Infection Prevention and Control

Vancomycin Resistant Enterococci (VRE)
**Policy Title:** VRE Policy

**Executive Summary:** This policy aims to promote awareness of VRE and enable early identification, screening and isolation of high risk patients, which are all essential steps in the control of drug resistant organisms (Damanii, 2012). The guidance within promotes correct management of affected patients and aims to improve patient safety by limiting the spread of VRE within the Health Care Setting.

**Supersedes:** VRE policy 2016

**Description of Amendment(s):** Updated to reflect National guidelines and Organisational changes.

**This policy will impact on:** Clinical Staff

**Financial Implications:** Increased Screening due to identification of new cases

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**APPROVAL RECORD**

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1. Introduction

Enterococci are an increasingly common cause of healthcare associated infections caused by Vancomycin-Resistant Enterococci (VRE).

When these enterococci become resistant to both Vancomycin and Teicoplanin they are known as Glycopeptide Resistant Enterococci (GRE).

The infection control principles for individual cases or clusters are the same for both VRE and GRE (for the purpose of this policy the term VRE will be used).

VRE can cause bacteraemia, wound infections, genito urinary infections, and abdominal infections. Less commonly, they may also cause infections of heart valves causing endocarditis.

NHS providers are required under the Health and Social Care Act 2008 (revised 2015) to ensure that preventable healthcare associated infections do not occur, as part of maintaining patient quality and safety.

Although VRE colonisation appears to be more frequent than true infection, it is essential that transmission of these bacteria is controlled as colonisation frequently precedes infection. The risk of clinical infections developing is increased during any cluster or outbreak.

This policy ensures all Trust staff have a basic knowledge of VRE and follow appropriate infection prevention and control practices to minimise the risks of developing any associated infection and/or cross infection.

This policy will provide clinical staff with the information required to prevent and reduce transmission of VRE to patients and staff within the hospital setting.

Additionally it will ensure patients, families and carers understand the infection prevention and control measures implemented.

2. Purpose

This policy aims to promote awareness of VRE and enable early identification, screening and isolation of high risk patients, which are all essential steps in the control of drug resistant organisms (Damanii, 2012).

The guidance promotes correct management of affected patients and aims to improve patient safety by limiting the spread of VRE locally by implementing screening, isolation and effective standards of cleanliness.

The Health and Social Care Act (2008) (revised 2015) – Code of Practice on the prevention and control of infections and related guidance sets out criteria by which NHS organisations must ensure that:

- Risks associated with Health Care Associated Infections (HCAI) are minimised
- Patients are cared for in a clean environment that is fit for purpose
- Trusts adhere to polices that will prevent and control infections.

Compliance with this code is a statutory requirement for all healthcare workers and is measured by the CQC as part of their inspection process.
East Cheshire NHS Trust is committed to ensuring our health population is cared for in a clean environment by staff with appropriate skills to reduce the risk of avoidable HCAI

3. Roles and Responsibilities

3.1 Responsibilities

- **The Chief Executive**: has ultimate responsibility for the implementation and monitoring of the policies in use in the Trust. This responsibility may be delegated.

- **The Director of Nursing, Performance and Quality, Director of Infection Prevention and Control (DIPC)**: has strategic responsibility for Infection Prevention and Control within the Trust and will take the lead responsibility for the development and implementation of this policy with support of the Lead Nurse - Infection Prevention and Control, and the Infection Prevention and Control Doctor.

- **Consultant Microbiologist, Infection Control Dr**: has the role of providing clinical advice within the Trust and to GP’s, and to ensure the accuracy of pathology results.

- **Antimicrobial Pharmacist**: To monitor best practice when antimicrobial and suppression therapy is prescribed.

- **The Infection Prevention and Control Team (IPCT)**: have responsibility for ensuring that the policy is implemented and monitored across the Trust:
  - Day to Day advice and support from 8am- 5pm (Out of hours support via the on-call microbiologist)
  - Training and education to support clinical staff in implementing the policy
  - Implementing any changes to the Policy in light of new guidance
  - Ensuring compliance with the policy as part of a sustainable audit programme

- **Bed Managers/Site Managers**: are responsible for ensuring patients are placed in accordance with this policy, and escalating to the IPCT any situations where safe placement cannot be achieved.

- **All Employees**: are responsible for ensuring that standards of Infection Prevention and Control are maintained in line with Trust policy and procedures. Infection Prevention and Control training and standards will be monitored via the appraisal process

- **Occupational Health**: are responsible for providing confidential advice and support to staff relating to VRE screening and treatment, consulting with the Consultant Microbiologist as appropriate.

4. Definitions

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<tr>
<td>VRE</td>
<td>Vancomycin Resistant Enterococci</td>
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<tr>
<td>VRE Colonisation</td>
<td>When a person carries VRE in their bowel but it does not cause them any harm. This is more</td>
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common than infection. People who are colonised do not require treatment.

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<th>GRE</th>
<th>Glycopeptides Resistant Enterococci</th>
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<tr>
<td>Glycopeptides</td>
<td>antibiotics which inhibit cell wall synthesis, current drugs in this class are Vancomycin, Teicoplanin, Dalbavancin and Telavanacin</td>
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<td>Resistant Organism</td>
<td>one that will not be inhibited or killed by a normal dosage of an antimicrobial agent.</td>
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<tr>
<td>Colonisation</td>
<td>The presence of micro-organisms without causing signs and symptoms of infection.</td>
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<td>Enterococci:</td>
<td>Gram positive bacteria normally residing in the human gut.</td>
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<tr>
<td>Enterococcus faecalis</td>
<td>is the most frequent cause of clinical infection (approximately 90%).</td>
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<td>Enterococcus faecium</td>
<td>also identified as a human pathogen</td>
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<td>Laboratory confirmed case</td>
<td>A patient with recent laboratory confirmation of VRE infection/colonisation.</td>
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<td>Close contact</td>
<td>A person living in the same house or a patient sharing the same hospital bay.</td>
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(NB: This policy should be read in conjunction with the Hand Hygiene, Isolation and Universal Precautions for Infection Prevention and Control Policy).

