Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Document Type: **POLICY**		**Unique Identifier:** CORP/POL/359
Title: **Management of carbapenemase-producing Enterobacteriaceae**		**Version Number:** 6
		Status: Ratified
Target Audience: Trust Wide		**Divisional and Department:** Infection Prevention
Author / Originator and Job Title: Dr Ruth Palmer Consultant Microbiologist Jo Lickiss Infection Prevention Nurse Consultant Sharon Mawdsley Lead Infection Prevention Nurse		**Risk Assessment:** Not Applicable
Replaces: Version 4 Management of Carbapenemase-Producing Bacteria CORP/POL/359	**Description of amendments:** Patients who permanently reside outside of the UK should be screened, regardless of whether or not they have had a hospital admission. Patients who have had renal dialysis abroad are also to be screened.	
Validated (Technical Approval) by: Strategic Infection Prevention Team Meeting	**Validation Date:** 23/12/2015	**Which Principles of the NHS Constitution Apply?** 1 - 4
Ratified (Management Approval) by: Whole Health Infection Prevention Committee	**Ratified Date:** 08/01/2016	**Issue Date:** 08/01/2016
Review dates and version numbers may alter if any significant changes are made		**Review Date:** 01/01/2019

Blackpool Teaching Hospitals NHS Foundation Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that they are not placed at a disadvantage over others. The Equality Impact Assessment Tool is designed to help you consider the needs and assess the impact of your policy in the final Appendix.

CONTENTS

1 PURPOSE

The purpose of this policy is to ensure the early detection, management and control of carbapenemase-producing Enterobacteriaceae in Acute Healthcare settings.

2 TARGET AUDIENCE

This document applies to all healthcare personnel working within the Blackpool Teaching Hospitals NHS Foundation Trust.

3 POLICY

3.1 Introduction

3.1.1 What are carbapenemase-producing Enterobacteriaceae?

Enterobacteriaceae are a large family of bacteria that usually live harmlessly in the gut of all humans and animals. However, these organisms are also some of the most common causes of opportunistic urinary tract infections, intra-abdominal and bloodstream infections. They include species such as Escherichia coli, Klebsiella spp. and Enterobacter spp. Carbapenems are a valuable family of antibiotics normally reserved for serious infections caused by drug-resistant Gram-negative bacteria (including Enterobacteriaceae). They include meropenem, ertapenem and imipenem. Carbapenemases are enzymes that destroy carbapenem antibiotics, conferring resistance. They are made by a small but growing number of Enterobacteriaceae strains. There are different types of carbapenemases, of which KPC, OXA-48, NDM and VIM enzymes are currently the most common.

This policy has been written to provide expert advice on the management of colonisation or infection due to carbapenemase-producing Enterobacteriaceae in England, to prevent or reduce their spread into (and within) health and residential care settings. In the UK, over the last five years, there has been a rapid increase in the incidence of infection and colonisation by multi-drug resistant carbapenemase-producing organisms. A number of clusters and outbreaks have been reported in England, some of which have been contained, providing evidence that, when the appropriate control measures are implemented, these clusters and outbreaks can be managed effectively.

This policy focuses on carbapenemase-producing Enterobacteriaceae, rather than all carbapenemase-producing organisms, to be consistent with guidance provided elsewhere in the UK.

3.1.2 Why does carbapenem resistance matter?

Carbapenem antibiotics are a powerful group of β-lactam (penicillin-like) antibiotics used in hospitals. Until now, they have been the antibiotics that doctors could always rely upon (when other antibiotics failed) to treat infections caused by Gram-negative bacteria. Unless we act now, learning from experiences elsewhere across the globe, rapid spread of carbapenem-resistant bacteria has great potential to pose an increasing threat to public health and modern medicine as we know it in the UK.

3.1.3 How can carbapenemase-producing Enterobacteriaceae be detected early and spread prevented?

Advice is provided in the following sections to assist in the early detection, prevention and control of carbapenemase-producing Enterobacteriaceae. The approach recommended in this policy is taken from the latest guidance from Public Health England and focuses on the acute setting where the risk of spread, and its consequences, is greater. It is acknowledged that care in non-acute settings cannot, nor need be, subjected to the same stringent measures.

