NICE National Institute for Health and Care Excellence

Quality Standards Topic Expert Group TEG 3

Surgical Site Infection

Minutes of the meeting held on 2nd July 2013

Meeting held at Manchester

Attendees	Peter Jenks (PJ, Chair), Jennifer Bostock (JB), Lilian Chiwera (LC), Pauline Harrington (PH), Matt Hill (MH), Judith Jesky (JJ), Tracey Radcliffe (TR), Judith tanner (JT), Peter Wilson (PW) **NICE Attendees** Charlotte Bee (CB), Tony Smith (TS), Maxine Adrian-Fleet (MAF), Lisa Nicholls (LN)
Apologies	Abigail Mullings, Mike Reed, Martin Kiernan, Jenny Winslade, Alyson Whitmarsh

Agenda item	Discussions and decisions	Actions
1.Introductions and apologies	PJ welcomed the attendees, noted the apologies and reviewed the agenda for the day. The group confirmed that the minutes from the meeting held on 22nd March were an accurate record.	
Declaration of Interest	PJ asked the group whether they had any new interests to declare since the last meeting and none were declared.	
2.Review of progress so far and objectives of the day	TS reviewed the progress made on the quality standard (QS) so far. He advised the group that the main objectives of the day were to discuss the results of the consultation and agree the quality statements for progression into the final QS. TS reminded the group that the QS should only consist of aspirational statements addressing key areas of quality or variations in care. The group was also reminded that the QS should be as concise as possible and should not include anything that is standard practice. It was noted that QS statements must be based on accredited guidance recommendations. TS reminded the TEG that further changes may be made to the QS following the meeting, subject to discussion with and agreement of the TEG Chair and following Guidance Executive. TS confirmed that the group will have the opportunity to see and comment on the final version of the QS before publication.	

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3. Support for commissioners and others using the quality standard	MAF outlined the role of the NICE Costing and Commissioning team and advised the group that they will develop a support document for commissioners and other users to accompany the QS. She stated that the purpose of this document is to help commissioners and service providers consider the commissioning implications and potential resource impact of using the QS. MAF confirmed a draft document will be prepared for a 2 week consultation and the TEG will have the opportunity to comment on the document. MAF invited the group to provide input during its development. She also advised them that they will have the opportunity to comment on the document. MAF asked the group to contact her if they have any questions or would like to contribute further.	
4. Presentation and discussion of consultation feedback	CB gave a brief overview of the consultation comments received. In general the comments were positive and overall supportive of the draft QS. There were issues for the TEG to consider on alignment with the clinical guideline, avoiding overuse of antibiotics and simplifying the statements. CB advised the group that they would consider each statement and look at the consultation comments. The TEG would then decide whether to progress the statement and modify the statement if necessary. They would also need to consider any equalities issues, resource implications and outcomes.	

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5. Presentation, discussion and agreement of final statements	The TEG looked at each of the 10 statements and reviewed each statement based on consultation feedback.	
	Draft QS1: People having surgery are offered advice and help with personal preparations for surgery (including washing and advice not to remove hair). The TEG queried consistency in the wording of 'offered' in the statement and 'received' in the measures. TS advised that 'received' is more measureable but 'offer' is generally used in QS statements to convey patient choice. The TEG felt it was important to keep both aspects of patient preparation (washing and hair removal) in the statement. Advice on hair removal should be in relation to the surgical site. Washing would be defined in the definitions section. **Revised statement 1: To be re-worded and sent to TEG for comment**	CB to update statement wording
	Draft QS2: People having surgery are cared for by staff who follow practices that minimise the risk of surgical site infection. The TEG felt this was an aspirational statement and should focus on hand decontamination and theatre 'traffic'. The TEG agreed to focus on transfer of micro-organisms rather than the original wording of 'minimising risk of surgical site infection'. This statement will apply to all settings – primary and secondary care,	

