THE MANAGEMENT OF PATIENTS WITH CARBAPENEMASE-PRODUCING ENTEROBACTERALES IN NON ACUTE AND COMMUNITY SETTINGS

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Contents

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1. INTRODUCTION

1.1 Enterobacterales 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 Enterobacterales). They include meropenem, ertapenem, imipenem and doripenem. Carbapenemases are enzymes that destroy carbapenem antibiotics, conferring resistance. They are made by a small but growing number of Enterobacterales strains. There are different types of carbapenemase, of which KPC, OXA-48, NDM and VIM enzymes are currently the most common.

1.2 This policy has been written to provide advice on the management of colonisation or infection due to carbapenemase-producing Enterobacterales, to prevent or reduce their spread into (and within) health and residential care settings. There has been a rapid increase in the incidence of infection and colonisation by multi-drug resistant carbapenemase-producing organisms over the past decade. 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.

1.3 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. Urgent action is required, learning from experiences elsewhere across the globe, to tackle the rapid spread of carbapenem-resistant bacteria which has great potential to pose an increasing threat to public health and modern medicine as we know it in the UK.

1.4 Countries and regions with reported high prevalence of healthcare-associated carbapenemase-producing Enterobacterales.

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	
This is not an exhaustive list; admission to any hospital abroad should be considered when making a risk assessment. 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	
IMPORTANT: Healthcare providers have a 'duty of care' to proactively communicate any problems they are experiencing with carbapenemase-producing Enterobacterales, not only with colleagues in healthcare settings which are co-terminus, but with any organisation they deal with on the patient pathway, either routinely or sporadically	

1.5 Doctors rely on carbapenem antibiotics to successfully treat certain complicated infections when other antibiotics have failed. The spread of these resistant bacteria can cause problems to vulnerable patients in hospitals or other settings, because there are so few antibiotics available to treat the infections they cause.

1.6 If a person is a carrier, they do not need to be treated. If the resistant bacteria cause an infection then treatment, including antibiotics, will be required. These infections are difficult to treat due to their resistance to carbapenem antibiotics.

1.7 Individuals who have these bacteria living in their gut can contaminate their hands when they go to the lavatory. Because of this, there is a risk that the bacteria can contaminate and survive in the environment and potentially spread to other people, particularly when standards of hand hygiene and environmental cleanliness are poor. The bacteria can also be passed on by the hands of carers to others through touch.

1.8 Individuals who have been an inpatient in a UK hospital known to have had problems with spread of carbapenemase-producing Enterobacterales or those who have been an inpatient in a hospital abroad are at higher risk of acquiring carbapenemase-producing Enterobacterales. Appendices contain information leaflets which can be provided to individuals receiving care, their contacts and families of colonised individuals.

1.9 Most people will be unaware that they are a carrier and, in general, the chance of developing an infection from the bacteria is low. However, immunocompromised individuals and those receiving complex care in the community with frequent hospital admissions, will be more vulnerable. These individuals are at greater risk of colonisation and of suffering more serious consequences should they develop an infection. Colonised individuals with indwelling devices *in situ* may be at greater risk of developing an infection.

While the level of risk for infected or colonised individuals is lower than that in acute settings, if the levels of hygiene in the care setting are inadequate, resistant bacteria may spread among individuals who congregate together e.g. in a community hospital ward or care home. This may increase the risk of the spread of infection within the care setting.

2. PURPOSE

To enable staff working for East Coast Community Healthcare (ECCH) to understand the principles of precautions to be observed when caring for patients colonised or infected with carbapenemase-producing Enterobacterales (CPEs)

3. SCOPE

All staff either employed or contracted by ECCH who work in clinical areas with children or adults. These staff may work within ECCH premises, patients' own homes, or care settings owned by other agencies.

4. DEFINITIONS *(if relevant)*

The following definitions are intended to provide a brief explanation of the various terms used within this policy.

