journey to change

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Public – To be published on the Trust external website

Title: Multi Resistant Gram-Negative Bacteria

Ref: IPC-0001-020-v1.4

Status: Approved
Document type: Procedure
Overarching Policy: IPC Policy

Contents

1 Introduction

This procedure describes what you need to do to care for patients who have Multi-resistant Gram-negative bacterial infections/colonisation identified, and to prevent further spread of infection.

This procedure supports Our Journey To Change (OJTC) as set out in the Infection Prevention and Control Policy.

2 Purpose

Following this procedure will help the Trust to: -

- Reduce the risk of transmission of multi-resistant gram-negative bacteria in the healthcare setting.
- Manage and treat patients with multi-resistant gram-negative bacteria colonisation or infection.
- Manage the cleaning of rooms that have been used by a patient with multi-resistant gram-negative bacteria colonisation or infection.

3 Who this procedure applies to

This procedure will apply to all patients who are clinically suspected of having multi resistant gram negative bacteria.

4 Related documents

This procedures supports and adheres to the overarching Infection Prevention and Control policy.

The Standard (Universal) Precautions for Infection Prevention and Control defines the universal standards for IPC which you **must** read, understand and be trained in before carrying out the procedures described in this document.

This procedure also refers to:-

- ✓ Hand Hygiene
- ✓ Waste Management Policy
- ✓ Decontamination of Equipment

- ✓ Tissue Viability Policy
- ✓ Consent to Examination or Treatment Policy

5 Procedure

5.1 What is multi resistant gram-negative bacteria colonisation / infection?

Gram-negative bacteria are commonly found living naturally within the human gut where they generally do no harm. Species of bacteria commonly found in the bowels include the following: Escherichia coli (E-Coli), Klebsiella, Proteus, Pseudomonas aeruginosa, Enterobacter and Acinetobacter. For many reasons a small number of these bacteria have become resistant to the antibiotics that they have been sensitive to in the past. Antibiotic resistance makes infections very difficult to treat and can also increase the severity of illness and the period of infection.

Multi-resistant Gram-negative bacteria (MRGNB) is a term that is used to describe many different bacteria including those outlined above. Due to the way in which these bacteria react and become resistant to antibiotic treatment, they are often referred to as:

- Extended-spectrum Beta lactamases which is shortened to ESBL.
- Amp C beta-lactamase enzyme producing bacteria shortened to Amp C,
- Carbapenamase-producing Enterobacteriaceae shortened to CPE.

Current research indicates that the prevalence of multi-resistant cases is increasing globally (Nagvekar et al, 2020). Infection often happens when the bacteria enter the body through an open wound or via a medical device such as a urinary catheter. Wound and urine infections caused by MRGNB are difficult to treat and can cause complications such as delayed wound healing, pneumonia, and infection in the blood.

Some types of MRGNB can be carried on the skin and other body sites without causing symptoms of infection. This is termed colonisation, and in most cases patients with MRGNB colonisation do not pose a risk to other physically healthy patients. However, they may require isolation or application of IPC precautions especially if there are other vulnerable patients being cared for in the same unit.

CPE infections can be difficult to treat because they are resistant to some antibiotics. CPE can also pass their resistance on to other bacteria, making them harder to treat as well. CPE can be transmitted from person to person after touching contaminated surfaces such as bed rails, toilets or devices. People with weakened immune systems are more at risk of developing infections (UKHSA, 2022).

Some studies illustrate that risk factors for developing an ESBL infection include age, comorbidities, poor functional status, recurrent urinary tract infections, acute hospital stay, previous use of antibiotics, and colonisation with ESBL (Denis et al 2015).

The most common route of transmission of MRGNB is by:

- Poor hand hygiene following direct contact with an infected or colonised person.
- Person to person spread via touch
- Equipment that has not been appropriately decontaminated following use with an infected or colonised person
- Environmental contamination including hand washing sinks. Rooms and surfaces must be thoroughly cleaned daily. Hand hygiene sinks must not be used to decontaminate equipment or to dispose of drinks and other liquids as splashing can result in contamination of taps that could lead to further spread of infection.

