3.2 Screening and Management of patient with suspected or confirmed Carbapenemase producing Organisms

Questions and Answers

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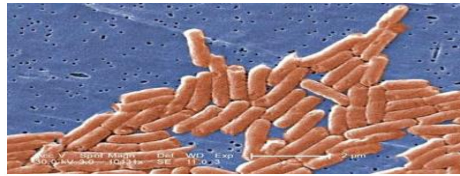
FOI ref 461-2425

1. What are Enterobacteriaceae? Enterobacteriaceae are a large family of Gram negative bacteria that usually live harmlessly in the gut of humans and animals.

They include species such as

Escherichia coli
Klebsiella spp
Enterobacter spp



These organisms are also some of the most common causes of opportunistic urinary tract infections, intra-abdominal and blood stream infections

All clinical staff who care for newly admitted patients should check iPortal for infection alerts.

Recognising the presence of an infection alert is important so that the appropriate infection prevention precautions can be applied, and if the patient has a life threatening infection, the right antibiotic can be selected.

2. What are Carbapenemase Producing Enterobacteriaceae (CPE)?

Carbapenemases are enzymes made by some strains of the bacteria which allow them to destroy carbapenem antibiotics and so the bacteria are said to be resistant to these antibiotics.

Carbapenem antibiotics include meropenem, ertapenem, imipenem and doripenim, these are a valuable family of antibiotics that until now, have been the antibiotics relied upon (when others failed) to treat infections caused by Gram-negative bacteria (including Enterobacteriaceae).

The most common types of carbapenemases are

KPC
OXA-48
NDM,
VIM

IMP

3. Where has it come from? In the United Kingdom (UK) over the last five years there has been a rapid increase in the incidence of infection and colonisation of 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.

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

- North West especially Manchester (KPC)
- London (KPC, OXA-48, NDM)

Countries and regions with reported high prevalence of healthcare-associated CPE:

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

Other countries not on the above list may have problems with CPE, but lack the systems/processes for detection/reporting.

4. Which patients do I screen for Carbapenemase Producing Enterobacteriaceae and other Multi Drug Resistant Gram Negative Bacteria (MGNB)?

All Overnight (>24h)

- Each adult and child (Excluding maternity) must be assessed to identify s**uspected** or **confirmed cases** of CPE colonisation or infection on admission to UHNM.
- If the patient (any age) fits the criteria below then a screen should be taken alongside the usual MRSA screen.

Spent > 24h as an inpatient in a hospital abroad, in the last 12 months
Spent > 24h as an inpatient in a hospital outside Staffordshire, in the last 12 months
Worked as a Healthcare worker in a hospital outside Staffordshire in the last 12 months and now admitted as a patient
CARB alert on iPortal
CARC alert on iPortal
Admitted from a Nursing Home/Residential Home/Care Home
Admitted with a long term urinary catheter in situ

Has a history of MGNB/carbapenemase producing organisms
Admitted to: - Elderly Care Wards - Renal Wards - Adult Critical Care Unit - Oncology and Haematology **Screen on admission to these wards, and then screen weekly**
Admitted to the Infectious Diseases Ward

