Review of Infection Prevention and Control Education and Training Requirements of Healthcare Workers in the Community

NHS Education for Scotland

Blake Stevenson’s Final Report

May 2012
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Review of Infection Prevention and Control Education and Training Requirements of Healthcare Workers in the Community

Executive Summary

Introduction

Blake Stevenson was commissioned to carry out research to identify key priorities for infection prevention and control education and training for healthcare workers in community settings. It was undertaken with the involvement of frontline and key local and national stakeholders.

Effective infection prevention and control (IPC) in community healthcare settings is becoming increasingly important as the balance of care provision continues to shift towards community settings, resulting in more ‘at risk’ patients being treated in non-acute settings than ever before. It is therefore imperative that education and training provision recognises the specific requirements of, and challenges for, healthcare staff working in these settings.

Research Methods

The research involved the following methods:

- a survey of health boards to identify existing education and training;
- a face to face/telephone survey of 90 frontline community healthcare workers across three health board areas (NHS Ayrshire and Arran, NHS Highland and NHS Tayside);
- indepth interviews with key stakeholders and managers with a responsibility for infection prevention and control from NHS Ayrshire and Arran, NHS Highland and NHS Tayside; and
- indepth interviews with stakeholders with a national remit for infection prevention and control.

Key Learning Needs in Relation to IPC

Findings suggest that generally staff are aware of their role and responsibilities in reducing the risk and spread of infection in community healthcare settings, and most staff seem to have basic awareness of the Standard Infection Control Precautions (SICPs). However, many do not have a detailed or up-to-date knowledge of guidance associated with the SICPs, apart from in relation to
hand hygiene, and lack the confidence and knowledge to implement SICP guidelines appropriately within community settings, particularly within patients’ homes. Overall, staff see hand hygiene as of greatest importance to their role and tend to be less clear about the relevance of other SICPs.

**Challenges in Implementing Infection Prevention and Control Guidance in Community Settings**

The study identifies a number of challenges for staff in implementing infection prevention and control measures within community healthcare settings, particularly in patients’ homes. These relate to: the complexity of and lack of control over the cleanliness of some community healthcare environments; the nature of relationships and communications with patients and the public, colleagues and other agencies; and access to adequate resources and support systems. Specifically, these challenges include:

- varying standards of cleanliness in patients’ homes;
- lack of facilities, such as elbow-controlled taps and powerful clinical cleaning products;
- staff’s fear of offending clients regarding the cleanliness of their home and staff use of personal protective equipment;
- lack of public awareness around the spread of infection and their role in preventing and controlling infection;
- staff not having sufficient time to implement IPC measures thoroughly;
- limited awareness of the evidence base that supports the need for IPC measures in community settings;
- inconsistent approaches to IPC by different agencies operating in community-based healthcare settings, particularly patients’ homes; and
- lack of training and support.

**Existing IPC Education and Training Provision**

All territorial Health Boards offer some form of mandatory IPC training to new staff, either online (learnPro) or face-to-face, usually with emphasis on hand hygiene. However, provision of IPC updates and refreshers varies greatly, with just six of the 14 boards having mandatory annual updates. Staff experiences also show that training is often largely focussed on delivery of care in acute settings.
The study highlights a number of strengths in current provision, including use of DVD resources and video conferencing, staff consultation regarding training needs, use of online training and delivery of tailored training in the workplace by Infection Prevention and Control nurses.

Barriers affecting uptake of training include: time pressures and staff shortages, lack of active buy-in from managers and senior staff, a lack of training that recognises the diversity and challenges of roles within community healthcare and a lack of computers to access e-learning.

The report identifies gaps in terms of training reach and content and highlights that current education and training provision does not always adequately support staff to respond to the challenges of reducing the risk of healthcare associated infections in community settings.

Conclusions and Recommendations

The findings of this review suggest that healthcare workers in the community tend to have a basic awareness of standard infection control precautions (SICPs), but, with the exception of hand hygiene, often do not have detailed or up-to-date knowledge of the associated guidelines and procedures they should follow to prevent and control infection.

Where staff knowledge is up-to-date and detailed, confidence and ability to reduce infection risk is often impeded by a number of factors, including:

- the unique range of challenges inherent in the delivery of care in community settings, of which delivering care in patient homes, especially lack of control over the cleanliness of the environment, provides the greatest issue; and
- the fact that current training does not adequately support staff to respond to these challenges.

The research concludes that while there has been progress in recent years, current training and guidelines on IPC issues are still focussed largely on delivery of care in acute settings. While there are some good examples of IPC training being delivered to community healthcare workers, more tailored training, guidance and support is required to enable them to best address the unique IPC barriers they encounter, particularly within patients’ homes.

Inconsistent approaches to IPC across health and social care are a significant concern given the increasing complexity of care packages delivered in community settings. Training programmes need to reflect the diversity of organisations commissioning and supplying community-based healthcare, both in terms of content and delivery. A joint programme of training along with adherence to joint IPC policies and procedures for community-based health and social care workers could improve this situation.
Based on the study findings, this report makes the following recommendations:

- **Recommendation 1**: We recommend NES develop materials and scenarios to support the application of existing SICP guidelines in community settings, paying particular attention to challenges associated with patients’ homes. These could take the form of a ‘how to guide’, ‘top tips’-style resource, or best practice guide for community-based settings. Community-based healthcare workers should be involved and consulted in the development.

- **Recommendation 2**: We recommend that NES consider its role in communicating and raising awareness, both among healthcare staff and those who support them, about available sources of information and guidance on IPC.

- **Recommendation 3**: We recommend that NES and Health Boards explore mixed approaches to IPC training and updates that do not rely solely on e-learning but allow for discussion of issues and challenges with colleagues.

- **Recommendation 4**: Local Infection and Prevention Control nurses are a valuable training resource delivering education tailored to teams and settings. We recommend that NES supports Health Boards in reviewing local education strategies to meet the demands of community staff and support the development of local IPC nurses to expand their knowledge and capability in response.

- **Recommendation 5**: We recommend that NES and Health Boards promote use of NES’ existing range of national education and training packages along with guidance for adapting to local use and within community settings.

- **Recommendation 6**: We recommend that NES works with education providers to ensure that infection prevention and control is an integral part of pre-registration/pre-qualification for all healthcare workers. While the Cleanliness Champion Programme is included in undergraduate programmes for medicine, dentistry and nursing, further research may be required to identify the exact level of IPC content that already exists in pre-registration education for other staff groups including AHPs and social care staff.

- **Recommendation 7**: We recommend that NES conducts further research with specific staff groups (e.g., AHPs, GPs, social care staff) to address gaps in engagement emerging from this research to fully explore the applicability of existing IPC guidelines to their roles.

- **Recommendation 8**: We recommend NES, alongside the Scottish Social Services Council (SSSC) explore how they can support greater consistency of approach to IPC across health and social care, and consider the feasibility of a joint programme of training supported by joint guidance and policies on IPC.
1 Research Context and Methodology

Introduction

1.1 In November 2011, NHS Education for Scotland (NES) commissioned Blake Stevenson to undertake a review of the infection prevention and control education and training requirements of healthcare workers operating in community settings. This report presents the study findings.

Context for the research

1.2 The Healthcare Quality Strategy for NHSScotland outlines a vision to deliver the highest quality health services to people in Scotland. Implementation of the strategy aims to improve patient care by providing services that are safe, effective and responsive to the needs of service users. Patient safety is central to this aim and prevention and reduction of infection is key to achieving this.

1.3 As the balance of care provision continues to shift towards community settings, it is imperative that healthcare workers in this sector are educated and trained in infection prevention and control. ‘Shifting the balance of care’ has resulted in more ‘at risk’ patients in the community than ever before. These patients are more susceptible to infection, present a greater risk of transmitting infection, and require more complex and invasive procedures to be undertaken in community settings.

1.4 Education and training provision needs to recognise the specific requirements of, and challenges for, healthcare staff in community settings and how these may differ from acute settings.

1.5 In 2009, in conjunction with an expert working group, guidance was developed by Health Protection Scotland to standardise the infection prevention and control guidance within NHS and non-NHS Primary and Community Care settings in NHSScotland. The guidance provides practitioners with infection prevention and control measures that should be applied at all times by all practitioners throughout Scotland when delivering healthcare within NHS and non-NHS Community and Primary Care settings.

1.6 Health Protection Scotland’s National Infection Prevention and Control Manual, published in 2012, provides guidance for all those involved in delivering care with the aim of reducing the risk of HAIs and of embedding infection prevention and control into everyday practice. The Manual includes the Standard Infection Control precautions (SICPs), which are intended for use by all staff, in all care settings at all times for all individuals, whether infection is known to be present or not to ensure the safety of all within the care environment. As such, SICPs are the basic infection prevention and control measures...
necessary to reduce the risk of transmission of micro-organisms from recognised and unrecognised sources of infection\(^1\). The ten elements of the SICPs relate to:

- patient placement;
- hand hygiene;
- respiratory hygiene/coughing and sneezing etiquette;
- personal protective equipment (PPE);
- management of care equipment;
- control of the environment;
- safe management of linen;
- management of blood and body fluid spillages;
- safe disposal of waste; and
- occupational exposure management (including sharps).

1.7 Prevalence of healthcare associated infections in patients in primary and community care settings in Scotland is not known and largely unexplored, due to methodological difficulties. Many infections in these patients may have been acquired in hospital and only identified following early discharge into the community. The risk of infection will also be influenced by the use of various medical devices, such as urinary and central venous catheters and enteral feeding systems.

1.8 Research is currently being undertaken on behalf of NES, into the learning needs of staff working in community hospitals and an evaluation of the impact on practice of NES’ DVD to support care home staff to implement correct infection prevention and control procedures. These studies alongside this review will provide NES with a picture of infection prevention and control training requirements across community settings.

**Study objectives**

1.9 Through consultation with frontline staff and local and national stakeholders, this research will support NES in identifying the key priorities for infection prevention and control education and training within the community healthcare settings.

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\(^1\) NHS Scotland (2012), National Prevention and Control of Infection Manual
1.10 The specific objectives of the review were to:

- develop a framework of anticipated knowledge, skills and behaviours of community healthcare workers in relation to infection prevention and control to inform the work;
- engage with professionals, stakeholders and patient representative bodies to identify education, training and learning needs;
- review existing educational and training programmes and opportunities available to community healthcare staff and, where possible, social care staff in the community;
- identify existing approaches, infrastructure, and solutions used currently across NHS Scotland to provide infection prevention and control education;
- map existing resources to support central/local delivery of infection control education and training requirement; and
- develop intelligence on gaps in provision and unmet needs of community healthcare workers.

**Methodology**

1.11 Our research involved the following methodology:

- a desk-based review of infection prevention and control policies and guidance;
- a survey sent to Health Boards requesting details of existing education and training available to healthcare workers in the community, including any gaps and barriers to training;
- nine interviews with stakeholders with a national remit (a full list of organisations consulted is in Appendix 2 and the interview schedule is in Appendix 3);
- 13 interviews with stakeholders from the three Health Boards which took part in the research: Ayrshire and Arran, Highland and Tayside. The interview schedule is in Appendix 4; and
- a survey of 90 frontline community healthcare workers in Ayrshire and Arran (34), Highland (32) and Tayside (24). 76 of these responses were gathered through telephone or face-to-face interviews, 13 responses were returned online and we received one paper response. The questionnaire used is in Appendix 5.
Methodological issues

1.12 There were several issues which restricted the number of survey responses we received and are discussed on the following pages.

1.13 **Recruiting Health Boards** - Health Boards face many competing pressures on the time of their staff, so it was challenging to recruit Health Boards willing to release staff to take part in the survey. This led to a delay in recruiting Health Boards, which delayed the distribution of the survey and meant we had a shorter time period than planned to collect responses.