All age groups can be affected, however people who have received multiple courses of broad-spectrum antibiotics or those who have poor immunity are most at risk.

5.2 Management of patients with Multi Resistant Gram-Negative Bacteria (MRGNB) colonisation / infection

Patients who are diagnosed with MRGNB infection or colonisation should be nursed in isolation to prevent transmission to other patients. It is important to involve the patient in any discussions regarding the need for isolation, explaining what to expect and how they will continue to be supported by the clinical team during any isolation period recommended by the IPC team. Isolation is usually carried out in a single (preferably en-suite) room with hand washing facilities and with the door kept closed. However, for some TEWV patients, isolation can be difficult due to ongoing mental health and learning disability ill health. In this instance, an individualised plan will need to be agreed between the patient and nursing team, the IPC team can help support this.

Where isolation is not possible a risk assessment should be performed and discussed with the Infection Prevention Control Team (IPCT). Patients who have Multi-resistant Gram-negative bacteria in their sputum and who are coughing, or those who have diarrhoea are at high risk of transmitting infection and isolation would be advisable for the duration of their symptoms. Whereas those who have a urinary tract infection are generally at low risk of transmitting the infection and if they are fully continent strict isolation is not necessary. In all cases standard IPC precautions must be applied. Please follow guidance in appendix 3.

Details of all decisions regarding management must be documented within the patient's notes.

5.3 Control Measures to be taken when caring for a patient with MRGNB

The Infection Prevention & Control team must be informed of all cases of MRGNB once identified in TEWV patients.

The IPC team will discuss each patient case individually and will advise on patient management and treatment.

5.3.1 Hand hygiene

Hand hygiene is essential. Clean your hands before and after patient contact using either liquid soap or alcohol hand gel if hands are not visibly soiled (refer to Hand Hygiene Procedure).

5.3.2 Personal Protective Equipment (PPE)

Wear disposable nonsterile gloves and a plastic apron for:

- direct patient care
- when handling patient equipment or personal items contaminated with blood/body fluids
- Contact with the patients' immediate environment (including bed making).

Remove & discard gloves and apron immediately after use, then wash and dry your hands.

5.3.3 Wounds

If the patient has any wounds, cover with an appropriate impermeable dressing.

5.3.4 Body fluids, toilets and bathing

- Disposal of body fluids – patients must be advised to use their own en-suite toilet where available. If bedpans are used these must be macerated immediately after use. If a commode is used this must be thoroughly decontaminated with a chlorine releasing agent immediately after each use.
- Patients who are fully continent and do not have diarrhoea can visit communal areas e.g. dining room, television room and can mix with other patients/residents.
- Patients should be encouraged to wash their hands after using the toilet and before meals.
- Where there are no en suite facilities, patients can use communal bathing/shower facilities, but these must be cleaned immediately after use with chlorclean 1,000 ppm solution.

5.3.5 Day centres and outpatient facilities

Patients can visit day centers and attend outpatient facilities however these services should be informed of the patient's infection status in case of any spillages of body fluids, the privacy and dignity of the patient is paramount and must be considered when handing over sensitive confidential information such as medical diagnoses.

5.3.6 Admission to a nursing or residential home

MRGNB is not a reason to refuse or delay admission to a nursing or residential home, however the nursing or residential home need to be informed of patient's infection status. The privacy and dignity of the patient is paramount and must be considered when handing over sensitive confidential information such as medical diagnoses.

5.3.7 Laundry and infected waste

- Relatives can take home personal clothing. Advise them to wash clothes separately from other washing on the hottest wash the clothing can withstand.
- Patient clothing should only be washed on the ward if the ward has an industrial washing machine with a sluice facility on the hottest temperature. Clothing should be washed separately from other patients clothing as standard.
- Soiled linen: place laundry in a suitable laundry bag and label the bag 'infected linen' as per laundry guidance.
- Dispose of all infected waste as clinical waste (refer to Trust Waste Policy for further details).