5. **VRE**

5.1 **What is VRE**

*Enterococcus* is a bacterium that colonises the bowel of most people with no ill effects or signs and symptoms).

There are many recognised species of enterococci, although *Enterococcus faecalis* is the most frequent cause of clinical infection (approximately 90%), with *Enterococcus faecium* also identified as a human pathogen.

Enterococcal infections are often preceded by colonisation (endogenous infection) with urinary tract infections being most commonly identified. Enterococci are opportunistic pathogens, with the capacity to cause more invasive infections in immunocompromised patients e.g.

- bacteraemia
- intravenous device associated infection
- wound infection
- cholangitis
- endocarditis
- meningitis
Acquired antimicrobial resistance has emerged in enterococci, in particular *E. faecalis* and *E. faecium*, with several resistant strains identified (VRE). High-level resistance to both vancomycin and Teicoplanin (glycopeptides) is of greatest significance. Excessive use of antimicrobials to treat minor infections is likely to be a major contributory factor to the emergence of VRE. The emergence of VRE has also been linked to use of antibiotics in animal husbandry.

The emergence of enterococcal resistance to vancomycin is particularly concerning as it can share the genetic material identifying resistance with *Staphylococcus aureus* resulting in vancomycin resistant *Staphylococcus aureus* (VRSA).

### 5.2 Risk Factors for developing VRE

- Prior antimicrobial therapy (particularly glycopeptides or cephalosporin), especially the use of oral vancomycin therapy
- Prolonged hospital admission, admission to Critical Care, Renal or Haematology Units
- Healthcare interventions that may result in immunosuppression.
- People with long term intravenous devices e.g. urinary catheters, central venous catheters.
- Contact with a known VRE positive patient

### 5.3 Transmission of VRE

- Direct contact
- Indirectly via the hands of staff
- Contaminated environmental surfaces
- Contaminated patient equipment

### 6 Screening

#### 6.1 Screening for VRE

Currently there is no national requirement to screen for VRE, however in order to ensure patients in high risk areas are identified in a timely manner the following high risk patient groups have been identified by the Consultant Microbiologist for routine screening:

- All patients admitted to ICU
- All patients with previously known VRE positive status.
- If a patient is admitted from another organisation, the Bed Managers must check their VRE status or if they have been in involved in a VRE outbreak.

#### 6.2 Identification of VRE

- VRE can standardly be identified via two routes:
  - Routine clinical specimen where VRE is present e.g. urine, wound swab, blood culture, line tip etc. The isolation of VRE if present is part of the routine culture and sensitivity process.
  - Specific screening for VRE requested as part of a contact screen (rectal swab or faecal specimen, as per Appendix 1).
- **Microbiology** will inform the IPCT during normal working hours of any positive VRE specimens. Results will also be available via the Lab centre system.
- Out of hours they will contact the clinical area directly.
Once advised of an out of hours VRE specimen, the nurse whom the positive result was given to must inform:

a) the relevant Dr on call and request a clinical review
b) The bed manager/ site manager to request isolation of the patient and inform them of the need to cohort contacts until screening results available.
c) Infection Prevention and Control Team via the answer machine on extension 1597.

Where VRE positive results (rectal or faeces) indicate colonisation of VRE, this is not infection. There is no treatment available for VRE colonisation. The patient may remain colonised for weeks or years. Any known VRE positive patient must be isolated in a side room on admission and screened, this will need to occur for every subsequent admission.

If the result is negative the IPCT will undertake a risk assessment on appropriate patient placement which may include discontinuing isolation.

VRE positive results (for example urine or blood) may indicate an infection therefore a comprehensive clinical review must be undertaken to determine the significance of the result. Further advice must be sought from the Consultant Microbiologist as treatment may require complex antimicrobial treatment.

6.3 Can a Patient refuse to have a VRE screen?
Wherever possible, informed consent must be gained from the patient by the nurse undertaking the screen. If a patient declines the screen, please document this in the patient’s medical notes the reason for refusal and escalate to the Infection Prevention and Control Team.

6.4 Should staff be screened for VRE?
Routine screening of staff for carriage of VRE is not required. The Consultant Microbiologist in co-ordination with Occupational Health may implement screening for staff based on the epidemiological pattern of increased isolates within a clinical area.

6.5 Screening Method for VRE

- Swabs for both positive and contact patients must be obtained from rectal screen or stool sample. In patients known to be VRE positive swabs should be taken from wound sites, leg ulcers and sites of any invasive devices e.g. catheter specimens of urine, tracheostomy sites (see Appendix 1)
- VRE information should be provided to the patient or relatives by the nurse caring for the patient (see Appendix 2)
- Gloves and aprons must be worn when obtaining the VRE screen
- A rectal swab should be obtained using a dry transwab. The cotton tip of the transwab should be gently inserted just inside the rectum (Appendix 1 details this process)
- Record the patients’ details on the swabs in addition the pathology request form must include as a minimum, Patients full name, DOB, NHS or Hospital number.
• Swabs are to be sent to the laboratory labelled clearly for VRE testing – ensure that any relevant clinical details are included e.g. antibiotic therapy. Incomplete forms/swabs will not be tested and returned to the clinical area to be repeated.