3.1.4 Countries and regions with reported high prevalence of healthcare-associated carbapenemase-producing Enterobacteriaceae

Bangladesh	North Africa (all)
The Balkans	Malta
China	Middle East (all)
Cyprus	Pakistan
Greece	South East Asia
India	South/Central America
Ireland	Turkey
Israel	Taiwan
Italy	USA
Japan	

As this is not an exhaustive list; any patient admitted with a history of hospital admission in **any country** within the last **12 months** must be screened. **Additionally, any patient who permanently resides abroad should be screened, regardless of whether or not they have had a hospital admission.** Lack of data from a country not included in this list may reflect lack of reporting / detection rather than lack of a carbapenemase problem (which may additionally contribute to an under-estimation of its prevalence)

UK regions / areas where problems have been noted in some hospitals:

North West especially:
Manchester

London

- Screening for CPE is not yet uniformly established across all hospitals. A patient carrying CPE may get transferred from any other hospital. Hence, locally we have agreed to screen all transfers from other hospitals.

- **Priority for the allocation of side rooms must go to those who have been inpatients abroad or in hospitals in Manchester and London.**

3.2 Patient Screening

Early recognition of individuals who may be colonised/have an infection

This risk assessment should be performed as part of the routine admission procedure to identify <u>suspected cases</u> of colonisation or infection with carbapenemase-producing Enterobacteriaceae
Assess each patient on admission, readmission *OR* on transfer from another healthcare facility (not at pre op assessment).
Has the patient been an inpatient in a hospital abroad in the past 12 months? *OR* **Had renal dialysis in a hospital abroad in the past 12 months?** *OR* **Been an inpatient in any <u>other</u> UK hospital in the past 12 months?** *OR* **Does the patient permanently reside in another country outside of the UK?** *OR* **Been a close household contact of a person who is known to have been colonised or have an infection with carbapenemase-producing Enterobacteriaceae. (Such as patients tagged on Maxims and Alert systems).** NOTE: if the patient is a recent BTH laboratory confirmed case of carbapenemase-producing Enterobacteriaceae infection / colonisation or confirmed at a transferring healthcare facility [UK facility only] bypass this step, isolate the patient immediately and treat as a positive case
If one or more of above applies then:
The patient is considered to meet the criteria for being a suspected case of carbapenemase-producing Enterobacteriaceae colonisation or infection (as applicable) **AND REQUIRES IMMEDIATE ISOLATION** Plus: • **instigation of *strict standard precautions* to prevent possible spread** • **screening to assess current status for colonisation or infection** • **assessment for appropriate treatment (applies to infection only)** **Priority for the allocation of side rooms must go to those who have been in hospitals abroad or in hospitals in Manchester and London.**

3.2.1 Early isolation of laboratory-confirmed and suspected cases

If the patient already has laboratory-confirmed infection or colonisation with carbapenemase-producing Enterobacteriaceae *OR* meets the criteria for a suspected case then:
Advise the patient (and relatives if appropriate) of the positive result or your suspicions (whichever applies) and your management plan – provide patient information leaflet *AND* Immediately place the patient into a single room (**with en suite facilities if a laboratory-confirmed case**) and send screening samples If no side rooms are immediately available please contact the Infection Prevention team for advice. *AND* Apply strict standard precautions in all settings.
All suspected patients should be isolated until screening results are known. If the patient is **POSITIVE** for carbapenemase-producing Enterobacteriaceae or is a laboratory-confirmed case (colonisation or infection): • **they should remain in isolation for the duration of their hospital stay** • **strict standard precautions must be practiced (whether the patient has infection or colonisation) including:** • **good hand hygiene** • **where any part of a staff uniform, not protected by an ordinary apron, is expected to come into contact with the patient, a long-sleeved disposable gown should be used e.g. when assisting movement for a dependent patient** • **use of personal protective equipment (PPE) in line with standard precautions** • **environmental cleaning and decontamination, with an enhanced focus on frequent cleaning of hand contact areas**

3.2.2 Early detection – screening of suspected cases and contacts

Screening of cases and contacts (based on the likelihood of exposure) will direct management, allow early instigation of infection prevention measures and help assess whether spread has occurred.

If the patient meets the criteria for a suspected case of infection or colonisation with carbapenemase-producing Enterobacteriaceae:

SCREEN THE PATIENT:

Immediately arrange for the patient to be screened - provide explanation & patient information leaflet.

AND

Inform the Infection Prevention team

Please note that a patient cannot be considered negative unless they have had three negative screens taken at 48 hour intervals.

Negative screen test results are usually available within 24 hours of being received in the laboratory. Presumptive positive results are usually available within 48 hours.

WHAT SAMPLES TO TAKE AND WHEN:

<u>Day of admission (Day 0)</u>

Obtain a rectal swab or stool sample - To ensure detection of the organism there must be visible faecal material on the swab. All suspected cases should be isolated in a side room initially.