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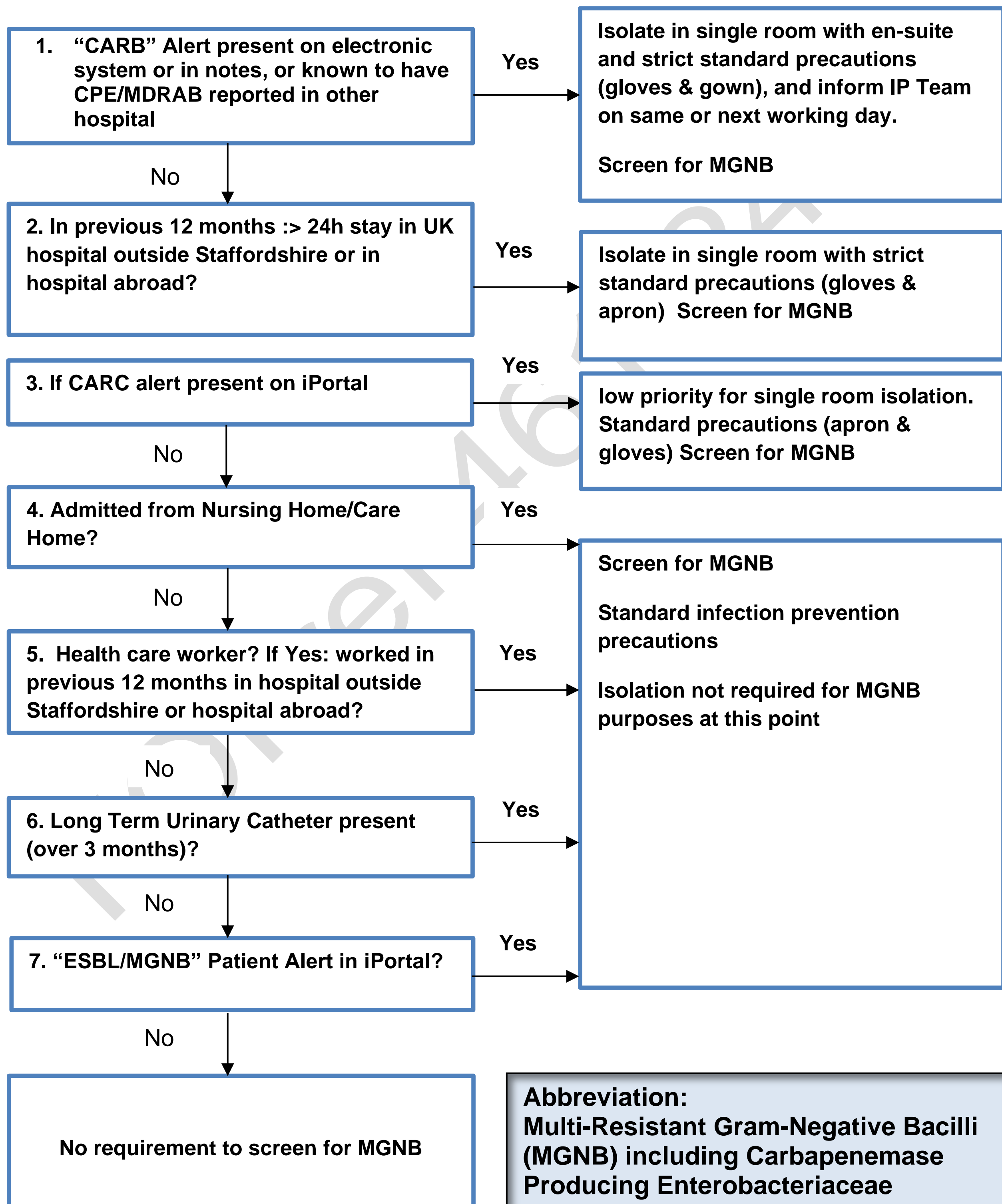
5. After assessing a patient for CPE and other Multi- Resistant Gram Negative organism what immediate actions do I need to take (inpatients)?

Flow Chart Risk-based Screening and Isolation on Admission

All Overnight (>24h) Emergency, Elective and Transfers

Start: check for patient alert on iPortal and Medical Notes



Prior to screening the reason for screening should be explained to the patient. Apply the yellow sticker to the patient record to evidence assessment.

1) CARB Patient Alert present on iPortal?
2) >24h stay in hospital outside Staffordshire in last 12 months?
3) CARC alert on iPortal?
4) Admitted from nursing home or residential Home?
5) Health Care Worker who in last 12 months worked in a hospital outside Staffordshire?
6) Long term urinary catheter present?
7) ESBL/MGNB patient alert on iPortal?

If YES to any question, TAKE MGNB SCREEN

If YES to 1:	ISOLATE IN SINGLE ROOM WITH EN-SUITE; USE GLOVES & GOWN
If YES to 2 or 3:	SINGLE ROOM & USE GLOVES & APRON PENDING SCREEN
If YES to 5, 6 or 7:	STANDARD PRECAUTIONS

Any screens taken must be documented in the patient's Medical Records

5. What screening samples do I take?

- Take a rectal swab, there must be visible faecal matter on the swab (this is the best sample type to achieve speedy results and to ensure detection of the organism) Swabs received that do not have visible faecal material will not be processed. This will be reported as INVALID. If invalid result, do not collect a repeat rectal swab instead take swab from the faeces stating "faeces swab" as specimen type. The stool sample itself should not be submitted unless required for other tests.

OR

- Collect a stool sample and take a swab directly from the faeces. This method can be used, if unable to obtain a rectal swab because patient declines rectal swab or rectal swab is inappropriate (e.g. stoma), or previous rectal swab was reported as INVALID stating "faeces swab" as specimen type. The stool sample itself should not be submitted unless required for other tests.

