INFECTION PREVENTION AND CONTROL AUDIT REPORT AND ACTION PLAN

Practice Name: East Croydon Medical Practice - H83044

Practice Code: H83044

GP Introduction

Introduction

The Health and Social Care Act (2008): code of practice on the prevention and control of infections and related guidance (revised 2015) outlines the role of infection prevention (including cleanliness) and optimising antimicrobial use and reducing antimicrobial resistance. This applies to NHS bodies and providers of independent healthcare and adult social care in England, including primary dental care, independent sector ambulance providers and primary medical care providers.

Effective prevention of infection must be part of everyday practice and be applied consistently by everyone. It is also a component of good antibiotic stewardship as preventing infections helps to reduce the need for antimicrobials. Good management and organisational processes are also crucial to ensure that high standards of infection prevention and control (including cleanliness) are set up and maintained Care Quality Commission (CQC) under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 ensures that the care people receive meets essential standards of quality and safety and encourages ongoing improvements by those who provide or commission care.

Providers must assess the risks to people's health and safety during any care or treatment and make sure that staff have the qualifications, competence, skills and experience to keep people safe. Where the responsibility for care and treatment is shared, care planning must be timely to maintain people's health, safety and welfare.

Providers must also ensure that the premises and any equipment used is safe, fit for purpose and where applicable, available in sufficient quantities. Medicines must be supplied in sufficient quantities, managed safely and administered appropriately to make sure people are safe.

Infection Prevention and Control in Primary Care General Practice

In primary care general practice there are a variety of ways where cross infection may be a potential risk, some of them may include:

· Overcrowding.

· Staff health

· Poor hand hygiene.

· Inadequate equipment cleaning / decontamination.

· Sharps management and transmission of blood borne viruses.

· Specimen handling

· Clinical waste segregation and management.

· Environmental cleaning and blood / bodily fluid spillages management.

All of these modes of transmission of infection are either avoidable or the risks can be minimised to low levels if the appropriate standard infection control procedures are followed. These measures include Hand hygiene, equipment management and decontamination, maintaining Aseptic Non-Touch Technique (ANTT), medicine management including cold chain system, environmental cleanliness and spillage management, wastes and sharps management, adhering to the correct usage of Personal Protective Equipment (PPE), staff health and management of infectious diseases. Hand hygiene is the single most effective means of preventing health care associated infections and should be a priority for implementation.

The Audit Process

NHS England London has placed increased emphasis on the use of audit to measure compliance to practice and the implementation of policies and procedures relating to infection control. The review of clinical practice through audit is a well-established means of monitoring and improving the quality of care and of supporting the implementation of change in practice.

As part of the process of ensuring that IPC standards are met, as well as ensuring that the quality of the infection control practice within primary care is of a high standard, NHS England London implements a continuing programme of practice visits, supported by experienced NEL Infection Prevention and control team.

The Audit Tool used is a consistent resource developed by NHS England London and NEL in collaboration with London Wide Local Medical Committees and Surrey and Sussex Local Medical Committees and is part of London region's Standard Operating Procedure, adopted by each Primary Care Commissioning Committee. The audit tool consists of several standards of IPC and defines acceptable criteria which minimises the risk of infection to patients, staff and relatives. The tool has recently been revised to take into account changes in standards, legislation and learning, where applicable to general medical practice, together with learning from more than 6 months of piloting and subsequent evaluation of the audit tool.

This new revised audit tool will present improved mechanisms for measuring compliance, identify best practice, and discover risks and vulnerabilities that may not have come to light using the current audit tool.

The audit tool standards and rating system have been updated to:
• More closely align with CQC registration compliance guidance where applicable
• provide clarification in terms of the requirements of primary medical contract holders related to the 'Health & Social Care Act 2008 code of practice on the prevention and control of infections', recognising that compliance with the act is a legal requirement, whereas the code of practice is considered guidance

• provide practices with a clearer understanding of the risks associated with non-compliance with each standard of the audit tool
• assist practices with their own risk assessments
• help practices to assure themselves that they are meeting infection control requirements in relation to CQC

The audit report and its recommendations help to ensure that practices improve their compliance to infection prevention and control in line with the Health & Social Care Act 2008 code of practice on the prevention and control of infections code of practice and other current national guidelines and should serve as a useful reference point.

Therefore it is essential that this report and its recommendations is given due consideration and that the agreed action plan which outlines how the practice plan to address the issues highlighted is completed and returned appropriately as advised.

Contractor Details

Practice Name	East Croydon Medical Practice - H83044
Practice Contract Number	H83044
Email Address	59 Addiscombe Road, East Croydon, CR0 6SD
Telephone No	0203 657 4170
Email address	sana.khan47@nhs.net
Practice Manager Name	Sana Khan
Principal GP Contractor	Dr Danny McCrea
Name of IPC Lead for Practice	Amanda Austin
Practice Nurse	Amanda Austin
Accompanying Practice Staff (One of whom must be the IPC Lead for the Practice)	Sana Khan and Amanda Austin
Date audit completed	2024-11-14
Audit carried out by	Stella Ojo
IUCD Fitting	Yes
Does the practice undertake minor surgery	No **Level:** None

Executive Summary

This is the report of infection prevention and control (IPC) audit carried out at East Croydon Medical Practice - H83044 on 2024-11-14. The audit was completed with the assistance of Sana Khan and Amanda Austin.

The practice has 18 consulting rooms and 7 treatment rooms. The practice does not undertake minor surgery. The practice has 4 vaccine fridges.

Findings:

The practice shows full compliance on all standards of IPC. Overall the practice showed full compliance with all standards of IPC designated as Essential Quality Requirements.

The practice was audited on 08/11/23 and this is a 12 month follow-up audit. All of the actions identified at the last audit have been completed. The Public Health IPC Team at NHSE acknowledges the input from staff to ensure compliance with all standards of Infection Prevention and Control.

Recommendations:

The practice is fully compliant, no action plan recommended. Advice was provided on the day of the audit on the importance of maintaining good IPC standards.

Most completed areas, equipment and surfaces within the practice appeared clean.

Risk assessment:

No risk assessment comments.

Next face-to-face audit: Next routine audit.

FURTHER CONSIDERATIONS

Thank you for colaborating with our audit.

Please complete this satisfaction survey to help us improve: NHS England Satisfaction Survey (click to open on a new window)

NHS England Contact Details

Organisation	Location	Names	Email Addresses
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		Stella Ojo Infection Prevention and Control Primary Care Specialist Nurse NHS England - London Work Mobile: 07795645888	stella.ojo@nhs.net
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Practice Details

Practice Building	Purposed built Leased
No of Consulting Rooms	18
No of Treatment Rooms	7
Minor surgery	No None
IUCD Fitting	Yes
Vaccine Fridge	Yes **Quantity**: 4 **Location**: Located in Room 8,12,19 and 21. **Make & SN**: 1.LEC S/N:207000654444440950 2.Labcold S/N:19800834 5000108 3.Coolmed S/N:732311121579PW 4.Coolmed S/N: - 732101240868PW
Cleaners storage facilities	Yes Limited space
Dirty Sluice Room	Yes
Clean Utility Room	Yes

Action Plan

The next section contains all details about the non-compliances found during the audit.

By now, you should have received an onboarding email to access MEG, where you will be able to manage the action plan and include the corrective actions.

If you haven't received any details or have any questions, please contact england.phipc@nhs.net

How to use MEG and access Action Plan (click to open on a new window)

IPC ACTION PLAN

No data yet!

Overall Compliance

100.0%

Compliance by Standard

General Management	**Staff Health**	**Environment**
100.0%	**100.0%**	**100.0%**
Hand Hygiene	**Personal protective equipment**	**Prevention and management of spillages**
100.0%	**100.0%**	**100.0%**
Safe handling and disposal of sharps	**Waste Management Policy and Procedures**	**Management of Specimens**
100.0%	**100.0%**	**100.0%**
Decontamination of medical devices	**Clinical Rooms**	**Vaccine Storage and Cold Chain**
100.0%	**100.0%**	**100.0%**
Notification of infectious diseases and contamination	**Antimicrobial Stewardship (AMS)**	**Minor Surgery rooms**
100.0%	**100.0%**	No data yet!

Full Audit Tool

1- Management of IPC - General Management

12 0 0 0

12 / 12 - 100.0%

Question	Issue	Comment	Attachments	Compliance
1. Is there a named clinical lead person in the practice for infection prevention and control? [M]	-	-	-	Compliant
2. Does the practice have infection prevention and control policies? [M]	-	-	-	Compliant
3. Is infection prevention and control included in all staff induction programmes? [M]	-	-	-	Compliant
4. Evidence to show that all clinical and non-clinical staff are up to date with IPC training specific to their roles? [M]	-	-	-	Compliant
5. Is there a process for internally recording/reporting untoward incidents in relation to infection prevention and control ? [M]	-	-	-	Compliant
6.1 Local IPC advice and support as needed [EQR & E]	-	-	-	Compliant
6.2 Local Hospital Consultant Microbiologists [EQR & E]	-	-	-	Compliant
6.3 Public Health England Health Protection teams [EQR & E]	-	-	-	Compliant
6.4 Local anti-microbial Pharmacy Lead [EQR & E]	-	-	-	Compliant
7 Does the practice have documentary evidence of IPC audits undertaken, evaluated and with actions taken to improve practice standards? [M]	-	-	-	Compliant
8 Has the Practice carried out a risk assessment for Legionella? [M]	-	-	-	Compliant
9 Does the practice have a written scheme for prevention of Legionella contamination in water pipes and other water lines? [M]	-	-	-	Compliant

Comments

The Legionella Risk Assessment was completed by Bison Assist on 17/09/24.

2- Management of IPC - Staff Health

4 0 0 0

4 / 4 - 100.0%

Question	Issue	Comment	Attachments	Compliance
1. Have all staff at risk been immunised against hepatitis B? [M]	-	-	-	Compliant
2. Are all staff routinely advised regarding immunisation against seasonal influenza? [EQR & E]	-	-	-	Compliant
3. Does the practice have access to Occupational Health service or access to appropriate occupational health advice? [M]	-	-	-	Compliant
4. Has the issue of immunity to Measles, Rubella and Varicella in clinical staff been considered in the practice and a risk assessment undertaken? [M]	-	-	-	Compliant

Comments

Guys and St Thomas' Hospital NHS Foundation Trust. is accessible to staff with a needlestick injury.

3- Environment

8 0 0 0

8 / 8 - 100.0%

Question	Issue	Comment	Attachments	Compliance
1. Are all areas including clinical areas and equipment visibly clean and free from extraneous items? [M]	-	-	-	Compliant
2. Are there comprehensive written specifications for cleaning the environment and equipment in the practice? [M]	-	-	-	Compliant
3. Are there up to date cleaning schedules which includes regular cleaning of clinical, admin and sanitary areas? [M]	-	-	-	Compliant
4. Are walls in all areas in good condition, intact and have smooth easy-to-clean surfaces? [EQR]	-	-	-	Compliant
5. Is flooring in all areas that are accessible to patients in a good state of repair and easy-to-clean? [EQR]	-	-	-	Compliant
6. Are furniture in clinical areas and other areas accessible to patients impermeable / washable / suitable for its use? [EQR]	-	-	-	Compliant
7. Are cleaning equipment and materials for cleaning colour coded, suitable for use and stored appropriately? [EQR]	-	-	-	Compliant
8. Is the area for storing cleaning equipment well ventilated, clean and tidy (no clutter) and is it of an adequate size? [EQR]	-	-	-	Compliant

Comments

Environmental cleaning is provided by Alliance cleaning Ltd.