ALSO

Include samples from any wounds and device-related sites (please note that all covered wounds should be undressed and swabbed as part of this screen). If these sites are not screened on the day of admission it may be impossible to determine whether or not any cross infection has occurred should later clinical samples test positive.

Request a 'Carbapenemase screen' test via the Cyberlab system for each specimen and send them to the Pathology laboratory as soon as possible.

Day 2 (or 48 hours after initial screen)

Obtain a second rectal swab or stool sample.

Day 4 (or 48 hours after the second screen)

Obtain a third rectal swab or stool sample.

Barrier nursing may be discontinued once a total of three negative screens have been obtained at 48 hour intervals.

SCREENING OF PATIENTS PRIOR TO ELECTIVE ADMISSIONS:

The PHE guidance advises that patients should be screened on admission to the Trust and makes no recommendations about pre admission screening.

The guidance also recommends that every patient who meets the criteria for being a suspected case of infection or colonisation with carbapenemase-producing Enterobacteriaceae should be isolated in a single side room. This may not always be achievable however and therefore it may be beneficial for the Divisions to establish which patients will require a side room on admission to the Trust by instigating pre admission screening. Should the Divisions choose this option then the following applies:-

At pre admission clinic/assessment

Collect a rectal swab or stool sample and samples from any wounds and device-related sites and send to the laboratory as above. To ensure detection of the organism there must be visible faecal material on the rectal swab.

Only patients with a confirmed negative screen can be barrier nursed in a bay on admission to the Trust whilst awaiting the remaining screen results.

On the day of admission

Obtain a second rectal swab or stool sample.

48 hours after admission

Take a third rectal swab or stool sample.

Please note that the Divisions will need to establish their own local process to facilitate pre admission screening and will also need to ensure that all pre admission screening activity and results are documented clearly for further follow up by the admitting ward.

SCREENING OF CONTACTS following a confirmed positive result of an inpatient:

Provide contact leaflet and undertake screening for contacts of a positive case based on the likelihood of exposure as follows:

1. *Screening of patients in the same setting* is NOT normally required if the case was identified on admission and isolated immediately

2. *Screening of patient contacts* of a positive case SHOULD be undertaken if the case had spent time (or remained) in an open ward or bay with other patients before (or despite) having a positive result for carbapenemase-producing Enterobacteriaceae

3. *Screening of household contacts and healthcare staff* is NOT required – there is no compelling evidence to suggest that screening the household or healthcare staff to check for colonisation will provide additional benefit in controlling spread in the healthcare setting. The main focus should remain on promotion of strict standard precautions throughout, especially hand hygiene.

ACTING ON RESULTS OF SAMPLES:

PATIENTS NOT KNOWN TO BE PREVIOUSLY POSITIVE.

If **NEGATIVE** on screening – ideally the patient should remain in a side room *until a further two consecutive samples test negative* samples being taken 48 hours apart i.e. day 0 (the initial sample), day 2 and day 4 (the further samples). Once achieved they can be removed from isolation with no further screening required. The patient should be advised / supervised to practice good hand hygiene.

Patients from hospitals abroad or from UK hospitals with endemic CPE problems should be barrier nursed in side room until three negative swabs have been obtained.

should still be barrier nursed until three negative screens have been obtained but can be moved out of a side room after first negative screen unless continued isolation in a side room is warranted due to clinical conditions such as TB, Chickenpox, diarrhoea cellulitis etc required continued S/R isolation)

Following risk assessment, patients from UK hospitals without endemic CPE can be removed from isolation in a side room and barrier nursed in a bay providing there is an initial negative screen result. **However this is only if the patient does not have diarrhoea, is not incontinent of faeces and does not have any other clinical condition that requires continued isolation in a side room such as TB or chicken pox etc.** Two further screens are still required please contact the Infection Prevention Team for advice.

Should any sample test POSITIVE – manage patient as positive case (below).

If **POSITIVE** (either from a screening sample OR from a routine clinical sample from this admission episode) the patient should remain in isolation, preferably for the duration of their hospital stay. The patient should be advised to practice good hand hygiene especially

after using the toilet. Once a patient is found to be colonised with CPE, they should always be considered positive and barrier nursed in a side room throughout this and future admissions. A discharge screen is required, either by rectal swab or stool sample.

Ensure:

- **patient, and family (as appropriate), have been informed of positive result and information leaflet provided**
- **a sticker is attached in the patient's notes**
- **MAXIMS and Alert are flagged with positive result.**
- **information about positive result is included on all transfer / admission documents (if moved to another healthcare setting or referred for community care)**

Careful risk assessment is required should it be deemed necessary to consider removing a previously positive or a colonised patient from isolation. A patient with an infection should not be removed from isolation.