1.14 **Recruiting frontline staff within the Health Boards** - The survey was conducted between December and March, a peak time for Health Boards and staff in terms of preventing and controlling infections related to seasonal viruses such as respiratory infections and norovirus. This presented challenges for the three Health Boards in recruiting frontline staff to take part in the survey. For example, there was an outbreak of the norovirus in one of the participating Health Boards while our survey was underway, which meant that the Health Board had to focus resources on management of the outbreak.

1.15 **Recruiting certain staff groups** - We encountered some challenges in recruiting certain staff groups. Table 1.1 illustrates the sampling frame we devised at the beginning of the study and the sample achieved. There were particular gaps in the number of responses from General Practitioners (GPs), Allied Health Professionals (AHPs), pharmacists, practice nurses and dental staff. We asked Health Boards to provide contact details of staff based on the intended sampling frame but, in practice, this was not possible. Health Boards sent details of the staff and services who were able to take part, which did not necessarily match up with our intended sampling frame. It is often difficult to recruit GPs to participate in studies such as this, however we note that it was a particularly challenging time of year, given clinical priorities, to seek participation from GP practices.

<table>
<thead>
<tr>
<th>Staff Type</th>
<th>Target number</th>
<th>Target %</th>
<th>Number - achieved</th>
<th>% achieved</th>
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</thead>
<tbody>
<tr>
<td>General practitioners</td>
<td>12</td>
<td>8%</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td>Facilities staff (domestic staff, supervisors or caretaking staff)</td>
<td>12</td>
<td>8%</td>
<td>13</td>
<td>14%</td>
</tr>
<tr>
<td>Nursing (district, midwifery, health visiting, mental health and learning disabilities)</td>
<td>42</td>
<td>28%</td>
<td>46</td>
<td>51%</td>
</tr>
<tr>
<td>Allied health professional (podiatry, physiotherapist, dietician etc)</td>
<td>27</td>
<td>18%</td>
<td>10</td>
<td>11%</td>
</tr>
<tr>
<td>Pharmacy/antimicrobial pharmacy staff</td>
<td>21</td>
<td>14%</td>
<td>6</td>
<td>7%</td>
</tr>
<tr>
<td>Practice Nurses</td>
<td>15</td>
<td>10%</td>
<td>5</td>
<td>6%</td>
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<td>Dental (dental nurse and dentist)</td>
<td>21</td>
<td>14%</td>
<td>8</td>
<td>9%</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>150</strong></td>
<td><strong>100%</strong></td>
<td><strong>90</strong></td>
<td><strong>100%</strong></td>
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2 We interviewed a range of AHPs including three physiotherapists, three podiatrists, two dieticians, one speech and language therapist and one occupational therapist.
1.16 Additionally, it was hoped that Health Boards would provide access to social care staff working in integrated community-based teams. However due to time pressures and the aforementioned infection outbreak in one of the Boards, this was not possible. This review therefore only presents a stakeholder perspective on the learning needs of social care workers in relation to infection control.

1.17 **Recruiting stakeholders** – due to the relatively short timescales for this research and competing work commitments, we were unable to access representatives from The Scottish Patient Safety Programme, Healthcare Environment Inspectorate, or Healthcare Improvement Scotland to participate in this review.

**Definitions**

1.18 This report should be read with the following definitions in mind:

- ‘Community healthcare workers’ refers to all health and care professionals (both NHS and non-NHS) who deliver care and services in healthcare settings other than acute hospitals.
- Healthcare associated infections (HAI) are infections that are acquired in hospitals or other healthcare settings and are caused by micro-organisms such as bacteria, fungi or viruses entering the body. This study is concerned with infections acquired in ‘other healthcare settings’ within the community, including clinics, GP practices and patients’ own homes.

**Scope of research**

1.19 This research focuses primarily on awareness, understanding and compliance with SICPs and issues arising from the unique challenges of healthcare delivered in community settings. It also includes some discussion on antimicrobial prescribing within community healthcare settings. It covers health and social care community-based staff who work in clinics and patients’ homes, including sheltered housing. In order to focus the scope, the research has not looked in detail at issues related to infection prevention and control in community hospitals and care homes as other research has been conducted in these settings.

**Acknowledgements**

1.20 This research would not have been possible without the significant time and effort of key contacts within each of the three participating Health Boards who co-ordinated the

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recruitment of participants. We would like to thank them, as well as the national and local stakeholders and community healthcare workers who took part in our research for their contributions.

The Report

1.21 The remainder of the report is set out as follows:

- Chapter 2 discusses community healthcare workers’ understanding of their role in preventing and controlling infection, their understanding and confidence related to applying guidance around the SICPs, and identifying their unmet learning needs.

- Chapter 3 discusses the challenges associated with implementing infection prevention and control guidance in community settings.

- Chapter 4 identifies existing education and training provision for community workers.

- Chapter 5 provides a summary of the key issues identified by our research and outlines our recommendations.
2 Learning Needs Analysis

Summary

2.1 This chapter discusses the unmet learning needs of community healthcare workers. Findings focus on the community healthcare workers’ understanding of their role in preventing and controlling infection and their understanding of and confidence applying guidance around SICPs. Findings suggest that:

- staff are generally aware of their role and responsibilities in reducing the risk and spread of infection in the community;
- most staff have a basic awareness of the SICPs;
- often, staff do not have a detailed or up to date knowledge of guidance associated with the SICPs, apart from that in relation to hand hygiene, and therefore knowledge of, confidence in and correct implementation of SICPs varies;
- where knowledge of SICPs is good, staff often lack confidence and understanding of how to implement guidance within non-clinical settings such as patients’ homes; and
- overall, staff see hand hygiene as of greatest importance to their role and tend to be less clear about the relevance of other SICPs.

Overview of respondents

2.2 The 90 respondents to our frontline staff survey were spread across three health board areas: 38% worked in Ayrshire and Arran, 36% worked in Highland and 27% worked in Tayside. As Figure 2.1 on the following page shows, respondents comprised a variety of staff categories, with nursing staff, excluding general practice nurses, making up over half of respondents.
2.3 Respondents worked in a range of community settings and 40% reported working in more than one (Figure 2.2). Most commonly, these were in patients’/clients’ homes and in GP practices or health centres. The smallest number of respondents worked in consulting rooms and day centres.

**Figure 2.2: Work Settings**

- 62% in Patient/client homes
- 51% in GP practice/Health Centre
- 40% in More than one setting
- 17% in Consulting Rooms
- 9% in NHS Day Centres
The role of healthcare workers in preventing and controlling infection

2.4 Participating healthcare workers were generally aware of their role in preventing and controlling infections. Staff recognised that infections can be caused and spread by the actions of healthcare workers and by the actions of patients, most notably in terms of poor hygiene and especially poor hand hygiene. Stakeholders agreed that healthcare workers contribute to the spread of infections in the community and felt that some healthcare workers do not have a sound enough understanding of the chain of infection. As one said, a key cause of infection is “staff not being aware of their actions” and “a lack of awareness [among staff and patients] of how infections can spread and failure to implement appropriate procedures like hand washing”.

2.5 The majority of respondents demonstrated awareness of the need to take precautions such as hand hygiene and cleaning surfaces regularly to ensure that the environment within which care is delivered is clean and safe in order to:

- minimise the risk of transferring infections between patients via healthcare staff; and
- minimise the risk of transferring infections from patients to healthcare workers and other members of the community, and vice versa.

2.6 A selection of comments from staff about their role and responsibilities in terms of preventing infection, transmitted between patients or between staff and patients and in terms of ensuring a safe and clean environment include:

“[Our role is] to prevent infections in a patient’s home, either caused by us or anything in the environment” (nurse).

“I have responsibility for reducing infections transmitted between patients” (nurse).

“Making sure the department is as clean as possible and that people don’t catch anything from us” (AHP).

“My role includes ensuring we don’t cause cross-infections – from myself to patients or vice versa or to other patients” (nurse).

“I am very aware of infection control – I have a family to go home to” (nurse).

2.7 Keeping up to date with the latest information and guidelines related to infection prevention and control (IPC) was seen by some staff as a key part of their role. As one AHP said, it is “an important role for me and the rest of my department to make sure we are up to scratch with [IPC] guidelines, practice and legislation”.

2.8 Some healthcare workers spoke of their role in supporting, educating and encouraging patients to maintain a clean environment in their home to minimise the risk of infections.
For example, respondents said their role includes “educating patients and supporting them to understand their own issues”; “education for clients to promote good hygiene” and “providing information to patients and carers as appropriate”. Specific examples of this given by two nurses were “encouraging mothers to properly sterilise bottle feeders etc and encourage cleanliness”; and “giving information to patients with feeding tubes about the risk of infection and what they can do to prevent this”.

2.9 More senior healthcare workers with team lead and supervision responsibilities acknowledged their role in supporting and monitoring other healthcare workers to ensure their actions are in line with IPC guidelines. For example, respondents said:

“[My role involves] providing adequate infection prevention and cleanliness champion training to all clinical staff and providing the necessary tools (alcohol gels, skin cleansers etc) to reduce potential for spread of infection” (General Practice nurse).

“I’m responsible for the practice – I make sure that protocols are up to date” (dentist).

“Make sure staff follow guidelines” (AHP).

“As a team leader I’m responsible for checking my staff consult the policies around each of the SICPs as and when required” (nurse).

2.10 Facilities staff also recognised their role in supporting staff by ensuring that clinical premises are as clean as possible (“my role is to create a safe, clean and pleasant environment for staff and patients”) and by ensuring that staff have adequate access to appropriate equipment (“making sure they have appropriate clothing, gloves, aprons etc”).

Staff views on the relevance of SICPs to their role

2.11 Figure 2.3 on the following page illustrates the SICPs that respondents consider to be most relevant to their role. The vast majority (84%) said that hand hygiene is pertinent to their role but much smaller proportions identified the other SICPs as having significant relevance to their role.

Figure 2.3: SICPs that staff consider most relevant to their role

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4 In addition to the 10 SICPs, we asked specific questions around assessing situations for risk of infection, including staff confidence and the perceived relevance of doing so.
2.12 Community healthcare workers clearly view hand hygiene as the key component of their role in terms of preventing and controlling infections. This is important, in the words of a nurse “because we’re going into people’s homes – some of them aren’t particularly clean” and because “we have a lot of contact with patients and prescriptions that may carry germs” (pharmacist). However, one stakeholder cautioned: “we’ve got the message out about hand hygiene and Cleanliness Champions, but have we focused on this to the extent that other infection control issues have been missed?”

Compliance with SICP guidelines and other infection control procedures

2.13 In this section, we discuss healthcare workers’ understanding and awareness of IPC guidelines\(^5\) and their confidence and ability in applying them.

Understanding, awareness and confidence with SICPs

2.14 Survey responses suggest the majority of staff have a basic awareness of the SICPs. 79% of respondents rated their understanding and awareness of SICPs as ‘good’ or ‘very good’ and 73% said they were aware of SICPs before taking part in the interview with us.

\(^5\) Health Protection Scotland and NHS National Services Scotland (2012), \textit{National IPC Manual}.\[10.5pt\]
Similarly, staff reported high levels of confidence when applying the SICPs in practice. Figure 2.4 displays the percentage of survey respondents who reported ‘very good’ or ‘good’ levels of confidence in applying standard infection control precautions.

**Figure 2.4: Staff’s confidence about applying the SICPs**

![Confidence Levels Diagram]

- Managing linen: 26%
- Placing patients appropriately: 34%
- Managing care equipment: 60%
- Managing blood and body fluid spillages: 61%
- Assessing a situation for risk of infection: 68%
- Ensuring a safe environment: 77%
- Safe disposal of waste: 78%
- Risks associated with sharps: 79%
- Using personal protective equipment: 83%
- Respiratory hygiene: 83%
- Hand hygiene: 94%

2.16 Figure 2.4 shows that over three quarters of respondents reported a ‘very good’ or ‘good’ level of confidence with all SICPs except the following:

- assessing a situation for risk of infection (68%);
- managing blood and body fluid spillages (61%);
- managing care equipment (60%);
- placing patients appropriately (34%); and
- managing linen to prevent contamination (26%).