• A stool sample can be accepted if a rectal swab is deemed inappropriate e.g., patients with a stoma, paediatrics. Please label the stool sample for VRE testing and provide details of why a stool sample has been sent instead of a rectal swab.

6.6 Screening and Management of Patients in ICU

• All patients admitted to ICU must have a VRE screen on admission

• If the patient is subsequently identified as VRE positive they must be isolated in a single occupancy room. If an isolation room is not available then a suitable risk assessment must be undertaken by ICU staff to either:
  a) Undertake patient moves based on clinical priorities to facilitate transferring the VRE patient into a single room
  b) Manage the VRE patient in the main ICU, whilst implementing full infection prevention and control precautions in discussion with the IPCT
  c) If the patient is clinically stable move out of the ICU to a side room in the appropriate clinical area

    When the patient is clinically fit for discharge from ICU if they are VRE positive they must be transferred to a side room in the appropriate clinical area.

    If the patient is clinically fit for discharge prior to the VRE screen result being available the patient ideally should be discharged to a side room pending the result outcome, if there is no side room available they can be discharged to a main bay next to a sink. The exception to this is any patient requiring discharge back to the Orthopaedic ward they MUST be transferred into a side room until the VRE screen result has been received.

    During normal working hours the Infection Prevention and Control team can be contacted to assist in reviewing side room capacity, out of working hours this can be done with the hospital site manager. However, the receiving ward must be informed of the outstanding VRE result as this may require them to undertake patient moves to facilitate the admission.

6.7 Management of VRE patients and VRE screening in Ward area

• Patients with a known VRE history, or newly identified as VRE positive, must be isolated into a side room ideally with an en-suite bathroom. If no side room is available, they must be moved to the bed space near a sink, and full infection control precautions implemented.

• They must have dedicated equipment allocated to them, including BP machine, commodes, and tourniquet.

• Alert stickers must be added to the patients’ medical records and the CRIS bed management system.

• Contact screens will be required from any patient in the bay who has had more than 24hrs contact with the index case.
The bay will be classed as a low risk bay; meaning patients should only be admitted to the bay conditional upon them having no more than one invasive devices or any wounds.

If a further positive case is identified, the Consultant Microbiologist may decide to close the bay pending further results.

Cohort nursing of VRE positive patients may be required; staff must follow strict infection prevention and control precautions in accordance with the Isolation Policy.

### 7 Control Measures

- Patients who are identified as VRE positive (either colonisation, and/or infection) must be isolated in a side room as far as practicable preferably with en-suite facilities. They must be moved on their current bed and mattress (this will require cleaning /disposal once the patient is discharged).

- A risk assessment must be undertaken to establish clinical priority for allocation of patients to side rooms by the nurse in charge of the ward in consultation with the IPCT/Site manager. If any clinical concerns further discussion must occur in hours with the Infection Prevention and Control team and out of hours the bed management team/ Senior Nurse

- A commode must be allocated for this patient’s sole use. If they are mobile a designated bathroom must be identified for their sole use if they do not have en-suite facilities.

- The appropriate infection control notices must be clearly displayed on the door

- The patient and with their permission their relatives must be informed of the rationale for isolation nursing.

- If the patient requires treatment in another clinical area, the area must be informed of the patients VRE status; and as far as practicable they should see the patient at the end of the session/list to ensure infection control practice is maintained.

- Patients who require surgery should be scheduled for the end of the list unless there is a clinical reason that this cannot occur. A risk assessment should be undertaken by the Theatre co-ordinator to reflect the decision making process.

- Patients who have active symptoms of diarrhoea should not visit other departments unless the treatment is critical to their current care (this applies to all patients who have suspected infective diarrhoea).

- Patients who are VRE positive must not be moved to another ward unless clinical need dictates and discussion should be held with the Consultant Microbiologist/ IPCT and the Nurse in charge of both areas. They must be transferred directly into a side room, with the receiving area being fully informed of the patients VRE status.

- Access to the patient should be limited to essential staff to prevent transmission to other patients.
• Visitors should be asked to limit the numbers visiting and as far as practicable avoid bringing in small children.

• Equipment must be kept to a minimum in the bay/side room, e.g. incontinence pads, tape. All consumables must be destroyed on the patients discharge.

• Patient's notes must be kept outside the side room

**7.1 Hand hygiene requirements for staff, patients, visitors and carers**

• All clinical staff must decontaminate their hands before and after any patient contact, or following contact with the patient environment. This must be done with liquid soap and water or alcohol hand gel.

• Patients must be offered hand hygiene facilities prior to eating and after using the toilet or commode (This must occur for all patients regardless of their infection status).

• Visitors / carers must also be asked to wash their hands on entering and leaving the side room and if they are giving any patient contact.

**7.2 Personal Protective Equipment (PPE) for staff, visitors and carers**

• All healthcare staff must wear single use gloves and aprons when in contact with the patient or their environment.

• PPE is to be applied before entering the isolation room

• PPE is to be removed prior to leaving the isolation room

Following removal of PPE, hands must be decontaminated before exiting the room using liquid soap and water.

• Visitors are not required to wear PPE unless they are delivering direct patient care.

**7.3 Linen management for Patients with VRE**

• Patient’s bed linen must be changed on a daily basis. Relatives should be asked to provide clean night attire and towels as part of this daily change.

• Linen must not be placed on the floor.

• Used linen to be placed in a red alginate bag and then into a white outer bag.

• Used linen to be removed from the isolation room and disposed of as quickly as possible.

• Patients own clothing can be washed as normal on the hottest temperature for the fabric. This should be placed in the patients locker and relatives asked to take these home as soon as practicable.

**7.4 Waste disposal requirements for patients with VRE**

• Waste to be placed into clinical waste bin in patient’s room and managed as per Trust policy.

