Leicestershire Partnership NHS Trust

The Management of Multi Resistant Gram Negative Organisms (MRGNO), Extreme Drug Resistant (XDR) and Pan Drug Resistant (PDR) Policy

This policy describes the key processes and protocols for patients colonised or infected with a multi resistant gram negative organism and an extreme drug resistant organism. It identifies the management of the patient and care delivery requirements.

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Which Relevant CQC Fundamental Standards?		

Contents

Version Control and Summary of Changes

Version number	Date	Comment (Description change and amendments)
Version 1	August 2013	Development of a new policy to provide key processes and protocols for patients colonised or infected with extended spectrum beta lactamase-producing organisms. It identifies the management of the patient and care delivery requirements. Circulated for comments to the infection prevention and control team and key individuals within LPT and also key individuals outside the organisation that can provide an expertise review.
Version 2	September 2014	Amendments following review of the policy and the processes and protocols required for patients colonised or infected with extended spectrum beta lactamase-producing organisms within the community
Version 3	September 2017	Review of policy and amalgamation of The Management of Extended Spectrum Beta Lactamase-Producing Organisms Policy and The Management of Multi Resistant Gram Negative Organisms Policy

For further information contact: Infection Prevention and Control Team

Definitions that apply to this Policy

Beta lactam antibiotics	B-lactam antibiotics (beta-lactam antibiotics) are a broad class of antibiotics, consisting of all antibiotic agents that contain a β-lactam ring in their molecular structures. This includes penicillin derivatives (penams), cephalosporins (cephems), monobactams, and Carbapenems.
Carbapenem	A group of beta lactam antibiotics normally reserved for serious infections caused by antibiotic resistant Gram negative bacteria
Carbapenem Resistant Organisms (CRO)	These are extremely drug resistant organisms that are resistant to the Carbapenem group of antibiotics. They also routinely demonstrate resistance to other groups of antibiotics.
Carbapenemase Producing Enterobacteriaceae (CPE)	These are enterobacteriacea which have become resistant to carbapenems, a group of powerful antibiotics. The resistance is aided by carbapenemases, which are enzymes ade by some strains of the bacteria, which allow them to destroy carbapenem antibiotics and so becoming resistant to them and most other penicillin-like antibiotics.
Cohort nursing of infected patients	Grouping of patients who are deemed to be infectious and nursing them within an area of an in-patient facility. It is often recommended as an overflow strategy when single room isolation is not available.
Colonisation	Colonisation is the multiplication of a micro-organism after it has attached to host tissue or other surfaces, but causing no harm to the person. People who are colonised may not display signs or symptoms of infection. .
Exposure	A state of contact or close proximity to a pathogen, by ingesting, breathing or direct contact, e.g. on skin
Extended Spectrum Beta Lactamase (ESBL)	ESBL producing organisms are resistant to certain types of antibiotics which would normally be used to treat such infections.
Extreme Drug Resistant (XDR)	An extensively drug resistant organism has non-susceptibility to at least one agent in all but two or fewer antimicrobial categories
Gram negative bacteria	A class of bacteria that do not retain the crystal violet stain used in the Gram staining method of bacterial differentiation. Gram-negative bacteria cause infections including Urinary Tract Infections, hospital acquired pneumonia, intra-abdominal infections, blood stream infections, abdominal wound or surgical site infections, neonatal sepsis and meningitis in healthcare settings. Some Gram-negative bacteria are resistant to multiple drugs and are increasingly resistant to most available antibiotics.
HealthCare Associated Infection (HCAI)	Healthcare associated infection is any infection acquired as the result of a course of treatment, intervention or care.
Heavily exfoliating skin condition (i.e. eczema or	A skin condition that creates a large amount of shedding skin, which then contaminates the environment.