5.3.8 Cutlery and crockery

Cutlery and crockery – normal ward issue, ensure all cutleries and crockery used by the patient is machine washed in a dishwasher or heat sanitiser.

5.3.9 Cleaning

- Ensure that daily cleaning of a patient's room/bed area is maintained using a chlorine releasing agent while the patient remains symptomatic. Ensure that the hotel services team are informed and implement isolation room cleaning precautions.

- Multi patient use equipment used with patients who have MRGNB infection or colonisation must be thoroughly cleaned after each use with a chlorine releasing agent (refer to Decontamination of Equipment procedure).

5.3.10 Transfer or Discharge

- Inform the IPCT if a patient with MRGNB is transferred or discharged to another area.

5.3.11 IPC precautions

IPC precautions are to remain in place:

- throughout the hospital stay of a symptomatic patient
- while the patient with MRGNB has symptoms of diarrhoea.
- until a negative specimen has been obtained from the original positive site, where the patient has received treatment for MRGNB in their sputum or wound. The repeat specimen must be taken 48hours after completion of treatment.
- repeat specimens are NOT required following treatment for a urinary tract infection.
- until the Infection Prevention Control Team advise that IPC precautions can be removed for colonised patients. This must be discussed and documented for each individual case.

Always cover infected or colonised wounds with a secure appropriate dressing. See Tissue Viability Policy

5.4 Treatment of infection due to MRGNB

Antibiotic treatment is not recommended for colonised patients as in these cases the bacteria is not causing an infection.

If the patient has signs and symptoms of an infection, then the Medical Staff or Physical Healthcare Practitioners must contact the local acute hospital Microbiologist or Infection Control Doctor for advice prior to commencing treatment for every individual patient. Treatment will vary depending on which bacterium has been identified.

5.5 Transfer to other departments/areas

Task	Action required
Transfer to another ward or department within the Trust	• MRGNB should **not** compromise patient care/treatment if the patient needs transfer to other departments /specialist areas. • Inform staff in the receiving ward/department of the patient's MRGNB status before the patient leaves the ward, to ensure that Infection

	Prevention and Control measures are implemented. • Cover infected or colonised wounds/lesions with a secure and appropriate dressing
Transfer to another hospital outside of the Trust	• Inform staff in the receiving hospital prior to transfer of the patient. • Inform the IPC Team.
Ambulance transportation	• Notify the ambulance service of the patient's MRGNB in advance. • Normal procedures for transportation of patients apply, i.e. **a separate ambulance is not required**.
Deceased patients	• Take the same precautions as those observed during life. • Cover any lesions with occlusive dressings. • Inform the undertakers. • **NB: Cadaver(body) bags are not necessary.**

5.6 Cleaning of patient's room

When	Action required
Daily while the patient is symptomatic	• Follow the specific cleaning instructions which are available from the hotel services supervisor. • Each day the room should be thoroughly cleaned, using chlorclean 1,000 ppm paying attention to dust-collecting areas i.e. all flat surfaces.
After patient's discharge / transfer	• Clean the room thoroughly as above. • Change and launder curtains.

5.6 Communication

Communication	Action required

With patient	The patient must be informed of their infection / colonisation and given the opportunity to discuss any concerns with ward staff or the IPCT.
With relatives/carers	The same information that is given to patients may need to be given to relatives and carers **after** you have obtained the patient's/client's consent.
Between organisations	Good communication is the key to effective MRGNB management. It is important therefore when transferring individuals with MRGNB colonisation or infection, to another setting, to inform the person in charge at the receiving establishment.

5.7 Discharge planning

MRGNB is **NOT** a contra-indication to hospital admission or to discharge plans either to the patient's own home or to a residential / nursing home. The importance of communication with other agencies is vital if a patient is transferred to their own home their GP must be informed. The IPC team should be involved in any discharge planning.

