Are your IPC policies fit for purpose?

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Abstract

Infection prevention and control practitioners are well versed in protecting patients from harm. Recent political, public and media attention about unsafe organisations has brought doubts into many minds as to the safety of our healthcare services. Infection prevention and control policies are the mainstay in ensuring compliance with best evidence-based practices, but with many mergers of community and secondary care infection prevention and control teams, policies have to be reviewed and revised to ensure they meet both organisational and patient/employer safety needs. This paper reflects contemporary literature around policy development. It will discuss how to develop, implement and evaluate comprehensive policies that will fit the needs of organisations while protecting their population of employees and patients.

Introduction

While the goal of all infection prevention and control practitioners (IPCP) is to provide a quality, compassionate and caring service, organisational policies do not always readily adapt to the variety of healthcare settings. The general public, politicians and healthcare workers (HCW) have, through multi-media and political attention, become aware that healthcare systems are possibly not as safe as they could be (Burns, 2004). The Health and Social Care Act (2008) established infection prevention and control (IPC) as an integral responsibility of all employees' contracts. In England, the National Patient Safety Agency (NPSA), and the Care Quality Commission (CQC) in tandem with the NHS and many other care organisations, have in recent years, responded to the World Health Organization's *Patient Safety Challenge* (2005), by implementing policies and guidance to ensure patient safety needs are met. However, recent reports (Francis Report, 2013; Keogh Review, 2013) have highlighted many shortfalls in providing quality, safe care.

The prevention and control of infection is an integral component of clinical governance and resides with a number of other specialties and quality initiatives as part of the overarching framework for improving healthcare provision (Swage, 2004).

The main aim of this article is to assist IPCP in the development, review and revision of IPC policies, which address the many differing healthcare environments, incorporating the best evidence for practice,

while addressing the consistency of IPC interventions and decision making at operational levels. Robust policies and guidance will enable all HCW to be proactive and "do the right thing" when addressing IPC specific safety issues in their working arenas.

Where to start

The role of the IPCP is multifaceted. One integral element is the development of IPC policies, which serve to safeguard the patient, practitioners, general public and the organisation by providing consistent guidance for interventions to prevent and minimise harm. Policies are fundamental resources which reflect the organisation's mission, culture and values (Randolph, 2006). They need to be research-evidence based, underpinned by a philosophy of minimising harm and standardised in order to protect the health of patients, employers/employees and the general public (Cochrane, 2000).

Recent mergers between secondary and primary care infection prevention and control teams (IPCT) presents many challenges, when the employing organisation requires IPC policies that cover the broad spectrum of their healthcare provision.

Many IPCP are well equipped with the skills and knowledge to develop policies, but for the novice IPCP, in today's changing healthcare environments, it is not always easy to identify that policies for secondary care settings cannot always be adopted into other healthcare settings. For example, in mental health, and some secure environments, many personal safety issues have to be considered as some items of equipment could be used as potential weapons or missiles. Similarly in primary care, unless the premises are owned by your organisation, you have very little control over what can be implemented. Another example is that some professional disciplines are required to work to strict standard operating procedures from which they should not deviate. However, in health care today, with the complexities of providing quality care, one size does not fit all.

Despite the complex nature of modern health care, with careful consideration and examining patient/client group characteristics and anomalies, robust policies, guidelines and protocols can be developed that meet the patients', staff and service needs.

Many questions have to be considered in firstly asking whether we need a policy, a guideline or a protocol for this issue. What is the rationale of the proposed policy? Table 1 provides questions which may be considered when embarking on the policy formulating challenge.

Table 1. Rationale for developing a policy

What is the problem – is it clearly identified?	Is it in response to government guidelines, European/WHO guidelines on harm reduction, legislation, codes of conduct?
Is the issue a priority requiring new policy guidance?	For the patient/public For the organization For all healthcare workers For clinical practitioners For professions allied to medicine
Are key stakeholders involved/represented in the development group?	
What expert opinion is required?	Who do you need to involve for their expertise?
Who will own the new policy/guidance when developed/formulated?	
Will there be a consultation period with health professionals and other parties prior to ratification?	
Who will approve the final document?	
Is there consensus of opinion?	

