

**RESPONSE FORM FOR THE CONSULTATION ON THE REVISED VERSION OF THE HEALTH AND SOCIAL CARE ACT 2008 CODE OF PRACTICE ON PREVENTION AND CONTROL OF INFECTIONS AND RELATED GUIDANCE (THE CODE)**

Please send this completed form to [AMR@dh.gsi.gov.uk](mailto:AMR@dh.gsi.gov.uk) by 13 March 2015

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<p>Q1 Does the revised Code explain the changes in the new registration requirements</p> <p>Yes</p>	
<p>Q2 Does the revised Code explain the need to ensure infection prevention and control systems take a holistic approach by including antimicrobial stewardship and cleanliness?</p> <p>Yes</p> <p>The inclusion of antimicrobial stewardship is welcome</p>	
<p>Q3 Which phrase is most suitable for use in the Code? a) infection prevention or b) infection prevention and cleanliness? Why?</p> <p>Infection prevention</p> <p>The Code's language should be as simple as possible. Cleanliness is only one element of IPC and should be highlighted but not dominate above other elements.</p>	
<p>Q4 Are the definitions of AMR and stewardship clear on page 7</p> <p>Yes</p>	
<p>New version of compliance criterion. Please explain the reasons for any concerns that you have in relation to this revised criterion.</p> <p>Q5 Do you agree that merging compliance criteria 3 and 4 reduces the scope for confusion on provision of information?</p> <p>Yes</p>	

Q5a Do you have any comments on the guidance for compliance for the new criterion 3?

Yes – see below

3.1 Systems should be in place to manage and monitor the use of antimicrobials to ensure inappropriate and harmful use is minimised and patients with severe infections such as sepsis are treated promptly with the correct antibiotic. These systems draw on national and local guidelines, monitoring and audit tools such as NICE Clinical guidelines, the TARGET toolkit in primary care and Start Smart then Focus in secondary care (SSTF). **Suggest changing to guidance**

3.4 Providers should have access to timely microbiological diagnosis, susceptibility testing and reporting of results, preferably within 24 hours. Prescribers should have access to a suitably qualified individual who can advise on appropriate choice of antimicrobial therapy. **This could be interpreted as 1 person is sufficient which may not meet needs so needs amending to 'individuals or suitably qualified individuals within a microbiology service'**

Q5b Do you have any comments on the guidance for compliance for the new criterion 4?

Yes –see below

- the importance of compliance by visitors with hand hygiene
- the importance of not visiting if unwell with norovirus like symptoms**
- the importance of compliance with the registered provider's policy on visiting;
- reporting failures of hygiene and cleanliness;
- explanations of incident/outbreak management
- How to report concerns**

Q5c Do you have any specific comments on the interpretation of criteria 3 and 4 in specific settings outlined in appendices

No

Q6 Do you have any comments on the re-wording of criterion 10 on occupational health?

Yes

We appreciate the wording of this criteria is difficult. As the word infection can imply the presence of a known infection incident it could be seen to exclude the prevention of infection linked for example to vaccination or management of staff where colonisation of specific bacteria could have implications for their role.

<p>We suggest ‘ Providers have a system in place to manage the occupational health needs of staff in relation to <b>infection related issues</b>’.</p>
<p>Q7 Do you have any comments on the inclusion of reference to a water safety lead on page 12</p> <p>No this is appropriate</p>
<p>Q8 Do you have any specific comments on the appendices</p> <p>No</p>
<p>Q9 Any other comments?</p> <p>Yes</p> <p>We would be interested to hear of any general concerns about the revised Code, including topics not covered by the guidance, areas where clarification is required and amendments to the bibliography</p> <p>Page 7 – terms ‘The term ‘care worker’ is used to refer to any employee whose normal duties involve providing direct care to service users, for example medical staff, nurses, healthcare assistants, care assistants and volunteers.’ This definition as it currently stands excludes staff who support but do not provide direct patient care e.g. porters, catering staff. This requires further explanation/inclusion.</p> <p>Page 12 - assurance is in place to ensure that key policies and practices are being implemented and adhered to appropriately; the word ‘updated’ should be included</p> <p>page 13 - 1.3 The DIPC<sub>1</sub> in NHS Provider organisations should: <b>Suggest Winning ways should be referenced as this is the only description of the role</b></p> <ul style="list-style-type: none"> <li>• Have clear role description which identifies responsibilities and clear lines of accountability/responsibilities</li> <li><input type="checkbox"/> provide oversight and assurance on IPC to the Trust board or equivalent, and in non-NHS settings the registered provider. They should report directly to the board but are not required to be a board member;</li> <li><input type="checkbox"/> be responsible for leading the organisation’s infection prevention team;</li> </ul>

