Working together to prevent and control infections

A study of the arrangements for infection prevention and control between hospitals and care homes

September 2009
About the Care Quality Commission

The Care Quality Commission is the independent regulator of health and adult social care services in England. We also protect the interests of people whose rights are restricted under the Mental Health Act.

Whether services are provided by the NHS, local authorities, or private or voluntary organisations, we make sure that people get better care. We do this by:

- Driving improvement across health and adult social care.
- Putting people first and championing their rights.
- Acting swiftly to remedy bad practice.
- Gathering and using knowledge and expertise, and working with others.
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Infection prevention and control is not simply an issue for hospitals – many infectious diseases can spread within care homes, where large numbers of people, many of whom may be susceptible to infection, share living accommodation. Infection can be a major cause of illness among residents of care homes, which can result in them being admitted to hospital. For people living in care homes in some developed countries, infection is a common cause of hospitalisation. People can enter care homes colonised with organisms acquired in hospital that are resistant to antibiotics. These homes can then become ‘reservoirs’ of infection. This, and the fact that many people living in care homes have frequent contact with healthcare services, has created a ‘revolving door’ situation, where people are re-admitted to hospital for conditions that could be managed within a care home.

Infections can range from mild food poisoning to life threatening bloodstream infections and are caused in many different ways. This report is about those infections that are associated with the care provided by healthcare organisations or care homes. Infections caused by Meticillin resistant Staphylococcus aureus (MRSA) and Clostridium difficile can often be portrayed by the media in a way that can be alarming to residents of care homes, their relatives and carers. Information on the standards of infection prevention and control in care homes is therefore very important, not only so that people who use services can make informed choices, but also because it promotes confidence in the care being provided. Families and carers want to be assured that the care their relatives and dependants are receiving is being provided in a clean and safe environment.

Programmes for preventing and controlling infections are important in hospitals and care homes and they should address the complex care services provided. However, little is known about the impact of these programmes in care homes. The Department of Health’s current infection prevention and control strategies focus on acute hospitals, since these are perceived to present a greater risk of infection. However, some studies have suggested that the number of infections in care homes may be comparable to those in hospitals. There is a wealth of information about infection risks in hospitals, but little is known about the risks associated with care homes, particularly the arrangements for preventing and controlling infections at the interface between these settings. This is complicated by changes in regulation. From 1 April 2010, all NHS healthcare providers will be required to comply with the requirements of the Heath and Social Care Act 2008 (Registration Requirements) Regulations 2009 and to follow the requirements contained in the Care Quality Commission’s guidance about compliance and the Department of Health’s Code of Practice related to infection prevention and control. By October 2010, all care homes and independent providers of healthcare will be registered against the same regulatory requirements. The requirements that this report focuses on are that providers of care should:

- Work with each other to ensure that services are joined up.
- Provide information to each other relating to a person’s care while observing a person’s right to confidentiality.
Ensure that staff are adequately trained and competent to carry out their work.

Have regard to national guidance relating to infection prevention and control.*

To shed light on this area, the former Healthcare Commission and the Commission for Social Care Inspection (both organisations, along with the Mental Health Act Commission, were merged into the Care Quality Commission on 1 April 2009) commissioned a short study in England with two aims:

- To develop a better understanding of how the arrangements for preventing and controlling infections are working in practice at the interface between registered social care homes and hospitals.
- To gather and share information that could help care providers prepare for the new Code of Practice and the new arrangements for their registration and regulation by the Care Quality Commission.

The work was carried out between December 2008 and May 2009 and consisted of:

- Qualitative case studies of 13 care homes, mapping how they interacted with healthcare and other social care providers.
- A quantitative, web and paper-based survey of over 1,000 care homes (a statistically significant sample of around 4% of all care homes in England).

The research aimed to answer five key questions that were designed to provide information on how well service providers were prepared for the proposed changes in regulation. The questions were:

- How is information about infection prevention and control shared between health and social care settings?
- How is information about infections or their prevention and control shared with people living in a care home and their family members?
- What advice and support on infection prevention and control is available to care homes?
- How are staff trained and supported to be competent in preventing and controlling infection in care homes?
- How well are care homes prepared for the forthcoming regulatory changes, including registration with the Care Quality Commission?

**Key findings and recommendations**

**Our key findings**

1. Good leadership and well-trained care staff are key to the overall success of the home in preventing and controlling infection.

2. Care homes have not effectively implemented the guidance on improving infection prevention and control and their knowledge of the forthcoming regulatory changes is not widespread.

3. Care homes and hospitals are required to provide information on infections to each other. However, this does not happen in a coordinated way, which means that people with an infection may not receive the most effective care and recover more slowly, or not at all – and they may pass their infection on to others as a result. This situation is

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* Further details on specific regulations and compliance criteria will be published late in 2009.
made worse, because staff are confused about what information they can share, and with whom, in the discharge summary information, while complying with data protection and confidentiality requirements.

4. There is a lack of effective information in suitable formats and languages to help staff talk about infection and control measures with people living in care homes and their families.

5. Advice on infection prevention and control needs to be improved, including advice in specialist areas such as tissue viability and continence.

Our recommendations

All care providers should:

- Ensure that their information about infections, and any particular care needs related to those infections and their control, are being communicated effectively when a person moves from their care to the care of another person or organisation.
- Ensure that their arrangements for sharing information on a person’s care, treatment or support helps to prevent and control infections, while observing national guidance and people’s rights to confidentiality.
- Ensure that their discharge summaries are readable and that infection risks and associated care needs are highlighted.
- Include ambulance trusts and other providers of care in their communication strategy.
- Regularly discuss good, basic hygiene principles with people in their care and their relatives or carers, to help them make their own choices. This should be supported with good written information.

Care homes should:

- Ensure that all their staff and, in particular, managers and leaders, receive adequate training or personal development to ensure that they provide strong leadership for infection prevention and control.
- Ensure that all care staff, particularly nursing staff, receive training, refreshers and updates on infection prevention and control.
Provide evidence to support their registration application, by consulting guidance such as *Essential Steps*, *Infection Control Guidance for Care Homes*, the draft Code of Practice and the Health Protection Agency’s training DVDs, and making sure that the relevant sections are implemented. Information is also available from the Clean, Safe Care website at www.clean-safe-care.nhs.uk.

Commissioners of care should:

- Ensure that they include standards for discharge summaries in relevant contracts and monitor how these are implemented.

The Department of Health should:

- Promote *Essential Steps* and other guidance to care homes, emphasising its value as a good practice guide as well as an audit tool.
- Ensure that care homes can access authoritative information on infection prevention and control that is relevant to care homes and comparable with that available to the NHS.

The Care Quality Commission will:

- Develop an action plan to take forward the recommendations of this report with relevant stakeholders.
- Develop clear policy on how the forthcoming Code of Practice and regulatory requirements relating to infection prevention and control will be applied to care homes.
- Work closely with the National Information Governance Board and the Department of Health to produce definitive guidance concerning the sharing of information on infections between the NHS and care homes.
- Work with other organisations to ensure that it uses the best data to assess infection risks in care homes.
- Develop robust methodologies and indicators on infection prevention and control to assess the performance of care homes, and take appropriate action when problems arise.
**Our findings**

**How is information on infection prevention and control shared between health and social care settings?**

Sharing information is important because it allows staff, whether in a hospital or care home, to care for a person with an infection in a way that increases the chances of a positive outcome for that person and reduces the risk of transmitting infections to other people. Primary care trusts use service agreement contracts when they commission health services. These contracts clearly specify the types of information that should be provided when someone is discharged from hospital and this includes information on infections. In addition, the Health and Social Care Act 2008 Code of Practice relating to infections specifies that information regarding infections or a person’s care needs should be passed between health and social care settings when a person moves from one to the other.