Formulation and development of the policy

There is a need to ensure that those involved in formulating policies are guided not only by their organisation's mission statements and goals but also by the demographics of the infection control and prevention (ICP) service. Policies should meet international/national/government standards, or an identified need, or a service gap (Randolph, 2006). This is also true of guidelines, procedures and protocols that should reflect policy content and the most contemporary evidence for best practice (Chambers et al, 2007).

The process of policy development will enable practitioners to continue striving for clinical excellence within their work arena. The "15 pillars of excellence" are discussed by Kapur (2009). These 15 pillars are subdivided into the three domains of "technical" (how capable are you in your job?), "personal" (how good a person are you?) and "future" (what improvements will you leave behind?). These domains and 15 pillars include many elements of knowledge, evidence-based practice and critical thinking, which can be mapped to the Infection Prevention Society IPCP competences (Burnett, 2011). In collaboratively and critically developing policies the only pillar of effectiveness that is possibly not achieved is that of income or resource generation.

All organisational policies/protocols and guidelines should be underpinned by the most up-to-date evidence for best practice. Evidence which is considered to be clear and explicit is more likely to be adopted and implemented (Barker, 2013). However, reviewing the evidence often raises conflict in the minds of practitioners. Can you really trust what you read (Cottrell, 2005)? This is where practitioners have to ensure that their critical analysis skills enable them to distinguish good published evidence from that of a poorer quality.

Policy development may adopt a team approach, but very often it is one team member who provides a skeleton framework, upon which the team can build. For the inexperienced or new team member, it can be very daunting when reviewing a current policy for currency and applicability. It is however, a process that cannot be hurried. Examining the research-evidence base takes time. Many practitioners opt for anecdotally handed down evidence from specialist practitioners, which as Ross (2012: 16) comments, "results in staff knowing the right thing to do but not knowing why it is the right thing".

For IPCP in Wales and Scotland, government websites have a plethora of IPC information and often exemplar templates for policy development. However, although it could be argued that this is a great idea, and provides a standardised template, paradoxically does it encourage

practitioners not to think for themselves? Also, do those governments invest in these sites, and are they updated regularly to include the latest published evidence for practice? Are the specialist practitioners and experts, who provide the updates, afforded protected time to undertake the work?

Organisational policies need to be viewed as pertinent to every healthcare worker and practitioner in their daily practice and are an integral component of risk management (Chambers et al, 2007). Just as for national guidelines, key stakeholders need to be involved to determine what changes (if any) need to be made to practice, and to examine mechanisms as to how policy content will be disseminated. Collaborative multidisciplinary working with key stakeholders can greatly assist the processes of examining the evidence and highlighting areas of current policy or guidance that is not applicable to some working environments. Table 2 provides additional points for consideration during the formulation stage.

Involvement of stakeholders assists in reducing duplication of efforts by sharing knowledge, information and good practice from across the organization (Swage, 2004). For example if IPCP are reviewing or formulating a head lice policy – have they contacted school nurses, health visitors, or health protection teams regarding their head lice policies? Can this policy be adopted or adapted to suit the organisation's needs?

Many IPC policies are formulated and developed by the organisation's infection control committee (ICC). Members of the ICC will be representing their particular division or area of responsibility, but it cannot be assumed that they have all of the requisite knowledge, skills and expertise to inform all areas of policy. Therefore during the consultation processes, it may be necessary to disseminate draft documents to a wider participatory audience.

Unfortunately most IPC policies are generic. In some complex situations, policies/guidelines can conflict with the concept of individualised care particularly when patients have complex co-morbidities that need the involvement of multiple practitioners or organisations and possibly relatively poor communication exists between parties. What does the IPCP advise here?

Complex patients can rarely be compartmentalised into a generic pigeonhole. In many instances of complex patient issues, there may be a need to formulate an individual guideline relevant only to the needs of that individual patient being met in a safe, caring and compassionate manner. This guideline should reflect the main points of the generic policy, but be tailored to meet the patient's individual circumstances.

