Policy for the development, ratification, publication, maintenance and storage of antimicrobial guidance.

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<tr>
<th>Approved By:</th>
<th>Policy and Guideline Committee</th>
</tr>
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<tr>
<td>Date Approved:</td>
<td>January 2014</td>
</tr>
<tr>
<td>Trust Ref:</td>
<td>B28/2014</td>
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<tr>
<td>Author / Originator(s):</td>
<td>Lead Antimicrobial Pharmacist, Kate Dawson</td>
</tr>
<tr>
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</tr>
<tr>
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REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

March 2016 – no changes

KEY WORDS

Policy for Antimicrobial Guidance
Developing and Approving Antimicrobial Guidance
AWP guidance ratification process
UHL Antimicrobial Guidance

SUMMARY

1.0 This policy sets out the process for developing, approving, publishing and storing antimicrobial guidance documents.

2.0 Antimicrobial Guidance is guidance which simply recommends the use of an antimicrobial, and whose remit does not extend beyond this.

3.0 All AG’s should use a UHL antimicrobial guidance template when submitted for approval (appendix1).
1 INTRODUCTION

1.1. This document sets out the University Hospitals of Leicester (UHL) NHS Trusts Policy and Procedures for the ratification, publication, maintenance and storage of UHL Antimicrobial Guidance (AG’s). For the purpose of this policy a ‘UHL Antimicrobial Guidance’ is guidance which simply recommends the use of an antimicrobial, and whose remit does not extend beyond this.

1.2. A formal process is required for the maintenance of UHL antimicrobial website contents where AG’s are maintained and published. AG’s will help clarify operational requirements and bring consistency to day to day practice. In addition they can improve the quality of work and increase the successful achievement of objectives.

1.3. A common format and approval structure for such guidance helps to reinforce corporate identity and, more importantly, helps to ensure that AG’s in use are current and reflect an organisational approach.

1.4. A standard format will also avoid confusion and to assist staff (and patients) in following the Antimicrobial Working Party (AWP) requirements. Equally important is the use of plain English and the avoidance of jargon.

1.5. It is the responsibility of the AWP to ensure that all AG’s are appropriately evidence based, rigorously developed, formally approved, effectively implemented and routinely monitored and reviewed.

2 POLICY AIMS

To provide a robust assurance framework and practical system for the management of UHL antimicrobial guidance.

2.1 The aim of this policy is to ensure that guidance documents available on the antimicrobial website are fit for purpose by:

a) Providing a clear process for robust development and consultation of all AG documents.

b) Ensuring that the template (appendix 1) is used for developing UHL AG.

c) Setting out the appropriate approval and publication process for all AG.

3 POLICY SCOPE

3.1 This Policy applies to all members of staff working within UHL who are involved in any aspect of AG development, the members of the Antimicrobial Working Party, and the persons responsible for the contents and maintenance of the UHL Antimicrobial Intranet site (AIS) titled ‘Guide to Antimicrobial Use at UHL’.

3.2 This policy applies to all AG documents used in the Trust.

3.3 The policy does not apply to the development and approval of guidelines whose remit extends beyond simply recommending the use of an antimicrobial in a specified clinical situation. These should be reviewed and approved in accordance to Trust Policy for Policies. (Ref B16/2004);

3.4 This policy covers all UHL AG which relates to patient care throughout the Trust.

4 DEFINITIONS

For the purpose of this policy ‘UHL Antimicrobial Guidance’ is any guidance which recommends the administration of an antimicrobial to a UHL patient.

In line with the UHL definitions:
Antimicrobial

A general term for natural or synthetic compounds which at certain concentrations inhibit growth of, or kill, micro-organisms. The term antimicrobials is a collective for anti-virals, anti-bacterials, anti-fungals and anti-protozoals.

Guidance

A document that sets out the preferred method of operation. Other methods are not prohibited but a reason for deviation from the guidance should be fully justifiable and agreement from senior staff sought in all cases of any doubt.

Guidance is mainly used in the clinical setting where they provide a clear indication of the best choices for the management of a patient’s clinical condition.

Guidance should relate to an overarching policy but may be stand alone. Again where more specific clinical detail is required this should be contained within a supporting procedural document.

5 ROLES AND RESPONSIBILITIES

Responsibilities within the Organisation

5.1 Executive and Operational Responsibility

The Executive Director responsibility for this policy shall be the Medical Director and he shall notify the Trust Board of any matters or issues regarding this policy. The AWP is chaired by the Deputy Director of Infection Prevention.

