NICE National Institute for Health and Care Excellence

Appendix B: Stakeholder consultation comments table

2019 surveillance of Healthcare-associated infections: prevention and control (2011)

Consultation dates: 09 to 20 September 2019

1. Do you agree with the proposal to not update the guideline?

Stakeholder	Overall response	Comments	NICE response
Infection Prevention Society	Yes	There are other guidelines which adequately cover this topic area.	Thank you for your comment. We have decided not to update PH36 as no evidence was identified through the surveillance review to indicate the quality improvement statements are out of date. We agree there are a number of other relevant products covering the prevention and control of healthcare-associated infections. A mapping exercise conducted as part of the surveillance review indicated that PH36 had some unique content compared with other guidance, policy and legislation. Therefore, we feel there is value to the system in retaining this quality improvement guide.
SC Johnson Professional	No	An update to the guideline (particularly in relation to QIS2) is needed to define what represents effective hand hygiene auditing. Accurate auditing is essential to driving	Thank you for your comment. The evidence of achievement statements in QIS2 note that trusts should promote a culture of learning in relation to infection prevention and control. A practical example of this could be auditing

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		improvement in hand hygiene compliance and reducing HCAI rates (Kelly, et al., *AJIPC*, August 2016).	hand hygiene practice and feeding back to staff as part of a continuous improvement cycle. Thank you for providing the reference on Electronic hand hygiene monitoring as a tool for reducing health care–associated methicillin-resistant Staphylococcus aureus infection. From an assessment of the abstract, this study reports a correlation between improvement in hand hygiene compliance and reductions in methicillin-resistant *Staphylococcus aureus* (MRSA) infection rates. As an observational study, it may not be accurate to indicate that the reduction in MRSA rates was a direct association with improved hand hygiene as other variables or changes in practice (such as changes to hospital cleaning protocols) could have confounded the results. Additionally, the abstract does not explain the process for conducting the hand hygiene audits and therefore doesn't provide any further information to define what constitutes effective hand hygiene auditing. As part of the surveillance review, we conducted a mapping exercise to identify policy documents covering the prevention and control of healthcare-associated infections. We identified that the Health and Social Care Act 2008 covers a code of practice for infection prevention and control and NHS Improvement has produced more recent Epic3 guidelines for preventing healthcare-associated infections (2017). We noted that hand hygiene audit is: • Partially covered by the Health and Social Care Act 2008 • Included in EPIC 3 guidance, including what constitutes effective hand hygiene practice As we didn't identify any evidence through this surveillance review to indicate what would be the most effective method of hand hygiene auditing and other policy or legislative documents include detail on hand hygiene auditing, we do not feel an update of PH36 in this area is warranted.

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2. Do you have any comments on areas excluded from the scope of the guideline?			
Stakeholder	**Overall response**	**Comments**	**NICE response**
Infection Prevention Society	No	No comment	Thank you.
SC Johnson Professional	Yes	QIS2 states that "Trusts [should] use information from a range of sources to inform and drive continuous quality improvement to minimise risk from infection", with auditing of hand hygiene practices given as a practical example of how to implement QIS2. However, no detail on what constitutes an effective audit is provided. We agree with the expert analysis, cited in the consultation document, that "compliance with hand hygiene audits could be added to QIS2 as an evidence of achievement." A significant body of evidence demonstrates that, currently, actual hand hygiene compliance rates do not match reported hand hygiene compliance rates (Diller et al., *AJIC*, June 2014; Kelly, et al., *AJIPC*, August 2016; Alper, *Patient Safety & Quality Healthcare*, June 2016). This reality is acknowledged by a wide range of stakeholders in the UK, such as HM Government – the Minister of State for Health has stated the Government "recognise[s] the limits of direct observation [as a means of auditing] and how behavioural change may respond to those." (Hansard, May 2018). SJCP has run several pilots at NHS trusts demonstrating the gap between compliance reported using existing approaches and actual compliance, with further research underway. We are happy to share research findings confidentiality.	Thank you for your feedback about including more detail on hand hygiene audits within PH36 and for highlighting studies, the Care Quality Commission report and the Government debate on infection prevention and control to support your view. We agree that audit is key in a continuous improvement cycle to promote a culture of learning. However, from reviewing the references provided (see detailed assessment below), it seems there is limited evidence to suggest any one hand hygiene audit protocol is better than the other. Although PH36 gives the example of auditing hand hygiene practice and feeding back to staff as a mechanism to promote a culture of learning, it is not restrictive on how this should be performed. As part of the surveillance review, we conducted a mapping exercise to identify policy documents covering the prevention and control of healthcare-associated infections. We identified that the Health and Social Care Act 2008 covers a code of practice for infection prevention and control and NHS Improvement has produced more recent Epic3 guidelines for preventing healthcare-associated infections (2017). We noted that hand hygiene audit is: • Partially covered by the Health and Social Care Act 2008 • Included in EPIC 3 guidance, including what constitutes effective hand hygiene practice

