Version 1, November 2010

Department of Health 2010. *Infection Prevention and Control of Vancomycin-Resistant Enterococci (VRE) in Western Australian Acute Care Healthcare Facilities (Version 1)*, Healthcare Associated Infection Unit (HAIU), Communicable Disease Control Directorate, Department of Health, Western Australia.

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Version 2, December 2011

Department of Health 2011. *Infection Prevention and Control of Vancomycin-Resistant Enterococci (VRE) in Western Australian Acute Care Healthcare Facilities (Version 2)*, Healthcare Associated Infection Unit (HAIU), Communicable Disease Control Directorate, Department of Health, Western Australia.

**Modified by VRE Action Group**

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Introduction

The purpose of these guidelines is to reduce the transmission of vancomycin-resistant enterococci (VRE) to protect higher-risk patients thereby minimising the associated morbidity and mortality from VRE. Identification of patients at increased risk of VRE infection and performing routine screening of these patients has been shown to be a cost effective infection prevention management approach.

These guidelines represent the minimum requirements for the screening and management of patients with VRE in acute care HCFs. Additional measures may be required in some acute care HCFs on advice from their infection prevention and control professionals. This document is not intended for use in residential care facilities (RCFs).

The strict adherence to standard precautions and the adoption of transmission-based contact precautions when VRE colonisation or infection is identified is the appropriate management for VRE-positive patients.

At no time shall a person’s VRE status interfere with the admission to, or provision of, appropriate healthcare in any WA healthcare facility.

Risk Assessment

All VRE-positive patients must be assessed individually for risk factors for transmission (refer page 4). In certain circumstances, and only on the advice of their infection prevention and control professional, an acute care HCF may manage a VRE-positive patient who has no risk factors for transmission with modified transmission-based contact precautions e.g. shared room, standard precautions.
Definitions

**Carrier** refers to any patient who has had VRE isolated from any site.

**Colonisation** is the presence, growth and multiplication of microorganisms without observable clinical signs or symptoms of infection. Enterococci are not a cause of diarrhoea, so if isolated from a faecal specimen collected from a patient with diarrhoea, this is colonisation and not infection.

**Contact** refers to any patient who has shared a room, bathroom or toilet facility with a VRE-positive patient. Acute care HCFs may choose to broaden the definition to include additional patients depending on the facility design and patient / ward casemix e.g. higher risk ward, VRE patient with risk factors for dissemination or during an outbreak.

**Healthcare facility (HCF)** includes all public and private hospitals, private haemodialysis units and acute care mental health facilities. Home-based haemodialysis services are excluded.

**Higher-Risk Units** refers to services within acute care HCFs providing care to patients known to be at increased risk of VRE infection. This includes, but is not limited to, solid organ and bone marrow transplant recipients, haematology and medical oncology patients, haemodialysis recipients and those admitted to intensive care units.

**Infection** refers to invasion of bacteria into tissues with replication of the organism. Infection is characterised by isolation of the organism accompanied by clinical signs of illness such as fever, inflammation or pus formation.

**Residential care facility (RCF)** refers to all private and public facilities registered to provide 24 hour non-acute care to persons who are not able to live independently. This includes nursing homes, hostels, psychiatric facilities, hospices and rehabilitation facilities.
Characteristics

VRE have emerged as important pathogens that contribute to healthcare-associated infections.

Reservoir

- Enterococci are part of the normal flora of the lower gastro-intestinal tract and can be found at other body sites such as skin surfaces, vagina, urethra and the hepatobiliary tree.
- VRE are found in the faeces of colonised people.
- Most patients who acquire VRE are colonised rather than infected.
- Enterococci are capable of prolonged (months) survival on environmental surfaces.

Risk Factors for Acquisition (colonisation or infection)

- Certain patients have an increased risk for acquiring VRE, including:
  - critically ill patients requiring intensive care
  - patients with severe underlying disease
  - patients with immunosuppression
  - patients who have had prolonged hospitalisation
  - patients with invasive devices
  - patients with previous or current antibiotic exposure (particularly vancomycin or broad spectrum agents)
  - patients who are in proximity to a VRE colonised / infected patient.