5.2 Director of Infection Prevention

Challenge non-compliance with this policy (inappropriate practice and inappropriate antibiotic prescribing decisions)

Assess the impact of this policy on infections and make recommendations for change.

5.3 Corporate and Clinical Management Groups

5.3.1 Directors, Clinical and Managerial Leads for Corporate Directorates, Clinical Management Groups, Microbiology Consultants, ID physicians and Antimicrobial pharmacists are responsible for identifying the need for antimicrobial guidance documents that support specialist practices in the Trusts and their CMGs. In addition for ensuring that any such documents are developed in line with this policy and that the guidance within the document is in line with any existing Trust-wide guidelines.

5.3.2 CMG Medical Leads and Managers are responsible for ensuring that processes for agreeing antimicrobial guidance in their areas fulfil the requirements of this policy.

5.4 Committee/Service/Individual requesting antimicrobial guidance

5.4.1 The need for development of an antimicrobial guidance will normally be identified by either a service or the AWP committee. The lead consultant clinician of the service must oversee the development of the guidance.

5.4.2 The lead consultant clinician, lead consultant microbiologist and CMG pharmacists are responsible for addressing any implementation issues with support and advice from the antimicrobial pharmacists.
5.4.3 Authors and/or CMG medical leads (as appropriate), are responsible for establishing the monitoring process of the final AG.

5.5 Antimicrobial Guidance Authors

5.5.1 AG authors take overall responsibility for the development, consultation, approval and dissemination of their guidance documents.

5.5.2 In most cases, but dependant upon the AG scope and subject, there would also be a microbiology/ID Physician, antimicrobial pharmacist author in which case both would be responsible for the following:

5.5.3 Ensuring that there is appropriate representation of 'experts' in the development stage

5.5.4 Ensuring robust evidence and national guidance documents such as NICE are used to inform the AG recommendations where applicable

5.5.5 Ensuring the consultation is wide and involves all necessary staff groups and specialties

5.5.6 The AG authors are responsible for implementation of the AG including identification and actioning of any training, financial or other implementation issues.

5.5.7 Ensuring dissemination of approved guidance to all necessary staff groups

5.5.8 Identifying appropriate timescales and lead for review of the AG

5.5.9 The AG authors are specifically responsible for ensuring the document content and layout meet the standards as detailed in Appendix 1 of this policy.

5.6 UHL Staff Members

5.6.1 Whilst all members of staff are responsible for being aware of policies and guidelines relevant to their area, the following specific roles and responsibilities will only be relevant to those directly involved in the development and approval process.

5.6.2 All UHL staff are responsible for informing relevant managers and clinical leads if there are any implementation or compliance issues with newly developed AG and for participating in the monitoring of compliance as applicable.

5.7 UHL Policy and Guidelines Committee

5.7.1 The Policies & Guidelines Committee (PGC) reports directly to the Executive Team.

5.7.2 The Committee is responsible for reviewing this policy and approving trust-wide policies and procedural documents.

5.8 Trust Infection Prevention Assurance Committee (TIPAC)

The TIPAC should be informed of any non-adherence issues to this policy, specifically:

- any AG out of date that has not been reviewed in a suitable timely manner without a valid reason.
- deliberate and consistent non-adherence to AG by prescribers/CMG’s.

5.9 Antimicrobial Working Party

5.9.1 The AWP reports directly to the TIPAC.
5.9.2 It is responsible for reviewing all AG and either approving them for adoption, (with or without further amendments), or not approving them.

5.9.4 It is responsible for ensuring that authors of AG’s are reminded when AG review dates are forthcoming and to monitor the timely review of AG’s.

5.9.5 The Terms of Reference and Membership of the AWP are in Appendix 2.

5.10 Antimicrobial website manager/administrator

5.10.1 Must be competent in using the websites latest technology and computer programme, and also be aware of Trust governance arrangements for the storage of guidance documents.

5.10.2 Responsible for ensuring effective administration of the UHL antimicrobial website e.g. the timely uploading of revised guidance, removal of out of date or inaccurate guidance, additions to the past development section and the alert/news section.

5.11 Antimicrobial meeting lead

To co-ordinate and manage the AWP workload, and provide administrative support to the AWP meetings.

6 POLICY STATEMENTS, STANDARDS*, PROCESSES*, PROCEDURES* AND ASSOCIATED DOCUMENTS

This policy details the process for the ratification, maintenance, publication and storage of UHL Antimicrobial Guidance.