Term	**Definition**
Policy	A policy is a formal written statement detailing an enforceable set of principles or rules. Policies set the boundaries within which we operate. They also reflect the philosophy of our organisation.
Carbapenemase	Enzymes (such as Klebsiella pneumoniae Carbapenemase (KPC), OXA-48 Carbapenemase, New Delhi Metalo-beta Carbapenemase (NDM) and Verona integron-encoded metallo-β-lactamase (VIM)) produced by some bacteria which cause destruction of the Carbapenem antibiotics, e.g. Meropenem, thus resulting in resistance.
Colonisation	The presence of micro-organisms living harmlessly on the skin or within the bowel and causing no signs or symptoms of infection.
Community-acquired infection (CAI)	An infection that is not related to a healthcare intervention in a hospital.
Medical Tourism	A medical tourist "elects to travel across international borders to receive some form of medical treatment". Most commonly includes dental care, cosmetic surgery, elective surgery and fertility treatment, though it may span the full range of medical treatment.' OECD (2010)

5. RESPONSIBILITIES

- **ECCH Employees** – Are responsible for the implementation of this policy and following the requirements of the policy.

- **Chief Executive of ECCH** – Overall responsibility for the enforcement of this policy lies with the Chief Executive of ECCH

- **ECCH Managers** – Are responsible for ensuring staff follow this policy.

- **IPACC** – Is responsible for approving the policy.

6. POLICY STATEMENT

It is the responsibility of all department heads/professional leads to ensure that the staff they manage adhere to this policy.

7. PROCEDURE

7.1 **Early recognition of individuals who may be colonised/have an infection.**
A risk assessment must be used as part of the routine admission procedure to identify suspected cases of colonisation or infection with CPE.
N.B. Patients transferred to ECCH care from Acute hospitals should have had this assessment carried out on their admission to those hospital and the result documented in their notes.

Assess each patient at pre-assessment, admission and transfer/repatriation taking a thorough history and asking the following key questions:

Has the patient, in the last 12 months?

a) Been previously identified as CPE positive
OR
b) Been an inpatient in any hospital, in the UK or abroad
OR
c) Had multiple hospital treatments e.g., are dialysis dependent
OR
d) Had known epidemiological link to a known carrier of CPE
OR
e) They are admitted into augmented care or high-risk units e.g., immunosuppressed, critical care, burns units

*Check WebIce for an electronic alert as any patients with a positive CPE result previously known to James Paget University Hospital or the Microbiology laboratory should have an electronic alert in place.

If the patient answers **no** to all four questions above, document this in the patient care record or pre-assessment paperwork and manage as per standard protocols.
If the patient answers **yes** to any of the four questions above, manage as a potential case of CPE and follow each stage of this guideline whilst screening is undertaken

7.2 **Early isolation of suspected and laboratory-confirmed cases**

If the patient has already had a laboratory-confirmed infection or colonisation with CPE ***or*** meets the criteria for a suspected case then:

- Advise the patient (and relatives if appropriate) that they meet the criteria for screening due to the risk of CPE and your management plan for their care – provide a patient information leaflet (Appendix).
- Immediately place the patient into a single room (with en-suite facilities if possible). If a single room is not available for a screened or known CPE positive patient a risk assessment should be undertaken by the IPC and clinical teams to determine where to care for patients.
- Apply the principles of policy for management of ward/departmental outbreak in all settings with dedicated equipment.
- The following factors will increase the transmission risks and need to be considered carefully:

Diarrhoea	Discharging wounds	Medical devices in situ
Incontinence of (faeces or urine)	High risk of wandering /unable to comply with IPC requirements	Tracheostomy and associated airway management Coughing or Colonised in Respiratory Tract

7.3 **Prompt sampling to detect CPE**

When screening samples are required for patients at risk of CPE, they should be collected on admission. Ongoing screening is indicated in the UKHSA framework (2022) for those patients in high risk units or screening related to an outbreak. Outside of the acute care sector, screening strategies should be based on local epidemiology, patient acuity and level of interventions, such as long-term ventilation and rehabilitation facilities.