Table 2. Formulation of new policy/guidelines – points for consideration

Who will do?	Identify the lead person for this initiative Are other stakeholders involved? Has it a date (even drafts)? A draft cannot supersede existing policy. Revise/review dates Name of author/person ratifying the policy and date of ratification. Working party where appropriate with names listed and their job titles
What will be the health gain to the patient, staff or the organisation?	Is it a MUST DO because of legislation etc.? Is it for standardised delivery of all aspects that the policy covers? Will it minimise harm?
Format of a policy document	Is it standardised?
Is it a mechanism for quality indicators/benchmarking/disciplinary action?	Can you devise clinical audit tools? Is it measurable?
Is there a clear description of the aetiology/epidemiology of the infection/disease?	
What are the proposed management and treatment interventions?	Have you considered that no interventions may be necessary depending upon the pathogen?
What evidence supports these interventions? Is it a strong evidence base and is it transferable to generic clinical practice?	Who, within the team, has decided the evidence is reliable and valid? How has this been achieved?
How many patients/staff would need to be screened/treated in order to avoid one adverse event?	
Could negative health effects associated with the proposed policy/guidance compromise clinical benefit?	
Has the possibility to administer no treatment or special arrangements been considered as an option?	
Special considerations?	Children/neonates/elderly/comorbidities/adverse reactions to intervention. Different healthcare environments, e.g. secure units, GP practice, clinics etc.
Consultation	Discussion date of comments. Inform others about what you are doing and when/what can be expected (prevents duplication of work effort). Contact names and numbers
Final approval/ratification	Who validates the policy? What is the timescale from draft to approved policy?

Again, multidisciplinary discussions or case reviews will be extremely valuable here, particularly if the patient has a case manager, who is well versed in the individualised care of the patient and who coordinates all services for the patient. We should also not forget about the patient/carer viewpoints, as patients do have a choice in their treatment and care and often are best placed to tell professionals what works and what does not in their given situation (Berwick Report, 2013).

In areas of complex morbidities, IPCP may need to consult with the ward/departmental staff regarding any special measures that may need to be adopted specifically for that specialist area. An example here is Severe Combined Immunodeficiency Units (SCIDS) where hand hygiene policies may need to be more specific in terms of the length of time of hand washing, the type of products used, tap filters etc. Similarly paediatric considerations often have to be taken into account, for instance certain products could be potentially harmful to, for example, neonates.

In primary care, mental health, and private sector services, it cannot be expected that policies attuned to acute hospital facilities can immediately be adopted. Community IPCP place emphasis upon applying research-evidence-based policies and procedures, but this can be very problematic in facilities not owned by the employer (Cole, 2008).

Adaptations of policies and procedures, with perhaps additional guidance, pertinent to the complex patient or issue or the non-acute

sector, may need to be formulated to ensure that all practitioners within those environments are able to fulfil their purpose of ensuring good standardised practice for all patients and situations at all times.

Implementation

We all recognise that infections do not respect the social constructs of societies or boundaries within organisations (Cochrane, 2009). IPCP are acutely aware of this and are well conversant with patient safety standards both from the government and their organisation. Any new or revised policy/guideline/protocol/procedure will ultimately impact upon all personnel, and personnel need to be informed of the changes, including the rationale underpinning the changes to current practice (Randolph, 2006). According to Burns (2004) and Cole (2008), if all healthcare personnel are informed and involved with policy development, then they will perform to a high standard in providing safe care. Therefore policy implementation has to be the main focus in the delivery of effective care practices (Hewison, 2008).

Disseminating the new policies can be undertaken in a variety of ways, e.g. organisational intranet services. However, here an assumption is made that all employees are computer literate and have readily available access to computers in the workplace. Other dissemination strategies may involve memoranda, roadshows, bulletin boards, organisational journals/magazines, team briefings etc. There may also

Table 3. Implementation of new policy/guidelines

Has consideration been given to risk management?	
Circulation/Implementation	If on intranet how do you know who has accessed and read any changes to current policy? Electronic technology applications and social media Education and training events Roadshows
Has consideration been given to identify and meet the training needs of healthcare workers in implementation of new/revised policy/guidelines?	Included in induction Link practitioner involvement Bespoke sessions for individual wards/departments. Bespoke session for specialist units/departments Other educational avenues to be explored, e.g. simulation?
Is there a need for new/revised written information for patients?	Leaflets/how many/various languages? Budget?
Is there an implementation plan, including resources? Has this been scrutinised for efficacy?	Involvement of human resources and IT departments
Who has responsibility for managing the implementation?	

