and adult social care in England, including primary dental care, independent sector ambulance providers and primary medical care providers. We have revised the previous code of practice document to reflect the structural changes that took effect in the NHS from 1 July 2022 and the role of IPC (including cleanliness) in optimising antimicrobial use and reducing antimicrobial resistance. The law states that the code is to be taken into account by the CQC when it makes decisions about registration against the IPC (including cleanliness) requirements. The regulations also state that registered providers must have regard to the code when deciding how they will comply with registration requirements. So, by following the code, registered providers will be able to show that they meet the relevant requirements set out in the regulations. However, the code is not mandatory so registered providers do not by law have to comply with the code. A registered provider may be able to demonstrate that it meets the regulations in a different way (equivalent or better) from that described in this document. The code aims to exemplify what providers need to do in order to comply with Regulations for Service Providers and Managers – Care Quality Commission 2022. 1. Introduction Good infection prevention control (IPC), including cleanliness and prudent antimicrobial stewardship (AMS), is essential to ensure that people who use health and social care services receive safe and effective care. Effective prevention of infection must be part of everyday practice and be applied consistently by everyone. It is also a component of good antimicrobial stewardship as preventing infections helps to reduce the need for antimicrobials. Good management and organisational processes are crucial to make sure that high standards of IPC (including cleanliness) are set up and maintained. As the regulator of health and adult social care in England, the Care Quality Commission (CQC) will provide assurance that the care people receive meets the fundamental standards of quality and safety. These standards are set out in the regulations. This document outlines what registered providers in England should do to ensure compliance with the registration requirement at Regulation 12(2)(h) of the regulations. This includes 'assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are healthcare associated'. It also sets out the 10 compliance criteria against which registered providers will be judged. Providers should note that Regulation 15 is also relevant to IPC (including cleanliness) and that other provisions of the regulations may also apply. The CQC has published guidance for providers on meeting the requirements of the regulations, including the enforcement policy, and will use these documents in conjunction with this code of practice and related guidance when judging compliance. Because of the wide range of services provided by all registered providers, the code will be applied in a proportionate way. The code of practice The main purposes of the code are to: make the registration requirements relating to IPC (including cleanliness) clear to all registered providers so that they understand what they need to do to comply provide guidance for CQC staff to make judgements about compliance with the requirements for IPC (including cleanliness) provide information for people who use the services of a registered provider provide information for commissioners of services on what they should expect of their providers provide information for the general public Readers will note that only paragraphs in part 3 of this document have been numbered, as these particular sections are likely to be specifically referenced by the CQC in ensuring compliance with the regulations. The terms used in this document There are a wide range of terms relating to services and organisational structures, and different ways to describe the same or similar things across health and social care. In this document we have tried to harmonise some of those terms and use descriptions that are meaningful across all sectors. For example, we have used the term 'service user' to describe patients, donors, residents and clients. Because National Health Service (NHS) trusts (as an entity), primary medical and dental care, independent healthcare, independent sector ambulance providers and adult social care providers are all required to register with the CQC as providers of health or social care, they are referred to in this document as 'registered providers'. The term 'health and care worker' is used to refer to anyone whose normal duties involve providing direct care to service users, for example clinical staff, nurses, healthcare assistants, care assistants as well as volunteers. The term 'independent-sector ambulance provider' covers triage, medical or clinical advice provided remotely, face-to-face treatment and transport services. Transport services are those provided by means of vehicles, which are designed for the primary purpose of carrying a person who requires treatment. The term 'vehicle' includes road, air and water ambulances. The term 'infection' is used throughout this document, rather than the more explicit term 'healthcare associated infection', except for circumstances where the specific term is appropriate. Antimicrobial resistance (AMR) is defined as resistance of a microorganism to an antimicrobial drug that was originally effective for treatment of infections caused by it, and applies to antivirals, antifungals, antiparasitics and antibiotics. Antimicrobial stewardship (AMS) is defined as 'an organisational or healthcare-system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness'. It includes promoting optimal diagnosis of infection, drug choice, regimen, dose, duration and administration route. The aim is for optimal clinical outcome and to limit selection of resistant strains. This is a key component of a multi-faceted approach to preventing antimicrobial resistance. The code recognises that many infections that arise in the community may not be related to the delivery of health or adult social care. Nevertheless, some of these infections may be preventable by good practice, such as hygiene and immunisation, which is dealt with in the code and the related guidance. Appendix D provides further definitions. Background This document builds on the previous H&SCA 2008 code of practice for health and adult social care on the prevention and control of infections and related guidance. The previous code of practice applied to NHS bodies and providers of independent healthcare and adult social care in England and was used by the CQC to judge whether those providers complied with the registration requirement for IPC (including cleanliness). This refreshed code strengthens some elements such as how to prevent antimicrobial resistance and provides additional clarity in some of the criteria, as well as an updated bibliography. The way that health and adult social care is regulated has changed since April 2009 because of the introduction of the Health and Social Care Act (H&SCA) 2008. The regulations, as made under the H&SCA 2008, describe the health and adult social care activities that may only be carried out by providers that are registered with the CQC, and set out the registration requirements that these

providers must meet to become and stay registered. Further details on how the CQC assesses whether providers meet the requirements can be found here. The H&SCA 2008 and regulations are law and must be complied with. The CQC has enforcement powers that it may use if registered providers do not comply with the law. NHS bodies providing regulated activities, including prison healthcare services, have been required to comply with the full set of registration requirements since 1 April 2010. Independent healthcare and adult social care providers of regulated activities have been required to comply with the registration requirements since 1 October 2010. Primary dental care and independent sector ambulance providers have been required to register by April 2011, and primary medical care providers by April 2012. The regulated activities and registration requirements are set out in the H&SCA 2008 (Regulated Activities) Regulations 2014. How the code should be used Section 21 of the H&SCA 2008 enables the Secretary of State for Health to issue a code of practice about the prevention and control of healthcare associated infections. The code contains statutory guidance about compliance with the registration requirement relating to IPC (including cleanliness) (Regulation 12 (2) (h) and 21(b) of the regulations). The law states that the code must be taken into account by the CQC when it makes decisions about registration against the IPC (including cleanliness) requirements in Regulations 12 (2) (h) and 21(b). The regulations also say that providers must have regard to the code when deciding how they will comply with the relevant registration requirements. So, by following the code, registered providers will be able to show that they meet the regulation on IPC (including cleanliness). However, they do not by law have to comply with the code. A registered provider may be able to demonstrate that it meets the registration requirement regulation in a different way (equivalent or better) from that described in the code. The CQC's guidance about compliance with the regulations includes a reference to this code in relation to the 'premises and equipment' regulation (Regulation 15) as CQC considers this code to be relevant for the purposes of meeting that regulation. To become and stay registered, providers must meet the full range of registration requirements. The CQC has published guidance about how to comply with all the requirements other than the one on infection control. This guidance is contained in the CQC Guidance for providers on meeting the regulations. The code does not replace the requirement to comply with any other legislation that applies to health and social care services; for example, the Health and Safety at Work Act 1974 and the Control of Substances Hazardous to Health Regulations 2002. How compliance will be judged The CQC is responsible for judging compliance with the registration requirements set out in the regulations. When doing this for IPC (including cleanliness), it will take account of the code and how registered providers are complying with the code. It will do this in a way that is proportionate to the risk of infection. All registered providers will need to have adequate systems for IPC (including cleanliness) as stated in the code (see part 2), if they are to comply with the law; but because of the wide range of services provided by all registered providers, the code will be applied in a proportionate way. For example, in an acute hospital setting there is a greater risk to service users of infection and therefore the registered provider will need to comply with most aspects of the compliance criteria. However, in a service provided in someone's own home or a care home where people are supported to be independent in a domestic setting, the registered provider will not need to have the same facilities and approach as an acute hospital. What may happen if a registered provider does not meet the requirements in the code The CQC may use its enforcement powers or take other action where it decides that a registered provider is not meeting its legal obligations as set out in the regulations. The CQC will reach this decision by looking at whether a registered provider can demonstrate regard to the code. If a registered provider is not following the code, then the CQC will want to consider whether that is because it is not appropriate to the type of service being provided. If it is appropriate, the CQC will want to consider whether a registered provider is still protecting people from the risk of infection in another, equally effective way. The CQC can prosecute a provider that breaches any part of Regulation 12(2)(h) if a failure to meet the regulation results in a risk of exposure to significant harm or avoidable harm to a person using the service, or if a person using the service is exposed to a significant risk of harm. The CQC website provides further information about how the CQC assesses registered providers and what action it can take if a registered provider does not comply with the regulations. Alternatively, you can contact its customer services team on 03000 616161. Commissioning of services The CQC is responsible for monitoring compliance with the requirements of the H&SCA 2008 (Regulated Activities) Regulations 2014. Commissioning organisations may wish to assure themselves that the services that they commission are meeting expected requirements, and this may involve contract monitoring of the service. In doing so, commissioners must make it clear to the provider that this does not replace or duplicate the regulatory role of the CQC. Key components to support compliance This document provides a range of information, including appendices, tables, definitions and an extensive bibliography to support providers in complying with the regulations. Part 2 (The code) details the criteria against which the registered provider will be judged on how it complies with the registration requirements for IPC (including cleanliness). Part 3 (Guidance for compliance) provides guidance on how to interpret the compliance criteria and develop risk assessments. Part 4 (Guidance tables), attached as a separate pdf document, details the relevant criteria that might apply to each regulated activity, offers potential sources of professional advice on IPC (including cleanliness) and antimicrobial stewardship, and lists which policies may be required to demonstrate compliance with Regulation 12 (Safe Care and treatment) and Regulation 15 (Premises and Equipment) of the regulations. The appendices provide examples of how a proportionate approach could be applied to the criteria in acute care, adult social care, primary dental care, independent sector ambulance providers and primary medical care services. However, it is important to read the examples given in the appendices, alongside the guidance under each criterion in part 3 of this document, and not just selective parts. The bibliography lists a range of supporting national guidance, advisory and regulatory documentation. 2. The code of practice The list below is the code of practice for all providers of healthcare and adult social care on the prevention of infections for the purposes of s.21 of the H&SCA 2008. This sets out the 10 criteria against which a registered provider will be judged on how it complies with the registration requirements related to IPC (including cleanliness), as set out in the regulations. Not all criteria will apply to every regulated activity. Parts 3 and 4 of this document will help registered providers interpret the criteria and develop their own risk assessments. Compliance criterion What the registered provider will need to demonstrate Criterion 1 Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them. Criterion 2 The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections. Criterion 3 Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance. Criterion 4 The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion. Criterion 5 That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people. Criterion 6 Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection. Criterion 7 The provision or ability to secure adequate isolation facilities. Criterion 8 The ability to secure adequate access to laboratory support as appropriate. Criterion 9 That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections. Criterion 10 That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control. 3. Guidance for compliance To achieve compliance with the registration requirements relating to IPC (including cleanliness), registered providers would normally be expected to demonstrate that they have in place the policies and procedures to meet each relevant criterion listed in part 2, and have taken account of the following guidance for compliance. This guidance is not mandatory but is considered to represent the basic steps that are required to ensure that the criteria can be met. There may be additional or alternative strategies that a registered provider is able to justify as equivalent, or more effective, in achieving compliance in their circumstances. Registered providers are free to decide to use alternative approaches but should be prepared to justify to the CQC how the chosen approach is equally effective or better in ensuring that the criteria are met. Providers of regulated activities need to recognise that effective management of IPC is an important service-user safety issue. The tables in part 4 may be used as a guide to help to decide on the application of the individual compliance criteria and the available sources of advice on IPC (including cleanliness). The principle of proportionality extends throughout this guidance and the level of detail and complexity for each policy will depend on local risk assessments. In particular, a local risk assessment will be needed to assess services that combine low and higher risk activities. Guidance for compliance with criterion 1: systems to manage infection Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them. Appropriate management and monitoring arrangements 1.1 These should ensure that: the registered provider has arrangements in place to minimise the risks of infection; there is a clear governance structure and accountability that identifies a lead for IPC (including cleanliness) accountable directly to the registered provider there are mechanisms in place by which the registered provider can ensure that sufficient resources are available to secure effective IPC these should include the implementation of an IPC (including cleanliness) programme, infrastructure and the ability to monitor and report infections, as well as antimicrobial stewardship all staff receive suitable and sufficient IPC information, training and supervision relevant to their roles throughout their employment, to minimise the risks of IPC relevant principles of antimicrobial stewardship, risk assessment and how to escalate concerns systems are in place for service users and staff to raise concerns and to receive feedback assurances are in place to ensure that key policies and practices are being implemented, updated and adhered to appropriately a decontamination lead is designated, where appropriate a water safety group and water safety plan are in place, where appropriate a ventilation/air safety group is in place, where appropriate Risk assessment 1.2 All registered providers should ensure that they have: undertaken and recorded a comprehensive and dynamic assessment of infection risks to identify the potential and actual risks to the service user receiving care identified and documented the steps that need to be taken to reduce or control those risks, including awareness of vaccination status methods and interventions in place to monitor the risks of infection, to determine whether further steps are needed to reduce or control infection Directors of IPC (DIPC) (including cleanliness) in NHS provider organisations 1.3 The DIPC in NHS provider organisations should: provide oversight and assess assurance on IPC (including cleanliness), the built environment and antimicrobial stewardship to the trust board or equivalent. Where significant risks are identified the DIPC should advise the board on how to mitigate these. They should report directly to the board but are not required to be a board member be responsible for leading the organisation's IPC (including cleanliness) team strategy and improvement plan oversee infection prevention and control policies and work with IPC leads to promote a systemwide approach be a full member of the IPC and antimicrobial stewardship committee and regularly attend its IPC (including cleanliness) and stewardship meetings have the authority to challenge inappropriate practice and inappropriate antimicrobial prescribing decisions have the authority to set and challenge standards of cleanliness assess the impact of all existing and new policies on infections and make recommendations for change be an integral member of the organisation's clinical governance, patient safety teams, relevant structures produce an annual report for IPC and make it publicly available IPC lead (for example, adult social care, primary dental and medical care, independent healthcare providers and independent sector ambulance providers) 1.4 Outside of NHS organisations, the responsibilities of the DIPC are discharged by the IPC lead for the registered provider. This role will vary across adult social care, primary dental care, primary medical care, independent healthcare