4- Hand Hygiene

13 0 0 0

13 / 13 - 100.0%

Question	Issue	Comment	Attachments	Compliance
1. Does the practice has a Hand Hygiene Policy? [M]	-	-	-	Compliant
2. Is the hand hygiene technique displayed as a laminated poster adjacent to the hand washbasin or is it featured on the soap dispenser? [EQR]	-	-	-	Compliant
3.Does your practice policy demonstrate an awareness of the DH uniform policy? [EQR]	-	-	-	Compliant
4. Are there wash basins dedicated to hand hygiene in each clinical and consulting room which can be easily accessed? [EQR]	-	-	-	Compliant
5. Do all hand wash basins for use in connection with clinical procedures have elbow or wrist operated mixer taps? [EQR]	-	-	-	Compliant
6. Is the hot water thermostatically controlled? [EQR]	-	-	-	Compliant
7. Are taps at all clinical hand wash basins free from swan neck type taps? [EQR]	-	-	-	Compliant
8. Are all hand wash basins free from plugs? [EQR]	-	-	-	Compliant
9. Are all hand wash basins in clinical and consulting rooms free from an overflow? [EQR]	-	-	-	Compliant
10. Are hand hygiene facilities clean and free from clutter? [EQR]	-	-	-	Compliant
11. Are hand hygiene facilities free from damage? [EQR]	-	-	-	Compliant
12. Is the tap off-set from the waste outlet? [EQR]	-	-	-	Compliant
13. Is liquid soap dispensed from single use cartridges or bottles? [EQR]	-	-	-	Compliant

4 0 0 0

4 / 4 - 100.0%

Question	Issue	Comment	Attachments	Compliance
14. Is alcohol-based hand rub available for use when required, including use during domiciliary visit? [EQR]	-	-	-	Compliant
15. Are paper hand towels available? [EQR]	-	-	-	Compliant
16. Are hand wash basins free from nail brushes? [EQR]	-	-	-	Compliant
17. Are there separate arrangements available to dispose of waste materials other than using the hand washbasin? [EQR]	-	-	-	Compliant

Comments
-

5- Personal Protective Equipment (PPE)

9 0 0 0

9 / 9 - 100.0%

Question	Issue	Comment	Attachments	Compliance
1. Does the practice have a policy on the appropriate use of PPE? [M]	-	-	-	Compliant
2.1 Gloves (sterile/non-sterile) are appropriate for use, i.e, latex & latex free nitrile? [EQR]	-	-	-	Compliant
2.2 Disposable aprons available? [EQR]	-	-	-	Compliant
2.3 Disposable face and eye protection? [EQR]	-	-	-	Compliant
3. Are staff aware of the principles of wearing and disposing of PPE? [EQR]	-	-	-	Compliant
4. Are PPE items worn as single use items? [EQR]	-	-	-	Compliant
5. Where required are aprons and gloves changed between different episodes of care on the same patient? [EQR]	-	-	-	Compliant
6. Are gloves removed and hand hygiene performed after every clinical activity? [EQR]	-	-	-	Compliant
7. Are staff aware on the decontamination process required for re-usable goggles? [EQR]	-	-	-	Compliant

Comments
Masks, goggles, visors were available for facial protection.

6- Prevention and management of spillages

4 0 0 0

4 / 4 - 100.0%

Question	Issue	Comment	Attachments	Compliance
1. Does the practice have a policy for managing spillages in healthcare premises? [EQR]	-	-	-	Compliant
2. Are all staff aware of the procedure for dealing with spillages of blood or other body fluids? [EQR]	-	-	-	Compliant
3. Are spillage kits available for dealing with spillages of blood/body fluids? [M]	-	-	-	Compliant
4. Are disposable cloths or mop heads available for cleaning blood or other body fluid spillages? [EQR]	-	-	-	Compliant

Comments↓↑
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7- Safe handling and disposal of sharps

11 0 0 0

11 / 11 - 100.0%

Question	Issue	Comment	Attachments	Compliance
1. Does the practice have a policy on safe handling & disposal of sharps? [M]	-	-	-	Compliant
2. Are sharps containers that conform to BS 7320 and UN3291 available in every clinical/consulting area? [M]	-	-	-	Compliant
3. Are sharps containers discarded when two thirds full and stored in a secure facility away from public access until collected for disposal? [EQR]	-	-	-	Compliant
4. Is blood sampling undertaken by using a ‘Sharp Safe’ single-use vacuum blood collection system? [EQR]	-	-	-	Compliant
5. Is Aseptic Non-Touch Technique (ANTT) used when performing venepuncture? [EQR]	-	-	-	Compliant
6. Sharps used for taking blood from patients at home/care home disposed of in to an appropriate sharps container? [EQR]	-	-	-	Compliant
7. Is there evidence that the practice has undertaken a review of sharps management? [EQR]	-	-	-	Compliant
8. Are sharps containers assembled according to manufacturer's instructions? [M]	-	-	-	Compliant
9. Are staff encouraged to wear gloves when undertaking venepuncture? [EQR & E]	-	-	-	Compliant
10. Are staff aware of the correct procedure to follow after a needle stick injury, other sharps or blood splash exposure? [M]	-	-	-	Compliant
11. Are posters available which show staff the emergency algorithm to follow in case of a sharp injury and is it up to date? [EQR]	-	-	-	Compliant

Comments
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8- Waste Management Policy and Procedures

9 0 0 0

9 / 9 - 100.0%

Question	Issue	Comment	Attachments	Compliance
1. Does the practice have a policy on waste management? [M]	-	-	-	Compliant
2. Is there documentary evidence to show that all clinical waste is disposed of by a registered waste collection company? [M]	-	-	-	Compliant
3. Are records of waste transfer and disposal arrangements kept and stored in accordance with the EPA 1990? [EQR]	-	-	-	Compliant
4. Are there easily accessible and compliant foot-operated & fully enclosed clinical waste bins available in each clinical area? [EQR]	-	-	-	Compliant
5. Is clinical and domestic waste correctly segregated? [EQR]	-	-	-	Compliant
6. Are clinical waste bags marked with the practice code when securing for disposal? [EQR]	-	-	-	Compliant
7. Are waste bags less than 2/3 full and securely tied? [EQR]	-	-	-	Compliant
8. Where clinical waste is not collected directly from clinical areas, is it stored in a separate, secure area for waste? [EQR]	-	-	-	Compliant
9. Are staff encouraged to report all incidents to the designated infection control lead at the practice? [EQR]	-	-	-	Compliant

Comments

The clinical waste contract is with SRCL Ltd. Offensive waste stream has not been implemented at the practice. New guidance on offensive waste has been sent to staff.

9- Management of Specimens

4 0 0 0

4 / 4 - 100.0%

Question	Issue	Comment	Attachments	Compliance
1. Does the practice have a policy or procedure for specimen handling? [M]	-	-	-	Compliant
2. Where applicable are specimens stored in a dedicated refrigerator (not with food, vaccines or medicines)? [EQR]	-	-	-	Compliant
3. Are arrangements for specimen testing appropriate in consulting rooms? [EQR]	-	-	-	Compliant
4. Are staff aware of the appropriate way to handle and transport specimens? [EQR & E]	-	-	-	Compliant

Comments↓↑
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10- Decontamination of medical devices

7 0 0 0

7 / 7 - 100.0%

Question	Issue	Comment	Attachments	Compliance
1. Does the practice have a policy which outlines the decontamination processes the GP Practices use for all medical devices? [M]	-	-	-	Compliant
2. Does the practice use single use surgical instruments? [EQR]	-	-	-	Compliant
3. Does the practice use an accredited external sterile supply service? [EQR]	-	-	-	Compliant
4. Are all medical devices stored appropriately and above floor level to avoid contamination? [EQR]	-	-	-	Compliant
5. Are all items of sterile equipment within their use-by date? [EQR]	-	-	-	Compliant
6. All items of equipment that come into contact with patients cleaned or decontaminated according to guidelines or are disposed of after each use? [M]	-	-	-	Compliant
7. Is there a cleaning schedule/check list maintained for all items requiring cleaning? [EQR]	-	-	-	Compliant

Comments
-

11- Clinical Rooms

8 0 0 0

8 / 8 - 100.0%

Question	Issue	Comment	Attachments	Compliance
1. Are all clinical rooms and all work surfaces clean and free from extraneous items? [M]	-	-	-	Compliant
2. Is flooring impervious to liquids, non-slip, intact and clean? [EQR]	-	-	-	Compliant
3. Does the flooring form a coved skirting OR is the gap between the floor and the skirting sealed and is the seal maintained? [EQR]	-	-	-	Compliant
4. Are walls and ceilings clean, dry and free from visible defects and have smooth easy to clean surfaces? [EQR]	-	-	-	Compliant
5. Is there an examination couch with an intact, impervious cover and single use roller paper available for use? [EQR]	-	-	-	Compliant
6. Is the examination couch fitted with a paper roll holder? [E]	-	-	-	Compliant
7. Are there sufficient work surfaces and dressing trolleys of smooth, impervious and cleanable material? [EQR]	-	-	-	Compliant
8. Are all treatment surfaces in the room cleaned every working day? [EQR]	-	-	-	Compliant

Comments↓↑
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12- Vaccine Storage and Cold Chain

11 0 0 0

11 / 11 - 100.0%

Question	Issue	Comment	Attachments	Compliance
1. Does the practice have an up to date cold chain policy as per the standards of the Green Book and is this accessible to all staff? [M]	-	-	-	Compliant
2. Is there a designated person/s in the practice responsible for the ordering, delivery and storage of vaccines? [EQR]	-	-	-	Compliant
3. Are vaccines monitored for their expiry dates and the close to expiry stocks clearly labelled? [EQR]	-	-	-	Compliant
4. Is the refrigerator specialised for the storage of vaccines? [M]	-	-	-	Compliant
5. Are vaccines correctly stored to allow good air flow within the vaccine refrigerator? [EQR]	-	-	-	Compliant
6. Are there measures in place to prevent the fridge from being turned off? [EQR]	-	-	-	Compliant
7. Is/Are the vaccine fridge/s located in a well-ventilated area? [EQR]	-	-	-	Compliant
8. Is the temperature of the vaccine fridge continually monitored with a min/max thermometer and the temperatures are recorded each working day to ensure vaccines are maintained at 2-8OC? (Min, max and actual fridge temperatures are recorded)? [M]	-	-	-	Compliant
9. Does the practice has a maintenance contract that allows for at least yearly servicing, calibration of the temperature gauge? [EQR]	-	There is a contract in place for J Pen Ltd to service the vaccine fridge and calibrate the fridge's temperature gauge.	-	Compliant
10. Is a second min/max thermometer or Data Logger temperature recording device available and used? [EQR]	-	-	-	Compliant
11. Is the fridge either self-defrosting or is it defrosted monthly or sooner if needed? [EQR]	-	-	-	Compliant

3 0 0 0

3 / 3 - 100.0%

Question	Issue	Comment	Attachments	Compliance
12. Is there a process in place for safe disposal of expired, damaged or surplus vaccines? [EQR]	-	-	-	Compliant
13. Does the practice have records of vaccines received? [EQR]	-	-	-	Compliant
14. Is there accessible written guidance on what staff should do in the event of a power cut or a temperature reading outside the required range? [EQR]	-	-	-	Compliant

Comments

-

13- Notification of infectious diseases and contamination

6 0 0 0

6 / 6 - 100.0%

Question	Issue	Comment	Attachments	Compliance
1. Does the practice have a policy on managing patients with communicable diseases? [M]	-	-	-	Compliant
2. Does the practice notify all reportable infectious disease on suspicion to the proper officer at the local authority? [M]	-	-	-	Compliant
3. Does the practice have access to notification forms? [EQR]	-	-	-	Compliant
4. Does the practice notifying gastro intestinal disease (food poisoning) on suspicion? [EQR]	-	-	-	Compliant
5. Does the practice notify Gastro intestinal disease (food poisoning) when stool specimen results are received from the microbiology laboratory? [EQR]	-	-	-	Compliant
6. Is the practice aware of the new requirements to notify cases of contamination and other diseases? [EQR]	-	-	-	Compliant

Comments↓↑
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14- Antimicrobial Stewardship (AMS)

13 0 0 0

13 / 13 - 100.0%

Question	Issue	Comment	Attachments	Compliance
1. Are GP prescribers in the practice aware of the TARGET toolkit? [EQR]	-	-	-	Compliant
2. Have all GP prescribers completed the Antimicrobial Stewardship Self-Assessment Checklist available in TARGET? [EQR]	-	-	-	Compliant
2.1 Give number of GP prescribers using the self-assessment checklist against those who do not [EQR]	-	-	-	Compliant
3. Is the document “Antimicrobial prescribing and stewardship competencies” available and/or has it been read by prescribers in the practice? [EQR]	-	-	-	Compliant
3.1 Give number of prescribers who are aware of this document against those who are not [EQR]	-	-	-	Compliant
4. Are all the prescribers in the Practice aware of the Public Health England AMR local indicators? [EQR]	-	-	-	Compliant
5. Is the practice aware of how they may access their antibiotic prescribing data online? [EQR]	-	-	-	Compliant
6. Are all prescribers in the practice aware of the NICE guidelines on AMS [EQR]	-	-	-	Compliant
7. Do all prescribers give information to their service users of how they should correctly use antimicrobial medicines and the dangers associated with their overuse and misuse? [EQR]	-	-	-	Compliant
8. Are all prescribers aware of the UK’s 5-year Antimicrobial Resistance Strategy? [E]	-	-	-	Compliant
9. Does the practice actively participates in the European Antibiotic Awareness Day/Week (EEAD) held in November each year? [E]	-	-	-	Compliant
10. Are all clinical staff in the Practice aware of the PHE Antibiotic Guardian campaign? [E]	-	-	-	Compliant
11. Does the practice have an identified sepsis lead / link? [E]	-	Dr Paul Rybinski is the Sepsis Lead.	-	Compliant

3 0 0 0

3 / 3 - 100.0%

Question	Issue	Comment	Attachments	Compliance
12. Are clinicians/GPs aware of and/or have received training in identifying sepsis? [EQR]	-	-	-	Compliant
13. Does the practice promote the use of the GRASP Fever Audit tool? [E]	-	-	-	Compliant
14. Does the practice make use of the National Early Warning Signs (NEWS) tool and the Paediatric Early Warning Signs (PEWS) tool? [EQR]	-	-	-	Compliant

