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This strategy applies to all staff employed by NHS Greater Glasgow & Clyde and locum staff on fixed term contracts.


KEY CHANGES FROM THE PREVIOUS VERSION OF THIS SOP

- Revised SICPs data collection tool based on Chapters 1 and 2 of NIPCM
- CAIR used as the single repository of all SICPs audit data
- Revised scoring and supporting actions
- Additional actions by SCN/Departmental staff to monitor sustained improvement
- Stronger use of quality management and improvement strategies
- Supportive role for IPCT to provide assurance on the application of SICPs

Document Control Summary

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“The purpose of audits is essentially to improve the quality of patient care and outcomes through systematic review of care against explicit criteria and the implementation of change as a result correcting practice where it falls short, and re-auditing to confirm that standards are now met.”

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1. Standard Infection Control Precautions (SICPs) Audit – a new approach


NHS Health boards are required to demonstrate the application of standard infection control precautions as the basis of all healthcare delivery to prevent and control infection. In 2012 the Chief Nurse for Scotland (CNO) recommended a programme of data collection to inform and provide evidence to Healthcare Environment Inspectors (HEI) of SICPs implementation and compliance (CNO, (2012)1).

Historically, NHS Greater Glasgow and Clyde (NHS GGC) has developed and used IPC audit tools and reporting strategies to support clinical application of SICPs. This has included multi-disciplinary audit undertaken by facilities, clinical and infection prevention and control teams (IPCT'S) reporting to Board Management teams to provide assurance.

Health Protection Scotland (now ARHAI) published a National Monitoring Framework (2018) to support what was termed “safe and clean care audit programmes”. These included 5 key themes which are covered in audit activity across NHS GGC:

- Standard and transmission based precautions –covered in the SICPs audit tool
- Decontamination of reusable equipment and the environment – covered in the SICPs and Facilities Management (FM) audit tools
- Insertion and maintenance of invasive devices – covered in PVC and CVC sweeps by IPCT and line care audits by local teams
- IPC education – monitored by management teams locally
- IPC communication to HCW, patients and public – as demonstrated in IPC audit of systems and processes and standing agenda for all IPC incident meetings

In 2020, the QEUH Oversight Board Final report recommended that NHS GGC undertake a review of its programmes of audit relating to IPC in line with the Healthcare Improvement Scotland framework for quality planning and improvement. The aim is to ensure consistency in RAG rating and a stronger link to a continuous culture of improvement. In particular the

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report stressed the importance of an organisational approach ensuring that it is not the sole responsibility of the IPCT.

This strategy focuses on SICPs audit.

NHS GGC undertook a review of the Standard Infection Control Precautions (SICPs) audit tools used by the Infection Prevention and Control Team (IPCT) and by the Senior Charge Nurse (SCN) within Care Assurance Improvement Resource (CAIR). A SICPs reference group was set up with broad multi-disciplinary membership including oversight by representatives from ARHAI and HEI. The SICPs tool was co-designed by a short life working group and included two PDSA cycles as part of the quality improvement methodology and a final tool is now available. This programme of work was overseen by the IPC Quality Improvement Collaborative leads for the Steering and Operational groups and also approved through the Board Infection Control Committee (BICC).

The changes to the NHS GGC SICPs audit programme reflect a change in responsibility from IPCTs to local clinical management teams which is underpinned by organisational governance structures ensuring strategic oversight.


Development of SICPs audit tools

The revised SICPs audit tool is aligned to precautions criteria contained within Chapters 1 and 2 of the National Infection Prevention and Control Manual and will complement other audits being undertaken. The tool is accompanied by a criteria aide memoire which directs the auditor to look at key evidence to support the SICPs data collection.

SICPs criteria will be available to cover the following areas:

- Safe Infection Prevention & Control Practice in Acute Care
- Safe Infection Prevention & Control Practice in Theatre Care
- Safe Infection Prevention & Control Practice in Mental Health Care (HSCP)
- Safe Infection Prevention & Control Practice in OPD and Dental Services
- Safe Infection Prevention & Control Practice in Decontamination Services

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A quality management process – vision and purpose

The SICPs audit strategy has been updated to embed data collection and reporting within a quality management process underpinned by a clear, systematic and coordinated approach to improving the quality of care received by our service users.