Table 4. Evaluation

What are the outcome indicators and targets?	Has a date for auditing been set? Collection of surveillance and audit data? Observations of practice
Who has responsibility for managing the evaluation and collating any data?	Also consider who will collect the data, who will input and collate the data and who interprets the findings?
How will impact on clinical/organisational practice be monitored and reviewed?	Reporting mechanisms

be a need to provide some tailored educational and training programmes to highlight key issues and themes within the new or revised policy (Barnidge et al, 2013).

Table 3 provides some questions which may be considered when implementing a new or revised policy.

Electronic documents can be cost effective not only in saving paper, but also in manpower and time as individual pages can be revised easily by the person with the writing access rights to the documents. Perhaps organisations' information and technology (IT) departments, in collaboration with human resources/staff training departments, could utilise software that facilitates recording those personnel who have or have not accessed the revised or new policy. Information gleaned here can inform staff appraisals and staff development.

Involvement of healthcare workers across all disciplines in policy development provides them with a sense of ownership in shaping service delivery. It reduces resistance to change and encourages proactivity, with the patient being the primary focus (Barnidge et al, 2013). Involving staff in this way can lead to good evidence-based practice being implemented in a cohesive way and provide positive patient outcomes (Rütten et al, 2010).

Evaluation

Any new initiative should engage consultation, be piloted and evaluated if it is to be viable and sustainable (Cochrane, 2009). As policies are a quality assurance mechanism to enhance standards of care and maintain patient safety, they have to be evaluated to ensure compli-

ance with evidence-based contemporary practice (Freeman et al, 2009; Ball, 2013).

Some considerations for policy evaluation are demonstrated in Table 4.

Ball (2013) recommends that assessment of policy compliance should be undertaken at regular intervals, while Weston (2013) highlights how clinical audit is an integral component of IPC programmes. IPCP undertake regular clinical audits to observe compliance and assess and evaluate if best evidence is being applied in practice. Within the clinical audit process, staff are often questioned as to the content of specific policies. This facilitates identifying the understanding of policy content and can assist in developing teaching activities to address any gaps in knowledge and understanding.

It is suggested by Randolph (2006) that policies are reviewed on an annual basis. It would seem that the norm in most organisations is for policies to be reviewed annually or bi-annually, but more frequent reviews are undertaken if there is new national or international guidance, emerging infection or researched evidence to drive policies forward.

Conclusion

There is ever increasing, very close scrutiny of healthcare provision following adverse media reports, resulting in patients and the public have varying degrees of trust in healthcare professionals. That confidence and trust can be restored if all healthcare workers can demonstrate that they use their previous knowledge and learning in their

daily practice and adhere to policies, guidelines, protocols, processes and outcomes.

A written policy alone serves no real purpose unless the content of the policy is widely communicated to all personnel. Multidisciplinary working to formulate, disseminate and evaluate IPC policies facilitates improvement in service delivery. The reality for IPCP who effectively develop and disseminate robust, evidence-based, organisational policies/guidelines and protocols through stakeholder engagement in the processes, allows healthcare workers to take ownership of the policy and support in the work they undertake.

Implementing new or revised policy, in a well-planned and coordinated manner, using a range of implementation strategies, will ensure a wide dissemination of content and any changes to current practices being implemented promptly by informed personnel.

Today's healthcare environments are complex entities, but IPCP policies should encourage innovation in meeting individual areas of practice and their IPC needs, encourage engagement in learning and

teaching, utilise appropriate new technologies, consolidate best practice and perhaps expand current service provision.

Communicating effectively to share information with others is vitally important in providing evidence based practices and strategies. IPCP are specialists in promoting patient safety, but all healthcare personnel have to take responsibility for their own actions and should become familiar with infection control policy content. This not only assists the clinical and cost effectiveness of the quality of care provided, but also ensures that clinical governance mechanisms are better supported by the improvements in patient safety.

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