Derby Hospitals NHS
NHS Foundation Trust

Trust Policy and Procedure for Multi-Resistant Acinetobacter and Multi-Resistant Pseudomonas

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	1	September 2011	H. Forrest	Update guideline into policy
Intended Recipients: All medical and clinical staff, Associate Directors, Service Managers, Heads of Nursing, Quality Improvement Leads, Matrons.				
Training and Dissemination: Dissemination via the Trust Intranet. Periodic infection control training.				
To be read in conjunction with: Trust Policy for Standard Infection Control Precautions; Trust Policy and Procedure for Hand Hygiene; Trust Policy for Personal Protective Equipment. Trust Policy and Procedure for the Prevention of Pseudomas Aeruginosa and Management of Water Systems in Augmented Care Units				
In consultation with and Date: Infection Control Operational Group Committee (May 2011), Consultant Microbiologists (June 2011). Matron Delivery Group (June 2011). Medical Advisory Committee (September 2011). Infection Control Committee (April 2012)				
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Contact for Review	Acting Matron Infection Control
Executive Lead Signature	Director of Patient Experience & Chief Nurse
Approving Executive Signature	Director of Patient Experience & Chief Nurse

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1. Introduction

Acinetobacter spp are gram-negative environmental bacteria that are widespread both in and outside healthcare premises. However the main species associated with human infection is *Acinetobacter baumannii* (ACB). This species can generally be found only in hospitals. Pseudomonas is found in the environment, especially where there is water e.g. sinks, moist central venous catheter sites and urinary catheters. They can be especially problematic in ICUs and cause pneumonias in ventilated patients.

Acinetobacter are carried on the skin of at least 25% of healthy people and most commonly colonises the skin, respiratory and urinary tract of patients (Hartley 2005). In general, the isolation of a patient with *acinetobacter* other than those with ACB is unnecessary.

Both of these organisms are inherently resistant to many antibiotics. Infection occurs mostly in patients with invasive devices, those immuno-suppressed and those who have had multiple courses of antibiotics. Outbreaks may occur in individual ICUs and occasionally can spread across to all ICUs within a particular region.

2. Purpose and Outcomes

This policy aims to prevent and reduce the risk of transmission of multi-resistant Acinetobacter and Pseudomonas to patients and staff within the hospital setting and ensure patients have appropriate infection prevention and control related care and management.

This policy applies to all Trust staff.

3. Definitions Used

Colonised:	When an organism is isolated without evidence of infection
Multi-Resistant ACB:	Multi-Resistant Acineetobacter

4. Key Roles and Responsibilities

4.1 The Infection Prevention & Control Team (IPCT)

Has the responsibility to assess the infection risks and provide advice and education on infection control special precautions for all patients who are multi-resistant ACB positive.

4.2 Healthcare Staff

All staff that have contact with patients have a responsibility to ensure they adhere to the necessary infection prevention & control special precautions advised by the IPCT.

5.0 Managing the Policy for Multi-resistant Acinetobacter and Multi-resistant Pseudomonas

5.1 Transmission

The bacteria can survive on the hands and in the environment, e.g. door handles, telephones, etc for long periods. Therefore the bacteria is readily spread around the patients' and healthcare workers' environment by touching. Special attention should be paid to horizontal surfaces and dust collecting areas.

5.2 Identification of Patients with Multi-Resistant Acinetobacter

Multi-resistant ACB is diagnosed from a clinical specimen sent to the Microbiology laboratory. It is most often found in sputum, blood cultures, wound swabs or urine samples.

Unlike MRSA, routine screening swabs (nose, perineum) are not normally performed to detect multi-resistant ACB unless specifically advised. Patients with multi-resistant ACB transferred from another critical care unit (particularly from abroad or a burns unit) pose a particular risk and screening may be required. The IPCT will advise.

Wards will be informed of a positive result by the IPCT. If the patient has previously been positive for multi-resistant ACB or Pseudomonas then the IPCT must be informed at the earliest opportunity. The IPCT will conduct a risk assessment and advice on the infection prevention and control measures.

5.3 Control Measures

- Patients who are infected or colonised with Multi-resistant Acinetobacter spp or Multi-resistant Pseudomonas spp should be isolated under contact precautions, due to potential risk to other susceptible patients. Patients must remain in isolation for the duration of the hospital admission.
- Where side rooms are unavailable, patients may receive contact precautions on the open ward after discussion with the IPCT, except when a Carbapenem resistant strain is identified from a sputum specimen. Strict respiratory precautions are required for this strain.

