Guidance on Control of Carbapenemase Producing Enterobacterales (CPE) and similar Antimicrobial Resistant Organisms in Palliative Care

CPE Expert Group

National Guidance Document, Version 1.0

Scope of this Guidance

This guidance is intended for healthcare professionals working in palliative care. It is recommended that wherever possible support of Infection Prevention and Control Practitioners is accessed to support implementation. For additional guidance or to confirm that you are using the most current version of this guidance, please go to www.hse.ie/infectioncontrol.ie and www.hpsc.ie

Next review of this guidance document

This guidance document will be reviewed in two years.

Footnote[1] Recent changes in microbial nomenclature have altered the meaning of the term "*Enterobacteriaceae*" and mean that the term "Enterobacterales" now corresponds more closely to the former meaning of "*Enterobacteriace*"

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Summary of Key Recommendations

In all healthcare settings, Infection Prevention and Control (IPC) practice must be applied with due regard to the needs of the individual patient and their family and friends. This requirement merits attention in the context of palliative care in general and in particular in the context of end-of-life care.

Each in-patient/residential palliative care centre should evaluate the intensity of care delivered in the centre to determine if the intensity of care is most closely similar to an acute hospital or most similar to a community hospital/long-term care facility. It may be that individual sections within a centre may be categorized differently and will apply different guidance.

Each in-patient/residential palliative care centre should implement either the national CPE Guidance relevant to the acute hospital setting (document 1 below) or the CPE Guidance relevant to the community hospital/long-term care facility (document 2 below) as appropriate based on their evaluation of the intensity of care provided. Note that in relation to out-patient services and care delivered in the patients home the general guidance available is applicable to palliative care as to other types of care (in documents 3 and 4 below).

1. Control of Transmission of Carbapenemase Producing Enterobacterales (CPE) in the Acute Hospital Setting (2019)

https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/hcai/resources/cpe/

2. Guidance relating to Carbapenemase Producing Enterobacterales1 (CPE) for Long- Term Care Facilities for Older People

https://www.hpsc.ie/a-z/microbiologyantimicrobialresistance/strategyforthecontrolofantimicrobialresistanceinirelandsari/carbapenemresistantenterobacteriaceaecre/guidanceandpublications/Guidance%20relating%20to%20CPE%20for%20long%20term%20care%20facilities_final_14Jun18_signedoffamended.pdf

3. Hospital Out-Patient and Day Care for people colonised with Antimicrobial Resistant Organisms (AMRO) including Carbapenemase Producing Enterobacterales (CPE)

https://www.hpsc.ie/a-z/microbiologyantimicrobialresistance/strategyforthecontrolofantimicrobialresistanceinirelandsari/carbapenemresistantenterobacteriaceaecre/guidanceandpublications/Hospital%20Out%20Patient%20and%20Day%20Care%20for%20people%20with%20AMRO%20or%20CPE_15Sept2018.pdf

4. Guidance relating to healthcare of people colonised or infected with Antimicrobial Resistant Organisms including Carbapenemase Producing Enterobacterales (CPE) for Healthcare Workers in the Community (excluding long-term healthcare facilities for older people)

https://www.hpsc.ie/a-z/microbiologyantimicrobialresistance/strategyforthecontrolofantimicrobialresistanceinirelandsari/carbapenemresistantenterobacteriaceaecre/guidanceandpublications/People%20with%20AMRO%20or%20CPE%20for%20healthcare%20workers%20in%20the%20community_15Sept2018.pdf

Background

The following background to palliative care services in Ireland comes from "**The adult palliative care services model of care for Ireland**" which states that its aim is that *"Every person with a life-limiting or life-threatening condition can easily access a level of palliative care appropriate to their needs, regardless of care setting or diagnosis, in order to optimise quality of life".*

"Palliative care is care that improves the quality of life of patients and their families who are facing the problems associated with life limiting or life threatening illness. Palliative care prevents and relieves suffering by means of early identification, impeccable assessment and treatment of pain and other physical, psychosocial and spiritual problems. Palliative care is understood as both a set of principles that underpin an approach to care, and as a type of service that is provided. In Ireland palliative care services are organised into specialist and non-specialist services that operate in partnership as part of an integrated network of providers.

