NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Infection control

Date of Quality Standards Advisory Committee post-consultation meeting:
22 January 2014

2 Introduction

The draft quality standard for infection control was made available on the NICE website for a 4-week public consultation period between 19 November and 17 December 2013. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 42 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the Quality Standards Advisory Committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the Committee as part of the final meeting where the Committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the Committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include overarching outcomes, thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the Committee should read this summary alongside the full set of consultation comments, which are provided in appendix 1.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

Stakeholders were also invited to respond to the following statement specific questions:

3. For draft quality statement 2: Does reference to an organisation's 'board' adequately apply to all organisations that deliver healthcare or can you suggest a more appropriate term?

4. For draft quality statement 4: What are the specific components of the procedures defined that are the main areas for quality improvement?

5. For draft quality statement 5: What are the specific components of the procedures defined that are the main areas for quality improvement?

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- Title of the quality standard should include prevention.
- Stakeholders highlighted the recent publication of the EPIC 3 guidance and the alignment needed between the new guidance and the definitions within the QS.
- Updated figures needed for introduction.
- Stakeholders highlighted that carers have a greater role in infection control.
- Query on how the QS aligns with other documents e.g. Surgical site infection quality standard, PH36.
- Query over the settings included in the QS – are mental health trusts, learning disability units, pre-hospital care, care homes and tertiary settings included?
- General comments on structural changes.
- Additional indicators from outcomes framework suggested.
- Stakeholders highlighted that pharmacists have a role in infection control – already use appropriate measures and have many interactions with patients.
- Suggested reference to the changing epidemiology of HCAI, especially in relation the increase of infection caused by Gram negative organisms, including those that are multi-drug resistant.

Consultation comments on data collection

- Data felt to be collectable but time consuming although some aspects were already being collected.
- Concerns raised over how to join up data and linking process with outcomes.
- Concern with the outcomes measures on incidence of HCAI and suggestion to expand to other organisms.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

People are prescribed antibiotics in accordance with local antibiotic formularies as part of antimicrobial stewardship.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- Statement:
  - Stakeholder suggested expansion of the supporting information to include cross reference to prescribing behaviours and principles of good prescribing, policies based on local surveillance and the need for regular review, monitoring of prescribing, awareness, education and the involvement of stakeholders in the AS programme.
  - Concern over antibiotic prescribing in primary care and the negative effects of restricted formularies and lack of access to microbiologists.
  - Concern over the use of local formularies to make financial savings.
  - Rationale should highlight the appropriate use of antibiotics for the right pathogen and the right patient, and should distinguish between community and hospital use.
  - Medical microbiologist (not microbiologist).
  - Include time to first dose in sepsis.
- Measures:
  - Suggested measures on compliance with written prescribing on the drug chart (clinical indication/duration or review date/route/dose).
  - Concern that if the number of prescription items for cephalosporins and quinolones are monitored it could encourage increased prescribing of Co-amoxiclav which would be undesirable in terms of antibiotic stewardship.

5.2 *Draft statement 2*

People receive healthcare from organisations in which leadership, multi-agency working and surveillance are part of a strategy for continuous improvement in infection prevention and control.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- Statement:
  - Include antibiotic stewardship as well as infection prevention and control and appropriate leadership for both.
  - Statement too vague, needs to be more explicit for contracts.
  - Not clear what surveillance should be done.
- Measures:
  - Most of the data already produced so should be easily obtainable.
  - Not clear how the measures will bring about quality improvement.
  - Suggested measures on infections and outpatient antimicrobial therapy within homecare.
  - Concern over how primary and community settings would deliver an adequately resourced surveillance system.
  - Concern over how ambulance service provider can define objectives and priorities given the limitation of outcome data.
  - Measure is of low quality as it is a crude figure rather than a rate and can result in gaming with some trusts reducing the number of specimens taken.

Consultation question 3

Stakeholders made the following comments in relation to consultation question 3:

- Board was felt to be appropriate for NHS acute organisations but was not felt to be appropriate for other settings.
- Other suggestions:
  - Define as an accountable organisational group with overall responsibility for governance, safety and quality.

- Board/managing body.
- Board/ Accountable Director/registered provider.
- Board or executive.
- Senior management team.
- Those at a strategic level within healthcare management.

5.3 Draft statement 3

People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- Reference to WHO 5 moments for hand hygiene.
- Statement:
  - Concern raised over only including one group rather than all including patients and visitors, ancillary staff etc.
  - Expand to include standard precautions (use of personal protective equipment)
  - Suggestion to extend the statement to add ‘in an organisation that supports, positively reinforces and facilitates best practice in hand hygiene’.
  - Expand direct care to cover all care as staff have a duty to decontaminate their hands even when NOT providing direct care but when hands becomes soiled.
- Measures:
  - Difficult to measure – hand hygiene audits are not valuable to predicting the overall compliance to protocol.
  - Data source to include hand hygiene audits.
- Definitions:
  - Use of alcohol hand rubs rather than just hand rubs
  - Further definition needed of direct contact and care especially for pharmacists.

5.4 Draft statement 4

People needing a long-term urinary catheter have their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the catheter.

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- Statement:
  - Inclusion of short term catheters
  - Inclusion of all catheterisations
  - Concern with the defining point for the term 'long term Foley' being 28 days which in the acute setting is the minority. Suggestion to change to longer than 2 days.
  - Statement to include regular review to remove catheters from those who do not need them.
- Measures:
  - Data collection time consuming for the number of people affected and the number of components needed to be collected that are not currently joined up.
  - Outcome measure on UTIs should be catheter associated UTIs (CAUTIs).
  - Difficult to evidence in community settings.
- Definitions:
  - Change 'an appropriate lubricant' to a 'triple action anaesthetic, antiseptic lubricant'.
  - Documentation should be patient care records.
  - Regularly needs to be specific i.e. <12 weeks for long term catheter.

Consultation question 4

Stakeholders made the following comments in relation to consultation question 4:

- Statement requires management of the entire process.
- Components should be those in the high impact intervention audits.
- Suggestions to include the following:
  - Assessment of need (particularly the use of bladder scanners) for catheterisation.
  - Use of specialist continence services to support alternatives to catheterisation.
  - Risk assessment.
  - Regular review of need/consideration of removal.

- Compliance with appropriate levels of hand hygiene maintained at all times.
- Discourage sampling from bag urine as this is highly likely to be contaminated.
- Refer to aseptic non-touch techniques.

5.5 Draft statement 5

People needing a vascular access device have their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the device.

Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

- Statement:
  - Confusion if statement applies to central or peripheral lines or both and the statement should reflect this.
  - Is antimicrobial liquid soap needed compared to standard soap products?
  - Suggestions for the following to be included in the definitions: length of time a peripheral device should be in situ; visual infusion phlebitis (VIP) scoring as routine; length of time dressing stays in place.
  - Religious beliefs and alcoholic handrubs for hand decontamination.
  - Reference to the subclavian site felt to be problematic.
- Measures:
  - More accurate to measure the incidence of central line associated blood stream infection.
  - Suggest the measures relate to central venous catheter infections and not all HCAI or vascular access device associated infections.
  - Difficult to evidence in community settings.

Consultation question 5

Stakeholders made the following comments in relation to consultation question 5:

- Statement requires management of the entire process.
- Suggestions included:
  - Use of peripheral lines 'just in case'.

- Assessing clinical need for vascular catheter prior to insertion.
- Regular assessment of ongoing need and signs of infection and removal when device no longer needed.
- Daily inspection of the insertion sites and explicit protocols around maximum indwell time.
- Appropriate skin decontamination performed prior to insertion and redressing.
- Compliance with appropriate levels of hand hygiene.
- 2% alcoholic chlorhexidine in a single use applicator and adherence to full-barrier precautions.
- Chlorhexidine gel dressings at the site of insertion.
- Use of closed systems reduces the risk of infection and should be encouraged.
- Records of the planned care of such devices including planned or anticipated date for removal

5.6 Draft statement 6

People with long-term urinary catheters, vascular access devices or enteral feeds are educated about the safe management of their device or equipment, including techniques to prevent infection.

Consultation comments

Stakeholders made the following comments in relation to draft statement 6:

- Statement could be measured through patient/carer feedback
- Clarity needed for definitions of catheters and devices.
- Query how useful the outcome measure is.
- Suggestion to check the understanding of the patient.
- Data collection would require significant resources.

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- Improvement of communication of patient status (e.g. MRSA/Cdiff/VRE/ESBL/CPE) on ward or inter-hospital transfer.

- Improvement of isolation procedures upon identification of MRSA/Cdiff/VRE/ ESBL/CPE.
- Care delivered in a safe and clean environment including enhanced cleaning.
- Surveillance and reporting.
- Use of technologies.
- Wound care and aseptic non-touch technique (ANTT)
- Treatment of leg ulcers which often requires multiple antibiotics.
- Provision and standardisation of efficient and effective community infection, prevention and control (CIPC) services.
- Minimum standards for IPC capacity and capability in the acute and non-acute sector to provide safe, high quality care.
- Statement on enteral feeding (in line with statements 4 and 5).
- Tracheostomy care.
- Immunisation.
- Surgical site infections and chest infections.

Appendix 1: Quality standard consultation comments table

ID	Stakeholder	Statement No	Comments Please insert each new comment in a new row.
1	Department of Health	Title	Please refer to 'infection prevention and control' throughout.
2	Public Health Wales NHS Trust	Title	The term infection prevention (+/- and control) is preferable to infection control, throughout the document.
3	Rotherham Doncaster and South Humber NHS Foundation Trust	Title	Quality Standard title should be called infection **prevention** and control to reflect on the need for practices to prevent not just control infections.
4	The Association for Perioperative Practice	Title	This should be the standard for infection prevention and control. It is important that there is a focus on prevention. This document frames some interesting concepts.
5	Urology User Group Coalition	Title	The Urology User Group Coalition (UUGC) welcomes the development of this quality standard for infection control and prevention which we hope will lead to significant reductions in the number of healthcare associated infections such as urinary tract infections. By way of background, the UUGC is a coalition of several charities that represent users who rely heavily on urology products and services to maintain their health and wellbeing – including conditions such as cancer, stroke, spinal cord injury, multiple sclerosis, spina bifida, and Parkinson's disease.
6	British Orthopaedic Association	General	In the statement on "why this quality standard needed" it is inappropriate to present 2007 data as current - when huge impact has been made on rates of these infections in the last 5 years. "It is estimated that 300,000 patients a year in England acquire a healthcare-associated infection as a result of care within the NHS, a prevalence rate of 8.2%. In 2007, methicillin-resistant Staphylococcus aureus (MRSA) bloodstream infections and Clostridium difficile infections were recorded as the underlying cause of, or a contributory factor in, approximately 9000 deaths in hospital and primary care in England." To avoid sensationalisation, perhaps more up to date figures should be used.
7	Carers Trust	General	As the UK's largest organisation supporting unpaid carers, Carers Trust would like to make the following comments with regard to the section entitled 'Role of families and carers' on page three of the draft Infection Control (IC) Quality Standard:- We fully support the statement that families and carers play an important role in infection control and that they should be involved in decision-making processes. However nothing is mentioned about the practical role some carers play in controlling infection and how to best support them if quality is to be maintained when the patient is in the care of the carer as opposed to the healthcare worker.

ID	Stakeholder	Statement No	Comments Please insert each new comment in a new row.
			Today's patient will spend much less time in hospital following surgery than ten years ago and while some post-discharge support will be provided by community nurses and healthcare workers, this may consist of a short visit to dress a wound. Carers, therefore, need training to provide care of the high level to which the NICE standard aspires. Any training in infection control provided to carers should be accompanied by the appropriate equipment to enable them to put the training they have received into practice. At the same time, carers themselves also need to be protected from infection. Therefore disposable gloves, aprons and anti-bacterial gels should be available to carers free of charge from the NHS. It is also worth highlighting the key role carers play with regard to 'observation of the patient'. Following discharge after surgery, carers need to be aware of the signs of infection. One carer told us that after her 79 year-old mother, who had been discharged into her care after surgery for a fractured femur, began to complain of nausea and a 'burning sensation' at the site of her operation two weeks post-surgery. The carer was unaware that these could be signs of a deep wound infection and thought it was 'normal' to feel that way after major surgery. It was several days before she sought medical help after which her mother was admitted to hospital and diagnosed with MRSA only to pass away a few weeks later. On reflection, the carer felt that somebody could have told her to look out for the symptoms her mother was experiencing. Another carer comments: "If you were to replace the carer with a NHS professional, then they would have access to free equipment as part of their job. The carer should have exactly the same access to that equipment. Another alternative is for carers to keep detailed records of the equipment they have to purchase and offset the cost against their own tax. If they pay zero tax they can still request a refund."
8	Department of Health	General	Epic 2 has been superseded: http://www.journalofhospitalinfection.com/article/S0195-6701(13)60012-2/abstract
9	Department of Health	General	Asepsis, standard precautions, including the use of personal protective equipment, and education of healthcare workers were included in the briefing paper for the quality standard, but excluded from the consultation draft. It would be helpful if NICE could explain the rational for this.
10	Department of Health	General	It would be helpful if NICE could explain how this Quality Standard is to be used alongside the Code of Practice for the prevention and control of infection and related guidance (2010) as this lists the ten criteria against which a provider of regulated activities will be judged on how it complies with the registration requirement for cleanliness and infection control.
11	Department of Health	General	It would be helpful if NICE could explain how this Quality Standard is to be used alongside the NICE public health guidance 36 - Prevention and control of healthcare-associated infections (2011).
12	Department of Health	General	The Department welcomes the explicit statements for commissioners included with each QS.
13	Department of Health	General	Do primary, community and secondary care settings include mental health trusts, learning disability units, pre-hospital care and care homes?