**7.5 Environmental cleaning to manage the risk of transmission of VRE**

VRE has a higher capacity than some microorganisms to survive in the environment, on equipment and surfaces. It is therefore essential that robust standards of cleaning are implemented:
- Once a patient is moved into isolation, ISS must be informed via the hotline number (x1999) by the nurse in charge that a **twice** daily infection cleaning is required.

- All horizontal, vertical surfaces including frequent touch point areas for examples bedside tables, door handles must be cleaned **twice** daily using a sporidical product e.g. Tristal.

- Dedicated equipment must be used for patients requiring isolation, however on occasions where this is not practicable (for example hoists), the equipment must be cleaned immediately after use (refer to the manufacturer’s instructions to ensure correct decontamination occurs). For the majority of items e.g. commodes, chairs, Tristal or sporidical wipes will be appropriate.

- As far as practicable keep items to a minimum, this includes patient’s personal items. It may be appropriate to request extra items are sent home.

### 7.6 Specialist Infection Control Clean for Patients with VRE

- Once a patient is identified as being medically fit for discharge, the Nurse in charge of the ward, the ICN and the ISS supervisor must plan a Post Infection/Deep Clean prior to any new admissions into this area (see **Appendix 3**).

- All equipment including curtains must be stripped from the room, cleaned or disposed of appropriately.

- Pillows must be disposed once the patient is discharged.

- Mattresses must be checked as per the Tissue viability mattress check list once the patient has been discharged:
  
  i. Inspect the mattress for any visible signs of damage to mattress integrity, if noted inform the nurse in charge as a replacement mattress must be sought and the damaged mattress disposed of.
  
  ii. Unzip the mattress and inspect inner mattress for signs of soiling. If there are any stains / decolouration to the underside of the cover remove the mattress from circulation and inform nurse in charge so that a replacement mattress can be sought and the damaged mattress disposed of.
  
  iii. If soiling not evident, proceed with water leak test:
  
  iv. Place a sheet of absorbent tissue between the top surface of the mattress and the cover in the area where the patients "bottom" would normally be.
  
  v. Re-zip the mattress cover
  
  vi. Using the fist, indent the mattress over the area where the tissue is located to form a shallow well and pour approximately 30 mls of tap water into the well.
  
  vii. Agitate the area with the fist for one to two minutes
  
  viii. Mop up the water with disposable paper towels and discard as domestic waste.
  
  ix. Undo zip and inspect tissue for water spots.
  
  x. If the absorbent tissue is wet, then the integrity of the mattress has been breached and the mattress must be replaced.

The mattress should be removed from use and the mattress cover should be replaced if it is found to fail the above test or if it is visibly damaged.
• Specialist hired mattress must be returned to the company for cleaning and decontamination

• The Post Infection/Deep clean will include as a minimum steam, Tristal. On a risk assessment basis the IPCT may bring in additional measure of UVA light treatment

• The bed management team must be informed that this area is unlikely to be available for a patient admission for the next 6 hours

• Once completed the specialist infection clean must be signed off using the post infection clean documentation (appendix 2) by the Site Manager/ Matron/IPCT and the ISS supervisor.

8 Discharge process for a patient with VRE

• Patients can be discharged to another care provider, however their VRE status must be clearly detailed in the EDNF

• Ambulance staff must be notified of the patient’s VRE status to enable them to make appropriate preparations

• Patients can be discharged to their own homes without any additional requirements, however they should be advised to continue with good hand hygiene, general cleaning (no specific products are required)

• Patients should be reassured that they pose no danger to their family members and offered a VRE patient information leaflet

• If a patient is discharged home and requires additional support from District nurses, or other support service they MUST be informed of the patient’s VRE status as they may not see the EDNF

• All wounds and/or invasive devices must be managed in accordance with the principles of ANTT

• Advice on clinical signs of infection in the community should be obtained from the patients GP, additional advice re antimicrobial management can be obtained from the Consultant Microbiologist.

9 Precautions required for a patient who dies with VRE

The precautions taken when attending to those who have died are the same as in life. Body bags are not required. No special requirements other than those normally used by mortuary personnel and undertakers are required.

10 VRE Outbreak management

In the event of a VRE Outbreak the Infection Prevention and Control team will advise and lead on actions to be taken and screening required. An outbreak is identified based on national guidance of two or more linked cases, this will be managed under the Trust outbreak policy, notification will also be made to Public Health England.
11 Training
All clinical staff must undertake Trust infection control mandatory training annually. Additional training on VRE management will be provided by the IPCT.

12 Monitoring Compliance
The infection prevention and control team will review and investigate incidents reported relating to this policy and audit departments compliance as part of the annual audit programme.

Failure to follow the guidance in this policy will be reviewed as part of the Post Infection Review process and consideration given if this constitutes a Lapse in Care contributing to the development of an infection. This will be monitored through the Infection Prevention and Control Committee.

Non-compliance with the policy will be managed via the staff disciplinary route; this will be supported by the Director of Nursing, Quality, Performance, DIPC, and the Medical Director.

