

Livewell Southwest

**Glycopeptide-Resistant
and
Vancomycin- Resistant Enterococci
Management policy**

Version No. 4
Review: May 2019

Notice to staff using a paper copy of this guidance.

The policies and procedures page of LSW intranet holds the most recent version of this document and staff must ensure that they are using the most recent guidance.

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Glycopeptide-Resistant and Vancomycin – Resistant Enterococci: Management policy

1. Introduction

Summary

- Appropriate use of antibiotics will greatly reduce the selection pressure for colonisation and infection with Glycopeptide-resistant Enterococci (GRE) and Vancomycin Resistant Enterococci (VRE) Vancomycin is a Glycopeptide antibiotic and some patients may have an identification for carriage of VRE, for the management of these patients the terms VRE or GRE is equally applicable. Those prescribing antibiotics should adhere to Livewell Southwest (LSW) Antimicrobial Treatment Guidelines.
- Advice on the clinical management of patients with infections due to GRE / VRE should be obtained from a Consultant Microbiologist, who will advise on the appropriate specimens to send and the type and duration of antibiotic therapy.
- The most effective means of preventing cross infection and colonisation with GRE / VRE is good hand hygiene, patient isolation and implementation of standard contact precautions.
- Twice daily enhanced cleaning of the patient environment and decontamination of equipment should be performed. (See the Decontamination Guidelines and Procedures.Cleaning and Disinfection of medical devices and patient care equipment Appendix B)
- A deep clean with a detergent followed by a bleach solution should be performed following patient discharge.

2. Purpose.

These guidelines aim to:

1. Ensure that patients colonised or infected with GRE/VRE receive effective and appropriate care
2. Minimise the risk of transmission of GRE/ VRE

3. Duties

- 3.1 The **Chief Executive** is ultimately responsible for infection prevention and control and the content of all Policies and their implementation. The Chief Executive delegates the day to day responsibility of implementation of the

policies to the **Director of Infection Prevention and Control (DIPC)** and the Infection Prevention and Control team (IPCT).

- 3.2 **Directors** are responsible for identifying, producing and implementing LSW Policies relevant to their area.
- 3.3 The **Directors** will support and enable operational Leads and Locality Managers to fulfil their responsibilities and ensure the effective implementation of this Policy within their speciality.
- 3.4 The **Modern Matron** is responsible for ensuring that the development of local procedures / documentation doesn't duplicate work and that implementation is achievable.
- 3.5 **All Staff both clinical and non clinical** have a responsibility for ensuring they have read, understood and adhere to local Protocols and Policies.

4. **Enterococci**

Enterococci are usually found as part of the normal gut flora and, because they are of low virulence, are usually harmless to fit, healthy people. However, they may cause nosocomial infections, particularly in vulnerable patients who are ventilated, have complex medical/surgical problems, wounds, or intravascular or urinary catheters. The appearance of enterococci resistant to glycopeptide agents, such as vancomycin and teicoplanin, has made treatment of such infections more difficult. Glycopeptide-resistant and Vancomycin -resistant enterococci are more common in renal, liver, haematology, oncology, transplant and intensive care units. The transferable nature of the resistance determinants has raised the possibility of possible dissemination to other pathogens, such as meticillin-resistant *Staphylococcus aureus* (MRSA). The two main types of Enterococci associated with human diseases are *Enterococcus faecalis* and *Enterococcus faecium*, *Enterococcus faecium* is most likely to cause bacteraemias. Glycopeptide resistant enterococci (GRE) are resistant to Vancomycin, usually Teicoplanin and often other antibiotics. During mid 1980s enterococci resistant to Vancomycin emerged and were therefore termed Vancomycin Resistant Enterococci (VRE).

Enterococci have the potential for cross-infection and by far the most important route of transmission is via the hands of healthcare workers. Contamination of hands is particularly likely when handling urinary or intravascular catheters or respiratory secretions of an infected patient. Transmission can also occur via equipment (such as commodes and wash bowls) and/or environmental contamination

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During mid 1980s enterococci resistant to vancomycin emerged and therefore often termed as Vancomycin Resistant Enterococci (VRE). GRE

It is important to control the emergence and spread of GRE / VRE because of the limited therapeutic options, an increasingly compromised inpatient population and the possibility for transfer of glycopeptide resistance / Vancomycin-resistance to more pathogenic bacteria such as *S. aureus* (including MRSA).

GRE / VRE colonisation or infection may be sporadic, endemic or epidemic. When cases of GRE / VRE are identified, the management strategy should be informed by a risk assessment that takes into account the background epidemiological pattern and the risk category of the patients involved (1).

