**Risk assessment tool for adult care settings for admission of residents with Carbapenemase-producing Enterobacterales (CPE)**

**Name: …………………………………………………………. NHS number: …………………………… DOB:……………………………….**

**Shared Care Risk Assessment**

|  |  |  |
| --- | --- | --- |
| **HIGH RISK** | **CPE carrier had faecal incontinence, wound, devices in situ, confusion/dementia** | Discuss possible isolation considering the mental and physical health and well-being of the CPE carrier |
| **MEDIUM RISK** | **CPE carrier requires assistance with hygiene, mobility and physical activities** | No immediate risk of infecting others identified |
| **LOW RISK** | **CPE carrier is independent and self-caring** | No immediate risk of infecting others identified |

**CPE Colonised/Infected Individual Risk Assessment**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Clinical element** | **Y** | **N** | **Comments/additional information** | **Mitigation of identified risk** |
| **Any patient colonised/infected with CPE MUST have a single room with dedicated ensuite containing shower/bath, toilet and hand wash basin with liquid soap and disposable paper towels** | | | | |
| Is the patient infected or colonised with CPE?  **Colonisation definition**:  the presence of bacteria on a body surface, such as skin or gut, without  causing disease in the person  **Infection definition**: invasion and growth of organisms in the body that cause harm |  |  |  |  |
| Where has CPE been identified? e.g., urine, rectal swab other |  |  |  |  |
| Who informed you of the CPE result and is the residents GP aware of the result? |  |  |  | * Obtain evidence of CPE screening result * Inform GP and other healthcare professionals who have contact with the resident * Communicate the CPE status of the resident when transferring between care settings. |
| Does the patient have any chronic wounds?  *In the comments box provide further detail e.g., is the wound leaking, site, size, has the wound been graded? etc* |  |  |  | * The wound is covered, and the exudate is safely managed * Patient compliant with wound care plan * Staff carrying out wound management are trained and demonstrate excellent compliance in wound care and PPE * Support provided by appropriate community professionals e.g., District Nurse, Tissue Viability Nurse (TVN) |
| Does the patient require long term ventilation or CPAP? |  |  |  | * Patient is contained within a room where high level surface decontamination can take place * Consumables for ventilator/CPAP machine are cleaned/replaced in line with manufacturers guidance * Staff supporting the resident are trained and demonstrate excellent compliance with PPE |
| Is the patient undergoing invasive procedures? e.g., suctioning |  |  |  | * Suction machine is calibrated, and contents are contained with a single use disposable liner * Staff are competent to carry out suctioning * Suction machine is cleaned in line with manufacturers guidance |
| Does the patient have an underlying bowel condition or a long-term discharging anal rectal wound? |  |  |  | * A care plan is in place and staff adequately trained to manage the condition * Support provided by appropriate community professionals e.g., District Nurse |
| Is the patient faecally incontinent? |  |  |  | * Resident incontinence is managed safely and care plan in place to ensure the patient regularly empties their bowels |
| Will the patient require a commode and or urinal? |  |  |  | * The commode is resident specific and not used for any other residents, including the commode pot and urinal * The commode pot and urinal contents are disposed of as one in the washer disinfector * The commode pot is cleaned through an automated washer disinfector * Washer disinfector reaches required temperature * Staff are assured that pots are clean on completion of wash cycle |
| Is the frequency of loose/formed stools known? Is there a regular bowel pattern? |  |  |  | * If required bowel care medication in place which is regularly reviewed * Bowel care plan in place and up to date Bristol Stool chart |
| Is the patient incontinent of urine? |  |  |  | * If resident is incontinent of urine, they have sufficient & appropriate supply of continence pads which can be discarded in an infectious waste stream after use |
| Does the patient have any indwelling/invasive devices? E.g., urethral catheter, supra-pubic catheter, tracheostomy, PEG etc |  |  |  | * Any device in situ is safely managed by fully trained staff to minimise risk of developing clinical infection * If resident has a urethral/supra pubic catheter the urine is emptied into a clean receptacle which is either single use/disposable or cleaned in an automated washer/disinfector as above * The receptacle and contents are disposed of as one in the washer disinfector * Current and up to date care plan is in place/ catheter passport is in place * Ability to report any concerns to appropriate community health care specialist |
| Does the resident require any sharps equipment to be used? |  |  |  | * Sharps are safely used and managed by fully trained staff * Staff supporting the resident are trained and demonstrate excellent compliance with safe sharps disposal and PPE * Staff are aware of sharps injury process |
| Does the patient have capacity? E.g., dementia, neurological conditions – would they be able to understand IPC precautions? |  |  |  | * The patient is supported to ensure they get adequate support with their neurological needs that results in minimal disruption to other residents |
| Is the patient mobile? |  |  |  | * If patient is mobile, they are supported to understand the importance of IPC measures * Dedicated toilet facilities are provided where possible, resident is instructed to use this facility when not in own room * Enhanced cleaning schedule is in place for this toilet after use |
| Is the patient bed bound? |  |  |  | * The resident should have their own dedicated hoist slings and slide sheets * The hoist must be decontaminated after use * All used linen and clothing should be treated as infected and contained in sealed red alginate liner for sluice cycle laundering |
| Is the patient immunosuppressed/immunocompromised? |  |  |  | * Monitor vital signs for signs and symptoms of infection, using remote monitoring systems. * Escalate any concerns to GP for further advice and support |