Risk Factors for Transmission

- Certain VRE patients are more likely to contaminate the environment and hands of healthcare worker (HCWs). These include:
  - patients with diarrhoea or faecal incontinence
  - patients with enterostomies
  - patients with discharging wounds
  - catheterised patients with VRE colonisation of the urinary tract
  - patients who are incapable of maintaining their own personal hygiene.
HCWs providing direct care to these patients are at increased risk of transient acquisition of VRE on their hands if standard and transmission-based precautions are not followed.

Routes of Transmission

The routes of transmission from patient to patient are either by:
- direct contact through carriage of VRE on the hands of HCWs or
- indirectly via contaminated environmental surfaces or shared equipment.
Infection Prevention and Control

1. Screening Requirements

The following patients shall have routine VRE screening performed by obtaining one specimen as described in section 2.

**NOTE: No pre-emptive isolation is required pending screening results, unless the patient is a direct transfer from a HCF or RCF outside of WA.**

1.1 General Patients

- Any person who has been a hospital inpatient in a HCF or a resident in a RCF outside of WA in the past 12 months shall be screened for VRE prior to, or on admission to a WA acute care HCF.
- WA acute care HCFs should consider screening patients admitted from WA RCFs.
- Any patient who is a direct transfer from a HCF or RCF outside of WA shall be screened on admission to a WA acute care HCF. These patients require a single room and transmission-based contact precautions to be implemented.
- Routine screening of patients hospitalised within WA acute care HCFs, in the absence of a micro-alert, is not required.

1.2 Haemodialysis Units

- All in-centre (within acute care HCFs) haemodialysis patients shall be screened for VRE on initial admission to the unit.
- All haemodialysis patients (in-centre and satellite) are to be screened following provision of dialysis outside of WA.
- Routine three monthly screening shall be performed for all haemodialysis patients, excluding home-based haemodialysis patients, who will be screened when admitted to an in-centre haemodialysis unit.
- A copy of the patient’s most recent screening result shall be made available when transfer between units occurs. If a patient has been screened within the last 3 months, the patient does not require rescreening prior to transfer.
- More frequent surveillance screening may be implemented within an acute care HCF on the advice of their infection prevention and control service e.g. in the event of a VRE outbreak.
1.3 Specialised Higher-Risk Units

- Each acute care HCF shall identify their higher-risk patient groups who require routine VRE screening.
- Patients admitted to specialised higher-risk units, which are those units that service patients identified as having an increased risk for VRE acquisition and subsequent development of invasive infections shall be screened for VRE on admission to the unit. Screening of long-term inpatients (admission beyond one week) in these units is recommended and on discharge from the unit.

1.4 Opportunistic Screening

- All faeces samples collected, as part of standard medical care, from patients in higher-risk units shall be tested for VRE.

2. Specimen Collection

- A faecal specimen in a clean container or a rectal swab is required.
- For those patients with enterostomies a stomal specimen is to be collected.
- The procedure for collecting a rectal swab is as follows:
  - dip a sterile cotton swab in sterile water or normal saline
  - insert swab 1cm into rectum and gently rotate 360 degrees
  - place swab into transport container and process as per normal procedure.
- All laboratory request forms to be marked “For VRE Screening.”

3. Surveillance and Clearance Screening

- There is no screening protocol to clear VRE-positive patients in WA and repeated screening of VRE-positive patients is not routinely required. Under the control of the infection prevention and control service, an acute care HCF may undertake screening of certain VRE-positive patients as part of a risk assessment when considering modification of transmission-based precautions.
- For surveillance screening collect one faecal specimen or rectal swab.
- Clearance screening for patients identified as a VRE contact is achieved by the collection of three specimens collected on three separate days.
- Clearance swabs of ‘contacts’ can be collected during antibiotic treatment.
4. **Antimicrobial Stewardship**

- All WA acute care HCFs shall establish a formulary restriction and approval policy that includes restricting broad-spectrum antimicrobials known to select for VRE and other multi-resistant organisms to patients in whom their use is clinically justified.
- All WA acute care HCFs shall have a monitoring process to ensure compliance with the formulary restriction and approval policy.
- Restricted use antimicrobials shall only be used on the prescription or recommendation of a Clinical Microbiologist or Infectious Diseases Physician, or within protocols approved by such specialists for specific units.
- A dedicated pharmacist service to contribute to antimicrobial stewardship at each acute care HCF is recommended.