5. Antibiotic Guidelines.

One factor associated with infections due to GRE/ VRE is the widespread use of broad-spectrum antibiotics. Appropriate and prudent use of antibiotics will greatly reduce the selection pressure for colonisation and infection with GRE / VRE. Those prescribing antibiotics should adhere to the Trust's Antimicrobial Treatment Guidelines.

6. Clinical management of infections due to GRE / VRE

Advice on the clinical management of patients with infections due to GRE / VRE should be obtained from a Consultant Microbiologist, who will advise on the appropriate specimens to send and the type and duration of antibiotic therapy.

Whenever possible, urinary and intravascular catheters should be removed or replaced from patients with urinary tract or line-related infections due to GRE / VRE.

For patients requiring surgical intervention, additional antibiotic prophylaxis effective against the GRE / VRE may need to be added to the usual peri-operative regimen as outlined in the surgical prophylaxis guidelines. Advice on the choice of antibiotic should be sought from a Consultant Microbiologist.

Patients known to carry a GRE / VRE will be identified by a Clinical Alert on their clinical notes and electronic record SystemOne. The Infection Prevention and Control Team (IPCT) will be responsible for generating these Alerts for each new patient identified as carrying a GRE / VRE. Clinical Alerts on patient's notes or the electronic record (SystemOne) should only be added or removed by the IPCT and will be considered on an individual patient basis.

Staff responsible for the admission of patients should check the Infection Control Clinical Alerts on the patient's notes and electronic record (SystemOne)

for evidence of previous colonisation with a GRE / VRE. If these are present, the IPCT should be informed and a risk assessment for standard isolation precautions performed. Screening of the patient (e.g. urine or perineal/rectal swab) may be considered appropriate, for example if the patient is to undergo invasive procedures or is to continue on antibiotics. After taking the appropriate diagnostic samples, advice on treatment of suspected sepsis due to a GRE / VRE **should be sought from a Consultant Microbiologist.**

The IPCT will undertake prospective, targeted surveillance of GRE / VRE and feedback the results the relevant stakeholders.

7. Tests for colonisation with GRE / VRE

Screening for carriage of GRE / VRE is not routinely performed. Under certain circumstances, such as the investigation and control of outbreaks or in response to specific incidents, tests for colonisation may be undertaken. Certain high-risk patients may also require surveillance cultures. In these situations, the Infection Prevention and Control Team (IPCT) and a Consultant Microbiologist will make appropriate recommendations regarding when sampling should be performed and which specimens should be sent. The interpretation of results and management of colonised patients will be performed by the IPCT and a Consultant Microbiologist.

Screening staff for stool carriage of GRE / VRE is not routinely performed. Under certain circumstances, such as the investigation and control of outbreaks or in response to specific incidents, tests for colonisation may be undertaken. Certain high-risk patients may also require surveillance cultures. In these situations, the IPCT and a Consultant Microbiologist will make appropriate recommendations regarding when sampling should be performed and which specimens should be sent. The interpretation of results and management of colonised patients will be performed by the IPCT and a Consultant Microbiologist. Under exceptional circumstances, staff may be required to submit screens for carriage of GRE / VRE. Those identified as being colonised will be managed on a case-by-case basis the Occupational Health and Wellbeing Department and the IPCT.

8. Prevention of spread of infection between patients

The predominant means of spread is on the hands of staff and this can be interrupted by good hand hygiene. Secondary modes of transmission include via fomites. The following procedures are intended to minimise transmission.

8.1. Hand Hygiene

Prevention is based on rigorous hand hygiene before and after contact with patients and their potentially contaminated environments (please refer to Hand

Hygiene Policy). Hand washing and decontamination with alcohol hand gel is essential when in contact with the patient and the patient's environment.

In addition, hands should be washed with soap and water at the start and end of clinical duties, when hands are visibly soiled or potentially contaminated and following the removal of gloves. Routine periodic hand decontamination with alcohol-based rub should be performed between every patient contact, or between each activity for the same patient, when hands are not visibly soiled.

8.2. Isolation

A risk assessment of the potential for cross-infection should be performed following a review with the Ward Manager and IPCT. When there is increased risk of transmission, source isolation in a side room is required (see Appendix A). The reasons for isolation must be explained to the patient and their visitors, and a GRE / VRE patient / carer information will be provided. This is particularly important for children requiring isolation

Patients colonised with the same resistant organism may be nursed in the same cohort bay. This should only be considered on the advice of the IPCT. On occasion, when isolation is not possible, GRE / VRE-colonised patients should not be nursed next to patients who have urinary or intravascular catheters, open wounds, a history of transplantation or who are immunosuppressed.