AND

- Send a catheter specimen of urine (CSU) if a long term urinary catheter is present
- Send the sample(s) to the laboratory as soon as possible and mark the request form **MGNB/CPE screening.**
- Also if the patient has been hospitalised in the previous 12 months in a hospital outside Staffordshire or abroad, include samples from any wounds and device related sites for MGNB/CPE screening, to detect the presence of other carbapenemase-producing multi-drug resistant bacteria such as carbapenemase-producing multi-drug resistant Acinetobacter baumannii (MDRAB).

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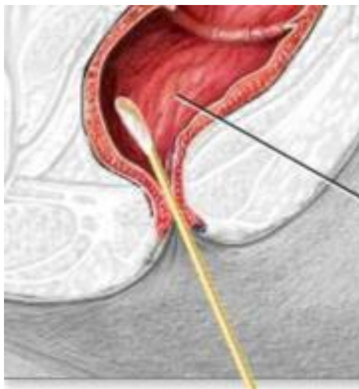
Please note: consider sending swab of faeces from the following patients:

- Patients with a stoma, colon cancer, recent anal or rectal surgery or young children/babies
- Patients who decline a rectal swab
- Patients without capacity to consent to a rectal swab
- Previous INVALID rectal screen

7. How do I take a rectal swab?



A rectal swab is a specimen taken by gently inserting a swab inside the rectum, approximately 3 cm (adults) beyond the anal sphincter

8. What action so I need to take if the patient refuses to be screened?

If the patient declines a rectal swab but not screening in general then see question 6.

Should a patient refuse to be screened following explanation by the clinician/nurse then this should be documented in the patients' notes
Contact Infection Prevention Team for advice as the patient may still require isolation

9. What action do I need to take if the screen is negative? If negative on screening and the patient **does not** have a laboratory or confirmed **history** of CPE then the patient can be removed from isolation unless a different indication for isolation applies (e.g. MRSA, C.diff Infection).

Please note: A patient who in the last 12 months has had a laboratory confirmed CPE or is known to have had a CPE reported in a different hospital, must remain in isolation during their entire hospital stay despite any negative CPE screen investigation during the current admission.

Experience from other areas in the UK and abroad has shown that on some occasions an apparently cleared CPE can regrow to a detectable level in gut flora. A previously positive individual with subsequent negative screening results revert to a positive state, especially after a course of antibiotics.

10. How long are negative screens valid for?

Negative results from elective screens remain valid for 6 months provided the patient has not stayed overnight in any hospital (UK or abroad) between the date of screening and the date of elective admission, in which case the screening will need to be repeated prior to admission.

11. What action do I take if the screening is positive for CPE/MDRAB? Advise the patient (and relatives if appropriate) of the confirmed positive result and provide a patient information leaflet. (For ESBL refer to chapter 3.3)

Door sign	ISOLATION sign
Nursing Staff	Designated nursing staff if possible
Single room with en-suite facilities where possible	Isolation room: The door should be kept closed unless it is documented in the patient's notes why this is not appropriate. **The patient should remain in isolation for the duration of their hospital stay.** Careful assessment is required should it be deemed necessary to consider removing a previously positive or a colonised patient from isolation, this should be discussed with the Infection Prevention Team. Loose stool or diarrhoea (for any reason) increases the risk of spread of the bacteria from the gut.
Hand decontamination	Hands must be decontaminated after contact with the patient or equipment and before leaving the room. Follow the WHO "five moments for hand hygiene" Alcohol gel or/and soap and water can be used.

FOI ref 21-242

	Alcohol hand rub should be available for use immediately after leaving the room. Encourage patients to clean their hands before meals, before medication after using the toilet or commode.
Gown	Staff to wear a gown that covers the uniform for direct patient contact, when handling body fluids or handling contaminated equipment, or when entering the isolation room or bed space (Critical Care Unit) Remove gown before leaving the isolation room/bed space and decontaminate hands.
Disposable gloves	Staff to wear non-sterile well-fitting disposable gloves to be for patient contact, when handling body fluids or equipment. Remove gloves before leaving the isolation room and decontaminate hands.
Masks/Eye Protection	Masks and eye protection are only required if there is a likelihood of body fluids splashing to the face.
Linen	Bed linen, clothing and towels should be changed daily and before attending other departments. Linen should be discarded in a RED soluble bag and placed in a white 'outer' bag.
Crockery/Cutlery/ water jugs/beakers	They should be decontaminated in an automated dishwasher.
Waste Disposal	Discard all contaminated waste into an ORANGE clinical waste bag.
Equipment	It is strongly recommended that equipment should be dedicated to the patient and single use where possible e.g. BP cuffs, tourniquets, stethoscopes. Ensure all equipment is decontaminated before use by other patients using the disinfectant approved for the ward/areas.
Mattresses	Conventional mattress covers should be disinfected after use.