Prior to commencing development of a new AG, confirmation should be sought, as to whether a similar AG is already under development, or is planned; also to identify whether any related or overlapping Policy and Guideline exists.

In order to confirm the above, one of the following must be contacted:

a) Antimicrobial website manager or administrator (refer to AIS for upto date contact details)

b) Antimicrobial Pharmacists or Lead Consultant Microbiologist for the hospital site/clinical area.

The AG template (Appendix 1) must be used to confirm that all aspects of AG development have been appropriately considered.

Any antimicrobial guidelines or guidance the Trusts PGC receives should be referred to the AWP.

If the AWP receives any antimicrobial guidance or guidelines that are relevant for the Trusts PGC to receive, it should be cross referenced to note AWP approval prior to its referral onto the PGC.

All AG must be co-authored or reviewed with a nominated consultant microbiologist /ID Physician prior to submission to the AWP.

New AG’s to be submitted, with a completed template (Appendix 1), to AWP meeting lead for submission to the next AWP meeting for ratification.

AG’s to be reviewed every 3 yearly. AWP meeting lead to send authors a review reminder 3 months prior to the next AWP meeting. Authors to submit new versions (or versions stating no amendments), with a completed template (Appendix 1), to the AWP.
meeting lead 1 week prior to the next AWP meeting, for submission to the AWP meeting and ratification.

6.1 Legal Implications of Policy and Guidelines Documents
Authors of AG’s (both at drafting stage and at review stage) should consider the legal implications of any practices introduced, authorised, or prohibited. For further advice contact: Head of Legal Services on 0116 258 8960.

6.2 Legal Liability Statement for use in Guidance Documents
Guidance issued and approved by the Trust are considered to represent best practice. Staff may only exceptionally depart from any relevant Trust guidance and always only providing that such departure is confined to the specific needs of individual circumstances. In healthcare delivery such departure shall only be undertaken where, in the judgement of the responsible healthcare professional it is fully appropriate and justifiable - such decision to be fully recorded in the patient’s notes.

6.3 Approval, Adoption and Registration of AG
6.3.1 All new AG documents need to be submitted to the AWP via the AWP meeting lead.
6.3.2 Any AG submitted for approval, must have been through an appropriate review and consultation process beforehand.
6.3.3 All new AGs, must be formally approved and given an AWP Reference Number before being implemented.

6.4 Process for Submitting Antimicrobial Guidance documents for Approval
6.4.1 All submitted AG document must be accompanied by a completed:
   a) AG Template (Appendix 1)

6.4.2 Equality Issues
   a) When drafting AGs, due care should be taken to ensure they do not contain or could be interpreted as containing any matters of a discriminatory nature, including but not limited to age, sex, race, culture or sexual orientation.
   b) The AWP prior to ratifying an AG will ensure if an adverse impact is likely a full impact assessment should be undertaken with support from the Service Equality Team (ext 4382). Any changes made as a result of the impact assessment need to be consulted on (UHL’s Service Equality Panel undertake this function) and the full impact assessment published alongside the policy.
   c) The AIS to include the following statement to confirm that an Equality Impact assessment has been carried out:

   The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

   As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.
6.4.3 Consultation

a) All AGs being submitted to the AWP for approval must have the consultation section of the AG template completed (Appendix 1)

b) Consultation should specifically include key stakeholders.

c) Where consultation has been included as part of a meeting, this should be clearly documented.

d) If the AG has an impact upon patients or is a major departure from current practice, patient or patient representatives must form part of the consultation process as required by section 242 of the Health and Social Care Act (2001).

6.4.4 Dissemination of AG’s

The responsibility for dissemination remains with the authors. The AWP meeting lead will email lead authors, CMG medical and pharmacy leads raising awareness and encouraging staff to read the document. Antimicrobial website manager or administrator to upload new version, complete past developments section of AIS and if applicable the news section on front page. Lead authors to further disseminate to other relevant colleagues via email, making them aware of the new version is available on the AIS.

Although all AGs should be uploaded onto antimicrobial website for immediate accessibility, it cannot be assumed that all staff will be aware of the new / revised version.