oversee local prevention and control of infection policies and their implementation;

Page 14 assurance framework – this should include reference to the use of data on complaints relating to IPC and whether there is any requirement to align with the duty of candour

Page 15 – IPC infrastructure – this should not just refer to nursing and consultant expertise – midwifery is a growing area if inclusion.

in acute healthcare settings, for example, an ICT consisting of an appropriate mix of both nursing and consultant medical expertise (with specialist training in infection prevention and cleanliness), **other healthcare workers** and appropriate administrative and analytical support, **suggest 'other HCWs' is a vague word see comment above**

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in healthcare, the designated lead for **cleaning must work closely with members of the multi-disciplinary team including directors of nursing**, matrons and the ICT or persons of similar standing in all aspects of cleaning services, from contract negotiation and service planning to delivery at ward and clinical level. **See suggestion above**

Page 17 - 2.4 The arrangements for cleaning should include:

- clear definition of specific roles and responsibilities for cleaning;
- clear, agreed and available cleaning routines/**schedules**;
- sufficient resources dedicated to keeping the environment clean and fit for purpose;
- consultation with ICTs or equivalent local expertise on cleaning protocols when internal or external contracts are being prepared; and
- details of how staff can request additional cleaning, both urgently and routinely **including out of normal working hours**

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Reusable medical devices should be reprocessed at one of the following three levels: **suggestion - Disinfection is not included and should be**

- sterile (at point of use);
- sterilised (i.e. having been through the sterilisation process);
- clean (i.e. free of visible contamination)

Page 20 – Guidance for compliance with criterion 7

This should include the provider having a system for assurance of the adequacy of isolation facilities by monitoring 'failure to isolate' and providing rationales as to

why this did not occur. It is recognised that a patient's clinical condition sometimes overrides isolation for IPC based on a risk assessment. The assurance data should form part of the DIPC report and this information should go to the Board

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c)

All registered providers should report significant outbreaks of infection to their local health protection team, including outbreaks in service users who are detained under the Mental Health Act 1983, if advised to do so by **suitably informed practitioners** **suggestion – practitioners** is too vague a term

e) - *Safe handling and disposal of sharps*

Relevant considerations include:

risk management and training in the **prevention and** management of mucous membrane

Additional point should be included;

- Reporting of incidents involving used or discarded sharps should be included in the IPC annual report with an analysis of trends and actions to reduce incidents

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the wearing of gloves and other protective clothing; **this should be PPE not protective clothing**

page 23 - *Management of occupational exposure to BBV's and post-exposure prophylaxis*

Management should ensure:

that any member of staff who has a significant occupational exposure to blood or body fluids is aware of the immediate action required and is referred appropriately for further management and follow-up; **question What is a significant occupational exposure?**

*i. Disinfection*

The use of disinfectants is a local decision, and should be based on current accepted good practise **note: include and available evidence**

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*Carbapenem resistant organisms (CRO's), Acinetobacter, extended spectrum beta-lactamase (ESBLs) and other antibiotic resistant bacteria*

The policy should make provision for:

surveillance and/or screening of patients at high risk of drug-resistant infection;

- procedures for managing infected patients to prevent spread of infection;
- Viral haemorrhagic fevers (VHF)

VHF's should have a separate policy and not be included within multi-resistant organisms