ID	Stakeholder	Statement No	Comments Please insert each new comment in a new row.
14	Department of Health	General	It is stated that 'all healthcare workers and social care and public health practitioners involved in infection control should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard.' Does NICE intend to work with Health Education England to develop appropriate training and competencies?
15	Department of Health	General	The High Impact Intervention on urinary catheter care refers to short term catheters
16	Faculty of Intensive Care Medicine	General	NICE may like to know that Health Protection England has brought together a multiprofessional group to establish a national surveillance, reporting, and quality improvement system for infection control in intensive care units (ICCQIP). The professional organisations cover intensive care, microbiology and infection control, and include adult, paediatric and neonatal ICUs. This will produce national surveillance data initially on bacteremia and central venous line infection but extending to other infections later.
17	HCAI SURF	General	SURF generally welcomes the areas covered by the statements.
18	Hertfordshire Community NHS Trust	General	Please be specific who is responsible for setting the locally defined standards CCG
19	Independent Healthcare Advisory Services (IHAS)	General	IHAS have welcomed the opportunity to comment on the draft Quality Standard and supports it.
20	NHS Sheffield CCG	General	Additional information please note I am aware that the EPIC 3 National Evidence based guidelines for preventing healthcare associated infections has just been released. Please update your source guidance.
21	Nottinghamshire Healthcare NHS Trust	General	All statements that reference EPIC guidelines 2007 require updating to the 2013 version
22	Oxford Health NHS Foundation Trust	General	Data regarding prevalence of HCAI is 2007- there has been more recent 2011
23	Public Health England	General	It is important to note that such quality standards should start with the most desirable outcome, in this case that of infection prevention, rather than focusing solely on control. Our AMRS & HCAI Regional Leads network has expressed concern that very few Infection Prevention Control Nurses (IPCNs) were involved in the project team for the development of the Quality Standard and neither was the Infection Prevention Society. It is felt that this may have negatively impacted on the quality of the statements.
24	Public Health England	General	Given that primary, community and secondary care settings are included, to be all-encompassing, we suggest including tertiary care settings.
25	Public Health England	General	It is acknowledged that this table is taken from an existing NHS document; however, the Key Performance Indicators (KPIs) should now cover more than MRSA and C. difficile to include other clinically significant organisms and infections. Gram-negative bacteria must be recognised for their importance, with multi-resistance a growing concern. This would tie in with the recently published Department of Health UK Five Year Antimicrobial Resistance Strategy (2013-2018) where infection prevention and control is key to slowing the upward trend of antimicrobial resistance.
26	Public Health Wales NHS	General	"*It is estimated that 300,000 patients a year in England acquire a healthcare-associated infection as a result of care*

ID	Stakeholder	Statement No	Comments Please insert each new comment in a new row.
	Trust		*within the NHS, a prevalence rate of 8.2%."* – this appears to be a description of **incidence** not prevalence
27	Royal College of Anaesthetists	General	Our members feel that this a good draft document and would be happy to endorse it after publication. There is no specific mention of regional anaesthesia interventions, as there is for vascular access, but these are covered in the generic standards.
28	Royal College of Anaesthetists	General	The guideline developers might find the following guideline on infection control in anaesthesia useful: http://www.aagbi.org/publications/guidelines/infection-control-anaesthesia-2
29	Royal College of General Practitioners	General	On dissemination of information there are several sources of information distributed in a variety of ways. I like the HPA material. http://www.hpa.org.uk/webc/hpawebfile/hpaweb_c/1279888711402
30	Royal College of General Practitioners	General	How can the information be co-ordinated and disseminated in an accessible format? Most GPs and community nurses regularly use BNF and Mims and it would be useful to have these contain a simple guide.
31	Royal College of paediatrics and Child Health	General	Thank you for inviting the Royal College of Paediatrics and Child Health to comment on the infection control draft standard. We have not received any responses for this consultation.
32	Royal Liverpool and Broadgreen University Teaching Hospitals NHS Trust	General	Other sources that may be used – Pratt et al EPIC 2. Please note EPIC 3 has just been published so all references to EPIC 2 in the NICE quality standard need to be reviewed.
33	Royal Pharmaceutical Society	General	The Royal Pharmaceutical Society (RPS) welcomes NICE Quality Standards on infection control and overall support the quality statements. We'd like to highlight that pharmacists, as key providers of care, already use appropriate measures to prevent and control infection within their organisations. Also as experts in medicines pharmacists can provide advice on the usage of medicines and appliances to support the proposed quality statements. They can additionally support in educating patients on infection control through the many interactions they have with patients in primary, community and secondary care settings.
34	Royal Pharmaceutical Society	General	The RPS, as a professional body for pharmacists and pharmacy, would also like to submit the following comments from the Guild for Healthcare Pharmacists (who represent "pharmacists working in hospitals, primary care and other healthcare institutions for both the NHS and commercial healthcare providers throughout the UK"). We would like to express our general support for the principles provided in the paper, adding that: The paper may have an impact on Guild members at the professional level regarding antimicrobial stewardship as they are the clinicians often leading this work, and also regarding hand washing procedures due to the increasing role of pharmacy staff having 'hands on' direct patient contact. For secondary care the data source highlighted for antibiotic prescribing in the paper "that might be used" is epic2 (National evidence-based guidelines for preventing healthcare-associated infections in NHS hospitals in England Journal of Hospital Infection 65 (supplement1):S1–64). This may be an issue for accurate data gathering as although

ID	Stakeholder	Statement No	Comments Please insert each new comment in a new row.
			epic2 provided comprehensive recommendations for preventing HCAI in hospitals and other acute care settings based on the best currently available evidence, it went on to state "this is not always the best possible evidence and an agenda for further research was required". Under the prescribing measures for secondary care, the document states that certain information should be recorded on the inpatient medication chart and in the patient notes. This is not possible for a number of organisations as they no longer use medication charts and instead use e-Prescribing and Administration (EPMA) but this is a failing in the system for some EPMA applications as there is no facility to add a soft 'review date' to a prescription.
35	Salford City Council	General	**Introduction –** The comment '£1 billion a year' is widely uses, however is this figure up to date, and is this referenced?
36	Salford City Council	General	**Table 1, NHS Outcomes Framework 2013/14—Domain 5, Improvement Areas, 5.2i MRSA, 5.2ii CDiff,** Comment—Have our eyes been taken off the ball while concentrating on these two infections? There are also other re-emerging infections and multi-resistant bacteria which are just as, if not more, problematic in terms of future incidence.
37	Salford City Council	General	**Statement 2** Comment - Since the re-organisation of the NHS and the disbanding of the PCT's, networks have also unfortunately been dissipated and overarching responsibility is unclear in areas. Infection control in local authorities has been affected by changes in roles and loss of some aspects of clinical leadership and autonomy, including most importantly loss of patient contact due to information governance and CQC registration funding and clarity. **Statements 4&5** Comments—there is no national decolonisation policy for MRSA for high risk patients. Salford have attempted to introduce to prevent risk and incidence. **Statement 6** – self care requires extensive individual assessment, auditing, training and ongoing management measurement to improve outcomes
38	UK Clinical Pharmacy Association (UKCPA)	General	If a policy is going to deal with antimicrobial stewardship then it should be mandatory to have an Antimicrobial Pharmacist involved, so that some of the issues above may have already been resolved.
39	Urology User Group Coalition	General	The quality standard could also contribute to achieving measures in the Adult Social Care Outcomes Framework, specifically Domain One, outcome measure 1B, the proportion of people who use services who have control over their daily life.
40	Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infections	Question 1	No – how was the list identified? Does it link with the top evidenced based practices for patient safety that hospitals should have in place? Does it map clearly with the similar areas in code of practice? The list specifically omits short term catheterisation, dangerous to include statements on hand disinfection that imply

ID	Stakeholder	Statement No	Comments Please insert each new comment in a new row.
	(ARHAI)		only one group rather than all including patients and visitors, ancillary staff etc. ARHAI has concluded on a number of occasions that the guidance is already there but is often not followed in it's entirety.
41	Association for Clinical Biochemistry and Laboratory Medicine	Question 1	• Other key areas to consider are: o Improvement of communication of patient status (e.g. MRSA/Cdiff/VRE/ESBL/CPE) on ward or inter-hospital transfer. o Improvement of isolation procedures upon identification of any of the above.
42	Association of British healthcare Industries	Question 1	The main area that is lacking is the time used as a defining point for the term 'long term Foley'. This QS only refers to those people who have a Foley for longer than 28 days which in the Acute setting is by far and away the minority. We would propose that the QS should capture individuals who have a Foley for longer than 2 days to be a risk of and CAUTI which will be far more helpful in identifying those at risk. The majority of patients will not be captured in the current proposed scope.
43	Department of Health	Question 1	The standard does not make any reference to the changing epidemiology of HCAI, especially in relation the increase of infection caused by Gram negative organisms, including those that are multi-drug resistant. Asepsis, standard precautions, including the use of personal protective equipment, and education of healthcare workers should be included in the standard.
44	Great Western Hospital NHS Foundation Trust	Question 1	Could not find the quality standard – just the list of quality statements. I presume it is the whole document. Surprised there is no mention of care delivered in a safe and clean environment. This document does not link to surgical site wound infections for long term wounds such as ulcers.
45	Hertfordshire Community NHS Trust	Question 1	These quality statements are appropriate and very patient focused and have captured the key areas that require focus on to ensure that the economy can reduce the rates of healthcare associated infections.
46	Independent Healthcare Advisory Services (IHAS)	Question 1	IHAS thinks that the Quality Standard is very good, clearly written with measurable quality measures. However, IHAS feels that there is a huge missed opportunity to have an individual statement around the cleanliness of the healthcare environment.
47	Independent Healthcare Advisory Services (IHAS)	Question 1	The draft Quality Standard does reflect accurately the key areas for quality improvement as far as it goes. As stated above it is felt that an opportunity to include the environment was missed. The need has been evidenced by the recent (December 2013) CQC report on primary care settings.
48	Johnson & Johnson Medical Ltd	Question 1	Johnson & Johnson Medical welcome the opportunity to consult on the draft Quality Standards in Infection Control. We are broadly supportive of the proposals and welcome all of the measures proposed. However, we believe three important amendments should be considered prior to publication. Firstly, we feel the draft quality standards miss the opportunity to further support the extended implementation of Healthcare Acquired Infection surveillance and reporting on a mandatory basis.

ID	Stakeholder	Statement No	Comments Please insert each new comment in a new row.
			Given the successful impact associated with the mandatory reporting of MRSA, C-Diff and, more recently Surgical Site Infection within the Orthopaedic speciality, we believe all providers of healthcare should be further encouraged to capture and, importantly, publically report all types of infection over and above their contractual requirements to do so. Such measurement and transparency has played a key role in the deployment of infection prevention strategies at a local and national level. Furthermore, we believe mandatory surveillance is one of the key drivers to support the work around Antimicrobial Stewardship which is well set out within the draft guidance. We believe a similar level of emphasis should be placed on mandatory surveillance as an opportunity to adequately identify and plan infection prevention opportunities and avoid over prescribing. Secondly, while we are delighted to observe guidance around the appropriate delivery and maintenance of Vascular Access Devices we are disappointed to see that the methods described are related to the EPIC 2 guidelines and not the recently updated, and NICE supported, EPIC 3 guidelines. While a clear link to nationally recognised implementation standards is a positive step, such links need to be in line with the most up to date evidence and methods in order to remain relevant and impactful. We therefore propose that the section titled *"Specified procedures necessary for the safe insertion and maintenance of vascular access devices"* is updated to include information from the EPIC 3 guidance. For ease we have included a link to the document. Lastly, we believe the role that technology and innovation can play in the Infection Prevention arena is understated throughout the Quality Standard. While we appreciate this document is not the appropriate vehicle to endorse specific technologies we believe additional emphasis should be placed on ensuring knowledge of technological development is appropriately disseminated. Furthermore , guidance should be provided to reflect the importance of "cross boundary" budgetary planning to avoid minimise the impact of silo'd decision making within the community and secondary care sector. On this particular issue we believe learning's can be taken from the NICE Public Health Improvement Guidance where specific measures were proposed to ensure "*Evidence that information on relevant new technologies and innovation is disseminated to directorates, along with guidance on evaluation and implementation" was available for key NHS decision makers and budget holders."* We propose a similar inclusion within this Quality Standard.
49	Leg Ulcer Forum	Question 1	The only comment I would make on behalf of the LUF is the omission regarding wound care, and ANTT. The other areas covered in the document are of value, but there is a need to discuss the standards regarding the management of wounds.
50	Medway Community	Question 1	Yes

ID	Stakeholder	Statement No	Comments Please insert each new comment in a new row.
	Healthcare		
51	MRSA Action UK	Question 1	MRSA Action UK welcomes the areas covered by the statements.
52	NHS England	Question 1	It is fine as far as it goes but there is an important omission. The first statement is about prescribing antibiotics in line with local formularies. There is no statement about how quickly antibiotics should be administered. There is evidence that it is common for people who develop sepsis not to actually be given their (IV) antibiotics quickly enough, and this associated with considerable mortality and morbidity. The UK Sepsis Trust has lots of info on this. Once sepsis is recognised antibiotics should be in the patient within an hour.
53	NHS Sheffield CCG	Question 1	Yes it does
54	Papworth Hospital NHS Foundation Trust	Question 1	There are further areas which could be added for improvement such as provision of adequate facilities for management of infected inpatients (isolation facilities), adequate cleaning of environment and decontamination of equipment.

