14th March 2017

Dear colleagues,

Re: Infection Prevention Care Bundles; High Impact Interventions Draft for Consultation

We write on behalf of the Royal Pharmaceutical Society (RPS) and the UKCPA Pharmacy Infection Network to respond with comments to the above document.

The **United Kingdom Clinical Pharmacy Association** (UKCPA) is a national group which aims to foster and support excellence in clinical pharmacy practice. The Pharmacy Infection Network (PIN) is one of the specialist groups within UKCPA and comprises of approximately 800 pharmacists predominantly from the UK with membership from Europe and Commonwealth countries. PIN is regularly consulted on national anti-infective guidance and works closely with other infection societies.

The Pharmacy Infection Network objectives are to:
• Develop and lead on UK antimicrobial stewardship initiatives
• Provide an educational programme to enable the sharing of knowledge and allow networking opportunities
• Undertake research and support national and international collaboration with other infection societies
• To advise the Royal Pharmaceutical Society, Department of Health or other government organisations on UK infection matters

The **Royal Pharmaceutical Society** (RPS) is the professional body for pharmacists in Great Britain. We represent all sectors of pharmacy in Great Britain and we lead and support the development of the pharmacy profession including the advancement of science, practice, education and knowledge in pharmacy. In addition, we promote the profession's policies and views to a range of external stakeholders in a number of different forums. The response to this consultation has been informed by the members of the RPS Antimicrobial Expert Advisory Group http://www.rpharms.com/expert-advisory-groups/antimicrobial-expert-advisory-group.asp .

General comments

It would be helpful to clearly state the target audience for the High Impact Interventions (HIIs) and context in which they should be used. e.g are the HII for secondary care (acute and/or community) as well as primary care? We believe from historical work that this is for secondary care but it is not clear especially for those who are new to the field.

It is important to clarify that HIIs are audit tools as there are several more actions that could be recommended for each of the groups/phases.

Could the previous HII audit sheets be updated and included?

HII – Antimicrobial Stewardship

Why use the care bundle?
This care bundle is based on the Start Smart then focus (2015) toolkit, the Health and Social Care act: Infection Prevention and Control Code of Practice; 5 year UK antimicrobial resistance strategy and NICE guidance for antimicrobial stewardship. Organisations should use this care bundle as part of their antimicrobial stewardship strategy, thus enhancing stewardship in antimicrobial usage, and ensuring optimal patient care by reducing inappropriate prescribing. It is evidence-based, taking into consideration recent scientific and medical literature, as well as widespread clinical experience.

Comments on actions:

Nursing actions: perhaps retitle as nursing administration actions?

We support the inclusion of points for nursing staff, we strongly support their role and engagement in AMS, particularly in prompting 72h review. However, it seems inconsistent to ask nurses to 'ensure' documentation and review as part of their list of actions, when neither are in the list of actions for the prescribers, this implies that these are nursing responsibilities, not the prescriber's. Arguably these should be in both lists and we suggest changing the term 'ensure' to 'check that this is done and prompt prescriber to rectify if absent', or words to that effect, in the nursing list.

The nursing list needs renumbering (2./2./3.)

We believe there could also be actions for nurses around

- Timely antibiotic administration, especially for patients with sepsis
- The need to educate/discuss therapy with patients and carers

Prescriber actions (we suggest these should come before nursing actions) :

We suggest that the actions should directly mirror Start Smart then Focus. Suggested text below:

The principles of Start Smart then Focus should be followed.

START SMART:

1. Take thorough drug allergy history
2. Initiate prompt effective antibiotic treatment within one hour of diagnosis (or as soon as possible) in patients with severe sepsis or life-threatening infections[α]
3. Comply with local antimicrobial diagnostic and prescribing guidelines
4. Document clinical indication (and disease severity if appropriate), dose and route on drug chart and in clinical notes
5. Obtain cultures prior to commencing therapy where possible (but do not delay therapy)

Between 24 and 72 hours FOCUS:

Conduct a clinical review, check microbiology and make a clear plan[a] including one of the antibiotic prescribing decisions.

a) STOP

b) IV to oral switch [b]

c) Change antibiotic

d) Continue

e) OPAT*

Document this decision & Next Review Date or Stop Date

[a]When culture and sensitivity results are available, antibiotics are prescribed according to positive microbiology test results or *where empiric treatment* was initiated, broad spectrum antibiotics are de-escalated to narrow spectrum agents where clinically possible

[b] Intravenous antimicrobials are reviewed after 48 hours and switched to oral (according to local policy). If IV required beyond 48 hours, it is reviewed daily and decision on continuation and next review date for antimicrobial therapy is documented in the medical notes.

Is there a reason why there are no actions for pharmacists? We suggest that actions for ward pharmacy teams are also added as follows:

1. Medicines reconciliation – ensure antibiotic allergies are appropriately classified and documented. Confirm if patients have had any recent antibiotic courses and document as part of the drug history.

2. Antibiotic initiation – when screening antibiotic prescriptions, ensure antibiotics are prescribed in accordance with local (or national) guidelines with appropriate documentation (indication and duration)

3. Review the need for continued antibiotic therapy within 72 hours:

    a) Encourage review of culture results and amendment of antibiotic choice 48-72 hours from initiation

    b) Encourage IV to oral switch as soon as clinically indicated (in line with local policies)

Would there also be an opportunity to include some information on therapeutic drug monitoring for nurses, pharmacists and prescribers and some information on the importance of educating/discussing therapy with patients and carers.

We hope these comments are helpful.

Kind regards

Ruth Wakeman
Assistant Director of Professional Development and Support, Royal Pharmaceutical Society

Jacqueline Sneddon
Chair of UKCPA Pharmacy Infection Newtwork

References:

UK Five Year Antimicrobial Resistance Strategy 2013 to 2018, Department of Health, 2013
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/244058/20130902_UK_5_year_AMR_strategy.pdf