5. **Routine Environmental and Equipment Cleaning**

- The importance of regular routine cleaning and disinfection (when required) of the environment and shared equipment in accordance with standard precautions is critical to the prevention of transmission of microorganisms. All acute care HCFs shall:
  - have documented cleaning schedules for all areas of the HCF available
  - ensure routine cleaning is performed in all areas on a daily basis and on patient discharge
  - consider increased cleaning frequency of higher-risk areas e.g. shared toilets. Frequency to be determined by the acute care HCF
  - consider routine cleaning with detergent and chlorine-based disinfectant for higher-risk areas, the frequency to be determined by the acute care HCF
  - have documented surface disinfection procedures available to render shared equipment safe for re-use on other patients
  - provide education to cleaning staff on the correct use of detergent and chlorine-based disinfectant solutions, including dilution methodologies
  - investigate the use of automated dispensing systems for all cleaning solutions.
Physical cleaning is the most important step in the cleaning process and sole reliance on a disinfectant without physical cleaning is not recommended.

Cleaning regimens must include all horizontal surfaces, walls that are visibly contaminated, and frequently touched items such as door handles, bed rails, bedside lockers, over-bed tables, call bells, IV poles, telephones, TV remote control devices, vital sign monitors and bathroom and toilet amenities, including hand basin fittings.

6. Surveillance and Notification

- Microbiological surveillance is required by all pathology laboratories and the testing of clinically significant enterococcal isolates for vancomycin susceptibility is required.
- All laboratories isolating VRE shall ensure prompt notification is made to the medical practitioner responsible for the care of the patient. In the case of an admitted patient, notification should be made to the hospital infection prevention and control personnel, the nurse in charge of the ward or unit and other personnel as specified at a local acute care HCF level.
- All VRE isolates are to be sent to the Australian Collaborating Centre for Enterococcus and Staphylococcus Species (ACCESS) Typing and Research.
- Each acute care HCF shall ensure local data collection of all VRE isolates occurs, including patient demographics, ward location and any identified patient contacts.

7. Micro-Alert System

- VRE-positive patients are to be assigned a ‘V’ alert on the Micro-Alert System and will be provided with written information (appendix 1).
- As carriage of VRE can be prolonged and there is no clearance procedure utilised in WA, ‘V’ alerts are to remain in place for the life of the patient.
- A Micro-Alert ‘F’ is to be initiated for those patients identified as a VRE contact and for whom screening has not been undertaken or completed prior to discharge or transfer to another HCF.
It is recommended that patients on Micro-Alert ‘F’ are placed in a single room with ensuite facilities until cleared, especially if the patient has risk factors for transmission.

8. Outbreak Management

- An outbreak is defined as when a particular strain of VRE is detected at rates that are clearly higher than expected. For example, when transmission between patients beyond direct physical contacts is detected or closure of wards to admissions is required as part of the management plan.
- All acute care HCFs shall have an outbreak management plan to ensure prompt action is taken to identify the source, stop further spread and ensure communication occurs between all concerned parties.
- Depending on the severity and location of an outbreak the acute care HCF Executive should consider convening a VRE action group with representation across all relevant departments within the acute care HCF. This group should meet regularly until the outbreak is contained.
- Acute care HCFs shall consider convening dedicated cleaning teams led by an appropriately trained Supervisor.
- All HCFs shall notify an outbreak of VRE to the Healthcare Associated Infection Unit (HAIU) within the Communicable Disease Control Directorate (CDCD).
- The HAIU is responsible for further communication to other hospitals and other key stakeholder groups with regular updates as required.
- Depending on the severity of the outbreak, the Director of the CDCD shall consider convening a statewide expert advisory group.

9. Management of VRE Positive Patients (Hospital Inpatient)

- Transmission-based contact precautions are required.
- An individual patient risk assessment is required when VRE-positive status is confirmed to assess patient risk factors for transmission.
In some circumstances, for VRE-positive patients with no risk factors for transmission it may be appropriate to manage them with modified contact precautions. This needs to be determined at an individual acute care HCF level by staff with infection prevention and control expertise and responsibility.

