### Glycopeptide/Vancomycin Resistant Enterococci (GRE/VRE) Policy

<table>
<thead>
<tr>
<th>Post holder responsible for Procedural Document</th>
<th>Judy Potter, Lead Nurse/Director Infection Prevention &amp; Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author of Policy</td>
<td>Judy Potter, Lead Nurse/Director Infection Prevention &amp; Control</td>
</tr>
<tr>
<td>Division/ Department responsible for Procedural Document</td>
<td>Specialist Services, Infection Prevention &amp; Control</td>
</tr>
<tr>
<td>Contact details</td>
<td>Extension number x2690</td>
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<tr>
<td>Impact Assessment performed</td>
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<tr>
<td>Ratifying body and date ratified</td>
<td>Infection Control and Decontamination Assurance Group: 30\textsuperscript{th} October 2017</td>
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<tr>
<td>Review date (and frequency of further reviews)</td>
<td>April 2022 (every 5 years)</td>
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<tr>
<td>Expiry date</td>
<td>October 2022</td>
</tr>
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<td>Date document becomes live</td>
<td>16 November 2017</td>
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Please specify standard/criterion numbers and tick ✓ other boxes as appropriate

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<th>Monitoring Information</th>
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<td>Develop Acute services</td>
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Other (please specify):

Note: This policy has been assessed for any equality, diversity or human rights implications

**Controlled document**

This document has been created following the Royal Devon and Exeter NHS Foundation Trust Development, Ratification & Management of Procedural Documents Policy. It should not be altered in any way without the express permission of the author or their representative.
### Full History

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<th>Date</th>
<th>Author (Title not name)</th>
<th>Reason</th>
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### Associated Policies:
- Decontamination Policy and Procedures
- Antimicrobial Policy

### Key Words
- GRE, VRE, Enterococci, Vancomycin, Glycopeptide

### In consultation with and date:
- Infection Prevention & Control Team: 25/08/2017
- Consultant Microbiologists: 25/08/2017
- Governance Managers, Corporate Managers, Department Managers, Service Managers, Senior Operational Managers, Lead Nurses, Senior Nurses, Matrons, Community DD and ADN, Equality Team: 25/08/2017
- Policy Expert Panel: 03/10/2017
- Infection Control and Decontamination Assurance Group: 30th October 2017

### Contact for Review:
- Lead Nurse, Infection Prevention & Control

### Executive Lead Signature:
- Medical Director
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1. INTRODUCTION

1.1 Glycopeptide-Resistant Enterococci (GRE) are enterococci that are resistant to the glycopeptide group of antibiotics (vancomycin and teicoplanin). In 1986 the first detection of GRE occurred in the United Kingdom and subsequently in other countries (Public Health England, 2013). GRE are sometimes referred to as VRE (Vancomycin-Resistant Enterococcus).

1.2 Enterococci or faecal Streptococci colonise the gut of most healthy people. There are many different species of Enterococci but only a small number have an ability to cause infection in humans. Infection occurs more commonly in immunocompromised patients and is often associated with the urinary tract or wounds but can also cause bacteraemias and endocarditis. More than 95% of VRE infections are due to Enterococcus faecium or faecalis. Other species include Enterococcus gallinarum and casseliflavus.

1.3 Failure to comply with this policy could result in disciplinary action.

2. PURPOSE

2.1 To provide Royal Devon & Exeter NHS Foundation Trust (hereafter referred to as “the Trust”) staff with the information they need to identify and manage patient/s that are colonised or infected with GRE, and those who are at high risk of being so.

2.2 Ensure that patients with GRE have effective and appropriate care wherever that care is delivered.

2.3 Reduce the risk of transmission of infection from GRE.

3. DEFINITIONS

3.1 Colonisation/carriage with GRE occurs when it is present in the body for a significant period of time but causes no ill effects. Patients may be colonised with GRE, sometimes for several months or years, without it being a problem to them. However, if a colonised patient requires antimicrobials, careful consideration should be given to antimicrobial choice and can be discussed with a medical microbiologist.

3.2 Infection with GRE occurs when the presence of GRE causes clinical consequences, e.g. inflammation, swelling and pus formation. GRE infection can occur in the gut, urinary tract or in the blood stream.

