1. Introduction

The Newcastle upon Tyne Hospitals (NuTH) NHS Foundation Trust recognises that the effective prevention and control of healthcare associated infection (HCAI) is essential to patient and staff safety and to the overall performance of the organisation.

1.1. Carbapenemase-producing Enterobacteriaceae:

Enterobacteriaceae are a large family of bacteria that usually live harmlessly in the gut of all humans and animals. However, these organisms are also some of the most common causes of opportunistic urinary tract infections, intra-abdominal and bloodstream infections. They include species such as Escherichia coli, Klebsiella spp. and Enterobacter spp.

Carbapenems are a valuable family of antibiotics normally reserved for serious infections caused by drug-resistant Gram-negative bacteria (including Enterobacteriaceae). They include meropenem, ertapenem, imipenem and doripenem. carbapenemases are enzymes that destroy carbapenem antibiotics, conferring resistance. They are made by a small but growing number of Enterobacteriaceae strains. There are different types of carbapenemases, of which KPC, OXA-48, NDM and VIM enzymes are currently the most common.

Countries and regions with reported high prevalence of healthcare-associated carbapenemase-producing Enterobacteriaceae

Bangladesh
The Balkans
China
Cyprus
Greece
India
Ireland
Israel
Italy
Japan
North Africa (all)
Malta
Middle East (all)
Pakistan
South East Asia
South/Central America
Turkey
Taiwan
USA

This is not an exhaustive list; admission to any hospital abroad should be considered when making a risk assessment. Lack of data from a country not
included in this list may reflect lack of reporting / detection rather than lack of a carbapenemase problem (which may additionally contribute to an under-estimation of its prevalence).

Many areas outside the North East of England have also seen significant problems

2. Scope

This policy applies to all healthcare professionals working across acute services within NuTH; this includes medical staff, nurses, allied health professionals, students and temporary clinical staff working in the Trust or those working in the Trust from other organisations.

3. Aim

The aim of this policy is to minimise the risk of transmission of carbapenemase-producing Enterobacteriaceae within the Trust and to ensure that appropriate infection prevention control measures are taken when caring for patients colonised or infected with these organisms.

Policy Summary:
- Early recognition and risk assessment of patients colonised or infected with carbapenemase-producing Enterobacteriaceae.
- Procedures to be followed to prevent spread of these organisms including screening, isolation and other infection control precautions.
- Actions to be taken in the event of an outbreak
- Patient information leaflet.

4. Duties - Roles and Responsibilities

4.1 The Chief Executive has overall responsibility for implementation, monitoring and review of this policy. This responsibility is delegated to the Director of Infection Prevention and Control (DIPC).

4.2 The Infection Prevention and Control Committee (IPCC) will review and ratify the policy and any new evidence base within the time frame set out in the policy.

4.3 Strategy and operational decisions on prioritisation of infection prevention and control issues and resource allocation will be made by the IPCC via the Infection Prevention and Control Operational Group, with advice from the DIPC, and where necessary referred to the Trust Board.

4.4 The Infection Prevention and Control (IPC) Team is responsible for providing expert advice in accordance with this policy, for supporting staff in its implementation, and assisting with risk assessment where complex decisions are required.

4.5 Patient Services Co-ordinators (PSC) in collaboration with clinical staff and the IPC team are responsible for ensuring patients are placed in accordance
with this policy. In any situations where safe placement cannot be achieved this will be escalated to site IPC Doctor, DIPC and Senior Nursing Team where appropriate.

4.6 On–Call Managers are responsible, in the out-of-hours period, for providing senior and executive leadership to ensure implementation of this policy, and for ensuring infection risks are fully considered and documented when complex decisions need to be made regarding capacity and patient flow.

4.7 It is the responsibility of the Trust to ensure that policies, education, training and procedures are in place to minimize the risk of infection.

4.8 It is the responsibility of all staff to ensure that they understand and implement this policy and attend training sessions as specified in their role.