psoriasis)	
Heavily exudating wound	A wound that is infected and produces a discharge or exudate which cannot be contained in a dressing. Within the terms of this policy it refers to wounds that require re-dressing within 24 hours due to the amount of exudate produced
Immunosuppression	Suppression of the immune response, usually by disease or by drugs
Infection	Where an organism is present at a site and causes an inflammatory response or where the organism is present in a normally sterile site.
Invasive device	A device that breaches the skins normal line of defence i.e. urinary catheters, intravenous devices.
Multi Drug Resistant (MDR)	A multidrug resistant organism has non-susceptibility to at least one agent in three or more antimicrobial categories
Multi Resistant gram negative organism (MRGNO)	Multi-resistant Gram Negative Organism These can be further classified as MDR, XDR or PDR. May be one of number of different bacteria predominately from the Enterobacteriaceae group
Pan Drug Resistant (PDR)	A pan drug resistant organism has non susceptibility to all agents in all antimicrobial categories.
Personal Protective Equipment (PPE)	Specialised clothing or equipment worn by employees for protection against health and safety hazards and includes: gloves, aprons, gowns, masks and eye protection.
Productive cough	A cough that produces sputum
Source Isolation	Isolation for the control of infection is used to prevent infected patients from infecting others.
Standard Precautions	Precautions that are used such as Personal Protective Equipment (PPE) and hand washing to prevent the spread of infection.
Strike Through	Blood absorbed right through a dressing so as to be visible on the outside.

1.0 Purpose of the policy

The aim of this policy is to provide guidance to staff employed by Leicestershire Partnership Trust (LPT) with regards to caring for patients who are known or suspected of having a multi-resistant gram negative organism (MRGNO). The policy will discuss the differences between a MRGNO, Extreme Drug Resistant (XDR) and Pan Drug Resistant (PDR) organism and the precautions required for each condition.

2.0 Summary and Key Points

This policy is an amalgamation of two previous infection prevention and control policies; namely the management of multi-resistant gram negative organisms policy and the management of patients with an extended spectrum beta lactamase policy**.**

These organisms are resistant to many antibiotics, (MRGNO), most antibiotics (XDR) or all known antibiotics (PDR). They are a growing concern within healthcare and it is essential, therefore, that any persons who are known to have or suspected of having an MRGNO, XDR or PDR are cared for appropriately and source isolation precautions undertaken where necessary.

All patients with known or suspected MRGNO require source isolation precautions within a hospital setting if they have certain risk factors.

Patients with known or suspected XDR or PDR will require source isolation precautions within a hospital setting regardless of whether they have risk factors or not.

Patients nursed within the community setting and their own homes who have known MRGNO, XDR or PDR will require strict standard precautions which include all waste being treated as clinical waste and also being seen last on the list for community nursing staff or out patients etc.

3.0 Introduction

The purpose of this policy is to ensure that staff employed by LPT are aware of the correct procedure and precautions to take when caring for patients with known or suspected MRGNO's correctly. (Note MRGNO's include XDR and PDR).

The policy will ensure that all staff employed by LPT are providing evidence based care which is in accordance with the Health and Social Care Act (2015) and the latest guidance provided by Public Health England (PHE).

Resistant organisms are not themselves a disease entity, but they can affect many organisms that cause a range of infections. MRGNOs render many antimicrobial agents available to us within healthcare ineffective as treatment options. Therefore it is imperative that we implement infection prevention and control measures where possible to eliminate the risk of transference of the organism to other patients and also to eliminate the risk of the patient being isolated of contracting a healthcare acquired infection.

4.0 Multi Resistant Gram Negative Organisms (MRGNO)

As a result of the growing resistance to antibiotics, infections caused by MRGNO can be difficult to treat. Due to the global increase in resistance to antibiotics the prevalence of these bacteria and infections caused by them are becoming more common in both community and healthcare settings.

There are still some antibiotics available to treat MRGNO infection, but they need to be used with caution. Antibiotic treatment is not generally recommended for people who are colonised and do not present with signs and symptoms of infection.

MRGNO can be transmitted by direct or indirect contact and therefore within an inpatient setting patients with an MRGNO are risk assessed to determine whether they require source isolation precautions. The risk assessment is undertaken on all patients with a known or suspected MRGNO, regardless of where the infection is within the patient.