4. DUTIES AND RESPONSIBILITIES OF STAFF

4.1 Board of Directors
The Board of Directors, through the Chief Executive and the Medical Director, will delegate to the Joint Directors of Infection Prevention and Control responsibility for supporting and encouraging compliance by:

- Regarding lapses in compliance with this policy as a serious issue
- Supporting education at induction for all staff and appropriate updates for staff involved in direct patient contact
- Ensuring that appropriate facilities are provided for the management of patients with GRE
• Involving the Infection Prevention and Control Team in the planning process for new construction and refurbishment work so that advice can be given on appropriate isolation facilities as emphasised by *Infection Control in the Built Environment* (Department of Health, 2013) and the Health and Social Care Act 2008 - Code of Practice on the prevention and control of infections and related guidance (Department of Health, 2015)

4.2 Divisional Directors, Associate Medical Directors and Assistant Directors of Nursing

4.2.1 Each divisional management team is responsible for:

• Ensuring that there is process in place for all relevant staff, including junior medical staff, to complete infection control training and annual updates
• Providing facilities and equipment for appropriate placement of patients with GRE
• Ensure that MRSA surveillance results and post infection review action plans are monitored at Divisional Governance Group meetings as part of the infection control standing agenda item and reported and investigated in accordance with the Incident Reporting, Analysing, Investigating and Learning Policy.

4.3 Infection Prevention and Control Team (IPCT)

4.3.1 The IPCT is responsible for:

• Providing advice on appropriate placement of patients with GRE in hospital
• Producing timely feedback on surveillance of GRE acquisition for wards/units, directorates and Trust
• Ensuring that patients with first time isolates of GRE have an Infection Control (IC) alert placed on the Patient Administration System (PAS)
• Investigating suspected incidents of cross infection
• Advising on screening of patients with regards to GRE

4.4 Microbiology Department

4.4.1 The microbiology laboratory and medical microbiologists are responsible for:

• Ensuring that appropriate tests are available for identification of GRE
• Ensuring that results are communicated promptly to clinical teams
• Providing timely advice to clinicians regarding appropriate treatment, where relevant
• Monitoring the use of antimicrobial agents within the Trust and feedback on areas for improvement

4.5 Matrons and Other Registered Nurses

4.5.1 Matrons and other registered nurses are responsible for:

• Ensuring that arrangements are in place to check for an IC alert on PAS/Whiteboard to identify patients with a history of GRE on admission or pre admission to hospital
• Ensuring the infection control risk assessment is completed on admission to hospital or to community caseload.
• Ensuring that patients are provided with adequate information, including provision of a relevant information leaflet.
- Ensuring that ward vacated bed spaces/rooms and associated equipment used by patients with GRE are terminally cleaned and disinfected prior to use by another patient.
- Ensuring that GRE status is communicated at the time of referral to community teams who will care for the patient in their own home.

4.6 Consultant and Other Medical Staff including GPs

4.6.1 Consultants and other medical staff are responsible for:

- Prescribing antimicrobial agents prudently
- Complying with Trust Antimicrobial Policy and guidelines taking into consideration GRE history
- Commencing treatment of patients with GRE in accordance with this policy or microbiology advice

4.7 Site Management Team

4.7.1 The site management team is responsible for:

- Assisting ward staff to identify single room accommodation for patients with suspected or confirmed GRE where risk assessment has shown that this is appropriate.

4.8 Housekeepers and Domestic/Hotel Services

4.8.1 Housekeepers and domestic service assistants are responsible for:

- Routinely maintaining a clean environment to reduce level of environmental contamination with GRE in hospital
- Providing terminal cleaning/disinfection of vacated bed spaces/isolation rooms on discharge/transfer of patients with GRE using products advised by the Infection Prevention and Control Team

4.9 All Staff

4.9.1 All staff have a personal and corporate obligation to comply with best practice in the prevention of infection and comply with this and all other related policies.