Our case studies showed that, although some care settings communicate well with each other, there seemed to be particular problems with information being communicated when somebody was discharged to a care home from hospital. Significantly, 17% of care homes that responded to our survey received no information at all regarding infections when people were discharged from a hospital to their care. This was not thought to be due to a lack of commitment or will on the part of hospital staff, but because they are overloaded with work. However, it may simply be because the information provided when a person is discharged is sent to their GP, as specified by the NHS standard contract, and not to their care home. We found that the information required by standard NHS contracts in a written discharge summary, including information on relevant infections, was often incomplete or missing. Homes that only provide personal care seemed to have the greatest difficulty in accessing this information from hospitals.

Crucially, ambulance crews, a common link between hospitals and care homes, are often left out of the information loop, even though they could perform a vital role both in caring for people and transferring information about their care needs. Also, if ambulance crews are not told about someone’s infection status, they could facilitate further transmission of infections.

Our survey revealed a variety of ways in which health and social care staff communicated with each other about infections varied, with the most common being verbally. This is contrary to the NHS standard contract, which specifies that this information should be presented in a written summary. Care plans were also a common way of communicating.

We were told that staff were sometimes confused by data protection, patient consent and confidentiality issues. This confusion could lead to inefficient communication. This is a complex area, involving different pieces of legislation and guidance, which may explain why this information is provided inconsistently. Current Department of Health guidance states that information should not be shared by clinicians with a third party without informed consent, but this may be difficult to obtain in some circumstances. Clinicians and care home staff rightly focus on the rights and needs of the individual and it is likely that data is withheld for the best reasons. However, attempts to protect the rights of an individual may result in unsafe practice by undermining infection prevention and control measures for that individual and others. This is an area that requires clear guidance to ensure that carers carry out their responsibilities in a way that balances these needs.

**When someone living in, or moving to, a care home has an infection, how is this information shared with them and their family members?**

Good communication, for example regarding hand washing, personal hygiene and treatment, is
essential to help a person recover from an infection and prevent it being transmitted. Our case studies showed that care homes placed a strong emphasis on verbal communication to introduce and reinforce messages about infections to their residents and their families, particularly when somebody is being isolated or is concerned about a change to their routine due to an infection. They use a wide range of information and resources of varying quality, which means its effectiveness depends on the knowledge and judgement of the staff using the materials. Information within a home should be shared in a way that promotes good infection prevention and control measures, while protecting people’s rights to dignity and confidentiality.

What kinds of advice and support on infection prevention and control are available to care homes?

Care homes, unlike hospitals, generally have fewer resources and may not have ‘in house’ expertise relating to infection prevention and control, therefore relying on specialist advice from other organisations.

Our case studies showed that care homes had very different experiences when seeking advice and support, especially in the availability of proactive and reactive advice. For example, all homes knew where to seek advice in the event of an outbreak of infection, but there was a general need for advice to help them develop policies and procedures in line with current good practice.

Our survey showed that homes sought external advice most often when they were developing policies and procedures, caring for an individual with an infection or when dealing with an outbreak. This was most commonly sought from primary care organisations, the Health Protection Agency and local authorities. The majority of homes (87%) said that advice and support was always available when needed but 13% disagreed. When asked whether they paid for this advice, the majority of care homes (86%) said “no”, 11% said “occasionally” and only a small minority (3%) said “yes”. Historically, this advice has been provided free of charge by various organisations, but this is currently being reviewed, which means that care homes may need to fund this in the future. GPs commonly provided advice to care homes during an outbreak, but they also helped 11% of homes to develop their infection prevention and control procedures.

What are staff trained and supported in preventing and controlling infection in care homes?

Good leadership and training, firmly embedded within the culture of an organisation, is regarded as a key component in successfully preventing and controlling infections in healthcare settings. However, our case studies showed that care homes found it difficult to maintain a fully trained workforce due, in part, to a high turnover of staff. Also, since many care homes employ staff whose first language is not English, they need to provide training materials in different formats and languages. And we found that where sick pay was not available, staff sometimes worked with an infection such as influenza or diarrhoea without disclosing it. There is currently no information to indicate how common these events are and so it is difficult to estimate the risk to staff and residents. However, care homes should have clear infection prevention and control policies on when staff should not attend work.

Our survey showed that nearly all homes train their staff in preventing and controlling infections on induction and that further mandatory training and updates are widely used. However, staff with nursing qualifications received considerably less training than others – perhaps because it is perceived that nurses learn enough about infection prevention and control during their professional training.
How well are care homes prepared for the forthcoming regulatory changes?

We asked care homes what management systems they had to prevent and control infections, including policies and procedures and performance indicators. We also assessed how well they were following two key pieces of national guidance.

We did not scrutinise these policies and procedures but asked whether staff found them useful. The quality and content of policy and procedure documents on infection prevention and control varied immensely, as did the way they were applied. Some care home managers were more familiar with their policies than others.

We also asked care homes whether they used indicators to track their performance on infection prevention and control. We would expect indicators on the number of infections, and compliance with hand washing and cleaning, as well as adherence to good practice around procedures such as enteral feeding (for people unable to be fed orally) and catheter management. The majority of respondents (61%) used no performance indicators at all, and those that did used them because they were required as part of the contracts with organisations that commissioned their services.

The two key documents that have been published by the Department of Health to help care homes meet essential requirements of infection prevention and control are Essential Steps and Infection Control Guidance for Care Homes – both published in 2006. These provide a framework for good practice in care homes, including preventing the spread of infection, urinary catheter care and enteral feeding. Essential Steps also provides a way of auditing compliance with its requirements. Our case studies showed that knowledge of this guidance was extremely variable; some homes were aware of it and had found it useful and relevant, whereas others, while aware of it, were not applying it. Some care homes were also confused over which document applied and whether one publication had superseded another.

Forty per cent of care homes that responded to our survey told us that they were not using Essential Steps. Those that were reported varying levels of implementation, with only 38% saying that they were using the measures recommended for safe urinary catheter care and only 21% implementing the steps relating to enteral care. These are important because enteral feeding is becoming more common in care homes and urinary tract infections are common in people who are catheterised. In addition, specialists in social care infection control who were in our Reference Group said that care homes may find it difficult to implement Essential Steps because they may not appreciate that it contains broader good practice guidance, despite its primary design as an audit tool.

A quarter of respondents to our survey were not using the Department of Health’s Guidance on Infection Prevention and Control for Care Homes, which includes advice on cleaning and decontamination, food hygiene, antibiotic prescribing and general infection prevention and control measures. Care homes that used this guidance were implementing it inconsistently. Sixty nine per cent of homes had implemented the recommendations on decontamination and cleaning, just over half (55%) followed the guidance on managing infections, including isolation, but less than a quarter (22%) had implemented the guidance on antibiotic prescribing and management. This guidance has been redrafted by the Department of Health and accompanies the consultation on the draft Code of Practice on healthcare associated infections and related guidance to help care homes meet the proposed registration requirements.
From 2010, care homes will be required to register with the Care Quality Commission and comply with a new version of the Health and Social Care Act 2008 Code of Practice on the prevention of care associated infections. When asked whether they were aware of the new requirements for registration and regulation by the Care Quality Commission, over half of respondents (55%) said that they were not. However, this is likely to have changed now because the study was carried out as the Care Quality Commission was being established and a number of events have been held and documents published for consultation which will have raised the profile of these requirements.
Introduction

Who is this report for?

We have written this report chiefly for providers of care – social care homes themselves, those who commission their services, and NHS healthcare providers. The report will also be of interest to policymakers and regulators at both national and local levels, because the findings could contribute to an evidence-based approach to regulating social care homes.

Background

Infections associated with healthcare have received much media and Government attention in the last five years, with infections such as Meticillin resistant Staphylococcus aureus (MRSA) and Clostridium difficile becoming familiar household names. However, infection prevention and control is not simply an issue for hospitals. Although the Department of Health’s strategies for preventing and controlling infections have focused on large hospitals, care homes play an important role in the transmission and management of infections. For people living in care homes in some developed countries, infection is a common cause of hospitalisation. People can enter care homes with organisms that they acquired in hospital that are resistant to antibiotics. These care homes can then become ‘reservoirs’ of infection. This, and the fact that many people living in care homes have frequent contact with healthcare services, has created a ‘revolving door’ situation, where people are re-admitted to hospital for conditions that could be managed within a care home. Residents of care homes are at particular risk of infection because of the following factors:

- The advanced age of residents.
- Underlying diseases.
- The transfer of patients between health and care settings, especially from a nursing home.
- Prolonged hospitalisation.
- Exposure to invasive devices.
- Exposure to antimicrobial drugs.

