

Index No: IPC 22

Detection and Management of Patients Colonised / Infected with MRSA

Part 1 Care of Patients Colonised / Infected with Meticillin **Resistant** *Staphylococcus aureus* (MRSA)

Part 2 Guidance for MRSA screening for all elective surgical and emergency admissions

Part 3 Guidance on diagnosis and management of Panton Valentine Leukocidin (PVL) -associated Staphylococcal infections in the UK

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Index No. IPC 22	Detection and Management of Patients Colonised / Infected with MRSA
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Completion of the following signature blocks signifies the review and approval of this process.

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Change History

Version	Date	Author	Reason
1	2000	Celia Conquest	Update in relation to new guidelines
1.2	2002	Julie Fraser	Review
1.3	2004	Julie Fraser	Review
2	2008	Pam Howe	Update in relation to new guidelines
2.1	2010	Pam Howe	Update in relation to new guidelines
2.2	2011	Pam Howe	Update in relation to new guidelines

Name of Committee	Name of Chairperson	Date of Approval
IC Committee	Mrs Lorene Read CEO KGH FT	

Impact Assessment

Undertaken by	Date
Pam Howe	Aug 2010

A translation service is available for this policy. The Interpretation/Translation Policy, Guidance for Staff (I55) is located on the library intranet under Trust wide policies.

Contents

Section		Page
1,2	Introduction, Aims,	5
3,4,5	Objectives, Definitions, Policy	6
5	Categories of high risk patients	7
	MRSA Isolation precautions	7
	Follow-up of patients colonised with MRSA	8
	Part 2 -Guidance for MRSA screening for all elective surgical / invasive procedure/ investigatory admissions	9
	Justification, Links to standards	10
	Responsibilities	11
	Training, Stakeholders, responsibility of Document Development	13
	References	15
	Appendix 1 MRSA Care plan	16
	Appendix 2 MRSA Weekly/ Monthly screening	19
	Appendix 3 How to use the Body Wash	20
	Appendix 4 MRSA Elective Screening Pathway	22
	Appendix 5 MRSA Patient Information	22
	Appendix 6 MRSA MRSA treatment pathway for positive PEMS	24
	Appendix 7 MRSA Emergency Screening Pathway For all emergency admissions – excluding paediatrics and maternity	25
	Part 3 - Guidance on diagnosis and management of Panton Valentine Leukocidin (PVL) -associated Staphylococcal infections in the UK	27
	Check List	30
	Procedural Document Check List	33
	Race Impact Assessment Tool	35
	Action Plan	42

Detection and Management of Patients Colonised / Infected with MRSA

1 Introduction

The Trust takes its obligations under Equality Legislation very seriously and aims to provide fair and equitable treatment to, and value diversity in, its staff, patients and visitors. In doing so it aims to ensure that its actions and working practices comply with both the spirit and intention of the Human Rights Act (1998) and the forthcoming Equality Act which aims to consolidate existing equality legislation relating to the six strands of diversity i.e. race, gender, disability, religion/faith, sexual orientation and age. This policy is for the benefit of all staff, patients, carers and visitors regardless of their diverse background.

Meticillin-resistant *Staphylococcus aureus* (MRSA) is a potentially pathogenic micro organism, which frequently causes infections in both hospital and the community. (Meticillin – previously known as Methicillin) Coia (2006)

Patients can be colonised or infected with MRSA. Some patients may become colonised with MRSA and can carry this for many months or even years without developing an infection. Coia (2006)

The most common mode of transmission is by direct contact, usually by hands. The use of gloves, aprons and thorough hand hygiene is essential for management of patients known to be infected or colonised with MRSA whilst in hospital.

Direct contact with the patient, bed linen, equipment may lead to transmission to other patients from staff clothing. Duckworth (1998)

Transmission may also occur via dust containing skin squames, therefore direct contact with patient environment could potentially lead to cross infection. Daily cleaning of environment is important as MRSA can survive in dust for many months

MRSA may be found in any clinical specimen taken to aid diagnosis when considering signs and symptoms of infection. These specimens may include wound swabs, urine specimens, sputum etc.

Patients found to be positive to MRSA from blood cultures (MRSA Bacteraemia) will be treated promptly and this episode of infection recorded on the HPA infection data capture system which collates a national record of incidents of this type of infection. Root cause analysis (RCA) will be completed for all MRSA bacteraemia, whether community or hospital attributed to ensure shared learning. In 2004 the Department of Health set a target of a 50% reduction of MRSA bacteraemia nationally within 4 years, which has been achieved.