2.17 Staff commonly reported that their awareness and confidence around infection control issues resulted from pre-registration training, experience and common sense, rather than an in-depth knowledge of up to date policies and guidelines. A common response from staff was that they feel their practice is in line with IPC guidelines because the issues have been “*drummed into*” them since their pre-registration training and they prevent and control infection as “second nature”. One General Practice nurse commented that her
2.19 Examples which further illustrate this point include:

- a nurse said that she has a “lack of confidence in being up to date with developments in infections”;
- an AHP said “I’m probably not completely clear when I should be using each of these (SICPs)”; 
- a stakeholder said staff “are aware of the SICPs but not really the guidance”; and
- another stakeholder commented that community healthcare workers “have the ability but SICPs are very new. They apply to all care settings but understanding is probably pretty limited for community staff because it’s still very new”.

2.20 A summary of staff’s confidence applying each of the SICPs is provided below.

**Hand hygiene**

*Key issues: length of time, thoroughness, contamination from taps/disposing of towels*

2.21 Most staff were able to confidently describe elements of effective hand hygiene processes including the ‘five key moments’. Descriptions of the length of time and thoroughness of hand washing, as well as removal of jewellery and ensuring hands are not contaminated when turning off taps/disposing of towels, were less commonly given. Examples of staff’s incorrect hand hygiene techniques were given by a number of stakeholders who suggested that despite the emphasis on hand hygiene, staff are still displaying incorrect practice e.g., decontaminating hands in car before seeing a patient, then touching the car and front door of the patient’s home before delivering care.

2.22 Many staff mentioned the use of hand hygiene instructions on walls near sinks in their offices and clinics and found these helpful in supporting compliance with approved techniques. However these reminders are not always available in community settings, particularly patients’ homes.
Managing blood and body fluid spillages
Key issues: how to clean up, when to clean up (roles and responsibilities)

2.23 There is a mixed level of awareness and confidence linked to this SICP among survey respondents. Some respondents described how they would deal with a spillage of blood or body fluids using the correct cleaning solution, wearing personal protective equipment and disposing of the debris appropriately in accordance with current waste disposal guidance.

2.24 However, many others, while aware of the importance of these procedures, were unsure of how to clean a spillage. One nurse said “I’m not sure what to do” and another said “I would need an update on blood spillages”. Several staff said that they would call for a special waste uplift from a specialist cleaning team employed by the Health Board: as an AHP said, “I would call for somebody with more experience in this” and a nurse said “this doesn’t usually happen but in an emergency I would mop up and dispose in clinical waste and get in touch with my team to deal with”. Another nurse said that they have packs available in the health centre to deal with spillages but “if it happened in the patient’s home we’d have to call someone”. One nurse gave the example of a time where, with the support of their team, they removed a patient from their home temporarily and arranged for industrial cleaners to come in to deal with a body fluid spillage because of the extent of the incident.

2.25 There were several examples of the lack of awareness about roles and responsibilities for dealing with spillages. Some staff seemed unsure of their role in cleaning spillages and said that if a spillage occurred in a patient’s home, they would ask the patient to clean it: as a nurse said, “I would expect them to clean it up themselves”. A couple of respondents said that spillages would be something that a paid carer would deal with in a patient’s home.

Respiratory hygiene and coughing and sneezing etiquette
Key issues: awareness of current guidelines

2.26 Most staff were able to describe effective coughing and sneezing etiquette but many acknowledged that this was based on common sense or familiarity with public education campaigns such as ‘Catch It, Kill It, Bin It’ rather than up to date knowledge of current guidelines.

Using personal protective equipment
Key issues: removal and disposal, use in patients homes

2.27 Most staff accurately described some aspects of good practice related to using personal protective equipment (PPE) such as knowing when to use them and the importance of hand hygiene in conjunction with use of PPE. However, generally staff demonstrated less knowledge about applying guidelines related to removing and disposing of PPE. The following comment by an AHP illustrates a similar point made by other staff “I’m ok with putting them on but unsure of the order for taking off”. One nurse said “I remember being told the order, but can’t remember what it is”.

2.28 There is evidence from our research that while staff might understand when to use PPE, they are not always compliant with guidelines in patient’s homes because they feel uncomfortable doing so and do not want to offend the patient. Some staff said they experience difficulties accessing PPE – these issues are further discussed in chapter 3.

**Ensuring a safe environment for you and your patient**

*Key issues: responding to a lack of control over the environment*

2.29 Staff demonstrated quite a defeatist attitude towards ensuring a safe and clean environment when working in patient’s homes, often commenting that this is largely “out of our control”. Several staff gave examples of “shocking situations” they had witnessed such as the presence of material including dog faeces, drug litter and human waste in patients’ homes. Many respondents felt that it is “impossible” to ensure a safe environment when working in a patient’s home given the extent of variables outwith the worker’s control including the patient’s general personal and domestic hygiene, the extent of clutter and mess in the house and the behaviour of children and pets.

2.30 Staff gave some examples of how they would ensure the environment was as clean as possible, although these are not all compliant with SICP guidelines:

“I always take my folder into a patient’s home so at least I can sit on that if there’s nowhere else clean” (nurse).

2.31 One nurse said she used her case to provide a clean surface, instead of a sterile trolley, when using aseptic techniques in unclean patient homes. Other staff repeatedly use hand gel instead of soap and water when it is not available.

2.32 The variable nature of home environments presents a major barrier to implementing IPC guidelines among community healthcare workers and is discussed in more detail later in chapter 3.

**Managing care equipment**

*Key issues: understanding role and responsibilities*

2.33 Many respondents seemed to be unsure of their responsibilities related to managing care equipment and ensuring it is decontaminated if it is not for single-use. For instance, a dentist said “I’m not confident in the use of decontamination equipment” and a nurse commented that it’s particularly difficult when working in patients’ homes “it’s difficult if you don’t have the right stuff with you”. Some staff reported that guidance for cleaning equipment varied between department and this heightened the sense of uncertainty about staff’s role in this. As an AHP said, “there is variation between departments as to whose responsibility it is to clean equipment”. Staff generally made little reference to the practice points in the SICP guidance.

2.34 One example was given of a team of AHPs who spent one hour each week cleaning the equipment in their clinic thoroughly but, for the most part, where examples were given of staff managing the cleaning of care equipment, this tended to be using detergent wipes
before they used it with a patient, for example wiping down baby scales and chairs between appointments. One nurse expressed concern about the amount of care equipment gets transported in the team’s pool car as she felt the car was too dirty and should be subject to similar regular inspection and cleaning to hospital wards are.

**Managing linen to prevent contamination**
*Key issues: understanding role and responsibilities*

2.35 This SICP was identified as the least relevant to the staff who completed the survey as they rarely had to deal with bedding in either clinical or home settings. Only 26% said they had ‘very good’ or ‘good’ confidence in relation to this SICP. One AHP gave an example where they had realised they had not been following procedures correctly. They had been taking the linen to the washing basket rather than vice versa. Other health staff suggested that this would be a task that social care staff or unpaid carers would undertake in the home and did not seem to envisage a time where they would ever be required to change linen or understand how to do so in line with IPC guidelines.

**Safe disposal of waste**
*Key issues: procedures for patients’ homes*

2.36 Whilst 78% of staff reported that they were confident in the safe disposal of waste, during the qualitative discussion staff generally seemed to be unsure and lack confidence about appropriate procedures to follow when dealing with waste in a patient’s home. Some said they would use the patient’s own bin while others said they would take the waste away with them in their car or bag to dispose of in colour-coded bins at their base. Staff expressed the need for clarity about what correct procedure is. In clinical settings there was also some uncertainty as some staff found it difficult to remember the colour-coding of bins, illustrated by a couple of respondents who said when they get confused they dispose of everything in clinical waste bins as they know “this will be incinerated and is therefore safe.”

**Placing patients appropriately**
*Key issues: uncertainty about meaning and relevance to patient’ homes*

2.37 This SICP relates to the appropriate placement of individuals who could potentially contaminate the environment with blood or body fluids, or are suspected to be suffering from an infectious agent. We found that many respondents were not sure what this SICP meant and only 34% of respondents said their confidence in applying this was ‘very good’ or ‘good’. A few talked about it in relation to the order in which they visit patients, for example, ensuring that patients they know to have an infection, particularly something such as MRSA, are last in their rounds. There were no clear examples of how this SICP is implemented in community-based clinical settings such as GP or dental practices. The majority felt this SICP does not apply to delivering care in patient’s homes as they are limited in terms of where to place the patient, and the need to place the patient appropriately is less pressing due to minimal numbers of other people involved in the
scenario. Staff felt there was a lack of clarity over what this SICP means within patient homes.

**Assessing a situation for risk of infection**  
*Key issues: uncertainty about how to assess application of SICP*

2.38 Again, while 68% staff said they felt confident about this SICP, in qualitative discussions, respondents were unsure about, with several commenting that they would like more training and awareness raising. As one AHP said, “*I would like more guidance and support around assessing situations and what to do if risk is identified*”. Some seemed unsure or unaware about what this SICP refers to – as one AHP said “*I don’t know if I’ve ever had to do this*” and a nurse said “*we don’t have to do that much*”. Another nurse said that they feel their assessment of infection risk is often quite “*instinctive rather than objective*” and that they would appreciate support with this SICP.

**Managing the risks associated with sharps**  
*Key issue: disposal in absence of sharps box*

2.39 In general, staff who deal with sharps feel confident in managing the risks associated with their use and this is something staff who come into contact with sharps regularly tend to be conscious of, recognising the potential high risk to themselves of mismanaging sharps. Dental staff highlighted needle stick injuries as one of the key causes of infections in their work and demonstrated high levels of confidence in applying guidance around use of sharps. Some staff reported concerns about being able to dispose of sharps correctly when working in patients’ homes: as a nurse said, “*it depends if the patient has a sharps box*” and another said “*we are not routinely given sharps boxes*”. There were no clear examples given of how staff prepare sharps for disposal. Responses indicated a need for staff to be made aware of how to dispose of sharps appropriately when a sharps box is not available.

**Antimicrobial prescribing**  
*Key issues: patient perceptions, inconsistent approaches to training, lack of up to date knowledge about correct prescribing*

2.40 While this research primarily focused on staff understanding, awareness and confidence around the SICPs, issues related to antimicrobial prescribing in community healthcare settings also emerged. The number of staff participating in our research with prescribing responsibilities was limited and therefore detail on the key issues in relation to antimicrobial prescribing is limited. Staff with prescribing responsibilities were aware of the importance of advising patients to deal with coughs and colds without antibiotics. As a nurse said, “*we encourage people to protect and treat themselves rather than taking antibiotics*” and a GP commented that “*we follow the Health Board’s antibiotic prescribing policy which seeks to limit use of antibiotics*”. However, the expectation among some patients that they will receive antibiotics can put pressure on GPs and nurses to prescribe these. As a practice nurse said, “*we don’t prescribe antibiotics for viruses but it’s more and more difficult with patients. As a nurse, if they don’t get what they want they will make an*
appointment with a doctor”. Stakeholders noted that staff need support to manage patients’ expectations.

2.41 Stakeholders also highlighted a number of other issues regarding antimicrobial prescribing. Firstly, the fact that some prescribing is done by General Practice nurses and that it is important to ensure that training delivered to this group of staff is consistent; currently, approaches to training can be inconsistent because some are employed by the NHS and others by GPs. Secondly, one stakeholder said that their recent discussions with GPs suggested that it would be good to “go back to basics” with regards to what should be prescribed when: “they get info in medical school and then nothing afterwards”.