55	Public Health England	Question 1	In relation to key areas for quality improvement, we are somewhat disappointed that the standards have missed an opportunity to provide 'added value' by going beyond what already exists as High Impact Interventions e.g. for urinary catheters and devices, to cover other areas of infection prevention and control such as the environment, cleaning and maintenance. We suggest that the key areas for quality improvement should also include the following:
			
			• Provision and standardisation of efficient and effective community infection, prevention and control (CIPC) services.
			• Minimum standards for IPC capacity and capability in the acute and non-acute sector to provide safe, high quality care
			• Environmental cleanliness, including;
			    o Enhanced cleaning of the environment with chlorine releasing agents to prevent spread of C difficile and,
			    o Standard processes to descale and decontaminate taps and sinks and the use of filters in augmented care areas
			
			Throughout, there is inconsistency in that infection prevention is, at times, omitted in favour of using infection control; both should be included.

56	Public Health Wales NHS Trust	Question 1	There are any number of areas of infection prevention and control that could have been included in this quality standard, though laudable and of some importance it's not clear why patient self care of long term devices has been chosen as a priority indicator.
57	Rotherham Doncaster and South Humber NHS Foundation Trust	Question 1	No - Cleanliness is a major issue in most Trusts but this is not reflected in this standard. This includes medical devices and the environment. This is a worry especially when there are outbreaks of infection.

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			There is no statement for enteral feeding (in line with statements 4 and 5); it is only mentioned in statement 6 under education. Tracheostomy care is not included in a statement.
58	Royal College of General Practitioners	Question 1	I agree with the quality statements. Is there scope to include a statement about the treatment of leg ulcers which appears often requires multiple antibiotics.
59	Royal College of Nursing	Question 1	No, The RCN would like to see the standard strengthened through inclusion of a quality statement regarding immunisation (for example influenza and pneumococcal vaccination for inpatients) and the importance of this as a contributory factor in reducing preventable illness and contact with healthcare which could result in HCAI (through commissioning of vaccination programmes in community settings).
60	Royal Liverpool and Broadgreen University Teaching Hospitals NHS Trust	Question 1	The standard focuses on two important invasive devices but omits reference to surgical site infections or chest infections.
61	South West Yorkshire NHS Foundation Trust	Question 1	All statements are relevant and are key to promoting best practice
62	St John Ambulance	Question 1	The QS accurately reflects the key areas to be improved.
63	Tees Esk and Wear Valley NHS trust	Question 1	I think there needs to be a statement not only saying dont treat mild infections but actually using suboptimal doses – increase the risk of resistance and is harmful.
64	The Association for Perioperative Practice	Question 1	All key areas are represented.
65	Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infections (ARHAI)	Question 2	In regards to the systems and structures: There is a huge emphasis on data collection locally. Is there the capacity to do this? Who will audit this, will there be penalties? Gaming? Will this improve the uptake of guidance that is already out there? In regards to the possibility of data collection: Probably. Particularly if targeted. Much could be done by using existing systems more intelligently, with appropriate data linkage and investment in data management and analysis within IPC/AS or provided by the hospital. This is information required for improving patient safety, however resources supporting hospital epidemiology and the analysis of local data to monitor and drive quality and improved patient safety are often inadequate. Statement 2 is strong and welcomed, but is not clear about what surveillance should be done, although the statement in general is fully supported. Perhaps as well as surveillance, the statement could include the monitoring of some key processes in IPC and AS, as

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			well as other critical measures for effective IPC such staffing levels, occupancy rates, training and education etc. Statement 2 should state that leadership is required in both infection prevention and control and in antibiotic stewardship. It perhaps should also state that these be core components of the hospital's safety programme.
66	Association of British healthcare Industries	Question 2	The data needed is quite simple: The date of catheterisation, review date, date of removal. Any microbiological evidence, prior and after catheterisation, of suspected or actual infection or commenced antibiotics for suspected infection is important but as there is not a clearly recognised definition used in the UK of a CAUTI it is tricky know how this would be captured. The reason for catheterisation, a record of competence training and assessment for the HCP responsible for insertion and on-going care is important. Validation of the local protocol. Given that this is not currently joined up we would imagine it difficult to capture
67	Department of Health	Question 2	Potentially in the longer term. The Department has recognised that there are currently major challenges, for example, collecting systematic infection data in primary care, linking prescribing data to patient outcomes in all settings, meaningful hospital prescribing data, systematic device utilisation data in both primary and secondary care etc.
68	Independent Healthcare Advisory Services (IHAS)	Question 2	The data proposed for the quality statements can be collected given that the systems and structures are in place. IHAS particular like that it is compliance that is collected and not non-compliance which provides a positive rather than negative i.e. success rate. However, it also identify where the standard is not followed assisting in learning and review of practice with an aim to improve. Outcome provides tangible feedback.
69	Medway Community Healthcare	Question 2	Yes (audit)
70	NHS England	Question 2	Statement 1 is easy from pharmacy records, statement 3 is already routinely audited at ward level, statements 4 and 5 should be implemented with a care bundle approach e.g. sticky labels in notes or equivalent on electronic patient record. Latter much easier to audit without having to manually trawl notes. Statement 6 can be explored through patient/carer feedback systems if appropriate questions asked.
71	NHS Sheffield CCG	Question 2	Yes however presumably this could potentially mean an increase in the number of audit or surveillance personnel.
72	Papworth Hospital NHS Foundation Trust	Question 2	Yes but the required systems/structures would be labour intensive and time consuming in most cases unless appropriate technology was available. For example for statement 2 electronic prescribing would be a system that would help collect the data.
73	Public Health England	Question 2	We have concerns about using 'incidence of Healthcare Associated infection (HCAI)' as the outcome measure for many of the Quality Statements (QS). We feel that undertaking incidence surveillance in all HCAI is unlikely to be cost-effective - it is not recommended in any peer-reviewed papers. Instead, we suggest that regular prevalence surveys of HCAI should be undertaken and high-prevalence areas (such as ICUs) or high risk areas (such as surgery, devices) should have incidence surveillance performed.

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			In QS2, Section 2, our AMRS & HCAI Regional Leads network has expressed concern in relation to how primary care settings would deliver on "adequately resourced surveillance systems". In QS6, we feel that it should be recognised that the resources involved in the data collection for this statement would likely represent a workstream in their own right. In addition, we suggest that quality indicators should be provided for the training to ensure that the data collection is meaningful.
74	Rotherham Doncaster and South Humber NHS Foundation Trust	Question 2	Yes at the moment it is difficult to collect antimicrobial prescribing data as an electronic prescribing system is not in use. The data collected is also dependant on the systems being changed so that the information required can be collated accurately. E.g. include a section that shows that the patient/carer has been educated.
75	Royal College of Nursing	Question 2	No – challenges to collecting data on prescribing and dispensing of antibiotics exist in healthcare organisations.
76	Royal Liverpool and Broadgreen University Teaching Hospitals NHS Trust	Question 2	Collecting incidence outcome data would be resource intensive and time consuming in the absence of accurate electronic institutional and patient held records shared across the health care community and linked to relevant diagnostic, interventional and therapeutic services. As bundles of care have been recognised to reduce the risk of infection measuring incidence of healthcare infection and relating it directly to hand hygiene alone is unlikely to be feasible. This has been demonstrated to be research project on its own (Pittet D.,et al. Effectiveness of a hospital wide programme to improve compliance with hand hygiene. Lancet 2000; 356: 1307–12.) This challenge also applies to recognising and accurately diagnosing catheter associated urinary tract infections. In order to calculate incidence data this requires that the insertion of every urinary catheter in a trust is centrally recorded along with the date of removal and validation of whether an individual was diagnosed and treated for a CAUTI which can also occur in the days close to the date of removal. There are also some ongoing challenges in differentiating between bacteriuria and infection. Whilst there may be a proportion of hospitalised patients with urinary catheters in situ for more than 28 days patients. There will also be a group of patients with long term urinary catheters (e.g due to inoperable obstruction) who regularly pass between different health care providers. In order to estimate the true incidence of infection for the latter patients a lead from the community health sector to co-ordinate the follow up of patients would be needed. To date healthcare associated infection in hospitals has been measured using prevalence surveys. The most recent in 2011 coordinated by the Health Protection Agency (now Health Protection England) and the European Centre for Disease Prevention and Control. Fourth National Point Prevalence Survey on Healthcare Associated Infections and

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			First National Point Prevalence Survey on Antimicrobial Use and Quality Indicators The national surgical site surveillance programme is currently set up to facilitate data collection on incidence of surgical wound infections. The outcome measures of incidence are aspired to but it is not clear whether all possible healthcare associated infections are being included or just those for which national targets have been set.(Ref page 14 data source a) There also has to be a realistic appraisal of time frames and resources to ensure resources are in place to obtain incidence data. In the absence of a comprehensive trust wide surveillance and data collection system, targeted rather than whole trust incidence surveys may be an appropriate interim approach. There may also be a case for prevalence surveys.
77	St John Ambulance	Question 2	As an independent ambulance service provider, how can we ensure consistency in reporting as we do not have access to the national information services portal? HCP and non medical prescribers working for St John Ambulance prescribe antibiotics so this is relevant to our service provision.
78	The Association for Perioperative Practice	Question 2	Yes, in most cases stated data is currently gathered and reviewed as care bundles/high impact interventions where each stage of the process (whether actual intervention or ongoing and continuous care) is monitored.
79	Great Western Hospital NHS Foundation Trust	Question 2	Possible and already done with some of the statements. Hand hygiene for every episode would have to be a snapshot/ regular audit / patient feedback.
80	Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infections (ARHAI)	Quality statement 1	Statement 1: Please note that ARHAI in conjunction with Public Health England are developing antimicrobial prescribing quality measures for both Primary and Secondary care sectors.
81	Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infections (ARHAI)	Quality statement 1	Statement 1 is too soft, picking only one aspect of stewardship; 'the formulary'. Formularies will have the local drug choices, but not address prescribing behaviours and principles of good prescribing. There is nothing about policies based on local surveillance and the need for regular review, monitoring of prescribing, awareness, education and the involvement of stakeholders in the AS programme.
82	Association for Clinical Biochemistry and Laboratory Medicine	Quality statement 1	• The presence of a local antibiotic formulary is not enough to show that prescribing is compliant. Antibiotic prescribing data should be relatively easy to collect. • Each Trust's formulary is different so a standard set of antibiotics, to measure prescribing rates, will not be compatible with some organisation's formularies, thus making the data less representative, and making comparisons between different institutions more difficult. • "Compliance with formulary" rates produced locally by each organisation would enable direct comparison but would

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			be much more difficult to collect/calculate. • An alternative quality measure could be to measure compliance with written prescribing on the drug chart (clinical indication/duration or review date/route/dose).
83	British Association of Oral & Maxillofacial Surgery	Quality statement 1	In the section on Antimicrobial Stewardship, I agree on the points listed. Limitation of antibiotics is important, and should be reserved only for those cases where evidence is available to show that there is a substantial benefit. Where this is the case for surgical prophylaxis or management of certain conditions specific to a certain surgical specialty, it may be worth trying to obtain a consensus opinion from the surgical specialty's national organisation, so that everyone in that specialty is working in a similar fashion. Obviously it would then be up to the local hospitals as to whether they took up the advice/guidance given in the document
84	British Orthopaedic Association	Quality statement 1	On the subject of surgical antibiotics prophylaxis, there is a debate about single vs. multiple dosage in orthopaedic surgery. There is no evidence either way in joint replacement. However, we are in agreement that antibiotics prophylaxis should not be extended beyond 24 hours. Given that this standard has to cover all of surgery could we suggest: "Surgical antibiotic prophylaxis should be single dose if evidence exists for the type of surgery, and for a maximum of 24 hours. The choice of antibiotic should be based on: likely contaminating organisms, organisms identified in known infections and the risk profile of the antibiotic used"
85	Department of Health	Quality statement 1	The Department welcomes the inclusion of a statement on antimicrobial stewardship.
86	Department of Health	Quality statement 1	At the request of DH and the Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) Public Health England have established English Surveillance Programme for Antimicrobial Utilisation and Resistance (ESPAUR) Oversight Group. Aims and Objectives The aim of the ESPAUR is to develop and maintain robust data information and surveillance/monitoring systems to measure antimicrobial utilisation and resistance in England and its impact on antimicrobial resistance and patient safety. The objectives of the ESPAUR will focus on delivering objectives within the UK Five-Year Antimicrobial Resistance Strategy. Specifically, the oversight group will: I. Provide input into the key components of the annual report from the ESPAUR. II. Provide input into the integration and analysis of varying antimicrobial usage datasets across primary and secondary care;

