This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

Infection Prevention and Control Resource for Adult Social Care
Stakeholder Consultation
Feedback Form

Instructions

Thank you for reviewing the IPC resource for Adult Social Care. Please read the instructions below before providing your feedback.

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

To complete the stakeholder consultation feedback form you will need:

- Information Pack: Stakeholder consultation on the draft Infection Prevention and Control Resource for Adult Social Care
- IPC resource for ASC (Sections 1- 13)

We advise stakeholders to read the IPC Resource for ASC in order.

Each section will be set out to include feedback on:

- **Content:** Comments on content and accuracy. Please highlight anything that may be missing.
- **Language and accessibility**: Does the language used make sense to you, is there any parts that need to be made clearer for the sector?
- **Practicality:** Is the advice clear, workable and easy to follow?

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

Some sections include specific questions for your consideration. These points were identified during the development process and we welcome your feedback. These questions are in the relevant sections and in the feedback forms. Stakeholders are not expected to answer every section or question and should only respond to those that are relevant to their role or experience.

If there are any points you do not agree with or you think can be improved, please provide suggested alternative wording for review.

We welcome any suggestions you may have for improving the wording, including proposed alternatives for review.

At the end of the form there is a General comments box for any additional reflections.

How your information will be used and stored

Your personal information will be stored on DHSC systems. Your organisation name and comments will be shared with UKHSA. All feedback will be collated and arranged according to the relevant sections of the resource so that every comment can be reviewed and addressed in a consistent and fair way.

Please do not include any personal identifiable information in the comment boxes, this includes personal information of other people.

For further information about how your data will be used, please refer to the DHSC privacy notice - GOV.UK and UKHSA privacy notice - GOV.UK.

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

Personal details

Name	Paul Cooper
Job title	Senior Quality, Compliance, and Innovation Specialist
Organisation	Homecare Association
Email address	paul.cooper@homecareassociation.org.uk

Publication

Would you like to be notified when the IPC resource for ASC is published?	Yes

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

Declaration of interest

If any stakeholder has a conflict of interest relevant to the remit of the project, they should declare it. To identify potential conflicts of interest, Stakeholders are asked to list their interests below.

Please consider the following, non-exhaustive list of potential interests:

- Commercial interests (e.g., businesses owned, contracts awarded)
- Research interests
- Funding secured (past or present) and/or applied for
- Previous provision of expert opinion and/or testimony

If you have no interests to declare, please state, Not Applicable (NA).

Nature of any conflict of interest (if applicable)	NA
Start date and end date (if applicable)	NA
Any additional comments	NA

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

Table of contents- Feedback form- IPC resource for ASC

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

1. Introduction

Please indicate the page number and section heading for any comment that refers to a specific part of the document.

Content	Our central recommendation is that the final resource should be redesigned so that homecare (domiciliary care) is not treated as an adaptation of care home IPC, but as a distinct delivery model with its own risks, controls, escalation routes and practical limits. However, we have concerns about how clearly the introduction prioritises homecare and frontline use. The introduction sets out a wide scope and a wide audience, and it covers many system roles in detail. The guidance should reflect that a person's home is not a regulated communal setting; IPC advice must therefore be balanced with consent, dignity, autonomy, proportionality and the person's right to live in their own home. This would make our position more distinctive and less purely operational. The text positions the resource as for "all people working in ASC settings" (p.2), and it lists settings including "care provided at home (domiciliary care)" (p.3), but it does not yet draw out what changes in practice for homecare delivery. We also note that the introduction includes substantial system context (for example, detailed descriptions of ICBs, UKHSA, HPTs, local authorities and directors of public health, P.3). That is important information, but it may fit better as supporting material or a later section, rather than taking space that could orient frontline staff quickly. **For your consideration** Add a "homecare quick-start route", what this means in people's homes summary at the start, and signpost directly to the sections that staff will use most often. See below for more detail.

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

	Reduce and relocate some of **the system-role detail from the** introduction, keeping only what staff need to understand escalation routes.
Language and accessibility	The tone is professional and consistent with a national guidance resource. You could consider an approach that makes it easier for time-pressed staff to find the "so what" quickly. The document also sets out an intention to be "clear, practical and easy to use", so the opening section needs to model that standard.
Practicality	We support the emphasis on proportionality and risk assessment, including the statement that "IPC measures should be applied proportionately, based on risk assessments, and with input from the individuals receiving care." p.4. That framing fits homecare, where staff adapt to each person and household environment. We also support the clear expectations placed on registered to ensure staff access the resource, complete training, and implement monitoring and corrective action, because those are practical steps that drive delivery. However, we hold concerns that the introduction does not yet provide a practical "route in" for homecare teams. Homecare staff often work alone, travel between households, and make quick judgements in variable settings. They need rapid access to role-specific actions and escalation routes. The introduction currently provides breadth, but not enough immediate, task-based signposting for homecare delivery. Where the resource recommends additional supplies, training, audit activity, PPE stock, mobile equipment or management oversight, DHSC should recognise that implementation depends on commissioned time, adequate fee rates and funded infrastructure. Guidance should avoid

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

	creating unfunded expectations that providers cannot reliably deliver under current commissioning arrangements.
	
	For your consideration - Quick start route (homecare).
	Add a clear, prominent quick-start section at the beginning to support fast, practical use. This should include:
	• A **homecare quick-start pathway** (with links to relevant sections) covering:
	  ○ routine visits
	  ○ suspected infection in a household
	  ○ managing risk when staff visit multiple households
	  ○ escalation steps (registered manager to local IPC support to UKHSA/HPT where needed)
	• A short **"what this means in people's homes"** summary to translate key principles into domiciliary care practice
	• Simple call-out boxes to guide action:
	  ○ **"What you need to do in homecare"**
	  ○ **"When to escalate"**
	• A **"Where to find the right section fast"** signpost to the most commonly used parts of the resource
	• One brief **homecare scenario** showing how to apply proportionate IPC in a person's home

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

2. Why preventing infections is important

Please indicate the page number and section heading for any comment that refers to a specific part of the document.