4.10 Infection Control and Decontamination Assurance Group (ICDAG)

4.10.1 ICDAG is responsible for:

- Ratifying the GRE policy
- Escalating issues and concerns about GRE performance to the Safety and Risk Committee
- Reviewing the GRE policy every five years and making any necessary revisions in light of local surveillance and national evidence based guidance

5. SIGNIFICANCE

5.1 Resistance to glycopeptides reduces options for antibiotic treatment where clinical infection is evident. Resistance in Enterococci can transfer to other organisms. For example, the first detected clinical case of Vancomycin resistant Staphylococcus aureus (VRSA) occurred in the USA in 2002. This was caused by vancomycin resistant genes transferring to Meticillin resistant Staphylococcus.
aureus (MRSA). May 2013 saw the first case of VRSA in Europe. This occurred in a patient in Portugal (Lancet/ Melo-Cristino, J., Resina, C., Manuel, V., Lito, L. and Ramirez, M., 2013). The risk of VRSA and potentially untreatable Staphylococcus aureus infections is an important reason for controlling the spread of GRE.

6. PATIENT RISK GROUPS

6.1 Currently surveillance cultures in the Trust are only conducted in high risk groups, e.g. for neutropenic inpatients. Therefore unless isolated from specimens such as blood cultures or wound swabs, the presence of GRE may go unnoticed. Despite its detection in an at risk population, at present GRE appears to be sporadic rather than endemic in the Trust.

6.2 The emergence of GRE as a clinical problem can often be linked to the convergence of multiple risk factors. Prior and prolonged antibiotic use is an important risk factor. Widespread use of broad spectrum antibiotics, especially cephalosporins is a feature of outbreaks of GRE. Glycopeptide use is particularly associated with GRE emergence.

6.3 Other risk factors for acquiring hospital infection with GRE include significant immuno-suppression, admission to a haematology, renal or intensive care unit and prolonged or multiple hospital admissions. Transfer of patients from hospitals with a high rate of VRE reporting may also present a problem.

7. PREVENTION

7.1 Prevention of GRE requires recognised risks to be minimised or avoided.

7.2 Appropriate antibiotic prescribing is essential. Cephalosporins should be avoided where possible, especially in high risk areas. Vancomycin use must be controlled. Vancomycin can be used as a first line agent with caution and according to current treatment guidelines for treating patients with Clostridium difficile diarrhoea or colitis as many of the risk factors for GRE exist in these patients.

7.3 As with other organisms, good infection control practice and hygiene are the cornerstone of prevention. This includes appropriate surveillance and isolation of known GRE patients in high risk areas.

8. TRANSMISSION

8.1 Within a hospital setting transmission is by contact. This usually occurs via the unwashed hands of healthcare workers following contact with colonised or infected patients, their equipment or their environment.

9. IDENTIFICATION

9.1 As colonisation is more common than infection, careful consideration is required when interpreting positive microbiology results. When GRE is isolated from a clinical specimen the following screening of the patient is advised. This should be done whether infection or colonisation is suspected. In the case of infection the screening should take place prior to commencement of antibiotics. This is done to minimise the risk of false negative screening results due to antibiotic therapy. If this is not possible then screening can take place a minimum of 48hrs post antibiotic completion.
• Stool sample (or, if unavailable, rectal swab)  }
• Wound swabs  } Request “GRE
• Central vascular catheter sites  } screen only”
• Catheter specimen of urine  }

9.2 If an outbreak of GRE occurs, the Infection Prevention and Control Team (IPCT) will advise on the screening of any contacts. The above specimens should also be taken if contact screening is requested.

10. PATIENT TREATMENT AND ONGOING MANAGEMENT

10.1 Patients colonised with GRE (bacteria are present but have no symptoms of infection) do not need treatment. Patients who are infected should receive appropriate antimicrobial therapy.

10.2 However, successful treatment of infection does not always indicate clearance of GRE from the body and colonisation can continue. Therefore the following screening is recommended:

- First screen: Obtain swabs/specimens as listed above a minimum of 48 hours after antibiotic treatment has ceased.
- Second screen: If 1st screen results are negative then obtain second screen at least one week after the initial screen.
- Third screen: If 2nd screen results are negative then obtain third screen at least a week after previous screen.

10.3 Patients can be considered clear if carriage has not been detected in three consecutive screens. If it is established that a patient has stool carriage for GRE, there is little value in attempting to identify clearance through screening in the short term. Stool carriage can persist for months or years, and therefore patients who are stool positive should be managed as detailed in section 9, whenever they are admitted to hospital. On subsequent admission, a stool sample can be submitted for GRE screening, and, if negative, the process of clearance screening can commence.