Many people still think of palliative care as care provided at the very last stage of life, around the time of death. However, in the last 20 years the scope of palliative care has broadened to providing palliative care at an earlier stage in the disease trajectory. In this model of integrated palliative care provision, palliative care is not dependent on prognosis and can be delivered at the same time as curative treatment. While the broader definition is far from the original idea of terminal or end of life care it does still include it. As Cicely Saunders stated "you matter because you are you, and you matter to the end of your life. We will do all we can not only to help you die peacefully, but also to live until you die."

Palliative care is delivered in homes, clinics, hospital and in specialist in-patient units and hospices. Existing infection prevention and control (IPC) guidance for care in the community and for hospital care applies to palliative care delivered in those settings. The Model of Care document refers to 236 in-patient beds provided by 9 palliative care organisations in 11 locations. It is with respect to these in -patient beds that there is a requirement for guidance regarding IPC practice. The in-patient specialist palliative care services are quite heterogeneous reflecting differences in the emphasis or focus required for the care of patients with very different care needs. In some units, the intensity of care is comparable to that delivered in an acute hospital setting and the patient's journey involves frequent transitions between in- patient palliative care and acute hospitals. In other units, the focus is more on care in the setting of advanced disease and for patients who have decided that they will not return to the acute hospital sector.

In all healthcare setting the principles of Standard Precautions are essential to control the risk of healthcare associated infection. Transmission Based Precautions are always in addition to Standard Precautions. Antimicrobial stewardship is also essential in all healthcare delivery both to protect patients from avoidable harm related to use of

antimicrobial agents and to support Infection Prevention and Control Practice in limiting the spread of antimicrobial resistant organisms. There is a particular challenge in relation to end of life care for patients colonised or infected with CPE or other MDRO because of the need to minimizing element of IPC practice that are intrusive while ensuring that other patients are protected to the greatest degree practical from acquiring CPE or other MDRO that may compromise their health or complicate their care.

Recommendations

Given the heterogeneity of practice, it is not appropriate to proscribe a common approach to IPC for all palliative care settings. Therefore, the following is recommended with respect to in-patient palliative/residential palliative care settings.

1. In all healthcare settings, Infection Prevention and Control (IPC) practice must be applied with due regard to the needs of the individual patient and their family and friends. This requirement merits attention in the context of palliative care in general and in particular in the context of end-of-life care.

2. Each in-patient/residential palliative care centre should evaluate the intensity of care delivered in the centre and within each discrete section of the centre to determine if the intensity of care is most closely similar to an acute hospital or most similar to a community hospital/long-term care facility. It may be that individual sections within a centre should be categorized differently.

3. Each palliative care centre should implement the national CPE Guidance relevant to the acute hospital setting or the CPE Guidance relevant to the community hospital/long-term care facility as appropriate based on their evaluation.

4. If the Acute Hospital Guidance is adopted for a particular unit the following qualifications may need to be applied

    a. CPE screening and other MDRO screening should generally not be performed in the context of end-of-life care
    b. Relatives and friends should not be required to wear personal protective equipment but should be encouraged to perform hand hygiene at the end of a visit
    c. There should be no restrictions on visiting related to colonisation with CPE or other MDRO
    d. No IPC restrictions should be placed on having flowers or other items that provide comfort in the person's room
    e. Strict source isolation should rarely if ever be implemented
    f. In relation to floor coverings, furniture and fittings, flexibility may be required in relation to comfort and noise control *versus* the ease of cleaning, in particular in the context of

end-of-life care

g. In relation to cleaning schedules – it may be appropriate to modify cleaning schedules to minimise intrusion in certain clinical settings