Content	Overall, the purpose and structure of this section are clear. However, in the domiciliary care subsection it states homecare "usually carries a lower risk of infection spread" and that risk is "similar to the general population" (p.7). This may understate practical risks linked to staff visiting multiple households, providing close personal care, and working within the constraints of domestic environments. It also does not fully reflect that people drawing on care and support are, by definition, more likely to be at higher risk of infection due to age or underlying health conditions. We would recommend reframing this to reflect that, for example: "household transmission may be lower, but operational exposure and variability can raise risk", and to make the link to risk assessment explicit. The whole section on "Water safety" (p.9) appears to be focused on residential / communal settings, as there are areas that are not necessarily within the control of home care providers. For example: "Taps should be labelled, and vessels maintained to avoid contamination. This applies to private water supplies as well." (p.11). Was this the intention? It may be more appropriate for home care to be explicitly framed around awareness, safe practice, and escalation, rather than full water safety plans. The detail on "pets and pests" (p.12) is useful, especially in homecare where clients may have pets. The text that reads "…hygiene precautions are in place to reduce infection risk." and "Carry out a risk assessment for hygiene, including handwashing and cleaning to reduce infection risks between pets, individuals and care and support workers to a safe level." would benefit from acknowledging the level of control care workers have in someone's own home.

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

Language and accessibility	We support the generally plain-language explanations (for example, what is an infection; The chain of infection; and the hierarchy of controls). These are teachable concepts for frontline staff. We have concerns that the current length and structure make the guidance harder to use in practice. Several subsections are lengthy and combine purpose, theory and operational detail, which reduces usability. For homecare workers, guidance needs to be quick and practical to use. **For your consideration** Add short “What this means in homecare” call-outs after: chain of infection, hierarchy of controls, and AMR/stewardship. Tighten sentences and prioritise action-led phrasing in the “practical actions” (p.9) area so staff can scan and act. Use plain English and define key terms once (e.g. AMR, stewardship). After definitions, include a short “What this means on a visit” line to anchor these concepts in day-to-day practice. (p.7–9) Include homecare-specific examples to support understanding. Short, practical scenarios (e.g. no soap or towels available, pets present, dirty sink) would help improve consistency and make the guidance easier to apply in people’s homes. (p.7, p.12) Make the differences between homecare and care home settings explicit. For example, include a short “What changes in homecare?” call-out or a simple two-column comparison. This would avoid the need for readers to interpret differences across sections and support clearer application in practice. (p.6–7, p.7–8)

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

Practicality	In general, we support the inclusion of practical actions (IPC basics, early detection, engaging with prescribers, and record keeping). This usefully shifts the section from “why” to “what to do” (p.9–10). However, we are concerned about feasibility in domiciliary care unless the guidance is clearer about what homecare staff can and cannot control. In a person’s home, staff can improve practice through hand hygiene, safe equipment use, good documentation, and timely escalation. They cannot usually control plumbing systems, flushing regimes, or building-level water safety plans, and the guidance should acknowledge this boundary (water safety content: p.10–12). On page 12 (“Hand wash sinks in domiciliary (homecare) settings”), it is worth noting that home care workers do not control the environment, and it may not always be possible to meet these standards consistently (e.g. clutter, cleanliness, or layout of sinks). Consideration is needed when entering someone’s private home. Encouraging staff to carry soap and paper towels is pragmatic, but this should be framed as good practice rather than an expectation, given practical and cost implications. The instruction not to place equipment near sinks is appropriate, but again requires flexibility depending on the home environment. Use of alcohol-based hand rub where sinks are unsuitable is a proportionate and important fallback and should be clearly supported.

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

Specific questions

Stakeholders are not expected to answer every question and should only respond to those that are relevant to their role or experience.

Page	Section heading	Sub-heading	Question #	Question	Comment
7	Antimicrobial Resistance and Stewardship		1	Does this section clearly explain what care and support workers do both in domiciliary care and in care homes, and how their roles differ?	Mostly yes, but it needs a clearer contrast. The document describes “risk environments” and notes homecare is usually lower spread risk and affected by lifestyle/pets, but it doesn’t clearly set out how daily tasks differ (e.g., communal outbreak controls vs single-household visits). Adding a short comparison box that shows how care homes use communal, policy-led controls, while homecare relies on visit-by-visit risk assessment and escalation.
10	Practical actions for care and support workers	Monitoring antibiotic use	2	How does the monitoring of antibiotic use work in domiciliary care settings?	Responsibility primarily sits with the prescribing clinician, and arrangements can vary. In home care, monitoring typically relies on Medication Administration Record (MAR) charts (including doses

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

					given, missed doses, reactions, and start/review dates), alongside family involvement (if applicable) and remote clinical oversight. Care staff may support clients to take antibiotics where this forms part of agreed medicines support (for example through prompting or administration), while observing, recording, and escalating any concerns. In practice, this includes supporting adherence (right time, right dose), observing response and side effects, and keeping a simple record to inform clinical review. Staff should escalate promptly to the GP, NHS 111, or the office team if symptoms worsen, doses are missed, or adverse reactions occur, and ensure care plans are updated so that prescribed treatment and follow-up are clear. The guidance should reflect these

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

					arrangements and set out clear, proportionate expectations that can be delivered in home settings.
10	Water Safety		3	Is water safety best placed in this section. If not, where would it fit better?	This is not well suited as a "practical actions" item for homecare. Much of water safety (e.g. Legionella control, water safety plans, outlet flushing) applies to communal or residential providers rather than domiciliary services. As noted above, you could consider moving "water safety" to either "fundamentals of care" or a practical/environmental controls section, with a short signpost in this section. Alternatively, if it remains here, the distinction should be made explicit by separating "Communal settings: provider responsibilities"

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

					from “Homecare: what you can do on visits.”
11	Water Safety	Hand wash sinks in domiciliary (homecare) settings	4	Stagnant water can contain pathogens. Do we need to include further information about using water for flowers?	Yes—include a short, practical note for homecare settings, keeping it brief and behaviour-based: Avoid keeping stagnant vase water; change water regularly and carry out hand hygiene after handling. Do not use hand wash sinks for emptying or cleaning vases—use a designated sink or utility area where available, in line with guidance that hand wash sinks are only for handwashing.
12	Keeping pets and avoiding pests		5	Is 'Keeping pets and avoiding pests' best placed in this section? If not, where would it fit better?	This is highly relevant to homecare and would benefit from being positioned earlier under “Risk environments: domiciliary care.” You already identify pets

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

					and lifestyle factors as key homecare infection prevention and control challenges, so placing this content alongside the homecare risk description would improve flow and usability.

3. Standard Infection Control Precautions

Please indicate the page number and section heading for any comment that refers to a specific part of the document.