Experience from other areas in the UK / abroad has shown that, on some occasions, an apparently cleared carbapenemase-producer can re-grow to a detectable level in the gut flora. A previously positive individual with subsequent negative screening results can revert to a positive state, especially after a course of antibiotics.
Should a patient who is colonised or has an infection require a diagnostic test or procedure which cannot be undertaken in the patient's room, the procedure should be planned at the end of the day's list and the room and equipment terminally cleaned after use.

OUTPATIENTS AND RENAL DIALYSIS PATIENTS: similarly, known positive outpatients should be planned at the end of the day's list; known positive renal dialysis patients should be isolated.

FOR CONTACTS: If screening is indicated:

- **It is not necessary to isolate contacts whilst awaiting screening results** – cohort such contacts if possible and / or reiterate strict hand hygiene for staff and patients
- screen all patients in the bay (or ward, if patient has occupied more than one bay) on a weekly basis for a period of 4 weeks after the last case was detected
- restrict screening to patient contacts remaining in hospital
- If a patient is transferred to another ward they must be isolated in a side room until the four weeks of screens have been completed.

However, *should any contact screen positive, manage as positive case* (see above)

AND

In discussion with your PHE Centre, consider screening the whole ward *PLUS* discharged patients who occupied the bay (or ward, if case occupied more than one bay) at the same time as the positive case.

3.2.3 Effective treatment – antibiotics and decolonisation

Treatment of the patient with an infection caused by carbapenemase-producing Enterobacteriaceae should be undertaken under the advice of the microbiologist

Firstly, establish whether the patient has an infection or is colonised with carbapenemase-producing Enterobacteriaceae as confirmed on laboratory testing:

If the patient has an infection, *under the advice of the microbiologist*, consider:

Monotherapy (not recommended for treatment of severe infection):

- **Polymyxins (eg colistin)**
- **Tigecycline**
- **Fosfomycin14 (i.v. or, for lower UTI only, oral), is active against most carbapenemase-positive *E. coli,* but variable against other genera**
- **Aminoglycosides (less consistent)**

Combination therapy (supported by outcome analyses for treatment of severe infections):

- **Polymyxin + carbapenem**
- **Polymyxin + tigecycline**
- **Polymyxin + aminoglycoside**

For further advice about treatment please refer to section 5.2 'Other antibiotics' in: *UK Standards for Microbiology Investigations: Laboratory Detection and Reporting of Bacteria with Carbapenem-Hydrolysing β-lactamases (carbapenemases)* (2013) published at: http://www.hpa.org.uk/
Please also please refer to Start Smart, Then Focus. Department of Health's advisory committee on Antimicrobial Resistance and Healthcare-associated Infection (ARHAI): https://www.gov.uk/government/publications/antimicrobial-stewardship-start-smart-then-focus

If the patient is colonised:

- **no antibiotic treatment is required for colonisation**
- **decolonisation is *NOT* advised for the following reasons:**
- **Skin decolonisation – not advised as these bacteria generally colonise the gut rather than the skin**
- **Gut decolonisation (by prescribing antibiotics) – not advised as although antibiotics may provide some benefit, there is concern that their use would contribute to increasing resistance in the longer term.**
- **advise patient of the need for good hand hygiene, especially if they develop loose stools or diarrhoea (for any reason)**

If the patient develops an infection:

- **ensure treatment is started promptly**
- **treatment should be guided by susceptibility results**

3.2.4 Early instigation of effective Infection Prevention

Regardless of when the suspected or confirmed case is identified, be it on admission or later:

All relevant staff should be made aware that suspected / recent laboratory confirmed case(s) of carbapenemase-producing Enterobacteriaceae colonisation or infection has / have been identified

AND

An immediate initial risk assessment should be undertaken to investigate the likely source(s)

AND

Rapid promotion of strict adherence to this policy should take place, including the need for compliance with its recommendations.

