Cleanliness Champions Programme Evaluation Full Report
Full Report

An evaluation of the development & implementation of the NHS Education for Scotland Cleanliness Champions Programme

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CONTENTS

List of Figures
List of Tables

1  SECTION 1: BACKGROUND
1  1.1  Introduction
2  1.2  Development processes for the Cleanliness Champions Programme
4  1.3  External evaluation

5  SECTION 2: EVALUATION DESIGN & METHODS
5  2.1  Design
5  2.2  Methods
5  2.2.1  Review of literature and other evidence sources
7  2.2.2  Interviews with key informants
8  2.2.3  Questionnaire survey of students and mentors
10  2.2.4  Ethical considerations

11  SECTION 3: CONTEXT & REVIEW OF THE EDUCATIONAL PROGRAMME
11  3.1  Context
11  3.2  Review of the information resource pack
13  3.3  Evaluators' review of the Cleanliness Champions Programme
15  3.4  Review of modes of delivery

16  SECTION 4: FINDINGS FROM THE SURVEY OF CCP STUDENTS:
16  OVERVIEW OF ALL RESPONDENTS
16  4.1  What were the survey response rates?
16  4.2  How representative is this sample of CCP students?
17  4.3  Who were these respondents?
18  4.4  How long did it take them to complete the programme?
18  4.5  What was the main factor delaying completion time?
18  4.6  Which modes of programme delivery were used?
19  4.7  What were students' experiences of these delivery modes?
21  4.8  What did students think of the content of the programme?
21  4.9  What were students' views on possible modifications to the programme?
22  4.10  What were students' experiences of mentorship?
23  4.11  What impact did students feel the programme was having on their own practice?
24  4.12  What is known about initial integration of the CC role into practice?
24  4.13  What about those students who discontinued/withdrew from the programme?

25  SECTION 5: FINDINGS FROM THE SURVEY OF CCP STUDENTS:
25  PROFILES OF DIFFERENT OCCUPATIONAL GROUPS
25  5.1  Nurses
26  5.1.1  Personal/professional impact of programme
26  5.1.2  Wider impact and integration into practice
27  5.1.3  Lack of time
28  5.1.4  Management/organisational issues
29  5.2  Allied Health Professionals
30  5.3  Doctors
31  5.4  Healthcare Assistants
33  5.5  Dental nurses
34  5.6  Domestic staff
35  5.7  Ambulance staff
36  5.8  Others
36  5.8.1  The programme
37  5.8.2  Integration into practice/management of the initiative
SECTION 6: FINDINGS FROM THE SURVEY OF CCP MENTORS: OVERVIEW OF ALL RESPONDENTS

6.1 What were the survey response rates?
6.2 How representative is this sample of CCP mentors?
6.3 Who were the respondents?
6.4 What preparation did mentors have for the role?
6.5 What did the mentorship role entail?
6.6 What has been the overall impact for students?
6.7 What has been the overall impact for mentors?
6.8 What were mentors’ views of the integration of the CC role into practice so far?
6.9 Written comments from mentors
6.9.1 The programme
6.9.2 Time
6.9.3 General and specific influence of programme in practice so far
6.9.4 Getting staff on to the programme and through it
6.9.5 Mentorship quality issues
6.9.6 Motivation, momentum, management
6.9.7 Patients and visitors
6.10 A distillation
6.11 Medical students

SECTION 7: FINDINGS FROM INTERVIEWS WITH KEY INFORMANTS

7.1 The higher Education perspective
7.2 Perspectives from the NHS in Scotland
7.2.1 Pat: Urban Acute Care
7.2.2 Nina: Urban Acute Care
7.2.3 Seonaid: Combined Urban and Rural Acute and Primary Care
7.2.4 Gail: Combined Urban and Rural Acute and Primary Care
7.2.5 Larry: Urban Primary Care
7.2.6 Ailsa: Remote and Rural Care
7.2.7 Will: Remote and Rural Care
7.3 The national Scottish perspective

SECTION 8: INTEGRATIVE SUMMARY OF FINDINGS

SECTION 9: KEY MESSAGES

SECTION 10: CONCLUSION

SECTION 11: RECOMMENDATIONS

The programme curriculum as a whole
The modes of programme delivery
The target population for the programme
Support for staff to undertake and complete the programme
Support for staff to undertake mentoring
Support for enactment of the CC role
Support for continuing professional development for students and mentors
Further research

REFERENCES
LIST OF FIGURES

2 Figure 1.1: The NES Diamond Model

LIST OF TABLES

2 Table 1.1: Main processes for CCP development and implementation
3 Table 1.2: CCP learning units
14 Table 3.1: Evaluators’ review of Cleanliness Champions Programme
15 Table 3.2: Review of three main modes of delivery
17 Table 4.1: Student respondents by occupational group
17 Table 4.2: Student respondents by workplace setting
18 Table 4.3: Student respondents by mode of programme delivery
19 Table 4.4: Student respondents’ reasons for not using e-learning
21 Table 4.5: Students’ ratings of each learning unit
22 Table 4.6: Student respondents’ views on possible programme revisions
23 Table 4.7: Extent of scrutiny of learning folder
24 Table 4.8: Extent CC role supported by multidisciplinary team
24 Table 4.9: Students’ main reasons for discontinuing programme
40 Table 6.1: Mentors’ preparation for the role
41 Table 6.2: Activities carried out at mentorship meetings
42 Table 6.3: Perceived burden of mentorship role
49 Table 7.1: Perspectives from those in Higher Education
52 Table 7.2: Perspectives from those in the NHS in Scotland (Urban and Rural Health Boards)
53 Table 7.3 Perspectives from those in the NHS in Scotland (Urban Health Boards)
54 Table 7.4 Perspectives from those in the NHS in Scotland (Remote Health Boards)
59 Table 7.5: Perspectives from those with a national Scottish remit
63 Table 8.1: Summary of evidence and judgements in relation to evaluation remit
SECTION 1: BACKGROUND

1.1 Introduction

International recognition of the importance and significance of Healthcare Associated Infections (HAIs) on the functioning and management of healthcare organisations has resulted in a number of initiatives in various countries each designed to change the culture of health care services and to provide enhanced educational opportunities for all health care workers (Hann, Talbot and Schaffner 2005, Hendriks, Bogaers-Hofman and Kluytmans 2005 and Kalenic, Horvatic, and Lynch 2005).

Across the NHS in Scotland, Healthcare Associated Infections are recognised as a significant contemporary problem in terms of morbidity and mortality (NHSQIS 2005). Concern for the effective management of HAIs has resulted in a whole systems policy approach across Scotland which aims to improve quality at multiple levels (e.g. individual, organisational and environmental) in order to minimise the human and financial costs of an individual acquiring a healthcare associated infection (Healthcare Associated Infection Task Force 2004).

A large number of initiatives aimed at reducing the incidence of HAI, spearheaded by the Ministerial Action Plan (SEHD 2002) have been launched over the past three years. These address areas such as surveillance, prudent prescription of antibiotics, measuring performance against national quality assurance standards, and education. NHS Education for Scotland (NES) has been charged with taking forward the educational aspects of the Action Plan. This includes programmes of education for prevention and control of HAI such as mandatory training for all healthcare staff at induction and specialised training for Infection Control Teams.

One of the main prevention and control programmes that NES were asked to develop and help implement across NHS Scotland was aimed at the key middle ground between general induction training and specialist practice. In May 2002 it was suggested that there was a need for 3,500 “Cleanliness Champions” (SEHD 2002) and by the end of that year it had been decided that there should be at least one of these individuals (i.e. Cleanliness Champions) in each clinical area of the health service in Scotland who should have “a clearly defined role...and be appropriately trained” to support the infection control teams. Accordingly during 2002 NES representatives along with appropriate health professionals from across Scotland set about developing a work−based educational training programme to equip health care workers with the skills and knowledge necessary to ensure good local practice in preventing HAIs and to take on the role of Cleanliness Champion.
1.2 Development processes for the Cleanliness Champion Programme

The initial phase of this process involved consultation with NHS healthcare staff. This was taken forward through workshops held at various venues across Scotland. The reported consensus from these events was that NES should adopt a national approach to implementation. A Director of the HAI Education Initiative was appointed by NES to lead this work and two main strands of work were developed. These are summarised in Table 1.1.

Table 1.1: Main processes for CCP development and implementation

<table>
<thead>
<tr>
<th>Development of CCP educational programme</th>
<th>Preparing organisational infrastructure for implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appointment of an educationalist and an HAI specialist with educational experience.</td>
<td>Appointment of a Practice Education Co-ordinator dedicated to the project.</td>
</tr>
<tr>
<td>Identification of a curriculum development Steering Group.</td>
<td>Consultation and dissemination through workshops, seminars, conferences and newsletters.</td>
</tr>
<tr>
<td>Selection of an external provider of e-learning with specialist IT skills and experience.</td>
<td>Production of an information resource about the CCP and implementation.</td>
</tr>
<tr>
<td></td>
<td>Creation of an IT support help-line.</td>
</tr>
<tr>
<td></td>
<td>Piloting internal evaluation.</td>
</tr>
<tr>
<td></td>
<td>Developing a database and arrangements for managing materials.</td>
</tr>
</tbody>
</table>

The NES strategy for preparation and implementation was guided by the “Diamond Model” which had been developed previously (NES 2000). This is reproduced below in Figure 1.1.

Figure 1.1: The NES Diamond Model
A vital part of the preparation for co-ordinating a national project of this type was the setting up and establishment of a central information and registration database. Each NHS Health Board/Division was responsible for selecting suitable staff to undertake the programme and appropriate staff to provide mentorship. In addition each organisation appointed a local Registering Officer who supplied registration data (e.g. job title; occupational group; workplace setting) to the NES central records department. This office also managed all the published support material that accompanied the programme. Thus co-ordination of the CCP was planned to operate at the local and national level.

The major development phase of the Cleanliness Champion Programme (CCP) itself took place between 2002 and September 2003 when the programme was launched. One of the main requirements was to meet the needs of staff working in a range of professional and ancillary roles in a variety of health care settings. To facilitate uptake of the programme it was agreed to offer three main modes of delivery, namely: Web-based e-learning; CD Rom; and Hard Copy Open/Distance Learning (ODL). Moreover there was the option for local organisations to deliver content via in-person classroom sessions (Face to Face format) if desired. The developed CCP curriculum comprised 11 learning units (Table 1.2).

<table>
<thead>
<tr>
<th>Learning unit number and name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Why Cleanliness Champions?</td>
</tr>
<tr>
<td>2 The chain of infection</td>
</tr>
<tr>
<td>3 Hand hygiene Parts 1,2,3</td>
</tr>
<tr>
<td>4 Personal protective equipment (PPE)</td>
</tr>
<tr>
<td>5 Safe use and disposal of sharps</td>
</tr>
<tr>
<td>6 Maintenance of clean healthcare environment</td>
</tr>
<tr>
<td>7 Safe handling and disposal of waste</td>
</tr>
<tr>
<td>8 Food hygiene and pest control</td>
</tr>
<tr>
<td>9 Staff hygiene and dress</td>
</tr>
<tr>
<td>10 Patient care practices</td>
</tr>
<tr>
<td>11 The role of the Cleanliness Champion and its impact on the patient’s experience</td>
</tr>
</tbody>
</table>
Each unit involved a number of learning activities, some of which were work-based. The curriculum development group estimated that the programme’s on-line learning activities would take around 16–20 hours in total. Taking into account the related work-based activities, it was estimated that the programme could be completed in approximately 14–16 weeks. Each student was required to maintain a Folder of Evidence of Learning and it was recommended that their mentor authorised or “signed off” the satisfactory completion of a unit.

1.3 External evaluation

Following a process of competitive tendering, by NES in late summer 2004, the current authors were selected to undertake the external evaluation, starting in October 2004 and finishing a year later. The remit of the evaluation, as outlined by NES, was to examine the following eight components of the Cleanliness Champion Programme:

1. Curriculum development and implementation model in the context of the Ministerial Action Plan
2. Implementation support provided by NES to NHS organisations for a strategic approach to implementation of the programme
3. Support materials supplied by NES, including the resource pack circulated before the launch of the actual programme
4. Support provided by NES following the launch
5. Management of the relationship with the IT specialist company who were commissioned to build and maintain the e-learning delivery method of the programme
6. Uptake of the programme and interest from other organisations for adaptation/customisation
7. Elements of the delivery methods that worked well/not so well
8. Feelings of the students, mentors and managers who have been involved in the programme
SECTION 2: EVALUATION DESIGN AND METHODS

2.1 Design

The eight component remit outlined by NES was translated into following evaluation objectives:

1. To evaluate the role of NES in terms of its development of the programme, its strategy for supporting implementation, and congruence between intention and enactment.

2. To evaluate the educational programme curriculum in terms of its content, formats and related processes.

3. To evaluate the experiences of the students who undertook the programme, their mentors, and key health service managers who were involved in implementing the programme.

4. To make informed initial judgement in regard to the programme’s overall fitness for purpose.

The evaluation design was informed by the seminal educational evaluation approach of Stake (1967) who highlighted the value of:

• examining the logical contingency between the main elements of any educational programme

• examining the congruence between the intended educational programme and the programme as it was actually enacted.

The focus on internal programme dynamics offered by this approach was tempered by recognition of the need to evaluate the programme’s relevance to enactment contexts (i.e. diverse healthcare professionals in diverse healthcare settings). The latter consideration informed the choice and design of the three main methods used for data collection.

2.2 Methods

2.2.1 Review of literature and other evidence sources

At the start of the evaluation a formative review of the scope and nature of the international research literature on prevention and control of HAIs was undertaken. This was followed by a more specific search of the international literature focusing on educational interventions and related evaluation studies. These strategies were repeated towards the end of the study and were vital in situating the CCP and its evaluation within the wider context of relevant research-based knowledge.

However it was also necessary to attend to the particular dynamics of the UK and Scottish healthcare policy contexts, in terms of general developments, HAI-focused initiatives and related public concerns. This was addressed by review of key UK and Scottish policy documents (e.g. Winning Ways,
DOH 2003; Ministerial Action Plan, SEHD 2002; National Overview of HAI, NHSQIS 2005) and ongoing review of: DOH, SEHD and NHS Scotland websites; other electronic resources such as the RCN Clinical Governance e-bulletin; a selection of relevant current healthcare publications in the UK (e.g. British Medical Journal; Nursing Times; Health Service Manager); the wider UK national press; and attendance at a number of national conferences and seminars held during 2004-2005.

More specific evidential review was conducted by firstly collating textual sources relating to the CCP itself (e.g. the ODL package; CD Rom; Information Resource Pack for NHS organisations; summaries of outcomes from key meetings; newsletters etc.). This was facilitated by NES staff and included access to the web-based e-learning version of the programme, and access to a database maintained by the IT Specialist Company who developed and maintained this e-learning platform. Moreover the researchers attended several relevant NES meetings, including one of the Editorial Board which was concerned with issues of adaptation, customisation, and programme integrity.

These sources of evidence were mapped in terms of their relevance to each of the study's objectives, and in terms of their ability to inform understandings of key events in the development of the whole CCP initiative. As such, they comprised a key resource that was interrogated throughout the course of the evaluation.

Core parts of this resource were analysed using specifically formulated criteria. In particular, the educational curriculum and associated delivery formats were examined in relation to:

- philosophy of healthcare and education being advocated
- values inherent within the curriculum
- breadth and balance of subject coverage
- depth and quality of subject content
- clarity of language and readability of materials
- presentation of subject matter in terms of layout, graphics & overall cohesion

This enabled a range of judgements to be made about the internal validity, cohesion and applicability of the published NES curriculum. In turn these were informed by reference to an array of comparators, such as other HAI educational programmes and the expertise of the evaluation team in terms of education and health service management. The main sources of external judgement on the programme, however, were those who had directly engaged with its enactment in practice, namely: the students who undertook the programme, their mentors, and health service managers.
who were involved in implementing the programme. The latter group were seen as “key informants” who might offer views not only on the educational curriculum itself, but also on support from NES, and the programme’s relevance and feasibility within diverse healthcare contexts.

2.2.2 Interviews with key informants

In order to identify who the key informants would be multiple sources of information were collated so that we could map levels of involvement. These included: lists of registering officers across the NHS in Scotland; representatives of particular agencies (prison service, ambulance service independent health care sector) who had some involvement with the Cleanliness Champions Programme; those originally involved in the design of the curriculum and shaping of the initiative; representatives of the e-learning management business and those currently involved in the customisation of the programme. In addition preliminary results from the surveys were used to inform the selection of those working in NHS in Scotland who had a key role in the management of the CCP at Health Board or divisional level. A further set of criteria with regard to geographic spread and type of organisation were also built into the selection process. The underpinning rationale for this complex purposeful selection process was based on two questions:

1. What further information is needed to fulfill the evaluation objectives?
2. What further questions have arisen from the results of the surveys?

Twenty individuals were identified who between them had a diversity of involvement activities with the Cleanliness Champions Programme, from inception to the present day. These individuals became the key informants. Fifteen were invited to participate in a one to one telephone interview. Written and/or verbal consent was obtained and all interviewees were informed of the topics of discussion. The other five key informants had pivotal roles across the whole initiative and consequently information exchanges and interviews took place with these people on several occasions during the course of the evaluation. Consent to use this information as part of the evaluation evidence was obtained at the outset.

Two thematic guides were used to elicit information. For those working in the NHS in Scotland we focused on:

1. The informants own role and involvement at a local level with regard to the implementation of the Cleanliness Champions Programme.
2. The local processes of development and implementation of the CCP.
3. The extent and perceived quality of involvement with NES.
4. The aim of the CCP and their perception of the curriculum itself.
5. The integration of the CCP into practice and indicators of impact.
6. The strengths & weaknesses of the CCP & the implementation processes.

7. Future developments with regard to the CCP and HAI.

For those key informants who were involved in the development of the curriculum and the initiative, the national implementation and the customisation of materials the interviews focused on:

1. The informants own role and involvement with regard to the Cleanliness Champions Programme.
2. The strengths and weaknesses of the educational curriculum.
3. The strengths and weaknesses of the process of development and implementation.
4. The main issues affecting students mentors and managers.
5. The main differences between intentions of enactment and actual enactment.
6. The issues affecting the integration of the CCP into practice.
7. The future development of the CCP and HAI.

Interview records were collated and evidence grouped into themes. Transcription was used for selected sections of the interviews and particular care (through the omission of signal identifiers or paraphrasing of response) has been taken in the reporting process to protect anonymity.

2.2.3 Questionnaire survey of students and mentors

Questionnaire survey was chosen as the best method through which to obtain the views of students and mentors. The questionnaires for each of these groups were developed from prototypes which had been tested in a small pilot study between May and December 2004 involving 79 CCP students and 38 mentors from five different NHS Divisions across Scotland. The results yielded useful insights not only in regard to the performance of the questionnaire, but also with regard to emergent perceptions of the CCP.

Following a number of modifications and the addition of several new questions, final versions of the student and mentor questionnaires were produced. The former comprised six sections (Annexe 1):

1. Information about you (demographics; contextual information)
2. Your involvement with the CCP (volunteer or nominee; start time; completion? etc.)
3. Your evaluation of the educational programme (learning units; delivery modes etc.)
4. Your evaluation of mentorship support (nature; format; adequacy etc.)
5. Integration into practice (impact on own practice; support from others etc.)

6. Your final reflections (strengths, weaknesses etc.)

The mentor questionnaire was of similar design and comprised five sections (Annexe 2):

1. Information about you (demographics; contextual information)
2. Your mentorship role (mentees; activities; contact modes; perceived burden etc.)
3. Preparation and support for your mentorship role
4. Integration with practice (influence of CCP; organisational approach to implementation etc.)
5. Your final reflections (strengths, weaknesses etc.)

Previous consultations with NES had suggested that it would be difficult to focus on samples from particular target populations within the overall body of students and mentors (e.g. those who had completed; those who were currently undertaking the programme; and those who had withdrawn).

While NES held the central record of all those who had registered as starting the programme, Registering Officers within each Health Board/Division/organisation often held more detailed information such as full contact address and current progression through programme.

Accordingly it was decided that a full census of all those who had ever registered as students and/or mentors was the most feasible and comprehensive method. Initial exploration of ways to realise this strategy showed that it would be possible for NES to directly distribute around a third of student and mentor questionnaires (as full postal addresses were available), while the majority would have to be distributed through the local Registering Officers. Although reliance on intermediaries to distribute questionnaires was not seen as ideal, in terms of assuring delivery and maximising response, it did ensure that the research team would have no knowledge of any student or mentor identity thereby assuring the primacy of data protection and confidentiality.