Content	Translate each control into visit-based actions. Many sections still read as care home guidance. Adapt each chapter for domiciliary care by translating controls into clear, visit-based actions. Add a consistent “In domiciliary care, staff should…” call-out in each chapter, with 3–5 practical steps. Set out what this looks like across the visit: • Before the visit: check known risks, prepare equipment, plan PPE • During the visit: practise hand hygiene, prepare a clean space, use portable equipment, observe for symptoms, and deliver care safely within the constraints of the home • After the visit: clean equipment, document care and any risks identified, and report concerns to the office team

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

	Be explicit about what staff do directly during visits (prepare a clean space, carry and clean portable equipment, record actions, report concerns) and what they advise or raise with others (household cleaning, waste, water systems, and environmental risks). Make clear that staff identify and document risk, while the provider coordinates the wider response.
Language & accessibility	Strengthen "who does what" for homecare. Replace provider-led terms such as plans and schedules with visit-based actions: check, clean where safe, document, and escalate. This will align the guidance with how domiciliary care operates (p.16). Add short call-out boxes at the start of each major topic such as "What good looks like on a home visit" and "Escalate when…". This will support consistent practice across hand hygiene, PPE, equipment, waste, exposure, and laundry.
Practicality	Recognise limits in home environments. Some controls assume staff can change ventilation or equipment layout. In homecare, staff can advise and adapt, but households implement most changes. Make this explicit to keep expectations realistic. We support the practical, homecare-aware elements already included. The requirement for portable hand hygiene supplies is clear and actionable (p.5). The guidance also recognises limits in home environments and allows staff to prepare a surface to protect equipment before care (p.16). Equipment handling guidance is strong, particularly cleaning before and after use and safe storage in vehicles (p.21). However, the guidance needs tighter alignment with what staff can control. Ventilation advice assumes staff can adjust windows and doors; in practice, staff often rely on consent and

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

	household constraints (pp.8–10). Waste guidance recognises reduced control but needs clearer, simple steps on consent, storage, and escalation (p.30).

Specific questions

Stakeholders are not expected to answer every question and should only respond to those that are relevant to their role or experience.

Page	**Heading**	**Sub-heading**	**Question #**	Question	Comment
9	Respiratory and cough hygiene	Portable fans in ASC settings	1	What are your views on how the advice on portable fans can be put into practice?	Apply fan guidance clearly to homecare practice. In domiciliary care, staff should apply this through a visit-based risk assessment: avoid fan use where infection is suspected or confirmed, improve ventilation where possible, and position fans safely to avoid direct airflow at the person and reduce trip hazards (p.9–10). Clarify limits on cleaning and maintenance. Staff can check visible cleanliness and wipe

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

					external surfaces where safe, but they cannot maintain or deep-clean client-owned fans. State clearly that staff advise the person or family, record concerns, and escalate where risks remain (p.9–10, p.16). Differentiate communal and homecare expectations. Guidance on planned maintenance and cleaning schedules applies to communal settings. Reframe for homecare: staff risk assess, check that the fan is visibly clean, and advise or escalate if it is dusty or unsafe (p.9–10).
14	Types of PPE	Face masks (Type IIR fluid-resistant surgical masks)	2	Is this advice clear and practical for care providers when considering whether individuals with respiratory symptoms should wear a fluid-resistant surgical mask, ensuring it is only used where safe and appropriate?	Clarify mask use and alternatives in homecare. The guidance is clear that staff should only ask individuals to wear a Type IIR mask where it is safe and tolerated, and should avoid this where it

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

					affects breathing or causes distress (p.13–14). Strengthen practical application. Add a simple line for homecare: where a mask is not tolerated, staff should use other controls such as distancing, ventilation, tissues, and hand hygiene (p.8–9, p.13–14). Link to source control. Make the purpose explicit. State that staff may ask an individual to wear a mask to reduce transmission risk, but should not do so where this compromises safety, for example in cases of breathlessness or cognitive distress (p.13–14).
14	Types of PPE	Face masks (Type IIR fluid-resistant	3	Transparent masks can be obtained for use by care and support workers if individuals receiving care and support rely on lip-reading. How easy is it for your care setting	Clarify availability in homecare. Access to transparent masks is variable. Providers can purchase them, but supply,

		surgical masks)		to access and obtain transparent face masks?	cost, fit, and fogging can limit routine use (p.14). Add a practical prompt. Providers should hold a small supply for planned visits where people rely on lip-reading. Where masks are not available or suitable, staff should use alternative communication aids (p.14).
15	Types of PPE	Respiratory protective equipment	4	Is it clear in the following statement who should be wearing respiratory protective equipment (such as FFP3 masks or hoods),	Clarify RPE use. The guidance is mostly clear that individuals with respiratory infection do not usually wear RPE and that RPE is for care staff following risk assessment and IPC advice (p.15). Remove ambiguity. Replace the key line with: “Care and support workers wear RPE when an IPC advisor recommends it; individuals receiving care do not wear RPE.” (p.15)

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

32	Safe management of Laundry and Linen		5	How do you understand the terms linen and laundry, and should we use both terms, only one of them, or are they considered different in your view?	Clarify and standardise terminology. Define terms once and use them consistently: “linen” refers to bedding and towels (care textiles), and “laundry” refers to the process and includes both clothing and linen. Use a single phrase thereafter, for example “laundry (linen and clothing)” (p.32–33). Important to recognise here and in general that English is not the first language of a substantial proportion of the workforce and, even among the UK workforce, literacy levels are variable.
33	Safe management of Laundry and Linen	Linen Workflow	6	What are your views on the linen workflow in domiciliary care, and are there any specific considerations we should take into account?	Adapt laundry guidance to homecare practice. The principles are sound—separate clean from used or soiled items and avoid placing items on the floor—but the workflow should reflect domestic settings, where staff have limited space, no

					trolley, and variable responsibility for laundry (p.33, p.35). Strengthen practical steps for homecare. Staff should bag used or soiled items at the point of removal, minimise handling, and clean hands between handling clean and used items (p.33–35). Where staff do not manage laundry, they should advise on safe handling and storage, document actions, and escalate where infection risk is high (p.33, p.35). Avoid default requirements for separate baskets or trolleys. Instead, state that staff should use separate bags or containers where available (p.33).

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

4. Transmission based precautions

Please indicate the page number and section heading for any comment that refers to a specific part of the document.