5.8 Patient Screening

Routine screening swabs are **not** required for non-acute settings such as mental health facilities. Screening is only considered following advice from the IPC team.

Screening for CPE involves obtaining a rectal swab. Rectal swabs are most sensitive for detecting CPE, making sure faecal material and/or discolouration is visible on the swab. A stool sample is not acceptable. Additionally, a wound swab and/or urine sample if catheterised.

If screening is advised, the patient must be involved in the decision-making process to consider their preference of the gender of the clinician taking the rectal swab. Decisions must be documented in the patient's notes.

5.6.1 Screening criteria

The IPCT will advise if screening is required and only if the patient falls into the following risk groups:

In the 12 months has the patient:

- Been previously identified as CPE positive

- Been an inpatient in any hospital in the UK or abroad
- Had multiple acute hospital treatments e.g. renal dialysis
- Known link to a known carrier of CPE
- Admitted into an augmented care or high risk unit. (Augmented care environments include acute intensive care units, haematology /oncology and transplant wards).

At all risk levels ensure the following:

- Standard infection control precautions are always maintained.
- Effective environmental hygiene and cleaning: prevention of faecal and environmental contamination is crucial; remain alert to episodes that risk direct transmission to others and/or environmental contamination; ensure timely and thorough cleaning.
- Hygiene advice to individual and family/contacts it is important to inform individuals and those around them to ensure they take appropriate personal hygiene measures to prevent the spread of infection, especially when using the toilet.

5.6.2 Specific specimen taking guidelines

If screening is required, follow the Royal Marsden Manual online procedure for specific specimen taking guidelines:

- Swab sampling: **wound** - Royal Marsden Manual (rmmonline.co.uk)
- Swab sampling: **rectum** - Royal Marsden Manual (rmmonline.co.uk)
- Urine sampling: **catheter specimen of urine** - Royal Marsden Manual (rmmonline.co.uk)

5.6.3 Safe labelling of specimens

- ✓ Ensure each specimen is clearly labelled with the patient's name, date of birth, NHS number and location e.g., ward name.
- ✓ The pathology request form must also identify the patients details as well as relevant clinical details, reason for the specimen request and any current antibiotic treatment.
- ✓ Ensure the laboratory request form is also signed by the clinician who has requested the specimen.
- ✓ The specimen must be secured in the specimen container and placed into a leak proof sealed specimen bag along with the request form.
- ✓ Any specimens deemed as high risk of infection (e.g. from patients with blood borne viruses or diseases such as Creutzfeldt-Jacob Disease) must be placed into a mini grip plastic bag before being placed into the bag with the pathology request form, they should also be labelled as 'high risk' (high risk stickers can be ordered via cardea).
- ✓ Unlabelled or incorrectly labelled specimens will be discarded by the receiving laboratory department.

5.6.4 Transportation of laboratory specimens

- ✓ All pathology specimens must be transported in a leak proof, washable container. The container must be secure and must comply with UN 3373 standards.
- ✓ Specimen transport containers must not be left unattended in a patient access area.
- ✓ Specimen transport containers must be cleaned at least weekly, or immediately if they become contaminated.
- ✓ Where specimens are transported to the laboratory by vehicle, the transport specimen container must be placed into a cardboard transport box labelled with both the destination and senders name and address.
- ✓ Each specimen container must be in a separate plastic bag with sufficient material to fully absorb any leakage of the specimen
- ✓ Vehicles used for specimen transportation must be equipped with personal protective equipment and a spill kit. Any spillages must be cleaned immediately, and the specimen requester informed as a further specimen will need to be obtained.

5.6.5 Actions to take following screening

If the individual is colonised: single room with en-suite facilities including toilet or designated commode is recommended; where a single room is not available, it is recommended that a designated toilet or commode is made available. No curtailment of communal activities is required where standard precautions and effective environmental hygiene are being maintained and there is no risk of transmission to others.

If the individual is infected: If isolation is required, please refer to section 5.2 management of patients with Multi Resistant Gram-Negative Bacteria (MRGNB) colonisation / infection.