providers and independent sector ambulance providers. The IPC lead for the registered service provider should: be responsible for the organisation's IPC (including cleanliness), the built environment (where appropriate) and antimicrobial stewardship programme, as well as management and structure and the establishment of relevant groups oversee IPC policies and their implementation and work with other IPC system-wide leads when needed the lead will report directly to the registered provider promote respectful challenge of inappropriate practice amongst all workers and have the authority to set and challenge standards of cleanliness assess the impact of all existing and new policies on infections and make recommendations for change be an integral member of the organisation's governance, and safety teams and structures where they exist produce an annual statement with regard to compliance with practice on IPC (including cleanliness) and make it available on request Assurance framework in NHS provider organisations 1.5 Activities to demonstrate that IPC (including cleanliness) and antimicrobial stewardship are an integral part of quality assurance should include regular presentations from the DIPC and/or the IPC and antimicrobial stewardship teams to the NHS board or registered provider. These should feature a trend analysis for infections, antimicrobial resistance, antimicrobial prescribing and compliance, with quarterly reporting to the NHS board or registered provider by clinical directors and matrons (including nurses who do not hold the specific title of 'matron' but who operate at a similar level of seniority and who have control over similar aspects of the service user or the service user's environment). What is reported on will vary according to the local arrangements. For example, it may include: monthly cleanliness scores review of trends (for example, monthly) and peer comparison of broad-spectrum and total antimicrobial prescribing, use of intravenous route of administration, treatment course length and audits of adherence to local/national guidelines for the management of common infections annual patient led assessments of the care environment (PLACE) scores contract performance measures where provision is in-house or outsourced, which will include cleanliness measures and issues of non-compliance and subsequent improvement actions information taken from the organisation's self-assessment using the NHS premises assurance model (NHS PAM) decisions observations taken from board level or other staff, service users and family 'walk rounds' complaints and compliments relating to IPC (including cleanliness) a review of mandatory and voluntary surveillance data, including antimicrobial resistance (drug-bug combinations), outbreaks and serious incidents evidence of appropriate action taken to manage occurrences of infection or inappropriate prescribing of antimicrobials, including, where applicable, root cause analysis, with emphasis on lessons learnt and/or post infection review in adult social care, primary dental care and primary medical care independent healthcare providers and independent ambulance providers evidence of appropriate action taken to prevent and manage infection an audit programme to ensure that appropriate policies and measures have been developed and implemented evidence that the annual statement from the service provider has been reviewed through the organisation's governance structures and, where indicated, acted upon regular review of antimicrobial prescribing decisions 1.6 In accordance with health and safety requirements, where suitable and sufficient assessment of risks requires action to be taken, evidence must be available on compliance with the code or, where appropriate, justification of a suitable better alternative. This applies to all health and adult social care. IPC (including cleanliness) programme 1.7 The IPC (including cleanliness) programme should: set objectives that meet the needs of the organisation and ensure the safety of service users, health and social care workers and the public identify agreed priorities for establishing an improvement plan provide evidence that relevant policies have been effectively implemented report progress against the objectives of the programme in the DIPC's annual report or the service providers' annual statement IPC (including cleanliness) infrastructure 1.8 An IPC (including cleanliness) infrastructure should encompass the below. In acute healthcare settings, an IPC (including cleanliness) team consisting of an appropriate mix of: both nursing and consultant medical, antimicrobial pharmacists' expertise (and/or with specialist training - in IPC and antimicrobial stewardship) other healthcare workers and appropriate administrative and analytical support estates and facilities management adequate information technology The DIPC is a key member of the IPC (including cleanliness) team. Acute healthcare settings have a multidisciplinary antimicrobial stewardship committee to develop and implement the organisation's antimicrobial stewardship programme drawing on Start Smart then Focus (SMTF) AMS toolkit and National Institute for Health and Care Excellence (NICE) antimicrobial stewardship national guidance. In other settings, there will be a lead who is responsible for IPC (including cleanliness) matters and is aware of the local arrangements to obtain specialist infection control and antimicrobial stewardship expertise. 24-hour access to a nominated microbiologist or consultant in health protection/communicable disease control should be available. The registered provider should know how to access this advice. Movement of service users 1.9 There should be evidence of joint working between staff involved in the provision of advice relating to the prevention of infection and control: those managing bed allocation; care staff and domestic staff in planning service user referrals, admissions, transfers discharges and movements between departments; and within and between health and adult social care facilities. 1.10 A registered provider must ensure that it provides suitable and sufficient information on a service user's infection status whenever it arranges for that person to be moved from the care of one organisation to another, or to or from a service user's home, so that any risks to the service user, staff and others from infection can be minimised. If appropriate, providers of a service user's transport should be informed of the service user's infection status. Refer also to CQC guidance on compliance with Regulation 12 (2)(i) on Safe Care and Treatment – shared care. Guidance for compliance with criterion 2: clean environments Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections. Refer also to section on Regulation 15 on premises and equipment, contained in the CQC guidance for providers on meeting the regulations. 2.1 To minimise the risk of infection, a registered provider should ensure that: a specific individual has responsibility for oversight and management of cleaning, environmental services and decontamination of medical devices and equipment the designated lead for cleaning is responsible for all aspects of cleaning services, from contract negotiation and service planning to delivery at the care level there is collaboration with key stakeholders to ensure maintenance and cleaning is planned and implemented in health and social care, all clinical and non-clinical staff have personal responsibility and accountability for maintaining a safe and clean care environment the person in charge of any area has direct responsibility for ensuring that cleanliness standards are consistently maintained all parts of the premises from which it provides care are suitable for the purpose, kept clean and maintained in good physical repair and condition the cleaning arrangements detail the standards of cleanliness required as appropriate for the setting in each part of its premises and that a schedule of cleaning responsibility and frequency is available on request there is adequate provision of suitable hand-washing facilities and products there are effective arrangements for the appropriate cleaning of equipment that is used at the point of care, for example hoists, beds and commodes – these should be incorporated within appropriate cleaning, disinfection and decontamination policies for all healthcare settings, there are effective arrangements for the appropriate cleaning of equipment that is used at the point of care and which are based on the National Standards for Healthcare cleanliness responsibilities framework or equivalent standards and cleanliness charters. These should be incorporated within appropriate cleaning, disinfection and decontamination policies the storage, supply and provision of linen and laundry are appropriate for the level and type of care 2.2 'The environment' means the totality of a service user's surroundings when in care premises or transported in a vehicle. This includes the fabric of the building, related fixtures and fittings, and services such as air and water supplies. Where care is delivered in the service user's home, the suitability of the environment for that level of care should be considered. Policies on the environment Premises and facilities should be provided in accordance with best practice guidance. The development of local policies should take account of IPC, given by relevant expert or advisory bodies or by the IPC team. This should include liaison between any IPC practitioners and the person(s) with overall responsibility for the management of the service user's environment, where appropriate. Policies should address but not be restricted to: cleaning services building and refurbishment, including air-handling systems waste management laundry arrangements for the correct classification and sorting of used and infected linen planned preventative maintenance pest control management of drinkable and non-drinkable water supplies minimising the risk of Legionella and other water-supply and building-related infections, for example Pseudomonas aeruginosa and aspergillus, by adhering to national guidance food services, including food hygiene and food brought into the care setting by service users, staff and visitors Refer also to Regulation 15 in respect to premises and equipment contained in CQC guidance for providers on meeting the regulations. Cleaning services 2.3 The arrangements for cleaning should include: clear definition of specific roles and responsibilities for cleaning clear, agreed and available cleaning routines sufficient resources dedicated to keeping the environment clean and fit for purpose consultation with IPC teams or equivalent local expertise on cleaning protocols when internal or external contracts are being prepared details of how staff can request additional cleaning, both routinely and urgently (outside of usual frequency) cleaning and disinfection of the fabric, fixtures and fittings of a building (walls, floors, ceilings and bathroom facilities) or vehicle Decontamination of reusable medical devices, equipment and linen 2.4 The designated decontamination lead should have responsibility for ensuring that policies are implemented and that they take account of best practice and national guidance, ensuring that the following points are covered: reusable medical devices should be repurposed at one of the following 4 levels: clean (free of visible contamination) disinfected (a process used to reduce the number of viable infectious agents, but which may not necessarily inactivate some microbial agents, such as certain viruses and bacterial spores) sterile (at point of use) sterilised (meaning it has been through the sterilisation process) the decontamination and disinfection of linen is carried out, as well as the correct classification and sorting of used linen (for example, soiled and fouled linen, infectious linen, heat labile linen) the decontamination of non-invasive service user equipment is enforced, for example beds, commodes, mattresses, hoists and slings, examination couches, trolleys and stretchers 2.5 The reusable medical devices and equipment decontamination policy should demonstrate that: it complies with national guidance by establishing essential quality requirements, and that a plan is in place for progression to best practice procedures for the acquisition, maintenance and validation of decontamination equipment follow national guidance staff are trained in cleaning and decontamination processes and the safe use of decontamination equipment, and hold appropriate competences for their roles a record-keeping system is in place to ensure that decontamination processes are fit for purpose and use the required quality systems decontamination of reusable medical devices takes place in compliant facilities that are designed for the purpose of decontaminating medical devices through validated processing systems and controlled environmental conditions. This is to ensure that all potential environmental, cross-infection, handling and medical device usage risks are minimised Refer also to Regulation 15 Premises and Equipment contained in CQC guidance for providers on meeting the regulations. Guidance for compliance with criterion 3: antimicrobial use Ensure appropriate antimicrobial use and stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance. 3.1 Systems should be in place to manage and monitor the use of antimicrobials to ensure inappropriate and harmful use is minimised and service users with severe infections, such as sepsis, are treated promptly with suitable antimicrobial(s). These systems should draw on national and local guidelines, monitoring and audit tools, including, but not limited to, NICE guidelines, guidance on patient group directions, the Treat Antibiotics Responsibly, Guidance Education Tools (TARGET) toolkit in primary care, Start Smart then Focus in secondary care and national antimicrobial prescribing competences. 3.2 Service providers, where appropriate, should have in place a designated lead for antimicrobial stewardship responsible for developing, implementing and monitoring the organisation's stewardship programme and reporting to the executive board or equivalent, where available. Antimicrobial stewardship must be supported by strong leadership across clinical specialties with oversight provided by an antimicrobial stewardship committee or as part of an existing committee, such as a drug and therapeutics committee or equivalent. Membership of this committee will vary dependent on the setting but should be multidisciplinary and representative of the clinical specialities in accordance with NICE guidance. The committee should report antimicrobial stewardship activities, antimicrobial prescribing trends (this should include appropriate peer comparison data) to the trust board via the organisation's DIPC, or the designated lead for antimicrobial stewardship. 3.3 Providers should develop a local antimicrobial stewardship policy and local infection management guidelines drawing on national guidance (including from NICE), the British National Formulary and UK Health Security Agency (UKHSA) that takes account of local antimicrobial resistance patterns. The policy should cover the principles of diagnosis, treatment and prophylaxis of common infections, and prescribers should document allergy status, reason for antimicrobial prescription, dose, route and duration of treatment. Adherence to antimicrobial prescribing guidance and compliance with hospital post-prescribing review at 48 to 72 hours should be monitored and audited on a regular basis, with data fed back to prescribers and incorporated into service user safety reporting systems to boards and commissioners. Peer comparison and trend data, and prescribing audits should be used to demonstrate progress in antimicrobial stewardship in all settings. There should be evidence of appropriate action taken to deal with occurrences of inappropriate prescribing of antimicrobials including, where applicable, root cause analysis, emphasis on lessons learnt and/or post-infection review. 3.4 Providers should have access to timely microbiological diagnosis, susceptibility testing and reporting of results, preferably within 48 hours of specimen taking. Prescribers should have access at all times to suitably qualified individuals who can advise on appropriate choice of antimicrobial therapy. 3.5 In acute care settings, providers should report local antimicrobial susceptibility data (drug-bug combinations) and information on antimicrobial consumption to the national surveillance body. Surveillance information should be used by the local and regional stewardship committees or equivalent to monitor local resistance patterns and guide local antimicrobial prescribing guidelines and antimicrobial stewardship activities. This information should be communicated back to prescribers across the health and social care system to improve prescribing quality. 3.6 Providers should ensure that all health and care workers involved in prescribing, dispensing and administration of antimicrobials receive induction and appropriate training in prudent antimicrobial use and the principles of antimicrobial stewardship. They should be encouraged to maintain their knowledge through training and regular educational sessions. This should include being familiar with the principles of antimicrobial stewardship as set out in the antimicrobial prescribing, stewardship competencies, NICE guidance on antimicrobial stewardship and local AMS policy. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further health and social care support or nursing/ medical care in a timely fashion. 4.1 Information for service users and visitors Existing information sources suitable for people receiving care can be signposted, such as NHS Choices. Information should be co-produced, where appropriate, with service user representation organisations, such as the local Healthwatch and Patient Advice and Liaison services (PALS), in a timely and accessible way. 4.2 Areas relevant to the provision of information Themes relevant to the provision of information include: general principles on the prevention of infection and key aspects of the registered provider's policy on IPC, which takes into account the communication needs of the service user the roles and responsibilities of particular individuals, such as carers, relatives and advocates, in the prevention of infection to support them when visiting service users the importance of appropriate use of antimicrobials supporting service users' awareness and involvement in the safe provision of care the importance of compliance by visitors with hand hygiene procedures the importance of compliance with the registered provider's policy on visiting reporting concerns relating to hygiene and cleanliness, including hand hygiene explanations of incident/outbreak management and action taken to prevent recurrence key aspects of the registered provider's policy on IPC (including cleanliness) for their service users, carer(s), visitors and/or relatives the roles and responsibilities of particular individuals, such as carers, relatives and advocates, in the prevention of infection, to support them when visiting service users standard practices used to prevent and control infection and how these may impact on the service user experience of care, such as the use of personal protective equipment (PPE) specific information on elements of IPC (including cleanliness) as appropriate for the service user, including the importance of appropriate use of antimicrobials; supporting service users' and their carers' awareness and involvement in the safe provision of care the importance of compliance with the registered provider's policies to prevent introduction of infection to the service, including through visiting reporting concerns relating to hygiene and cleanliness, including hand hygiene explanations of incident/outbreak management and action taken to prevent recurrence 4.3 Materials Materials from global, national or local awareness campaigns could be used to develop information on appropriate principles of IPC (including cleanliness), including hand hygiene, respiratory hygiene and action to promote safe, effective and appropriate use of antimicrobials to reduce risk of developing antimicrobial resistance. Examples, such as World Health Organization (WHO) hand-hygiene tools, are included in the bibliography. Refer also to Regulation 9, Person Centred Care, contained in CQC Guidance for providers on meeting the Regulations. 