A study of care homes in Yorkshire showed that the following factors increased the risk of MRSA colonisation:

- Care homes with a low ratio of nurses to beds.
- Care homes in deprived areas.
- Being male.
- The use of invasive devices.
- Hospitalisation of more than 10 days during the previous two years.

Programmes for preventing and controlling infections are important in hospitals and care homes and they should address the complex care services provided. However, little is known about the impact of these programmes, especially at the interface between health and social care.

The Regulation of health and social care is changing significantly. The Health and Social Care Act 2008...
Code of Practice for health and adult social care on the prevention and control of infections and related guidance will apply to all providers in 2010 as a condition of registration with the Care Quality Commission. This system will replace the current regulatory system made under the Care Standards Act 2000 and national minimum standards.

The anticipated increase in the elderly population in the next few decades means that although social care is a growing industry, there is increasing pressure on both health and social care to manage costs. Measures to manage these costs, and to meet peoples’ wishes, have included increased home-based care, decreased numbers of hospital beds and people spending less time in acute healthcare facilities. This has resulted in the homecare and managed care industry becoming major providers of care.

Care homes face particular challenges in preventing and controlling infections:

- They are not healthcare facilities, they are people’s homes. Any control measures and regulation must therefore acknowledge this fact.
- Compared to hospitals, they have fewer resources and a smaller ratio of professionally qualified staff to care assistants.
- The organisational structure of care home providers varies immensely, ranging from national chains with hundreds of homes to individual small homes often owned and run by a single proprietor.

To shed light on this area, the former Healthcare Commission and the Commission for Social Care Inspection (both organisations have now merged into the Care Quality Commission), commissioned a short study with two aims:

- To develop a better understanding of how infection prevention and control is working in practice at the interface between registered social care homes and hospitals.
- To gather and share information that could help care providers prepare for the new arrangements for registration and regulation by the Care Quality Commission in autumn 2010.

Our study was underpinned by the principles and values of the Care Quality Commission, particularly:

- Working with others – a fundamental element of the research approach was to work collaboratively, openly and with the active participation of the four membership groups that represent providers of social care homes (English Community Care Homes Association, National Care Association, National Care Forum and the Registered Nursing Homes Association).
- Putting the people who use care services, and their families at the heart of the work – which meant involving an ‘expert by experience’ in the reference group for the study, and making sure we talked directly to people living in care homes and their families during our fieldwork.
- Focus on improvement – a key part of the research was to seek examples of good practice and to draw on the knowledge and experience of others, which can be shared more widely.

Our findings

Our findings present the common messages from our case studies and survey, highlight differences where we have found them, and include the stories of people living in care homes and the perspectives of health professionals. We have also highlighted examples of good practice and where homes have learned from their mistakes. Full versions of the case studies and the results of our survey are available on the Care Quality Commission’s website (www.cqc.org.uk).

These findings are structured under each of our research questions in the following five sections.
How is information shared between health and social care settings?

Good communication between health and social care professionals is crucial to make sure that somebody with an infection can be cared for properly and that the chances of an infection being passed on to other people are reduced. It is important that this information is sent to the right people at the right time so that they can act on it. For example, if somebody with diarrhoea is discharged from hospital to a care home, hospital staff must tell the care home’s staff about this so that suitable precautions, such as isolation and increased levels of cleaning, can be arranged.

Legal and contractual requirements

Providers of healthcare are obliged to provide information on infections to other professionals and to people in their care and their relatives. Although vital in ensuring good continuity of care, the sharing of information is governed by a number of pieces of legislation and guidance which, when considered together, make the issue somewhat complex (see Box 1). The legislation and guidance available on confidentiality, disclosure and data protection is clear. However, the responses we received indicated that staff responsible for providing information were sometimes confused about what they could and could not provide to third parties. Providers of care need to have clear policies concerning information governance, including information about infections, and these should be based on legal requirements and guidance. Staff who may be required to disclose information should be trained and supported to make these decisions.

We found some good examples of communication but, generally, communication between hospitals and care homes was not as good as it should be. A particular problem was that, even where information on an individual was communicated, it sometimes arrived at the care home weeks after the discharge date, drastically reducing its potential to prevent or control infections. It’s possible that, in accordance with NHS standard contracts, information is provided directly to the person’s GP. However, it is unlikely that GPs systematically review this information and feed it back to care homes in a timely fashion that would allow good infection prevention and control. Other examples described how care homes had to chase up and seek clarification from the discharging hospital because they were concerned about an individual’s apparent condition on their return. Many homes told us of problems they had when visiting a hospital to assess a new care home resident before they are discharged. Even though they were allowed access to the person’s files, they were unable to identify key information on infection status due to the quality or volume of the notes.
Box 1 – Legislation and guidance relating to information sharing

General duty of confidentiality
The common law duty of confidentiality requires that information is not disclosed without the consent of the individual, other than where required by legislation or where there is a robust public interest justification for disclosure. The person disclosing the information must be able to show that they have balanced the benefits of releasing the information with the rights of the individuals concerned and maintaining public trust in a confidential service.

The Data Protection Act 1998
Information about an individual must not be disclosed to other people, unless there is a legal or other overriding legitimate reason to share the information. The Data Protection Act makes it an offence for other people to obtain this personal data without authorisation.

Informed consent
Consent must be sought from a person before information about their care can be divulged to third parties. There are exceptions to this rule if the clinician thinks that, in the absence of consent, the person or other persons are put at risk. In such cases, they may waive this right and provide the information to third parties.

Standard NHS contract
This contract specifies the levels of service expected between organisations that commission healthcare services (primary care organisations) and those that provide them (hospitals). They clearly stipulate that a discharge letter and a copy of a discharge summary should be provided to the patient’s GP and the patient upon their discharge from their care. The discharge summary information should include information on infections, any immediate post-discharge requirement from the primary healthcare team and any other planned follow-up arrangements. This arrangement does not currently apply to care homes, yet local arrangements or policies should specify that this information be provided when a resident is transferred to another care setting.

The Health and Social Care Act 2008 and associated regulations
Among other requirements, these specify that any care provider should:

- Co-operate and share information with others involved in the person’s care, treatment and support, while having regard to people’s rights to confidentiality, particularly when they are sharing or transferring responsibility for care, treatment or support.
- Provide accurate and timely information on infections to any person concerned with providing further support or nursing/medical care to that person.
- Ensure that others are involved, including ambulance and other transport services, when developing joint plans to arrange the transfer of a person from one care setting to another.
Crucially, ambulance crews are often left out of the information loop, and often seemed to be considered as more of a transport service than as a healthcare service, even when dealing with an emergency admission. From our discussions with ambulance trusts, this may have arisen because most discharges from hospital are contracted out to independent patient transfer services. They are therefore not carried out directly by the hospital, except on the rare occasion that someone is discharged who is known to be very unwell.

Healthcare perspective

“The information disclosed to ambulance staff is usually restricted to the patient’s current problem and no information is usually given about their infection status, as staff regard that as breaching patient confidentiality.”

Ambulance trust infection control coordinator

The logistics of transferring somebody from a hospital to a care home or vice versa can be complex and involve many people, and verbal communication cannot always be relied upon. In addition, written notes preserve people’s confidentiality more than word of mouth and so should be used wherever possible.

In our survey, almost 300 (28%) care home managers raised concerns about hospitals’ communication when they discharge someone – especially providing illegible or inadequate papers.

Case study

Mr X broke his femur in a fall at home in his own flat. Up until then he had been active and mobile, coping well at home. After the fracture he remained in hospital for six or seven months and was then discharged from hospital into the care home with tuberculosis (TB), which was not reported in the hospital discharge summary, and identified subsequently by the care home staff. He became very frail and afraid, and was dependent on monthly blood transfusions, and eventually died after readmission to hospital. His death was the subject of a coroner’s inquiry in January 2009 when it was determined that the root cause of death was a TB infection contracted in hospital.