6.5 Process for Approving AG Documents

6.5.1 Following review of the AG document, the AWP will either:

a) Approve in full

b) Approve subject to minor changes

c) Not approve it – changes to be made and AG to be resubmitted for future AWP’s review

6.5.2 Trust P&G Documents Requiring Urgent Approval

a) Where there is a Trust-wide policy or other guidance document that needs to be ‘fast tracked’ due to clinical expediency or legal requirements, the Chair of the AWP should be contacted via AWP Meeting coordinator.

b) When sending the AG for Chair’s action, the author also needs to provide the relevant completed paperwork, (Appendix 1).

c) Once contacted, the AWP Chair will confirm the necessity of fast-tracking and ensure there is clarification about the development process of the document. The Chair may suggest that specific consultation or input from other relevant AWP members is also sought as a matter of urgency.

d) Following review of the AG and supporting documentation, in collaboration with other AWP members as applicable, the Chair would then be able to advise whether the AG document met the agreed criteria for approval. Full review of the AG will then take place at the next AWP meeting at the discretion of the Committee Chair.
6.5.3 Minor Changes

If minor changes are required to the AG before its formal review date, then these can be presented to the AWP in the form of a letter and approval requested.

Minor changes could be an update to a form that is attached to the document as an appendix, job title changes or due to new national guidance which does not materially change the scope or intention of the AG.

Approval of minor changes without full consultation, submission of proformas etc will be at the AWP discretion.

6.5.4 Submitting Reviewed AGs for Approval

The process for submitting fully reviewed and / or updated AG’s to the AWP is the same as for the development and approval of new documents.

a) Changes made

Upon submission of a reviewed and/or revised policy, details of changes or additions to the policy must be described in the AG Template (Appendix 1). Where the AG has been completely rewritten, this should be explicitly stated.

b) No changes made

If an AG has been reviewed and supporting evidence checked but no changes are needed, there should be a statement to say that the document has been reviewed and is ‘fit for purpose’ and that the original supporting evidence is still applicable. This should be documented in the AG Template (Appendix 1).

6.6 Process for AG Document Registration, Version Control and Archiving

6.6.1 Registration of AGs

a) Following approval, AWP meeting lead will allocate AWP reference number before the AG is implemented.

b) All AGs are recorded on the AWP AG Register, maintained and kept up to date by the AWP meeting lead.

c) All versions of AG’s on the same subject will aim to keep the same AWP reference number with a different version number used for each update.

6.6.2 P&G document control

a) All AGs should identify previous versions of the document.

b) The front cover of the AG should give state whether the document is an original or updated version.

6.7 Uploading of AGs

Once approved and further to any amendments requested by the AWP, the AWP meeting lead will allocate a reference number and send them to the Antimicrobial website manager or administrator, in order for the document to be ‘uploaded’ onto the AIS.

6.7.1 AG’s not approved / requiring amendments:

AWP meeting lead to inform authors of AWP comments and suggestions, and dates of the next AWP meeting.
Authors to re-submit, if applicable, new version to AWP meeting lead, with a completed template (Appendix 1), for submission to the next AWP meeting for ratification.

6.7.2 **Approved AG’s:**

AWP meeting lead to inform authors of AWP comments and approval. If minor amendments required authors to make and send amended versions to AWP meeting lead.

AWP meeting lead to issue the AG with a AWP reference number (if one is not already issued), send approved version to the antimicrobial website manager/administrator for uploading to AIS.

**AWP meeting lead:**

- Word version to be stored in current ‘Antimicrobial/AWP/Guidelines’ folder under the relevant clinical management group (CMG) on pharmacy shared database on 'uhldata06\data\Clinical Services Directorate\Pharmacy'

**Antimicrobial intranet site:**

Antimicrobial website manager or administrator:

- Convert word version to pdf.
- Upload pdf version to be uploaded to UHL antimicrobial website, word version to be stored in current ‘Antimicrobial/AWP/Guidelines’ folder under the relevant clinical management group (CMG) on pharmacy shared database on 'uhldata06\data\Clinical Services Directorate\Pharmacy'
- Upload new sections/pages which have been ratified by the AWP, ensuring the intranet’s A-Z index and other relevant pages are updated and cross linked with new pages / guidance.

6.8 **Process for version control, document archiving and review of the AG’s.**

Antimicrobial website manager or administrator:

If replacing older version, old version to be filed ‘Antimicrobial/AWP/Guidelines’ folder under the relevant clinical management group (CMG) in ‘old version’ folder on the pharmacy shared database on 'uhldata06\data\Clinical Services Directorate\Pharmacy'. ‘Old version’ folders to be kept indefinitely as a complete record of all guidance copies in place at any particular time.