5.6.6 CPE risk assessment for non-acute settings

Care needs	Guidance for risk assessment
HIGH RISK **For example, the individual has diarrhoea, faecal incontinence, smearing or 'dirty protests', discharging wound, long term ventilation, confusion/dementia, device(s) in situ,** **undergoing invasive procedures**	Identify if there is an immediate risk of infecting/contaminating others and the shared environment. • Discuss management with GP/clinician in charge, IPC nurse • Consider the mental and physical health and wellbeing of the individual and the level of supervision required
MEDIUM RISK	No immediate risk of infecting others identified:

For example, the individual requires assistance with hygiene, mobility or physical rehabilitation	• Standard infection control precautions are maintained • Hygiene advice is provided to individual and family/contacts as appropriate • Maintain effective environmental hygiene If unsure, contact IPCT.
LOW RISK **For example, the individual is independent and self-caring**	No immediate risk of infecting others identified: • Standard infection control precautions are maintained • Hygiene advice is provided to individual and family/contacts as appropriate • Maintain effective environmental hygiene If unsure, contact IPCT.

6 Definitions

Term	Definition
MRGNB	Multi-resistant Gram-negative bacteria
Enterobacteriaceae this is a general term that encompasses several gram-negative bacteria including; Escherichia coli Klebsiella, Proteus & enterobacter	These bacteria live harmlessly in the gut of many people. They are opportunistic bacteria that can pose a problem to debilitated people, such as those who are hospitalised, immunocompromised or elderly. In general, infection with these bacteria can be avoided through the practice of good hygiene by healthcare workers and visitors to hospital; the environment should be kept clean
Acinetobacter	Acinetobacter species belong to a group of Gram-negative bacteria that are readily found throughout the environment including drinking and surface waters, soil, sewage and various types of foods. Healthy individuals are at low risk of infection by Acinetobacter species. Acinetobacter infections acquired in the community are very rare and most strains found outside hospitals are sensitive to antibiotics. A few species, particularly Acinetobacter baumannii, can cause serious infections in hospital patients who are already very unwell. These ‘hospital-adapted’ strains of Acinetobacter baumannii are sometimes

	resistant to many antibiotics and the infections that they cause can therefore be difficult to treat.
Pseudomonas aeruginosa	Pseudomonas aeruginosa is a Gram-negative bacterium often found in soil and ground water. P. aeruginosa is an opportunistic pathogen and it rarely affects healthy individuals. It can cause a wide range of infections, particularly in those with a weakened immune system e.g. cancer patients, newborns and people with severe burns, diabetes mellitus or cystic fibrosis.
Carbapenamase-producing Enterobacteriaceae (CPE)	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. Carbapenems are one of the most powerful types of antibiotics. Carbapenemases are enzymes (chemicals), made by some strains of these bacteria, which allow them to destroy carbapenem antibiotics and so the bacteria are said to be resistant to the antibiotics.
Extended Spectrum Beta-Lactamases (ESBL)	Extended Spectrum Beta-Lactamases (ESBLs) are enzymes produced by different species of gram-negative bacteria, that are mainly found naturally occurring in the human bowel. ESBLs can be resistance to a range of frequently used antibiotics including penicillin's and cephalosporins. As a result, infections caused by these bacteria can be difficult to treat.
AmpC beta-lactamases (Amp C)	Similar to ESBL but less common
Colonisation	MRGNB is present on or in the body without causing an infection.
Infection	MRGNB is present on or in the body and is multiplying causing clinical signs of infection, such as in the case of septicaemia or pneumonia, or for example in a wound causing redness, swelling, pain and or discharge.
IPC	Infection Prevention and Control
IPCN	Infection Prevention and Control Nurse
IPCT	Infection Prevention and Control Team
Patients at risk of infection from MRGNB	• Patients with underlying illness • The elderly – particularly if they have a chronic illness • Patients with open wounds • Patients with invasive devices such as a urinary catheter, gastrostomy tubes

	• Patients who have frequent and recurrent urinary tract infections
Routes of transmission	• Direct spread via hands of health care workers • Equipment that has not been appropriately decontaminated • Environmental contamination including inappropriately used hand hygiene sinks.