The tools, methodology and process for SICPs data collection and reporting will continue to be monitored to ensure that data collection tool functions to improve delivery of safe care by reducing the risk of healthcare associated infection as the clear vision and purpose of this strategy. It is expected that the tool will be reviewed every 4 years and when national policy changes.

Reports from audit, infection incidents and outbreaks, as well as infection data such as MRSA, CDI etc. will be used to inform the success of this strategy.

Assurance and Governance

Audit and re-audit programmes undertaken by senior charge nurses (SCN) and department managers will be supported by quality improvement and practice development leads, educationalists and the IPC local teams whose shared goal will be the consistent application of SICPs. Quality improvement methodology will be used to support use of SICPs routinely, demonstrating sustained improvement through outcome measurement.

Management teams will support their staff to embed a culture of safety by monitoring SICPs audit results at directorate and sector governance meetings. Where SICPs cannot safely be applied, this is reflected in documented risk assessments with appropriate mitigating actions in place and visible at senior level. A process of review by re-audit of those SICPs criteria will reflect a continuous improvement process aimed at reducing as far as possible all infection risk.

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Learning culture in the organisation

NHS GGC IPC audit programme will aim to provide robust assurance that NHS GGC provides a safe healthcare environment.

Success will be celebrated and shared through capturing staff improvement stories on the IPC web page and in the IPC QI collaborative newsletter.


Where risks are identified, these will be shared and communicated with all disciplines through safety huddles/meetings and staff notices (physical and virtual). They will be captured in sector and directorate reports and shared at ICC and governance committees. Data and themes from SICPs audit will be used to inform training by the IPCT to healthcare staff using a variety of learning platforms including face to face. This will be an adjunct to the mandatory training provided to staff at induction / updates via on-line modules monitored by management teams and reported to directorate /sector management and governance teams.

2. **Safe and Clean Care Audits by Clinical Team**

The SICPs audit programme

The SCN/departmental manager will undertake a SICPs audit every 6 months (CNO, DL (2012)1) using the SICPs tool and record the data on the Care Assurance Information Resource (CAIR) dashboard. An improvement action plan will automatically be generated with a timeframe for completion. Critical non-compliances (CNC) or **short term actions** will require immediate attention or action within 24 hours. **Medium term actions** must be completed within one month. **Long term actions**, for example, installation of a fully compliant clinical wash hand basin within a room used for isolation of a patient with a known/suspected alert organism, will require to be placed on the risk register for the individual service until the action is complete.

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Once the action required is registered on FM First, the action can be closed. Improvement action plans will be available once all data is input to CAIR and this should be done as soon as possible following data collection.

Depending on the outcome of audit (% compliance), a re-audit timescale will be generated and the following actions undertaken:

	GREEN: ≥ 90%	Well done! Share result with lead nurse* Complete improvement action plan within timescale Check for consistent failures and consider project to improve using PDSA. Re-audit in 6 months as part of SCN/department manager programme
	AMBER: 67-89%	Room for improvement! Share result with lead/chief nurse/service/general manager* Complete improvement action plan within timescale Check for consistent failures and consider project to improve using PDSA. Consider support from IPCT Re-audit in 3 months by SCN/departmental manager
	RED: <66%	Improvement strategy required! Share results with lead/chief nurse/ service/general manager/ director * Complete improvement action plan within timescale Identify SICPs that require supportive improvement and discuss with QI and IPC teams Re-audit in 1 month by SCN/departmental manager and IPCT


*Or equivalent for that service

If the audit programme cannot be completed, this will be escalated to senior management team to consider any supports that can be provided to complete the programme.

SICPs audit reports and improvement action plans

All audit reports and improvement action plans (including completion) using the new SICPs tool will be reported and visible via the CAIR dashboard. Responsibility for taking action to improve will also be clearly stated.