What samples to take:

- Take a rectal swab using a plain swab after securing informed consent.
- A rectal swab is the best sample type to achieve speedy results; to ensure detection of the organism there must be visible faecal material on the swab and then placed in the swab casing.
- A rectal swab may be contraindicated for patients with haematological conditions and those at risk of bleeding; discuss with the doctor to confirm appropriate sampling method.

Or

- Collect a stool sample (ensure any delay in collection is clearly documented in the patient care record).

AND (using separate charcoal swabs)

- Swab skin lesions and wounds.
- In-dwelling devices e.g. PEG site (excluding peripheral cannulae and long term intra vascular devices e.g. Hickman line unless there are clinical signs of infection).

Request a 'CPE Screen' on WebIce under the microbiology tab. List the sample site and patient risk factors in the global clinical details section of the request.

7.4 **Results of CPE screening/clinical samples**

Clinical teams are responsible for checking and acting on laboratory results. Clinicians are also responsible for informing the patient of their screening results.

If the result is **NEGATIVE,** a risk assessment should be undertaken before removing from isolation (ensuring other potential infections have been excluded).

If the patient is **POSITIVE** on screening/clinical samples for CPE a preliminary report will be released initially pending formal confirmation from the national reference laboratory. The patient should be informed, offered a patient leaflet (Appendix A) and managed as per section 7.6 for the duration of their inpatient stay.

7.5 **Communication**

Effective communication is crucial to ensure that the risks of transmission and clinical infection are minimised.

- Patients must be informed of the screening process (leaflet available) and notified of their results (whether CPE is detected or not)
- CPE results to be included in nursing and medical handovers
- Notify receiving units and include information about positive result on all transfer/admission documents (if moved to another healthcare setting or referred for community care)
- CPE screening results must be included on all discharge letters for GP reference
- CPE electronic alerts will be added to WebICE

Notify IPCT if any patients are transferred with a known CPE positive result or are being traced as potential contacts from another healthcare facility

Early detection – screening contacts of confirmed cases

Screening of contacts (based on the likelihood of exposure) may be required if a patient is found to be positive for CPE and spent time in a multi occupancy bed space. Screening will be directed by the IPCT with the aim of identifying any further cases and instigate further control measures.

Provide information leaflet (Appendix B) and undertake screening for contacts of a positive case on the advice of the IPCT based on the likelihood of exposure as follows:

- Screening of patient contacts of a positive case SHOULD be undertaken if the case had spent time (≥8 hours) or remained in an open ward or bay with other patients before (or despite) having a positive CPE result.
- Screening of household contacts and healthcare staff is NOT required. The main focus should remain on promotion of enteric precautions throughout, especially hand hygiene.
- It is not necessary to isolate contacts whilst awaiting screening results – cohort such contacts if possible and/or reiterate strict standard precautions, particularly hand hygiene for staff and patients and decontamination of shared equipment.
- 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.

Should any contact screen positive, manage as positive case (see above).

In discussion with the local Public Health England PHE Centre, screening the whole ward PLUS discharged patients who occupied the bay (or ward, if case occupied more than one bay) at same time as case may be considered by the DIPC and IPCT.