This policy should be read in conjunction with (but not exclusively):

- Standard Precautions policy
- Isolation Policy
- Outbreak Policy
- ANTT Policy
- Blood Culture policy
Legislation, Guidance and References


Countess of Chester NHS Foundation Trust VRE policy 2015


NICE quality standard (2014) Guidelines for Infection Prevention and Control

Appendix 1

Screening for (VRE) Vancomycin Resistant Enterococci

Specimen type:
- Rectal screen (preferred sample type)
- Stool sample (if patient declines or is unable to provide a rectal screen)

Performing a rectal screen:
- Explain the procedure to the patient to gain their consent. Ensure the patient’s privacy & dignity while performing the procedure.
- Decontaminate hands using liquid soap and water.
- Confirm patient details on the pathology request card with the patient, or against patient’s ID band.
- Put on non-sterile examination gloves and plastic apron to collect specimen.
- Insert the dry charcoal swab into the rectum approximately 2.5 cm (for adults) beyond the anal sphincter and very gently rotate to obtain faecal flora.
- Ensure that the tip of the swab is well covered in faecal material.
- Remove apron and gloves.
- Decontaminate hands using liquid soap and water.
- Dispose of PPE / equipment into appropriate waste stream.
- Label specimens correctly and organise transport to laboratory.

Complete pathology request form:
- A minimum of 3 patient identifiers must be evident on the pathology form e.g. patient’s name, Hosp. No, NHS No, DOB etc.
- Document rationale for VRE request e.g. VRE screen, VRE contact screen.
What is enterococci and VRE?

VRE is a type of bacterium (or germ) that is commonly found in the gastrointestinal tract (gut or bowel) and in the genital tract of women. In the majority of people the enterococcus is harmless, but in some people it can cause infection such as urinary tract, wound or bloodstream infection.

VRE (Vancomycin Resistant Enterococcus) is a type of Enterococcus that has become resistant to the antibiotic Vancomycin. Vancomycin is an important antibiotic belonging to the glycopeptide class of antibiotics which are used to treat serious infections. When Enterococcus is Vancomycin resistant, the antibiotic cannot kill the bacterium and therefore cannot be used to treat infections.

What is colonisation? This is when some people carry VRE for weeks or months, usually in the gastrointestinal tract without becoming ill. VRE colonisation produces no symptoms but the bacterium can be passed on from a colonised patient to other patients. VRE can also be spread to objects and surfaces in a room as a result of contact with the bacterium.

In normal healthy people illness due to VRE is very rare, hence family members and household contacts of patients with VRE are not at any risk. Normal social hygiene should prevent them acquiring the organism.

Who gets VRE?

People most likely to become colonised or infected with VRE are those who:

- Have a serious illness which affects the body’s ability to fight infection.
- Spend long periods of time in hospital
- Have been taking antibiotics for a long time including Vancomycin.
- Have had medical devices e.g. urinary catheters which have stayed in place for a long time.
- Have undergone surgical procedures such as abdominal or chest surgery.

How do healthcare organisations prevent VRE transmission?

Hospitals use special precautions to help prevent the spread of VRE by:

- Prioritising the use of certain antibiotics helps to limit the development of VRE.
- Screening for VRE in some specialist areas on admission to ensure patients are cared for appropriately. This usually involves taking a swab from the area around the bottom (anus).
- Nursing patients in single rooms or nursing patients together in a bay. Patients requiring special precautions must stay in their room when possible. When leaving the room patients and visitors must wash their hands with liquid soap and water and dry with paper towels in order to help protect other patients, staff and visitors. Patients’ personal items should be kept to a minimum and stored in drawers or cupboards to keep the surfaces clear to allow for effective cleaning.
- Abiding to strict hand hygiene practices using liquid soap and water on entering and leaving a room/ bay (staff and visitors).
• Keeping non-essential items in a room to a minimum to allow effective cleaning.
• Staff / relatives wearing gloves and aprons when undertaking clinical care which must be removed prior to leaving the room / bay

**Discharge from hospital**

Your discharge will not be compromised by VRE, once you are home you can return to your normal routine. Laundry / dishes can be done as usual and no special cleaning is required.

If you receive care from other healthcare professionals e.g. Doctors, Nurses, Physios etc or if you are readmitted to hospital it is important you inform them that you are colonised with VRE.

For more information about Vancomycin Resistant Enterococci, please contact:

The Infection Prevention & Control Nurses at:

Macclesfield District General Hospital
Victoria Road
Macclesfield
Cheshire, SK10 3BL.

01625 661597
Appendix 3 - Post Infection Specialist Clean/ Deep Clean Process

Required outcome:
When notified by Infection Prevention and Control that a “Post Infection Clean or a Deep Clean/Triple Clean” is to occur the following procedures must be followed. Post infection / Specialist cleaning prior to a ward re-opening will only occur on recommendation of the Infection Prevention and Control Team and be based on risk assessment. On completion of the clean the checklist at the end of the document must must be completed by the Senior Sister / Deputy, ISS supervisor, out of hours Site Manager. This documentation will provide evidence it has occurred to a satisfactory standard.

Key Contacts:
- Infection Prevention and Control Nurse (IPCN)
- Senior Sister / deputy (as appropriate)
- Matron
- ISS team
- Estates
- ISS manager / supervisor
- Catering Department
- Bed Managers

Ward Manager Responsibilities:
- To liaise with Infection Prevention and Control and all appropriate departments / teams involved in the Post Infection Clean/ Deep clean process to ensure timely completion
- To organise sufficient staffing levels to complete deep clean without affecting patient care.
- To identify a lead person each shift to work in liaison with ISS to assist with the co-ordination of the deep clean
- To identify a responsible qualified staff member each shift to take responsibility for signing off completed cleaning elements on behalf of the ward / ward manager in their absence.
- To ensure appropriate PPE is available for staff
- To contact ISS portering services to assist in the removal of condemned furniture / equipment (de-clutter)
- To liaise with linen department to ensure sufficient supply of fresh linen for ward.
- To organise replacement mattresses as required
- To condemn rusty / faulty patient related equipment
- Ensure food / beverages e.g. bread, coffee etc are stored in sealed containers.