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An investigative approach is encouraged to identify cause when SICPs are not able to be applied either partially or wholly and possible means to correct this considered. This will provide a picture of consistent SICPs application and also support an understanding of the key SICPs elements that may be challenging in that area. The lead nurse/head of department will oversee SICPs audit activity and have a clear understanding of the outcomes of SICPs compliance for the areas s/he is responsible for.


They will support a quality improvement approach by bringing together local teams to understand why practice is not optimal and what changes can be supported realistically. Quality improvement leads should be utilised to support small tests of change using the PDSA cycle where appropriate to demonstrate sustained improvement. Involvement in the local multi-disciplinary team will ensure success.

Hand hygiene audit

SCN will complete a full hand hygiene audit monthly. This must include 20 observations of technique and opportunity spread across the 4 healthcare worker groups (ancillary, nursing, medical and AHP). CAIR will highlight incomplete audit activity. The Board local hand hygiene coordinator (LBHHC) will undertake a programme of hand hygiene compliance which will include:

- 20% of wards per year in a rolling programme (acute and mental health)
- Annual audit of all high risk areas (ICU, PICU, NICU and BMT)
- Wards where hand hygiene audit has been requested as part of actions agreed at an IMT (see below) for assurance

Hand hygiene audit activity may also be supported by other members of the IPCT. All hand hygiene audit activity will be entered on to the CAIR dashboard and reported in the IPC monthly directorate/sector/board reports. The LBHHC will provide support including feedback, training and re-audit where required.

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3. SICPs Audit by IPCT for assurance

All SICPs audit activity by IPCTs will be recorded on CAIR using the new SICPs audit tool. As well as supporting local teams to complete action plans and re-audit programmes, the IPCT will undertake a programme of audit to provide assurance re the application of the audit process and strategy. IPCTs will develop their own programmes of audit of clinical areas as follows:

- All high risk areas (ICUs, NICUs, PICU and BMT) annually
- 20% of wards on a rolling annual programme
- Wards where SICPs audit has been requested as part of actions agreed at an IMT (see below)

SCN/departmental manager will be expected to complete all actions required from all audit. Where there is a discrepancy between IPC and SCN/departmental manager audit results, the IPCT will review the process and criteria used to undertake SICPs audit to ensure that the audit process and criteria for data collection is applied consistently by those involved in audit.

SICPs audit request by Incident Management Team


The IPCT will also undertake a programme of SICPs audit at the request of an IMT as part of the investigation of an incident where this is considered relevant. Latest SICPs and hand hygiene audit activity will be discussed on all relevant IMTs and further audit activity described and agreed for report back to the IMT. Resulting completed action plans will be tabled at ongoing IMTs for assurance that all SICPs criteria are met.

Results of audit will be captured in IMT minutes and incident debrief reports.

4. SICPs Process on Care Assurance Information Resource (CAIR)

All SICPs and hand hygiene audit undertaken across NHS GGC will be captured on the CAIR dashboard in Microstrategy. Data input will be as described in *NHS GGC Guidance documentation for the CAIR data input dashboard (2018)*.

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At a glance, compliance with 6 monthly SICPs audit can be determined. Audit results, scores and action plans for each audit are also visible to hospital and ward level. All non-complaint criteria will be subject to improvement within timescales as described. SICPs compliance scores will be tabled in monthly IPC directorate and sector reports tabled at governance groups for oversight by senior management teams.

5. References

[National Infection Prevention and Control Manual: Home \(scot.nhs.uk\)](http://scot.nhs.uk)

[CNO \(2012\)1 - National Infection Prevention and Control Manual for NHS SCOTLAND: chapter 1: Standard Infection Control Precautions \(SICPs\) policy](#)

[National-manual-compliance-tool-2015-final.pdf \(scot.nhs.uk\)](#)

[Quality-Management-System-Framework-working-draft-3 \(2\).pdf](#)

[National Monitoring Framework \(2018\)](#)