1. All staff must adhere to strict isolation precautions *as a norm* including:
- **hand hygiene**
- **personal protective equipment**
- **aseptic technique**
- **laundry management**
- **safe use of sharps**
- **waste disposal (especially faeces)**

2. Scrupulous infection prevention practices are emphasised as being particularly important when using and caring for devices / equipment such as:
- **intravenous / peripheral line**
- **central venous catheter line**
- **urinary catheter**
- **ventilators**
- **renal dialysis equipment**
- **enteral feeding equipment**
- **colostomy or ileostomy**
- **any re-usable diagnostic equipment**

NOTE: Loose stools or diarrhoea (for any reason) increase the risk of spread of the bacteria from the gut, therefore:

- **observe strict infection prevention measures**
- **provide assistance to patients where effective hand hygiene is in doubt**

Further advice can be found at:
The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (2010)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216227/dh_123923.pdf
epic3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England (due for publication in the Journal of Hospital Infection January 2014)

3.2.5 Cleaning and decontamination

No increased frequency of cleaning is required (unless there is evidence of transmission) – but scrupulous routine cleaning is required

Carbapenemase-producing Enterobacteriaceae can be eliminated from the environment by stringent application of normal standards of cleaning and decontamination

THIS INCLUDES THE FOLLOWING:

- **adherence to high standards of cleaning should be promoted and audited**
- **routine but stringent decontamination of equipment is required after use with an affected patient, especially when the equipment may be shared with other patients**
- **dedicated / single-patient or single-use equipment is preferable**

TERMINAL DECONTAMINATION: FOR POSITIVE CASES

Decontamination is most crucial following a patient leaving a specific area – for example from an isolation room or bed space. This will need coordination between domestics, healthcare assistants, nurses and other specialties, as appropriate.

Should the patient require a diagnostic test or procedure, ideally it should be undertaken in the patient's room (if appropriate or feasible). If not, it should be planned at the end of the day's list and the room, where the procedure was undertaken, and equipment terminally cleaned after use.

Surface cleaning and hand-touch / contact areas:

- **scrupulous cleaning and disinfection of all surfaces is required with particular attention to those that may have had patient or staff hand contact**

Mattresses are of particular importance:

- **conventional mattress covers should be cleaned and disinfected**
- **dynamic mattresses should be disassembled, cleaned and disinfected – usually by specialist external contractors or in specialist facilities within the hospital**

Other close-patient contact equipment and items

- **pulse oximeters require normal cleaning and disinfection or single-patient use only**
- **blood pressure cuffs should be single-patient use only**
- **stethoscopes and thermometers should be single-patient use only**
- **there are no extra decontamination requirements for endoscopes above the normal organisational procedures. Any attached cameras / equipment which cannot be steam sterilised, should be protected using a single-use covering and thoroughly chemically disinfected between patients once the covering has been removed**
- **privacy curtains should be removed and laundered or single-use only**
- **unused wrapped single-use items in the patient's immediate vicinity (that may have become contaminated by hand contact) should be discarded. The burden of this may be minimised by keeping limited stocks near the patient**
- **tubes of ointment and lubricant should be disposed of**

3.2.6 Early communication on discharge or medical transfer of patients

Robust healthcare communications (within and between acute, non-acute / community settings) are crucial to a successful concerted effort to prevent and control spread
Commence communications as soon as the first suspected or confirmed case comes to light
Maintain communications within the organisation from board level down (including the local laboratory and between departments) AND Alert neighbouring trusts and providers to allow them to put the necessary precautions and level of alertness in place to prevent spread. AND It is the Ward or Departments responsibility to ensure good communication with receiving organisations ***prior to*** patient transfer or discharge and with all healthcare professionals along the patient pathway INCLUDE The family and / or care facility to which the patient is to be discharged providing an accurate explanation of risk in a non-acute / community setting, Infection prevention management advice and an opportunity for questions BY Carefully planning ***well in advance*** of the patient's movements and discharge / transfer
Communication is required between and with: The patient so that they understand on discharge: • **their current status (e.g. infection cleared but may still be a carrier), and the need for good hand hygiene** • **that, should a close contact be admitted to hospital / healthcare setting for any reason, they need to inform healthcare staff of their exposure** Internal colleagues • **the microbiologist and laboratory personnel** • **the infection prevention team to remind ward staff (including domestic and visiting staff) of infection prevention measures within this Carbapenemase-producing Enterobacteriaceae Management Policy**

Healthcare colleagues:

- **microbiologists, INFECTION PREVENTION teams in neighbouring healthcare trusts and the community**
- **hospitals, care homes, primary care services *especially* the patient's GP plus any other relevant care provider along the patient pathway.**
- **any trusts where there is regular inter-trust transfer from one unit to another eg liver units (where one unit is affected)**

Key partners such as:

- **Public Health England, particularly your local PHE Centre**
- **clinical commissioning groups**
- **the local Director of Public Health**
- **the local Health and Wellbeing Board**

