National Patient Safety Alert

UK Health Security Agency

Potential contamination of non-sterile alcohol-free skin cleansing wipes with *Burkholderia spp:* measures to reduce patient risk

Date of issue:	26/06/2025	Reference no:	NatPSA/2025/002/UKHSA

This alert is for action by: Acute trusts, private providers/independent treatment centres, ambulance trusts, mental health trusts, community trusts, general practice, hospital and community pharmacy, and other health and care providers using non-sterile alcohol-free skin cleansing wipe products.

This is a safety critical and complex National Patient Safety Alert. Implementation should be co-ordinated by an executive lead (or equivalent role in organisations without executive boards).

Explanation of identified safety issue:

UKHSA is investigating an outbreak of *Burkholderia stabilis* involving individuals across the UK, linked to wipes. Following testing, *Burkholderia spp* (full identification pending) has been recovered from several non-sterile alcohol-free skin cleansing wipes, including those used for wound care and included in first aid kits.

There are currently 48 confirmed cases associated with an outbreak of *B. stabilis* (ST480) in the UK and one case in the Republic of Ireland. Specimen dates are between June 2018 and April 2025. Information from trawling questionnaires (returned for 40 cases) indicates that cases included clinically significant infections (65% of cases) and colonisations (without infection). 77% of case isolates were retrieved from normally sterile body sites (67% from blood). 75% of cases had indwelling intravascular devices or recent line insertion/removals, though cases also presented with skin and wound infections. Cases included individuals with significant co-morbid illness e.g. malignancy (38%) and conditions associated with immunosuppression (42% where information was available). No cases had cystic fibrosis. There are no known attributable deaths to date.

B. stabilis is a species of the *Burkholderia cepacia* complex (Bcc) found in natural environments. Bcc are opportunistic pathogens, rarely causing infection in healthy individuals but can cause severe infections in some groups, including those with cystic fibrosis, immunocompromised patients, and when introduced into normally sterile body sites such as blood. Bcc has been implicated in previous healthcare outbreaks and associated with contamination of healthcare products both in the UK and globally.

Health professionals should be aware that skin cleansing wipes not marked as ‘sterile’ may present risk. Non-sterile alcohol-free wipes should not be used for cleaning of intravascular devices or for care of broken skin including wounds. UKHSA is making recommendations to reinforce good practice to protect patients including those most at risk of significant health consequences from *B. stabilis*.

Actions required

Actions to be completed by 29 August 2025

1. For intravascular access device care: ensure local guidance and practice reflects National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England (EPIC3). Non-sterile alcohol-free wipes are not suitable for this purpose.

2. Ensure that patients in the community with intravascular devices are aware to only use wipes if instructed to by their clinical team. These patients should only use wipes provided or recommended by their clinical team in accordance with (1). Non-sterile alcohol-free wipes are not suitable. All patients with intravascular devices need this information even if they have not been instructed to access their line. Incorporate this into local guidance, patient education and information.

3. Community healthcare providers should advise patients to only use wipes marked as sterile on any broken skin including wounds. Ensure that local guidance, practice and patient information reflects NHS guidance.

4. NHS Trusts and independent sector laboratories are requested to submit any isolate from a new infection with *Burkholderia cepacia* complex, including any new isolations from cystic fibrosis patients to the UKHSA AMRHAI reference laboratory (details provided below).

For any enquiries about this alert contact: hcaiamr.ioig@ukhsa.gov.uk

Additional information:

Further information and resources for healthcare professionals.

1. Healthcare professionals are asked to ensure local guidance and clinical practice is aligned with relevant guidelines for patients with intravascular devices, including:
   - National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England (EPIC3)
   - WHO's (2024) 'Guidelines for the prevention of bloodstream infections and other infections associated with the use of intravascular catheters - Part 1: peripheral catheters'.

2. Wipes used in first aid kits should be individually wrapped and sterile, in compliance with British Standard BS8599-1.

3. Advice for patients:
   - Patients with intravascular access devices who have concerns about their wellbeing or who have queries regarding their care in relation to this alert, should be instructed to contact their clinical team.
   - If patients are acutely unwell, they should seek medical attention via appropriate routes: NHS get medical help advice
   - Symptoms of intravascular line infections can include signs such as fever, chills, and redness, swelling, or pain around the insertion site.
   - Symptoms of infection can include redness, swelling, increased pain, warmth around a wound/break in skin, and pus or other drainage from the wound/break in skin.

Instructions for laboratories regarding submission of isolates

Laboratories are to submit isolates to the AMRHAI reference laboratory using the Healthcare pathogens request form H1 (multiple isolates) or H2 (single isolates) available at AMRHAI reference unit: reference and diagnostic services.

Stakeholder engagement

The following stakeholders have been engaged in the incident management and consulted in the drafting of this alert: NHS England, Department of Health and Social Care, Medicines & Healthcare products Regulatory Agency, Antimicrobial Resistance and Healthcare Associated Infection Scotland (ARHAI) Scotland, Public Health Wales, Public Health Agency Northern Ireland, NHS Supply Chain.

Infection-related hazards	England*
Chemical-related hazards	England & Wales*
Radiation-related hazards	The whole of the UK

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Advice for Central Alerting System (CAS) officers and risk managers

This is a safety critical and complex National Patient Safety Alert. In response to CHT/2019/001 your organisation should have developed new processes to ensure appropriate oversight and co-ordination of all National Patient Safety Alerts. CAS officers should send this Alert to the executive lead nominated in their new process to coordinate implementation of safety critical and complex National Patient Safety Alerts.