An Isolation Daily Review Care Plan must be commenced for each patient.

Isolation precautions should only be discontinued after a review with the Ward Manager and IPCT.

8.3. Standard Contact Procedures

Standard contact procedures reduce hand and clothing contamination, and are intended for all staff having contact with colonised or infected patients and their immediate surroundings. Meticulous hand hygiene and contact precautions must be employed not only when in contact with patient but also their surroundings.

The following procedures are particularly high risk:

- Draining urinary catheter bags. Particular attention is required when caring for patients with urinary catheters. Please see Policy on the Management of Urinary Catheters
- Dressing wounds
- Draining surgical drains
- Manipulating vascular access devices / cannulae
- Manipulating tracheostomies.

Standard infection control procedures (please see appropriate care plan available from the IPCT and Appendix B) include:

- **Hand-washing.** All staff and visitors must decontaminate their hands before and after contact with the patient, their immediate surroundings and on leaving the room/area
- **Gloves.** Health care workers must wear disposable gloves when in contact with potentially colonised skin, secretions and surroundings. Remove and dispose of gloves prior to leaving the patient's room/area and perform hand washing with soap and water
- **Plastic apron.** A disposable plastic apron is to be worn when clothing is likely to come into contact with colonised/infected patients or their surroundings. Remove and dispose of apron prior to leaving the patient's room/area. Perform hand washing with soap and water
- **Linen.** Treat linen as infected. Please refer to Linen Services Policy
- **All Waste.** Treat all waste, including household, as clinical waste
- **Stethoscopes.** Stethoscopes should be wiped with a detergent or alcohol wipe after each patient use
- **Cleaning.** See below
- **Death.** No special precautions are required when handling the deceased

In general, other than observing good hand hygiene practice, visitors do NOT need to follow the same precautions unless they have certain conditions (e.g. open and suppurating wounds) or if they are assisting with the nursing care of a patient.

Standard infection control precautions should only be discontinued on the advice of the IPCT.

8.4. Cleaning

Twice daily enhanced cleaning of the patient environment and decontamination of equipment should be performed. All clinical equipment must be cleaned according to manufacturer's recommendations and in line with the LSW Decontamination and Cleaning Policy. Commodes must be cleaned after each use with detergent and bleach or Clinell Universal Sanitising Wipes

Clean all 'patient-touch' surfaces, including bed frames, with detergent solution daily. Enterococci are able to survive in a moist environment, so special care and cleaning is essential for wash bowls, nebuliser equipment etc. All items must be stored dry.

On discharge, there should be a deep clean with a detergent solution, then bleach (0.1% (1000 parts per million) sodium hypochlorite (to surfaces that will tolerate it)). Sodium hypochlorite should be diluted with tepid, not hot, water, and surfaces should be wiped with a damp cloth to remove any residue. The Ward Manager should assess the cleanliness of the fittings.

9. Admissions, discharges and transfers

9.1. Admission of patients colonised with GRE / VRE

Patients who are known to be colonised or infected should undergo a risk assessment of the potential for cross-infection. Glycopeptide-resistant enterococci / Vancomycin – resistant enterococci are more common in renal, liver, haematology, oncology, transplant and intensive care units and risk assessment is particularly important in these areas. This should be performed by the Ward Manager and IPCT. Where there is an increased risk of transmission, source isolation in a side room is required.

9.2. Discharge of patients colonised with GRE / VRE

Ward staff must ensure that the patient's status is documented in the patients discharge notes/letter.

If discharged to a nursing/residential home, the home's senior nursing staff should be made aware of the patient's status by the Ward Manager. Rarely should this hamper the patient discharge.

9.3. Transfer to another hospital or long-term care facility

It is the responsibility of the Ward Manager to inform the receiving ward's nursing and ambulance staff of the patient's status and the medical staff to inform the receiving doctors or General Practitioner. This should be documented in the referral notes.

Surfaces that come into direct contact with the patient during transfer, such as stretchers, should be cleaned with detergent and water after use. Ambulance staff are not required to take specific precautions over and above normal contact precautions and good hand hygiene.

9.4. Transfer of colonised/infected patients within the hospital

Transfer of patients colonised or infected with GRE / VRE should be avoided if possible. Such patients should be transferred to an isolation facility in the receiving ward.

Infected/colonised patients may attend clinical service departments for necessary investigations or treatments.

There should be clear communication between departments about the patient's status and transfer should only proceed when the receiving area are fully prepared.