Nursing Responsibilities:
- To organise the movement of patients within the ward area to facilitate cleaning of empty bays / siderooms
- To remove patient belongings / medicines from area being cleaned
- To order replacement specialist mattresses in anticipation of patient needs
- To dispose of opened clinical supplies e.g. pads, patient wipes stored in bays / single rooms
- To remove and dispose of non-laminated notices, organising replacements where necessary
- To complete cleaning tasks without affecting patient care.

**ISS Management / Deputy Responsibilities:**
- To liaise with Infection Prevention and Control and Senior Sister to co-ordinate the smooth running of the post infection / deep clean and be present from start to finish.
- To sign off the completed cleaning elements on behalf of ISS
- To remove and replace all curtains on the ward / dept as appropriate.
- To clean all mattresses including specialist mattresses.
- To empty and clean all dispensers and replace stock when cleaning completed.
- To wash all walls in the ward / dept.
- To fully steam clean all areas and equipment followed by a thorough sporacidal (Tristel) wipe down of all surfaces.
- To scrub all hard flooring
- To liaise with estates to clean equipment thoroughly e.g. estates remove radiator covers and ISS clean inside
- To fully steam clean and wipe down all bathrooms, toilets, shower/wet rooms using sporacidal (Tristel)
- To replace all shower curtains
- To damp dust high and low level surfaces with sporacidal e.g. Tristel
- To wipe down beverage trolley with with sporacidal e.g. Tristel
- To wipe down all window blinds with with sporacidal e.g. Tristel
- To clean domestic cleaning trolley with sporacidal e.g. Tristel
- To complete sign off checklist with Senior Sister or the Nurse in Charge
- To liaise with Senior Sister / allocated responsible person prior to condemning equipment

**Estates Responsibilities:**
- To liaise with ISS to organise removal of radiator covers, clean vents, wall-mounted fans, light fittings etc required for cleaning to occur
- To replace radiator covers, light fittings etc on completion of cleaning
- To plan for extended hours to assist with co-ordination and completion of clean
- To clean and maintain smoke detectors
- To clean vents
- Ceilings in liaison with ISS e.g. removal of ceiling tiles
DEEP CLEAN / POST INFECTION CLEANING PROCESS

Specialist Clean – Estates:
- To remove all radiator covers throughout the ward / dept. in preparation for cleaning and replace when cleaning completed
- To clean all fans
- To clean all ceiling vents
- To clean all lights and fittings throughout the ward
- To remedy small repairs on the ward

Specialist Clean – ISS (Supervisors Checklist)

Bathrooms / toilets
- Clean toilet, pipework and sanitary fittings
- Descale toilets, showers and baths
- Clean all dispensers (inside and outside) and refill
- Wash sinks and tiles in line with standard operating procedure
- Clean bins inside and out
- Clean any wall mounted fittings
- Clean floor
- Remove and replace shower curtain
- Replenish consumables

Clinical room / clean utility room
- Clean stacking systems inside and outside
- Clean shelving and fixtures
- Clean high level and walls
- Clean hand hygiene dispensers (inside and outside) and replenish
- Clean sink and fittings as per standard operating procedure
- Clean floor
- Wipe outside of medication lockers

General ward area:
- Clean buffer bars, picture frames, fixtures and fittings
- Complete high and low level cleans and wall washes using sporacidal e.g. Tristel
- Clean sink as per standard operating procedure
- Clean dispensers inside and out and replenish consumables
- Clean around nurses station once staff have removed stationary etc
- Clean floor and behind stand alone units e.g. drawers
- Clean all door vents, fittings and hand contact areas
- Machine scrub, prepare and polish floors and edging
Entrance corridor / Link corridor to clinical area:
- Complete high and low level cleans and wall washes using sporacidal e.g. Tristel
- Clean floor
- Clean beverage machine
- Clean notice boards

Bays/single rooms
All furniture, fixtures and fittings must be steam cleaned and then cleaned with sporacidal e.g. Tristel
- Take down and replace with clean curtains
- Clean bed tables, including underside and wheels
- Dispose of consumables left by ward staff – discuss with ward staff prior to disposal of consumables
- Clean bins inside and out
- Clean curtain rails using sporacidal e.g. Tristel
- Clean sink as per standard operating practice
- Clean external light fittings
- Clean notice boards
- Clean window sills
- Clean buffer bars
- Clean dispensers inside and out and replenish
- Clean bed lockers inside and out
- Clean floor
- Clean bed & bed frames
- Wash chairs and foot stools, including legs and under seat. Advise ward staff of any torn / broken equipment to discuss condemning the item.
- Clean patient buzzers, bed lights, switches etc

Kitchens:
- Clean inside and outside of bins, cupboards, fridge, dishwasher, microwave, Toaster,
- Ensure food is within expiry date
- Clean high and low level shelving,
- High and low level clean walls and floors
- Clean sinks as per standard operating practice

Ward Staff responsibilities
Nurses station / office:
- Clear desk, remove and sort all stationary, dispose of none laminated posters and replace as appropriate
- Clean computer equipment, phones, IPADs, COWS,
- Empty and clean patient notes trolleys (inside and out)
Clinical room:
- Empty store room in preparation for ISS to clean
- Remove patient medication / equipment from drawers/ shelves / drawers / boxes in preparation for ISS to clean. Replace items following clean.
- Clean patient associated equipment e.g. glucometer machines
- Clean inside of medications cupboard
- Remove stationary in preparation for ISS to clean surfaces