Towards the end of April 2005 NES cross-checked current registration information with each local Registering Officer, and numbers were thereby obtained for each NHS Health Board/Division, the independent/voluntary sector and the ambulance service. The total number of student registrants (nationally) at this time was 2025, while registered mentors numbered 367.

The survey commenced at the start of May 2005 when the research team coded an appropriate number of individual questionnaires for each organisation, pre-packed them in envelopes, and forwarded them to NES.
and the Registering Officers for direct distribution. Each envelope also contained a letter of invitation to participate, an information sheet on the study, and an invitation to take part in a prize draw for £100 worth of book tokens. Towards the end of June 2005 the entire process was repeated with a view to increasing response rates.

Answers to the limited response choice questions within the survey questionnaires were entered numerically on to a pre-coded SPSS database (version 13). Routine cross-checking of data entry was carried out throughout the study and this was augmented by a further series of checks on completion of data entry. Following this process, descriptive statistical analyses took place at the level of producing basic frequencies for each numeric variable and measures of central tendency for those that were continuous in nature.

Following further checks of internal validity, three main methods were used in order to explore relationships within the data and make inferences. Firstly cross-tabulation was used to explore associations between nominal, categorical variables. The Contingency Co-efficient figure was used to measure the strength of associations, with significance being inferred at the 5% level (i.e. p = <0.05) and expected values being generated in order to understand the direction of associations. Secondly, where data were ordinal in nature, non-parametric tests of independent samples were used as appropriate (Wilcoxon, Mann Whitney U and Kruskal-Wallis). These compare median responses based on ranking. Again significance was inferred at p = <0.05. Thirdly where variables were continuous in nature (e.g. total time taken to complete the programme), comparison of means undertaken for sub group analysis used either the related t test or the one way ANOVA procedure, as appropriate.

Answers to space-limited free-text questions within the survey questionnaire were initially entered in their entirety on the same database as “string” variables. However, through an iterative process whereby the research team read and compared these responses, a number of thematic coding categories were generated for most of the free-text variables. Discussion and critical reflection then took place between members of the research team so that the process of prospective coding using these categories could be checked, refined and standardised. Following this, the coded data was entered numerically onto SPSS and basic frequencies were generated.

2.2.4 Ethical considerations
Ethical approval for the research was sought through the national NHS REC procedures. A favourable opinion was obtained and the study was granted “no local investigator” status. The Research and Development Departments of all relevant NHS care organisations were informed of the study, in line with the new national procedures introduced in April 2005.
SECTION 3: CONTEXT AND REVIEW OF THE EDUCATIONAL PROGRAMME

3.1 Context
A review of the international research literature was carried out in order to place this initiative in context. From the literary evidence there is a general recognition that:

- Health care workers knowledge of universal precautions with regard to infection control is inadequate (Carroll et al 2005 and Gould 2005);
- There is a need for organisational change within health care services to prevent or more effectively manage health care associated infections (Beneda, Lang and Neuzil 2005, Holmes 2005, Gould 2005, Kaelenic, Horvatic & Lynch 2005, & Van Bokhoven, Kok & Van der Weijden 2003).
- Patients, carers and families are concerned about healthcare associated infections and should also engage with certain aspects of universal precautions (Guinan et al 2005, Finerty et al 2005 and Qutaishat, Giese and Nienow 2005).

Against this context of international research and the current UK policy context (Winning Ways, DOH 2003; Ministerial Action Plan, SEHD 2002; National Overview of HAI, NHSQIS 2005) the Cleanliness Champions Programme and implementation initiative is well-grounded and most relevant in terms of content and modes of delivery.

3.2 Review of the Information Resource Pack
The information resource pack provided by NES is comprehensive in its coverage of the stages of implementation. It has been designed to support those with the lead responsibility for implementation of the Cleanliness Champions Programme and is designed around four main areas: Strategy, Resources, Support Structures, and Outcomes. Prior to implementing the Cleanliness Champions Programme the Pack urges those responsible to:-
1. Develop a strategic action plan which encompasses a multi-disciplinary approach to implementation.

2. Identify ways in which the CCP links with broader issues of clinical governance and fits with extant quality and performance frameworks.

3. Plan the order of roll out of the programme so that: mentors are prepared in advance; the uptake of the CCP fits with priority areas and articulates with other mandatory training.

4. Consider the educational delivery options and any additional IT skills training required.

5. Appraise resources in terms of IT access and support, library facilities, mentorship arrangements, administration of the initiative and management of protected student time.

6. Develop supporting structures to facilitate the implementation such as establishing management systems to monitor and evaluate the effectiveness of the programme; identifying lead persons to take the initiative forward; making lines of communication explicit; formulating selection criteria for students and mentors; developing internal quality assurance mechanisms; and collaborating with higher and further education institutions to formalise educational opportunities.

7. Develop ways of measuring outcomes.

This staged approach to implementation is helpful and should pre-empt problems. The Pack focuses primarily on management issues associated with the introduction and monitoring of an education programme. The evaluators suggest that the utility of the Pack could be enhanced by including a section on identifying motivational issues and techniques.

Evidence gathered during interviews suggested that individuals valued the information resource pack. There appeared, however, to be a hiatus between its perceived value and its actual usefulness in guiding and planning the implementation of the Cleanliness Champions Programme in context. Across the NHS many areas have been informed and indeed have shaped their operational practices by parts of the pack to good effect, especially in relation to the registration and monitoring of students. With regard to the development of a multidisciplinary approach to implementation this has
been variable and problematic with many areas recruiting students and mentors predominately from within the nursing profession. For many areas the facilitating completion of the CCP was also problematic. Further insight into these issues is given throughout the report when we present the evidence from the surveys and interviews.

3.3 Evaluators’ review of the Cleanliness Champions Programme

The main strength of the programme rests in the fact that there are essentially two ways of engaging with it at either:

- the face validity level which is clearly structured, easy to follow and provides information about how and why good infection control precautions are necessary in the health care context.
  
or

- for those with more knowledge of the subject matter it is possible to delve deeply into many topics by following the suggested reading and web-links.

In this respect the programme is student centred and flexible enough to meet the educational needs of diverse occupational groups who are currently engaged in the provision of direct and indirect health care for the Scottish population. The reflective and interactive tasks for students to undertake are well structured and the provision of comparative check-lists is very helpful in building a sound knowledge base. The recommended audit activities are excellent for initiating change and impact on practice. The audit tools provided are simple and easy to use. The following schema (Table 3.1) provides a review of the strengths of the learning units and some suggested improvements.
### Table 3.1: Evaluators’ review of Cleanliness Champions Programme

<table>
<thead>
<tr>
<th>Learning Unit</th>
<th>Existing strengths</th>
<th>Suggested improvements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why Cleanliness Champions</td>
<td>Competency explained well importance of reflection identified and importance of discussing issues with colleagues and mentor.</td>
<td>Provide more guidance on the role, how to raise issues with colleagues and the importance of team working.</td>
</tr>
<tr>
<td>The chain of infection</td>
<td>Content covers environment, organism, specimen and individual. Tasks appropriate and transferable.</td>
<td></td>
</tr>
<tr>
<td>Hand hygiene 123</td>
<td>Content covers importance of hand hygiene, decontamination and non-compliance.</td>
<td>Give guidance on how to develop an action plan and introduce change with regard to hand hygiene practices.</td>
</tr>
<tr>
<td>Personal protective equipment (PPE)</td>
<td>Content covers when and how to use protective personal equipment. Audit of use of PPE in work environment.</td>
<td>Provide more information on: allergy (latex); and incident reporting of exposures.</td>
</tr>
<tr>
<td>Safe use and disposal of sharps</td>
<td>Content very comprehensive. Step by step management of an injury. Reflective exercises audit and checklist.</td>
<td></td>
</tr>
<tr>
<td>Safe handling and disposal of waste</td>
<td>Types of waste and correct disposal.</td>
<td></td>
</tr>
<tr>
<td>Food hygiene and pest control</td>
<td>Contamination labelling. Audit of hygiene practices. Review of visitor information.</td>
<td>Provide information on how and why this topic is relevant in all health care contexts and to all working in such contexts.</td>
</tr>
<tr>
<td>Staff hygiene and dress</td>
<td>Purpose of dress code. Cleanliness. Compliance audit and action plan to deal with infringement.</td>
<td>Give guidance on how to develop, plan and manage change with regard to staff hygiene and dress codes.</td>
</tr>
<tr>
<td>Patient care practices</td>
<td>Content on catheterisation processes and management of intravenous therapy. Patient hand hygiene.</td>
<td>Incorporate section on promoting visitors’ practices, family practices and patient to patient practices.</td>
</tr>
<tr>
<td>The role of the Cleanliness Champion and its impact on the patient’s experience</td>
<td>Reflective exercises.</td>
<td>Incorporate sections on the dynamics of influencing others and how to identify indicators of effectiveness.</td>
</tr>
</tbody>
</table>
3.4 Review of main modes of delivery

Each of the three main modes of delivery is appropriate for the learning content and each facilitates the student to work at his or her own pace. The electronic formats (CD ROM and E-Learning) enable easy access to additional materials.

Table 3.2: Review of three main modes of delivery

<table>
<thead>
<tr>
<th>Hard Copy</th>
<th>CD ROM</th>
<th>E-Learning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well presented easy to read and compact to carry. Well referenced to further materials. Good structure for working through. Need high level of motivation to follow up references.</td>
<td>Set up introduction check very easy. Provided direct link to on line articles. Download time on average 2 minutes. Some problems when closing web link articles. Features such as video clips, definition buttons, photos and personal stories very good. Format for tasks very good and streamlined (type directly onto the page and then use large print button to produce evidence for folder of learning).</td>
<td>Very straightforward to use. Introduction section gives good guidance on how to navigate the system. Connection times (on high specification computers and servers) are relatively short (15-60 seconds). User interface is clear and easy to read. Web links to articles are very good and easy to navigate. Features such as video clips, definition buttons, photos and personal stories very good. Format for tasks very good and streamlined similar to CD ROM.</td>
</tr>
</tbody>
</table>
SECTION 4: FINDINGS FROM THE SURVEY OF CCP STUDENTS: OVERVIEW OF ALL RESPONDENTS

4.1 What were the survey response rates?

The overall response rate was 40%, as 2025 questionnaires were sent out and 801 were returned. 773 responses were useable (38%). Comparison of the two different methods of questionnaire distribution showed that direct mailing to students undertaken through NES produced a 46% return, while distribution through Registering Officers in Health Boards/Divisions yielded a 34% return. Response rates from each individual Health Board/Division ranged widely from 20% up to 74%.

4.2 How representative is this sample of CCP students?

The denominator figure of 2025 reflects the number of CCP students registered with NES in April 2005 prior to the start of the survey. At that time it was not possible to identify precisely which of these individual registrants had: actually started the programme; had completed it; and/or had withdrawn. Accordingly the decision to conduct a census of all registrants was an ambitious one that set a high denominator. This was confirmed during the survey when one Division informed us that they were aware that 116 of their registrants who received questionnaires had not actually started the programme yet. Thus the figure of 40% is certainly a very conservative estimate of the survey’s representitiveness of the experiences of those who have actually had engagement with the learning programme as students.

This is strongly endorsed through scrutiny of NES’s own total figures for registrants as at the 31st July 2005 (the end of the survey period). These show 3099 as ever having registered, with 523 completions and 195 withdrawals. Within our own survey sample 369 respondents (48%) had completed the programme and 54 (7%) had withdrawn. In effect this means the survey has had responses from 71% of all those who have completed the programme (i.e. over 7 out of every 10 of these students). Accordingly the survey findings are authoritative in this regard. Moreover responses have been obtained from 28% of all those known to have withdrawn. This is a reasonable figure given the well-recognised difficulties of accessing those who discontinue and may move away.

The characteristics of our survey respondents (as detailed in the following sections) were also subsequently cross-checked with the student data held by NES (as collated from every initial registration form). This showed the two data sets to be very similar indeed (e.g. in terms of occupational groupings, workplace settings and other basic demographic variables). Again this strongly suggests that our sample is representative of the total CCP student population.
4.3 Who were these respondents?
Table 4.1 shows the occupational groups that respondents stated they belonged to.

Table 4.1: Student respondents by occupational group

<table>
<thead>
<tr>
<th>Occupational group</th>
<th>Number of respondents</th>
<th>% of total respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse</td>
<td>505</td>
<td>65%</td>
</tr>
<tr>
<td>Healthcare Assistant</td>
<td>65</td>
<td>8%</td>
</tr>
<tr>
<td>Domestic</td>
<td>30</td>
<td>4%</td>
</tr>
<tr>
<td>Allied Health Professional (e.g. Physiotherapist, Dietician)</td>
<td>28</td>
<td>4%</td>
</tr>
<tr>
<td>Ambulance staff</td>
<td>18</td>
<td>2%</td>
</tr>
<tr>
<td>Dental Nurse</td>
<td>16</td>
<td>2%</td>
</tr>
<tr>
<td>Doctor</td>
<td>11</td>
<td>1%</td>
</tr>
<tr>
<td>Dental Hygienist</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Pharmacist</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Other (e.g. Social Care Worker, Receptionist)</td>
<td>87</td>
<td>11%</td>
</tr>
<tr>
<td>No response to this question</td>
<td>11</td>
<td>1%</td>
</tr>
</tbody>
</table>

Thus nurses comprised two thirds of all respondents. Similarly around two thirds of all respondents were based in an acute hospital setting, as detailed in Table 4.2.

Table 4.2: Student respondents by workplace setting

<table>
<thead>
<tr>
<th>Workplace</th>
<th>Number of respondents</th>
<th>% of total respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute hospital</td>
<td>501</td>
<td>65%</td>
</tr>
<tr>
<td>Community hospital</td>
<td>78</td>
<td>10%</td>
</tr>
<tr>
<td>Health centre/GP practice</td>
<td>35</td>
<td>5%</td>
</tr>
<tr>
<td>Nursing/care home</td>
<td>11</td>
<td>1%</td>
</tr>
<tr>
<td>Other (e.g. Family Planning Clinic; Dental Hospital)</td>
<td>130</td>
<td>17%</td>
</tr>
<tr>
<td>No response to this question</td>
<td>18</td>
<td>2%</td>
</tr>
</tbody>
</table>

The vast majority of respondents were female (90%) and middle aged (median age of 43; range = 18-61 years). There was typically very extensive experience of ongoing employment in healthcare settings (median time = 20 years). In the context of delivering a structured educational programme targeted at local practice level, it is perhaps even more striking that respondents had typically been based in their current workplace setting for a lengthy period (median time = 8 years). Eighteen respondents (2%) were employed by independent or voluntary sector organisations but the
remaining overwhelming majority of the survey respondents were employed by NHS Scotland.

Just over half of the sample had volunteered to undertake the programme (399 respondents; 52%), while 350 had been nominated (45%). Within the sample there was no significant association between method of selection for the programme and having completed it or not.

4.4 How long did it take them to complete the programme?

The median completion time was 5 months, but there was huge variation in these self-reported times (from 3 days to 18 months). Thus respondents were usually taking around 1-2 months longer than the initial estimation of 14-16 weeks to complete. Interestingly, volunteers were found to have completed the programme significantly faster than nominees ($p = 0.004$). Median completion time for volunteers was 4 months while nominees typically took around 6 months. Some occupational groups were typically faster than others in completing the programme. Healthcare assistants usually took just over 4 months while AHPs took around 7.5 months.

4.5 What was the main factor delaying completion time?

By far the most common difficulty that respondents cited was getting time to work on and complete the programme during working hours. Over one third of the sample (274; 35%) explicitly added explanatory comments to this effect, with 40 (5%) adding that they had found the programme too long or lengthier than expected. Fifty four respondents (7%) described using substantial amounts of their own time to do the programme. Indeed several mentioned that it had all been done in their own time apart from the workplace activities.

4.6 Which modes of programme delivery were used?

The modes used by respondents are summarised in Table 4.3.

<table>
<thead>
<tr>
<th>Mode of programme delivery</th>
<th>Number of respondents</th>
<th>% of total respondents*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Web-based e-learning</td>
<td>353</td>
<td>48%</td>
</tr>
<tr>
<td>Printed hard copy (Open/Distance learning pack)</td>
<td>298</td>
<td>39%</td>
</tr>
<tr>
<td>CD Rom</td>
<td>78</td>
<td>10%</td>
</tr>
<tr>
<td>Face to face instruction</td>
<td>45</td>
<td>6%</td>
</tr>
</tbody>
</table>

*Percentages total over 100% as some respondents reported using two modes (e.g. switching from e-learning to CD ROM)
Thus web-based e-learning was the main mode of delivery used with hard copy open and distance learning coming second. Respondents’ reasons for not using web-based e-learning are detailed in Table 4.4.

Table 4.4: Student respondents’ reasons for not using e-learning

<table>
<thead>
<tr>
<th>Reason for not using web-based e-learning</th>
<th>Number of respondents</th>
<th>% of total (all) respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>I preferred another mode of delivery</td>
<td>146</td>
<td>19%</td>
</tr>
<tr>
<td>I had limited access to a computer</td>
<td>108</td>
<td>14%</td>
</tr>
<tr>
<td>I felt I lacked appropriate skills</td>
<td>72</td>
<td>9%</td>
</tr>
<tr>
<td>Technical problems with access to web</td>
<td>41</td>
<td>5%</td>
</tr>
<tr>
<td>My employer preferred another delivery mode</td>
<td>32</td>
<td>4%</td>
</tr>
<tr>
<td>Other reason</td>
<td>31</td>
<td>4%</td>
</tr>
</tbody>
</table>

*Respondents could cite several of these options if relevant.

4.7 What were students’ experiences of these delivery modes?

Feedback on the web-based e-learning experience was mostly positive and students often commended the format as well designed. The main problems reported by e-learning students involved securing sustained time and opportunity to work on the programme via workplace computing facilities. Twelve respondents specifically added comments to the effect that actual on-line time exceeded the NES estimate of 16-20 hours. Fifteen respondents indicated that it was necessary to print off substantial amounts of material, and downloading was a particular problem for those using a home personal computer as they incurred related printing costs. At some workplace settings where several students were using the web, downloaded materials were shared by photocopying. This could be useful but there were reports of poor quality reproduction of “spot-the-problem” photographs. Thirty seven e-learning students reported difficulties in accessing web links incorporated in the on-line programme, with some being out of date. Several respondents suggested that e-learning students should also get the hard copy Open and Distance Learning (ODL) pack.

Users of the ODL package tended to value the versatility of having paper-based materials that could be carried around. Although this hard-copy version gave details of web site links, some students felt that the material to be found at these sites should have been included in the printed package as they had difficulties with web access. Several hard copy users complained that their organisation had given them photocopied versions of the original colour package, and that the resultant quality was poor. Nineteen students felt that they had to do too much photocopying of pages themselves (e.g., for audit activities) and some of these respondents also suggested that the Folder of Evidence of Learning be integrated into the main ODL package.
CD Rom users tended to report that they were using this format because they lacked access to a computer at work and that it was more suited to the specification of their home computer. One user cited its versatility as she travelled a lot and used a laptop computer. A few of the students who were using CD Rom reported that they had not been given the choice of web-based e-learning by their organisation.

Although relatively few respondents had undertaken the programme in a way where face-to-face classroom delivery was a characteristic element, those who did were generally happy with this mode. Predictably one of the main benefits was peer support and encouragement, and most of these students felt that they had a good CC support network within their organisation. Indeed some of the students who were using other formats (such as e-learning) commented that they would have liked at least some communal study days. Conversely some of those whose programme was face-to-face based indicated that they had not been offered any choice in terms of delivery mode.

Completion times for the programme were broadly similar for the web-based e-learning, hard copy ODL, and CD Rom modes. However those who had their programme delivered primarily in face-to-face mode tended to take around 1.5 months less to complete than users of other modes.
4.8 What did students think of the content of the programme?

Students' feedback on programme content was very positive, with over a third of respondents (286; 37%) explicitly adding explanatory comments commending the overall package. Ratings of individual learning units are presented in Table 4.5.

