Department of Health
Communicable Disease Control Branch

18 June 2002

TO: ***ALL PUBLIC AND PRIVATE ACUTE AND RESIDENTIAL HEALTH CARE FACILITIES***

RECOMMENDATIONS OF THE STATE INFECTION CONTROL ADVISORY COMMITTEE (SICAC) FOR THE MANAGEMENT OF VANCOMYCIN RESISTANT ENTEROCOCCI (VRE) COLONISED PATIENTS OR VRE CONTACT PATIENTS

INTRODUCTION

Vancomycin Resistant Enterococci (VRE) were first detected in Western Australia in 1996. Only around 20 cases, with colonisation or infection, and nearly all sporadic, were identified between 1996 and mid-2001. In this period, management of VRE infected/colonised patients was guided by Operational Circular OP 1286/00, "Guidelines for the Management of Patients with Vancomycin Resistant Enterococci (VRE) Infection/Colonisation" .

There was a large outbreak of VRE centred on Royal Perth Hospital (RPH) in the latter half of 2001, with over 150 colonised individuals detected through an active screening program. There were four cases with VRE infection.

The response to the RPH outbreak in the wider health care system in WA was guided by an Infection Control Task Force convened by the then A/Commissioner of Health. Because of the need for special response measures beyond those encompassed in the existing Operational Circular two memoranda with provisional guidelines were distributed to health care facilities:

1. Statewide response to Vancomycin Resistant Enterococcus (VRE) outbreak at Royal Perth Hospital — Released 26 October 2001.
2. Recommended discharge/transfer arrangements for patients colonised with or contacts of Vancomycin Resistant Enterococcus (VRE) in WA, with particular reference to residential care — Released 9 November 2001.

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There has been no official communication to health care facilities since these memoranda were released, pending availability of data on several issues, including the need for ongoing screening of " contact" patients and optimal screening regimens. There continues to be uncertainty in many health care facilities as to the most appropriate action to take in managing patients connected with the RPH outbreak, and sporadic VRE-colonised/infected patients.

The State Infection Control Advisory Committee (SICAC) has now made several decisions regarding the ongoing screening and management of VRE-colonised patients or contacts of VRE-colonised patients. These decisions have been based on a range of information, including data indicating that there is now a very low yield of VRE-colonisation detected through screening of Micro Alert F (contact) patients in the community, and information from outbreaks elsewhere that indicates there is a low risk of VRE spread in residential care facilities and non-tertiary acute health care facilities.

This Memorandum supersedes those issued on 26 October 2001 and 9 November 2001. Health care facilities should now revert to Operational Circular OP 1286/00 for guidance on managing VRE, except where the following recommendations are at variance.

RECOMMENDATIONS

1. Removal from Micro Alert System

Patients currently registered as Micro Alert F (i.e. formerly inpatient contacts of VRE-colonised RPH outbreak patients) will be removed from the Micro Alert system 12 months from their date of registration. This is to allow tertiary hospitals with high risk units (e.g. intensive care, dialysis and oncology units) to continue discretionary VRE screening of these patients.

Patients currently registered as Micro Alert V (i.e. VRE-colonised patients) will remain on the Micro Alert system indefinitely. Micro Alert V patients should be assessed for risk of VRE transmission by the admitting hospital's infection control practitioner and/or Clinical Microbiologist and managed accordingly.

2. Rural Hospitals

Rural hospitals should cease screening new patients for a history of admission to RPH in the latter part of 2001 and cease telephoning the RPH VRE Hotline (which ceased operation in April 2002) or other sources to check the Micro Alert status of these patients.

However, patients currently registered as Micro Alert V will progressively be mailed a letter explaining their VRE status and advising them to inform the staff of any hospital they are admitted to of their VRE status.

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3. Metropolitan Private Hospitals

If they wish, major metropolitan private hospitals may continue screening (by a question at the time of admission) new patients for a history of admission to RPH in the latter half of 2001 and telephone infection control staff at either Royal Perth Hospital, Sir Charles Gairdner Hospital, or Fremantle Hospital, to determine the patient's Micro Alert status.

If the patient is found to be registered as Micro Alert "F" then the RPH Microbiology Department should then be telephoned to determine how many successive clear VRE swabs the patient has had. The patient should be assessed for risk of VRE transmission, admitted with Standard or Additional Precautions, and commenced or recommenced on the VRE clearance schedule (four successive rectal/perianal swabs or faecal samples on separate days).

4. Screening of Contacts of Epidemic VRE

Until further notice, the testing protocol developed during the RPH VRE outbreak (i.e. four rectal swabs, perianal swabs or faecal samples collected on four separate days) will continue for Micro Alert F patients in the setting of major metropolitan hospitals. The protocol would also apply to inpatient contacts of an epidemic strain of VRE during an epidemic (i.e. not just the RPH outbreak strain).

On receipt of four successive negative VRE culture results, health care staff should notify infection control staff or the Microbiology Unit at RPH of these results and request that the patient be deregistered from the Micro Alert system.

5. Screening Contacts of Sporadic VRE Cases

Institutions should make their own decisions regarding whether and how to screen room or ward contacts of sporadic cases of VRE-colonisation or infection, based on risk assessment.

6. Laboratory Testing of Specimens

Swabs or specimens collected for detection of VRE should now be cultured in the Microbiology Laboratory of the patient's hospital or health care facility. However, all VRE isolates should then be forwarded to RPH Microbiology Department for further typing.

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7. Routine VRE Screening in High Risk Units

The frequency and nature of routine VRE screening in high risk units (e.g. haemodialysis, intensive care) should be determined by the respective health care facility's Clinical Microbiologist and the Unit's Director.

8. Residential Care Facilities

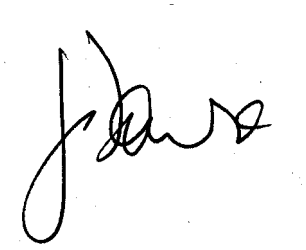
There is no place for VRE screening of Residential Care Facility (RCF) patients who were contacts of VRE patients in RPH in 2001. Acute hospitals should inform RCF when VRE-colonised patients are being transferred to those RCF, and vice versa.

Standard Precautions are applicable to VRE-colonised patients in RCF. VRE-colonised patients who are faecally incontinent can still be managed in RCF, but Additional Precautions may be advisable, depending on the capacity of the RCF and advice from an infection control professional.

9. Hostels and Day Care Establishments

Acceptance of people into day care or hostel situations should not be denied on the basis of VRE-colonisation. Evidence suggests that there is little risk of spread in such settings. Standard Precautions apply.

10. VRE-colonisation, or contact with a VRE-colonised person, is not a bar to inpatient or outpatient treatment at any acute health care facility, or admission to any residential care facility.



Dr Gary Dowse
CHAIRMAN
STATE INFECTION CONTROL ADVISORY COMMITTEE

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