**Environmental assessment:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criteria** | **Y** | **N** | **Comments/additional information** | **Mitigation of identified risk** |
| Can the patient be provided with their own bedroom which has an en-suite facility? The en-suite should include hand wash basin, toilet and shower/bath |  |  |  | * If an individual room and ensuite bathroom cannot be provided the home ***could consider*** accepting the resident, considering also the implications associated with a lower risk patient, * If the home accepted the patient the communal bathroom/shower room/toilet and items within it would **MUST** be decontaminated immediately ***after every use. The home must have enough staff trained to do this as required.*** |
| If the patient requires a commode or urinal, does the care home have a washer disinfector? |  |  |  | * If the home does not have a washer disinfector, they should consider whether to accept the patient based on the patient risk outlined above * If a washer disinfector is in place this must be on an annual maintenance plan and contingencies provided to cover break down * All staff should be aware of how to use this equipment and the process for checking to ensure the cleanliness of each item after removal from the machine * Any concerns with its function should be reported to the home manager immediately and for prompt action to be taken to rectify issue. * Should the resident’s care need change during their stay within the home e.g., urinal, commode pot is required, and no washer disinfector is in place the home must use disposable items which are disposed of as clinical waste |
| If yes to the above, is this on a regular maintenance programme? |  |  |  | * As above |
| Does the home have access to a dedicated housekeeping team? |  |  |  | * Cleaning in the facility should be carried out by housekeeping staff who are trained to clean and who only carry out this function within the home * National cleaning standards apply, and this room risk assessed in accordance with these standards |
| Do the housekeeping staff work 7 days a week?  **In the comments box please record the numbers of hours worked and numbers of staff that work each day, no. of rooms required to clean over no. of floors** |  |  |  | * Cleaning services should operate 7 days a week, covering morning and afternoon hours, delivered by specialist staff who are trained how to clean * If the hours are not sufficient then the provider should consider increasing hours and staff levels |
| Do the housekeeping staff have access to detergents and appropriate disinfectants? E.g., chlorine |  |  |  | * The home is cleaned with appropriate detergents and disinfectants, especially the resident’s room daily (and their equipment) |
| Can the wastewater generated during cleaning be discarded in a dedicated janitorial unit? |  |  |  | * Dirty water generated through cleaning should be discarded in a dedicated janitorial unit or sluice hopper. The environment should be cleaned afterwards |
| Are the communal areas of the care home easy to clean? E.g., is there a lot of fabric chairs, carpet, ornaments etc |  |  |  | * Equipment within the home should be washable/wipeable * Fabric items should be on a regular clean/steam clean schedule |
| Are the communal areas well-spaced? |  |  |  | * Communal spaces to allow adequate room in between each resident |
| Does the home use agency or bank staff? |  |  |  | * Home to have adequate staffing levels and if agency staff used this is in general the same staff who support the home * All agency/bank staff are made aware of the infectious risks at the beginning of each shift and appropriate management of this patients in the mitigation of these risks |
| Does the laundry have an adequate dirty to clean flow? |  |  |  | * Laundry to have a clear identified route of dirty to clean flow to ensure no cross over of items * Where the laundry is limited space, evidence that this is maintained e.g., specific times for collection for dirty and distribution of clean etc * Dirty items are managed in accordance with laundry regulations * Infected linen is laundered on sluice cycle and contained within alginate liner before going to laundry |
| Does the laundry have industrial washing machines and tumble dryers? |  |  |  | * Washing machines and tumble dryers should be industrial and on a regular maintenance plan |
| Does the laundry have a dedicated hand wash sink? |  |  |  | * A dedicated hand wash sink should be available with liquid hand soap and disposable paper towels |
| Has the home participated in the ‘Say No to Infection’ programme? |  |  |  | * Contact C&W ICB IPCT for advice on how to sign up * Email address: [warnoicb.covwarksc19outbreaks@nhs.net](mailto:warnoicb.covwarksc19outbreaks@nhs.net) |
| Is compliance to IPC mandatory training for all staff above 90%? |  |  |  | * Ensure all eligible staff have received training |
| Does the home have in progress a regular hand hygiene, PPE compliance and IPC audit programme? |  |  |  | * Instigate Hand hygiene audits and cleaning audits to provide assurance around cleanliness and hand hygiene * Hand hygiene applies to residents as well as staff |