9.1 Patient Placement

- Single, non-carpeted rooms, with ensuite facilities are recommended.
- A clinical hand basin should be inside, or in close proximity to, the room.
- If there are two or more cases and no single rooms are available, shared cohorts of confirmed VRE positive cases can be established.

9.2 Room Preparation

- Remove all non essential equipment.
- Ensure impermeable mattress and pillow covers are intact.
- Patient charts shall be left outside the patient room.
- Personal protective equipment (PPE) supplies are to be available outside the room or in the ante room, if present (refer 10.4 for PPE requirements).
- Signage advising of contact precautions shall be evident outside the room.

9.3 Hand Hygiene

- All patients and visitors shall be advised (via signage) of the importance of performing hand hygiene. Alcohol-based hand rubs (ABHRs) shall be made available for their use.
- HCWs shall use an ABHR or antiseptic hand wash for all hand hygiene.
- All HCWs shall perform hand hygiene in accordance with the ‘5 moments of hand hygiene’ standard.
- In addition, the requirements for performing hand hygiene associated with donning and removing PPE shall be followed. Hand hygiene must always be performed after removal of gloves.
- Gloves are not a substitute for hand hygiene and improper use of gloves has been associated with VRE transmission.
9.4 Personal Protective Equipment

- Contact precautions require the HCW to don gown and gloves prior to entering a room if contact with the patient or environment is anticipated.
- Disposable long-sleeved, fluid resistant gowns are preferred. If not available, utilise cloth gowns with the addition of a plastic apron. All gowns / aprons are for single use only and are not to be left hanging in the patient’s room for use on subsequent occasions.
- When gloves are worn, avoid touching and therefore contaminating environmental surfaces e.g. light switches, door handles.
- Prior to leaving the patient’s room, gown and gloves are to be removed and hand hygiene performed.
- As per standard precautions, masks and eyewear are required in addition to gown and gloves whenever there is potential for exposure to blood and / or body fluids.

9.5 Patient Equipment

- Disposable, single-use patient care equipment is preferred, whenever possible.
- Dedicate non-critical items to the patient’s room e.g. stethoscope.
- Minimal stocks of disposable items e.g. dressings, kidney dishes, are to be stored in the room. On patient discharge, these items are to be discarded.
- Equipment that is designated reusable and required for use on other patients shall be cleaned with detergent and disinfected prior to leaving the room.
- Alcohol disinfectant wipes may be used for specialised medical equipment e.g. x-ray and ECG machines.
- Items requiring further reprocessing e.g. sterilisation shall be processed as per normal.
- Used bedpans / urinals / measuring jugs shall be sanitised in a pan sanitiser immediately following use, or disposed of in a macerator.
9.6 Environmental Cleaning

Persistence of environmental reservoirs of pathogens during outbreaks is related to a failure to follow recommended cleaning procedures rather than specific cleaning and disinfectant agents. For effective environmental disinfection, physical cleaning with detergent and thorough application of the disinfectant that allows for adequate contact time with the surfaces is required. Physical cleaning is very important, whether two-step (detergent then disinfectant) or 1-step (detergent plus disinfectant in the one product) disinfection is employed.

- Cleaning regimens shall ensure the room is cleaned on a daily basis using detergent and a chlorine-based disinfectant. Increased cleaning is recommended if the patient has risk factors for dissemination, such as diarrhoea or discharging wounds.
- When VRE-positive patients are co-horted, it is recommended shared bathrooms and toilet facilities are cleaned twice daily.
- Disposable single-use cleaning equipment shall be used when available.
- Cleaning equipment should be dedicated to the patients room e.g. mop bucket and cleaned and disinfected after each use. If re-useable mop heads are used they shall be bagged and sent for laundering at the completion of each use.
- Two-step cleaning, using a neutral detergent followed by the use of a chlorine-based disinfectant, or a one-step clean using a 2-in-1 product that contains detergent and a chlorine based disinfectant is to be used.
- Chlorine-based solutions are to be utilised at a dilution of 1000ppm of sodium hypochlorite.
- On patient discharge:
  - any unused / unopened disposable medical items in the patients rooms shall be discarded and unused linen sent for laundering
  - patient bed screens (and window curtains, if fitted) shall be sent for laundering / dry cleaning
  - a disinfectant clean that utilises detergent and a chlorine-based solution is to be used
  - the room can be used immediately after cleaning, once surfaces are dry.
9.7 Use of Disinfectants

- As disinfectants are inactivated by organic material, any visible soiling should be removed with paper towels prior to cleaning.
- Information on how to prepare and use the disinfectant and relevant material safety data sheets (MSDS) shall be available to cleaning staff.
- Automated dispensing systems for chlorine-based solutions should be considered.