Table 4.5: Students' ratings of each learning unit (%)

<table>
<thead>
<tr>
<th>Learning unit number &amp; name</th>
<th>Very useful</th>
<th>Useful</th>
<th>Of limited use</th>
<th>Not at all useful</th>
<th>Unit not yet completed/No answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Why Cleanliness Champions?</td>
<td>334 (43%)</td>
<td>232 (30%)</td>
<td>101 (13%)</td>
<td>22 (3%)</td>
<td>84 (11%)</td>
</tr>
<tr>
<td>2 The chain of infection</td>
<td>495 (64%)</td>
<td>126 (16%)</td>
<td>27 (4%)</td>
<td>6 (1%)</td>
<td>119 (15%)</td>
</tr>
<tr>
<td>3 Hand hygiene Parts 1, 2, 3</td>
<td>499 (65%)</td>
<td>77 (10%)</td>
<td>27 (4%)</td>
<td>10 (1%)</td>
<td>160 (21%)</td>
</tr>
<tr>
<td>4 Personal protective equipment (PPE)</td>
<td>352 (46%)</td>
<td>154 (20%)</td>
<td>36 (5%)</td>
<td>9 (1%)</td>
<td>222 (29%)</td>
</tr>
<tr>
<td>5 Safe use and disposal of sharps</td>
<td>330 (43%)</td>
<td>124 (16%)</td>
<td>41 (5%)</td>
<td>12 (2%)</td>
<td>266 (34%)</td>
</tr>
<tr>
<td>6 Maintenance of clean healthcare environment</td>
<td>318 (41%)</td>
<td>122 (16%)</td>
<td>31 (4%)</td>
<td>9 (1%)</td>
<td>293 (38%)</td>
</tr>
<tr>
<td>7 Safe handling &amp; disposal of waste</td>
<td>293 (38%)</td>
<td>128 (17%)</td>
<td>35 (5%)</td>
<td>6 (1%)</td>
<td>311 (40%)</td>
</tr>
<tr>
<td>8 Food hygiene and pest control</td>
<td>175 (23%)</td>
<td>126 (16%)</td>
<td>92 (12%)</td>
<td>37 (5%)</td>
<td>343 (44%)</td>
</tr>
<tr>
<td>9 Staff hygiene and dress</td>
<td>237 (31%)</td>
<td>122 (16%)</td>
<td>57 (7%)</td>
<td>6 (1%)</td>
<td>351 (45%)</td>
</tr>
<tr>
<td>10 Patient care practices</td>
<td>247 (32%)</td>
<td>88 (11%)</td>
<td>39 (5%)</td>
<td>19 (3%)</td>
<td>380 (49%)</td>
</tr>
<tr>
<td>11 The role of the Cleanliness Champion and its impact on the patient's experience</td>
<td>255 (33%)</td>
<td>90 (12%)</td>
<td>32 (4%)</td>
<td>8 (1%)</td>
<td>388 (50%)</td>
</tr>
</tbody>
</table>

Units 2 and 3 were seen as particularly valuable. Unit 2 was typically seen as providing the most new information. Unit 3 was typically seen to have proved most helpful in improving practice and within this context the workplace audit of staff hand hygiene was widely praised. Some units proved less useful to particular occupational groups and particular workplace settings. Seventy three respondents (9%) added comments indicating that specific content was not applicable to them. Further details are presented within the profiles of the experiences of different occupational groupings. From respondents' feedback the educational level of the programme was usually seen as about right, and many students commended the clarity of layout and language. However a small number felt the programme was too simplistic. A smaller group again thought some of the language had too much jargon. There were no significant differences in ratings of units' usefulness between those who had volunteered for the programme and those who had been nominated.
4.9 What were students’ views on possible modifications to the programme?

Respondents were asked to give their views on a number of possible revisions to the programme. Table 4.6 summarises their responses.

<table>
<thead>
<tr>
<th>Possible revisions</th>
<th>Agree</th>
<th>Disagree</th>
<th>Don’t know</th>
<th>No answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change the “Champion” name to something else</td>
<td>420 (54%)</td>
<td>175 (23%)</td>
<td>83 (11%)</td>
<td>95 (12%)</td>
</tr>
<tr>
<td>More spot the problem photos</td>
<td>426 (55%)</td>
<td>144 (19%)</td>
<td>95 (12%)</td>
<td>108 (14%)</td>
</tr>
<tr>
<td>Section on team working</td>
<td>517 (67%)</td>
<td>65 (8%)</td>
<td>90 (12%)</td>
<td>101 (13%)</td>
</tr>
<tr>
<td>Examples of local policies</td>
<td>520 (67%)</td>
<td>87 (11%)</td>
<td>73 (9%)</td>
<td>93 (12%)</td>
</tr>
<tr>
<td>Sorting the programme into optional &amp; core elements</td>
<td>313 (41%)</td>
<td>239 (31%)</td>
<td>115 (15%)</td>
<td>106 (14%)</td>
</tr>
<tr>
<td>Customising the programme by occupation</td>
<td>436 (56%)</td>
<td>174 (23%)</td>
<td>67 (9%)</td>
<td>96 (12%)</td>
</tr>
<tr>
<td>More web links</td>
<td>219 (28%)</td>
<td>257 (33%)</td>
<td>176 (23%)</td>
<td>121 (16%)</td>
</tr>
<tr>
<td>More content relevant to primary care</td>
<td>264 (34%)</td>
<td>126 (16%)</td>
<td>255 (33%)</td>
<td>128 (17%)</td>
</tr>
<tr>
<td>More content on cleaning</td>
<td>378 (49%)</td>
<td>177 (23%)</td>
<td>113 (15%)</td>
<td>105 (14%)</td>
</tr>
<tr>
<td>More content on chemical spills</td>
<td>301 (39%)</td>
<td>211 (27%)</td>
<td>160 (21%)</td>
<td>101 (13%)</td>
</tr>
</tbody>
</table>

Respondents own suggestions for improvement of the educational materials typically centred on reducing repetition (62 comments; 8%) and shortening the programme (40 comments; 5%). Respondents seldom articulated any need to change the assessment processes within the programme, but 20 did suggest that assessment should take place at the end of each learning unit (e.g. by on-line tests using multiple choice questions). Several suggested that organisations identify a number of designated assessors, rather than having mentors scrutinise the Folder of Evidence of Learning. A few respondents expressed a desire that the programme be academically accredited with SCOTCAT points.

4.10 What were students’ experiences of mentorship?

Almost two thirds of respondents (n=506; 66%) felt that their mentor gave them adequate support, while 21% had a less satisfactory experience. Where the latter had been the case, the main reasons were seen as the mentor lacking time (n=79; 10%) or that access to the mentor was difficult due to geography (n=66; 9%). Typically students discussed progress with their mentors between 1-5 times during the programme, although around a fifth had substantially more contact. Almost two thirds of such contacts between students and mentors took the form of one-to-one meetings (62%). Telephone contact (25%), group meetings of students with a
mentor (20%) and e-mail contact (15%) were also used. Students were asked for feedback on the extent to which their mentor scrutinised their Folder of Evidence of Learning. Findings are summarised in Table 4.7.

Table 4.7: Extent of scrutiny of learning folder

<table>
<thead>
<tr>
<th>Extent of scrutiny of Learning Folder</th>
<th>Number of respondents</th>
<th>% of total respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>In detail for each learning unit</td>
<td>382</td>
<td>49%</td>
</tr>
<tr>
<td>In general overview</td>
<td>114</td>
<td>15%</td>
</tr>
<tr>
<td>In detail for some learning units</td>
<td>41</td>
<td>5%</td>
</tr>
<tr>
<td>Not at all</td>
<td>42</td>
<td>5%</td>
</tr>
<tr>
<td>No response to this question</td>
<td>194</td>
<td>25%</td>
</tr>
</tbody>
</table>

Seventeen percent of the students were now mentoring others as part of their Cleanliness Champion role.

4.11 What impact did students feel the programme was having on their own practice?

Students were asked to reflect on ten aspects of their own practice before and after completing relevant parts of the programme. They were then asked to rate these aspects using a 1-5 scale, where 1 represented poor practice and 5 represented excellent practice. The difference (improvement) between before and after ratings was statistically significant for all these aspects (p = 0.001). The greatest perceived improvement was in relation to:

(1) Challenging others practice
(2) Acting as a role model
(3) Hand washing

Although improvements were significant in the following aspects, they tended to show the least impact:

(8) Food handling
(9) Handling of sharp objects
(10) Preventing needlestick injuries

Those who had volunteered for the programme tended to rate impact on all aspects of practice similarly to those who had been nominated (i.e. there were no significant differences).

Respondents’ written comments often gave examples of a wider influence on practice within the multidisciplinary team. Some examples of these are included within the profiles of the different occupational groups.
4.12 What is known about initial integration of the CC role into practice?

Students were asked if they had key allies within their workplace setting who were helping them to integrate good practice in regard to cleanliness and infection control. Five hundred and fifty one (71%) replied affirmatively, while 130 (17%) did not. Given that most respondents were nurses it is not surprising that various nurses were most often cited as key allies. Local Infection Control Nurses and Infection Control Teams were also prominent in this regard. Students were also asked which groups of colleagues were least aware of their Cleanliness Champion role. Medical staff clearly emerged as the group who were seen as least aware of local Cleanliness Champions.

Moreover, a mixed picture emerged generally in relation to the extent that the CC role was perceived to be supported by multidisciplinary teams within workplace settings. Table 4.8 summarises responses.

Table 4.8: Extent CC role supported by multidisciplinary team

<table>
<thead>
<tr>
<th>Extent CC role supported by m/d team</th>
<th>Number of respondents</th>
<th>% of total respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completely</td>
<td>103</td>
<td>13%</td>
</tr>
<tr>
<td>Largely</td>
<td>244</td>
<td>32%</td>
</tr>
<tr>
<td>Partially</td>
<td>170</td>
<td>22%</td>
</tr>
<tr>
<td>Very little</td>
<td>107</td>
<td>14%</td>
</tr>
<tr>
<td>Not at all</td>
<td>36</td>
<td>5%</td>
</tr>
<tr>
<td>No answer to this question</td>
<td>113</td>
<td>15%</td>
</tr>
</tbody>
</table>

Looking beyond immediate workplace setting, 444 respondents (57%) felt there was an adequate support network for CCs within their organisation, while 30% disagreed.

4.13 What about those students who discontinued/withdrew from the programme?

Where students stated that they had discontinued the programme, the main reason cited was lack of time due to other work commitments. Table 4.9 presents details along with other reasons given.

Table 4.9: Students’ main reasons for discontinuing programme

<table>
<thead>
<tr>
<th>Main reason for discontinuing programme</th>
<th>Number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of time due to other work commitments</td>
<td>28</td>
</tr>
<tr>
<td>Change of job</td>
<td>6</td>
</tr>
<tr>
<td>Personal/family reasons</td>
<td>5</td>
</tr>
<tr>
<td>Lack of support from mentor</td>
<td>5</td>
</tr>
<tr>
<td>Lack of support from employer</td>
<td>3</td>
</tr>
<tr>
<td>Other reason</td>
<td>4</td>
</tr>
<tr>
<td>Ambiguous answer</td>
<td>3</td>
</tr>
</tbody>
</table>
SECTION 5: FINDINGS FROM THE SURVEY OF CCP STUDENTS:
PROFILES OF DIFFERENT OCCUPATIONAL GROUPS

5.1 Nurses
Five hundred and five nurses responded to the student questionnaire (65% of all respondents), making this by far the largest occupational grouping. Respondents were typically Staff Nurses or working as Charge Nurse/Sister/Ward Manager. Seventy percent were based in acute hospitals, 11% in community hospitals, 4% in Health Centres/GP practices and only 1% in Nursing/Care Homes. Thus the sample of respondents from nursing is very much dominated by hospital nurses.

Slightly more of the respondents had volunteered than been nominated (53% v. 44%) and just under half of all respondents had completed the programme at the time of the survey (48%). The most frequently used format was web-based e-learning (48%), closely followed by hard copy ODL (40%). A number of reasons were cited as to why they had preferred another format to web-based e learning: 13% reported limited access to a computer; 10% felt they lacked appropriate skills; and 6% reported technical problems with access to the web.

Overall feedback on the programme was very positive indeed, with very few nurses having predominantly negative experiences. As with the whole sample of 773 survey respondents, the key problem for nurses was that of finding time to do the programme. While some nurses cited specific areas of difficulty in relation to the programme’s content and format, this was almost always in the context of a generally positive experience of the learning materials and many also offered valuable constructive suggestions for enhancing the programme. Unit 2 was usually seen as providing the most new information, but Units 3 and 6 were also frequently mentioned in this regard. Unit 3 was typically seen to have proved most helpful in improving practice, but many other units were cited as having high impact on practice (e.g. 2, 4, 6, 10 and 11). Although Units 1 and 8 were valued by many, they emerged as the least useful for this group.

There was a 2:1 ratio in favour of changing the Cleanliness Champion title and just over half of these nurses supported customisation of the programme by occupation. Opinion on sorting the programme into core and optional elements was almost evenly divided (38% in favour v. 35% against).

In terms of mentorship support, two thirds of respondents felt that they received adequate input, while 21% felt that support was insufficient. Rather more (30%) felt that overall there was an inadequate support network for Cleanliness Champions within their local organisation, but relatively few (14%) were unable to cite key allies within their actual place of work. The median time taken to complete the programme was 4.75 months, but there was substantial variation ranging from a minimum of 3 days to a maximum of 18 months.
Respondents from nursing generated a vast amount of written comments on the strengths and weaknesses of the programme. Some examples that typify themes and sub-themes are now presented under the main headings of: personal/professional impact of programme; wider impact and integration into practice; lack of time; and management/organisational issues.

5.1.1 Personal/professional impact of programme

The huge volume of written comments from nurses highlighting the positive personal impact of the programme materials was remarkable. The following are typical:

“Great tool to “brush up” on practice already in place and to provide rationale for poor practice to stop” (Ward Manager, Acute Hospital, Urban setting)

“Able to take as much time as I want for each unit, not being rushed. I can study to my abilities - you can learn as much as you feel necessary for the knowledge you want to achieve” (Staff Nurse, Community Hospital, Island setting)

“Excellent learning tool. Refresher in terms of education and stimulates reflection of clinical practice” (Nurse Manager, Acute Hospital, Urban setting)

“I have gained so much confidence & knowledge and able to address any problems that occur. I see myself as a role model to all staff” (Staff Nurse, Nursing Care Home, Independent Sector)

5.1.2 Wider impact and integration into practice

Many of the above comments spontaneously mentioned that this was influencing care in a wider way:

“I learned a lot from doing the programme. I use some of the information from this when educating new staff about infection control practices. We had developed an infection control link group in our area a few years ago. 3 of us have done the programme, one has mentored us. We have introduced changes to the unit through this such as: hand hygiene audit of all staff (multidisciplinary team); purchased new equipment with ease of cleaning in mind. Weekend cleaning book reintroduced to help maintain cleanliness of equipment.” (Charge Nurse, Acute Hospital)

“Raising awareness of IC issues throughout the organisation of NHS staff. Promoting team/core training for AHP’s and nursing/domestic staff. Have seen a wonderful example of a CC challenge domestic staff in an outbreak situation” (Health Protection Nurse Specialist, Public Health Protection Team)

“As I have worked through this programme I have found that I have worked more closely with, for example, domestic staff, waste managers etc. I have been thrilled by changes and improvements made and am enthusiastic to build on this” (Senior Nurse, Acute Hospital)
“I am able to challenge other staff regarding their practice, to influence changes in equipment, provision of hand gels, confident in speaking to visitors”
(Sister, Community Hospital)

“Able to communicate in a way that people do not take offence & explain why bad practices should be changed and challenged”
(Staff Nurse, Community Hospital)

As the latter comments indicate, many nurses who were Cleanliness Champions reported having the authority, autonomy and means to influence practice in their local area. However a smaller proportion reported problems in this area:

“As a champion I have no authority to make changes, although I can ask management to encourage changes” (Staff Nurse, Health Centre/GP practice)

“I still lack confidence to challenge colleagues on any poor practice I may observe”
(Staff Nurse, Acute Hospital)

5.1.3 Lack of time
The deluge of positive comments about the content, format and initial influence of the programme was matched, however, by the number of respondents who raised the issue of time constraints. Some explicitly reported using their own off-duty time. In this regard the amount of motivation being showed by these nurses was striking. The following comments are typical:

“The time allocated to completing the programme was too short as it had to be done during work time! I could not possibly do this and did most of it at home. Time allocated 16 hours. Time to complete 50 hours” (Staff Nurse, Health Centre/GP practice)

“Time span - completing the work in my own time due to staff shortages”
(Staff Nurse, Community Mental Health

“Lack of time. It was often difficult to get time to do the workplace activities. My colleague & I shared these which was easier (working as a team)”
(Staff Nurse, Acute Hospital)

“Not accredited, no study time, did not take account of existing knowledge or area of work” (Staff Nurse, Nurse-led Minor Injuries Unit, Community Hospital)

“It takes longer than stated to complete. It is difficult to get protected time and access to computer at work. There is no real authority attached to role”
(Infection Control Nurse, Primary Care Division)
5.1.4 Management/organisational issues

Many comments related to the fit between the programme, local management and organisational needs/priorities. Many also incorporated helpful suggestions. A selection is now presented:

“The programme order doesn’t necessarily reflect the IC priorities in the organisation or in the Inf Control programme. More flexible approach to selecting the order of the modules would be helpful” (Matron of Hospice)

“Difficult to complete the course until the Trust organised set days where you could attend and librarian, computer, infection control nurse, hardcopy reading material all set up and in attendance. These were 2/3 month and very beneficial” (Staff Nurse, Acute Hospital)

“Need to get more people doing the programme more quickly- I am the only one in the ward who has done it and difficult to keep all colleagues motivated to provide excellent practice” (Staff Nurse, Acute Hospital)

“Maybe a shortened version may be an idea to get more staff through course” (Staff Nurse, Acute Hospital)

“Despite years in nursing learned many new simple ways to reduce cross infection. Worthwhile course for all ward managers. CC needs support from manager to implement improved practice. Long overdue programme. Domestic services a major issue” (Sister, Acute Hospital)

“Not enough input from management at a local level. I feel areas of concern outlined in action plans could be used to improve standards. Some were addressed by our unit’s Inf. Control liaison group within our own time. Lack of time leads to lack of motivation!” (Senior Staff Nurse, Acute Hospital)

“No incentives once course completed. Should have more support from NES, and no provisions made if you have problems with mentorship” (Staff Nurse, Acute Hospital)

“After completion of programme it would be beneficial to have support group/meetings to share views and experiences in infection control. Learn from each other” (Sexual Health Nurse, Primary Care Clinic)

“What is being done to maintain the knowledge gained after completion? Completed Champions should be given some direction what to do with increase in knowledge (i.e. liaise with ICTs). This would maintain the motivation gained during the programme” (Staff Nurse, Adult Critical Care Unit)

“Scottish Executive wishes all G Grades to do course - in community may not be necessary e.g. 5 H V’s all G Grades and 2 DN G Grades in our health centre. Probably better one from each team more appropriate” (District Nurse, Health Centre)
“I thoroughly enjoyed the course and would like to see it accredited. It would be good to have photographs of CC in every work area or badges to that effect - thus making them visible to other staff and patients”
(Sister, Community Hospital)

“Medical staff must be included. Nurses on the whole are changing their practice or are open to constructive comment about their practice and often improve because of this, but medical staff still lag way behind. Also increase numbers of domestic staff = cleaner hospital” (Staff Nurse, Acute Hospital)

“I think this course in the acute setting should be made compulsory to domestic staff and doctors” (Deputy Charge Nurse, Acute Hospital)

“Health care workers continue to wear uniforms out of workplace. Allied Health Professionals lack of handwashing” (Staff Nurse, Community Hospital)

“More public involvement section - I have been invited to patients’ forum to discuss my role and changes made. The participants need to be supported throughout and need a dedicated budget to make changes” (Practice Development Nurse, Community Health Partnership)

5.2 Allied Health Professionals

Twenty nine AHPs responded to the student questionnaire (4% of all respondents). Nine were physiotherapists, while the remainder comprised a mixture of OTs, radiographers, podiatrists and dieticians. Only one pharmacist responded to the survey and she was subsequently integrated into the AHP category.