Measures to reduce the risk of transmission should be taken. The colonised patient should be last on any list and there should not be excessive waiting in the Department. Exposed sites of colonisation, such as pressure sores and skin ulcers, should be covered with an occlusive dressing before leaving the ward. Surfaces exposed to the patient or their potentially contaminated secretions should be wiped after use down with water and detergent.

10. Responsibilities

10.1. Responsibilities of all staff

These guidelines rely heavily on staff taking responsibility for infection control and accepting that they are the principle route of transmission. All staff should accept responsibility for maintaining a high standard of infection control in their practices and reminding others of their responsibilities. These are as follows:

- All staff should be familiar with the practices referred to in these guidelines, including standard isolation procedures
- All staff should be familiar with Trust policy on hand decontamination as described in the 'Hand Hygiene Guidelines'
- If there is any doubt about infection control procedures staff should consult their line manager or a member of the IPCT
- Staff should ensure they are up to date with infection control training by attending update training sessions provided by the IPCT. If more training would be helpful the Team should be contacted
- Staff responsible for the admission of patients should check the Clinical Alerts on the patient's notes and electronic record (SystemOne) for evidence of previous colonisation with a GRE/ VRE. If these are present, a risk assessment for standard isolation precaution should be performed and the IPCT informed.
- Under exceptional circumstances, staff may be required to submit screens for carriage of GRE / VRE. Those identified as being colonised will be managed on a case-by-case basis the Occupational Health and Wellbeing Department and the IPCT.

10.2. Responsibilities of the Infection Prevention and Control Team

- Communicate results of colonisation or infection to the ward staff and the patient. If available, an information leaflet will be given to the patient. The IPCT will also be available to discuss the result with relatives and visitors if requested
- Whenever possible, all newly identified cases will be visited by the IPCT. The LSW IPCT will place an alert marker on SystemOne electronic record of patients colonised with a GRE / VRE ,if this has not already been done by staff in the Clinical Area.
- Ensure staff are aware of and comply with this policy
- If appropriate, complete a Care Plan in the patient's nursing notes (Isolation and Daily Review Care Plan available on SystemOne)
- A GRE/ VRE information leaflet is available on the intranet
- Audit and assess the effectiveness of this policy and infection control practices in general
- Undertake prospective, targeted surveillance of GRE / VRE and feedback the result the relevant stakeholders
- Assist ward staff in patient risk assessment for the use of standard isolation or contact precautions.

10.3. Responsibilities of Ward Manager

The Ward Manager is responsible for ensuring that all members of staff, patients and visitors adhere to good infection control procedures and as such should:

- Emphasise the need to maintain good hand hygiene and support initiatives to improve compliance with hand hygiene policy (e.g. Clean**your**hands campaign)
- Ensure all staff attend infection control training sessions
- Support the ward Infection Control Link Practitioner and, whenever possible, allow them two hours of protected time per week to perform infection control-related duties
- Ensure staff check all admissions for Clinical Alerts on the patient's notes and electronic record for evidence of previous colonisation with a GRE / VRE. If these are present, a risk assessment for standard isolation precautions should be performed and the IPCT informed
- Comply with these guidelines and ensure patients are risk assessed for source isolation

- Ensure staff observe standard infection control precautions when attending the patient or their immediate surroundings
- Inform relevant hospital staff of the colonisation status
- Ensure the patient receives therapeutic treatments as prescribed or advised by the IPCT or medical staff
- Liaise closely with the IPCT with regards to the ongoing management of colonised patients
- Adhere to admission, transfer and discharge protocols
- Screen patients as directed by the IPCT
- Communicate the colonisation status of individual patients on discharge to district nursing, community hospital nursing or nursing home team as appropriate.

10.4. Responsibilities of doctor in charge of patient

- Medical staff responsible for the admission of patients should assist the Ward Manager in assessing the risk the patient poses to others and isolate as appropriate
- Medical staff responsible for the admission of patients should check the Clinical Alerts on the patient's notes, and, electronic record, for evidence of previous colonisation with a GRE / VRE.
- Practice good infection control procedures as laid down in this and associated policies.
- Inform the patient of the situation and provide information regarding its management as required
- Inform relevant hospital staff of the colonisation status
- Prescribe therapeutic antibiotics as advised by a Consultant Microbiologist
- Prior to transfer of a colonised/infected patient to another hospital, notify the receiving clinician at the receiving hospital
- On transfer back to primary care inform the patient's General Practitioner of the patient's colonisation status and advise on further management.