**AWP meeting lead**

AWP timetable database to be updated, with information on when new guidance or versions were ratified, and uploaded.

AWP timetable to be maintained and kept indefinitely as a complete timeline record of when guidance documents were in place at any particular time

6.9 **AG Review**

6.9.1 **AG Review Dates**

The first review of new AG documents should be within 3 years of approval. Subsequently each AG must state a 'commencement of review date' which is no more than 3 years from original development or latest review unless otherwise explicitly stated.
6.9.2 AG Review timescales
The review must be completed within 6 months from the review date.

6.9.3 AG Review Lead
There must be an identified individual who is responsible for ensuring the review takes place. Job titles should be used rather than names as staff may change posts before a review date is due.

6.9.4 Submitting Reviewed AGs for Approval
The process for submitting fully reviewed and / or updated AG’s to the AWP is the same as for the development and approval of new documents.

a) Changes made
Upon submission of a reviewed and/or revised policy, details of changes or additions to the policy must be described in the AG Template (Appendix 1). Where the AG has been completely rewritten, this should be explicitly stated.

b) No changes made
If an AG has been reviewed and supporting evidence checked but no changes are needed, there should be a statement to say that the document has been reviewed and is ‘fit for purpose’ and that the original supporting evidence is still applicable. This should be documented in the AG Template (Appendix 1).

6.9.5 Delayed Reviews and Extending the Review Period
a) Any AG not reviewed within the 3 month timeframe must be referred to the AWP with
   • rationale for delay
   • anticipated timescales for completion
   • any associated risks.

b) The AWP will then assess whether the review period can be extended or the AG needs to be removed from circulation

c) Any delayed beyond 6 months, with no valid reason must be referred to the IPC for information, and discussion.

7 EDUCATION AND TRAINING FOR THIS POLICY
7.1 For further advice or clarification regarding the developing AGs or the approval process, please contact the AWP meeting lead – name and contact details on AIS.

7.2 Training sessions on literature searching and reviewing clinical evidence is available through the clinical libraries.

8 PROCESS FOR MONITORING COMPLIANCE
8.1 AWP meeting lead every 6 months to report to AWP, and TIPAC any AG reviews not ratified within required timeframe.

Policy for the ratification, maintenance, publication and storage of UHL Antimicrobial Guidelines
Latest version approved by Policy and Guideline Committee 18 March 2016, Trust Ref: B28/2014

NB: Paper copies of this document may not be most recent version. The definitive version is held on INsite Documents
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<th>Tool</th>
<th>Frequency</th>
<th>Reporting arrangements</th>
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<td>6 monthly</td>
<td>AWP and annually to Trust Infection Prevention Assurance Committee (TIPAC)</td>
<td>TIPAC</td>
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### 9 Equality Impact Assessment

#### 9.1
The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

#### 9.2
As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

### 10 Legal Liability

The Trust will generally assume vicarious liability for the acts of its staff, including those on honorary contract. However, it is incumbent on staff to ensure that they:

- Have undergone any suitable training identified as necessary under the terms of this policy or otherwise.
- Have been fully authorised by their line manager and their Directorate to undertake the activity.
- Fully comply with the terms of any relevant Trust policies and/or procedures at all times.
- Only depart from any relevant Trust guidelines providing always that such departure is confined to the specific needs of individual circumstances. In healthcare delivery such departure shall only be undertaken where, in the judgement of the responsible clinician it is fully appropriate and justifiable - such decision to be fully recorded in the patient’s notes.

It is recommended that staff have Professional Indemnity Insurance cover in place for their own protection in respect of those circumstances where the Trust does not automatically assume vicarious liability and where Trust support is not generally available. Such circumstances will include Samaritan acts and criminal investigations against the staff member concerned.

Suitable Professional Indemnity Insurance Cover is generally available from the various Royal Colleges and Professional Institutions and Bodies. For further advice contact: Head of Legal Services on 0116 258 8960

The Trust will generally assume vicarious liability for the acts of its staff, including those on honorary contract. However, it is incumbent on staff to ensure that they:

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• Fully comply with the terms of any relevant Trust policies and/or procedures at all times.

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11 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

UHL Policy for Developing and Approving Clinical and Non-Clinical Policies and Other Guidance\(^1\) Documents (known as ‘Policy for Policies’ – Trust Ref B16/2004

This policy is supported by the following found in the associated documents as detailed below, which must be used in conjunction with this policy:

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<thead>
<tr>
<th>Procedure / Process / Standard</th>
<th>Appendix</th>
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<tbody>
<tr>
<td>Antimicrobial Guidance template</td>
<td>1</td>
</tr>
<tr>
<td>Antimicrobial Working Party Terms of Reference</td>
<td>2</td>
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</tbody>
</table>

12 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

This document will be uploaded onto SharePoint and available for access by Staff through INsite. It will be stored and archived through this system.