5. Definitions

**Carbapenemases:**
Enzymes (such as KPC, OXA-48, NDM and VIM) produced by some bacteria which cause destruction of the carbapenem antibiotics, resulting in resistance

**Close contact:**
A person living in the same house; sharing the same sleeping space (room or hospital bay); or a sexual partner

**Colonisation:**
The presence of micro-organisms living harmlessly on the skin or within the bowel and causing no signs or symptoms of infection

**Rectal swab:**
A rectal swab is a specimen taken by gently inserting a swab inside the rectum 3-4cms beyond the anal sphincter, rotating gently and removing. Normal saline can be used to moisten the swab prior to insertion. The swab should have visible faecal material to enable organism detection in the laboratory. A rectal swab should not be mistaken for a perineal swab.

6. Early recognition of individuals who may be colonised / have an infection

On admission, all patients must be asked if they have been in hospital overseas or outside the North East of England (in the last 12 months)

If the patient answers yes and is considered to meet the criteria for being a suspected case of carbapenemase-producing Enterobacteriaceae colonisation or infection (as applicable) then immediate isolation is required.

PLUS
- instigation of strict standard precautions to prevent possible spread
- screening to assess current status for colonisation or infection
- assessment for appropriate treatment (applies to infection only)
7. Early detection – screening of suspected cases and contacts

If the patient meets criteria for a suspected case of infection or colonisation with carbapenemase-producing Enterobacteriaceae

Screen the Patient:

Immediately arrange for the patient to be screened within 24 hrs of admission to the Trust- provide explanation & factsheet (Appendix 1). When explaining procedures and information it is particularly important, where required, to work with interpreters, other communication support and provide information in a format that patients can understand.

What Samples To Take:

Rectal swab or stool sample.
Using a charcoal swab, obtain a rectal swab by gently inserting a swab inside the rectum 3-4cms beyond the anal sphincter, rotating gently and removing. Normal saline can be used to moisten the swab prior to insertion. The swab should have visible faecal material to enable organism detection in the laboratory. A rectal swab should not be mistaken for a perineal swab. Also include samples from any wounds and device-related sites.

Screening of Contacts:

Provide leaflet to contacts (Appendix 1) and undertake screening for contacts of a positive case based on the likelihood of exposure as follows:

- Screening of patients in the same bay is NOT normally required if the case was identified on admission and isolated immediately.
- Screening of patient contacts of a confirmed positive case MUST be undertaken if the case had spent time (or remained) in an open ward or bay with other patients before (or despite) having a positive result for carbapenemase-producing Enterobacteriaceae.
- Screening of household contacts and healthcare staff is NOT required.

7.1. Acting on Results of Sample - (Appendix 2)

If results from admission swab are NEGATIVE (Day 0) the patient should remain in isolation until a further two consecutive samples test negative.

Screening Schedule: Samples being taken 48 hours apart i.e. day 0, day 2 and day 4.

Once 3 negative swabs have been obtained the patient can be transferred out with no further screening required. The patient should be advised / supervised to practice good hand hygiene. If there is pressure on side rooms and need to move the patient out of isolation, discuss with IPC team.

Should any sample test POSITIVE – manage patient as positive case.

If any of the swabs are POSITIVE
The patient should remain in isolation, preferably for the duration of their hospital stay.

Whilst in hospital, weekly screening samples (rectal swabs) are advised.

Ensure patient, and family/carers (as appropriate), have been informed of positive result and factsheet (appendix 1) provided.

Ensure patient’s electronic records are flagged with positive result.

Ensure that information about positive result is included on all transfer/admission documents.

Careful risk assessment is required should it be deemed necessary to consider removing a previously positive or a colonised patient from isolation. A patient with an infection should not be removed from isolation. It is the responsibility of the clinical team to discuss with the IPCNs about when to cease isolation.

A previously positive individual with subsequent negative screening results can revert to a positive state, especially after a course of antibiotics.

OUTPATIENTS AND RENAL DIALYSIS PATIENTS: Known positive outpatients should be planned at the end of the day’s list; known positive renal dialysis patients must be isolated.