Patient equipment:
- Remove all patient equipment from bay / single room in preparation for cleaning
- Remove suction pots, clean and replace when bay / single room ready for patient occupation.
- Clean all patient related equipment and label with green “I am clean” tape on completion of cleaning item. This list is not exhaustive but includes:
  - Resus Trolley, ECG machines, hoists, patient scales, drip stands, commodes, dynamaps, bed pan holders, thermometers, cardiac monitoring equipment, walking aids, sharps / ANNTT trays, drip stands, stacker units, wheelchairs, walking frames
  - Strip bed in preparation for clean and remake beds prior to re-occupation by patients
  - Checks mattresses and pressure relieving devices for signs of damage allowing bodily fluids to be absorbed. Condem if cover torn or damaged.
  - Replace patient related equipment in bays / single rooms following cleaning

Sluice / dirty utility:
- Clean commodes in preparation for steam cleaning by ISS
- Dispose and replace broken / cracked patient wash bowls
- Condem any rusty equipment and organise replacement if required

Ward office:
- Ward staff to prepare room ready for ISS to clean
### POST INFECTION SPECIALIST CLEAN
### DEEP CLEAN – SIGN OFF CHECKLIST

**Date ………………**

**Ward ………………..**

<table>
<thead>
<tr>
<th>Element</th>
<th>Responsible people</th>
<th>Element completed by (only sign on completion of element)</th>
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<tbody>
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<td>Date &amp; signature (Print name)</td>
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<td>Shower room 1 Room Number.....</td>
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<td>Room Number.....</td>
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<td>Responsible people</td>
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<td>Shower room 3</td>
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<td>Room Number.....</td>
<td>Shower room 4</td>
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<td>Room Number.....</td>
<td>Sluice</td>
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<td>Room Number.....</td>
<td>Nurse’s Station</td>
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<td>Room Number.....</td>
<td>Meeting Room</td>
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<td>Room Number.....</td>
<td>Store Room</td>
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<td>Room Number.....</td>
<td>Ward office</td>
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To be signed off as a minimum by a member of staff representing the ward and ISS

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<thead>
<tr>
<th>Date</th>
<th>Designation</th>
<th>Signature</th>
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<tbody>
<tr>
<td></td>
<td>Senior Sister / Nurse in Charge</td>
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<td></td>
<td>ISS supervisor</td>
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<td></td>
<td>Infection Prevention and Control</td>
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</table>
Equality Analysis (Impact assessment)

Please START this assessment BEFORE writing your policy, procedure, proposal, strategy or service so that you can identify any adverse impacts and include action to mitigate these in your finished policy, procedure, proposal, strategy or service. Use it to help you develop fair and equal services.

Eg. If there is an impact on Deaf people, then include in the policy how Deaf people will have equal access.

1. What is being assessed?

VRE Policy

Details of person responsible for completing the assessment:

- Name: Anita Swaine
- Position: Lead Nurse Infection Prevention and Control
- Team/service: Infection Prevention and Control

State main purpose or aim of the policy, procedure, proposal, strategy or service: (usually the first paragraph of what you are writing. Also include details of legislation, guidance, regulations etc which have shaped or informed the document)

This policy aims to promote awareness of VRE and enable early identification, screening and isolation of high risk patients, which are all essential steps in the control of drug resistant organisms (Damanii, 2012). The guidance within promotes correct management of affected patients and aims to improve patient safety by limiting the spread of VRE within the Health Care Setting.

2. Consideration of Data and Research

To carry out the equality analysis you will need to consider information about the people who use the service and the staff that provide it. Think about the information below – how does this apply to your policy, procedure, proposal, strategy or service

2.1 Give details of RELEVANT information available that gives you an understanding of who will be affected by this document

Cheshire East (CE) covers Eastern Cheshire CCG and South Cheshire CCG. Cheshire West & Chester (CWAC) covers Vale Royal CCG and Cheshire West CCG. In 2011, 370,100 people resided in CE and 329,608 people resided in CWAC.

Age: East Cheshire and South Cheshire CCG’s serve a predominantly older population than the national average, with 19.3% aged over 65 (71,400 people) and 2.6% aged over 85 (9,700 people).

Vale Royal CCGs registered population in general has a younger age profile compared to the CWAC average, with 14% aged over 65 (14,561 people) and 2% aged over 85 (2,111 people).
Since the 2001 census the number of over 65s has increased by 26% compared with 20% nationally. The number of over 85s has increased by 35% compared with 24% nationally.

Race:
- In 2011, 93.6% of CE residents, and 94.7% of CWAC residents were White British.
- 5.1% of CE residents, and 4.9% of CWAC residents were born outside the UK – Poland and India being the most common.
- 3% of CE households have members for whom English is not the main language (11,103 people) and 1.2% of CWAC households have no people for whom English is their main language.

Gender:
- In 2011, c. 49% of the population in both CE and CWAC were male and 51% female. For CE, the assumption from national figures is that 20 per 100,000 are likely to be transgender and for CWAC 1,500 transgender people will be living in the CWAC area.

Disability:
- In 2011, 7.9% of the population in CE and 8.7% in CWAC had a long term health problem or disability.
- In CE, there are c.4500 people aged 65+ with dementia, and c.1430 aged 65+ with dementia in CWAC. 1 in 20 people over 65 has a form of dementia.
- Over 10 million (c. 1 in 6) people in the UK have a degree of hearing impairment or deafness.
- C. 2 million people in the UK have visual impairment, of these around 365,000 are registered as blind or partially sighted.
- In CE, it is estimated that around 7000 people have learning disabilities and 6500 people in CWAC.
- Mental health – 1 in 4 will have mental health problems at some time in their lives.

Sexual Orientation:
- CE - In 2011, the lesbian, gay, bisexual and transgender (LGBT) population in CE was estimated at18,700, based on assumptions that 5-7% of the population are likely to be lesbian, gay or bisexual and 20 per 100,000 are likely to be transgender (The Lesbian & Gay Foundation).
- CWAC - In 2011, the LGBT population in CWAC is unknown, but in 2010 there were c. 20,000 LGB people in the area and as many as 1,500 transgender people residing in CWAC.