7.6 **Managing a patient with a CPE (colonisation/infection) in an Inpatient setting**

Infection Prevention and Control key measures summary		
Precaution/ measure	**Yes/No or N/A**	**COMMENTS**
Isolation	**Yes**	Isolate patient in a single room with enteric precautions if risk factor triggered. Positive (currently or previously) should remain isolated for the duration of their inpatient stay.
Can patients be cohort nursed? (multiple patients in one bay)	**No**	Only under special circumstances as directed by the IPCT following advice from the ECCHs IPC Doctor.
Gloves	**Yes**	Wash hands with soap and water after removing gloves. Change gloves and decontaminate hands when moving from one body site to another on the same patient
Aprons/Gowns	**Yes**	Where any part of staff uniform/clothing, not covered by a standard 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, bed bathing, wound dressing changes)
Mask & eye protection	**Risk assess**	If there is a risk of bodily fluids splashing/contaminating your face or if undertaking an aerosol generating procedure e.g. airway suction.
Dedicated equipment	**Yes**	Dedicated observation equipment (blood pressure cuff, thermometer, and stethoscope). Non-dedicated equipment must be thoroughly disinfected after use using Clinell/Medipal wipes (Green) or in the presence of diarrhoea, SoChlor solution. Re-usable SSD instruments to be managed according to ECCH procedures.
Cleaning measures	**Yes**	Daily cleaning and disinfection with SoChlor solution is a key control measure. Clinical clean must take place on discharge. Mattresses must be checked prior to cleaning and disinfecting.
Linen and Waste		Treat as 'infected' as per Laundry policy and waste categorised as Infectious waste as per the Waste policy
Antibiotic Management	**Clinically assess**	If signs of infection, contact Duty Medical Microbiologist for clinical review and advice.
Visiting restrictions	**Risk assess**	Visitors must follow IPC precautions (PPE & hand hygiene)
Patient/relatives information	**Yes**	CPE leaflets available for screening, contacts & positive results. See Appendices
Inform Occupational Health	**Risk assess**	Not unless managing an outbreak in which staff screening is required as directed by the organisations IPC Doctor or a member of staff is found to be colonised/ infected with CPE.
Inform other service providers	**Yes**	Ensure other departments/wards are notified of the patient's CPE status and necessary precautions as appropriate when patient is transferred for diagnostic/ therapeutic purposes
Discharge	**Yes**	CPE patients can be discharged to community settings, but their status must be clearly communicated in advance of the discharge and the GP notified in the discharge letter.

7.7 **Additional services, investigations and interventions**

All additional services, investigations and interventions will need to be risk assessed based on the clinical need and the CPE status of the patient. The IPCT can assist in this risk assessment process if required.

Diagnostic tests and attendance at Outpatient Services

Diagnostic Tests

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, close liaison must take place with the receiving department and any transport services utilised.

Therapy services

All therapy services will continue as clinical need dictates. The patient should be visited last if practicably possible. All therapy staff will adhere strictly to the use of appropriate PPE, hand hygiene and the thorough decontamination of any equipment used during their assessment in line with section.

Trolleys and Wheelchairs

Trolleys and wheelchairs used to transfer patients must be thoroughly cleaned and disinfected after use for a patient transfer with Medipal wipe (Green) if the patient is suffering with diarrhoea, use SoChlor Plus solution

Non-essential services

Non-essential services including the following: Newspaper trolley, Library trolley and sweet trolley will not go into the rooms accommodating patients with CPE but will continue on other areas of the ward not used for patients with CPE. Patients requiring items can request that staff to go to the trolleys on their behalf.

Visitors

All visitors entering an isolation room should be advised to use aprons and gloves and wash their hands with soap and water before and after each patient contact. Any refusal to do so should be addressed by senior members of the clinical team and records of advice given be documented in the patient's Patient Care Record (PCR).

7.8 **Cleaning (Routine and Terminal Cleaning)**

Daily cleaning

Isolation rooms must be cleaned daily by domestic services using SoChlor solution. The patient should be encouraged to minimise their belongings being stored on surfaces in the room to allow the domestic staff to clean the room effectively.

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

Clinical staff are responsible for cleaning and disinfecting the dedicated clinical equipment in the isolation room on a daily basis and documenting these actions.

- Patient wash water, body fluids or secretions, **must not** be discarded down a clinical hand wash basin as this poses a high risk of environmental contamination.
- Pulse oximeters require normal cleaning and disinfection after each use or be single-patient use only.
- Blood pressure cuffs should be single-patient use only. Disposable single patient use cuffs are recommended.