11. PATIENT INFORMATION

11.1 To supplement verbal information given to patients regarding their treatment and potential isolation, a patient leaflet has been produced and is available from the Trust. If the patient/family have further questions, the Infection Prevention and Control Team (IPCT) can be contacted.

12. INFECTION CONTROL MEASURES

12.1 Isolation

12.1.1 Isolation in a single room is essential, with en suite facilities if available. Cohort nursing may be advised by the IPCT in the event of an outbreak.

12.1.2 Source isolation precautions should be initiated. Gloves and aprons must be worn by staff for direct patient contact and cleaning the environment. Protective clothing must be removed prior to leaving the room. It is unnecessary to wear protective clothing for activities that do not involve significant patient or environmental contact, e.g. giving oral medication. Hands must be cleansed immediately after glove removal, in between procedures on the same patient and before exiting the isolation
room. In addition, use alcohol gel to clean hands after leaving the room. Keep the door closed.

12.1.3 In community care settings, i.e. own home or care homes, segregation from other people is not usually required, and standard infection control precautions are adequate. Discussions with carers/care providers in these settings should take place prior to transfer and involve the Infection Prevention and Control Team.

12.2 Maintaining Standards of Care

12.2.1 It is important to remember that control measures do not compromise standards of care or the need for urgent specialist care. The patient’s overall needs must take precedence.

12.3 Visits to Other Departments

12.3.1 Patients can undergo investigations in all departments, provided the department has been informed in advance. Staff within the department must wear personal protective equipment (as in section 9.1.2). Equipment should be decontaminated, in accordance with the decontamination policy, before use on the next patient.

12.4 Mobilisation

12.4.1 If isolated in a single room, the patient can leave the room to allow mobilisation in an area away from the ward, e.g. main corridor. This does not mean that the patient can wander freely around the ward where close contact with other vulnerable patients is possible. The distinction must be explained carefully to patients who may find it confusing.

12.5 Personal Hygiene

12.5.1 If en suite facilities are not available, patients may use communal facilities but these must be terminally cleaned after use. If patients are leaving an isolation room for this purpose, they must be advised this does not mean they can move freely around the ward.

12.6 Decontamination of Equipment/Environment

12.6.1 To minimise the risk of cross infection via the environment, attention to decontamination is crucial. The room and any patient equipment must be cleaned routinely on a daily basis (as per Trust decontamination policy and procedures) during the patient’s stay. On transfer or discharge the room must be cleaned according to the terminal cleaning procedure.

12.7 Transfer/Admission of Patients with GRE

12.7.1 If a patient is to be transferred to another ward or hospital, the receiving clinical staff should be informed. Advice can be sought from the IPCT if required. If a patient who has had GRE on a previous admission is readmitted it is likely that the patient is still colonised. Contact IPCT for more information.

12.8 Transporting by Ambulance or Car

12.8.1 If their clinical condition allows, patients with GRE can be transported in an ambulance with other patients as long as open wounds are covered, they are
continent of urine and faeces and the ambulance crew maintains standard infection control precautions.

12.8.2 Likewise, outpatients can be transported in cars without concern for the driver or subsequent passengers, as long as the patient is continent, and any open wounds covered.

13. **ARCHIVING ARRANGEMENTS**
The original of this guideline, will remain with the Lead Nurse, Infection Prevention & Control. An electronic copy will be maintained on the Trust Intranet, (A-Z) P – Policies (Trust-wide) – G – Glycopeptide/ Vancomycin Resistant *Enterococci* (GRE/VRE) Policy. Archived electronic copies will be stored on the Trust's “archived policies” shared drive, and will be held indefinitely. A paper copy (where one exists) will be retained for 10 years.

14. **PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE POLICY**

14.1 To monitor compliance with this policy, the auditable standards will be monitored as follows:

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<tr>
<th>No</th>
<th>Minimum Requirements</th>
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<td>1.</td>
<td>Annual Audit</td>
<td>Appropriate isolation of patients during the annual patient placement audit</td>
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14.2 **Frequency**
On a case by case basis as part of a routine review of infectious patients. In each financial year, the Infection Prevention and Control Nurse Specialist will audit patient placement to ensure that this policy has been adhered to and a formal report will be written and presented at the Infection Control and Decontamination Assurance Group. Significant incidents will be included in the DIPC annual report.