Challenges in implementing IPC guidelines

2.42 This chapter has identified a number of gaps in terms of staff awareness, understanding and confidence when applying different elements of IPC. This research has identified that staff’s ability to apply guidance around the SICPs is further affected by the following issues, addressed in the next two chapters of this report:

- the various infection prevention and control challenges faced by healthcare workers delivering care in community settings, particularly in patients homes, addressed in Chapter 3; and

- the quality of and access to education and training around infection prevention and control, addressed in the following chapter (Chapter 4).

2.43 The following chapter discusses the range of challenges that healthcare workers face and how these impact on their ability to comply with approved infection prevention and control procedures.
Challenges in Implementing Infection Prevention and Control in Community Settings

Summary

3.1 In the previous chapter we highlighted gaps in terms of community healthcare workers’ knowledge, confidence and understanding in applying aspects of infection prevention and control in their daily practice. These gaps highlight a number of learning needs that future training should seek to address.

3.2 However, even where knowledge, confidence and understanding of SICPs is high, this review has identified that staffs’ ability to follow correct infection and prevention control procedures is often impeded by the challenges inherent in delivering care within community settings. This chapter explores these challenges, as summarised in Figure 3.1.

Figure 3.1: Challenges that impede implementation of IPC guidelines in community settings

3.3 We discuss these challenges on the following pages.
The Community Healthcare Environment

Delivering care in patients’ homes

3.4 Stakeholders and staff feel that the main barrier to implementing IPC guidelines in the community setting is lack of control over the environment where care is delivered. The following comments illustrate this:

“It’s impossible to ensure [a safe environment] when we’re in a patient’s home” (nurse)

“I have a very good understanding of the theory and how to implement precautions in an ideal situation, but it’s very different in the community. In reality it is not a sterile environment and there are many things you can’t control” (nurse)

“We go into homes where you run greater risk of infection through using the sink and facilities to wash your hands than you do without washing hands” (AHP)

“I work with disenfranchised individuals with mental health and substance misuse issues. More often than not the environments they live in are both untidy and dirty” (nurse)

3.5 The cleanliness of the patient’s home and its suitability as a place to deliver care is determined by the following factors:

- the patient’s own behaviour such as coughing and sneezing appropriately;
- the general cleanliness of the house and surfaces within it;
- the patient’s understanding of the importance of maintaining a clean and hygienic home;
- the patient’s ability to maintain a clean and hygienic home; and
- the presence and behaviour of pets and children while appointments are being carried out.

3.6 Healthcare workers gave many examples of patients living in unsanitary and unhygienic conditions which restricted their ability to deliver care in a clean and safe environment. Healthcare workers said they can and do take steps to make areas of the house cleaner to a limited extent, but often they do not have the time or equipment, to make the environment as clean and safe as guidelines advise. They have limited control over whether a home environment is clutter free, well-maintained, or clean. While some staff said they try to educate and encourage patients to clean their homes and take simple measures such as changing bed linen regularly, they said they cannot ensure patients follow this advice.
3.7 Staff’s ability to follow IPC guidelines in patients’ homes is further restricted by a lack of facilities in patients’ homes. Unsurprisingly, patients’ homes lack facilities that you would normally find in a clinical setting, such as elbow-controlled taps and powerful clinical cleaning products. However respondents said that often patients lack even domestic cleaning products and suitable hand washing facilities such as a clean sink, soap and towels. This means that often staff need to use “what’s available rather than what’s appropriate” (stakeholder). The majority of staff reported carrying alcohol hand gel to wash their hands where no other suitable facilities are available, despite recognising that alcohol gel is not as effective in preventing infection as washing hands with water and soap and that for Colostridium Difficile and norovirus micro-organisms, it is not appropriate.

3.8 Some staff said that where a patient’s home is too unclean to deliver care they would ask them to attend an appointment in a clinical setting, but noted that this is not always possible due to the patient’s condition and/or the capacity of clinical settings.

3.9 Healthcare workers commented that where patients were receiving a complex package of care with regular support from paid carers, home environments tended to be cleaner and more manageable.

3.10 Overall, staff reported severe barriers to implementing IPC guidelines caused by the state of the patient’s home and in these circumstances, staff do the best they can with the materials they have available, but they are aware that this does not always meet IPC guidelines.

Conducting aseptic techniques in patients homes

3.11 In general, staff who were involved in delivering aseptic procedures felt confident in doing so and recognised that poor aseptic technique and asepsis may lead to cross contamination of pathogenic micro-organisms. However, staff also noted particular barriers in delivering these procedures in patients’ own homes and often did not feel supported to adapt the aseptic technique to a non-clinical environment. A nurse gave an example of where a patient’s house was so unclean it was not possible to administer a depot injection so he took the patient out to his car to deliver the injection.

3.12 Many of the issues noted in this chapter make it challenging for staff to comply with aseptic techniques in patients’ homes, including feeling uncomfortable touching patients with gloves, hand hygiene being difficult to ensure, the temperature and cleanliness of the environment being dictated by patient’s home environment and lack of access to disinfectant to clean surfaces which leaves staff relying on the products (or lack thereof) in patients’ houses.

3.13 Stakeholders suggested that staff often believe aseptic techniques not possible in patients home and assume they can’t use aseptic techniques in these circumstances. They felt community staff would benefit from training to increase their skills and confidence in
delivering these procedures and to raise awareness of best practice in delivering aseptic techniques in patient home settings, particularly where catheter and intravenous care, or pressure ulcer care is involved.

**Lack of facilities in clinical settings**

3.14 Respondents found it easier to ensure a clean and safe environment in clinical settings. However, respondents commented that sometimes controlling the care environment in clinical settings can also be challenging. As a nurse said, “sometimes health centres don’t have adequate washing facilities” and this appears to be particularly prevalent in older premises. As a member of facilities staff said, “older style premises have no hand washing basins and no appropriate domestic service rooms”.

3.15 Similarly, when premises are being renovated, temporary accommodation does not always provide conditions conducive to preventing and controlling infections. A pharmacist gave an example where their service was delivered in a portakabin, which was “not easy to keep clean”.

3.16 In addition, some settings lack facilities that would make it easier for staff to prevent and control infections. For example, one nurse said that their base does not have a shower or changing facilities, which would be helpful to use following any visits to patients’ homes that are unclean.

3.17 Some dental practices, particularly smaller practices, can find it challenging to adhere to new decontamination guidelines that require a decontamination unit that is separate to the clinical area. This is often due to small staff numbers, older buildings and the significant resource implications involved. Stakeholders said that many practices are exemplary and implement the guidelines stringently but for some the cost of running and setting up a decontamination unit is prohibitive. As one dentist said, “we had to build new premises for it – not everyone is in a position to do this and it causes massive upheaval”.

**Relationships and communications - Patients and the public**

**Fear of offending patients**

3.18 Some staff are reluctant to take IPC measures for fear of offending the patient by implying the patient, or their home, is unclean. Some respondents said they would avoid using PPE like aprons, and sometimes gloves, for this reason. This reflects staff lack of understanding of the importance of, and the health and safety requirements for wearing PPE to ensure patient and staff safety. For example, an AHP said that on one occasion a patient had been using a bucket as a commode and there was extensive urine spillage in the home. The AHP put gloves on to clean the patient but “felt a bit embarrassed doing so”.
3.19 There are also sensitivities related to educating patients and encouraging them to improve their domestic or personal hygiene. While staff generally recognise their responsibilities in this respect, some reported being cautious of the reaction of patients and afraid for their own safety, others were fearful that they might damage their relationship with the patient: “people may have substance misuse or other issues and you are wary about trying to tell them how their environment should be cleaner”(AHP) and “patients’ attitudes can be difficult if you challenge them or try to educate them... we have to be careful not to damage the relationship”(nurse).

Lack of public awareness

3.20 Linked to the point above about educating patients, staff and stakeholders felt that workers would be more able to implement IPC guidelines if members of the public had greater awareness of the nature of infections and of their role in preventing and controlling them. As a couple of respondents said: “a lot of clients have never been taught basic domestic and personal hygiene by anyone”(nurse) and “it would help if patients were more aware of the hygiene needs that health workers have – more access to clean sinks, somewhere to dispose of gloves etc” (AHP). Many staff commented that their role would be easier if their patients were more aware of these issues.

Patients’ expectations around prescribing

3.21 Patients’ expectations that health staff will prescribe antibiotics for them impacts on the ability of staff with prescribing responsibilities and antimicrobial teams to reduce infections associated with over-prescription of antibiotics. Staff with prescribing duties who took part in our survey were aware of the advice to encourage patients to deal with coughs and colds without taking antibiotics but, as a stakeholder said “the challenge is to manage patients’ expectations. GPs know often they should not give an antibiotic but they are under pressure to get the patient out the door”. A practice nurse said “it’s more and more difficult with patients. As a nurse, if they don’t get what they want they will make an appointment with a doctor”. This illustrates the need to continue to support GPs and nurses and other staff with prescribing responsibilities to manage patients’ expectations related to the availability of prescriptions.

Relationships and communications – colleagues

Difficulties raising issues with colleagues

3.22 A few staff reported feeling uncomfortable in challenging or advising colleagues about their adherence to IPC guidelines. For example, a dentist said he felt uncomfortable approaching colleagues to suggest improvements they could make to their practice and a
facilities staff member said she had completed the cleanliness champions training but felt uncomfortable raising issues with nursing or clinical staff if she observed any bad practice.

Working across the health family

3.23 Our research found a few examples of poor communication between hospital and community staff, which exacerbated attempts to prevent and control infection. For example, a staff member told us about instances where patients had been discharged from hospital but there was no mention on their discharge letter that they had MRSA – while the SICPs should be applied regardless of whether infection is known or not, this information would allow staff to apply extra precaution to reduce infection risk, such as seeing the patient at the end of their shift.

Relationships and communication – working with other agencies

3.24 Healthcare workers commented that where patients were receiving a complex package of care with regular support from paid carers, home environments tended to be cleaner and more manageable.

3.25 However, a key concern for a number of stakeholders was the fact that due to increasingly complex packages of care in community settings, multiple care providers will be accessing a patient’s home, from both health and social care. Stakeholders are concerned that approaches to IPC between agencies are inconsistent which reduces the effectiveness of good practice. As one stakeholder put it: “if you’ve got six people delivering care in one home over the course of a day, and they haven’t received the same training and their approaches are different, then one person’s very good infection control can very easily be undone by the poor practice of others. We desperately need consistency of approach if we are to really control the spread of infections in the community”.

3.26 Due to sample gaps, it was not possible to explore the learning needs of frontline social care staff in detail through this research, however stakeholders suggested that apart from the NES DVD for care home staff, there is limited training available for social care staff and that where training is delivered, this does not always promote awareness and application of SICPs. One stakeholder commented on an over reliance by social care staff on the using hand gel: “they see nurses using hand gel and copy this practice, but they haven’t had the training to understand when hand gel is ineffective and that use of hand gel must also be accompanied by hand washing”.

3.27 There seems to be some lack of clarity or misperception among some health staff regarding the role of social care staff. Some health staff appeared to feel that dealing with IPC issues is more of an issue for social care staff and did not fully understand their own role in addressing these issues. Relating back to a similar point made in chapter 2, one AHP
commented that “where patients have a paid carer, they are responsible for keeping things clean and dealing with spillages”.

Resources and support systems

Access to and use of personal protective equipment and infection prevention accessories

3.28 Three quarters of respondents to our survey said that they have adequate access to protective equipment such as gloves, aprons, face protection and hand hygiene. However, some said that it was difficult to access these resources. Very few staff had access to small bottles detergent which would help them adhere to guidelines around spillages, and lack of access to paper towels and liquid soap to support hand hygiene was commonly mentioned. As a nurse said, “we don’t have alcohol gel when going out to patients’ homes – it would be helpful to have this” and an AHP said “I have to go and find or nick things for myself”. A stakeholder said that more resources should be available to staff visiting patients’ homes: “they should have packs – hand gel is often all they have”. One dentist who had inspection responsibilities for other practices said they had inspected a number of practices who did not appear to have sufficient supplies of gloves to change them.