Comments

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15- Minor Surgery rooms

0 0 0 13

0 / 0 - -

Question	Issue	Comment	Attachments	Compliance
1. Is there is a dedicated room for minor surgery or is the clinical room of sufficient standard for undertaking level 2 minor surgery? [M for Level 2&3 minor surgery]	-	-	-	-
2. Are all sterile packs and other equipment stored appropriately and is there adequate storage space? [M for Level 2&3 minor surgery]	-	-	-	-
3. Is the practice using disposable single use instruments, supplied by a recognised manufacturer of sterile disposable instruments? [M for Level 2&3 minor surgery]	-	-	-	-
4. Where applicable, is an accredited external sterile supply service used for re-usable surgical instrument that need to be sterile at the point of use? [M for Level 2&3 minor surgery]	-	-	-	-
5. Is the minor surgery room clean and free from extraneous items? [M]	-	-	-	-
6. Are walls in good condition, intact and have smooth easy-to-clean surfaces? [M for Level 2&3 minor surgery]	-	-	-	-
7. Is flooring impermeable, intact and have continuous edging coved up the walls? [M for Level 2&3 minor surgery]	-	-	-	-
8. Are ceilings intact and free from visible cracks or visible defects? [M for Level 2&3 minor surgery]	-	-	-	-
9. Are ceiling lights protected / enclosed from potential contamination? [M for Level 2&3 minor surgery]	-	-	-	-
10. Does the room have adequate ventilation - natural or mechanical (no desktop fans)? [M for Level 2&3 minor surgery]	-	-	-	-
11. Is the heat source and pipe work in the room enclosed to prevent accumulation of dust and dirt? [M for Level 2&3 minor surgery]	-	-	-	-
12. Is the treatment couch intact and is protected with disposable paper towel that is changed after each patient? [M for Level 2&3 minor surgery]	-	-	-	-
13 Are all work surfaces intact, smooth, and impervious easy to clean and are able to withstand cleaning with chemical disinfectants? [M for Level 2&3 minor surgery]	-	-	-	-

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Question	Issue	Comment	Attachments	Compliance
14. Are all wall cabinets intact with doors? [EQR]	-	-	-	-
15. Does the clinical hand wash basin conforms to current recommended guidance (HTM 00-10; HBN 00-09)? [M for Level 2&3 minor surgery]	-	-	-	-
16. Are there wall mounted dispensers for liquid soap and is the liquid soap dispensed via non-refillable cartridges? [M for Level 2&3 minor surgery]	-	-	-	-
17. Are there wall mounted dispensers with good quality disposable paper hand towels? [M for Level 2&3 minor surgery]	-	-	-	-
18. Is the clinical hand wash basin free from re-usable nail brushes? [M for Level 2&3 minor surgery]	-	-	-	-
19. Are single use sterile and non-sterile gloves available in latex and non-latex nitrile material? [M for Level 2&3 minor surgery]	-	-	-	-
20. Is there is a designated stainless steel trolley available for use in this room only? [M for Level 2&3 minor surgery]	-	-	-	-
21. Is there a clean clinical waste bin with a foot pedal with waste bag fully enclosed and is it in good operating condition? [M for Level 2&3 minor surgery]	-	-	-	-
22. Do all staff use recommended PPE when splashing of body fluids is anticipated? [M for Level 2&3 minor surgery]	-	-	-	-
23. Are disposable sterile drapes available and used for level 2 and level 3 minor surgeries? [M for Level 2&3 minor surgery]	-	-	-	-
24. Does the GP Practice audit post-operative wound infections and are records kept? [M for Level 2&3 minor surgery]	-	-	-	-

Comments↓↑
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Signatures

Stella Ojo:

APPENDIX

Key - Infection Prevention & Control Questionnaire

- **Mandatory [M]**: either required on a statutory and/or contractual basis and aims to align with relevant CQC requirements that result in CQC reports specifying that a practice ‘must do…’
- **An Essential Quality Recommendation [EQR]**: the minimum expected standards for compliance as detailed in the Health and Social Care Act 2008 (Hygiene Code). EQRs will typically align with relevant CQC requirements that result in CQC reports specifying a practice ‘should do…’
- **Educational [E]:** these are best practice standards, which align with what practices should ‘know about’. Contractors are advised to record that there has been a discussion about these standards within the practice.

Section 1: The Management of Infection Prevention and Control (General Management)

Standard: Infection prevention and control is managed effectively and complies with the Health and Social Care Act 2008: Code of practice on the prevention and control of infection and related guidance (July 2015)

#	Questions	M= Mandatory EQR= EQR E= Educational	Risk Level	Remedial action recommended to resolve problem	Ref
1	**Is there a named clinical lead person in the practice for infection prevention and control?**	**M** **This is a requirement of Criterion 2 of the Health & Social Care Act 2008 (Amended 2015),** which states that: The IPC Lead should: • be responsible for the organisation's infection prevention (including cleanliness) management and structure and the establishment of a water safety group; • oversee local prevention of infection policies and their implementation; • report directly to the registered provider; • have the authority to challenge inappropriate practice, if appropriate, including antimicrobial prescribing practice; • have the authority to set and challenge standards of cleanliness; • assess the impact of all existing and new policies on infections and make recommendations for change; • be an integral member of the organisation's governance, water safety group, and safety teams and structures where they exist; and • produce an annual statement with regard to compliance with practice on infection prevention and cleanliness and make it available on request.	**Moderate**	To ensure that there is a named clinical lead person in the practice for infection prevention and control.	**1**

2	**Does the practice have infection prevention and control policies?**	**M** **Criterion 9 of The Health & Social Care Act 2008 (Updated 2015) requires registered provider to:** Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections. 9.- A registered provider should, in relation to preventing, reducing and controlling the risks of infections, have in place the appropriate policies concerning the matters mentioned in a) to y) below. All policies should be clearly marked with a review date and the review date adhered to. 9. - Any registered provider should have policies in place relevant to the regulated activity it provides. Each policy should indicate ownership (i.e. who commissioned and retains managerial responsibility), authorship and by whom the policy will be applied. Implementation of policies should be monitored and there should be evidence of a rolling programme of audit and a date for revision stated.	**Moderate** It is a requirement of the Health and Social Care Act 2008 (Amended 2015) Criterion 9 that practices have and adhere to policies designed for the individual care and provider organisations that will help to prevent and control infections.	To ensure that the practice have up to date infection prevention and control policies.	2
3	**Is infection prevention and control included in all staff induction programmes?**	**M** The Health and Social Care Act 2008 (Amended 2015) Criterion 6, section 6.2 states that 'Infection prevention would need to be included in the job descriptions and be included in the induction programme and staff updates of all employees (including volunteers)'.	**Moderate**	To ensure infection prevention and control included in all staff induction programmes.	3
4	**Does the practice have evidence to show that all clinical and non-clinical staff (including cleaning staff) are up to date with infection prevention and control training specific to their roles?**	**M** **Criterion 6 of The Health and Social Care Act 2008 (Amended 2015)** requires providers to have systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	**Moderate** Criterion 6 of The Health and Social Care Act 2008 (Amended 2015) requires providers to have systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	To ensure the practice have evidence to show that all clinical and non-clinical staff (including cleaning staff) are up to date with infection prevention and control training specific to their roles.	4

5	**Is there a process for internally recording/reporting untoward incidents in relation to infection prevention and control (e.g. sharps and body fluid splashes)?**	**M** **Under 'Health and Safety (Sharp Instruments in Healthcare) Regulations 2013** **Guidance for employers and employees'** Recording and investigating the incident – regulation 7(1) Employers must make a record of the sharps injury when they are notified of it, whoever provides that notification. They must investigate the circumstances and causes of the incident and take any action required. The injured person is required to provide sufficient information to their employer to allow them to carry out this investigation. The record of the injury should include who was injured, and when and where the incident occurred. If possible, the summary record should contain sufficient detail to identify what type of sharp was involved, at what stage of a procedure or post-procedure/disposal of the sharp the injury occurred, and the severity of the injury. If the employer has an existing accident book or other recording system, it will be appropriate to use this for the record of sharps injuries. Under the EH 40/2005 Workplace Exposure Limit**,** it is required that those responsible for controlling exposure to hazardous substances at work are not breaching the Health and Safety at Work Act 1974.	**Moderate - High** Under the EH 40/2005 Workplace Exposure Limit, it is required that those responsible for controlling exposure to hazardous substances at work are not breaching the Health and Safety at Work Act 1974.	To ensure there is a process for internally recording/reporting untoward incidents in relation to infection prevention and control.	5
6	**Does the practice have a recorded process in place that includes access to:**				6
6.1	**Local IPC advice and support as needed.**	**EQR & E**	**Low**	Ensuring systems are in place to allow staff to seek expert IPC advice	
6.2	**Local Hospital Consultant Microbiologists.**	**EQR & E**	**Low**	Ensuring systems are in place to allow staff to seek expert microbiology advice.	
6.3	**Public Health England Health Protection teams**	**EQR & E**	**Low**	To ensure that systems are in place to allow staff to seek expert public health advice.	
6.4	**Local anti-microbial Pharmacy Lead**	**EQR & E**	**Low**	To ensure that systems are in place to allow staff to seek expert antimicrobial advice.	
7	**Does the practice have documentary evidence of infection prevention and control audits undertaken, evaluated and with actions taken to improve practice standards?**	**M** **Criterion 1 of The Health & Social Care Act 2018 (Amended 2015)** requires that providers have 'Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them'.	**Moderate**	To ensure there is documentary evidence of infection prevention and control audits undertaken, evaluated and with actions taken to improve practice standards.	2

8	**Has the Practice carried out a risk assessment for Legionella under the Health & Safety Executives "Legionella' disease – the control of Legionella bacteria in water systems: Approved code of practice & Guidance" (also known as L8)**	**M** **Legionella disease – The control of legionella in water system: Approved Code of Practice (ACOP):** A suitable and sufficient assessment must be carried out to identify and assess the risk of exposure to legionella bacteria from work activities and water systems on the premises and any precautionary measures needed. The duty-holder is responsible for ensuring the risk assessment is carried out.	**Moderate - High.** A detailed risk assessment will inform the practice of any areas of non-compliance such as dead legs, dirty water tanks and any remedial actions required to minimise the risk of legionella proliferation. Some groups of patients such as immunocompromised may be at risk of infection from the legionella bacteria.	To ensure the Practice has carried out a risk assessment for Legionella under the Health & Safety Executives "Legionella' disease – the control of Legionella bacteria in water systems: Approved code of practice & Guidance.	7, 8, 9, 10
9	**Does the practice have a written scheme for prevention of Legionella contamination in water pipes and other water lines?**	**M** **Legionella disease – The control of legionella in water system: Approved Code of Practice (ACOP):** A suitable and sufficient assessment must be carried out to identify and assess the risk of exposure to legionella bacteria from work activities and water systems on the premises and any precautionary measures needed. The duty-holder is responsible for ensuring the risk assessment is carried out.	**Moderate - High.** A detailed risk assessment will inform the practice of any areas of non-compliance such as dead legs, dirty water tanks and any remedial actions required to minimise the risk of legionella proliferation. Some groups of patients such as immunocompromised may be at risk of infection from the legionella bacteria	To ensure the practice have a written scheme for prevention of Legionella contamination in water pipes and other water lines.	11

Section 2: The Management of Infection Prevention and Control (Staff Health)

Standard: Infection prevention and control is managed effectively and complies with the Health and Social Care Act 2008: Code of practice on the prevention and control of infection and related guidance (July 2015)

#	Questions	M= Mandatory EQR= EQR E= Educational	Risk Level	Remedial action recommended to resolve problem	Ref
1	**Have all staff at risk been immunised against hepatitis B and have they had their response to vaccination confirmed by serology for anti HBs antibodies? It is recommended that practices keep a copy of the hepatitis B levels. {*At risk staff are those who may have direct contact with patient's blood or blood stained body fluids (including cleaning staff)}***	**M** **Criterion 9 of The Health & Social Care Act 2008 (Updated 2015) requires registered provider to:** Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections. *f. Section F: Prevention of occupational exposure to blood-borne viruses (BBVs) including prevention of sharps injuries* Measures to avoid exposure to BBV's (hepatitis B and C and HIV) should include: • immunisation against hepatitis B, as set out in *Immunisation against infectious disease*, better known as 'The Green Book' (published by Public Health England); • the wearing of gloves and other protective clothing; • the safe handling and disposal of sharps, including the provision of medical devices that incorporate sharps protection where there are clear indications that they will provide safe systems of working for staff; and • measures to reduce risks during surgical procedures	**High** Low level of immunity or no immunity to Hepatitis B may place HCWs at risk of cross infection especially in cases of inoculation accidents.	Up to date immunisation status and immunity levels on hepatitis B should be kept at the practice and made available on inspection.	**12, 13**
2	**Are all staff routinely advised regarding immunisation against seasonal influenza?**	**EQR & E**	**Moderate** Some groups of patients may be at risk of influenza infection which may be transmitted by healthcare workers.	To ensure that clinical staff are encouraged to be immunised against seasonal influenza.	**3, 14, 15**