Some gram negative organisms can produce an enzyme known as an Extended-spectrum Beta lactamase (ESBL) which inhibits all antibiotics from the penicillin class from working. Any gram negative organisms can potentially produce ESBLs. They can occur within a healthcare or a community setting and can also be grown from specimens from invasive device such as urethral and venous catheters.

Escherichia coli (E.coli) is the most common cause of urinary tract infections (UTIs) and can also cause wound and respiratory infections. However, not all E.colis are ESBL-producing organisms. In most situations ESBLs do not cause infection but merely colonise the individual. However, when infections do occur they can range from mild urinary tract infections to severe life threatening blood stream infections (septicaemia).

Klebsiella species are also a common organism that can develop into an ESBL-producing organism, but again not all Klebsiella species will develop into an ESBL-producing organism. The most common infection is urinary tract infections.

5.0 Extreme Drug Resistant Organisms (XDR)

XDR are drug resistant organisms that are extremely drug resistant. In essence there are very few antibiotics available to treat these infections.

The main XDR are Carbapenemase-producing Enterobacteriaceae (CPE) and Carbapenem Resistant Organisms (CRO). Prior to 2007 the few CPE/CRO that were detected in the UK were most likely to have been imported. However since 2007 the number of cases of CPE/CRO has risen and there have been some that have been identified as originating from within the UK.

These type of resistant organisms are of more of a concern than those referred to as MRGNO's due to the more limited treatment options available. They will be flagged from microbiology as Extreme Drug Resistant.

The emergence of these organisms is a major public health concern, with a rapid increase in Carapenem non-susceptible Enterobacteriaceae worldwide. Although the

numbers of patients with XDR are still fairly low in the United Kingdom, these organisms are endemic in other areas of the world and we are beginning to see the numbers of patients diagnosed with XDR increase in the UK. There is strong evidence that when patients infected or colonised with CPE are transferred across borders this increases the risk of CPE being introduced into health facilities in the country of destination.

The clinical significance of infection with these organisms is considerable. Due to their resistance to multiple antimicrobials, there are very limited therapeutic options available to treat these infections. In addition to this, there are few new novel antimicrobial agents in the developmental pipeline and at present there are insufficient drug development programmes to provide therapeutic cover in 10 – 20 years. It is already evident that human infections with MRNGO's are associated with poorer patient outcomes, increased morbidity, mortality, prolonged hospital stay and higher hospital costs.

Patients with a known or suspected XDR must be isolated in a single room for their duration of stay in hospital regardless of any risk factors that may or may not be present. It is imperative that source isolation precautions are followed strictly to that the risk is minimised as much as possible. This ensures that patients with XDR do not acquire an avoidable hospital acquired infection and that other patients on the ward do not acquire XDR transmitted from the patient with a known or suspected XDR via healthcare workers. Currently there are very few antibiotics that can be used to treat such an infection, and as such an infection could be life threatening.

6.0 Pan Drug Resistant Organisms (PDR)

This is the term given to organisms that are resistant to all available antibiotics and is a serious clinical and public health challenge. They herald the onset of a post antibiotic era.

Patients with a known or suspected PDR must be isolated in a single room for their duration of stay in hospital regardless of any risk factors that may or may not be present. It is imperative that source isolation precautions are followed strictly so that the risk is minimised as much as possible. This ensures that patients with PDR do not acquire an avoidable hospital acquired infection, and that other patients on the ward do not acquire PDR transmitted from the patient with a known or suspected PDR via healthcare workers as there are no antibiotics available to treat a PDR and so any infection could be life threatening.

7.0 Risk factors for acquiring an MRGNO/XDR/PDR

There are many factors which contribute to the patient becoming infected or colonised with a multi resistant organism which can include:

- Prolonged hospital stay
- Prior anti-microbial therapy
- The strain of the organism
- The site at which the organism has been identified
- Immunosuppression
- The presence of invasive devices or wounds
- Severe underlying medical conditions
- Increasing age

8.0 Risk factors for transmitting an MRGNO

The following factors are deemed to be a risk factor for a patient to transmit an MRGNO to other patients. If a patient with a known or suspected MRGNO has one or more of these risk factors they will require source isolation precautions, ideally in a single room. If a single room is not available a risk assessment will need to be undertaken, documented and discussed as soon as possible with the infection prevention and control team.