4 ATTACHMENTS	
Appendix Number	**Title**
1	Patient screening flowchart
2	CPE – Checklist for clinical staff
3	Patient information
4	UK Inter-healthcare transfer form
5	Equality Impact Assessment Tool

5 PROCEDURAL DOCUMENT STORAGE (HARD AND ELECTRONIC COPIES)
Electronic Database for Procedural Documents
Held by Procedural Document and Leaflet Coordinator

6 LOCATIONS THIS DOCUMENT ISSUED TO		
Copy No	**Location**	**Date Issued**
1	Intranet	08/01/2016
2	Wards, Departments and Service	08/01/2016

7 OTHER RELEVANT / ASSOCIATED DOCUMENTS	
Unique Identifier	**Title and web links from the document library**
CORP/GUID/309	Antimicrobial Formulary – For the Management of Common Infections in Adults within General Medicine and Surgery http://fcsharepoint/trustdocuments/Documents/CORP-GUID-309.docx
CORP/POL/016	Infection Prevention Policy http://fcsharepoint/trustdocuments/Documents/CORP-POL-016.doc
CORP/POL/410	Glove Policy http://fcsharepoint/trustdocuments/Documents/CORP-POL-410.doc
CORP/PROC/418	Hand Hygiene Procedure http://fcsharepoint/trustdocuments/Documents/CORP-PROC-418.docx

7 OTHER RELEVANT / ASSOCIATED DOCUMENTS	
Unique Identifier	**Title and web links from the document library**
CORP/PROC/465	Safe Disposal of Clinical Waste http://fcsharepoint/trustdocuments/Documents/CORP-PROC-465.doc
CORP/PROC/488	Investigation, Management and Control of Outbreaks of Infectious Diseases http://fcsharepoint/trustdocuments/Documents/CORP-PROC-488.docx
LP/121/01	Inter-Healthcare Transfer Form http://fcsharepoint/divisions/corporateservices/informationgovernance/healthrecords_library/Documents/CPE%20transfer%20document%20(2).doc
PL/859	Carbapenemase Producing Enterobacteriaceae (CPE) http://fcsharepoint/trustdocuments/Information%20Leaflets/PL859.pdf

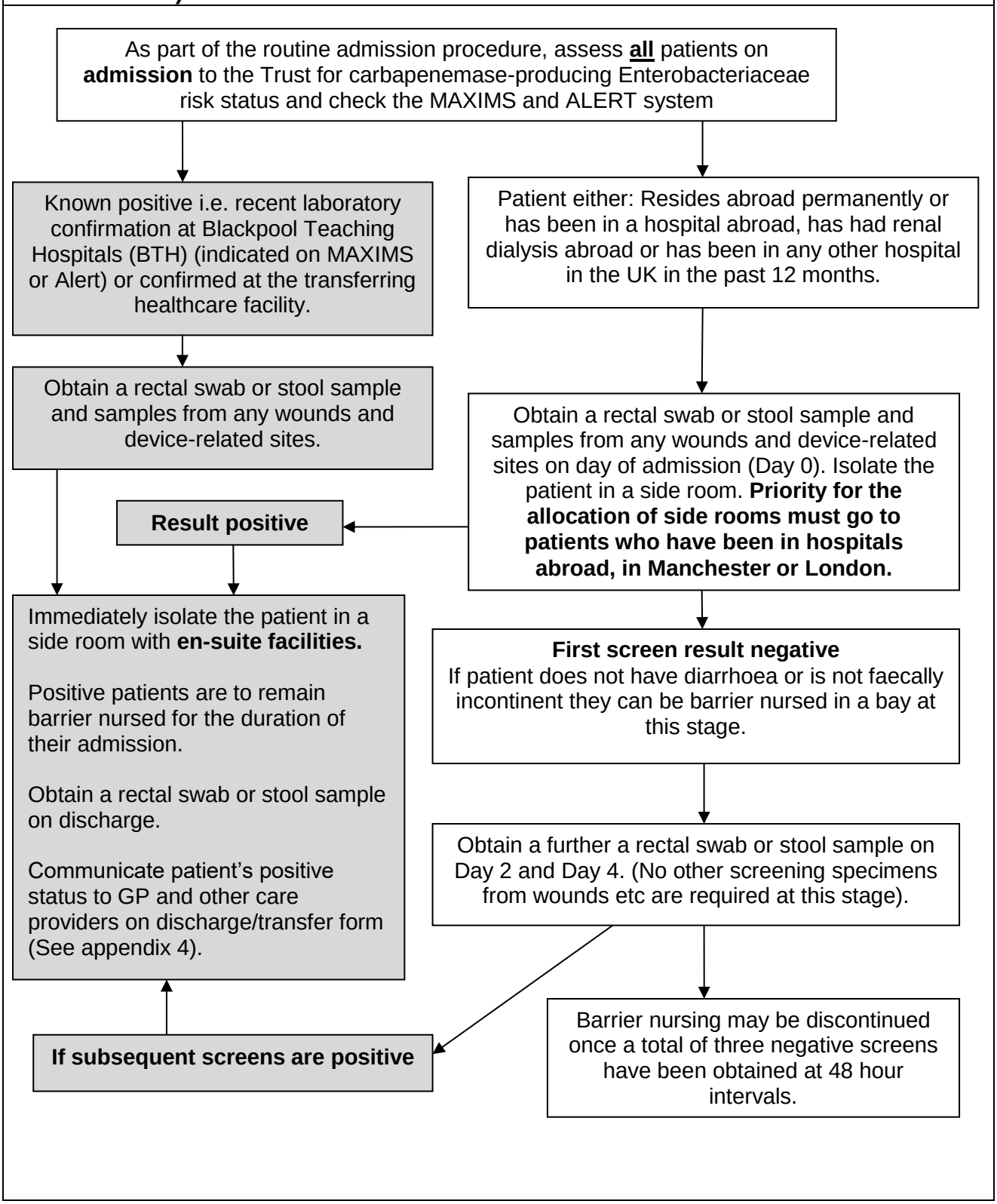
8 SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS
References In Full
Acute trust toolkit for the early detection, management and control of carbapenemase-producing Enterobacteriaceae. Public Health England 2013. http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317140378646
Advice on Carbapenemase Producers: Recognition, infection control and treatment. Health Protection Agency 2011. http://www.hpa.org.uk/web/HPAweb&Page&HPAwebAutoListName/Page/1294740725255