3	**Does the practice have access to Occupational Health service or access to appropriate occupational health advice? (This may include pre-employment checks to ensure appropriate immunisations have been given.)**	**M** Under the Health and Safety Act 1974, the Occupational Health are required to provide advice on health issues relevant to the working environment**.** **The Health & Social Care Act 2008** C Criterion 10, Section 10.3 Occupational health services in respect of BBVs should include: • having arrangements for identifying and managing healthcare staff infected with hepatitis B or C or HIV and advising about fitness for work and monitoring as necessary, in line with Department of Health guidance; • liaising with the *UK Advisory Panel for Healthcare Workers Infected with Blood-borne Viruses* when advice is needed on procedures that may be carried out by BBV-infected care workers, or when advice on patient tracing, notification and offer of BBV testing may be needed; • a risk assessment and appropriate referral after accidental occupational exposure to blood and body fluids; and • management of occupational exposure to infection, which may include provision for emergency and out-of-hours treatment, possibly in conjunction with accident and emergency services and on-call infection prevention and control specialists.	**Moderate**	To ensure that practice staff have access to occupational health service or appropriate occupational health advice.	**16**
4	**Has the issue of immunity to Measles, Rubella and Varicella in clinical staff been considered in the practice and a risk assessment undertaken?**	**M** **Criterion 9 of The Health & Social Care Act 2008 (Updated 2015) requires registered provider to:** Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections. *f. Section F: Prevention of occupational exposure to blood-borne viruses (BBVs) including prevention of sharps injuries* Measures to avoid exposure to BBV's (hepatitis B and C and HIV) should include: • immunisation against hepatitis B, as set out in *Immunisation against infectious disease*, better known as 'The Green Book' (published by Public Health England); • the wearing of gloves and other protective clothing; • the safe handling and disposal of sharps, including the provision of medical devices that incorporate sharps protection where there are clear indications that they will provide safe systems of working for staff; and • measures to reduce risks during surgical procedures	**Moderate** Some groups of patients may be at risk of measles, Rubella and Varicella infection which may be transmitted by healthcare workers.	To ensure that a risk assessment is undertaken for all clinical staff on issues of immunity to Measles, Rubella and Varicella.	**14**

Section 3: Environment

Standard: The environment is designed and managed to minimise reservoirs for microorganisms and reduce the risk of cross-infection to patients, staff and visitors.

#	Questions	M= Mandatory EQR= EQR E= Educational	Risk Level	Remedial action recommended to resolve problem	Ref
1	**Are all areas including clinical areas and equipment visibly clean and free from extraneous items?**	**M** Criterion 2 of The Health and Social Care Act 2008 (Amended 2015) requires all parts of the premises from which it provides care are suitable for the purpose, kept clean and maintained in good physical repair and condition.	**Moderate – High** This depends on whether it is a consulting room or treatment room where invasive procedures such as coil fitting is undertaken.	All areas including clinical areas should be visibly clean and free from extraneous items. Clutter allow dust and dirt to settle and may hinder adequate cleaning. To ensure that a thorough cleaning of high level surfaces as well as low level surfaces is undertaken. This type of cleaning should be carried out on a regular basis to minimise dust and dirt accumulation.	17, 18
2	**Are there comprehensive written specifications for cleaning the environment and equipment in the practice?**	**M** Criterion 2 of The Health and Social Care Act 2008 (Amended 2015) requires providers to maintain a clean and safe environment to maintain patient and staff safety.	**Moderate**	All health care premises should show adequate level of environmental cleaning in line with the revised Cleaning code.	18
3	**Are there up to date cleaning schedules which includes regular cleaning of clinical, admin and sanitary areas (e.g. toilets, fans, air conditioners, high areas, curtains, blinds, toys, computer keyboards, telephones and desks)?**	**M** Criterion 2 of The Health and Social Care Act 2008 (Amended 2015) requires providers to maintain a clean and safe environment to maintain patient and staff safety.	**Moderate**	Up to date cleaning schedules which includes regular cleaning of clinical, admin and sanitary areas (e.g. toilets, fans, air conditioners, high areas, curtains, blinds, toys, computer keyboards, telephones and desks) should be available and cleaning staff should follow the schedule protocol.	18
4	**Are walls in all areas in good condition (no cracked or peeling paintwork), intact and have smooth easy-to-clean surfaces?**	**EQR**	**Moderate – High** This depends on the condition of the walls. For example walls in a clinical room affected by damp and mould will pose a higher risk of cross infection if the room is being used for certain invasive procedures.	Wall surfaces and splash back in all clinical areas should be smooth without cracks or joints and easy to clean. Splash backs should be smooth finish, seamless and easy to clean. Ceramic tiles are not recommended because of multiple joints which can get damaged in many ways and may harbour harmful micro-organisms. To ensure that the wall surfaces and splash backs are rendered with an impervious and smooth finish.	**19**

5	**Is flooring in all areas that are accessible to patients (including corridors, staircase leading to consulting rooms, consulting rooms in a good state of repair and easy-to-clean? (Carpets are not recommended)**	**EQR** Where carpet flooring is available in consulting rooms, these should be in a good state of repairs and steam cleaned on a regular basis. **There should be a plan in place for carpet flooring in all patient associated areas to be replaced at the next practice refurbishment with flooring which are impervious to fluids, seamless and without joints and the edges with the walls should be either sealed or continuous to the walls with a coved edge.** **Flooring for clinical/ treatment rooms is covered in Section 11 of the audit tool.**	**Moderate – High** This depends on whether invasive procedures such as coil fitting is being undertaken in consulting rooms.	Carpets are not recommended for use in healthcare environment used by patients due to risks of contamination and spillage. Where carpet is available, these should be in a good state of repairs and are steam cleaned on a regular basis. There should be a plan in place for carpet flooring in all patient associated areas to be replaced at the next practice refurbishment with flooring which are impervious to fluids, seamless and without joints and the edges with the walls should be either sealed or continuous to the walls with a coved edge.	19
6	**Are furniture (e.g. chairs, couches, pillows etc) in clinical areas and other areas accessible to patients impermeable / washable / suitable for its use?**	**EQR** Furniture such as seating for patient in clinical rooms / waiting areas, should be impervious and easy to clean as well as compatible with detergents and disinfectants.	**Moderate** HTM 03-01 section 10.21 requires impervious surfaces for easy clean and to avoid the build-up of dust.	Furniture such as seating for patient in clinical rooms / waiting areas, should be impervious and easy to clean as well as compatible with detergents and disinfectants.	18,19
7	**Are cleaning equipment and materials for cleaning colour coded, suitable for use and stored appropriately?**	**EQR**	**Moderate** This is to minimise risks of bacterial growth and multiplication.	Mops and buckets used in the practice should be colour coded (Red, Blue, Green & Yellow) to ensure that the appropriate coloured cleaning equipment is used for defined areas such as clinical areas, kitchen, toilets and general areas. To ensure that the appropriate colour coded mops and buckets are available and used. Furthermore, we recommend that brackets are placed to hold the mops and ensure adequate drying. This will minimise risks of bacterial growth and multiplication. The brackets should be adequately spaced to prevent the mop heads from touching one another which will defeat the purpose of having separate mops.	17
8	**Is the area for storing cleaning equipment well ventilated, clean and tidy (no clutter) and is it of an adequate size?**	**EQR**	**Moderate** Mops and cleaning equipment need to be protected from risk of contamination. A well ventilated cleaning storage area will allow for mop heads to dry.	To ensure that the area for storing cleaning equipment is of an adequate size, well ventilated, clean and tidy.	17

Section 4: Hand Hygiene

Standard: The practice has a clear mechanism to ensure effective implementation of hand hygiene procedures are in place and hand hygiene is practiced at all times to reduce the potential for cross infection between staff, patients, the environment and equipment.

#	Questions	M= Mandatory EQR= EQR E= Educational	Risk Level	Remedial action recommended to resolve problem	Ref
1	**Does the practice has a Hand Hygiene Policy?**	**M** **Criterion 9 of The Health & Social Care Act 2008 (Updated 2015) requires registered provider to:** Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections. *a. A. Standard infection prevention and control precautions* Preventing infections reduces the overall need to use antimicrobials and helps to reduce selection pressure for the development of antimicrobial resistance. • Policy should be based on evidence-based guidelines, including those on hand hygiene at the point of care and the use of personal protective equipment; • Policy should be easily accessible and be understood by all groups of staff, service users and the public. • Compliance with the policy should be audited • Provisions on regular refresher training, support for patients to clean their hands, and products for staff with occupational dermatitis are among the issues that should be covered in the hand hygiene policy. The NHS Outcome Framework enforces the 'treating and caring for people in a safe environment and protecting them from avoidable harm'	**Moderate**	To ensure that a hand washing policy is developed. This policy should be made readily available for all staff to refer to as a source of reference.	**2**
2	**Is the hand hygiene technique displayed as a laminated poster adjacent to the hand washbasin or is it featured on the soap dispenser?**	**EQR**	**Low** This serves as a reminder for staff to use the correct techniques.	To ensure that posters featuring the hand hygiene process are displayed adjacent to hand washbasins.	**20**

3	**Does your practice policy demonstrate an awareness of the DH uniform policy particularly in treatment rooms and minor surgery room? (E.g. bare below the elbows).**	**EQR** https://www.nice.org.uk/news/article/effective-and-practical-measures-to-prevent-infection-outlined-by-nice	**Moderate** Clinical staff should be free from jewellery, wrist watches, long nails, artificial nails and nail varnish, as these will prevent adequate hand hygiene in clinical environment.	To ensure that clinical staff are free from jewellery, wrist watches, long nails, artificial nails and nail varnish, as these will prevent adequate hand hygiene in clinical environment.	**2, 21**
4	**Are there wash basins dedicated to hand hygiene in each clinical and consulting room which can be easily accessed?**	**EQR**	**Moderate** To comply with HBN 00-09 requirements.	To ensure that a dedicated hand washing sink is available in each clinical and consulting room. This will encourage hand washing and prevent cross infection.	**22**
5	**Do all hand wash basins for use in connection with clinical procedures have elbow or wrist operated mixer taps?**	**EQR**	**Moderate** To comply with HBN 00-09 requirements.	To ensure that all clinical hand washing sinks have taps with elbow or wrist lever operated mixer taps.	**18, 22**
6	**Is the hot water thermostatically controlled?**	**EQR**	**Moderate** To comply with HBN 00-09 requirements.	Hot water for hand washing sinks should be thermostatically in order to prevent scalding during hand washing.	**23**
7	**Are taps at all clinical hand wash basins free from swan neck type taps?**	**EQR**	**Moderate** To comply with HBN 00-09 requirements.	Taps with swan neck faucet are not compliant with current infection control guidance as they do not empty completely.	**19**
8	**Are all hand wash basins free from plugs?**	**EQR**	**Moderate** To comply with HBN 00-09 requirements.	Clinical hand washing sink should not contain a plug, as sink with plugs could be used for other purposes for example washing of re-usable instruments such as ear syringing equipment.	**22**
9	**Are all hand wash basins in clinical and consulting rooms free an overflow?**	**EQR**	**Moderate** To comply with HBN 00-09 requirements.	Clinical hand washing sinks with overflow are non-compliant because the tube that connects the overflow to the drain may contain a number of biofilms which may increase risks of hand contamination.	**22**
10	**Are hand hygiene facilities clean and free from clutter (check wash basins, taps, splash-backs, soap and paper-towel dispensers)?**	**EQR**	**Moderate** To prevent contamination and to adhere to Criterion 2 of The Health & Social Care Act 2008.	Hand washing sinks should be free from clutter and clean so as to prevent contamination and for ease of access to hand hygiene.	**18**
11	**Are hand hygiene facilities free from damage?**	**EQR**	**Low** To prevent the risks of multiplication of micro-organisms in grooves/ damaged surfaces which are not easily cleaned.	Damage to hand hygiene facilities can prevent proper cleaning and increase the risks of micro-organism settling in.	**19**
12	**Is the tap off-set from the waste outlet?**	**EQR**	**Moderate** This is a requirement for clinical hand washing sinks as detailed on page 16 of the HBN 00-09.	Taps discharging directly into a drain hole can cause splashing, which could disperse contaminated droplets. The tap outlet flow should not discharge directly into the waste aperture.	**22**
13	**Is liquid soap dispensed from single use cartridges or bottles? (I.e. no bar soap or refillable containers)?**	**EQR**	**Low** Liquid soap dispensers should be wall-mounted at all wash-hand basins and be designed to be operated without contamination from the user's hands coming into direct contact with the dispensing mechanism.	Refillable cartridges can present a risk to contamination of the whole container	**24**

