National Institute for Health and Care Excellence

NICE Quality Standards Consultation – Surgical Site Infection

Closing date: 5pm – 17 June 2013

Organisation	**British Association of Dermatologists (BAD)**
Title (e.g. Dr, Mr, Ms, Prof)	Please see below
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Please note: comments submitted on the draft quality standard are published on the NICE website.	
Would your organisation like to express an interest in endorsing this quality standard? ☒ Yes ☐ No For information about endorsing quality standards please visit http://www.nice.org.uk/guidance/qualitystandards/indevelopment	

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Please provide comments on the draft quality standard on the form below, putting each new comment in a new row. When feeding back, please note the section you are commenting on (for example, section 1 Introduction). If commenting on a specific quality statement, please indicate the particular sub-section (for example, statement, measure or audience descriptor). If your comment relates to the standard as a whole then please put 'general'.

In order to guide your comments, please refer to the general points for consideration on the NICE website as well as the specific questions detailed within the quality standard.

Please add rows as necessary.

Section	Comments
e.g. Section 1 Introduction or quality statement 1 (measure)	e.g. Comment about quality statement 1.
General	A very well worked out piece of work, which attempts to cover the breadth of surgical practice. However, a statement from the GDG on community- or hospital/outpatient-based skin surgery would be appropriate. Particularly, focusing on the breadth of skin surgery which is now done in minor procedure rooms rather than operating theatres (see below). Surgical site infection rates in dermatological surgery worldwide are low with most studies quoting 2-5%.
Quality statements 2, 6, 9 and 10	These are of particular importance and relevance to the sphere of dermatosurgery. Although it is well established that suspected or confirmed skin cancer surgery should, in the vast majority of cases, be carried out by the relevant hospital specialist (dermatologist/plastics/ENT/maxillofacial/facioplastic surgeons), there is still a significant volume of such surgery performed in the community, potentially leading to sub-optimal practices be it either individual technique or the operative environment. These particular statements are very important to try and standardise the care pathway and optimise patient experience. There is a considerable range and variance in standards with regard to pre-operative and post-operative patient information and counselling, levels of staff expertise and knowledge, the physical surgical environment and the

Section	Comments
	local culture for transparency and self-reflection. Any practical and simple guideline/document which helps to standardise care is to be welcomed. We note that a degree of local autonomy is advocated so that the guideline is not unwieldy or irrelevant.
Quality statement 1	The advice for patients to shower, wash or not remove hair pre-operatively is not routinely given pre-dermatological or plastic surgical procedures under local anaesthesia. Also, this should not be too prescriptive. Surgical preferences will vary – for example, for split-thickness skin grafts on the lower leg, patients would not normally be allowed to wash the area after 48 hours (usually 1 week). Hair is usually not removed during skin surgery procedures even if located on hair-bearing areas such as the scalp, but if necessary is often achieved by "close trimming" with scissors which minimises any surface trauma.
Quality statement 3	The use of antibiotics in dermatosurgery varies widely worldwide. Generally, most consensus documents state that unless the lesion being removed is crusted or ulcerated, routine antibiotic use is not suggested in patients undergoing dermatological surgical procedures. There is evidence in the literature that excision of an eroded (broken skin surface) tumour has a higher incidence of surgical site infection compared to excision of a tumour with an intact surface. Similarly, skin surgery performed in certain anatomic sites (below knee, flexural regions) is also associated with a higher incidence of surgical site infection. Some guidelines differ regarding antibiotic prophylaxis in patients, undergoing skin surgery, who have had recent prosthetic implants. Some scope for local autonomy is to be welcomed. Such anecdotal practices will probably continue until good RCT evidence becomes available in a dermatosurgical setting.
Quality statement 4	People having surgery are offered procedure-targeted case-finding for *S. aureus* and those who are positive are offered suppression. Although, the NICE guidance is that nasal decontamination aimed at elimination of *S. aureus* should not be routinely undertaken, there is literature to support routine surveillance (by pre-operative nasal swab) in patients undergoing more advanced facial skin cancer excision (Tai YJ *et al.*, *Australas J Dermatol 2013*; **54:**109-14). Thus, this draft statement is of particular relevance to patients undergoing skin surgery on the head-and-neck region, and supports the targeted surveillance in certain dermatosurgery patients.
Quality statement 5	People having surgery receive surgical skin antisepsis using an alcohol-based solution immediately before incision – most studies looking at the use of various perioperative antisepsis regimens have been concerned with

Section	Comments
	clean-contaminated surgery rather than clean surgery (i.e. dermatosurgery) (Darouiche RO *et al.*, *N Engl J Med 2010*; **362:**18-26). It is most surgeon's practice to use alcohol-based antiseptics (or povidone-iodine) although there has been some literature to suggest that simpler decontamination methods may be applicable in clean surgery procedures (Kalantar-Hormozi AJ *et al.*, *Plast Reconstr Surg 2005*; **116:**529-31). Until there is a body of further evidence to support this view, I personally agree with this draft statement in that patients should receive an alcohol-based solution immediately prior to incision.
Quality statement 6	The document should also not be prescriptive regarding surgical dressings – this again is a matter of individual preference. The document quite rightly states that there is no convincing evidence of superiority of one dressing over another. Additionally, "people" should read "patients and their guardians or carers".
Quality statement 7	Dermatological surgeons and specialist dermatology nurses are well accustomed to managing wounds left to heal by secondary intention – the involvement of a tissue viability nurse routinely is superfluous. People who have the recognised clinical features of surgical site infection are offered treatment with an antibiotic that covers the likely organisms. This statement is to be supported, though it should also mention that the relevant specimen (skin swab/pus/fluid) should be sampled and sent to microbiology BEFORE initiation of treatment so that antimicrobial therapy can be directed against the actual causal agent. It also helps to potentially outrule actual infection and differentiate vs. non-infection related wound inflammation.
Quality statement 8	This draft statement does not apply to dermatosurgical procedures.
Quality statement 9	Should "environment" read "approved location" to tie in with CQC? Prevention of infection following minor surgery being carried out in a community setting, either in a community hospital or a GP surgery, may need to be separately addressed, particularly with reference to recommendations for commissioners.
Quality statement 10	Should this read "infection rates" instead of "infection levels"? Who should the healthcare professional feedback infection rates/levels to?
Question 1	Yes.
Question 2	Overall yes, although there would be significant workload involved. This may cause problems in different specialties where the staffing levels are already insufficient to meet the daily clinical service demands. Such audit

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	work could be incorporated into a department's rolling audit activities but would probably require additional staffing levels (would be a useful part of a CNS work plan). Some of the audit work could be shared out between different departments (specific specialty/anaesthetics/microbiology/estates).
Question 3	Surgical site infections occur in a variety of surgical settings from minor invasive skin surgery to major surgery categories where body cavities/viscera are incised. Thus, different wound scoring systems will differ in their suitability and applicability depending on the surgical scenario involved. The CDC definition and criteria for diagnosis of a SSI is the most frequently used (in the literature) for dermatological surgery, though the ASEPSIS scoring system also seems applicable.

Closing date: Please forward this electronically by 5pm on **17 June 2013** at the very latest to QSconsultations@nice.org.uk

PLEASE NOTE: The Institute reserves the right to summarise and edit comments received during consultations, or not to publish them at all, where in the reasonable opinion of the Institute, the comments are voluminous, publication would be unlawful or publication would be otherwise inappropriate.