FOR CONTACTS: If screening is indicated:

- It is not necessary to isolate contacts whilst awaiting screening results – cohort such contacts if possible and/or reiterate strict hand hygiene for staff and patients.
- Screen all patients in the bay (or ward, if patient has occupied more than one bay) on a weekly basis for a period of 4 weeks after the last case was detected.
- Restrict screening to patient contacts remaining in hospital.

However, should any contact screen Positive, manage as positive case. AND if any further screening is required this will be decided by the IPC and Health Protection team.

7.2. Early instigation of effective infection prevention and control (IP&C) measures

Strict standard precautions must be practiced (whether the patient has infection or colonisation) including:

- Good hand hygiene especially after using the toilet.
- Where any part of a staff uniform, not protected by an ordinary apron, is expected to come into contact with the patient, a long-sleeved disposable gown should be used e.g. when assisting movement for a dependent patient.
- Use of personal protective equipment (PPE) in line with standard precautions.
- Environmental cleaning and decontamination, with an enhanced focus on frequent cleaning of hand contact areas.
ENSURE THAT:

1. All staff fully understand isolation procedures and adhere to standard precautions as a norm including:
   - hand hygiene [Hand Hygiene Policy]
   - personal protective equipment [Standard Precautions Policy]
   - ANTT
   - laundry management [Laundry Management Policy]
   - safe use of sharps
   - waste disposal (especially faeces)

2. Scrupulous IP&C practices are emphasised as being particularly important when using and caring for devices / equipment such as:
   - intravenous / peripheral line
   - central venous catheter line
   - urinary catheter
   - ventilators
   - renal dialysis equipment
   - enteral feeding equipment
   - colostomy or ileostomy
   - any re-usable diagnostic equipment

NOTE: Type 5-7 stools (for any reason) increase the risk of spread of the bacteria from the gut, therefore:
   - observe strict IP&C measures
   - provide assistance to patients where effective hand hygiene is in doubt

8. **Effective Treatment**

Appropriate advice will be provided by Microbiology.

No antibiotic treatment is required for colonisation

If the patient develops an infection: ensure treatment is started promptly, guided by susceptibility results

9. **Cleaning and Decontamination**

Carbapenemase-producing Enterobacteriaceae can be eliminated from the environment by stringent application of normal standards of cleaning and decontamination

Please refer to the following policies
   - [Cleaning and Disinfection Procedure]
   - [Cleaning and Environmental strategy]
   - [Decontamination of Healthcare equipment following Patient use and or prior to service or repair]
   - [Decontamination of the patient environment including Terminal and Deep cleaning]
   - [Decontamination Strategy]
10. **Early communication on discharge or medical transfer of patients**

Ensure good communication with receiving organisations prior to patient transfer or discharge and with all healthcare professionals along the patient pathway.

INCLUDE

The family/carers and/or care facility to which the patient is to be discharged providing an accurate explanation of risk in a non-acute/ community setting, IP&C management advice and an opportunity for questions.

11. **Training**

All staff working on Trust premises, including Trust employed staff, agency and locum staff are responsible for accessing IPC Policies via the intranet in order to assist in the management of their patients.

The basic IPC principles are incorporated in to all statutory and mandatory IPC e-Learning training programmes; CPE management is incorporated into IPC Level 2. It is the responsibility of the departmental/service lead to ensure that training is offered to all relevant staff in relation to CPE.

12. **Equality and Diversity**

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. This policy has been appropriately assessed.