The majority of AHPs worked in acute hospital clinical practice and had completed the programme using web-based e-learning. Several expressed frustrations about the amount of printing required and would have appreciated hard copy handouts. However the general tenor of feedback was very positive, especially in regard to Unit 2 which was almost always seen as providing the most new information. Unit 3 was typically seen to have proved most helpful in improving practice, and this was corroborated in respondents’ very high ratings of impact on their personal hand hygiene practice. Indeed AHPs were one of the occupational groups that reported the highest positive impact of the programme on their own personal practice in terms of: hand hygiene; acting as a role model; reducing risk of HAI generally; and challenging others.

The least useful learning units for AHPs were clearly units 5, 7, 8 and 10. The latter unit was often seen as very nurse orientated, while the others were often seen as of limited relevance to their own practice. Over two thirds of respondents favoured changing the Cleanliness Champion name and customising the programme by occupation. There was also a majority supporting the creation of core and optional elements.
Although the majority of these AHPs felt that mentorship support was adequate, around 30% had less satisfactory mentorship experience, lacked key allies in their workplace and lacked an adequate organisational support network for their role. This may be reflected in one of the most striking findings from AHP responses: the relatively long time they typically took to complete the programme. At an average (median) of 7.5 months, AHPs were the professional group that reported taking most time. While this did not reach the level of statistical significance, there was notable contrast with other respondent groups of comparable size such as domestics who averaged 2.5 months less. Several respondents suggested improvements in this regard: “shorten course so that not so off-putting”; “could do with being slicker as not easy getting time to do it”.

Nevertheless, there was considerable evidence of benefits perceived by a range of the different professions within the AHP grouping:

“We have changed local policies and are more actively risk assessing. Very interesting. Good support from Infection Control Team........Very useful on an individual and departmental level” (Senior II Physiotherapist)

“Clear written information, most of it relevant to OT practice. I feel I consolidated some knowledge while learning some new things”
(Senior Occupational Therapist)

“Not traditionally my role to reflect on other practice – need to be aware of new role and gain confidence” (Senior Dietician)

5.3 Doctors
Eleven doctors responded to the student questionnaire (1.5% of all respondents). They comprised: four senior microbiologists; three Directors of Care; two associate specialists and two hospital consultants. Thus the available responses predominantly reflect views from a small cadre of senior medical staff, few of whom were based in “front-line” clinical positions.

The majority of respondents had completed the programme using web-based e learning. Feedback on the programme was generally positive. While other occupational groups typically saw Unit 2 as providing the most new information, these doctors’ responses were more varied with Unit 6 often cited in this regard. However they shared the view that Unit 3 proved most helpful in improving practice, and this was corroborated in very high ratings of impact on their personal hand hygiene practice. Units 1, 9 and 10 were seen as least useful but this may to some extent reflect the more managerial and specialist profile of this group of respondents. Interestingly only two were in favour of the programme having core and optional elements, while four supported customisation by occupational group. The majority, however, wished to see a change to the Cleanliness Champion name.
Only two respondents experienced lack of mentorship support but lack of protected time to do the programme was a more commonly expressed constraint. Despite this the average completion time for this very small group was amongst the quickest of all the occupations (median of 4.5 months). This may relate to the fact that ten of the eleven were volunteers, a much higher proportion than in other occupational groups. The one nominee provided further illumination about her enrolment:

“Nominated by consultant as token doctor on course”
(Associate Specialist in Psychiatry)

Nevertheless this doctor and the majority of others generally viewed the programme as fit for purpose:

“Good basic info well presented. Stresses importance of all staff in avoiding infection” (Consultant Physician)
“Refocuses those who are experienced practitioners” (Director of Clinical Skills)

“Informs you about other members of staff’s roles in preventing HAI, making you a more useful multi-disciplinary team member”
(Associate Specialist in Paediatrics)

“The programme highlights the importance of infection control but also the fact that somebody in each area must take on the responsibility to ensure that everybody complies” (Medical Director, Community Health)

Moreover, several respondents highlighted a need for more of their professional colleagues to engage with the programme:

“Feel more medical staff in general wards should get involved”
(Associate Specialist in Psychiatry)

“Would like to see this package integrated into undergraduate medical courses. Its importance is rarely mentioned to undergraduates and yet its importance cannot be stressed enough, especially for young doctors” (Microbiology SHO)

5.4 Healthcare Assistants

Sixty five Healthcare Assistants (HCAs) responded to the student questionnaire (8% of all respondents). The majority described their job title as Auxiliary Nurse, but a small sub-group were less explicitly aligned to nursing (e.g. Clinical Support Workers) and a few respondents were aligned to other professions (e.g. radiography assistant).

Over 70% of these HCAs worked in acute hospitals and, unlike most other occupational groups, the majority of respondents had been nominated for the programme. Although a sizeable minority used the web-based e learning format or CD Rom, the hard copy paper format was the most popular. Many HCAs reported limited access to a computer and some felt they lacked appropriate IT skills. Thirteen (20%) had undertaken the
programme through a face-to-face instructional method.

Overall feedback was very positive for all the units of the programme, although Unit 8 was seen as of limited use/no use by eleven respondents (17%). While Units 2 and 3 emerged as particularly valuable, several other units were regularly cited in this regard (e.g. Units 6 and 10). Indeed HCAs were one of the occupational groups that reported the highest positive impact of the programme on their own personal practice in terms of: handling sharps; using protective clothing; acting as a role model; reducing risk of HAI generally; and challenging others.

As a group, HCA respondents were equivocal about the idea of customising the programme by occupation or offering optional and core elements. Dislike of the Cleanliness Champion title was also less marked than amongst other occupational groups.

HCAs tended to complete the programme relatively quicker than others, averaging just under 4.5 months (median). Mentorship support was adequate for the large majority of respondents, but 20% had a less satisfactory experience and lacked key allies in their workplace.

Written comments from HCAs tended to highlight the positive impact of the programme on personal knowledge and practice, and a related wealth of enthusiasm:

“I now question what I do and plan procedures fully” (Auxiliary Nurse)

“My only comments are the fact I was amazed how much information I learned. It was the most enjoyable course I have ever done and completed” (Rehabilitation Instructor)

“Feel this course has been very good for me. It is so easy to get into bad habits. It refreshes in my mind what I should be doing in my work area” (Outpatient Assistant)

Moreover, several respondents cited examples of influence on the multidisciplinary team:

“Knowledge and understanding of local policies brought to the fore enables us to discuss matters within multidisciplinary team” (Community Auxiliary Nurse)

“The information was well set out and enhanced policies. The role model design was excellent as I had positive feedback from staff re them emulating procedures, especially hand washing” (Occupational Therapy Technical Instructor)

However, comments also frequently highlighted difficulties relating to HCA’s enactment of their perceived new role:

“How do we in our own role get/encourage superiors/high head ones to comply?
Communication unit might be handy” (Community Auxiliary Nurse)

“If not careful the programme can make the would-be Cleanliness Champion very unpopular, which can be stressful and cause unhappiness” (Nursing Auxiliary)

“Trying to find the correct ways to approach students” (Healthcare Assistant)

“Lack of support on ward by senior staff. Discriminated against because I am a nursing assistant at ward level” (Nursing Assistant)

“It seems unfair to use people like myself to set an example and point out bad practices to people who are more senior, much better paid and more experienced than myself” (Clinical Support Worker)

5.5 Dental nurses
Sixteen dental nurses responded to the student questionnaire (2% of all respondents). One response from a dental hygienist was subsequently integrated into this category. No dentists responded.
The dental nurses worked in a range of clinical settings and were predominantly volunteers. Printed hard copy was the preferred format for this group as many had limited access to a computer. Overall feedback was very positive, especially in regard to Unit 2 which was almost always seen as providing the most new information. Unit 3 was typically seen to have proved most helpful in improving practice, but Unit 4 was also often cited as useful in this regard. Indeed dental nurses were one of the occupational groups that reported the highest positive impact of the programme on their own personal practice in terms of use of protective clothing.
The least useful learning units for dental nurses were clearly units 8 and 10. The latter unit was often seen as very nurse and ward orientated, while Unit 8 was usually seen as of limited relevance to their own practice. Over 80% of respondents favoured changing the Cleanliness Champion name and customising the programme by occupation. Just under half supported the creation of core and optional elements for the programme.
Almost 40% of respondents felt that their mentorship support was inadequate, a higher proportion than in any other occupational group. Median completion time was 5 months. Two thirds felt that they lacked an adequate organisational support network for their role and this may have some relationship to the range of occupational settings reported.
Programme content and presentation were generally praised:
“Easy to understand/ not too complicated information. Well presented” (Dental Nurse)
Some respondents found it repetitive, however, & one proposed a solution:

“Each student should be able to choose which units to complete dependent on which type of healthcare you are involved in” (Senior Dental Nurse based in Health Centre/GP practice)

Several respondents cited examples of the programme’s impact at personal level and beyond, but enacting a Cleanliness Champion role was not without difficulties:

“I Feel I have increased my awareness while promoting the prevention and control of infection within the workplace. Initially found after completing the handwashing audit and after discussion regarding the results that some senior staff not pleased about nurse informing them at times they had failed to decontaminate their hands correctly”

(Dental Nurse based in Community Hospital)

“Weakness is getting the time to complete units and the nerve to question the senior staff on their IC methods”

(Senior Dental Nurse, Dental Institute)

“At this time I have not been asked to fulfil the “Champion” role. I was the only one of our staff of 100 who completed the course. I am unsure of what is expected of me now as no one knows I have completed the course and I have not been asked to mentor anyone else”

(Oral Health Educator based in Health Centre/GP practice)

5.6 Domestic staff

Thirty members of domestic staff responded to the student questionnaire (4% of all respondents). Two thirds were in managerial or supervisory roles (e.g. domestic supervisor; hotel services manager). Half worked in acute hospitals, but the remainder were based in a range of settings, with a sizeable sub-group from community hospitals.

The majority of respondents had been nominated to undertake the programme, and the preferred method for most was printed hard copy. However around a quarter used the web-based e learning format. Overall feedback was very positive for all the units of the programme. While Units 2 and 3 emerged as particularly valuable, several other units were regularly cited in this regard (e.g. Units 6 and 7). Units 5 and 10 were seen as the least useful but it was notable that domestic staff were one of the occupational groups that reported the highest positive impact of the programme on their own personal practice in terms of handling sharps. Self reported impact on decontamination practices and general HAI risk reduction were also particularly high.

Just over half the group favoured changing the Cleanliness Champion title and offering optional and core elements for the programme. Rather more (73%) favoured customisation by occupational group.

Only two respondents (7%) felt that their mentorship support was
inadequate. Most could also identify key allies in their workplace and felt there was an adequate support network for Cleanliness Champions within the organisation. Average programme completion time was five months (median).

Written comments from domestic staff tended to highlight the positive impact of the programme on personal knowledge and practice, and a related wealth of enthusiasm:

“It has given me an insight into information that I otherwise would not have seen and given me a lot of understanding on problems which I didn’t realise existed” (Domestic Assistant, Acute Hospital)

“Very explicit in the explanations and workplace activities very useful” (Senior Hotel Services Supervisor)

“I thoroughly enjoyed the course and felt it covered all the necessary points and areas. I also felt it was a good team building exercise, as sourcing information and carrying out audits. I needed the help, support and guidance from my colleagues” (Housekeeping Manager, Acute hospital, Independent Sector)

The reservations expressed often focused on perceived bias within course content:

“I think a lot of the programme is based on nurses and auxiliaries and not a lot for the domestics and other staff, but it is still useful” (Domestic/Porter; Community Hospital)

Comments on role enactment varied. The comment below typifies the dynamics involved:

“I feel much more confident in talking to staff members and the public when hygiene matters arise. I still feel awkward speaking to senior members of nursing staff and feel that doctors ignore myself because of my work status” (Domestic Supervisor, Community Hospital)

5.7 Ambulance staff
Eighteen ambulance staff responded to the student questionnaire (2% of all respondents). They comprised a mixture of Team Leaders, paramedics and ambulance care assistants. All but one had volunteered and were using the web-based e learning format.

The respondents from the ambulance service had all started the programme during 2005, and none had yet completed at the time of the survey (May-July). Consequently few had completed more than the first five units. These had been generally well received, particularly Units 2 and 3. A few comments cited difficulties with web access and the amount of print-offs required.
The majority of these ambulance staff favoured changing the Cleanliness Champion title and customisation of the programme by professional group, although only a few favoured the idea of optional and core elements. The main difficulty they had experienced so far related to support for the programme within the service. One third felt that their mentorship support was inadequate and a half lacked key allies in the workplace. Two thirds felt that there was an inadequate support network for Cleanliness Champions within the organisation:

“Not supported sufficiently anywhere in the service” (Ambulance Paramedic)

This is perhaps unsurprising given that the service had only recently started to introduce the programme. Moreover, most of the respondents remained very positive about the programme:

“A very straightforward learning programme with very good links to further enhance good working practices” (Ambulance Paramedic)

5.8 Others
Due to the diversity of staff undertaking the programme, an “other” category was offered to respondents who felt they did not fit into the main occupational groups. A total of 87 respondents (11% of total sample) placed themselves in this category. Consequently this comprised a fairly large heterogeneous sub group which included job titles like: Senior Social Care Worker; Receptionist; Head Porter.

As a group their aggregated responses differed little from the norms of the total 773 respondents. However their individual comments offer much insight into viewpoints from some of the diverse occupational groups involved in the programme. The following illustrate the range of perspectives collated on: the programme; issues around integration into practice; and issues about management of the initiative.

5.8.1 The programme
“... units easy to follow e.g. practical demonstrations in the workplace”
(Depute Manager, Adult Social Work Services)

“Certainly helped me to see need to be a cleanliness advocate. Hopefully our example will rub off and others will imitate what I have learned and try to follow. Good too that can leave it at any time, go back exactly where left off”
(Clinical Measurement Technician, Clinical Research Facility)

“A Real eye opener regarding infections, risks, safety and patient care”
(Assistant Technical Officer, Pharmacy)

“I have enjoyed the process of becoming a Cleanliness Champion and I do feel equipped with the knowledge to change/improve practice. I have used it as a tool to raise awareness to all members of staff re infection control practices. The audits were great as I could observe people for example in washing their hands,
and using the audit tool could give immediate feedback re ways to improve their practice” (D Grade Staff Nurse who started the programme when a 3rd year student nurse)

“Can we have more educational material like this? e.g. Care Assessment or Customer Care or Tissue Viability, Intro to Research in Practice, many, many more! (Nurse Manager/Professional Nurse Advisor; Community Health Partnership)

“Feel programme totally irrelevant to Health Visitors working in clients’ homes. I registered only as it is now mandatory for all G grades” (Community Health Visitor)

“Time consuming particularly when clinical area so busy. All time spent on course (other than meeting with mentor) was my own” (Midwife, Large Maternity Hospital)

5.8.2 Integration into practice/management of the initiative

“Disagree with taking on extra responsibilities (e.g. audits) and resultant unpopularity for no recompense” (Phlebotomist/Medical Laboratory Assistant; Acute Hospital)

“It has no “clout”. You can see what’s wrong but you can’t change all the bad bits. Some people – like bank nurses – just drift about so they never get the chance to do this. Infection Control Nurses should be given more authority – advice is ok, but when they don’t listen and do their own thing, that’s when things go wrong” (Sewing Room Supervisor; Mental Health/Primary Care Division)

“Does not deal with supervisory management; needs to deal with methods of guiding other staff and avoiding complaint of harassment and discrimination” (Monitoring Officer, Non Clinical Services, Acute Hospital)

“Flavour of the Month at the moment – may be put on to the back burner. Require funding to improve environment, painting, flooring, cleaning in general. Cleaning and painting are always underfunded. Not enough cleaners. My particular painting budget is chopped every year, as is cleanliness of windows and general improvement of floor coverings. Stop using carpets – use more linoleum/vinyl, easier to keep clean” (Estates Officer, Buildings, Community Hospital)

“Getting the opportunity to do the course was empowering and encouraged me to take a more active role in the H&S committee. The Cleanliness Champion initiative is useful for raising awareness of good hygiene practice. However on a practical level basic procedures such as handwashing, waste disposal, keeping a clean working environment and PPE (white coats) are made so much more difficult by the poor standards of cleaning/supply of cleaning sundries by the cleaning contractors. A meeting of CC’s with hospital management/cleaning
contractors would be useful to improve communication and improve procedures” (Biomedical Scientist, Biochemistry Laboratory, Acute Hospital)

“The Cleanliness Champion programme is an ideal method of training to enhance the basic skills of staff, NHS or contractors in infection control and hygiene issues. The NHS does not apply the same level of training to contractor staff in PFI hospital. All contractor cleaning staff here are trained to BIC standard. The Trust fail to provide induction training of contractors into clinical areas (although this was provided in past) due to lack of resources (people) to carry out the training. Although it has been highlighted the standards in CMO letters – locally the NHS managers appear to consider PFI to be different and apply other rules” (Health and Safety Manager, PFI Contractor)

“The main reason so many nurses have not completed the programme is that no resource was given to the Trusts to implement this. If we require our staff to undertake circa 11 hours of study then we should be able to release them from the day job to do this. Personally I think it is wrong for so many staff to have to do this in their own time. In my hospital we are now giving staff two half days of facilitated time to complete the programme. As usual I have no money to backfill the nurses absence from the ward or dept, or to cover the ICNs who are going to facilitate these half day sessions. The training material is excellent and we all support the aim, but without the resource to backfill staff whilst they undertake the programme we cannot make progress” (Senior Nurse)
CHAPTER 6: FINDINGS FROM THE SURVEY OF CCP MENTORS
OVERVIEW OF ALL RESPONDENTS

6.1 What were the survey response rates?
The overall response rate was 44%, as 367 questionnaires were sent out and 161 were returned. 155 responses were usable (42%). Comparison of the two different methods of questionnaire distribution showed that direct mailing to students undertaken through NES produced a 46% return, while distribution through Registering Officers in Health Boards/Divisions yielded a 41% return. Response rates from each individual Health Board/Division ranged widely from 14% up to 100%.

6.2 How representative is this sample of CCP mentors?
The denominator figure of 367 reflects the number of CCP mentors registered with NES in April 2005 prior to the start of the survey. During the survey, however, it became apparent that not all those registered as mentors had actually started functioning in that role. For example, a Registering Officer from one Division informed us that she had sent out our questionnaires to the 29 mentors officially registered, but that to date only 3 people had actually been doing the mentoring. Thus, as with the student questionnaire, the decision to conduct a census of all registered mentors set a high denominator that overestimated the number of people who would actually have engaged with students in the mentorship role. Accordingly the figure of 44% is likely to be a very conservative estimate of the survey’s representativeness.

6.3 Who were these respondents?
The general profile of the CCP mentor respondents was very similar to the profile of the CCP student respondents in terms of age, gender and time spent within the workplace setting. However the sample of mentors was even more nurse-dominated than the sample of students. The most common job title listed was Infection Control Nurse (or variants thereof) which accounted for 36% of respondents (56 ICNs). Twenty four respondents (15%) described themselves as Charge Nurse/Ward Manager/Sister, while a further 12 (8%) were Staff Nurses.

Other occupational groups were sparsely represented. A few respondents were Educational Co-ordinators or Practice Development Facilitators. Two mentors had a medical background (Consultant Microbiologist and Consultant Physician). A few also had an overt management component within their job title (e.g. Support Services Manager; Hotel Services Manager). The dominance of the acute hospital was again very pronounced, with over 70% of respondents from this workplace setting.
Unsurprisingly, 130 respondents (84%) were providing mentorship for nurses, but often they also provided mentorship to other occupational groups. For example 10 respondents provided mentorship to medical staff (predominantly medical students). These mentors were usually Infection Control Nurses or Charge Nurses. Thus individual mentors were not necessarily drawn from the same occupational group or profession as their mentees (i.e. their students).

6.4 What preparation did mentors have for the role?
Just over a third of respondents had completed the CCP (55; 36%). Mentors were asked about a number of other relevant aspects related to preparation for the role. Responses are summarised in Table 6.1.

Table 6.1: Mentors’ preparation for the role

<table>
<thead>
<tr>
<th>Other aspects relevant to preparation for mentorship</th>
<th>Number of respondents</th>
<th>% of total respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Read NES Guide for Students and Mentors and familiarised myself with programme</td>
<td>94</td>
<td>61%</td>
</tr>
<tr>
<td>Prior role in infection control nursing</td>
<td>73</td>
<td>47%</td>
</tr>
<tr>
<td>No specific preparation for this role</td>
<td>33</td>
<td>21%</td>
</tr>
<tr>
<td>Participation in NES “Roadshow” event</td>
<td>20</td>
<td>13%</td>
</tr>
</tbody>
</table>

Just under two thirds of respondents (98; 63%) had accessed the CCP through the ODL hard copy mode. Seventy-one (46%) had accessed the web-based e-learning mode, while 37 (24%) had accessed the CD Rom version. Thirty-seven (24%) had taken part in face-to-face delivery of the programme.

