

**Monday December 12, 2011 Session: 10:00 a.m.**

**Is the presentation available to print off?**

*All of the presentations are available on the PHO website.*

**Could the link to QMP LS as I am not familiar with this organization**

*The link to QMP-LS is available on the PHO website however you will need to be an accredited laboratory to access the site with the guidance document. We recommend that you contact your laboratory to ensure that they have this information.*

**What does CLSI stand for?**

CLSI stands for Clinical Laboratory Standards Institute. One of the mandates of CLSI is to establish antibiotic break-point susceptibility for laboratories

**Will you be suggesting a screening tool to be used by hospitals?**

*We recommend that facilities use the screening tool that is currently in use for ARO. Individuals should be screened based on risk. We will not be providing a list of countries since this list is constantly changing and relying on a list of countries may result in the facility missing some individuals.*

**Will this be tailored for Long term care facilities?**

*The information in Annex A of the PIDAC-IPC best practice document is intended for use by all health care settings.*

**What are the screening expectations for CCC and rehab facilities?**

*At this point in time the focus is on understanding the incidence in acute care settings. You will need to speak with your referring agencies to understand what the incidence is in their setting.*

**What would be the role for private labs and what is meant by voluntary?**

*Private labs should follow the protocols for identification of CRE as defined by QMP-LS. The decision on submitting isolates to PHO Laboratory is a voluntary one that will be made by each laboratory. In order to fully understand the epidemiology of CRE in Ontario we rely on each laboratory to engage in this surveillance initiative however this has not been designated as a reportable disease so we cannot mandate participation.*

**Are patient consent and privacy issues for this voluntary reporting addressed? Do hospitals have to individually approach their REBs to participate?**

PHIPA s.39(2)(a.1) authorizes a Health Information Custodian to disclose personal health information (“PHI”) specifically to OAHPP if the disclosure is made for a purpose of the *Ontario Agency for Health Protection and Promotion Act (OAHPPA)*.

As outlined Dr. King’s letter the PHI disclosed by the Health Information Custodians is consistent with the mandate of Public Health Ontario as described in its legislation. More specifically:

- to provide scientific and technical advice and support to the health care system to protect and promote the health of Ontarians,
- to develop, disseminate and advance public health knowledge, best practices,
- to develop, collect, use, analyse and disclose data, including population health, surveillance and epidemiological data.

Further, OAHPP has in place appropriate technical, administrative and physical safeguards to ensure the security of the PHI in its custody.

**How soon do you expect the online reporting by ICPs come into force? Meanwhile what would be the process?**

*We are working with PHO IT services to implement the online surveillance form as quickly as possible however this may take several months. In the meantime, hospitals are asked to submit the information to the confidential fax number identified on the surveillance tool on the PHO website .*

**You mentioned screening with ertapenem >1 ..is this a standard breakpoint on commercial panels?**

Most of the commercial susceptibility panels have ertapenem drug that includes this breakpoint. Labs will have to check whether the panel they are currently using contains this breakpoint.

**If we receive a preliminary report should we put in contact precautions if not already done so. Also would PHO request information at this time from ICP's?**

*Contact precautions should be initiated as soon as a preliminary report is received if the patient is not already on precautions. PHO will only request information when the CRE has been confirmed and a final report received.*

**How long will it take for a confirmation? Will it clearly indicate if it is inducible or not transmissible?**

Depending on when and where isolates are submitted, confirmation will take from 2 to 5 business days. To ensure faster turnaround time, it is important to provide as much information as possible when submitting isolates. The report will not state whether AmpC is inducible or transmissible.

**What is the role for Public Health Units regarding this surveillance program? Will hospitals be expected to notify their local public health if they have positive results?**

*Public health units will be a resource to facilities however this is not a reportable disease so while we would encourage a dialogue between the hospital and the health unit, hospitals are not required to notify the public health unit of a positive result.*

**Do all PHO labs have PCR capability for CRE testing, or is it just the Toronto lab?**

*Testing will be done at the PHO laboratory in Toronto only.*

**Presumably all sample types will have to be screened ...or clinically significant sites only?**

It is recommended that all sample types that have *Enterobacteriaceae* be screened for CRE

**What are the clinical manifestations?**

*The clinical manifestations would be typical of the site of infection if the patient has an infection with a CRE. Most patients are colonized and would not present with any symptoms.*

**How will we alert what facilities in GTA/Ontario have CRE cases? I understand that this is part of the screening question.**

*Screening should be based on risk factors rather than country or location. Similarly to screening for any ARO the patient should be asked if they have been an inpatient in a facility where there has been an outbreak.*

**When PHL confirms CRE, is the hospital lab to enter the confirmation into the hospital lab system computer when it is received?**

The submitting laboratory will receive results back on specimens they submit for CRE confirmation. They will enter the results as per their protocol.

**Can a single rectal swab be used for MRSA, VRE and CRE detection?**

It is possible to use same single rectal swab for MRSA, VRE and CRE detection.

**If one carbapenemase is detected in an inpatient unit, does it warrant a CRE prevalence?**

Yes.

**Is this being done nationally as well?**

*The Canadian Nosocomial Surveillance Program has done surveillance on CRE in their member hospitals however we are looking for Ontario specific data.*

**Would a MacConkey plate with a CPD disc be an adequate screen?**

We are not aware of any study that shows MacConkey plate with CPD disc would be an adequate screen method for detecting CRE. Labs that wish to use this method would have to validate and verify this assay.

**Do you have any information regarding Pseudomonas/ Acinetobacter species? Also, we currently use Ertapenem disk for prelim testing, (you solely referred to MEM). Is this acceptable?**

Use of ertapenem to screen for CRE would result in more false-positives. In order to minimize false-positive isolates it is recommend that meropenem be used to screen for CRE isolates.

**If all carbapenemases are ESBLs, can you use the ESBL+ well on the vitek card to screen, instead of putting up a MERO disc on all gnr?**

All CRE organisms are ESBL. However not all ESBL+ positive organisms are CRE. Using ESBL screen test from vitek card to detect CRE will result in more false positive isolates. As a result, meropenem is recommended for detection of CRE.

**Are the MIC's on the Vitek cards the right range to pick up CRE's?**

Currently, ertapenem MIC ranges on Vitek card can be used to screen CREs. However, it is recommended that you further screen ertapenem resistant isolates with meropenem.

**What is the recommended plate to use for screening CRE. Is enrichment recommended for screening?**

ESBL selective plates commercially available can be used to screen for CRE organisms. At this point enrichment method is not recommended as this adds extra step which is thought to be unnecessary for detection of CRE.

**For the screening of high risk patients, how do we know which hospital (s) in Ontario have it in their facility?**

*At this point in time we do not have this information. That is why we are trying to understand the actual epidemiology of this within the province.*

**How do you interpret a Negative PCR ?**

PCR negative results should be interpreted as per QMP-LS guidelines.

**Is CRE testing replacing ESBL testing?**

No, CRE is not replacing ESBL testing as not all ESBL positive organisms will be CRE. Therefore, ESBL screening should be continued as per your policy.