The risk factors are as follows:

- Productive cough
- Faecal incontinence
- Urinary incontinence
- Urinary catheter in situ
- Heavily exudating wounds (ie, wounds that require daily dressings due to strike through of exudate
- Exfoliating skin conditions
- Intravenous lines in situ

For more information with regards to source isolation precautions, please refer to the infection prevention and control source isolation precautions policy for LPT.

9.0 Risk factors for transmitting an XDR

Patients with a known or suspected XDR, ie a CPE or CRO will need to be isolated in a single room for their duration in hospital regardless of any risk factors that may or may not be present. For more information with regards to source isolation precautions please refer to the infection prevention and control source isolation precautions policy for LPT.

10.0 Risk factors for transmitting a PDR

Patients with a known PDR will need to be isolation in a single room for their duration in hospital, regardless of any risk factors that may or may not be present. For more information with regards to source isolation precautions please refer to the infection prevention and control source isolation precautions policy for LPT.

11.0 Screening of patients

Sometimes patients who are colonised with an MRGNO/XDR or PDR can naturally eliminate such bacteria from their system. However, in those with severe underlying illness, some MRGNO/XDR or PDR may remain for months or even years.

Samples should not be sent for clearance of a MRGNO/XDR/PDR unless advised from infection prevention and control in conjunction with microbiology. Stool samples are not required and should only be sent if the patient is experiencing diarrhoea and an infection is being considered. Samples should only be sent if there is a clinical need.

Regardless of results of clinical samples sent the patient will need to be isolated dependant of their risk factors if they have an MRGNO and for the duration of their stay in hospital regardless of risk factors present or absent if they have a XD/PDR.

Screening in an acute hospital

If a patient has been in a hospital outside of the United Kingdom in the last 12 months and admitted to UHL they will be isolated on admission. If a patient has been in a hospital outside of the United Kingdom or a hospital in Manchester or London in the last 12 months, 3 rectal screens, 48 hours apart will be taken for CRO. If the patient is admitted to a community hospital part way through this process then the isolation and screening process should be continued. It is the responsibility of the admitting ward to check if the screening process has been commenced and completed. If the results show that the patient has CRO source isolation precautions must be continued.

12.0 Movement and transfer of patients

Patients who are colonised or infected with multi drug resistant organisms can visit other departments within the hospital and other hospitals or care environments for treatment or investigations if there is a clinical need. This can be facilitated following consultation with the head of the receiving department or their deputy.

Patients with risk factors for transmission of MRGNO and patients with XDR or PDR, and are therefore receiving source isolation precautions, should ideally be booked at the end of the session to allow time for cleaning and disinfection of patient contact areas by the relevant staff members.

Staff in the receiving department who are having direct contact with patients that have MRGNO and have risk factors for transmission, or with patients with XDR or PDR must wear a disposable apron and disposable nitrile gloves. PPE must be disposed of as clinical waste. After PPE has been discarded, hands must be decontaminated using soap and water followed by alcohol sanitiser. All equipment including the wheelchair or trolley used by the patient must be cleaned and decontaminated with Chlor-Clean.

If patients are transferred to care environments other than those within LPT the information related to infection status must be forwarded in advance to the receiving area, so that symptomatic patients can be isolated as per the receiving areas policies and guidelines.

If the ambulance service is used to transport patients, they must be informed at the time of booking if a patient with a known multi drug resistant infection and is receiving source isolation precautions so they can take the relevant precautions.

13.0 Visitors

The patient may continue to receive visitors. Any visitor should ensure that they wash their hands on leaving the isolation room and be instructed to use the alcohol hand sanitiser outside the room. Visitors are not routinely expected to wear gloves and aprons unless they are providing personal care.