	Air mattresses should be disassembled, cleaned, disinfected by external company once patient discharged or no longer deemed as infectious.
Visitors	Visitors should be advised to wash or gel their hands thoroughly on entering and leaving the room. Apron and gloves are NOT necessary unless *assisting* in care.
Room cleaning	Ward staff should inform housekeepers/Domestic staff/Sodexo that a barrier clean is required whilst the room is occupied. When patient is discharged from the room contact housekeeping/domestic to "terminally clean" the room with a full curtain change prior to its re-use, using approved disinfectant for the ward/area. Ensure that all "touch points" (e.g. remote controls) are effectively decontaminated. IPT will advise if the use of hydrogen peroxide is required.

A CARB infection control alert will be generated; this can be viewed on iPortal and will remain visible for 5 years.

12. Do I need to repeat the screen during the same admission for confirmed CPE positive patients? Inpatients who have been found positive for confirmed carbapenemase-producing Enterobacteriaceae on or during admission that remain an inpatient do not require repeat screening during the same admission, since the majority of patients remain carriers for months to years, and the patient should not be taken out of isolation.

13. Can a patient positive for CPE visit other departments for tests/investigations?

Should a patient colonised or infected with CPE 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 using approved disinfectant afterwards.

Outpatients and renal dialysis patients; similarly, known positives should be planned at the end of the days list, known positive renal dialysis patients should be isolated.

If a patient is to be transferred to another hospital or care home, the receiving organisation should be notified before transfer.

14. Action to take if a patient is re- admitted to UHNM and has an iPortal alert for CARB or previously tested positive for CPE at another Trust on a previous admission? The patient must be admitted into a single room, gowns and gloves to be worn by health care workers when entering the isolation room, contact with the patient and their environment. Take screening samples as question 6

If the screening sample is positive for CPE continue isolation as set out in question 11 until discharge.

If the screening sample is negative for CPE take 3 screens in total on different days with at least one of the three screens taken in the absence of antibiotic treatment. If all three samples are negative consider discontinuing isolation precautions.

15. Should we screen contacts of positive CPE patients? Screening of patients in the same setting is not normally required if the case was identified on admission and isolated immediately, however:

‘A close contact of CPE is a patient who has spent more than 8 hours in the same bay or open ward as a patient with confirmed CPE/CARB’ (UHNM definition). Screening of these contacts will be required.

The nurse in charge should compile a list of contacts and discuss with the Infection Prevention Team.
If possible cohort contacts in the same bay.
Three subsequent MGNB screens are required on different dates and at least one of the three screens taken 48 hours after any antibiotic treatment has finished.
Whilst awaiting the results of close contact screening for CPE, the patients being screened should not be transferred out of the ward except where there is an emergency clinical need. In close contacts who remain hospitalized in the UHNM, CPE PCR tests on special rectal swabs can speed up the process of screening (same day result), but do not replace the requirement to send three follow-up MGNB screens taken on different dates. A bay/ward should be closed to admission if it not possible to isolate a patient with (suspected) CPE. The bay/ward should remain closed to admissions until the CPE positive patient has been isolated