Use of discharge summaries

Standardised discharge information forms, as well as often being incomplete, generally did not include a specific section on infection status, even though this is specified in standard NHS contracts. This means that information on infection has to be included in the “other” box and relies on an individual remembering to include this information, rather than requiring it as a standard item.
Care home perspective

“Information on infections such as MRSA and *C. difficile* are not always communicated from the hospital.”

“The local hospital does not always inform us of the presence of infection and we have, in the past, found out by the medication the person is on. This stage of communication could be improved but sometimes Data Protection and confidentiality are quoted as the reason.”

“My experience has been that the healthcare professionals have insisted that they are discharging the person fully recovered. Within 12 hours we have had to get a GP out as the person has an infection. Recently this has happened three times in six months.”

“NHS transfer information is often inadequate, relying upon a ‘transfer letter’ which is only as good as the nurse or doctor who wrote it. No formal inter-healthcare infection control transfer form is used by hospitals in this area.”

“Sometimes discharge sheets from hospitals are duplicate copies that are illegible. This can make life very difficult, particularly if residents are discharged home late in the evenings.”

“I have on several occasions been sent an illegible pink discharge sheet which apparently informed me of an MRSA infection being present. I think it important to advise more clearly.”

“I feel sometimes the truth about infections is hidden, especially when transferred back home, as the acute beds are needed. Limited information is given on how to treat infections when discharged from healthcare.”

“There is an expectation from health professionals that social care workers have some nursing knowledge, so tend to assume a greater level of knowledge regarding infection control.”

*Care home managers*

Healthcare perspective

“This is an ongoing and widespread problem. Many acute trusts do not have specific discharge/transfer forms, and if infection status is included in the discharge letter, it is often sparse or illegible. If an infection status form is being used, it is usually a separate document, thus relying on someone to fill it out. However, “ward pressures” are frequently used as a reason not to introduce extra documentation.”

*Infection control specialist nurse*

Difficulties experienced by homes providing personal care only

We found that homes that only provide personal care often had more difficulties in obtaining timely and reliable information than those that provide nursing care. Homes that only provide personal care told us about having to rely on the district nursing staff for information about infection management, and tended to have the lowest levels of access to information when people are discharged from hospital.
How is information shared between health and social care settings? continued

**Healthcare perspective**

“As homes providing personal care generally have people who are less dependent, any information may be sent to the GP instead of to the home. This is the practice for people who are discharged back to their own homes.”

*Infection control specialist nurse*

Homes that only provide personal care seem to have a stronger ethos and focus on the rights and needs of the individual, but occasionally this may contribute to the problems of information flow. This is because staff may be more prepared to defer to a hospital’s decision not to share information, based on its claim of wanting to maintain confidentiality as part of protecting an individual’s rights. However, in nursing homes the rights-based ethos is sometimes less clear, and this seems to be linked to information flowing better. This could be partly because nursing staff are less likely to be deflected by a rights-based argument.

**Healthcare perspective**

“Information sharing from care homes to hospitals could also be improved. Though there may be a care plan for ‘revolving door’ patients, the colonisation status of a patient may not be known”.

*Infection control specialist nurse*

Many care homes escort their residents when they are admitted to hospital – particularly if it is during the day when there are more staff available, or if the person has dementia and is likely to be confused and distressed by the transfer. This seems to help effective communication, but care homes are unlikely to do this consistently, due to their reliance on resources and the availability of staff.

**Case study**

Mr R has *C. difficile*, which was contracted in hospital, and had been in an unsuccessful placement in a care home. He was re-admitted to hospital and his family had difficulties finding a care home that would take him. Staff from a home visited him in hospital to carry out an assessment and agreed to accommodate him. A room was set up for him, which is next door to a bathroom with incontinence flooring which has been isolated for use only by Mr R. Specific cleaning products are used to clean his room and the bathroom. Mr R is most at risk when he is taking antibiotics, so staff work very closely with his consultant infection control nurse and two consultant microbiologists at the hospital. If any clinical professional visiting him at the home identifies that he may need antibiotics, the staff encourage them to contact the infection control nurse so that options can be discussed.

**What helps good communication?**

We also found some examples of excellent communication between hospitals and care homes when people are discharged. However, these tended to be in services for younger adults. Younger adults often have lifetime needs (specifically, people with learning disabilities and some people with physical disabilities) so their care planning tends to be more comprehensive and structured. The frequency of movement between health and care settings for some groups of younger adults is likely to be less than older people. However, other groups, for example those with mental health or substance misuse needs, may move between different care settings more frequently.

Many care homes escort their residents when they...
Barriers to good communication

We do not think that poor communication is related to a lack of commitment or will on the part of staff in hospitals, but rather to the pressures of the wards being overloaded and understaffed. Many people who use services and their carers were unsure whether they should tell us about their concerns because they did not wish to be critical of health staff clearly doing their best in very challenging circumstances. Our discussions with healthcare-based infection control specialists seem to bear out these findings, indicating that current systems in place for recording and sharing information may often be inadequate.

Impact of data protection and confidentiality

People seemed to be confused about what data can be shared in relation to infection prevention and control, with regard to data protection and confidentiality, despite the fact that there is clear guidance on this subject, as outlined earlier.

Current policy on confidentiality and consent is clear that, subject to certain exclusions, any confidential information about a person should not be shared unless the provider can demonstrate otherwise. The NHS cannot infer a patient’s consent without allowing them to disagree or prevent their personal information being shared with others. Securing consent within one hospital may be relatively straightforward but implied consent is particularly difficult to justify when it involves sharing information outside the NHS. This may partly explain why homes that provide nursing care reported less difficulty in obtaining this information, since hospital staff may consider disclosing information on infection to a qualified nurse from a nursing home does not breach the guidance, as it is information shared between clinical peers. This confusion seems to be compounded by the perception held by hospital staff that care homes are reluctant to accept people with known infections.

Other initiatives have been developed to clarify practice in this area. For example, the Department of Health introduced its single assessment programme in recognition that many older people have wide-ranging welfare needs, and that agencies need to work together to ensure that assessment and subsequent care planning are effective, coordinated and involve people who use services. As part of this programme, guidance on sharing information locally is provided, including information on data sharing.

Healthcare perspective

“Results about positive infections and specimens are kept in patient notes in the form of laboratory reports, but may not always follow the patient through their journey. Some trusts have electronic access to laboratory results on every ward, but others are working from outdated systems and rely on hard copies, which are not necessarily filed correctly. Other sources of information are doctor and nursing notes, but these may not state the information needed in an easily accessible manner. Some patients have multiple volumes of notes, adding to the problem.”

Infection control specialist nurse
How is information shared between health and social care settings?  

**Healthcare perspective**

“There is confusion about data protection and confidentiality among hospital staff. This is an issue that is not addressed during data protection training. There is also sometimes a reluctance to share information as there are documented cases of homes refusing to take people with a perceived infection.”

*Infection control specialist nurse*

**Summary**

Our key finding is that hospitals and care homes do not have adequate procedures that are systematically implemented to ensure that information is transferred (particularly on transfer from hospital) reliably and at the right time, which always includes specific information on infection or colonisation status.
The Health and Social Care Act 2008: Code of Practice for the prevention and control of infections places duties on providers of care to provide information on infections to people in their care and their relatives. This information should include the general principles and policies related to infection prevention and control, help people to be aware and empower them to provide safe care, explain outbreak management and give information that is focused on the patient pathway or care plan.

Ways of sharing information

Care homes described different ways of sharing information with people living in their homes who have an infection. In our case study visits and in our survey, all homes emphasised the importance of verbal communication as the main way of sharing information – often stressing the importance of repeating messages, particularly when caring for people with cognitive impairment who may be easily confused and forgetful. Some homes used visual aids such as picture cards to help convey information, particularly when normal routines had been disrupted – for example when introducing isolation measures.