4.4 Information for those providing further support or care A registered provider should ensure that: accurate, clear and accessible information is communicated in a timely manner to appropriately reflect the needs of the service user and their care information should be available in a range of appropriate languages and formats, including digital, to meet the needs of local users and carers, relatives and/or visitors service users and carers, relatives and/or visitors should be provided with appropriate, accurate and up-to-date information in formats that tailor to individual needs the information facilitates the provision of best practice at all stages of the care journey, focusing on actions that prevent infection in people at risk and minimising the risk of inappropriate management and further transmission of infection within care services information on the risks of non-compliance with recommended actions should be communicated sensitively and clearly. Providers should ensure that clear and specific guidance is available describing how to take actions that are effective in reducing risk of infection to the service user and others 4.5 Provision of relevant information across relevant organisation boundaries is covered by the regulation requirement 9, Person Centred Care. Due attention should be paid to service user confidentiality as outlined in national guidance and training material. Guidance for compliance with criterion 5: those at risk of infection Ensure that people who have or at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people. 5.1 Registered providers (excluding providers of 'personal care') should ensure that advice is received from staff involved in a service user's management. Registered providers should inform their IPC team and the local UKHSA health protection team (HPT) of any potential outbreaks or serious incidents relating to infection in a timely manner. 5.2 Governance arrangements should demonstrate that responsibility for IPC (including cleanliness) is effectively devolved to all teams in the organisation involved in care provision and or management of the environment. 5.3 In an adult social care service, primary care clinicians/GPs will provide the necessary initial advice when a service user develops infection. The primary care clinician/GP may wish to draw on local expertise in IPC, infection management and/or health protection. Guidance for compliance with criterion 6: registered providers responsibility to health and social care workers and those in care settings (including contractors and volunteers) Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection. 6.1 A registered provider should, so far as is reasonably practicable, ensure that its staff, contractors, visitors and others involved in the provision of care co-operate with each other so far as is necessary to enable the registered provider to meet its obligations under the code. 6.2 The registered provider should include IPC (including cleanliness) in all job descriptions. It should also be included, together with antimicrobial stewardship, in induction programmes, and a suitable and sufficient programme of continual training for IPC should be organised for all staff and volunteers. The content should reflect the post holder's role and level of responsibility and a record of all training should be kept. 6.3 Where staff undertake procedures, which require skills such as aseptic technique, staff must be trained and demonstrate proficiency before being allowed to undertake these procedures independently. 6.4 The registered provider should have systems in place to regularly assess the IPC (including cleanliness) skills and competencies of its directly employed staff and volunteers and review and update its training programmes as required. 6.5 In meeting the above obligations, the registered provider must take into account the needs of staff and service users, and particularly those with learning disabilities, dementia, specific vulnerabilities or protected characteristics, to ensure working arrangements are equitable. 6.6 Education and training must be made available to all staff (including support staff, volunteers, agency/locum staff and staff employed by contractors). This should incorporate the principles and practice of prevention and control of infection and should explain the risk from existing, new and emerging infectious diseases. This information should also be taken into account when assessing service users, equipment and the environment. Guidance for compliance with criterion 7: isolation facilities Provide or secure adequate isolation facilities. 7.1 Healthcare registered providers (excluding providers of 'personal care') delivering inpatient care should ensure that they are able to provide, or secure the provision of, adequate isolation precautions and facilities, to prevent or minimise the spread of infection to service users, staff or visitors. This may include facilities in a day care setting. 7.2 Social care settings may not have dedicated isolation facilities for service users but are expected to implement isolation precautions when a service user is suspected or known to have a transmissible infection. 7.3 Policies should be in place for the allocation of appropriate isolation facilities based on service user needs and local risk assessment. The assessment could include consideration of the need for special ventilated isolation facilities, management of appropriate PPE, bare below the elbows (BBE) protocols, waste management strategies, impact of social isolation assessments, and the monitoring of service users. Sufficient numbers of staff with suitable training should be available. 7.4 Registered providers of health and social care should ensure that they are able to provide or secure facilities to physically separate a service user from other service users in an appropriate manner, to minimise the spread of infection. 7.5 Health and social care providers should ensure they have dedicated service user equipment allocated to the isolation facilities, wherever possible. Where this is not feasible, an appropriate decontamination strategy must be in place. Guidance for compliance with criterion 8: laboratory support Secure adequate access to laboratory support as appropriate. 8.1 A registered provider should ensure that laboratories that are used to provide testing services, in connection with arrangements for IPC, have appropriate protocols in place. These laboratories should operate according to the standards required by the relevant national accreditation bodies and associated regulatory frameworks. In adult social care, the service user's GP will arrange such testing and take responsibility for submitting specimens to the laboratory when necessary for the diagnosis, treatment and management of disease. 8.2 Protocols should include: a laboratory policy for investigation and surveillance of antimicrobial resistance and healthcare associated infections standard laboratory operating procedures for the examination of specimens timely reporting to the person requesting and IPC team, if relevant, including escalation procedures selective reporting of antimicrobial susceptibility testing results to prioritise prescribing of narrow-spectrum antimicrobials and adherence to local treatment guidelines Guidance for compliance with criterion 9: policies The service provider should have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections. NHSE organisations should adopt the National Infection Prevention and Control Manual (NIPCM) as their mandatory policy. Other organisations may also choose to adopt the NIPCM or equivalent guidance as a policy. 9.1 A registered provider should, in relation to preventing, reducing and controlling the risks of infections, have in place the appropriate policies concerning the matters mentioned in a) to y) below. All policy documents should be clearly marked, with the current version indicated by a review date, and evidence of a review within the timeframe. 9.2 A guide is given in table 3 as to which policies may be appropriate to regulated activities. A decision should be made locally following a risk assessment. 9.3 Any registered provider should have policies in place relevant to the regulated activity it provides. Each policy should indicate ownership, authorship and by whom the policy will be applied. Implementation of policies should be monitored and there should be evidence of a rolling programme of audit and a stated date for revision. See the listed policies below related to 9.3 and table 3. a) Standard and transmission-based IPC and control precautions Preventing infections reduces the overall need to use antimicrobials and helps to reduce the opportunity for the development of antimicrobial resistance: policy should be based on evidence-based guidelines, including those on hand hygiene at the point of care, including bare below the elbow (BBE) protocols, and the use of personal protective equipment policy should be easily accessible and be understood by all groups of staff, service users and the public compliance with policy should be subject to a quality improvement programme as part of assurance monitoring provisions on regular refresher training, support for service users to clean their hands, and products for staff with occupational dermatitis are among the issues that should be covered in the hand-hygiene policy b) Aseptic technique Where aseptic techniques are performed, it is important that: the principles of asepsis are followed clinical procedures are carried out in a manner that maintains and promotes the principles of asepsis education, training and assessment in the aseptic technique is available and provided prior to all persons undertaking such procedures the techniques are standardised across the organisation a quality improvement programme is undertaken to monitor compliance with the technique c) Outbreaks of communicable infection Procedures to follow: the degree of detail in the policy should reflect local circumstances. A low risk, single-specialty facility or provider of primary care will not require the same arrangements as those providing the full range of medical and surgical care professional advice on IPC for regulated activities may be drawn from a number of expert sources. Table 2 outlines the most likely arrangements for the different regulated activities policies for outbreaks of communicable infection should include initial risk assessment, communication, management and organisation, plus investigation and control, including vaccination, where appropriate all registered providers should notify outbreaks of infection to their local UKHSA health protection team (HPT) as soon as possible to monitor local and national outbreaks and trends. This enables UKHSA HPTs to focus support for the organisation to manage the outbreak as appropriate, and to investigate and mitigate any risk to the wider population reporting should include information on outbreaks in service users who are detained under the Mental Health Act 1983, if advised to do so by suitably informed practitioners d) Isolation of service users with an infection (see also criterion 7) Procedures to follow: the isolation policy should be evidence-based and reflect a documented risk assessment (see criterion 7) indications for isolation should be included in the policy, as should procedures for the IPC, including cleanliness and control management of service users in isolation information on isolation should be easily accessible and understood by all groups of staff, service users and the public health and social care facilities (excluding providers of 'personal care') should support safe and effective isolation for all service users as appropriately and reasonably as possible e) Safe handling and disposal of 'sharps' Important considerations include: risk management training in relation to mucous membrane exposure and sharps injuries and incidents provision of sharps medical devices with protection mechanisms, where there are clear indications that they will provide safe systems of working for staff a policy that is easily accessible and understood by all groups of staff training in the safe use, secure storage and disposal of sharps auditing of policy compliance compliance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 all staff handling sharps should be trained in safe use management and disposal and what to do in the event of an injury f) Prevention of occupational exposure to blood-borne viruses (BBVs), including prevention of sharps injuries Measures to avoid exposure to BBVs (for example, hepatitis B, C and HIV) should include: immunisation against hepatitis B, as set out in 'Immunisation against infectious disease', better known as the 'Green Book' the correct wearing of gloves and other PPE the safe handling and disposal of sharps, including the provision of medical devices that incorporate sharps protection where there are clear indications that they will provide safe systems of working for staff measures to reduce risks during surgical procedures g) Management of occupational exposure to BBVs and post-exposure prophylaxis Management should ensure that: any member of staff who has a significant occupational exposure to blood or body fluids is aware of the immediate action required and is referred appropriately for timely management and follow-up clear information is provided to staff about reporting potential occupational exposure – in particular the need for prompt action following a known or potential exposure to HIV or hepatitis B arrangements for post-exposure prophylaxis are in place for hepatitis B and HIV there is access to vaccination, where advised Refer also to Regulation 19, Requirements relating to workers contained in CQC Guidance for providers on meeting the Regulations. h) Closure of rooms, wards, departments and premises to new admissions Management should ensure that: a system is in place for the provision of advice from the HPT/DIPC/ICT for the registered provider there is clear criteria in relation to closures and re-opening, including clear communication internally and externally of escalation and de-escalation the policy addresses the need for environmental decontamination prior to reopening i) Disinfection The use of disinfectants is a local decision and should be based on current evidence and accepted good practice. j) Decontamination of reusable medical devices Decontamination involves a combination of processes and includes cleaning, disinfection and sterilisation, according to the intended use of the device. This aims to render a reusable item safe for further use on service users and for handling by staff. Effective decontamination of reusable medical devices is an essential part of infection risk control and is of special importance when the device comes into contact with service users or their body fluids. There should be a system to protect service users and staff that minimises the risk of transmission of infection from medical devices. This requires that the device or instrument set can be clearly traced to the individual process cycle that was used to decontaminate it, such that the success of that cycle in rendering the device safe for reuse can be verified. Reusable medical devices should be decontaminated in accordance with manufacturers' instructions and current national or local best practice guidance. This requires that the device should be clean and, where appropriate, sterilised at the end of the decontamination process and maintained in a clinically satisfactory condition up to the point of use. Management systems should ensure adequate supplies of reusable medical devices, particularly where specific devices are essential to the continuity of care. Reusable medical devices employed in invasive procedures, for example endoscopes and surgical instruments, have to be either individually identifiable or identified to a set of which they are a consistent component, throughout the use and decontamination cycle, to ensure subsequent traceability. Systems should also be implemented to enable the identification of service users on whom the medical devices have been used. Decontamination of single-patient use devices – that is, equipment designated for use only by one patient – should be subject to local policy and manufacturer's instructions Refer also to Regulations 15, Premises and equipment and Regulation 12 on safe care and treatment contained in CQC Guidance for providers on meeting the Regulations. k) Single-use medical devices Policies should be in place for handling devices for single use only. Single-use medical devices should be used once and disposed of safely. l) Antimicrobial prescribing and stewardship Prescribing should generally be harmonised with that in the NICE infection guidelines and British National Formulary (BNF), based on local and national guidance for specific infections, such as gonorrhoea. However, locally approved guidelines may be required in certain circumstances. Procedures should be in place to ensure prudent prescribing and antimicrobial stewardship. There should be an ongoing programme of audit, revision and update with feedback to management, prescribers and administrators. In healthcare settings this is usually monitored by the antimicrobial management team or local primary care medicine optimisation team. Antimicrobial pharmacists and integrated care board (ICB) pharmacy leads can support these activities This includes a requirement for NHS Trust Chief Executives to report all cases of Meticillin resistant Staphylococcus aureus (MRSA), Meticillin sensitive Staphylococcus aureus (MSSA), Escherichia coli, Klebsiella species, Pseudomonas aeruginosa bloodstream infections and respiratory infections, including COVID-19. The Health Protection (Notification) Regulations 2010 and The Health Protection (Notifications) (Amendment) 2020 require: attending doctors (registered medical practitioners) to notify the proper officer of the local authority of cases of specified infectious disease or of other infectious disease or contamination, which present, or could present, significant harm to human health, to allow prompt investigation and response diagnostic laboratories testing human samples to notify UKHSA of the identification of specified causative agents of infectious disease High consequence infectious diseases (HCID) The policy should refer to the latest guidance from the Advisory Committee on Dangerous Pathogens (ACDP) and the Control of Substances Hazardous to Health Regulations 2002 and make provision for: appropriate staff to be trained in how to isolate and risk-assess service users at risk of HCID appropriate staff to be aware of the special measures to be taken for nursing HCID service users, and to be properly trained in the application of full isolation procedures and use and safe removal of PPE patient risk assessment and categorisation handling of patient specimens at the appropriate containment level and using the correct packaging and protocols depending on classification for transport follow-up of all staff in contact with the patient at every stage of care special measures for the handling and on-site treatment of all waste and laundry special measures for transporting service users with HCID In cases of acquired carbapenemase-producing Gram-negative bacteria, including carbapenemase-producing Enterobacterales (CPE), the policy should make provision for: active patient admission screening of risk groups rapid detection of patients colonised or infected with CPE, with appropriate surveillance systems to enable ongoing monitoring consistent implementation of IPC practices and contact precautions minimisation of CPE reservoirs by effective environmental cleaning and decontamination antimicrobial stewardship programmes to minimise inappropriate use of broad-spectrum antibiotics, including carbapenems optimised laboratory methods to detect carbapenemase-producing Gram-negative bacteria, including Enterobacterales mandatory reporting to UKHSA's second generation surveillance system (SGSS), as well as results of any antimicrobial susceptibility test, and any resistance mechanism for any of the causative agents listed in susceptibility test, and any resistance mechanism for any of the causative agents listed in schedule 2 of the Health Protection (Notifications) Regulations 2010 prompt recognition of outbreaks to enable effective management organisational ownership to support the implementation of the CPE framework of actions to contain carbapenemase-producing Enterobacterales n) Control of outbreaks and infections associated with specific alert organisms/alert conditions This should take account of local epidemiology and risk assessment of the environment, infection and service. These infections must include, as a minimum, MRSA, MSSA, Escherichia coli, Klebsiella species and Pseudomonas aeruginosa bloodstream infections; respiratory infections, including COVID-19; high consequence infectious diseases (HCIDs), diarrhoea and/or vomiting outbreaks, Clostridiodes difficile infection and transmissible spongiform encephalopathies. There should be evidence