14	**Is alcohol-based hand rub available for use when required, including use during domiciliary visit?**	**EQR**	**Low** Guidance from WHO	To promote hand hygiene compliance during home visits.	**20**
15	**Are paper hand towels available? (I.e. no cloth towels in use).**	**EQR**	**Moderate** As detailed in HBN 00-09. The use of paper towels in rolls should be discouraged; they are difficult to tear off without contaminating the remaining roll.	Fabric towels are a source of cross-contamination and are not recommended in clinical areas.	**20**
16	**Are hand wash basins free from nail brushes?**	**EQR**	**Low**	Nail brushes can be a source of contamination and are not recommended in Practices	**25**
17	**Are there separate arrangements available to dispose of waste materials (e.g. urine) other than using the hand washbasin?**	**EQR**	**Moderate** This can be a source of cross contamination.	Waste materials should not be poured down the hand washing sinks but disposed of in a flushable sluice or toilets.	**26**

Section 5: Personal Protective Equipment (PPE)

Standard: Protective clothing is available/worn for all aspects of care which may involve contact with blood/body fluids or where asepsis is required

#	Questions	M= Mandatory EQR= EQR E= Educational	Risk Level	Remedial action recommended to resolve problem	Ref
1	**Does the practice have a policy on the appropriate use of PPE?**	**M** **Criterion 9 of The Health & Social Care Act 2008 (Updated 2015) requires registered provider to:** Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections. *Section f. Prevention of occupational exposure to blood-borne viruses (BBVs) including prevention of sharps injuries* M Measures to avoid exposure to BBV's (hepatitis B and C and HIV) should include: • immunisation against hepatitis B, as set out in *Immunisation against infectious disease*, better known as 'The Green Book' (published by Public Health England); • the wearing of gloves and other protective clothing; • the safe handling and disposal of sharps, including the provision of medical devices that incorporate sharps protection where there are clear indications that they will provide safe systems of working for staff; and • measures to reduce risks during surgical procedures	**Moderate**	To ensure that a policy on the appropriate use of PPE is developed. This policy should be made readily available for all staff to refer to as a source of reference.	**2**
2 2.1	**Are the following PPE available for staff?** **Gloves (sterile/non-sterile) are appropriate for use, i.e, latex & latex free nitrile?** ***Vinyl gloves are not recommended for clinical activities were blood/body fluid may be anticipated.***	**EQR**	**Moderate** Health and Safety Act 1974	To ensure that the practice have access to latex and latex free gloves. Alternative to non-latex would be to use Nitrile gloves Vinyl gloves can be used to perform many tasks in the health care environment, but are not appropriate when handling blood, blood-stained fluids, cytotoxic drugs or other high risk substances. The risks are: • They have absorbent properties • They are brittle and may tear easily	**27, 28, 29, 30**

2.2	**Disposable aprons available?**	**EQR**	**Moderate** Health and Safety Act 1974	To ensure that plastic disposable aprons are available in all clinical areas.	**31**
2.3	**Disposable face and eye protection (to be worn by staff if splashing of blood, body fluids or chemicals is anticipated)?**	**EQR**	**Moderate** Infection: Prevention and control of healthcare associated infection in primary and community care. (2012)	To prevent risks of contamination /transmission	**31**
3	**Are staff aware of the principles of wearing and disposing of PPE? (i.e. disposable gloves, aprons masks and goggles)**	**EQR**	**Moderate** Training of staff in the use of PPE to minimise risks of contamination.	To ensure all staff are aware of the risks when donning and doffing of PPE.	**31**
4	**Are PPE items worn as single use items?**	**EQR**	**Moderate** To minimise risks of cross contamination/transmission.	To ensure that items that are designated as single use are not re-used.	**31, 32**
5	**Where required are aprons and gloves changed between different episodes of care on the same patient?**	**EQR**	**Moderate** To minimise risks of cross contamination/transmission.	To ensure that aprons and gloves are changed between different episodes of care on the same patient in order to prevent cross infection.	
6	**Are gloves removed and hand hygiene performed after every clinical activity?**	**EQR**	**Moderate** Compliance with the WHO 5 moments of Hand Hygiene.	To ensure hand hygiene is performed in order to prevent risks of cross infection.	
7	**Are staff aware on the decontamination process required for re-usable goggles (if available)?**	**EQR**	**Low**	To prevent cross infection.	

Section 6: Prevention and management of spillages of blood & high risk body fluids

Standard: Equipment appropriate for cleaning blood or other body fluid is available specifically for dealing with such incidents safely.

#	Questions	M= Mandatory EQR= EQR E= Educational	Risk Level	Remedial action recommended to resolve problem	Ref
1	**Does the practice have a policy for managing spillages in healthcare premises?**	**EQR**	**Moderate** COSHH regulation/Health and Safety Act 1974	To ensure that a policy on the management of spillages in healthcare premises is developed. This policy should be made readily available for all staff to refer to as a source of reference.	**4, 33**
2	**Are all staff aware of the procedure for dealing with spillages of blood or other body fluids?**	**EQR**	**Moderate** COSHH regulation/Health and Safety Act 1974	To ensure staff are aware of dealing with spillages and body fluids.	**2, 31**
3	**Are spillage kits available for dealing with spillages of blood/body fluids, i.e, separate kits for dealing with blood spillages and a separate kit for dealing with urine/vomit spillages?**	**M** COSHH regulation/Health and Safety Act 1974 requirements.	**Moderate** COSHH regulation/Health and Safety Act 1974	To ensure that a spillage kit available for dealing with spillages of blood/body fluids is available.	**34**
4	**Are disposable cloths or mop heads available for cleaning blood or other body fluid spillages?**	**EQR**	**Moderate** COSHH regulation/Health and Safety Act 1974	To ensure that disposable cloths or mop heads available for cleaning blood or other body fluid spillages.	**34**

Section 7: Safe handling and disposal of sharps

Standard: Sharps are managed safely to reduce the risk of inoculation injury.

#	Questions	M= Mandatory EQR= EQR E= Educational	Risk Level	Remedial action recommended to resolve problem	Ref
1	**Does the practice have a policy on safe handling & disposal of sharps?**	**M** **Criterion 9 of The Health & Social Care Act 2008 (Updated 2015) requires registered provider to:** Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections. *Safe handling and disposal of sharps* Relevant considerations include: • risk management and training in the management of mucous membrane exposure and sharps injuries and incidents; • provision of medical devices that incorporate sharps protection mechanisms where there are clear indications that they will provide safe systems of working for staff; • a policy that is easily accessible and understood by all groups of staff; • safe use, secure storage and disposal of sharps; and • auditing of policy compliance	**Moderate**	To ensure that a policy on safe handling & disposal of sharps is developed. This policy should be made readily available for all staff to refer to as a source of reference.	**2, 35**

2	**Are sharps containers that conform to BS 7320 and UN3291 available in every clinical/consulting area and are they positioned safely; out of reach of vulnerable people?**	**M** **Criterion 9 of The Health & Social Care Act 2008 (Updated 2015) requires registered provider to:** Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections. *Safe handling and disposal of sharps* Relevant considerations include: • risk management and training in the management of mucous membrane exposure and sharps injuries and incidents; • provision of medical devices that incorporate sharps protection mechanisms where there are clear indications that they will provide safe systems of working for staff; • a policy that is easily accessible and understood by all groups of staff; • safe use, secure storage and disposal of sharps; and • auditing of policy compliance	**Moderate - High**	To ensure that all sharps containers are properly assembled and appropriately labelled with a name and date both on assembly and disposal. All sharps containers should be positioned safely, that is, above waste level and below shoulder level to minimise risks of accidental injuries.	**36**
3	**Are sharps containers discarded when two thirds full and stored in a secure facility away from public access until collected for disposal?**	**EQR**	**Moderate**	To ensure that used sharps are stored securely so as they cannot be accessed by unauthorised person.	**35**
4	**Is blood sampling undertaken by using a 'Sharp Safe' single-use vacuum blood collection system?**	**EQR**	**Moderate**	To ensure staff are safe from needle-stick injury.	**37, 38, 39, 40, 41, 44**
5	**Is Aseptic Non-Touch Technique (ANTT) used when performing venepuncture?**	**EQR**	**Moderate**	To prevent contamination of the venepuncture site.	**42, 43**
6	**Are sharps used for taking blood from patients at home/care home disposed of in to an appropriate sharps container which is returned to the surgery for safe disposal?**	**EQR**	**Moderate**	To ensure that used sharps are disposed of in appropriate sharps containers in order to prevent accidental injuries.	**35**

7	**Is there evidence that the practice has undertaken a review of sharps management within the practice and employed 'safer sharps' techniques where applicable?**	**EQR**	**Moderate** **Health and Safety (Sharp Instruments in Healthcare) Regulations 2013** **Guidance for employers and employees:** Use safer sharps (incorporating protection mechanisms) – regulation 5(1)(b) The employer must substitute traditional, unprotected medical sharps with a 'safer sharp' where it reasonably practicable to do so. The term 'safer sharp' means medical sharps that incorporate features or mechanisms to prevent or minimise the risk of accidental injury. For example, a range of syringes and needles are now available with a shield or cover that slides or pivots to cover the needle after use.	To minimise the risk of needle-stick injury.	**44**
8	**Are sharps containers assembled according to manufacturer's instructions and labelled in accordance with legal requirements?**	**M** **Criterion 9 of The Health & Social Care Act 2008 (Updated 2015**) requires registered provider to: Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections. *Safe handling and disposal of sharps* **Council Directive 2010/32/EU (2010)**	**Moderate** As detailed in HTM 07-01: Each container must be labelled in accordance with the details of the legal requirements for transporting and packaging the waste (the container should be tagged or labelled in a manner that identifies the individual producer).	To ensure that all sharps containers are properly assembled and appropriately labelled with a name and date both on assembly and disposal.	**45**
9	**Are staff encouraged to wear gloves when undertaking venepuncture?**	**EQR & E**	**Moderate**	To ensure a clean and safe medium when undertaking venepuncture and to minimise the risk of infection during an inoculation injury.	**37, 41**

10	**Are staff aware of the correct procedure to follow after a needle stick injury, other sharps or blood splash exposure?**	**M** **Criterion 9 of The Health & Social Care Act 2008 (Updated 2015) requires registered provider to:** Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections. *Section g. Management of occupational exposure to BBVs and post-exposure prophylaxis* Management should ensure: • that any member of staff who has a significant occupational exposure to blood or body fluids is aware of the immediate action required and is referred appropriately for further management and follow-up; • provision of clear information for staff about reporting potential occupational exposure – in particular the need for prompt action following a known or potential exposure to HIV or hepatitis B; and • arrangements for post-exposure prophylaxis for hepatitis B and HIV	**Moderate**	To ensure staff are aware of procedure to follow after a needle stick injury, other sharps or blood splash exposure.	**46**
11	**Are posters available which show staff the emergency algorithm to follow in case of a sharp injury and is it up to date?**	**EQR**	**Moderate**	To ensure staff are aware of procedure to follow in the event of needle-stick injury	**46**

Section 8: Waste Management Policy and Procedures

Standard: Waste is managed safely and in accordance with legislation to minimise the risk of infection or injury to patients, staff and the public.

#	Questions	M= Mandatory EQR= EQR E= Educational	Risk Level	Remedial action recommended to resolve problem	Ref
1	**Does the practice have a policy on waste management?**	**M** **Criterion 9 of The Health & Social Care Act 2008 (Updated 2015) requires registered provider to:** Have and adhere to policies, designed for the individual's care and provider organisations that will help to preve nt and control infections. *Section P: Safe handling and disposal of waste* e The risks from waste disposal should be properly controlled. In practice, in relation to waste, this involves: • assessing risk; • developing appropriate policies; • putting arrangements in place to manage risks; • monitoring, auditing and reviewing the way in which arrangements work; and • being aware of statutory requirements and; legislative change and managing compliance Precautions in connection with handling waste should include: • training and information (including definition and classification of waste); • personal hygiene; • segregation and storage of waste; • the use of appropriate personal protective equipment; • immunisation; • appropriate procedures for handling such waste; • appropriate packaging and labelling; • suitable transport on-site and off-site; • clear procedures for dealing with accidents, incidents and spillages; and • appropriate treatment and disposal of such waste Systems should be in place to ensure that the risks to service users from exposure to infections caused by waste present in the environment are properly managed, and that duties under environmental law are discharged. The most important of these are: • duty of care in the management of waste; • duty to control polluting emissions to the air; • duty to control discharges to sewers; • obligations of waste managers; • collection of data and obligations to complete and retain documentation including record keeping; and • requirement to provide contingency plans and have emergency procedures in place	**Moderate** HTM 07-01: Waste can only be handed to such authorised persons as registered carriers, permit/ licence holders or someone who is exempt from either being a registered carrier or operating under a permit/ licence.	To ensure that a policy on waste management is developed. This policy should be made readily available for all staff to refer to as a source of reference.	**1, 2, 3, 4, 5, 6, 18, 35**