Case study

Mr Y, in his 80s, was admitted to hospital with chest-related problems from his own flat where he lived alone. He was discharged from hospital to the care home for respite and rehabilitation with the aim of returning home after three weeks. The hospital did not provide any information on his infection status, but the home suspected a MRSA infection, which was subsequently confirmed. Mr Y is on continuous oxygen and it seems less likely that he will be able to return to his own home as planned. When we interviewed him, Mr Y (who has no cognitive impairment) was aware that he had had “lots of infections” but did not seem to know that he had contracted MRSA specifically. He appeared to be feeling very low, and during the interview referred consistently to his desire to return home and his anxiety and uncertainty about when this might happen.

Some care homes, particularly those for younger adults, described using care plans as a way of structuring their discussions with individuals and family members, and making sure that the information is available in written form as well as verbally. Responses to our survey showed that once a person has moved into a home, 72% of homes used the care plan to share information with the individual and their family, with 80% also communicating the information verbally. As well as verbal and written updates provided routinely and when an outbreak occurs, 12% of the homes in our
survey described other means of keeping all their residents up to date on infection prevention and control matters. Examples included using regular meetings, and training and information sessions for residents.

Most homes stressed the importance of preventative practice, by explaining to residents how important regular and frequent hand washing is when living in a shared environment, and by helping them make more informed choices about washing their hands. Most care homes also involved family members in this, and explained the measures that would be taken in the event of an outbreak. Generally, this tended to be verbal communication with written material more likely to be provided only in the event of an outbreak.

Some homes told us that they relied on family members to find out about a residents’ infection status when they were not obtaining it from the hospital.

Case study
When there was an outbreak of TB in a care home, letters were sent to all the residents and their families, explaining what had happened and what people needed to do. The care home gave out leaflets to those who wanted more information and provided contact details for the TB nurses.

Case study
The home tells residents, and phones family members, about new infections, explaining the situation, and letting them know about any swabs or samples that are going to be taken and when test results are due. Staff will then contact the family again once the results have come through, explaining the planned treatment and care to family members, and discussing any concerns.

Many people living in care homes value regular visits and contact with their family members, so it is important that these relationships do not break down as a result of fear or misunderstandings about infections. Care homes placed a strong emphasis on verbal communication and discussion with family members, particularly where information about infection status might affect their visiting patterns or relationship with their relative. Some homes provided written information to family members to help explain some of the details of the infection and the care management arrangements they had put in place to protect the individual, other residents and visitors to the home.

Balancing the need to protect the rights of the individual with protecting others

Several care homes stressed the importance of sharing information about infections with other care home staff and with family members in ways that continued to respect an individual’s dignity and right to privacy. Some homes had such a strong culture and ethos around confidentiality that it might sometimes be difficult to manage the balance between protecting the rights of an individual and managing the risks of infection to other residents, staff and visitors. In some cases, homes used small, discrete stickers above the door of an individual’s room to alert staff and relatives to any particular measures they should take. Others described placing notices in the individual’s room, while others commented that the use of notices in rooms would be unacceptable. Clearly, managers of care homes need to consider how acceptable these measures are before implementing similar initiatives.
Healthcare perspective
“Patient confidentiality can be compromised by notices, etc, so these should be used with caution. Informed consent from the patient or resident should always be sought before sharing personal information, but in my experience this frequently does not occur.”

Infection control nurse specialist

Healthcare perspective
“There have been recorded instances of managers not really understanding the infection itself, and practice and care being compromised as a result – for example, a care home where the manager would not allow a MRSA colonised resident out of her room.”

Infection control nurse specialist

Resources to help share information
Care homes from our case studies described receiving (or copying) the information and resources they use to communicate about infections from a variety of sources, including hospitals, the local primary care trust, central services within their organisation, social services, and the internet. Similarly, care homes responding to our survey described using assessment forms and letters, notice boards, signs on doors, posters, health information packs and downloaded information from the internet. Clearly the quality and reliability of this information may vary, particularly for information downloaded from the internet, and will also depend to a degree on the knowledge and judgement of the member of staff using or interpreting the materials.

Summary
The main way of sharing information with residents and their relatives is verbally, but this should be supported with standard written information in suitable formats and languages.
What kinds of advice and support are available to care homes?

Clearly, care homes require reliable sources of good quality advice on infection prevention and control in order to develop effective policies and procedures and be able to react to incidents and outbreaks. In this section, we summarise the findings from our case studies and survey, which indicate the kinds of advice and support available.

Sources of advice and support

Care homes had very different experiences and resources when seeking advice and support on infection prevention and control. Some homes that were part of larger organisations described very good internal support. This often included:
- Access to ready drafted policy and procedural material.
- Access to internal specialist advice.
- Support on preventative approaches.
- Internal support and advice during an outbreak.

Our findings showed that homes seek advice from an external source:
- When they develop policies and procedures.
- On the care of individuals.
- In the event of an outbreak.

Advice about infection prevention and control needs to come from an authoritative source, such as a clinician or an infection control specialist. Where homes received external advice and support, they told us that the main sources were primary care trusts (70%), the Health Protection Agency (55%) and local authorities (37%). Local authority advisors are likely to include both environmental health staff and those who commission services, especially where joint commissioning arrangements with the primary care trust are in place.

Our findings suggest that services for older people dealt with infections most often, and were therefore clearer about where they would turn for advice in the event of an outbreak. Homes that had experienced outbreaks tended to describe a mix of advice and support, including GPs for diagnosis and medication, district nurses (personal care only homes) for day-to-day nursing care and advice, and local health protection units. A number of homes mentioned the local primary care trust, and some also mentioned their local authority commissioner.

Some homes had no experience of dealing with infections and their responses were hypothetical rather than based on experience, and referred back to their policies and procedures. Across our case studies, the staff we interviewed seemed to be clearer about what to do in the event of an outbreak if they had directly experienced one. Although some staff were not confident that they knew entirely what to do, they were confident about where to look for written guidance and who to call on for advice.
Seventy per cent of homes told us that they receive advice and support from a GP when there is an outbreak of infection in the home, and 81% when a resident with an infection requires care. More unexpectedly, 11% of homes said that they received help from a GP in developing policies and procedures on infection prevention and control.

Although there is some regional variation, larger homes are generally more likely to receive external advice from the Health Protection Agency (HPA) than smaller homes, which may be less aware of HPA services. It is worth noting that the Health Protection Agency practice varies across the country but it is not generally the major provider of routine infection prevention and control advice to care homes. Although still providing some locally delivered specialist advice, the Agency is now working with other agencies such as health trusts to convey advice and support rather than providing advice directly to homes.

**Availability and funding for advice and support when needed**

In our survey we asked homes if advice and support was available when they needed it. The majority of respondents (87%) answered “yes” to this question, but 13% said it was only available “sometimes”. The majority of homes (86%) did not pay for the advice and support they received, while a small minority (3%) did pay and 11% paid occasionally. Where homes did pay, the advice was most likely to be funded through the home’s general budget rather than through a dedicated budget or through an organisational budget.

Our findings suggest that the availability of proactive rather than reactive advice varied. All homes knew where they would seek advice from when an outbreak occurs, but a number commented that they would value more written updates on current good practice. Unsurprisingly, advice and support is requested and received much more frequently when there is an outbreak within the home or when there is an individual needing care. Homes also told us that they would appreciate general updates and information on equipment and materials as well as practice, although one home said that it was difficult to implement advice on new products because purchasing arrangements were centralised within the organisation.

**Healthcare perspective**

“There is a shortage of trained infection control nurses in our region and therefore there isn’t the capacity to take on care homes as well as the ordinary workload. Acute trusts and primary care trusts generally seem to have very little to do with care homes unless there is local agreement – it is very much a case of who the nursing teams are and what they are prepared to get involved in. There is very little joined-up local healthcare economy working in some areas – there are some GPs who still show a marked lack of understanding regarding healthcare associated infections and infection control.”