of learning from the investigation of outbreaks. MRSA The policy should make provision for: screening of NHS service users on emergency or elective admission to relevant high-risk specialties. The arrangements for undertaking screening will be subject to local agreement suppression regimens for colonised service users, when appropriate isolation of infected or colonised service users transfer of infected or colonised service users within organisations or to other care facilities antibiotic prophylaxis for surgery undertaking a review of service users' treatment and care Clostridioides difficile The policy should make provision for: surveillance of Clostridioides difficile infection diagnostic criteria isolation of infected service users and cohort nursing environmental decontamination antibiotic prescribing policies contraindication of anti-motility agents Relevant policies for other specific alert organisms The specific alert organisms that follow may be relevant to any unit admitting or treating as out service users. Control of tuberculosis, including multi-drug resistant tuberculosis The policy should make provision for: isolation of infectious service users transfer of infectious service users within care organisations or to other care facilities contact tracing treatment compliance Respiratory viruses The policy should cover: alert system for suspected cases isolation criteria IPC and control measures for acute respiratory viruses, including influenza and COVID-19, should include immunisation to avoid exposure, as set out in 'Immunisation against infectious diseases', better known as the 'Green Book' Diarrhoea and/or vomiting infections The policy should cover: isolation criteria IPC (including cleanliness) measures cleaning and disinfection policy o) Creutzfeldt-Jakob disease (CJD/vCJD) Advice on the handling of instruments and devices in procedures on service users with known or suspected CJD/vCJD, or at increased risk of CJD/vCJD, including disposal/quarantine procedures, is provided in guidance from the ACDP Transmissible spongiform encephalopathies (TSE) working group. Refer also to Regulation 15, Premises and equipment and Regulation 12 on safe care and treatment contained in CQC Guidance for providers on meeting the Regulations. p) Safe handling and disposal of waste The risks from waste disposal should be properly controlled. In practice, in relation to waste, this involves: assessing risk, classifying and correctly segregating the waste in line with nation guidance and legal requirements developing appropriate policies putting arrangements in place to manage risks monitoring, auditing and reviewing the way in which arrangements work being aware of statutory requirements, legislative change and managing compliance Precautions in connection with handling waste should include: training and information (including definition and classification of waste) personal hygiene segregation and storage of waste the use of appropriate PPE immunisation appropriate procedures for handling such waste appropriate packaging and labelling suitable transport on-site and off-site clear procedures for dealing with accidents, incidents and spillages appropriate treatment and disposal of such waste accompanied by the correct documentation Systems should be in place to ensure that the risks to service users and staff from exposure to infections caused by waste present in the environment are properly managed, and that duties under environmental law are discharged. The most important of these are: duty of care in the management of waste duty to control polluting emissions to the air duty to control discharges to sewers obligations of waste managers collection of data and obligations to complete and retain documentation, including record keeping requirement to provide contingency plans and have emergency procedures in place Refer also to Regulation 15, Premises and equipment contained in CQC Guidance for providers on meeting the Regulations. q) Packaging, handling and delivery or laboratory specimens Biological samples, cultures and other materials should be transported in a manner that ensures that they do not leak in transit and are compliant with current legislation. Staff who handle samples must be aware of the need to correctly identify, label and store samples prior to forwarding to laboratories. In addition, they must be aware of the procedures needed when the container or packaging becomes soiled with body fluids. r) Care of deceased persons Appropriate procedures should include: risk assessment of potential hazards the provision of appropriate facilities and accommodation safe working practices arrangements for all visitors information, instruction, training and supervision health surveillance and immunisation (where appropriate) s) Insertion, use and care of invasive devices, including urinary catheters Policy should be based on evidence-based guidelines and should be easily accessible by all relevant care workers. Compliance with policy should be audited. Information on policy should be included in IPC training programmes for all relevant staff groups. Refer also to Regulation 15, Premises and equipment and Regulation 12 on safe care and treatment contained in CQC Guidance for providers on meeting the Regulations. t) Purchase, cleaning, decontamination, maintenance and disposal of equipment Policies for the purchase, cleaning, decontamination, maintenance and disposal of all equipment should take into account IPC advice that is given by relevant experts, manufacturers of equipment and advisory bodies. u) Surveillance and data collection For all appropriate health and social care settings, there should be evidence of local surveillance and use of comparative data, where available, to monitor infection rates, antimicrobial resistance and antimicrobial consumption, and to assess the risks of infection. This evidence should include data on alert organisms and other infections, where appropriate, alert conditions and wound infection per clinical unit or specialty. When appropriate or where they exist, recognised definitions should be used. Electronic reporting to UKHSA is recommended where the appropriate information technology is in place as set out in the Health Protection (Notification) Regulations 2010 to enable monitoring of outbreaks and trends at local, regional and national level. There should also be timely feedback to clinical units, with a record of achievements and actions taken as a result of surveillance. Post-discharge surveillance of surgical site infection should be considered and, where practicable, should be implemented. There should be a local protocol across the health and social care systems on information-sharing when referring, admitting, transferring, discharging and moving service users within and between health and adult social care facilities. This is to facilitate surveillance and optimal management of infections in the wider community. Guidance on data protection legislation also needs to be observed. Refer also to Regulation 9, Person-centred care contained in CQC Guidance for providers on meeting the Regulations. w) Isolation facilities There should be a policy concerning the appropriate provision and maintenance of isolation facilities. This should address: potential sources of infection ventilation systems the types of isolation facility needed for different infections the use of protective measures and equipment the management of outbreaks x) Uniform and dress code Uniform and workwear policies ensure that clothing worn by staff when carrying out their duties is clean and fit for purpose. Particular consideration should be given to items of attire that may inadvertently come into contact with the person being cared for. Uniform and dress code policies should specifically support good hand hygiene. y) Immunisation of service users Registered providers should ensure that: policies and procedures are in place with regard to the occupational health support and immunisation status of service users, so that there is a record of all immunisations given; also refer to criterion 10 the immunisation status and eligibility for immunisation of service users are regularly reviewed in line with 'Immunisation against infectious disease' (the 'Green Book') and other guidance from UKHSA following a review of the record of immunisations, all service users are offered further immunisation as needed, according to the national schedule Guidance for compliance with criterion 10: occupational health The registered provider will have a system or process in place to manage health and care worker health and wellbeing and organisational obligation to manage infection, prevention and control. Providers have a policy that describes the process in place to manage health and care worker health and wellbeing and obligations in relation to IPC (including cleanliness), control and management. 10.1 Registered providers should note that this criterion also covers health and care worker education and training in policies and procedures to reduce the risk of occupational infection. They should ensure that: all staff can access occupational health services or access occupational health advice either through their employee service provider or via their registered primary care clinician occupational health policies on the prevention and management of communicable disease in health and care workers are in place, to reduce risks of infections for both health and care workers and in service users decisions on offering immunisation should be made on national guidance and/or on the basis of a local risk assessment as described in 'Immunisation against infectious disease' (the 'Green Book') employers should make vaccines available free of charge to employees if national guidance or a risk assessment indicates risk of exposure to biological agents. Where effective vaccines exist, provision should be made to determine whether an employee is already immunised and immunisation should be offered to those not already immunised (Control of Substances Hazardous to Health (COSHH) Regulations 2002) there is an up-to-date record of relevant immunisation status. Such records should be kept, as part of confidential staff occupational health records, including where vaccination has been offered and refused the principles and practice of prevention of infection are included in induction and training programmes for new and existing staff, including occupational exposure to infections, such as sharps injury and appropriate respiratory protective equipment, for example FIT testing there is a record of IPC training and updates commensurate to aim and outcomes of the Clinical Skills Framework and aligned to Skills for Health and Skills for Care the responsibilities of each member of staff for IPC are clear and unambiguous 10.2 Occupational health services for staff should include: risk-based screening for communicable diseases, and assessment of immunity to infection should be part of the recruitment process offer of relevant immunisations arrangements for regularly reviewing the immunisation status of health and social care workers and providing vaccinations to staff as necessary in line with 'Immunisation against infectious disease' (the 'Green Book') and other guidance from UKHSA 10.3 Occupational health services in respect of BBVs should include: having arrangements for identifying and managing health and social care staff infected or potentially infected with hepatitis B or C or HIV and advising about fitness for work and monitoring as necessary liaising with the UK Advisory Panel for Healthcare Workers Infected with Bloodborne Viruses when advice is needed on procedures that may be carried out by BBV-infected health and social care workers, or when advice on patient tracing, notification and offer of BBV testing may be needed a timely risk assessment and appropriate referral after accidental occupational exposure to blood and body fluids management of occupational exposure to infection, which may include provision for emergency and out-of-hours treatment, possibly in conjunction with accident and emergency services and on-call IPC specialists this should include a specific risk assessment following a blood exposure incident 10.4 Occupational health services in respect of respiratory viruses should include arrangements for provision of seasonal vaccines, such as influenza vaccination and COVID-19, for health and social care workers where advised and consideration for emerging viruses. Refer also to Regulation 19, Fit and proper persons employed contained in CQC Guidance for providers on meeting the Regulations. 4. Guidance tables Guidance tables can be found in a separate document - Guidance tables for H&SCA code of practice on IPC. These tables are designed to help registered providers, the DIPC (NHS provider organisations) and service providers (adult social care, primary care dental and primary care medical and independent healthcare providers, independent sector ambulance providers) decide how the code and related guidance applies to the regulated activities and type of service they provide. Further guidance on the activities that are covered by regulations are available on the Care Quality Commission website. Because of the wide range of services provided in health and adult social care, service providers should carry out their own risk assessments to help them decide the elements to be included in their policies or whether or not a policy is required at all. They will need to be able to justify their decisions. Appendix A: examples of interpretation for adult social care It is essential to read the following examples alongside the guidance under each criterion in part 3 and not just selective parts. The examples demonstrate how a proportionate approach to the guidance could apply in certain types of adult social care services. They are examples only and registered providers and the designated IPC person should carry out their own risk assessments to help them decide which parts of the criteria apply to their particular service. Registered providers and designated IPC (including cleanliness) person(s) should make sure that they can provide evidence to support any decision to follow these examples or any other alternative approaches to the full guidance. Guidance for compliance with criterion 1 Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them. In a small service providing personal care or accommodation with personal care, the below apply. Someone with appropriate knowledge and skills will become the designated IPC lead and take responsibility for IPC (including cleanliness) and relevant antimicrobial stewardship principles. This could be the registered provider, registered manager or another member of staff. IPC (including cleanliness) programmes and infrastructures will not need to be as complex as in a larger adult social care or health setting. As a minimum the IPC measures should include: policies, procedures and guidance, and information on how they will be kept up to date and monitored to make sure they are effective and followed initial and ongoing training that staff will receive a record of the names and contact details of health practitioners who can provide advice. GPs, local IPC team, local UKHSA HPT and the local authority public health team are likely to be key contacts in the infrastructure guidance for staff about the type of circumstances in which contact should be made The annual statement, for anyone who wishes to see it, including service users and regulatory authorities, will not need to be as detailed as one prepared for a health setting. The service provider will ensure their annual statement for each facility provides a short review of any: known outbreaks of infection audits undertaken and subsequent actions action taken following an outbreak of infection risk assessments undertaken for prevention and control of infection education and training received by staff review and update of policies, procedures and guidance Refer to the corresponding item in part 3 of this document. Guidance for compliance with criterion 2 Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections. Domiciliary care services and extra care that provide support in people's own homes will not be expected to comply with this criterion. Care homes aim to provide a place where people feel at home and the arrangements to keep the environment clean must take this into account. All cleaning routines must respect the fact that in care homes a service user's bedroom and other shared areas may have furniture and other possessions that belong to that individual. In some care homes, the specific aim will be to support service users to be independent and to have choice and control over their daily life, including decisions about the environment in which they live. In a service where people have a learning disability, for example, but are generally well, they will be supported to develop independent living skills. In such cases, the following points apply: detailed cleaning schedules are not necessary. Cleaning responsibilities and routines should form part of the individual plan of care there may be a plan for cleaning communal areas that describes service user responsibilities for cleaning staff should carry out ongoing assessment of the standard

of cleanliness and support residents if cleanliness falls short of an acceptable minimum it is unlikely that the policy on the environment will need to cover all the points set out in the main guidance the decontamination policy is effectively a policy on how to clean all areas of the environment, fixtures and fittings (and medical devices if used) and what products to use. It will not need to be as complex as one in a healthcare setting. For example, in a care home or where care is provided in their own home, where service users are responsible for cleaning their own rooms as an element of independent living, this does not need to be included The policy should cover: how to clean the different areas of the environment, fixtures, fittings and specialist equipment (for example, a hoist) what products and equipment to use when cleaning what to do and what products to use if there is a spillage of blood or body fluids what training staff need to implement the policy Refer to the corresponding item in part 3 of this document. Guidance for compliance with criterion 3 Ensure appropriate antimicrobial use and stewardship to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance. Health and social care staff must know how to recognise the signs of infection, including atypical presentations, and know how to seek prompt medical advice so that diagnostic tests and antimicrobial therapy (if required) can be used optimally. For social care services providing personal care, providers should keep accurate records of antimicrobial prescriptions, including allergies, dose, duration and reason for treatment. Access to microbiological services and responsibility for stewardship activities rests with the service users' GP. However, providers should engage collaboratively across the local health and social care system to improve antimicrobial use and stewardship, as appropriate. Examples could include engaging with local projects on urinary tract infections, sepsis or audits of antimicrobial use usage. Refer to the corresponding item in part 3 of this document. Guidance for compliance with criterion 4 Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion. Domiciliary care services that provide support in people's own homes will not need to have the full range of information suggested to meet this criterion. However, they should provide information about their approach to prevention of infection, staff roles and responsibilities, and whom people should contact concerns about prevention and control of infection. Where they provide personal care to a group of service users in a supported living service or sheltered housing complex and take an active role in liaising with or contacting healthcare professionals on behalf of service users then the full criterion will apply. However, it may not be necessary to provide the level of detail that a healthcare setting would need. For adult social care services providing residential care, all the information suggested in the guidance should be included. However, it may not be necessary to provide the level of detail that a healthcare setting would need. Refer to the corresponding item in part 3 of this document. Guidance for compliance with criterion 5 Ensure that people who have or at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people. In an adult social care service, the primary care practitioner will provide the necessary initial advice when a service user develops an infection and may wish to draw on local professional expertise in IPC or