2	**Is there documentary evidence to show that all clinical waste (including sharps containers) is disposed of by a registered waste collection company?**	**M** **HTM 07-01: Safe Management of Healthcare Wastes.** Waste can only be handed to such authorised persons as registered carriers, permit/ licence holders or someone who is exempt from either being a registered carrier or operating under a permit/ licence.	**Moderate**	To ensure appropriate arrangements are in place in the collection and disposal of waste.	**47**
3	**Are records of waste transfer and disposal arrangements kept and stored in accordance with the EPA 1990?**	**EQR**	**Moderate** As detailed in HTM 07-01	To ensure evidence of good practice and to comply with HTM 07-01 requirements.	**47**
4	**Are there easily accessible and compliant foot-operated &fully enclosed clinical waste bins, with the appropriate colour coded bag (yellow or orange) available, in each clinical area? (E.g. the foot operation is in working order)?**	**EQR**	**Moderate** As detailed in HTM 07-01	To ensure that all clinical waste bins lidded and the waste bin liners are completely enclosed. The clinical waste bins should also be fire rated.	**35**
5	**Is clinical and domestic waste correctly segregated (clinical waste in yellow or orange bags, according to waste regulations and domestic waste in black bags)?**	**EQR**	**Moderate** As detailed in HTM 07-01	To ensure proper segregation and disposal of waste as per HTM 07-01 requirements.	**35**
6	**Are clinical waste bags marked with the practice code when securing for disposal?**	**EQR**	**Moderate** Criterion 9 of The Health & Social Care Act 2008 (Updated 2015) requires registered provider to: Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections. *Section P: Safe handling and disposal of waste.*	To ensure traceability of the waste being produced.	**35**
7	**Are waste bags less than 2/3 full and securely tied?**	**EQR**	**Low**	To prevent spillage and overflowing of waste.	**47**
8	**Where clinical waste is not collected directly from clinical areas, is it stored in a separate, secure area for waste which is kept clean and tidy and secure from vermin and/or other inappropriate/extraneous items?**	**EQR**	**Low**	Where clinical waste is not collected directly from clinical areas, it should be stored securely and safely. To ensure that the clinical waste bin is always kept locked and all clinical waste sacks and sharps containers are securely stored within the waste bin.	**47**
9	**Are staff encouraged to report all incidents (including near misses) to the designated infection control lead at the practice?**	**EQR**	**Low**	To promote learning and improve the system.	**47**

Section 9: Management of Specimens

Standard: All specimens will be collected packaged and transported safely in approved containers in line with recognised standards – Packaging Instruction 650 and 621 and requirements of UN3373 or UN3291 to minimise the risk of cross infection.

#	Questions	M= Mandatory EQR= EQR E= Educational	Risk Level	Remedial action recommended to resolve problem	Ref
1	**Does the practice have a policy or procedure for specimen handling?**	**M** **Criterion 9 of The Health & Social Care Act 2008 (Updated 2015) requires registered provider to:** Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections. *q.* *P Section Q: Packaging, handling and delivery or laboratory specimens* Biological samples, cultures and other materials should be transported in a manner that ensures that they do not leak in transit and are compliant with current legislation. Staff who handle samples must be aware of the need to correctly identify, label and store samples prior to forwarding to laboratories. In addition, they must be aware of the procedures needed when the container or packaging becomes soiled with body fluids.	**Moderate**	To ensure that a policy or procedure for specimen handling is developed. This policy should be made readily available for all staff to refer to as a source of reference.	**6**
2	**Where applicable are specimens stored in a dedicated refrigerator (not with food, vaccines or medicines)?**	**EQR**	**Moderate**	To ensure arrangements are in place to avoid cross contamination	**48**
3	**Are arrangements for specimen testing appropriate in consulting rooms?**	**EQR**	**Moderate**	To ensure arrangements are in place to avoid cross contamination	**48**
4	**Are staff aware of the appropriate way to handle and transport specimens?**	**EQR & E**	**Moderate**	To ensure that staff are aware of the appropriate way to handle and transport specimens.	**49, 50**

Section 10: Decontamination of medical devices

Standard: All medical devices are decontaminated in a safe and appropriate manner to minimise the risk of infection and cross-infection.

Note: Medical devices include not only surgical instruments but a wide variety of other equipment such as dressing trolleys, BP cuffs and baby scales. A risk assessment needs to be carried out on each medical device to ensure that the appropriate level of decontamination is carried out. For those in the high or medium risk categories cleaning and sterilisation must be carried out (e.g. autoclaving). For those in the lowest risk category cleaning or cleaning plus disinfection are needed depending on circumstances

#	Questions	M= Mandatory EQR= EQR E= Educational	Risk Level	Remedial action recommended to resolve problem	Ref
1	**Does the practice have a policy which outlines the decontamination processes the GP Practices use for all medical devices?**	**M** **Criterion 9 of The Health & Social Care Act 2008 (Updated 2015) requires registered provider to:** Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections. *j. Decontamination of reusable medical devices* • Decontamination involves a combination of processes and includes cleaning, disinfection and sterilisation, according to the intended use of the device. This aims to render a reusable item safe for further use on service users and for handling by staff; • Effective decontamination of reusable medical devices is an essential part of infection risk control and is of special importance when the device comes into contact with service users or their body fluids. There should be a system to protect service users and staff that minimises the risk of transmission of infection from medical devices. This requires that the device or instrument set can be clearly linked in a traceable fashion to the individual process cycle that was used to decontaminate it, such that the success of that cycle in rendering the device safe for reuse can be verified; • Reusable medical devices should be decontaminated in accordance with manufacturers' instructions and current national or local best practice guidance. This must ensure that the device complies with the 'Essential Requirements' provided in the Medical Devices Regulations 2002 where applicable. This requires that the device should be clean and, where appropriate, sterilised at the end of the decontamination process and maintained in a clinically satisfactory condition up to the point of use; • Management systems should ensure adequate supplies of reusable medical devices, particularly where specific devices are essential to the continuity of care; • Reusable medical devices employed in invasive procedures, for example, endoscopes and surgical instruments have to be either individually identifiable or identified to a set of which they are a consistent member, throughout the use and decontamination cycle in order to ensure subsequent traceability; • Systems should also be implemented to enable the identification of service users on whom the medical devices have been used; • Decontamination of single-patient use devices, i.e. that equipment designated for use only by one patient, should be subject to local policy and manufacturer's instructions	**Moderate**	To ensure that a policy which outlines the decontamination processes the GP Practices use for all medical devices is developed. This policy should be made readily available for all staff to refer to as a source of reference.	**2, 51, 52**

2	**Does the practice use single use surgical instruments?**	**EQR**	**Moderate**	To avoid transmission and cross infection.	**53**
3	**Does the practice use an accredited external sterile supply service for re-usable surgical instruments and devices that need to be sterile at the point of use?**	**EQR**	**Moderate - High**	To avoid transmission and cross infection.	**53**
4	**Are all medical devices stored appropriately and above floor level to avoid contamination?**	**EQR**	**Moderate**	To ensure that all medical devices are stored appropriately in order to prevent the risk of contamination.	**54**
5	**Are all items of sterile equipment within their use-by date?**	**EQR**	**High** All sterile instruments should be in date to maintain patient safety. Single use instruments should be discarded immediately after use. In the event that unused instrument packs are damaged, they should still be immediately discarded, because they have lost their sterile properties. A strict protocol should be maintained for checking sterile instruments and equipment for their use by date. Those that have exceeded their use by date should be disposed of immediately.	All sterile instruments should be in date to maintain patient safety. Single use instruments should be discarded immediately after use. In the event that unused instrument packs are damaged, they should still be immediately discarded, because they have lost their sterile properties. A strict protocol should be maintained for checking sterile instruments and equipment for their use by date. Those that have exceeded their use by date should be disposed of immediately. To ensure that a stringent process for checking expiry dates of sterile items is put in place and that all staff members follow that protocol.	**53**
6	**Are all items of equipment that come into contact with patients cleaned or decontaminated according to guidelines or are disposed of after each use?**	**M** **Criterion 9 of The Health & Social Care Act 2008 (Updated 2015) requires** registered provider to: Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections. *j. Decontamination of reusable medical devices*	**Moderate – High** This depends on the re-usable instruments being shared, the decontamination process and also the procedure that these instruments are being used for.	To ensure that all items of equipment that come into contact with patients cleaned or decontaminated according to guidelines or are disposed of after each use in order to prevent cross infection.	**26**
7	**Is there a cleaning schedule/check list maintained for all items requiring cleaning?**	**EQR**	**Moderate**	To ensure that a cleaning schedule/check list is maintained for all items/medical equipment requiring cleaning, such as peak flow meter, nebulisers, ear syringe, spirometer, and other including blood pressure cuffs.	**26**

Section 11: Clinical Rooms

Standard: The environment is designed and managed to minimise reservoirs for micro-organisms and reduce the risk of cross infection to patients, staff and visitors.

#	Questions	M= Mandatory EQR= EQR E= Educational	Risk Level	Remedial action recommended to resolve problem	Ref
1	**Are all clinical rooms and all work surfaces clean and free from extraneous items?**	**M** **Criterion 2 of The Health and Social Care Act 2008 (Amended 2015)** requires all parts of the premises from which it provides care are suitable for the purpose, kept clean and maintained in good physical repair and condition.	**Moderate - High**	To provide a safe and clean environment for the service user.	**17, 19**
2	**Is flooring impervious to liquids, non-slip, intact and clean?**	**EQR**	**Moderate**	Floor in clinical rooms should seamless and without joints and the edges with the walls should be either sealed or continuous to the walls with a coved edge. Carpets are not recommended for use in healthcare environment used by patients due to risks of contamination and spillage.	**17, 19**
3	**Does the flooring form a coved skirting (i.e. uplifted at the edges on to the walls) OR is the gap between the floor and the skirting sealed and is the seal maintained?**	**EQR**	**Moderate**	To avoid build-up of dust and to facilitate cleaning.	**55**
4	**Are walls and ceilings clean, dry and free from visible defects (no cracks, peeling paintwork) and have smooth easy to clean surfaces?**	**EQR**	**Moderate – High** Walls in clinical areas should be smooth without cracks or joints and easy to clean. If there are textured wall paper in clinical rooms, these should be removed and the walls made smooth. Clinical room affected by damp and mould will pose a higher risk of cross infection if the room is being used for certain invasive procedures.	Walls in clinical areas should be smooth without cracks or joints and easy to clean. If there are textured wall paper in clinical rooms, these should be removed and the walls made smooth. Clinical room affected by damp and mould will pose a higher risk of cross infection if the room is being used for certain invasive procedures.	**55**
5	**Is there an examination couch with an intact, impervious cover and single use roller paper available for use?**	**EQR**	**Moderate**	All furniture in the Practice should be suitable for its use, (e.g. impermeable / washable materials). To ensure that the examination couch is repaired with an impervious cover.	**17, 56, 57**
6	**Is the examination couch fitted with a paper roll holder?**	**E**	**Low**	To ensure that paper roll holder is fitted on examination couches and that paper rolls are placed on their respective paper roll holders to minimise risks of the paper rolls being left on the floor.	**17**
7	**Are there sufficient work surfaces and dressing trolleys of smooth, impervious and cleanable material?**	**EQR**	**Low**	To ensure the risk of contamination is minimised.	**56, 57**

8	**Are all treatment surfaces in the room cleaned every working day with hot water and detergent or detergent wipes in accordance with written practice cleaning schedules?**	**EQR**	**Moderate**	To ensure the service users are cared for in a clean environment with minimum risk of contamination/cross infection.	**56, 57**

Section 12: Vaccine Storage and Cold Chain

Standard: Vaccines are stored and transported safely.