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			III. Provide input into the real-time monitoring and measurement systems for antibiotic consumption in hospitals with a view to supporting antimicrobial stewardship in the NHS; IV. Review the systems developed to ensure that the antimicrobial usage data can be linked with C. difficile rates and bacterial resistance surveillance data; V. Provide input into the guidance for providers on linking antibiotic formulary to local susceptibility data and improve feedback mechanism for British National Formulary; VI. Enhance data analysis and advice on use of carbapenems and other Critically Important Antibiotics in the NHS; VII. Develop quality measures for optimal antimicrobial prescribing in primary and secondary care; and VIII. Develop methods to monitor the clinical outcomes including any unintended consequences; for example increased prescribing of particular antibiotics. IX. Develop initiatives to change public and professional behaviour around antimicrobial consumption and prescribing. ARHAI have established a Prescribing Quality Measures sub-group who will report on March 2014 to the parent committee and ESPAUR. The subgroup Terms of Reference 1. To determine the ability of the current data sets to provide a baseline from which to measure impact of the strategy. 2. To define a small number of local quality measures for community and hospital prescribing. Outputs to be used as a pilot for the development of national measures. 3. Determine the optimal methodology for monitoring and reporting for local quality measures. 4. Identify options to monitor the safety of the implementation of these antimicrobial prescribing quality measures on infection syndrome specific clinical outcomes. https://www.gov.uk/government/publications/advisory-committee-on-antimicrobial-resistance-and-healthcare-associated-infections-annual-reports NICE may wish to reconsider any quality measures related to the prescribing of antimicrobials in light of this work programme of ESPAUR and the ARHAI sub-group.
87	Department of Health	Quality statement 1	We are concerned that if the number of prescription items for cephalosporins and quinolones are monitored it could encourage increased prescribing of Co-amoxiclav which would be undesirable in terms of antibiotic stewardship.
88	Department of Health	Quality statement 1	The primary care section should make reference to TARGET – 'Treat Antibiotics Responsibly, Guidance and Education Tool' which is hosted by the RCGP. http://www.rcgp.org.uk/targetantibiotics/
89	Faculty of Intensive Care	Quality	Satisfactory

ID	Stakeholder	Statement No	Comments Please insert each new comment in a new row.
	Medicine	statement 1	
90	HCAI SURF	Quality statement 1	Antimicrobial stewardship is of great importance. In secondary care restricted formularies have led to more appropriate prescribing. Consultant microbiologists are relatively easy to contact if a patient has needs not met by the restricted formulary. However the same cannot be said for primary care. Patient education is paramount in reducing inappropriate prescribing for minor often viral illness. Restricted formularies in primary care do not take account of Quality Standard 15. Patients may have intolerances, allergies, inability to take tablets or strong beliefs that prevent taking of products with animal derivatives. The latter being covered under the Equality Act. Others with long term conditions may take long term antibiotics to prevent debilitating infections prescribed by a tertiary centre that might not meet local policy. Busy GP's do not have time to contact a microbiologist, leaving the patient with antibiotics they cannot take, leading to deterioration of their condition. The quality measures to underpin quality statement 1 will not be transparent if data from the Information Services Portal is unavailable to non-NHS users. It is not currently possible to download the full range of antibiotic prescribing data available on the system if you are a member of the public. This needs to be addressed. Reference is made to documenting clinical indication, duration or review date, route and dose of antimicrobials on the drug chart in secondary care, no reference to made documenting the same in primary care. With electronic records the documenting of choosing a 'no' or 'delayed' antibiotic strategy could also enhance a potential method of monitoring antimicrobial stewardship.
91	Hertfordshire Community NHS Trust	Quality statement 1	I would like to see a minimum suggested period of frequency for prescribing rates to be stated so that it is twice yearly or more frequently this is set. It would be beneficial that there is also a minimum acceptable pass rate such as 90% for each key statement. Clinical Support units/CCG will have prescribing rates per GP not by individual care homes so this may be difficult to measures in such organisations. Community hospitals already undertake audits.
92	Hertfordshire Community NHS Trust	Quality statement 1	Finish sentence – " obtain cultures first" prior to commencing any antibiotic course
93	Independent Healthcare Advisory Services (IHAS)	Quality statement 1	The quality statement will assist organisations to implement a programme of stewardship for all healthcare professionals and enable organisations to publish a formulary which would restrict use within their sites. Pharmacists already intervene when prescribing is inappropriate and a programme of stewardship will be a big move in the right direction.
94	Merck Sharp & Dohme Ltd	Quality statement 1	The rationale describes the importance of prescribing the use of antibiotics when they are needed (i.e. not for mild infections such as cold, sinusitis etc.), however, a clear distinction has not been made between community use for mild infections that require oral antibiotics versus use for serious life-threating infections acquired in the hospital

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			setting that require IV antibiotics. The rationale should highlight the appropriate use of antibiotics for the right pathogen and the right patient, and should distinguish between community and hospital use.
95	Merck Sharp & Dohme Ltd	Quality statement 1	MSD agree with this section, however, would also recommend that reference is again made to using the appropriate antibiotic for the right pathogen and for the right patient, and the choice of antibiotic should be based on data on the local ecology from the laboratory (on infection rates, susceptibility testing, resistance patterns, antimicrobial surveillance data etc.) We believe that in the hospital setting, rapid and bed-side diagnostics are the only way to achieve prescribing of the right antibiotics for the right pathogen. Using an inappropriate antibiotic (i.e. because it is the cheapest) can contribute to future antibiotic resistance in the same manner as over use.
96	MRSA Action UK	Quality statement 1	We support the principles of statement 1. Local policy should be flexible enough to always be in the best interests of the patient, particularly those who are dependent on antimicrobials for long term illness. The quality measures to underpin quality statement 1 will not be transparent if data from the Information Services Portal is unavailable to non-NHS users. It is not currently possible to download the full range of antibiotic prescribing data available on the system if you are a member of the public. This needs to be addressed. Reference is made to documenting clinical indication, duration or review date, route and dose of antimicrobials on the drug chart in secondary care, no reference is made to documenting the same in primary care. With electronic records the documenting of choosing a 'no' or 'delayed' antibiotic strategy could also enhance a potential method of monitoring antimicrobial stewardship.
97	Public Health England	Quality statement 1	We suggest that this is changed to include “People are prescribed APPROPRIATE antibiotics.…in keeping with GOOD antimicrobial stewardship…”
98	Public Health England	Quality statement 1	****We strongly suggest that antimicrobial prescribing quality measures should be delayed/suspended until ARHAI and PHE reports back to the Department of Health, AMR Strategy Higher Level Steering Group, and NHSE on recommended quality measures in primary and secondary care, based on evidence. These should then be incorporated.**
99	Public Health England	Quality statement 1	As per suggestion made under ‘list of quality statements’. We suggest that this is changed to include “People are prescribed APPROPRIATE antibiotics.…in keeping with GOOD antimicrobial stewardship…”
100	Public Health England	Quality statement 1	We suggest that the second sentence of this section is changed to include “…according to the principles of GOOD antimicrobial stewardship…”

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101	Public Health England	Quality statement 1	We suggest that the Healthcare professionals section is changed to include "…as part of GOOD antimicrobial stewardship."
102	Public Health England	Quality statement 1	We suggest that this section should be changed to include: First sentence: "GOOD antimicrobial stewardship is…" Bullet 2: change "to start prompt effective antibiotic treatment." to "to start prompt empirical antibiotic treatment that is likely to be effective." Bullet 4: Change "Obtain cultures first." to "Obtain cultures as a priority and review empirical antibiotic choice when sensitivity data become available, stepping down or escalating prescribing as warranted." Bullet 6: Change to "…continuing need for antibiotics by 48 hours POST-PRESCRIPTION" Bullet 11: Change to "…remain effective, because BROAD-SPECTRUM ANTIBIOTICS increase …"
103	Royal College of Nursing	Quality statement 1	Quality statement 1 – antibiotics should be prescribed and dispensed in line with local formulary, not just prescribed.
104	Royal Liverpool and Broadgreen University Teaching Hospitals NHS Trust	Quality statement 1	Second to last line suggest should read "**medical** microbiologist (not microbiologist) or infectious diseases physician"
105	Royal Liverpool and Broadgreen University Teaching Hospitals NHS Trust	Quality statement 1	Second to last line suggest should read "**medical** microbiologist (not microbiologist) or infectious diseases physician" .
106	Salford City Council	Quality statement 1	**Rationale –** should this not state – overuse of antibiotics / antimicrobials for viral self terminating infections? **Quality Measures, Data Source,** Comments • Responsibility for quality and local data collection does not sit in one place. Clarity is required - GPs, LAT, CCG, LA responsibility for data collection and reporting. • GPs are obliged to carry out self audit – data around practices reported to meds management who sit within CCG and CSU. • Previously, prescribing data for GPs and non-medical prescribers was the remit of meds management within the PCT using e-PACT. Is a user-friendly data capture system available nationally for capturing data around prescribing habits for GP and non-medical prescribers (including dentists; podiatrists; nurses; physiotherapists; pharmacists)? • To be able to feed back, educate and 'close the loop' a designated body should be identified to manage prescribing

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			issues. **What quality standard means… for commissioners?** Comment —Initiatives in place, however national data capture system and monitoring should be uniform. **Antimicrobial Stewardship,** Comments — **Do not start antibiotics…**samples are not routinely obtained by healthcare professionals, potentially due to training issues or cost implication **Document the following….**in community this requires embedding in practice **Obtain cultures first…**in the community samples are not obtained by GPs or other non-medical prescribers routinely **Clearly document the review…**GP training and understanding around documentation and note taking, particularly regarding rationale for out of guidance prescribing, requires attention **..use simple generic antibiotics…*who takes overall responsibility for this. We used to have an independent review panel based within PCT, however since re-organisation, it has been unclear where any challenges around mis-prescribing now sit.***
107	Tees Esk and Wear Valley NHS trust	Quality statement 1	Reviewing long courses of antibiotics for acne prophylaxis. Clinical Knowledge summaries Acne Vulgaris Reviewing long courses of antibiotic prophylaxis for UTI. Clinical Knowledge Summaries Urinary tract infection Both these points reflect that antibiotics are often started for prophylaxis and never stopped leading to resistance.
108	UK Clinical Pharmacy Association (UKCPA)	Quality statement 1	• It is unclear whether the suggestion is that antibiotics on the hospital drug formulary should be used, or if local guidelines should be followed. This needs to be more specific as the way it is currently written is not clear. • Has NICE liaised with ARHAI, who are currently looking at quality standards for antimicrobial stewardship? It would make sense to co-ordinate these pieces of work which overlap. • Monitoring of prescribing rates would be useful in primary care but is not available in all secondary care. Where it is available there is variability in the information which can make it difficult to benchmark with other trusts. It may be more useful in secondary care to measure compliance with Start-smart then focus, but measures like this are not

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			discussed in the document. • There is no mention of “time to first dose in sepsis” in statement 1, which is a major issue in antimicrobial stewardship.
109	Urology User Group Coalition	Quality statement 1	The UUGC wishes to raise concern about the use of local antibiotic formularies as a quality measure. While the UUGC entirely understands and agrees with the priority to reduce unnecessary antibiotic use, it is aware of anecdotal evidence that local drug formularies often are used to make financial savings, as the draft quality standard itself notes in the final paragraph on page 6. Our members have raised concerns that sometimes restricted formularies do not make proper allowances for drug interactions, the inability of some individuals to swallow large tablets, or allergies or other side effects. We are aware of cases whereby patients are encouraged to switch medications not based on a clinical assessment but upon what seems to be a cost-cutting exercise. While the draft quality standard notes that a policy may permit other drugs only on the advice of the microbiologist or physician responsible for the control of infectious diseases, we question whether this procedure would be used by a GP looking to prescribe off-formulary drugs in practice due to the time demands on all parties involved. We would also wish to draw attention to Quality Standard 15, on patient experience in adult NHS services, which includes a quality statement on awareness of the right to choose treatment. Instead, if local formularies are to be used, prescribers should be permitted to prescribe any antibiotic regardless of its presence on a formulary, without first seeking the approval from the lead microbiologist (retaining their professional clinical judgment). Prescription of otherwise-restricted antibiotics could be notified to the lead microbiologist/physician for infectious diseases, who can deal with improper use through alternative channels. We note that the Department of Health has previously communicated in relation to medical devices that while local formularies may list subsets of products/devices, clinicians still remain able to prescribe off-formulary if there is a clinical need. The UUGC also wishes to question why multiple local formularies are a more sensible method of tackling antibiotic resistance, compared to a single national list. The UUGC finds the section of the statement relating to antimicrobial stewardship compelling, and agrees that in secondary care restricted formularies have led to more appropriate prescribing given the closer relationship with pharmacists and microbiologists that exist.
110	Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infections	Quality statement 2	Quality statement 2 needs to include Antibiotic stewardship as well as infection prevention and control.