9.8 Patient Transfers

- VRE status must not compromise patient management.
- Patients with VRE shall not be refused admission to any HCF or RCF based on their VRE status.
- Regarding internal transfers:
  - avoid unnecessary transfers of VRE positive patients within the hospital
  - notify receiving departments of patient’s VRE status prior to transfer
  - whenever possible, place VRE positive patients last on procedural lists to allow time for adequate cleaning and disinfection of the environment and equipment.
- Regarding external transfers to private, public or RCFs:
  - the transferring facility shall notify the receiving HCF or RCF prior to the transfer of VRE positive patients or VRE contacts that have yet to be cleared to ensure appropriate bed management occurs
  - all relevant medical and nursing documentation accompanying the patient must clearly state details of the patient’s VRE history and include their risk assessment for VRE transmission.

9.9 Linen

- Standard precautions apply.
- Stockpiling supplies of linen in the patient’s room is not to occur and any unused linen is to be sent for laundering and not returned to general use.

9.10 Crockery and Cutlery

- Standard precautions apply.
9.11 Waste Disposal

- Standard precautions apply.

9.12 Laboratory Specimens

- Standard precautions apply.

9.13 Visitors

- Visitors are to be instructed to perform hand hygiene prior to entering, and on leaving, the patient’s room. No protective clothing is required to be worn by visitors.

9.14 Duration of Precautions

- Precautions are to continue for the length of the patient stay.

9.15 Patient Discharge

- All VRE-positive patients are to be provided with education (both verbal and written) on the risk of transmission of VRE, the importance of notifying health care providers of their status, and should be made aware of their possible lifelong carriage of VRE.

- It is recommended that acute care HCFs with VRE contacts who are discharged prior to clearance screening being performed notify the patient of their status and the need for screening should they be readmitted to a HCF within the next 12 months.

9.16 Care of the Deceased

- Standard precautions apply.
10. Management of VRE-Positive Patients (Specific Settings)

10.1 Hospital non-inpatient settings

- These include departments where the patient is not admitted to the facility overnight and invasive services are provided e.g. emergency, day surgery, endoscopy and radiology.
- Standard precautions apply for all patients in all non-inpatient settings, including the requirements for HCWs to comply with hand hygiene policies.
- Any patients colonised or infected with VRE shall be directed to perform hand hygiene with an ABHR prior to entering the area.
- If risk factors for transmission are present (refer page 3) the patient shall be physically separated from other patients, if this can be achieved without affecting the provision of care.
- On discharge, all surfaces contacted by the patient should be cleaned using a 2-step clean or a 1-step clean with a 2 in 1 product (see section 9.6).

10.2 Haemodialysis units

- Haemodialysis patients are a known higher-risk group for both colonisation and infection with VRE. An individual risk assessment shall be completed for each VRE-positive haemodialysis patient to identify risk factors for transmission (refer page 3).
- Routine screening shall be performed on all haemodialysis patients as described in section 1.2.
- The most recent screening result must be made available to the receiving facility when patient transfers occur between haemodialysis units.
- Infection prevention and control strategies described in section 9 are applicable in haemodialysis units with adjustments as described in Table 1.
10.3 Acute care mental health facilities

- The number of acute mental health patients that would require routine screening i.e. those hospitalised outside of WA in the last 12 months, is thought to be low. However, the rationale for the introduction of this screening is the higher prevalence of VRE in HCFs outside of WA and therefore routine screening as described in section 1.1 applies in this setting. However, screening may not be possible due to valid consent issues or a patient’s mental capabilities. Consideration should be given on an individual basis and risk assessment approach.