health protection. Refer to the corresponding item in part 3 of this document. Guidance for compliance with criterion 6 Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection. Refer to the corresponding item in part 3 of this document. Guidance for compliance with criterion 7 Provide or secure adequate isolation facilities. Care homes do not need to have dedicated isolation facilities. If isolation is needed, a service user's own room can be used. Ideally the room should be a single bedroom with en-suite facilities. Refer to the corresponding item in part 3 of this document. Guidance for compliance with criterion 8 Secure adequate access to laboratory support as appropriate. The registered GP will take responsibility for sending off any necessary routine samples to the laboratory. Adult social care services should ensure they know how to recognise infections and report these promptly to the GP or other appropriate health professional. Refer to the corresponding item in part 3 of this document. Guidance for compliance with criterion 9 The registered provider has and adheres to policies designed for the individual's care, and provider organisations that will help to prevent and control infections. Providers must have IPC policies in place. Providers can use table 3 and their own risk assessments to help them decide how the remaining policy areas might apply to their services. Refer to the corresponding item in part 3 of this document. Guidance for compliance with criterion 10 The registered providers will have a system or process in place to manage staff health and wellbeing and organisational obligation to manage infection, prevention and control. Providers have a system in place to manage the occupational health needs and obligations to staff in relation to infection. Small adult social care services that are not part of a large organisational structure may not have access to occupational health services. Service providers should ensure that they are able to get advice when needed, for example through their insurance company, a GP or an occupational health agency. The registered provider should ensure that all staff complete a confidential health assessment after a conditional offer of employment and give information about residence overseas, previous and current illness and immunisation against relevant infections. Policies for screening of staff should include: health screenings for communicable diseases how exposure to infections will be managed risk assessment of the need for immunisations, for example influenza vaccination, hepatitis B and COVID-19 the responsibilities of staff to report episodes of illness the circumstances under which staff may need to be excluded from work Induction All health and social care workers new in post are expected to complete competency training, for example undertake 'the care certificate' as part of their induction. More information on the care certificate is included in the bibliography. Ongoing training There are a range of knowledge and competence units for adult social care workers that can be taken as part of the diplomas for occupational competence. There are 3 level 2 knowledge units that cover IPC, the spread of infection and cleaning, decontamination and waste management. There are 3 competence units at levels 2, 3 and 5 that support the development of skills in managing IPC (including cleanliness) in the workplace. Details of these training units are included in the bibliography. A record should be kept by the registered manager of all staff induction and ongoing training. Refer to the corresponding item in part 3 of this document. Appendix B: examples of interpretation for primary care dental practices It is essential to read the following examples alongside the guidance under each criterion in part 3 and not just selective parts. The examples demonstrate how a proportionate approach to the guidance could apply in primary care dental practices. They are examples only and registered providers and IPC will be expected to provide evidence to support any decision to implement these examples or any other alternative approaches to implementation of the full guidance. Criterion 2 of the code describes the requirement to provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections. This includes a specific requirement for effective arrangements for the appropriate decontamination of instruments and other equipment. The Health Technical Memorandum (HTM) 01-05 is designed to assist all registered primary dental care services in meeting satisfactory levels of decontamination. The code has taken due note of HTM 01-05 and does not impose any additional burdens on decontamination. See the decontamination self-assessment dental audit tool. However, whilst HTM 01-05 describes essential quality requirements and provides guidance around decontamination, it is important to recognise that in the same way, the related guidance set out in this code of practice document provides guidance around the wider aspects of IPC (including cleanliness). Guidance for compliance with criterion 1 Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them. A designated person with appropriate knowledge and skills will take responsibility for IPC (including cleanliness) and control in the practice (the designated IPC person). This could be the registered provider, registered manager or another member of staff. The IPC lead is responsible for the development and implementation of the IPC and control and cleanliness programme for the practice. The programme should be in line with national guidance, such as the NIPCM. Practices should consider how: practice IPC policies, procedures and guidance are developed and implemented IPC policies, procedures and guidance will be kept up to date and monitored for compliance initial and ongoing training to staff is delivered, updated and recorded The practice should have a clear route for advice on IPC that will be included as part of their IPC policy. This might include recording information on how to contact key contacts, such as: IPC leads within NHS England/ICBs occupational health services consultants in dental public health NHS England dental clinical advisers GPs IPC leads within the ICBs public health teams within UKHSA and the local authority There should be guidance for staff about the type of circumstances in which contact should be made and how to identify which contact in the system is best able to help with the issue faced by the practice. An annual IPC statement should be prepared and kept on record for anyone who wishes to see it, including service users and regulatory authorities. The content of might include a short review of any: significant IPC events and the learning from them actions arising from the above audits undertaken and subsequent actions risk assessments undertaken for prevention and control of infection induction and training received by staff reviews and updates of policies, procedures and guidance Refer to the corresponding item in part 3 of this document. Guidance for compliance with criterion 2 Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections. Practices should take account of the guidance issued by DHSC, UKHSA and NIPCM. Please refer to HTM 01-05 for further information on decontamination. There should be a designated lead for cleaning and decontamination of the environment and equipment, who may be the same person as the lead for IPC, and who can access appropriate expert advice. Refer to the corresponding item in part 3 of this document. Guidance for compliance with criterion 3 Ensure appropriate antimicrobial use and stewardship to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance. Systems should be in place to manage and monitor the use of antimicrobials to ensure inappropriate use is minimised including having a designated AMS lead. These systems can draw on national and local guidelines, and monitoring and audit tools that focus on antimicrobial prescribing in dentistry available and/or signposted to in the national dental antimicrobial stewardship toolkit. All members of the dental team should maintain their knowledge of the management of dental pain and infections and the principles of antimicrobial stewardship. Refer to the corresponding item in part 3 of this document. Guidance for compliance with criterion 4 Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion. Primary dental care practices may not need to supply the full range of information suggested. However, they should have information available about their approach to IPC staff roles and responsibilities, and which people they should contact if they have concerns about IPC. It is unlikely that primary dental care practitioners will be required to provide this information except when referring service users to specialist services. In situations where service users require transfer to specialist services, staff should know how and under what circumstances information about a user's infection status can be shared, and how to ensure that the information they share complies with the legislation on the safe handling of information. Refer to the corresponding item in part 3 of this document. Guidance for compliance with criterion 5 Ensure that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people. Dental practitioners should regularly obtain a medical history, which may assist in identifying some risk factors for infection. IPC precautions should be applied to the management of all service users, in line with national guidance. Practices can use risk assessment processes to identify staff who may be at higher risk of transmitting or developing an infection. The practice should also have systems in place to manage the identified risk in its staff members. Refer to the corresponding item in part 3 of this document. Guidance for compliance with criterion 6 Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection. The registered provider must ensure that every person working in the dental practice, including agency staff, contractors and volunteers, understand and comply with IPC measures. Refer to the corresponding item in part 3 of this document. Guidance for compliance with criterion 7 Provide or secure adequate isolation facilities. Primary dental care facilities do not require dedicated isolation facilities. Refer to the corresponding item in part 3 of this document. Guidance for compliance with criterion 8 Secure adequate access to laboratory support as appropriate. This refers to laboratory support for diagnosis or surveillance of infection. Primary care dental practices are not required to have routine access to microbiology laboratory services. Refer to the corresponding item in part 3 of this document. Guidance for compliance with criterion 9 The registered provider has and adheres to policies designed for the individual's care, and provider organisations that will help to prevent and control infections. Providers must have IPC policies in place. Providers can use table 3 and their own risk assessments to help them decide how the remaining policy areas might apply to their services. Refer to the corresponding item in part 3 of this document. Guidance for compliance with criterion 10 The service providers will have a system or process in place to manage the staff health and wellbeing and organisational obligation to manage infection, prevention and control. Staff should have access to appropriate occupational health advice. Policies for the protection of staff can include for example: risk assessment of need for immunisation, in particular hepatitis B and COVID-19 immunisation health screening for communicable disease, including tuberculosis and where appropriate, blood borne virus (BBV) screening for those undertaking exposure prone procedures use of personal protective equipment (PPE), including staff training in the safe use and disposal of PPE post-exposure management, for example for inoculation injuries circumstances under which staff may need to be excluded from work or have their duties modified Refer to the corresponding item in Part 3 of this document. Appendix C: examples of interpretation for primary medical care It is essential to read the following examples alongside the guidance under each criterion in part 3 and not just selective parts. The examples demonstrate how a proportionate approach to the guidance could apply in primary medical care practices. They are examples only and registered providers and IPC (including cleanliness) leads should carry out their own risk assessments to help them decide which parts of the criteria apply to their particular service. Registered providers and IPC (including cleanliness) leads will make sure that they can provide evidence to support any decision to follow these examples or any other alternative approaches to the full guidance. Guidance for compliance with criterion 1 Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them. A designated person with appropriate knowledge and skills will take responsibility for IPC in the practice. This could be the registered provider, registered manager or another member of staff. IPC programmes, assurance framework and infrastructures will not need to be as complex as in larger health or adult social care settings. It is not envisaged that there should be a DIPC in most primary medical care settings. The IPC programme should say as a minimum what: IPC measures are needed in the practice policies, procedures and guidance are needed and how they will be kept up to date and monitored for compliance initial and ongoing training staff will receive, where appropriate The provider should have a record of the names and contact details of health practitioners who can provide advice. GP colleagues for the provider, local UKHSA health protection team, ICBs, NHS and the local authority are likely to be key contacts. There should be guidance for staff about the type of circumstances in which contact should be made. An annual statement, for anyone who wishes to see it, including service users and regulatory authorities, should be prepared by the designated IPC individual for each registered provider. This should provide a short review of any: known infection transmission event and actions arising from this audits undertaken, as part of a quality improvement programme, and subsequent actions implemented risk assessments undertaken and any actions taken and recorded for prevention and control of infection education and training received by staff review and update of policies, procedures and guidance antimicrobial prescribing and stewardship Refer to the corresponding item in part 3 of this document. Guidance for compliance with criterion 2 Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections. There should be a designated lead for cleaning and decontamination of the environment, who may be the same person as the lead for IPC and who can access appropriate expert advice. The furnishing of premises should take account of national guidance, and rooms with specialist functions, for example minor surgery, should be adapted accordingly following a risk assessment. Clinical procedures, planned examination of wounds and potential infected sites should be carried out in a designated setting designed for the purpose, for example a treatment room. The environmental cleaning and decontamination policy should specify how to clean all areas, fixtures and fittings, and specify what products to use. In those practices that perform invasive procedures, including minor surgery and acupuncture, a policy must be in place for the appropriate decontamination of the rooms used for those procedures. There should be a cleaning schedule, covering communal areas, consultation rooms, treatment areas and specialist surgical or other areas. Refer to the corresponding item in part 3 of this document. Guidance for compliance with criterion 3 Ensure appropriate antimicrobial use and stewardship to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance. Primary medical care practitioner prescribing accounts for 80% of NHS antibiotic use and this antibiotic use must be both necessary and appropriate. Antibiotics should not be prescribed or supplied for viral infections. Antimicrobial prescribing should follow local policies and national guidance such as NICE managing common infections, guidance for primary care and TARGET antibiotics toolkit. Evidence to demonstrate adoption and adherence to policies and guidelines should be available to commissioners. Prescribers should have access to advice on antibiotic use from medicines optimisation teams and microbiologists, and used when required. Primary care practices should participate in local and national activities designed to support antimicrobial stewardship, such as backup or delayed antibiotic prescribing, and national antibiotic awareness campaigns. Refer to the corresponding item in part 3 of this document. Guidance for compliance with criterion 4 Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/ medical care in a timely fashion. Primary medical care practices should make information available about their approach to prevention and control of infection, staff roles and responsibilities, and who people should contact where there are concerns about prevention and control of infection. They should also make available up-to-date information on current infection issues, for example influenza, COVID-19 and circulating infections. Practices may wish to involve or seek advice from their patient groups on the material they are using and how it is disseminated. Practices may wish to display their policies and information on their website or other websites, where appropriate. Primary medical care practitioners are key providers of information to other health and adult social care providers and to public health authorities, both concerning individual users and community outbreaks. Appropriate information should be held in the practice patient summary record. The registered provider may share information with other health and adult social care providers as appropriate, paying attention to service users' confidentiality. This could include circumstances where: a service user is referred or admitted to a hospital, adult social care or mental health facility a service user is scheduled for an invasive procedure a service user is transported in an ambulance there is an outbreak or suspected outbreak amongst service users Refer to the corresponding item in part 3 of this document. Guidance for compliance with criterion 5 Ensure that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people. The primary medical care practitioner will provide initial advice and treatment when a service user under their care develops an infection, and will assess any potential communicable disease control issues. In most cases further action will not be needed. If required, the primary medical care practitioner may consult with the designated source of specialist infection control advice and/or the local health protection team or refer to more specialist care. This may be applicable, for example, in cases of smear-positive pulmonary tuberculosis, highly transmissible diseases such as chickenpox or norovirus, or suspected outbreaks. Refer to the corresponding item in part 3 of this document. Guidance for compliance with criterion 6 Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection. The registered provider must ensure that every person working in the practice, including agency staff, locum staff, support staff, external contractors and volunteers, understand and comply with the need to prevent and control infections, including those associated with invasive devices. Refer to the corresponding item in part 3 of this document. Guidance for compliance with criterion 7 Provide or secure adequate isolation facilities. Primary medical care facilities do not require dedicated isolation treatment rooms but are expected to implement reasonable precautions when a service user is suspected or known to have a transmissible infection. Refer to the corresponding item in part 3 of this document. Guidance for compliance with criterion 8 Secure adequate access to laboratory support as appropriate. Primary care practices should have access to a diagnostic microbiology and virology laboratory service, which operates according to the requirements of the relevant national accreditation bodies for the investigation and management of disease. This may be from an NHS acute trust or from an alternative provider. For the NHS, this will be provided through local commissioning arrangements; non-NHS GPs will need to make appropriate arrangements. Refer to the corresponding item in part 3 of this document. Guidance for compliance with criterion 9 The registered provider should have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections. Providers