Religion/Belief:
The proportion of CE people classing themselves as Christian has fallen from 80.3% in 2001 to 68.9% In 2011 and in CWAC a similar picture from 80.7% to 70.1%, the proportion saying they had no religion doubled in both areas from around 11%-22%.
• Christian: 68.9% of Cheshire East and 70.1% of Cheshire West & Chester
• Sikh: 0.07% of Cheshire East and 0.1% of Cheshire West & Chester
• Buddhist: 0.24% of Cheshire East and 0.2% of Cheshire West & Chester
• Hindu: 0.36% of Cheshire East and 0.2% of Cheshire West & Chester
• Jewish: 0.16% of Cheshire East and 0.1% of Cheshire West & Chester
• Muslim: 0.66% of Cheshire East and 0.5% of Cheshire West & Chester
• Other: 0.29% of Cheshire East and 0.3% of Cheshire West & Chester
• None: 22.69% of Cheshire East and 22.0% of Cheshire West & Chester
• Not stated: 6.66% of Cheshire East and 6.5% of Cheshire West & Chester

Carers:
• In 2011, nearly 11% (40,000) of the population in CE are unpaid carers and just over 11% (37,000) of the population in CWAC.

2.2 Evidence of complaints on grounds of discrimination: (Are there any complaints or concerns raised either from patients or staff (grievance) relating to the policy, procedure, proposal, strategy or service or its effects on different groups?)

None

2.3 Does the information gathered from 2.1 – 2.3 indicate any negative impact as a result of this document?

None

3. Assessment of Impact

Now that you have looked at the purpose, etc. of the policy, procedure, proposal, strategy or service (part 1) and looked at the data and research you have (part 2), this section asks you to assess the impact of the policy, procedure, proposal, strategy or service on each of the strands listed below.

RACE: From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, racial groups differently?
  Yes ☐ No √

Explain your response: For any patient whose first language is not English, as information needs to be provided and understood, staff will follow the trust interpretation policy.

GENDER (INCLUDING TRANSGENDER):
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, different gender groups differently?
  Yes ☐ No √
Explain your response: No impacts identified.

**DISABILITY** From the evidence available does the **policy, procedure, proposal, strategy or service** affect, or have the potential to affect, disabled people differently?

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<tr>
<th>Yes</th>
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Explain your response: Clinical staff will need to implement support for patients in isolation as this is a mandatory requirement of this policy. Staff should follow the trust interpretation policy for people who are Deaf and involve the health facilitators for people with learning disabilities.

**AGE:** From the evidence available does the **policy, procedure, proposal, strategy or service**, affect, or have the potential to affect, age groups differently?

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<tr>
<th>Yes</th>
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Explain your response: Visitors at the extremes of the age range should be discouraged from visiting as they may be more susceptible,

**LESBIAN, GAY, BISEXUAL:** From the evidence available does the **policy, procedure, proposal, strategy or service** affect, or have the potential to affect, lesbian, gay or bisexual groups differently?

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<thead>
<tr>
<th>Yes</th>
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Explain your response: No impacts identified.

**RELIGION/BELIEF:** From the evidence available does the **policy, procedure, proposal, strategy or service** affect, or have the potential to affect, religious belief groups differently?

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<th>Yes</th>
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Explain your response: No impacts identified.

**CARERS:** From the evidence available does the **policy, procedure, proposal, strategy or service** affect, or have the potential to affect, carers differently?

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<tr>
<th>Yes</th>
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Explain your response: May need to be involved in the support of the patient during admission and post discharge. Therefore staff must ensure they receive the appropriate information on management of Isolation precautions and the management of a particular organism. On occasions language may be a barrier to the information required therefore Clinical staff should access interpreter services as per Trust guidelines.
OTHER: EG Pregnant women, people in civil partnerships, human rights issues. From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect any other groups differently?

Yes ☐ No √

Explain your response: No other impacts identified.

4. Safeguarding Assessment - CHILDREN

<table>
<thead>
<tr>
<th>a. Is there a direct or indirect impact upon children?</th>
<th>Yes ☐ No ☑</th>
</tr>
</thead>
<tbody>
<tr>
<td>b. If yes please describe the nature and level of the impact (consideration to be given to all children; children in a specific group or area, or individual children. As well as consideration of impact now or in the future; competing / conflicting impact between different groups of children and young people):</td>
<td></td>
</tr>
<tr>
<td>c. If no please describe why there is considered to be no impact / significant impact on children. This policy applies the same as for adult patients. If any concerns are noted with any child these would be escalated via the appropriate channels. Information would be provided to relatives to ensure they understand VRE, the need for screening and isolation</td>
<td></td>
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</tbody>
</table>

5. Relevant consultation

Having identified key groups, how have you consulted with them to find out their views and that the made sure that the policy, procedure, proposal, strategy or service will affect them in the way that you intend? Have you spoken to staff groups, charities, national organisations etc?

This policy has been ratified by the ICG which includes a member of the public. As with the majority of IC policies it is acknowledged that staff need to support individuals who require Isolation, any variance to this must be clearly documented in the patients notes as part of their clinical care

6. Date completed: 13/2/2017 Review Date: 27/2/2019

7. Any actions identified:

Have you identified any work which you will need to do in the future to ensure that the document has no adverse impact?

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Date to be Achieved</th>
</tr>
</thead>
</table>

8. Approval: At this point, you should forward the template to the Trust Equality and Diversity Lead lynbailey@nhs.net

Approved by Trust Equality and Diversity Lead: lynbailey

Date: 13.2.17