13. **Monitoring**

<table>
<thead>
<tr>
<th>Standards</th>
<th>Monitoring and audit</th>
<th>By Committee</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients will be risk assessed within 24 hrs of admission to the Trust</td>
<td>audit</td>
<td>IPCC</td>
<td>yearly</td>
</tr>
<tr>
<td>Immediate isolation</td>
<td>Isolation audits</td>
<td>IPCC</td>
<td>yearly</td>
</tr>
<tr>
<td>All patients meeting the risk criteria to be screened (rectal swab)within 24 hrs of admission to the Trust</td>
<td></td>
<td>IPCC</td>
<td>yearly</td>
</tr>
<tr>
<td>Insert e-record flag for positive results</td>
<td></td>
<td>IPCC</td>
<td>yearly</td>
</tr>
</tbody>
</table>

14. **Consultation and Review**

Widely discussed with consultant microbiologists, IPCNs and members of the Infection Prevention and control committee.
15. Implementation (including raising awareness)

Plan to implement guidelines through meetings with individual directorates

16. References

- PHE carbapenemase producing Enterobactereaciae toolkit. 

17. Associated documentation

- Cleaning and Disinfection Procedure
- Cleaning and Environmental strategy
- Decontamination of Healthcare equipment following Patient use and or prior to service or repair
- Decontamination of the patient environment including Terminal and Deep cleaning
- Decontamination Strategy
- Hand Hygiene Policy
- Laundry Management Policy
- Major Outbreaks of Infection: Investigation and Control Policy
- Standard Precautions Policy
What does ‘carbapenemase-producing Enterobacteriaceae’ mean?
Enterobacteriaceae are bacteria that usually live harmlessly in the gut of humans. This is called ‘colonisation’ (a person is said to be a ‘carrier’). However, if the bacteria get into the wrong place, such as the bladder or bloodstream they can cause infection. Carbapenems are one of the most powerful types of antibiotics. Carbapenemases are enzymes (chemicals), made by some strains of these bacteria, which allow them to destroy carbapenem antibiotics and so the bacteria are said to be resistant to the antibiotics.

How will I be screened for carbapenemase-producing Enterobacteriaceae?
Screening usually entails taking a rectal swab by inserting it just inside your rectum (bottom). Alternatively, you may be asked to provide a sample of faeces. The swab / sample will be sent to the laboratory and you will normally be informed of the result within two to three days. If the result is negative, the doctors or nurses may wish to check that a further two samples are negative before you can be accommodated on the main ward. These measures will not hinder your care in any way. If all results are negative no further actions are required.

Does carriage of carbapenemase-producing Enterobacteriaceae need to be treated?
If a person is a carrier of carbapenemase-producing Enterobacteriaceae (sometimes called CPE), they do not need to be treated. However, if the bacteria have caused an infection then antibiotics will be required.

How can the spread of carbapenemase-producing Enterobacteriaceae be prevented?
Accommodating you in a single room helps to prevent spread of the bacteria. Healthcare workers should wash their hands regularly. They will use gloves and aprons when caring for you. The most important measure for you to take is to wash your hands well with soap and water, especially after going to the toilet. You should avoid touching medical devices (if you have any) such as your urinary catheter tube and your intravenous drip, particularly at the point where it is inserted into the body or skin. Visitors will be asked to wash their hands on entering and leaving the room and may be asked to wear an apron.

What about when I go home?
Whilst there is a chance that you may still be a carrier when you go home quite often this will go away with time. No special measures or treatment are required; any infection will have been treated prior to your discharge. You should carry on as normal, maintaining good hand hygiene. If you have any concerns you may wish to contact your GP for advice.

Before you leave hospital, ask the doctor or nurse to give you a letter or card advising that you have had an infection or been / are colonised with carbapenemase-producing Enterobacteriaceae. This will be useful for the future and it is important that you make health care staff aware of it. Should you or a member of your household be admitted to hospital, you should let the hospital staff know that you are, or have been a carrier and show them the letter / card.

Where can I find more information?
If you would like any further information please speak to a member of your care staff, who may also contact the Infection Prevention and Control Team for you. The Public Health England website is another source of information: http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/CarbapenemResistance/
Appendix 2

### A.1 Acute trust – patient admission flow chart for infection prevention and control (IP&C) of carbapenemase-producing Enterobacteriaceae

As part of the routine admission procedure, assess all patients on admission for carbapenemase-producing Enterobacteriaceae status.