ID	Stakeholder	Statement No	Comments Please insert each new comment in a new row.
	(ARHAI)		
111	Association for Clinical Biochemistry and Laboratory Medicine	Quality statement 2	Most of this data should already have been produced, so it should be easily obtainable.
112	British Orthopaedic Association	Quality statement 2	"Evidence of support for, and participation in, joint working initiatives beyond mandatory or contractual requirements, to reduce healthcare-associated infections locally." We feel that the idea was that these QS statement would form the basis of contractual requirements? This statement is too vague and needs to be more explicit - perhaps surveillance of surgical site infections across all domains of surgery. Unless it is specific then there is too much room for apathy and inaction.
113	Department of Health	Quality statement 2	Will this statement apply to CCGs? We are aware of some concerns that CCGs do not have access to sufficient expertise in infection prevention and control.
114	Department of Health	Quality statement 2	It is not clear how these quality measures will bring about continuous quality improvement.
115	Department of Health	Quality statement 2	More information on the data to be collected locally would be helpful
116	Department of Health	Quality statement 2	Amend to a reduction in the incidence of healthcare-associated infection. The same comment applies to QS 3, 4 and 5.
117	Faculty of Intensive Care Medicine	Quality statement 2	Satisfactory, though we would note here that the fines (£50,000 per case) which commissioners can apply to hospitals whose Cl difficile rates exceed the maximum permitted number for the year are unsatisfactory because they profoundly alter the relationship between provider and commissioner. Moreover, the metric used is of low quality since it is a crude number, not a rate which takes into account hospital case mix. The financial penalty results in gaming with some Trusts reducing the number of specimens taken.
118	HCAI SURF	Quality statement 2	We support the principles of statement 2 The quality measures to underpin quality statement 2 relate to the mandatory reporting of HCAI, however this only covers MRSA and Cdiff, there are other organsims that are particularly significant in terms of antimicrobial resistance through the use of broad spectrum agents (ESBL producing E. coli, Acinetobacter baumannii, Pseudomonas, Klebsiella, Enterobacter, Glycopeptide resistant enterococci) and the publication of this data where significant numbers occur is an obvious marker for success or failing strategies to prevent and control infections caused by these organisms. Incidence of HCAI are also outcome indicators given for quality statements 3, 4, 5 and 6 and this equally applies.
119	Medway Community Healthcare	Quality statement 2	Would suggest that statement 2 requires the inclusion of infection control training.
120	Merck Sharp & Dohme	Quality	MSD are in agreement with structure b) "Evidence of support for, and participation in, joint working initiatives beyond

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	Ltd	statement 2	mandatory or contractual requirements, to reduce healthcare-associated infections locally" and believe it aligns with the Government agenda of discharging patients from hospital and having a healthcare service in place to provide care in their own home. The home environment is free from superbugs in contrast to the hospital setting where cross-infections are therefore more likely. There are several examples of homecare with OPAT (Out Patient Antimicrobial Therapy) where IV antibiotics have been provided by a specific nurse in a homecare team acting post-surgical discharge (Sheffield, Cambridge, and Glasgow are examples of where OPAT services are in place). It would be useful if the quality standard provided specific information on how to measure the effect of these homecare services on the incidence of infections.
121	MRSA Action UK	Quality statement 2	We support the principles of statement 2. The quality measures to underpin quality statement 2 relate to the mandatory reporting of HCAI, however this only covers MRSA and Cdiff, there are other organisms that are particularly significant in terms of antimicrobial resistance through the use of broad spectrum agents (ESBL producing E. coli, Acinetobacter baumannii, Pseudomonas, Klebsiella, Enterobacter, Glycopeptide resistant enterococci) and the publication of this data where significant numbers occur is an obvious marker for success or failing strategies to prevent and control infections caused by these organisms. Incidence of HCAI are also outcome indicators given for quality statements 3, 4, 5 and 6 and this equally applies.
122	Public Health England	Quality statement 2	We suggest a change to the second sentence to include "…with regards to infection PREVENTION and control…"
123	Public Health England	Quality statement 2	Our AMRS & HCAI Regional Leads network has expressed concern in relation to how primary care and community settings would deliver on "adequately resourced surveillance systems"
124	Public Health England	Quality statement 2	We suggest a more comprehensive evidence base to reflect all settings e.g. DH IP& C Guidance for Care Homes (Feb 2013)[1]
125	Royal College of General Practitioners	Quality statement 2	- Commissioning Lead with Infection Control responsibilities should be identified locally providing high level responsibility for this role - Local policy needs to be accessible – printed and widely distributed bright/ colourful; A4 size; Smart phone app - Incentivise Practices to audit antibiotic prescribing (LES) - Publicise Practice antibiotic prescribing data/ infection rates/ measures taken to control infection for both primary and secondary care - Public Health should hold Primary Care setting Infection Control Roadshows/ Practice events; public information and awareness events commissioned at local level (promoting self care ; antibiotic avoidance – wherever possible)

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214929/Care-home-resource-18-February-2013.pdf

ID	Stakeholder	Statement No	Comments Please insert each new comment in a new row.
			- Secondary care microbiology advice should be easily accessible – 'Microbiology hotline' - Advice re prescribing should be included in computer/ printed results of swabs / urine cultures etc - Clear communication with Primary care from Secondary care which antibiotics have been used for in-patient stay and why
126	Royal College of Nursing	Quality statement 2	Quality measure A-C – The RCN does not consider that these are sufficient to demonstrate leadership (particularly quality measure (a). Other quality measures relate to processes. Greater focus should be placed on the competence and skills/knowledge of the Infection Prevention and Control (IPC) team and the DIPC. The organisation should be in a position to describe its leadership structure in relation to IPC and describe the impact this has at different levels of the organisation and clinical and non-clinical settings. This is more than 'nominated leads' and should include systems such as link practitioners, working groups, local campaigns etc.
127	Salford City Council	Quality Statement 2	**General comment:** Infection control teams across England and Wales now sit within multiple organisations within the community following disbandment of Primary Care Trusts. Several organisations are now responsible for initiating and monitoring quality initiatives as opposed to one single organisation. **Outcome (quality measures) – s**hould this not read 'reduced incidence' of healthcare-associated infection.
128	St John Ambulance	Quality Statement 2	As an independent ambulance service provider, how can we define objectives and priorities given the limitation of outcome data; the focus will have to be on systems and processes which will have limiting benchmarking potential.
129	Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infections (ARHAI)	Question 3	'Board' will suffice
130	Department of Health	Question 3	Board is probably not an appropriate term for many healthcare providers outside of acute Trusts. Any arrangement holding a board or equivalent to account must be proportionate to the organisation and the risks of the population they serve. However, it is important that senior individuals in organisations are given defined responsibilities in relation to infection prevention and control, and are able to provide assurance that arrangements for this are robust.
131	Great Western Hospital NHS Foundation Trust	Question 3	'Board' fits our organisational structure; perhaps including reference to "an accountable organisational group with overall responsibility for governance, safety and quality" may also apply.
132	HCAI SURF	Question 3	With reference to question 3. The use of the term 'board' could be broadened to 'board/managing body'
133	Hertfordshire Community NHS Trust	Question 3	Board should be changed to Board/ Accountable Director/registered provider with CQC to capture the differences in structures for care agencies. Link to the terms used by the CQC to ensure consistency
134	Independent Healthcare Advisory Services (IHAS)	Question 3	The term "Board" in Statement 2 is appropriate for the Acute Independent Sector.
135	Medway Community Healthcare	Question 3	No idea!

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136	MRSA Action UK	Question 3	The use of the term 'board' could be broadened to 'board/managing body'
137	NHS Sheffield CCG	Question 3	Organisation's board is an acceptable term.
138	Papworth Hospital NHS Foundation Trust	Question 3	This would apply to NHS structures but not necessarily to private facilities
139	Public Health England	Question 3	We suggest referring to "board or executive"
140	Rotherham Doncaster and South Humber NHS Foundation Trust	Question 3	Could also use the term senior management team
141	Royal College of General Practitioners	Question 3	'organisations board' – does this cover informal care arrangements; voluntary sector providers however there needs to be accountability at a high level in organisation and the 'board' is this body.
142	Royal College of Nursing	Question 3	Yes, this would be the most appropriate term.
143	Royal Liverpool and Broadgreen University Teaching Hospitals NHS Trust	Question 3	Perhaps this could be worded Executive team and Board which would be relevant in our Trust.
144	Royal Pharmaceutical Society	Question 3	In response to the question about reference to an organisation's "board", we suggest that the definition of board is provided as this term may not be applicable to all pharmacy organisations. For example smaller independent community pharmacies will not have a board, however will have an owner or responsible pharmacist who may be accountable for infection prevention and control.
145	Salford City Council	Question 3	**Organisation's 'boards'**… Health and Wellbeing Boards are tasked with looking at overall local agendas. These are made up of several organisations, no single organisation now exists.
146	St John Ambulance	Question 3	The term 'board' is generally applicable to most organisations. The impact of the range of healthcare providers should be considered on the wording of point 'a' as some providers are large organisations, in some cases multi-national companies, which have an extensive portfolio of services (healthcare and non-healthcare).
147	The Association for Perioperative Practice	Question 3	The term 'board' is somewhat misleading as it does not fit with all healthcare organisations and may not be nationally appropriate? Needs to be more specific. Possible suggestions could include those at a strategic level within healthcare management.
148	Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infections (ARHAI)	Quality statement 3	Statement 3 should also say at the end of the statement .....'in an organisation that supports, positively reinforces and facilitates best practice in hand hygiene'.
149	Association for Clinical Biochemistry and Laboratory Medicine	Quality statement 3	This will be difficult to measure, data such as hand hygiene audits are not valuable in predicting the overall compliance to protocol.

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150	Department of Health	Quality statement 3	We would prefer this statement to be widened to encompass standard precautions, including the use of personal protective equipment, as the inappropriate use of gloves can lead to cross-infection.
151	Faculty of Intensive Care Medicine	Quality statement 3	In addition to Outcomes (incidence of HAIs) the Quality Measures refer to 'Structure' as follows**:** *Evidence of local arrangements to ensure that people receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care*. Does this include Process audits of compliance? if so, the term 'Process' rather than 'Structure' would be appropriate.
152	HCAI SURF	Quality statement 3	Whilst agreeing with this statement, we would suggest that further detail is given in the actual statement to prevent inappropriate interpretation. EPIC 3 guidance (Update of EPIC 2, published December 13) http://www.journalofhospitalinfection.com/supplements NICE have accredited the process used for the guideline development. In particular it is important to state that alcohol hand rubs should not be used when hands are visibly soiled or potentially contaminated with body fluids; or when caring for patients with vomiting or diarrhoeal illness, whether or not gloves have been worn. As for statement 2, broaden the publication of HCAIs to include organisms that are particularly significant in terms of antimicrobial resistance through the use of broad spectrum agents.
153	Hertfordshire Community NHS Trust	Quality statement 3	Data source - Should be specific that hand hygiene audits are also undertaken, specify the frequency of minimum times in a year that an audit should be undertaken
154	MRSA Action UK	Quality statement 3	Whilst agreeing with this statement, we would suggest that further detail is given in the actual statement to prevent inappropriate interpretation. EPIC 3 guidance (http://www.journalofhospitalinfection.com/supplements) gives details. This guidance has been accredited by NICE. In particular it is important to state that alcohol hand rubs should not be used when hands are visibly soiled or potentially contaminated with body fluids; or when caring for patients with vomiting or diarrhoeal illness, whether or not gloves have been worn. For monitoring outcomes - as for statement 2, broaden the publication of HCAIs to include organisms that are particularly significant in terms of antimicrobial resistance through the use of broad spectrum agents.
155	MRSA Action UK	Quality statement 3	For monitoring outcomes - as for statement 2, broaden the publication of HCAIs to include organisms that are particularly significant in terms of antimicrobial resistance through the use of broad spectrum agents.
156	Oxford Health NHS Foundation Trust	Quality statement 3	Quality measures- how does local data collection work- is there a recommended method as there will be variation
157	Public Health England	Quality statement 3	Staff have a duty to decontaminate their hands even when NOT providing direct care but when hands becomes soiled, for whatever reason, to prevent contamination of the environment in which the patient receives care and other staff and visitors circulate.
158	Public Health England	Quality statement 3	As mentioned earlier, staff have a duty to decontaminate their hands even when NOT providing direct care to prevent contamination of the environment in which the patient receives care.
159	Public Health England	Quality	We suggest that the 'WHO 5 moments of hand hygiene' and guidance on correct hand hygiene technique, including

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		statement 3	‘bare below the elbow’ should be included this section. Additionally, we suggest that that a more comprehensive evidence-base is referenced, including the newly published epic3 guidelines (http://www.sciencedirect.com/science/article/pii/S0195670113600122) – this also applies to the other Quality Statements that currently reference epic2.
160	Public Health England	Quality statement 3	We suggest that the first sentence should be changed to include “…and decreases TRANSMISSION EVENTS AND the incidence of preventable…” Third sentence should include “…this standard principle of infection PREVENTION and control…”.
161	Public Health England	Quality statement 3	Last sentence os service providers should include “…ensure that healthcare workers decontaminate hands….after any event which could have resulted in hand contamination…” to prevent contamination of the environment also.
162	Public Health England	Quality statement 3	As per suggested inclusion for service providers on p11 (above) for Healthcare workers and commissioners
163	Public Health England	Quality statement 3	We suggest that “hand rub” should be changed to “ ALCOHOL hand rub”
164	Royal College of General Practitioners	Quality statement 3	- Logistics/ cost of providing all staff (community) with hand decontaminant / sanitation - Has to be mandatory for all care settings (including social care settings) and they need to be full! - Training for HCP/ carer – who will have this responsibility and monitor its delivery/ quality - Public awareness – ask your nurse / doctor ‘ have you washed your hands’ - Commissioners need to monitor through all levels or organisation that decontamination procedures are in place
165	Royal College of Nursing	Quality statement 3	Quality statement 3 – this currently excludes the need to perform hand hygiene within episodes of care where contamination of hands may occur e.g. when moving from catheter care to mouth care on the same patient. Rewording of this statement should be considered to something such as ….’decontaminate their hands in line with evidence based episodes of care, for example…’ Also gloves are not referred to and should be included as a separate quality statement as inappropriate glove use undermines hand hygiene strategies.
166	Royal College of Nursing	Quality statement 3	The RCN is unsure of the value of using HCAI incidence data as the outcome measure for this statement. Not all HCAI’s result as a direct result of hand hygiene and hand hygiene is only one component of infection prevention programmes. Likewise few HCAIs are reported or are part of on-going surveillance systems therefore data quality would be poor and the impact of good or bad hand hygiene compliance inaccurate. Other outcomes should be considered that reflect organisational culture towards hand hygiene.
167	Royal Liverpool and Broadgreen University Teaching Hospitals NHS Trust	Quality statement 3	Suggest refer to WHO five moments for hand hygiene. **WHO Guidelines on Hand Hygiene in Health Care: a Summary World Health Organization 2009**