3.29 Some staff feel the infrequency with which incidents that pose an infection risk occur means that taking certain precautions is unwarranted. For example, a health visitor said that occasionally babies urinate on her clothing. She “[does] not tend to wear an apron” so in this situation she would go home or to her base to change clothes. She noted that Cleanliness Champions training advises workers to carry a spare set of clothes, but that “this kind of incident doesn’t take place often enough to warrant this”.

3.30 Another nurse said that “we don’t tend to have [gloves and aprons] as we don’t routinely carry them because we don’t require them often. If there was an encounter with severe infection... I might not have protective equipment to hand”.

3.31 Use of personal protective equipment (PPE) is a requirement of health and safety legislation and these examples illustrate that some staff and managers lack awareness of these requirements.

Lack of time to apply guidelines

3.32 Time pressures also restrict health workers’ ability to follow IPC guidelines. Several staff and stakeholders commented on the difficulties associated with cleaning surfaces and equipment between each patient when the time between appointments is short. As a pharmacist said, “we are advised to clean down chairs between appointments but don’t often have time for this”. A nurse said “we’re all too rushed just now – I’m sure things slip through the net without people meaning to – staff might not clean their hands as thoroughly as they should, might not pay proper attention to what their coat or bag has
come into contact with in a patient’s home”. The length of the appointment time for each patient was also felt to be a barrier to implementing correct IPC guidelines.

3.33 Further, domestic staff reported that the propensity of many GPs to work in their office until late in the evening and to offer early morning and evening appointments “makes it difficult to access rooms for cleaning when staff and patients aren’t around so cleaning doesn’t get done as thoroughly as it should” (facilities staff).

**Limited awareness of the evidence base**

3.34 There is a firm commitment to evidence-based practice across the whole of NHS Scotland and staff are expected to ensure this is an integral part of their work. However, currently there is a limited awareness of the evidence base around the prevalence of community based HAIs and whether infections are community associated or community healthcare associated infections. Without an awareness of this evidence, stakeholders commented that it can be difficult to make staff understand the importance of attending infection control training or adhere to SICP guidelines, as they believe the evidence which makes the case for it is not there. This is a significant gap given the emphasis within NHS Scotland on evidence based practice.

3.35 Stakeholders’ comments on this matter included:

“Can we really expect a GP to wash their hands in between seeing every patient, even if they don’t have physical contact with them, or to spend time attending training which they perceive to be irrelevant, if there is no evidence to back up how their actions will improve patient care?”

“To educate we first need to persuade individuals and organisations that there is a need, real and not theoretical”.

3.36 Some stakeholders felt that, to date, the focus of IPC policies and training activity has been on hospital settings. This has led to a perception among some staff that infection prevention issues are not as applicable in community settings – without the evidence, the drivers for practice change are lacking. In particular, stakeholders have found it difficult to engage GPs in training as “[a GP] does not see many infections on a day to day basis” (stakeholder). One stakeholder said, in order to see attendance at training “you need to convince people and make a case”.

**Lack of training/support**

3.37 Gaps in existing education and training and difficulties accessing appropriate training and support present a further challenge to staff being able to implement IPC guidelines in community settings. Barriers to training include lack of active buy-in from managers,
insufficient access to IT facilities, and the diversity of community healthcare worker’s roles. Training gaps include tailored content to community settings, applying SICPs in patient homes, lack of consistency in approach by health and social care, and lack of uptake by particular staff groups, including GP practices and social care staff. These issues are discussed in the following chapter.
4 Existing Education and Training Provision

Summary

4.1 This chapter discusses current infection prevention and control training provision for healthcare workers in the community and identifies gaps in and barriers to training, as well as examples of effective practice. The findings suggest that:

- all Health Boards seem to offer some form of mandatory IPC training to new staff, either online (learnPro) or face-to-face, usually with emphasis on hand hygiene;
- provision of IPC updates and refreshers vary, with just six of the 14 boards having mandatory annual updates;
- the strengths of current IPC training include use of DVD and video conferencing, staff consultation regarding training needs, and use of online training;
- there are a number of barriers affecting uptake of training including time pressures and staff shortages, lack of active buy-in from managers and senior staff, a lack of training that recognises the diversity and range of roles within community healthcare and a lack of computers to access e-learning; and
- substantial gaps have been identified in terms of training reach and content.

Overview of existing education and training provision around infection prevention and control

4.2 All 14 territorial Health Boards and one Special Health Board responded to the survey requesting details of existing education and training available to healthcare workers in the community, including any gaps and barriers to training. Full details of current education and training offered by each of the responding Boards is appended to this report (Appendix 1). This section presents an overview of existing activity.

4.3 While responses to the survey varied in terms of detail and level of completion, it appears that all Health Boards offer some form of mandatory training on infection prevention and control for new staff. Training varies from Board to Board in terms of content and level of detail, however it tends to include as a minimum:

- a general overview of SICPs paying particular attention to hand hygiene and approved techniques; and
• a general overview of organisational requirements for infection control and an overview of/signposting to infection control policies/infrastructure such as IPC manual and IC team.

4.4 In addition, in some Boards hand hygiene is offered as mandatory stand alone training. Mandatory induction training tends to be generic in focus and content, and is not tailored to or delivered separately to community-based staff. Mandatory training is commonly delivered via learnPro e-learning modules, although there are examples where it is delivered as part of face to face corporate induction days or sessions. Neither of these options seems to offer the opportunity for discussion around the challenges associated with applying IPC guidelines in community settings.

4.5 There are some examples of infection control training being tailored to different community-based roles and settings, but these are limited to where training is delivered by the infection control nurse/team on an ad hoc basis to teams in their own setting. Where this takes place, staff generally found the training very valuable.

4.6 There is greater variation in Boards’ approaches to updates and refresher training around infection control. According to survey responses, at least six Boards have mandatory annual updates on infection control, whereas in other Board areas updates appear to be available, in most cases with a view to annual completion, but are not mandatory.

4.7 A number of Boards referenced use of the NES Cleanliness Champions Programme. In one Board area this programme is mandatory for staff at Band 6 or above. A number of Boards are clearly aware of and offer their staff education and training using other NES resources. None of these are offered on a mandatory basis and it was unclear from survey responses the extent to which any of these are offered or promoted to community-based staff, or the level of uptake. The health board survey responses highlighted use of NES resources around the following areas of IPC:

• infection control in care homes (delivered via a DVD developed by NES);
• HAI;
• pressure ulcers;
• urinary catheterisation;
• presentations of infections in the older person;
• promoting hand hygiene in healthcare;
• MRSA tutorial/clinical scenario;
• needlestick injury;
• Clostridium Difficile tutorial/clinical scenario; and
• care for patients in isolation.
4.8 None of the frontline healthcare workers we spoke to explicitly referenced use of or access to any of the NES training materials or opportunities in the list above, although a number had been involved in the Cleanliness Champions programme.

**Views on current IPC training provision**

4.9 Frontline healthcare workers participating in our face to face survey were asked how recently they had received training on each of the SICP areas. Figure 4.1 below details their responses.

*Figure 4.1: Timeframe of staff training*

4.10 The majority of respondents (over 70%) had received training or updates in relation to hand hygiene either within the last 12 months or the last 6 months. Over 55% of respondents had received training within these timeframes on respiratory hygiene and...
ensuring a safe environment. With reference to the other SICP areas, 50% or less (in some instances, significantly less) had received training within the last 12 months.

4.11 As discussed in Chapter Two, the majority of staff felt that training around ‘placing patients’ and ‘managing linen’ was not relevant to their role and did not state how recently they had received training. With regards to the following SICP areas, the number of staff who had not received any training for more than five years was comparatively high:

- using personal protective equipment;
- managing spillages; and
- waste disposal.

4.12 When asked with what regularity staff receive updates/refreshers on infection prevention and control, almost half (47%) said they receive annual updates; roughly a third (31%) received irregular updates and were unsure of the intended or actual frequency; and 11% said they do not receive updates. A handful of respondents said they received some form of update every six months, and one respondent received quarterly updates. Where updates were delivered annually, staff said this tended to be focused on hand hygiene.

4.13 Further discussion with staff revealed that for many it is intended that they receive annual updates but that this does not always happen due to time pressures, sick leave or annual leave. Many staff commented on the role of the individual in keeping themselves updated of new policy and practice in relation to infection prevention:

“*We’re all very experienced and we ask the IC nurse if we need to know anything new*”

“*We don’t have any mandatory refreshers or updates but I do attempt to do learnPro modules on an annual basis if I can*”

“*We know where the IC manual is and it’s our responsibility to ensure we are up to date with this*”.

4.14 Some staff said they receive notifications by email of any local or national changes to policy and guidelines around infection prevention and control. Views on this approach to updating were mixed: some staff found it helpful, whereas other staff found the emails difficult to keep track of. One AHP mentioned that the intranet was so difficult to navigate that it was always unclear which were the most up to date policies and procedures they should be complying with.
Content of training

4.15 Of the staff that had received training in relation to infection prevention and control, 46% of respondents had received training with content and scenarios specific to community settings, and 54% received training which was generic or hospital-focused.

4.16 Comments from staff revealed that training that was not tailored to community settings often presented ideas that were impractical, and staff did not come away confident about how to adhere to SICPs, particularly within non-clinical community settings such as patients homes. As a nurse said, “we need more clarification on what should be happening in the community” and another said “we need support and advice on how best to ensure good hand hygiene in the community”.

4.17 Where training was tailored to community settings and staff teams, this tended to be delivered in situ by an infection control nurse and staff were generally satisfied by the training they received. Some felt that within this more tailored training, it would be helpful to have more scenarios and greater practical discussion and problem-solving around how to tackle the challenges presented by community settings.

4.18 Overall, comments suggested that there has been some progress over the past few years, with more training available that is tailored to the community and greater availability of infection prevention training delivered separately from acute staff and in community settings. One nurse said: “[training is] still very hospital-based, but better than it used to be!”

Impact of training

4.19 Respondents were asked to describe how any training they had undertaken in relation to IPC had impacted on their practice. Over 25% said that the training they received had had no impact on their practice, for example:

“No impact really – it just reinforced current practice” (nurse)

“No change at all – I’ve received the training every year for 30 years and things don’t change much” (AHP)

“Nothing – I already do everything correctly” (nurse)

4.20 Where staff felt training had changed their practice, the impacts commonly included the following:

- **Better equipped when doing home visits** – e.g., making sure, where possible to carry supplies such as hand gel, liquid soap, paper towels, disposable bags.
• **Improved hand hygiene** – for example, washing hands “more thoroughly and for longer”; removing watches/jewellery; better understanding of hand gel limitations; washing hands after using hand gel five times; and more regular hand washing.

• **Better understanding of the chain of infection** – including their involvement in minimising risk and consequently being more conscious about their actions; and

• **Improved use of personal protective equipment** – e.g. encouraging more frequent glove use; and remembering the correct order to remove PPE.

4.21 Other less common examples of changes in practice resulting from training were:

• replacing care equipment;

• putting up posters about hand hygiene and respiratory hygiene;

• thinking more carefully about keeping supplies in car;

• changing the type of hand gel; and

• establishing cleaning rotas to ensure appropriate management of care equipment.

*Effective delivery formats for IPC training*

*Figure 4.2: Most effective formats of learning and training*
4.22 As figure 4.2 shows, when asked about preferred learning and training formats, most staff favoured taught courses (72%), followed by e-learning (64%). Mentoring, job shadowing and support/best practice networks were all less favoured.

**E-learning**

4.23 Staff and stakeholders had mixed views about the use of e-learning for IPC education. The acknowledged merits included:

- flexibility in terms of time, location and pace of access: “[it’s] the easiest option” (General Practice nurse) as it is up to the individual “to do it in your own time and at your own pace” (nurse); and

- the ability to complete training in a less time-consuming way than, for example, travelling to attend a face to face training event.