10.5. Responsibilities of Occupational Health and Wellbeing

The management of members of staff who are colonised or infected with GRE/ VRE is the responsibility of Occupational Health. The Occupational Health and Wellbeing Department will:

- Accept referrals of staff being considered who are colonised or infected with GRE / VRE
- Manage these patients on a case-by-case basis with the IPCT and a Consultant Microbiologist
- Conduct follow-up screening of staff if required
- Ensure staff have access to appropriate patient information leaflets, available from the LSW intranet

10.6. Responsibilities of relatives and visitors

Relatives and visitors should be encouraged to visit patients. Those who wish to discuss issues related to infection status and isolation care should be referred to the IPCT who will meet with them and/or provide appropriate written information.

- Visitors are expected to comply with good infection control practice and are encouraged to practice hand decontamination as outlined in the Hand Hygiene Policy
- For patients nursed under Standard Isolation, visitors must decontaminate their hands before and after contact with the patient, their immediate surroundings and on leaving the room
- The wearing of gloves and apron is not required unless relatives and visitors are assisting with the nursing of the patient or visiting other patients on the same day
- Patients and visitors may challenge staff about hand decontamination. They should be able to do this without concern that it will adversely affect their clinical management or relationships with staff.

11. References/Bibliography

1. Cookson BD, Macrae MB, Barrett et al. Guidelines for the control of Glycopeptide-Resistant Enterococci in Hospitals. *Journal of Hospital Infection* 2006: 62; 6-21.

2. Brown DF, Brown NM, Cookson BD et al. National Glycopeptide-Resistant Enterococcal Bacteraemia Surveillance Working Group Report to the Department of Health. Journal of Hospital Infection 2006: 62: S1-S27.
3. Hospital Infection Control Practices Advisory Committee. Recommendations for preventing the spread of vancomycin resistance. Infection Control and Hospital Epidemiology 1995: 16; 105-113.
4. Chadwick PR, Oppenheim. Controlling Glycopeptide-Resistant Enterococci. Clinical Microbiology and Infection 1997: 3; 7-11.

Health protection – guidance Enterococcus species and glycopeptide-resistant enterococci (GRE) Public Health England at <https://www.gov.uk/guidance/enterococcus-species-and-glycopeptide-resistant-enterococci-gre>

epic3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England at

[http://www.journalofhospitalinfection.com/article/S0195-6701\(13\)60012-2/abstract?cc=y=](http://www.journalofhospitalinfection.com/article/S0195-6701(13)60012-2/abstract?cc=y=)

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

Signed: Lead Nurse, Director of Infection, Prevention and Control

Date: 12th May 2016

Appendix A : Standard Source Isolation

Accommodation

A single-bedded room is generally suitable, unless directed otherwise by the Infection Prevention and Control Team. When several patients are affected, as in an outbreak, cohort nursing in one or more bays or an entire ward may be appropriate.

Environmental Decontamination

Liaise with Hotel Services, for twice daily enhanced cleaning of the isolation room / bay.

Visitors

Visitors should seek permission of the nurse-in-charge before entering and should be encouraged to wash hands on entry and exit of the isolation room. In general visitors of patients isolated in Standard Isolation do not need to take any specific precautions providing they are not visiting other clinical areas.

Patients

Patients are advised not to leave this area without permission.

Visitors and staff should observe these rules:

Door	Keep closed (an external window may be opened).
Plastic Aprons*	Wear when in the room. Dispose as clinical waste.
Masks*	Not necessary.
Gloves*	Wear for all body fluids contacts. Dispose as clinical waste.
Hand washing	After removing and disposing apron and gloves. Then wash hands and apply alcoholic hand-rub.
Crockery & cutlery	Return to kitchen and wash in dishwasher.
Excreta	If the room has no toilet, provide a bedpan, urinal or commode exclusively for the patient and wear disposable apron and gloves when handling it. If the ward bedpan washer disinfects satisfactorily or disposable bedpans are in use, dispose of excreta by these means. If a commode has been used, ensure the frame is thoroughly cleaned with detergent and water before moving out of the area. Contact the IPCT if further advice is needed.

Linen	Put all used linen in a water-soluble bag within a red linen bag and securely fasten.
SDU equipment	Return to SDU in a sealed yellow bag with a blue return Bag clearly labelled with a 'Danger of Infection' label.
Equipment	Dedicated equipment or single-use items are preferred when possible
Medical equipment for Maintenance	Inform Maintenance Department (MEMS) before return and attach orange decontamination certificate.
Pathology requests	Put "Danger of Infection" label on request form and specimen. Use leak proof containers and send specimen and form in a sealed polythene specimen bag.

Queries: Contact a member of the Infection Prevention and Control Team on 34167.