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168	Royal Pharmaceutical Society	Quality statement 3	We suggest that further explanation of "direct contact and care" is provided as many pharmacists have direct face to face contact and care with patients in various setting and may not currently use hand decontamination procedures, for example, when supplying medication in a pharmacy over the counter or on prescription.
169	Salford City Council	Quality Statement 3	**Outcome (quality measures) –** as per previous comment – should this not read 'reduced incidence' of healthcare-associated infection? **Definition of terms –** hand decontamination – 'hand rub' is not recommended for effective hand decontamination in healthcare. Healthcare workers and all individuals involved in patient care are asked to wash hands effectively using liquid soap and water. Hand 'rubs' are not effective against certain infective organisms. Hand rub is only ever viewed as a substitute in the absence of soap and water.
170	St John Ambulance	Quality statement 3	As an independent ambulance service provider, how can we measure the incidence of HCAI occurrence as we are unlikely to know the HCAI rate for individuals we have transported.
171	Urology User Group Coalition	Quality statement 3	The UUGC supports this statement.
172	Association for Clinical Biochemistry and Laboratory Medicine	Quality statement 4	Collecting data on all urinary catheter insertions will be laborious, as will describing whether what was grown/treated was genuinely an infection without going through individual patient notes to then describe if the number of infections has been reduced.
173	CliniMed	Quality statement 4	**Recommend replacing 'using a lubricant' to 'using a triple action anaesthetic, antiseptic lubricant'.** The rationale for this is a lubricant with one of its primary functions being that of antiseptic action will have a significant impact on decreasing the rate of urinary tract infections post catheterisation. [Kambal C et al. Catheter-associated UTIs in patients after major gynaecological surgery. Professional nurse 2004; 19: 515-518]. Studies have shown that by providing a broad-spectrum antimicrobial coverage to the urethra it helps protect against urinary tract infection [Hofsetter A. Antimicrobial efficacy of lubricants. Urologe (B) 1987; 27; 359-360], reduces the risk of bacteria entering the bladder and significantly reduces MRSA microbial count within five minutes in vitro [Faul P. Efficacy of antiseptic catheter lubricants against methicillin- resistant staphylococcus aureus (MRSA). Urologe (A) 2005; 44: 282-285]. A lubricant containing chlorhexidine, which has antimicrobial properties shown to be effective up to six hours after application [Scales K. Correct use of chlorhexidine in intravenous practice. Nursing Standard 2009; 24: 41-46], alongside methyl and propyl-hydoxybenzoate will provide excellent broad spectrum in vitro antiseptic action [Hofsetter A. Antimicrobial efficacy of lubricants. Urologe (B) 1987; 27: 359-360] and help to minimise infection risk for those people needing a long-term urinary catheter and the procedures associated with this.
174	CliniMed	Quality statement 4	**Recommend replacing 'an appropriate lubricant' to 'a triple action anaesthetic, antiseptic lubricant'.** Rationale for this recommendation is that it is essential to minimise patient risk of urinary tract infection as well as ensuring comfort during a procedure relating to their long-term catheterisation that a lubricant with a triple purpose

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			action of antiseptic, anaesthetic and lubrication is used. A lubricant with one of its primary functions being that of antiseptic action has a significant impact on decreasing the rate of urinary tract infections post catheterisation. [Kambal C et al. Catheter-associated UTIs in patients after major gynaecological surgery. Professional nurse 2004; 19: 515-518]. Studies have shown that by providing a broad-spectrum antimicrobial coverage to the urethra it helps protect against urinary tract infection [Hofsetter A. Antimicrobial efficacy of lubricants. Urologe (B) 1987; 27; 359-360], reduces the risk of bacteria entering the bladder and significantly reduces MRSA microbial count within five minutes in vitro [Faul P. Efficacy of antiseptic catheter lubricants against methicillin- resistant staphylococcus aureus (MRSA). Urologe (A) 2005; 44: 282-285]. A lubricant containing chlorhexidine, which has antimicrobial properties shown to be effective up to six hours after application [Scales K. Correct use of chlorhexidine in intravenous practice. Nursing Standard 2009; 24: 41-46], alongside methyl and propyl-hydoxybenzoate will provide excellent broad spectrum in vitro antiseptic action [Hofsetter A. Antimicrobial efficacy of lubricants. Urologe (B) 1987; 27: 359-360] and help to minimise infection risk for those people needing a long-term urinary catheter and the procedures associated with this.
175	Coloplast Ltd	Quality statement 4	Page 13 - In relation to the “evidence of local arrangements to ensure that people needing a long-term urinary catheter have their risk of infection minimised”, we would appreciate a link or statement that stipulates what that risk minimisation requirement is.
176	Coloplast Ltd	Quality statement 4	Page 15 of the document defines a long-term urinary catheter as “an indwelling or an intermittent catheter that is used for a period greater than 28 days”. To avoid confusion, there is a need to separate out long term indwelling catheters and intermittent catheters. The majority of the information discussed in this standard is only applicable to indwelling catheters. However, there is clear evidence that intermittent catheterisation should be the first choice management option for the patient over an indwelling catheter but this does not get discussed in this Quality Statement. Many people who use intermittent catheters will be using them on a long-term basis, meaning that effort to reduce infections need to include a focus on this area.
177	Department of Health	Quality statement 4	We would prefer to also include short terms catheters in the text under this statement. Urinary tract infection (UTI) is the most common infection acquired as a result of health care, accounting for 19% of HCAI, with between 43% and 56% of UTIs associated with a urethral catheter including those that are defined as short term <28 days.
178	Department of Health	Quality statement 4	More information is needed on catheter avoidance strategies and that catheters should not normally be used to manage urinary incontinence.
179	Department of Health	Quality statement 4	If the desired outcome is to minimise the use of urinary catheters it would be more logical to measure urinary catheter utilisation rates. The proportion of UTIs related to urinary catheters would potentially be a better measure.
180	Department of Health	Quality statement 4	The mandatory surveillance of CDI is not relevant to urinary catheters. MRSA bacteraemias may have some relevance to UTIs, but these infections are caused by a wide range of organisms eg: *E.coli*
181	Department of Health	Quality statement 4	In the text relating to ‘What the quality statement means for patients, service users and carers’ there needs to be some additional text about ensuring a catheterised individual has a sufficient fluid intake.

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182	Faculty of Intensive Care Medicine	Quality statement 4	The metric proposed is satisfactory – a rate based on opportunity for compliance with best practice.
183	Great Western Hospital NHS Foundation Trust	Quality statement 4	This should encompass all catheterisations not just long term catheterisations as the principles are the same and the risk of infection post insertion is increased, requiring a management plan for early removal to reduce the risk of infection. This will then link in with the patient safety thermometer data.
184	HCAI SURF	Quality statement 4	Whilst we welcome the statement it should apply to all people who use or have urinary catheters. EPIC 3 covers the use of short term urinary catheters, short version attached. As for statement 2, broaden the publication of HCAIs to include organisms that are particularly significant in terms of antimicrobial resistance through the use of broad spectrum agents.
185	Hertfordshire Community NHS Trust	Quality statement 4	I totally agree that the process should be identifying how many patients have urinary catheters and how many have had the risk of an infection minimised as this is a positive outcome measure. This provides good assurance to organisations as well as patients. I think that we also need a minimum acceptable percentage to support this standard. It may be difficult to capture all patients if systems are not supported by appropriate IT to ensure that the data is accurate.
186	Hertfordshire Community NHS Trust	Quality statement 4	Outcome – need to agree what is an indicator for a urinary tract infection so that every provider to measuring the same thing. Will the incidence be per 1000 patients or per population?
187	Hertfordshire Community NHS Trust	Quality statement 4	I think that you need to state aseptic technique here. And that 100% of staff will be trained.
188	Hertfordshire Community NHS Trust	Quality statement 4	Regularly needs to be specific (i.e. <12 weeks for long tern catheter) Documentation should be patient care records
189	Medway Community Healthcare	Quality statement 4 (and 5)	No. LT catheters. Have reservations that we would be able to apply robust process as described. The audit process described reflects the in-patient Saving Lives audits, not the current Essential Steps audit process. Community nurses would have to complete an audit tool every time they had contact with a patient with a LT catheter. Currently, in Medway we have approx. 300 patients with LT catheters requiring many contacts over the year. This also applies to Statement 5.
190	MRSA Action UK	Quality statement 4	Whilst we welcome the statement it should apply to all people who use or have urinary catheters. EPIC 3 covers the use of short term urinary catheters, short version attached.
191	MRSA Action UK	Quality statement 4	For monitoring outcomes - as for statement 2, broaden the publication of HCAIs to include organisms that are particularly significant in terms of antimicrobial resistance through the use of broad spectrum agents.
192	Oxford Health NHS Foundation Trust	Quality statement 4	Is there any work planned for short term catheters?
193	Public Health England	Quality statement 4	Please see comments under QS4 for suggested wording.

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194	Public Health England	Quality statement 4	We feel that is should be made clear that there is no “safe” insertion and maintenance in relation to use of long term urinary catheters. Long term catheters always put patients at increased risk. We therefore suggest that this quality statement should be changed to “Removal of all long term urethral catheters unless a documented risk assessment shows its continuation is in the patient’s best interest and the patient has been fully informed of all risk and options.” As an alternative if it is not deemed possible to reverse the emphasis of this Quality Statement, we strongly suggest that the high level quality statement should include “and regular review to remove catheters from those who do not need them.”
195	Public Health England	Quality statement 4	We suggest that further reference should be made to Trial Without Catheters (TWOCs) and use of supra- pubic catheters where indicated.
196	Public Health England	Quality statement 4	Third sentence should include “…safe catheter insertion, maintenance and REVIEW OF NEED…” similarly throughout the section
197	Public Health England	Quality statement 4	We suggest that the data should be a sustained year on year reduction in the number of patients with a long term urethral urinary catheter or the % who have had a risk assessment.
198	Public Health England	Quality statement 4	We suggest that the HCAIs in relation to urinary tract infection (UTI) should be fully defined – for example Catheter Associated UTIs (CAUTIs) and the outcome should therefore be incidence or prevalence of CAUTI. Additionally, we suggest that UTI itself should be fully defined.
199	Public Health Wales NHS Trust	Quality statement 4	The statement about urinary catheters should apply to all indwelling urinary catheters
200	Royal College of General Practitioners	Quality statement 4	- Self care – education and responsibility should be shared with patients; washing / bag care/ trauma avoidance - Named nurse identified and shared responsibility (with patient) for the care of long term catheter – justification for insertion ; care plan detailing catheter care / hygiene; on-going care; review / removal details or date; patient education - Healthcare workers should wear uniform protection when attending to individuals catheter - Training for healthcare professionals - Microbiology input – ‘Microbiology Hotline’ providing advice on treatment of suspected UTI in patients with longterm catheter. - ? pathway development to include in careplan – patient has longterm catheter – suspected UTI – actions – Micro advice (default should not necessarily be GP / Antibiotic) - Service providers ensure ‘systems’ in place – what are these? are they shared with/ agreed by commissioners? - Commissioners should commission community services with service specification that details all above
201	Royal College of Nursing	Quality statement 4	Many of the elements to be included in process elements of catheter insertion and maintenance will be included in the EPIC 3 guidelines. The NICE quality standard could better support practitioners and organisations by focusing on

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			assessment of need (particularly the use of bladder scanners) for catheterisation and the use of specialist continence services to support alternatives to catheterisation. Organisations should be ensuring that nursing staff receive training in continence management and that a culture exists where catheter use is seen as an exception not the norm.
202	Royal College of Nursing	Quality statement 4	The use of CAUTI data as an outcome measure should be reconsidered due to the complexity of measuring this accurately and therefore demonstrating patient outcome improvement.
203	Royal Liverpool and Broadgreen University Teaching Hospitals NHS Trust	Quality statement 4	There is some contradiction in the section entitled long term urinary catheter. Whilst many urinary catheters will be removed following surgical intervention or recovery from acute illness there are many that need to remain in situ for inoperable conditions. Whilst these need to be reviewed regularly the statement “should be removed as soon as possible” is not very helpful. If the urinary catheter needs to stay in situ then it needs to be safely managed including removal and recatheterisation at appropriate intervals. There should be a focus on promoting intermittent urinary catheterisation where ever possible to avoid long term indwelling catheters and there should be sufficient staff trained in both primary and secondary care to support this in addition to education for patients themselves and family carers.
204	Royal Liverpool and Broadgreen University Teaching Hospitals NHS Trust	Quality statement 4	Last sentence first paragraph should read “needle free sampling port”
205	Royal Liverpool and Broadgreen University Teaching Hospitals NHS Trust	Quality statement 4	Last sentence should read “aseptic” not sterile procedures
206	Salford City Council	Quality Statement 4	**Process –** is this unnecessarily wordy? “Individuals with a long-term catheter will have risk of infection minimised through safe insertion and maintenance”. **What the quality statement means for patients…**These include careful hand washing, wearing disposable single use non-sterile gloves…….emptying the drainage bag when necessary and monitoring the colour and odour of urine……… **Definition of terms –** could this read, rather than decontaminate, “wash hands with soap and water”, and make clear non-sterile single use gloves.
207	South West Yorkshire NHS Foundation Trust	Quality statement 4	Will be difficult to evidence in community settings however this is the area where this standard may influence the biggest quality improvements. Similar data already collected in non mental health inpatient areas of the trust. Could require fairly substantial financial resources.
208	Urology Trade Association	Quality statement 4	On page 15 of the document, long-term urinary catheters are defined as “an indwelling or an intermittent catheter that is used for a period greater than 28 days”. There is a need to separate out the definition of a long-term indwelling