Content	Clarify the homecare pathway. Separate “communal setting” actions from “domiciliary care” actions more clearly. Most of the cleaning detail reads as care home–focused. Add a short homecare subsection under each precaution to set out what staff do during visits and what they advise or escalate. Define cohorting for homecare. The reference to “dedicated staff/cohorting” needs clearer application. In domiciliary care, this means limiting the number of care and support workers visiting and maintaining a consistent team, rather than cohorting within a building (p.2). Keep terminal cleaning expectations realistic. The guidance recognises some limits, but several steps still reflect communal settings. Reframe these for homecare. Remove or qualify measures such as HEPA vacuuming or steam cleaning, unless clearly marked as “where feasible” or “provider setting,” to avoid unrealistic expectations in private homes. We support the references to homecare realities, such as advising individuals and families on increased cleaning and recognising limits in what staff can remove during a terminal clean (p.3). However, the section does not yet provide a clear, practical pathway for what staff should do during visits when TBPs apply.
Language & accessibility	The homecare content is currently too brief to be actionable. Phrases such as “support individuals/families to increase cleaning” (p.3) would benefit from greater clarity (for example, what to prioritise, what to record, and what to escalate), so staff can apply this confidently within the time constraints of a visit.

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

	There are also some minor wording issues to address. For example, “transmit though the air” should read “transmit through the air” (p.3). **For your consideration** Add short call-out boxes alongside homecare content (e.g. “What to do on a home visit” and “Escalate to office team/IPC when…”) (pp.3–4). Replace or complete placeholder links (for example, “contact precautions”, p.4) so the guidance works as a standalone resource and can be used quickly in practice, including on mobile.
Practicality	Be explicit about what homecare staff can control versus influence. In people’s homes, staff can model safe practice, carry out targeted cleaning to deliver care, document, and escalate concerns. They cannot usually deep clean rooms, change soft furnishings, or control the wider environment. This boundary should be made clear to keep the guidance practical and avoid unrealistic expectations. We support the acknowledgement that only some actions are realistic in domiciliary care (for example, limited waste removal and advising on bedding and linen) (p.3). However, the section should more clearly distinguish between actions staff can take directly and those they can only advise on, to support consistent application in practice (p.2–3). Add a simple escalation route for homecare. You say “seek advice from IPC team or local HPT”; in homecare, staff often escalate via the provider office team/clinical lead first—add that as the practical first step. Check the temperature threshold practicality. “Above 37.8°C” may be hard to apply consistently in home visits where thermometers vary; consider phrasing as “fever/high temperature” with a threshold “if measured.”

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

5. Fundamentals of care which help prevent infections

Please indicate the page number and section heading for any comment that refers to a specific part of the document.

Content	We support the focus on fundamentals of care as core to infection prevention. The section links everyday care to preventing common infections such as UTIs and respiratory infections, which aligns well with homecare practice (p.1). However, the guidance needs clearer homecare application and tighter focus in some areas. Make the homecare role explicit. Some actions imply the provider completes assessments and maintains charts. In domiciliary care, staff usually contribute observations and the office team or clinical lead updates care plans. Add a short line to reflect this where you refer to fluid balance charts and oral health assessment (p.4, p.6–7). Keep expectations proportionate for visits. The requirement to complete a full oral health assessment may not be feasible during short visits. Reframe this as completing a basic oral health check, recording concerns, and escalating where needed (p.6–7). Similarly, ensure sharps guidance reflects home settings: staff should use single-person razors, store them safely, and follow provider processes for disposal, using sharps containers only where already in place (p.6). Strengthen practical escalation messages. The UTI section is clear on avoiding unnecessary testing, particularly dipsticks in over-65s. Add a simple homecare line: staff record symptoms and escalate for clinical review rather than testing (p.5).

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

Language & accessibility	Correct the wording error: “ethnical pigmentation” should read “ethnic pigmentation” or “natural variation by skin tone” (p.7). Use consistent, plain terms. For example, standardise on “hydration” and “drinks” rather than switching between alternatives (p.3–4). Strengthen directive language for care and support workers. Use clear actions such as “Offer drinks little and often” and “Record and escalate signs of dehydration” (p.3–4). We support the generally clear, care worker–focused tone, including practical prompts on hydration and escalation (pp.3–4). We also support the clear instruction not to use urine dipsticks in adults over 65 and the explanation of why, which reduces unnecessary antibiotic use (p.5). To strengthen usability you could add short, scan-friendly “What to do on a home visit” prompts for hydration and dehydration, UTI recognition, mouth care, and skin checks. This will support consistent, quick decision-making during visits (pp.3–7).
Practicality	We support the practical focus on hydration, continence, and UTI prevention. The actions are clear and align with homecare roles, including offering drinks beyond mealtimes, recognising dehydration, and avoiding unnecessary testing (p.3–5). However, the guidance needs clearer role boundaries and proportionate expectations for domiciliary care. Clarify homecare roles. Staff do not control meals, shopping, or dental access. Make this explicit across nutrition, hydration, and mouth care: staff prompt and support, record observations, and escalate concerns; providers coordinate care and access to services (p.2–3, p.6–7).

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

	Keep expectations realistic for visits. Fluid balance charts can support higher-need packages but are not always practical for short visits. State clearly that staff use charts where the care plan identifies risk, rather than as a default (p.4). Strengthen clarity on responsibilities. Mouth care guidance should reflect that staff complete basic checks, record concerns, and escalate, while providers and wider services arrange access to dental care (p.6–7). Support consistent practice. Add brief, task-focused prompts for key actions such as hydration escalation, recognising UTI symptoms, and skin/sharps checks to help staff apply guidance during visits (p.3–6).

Specific questions

Stakeholders are not expected to answer every question and should only respond to those that are relevant to their role or experience.

Page	Section heading	Sub-heading	Question #	Question	Comment
1	Fundamentals of care which help prevent infections		1	Is the current order of fundamentals of care considerations listed below helpful for you, or would it be helpful to have it listed alphabetically?	We support the current structure. It follows a clear care pathway—nutrition, hydration, personal hygiene and comfort, skin care, mouth care, and movement—which aligns with

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

					how homecare staff deliver support and supports practical application (p.1, p.2–8). Maintain structure and improve navigation. Do not reorder the content. If you want to improve quick access, add a short A–Z index or contents list at the end so staff can locate topics quickly without disrupting the care-focused flow.

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

6. Vaccinations for care and support workers and individuals receiving care and support

Please indicate the page number and section heading for any comment that refers to a specific part of the document.