- Stethoscopes and thermometers should be dedicated for single-patient use only.

Cleaning following discharge/transfer

- Following discharge/ transfer of the patient, the room and its contents should be cleaned and disinfected thoroughly as per the IPCT instructions.
  Special attention should be paid to removing all faecal soiling, and in particular to cleaning of furniture, toilets, commodes, call bells etc. fittings, and to horizontal surfaces.
- 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 must be disposed of.
- All mattress and pillow covers should be inspected (unzipped), cleaned and disinfected by clinical staff and all elements replaced if torn or leaking.
- Dynamic mattresses must be cleaned, bagged and then sent off site for thorough decontamination as per the protocol for infected mattresses.
- As part of the clinical clean all curtains must be removed from the bed space.
- Lavatory brushes and their holders should be disposed of as part of the clinical clean.

7.9 **Managing a patient with a CPE (colonisation/infection) in a Community setting** (i.e. Not a hospital inpatient)

ECCH Clinic Areas

- A record of the patient's status, any specimen results and the micro-organism involved must be recorded in the patient's notes.
- Known CPE positive patients (check WebICE alerts) should be planned at the end of the clinic list if possible, to enable thorough environmental cleaning to be undertaken following the appointment. Effective and thorough standard precautions, environmental and equipment cleaning must be followed strictly for all patients in these departments given the restrictions in identifying these patients prior to arrival in clinic. For all patients, if an admission is being planned, the Inpatient risk assessment questions must be completed, and the receiving ward/department must be notified of the need for isolation facilities with enteric precautions and the need for CPE samples as per this guideline.
- Contact precautions must be maintained by all health care staff at all times, in line with the standards within ECCHs Isolation Policy.
- Clean, non-sterile gloves should be worn when there is to be contact with an infected or colonised patient, their equipment or their environment. Change gloves and decontaminate hands when moving from one site to a different site on the same patient
- A clean plastic apron should be worn if there is to be contact with an infected or colonised patient, their equipment, their environment, or during procedures where contamination of clothing may occur. Standard aprons are normally sufficient, however, where any part of staff uniform/clothing, not covered by a standard apron, is expected to come into contact with the patient, their equipment or surroundings, a **long sleeved disposable gown** should be used (e.g., when assisting movement for a dependent patient, large wound dressing changes).
- Gloves and aprons should be removed and disposed of into an orange hazardous infectious waste bag before leaving the clinic room. Hands should then be decontaminated immediately by washing with soap and water.
- All waste must be disposed of via the hazardous infectious waste stream e.g. soft waste into orange waste bags

- All equipment used on affected patients must be thoroughly cleaned and disinfected or sterilised before returning to communal use (See ECCHs Decontamination Policy). Clinical Equipment must be thoroughly cleaned and disinfected after every use using Medipal/Clinell wipes (green) or SoChlor solution, should be used if the patient has diarrhoea. Any re-usable SSD instruments should be returned in the normal way.
- For all patients, if an admission is being planned, the risk assessment questions must be completed, and the receiving ward/department must be notified of the need for isolation facilities with enteric precautions and the need for CPE samples as per this policy.
- Communication – ensure that any service involved in the provision of health and social care are aware of the patient's CPE status. This is especially important where admission to a hospital setting is necessary. Information leaflets are available for patients, relatives and contacts (please see Appendices).
- If required, patients should be provided with the relevant information leaflet by clinic staff (See Appendices).

Core Standards – Patient's Homes and Care Homes

7.10 A record of the patient's status, any specimen results and the micro-organism involved must be recorded in the patient's notes.