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			catheter from an intermittent catheter which may be used over a long-period of time, particularly for people with long-term conditions. While intermittent catheterisation should be the first line management option before an indwelling catheter is considered, much of the information in this quality standard is more applicable to indwelling catheters. Intermittent and indwelling catheters will prevent different challenges in terms of infection control.
209	Urology User Group Coalition	Quality statement 4	The UUGC welcomes this statement but feels it could be broadened to include those using catheters for a period of 28 days or fewer, who also face the risk of urinary tract infections. Relevant clinical guidelines include CGs 148 and 159, as well as EPIC 3 guidelines.
210	Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infections (ARHAI)	Question 4	Requires management of the entire process (for short and long-term) in line with current guidance, also needs risk assessment to be mentioned in the process and the regular review of need/consideration of removal.
211	Association for Clinical Biochemistry and Laboratory Medicine	Question 4	• Assessing clinical need for urinary catheter prior to insertion and regular assessment of ongoing need afterwards. • Compliance with appropriate levels of hand hygiene is maintained at all times, including (but not limited to) catheter insertion and emptying of drainage bag. • Discourage sampling from bag urine as this is highly likely to be contaminated, and therefore not clinically useful.
212	Association of British healthcare Industries	Question 4	The points mentioned in question 2 need to be either recorded or assessed as the main areas for quality improvement. The outcome need to specifically be Catheter associated UTI rather just UTI.
213	Department of Health	Question 4	Catheter avoidance Documentation of the clinical indication for catheterisation Documentation of regular review of the continuing clinical need for catheterisation
214	Faculty of Intensive Care Medicine	Question 4	**Response to question for consultation:** Yes, ‘Board’ is a well-understood term.
215	Faculty of Intensive Care Medicine	Question 4	**Response to Question for consultation:** Under the heading Specified procedures necessary for the safe insertion and maintenance of urinary catheters the text refers solely to ‘an appropriate lubricant’ for insertion. This would normally be a proprietary product such as Instillagel which is a local anaesthetic combined with the antiseptic chlorhexidine – much more than just a lubricant. This is a crucial part of the aseptic technique and should be mentioned in the text.
216	Great Western Hospital NHS Foundation Trust	Question 4	Can you refer to Aseptic Non Touch Technique? Daily/planned review dates of the requirement for the device is included.
217	Great Western Hospital NHS Foundation Trust	Question 4	The person’s clinical need for catheterisation should be reviewed regularly and the urinary catheter removed as soon as possible. The need for catheterisation, as well as details about insertion, changes and care should be documented, include a removal plan were appropriate.

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218	Medway Community Healthcare	Question 4	Should include the use of the aseptic non-touch technique
219	NHS Sheffield CCG	Question 4	I am in agreement with the list of specified procedures.
220	Nottinghamshire Healthcare NHS Trust	Question 4	Main areas for quality improvement are as follows: Hand hygiene compliance, the on-going assessment of need and maintaining asepsis throughout catheter insertion and any on-going interventions.
221	Papworth Hospital NHS Foundation Trust	Question 4	Possible strategies for decreasing inappropriate insertion of urinary catheters and duration of catheterization could include: –A combined educational intervention and an indication checklist for use (including conditions that are NOT an indication for catheter use such as incontinence) –Nurse-led multidisciplinary rounds in the hospital with nurse empowerment to remove catheters. –Catheter passport schemes -Surveillance of infections using appropriate definitions of CA-UTI The data collection seems too simplified to be meaningful i.e. the number of people in the denominator who have their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the catheter divided by the number of people with a long-term urinary catheter, how will this be helpful without recording infection rates to show that the processes are effective?
222	Public Health England	Question 4	We feel that the emphasis of this Quality Statement should be reversed as per comments for statement 4 and the procedures defined would therefore subsequently need amending.
223	Public Health Wales NHS Trust	Question 4	There should be mention of the decision process regarding insertion of urinary catheter with an emphasis on avoiding such insertions unless necessary and justified. There is no mention of an aseptic technique for insertion in the specified procedures
224	Rotherham Doncaster and South Humber NHS Foundation Trust	Question 4	I think it is the components in the high impact intervention audits. If these actions are not completed then infections may occur: **Insertion:** • Aseptic Non Touch Technique • Disposable apron and gloves to be worn and disposed of following use and between patients • Catheterisation follows an assessment of clinical need which includes considering alternative options. • Clean the urethral meatus ○ Prior to insertion of catheter. ○ With sterile normal saline or sterile water ▪ use correct wiping technique (front to back) ▪ use sterile single use lubricant

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			• Sterile, closed drainage system
			  ○ Choice of urinary catheters based on individual patient assessment and local policy
			  ○ Correct size of catheter is selected, smallest size that will allow drainage
			• Hand hygiene
			  ○ Hands are decontaminated immediately before and after each episode of patient contact using the correct hand hygiene technique
			• Documentation
			• Document
			  ○ Date, reason for insertion, catheter size, operator undertaking insertion and if insertion was high risk with signature
			  ○ Patient education - Catheter care leaflets, contact numbers
			  ○ Staff 2 yearly up-dates on catheterisation
			
			On-going care
			
			• Hand hygiene
			  ○ Hands are decontaminated immediately before and after each episode of patient contact using the correct hand hygiene technique
			• Catheter hygiene
			  ○ Catheter site cleaned regularly as stated in local policy.
			  ○ Catheter is emptied a minimum of twice daily into clean container
			• Sampling
			  ○ All samples obtained using aseptic technique, via the catheter sampling port.
			• Drainage bag position
			  ○ Above floor but below bladder level to prevent reflux or contamination.
			  ○ Closed urinary drainage system intact or only disconnected as per manufacturer's instructions
			• Catheter manipulation
			• Examination gloves worn to manipulate a catheter, manipulation should be preceded and followed by hand decontamination.
			• Catheter needed?

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			○ Review need for catheter daily ○ Refer for Trial without catheter Document Date and time of removal of catheter, operator undertaking removal and with signature
225	Royal College of Nursing	Question 4	Main areas for quality improvement: - all element of the EPIC 3 guidelines should be included catheterisation only occurs following a thorough risk assessment and documented consideration of other options
226	Royal Liverpool and Broadgreen University Teaching Hospitals NHS Trust	Question 4	Facilitating consistent safe care for patients with long term urinary catheters accompanied by clear record of insertion, history, changes, antibiotic treatment and colonisation with resistant micro-organisms. The accuracy and quality of the patient held information is important. There needs to be effective communication between the healthcare services the patient with a long term urinary catheter will pass through. There needs to be sufficient information and expertise available in areas where patients with long term urinary catheters are cared for to safely manage any problems encountered with the urinary catheter. There are considerable challenges managing patients with confusion or dementia who require urinary catheters. The potential for colonisation and infection with multidrug resistant gram negative bacteria is of concern. Clear information about colonisation should be held in healthcare records and by patients to guide choice of empirical antibiotic therapy should it be required.
227	Salford City Council	Question 4	**Questions for consultation:** - Audit of indwelling devices in all community settings including care homes - Appropriate and timely referral and follow up of patients with urinary catheters by dedicated teams - Training and supervision for ALL individuals with indwelling devices, including appropriate training and support for families and all community care organisations including private companies
228	St John Ambulance	Question 4	The specific components of procedure that require improvement should include record of reason for catheterisation, documented plan of catheter care and documented date of planned removal or anticipated removal of catheter
229	The Association for Perioperative Practice	Question 4	Clinical need being reviewed regularly; safe insertion; regular emptying.
230	Association for Clinical Biochemistry and Laboratory Medicine	Quality statement 5	Collecting data on vascular catheter insertions should be simpler than for urinary catheters (fewer of them), as should defining whether genuine infections have been avoided since there should be greater microbiologist input.
231	British Orthopaedic Association	Quality statement 5	Vascular access devices. NICE have in other areas tasked specifically to look at this (prevention of surgical site infection) and have opted not to recommend 2% alcoholic chlorhexadine but only alcohol skin preparations.
232	Department of Health	Quality statement 5	As the text in this section only refers to central lines, it would more accurate for the title to be ‘ Central vascular access devices’
233	Department of Health	Quality statement 5	It would be more accurate to measure the incidence of central line associated bloodstream infection
234	Faculty of Intensive Care	Quality	Process metric: satisfactory. However, the Outcome metric is problematic (see: Dixon-Woods M, Leslie M, Bion J,

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	Medicine	statement 5	Tarrant C. What Counts? An Ethnographic Study of Infection Data Reported to a Patient Safety Program. Milbank Quarterly 2012; 90(3): 548–591
235	Great Western Hospital NHS Foundation Trust	Quality statement 5	I would advise alcohol hand rub on visibly clean hands; liquid/foam soap followed by alcohol rub when hands are not visibly clean. (Antibacterial soap is not widely used in healthcare for this type of task).
236	Great Western Hospital NHS Foundation Trust	Quality statement 5	No mention of how long the dressing stays in place.
237	HCAI SURF	Quality statement 5	We welcome this statement, the evidence base is increased in EPIC 3 http://www.journalofhospitalinfection.com/supplements As for statement 2, broaden the publication of HCAIs to include organisms that are particularly significant in terms of antimicrobial resistance through the use of broad spectrum agents.
238	Medway Community Healthcare	Quality statement 5 (and 4)	No. LT catheters. Have reservations that we would be able to apply robust process as described. The audit process described reflects the in-patient Saving Lives audits, not the current Essential Steps audit process. Community nurses would have to complete an audit tool every time they had contact with a patient with a LT catheter. Currently, in Medway we have approx. 300 patients with LT catheters requiring many contacts over the year. This also applies to Statement 5.
239	MRSA Action UK	Quality statement 5	We welcome this statement, the evidence base is increased in EPIC 3
240	MRSA Action UK	Quality statement 5	For monitoring outcomes - as for statement 2, broaden the publication of HCAIs to include organisms that are particularly significant in terms of antimicrobial resistance through the use of broad spectrum agents.
241	Oxford Health NHS Foundation Trust	Quality statement 5	Mentions antimicrobial liquid soap- is this really required as oppose to standard soap products.
242	Public Health England	Quality statement 5	Because peripheral lines are often left in “just in case”, increasing the risk of bacteraemia and localised infections, we believe the following should be included in the QS5 definition “…and if it not needed, it should be removed.”
243	Public Health England	Quality statement 5	As per suggestion made under ‘list of quality statements’. Because peripheral lines are often left in “just in case”, increasing the risk of bacteraemia and localised infections, we believe the following should be included in the Quality Statement ”and if it is not needed, it should be removed.”
244	Public Health England	Quality statement 5	We suggest that it should be made clear which devices this section refers to e.g. peripheral lines, central lines or both. Neither is specified in the definition and both are referenced at different places in the procedures, but it is not always clear which procedures relate to which type of intravenous (IV) device. This is particularly true of the following statements: • non-tunnelled central lines are referred to, but not tunnelled lines – we feel both should be addressed. • skin preparation for insertion of a peripheral IV device or a PICC is mentioned but then advice is given about

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			single patient use skin preparation for insertion of a central line – we feel that this could be made clearer. The reason is unclear why use of antimicrobial soap is necessary when accessing an IV device (type not specified) . We suggest that the following should also be included: • length of time a peripheral device should be in situ • Visual Infusion Phlebitis (VIP) scoring as routine • Aseptic technique
245	Public Health England	Quality statement 5	We suggest that the HCAIs referred to should be fully defined – we suggest that this quality standard relates to Central Venous Catheter (CVC infections) not all HCAI and the outcome should therefore be incidence or prevalence of CVC infections.
246	Public Health England	Quality statement 5	In relation to this statement, "If religious beliefs are a source of concern in relation to the use of alcohol handrubs for hand decontamination, then patients could be made aware of the official stand of religious bodies about the product;" we suggest that the relevant links to such potential concerns should be provided in the document.
247	Royal College of Anaesthetists	Quality statement 5	For statement 'Unless medically contraindicated, the subclavian site should be used in preference to the jugular or femoral sites for placing a non-tunnelled catheter'. Not all our members agreed with this statement and in their experience an insertion at the subclavian site can be more problematic. They are also unsure whether there is recent evidence to support this recommendation. There is also no mention of appropriate surgical fixation sutures for these procedures. Our members would like to point out that recently there have been many reported cases of allergic reactions to chlorhexidine and that other alternative antiseptics for decontamination should be mentioned here. http://www.mhra.gov.uk/Safetyinformation/DrugSafetyUpdate/CON140701
248	Royal College of General Practitioners	Quality statement 5	- P18 – "these include things like….." too vague and does not sound professional should be more specific - Care plan should include – timeline from insertion to planned removal. This should include device used; date dressing changed / due to be changed; on-going care; - When, how and by who - ? named nurse responsible for this and specific review regards removal / change of device - Awareness of allergy/ anaphylaxis to cleaning solution used
249	Royal College of Nursing	Quality statement 5	As above, the focus of the quality statement can better support organisations to improve rather than duplicating process areas included in EPIC. The focus on use of vascular access devices 'just in case' including insertion in Emergency Departments should be highlighted for improvement. Organisations should be encouraged to consider the use of specialist teams to support selection and insertion of the correct device for the patient (considering duration of therapy, drugs to be administered and condition of blood vessels). Patient feedback on the experience should also be collected.