14.0 Deceased Patients

Standard precautions must be in place during the care of a deceased patient. There is no specific risk from the body to relatives, mortuary staff or undertakers.

Plastic body (cadaver) bags are not necessary. Any lesions that leak should be covered with impermeable dressings. For further information refer to the LPT care of the person who has died policy.

15.0 Caring for patients within their own homes

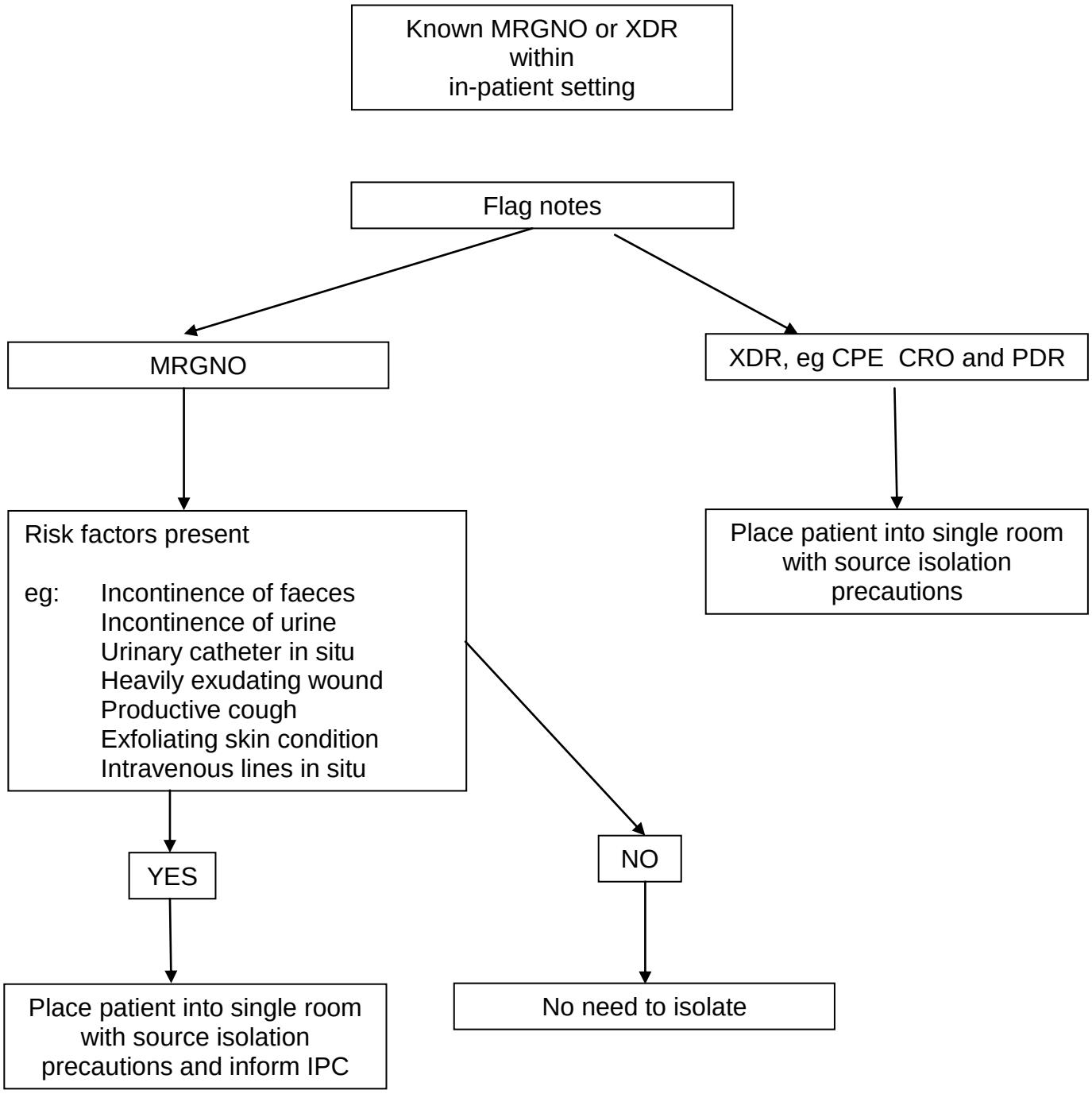
There is not a need for patients with MRGNO/XDR or PDR to have source isolation precautions implemented when they are nursed in their own homes. Standard precautions must, however, be in place at all times, as with any patient cared for by LPT staff, ie hand hygiene and the correct use of personal protective equipment (PPE). These measures, when used correctly, will reduce the risk of transmission to staff and other patients.