2 Aims

2.1 To reduce the risk of cross infection between patients by helping to identify those patients most at risk and ensure treatment is implemented in a timely fashion

2.2 To provide the correct and most current information for staff caring for patients with MRSA

3 Objectives

3.1 This policy incorporates all the necessary procedures and guidelines needed so that all patients with MRSA colonisation, infection or at risk of developing MRSA, will receive appropriate treatment or prophylaxis to reduce the risk of infection

4 Definitions

4.1 MRSA - Meticillin-resistant *Staphylococcus aureus*

4.2 Colonisation - an organism living in an environment without causing harm to the host e.g. on the surface of the skin.

4.3 Infection - the presence and multiplication of organisms in the body e.g. wound infections.

4.3 Cohort nursing - Patients with the same infection can be nursed within the same bay, cared for by a group of nurses who do not have contact with other patients.

4.4 KGH FT– Kettering General Hospital Foundation Trust

4.5 ICIS – Integrated Clinical Information System (Lorenzo)

4.6 ICP - Integrated Care Pathway

4.7 ICU – Intensive care unit

4.8 NICU– Neonatal Intensive Care Unit

4.9 CCU – Coronary care Unit

4.10 IV – Intravenous

4.11 HPA – Health Protection Agency

4.12 PEG- Percutaneous Gastrostomy

4.13 IPaCT – Infection Prevention and Control Team

4.14 HMB – Hospital Management Board

4.15 QGB – Quality Governance Board

5. Policy

The majority of patients being admitted for elective procedures including surgery, invasive procedures or investigations have been screened for MRSA since October 2008, following previous DoH Guidance (2006).

In accordance with DoH Guidance (2008), all patients being admitted as an emergency from December 31st 2010, were screened on admission. However, the Operating Framework 2011/12 no longer states the requirement of reporting compliance against screening for MRSA for all emergency admissions.

The IPaCT undertook a comparative study to consider if there were any differences between positivity rates of targeted screening from April to June 2010 to the same period of blanket screening all emergency admissions over the same period in 2011. MRSA positivity rate was 0.63% with targeted screening versus 0.65% with universal screening. Major risk factors for

acquisition were found to be age over 60, previous admission during the last year. Based on these findings, the ICC ratified that the Trust will now revert back to targeted screening with expanded risk factors and continue to decolonise all emergency admissions with Hibiscrub body wash.

Categories of High risk patients to be screened on admission

- MRSA previously positive patients
- Patients admitted within the last year,
- Patients from care homes,
- Patients over 65 years
- Patients with acute or chronic wounds,
- Patients with long term conditions (COPD, Diabetic etc.)
- Patients with long-term invasive devices (Urinary Catheter, PEG, Long line)

Emergency admission screens should be identified on the pathology request from as **M.E.A.S. (MRSA Emergency Admission Screening)**

Patients found to be positive on this initial screen will re-start the care bundle using Octenisan body wash.

Trust staff will continue to screen and decolonise all patients admitted to high risk areas, which are;

- ITU,
- Lilford (haematology),
- Fotheringhay ward (Isolation)
- All trauma orthopaedics and all emergency vascular surgery

Screening requires swabbing various parts of the body that have been identified as likely reservoirs of the bacteria, this includes as a minimum

- Nose
 - Perineum or groin
- And also if applicable**
- Skin lesions (wounds),
 - Manipulated sites e.g. indwelling devices such as peripheral cannula site, catheter specimen of urine, PEG site, supra pubic urinary catheter insertion site
 - Umbilicus of infant
 - Urine if clinically indicated
 - Sputum if clinically indicated

Pre-admission and on admission screening ascertains, where MRSA is colonising the patient and allows patient's with positive screens to be treated in a timely fashion. This is to reduce the risk to the patients and reduce the bio-burden and therefore reduce the risk of cross infection Coia, J. et al (2006) DOH (2006) Saving Lives

Staff must provide an MRSA screening information leaflet to all patients who are screened to ensure patients are supplied with appropriate information on this infection

On admission to the hospital into most specialities, (exclusions are maternity and paediatrics) High risk patients (as identified above) will be commenced on the MRSA care bundle using Hibiscrub body wash as decolonisation.

Patients who have been previously positive to MRSA should be commenced on the MRSA care bundle using Octenisan body wash as decolonisation.