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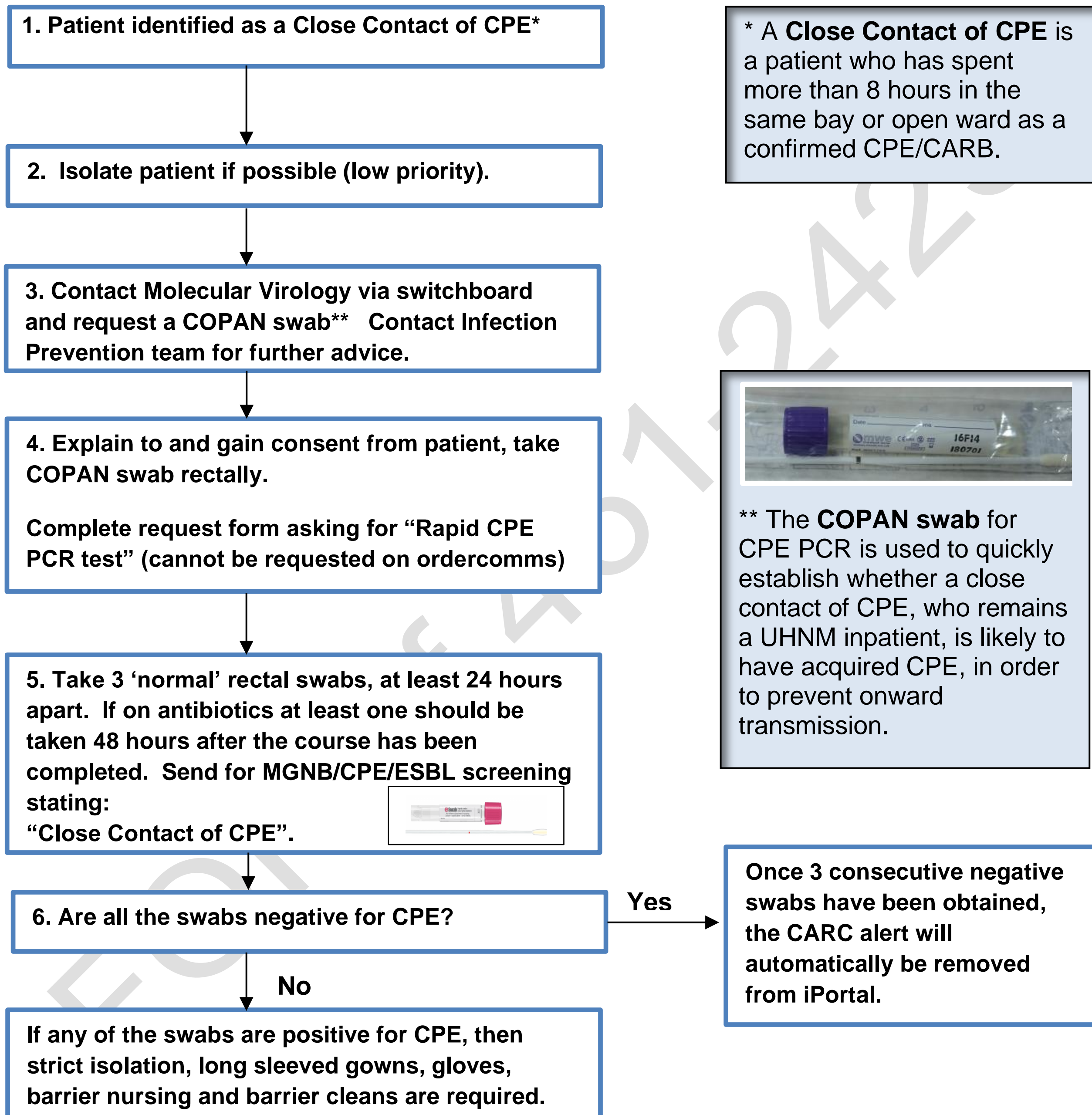
If secondary cases are identified than an outbreak team will be convened. The decision to close a ward to admission will be taken by the DIPC or Deputy DIPC. See question 16
Patients identified as a close contact of a CPE case, will be tagged with a "CARC" IC Patient Alert by the Infection Prevention Team in the iPortal system. This includes patients who have been discharged and may be admitted at a later date. The CARC alert will be visible in iPortal on re-admission. A CARC alert will disappear from iPortal if subsequently the patient has had three MGNB screens reported as "Multi-resistant Gram-Negative Bacillus not isolated". If the patient is identified with CPE in a clinical or screening sample, then the "CARC" alert is replaced by a "CARB" alert.
If a contact proven to be positive for CPE, manage as a positive case, see question 11
Patients who have been identified as a close contact of a confirmed case following discharge will have a CARC alert added to iPortal system in order that re-admissions are admitted into a side room and screened for MGNB/CPE. If the close contact has been transferred to another hospital or nursing home prior to having been screened, then the IP Team should inform the receiving organisation about the exposure to CPE.
If a patient has been identified as a close contact of a confirmed case following discharge, then the clinical team who issued the discharge letter to the GP should issue an update letter to the GP on request of the IP Team. The discharge letter should mention the exposure to CPE, and the GP should be advised to send an appropriate specimen for culture if the patient presents with urinary tract or lower respiratory tract infection.
Screening of household contacts and healthcare staff is NOT required.

16. What's the process for screening an inpatient who has been identified as a CPE Close Contact?

CPE Close Contacts Screening Flow Chart for inpatients at UHNM.