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		The consultation document (NICE, p. 4) is correct that ”Hand hygiene audits are a continuous improvement cycle”, however this cycle is dependent on accurate compliance data to motivate and demonstrate improvement. (Yen Lee Angela Kwok et al. *AJIC*, March 2017) Guidance on effective auditing is required to ensure the accuracy of compliance data which can drive improvement. Research demonstrates that accurate hand hygiene auditing data drives behaviour change, delivering improvement in real compliance rates. This in turn leads to a reduction in HCAI rates, along with associated costs from additional bed days and care requirements (Kelly, et al., *AJIPC*, August 2016; Yen Lee Angela Kwok, et al., AJIPC, December 2018; Robinson et al., Greenville Health System poster presentation). Effective hand hygiene auditing techniques have been identified and praised by the CQC.” (For instance, see: CQC, ‘Burton Hospitals NHS Foundation Trust Quality Report’, October 2015). The current ‘HCAI: prevention and control’ guidance should be updated to set out parameters for what constitutes effective auditing practice, such as the appropriate number of data points to build an accurate picture of compliance rates. SCJP is happy to provide further information to support the development of updated HCAI guidance. Additionally, SCJP would welcome the opportunity to submit a case study on effective hand hygiene auditing practice, working with one of our NHS partners.	As we didn’t identify any evidence through this surveillance review to indicate what would be the most effective method of hand hygiene auditing and other policy or legislative documents include detail on hand hygiene auditing, we do not feel an update of PH36 in this area is warranted. We are interested to note that there is ongoing research in this area, we would be happy to consider these projects in confidence and evaluate the impact of the results on the quality improvement guide when available. Consideration of studies • Diller et al, 2014: This study compared 24-hour video surveillance of hand hygiene episodes versus episodic observation of patient activity. The mean hand hygiene episodes per 24-hour period did not differ significantly between the groups indicating that no protocol was better than the other. • Kelly et al, 2016: From an assessment of the abstract, this study reports a correlation between improvement in hand hygiene compliance and reductions in methicillin-resistant *Staphylococcus aureus* (MRSA) infection rates. As an observational study, it may not be accurate to indicate that the reduction in MRSA rates was a direct association with improved hand hygiene as other variables or changes in practice (such as changes to hospital cleaning protocols) could have confounded the results. Additionally, the abstract does not explain the process for conducting the hand hygiene audits and therefore doesn’t provide any further information to define what constitutes effective hand hygiene auditing.

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			• Yen lee et al, 2017: This study focused on whether social cohesion could improve hand hygiene indicating that interventions for improving compliance are more likely to be successful in a ward with a social cohesive team. However, from an assessment of the abstract, no details were supplied about how the intervention was implemented and what factors were utilised to create a socially cohesive team, limiting the applicability of the results. • Yen lee et al, 2018: This study compared automated with covert hand hygiene auditing. Variable results were reported with no or minimal difference in compliance observed between protocols depending on the test ward. • Alper, 2016: As this was not a study it does not meet the inclusion criteria for this surveillance review. • Robinson et al: As this was a poster presentation and not a peer reviewed study, it does not meet the inclusion criteria for this surveillance review.

3. Do you have any comments on equalities issues?

Stakeholder	Overall response	Comments	NICE response
Infection Prevention Society	No	No comment	Thank you.
SC Johnson Professional	No	No comment	Thank you.

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