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	as well as community. 'Practices' will be covered in the definitions section. **Revised statement 2: People having surgery are cared for by staff who follow practices during the procedure that minimise the transfer of microorganisms**	CB to update statement wording
	Draft QS3: People having surgery have a record of being given antibiotic prophylaxis where indicated. The TEG discussed timing and dose when giving antibiotics, but wanted to be clear that those who need antibiotics receive them and that a record should be kept. It was agreed to address record-keeping in the structure measures. Wording changed to those that require antibiotics receive them in accordance with local antibiotic formulary to address appropriate prescribing and antibiotic stewardship. The TEG suggested reviewing SIGN guidance on use of antibiotic prophylaxis in surgery. **Revised statement 3: People having surgery that requires antibiotic prophylaxis receive this in accordance with the local antibiotic formulary**	CB to update statement wording and to consider use of SIGN guidance in developing the statement definitions.

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	Draft QS4: People having surgery are offered procedure-targeted case-finding for Staphylococcus aureus, and those who are positive are offered suppression. While screening for MRSA is universal under current national policy, and therefore not aspirational in terms of a QS, the intent of this statement had been to offer targeted suppression to people at high risk of serious morbidity from MSSA. This would be aspirational because it is not currently national policy. There was discussion about targeted case-finding for high risk patients for MSSA and the likelihood that this could reduce SSI rates. In light of potential changes to national policy on screening for MRSA, and because the current NICE guideline recommendation does not refer specifically to procedure targeted suppression of MRSA and MSSA, the NICE team advised that the draft statement was problematic. The NICE team agreed to consider a revised wording of the draft statement, and an alternative wording more in line with the NICE guideline recommendation in drafting the final quality standard. The NICE team advised that progression of this statement into the final draft QS was dependent on internal discussion on its alignment with the guideline recommendations and NICE-accredited evidence. **Revised statement 4 (for further consideration by NICE team): People having surgery which puts them at risk of serious consequences of Staphylococcus aureus infection are offered case-finding and suppression**	CB to update statement wording and present both statements for discussion with NICE senior team

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	Alternative revised statement 4: People having surgery do not receive nasal decontamination with topical microbial agents routinely for eliminating Staphylococcus aureus	
	Draft QS5: People having surgery receive surgical skin antisepsis using an alcohol-based solution immediately before incision. Although the NICE guideline says skin antiseptic can be an alcohol or aqueous solution, the TEG felt that emerging evidence showed alcohol solutions to be better practice. It was noted that NICE clinical guideline CG139 recommends the use of chlorhexidine gluconate in 70% alcohol and epic2 guidance the use of alcoholic chlorhexidine gluconate solution (preferably 2% chlorhexidine gluconate in 70% isopropyl alcohol) both for intravenous catheters. The TEG felt the principle applied to surgery generally although the NICE team confirmed that the TEG is not able to review primary evidence as part of the QS process. In order to make the statement align with accredited guidance, the NICE team advised that reference to the use of alcohol solutions should be restricted to vascular access devices. The NICE team advised that progression of this statement into the final draft QS was dependent on internal discussion on its alignment with the guideline recommendations and NICE-accredited evidence. **Revised statement 5: People having surgery [a peripheral vascular access device or a peripherally inserted central catheter] receive surgical skin antisepsis before incision using chlorhexidine gluconate in 70% alcohol.**	CB to update statement wording based on evidence sources for

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		discussion with NICE senior team.
	Draft QS6: People having surgery are given information and advice on wound and dressing care, including how to recognise a surgical site infection and who to contact if they are concerned. The TEG wanted to draw attention to carers of people having surgery getting the information as well as the people having surgery. The TEG wanted the QS to be underpinned by a definition of types of information. Measures to address how to capture feedback so you know the information is being given. For audit purposes capture this information in patient record / case notes or conduct a patient survey. The TEG felt it was important not to imply that patients are expected to identify surgical site infections (as they are not trained in the definition) and suggested revised wording around recognising 'problems with the wound'. **Revised statement 6: People having surgery [and their carers] are given information and advice on wound and dressing care, including how to recognise problems with the wound and who to contact if they are concerned.**	CB to update statement wording to include carers or define in definitions
	Draft QS7: People who have the recognised clinical features of surgical site infection are offered treatment with an antibiotic that covers the likely causative organisms.	