#	Questions	M= Mandatory EQR= EQR E= Educational	Risk Level	Remedial action recommended to resolve problem	Ref
1	**Does the practice have an up to date cold chain policy (reviewed within the last two years) as per the standards of the Green Book and is this accessible to all staff?**	**M** **Criterion 9 of The Health & Social Care Act 2008 (Updated 2015)** requires registered provider to: Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.	**High**	To ensure that an up to date cold chain policy (reviewed within the last two years) as per the standards of the Green Book is developed. This policy should be made readily available for all staff to refer to as a source of reference.	**58, 59**
2	**Is there a designated person/s (at least two recommended) in the practice responsible for the ordering, delivery and storage of vaccines?**	**EQR**	**Moderate** As detailed in Chapter 3 of The Green Book.	To ensure continuity in the safe delivery of care and maintenance of the Cold Chain responsibility.	**58, 59**
3	**Are vaccines monitored for their expiry dates and the close to expiry stocks clearly labelled?**	**EQR**	**Moderate** As detailed in Chapter 3 of The Green Book.	To ensure continuity in the safe delivery of care and maintenance of the Cold Chain responsibility.	**58, 59**
4	**Is the refrigerator specialised for the storage of vaccines (eg. the refrigerator has wire shelves/baskets or shelves capable of allowing air ventilation, there are no vaccines stored in enclosed plastic trays at bottom of refrigerator, domestic type refrigerators are not recommended)?**	**M** As detailed in Chapter 3 of The Green Book.	**Moderate** As detailed in Chapter 3 of The Green Book.	To ensure that the practice follow the standards set out in the Green Book (DH, 2010). Vaccine fridges should be dedicated for vaccine use only.	**58, 59, 62**
5	**Are vaccines correctly stored to allow good air flow within the vaccine refrigerator? (eg. vaccines are not stored against the back plates, touching the side of the fridge, at bottom of fridge or in vegetable bins and not stored in containers that are not webbed baskets)?**	**EQR**	**Moderate** As detailed in Chapter 3 of The Green Book.	The air flow within the vaccine fridge should not be disrupted by any means. Vaccines should be placed in such a way which will allow air to flow within them to maintain a constant temperature. Good air circulation around a vaccine storage unit is essential for proper cooling functions. A storage unit should be well-ventilated with space around the sides and top. Vaccines should not be stored in any integral enclosed plastic trays. These prevent the circulation of cool air and may lead to warming of vaccines. (HPS Scotland, vaccine-storage-handling-2013)	**58, 59**
6	**Are there measures in place to prevent the fridge from being turned off (switch-less socket or warning label on plug)?**	**EQR**	**Moderate** As detailed in Chapter 3 of The Green Book.	The vaccine fridge should be directly wired / fused spur to the main electrical supply (The Green Book). The use of multiple plug extension is not recommended.	**58, 59, 60**
7	**Is/Are the vaccine fridge/s located in a well-ventilated area. (eg. not located near any heat source, ie radiator, or direct sunlight)?**	**EQR**	**Moderate** As detailed in Chapter 3 of The Green Book.	To ensure that the vaccine fridge is not affected by external heat sources.	**58**

8	**Is the temperature of the vaccine fridge continually monitored with a min/max thermometer and the temperatures are recorded each working day to ensure vaccines are maintained at 2-8^{O}C? (Min, max and actual fridge temperatures are recorded)?** **(*It is best practice to record the temperatures twice daily*)**	**M** **As detailed in Chapter 3 of The Green Book.**	**Moderate** As detailed in Chapter 3 of The Green Book.	Temperature recordings on the vaccine fridge should include minimum and maximum temperatures as well as actual temperatures. Vaccine fridge thermometers should be reset on a daily basis. Daily resetting of the thermometer and any out of range temperatures should be documented. To ensure that the correct template is available for recording all the parameters of vaccine fridges as recommended in the GREEN BOOK. To ensure that all members of staff are aware of the correct way of recording temperatures and resetting the fridge thermometers.	**58, 61**
9	**Does the practice has a maintenance contract that allows for at least yearly servicing, calibration of the temperature gauge?**	**EQR**	**Moderate** As detailed in Chapter 3 of The Green Book.	To ensure that a maintenance contract that allows for at least yearly servicing, calibration of the temperature gauge. All records must be kept for a minimum of 2 years.	**58, 59**
10	**Is a second min/max thermometer or Data Logger temperature recording device, independent of mains electricity supply available and used?**	**EQR**	**Moderate** As detailed in Chapter 3 of The Green Book.	A second battery operated thermometer is recommended for benchmarking temperatures and should there be a power cut. According to The Green Book a data logger is recommended for that purpose.	**58, 59**
11	**Is the fridge either self-defrosting or is it defrosted monthly or sooner if needed and a validated cool box is then used to maintain the cold chain?**	**EQR**	**Moderate** As detailed in Chapter 3 of The Green Book.	To ensure that there is no build-up of ice which can affect the vaccines and alter the fridge temperature.	**60**
12	**Is there a process in place for safe disposal of expired, damaged or surplus vaccines?**	**EQR**	**Moderate** It is a requirement of the HTM 07-01: Safe management of Healthcare waste.	To ensure that medicinal wastes are disposed of in accordance with HTM 07-01: Safe management of Healthcare waste.	**58**
13	**Does the practice have records of vaccines received, batch numbers, expiry dates, fridge temperatures, servicing and defrosting of the fridge?**	**EQR**	**Moderate** As detailed in Chapter 3 of The Green Book.	To ensure that records of vaccines received, batch numbers, expiry dates, fridge temperatures, servicing and defrosting of the fridge are kept.	**58, 59, 62**
14	**Is there accessible written guidance on what staff should do in the event of a power cut or a temperature reading outside the required range?**	**EQR**	**Moderate** As detailed in Chapter 3 of The Green Book.	To ensure that written guidance is available on what staff should do in the event of a power cut or a temperature reading outside the required range.	**58, 59, 62**

Section 13: Notification of infectious diseases and contamination

Standard: All notifiable diseases are reported on suspicion, within the time frames set out in the Health Protection (Notification) Regulations 2010

#	Questions	M= Mandatory EQR= EQR E= Educational	Risk Level	Remedial action recommended to resolve problem	Ref
1	**Does the practice have a policy on managing patients with communicable diseases?**	**M** **Criterion 9 of The Health & Social Care Act 2008 (Updated 2015)** requires registered provider to: Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections. *Section d. Isolation of service users with an infection (see also criterion 7)* • The isolation policy should be evidence based and reflect local risk assessment;[1] • Indications for isolation should be included in the policy, as should procedures for the infection prevention and control management of service users in isolation; • Information on isolation should be easily accessible and understood by all groups of staff, service users and the public	**Moderate**	To ensure that a policy on managing patients with communicable diseases is developed. This policy should be made readily available for all staff to refer to as a source of reference.	**63**
2	**Does the practice notify all reportable infectious disease on suspicion to the proper officer at the local authority?**	**M** **Criterion 9 of The Health & Social Care Act 2008 (Updated 2015)** requires registered provider to: Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections. *Section d. Isolation of service users with an infection (see also criterion 7).*	**Moderate**	To ensure that all reportable infectious disease on suspicion to the proper officer at the local authority.	**63**
3	**Does the practice have access to notification forms?**	**EQR**	**Moderate**	To ensure that practice staff have access to notification forms.	**63**
4	**Does the practice notifying gastro intestinal disease (food poisoning) on suspicion?**	**EQR**	**Moderate**	To ensure that the practice notifying gastro intestinal disease (food poisoning) on suspicion.	**63, 64**
5	**Does the practice notify Gastro intestinal disease (food poisoning) when stool specimen results are received from the microbiology laboratory?**	**EQR**	**Moderate**	To ensure that the practice notify Gastro intestinal disease (food poisoning) when stool specimen results are received from the microbiology laboratory.	**64**
6	**Is the practice aware of the new requirements to notify cases of contamination and other diseases which may have public health significance that are not listed in the regulations?**	**EQR**	**Moderate**	To ensure that practice staff are aware of the new requirements to notify cases of contamination and other diseases which may have public health significance that are not listed in the regulations.	**63**

Section 14: Antimicrobial Stewardship (AMS)

Standard: Prescribers are aware of the relevant guidelines and regularly audit their own, and discuss in practice meetings, their antibiotic prescribing patterns. GPs are aware of TARGET: Treat Antibiotics Responsibly. Guidance, Education, Tool.

#	Questions	M= Mandatory EQR= EQR E= Educational	Risk Level	Remedial action recommended to resolve problem	Ref
1	**Are GP prescribers in the practice aware of the TARGET toolkit?**	**EQR** **H&SC Act 2008 –** Criterion 3 Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance. Antimicrobial prescribing should follow local policies and national guidance such as PHE primary care guidance: Managing common infections; guidance for primary care and TARGET. Evidence to demonstrate adoption and adherence to policies and guidelines should be available to commissioners.	**Moderate**	To ensure that all GP prescribers in the practice are aware of the TARGET toolkit.	**65**
2	**Have all GP prescribers completed the Antimicrobial Stewardship Self-Assessment Checklist available in TARGET?** **(Give number of GP prescribers using the self-assessment checklist against those who do not)** **_____ / _____**	**EQR**	**Moderate**	To ensure that all GP prescribers completed the Antimicrobial Stewardship Self-Assessment Checklist available in TARGET.	**66**
3	**Is the document "Antimicrobial prescribing and stewardship competencies" available and/or has it been read by prescribers in the practice? (Give number of prescribers who are aware of this document against those who are not)** **_____ / _____**	**EQR**	**Low**	To ensure that the document Antimicrobial prescribing and stewardship competencies" is available and/or has it been read by prescribers in the practice.	**67**
4	**Are all the prescribers in the Practice aware of the Public Health England AMR local indicators?**	**EQR**	**Moderate**	To ensure that all the prescribers in the Practice aware of the Public Health England AMR local indicators.	**68**
5	**Is the practice aware of how they may access their antibiotic prescribing data online?**	**EQR**	**Low**	To ensure that practice aware of how they may access their antibiotic prescribing data online.	**69**
6	**Are all prescribers in the practice aware of the NICE guidelines on AMS.**	**EQR**	**Low**	To ensure that all prescribers in the practice aware of the NICE guidelines on AMS.	**70**
7	**Do all prescribers give information to their service users of how they should correctly use antimicrobial medicines and the dangers associated with their overuse and misuse?**	**EQR**	**Low**	To ensure that all prescribers give information to their service users of how they should correctly use antimicrobial medicines and the dangers associated with their overuse and misuse.	**71**
8	**Are all prescribers aware of the UK's 5-year Antimicrobial Resistance Strategy?**	**E**	**Low**	To ensure that all prescribers are aware of the UK's 5-year Antimicrobial Resistance Strategy.	**72**

9	**Does the practice actively participates in the European Antibiotic Awareness Day/Week (EEAD) held in November each year?**	**E**	**Low**	To ensure that the practice actively participates in the European Antibiotic Awareness Day/Week (EEAD) which is held in November.	**73**
10	**Are all clinical staff in the Practice aware of the PHE Antibiotic Guardian campaign?**	**E**	**Low**	To ensure that all clinical staff in the Practice aware of the PHE Antibiotic Guardian campaign.	**74**
11	**Does the practice have an identified sepsis lead / link?**	**E**	**Moderate**	To ensure that there is an identified sepsis lead/ link in the practice.	**81**
12	**Are clinicians/GPs aware of and/or have received training in identifying sepsis?**	**EQR**	**Moderate**	To ensure that clinicians/ GPs have been trained in identifying sepsis.	**82**
13	**Does the practice promote the use of the GRASP Fever Audit tool?**	**E**	**Moderate**	To ensure that the practice promote the use of the GRASP Fever Audit tool.	**83**
14	**Does the practice make use of the National Early Warning Signs (NEWS) tool to assess adults for sepsis and the Paediatric Early Warning Signs (PEWS) tool to assess children?**	**EQR**	**Moderate**	To ensure that the practice make use of the National Early Warning Signs (NEWS) tool to assess adults for sepsis and the Paediatric Early Warning Signs (PEWS) tool to assess children.	**84**

Section 15: Minor Surgery rooms

Standard: The environment is designed and managed to minimise reservoirs for micro-organisms and reduce the risk of cross infection to patients, staff and visitors

#	Questions	M= Mandatory EQR= EQR E= Educational	Risk Level	Remedial action recommended to resolve problem	Ref
1	**Is there is a dedicated room for minor surgery (for practices performing level 3 minor surgery) or is the clinical room of sufficient standard for undertaking level 2 minor surgery?**	**M for Level 2 & 3 minor surgery** **H&SC Act 2008 –** All parts of the premises from which it provides care are suitable for the purpose, kept clean and maintained in good physical repair and condition.	**High** The risk depends on the level of minor surgical procedures being undertaken.	To ensure that minor surgery (level 2 & 3) are carried out in a dedicated room.	**55**
2	**Are all sterile packs and other equipment stored appropriately and is there adequate storage space?**	**M for Level 2 & 3 minor surgery** **Criterion 9 of The Health & Social Care Act 2008 (Updated 2015) requires registered provider to:** Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections. *j. Decontamination of reusable medical devices* • Decontamination involves a combination of processes and includes cleaning, disinfection and sterilisation, according to the intended use of the device. This aims to render a reusable item safe for further use on service users and for handling by staff; • Effective decontamination of reusable medical devices is an essential part of infection risk control and is of special importance when the device comes into contact with service users or their body fluids. There should be a system to protect service users and staff that minimises the risk of transmission of infection from medical devices. This requires that the device or instrument set can be clearly linked in a traceable fashion to the individual process cycle that was used to decontaminate it, such that the success of that cycle in rendering the device safe for reuse can be verified; • Reusable medical devices should be decontaminated in accordance with manufacturers' instructions and current national or local best practice guidance. This must ensure that the device complies with the 'Essential Requirements' provided in the Medical Devices Regulations 2002 where applicable. This requires that the device should be clean and, where appropriate, sterilised at the end of the decontamination process and maintained in a clinically satisfactory condition up to the point of use; • Management systems should ensure adequate supplies of reusable medical devices, particularly where specific devices are essential to the continuity of care; • Reusable medical devices employed in invasive procedures, for example, endoscopes and surgical instruments have to be either individually identifiable or identified to a set of which they are a consistent member, throughout the use and decontamination cycle in order to ensure subsequent traceability; • Systems should also be implemented to enable the identification of service users on whom the medical devices have been used; • Decontamination of single-patient use devices, i.e. that equipment designated for use only by one patient, should be subject to local policy and manufacturer's instructions	**Moderate**	To ensure that all sterile packs and other equipment stored appropriately.	**19, 75, 76**