Further information

- Remember: Strict Hand Hygiene, Personal Protective Equipment (aprons and gloves) and Standard Precautions.
- Provide CARC patient leaflet.
- Ensure faecal matter on swab.
- If unable to obtain rectal swab, send faecal sample stating the reason for sending a stool sample.
- If a patient is admitted and has a CARC alert on iPortal, isolate if possible, then check how many swabs have been sent since CARC alert added. Send further swabs to total 3 as per alert.
- If any of the 3 swabs are positive for ESBL then despite being negative for CPE, the CARC alert will remain in place on iPortal.

17. What is the treatment patients will require? Firstly establish whether the patient has an infection or is colonised with carbapenemase – producing Enterobacteriaceae as confirmed laboratory testing.

If the patient has an infection contact a Consultant Microbiologist for advice

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 – not advised as there is concern that their use would contribute to increasing resistance in the longer term.

If the patient develops an infection, e.g. UTI, pneumonia, sepsis, meningitis.
Ensure treatment is started promptly. Empiric antibiotic treatment should be discussed with a microbiologist, since ineffective antibiotic treatment is associated with increased mortality. Treatment should be guided by susceptibility results of the isolate.

18. What action do we take if an outbreak/period of increased incidence occurs? An outbreak team will be established if two or more patients who have been found HCAI positive with the same type of CPE (e.g. KPC, OXA-48, NDM, VIM) and who can be linked in time and place. This can sometimes be difficult to recognise because multiple bacteria species may be involved due to the mechanism in which CPE spread (transfer of antimicrobial-resistant coding genes) i.e. KPC positive *E.cloacae* and a case of KPC positive *Klebsiella pneumonia* can represent an outbreak.

The Infection Prevention Team must be informed as soon as an outbreak/period of increased incidence is suspected or confirmed.

Root cause analysis must be undertaken for an in depth investigation in cases when carbapenemase producing Enterobacteriaceae infection/colonisation was acquired at UHNM.

Where there are evidence lapses in infection prevention/secondary spread or unexpected cases identified some time later, then an outbreak Control Team should be convened.

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The ward/area should be closed to admissions and transfers to other wards or health care providers except for emergency clinical need.

	Care
Isolation Sign:	ISOLATION Door Sign in place
Isolation facilities:	Confirmed or suspected cases should be isolated in a single room or cohort if insufficient single rooms are available, this will be following advice from the Infection Prevention Team. If possible staff should be segregated to care for the positive CPE patients only. Patients with confirmed CPE during their current hospital stay should remain in strict contact isolation for their entire hospital stay.
Contact Screening	Initial screening as question 14. Also screen weekly and on discharge from the affected ward/area until no new cases have been identified for two weeks. Screening Healthcare workers for CPE is NOT recommended.
Hand decontamination	Hands must be decontaminated after contact with the patient or equipment and before leaving the room. Follow the WHO “five moments for hand hygiene” Alcohol gel or/and soap and water can be used. Alcohol hand rub should be available for use immediately after leaving the room. Encourage patients to clean their hands before meals, before medication after using the toilet or commode.
Personal Protective Equipment (PPE)	All staff entering an isolation-room must, for confirmed CPE positive cases, wear non-sterile disposable gloves and gown for all contact with the patient and their immediate environment. Apron and gown must be removed and hands decontaminated before leaving the isolation room. If a bed pan/commode is being transported out of the isolation room to the sluice then a clean apron and gloves should be worn and removed in the sluice followed by hand decontamination.

	For a patient with suspected CPE, apron and gloves must be worn for all contact with the patient and their immediate environment. Eye protection and masks are required if there is a risk of splashing to the face.
Environmental and Equipment Decontamination	Royal Stoke Hospital – liaise with Domestic/Sodexo services to arrange barrier cleans for the whole ward. County Hospital – liaise with Housekeeping to arrange barrier cleans for the whole ward. Environmental decontamination of rooms or bed spaces and equipment must be carried out using the Trust's approved disinfectant for the area. Medical equipment should be for single patient use (e.g. blood pressure cuffs, tourniquets), but if that is not possible it must be thoroughly decontaminated before and after each use, using the Trusts approved disinfectant for the area. Disinfectant agents must be made up to the correct concentration and stored in accordance with manufacturers' instructions, with particular attention paid to compliance with health and safety regulations. Terminal cleaning of a mattress, bed space, bay or ward area after the discharge, transfer or death of a patient must be thorough. This must include a full curtain change including window curtains and decontamination of window blinds. Use the Trust's approved disinfectant for the area.
Patient Transfer for Investigations/ Therapy interventions	Transfer and movement of patients must be reduced to an operationally effective minimum. Where patients need to attend other departments for essential investigations/therapies, they must be **'last on the list'** unless earlier investigation is clinically indicated. In advance of the transfer, the receiving area must be notified of the patient's CPE status. Arrangements must be put in place to minimise the patient's waiting time and hence contact with other patients. Decontaminate wheelchair/bed/trolley used to transport patient. If the patient is transported on their bed, decontaminate end of bed and rails with Trust approved disinfectant before and after transfer. When transfers to other healthcare facilities are required due to clinical need the ward must be notified of the individual's CPE status.