_Infection control nurse_

**Improving advice and support**

We also asked homes for their views on how advice and support could be improved. Over 450 homes responded to this question, including 113 (24%) who were satisfied with the levels of advice and support they receive.

There were also a number of suggestions for improvement:

- Dedicated staff, or an agency, or a helpline. Examples included infection specialist nurses, a GP, or case workers who could provide continuity (102 care homes).
What kinds of advice and support are available to care homes?  

continued

• Introducing written guidelines and updates that are regular, relevant, up to date, well publicised, simple and paper-based. These could be leaflets, newsletters, posters and booklets, including picture-based descriptions of procedures that would help residents as well as staff to understand (58 care homes).

• More training and education (47 care homes).

• More detailed information when people are being discharged from hospital to the home, to include the results of screening processes (42 care homes).

• An easily accessible website, online advice or portal with hyperlinks that can be used when staff work at weekends (29 care homes).

• Other suggestions included more preventative information and advice, and standardising the same recommended procedures and documents across different agencies.

Summary

Care homes have very varied experiences of advice and support, but overall there appears to be a need for more proactive and preventative advice, including advice in specialist areas – for example, tissue viability and continence.
How are care staff trained and supported in preventing and controlling infections?

Good infection prevention and control depends on the right people taking the right action to prevent a person’s condition deteriorating or passing on their infection to others. The measures needed to do this are not complicated, but staff need to have some background and competence to do this effectively and consistently.

Managers of care homes

Our findings suggest that positive leadership and good management within care homes are essential, irrespective of how the organisation is structured. The overall success of the home in preventing and controlling infection is therefore dependent on good leadership from the home manager, because care homes tend to operate as ‘stand alone’ organisations, even when they are part of a larger group or chain. This means that a focus on the manager’s competence, skills and knowledge in relation to infection prevention and control is particularly important if these are to be effectively shared with the care staff team.

Case study

The manager of a home that is part of a large national chain described her role in rebuilding the home’s reputation after the previous manager’s departure and intervention by the regulator and commissioners. A number of residents were now returning from temporary placements elsewhere, or from hospital after a period when the home had not been permitted to take any new referrals or residents discharged from hospital. Part of the problem had been caused by complacency from being part of a big infrastructure with good resources and reputation and an attractive and smart new building. The new manager needed to work hard to rebuild staff morale and confidence by providing a strong role model and assertive and directive leadership.

Other care staff

Nearly all homes responding to our survey reported that they train and induct staff in infection prevention and control – mainly through mandatory training and regular updates. Where training is provided by an external provider, this is most likely to be an independent provider (56%), the primary care trust (29%) or the local authority (26%).
Generally, most homes told us in our case studies and survey that, rather than learning the theory, it was more effective to carry out practical training, such as:

- On-the-job mentoring.
- Informal auditing.
- The use of tools, such as training DVDs.
- Role modelling.
- Mentoring.
- Regular refreshers and updates.

The topics most regularly covered in training were hand-washing techniques (95%) and day-to-day practice on the prevention of infection (94%). Care of people who have an infection was a training topic for 75% of homes and outbreak management for 71% of homes. The majority of homes (69%) reported training on the Department of Health’s *Infection Control Guidance for Care Homes* and 60% reported training on the Department of Health’s *Essential Steps* guidance. Other topics covered included:

- Food hygiene.
- Laundry services.
- Tissue viability and wound infections.
- Control of contamination.
- Infection control audit.
- Policies and procedures.
- Training on specific types of infection.

There were some comments in the survey on the consistency and levels of training for different staff grades and roles:

**Care home perspective**

“I think that within the Care national vocational qualification (NVQ), infection prevention and control should be a standard unit and not an optional or additional unit.”

“There seems to be no uniform level of required training, for example some care staff who have studied NVQ2 with a particular training provider have gone into infection control in much greater depth than those with another provider.”

“I feel that all staff should be trained in infection control.”

Our survey suggests that staff with nursing qualifications receive considerably less training on infection prevention and control than other managerial or care staff. The reasons for this are unclear, but it may be because managers, the nurses themselves, or both make assumptions that staff will have received sufficient infection prevention and control training during their professional qualification. However, these assumptions are flawed: many nurses will have trained a long time ago; infection prevention and control may not have been covered in sufficient depth during training; and, as with all staff, homes need to satisfy themselves that the knowledge of nursing staff is regularly refreshed and updated at the right levels.
Healthcare perspective

“Currently, training for nurses at university generally has a session of infection control each year, but this is not enough to cover in sufficient depth the level of knowledge needed.”

Infection control nurse specialist

Barriers to maintaining a well trained and competent workforce

A significant theme that emerged for many homes was the impact of high staff turnover, including managerial staff, and the difficulties in maintaining a fully trained workforce. All homes had mandatory training on infection prevention and control for the entire workforce, but some struggled to update existing staff when they had to prioritise training for newly arrived staff. This appeared to be an issue across the entire workforce and not just lower paid care staff.

A number of homes told us how important it is to translate training materials for staff whose first language is not English. Also, for some care staff it was important not to rely on their ability to read and write, but to provide training and information in a wider range of accessible formats, including for example DVDs, practical demonstrating and role modelling.

Case study

The manager of a care home ran her own internal training sessions for staff, which she opened up to a number of other homes that were part of the same organisation in her area. They reciprocated, and also shared practical, real life issues within the homes. This meant that training was distributed more consistently and frequently between the homes, the training material helped to tackle “live” issues that the homes were dealing with, and staff benefited by learning about the experiences and practices of other homes as well as their own.

Healthcare perspective

“Training is almost totally reliant on the management structure in care homes and mandatory training is generally around the basics of infection control, such as hand hygiene and universal precautions. There is scope for training to be extended into areas which would reduce the transmission of healthcare associated infections, but this may be limited by lack of resources or specialist trainers.”

Infection control nurse specialist

Sick pay was also a critical factor, although this did not apply in the one public sector run scheme included in the sample. Staff in some homes will not be paid if they do not come to work because they think they may be infectious. There is therefore an in-built perverse incentive for lower paid care staff to come to work when carrying infection. The risk to others is linked to the type of work that somebody carries out. Therefore, anyone recovering from an infection can carry out duties that present a lower risk of transmitting it to residents or staff – although this may present problems in very small care homes.
How are care staff trained and supported in preventing and controlling infections? continued

Case study
The manager of a care home told us that she was sympathetic to the financial problems faced by staff when they ring in sick. She therefore manages the rota flexibly, so that if a member of staff behaves responsibly when ill, she ensures that they are able to make the time and money up when they are better.

Summary
The overall success of a care home in preventing and controlling infection depends on good leadership from the home's manager, as care homes tend to operate as 'stand alone' organisations, even when they are part of a larger group or chain. It is therefore important to focus on the competence, skills and knowledge of the manager in relation to infection prevention and control in order to 'cascade' good practice throughout the care staff team.
How well prepared are care homes for the forthcoming regulatory changes?

Until 2010, infection prevention and control in care homes will be judged against the requirements of the Care Standards Act 2000 and the national minimum standards. However, during 2010, care homes will be required to register with the Care Quality Commission against a range of regulatory requirements, including one relating to infection prevention and control. In addition, the Department of Health has published two documents to help care homes meet existing requirements and expectations on preventing and controlling infection – Essentials Steps and Infection Control Guidance for Care Homes (under revision and subject to consultation), both published in 2006.

This is a major change to the way this area is regulated in the social care sector and we asked care homes a series of questions to assess how prepared they were for it. These included questions on:

- Policies and procedures.
- Use of performance indicators.
- Implementation of existing guidance from the Department of Health.
- Awareness of the forthcoming regulatory requirements.

Policies and procedures

Applying policy and procedure on infection prevention and control seemed very variable. While some managers were familiar with their policy documents and could refer to them with familiarity and ease, others struggled to locate them, and were clearly not very familiar with their contents. A number of managers told us that they and their staff did not need to refer regularly to the procedures because they knew them thoroughly through their training. They said that they would only refer to them in the event of an outbreak when they might need more detailed information. This indicates that regularly updated training is a more effective and safer way of implementing policy and procedure than relying primarily on policy manuals.