Please refer to the LPT infection prevention and control hand hygiene policy and the LPT infection prevention and control personal protective equipment policy.

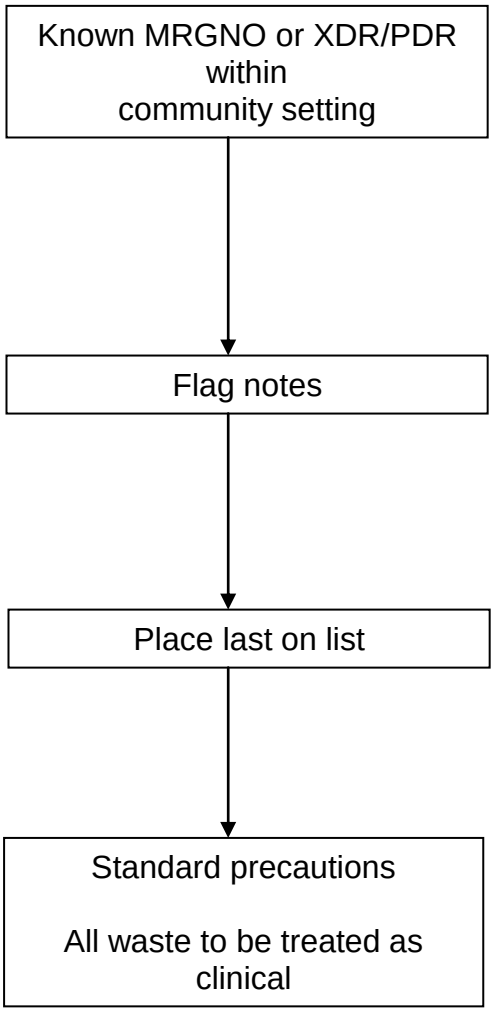
All waste produced with these patients by a healthcare activity from a member of LPT staff must be disposed of as clinical waste and should not go into the normal domestic waste stream. Consideration will need to be given to setting up a special waste collection if necessary.

Please refer to the LPT health and safety waste policy.

16.0 Flow chart for the care of patients with MRGNO, XDR or PDR in inpatient facilities



17.0 Flow chart for the care of patients with MRGNO, XDR or PDR in the community



18.0 References and bibliography

Centre for Disease Control and Prevention: Guidance for Control of Carbapenem-resistant Enterobacteriaceae (CRE) 2012 CRE Toolkit

Centre for Disease Control and Prevention: Management of Multidrug-Resistant organisms in Healthcare Settings 2006

DH. Antimicrobial resistance empirical and statistical evidence-base. A report from the department of health antimicrobial resistance strategy analytical working group (2016)

NHS Ayrshire & Arran: Extended Spectrum Beta-Lactamase (ESBL) Producing Organisms Infection Control Guidance (2010)

NHS North Yorkshire and York Community and Mental Health Services: North Yorkshire Community Infection Prevention and Control Policies and Guidance. Multi-Resistant Gram-Negative Bacteria including ESBL's (Extended Spectrum Beta Lactamase) (2008)

Public Health England. Toolkit for managing carbapenemase-producing Enterobacteriaceae in non-acute and community settings Centre for Disease Control and Prevention: Guidance for Control of Carbapenem-resistant Enterobacteriaceae (CRE) 2012 CRE Toolkit (2015)

LPT Infection prevention and control hand hygiene policy

LPT Infection prevention and control personal protective equipment policy

LPT Infection prevention and control source isolation precautions policy

LPT Infection prevention and control cleaning and decontamination policy

LPT Health and safety waste policy

LPT Care of the deceased policy

Appendix 1

Where can I find more information?