can use table 3 and their own risk assessments to help them decide how the remaining policy areas might apply to their services. Refer to the corresponding item in part 3 of this document. Guidance for compliance with criterion 10 The registered providers will have a system or process in place to manage the staff health and wellbeing and organisational obligation to manage infection, prevention and control. Risk assessments of need should be carried out for immunisation, in particular hepatitis B and COVID-19. Access to an occupational health service should be available. Refer to the corresponding item in part 3 of this document. Appendix D: definitions Term Definition Acute hospital Healthcare provided within a hospital setting Adult social care Social care includes all forms of personal care and other practical assistance provided for individuals who by reason of age, illness disability, pregnancy, childbirth, dependence on alcohol or drugs or any other similar circumstances are in need of such care or other assistance. For the purposes of the CQC, it only includes care provided for, or mainly for, adults in England Advocate An advocate is someone who speaks on behalf of another; or it can have special meaning derived from the Mental Health Act 1983 (amended 2007) and Mental Capacity Act 2005 and Care Act 2014. There are formal and informal advocates, and these can be: individuals acting informally (carers, relatives, partners, neighbours or friends, staff); those prescribed by legislation, such as independent mental health advocates and independent mental capacity advocates; or those provided by schemes run by local authorities, the NHS and charities. Alert organism Alert organism surveillance is used widely to detect and prevent outbreaks of infection. These organisms are reported to IPC teams on a regular basis to identify possible or potential outbreaks of infections. The organisms that are surveyed will depend on local or national epidemiology. Examples of alert organisms may include Acinetobacter and group A streptococcus. Antimicrobials Antimicrobials are substances that are used in the prevention or treatment of infection caused by bacteria (antibiotics), fungi (antifungals), parasites (antiparasitics) or viruses (antivirals). Antimicrobial resistance (AMR) Resistance of a microorganism to an antimicrobial drug that was originally effective for treatment of infections caused by it. Antimicrobial stewardship (AMS) Antimicrobial stewardship is defined as 'an organisational or healthcare-system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness'. It includes promoting optimal diagnosis of infection, drug choice, regimen, dose, duration and administration route. The aim of AMS is for optimal clinical outcome and to limit selection of resistant strains. This is a key component of a multi-faceted approach to preventing antimicrobial resistance. Aseptic technique Used to describe clinical procedures that have been developed to reduce the opportunity for contamination of wounds, susceptible body sites and invasive devices. Assurance framework A system for informing third parties that a process of due diligence is in place to assure safety and quality exists within that setting. Audit An audit is part of a quality improvement process that seeks to improve service user care and outcomes by carrying out a systematic review and implementing change. Blood-borne viruses (BBVs) Organisms such as hepatitis B, hepatitis C and HIV that are potentially transmissible in the occupational setting via percutaneous (sharp) or mucocutaneous (mucous membrane/broken skin) routes. Cohort nursing The physical separation of service users with the same infection or those displaying similar signs and symptoms of infection in a designated area. Colonisation Where an organism is present on or within a person's body but without signs or symptoms of disease. Care Quality Commission (CQC) The independent regulator of health and social care in England. Decontamination The combination of processes (including cleaning, disinfection and sterilisation) used to make a reusable item safe for further use on service users and for handling by staff. Decontamination lead The senior member of staff with responsibility for managing all aspects of decontamination. It is expected that this officer will report directly to the chief executive or registered provider. Director of IPC (DIPC) An individual with overall responsibility for IPC and accountable to the registered provider in NHS provider organisations. Disinfection A process used to reduce the number of viable infectious agents, but which may not necessarily inactivate some microbial agents, such as certain viruses and bacterial spores. Domiciliary care Homecare that helps people cope with disability or illness and allows them to maintain independence. Drug-bug combination Measures the susceptibility of specific bacteria to key antibiotics to monitor levels of antimicrobial resistance. Dynamic risk assessment A dynamic risk assessment accounts for risk in a live environment that has factors that may not have been possible to account for in a standard risk assessment. A dynamic risk assessment allows staff to go further and be prepared to assess developing situations as they arise. The purpose of dynamic risk assessments is to enable workers to quickly assess a situation and take steps to keep themselves and others safe, if necessary. Exposure prone procedure Exposure prone procedures are those invasive procedures where there is a risk that injury to the worker may result in the exposure of the patient's open tissues to the blood of the worker. Health and safety executive (HSE) The health and safety executive (HSE) is Britain's national regulator for workplace health and safety. Health and social care worker Any person whose normal duties involves the provision of care, diagnosis, treatment, accommodation or related services to service users and who has access to service users in the normal course of their work. This includes volunteers. Health and Social Care Act 2008 The legislation that established the CQC and lays out the framework for its powers and responsibilities. Health and Care Act 2022 Legislation to make it easier for health and care organisations to deliver joined-up care for people who rely on multiple services. Health protection team (HPT) Provides specialist local support to prevent and reduce the impact of infectious diseases, chemical and radiation hazards and major emergencies. Part of UK Health Security Agency (UKHSA). Healthwatch England Independent consumer champion that gathers and represents the public's views on health and social care services in England. Hierarchy of controls A way of determining which actions will best control exposures. The hierarchy of controls has 5 levels of actions to reduce or remove hazards (HSE definition). Infection Where the body is invaded by a harmful organism (pathogen) which causes disease or illness. Integrated care boards (ICBs) Integrated care boards are a statutory NHS organisation responsible for developing a plan with NHS trusts and other system partners for meeting the health needs of the population. Invasive device A device that, in whole or part, penetrates inside the body, either through a body orifice or through the surface of the body. Infection prevention and control (IPC) lead Will have overall responsibility for IPC (including cleanliness) and control and will be accountable to the registered provider. Infection prevention and control team (IPCT) IPC (including cleanliness) team role is to provide evidence-based best practice advice to ensure the safety of patients, staff, the general public and the environment. Isolation facilities Separation of a service user with a suspected or confirmed infection from other service users. Or the separation of a service user who is vulnerable to infection to prevent them being exposed to sources of infection. Managed premises Any premises where regulated activities are delivered but excluding a service user's home where domiciliary care is provided, and offices used purely for managerial services. Medical device Any instrument, apparatus, appliance, material or other article (whether used alone or in combination), including the software necessary to use it properly, intended by the manufacturer to be used for people for the purpose of: diagnosis, prevention, monitoring, treatment or alleviation of disease; diagnosis, monitoring, alleviation of or compensation for any injury or disability; investigation, replacement or modification of the anatomy or of a physiological process; control of conception. This also includes devices intended to administer a medicinal product. Medicines optimisation team A team that predominantly includes pharmacists and pharmacy technicians. They focus on the value that medicines deliver, making sure they are clinically effective and cost effective. They help ensure that people get the right choice of medicines, at the right time, and are engaged in the process by their clinical team. NHS Premises Assurance Model (PAM) NHS Premises Assurance Model is a management tool designed to provide assurance and a nationally consistent approach to evaluating NHS premises and facilities performance against a set of common self-assessment questions and established metrics. Commissioners may require providers to demonstrate active management of the NHS PAM as part of clinical service contracts. Patient Advice and Liaison Service (PALS) Patient Advice and Liaison Services, introduced to ensure that the NHS listens to service users and their relatives, carers and friends, and answers their questions and resolves their concerns. Personal care Physical assistance given to a person in connection with eating and drinking, toileting (including in relation to the process of menstruation), washing and bathing, dressing, oral care or the care of skin, hair and nails; or the prompting and supervision of a person, in relation to the performance of any of the activities where that person is unable to make a decision for themselves in relation to performing such an activity without such prompting and supervision. Post-exposure prophylaxis (PEP) This is a form of management to reduce the likelihood of infection after potential exposure, for example to blood-borne viruses. PEP typically includes the use of vaccines, immunoglobulins and/or antimicrobials. Post-infection review (PIR) A method of investigation used to identify how an infection occurred and to identify actions that will prevent similar cases occurring in the future. Primary dental care Refers to high street dental practices rather than community-based clinics and services. Primary care practitioners Health services primarily based in the local community, including community matrons, community nurses, GPs, pharmacists, dentists, optometrists, paramedics and podiatrists. This includes people employed by primary care trusts and primary medical care contractors. Registered manager An individual who is registered with the CQC to manage regulated activity at particular premises where the registered provider is not in day-to-day control. Registered person Any person (individual, partnership or organisation) who provides regulated activity in England. They must be registered with the CQC otherwise they commit an offence. Regulated activities Broad service areas or types of care that are set out in the regulations under section 8 of the Health and Social Care Act 2008. They will include those health and adult social care activities that an organisation needs to register with the CQC to provide care or treatment in England. Risk assessment A systematic assessment of the impact and likelihood of harm occurring. It should be used to identify the actions and mitigations required to reduce harm. A process to decide the policies, practices, and actions necessary to protect service users and staff from the risks of infection with and aim to eliminate or reducing risk of harm or potential harm. Serious incident Serious incidents are events in healthcare where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant an in-depth investigation and response. The emphasis with a serious incident is to gather appropriate learning to reduce the likelihood of recurrence in future practice. Service users A person who receives services provided in the carrying on of a regulated activity. Note: the regulations refer to 'service users' and where we refer to the regulation directly we use this phrase. In the CQC guidance the term 'people' or 'people who use services' is used. Single use device A medical device that is intended to be used on an individual patient during a single procedure and then discarded. Single patient use device Where a medical device has been designated as suitable for single patient use; more than one episode of use of this device on the same patient is permitted. The device may undergo some form of decontamination between each use in accordance with the manufacturer's instructions for reuse. Start smart then focus Evidence-based guidance on antimicrobial stewardship in secondary care. Treat antibiotics responsibly, guidance, education and tools (TARGET) toolkit. The TARGET toolkit is a central resource for clinicians, service users and commissioners to promote safe, effective, appropriate and responsible antibiotic prescribing. Traceability In respect of medical devices, primarily surgical instruments, traceability relates to either individual instruments or instrument sets being tracked through use and decontamination processes and traced in terms of identification of service users on whom they have been used. United Kingdom Health Security Agency (UKHSA) An agency responsible for protecting every member of every community from the impact of infectious diseases, chemical, biological, radiological and nuclear incidents, and other health threats. UKHSA provides intellectual, scientific and operational leadership at national and local level, as well as on the global stage, to make the nation's health secure. The following are extracts from the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Part 3 Section 2. Safe care and treatment 12.(1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things that a registered person must do to comply with that paragraph include: assessing the risks to the health and safety of service users of receiving the care or treatment doing all that is reasonably practicable to mitigate any such risks ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities for the safety of service users and to meet their needs the proper and safe management of medicines assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are healthcare associated where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users Premises and equipment 15.(1) All premises and equipment used by the service provider must be: clean secure suitable for the purpose for which they are being used properly used properly maintained appropriately located for the purpose for which they are being used (2) The registered person must, in relation to such premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used. (3) For the purposes of paragraph (1)(b), (c), (e) and (f), 'equipment' does not include equipment at the service user's accommodation if: such accommodation is not provided as part of the service user's care or treatment such equipment is not supplied by the service provider Bibliography The following bibliography represents current guidance, best practice and legislation that sets the level of care which should be applied in the prevention and control of infection in health and adult social care. It is expected that more chronic illness will be managed within the community, and it is beneficial for adult social and health care to be aware of each other's needs and priorities. It is for this reason that we do not differentiate between these two areas of care. It is not expected that carers become experts in both sectors – only that in the interests of service users' safety and high standards a greater awareness is achieved. However, when a medical procedure is carried out in an adult social care setting, the relevant healthcare guidance should be consulted. Procedures should be performed only by carers who have demonstrated the appropriate competency and who are able to work to levels that may be indicated in the following publications.

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Preventing infection in our Trust is taken very seriously, and staff, patients and visitors all play an important role in minimising the risks. Our infection prevention and control (IPC) team works hard to ensure patients and service users receive the highest standard of care in a clean, safe environment. It provides specialist advice, education and training to all Trust staff, and develops policies and procedures in line with the Health and Social Care Act (2008) to reduce the risk of infection. The team works very closely with other colleagues, including cleaning services, pharmacists, nurses, doctors and therapists, to ensure the healthcare environment and our practices are safe for all. Help us to keep patients safe Everyone has a vital part to play in helping prevent and control infections. Here are some simple steps we can all take. If you have suffered diarrhoea or vomiting, or have COVID-19 symptoms, a cough, cold or the flu, please stay away from visiting friends and relatives until you have recovered and have been free of symptoms for 48 hours. If in doubt, call the ward/clinic for advice. Also, please cover up any open wounds or cuts. Wash your hands or use the alcohol gel available when visiting our inpatient wards and after any contact with patients/service users. You may also be asked to wear personal protective equipment, such as a face mask, when visiting our sites during outbreaks of respiratory infections like the flu, to prevent spread of infection. There will be occasions where wards have a number of cases of an infectious illness (an outbreak). Visiting during these periods will be under advice of the nurse in charge, together with the infection prevention and control team. This will help both to protect visitors and reduce the risk of cross-infection on the ward. Report any problems, such as litter or spillages to our staff. They are responsible for making sure all areas where patients are being treated are clean and hygienic. If you want to speak to the manager responsible for the area you are being treated in or visiting, ask a member of staff. We don't mind being asked if we have washed our hands and used alcohol gel. Contact us Contact the IPC team on