Content	We support the clear message that vaccination is a core IPC measure and that providers should support uptake for both staff and people drawing on care and support. The section correctly distinguishes NHS responsibility for delivery from ASC's role in facilitating access and recording status (p.1–3). However, the guidance needs stronger homecare application and clearer operational detail. Clarify how providers facilitate access in homecare. You state that providers support access, but do not explain how this works in domiciliary care. It would be helpful to add practical examples such as booking support, reminders, transport planning, recording vaccination status, and escalation to GP or PCN where needed (p.3). Balance care home and homecare routes. The link to care home vaccine management is helpful, but add a parallel signpost to community pathways such as GP, pharmacy, and outreach clinics so homecare routes are clear (p.1–2). Reflect employer role in homecare delivery. You note employer responsibility for occupational vaccination and access via GP or pharmacy. Add a short clarification that many homecare providers rely on NHS delivery and focus on enabling access, encouraging uptake, and recording coverage (p.4). Make review points operational. Replace "review regularly" with clear triggers such as onboarding, annual review, and after hospital discharge or significant health changes (p.3).

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

	Improve usability for frontline staff. The reliance on external links is appropriate, but add a short summary of "what to do" so staff can act during visits. Set out provider actions versus NHS actions to reduce confusion and support consistent practice (p.2–4).
Language & accessibility	In general this has an accessible tone and clear inclusion of consent and Mental Capacity Act considerations, alongside the expectation to record acceptance or refusal (p.2). We also support the clear position that staff vaccination is strongly recommended, with practical reasons set out (p.3). You could consider making roles easier to follow. Separate key actions for different audiences—homecare workers, registered managers/office teams, and people/families—so staff can identify what they need to do quickly (p.2–4).
Practicality	We support the emphasis on recording vaccination status and regular review in care planning (pp.2–3). We also support the clarity that occupational vaccination is an employer responsibility, with staff accessing flu vaccination via GP or pharmacy where needed (p.4). Clarify consent and capacity in practice. You reference consent and best interest decisions. Add a practical line: homecare staff support discussions and record preferences, while clinicians obtain consent and administer vaccines (p.2–3). Make workforce access steps explicit. The GP or pharmacy route is helpful but needs clearer instruction. Add a simple "what to do" step, including what evidence of employment staff need and how providers supply it (p.4). Clarify roles and delivery model. State clearly that the NHS delivers vaccination, while ASC providers facilitate access, support consent conversations, and record status. This is particularly important in homecare, where coordination sits with office teams (pp.2–3).

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

7. Managing outbreaks in adult social care settings

Please indicate the page number and section heading for any comment that refers to a specific part of the document.

Content	Make the homecare pathway clearer and more prominent. You note that outbreaks in homecare are harder to detect and should be reported for advice (p.2), but most of the document focuses on care homes. Add a short “If you deliver domiciliary care” box near the start. Set out how staff can spot linked cases across households, define escalation triggers, and clarify who leads coordination. Reframe measures that do not translate to homecare. Items such as colour coded bags (p.7), segregation of infectious linen in specific bags (p.7), and whole-setting deep cleaning (p.9) apply mainly to residential settings. Provide homecare equivalents instead: give advice to the household, record and escalate concerns, minimise handling, and follow household waste disposal rules unless clinical waste requirements apply. Strengthen the “communication with partners” section (p.3) for homecare. Include explicit requirements to notify the provider’s clinical lead or office team, commissioners where relevant, and any other care agencies supporting the same person to reduce duplicate exposure. You already reference “other care providers” (p.5); bring this forward because it is critical in homecare.
Language & accessibility	Clarify who the “care provider” is in homecare. In domiciliary care, “provider” usually refers to the agency or registered manager, not the individual household. Tighten the language so responsibilities for reporting, communication, and outbreak planning sit clearly with the provider’s management team (p.4).

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

	Use plain thresholds and consistent terms. You define “fever (usually 38°C or higher)” clearly (p.3); maintain that approach throughout. Avoid jargon where possible. Define HPT at first mention (p.4) and then use the same term consistently. Avoid long multi-agency lists without a clear first step. The partner list covers the right organisations, but it lacks a simple instruction for frontline staff. Add a lead line such as: “Report to your registered manager or office team immediately; the registered manager contacts HPT, IPC, or the local authority as required.” This improves usability for homecare workers (p.4). Strengthen homecare-specific instructions to support consistent action. Homecare guidance often remains brief and sits within predominantly residential sections, which makes translation into practice harder. For example, “report it to the local IPC team for advice” is correct (p.2), but staff also need clear prompts on what to record and who to inform to support consistent escalation.
Practicality	In homecare, staff see people drawing on care and support one by one, so linked cases are identified across households using rostering data and staff observations. Make this explicit and add a practical step: providers should monitor rota patterns, sickness data, and call logs to detect clusters and act early (p.1–3). Clarify escalation routes for operational pressures. The commissioner/ICB support section (p.6) is helpful, but you should add a clear, actionable trigger: if staffing gaps risk missed calls or unsafe care, staff inform the registered manager or office team immediately, and the registered manager contacts the local authority or ICB commissioner as required. This links operational pressure directly to escalation and supports service continuity.

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

	Strengthen practical infection control instructions for homecare. You note that alcohol hand rub is not recommended for diarrhoea and vomiting outbreaks (p.9); add a clear homecare instruction to prioritise soap and water where available and plan ahead for visits where facilities are limited. More broadly, ensure staff have simple prompts on what to record, who to inform, and how to escalate concerns, so they can apply guidance consistently in a home setting. We support the emphasis on early recognition, prompt reporting, and clear routes to HPTs, alongside the expectation that staff use observations, and existing local reporting systems (p.4) when data is limited. We also support the focus on maintaining service continuity and escalating operational pressures (p.6) where these threaten safe care. The learning-from-outbreaks section is helpful, including the reference to notifying HPTs where outbreaks may link to domiciliary care and managing contacts in home settings (p.10). We do feel that the guidance still underplays the limits of control in homecare. Staff can identify patterns, record symptoms, apply precautions during visits, and escalate concerns quickly. They cannot implement setting-wide environmental controls, cohorting in the same way as care homes, or whole-setting cleaning beyond advising households and managing care-related waste. Reflect this distinction consistently throughout the document to reduce ambiguity and variation in practice.

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

8. Infections of concern A-Z

The IPC ASC Working Group identified several infections that would be helpful to include in order to provide a single source of information for people working in adult social care.

The guidance on Infection prevention and control for multidrug-resistant organisms in adult social care settings was published in January 2026, in advance of the IPC resource due to the recent Candidozyma auris outbreak in ASC.