Two thirds of respondents (103; 67%) felt that their preparation for the mentorship role had been adequate. Half of all respondents had volunteered to be mentors, while slightly less (45%) reported that they had been nominated for the role. Volunteer mentors were significantly more likely to have completed the CCP (p = 0.021) and to report feeling adequately prepared for the role (p = 0.006) than those who had been nominated.

However, completion of the CCP was not in itself significantly associated with feeling adequately prepared for mentorship. Rather it seems that having had a prior role in infection control nursing was more influential in this regard (p = 0.001).
6.5 What did the mentorship role entail?

Mentors typically supervised around 2 mentees at any one time and they estimated that around 5% of their working week was spent on this activity. However a smaller group of mentors (usually Infection Control Nurses) supervised relatively large numbers of students (ranging from 6 to 87) and devoted a relatively large part of their time to these mentees. Two respondents were employed specifically as Cleanliness Champion Co-ordinators and reported mentoring over 100 students each at any one time.

Mentorship was usually provided via one-to-one meetings with each mentee. Ninety four percent of mentors (145) reported using this method and most saw it as the best way of providing support. This was often supplemented by telephone and e-mail contact. Around a third of mentors (51; 33%) had used group meetings with several mentees attending.

Mentors were asked to indicate how frequently they carried out certain activities during mentorship meetings. Responses are summarised in Table 6.2 in percentage terms.

Table 6.2: Activities carried out at mentorship meetings

<table>
<thead>
<tr>
<th>Activities at mentorship meetings</th>
<th>Always</th>
<th>Usually</th>
<th>Occasionally</th>
<th>Never</th>
<th>No answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discuss individual’s concerns</td>
<td>65</td>
<td>21</td>
<td>10</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Review an individual’s Folder of Learning of Evidence of Learning</td>
<td>65</td>
<td>21</td>
<td>6</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Review programme learning materials</td>
<td>43</td>
<td>34</td>
<td>18</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Advise individuals on practice issues</td>
<td>41</td>
<td>36</td>
<td>17</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Review audit results</td>
<td>39</td>
<td>36</td>
<td>14</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Test an individual’s knowledge</td>
<td>36</td>
<td>37</td>
<td>19</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Agree timescales for unit completion with individuals</td>
<td>28</td>
<td>37</td>
<td>23</td>
<td>9</td>
<td>3</td>
</tr>
</tbody>
</table>

Those mentors who had a prior role in infection control nursing were significantly more likely to review individual mentee’s audit results at these meetings (0.035).

The learning unit that required most supervisory input from mentors was Unit 3. Other units that were reported as requiring significant input were Units 2, 6, 11 and 10. Mentors often viewed the ODL hard copy version as the best mode of programme delivery (57 responses; 37%), but a further 22% felt that the web-based e-learning was the preferable mode.
6.6 What has been the overall impact for students?
Over two thirds of mentors (107; 69%) felt that they were providing adequate support for their mentees. This mirrors the perceptions of these students themselves. Mentors reported a number of factors that they felt had enabled their mentoring. The cardinal factors were felt to be: their own personal knowledge; their availability and time management skills; and their good working relations within the organisation. Inhibitory factors were less frequently cited, but the main ones mentioned were lack of time and problems with geographical distance. Only three respondents (2%) saw lack of support from mentors as the main reason for student withdrawal from the programme. Rather they felt that lack of time due to other work commitments was the major cause of student withdrawal (92 responses; 59%). Again all these findings very much mirror findings from the student questionnaires.

6.7 What has been the overall impact for mentors?
The main benefits derived by the mentors themselves related to: personal development/job satisfaction (52; 34%); increased understanding of issues at “grass roots” level (49; 32%); and improving links and networking within the organisation (15; 10%). Perceptions of the burden imposed by this mentoring activity are summarised in Table 6.3.

Table 6.3: Perceived burden of mentorship role

<table>
<thead>
<tr>
<th>Perceived burden</th>
<th>Number of respondents (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate</td>
<td>76 (49%)</td>
</tr>
<tr>
<td>No burden</td>
<td>53 (34%)</td>
</tr>
<tr>
<td>Heavy</td>
<td>20 (13%)</td>
</tr>
<tr>
<td>Excessive</td>
<td>3 (2%)</td>
</tr>
<tr>
<td>No answer</td>
<td>3 (2%)</td>
</tr>
</tbody>
</table>

Those reporting heavy or excessive burden were predominantly Infection Control Nurses.

The majority of respondents (91; 59%) felt that their organisation had an adequate support network for CCP mentors, but it is noteworthy that a sizeable minority disagreed (60; 39%). Thus there seemed scope to improve this aspect, and it was also striking that only 49 respondents (32%) reported that their mentoring role was built into their annual performance appraisal processes.
6.8 What were mentors’ views of the integration of the CC role into practice so far?

Mentors were asked to identify which aspects of the CCP were having most influence in practice so far. The top three aspects cited by respondents were:

1. Units 3, 4 and 6 in combination (i.e. improved hand hygiene, use of personal protective equipment, and maintenance of a clean healthcare environment)
2. General increase in awareness of cleanliness and HAI
3. Audit and practice change

Mentors were also asked to think about their organisation’s overall approach to implementing the CCP to date and to rate the degree of importance that had been given to ten different factors. The four factors that emerged as most important in terms of organisational priority were:

1. Using existing infection control expertise for mentoring
2. Prioritising known HAI problem areas
3. Involving as many areas within the organisation as possible
4. Supporting any staff who were keen to be students or mentors

The four factors that emerged as having been least important in terms of organisational priority to date were:

1. Involving AHPs
2. Controlling speed of implementation to ensure quality of student/mentor experience
3. Involving medical staff
4. Involving patients and carers

6.9 Written comments from mentors

6.9.1 The programme

As with feedback from CCP students, the mentors were typically very positive about the content of the programme.

“Good pack. Well presented. Positive feedback from staff” (Infection Control Nurse Specialist Advisor, Acute Hospital)

“Good basic info, well presented. Stresses importance of all staff in avoiding infection” (Consultant Physician, Acute Hospital)
“Although the programme provided a lot of information and provided learning opportunities, it could be a bit “long winded” and a more concise programme would be of benefit” (Staff Nurse, Acute Hospital)

“This programme is fairly nursing orientated – however it allows domestic staff to appreciate how to control HAI from patients/staff. We have been able to improvise this programme to fit into the role of domestic” (Domestic Manager, Acute Hospital)

6.9.2 Time

Mentors’ saw lack of protected time at work as the main difficulty for students in regard to completion of the programme. Many also pointed out that they themselves lacked time to devote to supporting mentees.

“Not enough mentors for staff. It would be nice for some recognition for staff apart from a certificate at the end. We have to acknowledge that people are participating outwith their working hours” (Infection Control Nurse, Acute Hospital)

“Lack of time. Lack of mentors” (Discharge Coordinator, Acute Hospital)

“(Weakness is) staff finding time to do it. “Protected” time on ward cannot be guaranteed. Staff prefer hard copy they can do at home” (Senior Nurse Specialist Infection Control, Health Board/Division Level)

“People need to be given time to do it. Even the most keen can struggle at times. Many do the work at home because there is no “slack” time. Need much more commitment from all levels of management” (Infection Control Nurse, Acute Hospital)

6.9.3 General and specific influence of programme in practice so far

The programme was seen as impacting significantly in terms of raising general awareness. A number of more specific benefits were also identified in comments.

“Great to have someone other than a nurse as our Cleanliness Champion – Cleaner now has a mission in life!! Her pass was acknowledged by employer by pay rise!! Heightened awareness for all staff and upped standards” (Community Nurse, Remote and Rural Setting)

“Raising awareness of the need to control infection. Handwashing practices. Staff hygiene and dress. Our Trust still has problems with staff travelling in uniforms” (Staff Nurse, Acute Hospital)

“Not afraid to ask doctors to wash their hands” (Staff Midwife, Maternity Hospital)

“Principles of audit seem to be understood and actually practised” (Infection Control Nurse, Health Board Level)
“Appropriate use and changing of aprons and gloves”
(Staff Nurse, Acute Hospital)

“Others seeking Champions for assistance i.e. Infection Control Team use Champions for awareness sessions for staff and public and to help when carrying out local audits” (Practice Development Facilitator, Acute Hospital)

“Setting an example and discussing issues relevant within own specific area. Being a catalyst for changing and improving standards of cleanliness as a whole” (Midwife, Acute Hospital)

“Physio participant has really been excellent in the changes she has taken forward in her own department and likewise the auxiliary in outpatients now has the confidence to “remind” consultants about washing their hands because she has the knowledge to back it up if there is “discussion” (Infection Control Nurse, Acute and Community remit)

“Medical students completing before qualifying”
(Senior Charge Nurse, Acute Hospital; Mentor to Medical students)

**But**

“A little knowledge is dangerous. Concern that there may be fragmentation of the Infection Control Programme as people may start to “do their own thing” locally outwith the ICT programme” (Infection Control Manager, Primary Care)

“Some “Champions” attempt to change practice – then we have to sort out ensuing problems” (Senior Nurse Infection Control, Acute Hospital)

6.9.4 Getting staff on to the programme and through it

This was seen as one of the major organisational challenges, and mentors had a number of suggestions in this regard.

“Mentorship was replaced by action learning sets – decision was taken not to provide individual mentorship programme due to lack of availability of mentors” (Infection Control Manager, Primary Care)

“Need to deal with attitudes of staff, particularly G grades who feel this is “beneath them”. Some do struggle however with reflection”
(Senior Nurse, Health Board Level)

“Face to face delivery has just commenced. However this has provided a real network for G grades to come together and learn from their colleagues”
(Infection Control Nurse, Primary Care)

“Clarify to Cleanliness Champions and I/C Link Nurses the differing expectations. All link nurses who haven’t had any kind of I/C study should be a priority group for completing Cleanliness Champion programme”
(Infection Control Nurse, Community based)
“Mentees and mentors should meet in a group maybe each month or alternate months so that there is a need for the mentee to have progressed through the programme by the next meeting and there should be a time limit on how long they take to complete it” (Charge Nurse, Acute Hospital)

6.9.5 Mentorship quality issues
A few mentors raised issues about the quality of mentorship.

“As the CCP develops mentorship needs to be reviewed to ensure a good quality of support. Infection Control Nurses cannot mentor all those taking part. Medical staff, especially junior doctors, need to complete CCP. However the units need to reflect their practices/daily work” (Infection Control Nurse, Acute Hospital)

“There is a weakness surrounding verification of mentors’ work. At present no one checks that the mentor is applying the same standards to all students or the same as other mentors” (Community Infection Control Nurse, Public Health Department)

6.9.6 Motivation, momentum, management
Maintaining motivation, momentum and offering further development were major themes in mentors’ comments in regard to the future of the CCP. In this regard the active support of managers was seen as of cardinal importance.

“Separate programmes could be developed for different disciplines e.g. midwifery; medical; domestic etc. etc.” (Infection Control Nurse Specialist Advisor, Acute Hospital)

“Keeping it from becoming nurse dominated” (Consultant Physician, Acute Hospital)

“Keeping the CC’s motivated and updated. I am planning regular meetings with those who have completed the course. Also organising visits to places such as TSSU and laboratories to augment their learning” (Infection Control Nurse Specialist, Acute Hospital)

“I think this is a necessary and extremely interesting programme that will need continuous funding to ensure that the momentum is kept up” (Clinical Nurse Manager, Acute Hospital)

“We (locally) have update sessions for CC and this is essential to keep them up to date and ensure they are acknowledged for the role they play in this important area of prevention and control. They are a support for the IC Team.” (Lead Infection Control Nurse, Dental Hospital)

“Management should be involved in supporting this by registering risks within the clinical environment that are identified as a result of working through this course. A formal input to risk management registers should be a key responsibility of Champions. Also it should be a rolling programme of mentoring. If course completed satisfactorily the Champion mentors next staff member” (Enrolled Nurse, Acute Hospital)
“Its a great idea but I feel that it has lost impetus through not being followed up – someone, somewhere should have made sure that packs were completed and that practice was actually improved by the knowledge gained”
(Infection Control Nurse, Health Board Level)

6.9.7 Patients and visitors

Finally, a few mentors pointed out that cleanliness is not the sole preserve of clinical staff.

“The general public have a responsibility also, and patients’ handwashing. Correct disposal of litter. Reduced volume of visitors”
(Staff midwife, Maternity Hospital)

“Unless management is prepared to put actions into words – i.e. to tackle visitors on hygiene/barrier nursing – taking a proactive stand – closed visiting – then nothing will change” (Stroke Liaison Nurse, Community Hospital)

6.10 A distillation

The views of one 35 year old Staff Nurse (Acute Hospital) who has been a CC and a mentor

(i) Strengths of the programme

“The programme generated much discussion within my practice area. I was mindful of issues and have remained mindful of them. I have gained confidence in my practices and the care I provide”

(ii) Weaknesses of the programme

“Too few people have been reached. I feel completion/submission dates are needed to maintain focus. The majority of candidates are nurses – I know of no medics who have undertaken the course”

(iii) Main issues for the programme’s future

“Maintaining a rolling programme. Candidate groups i.e. involving staff other than nursing staff. Ensuring completed Champions review their Action Plans and continue their work”

(iv) Any other comments

“I would hope that senior management get more involved and give their support for this extremely worthwhile programme”
6.11 Mentorship of medical students

Medical students were a distinctive sub-group requiring mentorship. As mentioned previously, their mentors were usually Infection Control Nurses or Charge Nurses. Some insights into the particular challenges involved in mentoring this group were afforded in mentors’ written comments:

“Medical student not often in hospital – placements all over the country – difficult to get any continuity”

“When mentoring the medical students there was a heavy burden at the end as all 5 students handed in their folders at the same time (a few weeks before it was due to be handed in for the completion date)”

However the mentors who responded were all very positive about the experience and committed to the idea of multidisciplinary involvement:

“The Cleanliness Champion is an excellent way forward to increase awareness in a wide multidisciplinary group. It has allowed me access to staff who have daily challenges that can be burdensome yet they have happily taken on this programme”

“Medical staff have specific knowledge now about all aspects concerning IC. Before they demonstrated little awareness, like it was always someone else’s problem”

One mentor stated that medical students’ completion of the CCP before qualifying was the most important influence on practice to accrue from the programme so far.
SECTION 7: FINDINGS FROM INTERVIEWS WITH KEY INFORMANTS

Twenty key informants participated and the information elicited from these interviews has been organised and grouped to provide three distinctive perspectives on the development implementation and management of the Cleanliness Champions Programme within Scotland

1. Perspectives from those in Higher Education
2. Perspectives from those within the NHS in Scotland
3. Perspectives from those with a National pan Scottish remit

7.1 The Higher Education perspective

The following Table 7.1 presents an overview of the information gained from three interviewees who had each used the Cleanliness Champions Programme in the formal education of health professionals and were involved in the customisation of the programme.

Table 7.1: Perspectives from those in Higher Education

<table>
<thead>
<tr>
<th>Informant’s Involvement with CCP</th>
<th>Perceived strengths of programme</th>
<th>Perceptions of working with NES</th>
<th>Areas of concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isabel Implementation of the CCP within primary care sector and higher education. Member of NES updating group. Mentor of students. Involved in development of learning management systems.</td>
<td>Unit content: applicability to nursing and medical students.</td>
<td>Very good support from NES at all levels: Dissemination of information prior to course launch. Accessibility of key staff.</td>
<td>Time management to complete the programme. Sustaining motivation of students. Burden of mentorship. Development of pedagogy.</td>
</tr>
<tr>
<td>Callum Implementation of CCP into higher education. Member of NES updating group. Involved in development of learning management systems.</td>
<td>Unit content: applicability to specialist workers in health service.</td>
<td>Very good support from NES. Accessibility of key staff.</td>
<td>Development of the pedagogy.</td>
</tr>
<tr>
<td>Dee Involved in initial development of programme. Implementation of CCP into higher education and acute hospital contexts. Mentor of students and member of NES updating group. Involved in development of learning management systems.</td>
<td>Unit content: applicability to nursing and medical students. Audit activities. Effecting change in practice.</td>
<td>Good support from NES. Accessibility of key staff.</td>
<td>Development of the pedagogy. Mentorship burden. Student support for workbased activities.</td>
</tr>
</tbody>
</table>

When incorporating the Cleanliness Champions Programme into University courses various mapping exercises were carried to determine if the content of the CCP was already covered in the content of existing modules or if the CCP could be used as designed and incorporated into the existing programmes of education (either by substituting an existing module; or incorporating the CCP into the final year of a programme or incorporating it into the beginning of a specialist programme). Reported feedback from students who had completed the programme ranged from:
Programme is a success, students in semesters 4, 5 and 6 are now saying how valuable it is having completed it in semester 2. **Isabel**

We had one run of the CCP module with 6 students- they loved it. They liked the fact that it was basic **Callum**

68% of the students who completed our evaluation felt the CCP was good it refreshed their practice. 25% wanted it earlier in their course. Some found it simplistic and that some parts were not relevant but I feel it is important that they know what others would do **Dee**

Of the programme itself:

*This programme covers all the students needed. It is not a glamorous subject [infection control] but it [the CCP] is an attractive package and the students did it at their own pace. It didn’t require classroom time............... It’s important not to pull out bits............... gauging the pitch very important. It is important that standard infection control precautions are understood by all......... You could cut the CCP down keeping the same package............... it would be possible to give options on the web. It is important to learn what is necessary.** **Dee**

The CCP can be used at different levels. With my group the work-based activities were managed by discussion forum then PBL [Problem Based Learning] and scenarios. **Callum**

The CCP encourages self-directed study and adult learning. It gives them the basic knowledge of infection control. The programme is hospital oriented but they see it as important when they have more experience in hospital based care **Isabel**

*There is limited pedagogy. No requirement for online communication. The students can access high quality learning resources but need online discussion. Setting up small communities of practice would help.** **Callum**

With regard to mentorship and student support:

Mentors were largely infection control nurses, microbiologists, the odd doctor. Up to 10 students per mentor. The problem was that students all completed at the same time. Students were very good. Some excellent. On the wards most nurses were familiar with the CCP and not threatened. Those students who [had their placements in other parts of the UK] had problems - some nurses opposed the audits – some medics felt it was a waste of time – some managers warned that students would be auditing. **Dee**
Mentorship can be very heavy 3 or 4 mentor session with students and they bring their folders. We gave them a time log to complete and found it was around 34-35 hours to complete the CCP. Isabel

When asked how they found working with NES the following comments were made:

The NES roadshows helped us look at how the programme would be delivered. They gave a great deal of support to the Trusts. The transition of the programme into undergraduate education meant we had to map our own curriculum and NES were supportive. NES were less involved with the e-learning side initially. We’ve maintained our involvement with NES. The NES team worked well with us. Isabel

I met with the NES reps and looked at the module content syllabus. Very helpful, supportive and could see how we planned to use the CCP at the beginning of the module. Callum

Good support on implementation of the CCP both in the hospital and in the University. Dee

Communication with the NES group is good. We work efficiently occasional meetings – it is well managed and supportive. Callum

Finally when asked about any evidence regarding the impact of the CCP on practice one person commented:

No indicators demonstrating the impact of the programme. Need a critical mass of champions in the clinical environment where they can make a difference. Dee

To conclude this section it is worth summarising the range of concurrent educational developments that were introduced in the three HEIs in order to facilitate the deployment of the CCP into their programmes. These included:

- Establishing a web-based discussion forum.
- Problem-based learning scenarios to meet the needs of students unable to undertake the work-based audits identified in the programme.
- Guide to maintaining a succinct folder of evidence.
- Mentor guide to the programme.
- Time log.
- The integration of completion of CCP as a mandatory component of final assessment.
7.2 Perspectives from the NHS in Scotland

The following Tables 7.2, 7.3 and 7.4 present an overview of the information gained from nine interviewees who have a key role with regard to registration of students and who have each been involved with the CCP in a variety of other ways. Each informant works in a different Scottish Health Board, some have nursing backgrounds and others are administrators within infection control teams.