4.24 However, many staff and stakeholders have concerns about over-reliance on e-learning and feel that staff learning is not as effective when delivered through online rather than face to face. This reluctance was frequently due to lack of computing skills, lack of opportunity to ask questions or interact with others, and being unsuited to some individuals’ learning styles. One stakeholder said: “most [staff] don’t have time or resources to access online training and some don’t have the skills”. Other comments reflecting views on e-learning included “monotonous” (dental nurse); “this is not appropriate for my staff and not a useful way to learn,” (facilities manager) and “[online programmes] send me to sleep” (nurse).

4.25 Many noted that whilst e-learning is not ideal, it has its place and is good for basic information or as a refresher, with an AHP suggesting that “this may be useful as follow up, especially in rural settings.” A substantial number felt e-learning is better used in conjunction with other delivery formats. One stakeholder pointed out that “what we cannot get away from is that managers and staff value face-to-face training and are more likely to allocate staff time to attend. Online learning always gets pushed to the bottom of the list of priorities and this is one of the reasons it takes so long for people to complete – clear timescales for completion are essential”.

**Taught courses**

4.26 In terms of taught courses, the practical and interactive elements were particularly valued, and felt to lend themselves well to discussion around the challenges of IPC in community settings. One nurse mentioned it helped them measure their capabilities: “[providing] a chance to gauge where you are.” Taught courses have the advantage of participants being away from the stresses and distractions of their job allowing them to focus on learning: “I can concentrate and not think about all the other tasks I have” (nurse). Despite the overwhelming positives of taught courses, staff and stakeholders acknowledged that they
tend to take longer and sometimes necessitate significant travel, especially for staff based in remote areas.

**Job shadowing/mentoring**

4.27 While some staff found job shadowing to be an effective learning format for them and an effective way to support monitoring of compliance with IPC guidelines, others felt this was not appropriate for IPC training in the community where practitioners often work in isolation, as patients may be concerned by the presence of additional and unexpected staff members. Those who favoured mentoring felt that it can play a useful role in the training process either as primary training or for reinforcement, so long as mentors adhere to effective practice themselves. One nurse felt that it “allows more senior staff to identify areas for development and provide support with the benefit of experience.”

4.28 Other suggestions for learning and training delivery formats included use of DVDs in the workplace, video conferencing, discussion groups with colleagues and identifying particular staff as a resource for a specified area.

**Effective delivery**

4.29 Staff and stakeholders identified some valuable points about how training can be more effective as well as suggestions for learning and training delivery formats. They also highlighted:

- the value of training whole teams;
- the necessity for courses to be engaging;
- that content must be relevant to participants and tailored to their role and setting;
- the need for interdisciplinary learning for health and social care staff so that approaches can be consistent; and
- the value of mixed approaches to learning.

**Strengths/effective practice evident within current approaches**

4.30 Stakeholders and staff highlighted the following aspects as being effective at supporting community-based healthcare to reduce the risk and spread of infections. Strengths evident in existing approaches are highlighted in the following diagram (Fig 4.3).
4.31 Additionally, the work of NES’s National Infection Control Dental Support Team has been very well-received and is considered an effective, but costly, programme of training delivery around infection prevention and control.

Barriers affecting uptake of current training

4.32 Time pressures and staff shortages are often a barrier to training within health and social care. In addition to these common barriers, this research has highlighted a number of barriers affecting the uptake of training around infection prevention and control to healthcare workers in the community which are addressed below.

- **Lack of active buy-in from managers/senior staff** – examples included:
  - staff not being released for training due to competing priorities – particularly the case in GP practices;
  - managers not facilitating appropriate dissemination of updates/policy/practice changes by email or other means; and
  - managers not appreciating the importance of training in IPC.

- **Work-based IT facilities are not sufficient to support training** - lack of access to computers is a significant issue for community-based staff: “there’s one computer
for five of us here – you can barely check email at lunchtime so e-learning just isn’t feasible” (AHP). Many Boards offer mandatory IPC education via learnPro or other e-learning, so community staff are often inadvertently excluded.

- **Staff working in isolation** – this presents difficulties for timetabling training. Working in isolation also poses a problem for auditing compliance with SICPs and challenging poor practice.

- **Diversity of community healthcare worker roles** – a ‘one size fits all’ approach to education and training does not acknowledge the diversity and range of roles within community healthcare. This review suggests:
  - the SICPs and training delivery do not recognise this diversity or the challenges faced by community-based staff;
  - Staff are often turned off from attending training which is not tailored to them; and
  - some staff are excluded due to lack of ‘out of hours’ provision, or the distances required to access training in remote and rural areas.

- **Monitoring uptake of training** – there is no clear picture in Boards about what training community staff have undertaken. Similarly, the complexity of community settings makes monitoring compliance with IPC protocols particularly challenging. Staff learning needs are therefore difficult to identify making it challenging to keep training up to date and relevant.

- **Frequency of information and updates** – stakeholders and staff both reflected that when it comes to infection prevention and control, new guidelines and updates seem to be produced with such frequency, that it can be challenging for staff to keep track of exactly which policies and procedures they should be adhering to.

### Gaps in current training

4.33 The content of training can also act as a barrier to uptake. The learning needs, highlighted in the previous chapter, along with stakeholder and health board responses indicate gaps in current education and training, which broadly fall into categories relating to training ‘reach’ and training ‘content’. These are summarised in Figure 4.4 on the following page.
**Figure 4.4: Gaps in existing training**

<table>
<thead>
<tr>
<th>Gaps in terms of training reach</th>
<th>Gaps in terms of training content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community staff often excluded from annualised updates</td>
<td>Tends to be generic or acute-focused – often lacks community-specific scenarios or practical considerations for patient homes</td>
</tr>
<tr>
<td>Significant demand for face-to-face IPC training and discussion, e.g., sessions facilitated by local Infection and prevention control nurses</td>
<td>Messages for community around IPC need to be clear, simple, realistic and memorable</td>
</tr>
<tr>
<td>Lack of community-focused tools to support learning in the workplace</td>
<td>Tends to focus on hand hygiene and neglect other SICPs</td>
</tr>
<tr>
<td>Priority staff groups often absent from training: GP practice staff, care home staff, and other social care staff roles</td>
<td>Applying SICPs and aseptic techniques in home settings</td>
</tr>
<tr>
<td>Lack of multi-agency training to support health and social care staff to understand each other’s roles and apply consistent infection control precautions</td>
<td>Content needs to empower GPs and practice nurses to cope with public expectations in relation to antibiotic prescribing</td>
</tr>
<tr>
<td></td>
<td>More training around specific IPC issues including: CAUTI (catheter associated urinary tract infections), SABs and contributing factors, products available to reduce transmission of infection and their limitations</td>
</tr>
<tr>
<td></td>
<td>Lack of consistent approaches within health and social care training</td>
</tr>
</tbody>
</table>
5 Summary of Key Issues and Recommendations

Summary of key issues

5.1 The findings of this review suggest that healthcare workers in the community tend to have a basic awareness of standard infection control precautions (SICPs), but, with the exception of hand hygiene, often do not have detailed or up-to-date knowledge of the associated guidelines and procedures they should follow to prevent and control infection.

5.2 Where staff knowledge is up-to-date and detailed, confidence and ability to reduce infection risk is often impeded by a number of factors, including:

- the unique range of challenges inherent in the delivery of care in community settings, of which delivering care in patient homes, especially lack of control over the cleanliness of the environment, provides the greatest issue; and

- the fact that current training does not adequately support staff to respond to these challenges.

5.3 Our research has found that while there has been progress in recent years, current training and guidelines on IPC issues is still focused largely on delivery of care in acute settings. While there are some good examples of IPC training being delivered to community workers, more tailored and realistic training, guidelines and support for community health care workers is required to enable them to best address the unique barriers they encounter and to help them prevent and control infections, particularly within patients’ homes.

5.4 Inconsistencies in approaches to infection prevention and control across health and social care is a significant concern and training programmes need to reflect the diversity of organisations commissioning and supplying healthcare in community settings, both in terms of content and delivery. Further research is required to establish the nature of training received by social care staff within the community and to identify the protocols and procedures being promoted. A joint programme of training, along with adherence to joint IPC policies and procedures for healthcare workers from both health and social care would be beneficial and NES and SSSC should seek to explore the possibilities of achieving this through building on existing education and guidance resources. This will have resource implications for social care and Scottish Government should consider where funding can be contributed towards this to support a consistent approach to infection control.

5.5 As referenced above, our review found that, to date, the focus of IPC policies and training has been on hospital settings. This, combined with the perceived infrequency with which incidents that pose an infection risk occur in the community, has led to a perception among some healthcare workers that infection prevention and control issues are not so
applicable in community settings and, consequently, there is little imperative to make changes to working practices in line with IPC guidance. Staff need to be made aware of the existing evidence base and research may be required to further establish and highlight the prevalence of HAI in community settings, to underpin infection prevention and control precautions and the value of training. This may be of particular importance for GPs in achieving buy-in, when there are many competing demands for their CPD time, and to persuade managers and team leads of the need for training and changes to working practices.

5.6 The findings suggest work needs to be done to ensure community healthcare workers consistently have adequate access to the required resources and equipment to assist them in preventing and controlling infections. Health Boards should consult with community healthcare workers to identify the personal protective equipment and infection control accessories they need and ensure that staff have easy and adequate access to this equipment. This could be through ensuring staff have access to hygiene packs to carry with them on a daily basis.

5.7 There appears to be a lack of public awareness about the role and responsibilities of patients and the public in preventing and controlling infections in the community. Boards need to consider how at a local level they can promote public awareness of the importance of good personal and domestic hygiene and how they can support staff in their role to educate patients and the public.

5.8 This research has highlighted the need for community-based staff to be given clear, simple, memorable messages about how to implement effective infection prevention and control in community settings. Staff require clear advice from training, which is then reinforced by their managers, about the application of local/national SICP guidelines in practice, in particular, around what is acceptable practice within patients’ homes.

5.9 Figure 5.1 summarises the key issues arising from this research and the key requirements for community healthcare workers and their managers to support effective infection prevention and control.
**Figure 5.1: Requirements of Community Healthcare Workers**