01305 361132 or via dhc.infectionprevention.control@nhs.net. This is an alternative to the PDF document to assist with user accessibility. This is an evidence-based practice manual for use by all those involved in care provision in England. It should be adopted as mandatory guidance in NHS settings or settings where NHS services are delivered, and the principles should be applied in all care settings. The manual will ensure a consistent UK-wide approach to infection prevention and control, although some operational and organisational details may differ across the nations. Accessible version 2.11. Updated 24 April 2025. Standard infection control precautions (SICPs) are to be used by all staff, in all care settings, at all times, for all patients whether infection is known to be present or not, to ensure the safety of those being cared for, staff and visitors in the care environment. SICPs are the basic infection prevention and control measures necessary to reduce the risk of transmitting infectious agents from both recognised and unrecognised sources of infection. Sources of (potential) infection include blood and other body fluids, secretions or excretions (excluding sweat), non-intact skin or mucous membranes and any equipment or items in the care environment that could have become contaminated. The application of SICPs during care delivery is determined by assessing risk to and from individuals. This includes the task, level of interaction and/or the anticipated level of exposure to blood and/or other body fluids. To protect effectively against infection risks, SICPs must be used consistently by all staff. SICPs implementation monitoring must also be ongoing to ensure compliance with safe practices and to demonstrate ongoing commitment to patient, staff and visitor safety as required by the Health and Safety Executive and the care regulators, the Care Quality Commission. There are 10 elements of SICPs: patient placement/assessment of infection risk hand hygiene respiratory and cough hygiene personal protective equipment safe management of the care environment safe management of care equipment safe management of healthcare linen safe management of blood and body fluids safe disposal of waste (including sharps) occupational safety/managing prevention of exposure (including sharps) 1.1 Patient placement/assessment for infection risk Patients must be promptly assessed for infection risk on arrival at the care area, eg inpatient/outpatient/care home, (if possible, prior to accepting a patient from another care area) and should be continuously reviewed throughout their stay. This assessment should influence placement decisions in accordance with clinical/care need(s). Patients who may present a cross-infection risk include those: with diarrhoea, vomiting, an unexplained rash, fever or respiratory symptoms known to have been previously positive with a multi-drug resistant organism (MDRO), eg MRSA, CPE who have been an inpatient in any hospital in the UK or abroad or are a known epidemiological link to a carrier of CPE. The National Infection Prevention and Control Isolation Prioritisation Tool provides a systematic framework that can be used to assist in the prioritisation of isolation rooms as part of multidisciplinary assessment. NB the Isolation Prioritisation tool MUST not be used for patients with a suspected High Consequence Infectious Disease (HCID). Further information can be found in the patient placement literature review. 1.2 Hand hygiene Hand hygiene is considered one of the most important ways to reduce the transmission of infectious agents that cause healthcare associated infections (HCAIs). Clinical hand-wash basins must: be used for that purpose only and not used for the disposal of other liquids have mixer taps, no overflow or plug and be in a good state of repair have wall mounted liquid soap and paper towel dispensers. Hand hygiene facilities should include instructional posters. Before performing hand hygiene: expose forearms (bare below the elbow). If disposable over-sleeves are worn for religious reasons, these must be removed and disposed of before performing hand hygiene, then replaced with a new pair* remove all hand and wrist jewellery. The wearing of a single, plain metal finger ring, eg a wedding band, is permitted but should be removed (or moved up) during hand hygiene. A religious bangle can be worn but should be moved up the forearm during hand hygiene and secured during patient care activities ensure fingernails are clean and short, and do not wear artificial nails or nail products cover all cuts or abrasions with a waterproof dressing. *refer to NHS England uniforms and workwear guidance (Appendix B) for more information on the use of over-sleeves and longer-sleeved uniforms. To perform hand hygiene: Wash hands with non-antimicrobial liquid soap and water if: hands are visibly soiled or dirty caring for patients with vomiting or diarrhoeal illnesses caring for a patient with a suspected or known gastrointestinal infection, eg norovirus or a spore-forming organism such as clostridioides difficile. In all other circumstances, use alcohol-based handrubs (ABHRs) for routine hand hygiene during care. ABHRs must be available for staff as near to the point of care as possible. Where this is not practical, personal ABHR dispensers should be used, eg within the community, domiciliary care, mental health units etc. In settings where personal ABHR dispensers are deemed unsuitable due to staff safety concerns, organisations can consider alternative products and are responsible for ensuring safe systems of work, including the completion of a documented risk assessment approved through local governance procedures. Organisations must confirm the efficacy and suitability of the product (i.e., that it conforms with the relevant standards and is appropriate for the intended use) with the product manufacturer. Any differences in use and application, including volume, contact and disinfection time, of an alternative product compared with ABHR should be identified as part of this assessment and appropriate implementation plans should include education and supporting materials for staff. Where running water is unavailable, or hand hygiene facilities are lacking, staff may use hand wipes followed by ABHR and should wash their hands at the first opportunity. Perform hand hygiene: before touching a patient. before clean or aseptic procedures. after body fluid exposure risk after touching a patient; and after touching a patient’s immediate surroundings. Always perform hand hygiene before putting on and after removing gloves. For how to wash hands, see the step-by-step guide in appendix 1 of this document. For how to hand rub, see the step-by-step guide in appendix 2 of this document. Skin care dry hands thoroughly after hand washing, using disposable paper towels use an emollient hand cream regularly eg during breaks and when off duty do not use or provide communal tubs of hand cream in the care setting staff with skin problems should seek advice from occupational health or their GP and depending on their skin condition and the severity may require additional interventions or reporting. Surgical hand antisepsis Surgical scrubbing/rubbing (this applies to those undertaking surgical and some invasive procedures): perform surgical scrubbing/rubbing before donning sterile theatre garments or at other times, eg before inserting central vascular access devices remove all hand and wrist jewellery (including wedding band) nail brushes should not be used for surgical hand antisepsis nail picks (single-use) can be used if nails are visibly dirty soft, non-abrasive, sterile (single-use) sponges may be used to apply antimicrobial liquid soap to the skin if licensed for this purpose use an antimicrobial liquid soap licensed for surgical scrubbing or an ABHR licensed for surgical rubbing (as specified on the product label) ABHR can be used between surgical procedures if licensed for this use or between glove changes if hands are not visibly soiled. For surgical scrubbing (not rubbing), follow the step-by-step guide in appendix 3 of this document. For surgical rubbing (not scrubbing), follow the step-by-step guide in appendix 4 of this document. For hand hygiene posters/leaflet, refer to the resources section of NIPCM. Further information in the hand hygiene literature reviews: 1.3 Respiratory and cough hygiene Respiratory and cough hygiene is designed to minimise the risk of cross transmission of known or suspected respiratory illness (pathogens): cover the nose and mouth with a disposable tissue when sneezing, coughing, wiping and blowing the nose; if unavailable use the crook of the arm dispose of all used tissues promptly into a waste bin wash hands with non-antimicrobial liquid soap and warm water after coughing, sneezing, using tissues, or after contact with respiratory secretions or objects contaminated by these secretions where there is no running water available or hand hygiene facilities are lacking, staff may use hand wipes followed by ABHR and should wash their hands at the first available opportunity keep contaminated hands away from the eyes nose and mouth. Staff should promote respiratory and cough hygiene helping those (eg, elderly, children) who need assistance with this, eg providing patients with tissues, a dedicated receptacle i.e. waste bag for used tissues and hand hygiene facilities as necessary. Further information can be found in cough etiquette/respiratory hygiene in the hospital setting literature review. 1.4 Personal protective equipment (PPE) Before undertaking any procedure, staff should assess any likely exposure to blood and/or other body fluids, non-intact skin or mucous membranes and wear personal protective equipment (PPE) that protects adequately against the risks associated with the procedure. The principles of PPE use set out below are important to ensure that PPE is used correctly to ensure patient and staff safety. Avoiding overuse or inappropriate use of PPE is a key principle that ensures this is risk-based and minimizes its environmental impact. Where appropriate, consideration should be given to the environmental impact of sustainable or reusable PPE options versus single-use PPE while adhering to the principles below. All PPE must be: located close to the point of use. PPE for healthcare professionals providing care in the community and domiciliary care providers must be transported in a clean receptacle stored to prevent contamination in a clean, dry area until required (expiry dates must be adhered to) single-use only unless specified by the manufacturer changed immediately after each patient and/or after completing a procedure or task disposed of after use into the correct waste stream, eg domestic waste, offensive (non-infectious) or clinical waste discarded if damaged or contaminated. NB Reusable PPE such as goggles/face shields/visors, must be decontaminated after each use according to manufacturer’s instruction. Gloves must be: worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or likely changed immediately after each patient and/or after completing a procedure/task even on the same patient, and hand hygiene performed changed if a perforation or puncture is suspected appropriate for use, fit for purpose and well-fitting never decontaminated with ABHR or soap between use low risk of causing sensitisation to the wearer appropriate for the tasks being undertaken, taking into account the substances being handled, type and duration of contact, size and comfort of the gloves, and the task and requirement for glove robustness and sensitivity. Sterile gloves must be worn: when sterility is required in an operating theatre, and for some aseptic techniques eg insertion of central venous catheters, insertion of peripherally inserted central catheters, insertion of pulmonary artery catheters and spinal, epidural and caudal procedures NB Double gloving is NOT recommended for routine clinical care. However, it may be required for some exposure prone procedures, eg orthopaedic and gynaecological operations, when attending major trauma incidents or as part of additional precautions for high consequence infectious disease management. Gloves are NOT required to carry out near patient administrative tasks, eg, when using the telephone, using a computer or tablet, writing in the patient chart; giving oral medications; distributing or collecting patient dietary trays. Further information can be found in the gloves literature review. If worn, oversleeves must be: changed immediately after each patient and/or after completing a procedure/task even on the same patient, and hand hygiene performed removed and disposed of if visibly contaminated or soiled. Aprons must be: worn to protect uniform or clothes when contamination is anticipated or likely changed between patients and/or after completing a procedure or task. Full body gowns or fluid-resistant coveralls must be: worn when there is a risk of extensive splashing of blood and/or body fluids, eg operating theatre, ITU worn when a disposable apron provides inadequate cover for the procedure or task being performed changed between patients and removed immediately after completing a procedure or task sterile when sterility is required in an operating theatre and for some aseptic techniques eg for insertion of central venous catheters, insertion of peripherally inserted central catheters, insertion of pulmonary artery catheters and spinal, epidural and caudal procedures. Further information can be found in the aprons/gowns literature review. Eye or face protection (including full-face visors) must: be worn if blood and/or body fluid contamination to the eyes or face is anticipated or likely, eg by members of the surgical theatre team and always during aerosol generating procedures; regular corrective spectacles are not considered eye protection not be impeded by accessories such as piercings or false eyelashes not be touched when being worn. Further information can be found in the eye/face protection literature review. Fluid resistant surgical face masks (FRSM): Surgical face masks are required: as a means of source control, eg to protect the patient from the wearer during sterile procedures such as surgery, and to protect the wearer when there is a risk splashing or spraying of blood, body fluids, secretions or excretions onto the respiratory mucosa. as an element of PPE for droplet precautions (see section 2.4 and appendices 5b and 6). FRSM must be: worn (with eye protection) if a full-face visor is not available and spraying or splashing of blood, body fluids, secretions or excretions onto the respiratory mucosa (nose and mouth) is anticipated or likely (Type IIR) worn to protect patients from the operator as a source of infection, eg when performing surgical procedures or epidurals or inserting a central vascular catheter (CVC) (Type II (not classed as an FRSM) or Type IIR) well-fitting and fit for purpose, fully covering the mouth and nose (manufacturers’ instructions must be followed to ensure effective fit and protection) removed or changed: – at the end of a procedure/task – if the mask’s integrity is breached, eg from moisture build-up after extended use or from gross contamination with blood or body fluids – in accordance with manufacturers’ specific instructions. Further information can be found in the surgical face masks literature review. Footwear must be: visibly clean, non-slip and well-maintained, and support and cover the entire foot to avoid contamination with blood or other body fluids or potential injury from sharps removed before leaving a care area where dedicated footwear is used, eg theatre; these areas must have a decontamination schedule with responsibility assigned. Further information can be found in the footwear literature review. Headwear Headwear is not routinely required in clinical areas unless part of theatre attire or to prevent contamination of the environment such as in clean rooms. Headwear must be: worn in theatre settings and clean rooms, eg central decontamination unit well-fitting and completely cover the hair changed or disposed of between clinical procedures/lists or tasks and if contaminated with blood and/or body fluids removed before leaving the theatre or clean room individuals with facial hair must also cover this in areas where headwear is required, eg wear a snood. NB Headwear worn for religious reasons such as turbans, kippot veils, headscarves must not compromise patient care and safety. These must be washed and/or changed daily or immediately if contaminated and comply with additional attire requirements, for example, in theatres. Further information can be found in the headwear literature review. For the recommended method of putting on and removing PPE, refer to appendix 6. 1.5 Safe management of care equipment Care equipment is easily contaminated with blood, other body fluids, secretions, excretions and infectious agents. Consequently, it is easy to transfer infectious agents from communal care equipment during care delivery. Care equipment is classified as either: single use: equipment which is used once on a single patient then discarded. This equipment must never be re-used. The packaging will carry the symbol of the number two in a circle with a diagonal cross single patient use: equipment which can be reused on the same patient and may require decontamination in-between use such as nebuliser masks reusable invasive equipment: used once then decontaminated, eg surgical instruments and solid state reusable equipment, such as, flexible endoscopes and transducers reusable non-invasive equipment: (often referred to as communal equipment) – reused on more than one patient following decontamination between each use, eg commode, patient transfer trolley. NB Needles and syringes are single use devices, they should never be used more than once or reused to draw up additional medication. Never administer medications from a single-dose vial or intravenous (IV) bag to multiple patients. Before using any sterile equipment check that: the packaging is intact there are no obvious signs of packaging contamination the expiry date remains valid any sterility indicators are consistent with the process being completed successfully. Decontamination of reusable non-invasive care equipment must be undertaken: between each use/between patients after blood and/or body fluid contamination at regular predefined intervals as part of an equipment cleaning protocol before inspection, servicing or repair. If providing domiciliary care, equipment should be transported safely and decontaminated as above before leaving the patient’s home. Always adhere to Control of Substances Hazardous to Health (COSHH) risk assessments and manufacturers’ guidance for use and decontamination of all care equipment. all reusable non-invasive care equipment must be decontaminated between patients/clients using either approved detergent wipes or detergent solution, in line with manufacturers’ instructions, before being stored clean and dry. decontamination protocols must include responsibility for; frequency of; and method of environmental decontamination an equipment decontamination status certificate will be required if any item of equipment is being sent to a third party, eg for inspection, servicing or repair guidance should be sought from the infection, prevention and control team prior to procuring, trialling or lending any reusable non-invasive equipment medical devices and other care equipment must have evidence of planned preventative maintenance programmes. For how to decontaminate reusable non-invasive care equipment see Appendix 7. For decontamination of surgical instruments see HTM01-01 decontamination of surgical instruments. Further information can be found in the management of patient care equipment literature review. 1.6 Safe management of the care environment The care environment must be: Always adhere to COSHH risk assessments for product use and processes for decontamination of the care environment. Routine cleaning the environment should be routinely cleaned in accordance with the National Cleaning Standards use of detergent wipes is acceptable for cleaning surfaces/frequently touched sites within the care area a fresh solution of general-purpose neutral detergent in warm water is recommended for routine cleaning. This should be changed when dirty or when changing tasks routine disinfection of the environment is not recommended however, 1,000ppm available chlorine should be used routinely on sanitary fittings staff groups should be aware of their environmental cleaning schedules for their area and clear on their specific responsibilities cleaning protocols should include responsibility for, frequency of, and method of environmental decontamination. Further information can be found in the safe management of the care environment literature review. 1.7 Safe management of linen Healthcare laundry must be managed and segregated in accordance with HTM 01-04 . Healthcare linen is categorised as: Clean linen – linen washed and ready to be used. Used (soiled and fouled) linen – used linen, irrespective of state, which on occasion may be contaminated by blood or body fluids, and Infectious linen – linen that has been used by a patient who is known or suspected to be infectious. Storage and handling of clean linen: Hand hygiene should be performed prior to handling clean linen. Clean linen should be removed from plastic bags before storage to prevent the growth of Bacillus cereus. Clean linen should be stored above floor level in a designated area, preferably an enclosed cupboard that is clean, dry and cool. If clean linen is not stored in a cupboard, then the trolley used for storage must be designated for this purpose and completely covered with an impervious covering/or door that is able to withstand decontamination. Clean linen storage areas should be dedicated for the purpose and appropriately designed to prevent damage to linen and to allow for the rotation of stocks. Clean linen should be physically separated from used/infectious linen when in storage and during transport. Storage and handling of used (previously known as soiled/fouled linen) and infectious linen: Staff handling used and/or infectious linen must wear appropriate PPE (see section 1.4). Hand hygiene must be performed after handling used and/or infectious linen. Ensure a laundry receptacle is available as close as possible to the point of use for immediate linen deposit. Used items of linen should be removed one by one and placed in the used linen hamper/stream. do not: rinse, shake or sort linen on removal from beds/trolleys place used linen on the floor or any other surfaces eg a locker/table top re-handle used linen once bagged overfill laundry receptacles (not more than 2/3 full); or place inappropriate items in the laundry receptacle eg used equipment/needles Infectious linen must not be sorted but should be rolled together and sealed in a water-soluble bag (entirely water soluble ‘alginate’ bag or impermeable bag with soluble seams), which is then placed in an impermeable bag immediately on removal from the bed and secured before leaving a clinical area. Linen should be placed in an impermeable bag immediately on removal from the bed or before leaving a clinical department Linen bags/receptacles must be tagged (eg, hospital ward/care area) and dated Store all used/infectious linen in a designated, safe, lockable area while awaiting collection. Collection schedules must be acceptable to the care area and there should be no build-up of linen receptacles All linen that is deemed unfit for re-use, eg, torn or heavily contaminated, should be categorised at the point of use and returned to the laundry for assessment and disposal. Linen used during patient transfer, eg, blankets, should be categorised at the point of destination. Linen from patients infected with, or at high risk of having, Hazard Group 4 organisms (haemorrhagic fever viruses such as Lassa Fever) should be disposed of at the point of use as Category A waste and must not be returned to a laundry. Further information can be found in the safe management of linen literature review. For how to manage linen at care area level see Appendix 8. 