Table 7.2: Perspectives from those in the NHS in Scotland (Urban & Rural Health Boards)

<table>
<thead>
<tr>
<th>Informants involvement with CCP</th>
<th>Perceived strengths of programme</th>
<th>Perceptions of working with NES</th>
<th>Areas of concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don</td>
<td>Unit content: applicability to nurses AHPS and domestic staff. Audit activities. Effecting change in practice. Multiple modes of delivery.</td>
<td>Good support from NES at all levels: dissemination of information prior to course launch, registration of students and records update. Accessibility of key staff.</td>
<td>Adequate mentorship provision. Lack of target times to complete the programme. Bringing doctors on board. Surviving motivation of students.</td>
</tr>
<tr>
<td>Seonaid</td>
<td>Multiple modes of delivery.</td>
<td>Good support from NES: registration of students and records update.</td>
<td>Lack of target times to complete the programme. Lack of incentives.</td>
</tr>
<tr>
<td>Gail</td>
<td>Multiple modes of delivery.</td>
<td>Good support. Registration of students and records update.</td>
<td>Time management to complete the programme. Bringing doctors on board.</td>
</tr>
</tbody>
</table>

52
<table>
<thead>
<tr>
<th>Involvement with CCP</th>
<th>Perceived strengths of programme</th>
<th>Perceptions of working with NES</th>
<th>Areas of Concern</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pat</strong> Urban NHS Board. Registration of students, from acute care sector, with NES. Monitoring progression and liaison with infection control team. Facilitation of CCP study days.</td>
<td>Multiple modes of delivery. Audit activities. Effecting change in practice.</td>
<td>Very good support. Registration of students and records update.</td>
<td>Time management to complete the programme. Bringing doctors on board. Sustaining motivation of students.</td>
</tr>
<tr>
<td><strong>Nina</strong> Urban NHS Board Registration of students, from acute care sector, with NES. Monitoring progression, and liaison with infection control team. Convenor of regional multidisciplinary steering group pertaining to HAI.</td>
<td>Unit content: applicability to nurses AHPS doctors and domestic staff. Audit activities. Effecting change in practice.</td>
<td>Support from NES at all levels: Dissemination of information prior to course launch. Registration of students and records update. Accessibility of key staff.</td>
<td>Sustaining motivation of students.</td>
</tr>
<tr>
<td><strong>Larry</strong> Urban Primary Care NHS Board. Registration of students, from primary care sector, with NES. Monitoring progression, and liaison with infection control team. Mentorship of students. Co-ordination of study days.</td>
<td>Unit content: applicability to nurses. Audit activities. Effecting change in practice. Multiple modes of delivery.</td>
<td>Support from NES at all levels: Dissemination of information prior to course launch. Registration of students and records update. Accessibility of key staff.</td>
<td>Time to complete the programme. Hospital focus of programme. Lack of pre-hospital care content. Bringing doctors on board. Effect of CCP registrations as Performance Indicator. Effect on others of targeting of F and G Grade Nurses.</td>
</tr>
</tbody>
</table>
### Table 7.4 Perspectives from those in the NHS in Scotland (Remote Health Boards)

<table>
<thead>
<tr>
<th>Informants involvement with CCP</th>
<th>Perceived strengths of</th>
<th>Perceptions of working with NES</th>
<th>Areas of Concern</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ailsa Remote NHS Board</strong></td>
<td>Unit content: applicability to various groups. Audit activities. Effecting change in practice. Multiple modes of delivery.</td>
<td>Very good support from NES at all levels: Dissemination of information prior to course launch. Registration of students and records update. Accessibility of key staff.</td>
<td>Time management to complete the programme. Bringing doctors on board. Sustaining motivation of students.</td>
</tr>
<tr>
<td>Registration of students, from acute and primary care, with NES. Monitoring progression, and liaison with infection control team.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Donna Remote NHS Board</strong></td>
<td>Unit content: applicability to nurses, AHPS and domestic staff. Multiple modes of delivery. Effecting change in practice.</td>
<td>Good support: dissemination of information prior to course launch. Registration of students and records update.</td>
<td>Time to complete the programme. Bringing doctors on board.</td>
</tr>
<tr>
<td>Registration of students, from acute and primary care, with NES. Monitoring progression, liaison with infection control team. Mentorship of students.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
When introducing the CCP into the NHS in Scotland all key informants commented on the NES Roadshows and the value of these in providing information. The administration of student registrations with NES works extremely well and generally all know who to contact and how to do this. Additional support given by key personnel within NES has been highly valuable and very much appreciated by all.

Informants mentioned the importance of co-ordinating the roll out of the Cleanliness Champions Programme and across the sector there was considerable variation in how this has been managed. The majority initially adopted a laissez-faire approach to the management of the programme but increasingly as the significance of the programme has been realised at various levels within the organisation so there has been a need to formalise management processes. The number and rate of completions were issues of concern to the majority of key informants. All key informants commented on the timescales needed to complete the programme and the need for deadlines to be set and managed at a local level. Three mentioned that incentives were needed to motivate people to complete.

Finally there was a general consensus on the inherent value and relevance of the programme; a full appreciation of the flexibility it offered to accommodate different learning styles and the general relevance of the content to suit different occupational groups.

As yet there was limited evidence of the impact of the programme on clinical practice. Some informants mentioned the need for a critical mass of champions in clinical environments, others that there were the first signs of changes in budgets with regard to cleaning agents and decontamination of equipment. Evaluation of impact was an area that required to be developed further. With regard to sustaining levels of awareness and good practice instigated by the CCP there were limited plans for refresher sessions or clinical updates or for enabling key champions to move on to other programmes of learning associated with infection control.

The following interview extracts give insight into the various operational approaches used within the NHS; ideas about the programme and informants’ reflections on working with NES.
7.2.1 Pat Urban Acute Care
To begin with we piloted the programme in areas of high risk. We had a number of meetings and set up a pilot with around 40 people. We agreed a date to look at what was happening and evaluate it. Integral to this was the setting up of our own data-base. The biggest thing we discovered was the timescales………15-20 hour programme but we needed 30 or more hours……..The volume of reading material was high. In the early days there was a high proportion of those who got the thing and didn’t start it……..despite the calls we now have our own registration form on the intranet. People email it back to us. Within a week of receipt of this we send out a read me first slip and ask people to return it to us. I chase up people who don’t return this slip.

NES are highly efficient in sending out CD ROM or e-learning or hard copy pack. In the early days someone from NES helped co-facilitate study days.

We use the intranet to advertise and have devised flyers. We have tried to target domestics and porters. Medics – not really targeted – big brick wall there.

Most of the mentors come from the infection control team and some who have gone through the programme themselves. I try to encourage them to get modules signed off and crack on. Recently we’ve introduced a generic mentor and offered group study days so that folks can finish. These comprise of short presentations on why champions, e-learning and IT skills and then the rest of the day is a focused block of time with help on hand - myself and a member of the infection control team.

Everyone who has completed has enjoyed it. There are one or two people in conflict because things are bad in their areas. We’ve seen some changes in practice. Budgets gone through the roof on hand washing gels etc and special machines having to be specially cleaned

7.2.2 Nina Urban Acute Care
We have a multi-disciplinary steering group to make sure that this programme was not just about nursing. We rolled it our to AHPS as well. Our medical director is very pro-active. Initially we did not target specific areas. Just anyone who wanted to do it. The programme is a good refresher and reminder of what you should be doing. Initially we did not target specific areas. Just anyone who wanted to do it. The programme is a good refresher and reminder of what you should be doing. Our initial cohort found the web-based e-learning slow. Now we download the materials for people and copy. We need to work on ways of assessing the impact on practice. If you have a critical mass of people then you will have an impact on practice.

7.2.3 Seonaid Combined Urban and Rural Acute and Primary Care
It was a bit ramshackle at first. There wasn’t a lot of thought gone into the roll out of it. We need to identify ways of motivating people to complete. The CCP has been made one of our objectives we should have done this at the start. Time is a problem for some people. They won’t do it at home. We now organise drop in sessions on a monthly basis with support to get through the programme and we have two new facilitators.
7.2.4 Gail Combined Urban and Rural Acute and Primary Care
We keep a data-base and monitor timescales. I use a Gant chart for monitoring the numbers on the course and send out reminder letters after 4 months. NES gave us good guidance on implementation and copyright for materials. What we’ve done is we meet with mentors and have a newsletter for Cleanliness Champions. We have targeted specific groups nurses, domestics, and admin staff so that they get insight into the working environment. Tried pushing info to the docs but no takers. We need to capture them as they come into the organisation in their induction. For the G grades we want them to complete in 4 months we have set up a full study day and a half day follow up. Seems to be going OK..

7.2.5 Larry Urban Primary Care
The first cohort started 18-24 months ago. A group of 20 invited to an initiation day and used e-learning. On a monthly basis we sent out reminders of the 20 one fell away and 14 completed. Rest still in process. Since the focus on G grades we have reduced our numbers. This has restricted access. Seems a retrograde step. E grades are a better nursing target group. We’ve no initiative to target medical staff. The course content is excellent and I would promote it. We need some kind of question sheet to keep in PDP to reflect the individual’s contribution to minimising HAI..

7.2.6 Ailsa Remote and Rural Care
The hard copy of the materials is popular. You are able to work as you go. NES were very helpful initially with the launch. Contact since then has been excellent. The aim of the CCP is to focus on practice and audit. I feel it challenges practice well. The small units are good and broad and at an appropriate level. It is clearly fit for purpose. It seems to be easy to understand. Cleanliness champions have a high profile within our organisation. Domestic cleanliness champions in health centres have raised the cleanliness levels and challenged the medics. For example they have commented on insufficient hand towels in the bin therefore there has not been enough hand-washing going on. They are seen as a key person. In a medical ward there was issues about uniforms and wearing of jewellery. Staff were challenged by the cleanliness champion and things have improved and some of our policies have been reviewed as a result of the programme.

We have set up a cleanliness champions support group to update one another, deal with any issues and some areas of practice have been enhanced by sharing ideas. It has been important to us to be innovative about mentors and how to identify them. Students have mentored one another as well as other key people being involved.

7.2.7 Will Remote and Rural Care
We are now supporting all F and G Grades and AHPs to do it. Deadline has been set for registrations but they are struggling to do it because of the lack of dedicated time and often competing influences. The CCP seems to be brilliant best I’ve ever seen in terms of mode of delivery – its flexibility means its open to widening the scope of study – if the student is enthusiastic. The generic nature of the programme is its strength.
To conclude this section it is worth noting some of the necessary developments that have been introduced by NHS providers to support students and mentors and to generally manage the programme:

• Support groups for students and mentors
• Drop in sessions with access to expertise
• Customised guidance on how to complete the programme
• Triggered reminder systems and mail shots to those registered on the programme.
• Involvement of key personnel as champions from across the professions and occupations.

7.3 The national Scottish perspective
The following Table 7.5 provides an overview of the information gained from six key informants who have national pan-Scottish perspectives on the value, relevance, administration and management of the Cleanliness Champions Programme. Each has worked very closely with NES to develop different and various aspects of the programme (across the NHS in Scotland, into specialist care contexts such as the prison service, the ambulance service, the dental service or the independent care sector) construct the educational modes of delivery and establish and maintain informative data-bases.
Table 7.5: Perspectives from those with a national Scottish remit

<table>
<thead>
<tr>
<th>Key informants involvement with CCP</th>
<th>Perceived strengths of programme</th>
<th>Perceived support from NES</th>
<th>Areas of Concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frank</td>
<td>Implementation of CCP within specialist service, mentor, registering of students with NES and member of NES group. Involved in development of learning management systems.</td>
<td>Unit content: applicability to specialist workers in health service. Audit activities.</td>
<td>Support from NES at all levels: Dissemination of information prior to course launch. Registration of students and records update.</td>
</tr>
<tr>
<td>Steph</td>
<td>Initiator of CCP, liaison with NHS in Scotland re HAI and CCP, member of various NES and other national groups pertaining to HAI and infection control.</td>
<td>Unit content, applicability to short and long term objectives with regard to prevention of HAI.</td>
<td>Excellent support from key people in NES to ensure quality of product.</td>
</tr>
<tr>
<td>Diana</td>
<td>Initiator of CCP, liaison with NHS in Scotland, member of various NES and national groups. Development of learning management systems. Involved in wide-scale information dissemination and collation of reports.</td>
<td>Unit content: Audit activities. Multiple modes of delivery.</td>
<td>Excellent support from development of idea to registration process to facilitation at NHS level.</td>
</tr>
<tr>
<td>Grace</td>
<td>Liaison with NHS in Scotland and other agencies using CCP. Support given for implementation strategy. Member of various NES groups. Development of learning management systems. Involved in wide-scale information dissemination and collation of reports.</td>
<td>Unit content. Audit activities. Multiple modes of delivery.</td>
<td>Excellent support from key people at strategic and operational levels.</td>
</tr>
<tr>
<td>Carole</td>
<td>Member of NES group; involved in database design and liaison with all agencies using the CCP in Scotland. Involved in wide-scale information dissemination and collation of reports.</td>
<td>Multiple modes of delivery. Good liaison with key people.</td>
<td>Excellent support from key people.</td>
</tr>
<tr>
<td>Peter</td>
<td>Development of learning management system. Liaison with NES and various groups.</td>
<td>Unit content: adaptability to various learning formats. Multiple modes of delivery.</td>
<td>Very good support from NES at all levels: registration of students; update materials.</td>
</tr>
<tr>
<td>Jack</td>
<td>Development of learning management system. Liaison with NES and various groups.</td>
<td>Unit content: adaptability and modes of delivery.</td>
<td>Good support from NES at all levels: registration of students; update materials; business opportunities.</td>
</tr>
</tbody>
</table>
Generally speaking these informants have found their involvement with the Cleanliness Champions Programme both enlightening and challenging at the same time. Each has invested considerable personal and professional effort to enable the whole initiative to move forward in a planned way. On the whole their efforts and commitments have been recognised and appreciated by those in the NHS in Scotland, those in Higher Education, those in NES and those in specialist services such as ambulance service, prison service, independent care sector and dental services.

From their own perspectives all recognise the relevance, value and generic nature of the content of the programme, its flexibility in terms of modes of delivery and its adaptability to various health care contexts. They all also recognise that leadership of the initiative at national and local levels was essential for the Cleanliness Champions Programme to be accepted across Scotland.

When remembering the early days of the initiative and speaking of their own involvement and concerns our informants stated:

Starting at the beginning we were expected (from the highest authority) to come up with something. So we broke it down into what we could do in the short and long term. We formed a group and started to develop the curriculum. The main strength of the programme is the way it is written so that you understand the underpinnings of infection control precautions. We wanted to maintain depth but make it accessible across the workforce. This was quite a struggle. We could only do this again by cloning our key champions. An initiative like this needs a major champion who knew who had what skills and abilities from across Scotland. Steph

Finding a home for the Cleanliness Champions Programme was a problem to begin with. The NHS organisation had to do it. There is no real structural support for multi disciplinary education. So the team developed the programme then NES provided some practice development support in the NHS. NES need an exit strategy but maybe not yet. It is getting bigger all the time. Where do we go from here? Grace.

In the early days there were difficulties with the Champions initiative: initial resistance from infection control nurses; challenges from medics; conflict within the original steering group; NES not contracting the delivery out to HEIs; the problem of developing the educational materials at the right level to suit the diversity of potential students. We’ve come a long way. The enthusiasm is out there. Maybe we are beginning to see what we had hoped for. Diana
Working with NES I had a free hand. I could make suggestions and change minor things. For an initiative like this which goes across Scotland and across agencies you need an organisation like NES who through their own and other means have power. If this initiative is not fully supported by our organisations then I am saddened. The lights will go out. What we do (hand hygiene, decontamination disposal of waste) leads back to the patient. NES has enabled me to take this initiative into my organisation. **Frank**

With regard to the development of the educational materials, the registration and monitoring processes our informants stated that:

> It has been good working with NES although we would like to see the learning materials develop a bit further. ……… The learning management system allows for interrogation and we did offer super administration rights to registering officers so that they can track an individual's progress. **Jack**

> Managing changes to content was a headache to begin with but we did it with very tight deadlines. The learning management system is dynamic and can accommodate changes relatively easily. **Peter**

> The learning management system for e learning is professional and good. It has been quite a trial in places managing the changes to documents tracking these and monitoring them............... In the early days it was very time consuming. **Grace**

> There is no cost for the product – one of the benefits of it belonging to service providers................. There are some concerns about maintaining the integrity of the programme and avoiding institutions picking bits out and using the materials indiscriminately. **Diana**.

NES developed the registration data-base and send out reports to the registering officers on a monthly basis.......... We also send out the educational packs and provide information for the Executive....... Seems to work alright. We have seen some changes recently many more people registering but still not completing at the same rate. **Carole**.

Finally with regard to their own personal critical reflections on the overall initiative and working processes:

> We could have done things a bit better on the way along. We may have missed a valuable opportunity to start some people on an academic route..........

> Conscious that we are asking people to do all of this and maybe we should have some accreditation or reward. For a lot of people it's the first thing that they've done. It is so motivating........ We could have two routes through those who opt for completion and those who complete and are also formally assessed. **Steph**

61
As an organisation [providing health care] we need to attach ourselves to the Universities and develop ourselves……………. We could use the Cleanliness Champions approach in other areas of CPD……. ………. We need leadership champions, management champions, research champions, patient safety champions. Frank

Some places were slow to come on stream others started with great gusto and have not been sustained. ………Reminders to update their information and let us know about completions and withdrawals might help to keep the momentum Carole

In the health care contexts you need someone to take the lead and a clear point of contact in each organisation. If you have a key person in a key place then you can communicate changes. The whole process is to do with lines of accountability generally. We know how things are moving forward. We try to keep contact going in different ways. It has worked and still does. Grace

We worked hard at breaking down barriers. As we developed the programme we were invited to visit the Health Boards. We emphasised the point that the CCP is not about challenging your intellect but rather about challenging your practice. Diana.

To conclude this section it is worth summarising some of the key observations made by our informants. For the Cleanliness Champions Programme to have reached its current position across the health care sectors of Scotland the initiative has required:

- Clear leadership at national and local levels.
- Educational co-ordination to ensure the integrity quality and adaptability of the product.
- Dynamic learning management systems and information data-bases to be designed, established maintained and adapted as necessary.
SECTION 8: INTEGRATIVE SUMMARY OF FINDINGS

Having presented details of findings resulting from the main methods used, it is now useful to provide an integrative summary. The following table presents a review of the original evaluation remit along with a summary of evidence and the evaluators’ judgements.