14.3 ** Undertaken by**
Infection Prevention and Control Team.

14.4 **Dissemination of Results**
At the Infection Control and Decontamination Assurance Group which is held quarterly and the relevant Divisional Governance Groups if there is failure to comply with the guidance.

14.5 **Recommendations/ Action Plans**
Implementation of the recommendations and action plans will be monitored by the Infection Control and Decontamination Assurance Group, which meets quarterly. Any barriers to implementation will be risk-assessed and added to the risk register. Any changes in practice needed will be highlighted to Trust staff via the Governance Managers’ cascade system.

14.6 Any barriers to implementation will be risk-assessed and added to the risk register.

14.7 Any changes in practice needed will be highlighted to Trust staff via the Governance Managers’ cascade system.
15. REFERENCES


APPENDIX 1: COMMUNICATION PLAN

The following action plan will be enacted once the document has gone live.

<table>
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<th>All staff</th>
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<td>Routine update and changed from guideline format to policy format.</td>
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<tr>
<td>The key objectives</td>
<td>This policy outlines the framework for treatment and management of patients with GRE/VRE</td>
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<td>How new staff will be made aware of the procedure/policy and manager action</td>
<td>Induction process</td>
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<td>Specific Issues to be raised with staff</td>
<td>Clinical staff should be made aware of the policy.</td>
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<td>Training available to staff</td>
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<td>Any other requirements</td>
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<td>Location of hard / electronic copy of the document etc.</td>
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## APPENDIX 2: EQUALITY IMPACT ASSESSMENT TOOL

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<th>Glycopeptide/Vancomycin Resistant Enterococci (GRE/VRE) Policy</th>
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<tr>
<td>Name, job title and contact details of person completing the assessment</td>
<td>Nicola Colborne, Infection Prevention and Control Nurse Specialist</td>
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<tr>
<td>Date completed:</td>
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### The purpose of this tool is to:

- **identify** the equality issues related to a policy, procedure or strategy
- **summarise the work done** during the development of the document to reduce negative impacts or to maximise benefit
- **highlight unresolved issues** with the policy/procedure/strategy which cannot be removed but which will be monitored, and set out how this will be done.

### 1. What is the main purpose of this document?

To provide a framework for treatment and management of patients with GRE/VRE

### 2. Who does it mainly affect? (Please insert an “x” as appropriate:)

- Carers ☐
- Staff ☐
- Patients ☒
- Other (please specify) ☐

### 3. Who might the policy have a ‘differential’ effect on, considering the “protected characteristics” below? (By differential we mean, for example that a policy may have a noticeably more positive or negative impact on a particular group e.g. it may be more beneficial for women than for men)

*Please insert an “x” in the appropriate box (x)*

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<tr>
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<tr>
<td>Race</td>
<td>☐</td>
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<tr>
<td>Religion / belief</td>
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<td>☒</td>
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<tr>
<td>Sexual orientation – including: Marriage / Civil Partnership</td>
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</table>
4. Apart from those with protected characteristics, which other groups in society might this document be particularly relevant to... (e.g. those affected by homelessness, bariatric patients, end of life patients, those with carers etc.)?

None

5. Do you think the document meets our human rights obligations? ☒

Feel free to expand on any human rights considerations in question 6 below.

A quick guide to human rights:

- **Fairness** – how have you made sure it treat everyone justly?
- **Respect** – how have you made sure it respects everyone as a person?
- **Equality** – how does it give everyone an equal chance to get whatever it is offering?
- **Dignity** – have you made sure it treats everyone with dignity?
- **Autonomy** – Does it enable people to make decisions for themselves?

6. Looking back at questions 3, 4 and 5, can you summarise what has been done during the production of this document and your consultation process to support our equality / human rights / inclusion commitments?

Please give a brief summary- identifying:

1.) Consulted with the Infection Control and Decontamination Assurance Group

7. If you have noted any ‘missed opportunities’, or perhaps noted that there remains some concern about a potentially negative impact please note this below and how this will be monitored/addressed.

<table>
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<td>How is this going to be monitored/addressed in the future:</td>
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<tr>
<td>Group that will be responsible for ensuring this carried out:</td>
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