The quality of policy and procedure documents shown to us during our visits varied immensely – some were extensive and detailed, and others concise; some were written in clear English and others were very formal; some were clearly audited and updated, and for others it appeared that just the date had changed when reviewed. Some smaller providers had possibly put unnecessary work into ‘re-inventing the wheel’, but at least they had a strong sense of ownership of their policies and procedures.
Case study
The manager described the ‘update weeks’ the company runs regularly across all its homes. For that particular week, the home concentrates on updating their knowledge on a particular area (such as infection prevention and control) going through an update briefing at team meetings, practicing certain tasks under supervision and undertaking fun activities such as quizzes on the topic to reinforce learning and with a potential prize.

Use of performance indicators
Our survey asked care homes if they used any performance indicators to help them manage infection prevention and control. Examples we gave as prompts were the number of people with catheters who developed a urinary infection, and monitoring the number of cases of *C. difficile* over time. The majority (61%) of homes did not use performance management information.

The care homes included as case studies described using performance indicators for a number of reasons:
- To inform and improve practice.
- To manage and minimise risk more effectively.
- To improve internal management at organisational level.

Around 15% of homes responding to our survey used performance management information – usually because they were required to in their contracts with commissioners. Of these, 43% were contracted by social services departments, 36% by primary care trusts and 21% by other bodies, largely related to internal performance monitoring systems.

Implementation of the Department of Health’s guidance *Essential Steps*

*Essential Steps* is practical guidance on infection prevention and control, developed and published by the Department of Health with social care providers in mind. We asked homes whether they knew about *Essential Steps*, and if so, whether they applied it within the home. During our case studies we found that knowledge of the publication was extremely variable – some managers were familiar with it, had found it useful and relevant, and had it to hand, whereas others were aware of it, but were not applying it. Some homes in larger groups and chains relied on other staff in the organisation to incorporate the guidance within their organisational policies and procedures, and assumed that central staff would be aware or the publication.

In our survey, the majority of homes (60%) told us that they were implementing the guidance in *Essential Steps*, but a significant minority (28%) were not, and a further 12% were not aware of the guidance at all. Specialists on social care infection control who were involved in our Reference Group commented that homes may find it difficult to implement *Essential Steps* because it is primarily designed as an audit tool, and they may not feel that they have the skills and knowledge to apply it effectively for audit purposes. These comments seem to be supported by similar views from health practitioners, and may mean that care homes do not realise that there is broader good practice guidance within the publication.
Healthcare perspective
“Since Essential Steps is essentially an audit tool, there has been a reluctance to implement it in some areas. Its uptake could do with being higher, as the information behind it is robust, and although it is currently being reviewed by the Department of Health, its format is unlikely to change.

*Infection control nurse*

Those homes implementing the guidance told us that they mainly used Essential Step 1 – Preventing the Spread of Infection (81%) and the Self Assessment tool (71%). Only 38% of homes used Essential Step 2 – Urinary Catheter Care, 30% used the review tools and only 21% used Essential Step 3 – Enteral Care. These findings on homes using Essential Step 2 and 3 are concerning, since these are key, although less widely acknowledged, areas of care associated infection. The rates of urinary tract infections are not generally publicised, so high rates can go unchecked, despite the fact that with good practice, infections associated with short-term catheter use can be relatively easily controlled.

Healthcare perspective
“In care homes, urinary tract infections and wounds are possibly the largest healthcare associated infection risks. Enteral care is another forgotten area. All three of these can easily become a sepsis issue resulting in bacteraemia. Unfortunately because of the high publicity surrounding MRSA, bacteraemia from other pathogens tend to go unpublicised.”

*Infection control nurse specialist*

Implementation of the Department of Health’s Infection Control Guidance for Care Homes

Similar patterns were apparent for the Department of Health publication, *Infection Control Guidance for Care Homes*[^2], and some homes in our case studies were not clear which was which or whether one had replaced the other. This shows how important it is to continue to promote a targeted publication after its initial launch, particularly in this sector where turnover of managers is high, and staff can miss out on key information as a result of job moves or promotion. This guidance is currently subject to revision and public consultation due to end in November 2009.

In our survey, a higher proportion (75%) of homes told us that they had read the guidance, but a still significant minority of 17% had not read it and a further 8% were not aware of it at all. Smaller homes, in particular, were less likely to be aware of this guidance.

Of the homes implementing the guidance, 97% were applying the element on infection prevention and control, 85% the element on food hygiene, 69% the element on decontamination and cleaning, and 55% the element on managing infections, including isolation.

However, only 22% had used or implemented the antibiotic prescribing and management element. This is a matter for concern because, although care homes are not responsible for prescribing, they do play a key role in the management of antibiotic use and reliable knowledge is essential for both their own practice and to challenge poor practice by other agencies.

Care home perspective

“We had an infection in 2008, and for the first time monitored the spread of the infection, had an audit trail of whom we contacted, and an action plan etc, which was very effective and kept everyone informed.”

“We have developed a protocol for enteral feeds in line with Essential Steps and are currently working on a protocol for room decontamination.”

“Our laundry system was commented on as excellent with the Health Protection Agency last year. We have a dirty and clean entrance with a walkway which they commended us on.”

“We have introduced a ‘grab bucket’ on each level within the home. The bucket contains all the essential equipment to deal with an incident that may involve clearing up bodily fluids. This allows staff to access the equipment they need immediately.”

“We have recently had a tenant who has been diagnosed with bone cancer and the team has worked well with Cancer Research Technology Limited and the consultant at the hospital to ensure that guidelines have been put in place for control of infections if any.”

Awareness of forthcoming changes to the regulation of care

Only 45% of survey respondents were aware of the forthcoming changes. There were lower levels of awareness in:

- Homes for younger adults with drug and alcohol care needs.
- Smaller homes.
- The East and West Midlands.

Of those who knew about the forthcoming changes, most (88%) were aware of the specific changes for their home. Where homes were aware of the forthcoming changes, their sources of information were the Department of Health (36%), Commission for Social Care Inspection (29%), primary care trust (16%) and the local authority (9%).

Preparing for change

In our survey, we asked homes about the support they might need to help them prepare for the new arrangements. Over 600 respondents wanted help, including training, clear and concise guidelines, and help with preparing for an outbreak.

We asked homes for any examples of good practice they wanted to share (see above).

Summary

The existing guidelines that are designed to help care homes improve infection prevention and control have not been implemented widely or comprehensively, and knowledge of the forthcoming changes in regulation is not widespread across the care home sector. Care homes have expressed a need for more help with preparing for the forthcoming changes.
Appendix 1: Methods

There were two main elements within the study which were:

- A small number of case studies.
- A web and paper-based survey of a larger number of care homes.

Because of the variation among care homes, we had to ensure that different types of care homes were represented in the case studies and the surveys, so that we got a good balance between homes for older and younger people, larger and smaller homes, homes from a good range of different types of owner and organisation and homes from different regions of the country. This was done using data from the former Commission for Social Care Inspection (CSCI).

**Case studies**

We undertook 13 case studies of care homes, the first of which was used as a pilot study to refine our approach to the following 12. The care homes were selected by drawing a sample from CSCI’s database. The sample included homes providing care for both older and younger people and the make up of the sample is detailed in Appendix 2. Personal and nursing care delivered in service users’ individual homes or adult placements was specifically excluded from the sample as the context in which these services are delivered and the challenges they raise differ from those faced by care homes.

The sample was designed to reflect the national composition of care home provision contained in CSCI’s database. It targeted homes that had done either particularly well, or had problems in the past on managing infection, using CSCI’s inspection ratings based on the National Minimum Standards as an indicator (Standard 26 Hygiene and Infection Control in homes for older people and Standard 30 Hygiene and Control of Infection in homes for younger adults). Participating homes were all guaranteed confidentiality subject to our ethical and data protection protocols.

Within each case study, our aim was to research the network of healthcare surrounding each home with a specific focus on the way infection prevention and control was being managed at the interface with different healthcare providers.