7 How this procedure will be implemented

- This procedure will be published on the Trust's intranet and external website.
- Line managers will disseminate this procedure to all Trust employees through a line management briefing.

7.1 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
All Healthcare staff	Mand and Stat training – IPC eLearning directs staff to the IPC team	1hr	annually

8 How the implementation of this procedure will be monitored

Number	Auditable Standard/Key Performance Indicators	Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).
1	reviewing infections reported by nursing staff	IPC quarterly report to the IPC Committee members	IPC Committee
2	IPC mand and stat training compliance	Frequency = monthly Method = ESR Person = manager	locality management IPC – quarterly to IPCC

		Frequency – quarterly and annually Method = report from education team Person = IPC team	annual IPC assurance report

9 References

Clean Safe Care (2008) Reducing Infection and Saving Lives Department of Health.

Denis et al (2015) Prevalence, risk factors and impact on clinical outcome of extended-spectrum beta-lactamase-producing Escherichia coli bacteremia: a five-year study International *Journal of Infectious Diseases*

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Department of Health (2008) The Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infection. Department of Health Publications. London.
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UKHSA (2018) Pseudomonas aeruginosa: guidance, data and analysis [online] available from; https://www.gov.uk/government/collections/pseudomonas-aeruginosa-guidance-data-and-analysis

Public Health England (2019) *Laboratory surveillance of Acinetobacter spp. bacteraemia in England, Wales and Northern Ireland: 2018.* PHE Publications. London.

Wilson APR, Livermore DM et al (2016) Prevention and control of multi-drug resistant Gram-negative bacteria; recommendations from a Joint working Party. *Journal of Hospital Infection.*

Home - Royal Marsden Manual (rmmonline.co.uk) accessed 19 January 2023

10 Document control (external)

To be recorded on the policy register by Policy Coordinator

Required information type	Information
Date of approval	10 September 2024
Next review date	16 July 2027
This document replaces	Multi resistant gram negative bacteria IPC-0001-020-v1.3
This document was approved by	IPCC
This document was approved	16 July 2024 (and 10 Sept 2024 chair's action)
This document was ratified by	n/a
This document was ratified	n/a
An equality analysis was completed on this policy on	04 September 2024
Document type	Public
FOI Clause (Private documents only)	n/a

Change record

Version	Date	Amendment details	Status
1	May 2018	New document	Withdrawn
1.1	21 Jun 2018	Appendix 2 removed. Hyperlinks added to Multi-resistant gram-negative bacteria information leaflet	Withdrawn
1.2	June 2021 (publication delayed till Dec 2021)	References updated; Public Health England (2015) Toolkit for managing carbamenepase producing enterobacteriacea in non-acute and community settings superseded by Public Health England (2020) Framework of actions to contain carbapenemase-producing Enterobacterales.	Withdrawn

		Patient screening updated in line with above PHE guidance. Transferred to new template.	
v1.3	19 Jan 2023	Minor changes only: Information regarding safe labelling and transportation of specimens added to section 5.8, due to withdrawal of procedure Ref IPC-0001-015 v3 for specimen collection. Links to specimen collection procedures within the Royal Marsden Online Manual added into section 5.8 Royal Marsden online added to references.	Withdrawn
V1.4	10 Sep 2024	Minor changes only: References updated Public Health England (2020) Framework of actions to contain carbapenemase-producing Enterobacterales superseded by UKHSA (2022) Actions to contain carbapenemase-producing Enterobacterales (publishing.service.gov.uk) Hyperlinks to Multi-resistant gram-negative bacteria information leaflet removed as no longer applicable. New leaflet required. Inserted sub-headings to aid navigation of the document. How the implementation of his procedure will be monitored – updated to reflect monitoring of training.	Published