9 CONSULTATION / ACKNOWLEDGEMENTS WITH STAFF, PEERS, PATIENTS AND THE PUBLIC		
Name	**Designation**	**Date Response Received**
Dr Sharma	Consultant Microbiologist and Director of Infection Prevention & Control	
Dr Guleri	Consultant Microbiologist	

10 DEFINITIONS / GLOSSARY OF TERMS	
BTH	Blackpool Teaching Hospitals
NHS	National Health Service
PHE	Public Health England

11 AUTHOR / DIVISIONAL / DIRECTORATE MANAGER APPROVAL			
Issued By	Sharon Mawdsley	**Checked By**	Marie Thompson
Job Title	Lead Infection Prevention Nurse	**Job Title**	Director of Nursing and Quality & Director for Infection Prevention & Control
Date	January 2016	**Date**	January 2016

APPENDIX 1: ACUTE TRUST PATIENT ADMISSION FLOW CHART FOR INFECTION PREVENTION AND CONTROL OF CARBAPENEMASE-PRODUCING ENTEROBACTERIACEAE (ADAPTED FROM THE PUBLIC HEALTH ENGLAND (PHE) FLOW CHART)



APPENDIX 2: CPE CHECKLIST FOR CLINICAL STAFF

CPE Checklist for Clinical Staff

Has the patient been an inpatient in a hospital abroad in the past 12 months?

OR

Had renal dialysis in a hospital abroad in the past 12 months?

OR

Been an inpatient in any <u>other</u> UK hospital in the past 12 months?

OR

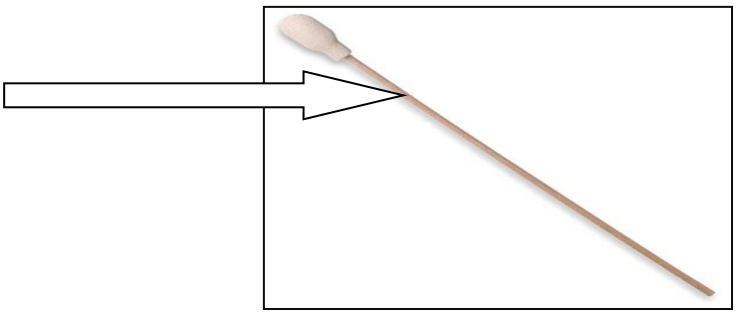
Does the patient permanently reside in another country outside of the UK?

OR

Been a close household contact of a person who is known to have been colonised or have an infection with carbapenemase-producing Enterobacteriaceae. (Such as patients tagged on Maxims and Alert systems).