Linen	For linen contaminated with diarrhoea, use a water soluble red bag, and an outer white bag and remove immediately. White and orange coloured plastic bags are available for patient's clothing to be taken home for washing.
Waste Disposal	Discard all contaminated waste into the ORANGE clinical waste system.
Crockery/cutlery/ water jugs/beakers	Return to catering department to be decontaminated in an automated dishwasher.

19. What are the key messages for other organisations and patients?

KEY MESSAGES
Ensure good communication with receiving organisations prior to patient transfer or discharge and with all healthcare professionals along the patient pathway. Ensure the patient/ family and / or care facility to which the patient is to be discharged are provided with an accurate explanation of the risk in a non-acute / community setting, infection prevention management advice and are given an opportunity to ask questions.
Make sure that when they are discharged, the patient understands: • Their current status (e.g. infection cleared but may still be a carrier), and the need for good hand hygiene. • That, should someone they have close contact with be admitted to hospital / healthcare setting for any reason, they need to inform healthcare staff of their exposure.

Internal and external colleagues
Staff on the receiving ward, if this is an internal transfer: this must be handed over verbally and clearly documented on transfer form.

FOI ref 40 242

Primary care providers, hospitals, care homes, receiving organisation Infection Prevention Team.
Patient's GP plus any other relevant care provider along the patient pathway: confirmed CPE or if patient is close contact of CPE positive patient must be mentioned in the discharge letter, and the discharge letter should advise to send an appropriate specimen for culture if following discharge the patient develops a urinary tract or lower respiratory tract infection.
Any trusts where there are regular inter-trust transfers from one unit to another.

20. What information do I provide to patients who have the bacteria present? A patient information leaflet is available on the Trust intranet, Infection Prevention page.

FOI ref 461-2425

21. CARB/CARC/ESBL alerts on iPortal - what precautions do I need to take in outpatient and day case settings?

<u>What do the iPortal alerts mean</u>?

CARB = Patient has a history of multi drug resistant producing bacteria e.g. CPE or multidrug-resistant Acinetobacter; such bacteria may be resistant to both Tazocin and Meropenem.

CARC = Patient has been in close contact with a **CARB** patient during a previous hospital stay.

ESBL = Patient has a history of ESBL-producing bacteria – ESBL-producing organisms are resistant to certain types of common antibiotics, but remain sensitive to Meropenem.

Care Environment	**CARB** iPortal alert		**CARC** iPortal alert		**ESBL** iPortal alert	
	Risk of Transmission		Risk of Transmission		Risk of Transmission	
	<u>HIGH*</u>	<u>LOW</u>	<u>HIGH*</u>	<u>LOW</u>	<u>HIGH*</u>	<u>LOW</u>
Day Case Unit including interventional day case/ Endoscopy						
Day Case Haemodialysis/ Day Case Chemotherapy		<u>N/A</u>		<u>N/A</u>		<u>N/A</u>
Out-Patient Department/ Physiotherapy						

Instructions

If the individual's care needs are not shown and you are unable to find an applicable scenario, contact the Infection Prevention Team for further advice. Risk assess each patient and scenario.

1. Choose care setting from left hand column and identify type of alert on iPortal then consider high risk transmission risk factors set out in Box 1 below.

2. *<u>HIGH TRANSMISSION RISK FACTORS:</u> IF ANY OF THE FOLLOWING SET OUT IN BOX 1, THEN TAKE PRECAUTIONS AS COLOUR-CODED UNDER 'HIGH' (Red or Amber)

3. If patient has none of the high transmission risk factors in Box 1 then take precautions as colour-coded under 'LOW' (Amber or Green)