Review details must be described in the Policy and must give details of timescale and who will be responsible for review and updating of the document.

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\(^{1}\) Guidelines, Procedures, Standard Operating Procedures, Protocols and any other document that provides guidance to staff.
## Policy Monitoring Table

The top row of the table provides information and descriptors and is to be removed in the final version of the document.

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<th>Lead</th>
<th>Tool</th>
<th>Frequency</th>
<th>Reporting arrangements</th>
<th>Lead(s) for acting on recommendations</th>
<th>Change in practice and lessons to be shared</th>
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**Antimicrobial Guidance (AG’s) Template to accompany AG’s being submitted for approval**

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**Checklist for the Review and Approval of Antimicrobial Guidance**

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<td>2.</td>
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<tr>
<td>3.</td>
<td>AG contains the following:</td>
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<tr>
<td></td>
<td>Clinical condition when to use the recommended antimicrobial.</td>
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<tr>
<td></td>
<td>Empirical and/or directed treatment, as appropriate.</td>
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<td>Allergy information and alternatives</td>
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<td>Target patient group</td>
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<td>Timing of administration (if clinically appropriate)</td>
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<td>Duration of therapy (IV and oral, and total duration)</td>
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<td></td>
<td>Therapy de-escalation advice</td>
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<td>IV to Oral therapy switch</td>
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<td>Monitoring requirements</td>
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<tr>
<td></td>
<td>Definitions – where applicable</td>
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<tr>
<td>4.</td>
<td>Supporting references, evidence Base and Related Guidelines/Policies (state below)</td>
</tr>
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<td>5.</td>
<td>Details of any changes made (state below)</td>
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<tr>
<td>6.</td>
<td>Process to Monitor Compliance</td>
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<td>Is there a requirement for additional monitoring of compliance (in addition to the 6 monthly Trust wide antimicrobial prescribing adherence audits)?</td>
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<tr>
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<td>Have audit timescales and audit lead been identified?</td>
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APPE NDX 2

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

ANTIMICROBIAL WORKING PARTY TERMS OF REFERENCE

PURPOSE

The purpose of the Antimicrobial Working Party is to provide practical and scientific advice to the Trust (UHL) on strategies to minimise the incidence of healthcare associated infections and to maintain the effectiveness of antimicrobial agents in the treatment and prevention of microbial infections.

OBJECTIVES

- To advise on antimicrobial use within UHL.
- To make recommendations to the list of formulary approved antimicrobials on behalf of the Therapeutic Advisory Service.
- To ensure appropriate up to date evidence based antimicrobial guidance documents are available.
- To ratify UHL antimicrobial guidance documents
- To review national antimicrobial guidance.
- To make recommendations to the Trust Infection prevention Assurance Committee
- To review surveillance data on local and national antimicrobial resistance.
- To review antimicrobial prescribing audit reports.
- To review, in conjunction with Medicines Management, antimicrobial related incidents.

Dates and time of meetings

Chair: Deputy Director of Infection Prevention
Meeting Lead: Lead Antimicrobial Pharmacist: Kate Dawson
Frequency of meeting: Two Monthly
Length of Meeting: Two Hours

Reporting responsibilities

Trust Infection Prevention Assurance Committee and escalated to Executive Quality Board as required
TAS requests: summary of recommendations to TAS

Minutes

TIPAC for information

Membership

Deputy Director of Infection Prevention
AWP Meeting Lead
Consultant Microbiologists
Lead Antimicrobial Pharmacist
Senior Antimicrobial Pharmacist
Infectious Diseases Physician
Senior Nurse, Medicine Management
Consultant Critical Care
Paediatric Consultant representative
Medicine Information Senior Pharmacist
Consultant Physician GUM
Lead Pharmacist LPT
Head of Prescribing East Leicestershire and Rutland CCG
Head of Prescribing, Leicester City CCG
Head of Prescribing West Leicestershire CCG Jasmeen Islam
Audit Facilitator, CASE team

Members as required:
Consultant Medical Staff and others to be invited for particular topic as necessary

Date: Feb 2013  Date of Review: Aug 2014