The Working Group helped to prioritise which infections to concentrate on, and the infections that were identified were, Tuberculosis and infectious diarrhoea & vomiting, which are part of this stakeholder consultation.

- Section 8a Tuberculosis
- Section 8b Managing suspected infectious diarrhoea and vomiting

These infections below will be developed but likely to be added after publication.

- Blood borne viruses (BBV)
- Clostridiodes difficile (C.difficile)
- High Consequence Infectious Diseases (HCIDs)
- Invasive group A strep (iGAS) and GAS
- Norovirus

Until dedicated sections can be developed for the infections listed above, this resource will offer a brief overview for each one. This will include key information with what you need to know information for individuals who receive care and support, information for care and support workers, what you need to do, and links to further guidance.

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

Specific questions

Stakeholders are not expected to answer every question and should only respond to those that are relevant to their role or experience.

Question #	Question	Comment
1	From this list of infections: • Blood borne viruses (BBV) • Clostridiodes difficile (C.difficile) • High Consequence Infectious Diseases (HCIDs) • Invasive group A strep (iGAS) and GAS • Norovirus which would you prioritise for dedicated guidance 'on the prevention and management of' and why?	1) Norovirus Prioritise first. It spreads rapidly and disrupts homecare operations. Focus on early recognition, visit decisions, soap-and-water handwashing, safe laundry and waste handling, and clear return-to-work/care timing. 2) Group A Streptococcus (GAS) / iGAS Prioritise second. Risk escalates quickly. Distinguish GAS from iGAS and set clear red flags, urgent escalation routes, and precautions for wound/skin infections. 3) Blood-borne viruses (BBV) Prioritise third. Emphasise consistent safe practice: sharps safety, no recapping, disposal at point of use, and a clear post-exposure pathway (first aid, report, seek advice). 4) C. difficile Prioritise fourth. Focus on post-discharge risk, recognition,

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

		hydration, and soap-and-water hygiene. Set realistic expectations for cleaning in home settings. 5) HCIDs Prioritise last. Keep guidance brief: stop non-essential contact, isolate where possible, and escalate immediately to HPT/IPC.

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

8a. Tuberculosis (TB) Guidance for Adult Social Care Settings

Please indicate the page number and section heading for any comment that refers to a specific part of the document.

Content	The guidance could be clearer homecare application, defined roles, and practical safeguards. Make the homecare pathway explicit in “suspected TB” actions. Current steps assume communal settings (for example, “stay in their own room” and “avoid communal areas”, p.4). Replace or supplement these with homecare equivalents: limit non-essential visitors, maintain distance where possible, ventilate the main room during care, and plan visit timing to reduce contact. Ensure mask guidance is safe and feasible. You advise asking the individual to wear an FRSM where TB is suspected (p.4). Add a clear qualifier: staff should only request this where it is safe, tolerated, and clinically appropriate, particularly where the person may experience distress or has cognitive impairment. Reinforce the position on latent TB (p.2). You explain that latent TB is not infectious; add a simple line that no additional TB precautions apply beyond standard IPC. This will reduce anxiety and avoid unnecessary PPE use.
Language & accessibility	Use consistent, plain labels for TB status. You currently use “TB disease (active TB)”, “infectious TB”, and “pulmonary/laryngeal TB”. Standardise terminology and add a short glossary box: latent TB (not infectious) and active TB affecting the lungs or voice box (can be infectious). This will improve understanding and reduce ambiguity.

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

	Reduce dense bullet chains. The “suspected TB” actions run long and are difficult to scan. Group them under clear headings—Recognise and escalate, Reduce exposure, Follow specialist advice—to support quick use by homecare staff during visits (p.4). Replace broken or unclear links. The Mental Capacity Act link appears as a long, unreadable string. Use a clear, labelled hyperlink to improve readability and professionalism (p. —).
Practicality	Acknowledge limits in private homes. “Ensure the environment is clean and tidy” (p.4) is not always achievable in domiciliary care. Reframe this to reflect what staff can control: prepare a small care area if needed, protect equipment, and escalate where environmental risks prevent safe care. Clarify ventilation advice for homecare. “Open windows if appropriate and comfortable” (p.4) is helpful; add a practical qualifier. Staff should balance ventilation with warmth, safety, and the person’s preference, and use short periods of ventilation during visits where needed. Make contact tracing expectations practical. The section on staff diagnosed with TB (p.5) is helpful but should include a clear operational step. Providers should maintain accurate rota and visit records so HPTs can identify prolonged contacts across multiple households. Define “close and regular prolonged contact” (p.3) in practice. You explain that TB transmission requires prolonged exposure. Add a clear line that TB teams or HPTs will define contacts, and staff should not self-classify or restrict care without specialist advice.

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

8b. Managing suspected infectious diarrhoea and/or vomiting in adult social care settings

Please indicate the page number and section heading for any comment that refers to a specific part of the document.

Content	We support the inclusion of a dedicated section on suspected infectious diarrhoea and/or vomiting, as this is a common and operationally significant issue in homecare. The section should make the homecare pathway more explicit. In homecare, staff need clear guidance on recognising symptoms, reporting promptly to the office team or registered manager, using soap and water for hand hygiene where available, minimising handling of soiled laundry, advising the household on cleaning, and applying the 48-hour exclusion rule. The guidance should distinguish between what care and support workers can do directly during a visit and what the provider, family, household, GP, NHS 111, HPT or IPC team may need to do. In particular, homecare staff cannot usually control the wider household environment, deep cleaning, laundry arrangements, toilet access, or waste disposal. They can observe, record, apply precautions during care, advise, and escalate concerns. We recommend adding a short “In homecare (domiciliary care)” box setting out: what to ask, what to record, what PPE/hand hygiene steps to use, when to escalate, and when staff should not attend work.
Language & accessibility	The section would be easier to use if the key actions were presented as a short decision pathway. For example: “Recognise symptoms”, “Report immediately”, “Use soap and water”, “Minimise handling”, “Record and escalate”, and “Apply the 48-hour rule”.

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

	The SIGHT approach is helpful, but should be supported by a plain-English, mobile-friendly summary for homecare workers. Staff on visits need quick prompts rather than long explanatory text. The poster should be redesigned as both an A4 version for offices/training and a phone-friendly version for staff in the field.
Practicality	In homecare, suspected infectious diarrhoea and/or vomiting can disrupt continuity of care and increase risk across multiple households because staff travel between people. Providers should monitor reports from staff, visit logs, and staff sickness to identify possible clusters early. The guidance should acknowledge that soap and water may not always be readily available or suitable in a person's home. Staff should be advised to plan ahead, carry appropriate supplies where provided by the employer, and escalate where facilities are inadequate. Alcohol-based hand rub should not be presented as sufficient for diarrhoea and vomiting organisms. Guidance on laundry, cleaning and waste should be framed realistically. Staff may be able to bag or minimise handling of soiled items, advise the household, and document concerns, but they cannot usually implement residential-style cleaning or waste processes.