Table 8.1: Summary of evidence and judgements in relation to evaluation remit

<table>
<thead>
<tr>
<th>Components of evaluation</th>
<th>Evidence</th>
<th>Evaluation judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Curriculum development and implementation model in the context of the Ministerial Action Plan.</td>
<td>Highly affirmative findings with regard to the way the curriculum was developed and rolled out across the health care sector in Scotland. Critical commentary and concern about: the way it is managed in the local context; the demands put upon staff and the lack of resources to facilitate completion of the programme and support mentors.</td>
<td>The Cleanliness Champions initiative has made considerable progress across the health care sector in Scotland. Due to its widespread influence and uptake it has the potential to be one of the most important elements in the range of activities being taken forward under the auspices of the Ministerial Task Force in Scotland to combat HAIs and optimise infection control precautions amongst those working in the health care sector.</td>
</tr>
<tr>
<td>Implementation support provided by NES to NHS organisations for a strategic approach to implementation of the programme.</td>
<td>Universally perceived as helpful, supportive and most beneficial to the organisation. Evidence of clear national leadership consultation and negotiation.</td>
<td>Good dissemination of information and support mechanisms to those in the NHS in Scotland in Higher Education and to those in specialist agencies. The motivation and commitment and credibility of key persons in the early stages were enabling.</td>
</tr>
<tr>
<td>Support materials supplied by NES, including the information resource pack circulated before the launch of the actual programme.</td>
<td>Perceived as helpful and informative.</td>
<td>Reliable and informative resources which have high utility. Information resource pack does not appear to have been used to optimum effect when planning the implementation strategy at the local level. The Pack could be developed by including a section on motivational issues and techniques.</td>
</tr>
<tr>
<td>Support provided by NES following the launch.</td>
<td>Universally perceived as very good and has contributed to the quality of the: product, registration and monitoring processes and local developments.</td>
<td>Leadership given by NES generally and in particular on practice development, customisation and data management. A small dedicated team has achieved a great deal by their commitment and the use of the Diamond Model to facilitate involvement at multiple levels.</td>
</tr>
<tr>
<td>Management of the relationship with the IT specialist company who were commissioned to build and maintain the e-learning delivery method of the programme.</td>
<td>Good evidence of professional working on the part of NES and the IT company.</td>
<td>Good practical management which was able to deal with the demands of multiple modes of delivery, reviewing and updating materials and launching an e-learning platform.</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>---------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td>Uptake of the programme and interest from other organisations for adaptation/customisation.</td>
<td>Strong evidence of the uptake of the programme across the NHS in Scotland and from other agencies. Evidence of the need to target specific groups within health care settings in order to ensure cleanliness is everybody’s business. Evidence of an open approach to customisation. Evidence of concern about numbers registered and numbers completed.</td>
<td>The uptake of the programme is still predominately by nurses. There is a need to involve other occupations within the health care sector in order to build a meaningful critical mass of champions. The initiative has been incorporated into organisational objectives and is seen as a performance indicator and as such many more registrations have taken place. There is a gap between the registration point and the actual starting point which produces spurious central statistics. The emphasis would be better placed on completions.</td>
</tr>
<tr>
<td>Elements of the delivery methods that worked well/not so well.</td>
<td>Evidence that all 4 modes of delivery generally worked well. Some concerns about web links, ability to download information and the quality of photographs in hard copy versions.</td>
<td>All four modes of delivery work well and should be retained. The curriculum could be enhanced as suggested in Table 3.1 and restructured to emphasise core and optional elements.</td>
</tr>
<tr>
<td>Feelings of the students, mentors and managers who have been involved in the programme.</td>
<td>Evidence that this has generally been a very positive experience. However, concerns about: time management and resource allocation to facilitate completion of the programme; how to involve the medical staff, patients and families and the applicability of content to all groups</td>
<td>The Cleanliness Champions Programme is flexible adaptable and transferable to many health care contexts. It is a generic programme which enables infection control precautions to be widely understood. It is amenable to incorporation into professional education programmes and health care induction programmes.</td>
</tr>
</tbody>
</table>
SECTION 9: KEY MESSAGES

As the preceding sections show, this research has yielded a large body of evidence from which to draw conclusions. For the evaluators the most striking, and indeed unusual, characteristic of this body of evidence is the degree to which the findings from different methods of enquiry with different professionals from different contexts are consistent, convergent and complementary.

Analysis and synthesis of these findings has identified a number of key messages (indicated in bold typeface). The first is that the Cleanliness Champions Programme has emerged as widely valued as a way of giving a broad array of healthcare staff core knowledge and skills in the prevention and control of Healthcare Associated Infections. The large volume of positive comments highlighting the usefulness and positive impact of the programme materials was remarkable, and was in no way confined to the initial wave of enthusiasts who gave the initiative momentum through their participation as students, mentors or key service managers. Nor was its perceived value confined to one particular occupational group, despite the dominance of nurses within the survey sample. Rather this educational programme appears to have substantively addressed the considerable challenge of meeting the basic needs of a broad range of staff with a wide spectrum of previous educational attainment. Considering that these staff often had considerable difficulty in getting opportunities to complete learning units within their working time, their commitment and enthusiasm for the programme justifies use of the term “remarkable”.

As such, the product developed by NES with a range of stakeholders has proved very largely fit for its intended purpose. The four modes of programme delivery have offered flexible means through which students from different workplace settings could access the programme. The e-learning platform has been largely successful in supporting a web-based delivery mode and this reflects a productive working relationship between NES and the commissioned IT specialist company. However the need for the ODL “hard copy” package as an alternative mode has been evident throughout the evaluation. The key message in this regard is the value of multiple, flexible formats for delivery of this type of national programme.

Evaluation of the processes of programme development revealed initial tensions amongst stakeholders in regard to the envisaged role for Cleanliness Champions and the balance of content for the educational programme. These reflected tensions that were evident in the Report on the HAI Convention (SEHD 2002), particularly concerning lines of accountability for Cleanliness Champions and their relationship with Infection Control...
link nurses and the Infection Control Team. In this regard it is important to note that the published CCP curriculum leaves substantial room for local interpretation of the CC role. Personal role modelling and acting in support of the ICT have been emphasised more than involvement of line managers and challenging colleagues practice.

From the research findings it would appear that the CC role has been translated into practice in a number of ways ranging from “silent” individual role modelling through to vocal advocacy, challenging of practice and service re-design. Not surprisingly this seems to have been dependent on individual motivation, perceived workplace support and perceptions of authority and autonomy. Thus by leaving substantial scope for interpretation of CC role enactment, the educational programme has encouraged enrolment of a relatively diverse range of healthcare staff in this initiative. This has been a successful initial strategy, but the compulsory participation of G grade nurses (announced in March 2005 by the Chief Nursing Officer for Scotland) suggests that the curriculum should now place rather more emphasis on: means of engagement with all staff within discrete clinical areas; lines of accountability, and implementing action plans. Accordingly a number of ways of doing this are suggested in our recommendations.

As the foregoing suggests, the process of programme development overcame some initial difficulties to produce a logically coherent educational curriculum that was acceptable to a range of stakeholders. Moreover it is clear that NES has encouraged and reacted positively to interest from other non NHS organisations (e.g. universities; independent and voluntary sector), in that it has developed functional guidance for adaptation/customisation of the programme in ways that have retained its overall integrity, yet have been perceived as helpful. However the main constituency for the initiative has been NHS Scotland, and the evaluation has shown that NES has adapted creatively and flexibly where there were gaps between the programme as intended and enacted. Indeed NHS staff had very little criticism of the implementation support provided by NES in terms of strategic guidance, resource material and ongoing input.

Rather there was almost universal acknowledgement that the main difficulty with the initiative so far has been the health service management of this relatively large-scale work-based programme. In particular most areas have struggled to find the capacity to resource and support their staff in such a way that substantial numbers can complete the programme in less than four months. This has been exacerbated by the recent requirement that all G grade nurses undertake the programme, and has led to a situation whereby large numbers of staff are now being registered as having started but few are managing
to complete within four months. In turn this has led some health service
managers to look at ways of “fast-tracking” students through the
programme and has increased pressure on NES to look at Accreditation
of Prior Learning (APL) and/or adaptation/customisation measures.

Within this context the research should be helpful as the findings suggest
that there are good evidential grounds for some restructuring of the
programme. The main criticisms of the programme were that it could be
repetitious and that some content was not relevant for certain groups of
students. The survey has helped to identify which learning units have been
least useful for particular occupational groups, and which have constituted
a core valued by almost all groups. In this regard clear patterns have
emerged. These also relate closely to the aspects of personal practice that
have been perceived as most improved by the CCP. Accordingly it is
suggested that learning units 1, 2, 3, 4, 6 and 11 can be seen as the core
of the CCP curriculum and that there is scope to give students some
options in regard to the remaining five modules. The latter could entail
making some workplace activities optional if mentors agree
that relevance to context or occupation is limited.

Increasing options may not only help students to complete the programme
quicker (with the associated benefits for health service management), but
could also help maintain focus and motivation for the new cadres of
CCPs which contain smaller proportions of voluntary students. Moreover
it could to some extent decrease mentorship commitments. The latter point
is particularly important for the Infection Control Nurses who have been
the backbone to date of the mentoring system. The evaluation findings
clearly show that this group of nurses and their other colleagues within
Infection Control Teams have played a pivotal role in the success of the
Cleanliness Champions Initiative to date. Initial fears about the nature of
the CC role have been largely overcome and Cleanliness Champions have
typically commended the high level of support that they have received from
local Infection Control Teams. This indicates that Infection Control Nurses
are already meeting the challenge to “pass the baton for operational infection
control on to those directly involved in patient care” (NHSQIS 2005).

Increasing options could also help towards securing more involvement from
several key professional groups who have been noticeable by their lack of
engagement with the programme to date. By the end of July 2005 a total
of 32 medical staff had registered for the programme, only five of whom
were at House Officer/Senior House Officer or Registrar level. This almost
total absence of front-line medical staff from the programme was
widely lamented by survey respondents and key informants who often
highlighted how much their medical colleagues could benefit from
this type of education. While rather more AHP staff have registered for
the programme (85 at 31/7/05), there is still considerable scope for wider participation from physiotherapists, occupational therapists, radiographers and other front-line staff. **Indeed if all the key professional groups mentioned above could be encouraged to engage with the programme in much greater numbers a critical mass could be achieved that could help to build a truly multidisciplinary culture of good practice in front-line HAI prevention and control.** The very positive experiences of the Healthcare Assistant and Domestic staff who undertook the programme suggest that this aspiration may actually be achievable if there is sufficient will and investment to capitalise on what has been achieved so far. A number of ways of doing this are identified in the recommendations section of the report.

Although the CCP was primarily designed as an educational intervention for those in current healthcare employment, from the study findings it is also clear that it has much potential as a core primary educational tool that may be used to prepare new healthcare staff for practice. The experiences of those who have pioneered its use with medical and nursing students have been predominantly positive, with necessary customisations being agreed through the NES CCP Editorial Group. **Given that NES has now made all the CCP materials available free to Scottish higher education institutions, there now exists an excellent opportunity to integrate the programme “at source”**. The research has highlighted some innovative ways of doing this in the pioneering Higher Education Institutions. Further gains could be realised by incorporating the programme within interprofessional learning initiatives.

The idea of increasing options for some learning units could not only be useful for the higher education setting, but could also help promote more involvement from non-acute healthcare settings. Although the CCP materials have been carefully prepared to be applicable to a range of workplaces, some of the learning units are necessarily more relevant to particular contexts than others (e.g. Unit 10 assumes contact with patients). The profile of CCP registrants to date reflects the dominance of the acute, general hospital as the main repository for efforts and expertise on HAI prevention and control. While some survey respondents from community and nursing/care home settings highlighted aspects of the CCP curriculum that were less relevant, their main concerns usually focused on management issues regarding support for CC implementation. This was mirrored in the interviews with key managers from Health Boards and it was striking that most of these implementation management issues tended to be very similar irrespective of whether Health Boards were rural or more urban in nature, and whether workplace settings were large hospitals or small local Health Centres. Importantly the research has highlighted some creative approaches to managing implementation of the initiative, which might be replicated elsewhere at relatively little cost.
Nevertheless another key message that has emerged from the findings is the need for further investment in the implementation management of the programme so that its full potential can be incorporated into front-line practice. While economic evaluation was beyond the remit of this study, it is clear that healthcare organisations have been expected to support the initiative predominantly from within pre-existing resource allocation. Moreover some employees have been expected to support the initiative by using their own time. Given these circumstances it is not surprising that there has been marked disparity between numbers registering and numbers completing. Rather what is surprising under these circumstances is the level of enthusiasm, commitment and priority that has been shown towards the programme’s substance and purpose. It is important to point out that the Watt Report recommendations, endorsed within the Ministerial Action Plan, state that infection control champions should:

“have clearly defined roles, dedicated time for infection control duties and be appropriately trained and supervised. The extra responsibilities and training should attract enhancement of salaries” (SEHD 2002)

The key messages in our report are tempered with rather less caution than might usually be associated with interpretations informed by 40 – 44% survey response rates. Our reasons for this have been alluded to previously, but are worth re-iterating. Firstly it is clear that our census of registrants included many who had yet to start the programme as a student or mentor. As such our survey respondents are likely to represent substantially more than half of all those who have ever actually engaged with the programme as a student or mentor. Secondly it is clear that we have included the views of over 70% of all those who are known to have completed the programme. Thirdly the profile of our student respondents almost exactly matches that of all student registrants kept by NES (in terms of occupational groupings, workplace settings and other basic demographic variables). Fourthly data from other sources such as interviews, conference proceedings and informal discussions with NHS staff have been very confirmatory of the survey findings, especially in terms of giving further insights into reasons for students struggling or failing to complete the programme. In effect, concerns over possible under-representation of the views of these students have been reduced through data triangulation and by making interpretations and recommendations that recognise their importance as a group.

It is also important to re-iterate that the study has been concerned primarily with the development and implementation of the CCP, and in this regard our research has highlighted the potential value of following-up its integration and impact in practice. Information gleaned from key informants indicates that there is little systematic evaluation of
the impact of the CCP on practice or evidence that those managing the implementation process have identified suitable indicators of effectiveness. Within some areas of the NHS there are signs of increased usage of cleaning agents and materials along with the introduction of more costly decontamination procedures. Further research is necessary to evaluate the impact on practice and on behaviour change.

Finally, the potential for more general applications of successful approaches used within this programme should be noted. The NES “Diamond Model” emerged as a useful template for assuring that the main aspects of programme implementation were considered in terms of strategy, scope and sequencing. While enaction of the resource appraisal dimension of the model can be criticised as inadequate in the light of the difficulties students experienced in securing protected study time, it is clear that this dimension was heavily reliant on information and support from other organisational partners (i.e. Health Boards and SEHD).

Similarly the web-based e-learning platform developed for this programme may serve as a useful template for future national multidisciplinary educational initiatives of this type. In this regard there is scope for further integration with the NHS Scotland e-library, particularly in relation to the recently developed Managed Knowledge Network portals.
SECTION 10: CONCLUSION

This evaluation research has shown that the Cleanliness Champions Programme is very largely fit for the purpose of giving a broad array of healthcare staff core knowledge and skills in the prevention and control of Healthcare Associated Infections. The programme materials and delivery modes have proved very useful and should remain as the basis of this multidisciplinary educational package. However, the potential value of some restructuring of the programme by means of core learning units and increased options has emerged clearly through evaluation.

In considering the notion of “fit for purpose” it is germane to reflect on the purpose itself, especially as the notion of having infection control/cleanliness champions in every clinical area was not universally acclaimed when first mooted in May 2002. During the past three years, however, professional appetite for this more radical, generic, and fundamental approach seems to have grown in response to increasing problems with HAIs and related public concern. Importantly, this is also evident in more recent research literature which tends to highlight the limitations of exclusively specialist infection control approaches (Gould 2005; Holmes 2005). Reflecting on this literature Bishop (2005) notes:

“there is a widely held view that until there is clarity regarding professional roles, and highly visible role models in clinical settings who understand that infection and hygiene are part and parcel of all aspects of care and not a separate speciality, any improvements are likely to be sporadic and short lived”.

As such the Cleanliness Champions initiative has the potential to be one of the most important elements within the raft of activities being taken forward under the auspices of the Ministerial Task Force in Scotland. Indeed the CCP has substantially informed the recent development of an on-line infection control training resource for all healthcare staff in England (NHS Core Learning Programmes Unit). In summarising progress to date, it is difficult to escape the conclusion that the development and implementation of the CCP has established a strategically important bridgehead in the battle to decrease HAIs through changing healthcare culture. This research has shown that Cleanliness Champions report substantial impact on their personal practice and cite many examples of influence on the practice of other staff. Accordingly, there would seem to be a strong argument for capitalising on this initial progress through further investment in, and expansion of, the Cleanliness Champions Programme. In this way a critical mass may be achieved that has sufficient multidisciplinary momentum to make good HAI prevention and control practices an embedded clinical reality.
SECTION 11: RECOMMENDATIONS

The programme curriculum as a whole

1) Given that the programme has been received very positively indeed by large numbers of nurses and a diverse array of other healthcare staff,

It is recommended that the learning materials developed so far should continue to constitute the main elements of the programme. However, these materials should be further developed and refined in line with suggestions outlined below and some of the detailed feedback contained within this report.

This would build from the success already achieved and preserve the overall integrity and identity of the programme.

2) Given that six of the learning units (Units 1, 2, 3, 4, 6 and 11) have clearly emerged as particularly useful for almost all occupational groups, and that some of the remaining five learning units have emerged as less useful for distinct occupational groups,

It is recommended that the structure of the curriculum is reviewed and that consideration is given to enhancing student choice.

This could bring a range of associated benefits that the research has highlighted as potentially useful. Firstly it could allow some customisation to occupational groups and to healthcare settings. Secondly it could decrease the amount of time typically taken to complete the programme. Thirdly it could help maintain focus and motivation for future cadres of CCPs containing larger proportions of students for whom participation is compulsory. Fourthly it could somewhat reduce associated mentorship commitment.

3) Given that concerns were raised about how best to challenge bad practice,

It is recommended that more emphasis be given within several of the CCP Learning Units to the social dynamics of influencing practice change within the multi-disciplinary team. Guidance on productive approaches should be incorporated and a related workplace learning activity should require active support from a senior member of departmental staff. In addition, more examples of how to promote meaningful involvement of patients and the public should be incorporated within Learning Unit 10 of the CCP.

This would help Cleanliness Champions to enact a quality improvement role in a way that minimises threat to self and others, yet maximises potential for real improvements to practice. This would also help to harness some of the potential for patients and the public in general to contribute to HAI prevention and control e.g. by passing on appropriate knowledge and skills to patients and their families, or by involving patients in local problem solving initiatives.
The modes of programme delivery

4) Given that the range of delivery modes was valued by students and mentors, and that each had particular strengths,

It is recommended that all the delivery modes developed so far should continue to be offered to students. However NES should consider making minor refinements to these modes in the light of some of the detailed feedback within this report.

This would build from the success already achieved and preserve the overall integrity and flexibility of the programme.

The target population for the programme

5) Given that this programme has emerged as substantively fit for the purpose of providing a broad array of healthcare staff with core knowledge and skills to address prevention and control of HAIs,

It is recommended that concerted efforts be made by SEHD, NES, relevant professional colleges/organisations, and all Health Boards/Divisions to ensure much wider participation in the programme by key professional groups such as “front-line” medical staff and allied health professionals.

This would help to promote a more truly multidisciplinary approach to building a shared culture of HAI prevention and control. Moreover it would be useful in assuring the public that responsibility for HAI prevention and control is every healthcare worker’s business rather than that primarily of nurses.

6) Given that the programme had particularly positive impact on the self-reported practice of Healthcare Assistants and Domestic staff, recognised their vital contribution, and generated much related enthusiasm,

It is recommended that in every clinical area one member of staff drawn from either of these groups should undertake the programme and act as a Cleanliness Champion.

This would enable key alliances to be formed in each clinical area whereby typically these Cleanliness Champions would be supported by Cleanliness Champions drawn from nursing, medicine or AHPs. This would also help to address some of the problems these Cleanliness Champions were having in challenging the practice of more senior colleagues.

7) Given that initial experiences of integrating the programme into the educational preparation of medical and nursing students have been generally positive,
It is recommended that concerted efforts be made to incorporate the CCP into the core educational preparation of all medical, dental, nursing, midwifery and AHP students.

This would realise the potential of the programme as a primary educational intervention and would underline the importance of a culture of HAI prevention and control for new generations of healthcare workers. It would also offer academic institutions significant scope to incorporate it within inter-professional learning initiatives.

Support for staff to undertake and complete the programme

8) Given that many healthcare staff have found it difficult to get time to devote to the programme within their working hours, yet have clearly valued the programme and shown remarkable enthusiasm and commitment towards completing it,

It is recommended that the SEHD consider “ring-fencing” monies to invest in the programme so that Health Boards/Divisions can provide more support for staff to undertake it during their working time.

This would enable more “back-filling” of staff time and more “block-release” study sessions.

9) Given that students and mentors have valued having opportunities to meet with others in the same position, and to focus on elements of the programme as a group,

It is recommended that all Health Boards/Divisions consider facilitating regular open sessions of this type, whether by means of attendance at one venue or teleconferencing.

This would enhance peer support and promote focus on achieving completion of learning units.

Support for staff to undertake mentoring

10) Given: the need to decrease mentorship burden on members of Infection Control Teams; the potential to involve growing numbers of CCs as mentors themselves; and that mentors often identified a lack of an organisational support network,

It is recommended that the SEHD consider “ring-fencing” monies to invest in the programme so that Health Boards/Divisions can provide more input to prepare and support staff to undertake the mentorship role during their working time.

74
This could be taken forward in part by the formation of local mentor support groups that would foster peer support, sharing of best practice and give a forum for addressing mentorship quality issues.

Support for enactment of the CC role

11) Given that Cleanliness Champions often identified a need for support in taking forward action plans for implementing change in practice,

It is recommended that Health Boards/Divisions facilitate local action groups whereby Cleanliness Champions can meet with relevant senior clinical staff (e.g. Infection Control Team; Charge Nurses; Consultants; GPs) in order to co-ordinate local approaches to improving prevention and control. This could feed into annual planning meetings (e.g. in regard to Quality Improvement Scotland HAI requirements).