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250	Royal College of Nursing	Quality statement 5	The RCN is unclear why the use of antimicrobial soap to access an IV device is included. Is this reference intended for central lines or all devices?
251	Royal Liverpool and Broadgreen University Teaching Hospitals NHS Trust	Quality statement 5	Outcome – currently “incidence of healthcare associated infection” – suggest this should be “vascular access device associated infection”
252	Royal Liverpool and Broadgreen University Teaching Hospitals NHS Trust	Quality statement 5	Need to be clearer about skin decontamination for central and peripheral intravascular devices. This needs to be consistent stating concentrations of chlorhexidine in alcohol. The recommendation on page 20 in the first paragraph regarding the use of aqueous solutions is not helpful as there are no concentrations specified or any recommendation regarding single use solutions rather than stock solutions which can potentially become contaminated with repeated use. In addition, it would be preferable to avoid products which cannot be disinfected using an alcohol based disinfectant.
253	Salford City Council	Quality statement 5	**Definitions of terms –** ……aseptic technique would preferably read “aseptic non touch technique” Also, use of alcohol hand rub is never recommended without careful hand washing first with soap and water.
254	South West Yorkshire NHS Foundation Trust	Quality statement 5	Will be difficult to evidence in community settings however this is the area where this standard may influence the biggest quality improvements. Similar data already collected in non mental health inpatient areas of the trust.
255	The Association of Anaesthetists of Great Britain and Ireland	Quality statement 5	“Unless medically contraindicated, the subclavian site should be used in preference to the jugular or femoral sites for placing a non-tunnelled catheter”. This sentence needs rewording, as although there may be evidence that the subclavian site is less prone to infection (albeit that I am not aware of any hard data supporting such an assertion), there are other factors unrelated to infection control that make the jugular insertion site safer than the subclavian site for the substantial majority of patients, not least of which are the ready ultrasound visibility of the internal jugular vein (the subclavian vein is hard to visualise), and the relative lack of nearby structures that can be punctured with adverse outcomes (other than those seen readily in the neck with ultrasound when performing a jugular cannulation. The subclavian route SHOULD NOT be used in universal preference to the jugular route. The route chosen depends upon a number of factors, only one of which is infection control.
256	Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infections (ARHAI)	Question 5	Vascular access safety should be a patient safety/quality improvement programme that should be run in hospitals. The components have been well described particularly in an ITU environment along with the monitoring of CLABSIs. However, hospitals should be asked about their vascular access programmes to ensure central lines in and outside ICU settings are inserted and managed safely and how this is monitored. This would include feeding lines and dialysis lines. Again this requires management of the entire process (for short and long-term) in line with current guidance
257	Association for Clinical Biochemistry and Laboratory Medicine	Question 5	• Assessing clinical need for vascular catheter prior to insertion and regular assessment of ongoing need afterwards. • Appropriate skin decontamination is performed prior to insertion. • Compliance with appropriate levels of hand hygiene is maintained at all times, including (but not limited to) catheter

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			insertion and manipulation of the catheter. • Regular monitoring of vascular catheter insertion site looking for signs of infection.
258	Association of British healthcare Industries	Question 5	We believe that there are important components of the procedures missing that could significantly improve quality. Specifically, the use of safety devices is demonstrated to reduce the risk of infection through injuries from medical sharps and is required wherever reasonable practical in the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. Similarly the use of closed systems also reduces the risk of infection and should be encouraged. We believe also that there should be daily inspection of the insertion sites and explicit protocols around maximum indwell time. These elements should be supported by accurate and timely documentation and record keeping. These factors if incorporated into the Quality Standard would do much to enhance an important and valuable piece of work
259	Department of Health	Question 5	Consideration of an implantable device if IV medication is going to be required long term. Maximal sterile precautions for insertion Avoidance of jugular or femoral sites The use single-patient-use application of alcoholic chlorhexidine gluconate solution before insertion. Hands decontamination before accessing or dressing a vascular access device. Use of an appropriate dressing Changing administration sets as appropriate
260	Faculty of Intensive Care Medicine	Question 5	**Response to Question for consultation: What are the specific components of the procedures defined that are the main areas for quality improvement?** The most important components are 2% alcoholic chlorhexidine in a single use applicator and adherence to full-barrier precautions. The main areas for quality improvement would be: • the addition of chlorhexidine gel dressings at the site of insertion • regular review of the intravascular device, and timely removal with daily review of the need for intravenous access.
261	Great Western Hospital NHS Foundation Trust	Question 5	Can you refer to Aseptic Non Touch Technique? Daily/planned review dates of the requirement for the device is included.
262	NHS Sheffield CCG	Question 5	I am in agreement with the list of specified procedures.
263	Papworth Hospital NHS Foundation Trust	Question 5	All the specific measures are being followed in our institution. The quality statement should include a clause to state that the need for the device should be reviewed regularly and the device removed as soon as no longer required. For data collection see comment for CA-UTI above – the same applies to CVC-BSI.
264	Public Health England	Question 5	We have not been able to comment on the main areas for quality improvement because we feel that the procedures needed further definition as per comments above before they could be commented on accurately.
265	Public Health Wales NHS	Question 5	The comment about avoiding insertion applies equally to vascular access devices (comment: There should be

<table>
<tr><th>ID</th><th>Stakeholder</th><th>Statement No</th><th>Comments
Please insert each new comment in a new row.</th></tr>
<tr><td></td><td>Trust</td><td></td><td>mention of the decision process regarding insertion of urinary catheter with an emphasis on avoiding such insertions unless necessary and justified. There is no mention of an aseptic technique for insertion in the specified procedures)</td></tr>
<tr><td>266</td><td>Rotherham Doncaster and South Humber NHS Foundation Trust</td><td>Question 5</td><td>Does this include peripheral cannula? The wording is a bit unclear. The definition of vascular access devices on page 19 suggests that it includes peripheral cannula but the rest of the statement does not.

Specifically for peripherally inserted central catheter (PICC) lines:-

• The patency of the line should be checked by aspirating/bleeding the line prior to use 2-3mls into an empty 10ml syringe to ensure that the Picc line has not been displaced. This should then be disposed of in the sharps bin.
• Once the line has been aspirated it should then be flushed as normal with a 10ml saline flush.
• The flush should be administered pre and post using pulsed push/pause technique.</td></tr>
<tr><td>267</td><td>Rotherham Doncaster and South Humber NHS Foundation Trust</td><td>Question 5</td><td>I think it is some of the components in the high impact intervention audits. If these actions are not completed then infections may occur:
On-going care:
• Hand hygiene
o Hands are decontaminated immediately before and after each episode of patient contact using the correct hand hygiene technique. (is recommended).
• Disposable apron and gloves to be worn and disposed of following use and between patients
• Site inspection
o Site is inspected daily for signs of infection and is recorded in the patient’s record.
• Dressing
o An intact, dry, adherent transparent dressing is present.
o Insertion site should be cleaned with 2% chlorhexidine gluconate in 70% isopropyl alcohol prior to if dressing changed.
• Catheter injection ports
o Injection ports are covered by caps or valved connectors.
• Catheter access
o Aseptic techniques are used for all access to the line.
o Ports or hubs are cleaned with 2% chlorhexidine gluconate in 70% isopropyl alcohol prior to catheter access.
o Flush line with 0.9% sodium chloride for lumens in frequent use.</td></tr>
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			• Administration set replacement
			  ○ Set is replaced immediately after administration of blood/blood products.
			  ○ Set is replaced after 24 hours following total parenteral nutrition (if it contains lipids).
			  ○ Set is replaced within 72 hours of all other fluid sets.

268	Royal College of Nursing	Question 5	Main areas for quality improvement: - see below for reference to EPIC 3 epic3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England H.P. Loveday*, J.A. Wilson, R.J. Pratt, M. Golsorkhi A. Tingle, A. Bak, J. Browne, J. Prieto, M. Wilcox (2013) Journal of Hospital Infection (2013) volume 86, supplement 1. S1-S70
269	Royal Liverpool and Broadgreen University Teaching Hospitals NHS Trust	Question 5	Hand hygiene Skin decontamination prior to insertion and redressing. Asepsis Exit site and Hub care. Insertion record Management record Early removal.
270	Salford City Council	Question 5	**Questions for consultation:** - ANTT should be observed by ALL professionals, including ambulance and private companies involved in vascular line insertion and aftercare - Standardisation of administration/giving sets and infusion pumps where possible to prevent unnecessary set changes and breakage of line/access sterility Consideration of sub cutaneous fluid delivery (hypodermoclysis) particularly for treatment of dehydration in older individuals as opposed to IV access therefore significantly reducing infection/bacteraemia risk. Particular consideration for rapid response teams.
271	St John Ambulance	Question 5	The specific components of procedure that require improvement should include records of the planned care of such devices including planned or anticipated date for removal
272	The Association for Perioperative Practice	Question 5	Compliance re. Hand decontamination prior to insertion. Correct dressing (transparent semi-permeable) decontamination of skin. And appropriate documentation should all be considered
273	Association for Clinical Biochemistry and Laboratory Medicine	Quality statement 6	This should be relatively easy to measure, as long as patient leaflets are distributed and accompanying teaching is performed. Some of this data also overlaps with Standards 4 and 5.
274	Coloplast Ltd	Quality statement 6	Page 22 discussed what the quality statement means for service providers, healthcare workers and commissioners and notes that there is a need for systems to be in place for people to be educated. We would appreciate more

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			detailed guidance on what needs to be in place so as to ensure these standards are met.
275	Coloplast Ltd	Quality statement 6	As we noted above in relation to Quality Statement 4, the definition of a long-term catheter creates confusion. Education on the safe management of devices, including how to prevent infection, is important to those using an intermittent catheter on a long-term basis, although this needs to be appropriately tailored to their specific circumstances. At present, this is not covered by the definition noted on page 15.
276	Coloplast Ltd	Quality statement 6	Page 23 defines a vascular access device as an "indwelling catheter". There is a need to be clear on definitions to ensure that there is no confusion with urinary catheters.
277	Department of Health	Quality statement 6	The QS refers to enteral feeds, but these are not included in the other statements
278	Department of Health	Quality statement 6	We do not think that the mandatory MRSA and CDI data will be reliable in measuring whether people with long-term urinary catheters, vascular access devices or enteral feeds have been educated about the safe management of their device or equipment, including techniques to prevent infection.
279	Department of Health	Quality statement 6	Amend to Central Vascular access device
280	Faculty of Intensive Care Medicine	Quality statement 6	Satisfactory
281	Great Western Hospital NHS Foundation Trust	Quality statement 6	This can be complicated in community cases where numerous agencies are involved in providing care for a patient including commissioned and private carers. Who would be ultimately responsible for providing this education – the referring hospital? Any information provided should include when pertinent to the person providing the care or other agencies including family and friends. A recent waste management concern with the pleurex drains are an example of where company's product information for patients go against waste regulations for attending healthcare workers to follow.
282	HCAI SURF	Quality statement 6	Whilst welcoming the statement, it should be extended to all users of urinary catheters, whether long term, short term (see EPIC 3 http://www.journalofhospitalinfection.com/supplements) or intermittent catheter users (see NICE CG 148 and 139). Urinary Tract Infection is the main complication of all. As for statement 2, broaden the publication of HCAIs.
283	Hertfordshire Community NHS Trust	Quality statement 6	I am not clear how staff will be able to measure no. of people educated. Is the standard that each provider will provide the education even if the first organisation who provided the patient with the device provided the education. Will there be a need to have a passport document that the patient carried that provides the evidence that education has taken place – we have introduced urinary catheter care passport to support this.
284	MRSA Action UK	Quality statement 6	Whilst welcoming the statement, it should be extended to all users of urinary catheters, whether long term, short term(see EPIC 3) or intermittent catheter users (see NICE CG 148 and 139). Urinary Tract Infection is the main complication of all.

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285	MRSA Action UK	Quality statement 6	For monitoring outcomes - as for statement 2, broaden the publication of HCAIs to include organisms that are particularly significant in terms of antimicrobial resistance through the use of broad spectrum agents.
286	Oxford Health NHS Foundation Trust	Quality statement 6	Statement 6- regarding education need to make distinction where possible as not all patients are able to meet this. Is this education by leaflet? Check understanding of patient
287	Public Health England	Quality statement 6	The resources involved in the data collection for this statement would be very significant. Acknowledging this, we suggest that quality indicators should be provided for the training to ensure that the data collection is meaningful. Additionally, standardisation of advice and education (including educational materials) is essential to ensure consistency across the health and social care system.
288	Royal Liverpool and Broadgreen University Teaching Hospitals NHS Trust	Quality statement 6	**Outcome incidence of healthcare associated infection.** **The patient information would be part of a bundle of care for patients. Reference to incidence of healthcare associated infection as an outcome needs to be clarified. Does this refer to specific infections or all possible infections? This impacts on the resources required for surveillance.**
289	Salford City Council	Quality Statement 6	**What the quality statement means…..**could this read "any indwelling device" (bottom paragraph pg 22) Again, with regards **Equality and diversity considerations,** all individuals involved in delivery of healthcare, including patients would not be recommended to use alcohol hand rubs. Careful hand washing with soap and water always recommended.
290	South West Yorkshire NHS Foundation Trust	Quality statement 6	Will be difficult to evidence in community settings however this is the area where this standard may influence the biggest quality improvements. Similar data already collected in non mental health inpatient areas of the trust. Could require fairly substantial financial resources.
291	Urology Trade Association	Quality statement 6	More detailed guidance would be welcomed on the need to ensure that there are "systems in place for people with long-term urinary catheters, vascular access devices or enteral feeds to be educated about the safe management of their device or equipment", to ensure that this standard is met.
292	Urology Trade Association	Quality statement 6	We would repeat the point made in response to Quality Statement 4 on the need to separate out long-term indwelling catheters and intermittent catheterisation. The advice and education provided should be tailored depending on the method of catheterisation being used.
293	Urology User Group Coalition	Quality statement 6	As per the UUGC's comments regarding statement 4, this could also cover those using catheters for a period of 28 days or fewer, who should also be educated about infection control. It could also be expanded to cover good hand hygiene.