<table>
<thead>
<tr>
<th>SICPs</th>
<th>Summary of research findings</th>
<th>All staff</th>
<th>Organisation/Managers (in addition)</th>
</tr>
</thead>
</table>
| Standard Infection Control Precautions (SICPs) | • Basic awareness but lack of up-to-date and detailed knowledge of associated policies and procedures  
  • Some SICPs not perceived as relevant by community healthcare workers, depending on their role  
  • Lack of confidence applying SICPs within patient homes  
  • Need for tailored training on SICPs to ensure relevant to staff settings, roles and responsibilities  
  • Need for protected time for training on SICPs | • Aware of SICPs  
  • Knows how to apply SICPs in community, (especially home) settings  
  • Reports any deficits in knowledge, resources and compliance in relation to SICPs, facilities/equipment or incidents that may result in transmission of HAI  
  • Attends any mandatory or updates in infection prevention and control education.  
  • Aware of and follows local Infection Prevention and Control policies  
  • Knows how to carry out risk assessments to assist in implementation of the SCIPs  
  • Has adequate support and resources available to implement and monitor compliance with Infection Prevention and Control policies | • Ensures Infection Prevention and Control policies are in place  
  • Knows how to audit compliance with Infection Prevention and Control policies especially for staff working in the home environment  
  • Ensures that Infection Prevention and Control is included as an objective in Personal Development Plans (or equivalent)  
  • Ensures Infection Prevention and Control training is provided and is relevant to community settings  
  • Provides resources such as personal protective equipment to help staff implement Infection Prevention and Control guidelines  
  • Signposts to relevant changes in policy and procedures |
| Hand hygiene                               | • Strong awareness and understanding of importance  
  • Approved techniques not always applied  
  • Ability impeded by lack of facilities and accessories and cleanliness of patients homes | • Familiar with and apply hand hygiene techniques  
  • Knows how to adapt hand hygiene techniques in the home setting, e.g. what is acceptable and what is not, as appropriate  
  • Knows how to adapt techniques when carrying out dressings or invasive procedures, as appropriate | • Provides staff with adequate training and equipment, e.g. soap, gels, disposable towels  
  • Provides guidance on how to adapt hand hygiene techniques in the home setting  
  • Ensures consistent messages are given, e.g. care home and NHS staff |
| Personal protective equipment              | • Lack of knowledge and confidence around removal and disposal  
  • Examples of limited by access to PPE  
  • Use of PPE in patients’ homes limited by fear of offending | • Knows when and how to use personal protective equipment  
  • Carries personal protective equipment as appropriate  
  • Knows when and how to use personal protective equipment when carrying out dressings or invasive procedures, as appropriate | • Provides staff with adequate personal protective equipment  
  • Provides guidance on how to adapt hand hygiene techniques in the home setting  
  • Provides guidance on explaining use of PPE to patients |
<table>
<thead>
<tr>
<th>SICPs</th>
<th>Summary of research findings</th>
<th>All staff</th>
<th>Organisation/Managers (in addition)</th>
</tr>
</thead>
</table>
| Control of the environment    | • Impeded by cleanliness/challenges presented in patients’ homes  
• Lack of knowledge about applying aseptic techniques in patients’ homes                                                                                                  | • Knows how to make the home, or other care environment, as safe as possible for both patients and themselves.  
• Able to advise patients on maintaining a clean and hygienic home.  
• Able to risk assess the patient’s requirements and their environment, and apply appropriate measures to ensure optimum patient care, as appropriate | • Provides guidance on how to ensure a safe environment in the home setting  
• Provides staff with adequate training and equipment  
• Ensures good communication between acute and primary care sectors and multidisciplinary teams, e.g. hospital discharge/patient status |
| Management of blood and body fluid spillages | • Lack of knowledge about how to clean up spillages  
• Lack of access to detergents in non-clinical settings  
• Misperceptions about roles and responsibilities                                                                                   | • Knows how to safely and effectively manage blood and body fluid spillage.  
• Knows how and when to request a special waste uplift  
• Able to carry out a risk assessment in the patient’s own home prior to the disposal of waste generated as a result of healthcare, as appropriate | • Provides guidance on how to effectively manage blood and body fluid spillage.  
• Puts procedures in place for special waste uplift for hazardous healthcare waste |
| Managing risk of sharps       | • Unsure of procedures for disposing of sharps in absence of sharps box                                                                                                                   | • Knows how to raise any health concerns e.g. occupational exposure injury e.g. needlestick injury, with the relevant agency  
• Understands what extra care to take when using sharps in the home setting when there may be issues with available work space and poor lighting or storing sharps equipment, as appropriate | • Provides guidance on how to minimise risk and deal with any occupational exposure  
• Provides guidance on sharps disposal in absence of sharps box |
| Management of care equipment  | • Lack of awareness of role and responsibilities  
• Lack of access to appropriate detergents in patients homes                                                                                       | • Knows how to manage equipment appropriately to limit the risk of infection being transmitted  
• Provide staff with appropriate resources and equipment.  
• Consider time required for cleaning in service design. |                                                                                                                                                                                                                                                                  |
| Management of linen           | • Lack of knowledge about correct procedure  
• Often not perceived as relevant                                                                                                            | • Able to advise patients or their carers on home laundering.  
• Provides guidance on roles and responsibilities in relation to management of linen |
| Safe disposal of waste        | • Unsure of procedures for waste disposal in patients homes                                                                                                                                          | • Knows how to manage waste in community/home settings.  
• Ensures correctly colour coded and labelled waste containers are available for use in community settings.  
• Provide guidance for staff on disposing of waste from patients’ homes. |                                                                                                                                                                                                                                                                  |
<table>
<thead>
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<th>SICPs</th>
<th>Summary of research findings</th>
<th>All staff</th>
<th>Organisation/Managers (in addition)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessing situation for risk of infection</td>
<td>- Lack of confidence assessing risk objectively</td>
<td>- Knows how to assess risk of infection in community settings</td>
<td>- Provides guidance on issues to consider when assessing risk, particularly in patients’ homes</td>
</tr>
<tr>
<td>Patient Placement</td>
<td>- Uncertainty about meaning within community settings</td>
<td>- Understands how SICP relates to community settings</td>
<td>- Provides guidance on how SICP relates to community settings, particularly patient homes</td>
</tr>
<tr>
<td>Antimicrobial prescribing</td>
<td>- Need for more regular training on what and when to prescribe</td>
<td>- Aware of guidance around limiting prescribing of antibiotics</td>
<td>- Supports staff with prescribing responsibilities to limit prescriptions and manages the expectations of patients</td>
</tr>
<tr>
<td></td>
<td>- Challenges presented by patient expectations</td>
<td>- Understands and keeps up to date about what antibiotics to prescribe, and when</td>
<td></td>
</tr>
</tbody>
</table>

Summary of research findings:

- All staff

- Organisation/Managers (in addition)
Recommendations

5.10 Based on the findings of this review, we make the following recommendations to assist NES in supporting community healthcare workers to overcome the barriers to implementing infection prevention and control guidelines.

- **Recommendation 1**: We recommend NES develop materials and scenarios to support the application of existing SICP guidelines in community settings, paying particular attention to challenges associated with patients’ homes. These could take the form of a ‘how to guide’, ‘top tips’-style resource, or best practice guide for community-based settings. Community-based healthcare workers should be involved and consulted in the development.

- **Recommendation 2**: Our review found that community healthcare workers would value regular updates including information about issues such as trends in infections, the latest IPC policies and guidelines, and advice on implementing IPC guidelines in community settings. We recommend that NES consider its role in communicating and raising awareness, both among healthcare staff and those who support them, about available sources of information and guidance on IPC.

- **Recommendation 3**: We recommend that NES and Health Boards explore mixed approaches to IPC training and updates that do not rely solely on e-learning but allow for discussion of issues and challenges with colleagues.

- **Recommendation 4**: Local Infection and Prevention Control nurses are a valuable training resource delivering education tailored to teams and settings. We recommend that NES supports Health Boards in reviewing local education strategies to meet the demands of community staff and support the development of local IPC nurses to expand their knowledge and capability in response.

- **Recommendation 5**: We recommend that NES and Health Boards promote use of NES’ existing range of national education and training packages along with guidance for adapting to local use and within community settings.

- **Recommendation 6**: We recommend that NES works with education providers to ensure that infection prevention and control is an integral part of pre-registration/pre-qualification for all healthcare workers. While the Cleanliness Champion Programme is included in undergraduate programmes for medicine, dentistry and nursing, further research may be required to identify the exact level of IPC content that already exists in pre-registration education for other staff groups including AHPs and social care staff.
• **Recommendation 7:** We recommend that NES conducts further research with specific staff groups (e.g., AHPs, GPs, social care staff) to address gaps in engagement emerging from this research to fully explore the applicability of existing IPC guidelines to their roles.

• **Recommendation 8:** We recommend NES, alongside the Scottish Social Services Council (SSSC) explore how they can support greater consistency of approach to IPC across health and social care, and consider the feasibility of a joint programme of training supported by joint guidance and policies on IPC.
Details of Existing Education and Training Resources

We have included details of existing education and training resources, identified by Health Boards, in a separate document.
Appendix 2

List of Organisations Consulted

Representatives of the following organisations took part in stakeholder interviews:

- A General Practitioner
- Health Improvement Scotland
- NHS Education for Scotland
- NHS Grampian
- NHS Health Facilities Scotland
- NHS Health Protection Scotland
- NHS Lothian
- NHS Tayside
- Scottish Government
Appendix 3

National Stakeholder Interview Schedule

NHS Education for Scotland – Review of infection prevention and control education and training requirements of healthcare workers in the community

Interview/Focus Group Schedule for key stakeholders

Introduction

We are working with NHS Education for Scotland to undertake a review of the education and training requirements of community-based healthcare workers in relation to controlling and preventing infection. As part of this we are speaking to a range of key stakeholders whose role relates to infection prevention and control.

We would like to ask you a few questions about your views on the learning and training needs of community-based healthcare workers around infection prevention and control, as well as any barriers or facilitators to controlling infection within community healthcare settings.

Throughout the discussion we will refer to ‘Community healthcare workers’ as a whole. Where possible and appropriate, please comment on the experiences/skills of any particular groups of staff, e.g.:

- health/social care staff;
- those working in clinical/non-clinical community-based settings etc.

Researcher: remember to probe for differences between staff groups throughout. Stakeholders will have different areas of expertise and levels of knowledge relating to Infection Control so the schedule will need to be tailored to acknowledge this.

1. Please describe your role and responsibilities and how these relate to infection prevention and control.

2. What do you feel are the main causes of HAIs in community-based healthcare settings?

3. What, if any, are the particular challenges for healthcare workers in preventing and controlling infection in community healthcare settings? What, if any, are the facilitators?
4. Do you think Community Healthcare Workers generally consider infection control to be part of their role and understand how they can help reduce the incidence of HAIs? Please explain your response.

5. To what extent do you think healthcare workers are aware of and compliant with the Health Protection Scotland Infection Prevention and Control Guidance for NHS and non-NHS Community and Primary care Settings and the Standard Infection Control Precautions (SICPs)? Please explain your response.

**Policies and systems**

6. If your experience allows you to comment, how effective do you feel current Health Board and local Authority policies and systems are at supporting and monitoring the prevention and control of HAIs within community-based healthcare settings? Are there any gaps? Can you suggest any improvements?

7. What, if any, do you feel are the challenges in relation to auditing compliance with infection prevention policies and procedures within community healthcare settings? Do you have suggestions as to how these can be addressed?

**Learning needs**

8. What would you say are the key learning and training needs of community-based healthcare workers in relation to infection prevention and control? (prompt for any learning needs or barriers around aseptic techniques and decontamination)

9. Overall, how would you describe the ability of Community Healthcare Workers to implement guidance around Standard Infection Control Precautions? Please explain your answer.

**Training provision**

10. To what extent do you feel current training adequately addresses the specific challenges of preventing and controlling infection in community settings? Can you suggest improvements?

11. Are you aware of any examples of effective practice/effective resources in training community healthcare workers in infection prevention and control? Please provide details.

12. To what extent do you feel current training adequately addresses the learning needs of Community Healthcare Workers? Are there any gaps? How could these be addressed?
13. What further support or resource is required to ensure community healthcare workers are adequately trained to prevent and control infection?

14. Do you have any other comments?
Appendix 4

Health Board Stakeholder Interview Schedule

NHS Education for Scotland – Review of infection prevention and control education and training requirements of healthcare workers in the community

Interview/Focus Group Schedule for Health Board/CHP Stakeholders

Introduction

We are working with NHS Education for Scotland to undertake a review of the education and training requirements of community-based healthcare workers in relation to controlling and preventing infection. As part of this we are speaking to a range of key stakeholders, including strategic managers and educators involved in supporting staff development around infection control.

We would like to ask you a few questions about your views on the learning and training needs of community-based healthcare workers around infection prevention and control, as well as any barriers or facilitators to controlling infection within community healthcare settings.

Throughout the discussion we will refer to ‘Community Healthcare Workers’ as a whole. Where possible, please comment on the experiences/skills of any particular groups of staff, e.g.:

- health/social care staff;
- those working in clinical/non-clinical community-based settings etc.

General

1. Please describe your role and how it relates to infection prevention and control.

2. What do you see as the main causes of HAIs in community-based healthcare settings?

3. What do you see as the particular challenges for healthcare workers in preventing and controlling infection in community healthcare settings? What, if any, are the facilitators?
4. Are you aware of the Health Protection Scotland *Infection Prevention and Control Guidance for NHS and non-NHS Community and Primary Care Settings*? How effective/useful do you feel the guidance is? *(probe for gaps/improvements)*

5. To what extent do you think healthcare workers in your organisation/team are aware of these guidelines and of the *Standard Infection Control Precautions (SICPs)* and how to implement them?