**No known risk:** Screening not required. Send routine clinical microbiological samples as clinically indicated.

**Carbenpemase-producing Enterobacteriaceae identified in a routine clinical sample?**

- **YES:** therefore...
  - **Result: Presumptive positive**
    - Laborotory: Save isolate and send to AMRHL reference laboratory.
    - Confirms positive?
      - **YES**
        - Can be removed from isolation (unless another reason for continuing isolation). No further action.
      - **NO**
        - All samples negative but previously known positive?
          - **YES**
            - Note: Previously positive individuals with subsequent negative screen can revert to a positive state, especially after a course of antibiotics – careful risk assessment is required if removing from isolation.
          - **NO**
            - Patient should remain in isolation until a further two consecutive samples test negative – samples being taken 48 hours apart (ie Day 0 [initial sample], day 2 and day 4).

- **NO**

**Recent laboratory confirmation (ie during this admission episode or confirmed at the transferring healthcare facility) treated as positive case (see below)**

**Patient is suspected* case of colonisation or infection**

- Take rectal swab & isolate patient (with en-suite). Apply strict standard precautions.

**Result Negative**

1. **A suspected case** is defined as a patient who, in the last 12 months, has been (a) an inpatient in a hospital abroad or (b) an inpatient in a UK hospital which has problems with spread of carbapenemase-producing Enterobacteriaceae (if known) or (c) is a previously positive case (see 1.5 and Card A.2).
2. There should be visible faecal material on the swab. Alternative is stool sample (see Card A.4).
4. Except if it is a repeat isolate of same species with same antibiogram (see SOP reference Card B.1).
5. Should any sample test positive, treat as positive.
6. See Section C for patient information leaflets.
7. Refer to template (see Card B.1).
8. See Card B.3 for outbreak checklist.
9. Screen any current inpatient contacts who shared an open ward/bay with non-isolated case (see Card A.4).
10. See Card B.4 for Inter-healthcare transfer.

*Inform IPC team & clinicians immediately

*Inform patient of infection/case status

*Flag patient notes with result

*Institute Carbapenemase-producing Enterobacteriaceae IP&C Plan

*Consider convening incident/outbreak control team

*Identify and screen contacts as indicated

*Review clinical management including use of antimicrobials and devices (whether latter required)

*Maintain robust communications

*Communicate patient's positive status to GP and other community care providers on discharge/transfer.
Appendix 3

Planning checklist for hospital / trust Infection Prevention & Control (IP&C) teams for the management of an outbreak, suspected outbreak or cluster of cases colonised or infected with carbapenemase-producing Enterobacteriaceae

1) **Early communications**
   Ensure senior managers, the board, and key senior clinical / ward staff are made aware of the case(s)

2) **Instigation of immediate control measures**
   Immediately refer to your dedicated plan for the management of carbapenemase-producing Enterobacteriaceae
   Refer to the PHE acute trust toolkit to ensure all early control measures to prevent spread have been instigated

3) **Convene an incident / outbreak control team (OCT) – consisting of:**
   Infection control leads – clinician and nurse
   Microbiologist
   Infectious disease physician (if available / appropriate)
   Trust executive representation
   Clinical representation and senior nurse manager
   Estates / domestic service representation
   Communications department
   Pharmacy / medicines management team
   Senior representative from the local Public Health England (PHE) Centre

4) **OCT review:**
   Line list of cases – produce and maintain an epidemic curve (or running tally for repeat sporadic cases)
   Microbiological investigations to date – diagnostic and screening, plus results
   Epidemiological investigations to date
   Current hypothesis(es) for incident / outbreak / cluster
   Control measures to date and effectiveness, include compliance / audit history
   Antimicrobial practices and compliance to policies
   Staff training and awareness