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

Specific questions

Stakeholders are not expected to answer every question and should only respond to those that are relevant to their role or experience.

Page	Heading	Sub-heading	Question #	Question	Comment
3	How to identify infectious diarrhoea and vomiting		1	Is completing a risk assessment (with or without support) something you would do in your role? If not, what is the process when a risk assessment is required?	Clarify roles in homecare escalation. In homecare, care and support workers gather key information (symptoms, onset, stool type, contacts, medicines or laxatives) and report immediately to the office team or registered manager. The registered manager or clinical lead carries out the formal risk assessment, agrees control measures, and escalates to GP, NHS 111, HPT, or IPC services as required. Also, commissioner/local authority if unsafe continuity of care becomes an issue.
11	IPC measures to use alongside the SIGHT approach	Training	2	Would it be helpful to reference the NHSE IPC educational framework in this training section. Is it a document you use?	Yes. Homecare providers may not use it routinely, but it offers a clear benchmark for training design and assurance (p.11).

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

15	Appendix One		3	Would a poster like this be helpful for your setting, and if so, would you find it useful for us to redesign it into a more visually appealing format?	A poster would support homecare use in A4 version for offices and training packs, a mobile-friendly one-pager for staff on visits, and a high-contrast, plain-English layout with clear “at home” actions and the 48-hour rule prominently displayed.

9. Essential IPC considerations for clinical interventions and procedures

Please indicate the page number and section heading for any comment that refers to a specific part of the document.

Content	Clarity on what staff control in homecare would be good. The section includes useful points (prepare a clean space, avoid bathrooms, clean surfaces), but it should recognise variable home environments. Add a clear line: staff prepare a small clean field, protect equipment, and escalate where conditions prevent safe care (p.5). Set clear expectations for aseptic technique. You state that staff should understand the principles. Strengthen this by clarifying trained and authorised tasks: care staff apply aseptic principles as part of routine care but only carry out specific aseptic procedures where they are trained, assessed as competent, and authorised by their provider. This defines the boundary clearly and reduces ambiguity about scope of practice (p.3–4). Align equipment responsibilities with homecare. Maintenance records for all equipment are not always realistic. Clarify that providers maintain records for provider-owned equipment, and staff check and report issues with client-owned or NHS equipment (p.5).

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

	Make specimen handling practical. Technical detail on UN3373 and transport is unlikely to apply to most homecare staff. Add a clear instruction: staff follow provider processes and only transport specimens where their role requires it; keep detailed requirements for managers or clinical leads (p.11–12).
Language & accessibility	Use consistent manager terms. Replace “care manager” and “nominated deputy” with clear, homecare-relevant roles such as “registered manager,” “office team,” or “clinical lead,” and use one term consistently (p.2, p.5). Keep instructions role-specific. Clearly separate actions for different roles. Label tasks that apply to registered clinicians (for example, specimen requesting and documentation) as “for managers/clinical staff,” and keep “care and support worker” actions distinct to avoid confusion (p.10–12).
Practicality	We support the practical approach to fridge monitoring. Stating that home fridge monitoring is not required is realistic and supports homecare delivery (p.10). Clarify PPE for medicines administration. The position that gloves and aprons are not routinely required is appropriate; add a clear default that staff carry out hand hygiene before and after administration and clean measuring devices (p.8–9). Make escalation routes explicit. Replace general instructions such as “report” or “contact” with a clear homecare pathway: staff report to the office team or clinical lead, who liaises with GP, district nursing, or IPC services as required (p.5–6, p.10–12).

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

Specific questions

Stakeholders are not expected to answer every question and should only respond to those that are relevant to their role or experience.

Page	Heading	Sub-heading	Question #	Question	Comment
5	Managing invasive indwelling devices and wounds		1	For those working in domiciliary care, does this final point on communication and education feel appropriate for home care (domiciliary) settings? What changes would you recommend to make it more useful?	Yes, but make it more operational for homecare (p.5–6). Strengthen escalation clarity. Add a clear route: staff record concerns and contact the office team or clinical lead, who then liaises with district nursing or the GP (p.5–6). Include a simple teach-back check. Prompt staff to confirm understanding (for example, “Tell me what you will look for and who you will call”). This supports safe care between visits (p.6). Use practical home-based cues. Include clear signs care and support workers and families can recognise (such as new leakage, foul smell, increased pain, spreading redness, or

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

					new confusion or fever) and link these directly to “what to do today” (p.5–6).
8	Antimicrobial administration		2	Should this section expand to all medicine administration rather than specifically antimicrobial medicines?	Yes—either broaden the section or split it. Most content already applies to medicines generally (for example, dose timing, missed doses, measuring, and storage). Keep a short, clearly defined antimicrobial subsection focused on stewardship, including course completion, avoiding unnecessary use, and recognising key risks such as *C. difficile* (p.8–10).
9	Antimicrobial administration	Adverse effects	3	Is it helpful to include a section on adverse effects?	Yes, and make it more structured. care and support workers often identify side effects first in homecare. Present this using a simple “mild vs urgent” format and retain the clear emergency instruction for severe allergic reactions (p.9–10).

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

10. Staff health and managing sickness related to infection

Please indicate the page number and section heading for any comment that refers to a specific part of the document.

Content	Strengthen continuity of care in homecare. You note that sickness absence affects continuity. Make the impact explicit: in domiciliary care, absence can lead to missed or late visits and increase safeguarding risk. Add a clear line on using contingency plans, including cover arrangements, prioritisation, and escalation when staff exclude themselves. Clarify roles and advice routes. The guidance refers to occupational health and HPT, but many homecare providers do not have occupational health support. Add a clear pathway: staff contact the registered manager or clinical lead first; the provider then liaises with HPT or IPC services as required.
Language & accessibility	Use consistent, homecare-relevant terms. Avoid switching between “care setting,” “ASC setting,” and varying role titles. Use consistent terms such as provider, registered manager, or clinical lead.
Practicality	Clarify symptom thresholds for respiratory infection. The table distinguishes “high temperature and unwell” from “mild symptoms,” but staff need a simple rule. You could add a clear line: if you feel unwell or feverish, do not attend work; if symptoms are mild, follow risk assessment and infection control measures. Reflect multi-household risk in homecare. Staff move between multiple households, which increases transmission risk. Add a brief line to emphasise the importance of early reporting and strict adherence to exclusions. Strengthen scabies advice for homecare. You state that staff can continue working with PPE until 24 hours after treatment. In practice, many tasks involve direct skin contact. Add a line to adjust duties or allocations where possible to reduce close contact during this period.(p.6)

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

11. Additional information and resources for adult social care managers

Please indicate the page number and section heading for any comment that refers to a specific part of the document.