1.8 Safe management of blood and body fluid spillages Spillages of blood and other body fluids may transmit blood borne viruses. Spillages must be treated immediately by staff trained to undertake this safely. Responsibilities for the management of blood/body fluid spills must be clear within each area/care setting. For management of blood and body fluid spillages see Appendix 9. If an organisation locally approves a product for use in the management of blood and body fluid spills, the organisation is responsible for ensuring safe systems of work, including the completion of a documented risk assessment approved through local governance procedures. Organisations must confirm the efficacy and suitability of the product (i.e., that it conforms with the relevant standards and is appropriate for the intended use) with the product manufacturer. A locally approved product which conforms to: EN17126, EN13727, EN14348, EN14476, EN13697, EN14885, EN13704, EN1650, EN1276 and EN13624 may be used for the management of blood and body fluid spills. Further information can be found in the management of blood and body fluid literature review. Healthcare providers should ensure that any polymer gel for non-patient use (eg spill kits, controlled drug destruction, use by cleaning staff) is kept secure and away from patients. See National Patient Safety Alert – National Patient Safety Alert – Superabsorbent polymer gel granules (2019) NatPSA/2019/002/NHSPS. 1.9 Safe disposal of waste (including sharps) Health Technical Memorandum (HTM 07-01) contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment and disposal. Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 outline the regulatory requirements for employers and contractors in the healthcare sector in relation to the safe disposal of sharps. Definitions Healthcare (including clinical) waste: Clinical waste means waste from a healthcare activity (including veterinary healthcare) that: contains viable micro-organisms or their toxins which are known or reliably believed to cause disease in humans or other living organisms. For example, if a patient is known or suspected to be infected, or colonised, by an infectious agent. Clinical judgement should be applied in the assessment of waste and should consider the infection status of a patient and the item of waste produced. contains or is contaminated with a medicine that contains a biologically active pharmaceutical agent, or is a sharp, or a body fluid or other biological material (including human and animal tissue) containing or contaminated with a dangerous substance within the meaning of Regulation (EC) No 1272/2008 of the European Parliament and of the Council on classification, labelling and packaging of substances and mixtures, as amended from time to time. Offensive waste is waste that: is not clinical waste, is not infectious, but may contains body fluids, secretions or excretions, is non-hazardous, and falls within waste codes 18 01 04 if from healthcare, or 20 01 99 if from municipal sources. Table 1: Categories of waste and segregation at source Category Segregation Treatment/disposal Offensive (non-infectious) Yellow bag with black stripe (tiger) bag Energy from waste, landfill or other permitted processes Clinical waste (infectious only) UN approved orange bag, UN approved box or sharps container For alternative treatment Healthcare waste contaminated with non-hazardous pharmaceuticals or chemicals) UN approved yellow bag, UN approved box or sharps container For incineration or other permitted process Waste contaminated with cytotoxic or cytostatic medication UN approved purple bag, UN approved box or sharps container For incineration Non-hazardous pharmaceuticals (no sharps) Blue box/container For incineration or other permitted process Anatomical waste/full blood bag and blood preserves UN approved red lidded container For incineration only Domestic Black/clear bags Energy from waste, recovery or landfill Recycling Clear, green or other colour bag Recycling Safe waste disposal at care area level: Always dispose of waste: immediately and as close to the point of use as possible; and into the correct segregated colour coded rigid container or sharps box if a sharp Liquid waste, eg, suction canisters, must be rendered safe by adding a polymer gel or compound to the container prior to placing in an orange lidded leak proof bin or yellow lidded leak proof bin if contaminated by pharmaceuticals. waste bags must be no more than 2/3 full and no more than the UN approved weight and must be securely tied using a plastic tie or secure knot using a ‘swan neck’ to close. Waste must be traceable back to ward/care area or department, this may be achieved by writing on bags (prior to use), attaching sticky labels or uniquely numbered tags with the post code on them. store all waste in a designated, safe, lockable area while awaiting collection. Collection schedules must be acceptable to the care area and there should be no build-up of waste receptacles. Local guidance on management of waste at care level, eg, domiciliary settings should be followed. Sharps containers (for safety devices, refer to section 1.10) Sharps containers must: have a handle (small community boxes do not require a handle) and temporary closure mechanism, employed when box is not in use be disposed of when the manufacturers’ fill line is reached be labelled with point of origin and date of assembly and disposal. Where re-usable sharps containers are used, organisations must have a protocol in place to assure themselves of safe use and reprocessing. Further information can be found in the Health Technical Memorandum (HTM 07-01). 1.10 Occupational safety: prevention of exposure (including sharps injuries) The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 outline the regulatory requirements for employers and contractors in the healthcare sector in relation to: arrangements for the safe use and disposal of sharps; provision of information and training to employees; investigations and actions required in response to work related sharps injuries. There is a potential risk of transmission of a BBV (blood bourne virus) from a significant occupational exposure and staff must understand the actions they should take when a significant occupational exposure incident takes place. There is a legal requirement to report all sharps injuries and near misses to line managers/employers. A significant occupational exposure is: a percutaneous injury eg injuries from needles, instruments, bone fragments, or bites which break the skin; and/or exposure of broken skin (abrasions, cuts, eczema, etc); and/or exposure of mucous membranes including the eye from splashing of blood or other high risk body fluids. For the management of an occupational exposure incident see Appendix 10. Safety devices Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 are concerned with reducing and eliminating the number of ‘sharps’ related injuries which occur within healthcare. Its basic guidance is: avoid unnecessary use of sharps if use of medical sharps cannot be avoided, source and use a ‘safer sharp’ device; if a safer sharp device is not available then safe procedures for working with and disposal must be in place eg sticky mats, sharps bins, safety procedures and training. Sharps handling must be assessed, kept to a minimum and eliminated, if possible, with the use of approved safety devices. manufacturers’ instructions for safe use and disposal must be followed needles must not be re-sheathed/recapped or disassembled after use sharps must not be passed directly hand to hand used sharps must be discarded at the point of use by the person generating the waste always dispose of needles and syringes as 1 unit if a safety device is being used safety mechanisms must be deployed before disposal. When transporting sharps boxes for community use these must be transported safely with the use of temporary closures. Further information can be found in occupational exposure management (incl. sharps) literature review. > The national infection prevention and control manual (NIPCM) is an evidence-based practice guide for use in England. It contains standard infection control precautions (SICPs) and transmission-based precautions (TBPs), which when applied correctly can help reduce the risk of healthcare associated infection (HCAI) and ensure the safety of those being cared for, staff and visitors in the care environment. The NIPCM aims to: make it easy for health and care staff to apply effective infection prevention and control (IPC) precautions reduce variation and optimise infection prevention and control practices throughout England help reduce the risk of HCAI help align practice, monitoring, quality improvement and scrutiny. The NIPCM should be applied by all NHS staff involved in patient care. Furthermore, the principles in the NIPCM should be applied across all care settings (including acute, community and social care), complementing specific guidance produced for these settings. Several supporting tools (appendices) are available to complement the NIPCM. The NIPCM is underpinned by scientific literature reviews, these are primarily aimed at infection control specialists and summarise the available evidence, highlight any research gaps. Currently, the NIPCM for England uses the Scottish NIPCM literature reviews as its evidence base. NHS England will use these reviews for an interim period, during which we will develop the IPC evidence base for England. This guidance sets out the defined methodology that will be used to achieve this aim. It is fundamental to the integrity and applicability of the NIPCM that a wide group of stakeholders is involved in its development. Involving experts from all appropriate multidisciplinary groups during development of the NIPCM, its associated literature reviews and supporting tools ensures its recommendations are evidence-based, appropriate, practical and acceptable in all healthcare settings. Two standing groups participate in developing the NIPCM: the NIPCM consensus group and the NIPCM clinical oversight group. In addition, topic-specific ‘review’ groups will be formed to support NIPCM literature reviews. Together, the NIPCM review, consensus and clinical oversight groups form the NIPCM guideline development group. The membership of the NIPCM consensus group is intended to reflect IPC practitioners at the front line across a range of services (acute, community, mental health, etc). All members must be employed in a relevant position, ie related to HCAI and infection control. The NIPCM consensus group membership is formed of frontline IPC specialists with responsibility for implementing IPC policy and guidance. The group has representation from across the seven geographical regions including acute, community, mental health and learning disability, and ambulance specialties. The full membership is available in the consensus group terms of reference. The NIPCM clinical oversight group has a wider professional membership. The following organisations and specialties are represented (or included for engagement/consultation purposes) on the NIPCM consensus group: Healthcare Infection Society (HIS) Infection Prevention Society (IPS) Royal College of Nursing Academy of Medical Royal Colleges Occupational medicine NHS England regional IPC leads UK Health Security Agency (UKHSA) Health and Safety Executive (HSE) Chartered Physiotherapy Society Care Quality Commission (CQC) NHS England Primary care services (including dentistry) Department of Health and Social Care (DHSC). NB This list is not exhaustive as membership is reviewed quarterly refer to Terms of Reference for current membership. Lay representatives are also engaged for the NIPCM clinical oversight group. They will have an interest in the NHS and in reducing the incidence and impact of HCAI through applicable and accessible infection prevention and control guidance. The lay representatives are expected to attend all meetings and comment on recommendations from the perspective of a patient or visitor. A specialist clinical ‘review’ group will also be formed for NIPCM literature reviews. The membership of these groups will vary but will comprise topic-specific (clinical and academic) experts and individuals with expertise in literature reviewing and guideline development. Members may also be drawn from the consensus and clinical oversight groups with relevant expertise. A key role of the groups involved in the NIPCM development is to represent the views of all appropriate staff members/groups within and across the represented organisation/regions. The roles and responsibilities of all members of the review, consensus and clinical oversight groups are laid out in full in the terms of reference corresponding to each group. Briefly, members must: contribute to the consultation process on the NIPCM (including literature reviews and any supporting documents/tools), feeding back the views of the professional groups/organisations they represent, such as barriers to implementation contribute to identifying evidence/research gaps in the literature pertaining to the NIPCM and support the development of research studies to enhance the evidence base. Review group members will provide specialist input into the review process. NHS England scientists will lead on developing research questions, search strategies, identification of evidence, critical appraisal/data extraction, summarising evidence and final write-up. Review group members will provide expert input and critique/peer review at each of these stages. Review group members will provide additional clinical or scientific advice and input to the review by assessing: the technical or clinical validity and clarity of research questions the search strategies and identifying any omitted terms, acronyms or synonyms the appropriateness of the eligibility criteria developed the studies identified by NHS England for full text review to identify any additional studies not identified or erroneously excluded the final draft of the literature review as part of the defined stakeholder engagement process (peer review). Review group members are not directly involved in the eligibility assessment, data extraction, appraisal, or in the drafting of the review. Meetings of both the consensus and clinical oversight groups are scheduled on a quarterly basis. For a meeting to be quorate at least 50% of members (including the chair or their deputy) must be present. All members (including chairs) of the NIPCM review, consensus, and clinical oversight group are required to declare any competing interests (see Appendix 2). NHS England literature reviews that inform the NIPCM are produced using systematic (iterative) methods that are conducted in accordance with current best practice, eg Cochrane review methodologies. The choice of literature review design is based on the topic, available resources and timescales required and must be agreed by the clinical oversight group and any review group formed for the purpose of conducting the review. Overview and intended use: Used when a systematic review is likely to be too restrictive to meet research objectives: for example, to clarify concepts or definitions, assess or map a body of evidence or identify knowledge gaps. Not typically intended for the development of evidence-based recommendations but this may be achievable with thoughtful design. Rigour of methodology is similar to a systematic review (ie an iterative and structured approach). Conducted in accordance with Joanna Briggs Institute methodology and reported in accordance with PRISMA extension for scoping reviews. No. of reviewers (NHS England scientists): 2 Evidence sources: Purposefully broad, includes grey literature, policy and legislation, other guidance/ guidelines, and multiple biomedical databases are searched. May include hand searching and snowball searching. Screening of search results: Screening of literature search results is performed in full by two reviewers. Critical appraisal and grading of evidence: Typically, no formal critical appraisal or grading of evidence is performed; data is extracted into evidence tables and checked (at least 30%) by the second reviewer. Evidence synthesis and reporting: A narrative synthesis is performed in accordance with SwIM and results are reported using the PRISMA extension for scoping reviews (PRISMA-ScR). Overview and intended use: Used to answer a research question that is extremely focused or to examine a topic where little is known/has been published or to examine a highly specialised and focused topic/specialty. Uses an explicit, systematic (iterative) and structured process to develop evidence-based recommendations. Similar to a systematic review but with a more restricted scope and typically shorter timeframe. Literature searches are restricted in number, and eligibility criteria are tighter/more focused than in a systematic review (eg, in terms of eligible date range). Conducted and reported in accordance with best practice (Cochrane and PRISMA). No. of reviewers (NHS England scientists): 2 Evidence sources: Purposefully focused; omits grey literature unless identified as key evidence source by the review group; typically a single biomedical database is searched Screening of search results: Screening of literature search results is performed in full by a single reviewer; a second reviewer checks a minimum 20% sample during the first screen and 100% of excluded studies from the second screen. Critical appraisal and grading of evidence: Varies by timescale and topic and is agreed by the review group in advance. Evidence synthesis and reporting: Typically, a single evidence table without an evidence summary reported in accordance with PRISMA and SwIM. Timescale: At least 3 months Overview and intended use: Used to answer focused research question(s) on a specific topic to develop evidence-based recommendations. Uses an explicit, systematic (iterative) and structured process to identify, select and critically appraise evidence, typically from primary research. Conducted and reported in accordance with best practice (Cochrane, PRISMA, AGREE). No. of reviewers (NHS England scientists): 2 Evidence sources: Multiple biomedical databases are searched. Includes grey literature, policy and legislation, other guidance/guidelines. Screening of search results: Two reviewers independently screen all search results against the eligibility criteria. Critical appraisal and grading of evidence: Critical appraisal and data extraction of all evidence as detailed in section 7 is performed by a single reviewer. A second reviewer performs a minimum 30% check. Evidence synthesis and reporting: Evidence tables and evidence summaries produced for each research question by a single reviewer. These are checked by the second reviewer and peer reviewed by the review group. Reported in accordance with PRISMA and SwIM. Overview and intended use: Used to summarise and collate mandatory recommendations or directives from existing legislation or policy, nationally and internationally recognised evidence-based guidelines. This may be used in combination with the two person systematic review if some of the research objectives require searching biomedical databases and appraising peer-reviewed published scientific literature etc. Follows a similar process to a two-person systematic review but with a single reviewer identifying eligible evidence and performing data extraction. No. of reviewers (NHS England scientists): 1 Evidence sources: Focused on current national policy and legislation, and up to date (