This included:

- Hospitals providing both acute and rehabilitative services.
- Ambulance trusts.
- Mental health trusts.
- Hospices.
- GP services.
Each case study also involved gathering perspectives from health practitioners, including infection control specialists and social care commissioners. During each case study, we visited each home and interviewed the manager and other key staff. We also talked directly to people living in the home who had experienced infection and to family members where possible.

**Survey**

We asked all care homes to complete the questionnaire either online or on a paper form with a freepost return address. A request to participate, with an electronic link to the survey and information on the paper version, was sent out by CSCI to all homes on its electronic mailing list – approximately 12,000 care homes, and 70% of all homes registered. Because this could distort the response to exclude homes less likely to use electronic communication, the reference group membership organisations also sent out paper-based briefings and paper copies of the form to their members. The survey was anonymous, although we asked for postcode information to help with regional mapping and to ensure there was no double counting. Participating homes were all guaranteed confidentiality subject to our ethical and data protection protocols.

The survey ran for a six-week period from 13 March to 27 April 2009. The questionnaire was completed by home managers or the person with lead responsibility for infection prevention and control within the home. We reviewed the profile of surveys returned on a weekly basis to ensure the response pattern was broadly similar to the profile of homes registered with the CSCI, and towards the end of the survey period we asked the membership organisation to send out briefings, which targeted types of homes that were under-represented. As a result we received 1,064 survey returns in total from a profile of homes broadly in line with the profile of homes registered with CSCI. This represented around 4% of care homes in England, which was deemed to be a sufficient sample size from which to draw statistical inference.

**Social care reference group and project steering group**

To ensure that social care providers were actively involved and able to collaborate with us from the outset, we established a reference group which involved an ‘expert by experience’ nominated by CSCI and representatives from each of the four membership organisations – English Community Homes Association, National Care Association, National Care Forum and the Registered Nursing Homes Association. This group acted as advisors as we designed the research tools, publicised the research among their membership and encouraged members to participate, including some follow-up publicity to make sure the survey response was representative, and helped us to review and validate the findings and recommendations. The reference group also helped us to pilot the survey questionnaire. Detailed membership of this group is provided in Appendix 3. A project steering group was convened, comprising both health and social care professionals to ensure a balanced perspective to the work. The membership of this group is described in Appendix 3.

**Methodological challenges**

To the best of our knowledge, this is the first attempt to research the arrangements for infection prevention and control at the interface between social and health care – an area where the continuity and quality of care can easily break down. Our study has provided a wealth of new information on the experiences and perspectives of care home providers in preventing and controlling infection.
Our study was designed and carried out in a short timescale, in order to give our findings in time to help social care homes and other care providers prepare for the publication of the new Code of Practice on infection prevention and control, which will apply to care homes in 2010. In addition, we will present our detailed findings to the Department of Health as part of the consultation on the new Code of Practice. Due to the timescale and because we are the first to study this area, there are inevitably limitations. However, we have sought to ensure that our findings are as accurate as possible in the following ways.

- Although we gathered information from both health and care professionals, our focus was very much on the experience and perspectives of social care home providers themselves. We thought this balance of emphasis was important and necessary for two reasons:
  - Firstly, because there is so little objectively recorded (as opposed to anecdotal) information on infection prevention and control within social care homes and at the interface of their work with healthcare providers.
  - Secondly, because the findings from this study will contribute to building an evidence base for regulating the future of care homes.

- Because of the relatively short timescales and the importance of encouraging smaller, and less-resourced homes to participate, we had to keep the survey form brief (to be completed in less than 20 minutes) and easy to complete without reference to other documents or data. This meant that we had to keep the number of questions to a manageable level, for example asking one general question where, in an ideal world, we would have asked five or six more detailed and specific questions on that topic.

- Although we received over 1,000 survey forms and achieved our response targets for statistical reliability and validity, we still do not know how these findings may differ from those who did not participate. We can infer, however, that those who responded may have more interest in infection prevention and control, or more awareness of the forthcoming changes, which motivated them to take part. This may well mean that the wider group of people who did not respond to our survey have lower levels of knowledge and awareness, and therefore the needs of social care homes that we have identified within our findings may in fact be understated.

- The responses from smaller care homes (those with 20 or less places) and privately owned homes were slightly under-represented. We think it is likely that these groups may also overlap considerably, as individually owned private homes tend to be smaller. This means that the needs of smaller, privately owned homes in particular may also be understated in our findings.

We anticipated that care providers might have concerns and anxieties about the impact of our research and its effect on their work, and others might be unaware of the forthcoming changes in regulation and therefore see the research as not being relevant to them. Most challenging of all was the fact that the main task in care homes is to provide full-time care in often pressured circumstances, therefore motivating people to fill in a voluntary survey, whether online or on paper would not necessarily be easy. However, we succeeded in achieving a good number of responses. The assistance and support of our Reference Group members was crucial in helping us to address these challenges effectively.
Appendix 2: Details of our case study sample

<table>
<thead>
<tr>
<th>Case ref</th>
<th>Group Description</th>
<th>Size</th>
<th>Region</th>
<th>Type</th>
<th>Ownership</th>
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<tbody>
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<td>North East</td>
<td>Care home with nursing</td>
<td>Private</td>
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<td>Voluntary</td>
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<td>South West</td>
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<td>Private</td>
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<td>Care home with nursing</td>
<td>Private</td>
</tr>
<tr>
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<tr>
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<td>Residential care home</td>
<td>NHS</td>
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<td>Category</td>
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<td>-------------------------------</td>
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<tr>
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<td>Learning disability</td>
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<td>Yorkshire and Humberside</td>
<td>Residential care home</td>
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<tr>
<td>13</td>
<td>Physical disability</td>
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<td>Residential care home</td>
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</tbody>
</table>
Appendix 3: Acknowledgements

To ensure good participation, to develop appropriate research design and data collection methods and to help validate our findings, we convened a social care reference group. We are very grateful to the members of this group for their help and support throughout the study. The membership of this group was:

- Lilias Gillies – Expert by experience (nominated by the Commission for Social Care Inspection).
- Des Kelly, Executive Director of the National Care Forum.
- Ann MacKay, Director of Policy; Suzanne Morris (Care UK); George Sampson and Sherin Hart (Methodist Homes for the Aged) and Glenda Edwards (Nightingale House) all part of the English Community Homes Association.
- Sheila Scott, Director of the National Care Association.
- Frank Ursell, Chief Executive and Ian Turner, Chair, Registered Nursing Homes Association.

We are particularly grateful to homes from the Registered Nursing Homes Association, 12 of whom completed the draft survey form and gave us detailed comments and practical feedback, which helped us to make the form more user-friendly and our questions more effective.

We were also supported throughout the life of the study by a small Steering Group convened by the former Healthcare Commission and former Commission for Social Care Inspection, comprising both health and social care professionals to ensure a balanced perspective to the work. The membership of this group was:

- Christine Braithwaite – Head of HCAI Inspection Programme, Healthcare Commission (until 31 March 2009).
- Anne Close – Clinical Advisor, Healthcare Commission/Care Quality Commission.
- Professor Barry Cookson – Director, Laboratory of Healthcare Associated Infection, Health Protection Agency.
- Dr Rekha Elaswarapu – Older People Strategy Lead, Healthcare Commission/Care Quality Commission.
- Nigel Ellis – Head of National Inspection and Assessment, Care Quality Commission from 1 April 2009.
- Richard Elson – Development Manager (Healthcare Associated Infections) and Project Sponsor Healthcare Commission/Care Quality Commission.
• Amy Hopwood – Lead Analyst Commission for Social Care Inspection and then Performance Analytics Manager Care Quality Commission.


• Ginny Storey – Head of Quality and Health Policy, Commission for Social Care Inspection until 31 March 2009 and then Head of Care and Clinical Governance, Anchor Trust.

This work was carried out on behalf of the Care Quality Commission by the following members of Tribal Consulting Limited.

• Jackie Gallagher.

• Janet Clark.

• Dr Heather Heathfield.
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