Content	You could strengthen homecare examples. Expand “systems and processes” with practical domiciliary examples: monitor clusters across households using rota data, check portable hand hygiene kits, manage PPE stock for mobile teams, and review incidents such as missed or late calls during outbreaks. Rebalance premises-focused content. Retain refurbishment guidance (p.1) but label it clearly as “communal settings.” Add a short homecare section covering vehicles, storage, and mobile equipment (clean/dirty separation, lidded boxes, and decontamination supplies).
Language & accessibility	Use consistent role terminology. Refer consistently to the “registered manager” when assigning responsibility for audits and outbreak planning, especially in homecare settings.
Practicality	Strengthen audit implementation in homecare. The audit list is clear, but it needs practical application for domiciliary care. Add examples for mobile teams, such as spot checks during visits, checks of portable hand hygiene kits and PPE, review of equipment cleaning logs, observation of practice through supervision, and use of rota and incident data to identify patterns and risks. Make IPC contact arrangements operational. You advise maintaining key contacts (GP, IPC, HPT, local authority public health). Add a clear step: store details in a shared directory, include out-of-hours contacts, and set a simple escalation route (staff → office team/registered manager → HPT/IPC). Keep annual statement expectations proportionate. The suggested IPC content is appropriate. Add one line to confirm that homecare providers can evidence this through incident logs, training records, and outbreak summaries, even without a building-based setting.

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

12. The Glossary

Please share your views on the glossary. Are the definitions clear and appropriate, and are there any terms that need to be added, updated or explained in more detail?

The glossary covers core IPC concepts in plain language and consistently includes domiciliary care within “adult social care settings,” which supports usability for homecare readers.

Correct priority definitions.

- **Single use:** Correct the definition. Single use means use once for one person, then dispose. Distinguish this from single individual/patient use, which allows reuse for the same person with cleaning as required. (p.9)
- **Infectious diarrhoea and/or vomiting:** The current wording describes suspected cases. Rename to “suspected infectious diarrhoea and/or vomiting” or revise the definition to match confirmed infection. (p.6)

Strengthen homecare relevance.

- **Alcohol-based hand rub:** Add one line that it is less effective for diarrhoea and vomiting organisms; use soap and water in these cases.
- **Water safety:** Reflect that, in private homes, staff identify risks and escalate rather than manage water systems.
- **Laundry and linen:** Clarify terms—linen (items such as bedding/towels) and laundry (the washing/drying process, including clothing).
- **Respiratory Protective Equipment RPE:** Include fit testing and fit checking.(p.9)

You could add short “Homecare note” lines to entries where control differs in private homes (for example, cleaning, waste, ventilation): staff advise, document, and escalate where they cannot control the environment.

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

13. Abbreviations

Please share your views on the abbreviations. Are there any terms missing?

Overall, the abbreviations list is clear and largely complete, but here are some suggested missing terms and key abbreviations that support homecare and outbreak management:

- MCA – Mental Capacity Act (used repeatedly in safeguarding statements)
- SIGHT – diarrhoea/vomiting protocol (used as a named approach)
- D&V – diarrhoea and vomiting (used frequently; many organisations abbreviate it)
- C. diff / CDI – Clostridioides difficile / C. difficile infection (referenced as a key risk)
- GAS / iGAS – Group A Strep / invasive Group A Strep (listed in outbreak content)
- BBV – Blood-borne viruses (frequently referenced in IPC contexts)
- Type IIR – Type IIR fluid-resistant surgical mask (you use “FRSM”, but Type IIR is often referenced alongside it)
- MAR – Medicines Administration Record (highly relevant to medicines/antimicrobial sections)
- NEWS2 – National Early Warning Score 2 (mentioned in earlier sections)
- DDT – Diagnostic Decision Tool (used in UTI content)
- HTM – Health Technical Memorandum (HTM 01-04 / HTM 04-01 are referenced)
- HBN – Health Building Note (referenced in the manager section)

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

14. General comments

For feedback on the entire IPC resource for Adult Social Care, please use the box below.

The resources set a clear purpose and link IPC to safer care, reduced harm, and antimicrobial stewardship. This helps staff understand why it matters. The content also covers the right topics across the pathway, supporting a whole-service approach. However, usability for home care / domiciliary care needs to be strengthened.

Make the homecare pathway explicit.
Many sections still read as care home guidance with limited homecare adaptation. Add a consistent “In domiciliary care…” call-out in each chapter, setting out what this means in practice. Be specific about what staff do during visits (prepare a clean space, carry and clean portable equipment, document, escalate) and what they advise or raise with others (for example, deep cleaning, water systems, household waste).

Clarify roles and escalation routes.
Set out provider processes clearly to reduce variation. Make explicit that frontline staff report to the registered manager or office team first, and the provider then assesses risk and coordinates contact with GP, HPT, or IPC services as required.

Keep actions realistic in private homes.
Reframe expectations that do not translate well to domestic settings (for example, “terminal cleaning” or formal maintenance schedules for household equipment). State clearly that staff identify and document risk, advise the household, and the provider coordinates response and reporting.

Fix access and consistency issues.
Ensure all links work and are easy to open on mobile devices. Use consistent terminology throughout (for example, a single term such as “registered manager”) and align the glossary and abbreviations with how terms are used in the resource.

This form is to be completed and returned to ascipcresource@dhsc.gov.uk **by Wednesday 20 May 2026**.

Improve scan-read design.
Support quick use in practice by adding one-page checklists, decision prompts, and “what to do now” boxes, particularly for outbreaks, D&V, TB, and PPE/RPE. Optimise key tools for mobile use.

What to keep.
Retain the clear, practical guidance on hand hygiene, respiratory hygiene, PPE, and 48-hour exclusion for D&V. Keep the emphasis on proportionate, person-centred care and rights-based visiting.