5) **OCT produce incident / outbreak control plan including:**
   Agreement on leadership, roles and responsibilities
   Frequency of meetings and reporting schedule (may change over time)
   Action plan for ongoing investigations and control measures (include timelines)
   Plans for maintaining and reinforcing enhanced cleaning schedule (increased frequency and terminal cleaning for rooms of affected patients), if evidence of transmission
   Transfer and discharge arrangements for affected patients
   Additional expert advice required
   Consideration of external expert or peer support visit in ‘difficult to control’ outbreaks
   Communications strategy including patients, relatives, the media and additional professionals / organisations.
Appendix 4

Ordering a CPE Screen

Open patient account and select orders from the main menu

Click on the ADD function key to open the search box

The order name is ‘Resistant Organism Screen’
Enter ‘resistant’ and the correct order will appear as so:

Select Resistant Organism Screen and complete the ordering clinician box

Select the swab types
The Newcastle upon Tyne Hospitals NHS Foundation Trust

**Equality Analysis  Form A**

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

**PART 1**

1. **Assessment Date:** 02/12/2014

2. **Name of policy / strategy / service:**
   
   Early detection, management and control of Carbapenemase-Producing Enterobacteriaceae

3. **Name and designation of Author:**
   
   Julie Samuel Consultant Microbiologist, ICD

4. **Names & designations of those involved in the impact analysis screening process:**
   
   Ashley Price DIPC, Louise Hall IPC Matron,

5. **Is this a:**
   
   Policy ✓ Strategy ☐ Service ☐

   **Is this:**
   
   New ✓ Revised ☐

   **Who is affected**
   
   Employees ☐ Service Users ✓ Wider Community ✓

6. **What are the main aims, objectives of the policy, strategy, or service and the intended outcomes?**

   The aim of this policy is to minimise the risk of transmission of carbapenemase-producing Enterobacteriaceae within the Trust and to ensure that appropriate infection prevention control measures are taken when caring for patients colonised or infected with these organisms

7. **Does this policy, strategy, or service have any equality implications?**  Yes X No ☐

   If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:
### Summary of evidence related to protected characteristics

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>Evidence, i.e. What evidence do you have that the Trust is meeting the needs of people in various protected Groups</th>
<th>Does evidence/engagement highlight areas of direct or indirect discrimination? If yes describe steps to be taken to address <em>(by whom, completion date and review date)</em></th>
<th>Does the evidence highlight any areas to advance opportunities or foster good relations. If yes what steps will be taken? <em>(by whom, completion date and review date)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Race / Ethnic origin (including gypsies and travellers)</td>
<td>Provision of Interpreting service E&amp;D Training</td>
<td>Studies show that when interpreters were provided, patients had a better understanding of their diagnoses and treatment plan than patients without interpreters. <strong>Action</strong> Ensure communication support is available.</td>
<td>None</td>
</tr>
<tr>
<td>Sex (male/ female)</td>
<td>Male and female practitioners are available to promote the dignity of patients when required</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Religion and Belief</td>
<td>Chaplaincy service provided with links to leaders of major faiths</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Sexual orientation including lesbian, gay and bisexual people</td>
<td>HIV listening service which is peer listening/support service for people diagnosed HIV positive – provides annual training events to support listening skills.</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Age</td>
<td>Innovations to support people with Dementia</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section</td>
<td>Provision of BSL Signers and Deaf Blind Guides LD Liaison Nurse Links to Psychological and Mental Health Services Involving family is included in the policy</td>
<td>Information in appropriate formats is needed to support effective treatment <strong>Action</strong> Ensure communication support is available.</td>
<td>None</td>
</tr>
<tr>
<td>Gender Re-assignment</td>
<td>Gender Identity sub group to identify and address needs in relation to</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Marriage and Civil Partnership</td>
<td>Gender Identity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------------</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>N/A</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

| Maternity / Pregnancy         | Women’s Health and Maternity Services will support pregnant and nursing mothers who have Tb | none | None |

9. Are there any gaps in the evidence outlined above? If ‘yes’ how will these be rectified?

   No

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

   Do you require further engagement? Yes [ ] No [ ]

11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?)

   No

PART 2

Name: Dr Julie R Samuel

Date of completion: 02/12/2014

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)