Staff must wear disposable gloves and aprons for direct contact with patients.

- Thorough hand decontamination must be performed after direct contact with
- the patient, after removing protective clothing and on leaving the isolation
- room.
- Clinical waste bags and linen bags must be secured within the room.
- Last offices: no special precautions are required.
- Infections with multi resistant pseudomonas and multi resistant acinetobacter should not prevent or delay discharge but any receiving hospital / healthcare facility must be informed prior to transfer.
- Ward staff must inform the Infection Prevention and Control Team if there are 2 or more patients with the same organism on the ward at the same time.
- Staff must consider the psychological effects and safety risks of isolation, and take these into account when planning care.
- The Medical Microbiologists will provide advice on the antibiotic treatment of a multi-resistant ACB infection.
- Patients having contact precautions may leave the side-room/bed area to mobilise in non-clinical areas.
- Patients may use ward bathroom facilities. The patient should be last to use the facilities and the environment must be thoroughly cleaned after use.
- Patients may visit other departments for necessary investigations. Good communication is essential. Staff should ensure that receiving departments are aware of the multi-resistant status to allow sufficient time for preparation. Where possible the patient should be “last on the list” and visits kept as short as possible.
- Wherever possible equipment should be designated for affected patients. if this is not possible then the equipment must be cleaned with a Chlorine releasing agent at 1,000 ppm available Chlorine before being moved to another patient.

5.4 Discontinuation of Infection Control Precautions

Only the IPCT/Medical Microbiologist can designate patients with multi-resistant ACB / Pseudomonas as negative. Precautions must never be discontinued without the approval of the IPCT.

Patients with multi-resistant ACB / Pseudomonas in the respiratory tract require two negative sputum specimens to be considered clear, however a persistent cough requires continued precautions.

5.5 Visitors/ Relatives

Visitors/relatives should be encouraged to visit patients. Gloves and aprons are not required, unless they are helping with nursing care, but visitors should wash their hands with soap and water prior to, and after visiting.

5.6 Transfer of Patients with Multi-Resistant Acinetobacter within the Hospital

Good communication is essential to ensure a safe transfer of patients with multi-resistant Acinetobacter / Pseudomonas.

Patients must only be transferred to another area due to clinical necessity. If these patients are transferred within the Trust, the receiving area must be fully aware of the precautions necessary prior to transfer. The patient must not be transferred until the receiving area is prepared.

If patients are transferred without the full knowledge of the receiving area this should be seen as an untoward incident and an incident report must be completed in accordance with the Trusts Incident Reporting Policy. The IPCT must also be informed.

5.7 Discharge/ Transfer of Patients with Multi-Resistant *Acinetobacter* and Multi-Resistant *Pseudomonas* to other Healthcare Facilities

Good communication is essential in ensuring a safe discharge of patients. A diagnosis of multi- resistant Acinetobacter or multi-resistant pseudomonas should not delay a planned discharge.

It is the responsibility of the medical staff caring for the patient to ensure that the receiving medical team is aware of the multi-resistant diagnosis.

The ward staff must ensure that the receiving ward is aware of the precautions that have been in place on initial referral.

When transferring to another hospital the IPCT will liaise with the receiving Trusts IPCT.

It is the responsibility of the ward staff to ensure that the ambulance service is fully aware of the multi-resistant ACB status of any patient being transferred via ambulance. Standard infection control precautions should be utilised on transfer discharge.

6.0 Monitoring Compliance and Effectiveness

Monitoring Requirement :	• The IPCT will monitor compliance with the management of all patients known or suspected to have a multi-resistant organism during the regular ward rounds • Any non compliance issues will be reported to the directorate Matron / Head of Nursing or the site

	manager as appropriate.
Monitoring Method:	• Adherence to policy will be monitored by the infection control nurse team • Non-compliance will be reported via the incident reporting system
Report Prepared by:	Divisional Matrons
Monitoring Report presented to:	Non-compliance will be reviewed through the infection control operational group
Frequency of Report	As required

7.0 References

Health Protection agency (2006) Working Party Guidance on the Control of Multi-Resistant Acinetobacter Outbreaks. Health Protection Agency London

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Theaker C, Azadian B, Soni, N (2003) The Impact of *Acinetobacter baumannii* in the intensive care unit, Anaesthesia, 58: 271-274.

Coelho J et al. Multiresistant acinetobacter in the UK: how big a threat? Journal of Hospital Infection 2004; 58:167-169