7.11 Clean, non-sterile gloves should be worn when there is to be contact with an infected or colonised patient, their equipment or their environment. Change gloves and decontaminate hands when moving from one site to a different site on the same patient

7.12 A clean plastic apron should be worn if there is to be contact with an infected or colonised patient, their equipment or their environment or during procedures where contamination of clothing may occur.

N.B. Standard aprons are normally sufficient, however, where any part of staff uniform/clothing, not covered by a standard apron, is expected to come into contact with the patient, their equipment or surroundings, a long sleeved disposable gown should be used (e.g., when assisting movement for a dependent patient, wound dressing changes).

7.13 Hands should be decontaminated by washing with soap and water.

7.14 All items used on affected patients must be thoroughly cleaned and disinfected or sterilised before returning to communal use in line with the standards set in ECCHs Decontamination Policy. Equipment must be thoroughly cleaned and disinfected after every use using Medipal/Clinell wipes (green). SoChlor solution should be used if the patient has diarrhoea. Any re-usable SSD instruments should be returned in the normal way.

7.15 Waste – waste generated as a result of healthcare interventions must be categorised as per the Community Risk Assessment tool

7.16 Patients should receive the relevant information leaflet (See Appendices).

7.17 **Additional advice for households**

- Environmental hygiene – Maintaining good hygiene in the household is a key control measure especially in toilets/bathroom areas and if the patient has diarrhoeal symptoms.
- Linen – launder bedlinen and clothing at the highest temperatures tolerated by the fabrics, tumble dry and iron

Patients

Screening of patients outside of hospitals is not routinely undertaken but may be indicated in the event of an outbreak or where patients have been identified as at high-risk of CPE carriage. Any screening requirement will be on the advice of the IPAC team in consultation with the Trust's Infection Control Doctor/Consultant Medical Microbiologist.

8. MONITORING AND REVIEW

This document will be reviewed by IPACC September 2025, or sooner if changes in legislation occur or new best practice evidence becomes available.

9. ASSOCIATED POLICIES & PROCEDURES *(To include but not limited to)*

Nordmann P, Naas T, Poirel L. (2011) Global spread of Carbapenemase-producing *Enterobacteriaceae*. Emerging Infectious Diseases 17(10). [04/07/2015].

http://dx.doi.org/10.3201/eid1710.110655

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https://doi.org/10.1080/21505594.2016.1222343

Organisation for Economic Co-operation and Development (OECD) (2010) Medical Tourism: Treatments, Markets and Health System Implications: A scoping review

http://www.oecd.org/els/health-systems/48723982.pdf

UKHSA (2022) Framework of actions to contain carbapenemase-producing Enterobacterales PHE publications gateway number: GW-1625

Actions to contain carbapenemase-producing Enterobacterales (publishing.service.gov.uk)

10. AUTHOR

Infection Prevention & Control Team September 2023

11. APPENDICES

1. **Appendix A – Inpatient colonized**
2. **Appendix B – Inpatient carrier**
3. **Appendix C – Inpatient contact**
4. **Appendix D – Community colonized**
5. **Appendix E – Community carrier**
6. **Appendix F – Community contact**
7. **Appendix G – Inpatient risk factor form**
8. **Appendix H – Non acute risk assessment**
9. **Appendix I – Acute care flow chart to contain CPE**
10. **Appendix J – Inpatient risk assessment tool**

Equality & Diversity Impact Assessment

In reviewing this policy, the HR Policy Group considered, as a minimum, the following questions:
- Are the aims of this policy clear?
- Are responsibilities clearly identified?
- Has the policy been reviewed to ascertain any potential discrimination?
- Are there any specific groups impacted upon?
- Is this impact positive or negative?

- Could any impact constitute unlawful discrimination?
- Are communication proposals adequate?
- Does training need to be given? If so is this planned?

Adverse impact has been considered for age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, sexual orientation.

DOCUMENT CONTROL SHEET

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Version Control

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March 2026	1	Teresa Lewis	New Policy
November 2017	2	Teresa Lewis	Reviewed
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