Appendix 1 - Equality Impact Assessment Screening Form

Please note: The Equality Impact Assessment Policy and Equality Impact Assessment Guidance can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Nursing and Governance / IPC and Physical Healthcare
Title	Multi resistant gram negative bacteria IPC-0001-020-v1.4
Type	Procedure
Geographical area covered	Trustwide
Aims and objectives	To set standards in practice to ensure the delivery of patient care is carried out safely and effectively by trust staff.
Start date of Equality Analysis Screening	02/07/2024
End date of Equality Analysis Screening	02/08/2024

Section 2	Impacts
Who does the Policy, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	Trust staff and patients
Will the Policy, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups? Are there any Human Rights implications?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** • **Sex** (Men and women) **NO** • **Gender reassignment** (Transgender and gender identity) **NO** • **Sexual Orientation** (Lesbian, Gay, Bisexual, Heterosexual, Pansexual and Asexual etc.) **NO** • **Age** (includes, young people, older people – people of all ages) **NO** • **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women / people who are breastfeeding, women / people accessing perinatal services, women / people on maternity leave) **NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** • **Armed Forces** (includes serving armed forces personnel, reservists, veterans and their families) **NO** • **Human Rights Implications NO** (Human Rights - easy read)
Describe any negative impacts / Human Rights Implications	
Describe any positive impacts / Human Rights Implications	Safe delivery of patient care for all patients.

Section 3	Research and involvement
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	See reference section
Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	yes
If you answered Yes above, describe the engagement and involvement that has taken place	Discussions in IPCC meeting which includes various nursing groups and representation from other healthcare professionals.
If you answered No above, describe future plans that you may have to engage and involve people from different groups	

Section 4	Training needs
As part of this equality impact assessment have any training needs/service needs been identified?	No
Describe any training needs for Trust staff	N/a
Describe any training needs for patients	N/a
Describe any training needs for contractors or other outside agencies	N/a

Check the information you have provided and ensure additional evidence can be provided if asked.

Appendix 2 – Approval checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee/group for consideration and approval.

Title of document being reviewed:	Yes / No / Not applicable	Comments
1. Title		
Is the title clear and unambiguous?	yes	
Is it clear whether the document is a guideline, policy, protocol or standard?	yes	
2. Rationale		
Are reasons for development of the document stated?	yes	
3. Development Process		
Are people involved in the development identified?	yes	
Has relevant expertise has been sought/used?	yes	
Is there evidence of consultation with stakeholders and users?	yes	
Have any related documents or documents that are impacted by this change been identified and updated?	n/a	
4. Content		
Is the objective of the document clear?	yes	
Is the target population clear and unambiguous?	yes	
Are the intended outcomes described?	yes	
Are the statements clear and unambiguous?	yes	
5. Evidence Base		
Is the type of evidence to support the document identified explicitly?	yes	
Are key references cited?	yes	

Are supporting documents referenced?	yes	
6. Training		
Have training needs been considered?	yes	
Are training needs included in the document?	Yes	
7. Implementation and monitoring		
Does the document identify how it will be implemented and monitored?	yes	
8. Equality analysis		
Has an equality analysis been completed for the document?	yes	
Have Equality and Diversity reviewed and approved the equality analysis?	yes	AH 04/09/2024
9. Approval		
Does the document identify which committee/group will approve it?	yes	
10. Publication		
Has the policy been reviewed for harm?	yes	
Does the document identify whether it is private or public?	yes	
If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	n/a	
11. Accessibility (See intranet accessibility page for more information)		
Have you run the Microsoft Word Accessibility Checker? (Under the review tab, 'check accessibility'. You must remove all errors)	yes	
Do all pictures and tables have meaningful alternative text?	yes	
Do all hyperlinks have a meaningful description? (do not use something generic like 'click here')	yes	

Appendix 3 – Flowchart for the management of patients with Multi-resistant Gram-negative bacteria (MRGNB)