3	**Is the practice using disposable single use instruments, supplied by a recognised manufacturer of sterile disposable instruments*?*** ***If the answer is 'No' the practice should contact the local IPC advisors for advice.***	**M for Level 2 & 3 minor surgery** **Criterion 9 of The Health & Social Care Act 2008 (Updated 2015) requires registered provider to:** Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections. *j. Decontamination of reusable medical devices* • Decontamination involves a combination of processes and includes cleaning, disinfection and sterilisation, according to the intended use of the device. This aims to render a reusable item safe for further use on service users and for handling by staff; • Effective decontamination of reusable medical devices is an essential part of infection risk control and is of special importance when the device comes into contact with service users or their body fluids. There should be a system to protect service users and staff that minimises the risk of transmission of infection from medical devices. This requires that the device or instrument set can be clearly linked in a traceable fashion to the individual process cycle that was used to decontaminate it, such that the success of that cycle in rendering the device safe for reuse can be verified; • Reusable medical devices should be decontaminated in accordance with manufacturers' instructions and current national or local best practice guidance. This must ensure that the device complies with the 'Essential Requirements' provided in the Medical Devices Regulations 2002 where applicable. This requires that the device should be clean and, where appropriate, sterilised at the end of the decontamination process and maintained in a clinically satisfactory condition up to the point of use; • Management systems should ensure adequate supplies of reusable medical devices, particularly where specific devices are essential to the continuity of care; • Reusable medical devices employed in invasive procedures, for example, endoscopes and surgical instruments have to be either individually identifiable or identified to a set of which they are a consistent member, throughout the use and decontamination cycle in order to ensure subsequent traceability; • Systems should also be implemented to enable the identification of service users on whom the medical devices have been used; • Decontamination of single-patient use devices, i.e. that equipment designated for use only by one patient, should be subject to local policy and manufacturer's instructions	**Moderate**	To ensure that all disposable single use instruments, supplied by a recognised manufacturer of sterile disposable instruments.	**40, 54**

4	**Where applicable, is an accredited external sterile supply service used for re-usable surgical instrument that need to be sterile at the point of use?** **If a GP contractor wishes to have advice about in-house decontamination arrangements, they should contact NEL to establish what this would entail, together with the associated monitoring.**	**M for Level 2 & 3 minor surgery** **Criterion 9 of The Health & Social Care Act 2008 (Updated 2015) requires registered provider to:** Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections. *j. Decontamination of reusable medical devices* • Decontamination involves a combination of processes and includes cleaning, disinfection and sterilisation, according to the intended use of the device. This aims to render a reusable item safe for further use on service users and for handling by staff; • Effective decontamination of reusable medical devices is an essential part of infection risk control and is of special importance when the device comes into contact with service users or their body fluids. There should be a system to protect service users and staff that minimises the risk of transmission of infection from medical devices. This requires that the device or instrument set can be clearly linked in a traceable fashion to the individual process cycle that was used to decontaminate it, such that the success of that cycle in rendering the device safe for reuse can be verified; • Reusable medical devices should be decontaminated in accordance with manufacturers' instructions and current national or local best practice guidance. This must ensure that the device complies with the 'Essential Requirements' provided in the Medical Devices Regulations 2002 where applicable. This requires that the device should be clean and, where appropriate, sterilised at the end of the decontamination process and maintained in a clinically satisfactory condition up to the point of use; • Management systems should ensure adequate supplies of reusable medical devices, particularly where specific devices are essential to the continuity of care; • Reusable medical devices employed in invasive procedures, for example, endoscopes and surgical instruments have to be either individually identifiable or identified to a set of which they are a consistent member, throughout the use and decontamination cycle in order to ensure subsequent traceability; • Systems should also be implemented to enable the identification of service users on whom the medical devices have been used; • Decontamination of single-patient use devices, i.e. that equipment designated for use only by one patient, should be subject to local policy and manufacturer's instructions	**High**	To ensure that where re-usable surgical instrument are used, these are supplied by an accredited external sterile supply provider.	**40, 54**
5	**Is the minor surgery room clean and free from extraneous items?**	**M** H&SC Act 2008 – Criterion All parts of the premises from which it provides care are suitable for the purpose, kept clean and maintained in good physical repair and condition.	**High**	All areas including clinical areas should be visibly clean and free from extraneous items. Clutter allow dust and dirt to settle and may hinder adequate cleaning. To ensure that a thorough cleaning of high level surfaces as well as low level surfaces is undertaken. This type of cleaning should be carried out on a regular basis to minimise dust and dirt accumulation.	**77**
6	**Are walls in good condition (no cracked, damaged or peeling paintwork or rough surface finishes), intact and have smooth easy-to-clean surfaces?**	**M for Level 2 & 3 minor surgery** **H&SC Act 2008 –** All parts of the premises from which it provides care are suitable for the purpose, kept clean and maintained in good physical repair and condition.	**Moderate - High.** The risk will depend on the type and condition of the wall surfaces. Evidence of damp for example will be considered as a high risk for the minor surgery room.	To ensure that wall surfaces in all clinical areas are smooth without cracks or joints and easy to clean. Any damage/ cracks on wall surfaces in the minor surgery room should be repaired and made smooth.	**77**
7	**Is flooring impermeable, intact and have continuous edging coved up the walls?**	**M for Level 2 & 3 minor surgery** **H&SC Act 2008** – All parts of the premises from which it provides care are suitable for the purpose, kept clean and maintained in good physical repair and condition.	**Moderate**	Floor in the minor surgery room should seamless and without joints and the edges with the walls should be either sealed or continuous to the walls with a coved edge.	**19, 77**

8	**Are ceilings intact and free from visible cracks or visible defects?**	**M for Level 2 & 3 minor surgery** **H&SC Act 2008 –** All parts of the premises from which it provides care are suitable for the purpose, kept clean and maintained in good physical repair and condition.	**Moderate**	Ceilings in the minor surgery room should be intact and free from visible cracks and defects.	**35**
9	**Are ceiling lights protected / enclosed from potential contamination?**	**M for Level 2 & 3 minor surgery** **H&SC Act 2008 –** All parts of the premises from which it provides care are suitable for the purpose, kept clean and maintained in good physical repair and condition.	**Moderate**	Ceiling light in the minor surgery room should be protected / enclosed to minimise risks from potential contamination. To ensure that the ceiling light is enclosed.	**35**
10	**Does the room have adequate ventilation - natural or mechanical (no desktop fans)?** ***For level 3 minor surgery, the room should have mechanical ventilation with a minimum of 10 air exchanges as per current guidelines.***	**M for Level 2 & 3 minor surgery** **H&SC Act 2008 –** All parts of the premises from which it provides care are suitable for the purpose, kept clean and maintained in good physical repair and condition.	**Moderate**	To ensure that the room where minor surgery is carried out adequately ventilated - natural or mechanical (no desktop fans)? *For level 3 minor surgery, the room should have mechanical ventilation with a minimum of 10 air exchanges as per current guidelines.*	**35, 79, 80**
11	**Is the heat source and pipe work in the room enclosed to prevent accumulation of dust and dirt?**	**M for Level 2 & 3 minor surgery** **H&SC Act 2008 –** All parts of the premises from which it provides care are suitable for the purpose, kept clean and maintained in good physical repair and condition.	**Moderate**	To ensure that the heat source and pipe work in the room where minor surgery is performed is enclosed to prevent accumulation of dust and dirt.	**35, 77**
12	**Is the treatment couch intact and is protected with disposable paper towel that is changed after each patient?**	**M for Level 2 & 3 minor surgery** **H&SC Act 2008 –** All parts of the premises from which it provides care are suitable for the purpose, kept clean and maintained in good physical repair and condition.	**Moderate**	To ensure the service users are cared for in a clean environment with minimum risk of contamination/ cross infection.	**78**
13	**Are all work surfaces intact, smooth, and impervious easy to clean and are able to withstand cleaning with chemical disinfectants?**	**M for Level 2 & 3 minor surgery** **H&SC Act 2008** – All parts of the premises from which it provides care are suitable for the purpose, kept clean and maintained in good physical repair and condition.	**Moderate**	To ensure that all work surfaces are intact, easy to clean, smooth and impervious to fluids. All surfaces should be able to withstand cleaning with chemical disinfectants.	
14	**Are all wall cabinets intact with doors? (open shelves are not recommended, wall cabinets should continue to ceiling level or have sloped tops).**	**EQR** **H&SC Act 2008 –** All parts of the premises from which it provides care are suitable for the purpose, kept clean and maintained in good physical repair and condition.	**Moderate**	To ensure that all wall mounted cabinets are either continuous to the ceiling or have sloped top. All open shelving should be removed in order to minimise dust settlement.	**17, 19**
15	**Does the clinical hand wash basin conforms to current recommended guidance (HTM 00-10; HBN 00-09) with the following available facilities:** • **Elbow, foot operated mixer taps** • **No swan neck fittings on taps** • **Thermostatically controlled hot / cold water** • **Free from sink plugs and overflows** • **Water from the tap does not drain directly into the drainage outlet** • **Hand hygiene facilities are intact.**	**M for Level 2 & 3 minor surgery** **H&SC Act 2008 –** All parts of the premises from which it provides care are suitable for the purpose, kept clean and maintained in good physical repair and condition.	**Moderate**	To ensure that all clinical hand washing sinks have taps with elbow or wrist lever operated mixer taps. - Taps with swan neck faucet is not compliant with current infection control guidance as they do not empty completely. - Hot water for hand washing sinks should be thermostatically in order to prevent scalding from hot water. - Clinical hand washing sinks with overflow are non-compliant because the tube that connects the overflow to the drain may contain a number of biofilms which may increase risks of hand contamination.	**35, 77**

16	**Are there wall mounted dispensers for liquid soap and is the liquid soap dispensed via non-refillable cartridges?** **(Antiseptic hand wash must also be dispensed via wall mounted dispensers and dispensed from non-refillable cartridges)**	**M for Level 2 & 3 minor surgery** **H&SC Act 2008 –** All parts of the premises from which it provides care are suitable for the purpose, kept clean and maintained in good physical repair and condition.	**Moderate**	Liquid soap dispensers should be wall-mounted at all wash-hand basins and be designed to be operated without contamination from the user's hands coming into direct contact with the dispensing mechanism.	**19, 35**
17	**Are there wall mounted dispensers with good quality disposable paper hand towels?**	**M for Level 2 & 3 minor surgery** **H&SC Act 2008 –** All parts of the premises from which it provides care are suitable for the purpose, kept clean and maintained in good physical repair and condition. As detailed in HBN 00-09. The use of paper towels in rolls should be discouraged; they are difficult to tear off without contaminating the remaining roll.	**Moderate**	Paper towel dispensers should be wall-mounted by all wash-hand basins and be designed to be operated without contamination from the user's hands coming into direct contact with the dispensing mechanism.	**19, 35**
18	**Is the clinical hand wash basin free from re-usable nail brushes?**	**M for Level 2 & 3 minor surgery**	**Moderate**	Re-usable nail brushes should not be used.	**19, 77**
19	**Are single use sterile and non-sterile gloves available in latex and non-latex nitrile material?**	**M for Level 2 & 3 minor surgery**	**Moderate**	To ensure that single use sterile and non-sterile gloves are available in latex and non-latex nitrile material.	**78**
20	**Is there is a designated stainless steel trolley available for use in this room only?**	**M for Level 2 & 3 minor surgery**	**Moderate**	A designated stainless steel trolley should be available for use in this room only.	**78**
21	**Is there a clean clinical waste bin with a foot pedal with waste bag fully enclosed and is it in good operating condition?** **(Waste bags must not be attached to cupboards / trolleys etc).**	**M for Level 2 & 3 minor surgery** **HTM 07-01:** Management of Healthcare Wastes	**Moderate**	All clinical waste bins should have a lid and the waste bin liners are completely enclosed. The clinical waste bins should also be fire rated.	**78**
22	**Do all staff use recommended PPE (including disposable goggles) when splashing of body fluids is anticipated?**	**M for Level 2 & 3 minor surgery** **Criterion 9 of The Health & Social Care Act 2008 (Updated 2015) requires registered provider to:** Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections. *Section f. Prevention of occupational exposure to blood-borne viruses (BBVs) including prevention of sharps injuries* M Measures to avoid exposure to BBV's (hepatitis B and C and HIV) should include: • immunisation against hepatitis B, as set out in *Immunisation against infectious disease*, better known as 'The Green Book' (published by Public Health England); • the wearing of gloves and other protective clothing; • the safe handling and disposal of sharps, including the provision of medical devices that incorporate sharps protection where there are clear indications that they will provide safe systems of working for staff; and • measures to reduce risks during surgical procedures	**Moderate**	To ensure that all staff use the recommended PPE (including disposable goggles) when splashing of body fluids is anticipated.	**78**
23	**Are disposable sterile drapes available and used for level 2 and level 3 minor surgeries?**	**M for Level 2 & 3 minor surgery**	**Moderate**	To ensure that disposable sterile drapes are available and used for level 2 and level 3 minor surgeries.	**78**

24	**Does the GP Practice audit post-operative wound infections and are records kept?**	**M for Level 2 & 3 minor surgery**	**Moderate**	It is recommended that the Practice audit post-operative wound infections and records are retained.	**26, 78**

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