**Systems, resources and audit**

6. Please describe the policies and procedures that are in place within your organisation to support the prevention and control of HAIs within community-based healthcare settings.

7. To what extent do you feel community healthcare workers are generally aware of and compliant with these?

8. What systems and resources are in place to monitor compliance with infection prevention policies and procedures and who is responsible for monitoring compliance within your organisation?

9. What, if any, are the challenges in relation to auditing compliance with infection prevention policies and procedures within community healthcare settings? How can these be addressed?

**Training provision**

10. What training do community healthcare workers in your organisation currently receive around infection prevention and control?

11. How is this currently delivered? How often do staff receive updates?

12. Is infection prevention and control included as an objective in Personal Development Plans (or equivalent)?

13. Can you highlight any examples of effective approaches when training community healthcare workers in infection prevention and control?

14. To what extent do you feel current training adequately addresses the specific challenges of preventing and controlling infection in community settings? Can you suggest improvements?
15. What are the challenges in training community healthcare workers in infection prevention and control? Do these apply to any particular staff groups/community settings more than others? How are these currently addressed?

Learning needs

16. What would you say are the key learning and training needs of community-based healthcare workers in relation to infection prevention and control, within your organisation/area?

17. Overall, how would you describe the ability of healthcare workers in your organisation to apply guidelines around each of the SICPs? *(prompt for any learning needs or barriers around aseptic techniques and decontamination)*

18. To what extent do you feel current training adequately addresses the learning needs of healthcare workers in your organisation/area? Are there any gaps? How could these be addressed?

19. What further support or resource is required to ensure community healthcare workers are adequately trained to prevent and control infection?

20. Do you have any other comments?
### Health Board Survey Proforma

**NHS Education for Scotland – Review of Infection Prevention and Control Education and Training Requirements of Healthcare Workers in the Community**

**Survey of education provision for healthcare workers in community settings**

<table>
<thead>
<tr>
<th>1. Please tell us which Health Board you represent</th>
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<thead>
<tr>
<th>2. What current education provision does your organisation offer around the prevention and control of healthcare associated infections (HAIs) to community-based Healthcare workers?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please complete the attached excel sheet with the following details for each course/resource as applicable:</td>
</tr>
<tr>
<td>- Name of course/resource</td>
</tr>
<tr>
<td>- Delivery organisation(s)</td>
</tr>
<tr>
<td>- Mode of delivery (e.g. taught/online)</td>
</tr>
<tr>
<td>- Target audience (including level)</td>
</tr>
<tr>
<td>- Attendance requirements (i.e., mandatory, elective, optional etc)</td>
</tr>
<tr>
<td>- Is training delivered separately for community and hospital staff?</td>
</tr>
<tr>
<td>- Brief details of content and topics covered (include attachments if appropriate)</td>
</tr>
<tr>
<td>- Learning outcomes</td>
</tr>
<tr>
<td>- Assessment – how are learning outcomes measured?</td>
</tr>
</tbody>
</table>
3. What do you see as the gaps in education provision around HAIs for community-based healthcare workers in your Board area and how can these best be addressed?

4. What do you think the challenges are for community-based healthcare workers in preventing and controlling healthcare associated infections? How do you think these challenges can be overcome?

5. What do you think the barriers are for community-based healthcare workers in terms of accessing training and education around infection prevention and control? How do you think these barriers can best be addressed?
6. What, if any, resources and/or support would assist your organisation in providing infection prevention and control education and training to community-based healthcare workers?

Many thanks for your assistance, it is greatly appreciated.
Practitioner Survey

NHS Education for Scotland

Review of Infection Prevention and Control Education and Training Requirements of Healthcare Workers in the Community

Survey of Community-based Healthcare Workers

Blake Stevenson Ltd is a social research company that has been commissioned by NHS Education for Scotland to undertake research with the aim of identifying the education and training requirements of healthcare workers in the community in relation to infection prevention and control. Below are some questions about your awareness of and confidence with various aspects of infection prevention and control. We would also like to know about what could be done to assist you in your role to prevent and control infections.

We would greatly appreciate it if you could complete this questionnaire by Friday 17 February. If you have any questions, please contact Ian Christie or Sophie Ellison at Blake Stevenson on 0131 335 3700 or email ian@blakestevenson.co.uk.

Please answer honestly and openly. All responses are anonymous and non-attributable.

1. Which Health Board area do you work in?
   - Ayrshire and Arran
   - Highland
   - Tayside

2. What is the name of your department or team?

________________________________________________________________________________
________________________________________________________________________________

3. What is your job title?

________________________________________________________________________________
________________________________________________________________________________

3.a Which category of staff applies to you?
   - General practitioner
   - Facilities staff (domestic staff, supervisors or caretaking staff)
   - Nursing (district, midwifery, health visiting, mental health and learning disabilities)
   - Allied health professional (podiatry, physiotherapist, dietician etc)
   - Pharmacy/antimicrobial pharmacy staff
4. Does your role primarily involve direct contact with patients/clients?
   - Yes
   - No

5. Which community setting(s) do you most often work in?
   - GP practice/Health Centre (either NHS/Private)
   - Consulting Rooms eg pharmacy, optician etc
   - NHS Day Centres
   - Patients'/clients' homes including Sheltered Housing
   - Other (please specify)

6. What do you see as your role and responsibilities in preventing and controlling healthcare associated infections?

6.a Within the settings in which you work, what do you see as the main causes of healthcare associated infections?

7. How would you describe your understanding and awareness of Standard Infection Control Precautions (SiCPs)?
   - Poor
   - Quite poor
   - Good
   - Very good

8. Which of the standard infection control precautions do you feel are most relevant to your role and the settings you work in? Please explain your answer
8.a
Were you aware of the SICPs before today?
☐ Yes  ☐ No

9.
How recently have you received any training/briefings/instruction/updates on the following aspects of infection prevention and control?

<table>
<thead>
<tr>
<th></th>
<th>Within last 6 months</th>
<th>Within last 12 months</th>
<th>Within last 2 years</th>
<th>Within last 5 years</th>
<th>More than 5 years ago</th>
<th>N/A</th>
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</thead>
<tbody>
<tr>
<td>Hand hygiene</td>
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<tr>
<td>Respiratory hygiene/coughing and sneezing etiquette</td>
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<tr>
<td>How to use personal protective equipment such as gloves, aprons, face protection</td>
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<tr>
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<tr>
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<tr>
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<tr>
<td>Placing patients appropriately to reduce the risk of infection for both the patient and others</td>
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<tr>
<td>Assessing a situation for risk of infection</td>
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</tbody>
</table>

Comments/details
________________________________________________________________________________
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10.
Did any of the training involve content/scenarios specific to community based settings?
☐ Yes  ☐ No

Comments. Could it have been made more relevant or appropriate? If yes, how?
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

11.
What changes, if any, did you make to your practice after undertaking the training?
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
12. How often do you tend to receive updates or refresher training on the above issues? If you don’t, why don’t you? What are the barriers?
________________________________________________________________________________
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13. How would you describe your confidence in applying the following aspects of infection prevention and control?

<table>
<thead>
<tr>
<th></th>
<th>Poor</th>
<th>Quite poor</th>
<th>Good</th>
<th>Very good</th>
<th>N/A</th>
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<tbody>
<tr>
<td>Effective hand hygiene</td>
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<tr>
<td>Respiratory hygiene/coughing and sneezing etiquette</td>
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</tbody>
</table>

Comments/details (please use this box for general comments and use the following boxes for any comments you have about your confidence related to any of these aspects of infection prevention and control)
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Effective hand hygiene
________________________________________________________________________________
Respiratory hygiene/coughing and sneezing etiquette
________________________________________________________________________________
Using personal protective equipment such as gloves, aprons, face protection
________________________________________________________________________________
Ensuring a safe environment for you and your patient
________________________________________________________________________________
Managing blood and body fluid spillages
________________________________________________________________________________
Managing care equipment

Understanding and managing the risks associated with sharps

Managing linen to prevent contamination

Safe disposal of waste

Placing patients appropriately to reduce the risk of infection for both the patient and others

Assessing a situation for risk of infection

14. Within the settings in which you work, are there any barriers that constrain you from applying guidelines around the following aspects of infection prevention and control?

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective hand hygiene</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
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<tr>
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<td>☐</td>
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</table>

If you have answered yes to any of the above, please use the boxes below to describe the barrier(s)

Effective hand hygiene

Respiratory hygiene/coughing and sneezing etiquette

Using personal protective equipment such as gloves, aprons, face protection

Ensuring a safe environment for you and your patient

Managing blood and body fluid spillages

Managing care equipment
Understanding and managing the risks associated with sharps
Managing linen to prevent contamination
Safe disposal of waste
Placing patients appropriately to reduce the risk of infection for both the patient and others
Assessing a situation for risk of infection

15. What do you understand to be the main elements of approved hand hygiene techniques?
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

16. What would assist you to be able to follow approved hand hygiene techniques more consistently in the workplace?
________________________________________________________________________________
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17. Can you describe what you see as some of the key elements of good practice related to respiratory hygiene and coughing and sneezing etiquette?
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

18.a Are you involved in handling invasive devices? (eg catheters)
☐ Yes ☐ No
18.b  If yes, have you had training on this?

☐ Yes  ☐ No

Comments

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

18.c1  Do you feel you have adequate access to personal protective equipment such as gloves, aprons, face protection and to soap, gels and towels etc within the workplace?

☐ Yes  ☐ No

Please explain your answer

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

19.  Can you describe what you see as some of the key elements of good practice related to the use of gloves and aprons when providing care to a patient?

________________________________________________________________________________

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19.  Can you describe what you see as some of the key elements of good practice related to the use of gloves and aprons when providing care to a patient?

________________________________________________________________________________

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________________________________________________________________________________

20.a  Do you have any prescribing responsibilities or are you part of an antimicrobial team?

☐ Yes  ☐ No

20.b  If yes, what do you understand by the advice on coughs and colds to 'take care not antibiotics'?

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

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________________________________________________________________________________

20.c  If you answered yes to question 20.a, how would you make the decision to prescribe an antibiotic and how would you select an antibiotic to prescribe?

________________________________________________________________________________

________________________________________________________________________________

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________________________________________________________________________________
21. Can you describe how you ensure that the environment where you are delivering care is safe and clean for both yourself and the patient?
________________________________________________________________________________
________________________________________________________________________________
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22. Can you give an example where it has been difficult for you to ensure that the environment is safe and clean for you and/or your patient? What did you do?
________________________________________________________________________________
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23. What steps would you take to treat a patient if the environment, either clinical or in a patient’s home, was unclean?
________________________________________________________________________________
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24. Can you describe how you would deal with any spillages when treating a patient?
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25. How do you ensure that you are person-centred when assessing and responding to risk of healthcare associated infections?
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26. What would assist you in your role to prevent and control HAIs?
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27. Based on the issues we have discussed, what do you feel your three most important learning/development needs are regarding preventing and controlling infection within community healthcare settings?
1
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2
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________________________________________________________________________________

3
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28. Which formats of learning and training are most effective for you?

☐ E-learning
☐ Job shadowing/on the job learning
☐ Mentoring
☐ Taught courses
☐ Support/best practice networks

Other (please specify)
________________________________________________________________________________

Please explain why you selected the above formats of learning and training
E-learning
________________________________________________________________________________
________________________________________________________________________________

Job shadowing/on the job learning
________________________________________________________________________________
________________________________________________________________________________

Mentoring
________________________________________________________________________________
________________________________________________________________________________

Taught courses
________________________________________________________________________________
________________________________________________________________________________

Support/best practice networks
________________________________________________________________________________
________________________________________________________________________________
29. Do you have any other comments?

________________________________________________________________________________
________________________________________________________________________________
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Thank you for giving up your time, your input is greatly appreciated.