Many Health Boards/Divisions have already developed good practice in this regard, but there is a need for this key mechanism to become integrated as standard practice.

12) Given that the majority of students and many mentors wished to change the Cleanliness Champion name, and that it was often seen as a hindrance in practice,

It is recommended that NES and the SEHD consider the issue of re-naming the programme and the associated role.

This could be seen as helpful by many practitioners. The disadvantage would lie in possible loss of some of the distinctive identity the educational programme has created to date. In either event, further measures should be taken to positively validate the role of the Cleanliness Champion in professional and public domains.

13) Given that some students and mentors highlighted possibilities for more patient, carer and public engagement within the whole CCP initiative,

It is recommended that the local Cleanliness Champion role be made more visible to patients, relatives and the general public through information notices (e.g. including names and photographs of Cleanliness Champions) in clinical and non-clinical areas.

This might also invite involvement from interested patients, relatives and the general public. For example they might be invited to join working groups as appropriate.
Support for continuing professional development of students and mentors

14) Given that many students and mentors identified a need for Cleanliness Champions to keep updated on good practice and to maintain their focus on prevention and control of HAIs,

It is recommended that “communities of practice” be established at local and national levels for Cleanliness Champions. The former would involve Health Boards/Divisions establishing support fora for Cleanliness Champions and these could be contiguous with the suggested student and mentor support groups. At national level NES could establish a web-based community of practice for Cleanliness Champions to share experiences, access resources, and update knowledge and skills. This might be taken forward through the HAI Managed Knowledge Network portal within the NHS Scotland e-library.

Several Health Boards/Divisions have already developed good practice in this regard, but there is scope for wider adoption of what may be an important mechanism for binding professional development, quality improvement and practice development.

Further research

15) Given that this research has primarily focused on the development and implementation of the educational programme, and that only initial indications of its wider impact on practice have been identified,

It is recommended that research be commissioned that examines impact on practice, with particular focus on the social dynamics involved in influencing multidisciplinary HAI prevention and control practice through the establishment of a national educational programme with an associated role enactment component.

This would address a gap in knowledge and would potentially be useful to educators, practitioners, researchers and the wider public both in Scotland and internationally.
REFERENCES
Aragon, D, Sole, ML, Brown, S, (2005) Outcomes of an infection prevention project focusing on hand hygiene and isolation practices AACN Clinical Issues: Advanced Practice in Acute Critical Care 16 (2) 121-132


Beneda, H, Lang, E, Neu2il, K,(2005) Infection control risk reduction strategies through rapid and effective two way communication. (Conference Abstract) American Journal of Infection Control 33(5) E90-91


Parris,N, Peraino, V, Reduction of Noscomial acquisition of MRSA in a community hospital through adherence to standard precautions.
(Conference Abstract) *American Journal of Infection Control* 33 (5) E80-81


Stake, R (1967) *The countenance of educational evaluation* In Beyond the numbers game (Hamilton D et al eds 1977) pp 146-155
Macmillan Education


EVALUATION OF NES CLEANLINESS CHAMPIONS PROGRAMME

MENTOR QUESTIONNAIRE

As part of the evaluation of the NES Cleanliness Champions Programme (CCP), we are seeking feedback from all those who are registered with NES as having provided mentorship support to students. We would like to hear your views whether you are currently mentoring students or have done so in the past. If you have been a student yourself on the CCP and have been sent a student questionnaire, we would be most grateful if you could also complete this mentor questionnaire. The questionnaire should take around 15 minutes to complete. Once you have done this, please post it in the attached FREEPOST envelope or use the following FREEPOST ADDRESS.

Dr Bernice J M West
Research Director
FREEPOST AB313
The Robert Gordon University
School of Nursing and Midwifery
Garthdee Campus
Aberdeen
AB10 1GG

Many thanks for taking the time to complete this questionnaire. Your help is very much appreciated and will inform future national and local educational development.
Section 1: Information about you Please indicate:

1. Your gender
   - Female [ ]
   - Male [ ]

2. Your age
   [ ]

3. Your job title
   [ ]

4. Your place of work
   - Acute Hospital [ ]
   - Community hospital [ ]
   - Nursing/Care Home [ ]
   - Other [ ]
   - Health Centre/GP Practice [ ]
   (please specify) [ ]

5. The name of your NHS Trust or other employer
   [ ]

6. Length of time employed in your current care setting
   [ ] years

7. Total length of time employed in health care work
   [ ] years

8. For which of the following staff groups have you provided mentorship?
   (Please tick all that apply)
   - AHP [ ]
   - Dental Nurse [ ]
   - Doctor [ ]
   - Healthcare Assistant [ ]
   - Pharmacist [ ]
   - Dental Hygienist [ ]
   - Dentist [ ]
   - Domestic [ ]
   - Nurse [ ]
   - Ambulance personnel/paramedic [ ]
   - Other [ ]
   (please specify) [ ]

9. How were you selected as a mentor?
   - Volunteered [ ]
   - Nominated [ ]

10. If you volunteered to be a mentor please explain briefly your reasons why.
    [ ]

11. If you were nominated to be a mentor please give your understanding of the reasons why.
    [ ]
Section 2: Your mentorship role

12. Have you completed the Cleanliness Champions Programme?
   Yes     ☐
   No      ☐

13. In which of the following formats have you accessed the CCP educational materials?
    *(Please tick all that apply)*
    - Printed 'hard copy' version  ☐
    - CD-ROM  ☐
    - Web-based E-Learning  ☐
    - Face-to-face (in-person delivery)  ☐
    - Unable to access the materials in any format  ☐

14. How many mentees?
   Currently........................................................  Previously.......................................................

15. What is the optimum number of mentees for you at any one time?  ................................................

16. Which of the following ways have you used to provide mentorship?
    *(Please tick all that apply)*
    - One to one meeting  ☐
    - By telephone  ☐
    - Group meeting  ☐
    - By Email  ☐
    - Other  ☐
    *(please specify)..............................................................................................................................

17. Which of the above ways has worked best for you?
    ............................................................................................................................................

18. During mentorship meetings, how often do you carry out the following activities?
    *(Please tick one box for each activity, as appropriate)*
    - Discuss individual's concerns
    - Review the programme learning materials
    - Review an individual's Folder of Evidence of Learning
    - Test an individual's knowledge
    - Review audit results
    - Advise individuals on practice issues
    - Agree timescales for unit completion with individuals

<table>
<thead>
<tr>
<th>Activity</th>
<th>Always</th>
<th>Usually</th>
<th>Occasionally</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discuss individual's concerns</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review the programme learning materials</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review an individual's Folder of Evidence of Learning</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Test an individual's knowledge</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Review audit results</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advise individuals on practice issues</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree timescales for unit completion with individuals</td>
<td></td>
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</tbody>
</table>
19. Approximately what percentage of your working week has been spent on mentorship for the CCP?

.................%

20. How would you describe the burden that this mentorship has put on you?

Excessive ☐
Heavy burden ☐
Moderate burden ☐
No burden ☐

Comments .............................................................................................................................................................
..............................................................................................................................................................................

21. Please identify any benefits that mentoring on the CCP has brought to you.

..............................................................................................................................................................................
..............................................................................................................................................................................

22. In general, have you felt able to provide adequate support to your mentee(s)?

Yes ☐
No ☐

If yes, what have been the main factors that enabled this?

..............................................................................................................................................................................
..............................................................................................................................................................................

If no, what have been the main reasons that prevented this?

..............................................................................................................................................................................
..............................................................................................................................................................................

23. Which format of the programme has been best for mentees? (Please tick one box only)

Hard copy version ☐
Web-based E-Learning ☐
CD-ROM ☐
Face-to-face (in-person delivery) ☐
Unable to say ☐
24. Which unit of the programme has required most input from you and why?  
(Please tick one unit only and add explanatory comments)

<table>
<thead>
<tr>
<th>Unit</th>
<th>Learning units</th>
</tr>
</thead>
</table>
| 1    | Why Cleanliness Champions?  
*Comments* |
| 2    | The chain of infection  
*Comments* |
| 3    | Hand hygiene  
*Comments* |
| 4    | Personal Protective Equipment (PPE)  
*Comments* |
| 5    | Safe use and disposal of sharps  
*Comments* |
| 6    | Maintenance of a clean healthcare environment  
*Comments* |
| 7    | Safe handling and disposal of waste  
*Comments* |
| 8    | Food hygiene and pest control  
*Comments* |
| 9    | Staff hygiene and dress  
*Comments* |
| 10   | Patient care practices  
*Comments* |
| 11   | The role of the Cleanliness Champion and its impact on the patient’s experience  
*Comments* |

25. What do you see as the main reason why mentees withdraw from the CCP?  
(Please tick one box only)

- Change of job
- Personal/family reasons
- Lack of time due to other work commitments
- Lack of support from mentor
- Lack of support from employer
- Other

*(please specify)*...........................................................................................................
Section 3: Preparation and support for your mentorship role

26. What preparation did you have for your mentorship role on this programme?  
(Please tick all that apply)

- Prior completion of the programme
- Read NES ‘Guide for Students and Mentors’ and familiarised myself with programme
- Prior role in infection control nursing
- Participation in NES roadshow event
- No specific preparation
- Other

(please specify)....................................................................................................................

Comments
...........................................................................................................................................
...........................................................................................................................................

27. Did you feel adequately prepared for this role?

Yes □
No □

Comments
...........................................................................................................................................
...........................................................................................................................................

28. Do you feel that there is an adequate support network within your organisation for mentors on the CCP?

Yes □
No □

Comments
...........................................................................................................................................
...........................................................................................................................................

29. Is your mentoring role on the CCP built into your annual appraisal process?

Yes □
No □

Comments
...........................................................................................................................................
...........................................................................................................................................
Section 4: Integration with Practice

30. Thinking of your organisation's overall approach to implementing the CCP so far, please rate the degree of importance that has been given to each of the factors listed below. (Please tick one box per factor)

<table>
<thead>
<tr>
<th>Factor</th>
<th>Very important</th>
<th>Important</th>
<th>Of little importance</th>
<th>Of no importance</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prioritising known HAI problem areas</td>
<td></td>
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<tr>
<td>Involving as many areas within the organisation as possible</td>
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<tr>
<td>Using existing infection control expertise for mentoring</td>
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<td></td>
</tr>
<tr>
<td>Controlling speed of implementation to ensure quality of student/mentor experience</td>
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<td></td>
</tr>
<tr>
<td>Supporting any staff who are keen to be students or mentors</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Involving students' and mentors' line managers</td>
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<tr>
<td>Involving ancillary staff</td>
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<tr>
<td>Involving AHPs</td>
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<tr>
<td>Involving medical staff</td>
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<td></td>
<td></td>
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<tr>
<td>Involving patients and carers</td>
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</tr>
</tbody>
</table>

Comments on any of the above factors
...........................................................................................................................................
...........................................................................................................................................

31. What aspects of the CCP itself do you see as having most influence in practice so far?

   (i) .........................................................................................................................
   (ii) .........................................................................................................................
   (iii) .........................................................................................................................
Section 5: Your final reflections

32. Thinking of your own local experience of the Cleanliness Champions Programme so far, what do you see as the main strengths and weaknesses?

Strengths
...........................................................................................................................................
...........................................................................................................................................
...........................................................................................................................................

Weaknesses
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...........................................................................................................................................
...........................................................................................................................................

33. Thinking of the future, what do you see as the main issues for the Cleanliness Champions Programme?
...........................................................................................................................................
...........................................................................................................................................
...........................................................................................................................................

34. If you have any other comments please add them below.
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Thank you very much for taking the time to fill in this questionnaire - please use the FREEPOST address on the front of the questionnaire to return it to The Robert Gordon University. If you wish to take part in the draw for £100 of book tokens, please include the completed prize draw form.
EVALUATION OF NES CLEANLINESS CHAMPIONS PROGRAMME

STUDENT QUESTIONNAIRE

As part of the evaluation of the NES Cleanliness Champions Programme (CCP), we are seeking feedback from all students who have registered on the programme.

If you have already completed the programme, please complete the questionnaire fully.

If you are currently in the process of undertaking the programme, please complete the questionnaire fully, basing your answers on your experiences up to now.

If you have discontinued the programme, please complete questions 1-16 only.

The questionnaire should take around 15-20 minutes to complete. Once you have done this, please post it in the attached FREEPOST envelope or use the following FREEPOST ADDRESS.

Dr Bernice J M West
Research Director
FREEPOST AB313
The Robert Gordon University
School of Nursing and Midwifery
Garthdee Campus
Aberdeen
AB10 1GG

Many thanks for taking the time to complete this questionnaire. Your help is very much appreciated and will inform future national and local educational development.
### Section 1: Information about you

Please indicate:

1. **Your profession (Please tick one box only)**
   - AHP
   - Dental Nurse
   - Doctor
   - Healthcare Assistant
   - Pharmacist
   - Dental Hygienist

   *(please specify)* ...........................................................

2. **Your gender**
   - Female  
   - Male

3. **Your age**  .........................

4. **Your job title**  ...........................................................................................................................

5. **Your place of work**
   - Acute Hospital  
   - Nursing/Care Home
   - Health Centre/GP Practice

   *(please specify)* ...........................................................

6. **The name of your NHS organisation or other employer**  ..........................................................

7. **Length of time employed in your current care setting**  ............ years

8. **Total length of time employed in health care work**  ............ years
Section 2: Your involvement with the CCP

9. When did you start the programme? .................. Month ................. Year

10. Have you completed the programme?
   Yes ☐ No ☐

11. If yes, how long did this take you? ............... Weeks .................. Months ............. Years

12. If no, how many of the 11 CCP learning units have you completed? .................................

13. How were you selected for the programme?
   Volunteered ☐ Nominated ☐

14. If you volunteered to undertake the programme, please briefly explain your reasons.
   ............................................................................................................................................
   ............................................................................................................................................

15. If you were nominated for the programme, please give your understanding of the reasons.
   ............................................................................................................................................
   ............................................................................................................................................

16. If you have discontinued, please indicate your main reason. (Please tick one box only)
   Change of job ☐ Lack of support from mentor ☐
   Personal/family reasons ☐ Lack of support from employer ☐
   Lack of time due to other work commitments ☐ Other ☐
   (please specify)....................................................................................................................

Section 3: Your evaluation of the educational programme

17. Which version of the programme did you use?
   Printed 'hard copy' version ☐ CD-ROM ☐
   Web-based E-Learning ☐ Face-to-face (in-person delivery) ☐

18. If you didn’t use web-based e-learning, why not? (please tick all that apply)
   I preferred another mode of delivery ☐ Technical problems with access to web ☐
   My employer preferred another mode of delivery ☐ I felt I lacked skills ☐
   Limited access to a computer ☐
   Other ☐
   (please specify)....................................................................................................................
19. The following table lists each of the learning units. Please rate their usefulness to you, using a scale of 1–4 (1 being not at all useful and 4 being very useful), and add any comments. If there are any units that you have not completed yet, please indicate this.

<table>
<thead>
<tr>
<th>Unit</th>
<th>How useful were the following learning units?</th>
<th>Rating (1–4)</th>
<th>Unit not completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Why Cleanliness Champions?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>The chain of infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Hand hygiene</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Personal Protective Equipment (PPE)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Safe use and disposal of sharps</td>
<td></td>
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<tr>
<td>6</td>
<td>Maintenance of a clean healthcare environment</td>
<td></td>
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<tr>
<td>7</td>
<td>Safe handling and disposal of waste</td>
<td></td>
<td></td>
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<tr>
<td>8</td>
<td>Food hygiene and pest control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Staff hygiene and dress</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Patient care practices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>The role of the Cleanliness Champion and its impact on the patient's experience</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
20. Which learning unit has provided you with the most new information?
...........................................................................................................................................

21. Which learning unit has proved to be most helpful in improving your practice?
...........................................................................................................................................

22. Which workplace activities undertaken during the programme were:
   most useful? ..................................................................................................................
   ..................................................................................................................
   least useful? ...........................................................................................................
   ..................................................................................................................

23. Some possible revisions to the programme are listed below. Please indicate whether you agree or disagree with them.

<table>
<thead>
<tr>
<th>Possible revisions</th>
<th>Agree</th>
<th>Disagree</th>
<th>Don’t Know</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change the 'Champion' name to something else</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More 'spot the problem' photos</td>
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<tr>
<td>A section on team working</td>
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<tr>
<td>Examples of local policies</td>
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<tr>
<td>Sorting the programme into optional and core elements</td>
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<tr>
<td>Customising the programme by occupation</td>
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<tr>
<td>More web links</td>
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<td></td>
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<tr>
<td>More content relevant to primary care</td>
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<tr>
<td>More content on cleaning</td>
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<tr>
<td>More content on chemical spills</td>
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</tbody>
</table>

24. Please suggest any other ways in which the educational materials could be improved.
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25. What changes, if any, should be made to the assessment of the programme?
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Section 4: Your Evaluation of Mentorship Support

26. Did you feel that your mentor gave you sufficient support for the programme?

Yes ☐  No ☐

If no, why not? (Please tick all that apply)

- Lack of time ☐
- Didn’t know who my mentor was ☐
- Mentor did not understand the requirements of the programme ☐
- Mentor did not value the content of the programme ☐
- Access to mentor difficult due to geography ☐
- Any other reason (please specify) .................................................................

27. How many times did you have contact with your mentor to discuss your progress?

- 1–5 times ☐
- 6–11 times ☐
- Over 11 times ☐

Comments ..................................................................................................................

28. What form(s) did this contact with your mentor take? (Please tick all that apply)

- One to one meeting ☐
- Group meeting ☐
- By Telephone ☐
- By Email ☐
- Other (please specify) ..........................................................................

29. To what extent did your mentor scrutinise the work that you compiled in your Folder of Evidence of Learning? (Please tick one box only)

- In detail for each unit ☐
- In detail for some units ☐
- In general overview ☐
- Not at all ☐

Comments .............................................................................................................

30. Do you now provide mentorship for others undertaking the Cleanliness Champions Programme?

Yes ☐  No ☐

31. If yes, how many mentees do you currently have.............................................
Section 5: Integration into Practice

32. For each of the following activities, please rate your practice before and after completing the programme. Please use a scale of 1-5, with 1 being poor practice and 5 being excellent practice. If you have not yet completed the relevant part of the programme, please tick the N/A column. Please add any comments if you wish.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Before Rating</th>
<th>After Rating</th>
<th>N/A</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand washing</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Handling of sharp objects</td>
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<tr>
<td>Decontaminating equipment</td>
<td></td>
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<tr>
<td>Handling food</td>
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<td></td>
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<tr>
<td>Using protective clothing</td>
<td></td>
<td></td>
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<tr>
<td>Challenging others’ practices</td>
<td></td>
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<tr>
<td>Handling laboratory specimens</td>
<td></td>
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<tr>
<td>Preventing needlestick injuries</td>
<td></td>
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<tr>
<td>Reducing the risk of patients getting healthcare acquired infection</td>
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<tr>
<td>Acting as a role model</td>
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</tbody>
</table>

33. Do you have key allies within your work setting who are helping you to integrate good practice in regard to cleanliness and infection control?

- Yes [ ]
- No [ ]

34. If Yes, please indicate their job titles.

........................................................................................................................
........................................................................................................................

35. Which groups of colleagues are least aware of your Champion role?

........................................................................................................................

36. To what extent is your Cleanliness Champion role supported by the multidisciplinary team in your own immediate place of work?

- Completely [ ]
- Largely [ ]
- Partially [ ]
- Very little [ ]
- Not at all [ ]

Comments

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37. Do you feel that there is an adequate support network within your organisation for Cleanliness Champions?

Yes [ ]

No [ ]

Comments
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38. Where do you take issues in practice if a problem arises in relation to cleanliness and infection control?
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Section 6: Your Final Reflections

39. Thinking of your own local experience of the Cleanliness Champions Programme, what do you see as the main strengths and weaknesses?

Strengths
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Weaknesses
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40. If you have any other comments please add them below.
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Thank you very much for taking the time to fill in this questionnaire - please use the FREEPOST address on the front of the questionnaire to return it to The Robert Gordon University. If you wish to take part in the draw for £100 of book tokens, please include the completed prize draw form.