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	The TEG agreed the statement should focus on the principles of treatment, not on how infections are identified. The use of tools was for local consideration, and treatment was in the context of local resistance patterns. The TEG included 'results of microbiological tests' to ensure appropriate treatment of confirmed infections. **Revised statement 7: People with a surgical site infection are offered treatment with an antibiotic that covers the likely causative organisms [and] based on local resistance patterns and the results of microbiological tests.**	
	Draft QS8: People having surgery should have normothermia maintained before, during and after surgery. The TEG discussed changing the wording from normothermia to normal body temperature, but decided the original wording had a working definition that should be kept (and used in the definitions section of the QS). The TEG agreed to add 'unless active cooling is part of the procedure' to cover relevant surgery. In the measures / rationale, include transfers to surgery and define before during and after surgery. **Revised statement 8: People having surgery have normothermia maintained before, during (unless active cooling is part of the procedure) and after surgery.**	CB to update statement wording.

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	Draft QS9: People having surgery are cared for in an environment that minimises the risk of surgical site infection. The TEG felt the main focus here should be on operating areas (both hospitals and primary/community care) and maintaining their ventilation, rather than the environment generally. The TEG changed the wording to say minimises the risk of contamination, rather than surgical site infection. They also added physical in front of environment, as this was more specific and focused on where the procedure would be taking place rather than covering the whole pathway. By changing the wording the TEG felt this was more relevant to the surgical site infection QS rather than the upcoming infection control QS. The NICE team advised that any potential statement must be specific to SSI, rather than being an aspect of infection control that would best be covered by the forthcoming QS on infection control. It was essential that the revised wording was based on accredited guideline recommendations relating specifically to surgical site infection and the issues raised above (ventilation). **Revised statement 9: People have surgery in a physical environment that minimises the risk of contamination of the surgical site**	CB to update statement wording based on review of guideline recommendations and discussion with NICE senior team on potential overlap with upcoming infection control QS

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	Draft QS10: People having surgery should be cared for by healthcare providers that monitor and feedback infection levels and use the information to adjust clinical practice, where necessary. Considering consultation comments on the potential cost of data collection and surveillance, the TEG felt that there was cost saving in continued surgical site surveillance and the reduction of SSI rates. The TEG felt this should become part of standard good practice. The TEG included post-discharge into statement wording as it was suggested that by missing this group you risk missing out on the majority of infections. The NICE team advised that any potential statement must be specific to SSI, rather than being an aspect of infection control that would best be covered by the forthcoming QS on infection control. It was essential that the revised wording was based on accredited guideline recommendations relating specifically to surgical site infection. The agreed rewording included reference to 'stakeholders', who would be covered in definitions. **Revised statement 10: People having surgery are cared for by healthcare providers that monitor surgical-site (including post-discharge) infection rates and feedback to relevant staff and stakeholders for continual improvement through adjustment of clinical practice**	Include post-discharge in statement or add under definitions CB to update statement wording based on guideline recommendations

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8.Summary of meeting and agreement of final statements	CB presented a summary of the revised statements to the TEG. The TEG discussed the other areas for additional statements suggested by stakeholders. It was agreed that none should be progressed into QS statements – several had already been considered by the TEG at their prioritisation meeting.	
9.Equality Impact assessment	No further potential equality issues were identified.	
10.Next steps •Timelines •Final quality standard product •endorsement	LN outlined the next steps, including key dates in the QS development process. The TEG was also informed that some organisations had expressed an interest at the consultation stage to endorse the standard. LN briefed the group on the CCGOIS and QOF indicators process. They were reminded that they would be invited back to a meeting to discuss these indicators for surgical site infection.	
11.AOB	PJ thanked the group and closed the meeting.	