If you have any concerns or queries you may wish to speak to your healthcare worker or contact your GP for advice. Alternatively, if you would like any further information the Public Health England website is another source:

https://www.gov.uk/government/collections/carbapenem-resistance-guidance-data-and-analysis

Public Health England

Protecting and improving the nation's health

Toolkit for managing carbapenemase-producing Enterobacteriaceae in non-acute and community settings

Annex B:

Advice for individuals receiving care at home or in the community who have an infection with or are colonised by carbapenemase-producing Enterobacteriaceae

Appendix 1

What are 'carbapenemase-producing Enterobacteriaceae'?

Enterobacteriaceae are bacteria that usually live harmlessly in the gut of humans. This is called 'colonisation' (a person is said to be a 'carrier'). However, if the bacteria get into the wrong place, such as the bladder or bloodstream they can cause infection.

Carbapenemase-producing Enterobacteriaceae (sometimes abbreviated to CPE) are Enterobacteriaceae which have become resistant to carbapenems, a group of powerful antibiotics. The resistance is helped by carbapenemases, enzymes made by some strains of the bacteria, which allow them to destroy carbapenem antibiotics and so becoming resistant to them and most other penicillin-like antibiotics.

Why does carbapenem resistance matter?

Carbapenem antibiotics can only be given in hospital directly into the bloodstream. Until now, doctors have relied on them to successfully treat certain 'difficult' infections when other antibiotics have failed to do so. Therefore, in a hospital or other care setting, where there are many vulnerable patients, spread of these resistant bacteria can cause problems.

Does carriage of carbapenemase-producing Enterobacteriaceae need to be treated?

If you are carrier of carbapenemase-producing Enterobacteriaceae, you do not need to be treated. As mentioned, these bacteria can live harmlessly in the gut. However, if the bacteria have caused an infection then antibiotics will be required. Please do ask your doctor or healthcare worker to explain your situation to you in more detail.

How can the spread of carbapenemase-producing Enterobacteriaceae be prevented?

The most important measure you can take is to maintain effective hand hygiene, washing your hands well with soap and water, especially after going to the toilet. You should avoid touching any medical devices (such as your urinary catheter tube or other medical tubes) if you have any, particularly at the point where it is inserted into the body or skin.

As you are receiving care in your own home, you should not restrict your lifestyle in any way; however a few sensible measures will prevent spread to others. As well as effective hand hygiene, keeping toilet and bathroom areas clean, and using separate towels, are the best ways to prevent spread. You should expect that visiting healthcare workers will clean their hands on arrival, before and after providing direct care, and on leaving. They will use gloves and an apron when caring for you.

What about my family and visitors?

There is no need for you to advise visitors that you are a carrier or have an infection, as long as hygiene measures are adequate. If you have an infection, it is important to work with your healthcare worker to ensure that any discharge from a wound, for example, is contained within an appropriate dressing to prevent contamination of clothes or soft furnishings.

Your doctor or nurse may give you a letter or card advising that you have had an infection or been colonised with carbapenemase-producing Enterobacteriaceae. This will be useful for the future and it is important that you make health care staff aware of it. Should you or a member of your household be admitted to hospital or other healthcare facility, you should let the hospital staff know that you are, or have been, a carrier and show them the letter / card.

Where can I find more information?

If you have any concerns or queries you may wish to speak to your healthcare worker or contact your GP for advice. Alternatively, if you would like any further information the Public Health England website is another source of information:

https://www.gov.uk/government/collections/carbapenem-resistance-guidance-data-and-analysis

Public Health England

Protecting and improving the nation's health

Toolkit for managing carbapenemase-producing Enterobacteriaceae in non-acute and community settings

Annex D:

Advice for the family of a person who is a carrier of a carbapenemase-producing Enterobacteriaceae (CPE)

Appendix 2

What are 'carbapenemase-producing Enterobacteriaceae'?