- Management of any VRE-positive patient in this setting needs to be based on an individual patient risk assessment by the HCFs infection prevention and control personnel. Where possible, the procedures outlined in this document should be followed to reduce the transmission between patients as transfer of acutely ill mental health patients to higher-risk hospital units may occasionally occur.
Table 1 Management of VRE-Positive Patients in Haemodialysis Units

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Does the Patient have Risk Factors for Transmission</th>
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<tbody>
<tr>
<td></td>
<td>No</td>
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<tr>
<td>Patient Placement</td>
<td>Open dialysis area</td>
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<tr>
<td></td>
<td>Place clean sheet over dialysis chair</td>
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<td></td>
<td>Hand basin in close proximity</td>
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<td></td>
<td>If multiple patients - cohort in adjoining bays and allocate to one nurse.</td>
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<tr>
<td>Patient Scheduling</td>
<td>Consider dialysing patient on the last session for the day to allow for adequate time to perform environmental cleaning.</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>If hands are visibly soiled - wash with soap and water, otherwise use an antiseptic hand wash or ABHR for all hand hygiene.</td>
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<tr>
<td>Toilet Facility (Shared Use)</td>
<td>Ensuite unavailable or unable to dedicate a toilet for VRE positive patient:</td>
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<td></td>
<td>instruct patient to close toilet lid after use and prior to flushing to minimise environmental contamination by aerosols</td>
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<td></td>
<td>the toilet is to be cleaned and disinfected prior to use by other patients.</td>
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<tr>
<td>Environmental Cleaning</td>
<td>Following discharge of a VRE positive patient from the unit:</td>
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<td>ensure any reusable patient equipment is cleaned and disinfected prior to reuse on another patient</td>
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<td></td>
<td>ensure dialysis chair / bed and all patient associated surfaces are disinfectant cleaned prior to use by another patient.</td>
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</tbody>
</table>
What are Enterococci?
Many people carry bacteria called enterococci in their bowel and it causes no illness. Sometimes enterococci can find their way into other parts of the body and cause an infection, most often in people whose ability to fight infections is low e.g. cancer patients, dialysis patients.

What are VRE?
VRE stands for Vancomycin Resistant Enterococci.

Vancomycin is an antibiotic that can be used to treat enterococci infections. VRE are enterococci strains that have become resistant (no longer killed by) to vancomycin. There are other antibiotics that can be used to treat VRE.

People who carry VRE are described as being ‘colonised’. They usually have no symptoms and experience no ill-effects. The VRE live harmlessly in the bowel or on the skin. VRE colonisation is not a problem for most patients. However, VRE can cause infections in very sick patients. So it is important to prevent VRE from spreading within our hospitals.

How are VRE spread?
VRE are usually spread from person-to-person by physical contact, either directly from the hands of another person or from medical equipment. It is not spread through coughing or sneezing.

How can the spread of VRE in hospitals be prevented?
All hospitals have infection prevention and control policies in place to address this. Prevention depends on encouraging good hand hygiene practices amongst staff, visitors and patients and ensuring thorough cleaning of the hospital. Another way hospitals ensure VRE does not spread is by early identification of patients by the use of a computer ‘alert’ system.

What is the computer ‘alert’ system?
If it is found that you are carrying VRE, an ‘alert’ will be placed on your name in the computer system that can be seen at all the public hospitals in WA. This alerts the staff at the time of your admission that extra precautions may be required during your stay.

As there is no method for this information to be shared with WA private hospitals or hospitals outside WA, it is important you tell these health providers that you have acquired VRE.

What are the extra precautions?
These are referred to as ‘contact precautions’ and are implemented to reduce the risk of staff ‘picking up’ VRE and transferring it to other patients. They include being placed in a single room and the use of gown and gloves during ‘hands-on’ care. These precautions will not interfere with your treatment or the quality of care provided to you.

Can people with VRE have visitors?
VRE does not harm healthy people, including pregnant women, children and babies. Visitors need to wash their hands or use an alcohol-based hand rub before and after visiting. At home, continue with normal hygiene practices.

What happens when I am discharged from hospital?
Carrying VRE will not affect other members of your family or friends, provided that you have good hygiene practices, e.g. washing hands before eating or after going to the toilet.

Where can I get further information or advice?
You can obtain further information about VRE by talking to your general practitioner or hospital doctor and/or the hospital Infection Prevention and Control Nurse.