Box 1* High Transmission Risk Factors

- Undergoing Gastro intestinal endoscopy e.g. gastroscopy, ERCP, colonoscopy, sigmoidoscopy
- Undergoing uroscopy, cystoscopy
- Undergoing Prostate biopsy
- Urinary catheter in situ, nephrostomy, renal dialysis, enteral feeding tubes
- Chemotherapy treatment in progress
- Has diarrhoea or contaminates the environment with faeces
- Has faecal or urinary incontinence
- Discharging wounds or oozing from an infected area
- Has confusion or dementia, which may impact on their capacity to maintain adequate personal hygiene
- Close patient contact e.g. log roll, manual handing

	Precautions
RED	**Place patient last on procedure list.** Patient can sit in communal waiting room if no diarrhoea or incontinence, Chemotherapy; day case haemodialysis if possible take patient directly to single room. **Isolate patient in single room/cubicle with allocated toilet facilities/ensuite.** Encourage patient and visitors to gel hands when entering clinical area. **Staff hand hygiene:** Staff to follow the "five moments for hand hygiene" at all times. Use alcohol gel or soap and water if hands are visibly soiled, contact with bodily fluids or patient has diarrhoea. **Personal protective equipment** **Staff** to wear long sleeved gowns and gloves during procedures e.g. endoscopy, chemotherapy, haemodialysis close contact with patient .No routine use of masks or eye protection required unless there is a risk of splashes to face, mouth or eyes. No apron and gloves for visitors unless participating in patient care. **Decontamination of equipment and environment – allocate to patient during hospital visit** Terminal clean of couch/bed space and toilet. Terminal clean of procedure rooms and equipment.
AMBER	**Appointment time end of list.** Patient can sit in communal waiting room (but inform staff if diarrhoea in waiting room toilet). Encourage patient and visitors to gel hands when entering clinical area.

FOI ref 461-24

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Hand hygiene: Staff to follow the “Five moments for hand hygiene” at all times. Use alcohol gel, or soap and water if hands are visibly soiled or contact with bodily fluids or patient has diarrhoea.

No apron or gloves required for visitors.

Allocate equipment to patient during hospital visit.

<u>Haemodialysis, Chemotherapy Unit, Endoscopy Unit and Day Case Unit</u>

Isolate patient in single room/cubicle with ensuite if possible, otherwise continue with strict emphasis on hand hygiene and environmental cleaning.

Staff PPE: apron and gloves

<u>Decontamination of equipment and environment</u>

Decontamination: Terminal clean on all active CPE/ESBL infections (urine, wounds, blood, sputum and drainage fluid) or CARC alert tagged with unknown or no negative confirmation test from Copan/ pink copan swabs for MGNB/ESBL.

<u>Outpatient Department and Physiotherapy Department</u>

Isolation of patient is not required, if diarrhoea present allocate own toilet and terminal clean after use.

Strict emphasis on hand hygiene and environmental cleaning.

PPE: Risk assess the procedure. Follow Standard Infection Prevention Precautions, disposable plastic aprons when it can be reasonably anticipated that staff clothing may come into contact skin, blood, body fluids or contaminated equipment, or when performing Aseptic Non Touch Technique. Gloves if contact or potential contact with blood or bodily fluids or performing Aseptic Non Touch Technique. No routine use of masks or eye protection required unless there is a risk of splashes to face, mouth or eyes.

<u>Decontamination of equipment and environment</u>

Decontamination: Routine discharge cleans of chair, couch and any non-invasive equipment e.g. Physio equipment, BP cuff pulse oximeter, E.C.G with Trust approved disinfectant immediately after care episode. For a patient having sigmoidoscopy, uncontrolled diarrhoea incontinence oozing wound that has leaked onto equipment or the environment in clinic rooms then a terminal clean of room/couch space would be required.
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<td><u>GREEN</u></td>
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Appointment time end of list.

Isolation of patient not required.

Patient can sit in communal waiting room.
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FOI ref 461-2425

	Encourage patient and visitors to gel hands when entering clinical area. Staff to follow the “Five moments for hand hygiene” at all times. Hand hygiene using alcohol gel, or soap and water if hands are visibly soiled or contact with bodily fluids. Disposable plastic aprons only when it can be reasonably anticipated that staff clothing may come into contact with blood, body fluids, skin scales or contaminated equipment. Gloves if contact with blood or bodily fluids or aseptic non touch technique. No mask or facial protection required unless risk of splashing to face or eyes. Patient can use communal toilet. No personal protective equipment required for visitors **Routine discharge clean** of couch/chair and any non- invasive equipment e.g. BP cuff pulse dosimeter, E.C.G, physio equipment immediately after care episode with Trust approved disinfectant.

Trust approved disinfectant: Virusolve at Royal, Tristel at County Hospital

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