If the answer to any of the above is "yes" then send:

A Rectal swab or **stool sample** – A rectal swab is a specimen taken by *gently* inserting a swab inside the rectum **3-4cms** beyond the anal sphincter, rotating *gently* and removing. Normal saline can be used to moisten the swab prior to insertion. The swab should have visible faecal material to enable organism detection in the laboratory. **A rectal swab *should not* be mistaken for a perineal swab.**



ALSO
Include samples from any wounds and device-related sites.

AND
Request a 'Carbapenemase screen' test via the Cyberlab system for each specimen and send them to the Pathology laboratory as soon as possible.

Please also alert the Infection Prevention team.

APPENDIX 3: PATIENT INFORMATION

http://fcsharepoint/trustdocuments/Information%20Leaflets/PL859.pdf

APPENDIX 4: UK INTER-HEALTHCARE TRANSFER FORM – NOTIFICATION OF A PATIENT COLONISED OR INFECTED WITH A CARBAPENEMASE–PRODUCING ENTEROBACTERIACEAE OR OTHER MULTIDRUG-RESISTANT ORGANISM
http://fcsharepoint/divisions/corporateservices/informationgovernance/healthrecords_library/Documents/CPE%20transfer%20document%20(2).doc

APPENDIX 5: EQUALITY IMPACT ASSESSMENT FORM

Department	Organisation Wide	**Service or Policy**	Procedure	**Date Completed:**	November 2012

GROUPS TO BE CONSIDERED

Deprived communities, homeless, substance misusers, people who have a disability, learning disability, older people, children and families, young people, Lesbian Gay Bi-sexual or Transgender, minority ethnic communities, Gypsy/Roma/Travellers, women/men, parents, carers, staff, wider community, offenders.

EQUALITY PROTECTED CHARACTERISTICS TO BE CONSIDERED

Age, gender, disability, race, sexual orientation, gender identity (or reassignment), religion and belief, carers, Human Rights and socio economic/deprivation.

QUESTION	**RESPONSE**			**IMPACT**
	Issue	Action	Positive	Negative
What is the service, leaflet or policy development? What are its aims, who are the target audience?	The Procedural Document is to ensure that all members of staff have clear guidance on processes to be followed. The target audience is all staff across the Organisation who undertakes this process.	Raise awareness of the Organisations format and processes involved in relation to the procedural document.	Yes – Clear processes identified	
Does the service, leaflet or policy/ development impact on community safety • Crime • Community cohesion	Not applicable to community safety or crime	N/A	N/A	
Is there any evidence that groups who should benefit do not? i.e. equal opportunity monitoring of service users and/or staff. If none/insufficient local or national data available consider what information you need.	No	N/A	N/A	
Does the service, leaflet or development/ policy have a negative impact on any geographical or sub group of the population?	No	N/A	N/A	
How does the service, leaflet or policy/ development promote equality and diversity?	Ensures a cohesive approach across the Organisation in relation to the procedural document.	All policies and procedural documents include an EA to identify any positive or negative impacts.		
Does the service, leaflet or policy/ development explicitly include a commitment to equality and diversity and meeting needs? How does it demonstrate its impact?	The Procedure includes a completed EA which provides the opportunity to highlight any potential for a negative / adverse impact.			
Does the Organisation or service workforce reflect the local population? Do we employ people from disadvantaged groups	Our workforce is reflective of the local population.			
Will the service, leaflet or policy/ development i. Improve economic social conditions in deprived areas ii. Use brown field sites Improve public spaces including creation of green spaces?	N/A			
Does the service, leaflet or policy/ development promote equity of lifelong learning?	N/A			
Does the service, leaflet or policy/ development encourage healthy lifestyles and reduce risks to health?	N/A			
Does the service, leaflet or policy/ development impact on transport? What are the implications of this?	N/A			
Does the service, leaflet or policy/development impact on housing, housing needs, homelessness, or a person's ability to remain at home?	N/A			
Are there any groups for whom this policy/ service/leaflet would have an impact? Is it an adverse/negative impact? Does it or could it (or is the perception that it could exclude disadvantaged or marginalised groups?	None identified			

APPENDIX 5: EQUALITY IMPACT ASSESSMENT FORM

ACTION:			
Please identify if you are now required to carry out a Full Equality Analysis		**No**	**(Please delete as appropriate)**
Name of Author: **Signature of Author:**	Dr. Rashmi Sharma	**Date Signed:** **November 2012**	
Name of Lead Person: **Signature of Lead Person:**		**Date Signed:**	
Name of Manager: **Signature of Manager**	Dr Mark O'Donnell 	**Date Signed:** **November 2012**	