Enterobacteriaceae are bacteria that usually live harmlessly in the gut of humans. This is called 'colonisation' (a person is said to be a 'carrier'). However, if the bacteria get into the wrong place, such as the bladder or bloodstream, they can cause infection.

Carbapenemase-producing Enterobacteriaceae (sometimes abbreviated to CPE) are Enterobacteriaceae which have become resistant to carbapenems, a group of powerful antibiotics. The resistance lies in carbapenemases, enzymes made by some strains of the bacteria that enable them to destroy carbapenem antibiotics and so become resistant to them and most other penicillin-like antibiotics.

Why does carbapenem resistance matter?

Carbapenem antibiotics can only be given in hospital directly into the bloodstream. Until now, doctors have relied on them to successfully treat certain 'difficult' infections when other antibiotics have failed to do so. Therefore, in a hospital, where there are many vulnerable patients, spread of bacteria resistant to carbapenems can cause problems.

Does carriage of carbapenemase-producing Enterobacteriaceae need to be treated?

If a person is a carrier of carbapenemase-producing Enterobacteriaceae (sometimes called CPE), they do not need to be treated. As mentioned, these bacteria can live harmlessly in the gut. However, if the bacteria have caused an infection then antibiotics are needed.

How are carbapenemase-producing Enterobacteriaceae spread?

In a hospital or healthcare setting where a patient is carrying this bacterium, the environment can become contaminated and the bacterium can spread to others through direct or indirect contact. Staff work hard to ensure that the environment is kept clean; you will see staff cleaning their hands. If you have any concerns please speak to the staff or your carer.

Are the family at risk of contracting carbapenemase-producing Enterobacteriaceae?

Carbapenemase-producing Enterobacteriaceae are not a risk to healthy people. The most important measure family members can take is to maintain good personal hygiene, including washing hands with soap and water, especially after going to the toilet. Good hygiene such as keeping toilet and bathroom areas clean and using separate towels are the best ways to prevent the spread. Clothes and laundry in the household should be washed normally at the hottest temperature advised on the label.

Will the close family have to be screened for carbapenemase-producing Enterobacteriaceae if admitted to hospital?

If admitted to hospital, tell a member of hospital staff that a member of your household is or has been a carrier of carbapenemase-producing Enterobacteriaceae. You may be screened for carbapenemase-producing Enterobacteriaceae as part of the admission procedure.

Appendix 3

PRIVACY IMPACT ASSESSMENT SCREENING

Privacy impact assessment (PIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet individual's expectations of privacy. The first step in the PIA process is identifying the need for an assessment. **The following screening questions will help decide whether a PIA is necessary. Answering 'yes' to any of these questions is an indication that a PIA would be a useful exercise and requires senior management support, at this stage the Head of Data Privacy must be involved.**			
Name of Document:	**The management of multi resistant gram negative organisms (MRGNO), extreme drug resistant (XDR) and pan drug resistant (PDR) policy. Infection prevention and control**		
Completed by:	**Mel Hutchings**		
Job title	**Infection Prevention and Control Nurse**	**Date**	**22/05/18**

	Yes / No
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.	**No**
2. Will the process described in the document compel individuals to provide information about themselves? This is information in excess of what is required to carry out the process described within the document.	**No**
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?	**No**
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?	**No**
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.	**No**
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?	**No**
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.	**No**
8. Will the process require you to contact individuals in ways which they may find intrusive?	**no**

If the answer to any of these questions is 'Yes' please contact the Head of Data Privacy Tel: 0116 2950997 Mobile: 07825 947786
Lpt-dataprivacy@leicspart.secure.nhs.uk
In this case, ratification of a procedural document will not take place until approved by the Head of Data Privacy.

IG Manager approval name:	
Date of approval	

Acknowledgement: Princess Alexandra Hospital NHS Trust

Appendix 4

Contribution List

Key individuals involved in developing the document

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