All patients found to be MRSA positive will have an Alert for MRSA identified on the patient management system ICIS/Lorenzo, to identify their status. This will be implemented by the Infection Prevention and Control team

Isolation Precautions for MRSA positive patients

(Contact Precautions- Blue Hand)

- If able to isolate in a single room keep the door closed during care /procedures.
- If no side rooms are available, a single MRSA patient should be nursed preferably in the bed nearest to the sink. Multiple MRSA patients should be cohort nursed in the same bay, next to each other whenever possible
- Display isolation card (blue contact precautions)
- Hand washing/hand sanitiser for hand decontamination
- Wearing disposable gloves and apron for all care and bed making
- Masks are rarely necessary, but should be used when indicated (e.g. chest physiotherapy if sputum positive as advised by IPaCT)
- Dispose of potentially infected items according to hospital policy
- Dispose of soiled/used linen in a red bag, use clean linen every day
- Provide MRSA information leaflet to ensure patients are provided with appropriate information on this infection
- Change all patients' clothes and bed clothes daily after body wash. Garments should be laundered in a hot machine wash (60°C or over).

Eradication treatment for patients' infected / colonised with MRSA –

- Commence the MRSA care Bundle (See Appendix 1)
- Daily wash / bath with Octenisan cleansing solution applying directly to wet skin or hair, leave application for 2 minutes then rinse thoroughly. Shampoo hair at least twice weekly. (Appendix 3)
- If nose positive, or the patient has an invasive device, acute or chronic wound, apply Mupirocin Nasal ointment to inner surface of each nostril three times daily for 5 days. Wash hands after each application.
- Should a clinical specimen, wound, urine or sputum be positive and the patient is demonstrating clinical signs of infection it is essential to contact the Consultant Microbiologist regarding appropriate antibiotic treatment.
- **Patient's commenced on antibiotic therapy for clinic specimens must also be started on decolonisation treatment at the same time**

Treatment of lesions should be discussed with the Infection Prevention and Control Team and/or Tissue Viability Nurse.

Follow-up of Patients Colonised with MRSA In hospital

- After completing 5 days of eradication treatment leave a further 2 days before taking further screen from nose, perineum/groin, skin lesions and any invasive devices. (As Care Bundle)
- All patients who have a positive MRSA result will remain 'previously positive' even following negative screens. Up to 30% of patients who have been previously colonised with MRSA are likely to become re-infected/colonised with MRSA at a later date
- IPaCT will provide further advice regarding decolonisation and treatment

Patients screened on admission but discharged prior to positive result being known

- IPaCT will inform the GP of the result with advice regarding appropriateness of treatment via a posted letter
- The patient will be sent a copy of the letter to the GP advising them to contact the GP for treatment
- The Community Infection Prevention and Control team and/or the admitting Consultant Secretary will be informed by telephone by IPaCT

Environmental Cleaning during an admission and on discharge

- Nursing staff must inform the clinical area Housekeeper.
- Only take essential equipment into the isolation room.
- Ensure daily environmental cleaning, in particular, removal of dust, especially around bed space.
- Terminal cleaning on patient discharge or transfer for all MRSA patients (Use Chlor-clean on all surfaces within the room/bed space and change curtains).

Patients admitted to ICU, Lilford and Fotheringhay wards

- On admission to these clinical areas all patients should be screened and commenced on the MRSA care bundle, whatever their previous status
- All patients admitted to ICU will be screened for MRSA within 6 hours of admission.
- For patients with previously unknown MRSA status, following a negative screen on admission complete one cycle of the pathway, then patients should have weekly screening whilst on the high-risk areas listed above.
- Patient notes/records should be clearly identified for infection control purposes.
- **All previously positive patients, if negative on their admission screen, must be kept on regular weekly screening. (See additional sheet for care bundle – Appendix 2)**
- **All patients admitted for over 28 days must be screened monthly**

Part II

Guidance for MRSA screening for all elective surgical / invasive procedure/ investigatory admissions

1. Introduction

The Department of Health have issued guidelines, which state that all elective procedures or surgery patients must be screened for MRSA. This is to be in place by March 2009.

There are a number of surgical procedures that are exceptions to this;

- Day case ophthalmology (KGH exception -screening will continue for cataract or other implant surgery)
- Day case dental
- Day case endoscopy
- Minor dermatology procedures e.g. warts or other liquid nitrogen applications
- Children/ paediatrics unless already in high risk groups
- Maternity except elective caesareans DoH (2008)

However, as with previously identified high risk categories, patients who have been previously positive to MRSA, patients from care homes, and patients with previous admissions to hospital in the last year, patients transferred from other hospitals or hospitals aboard and fall into the above exception categories must still be screened. On admission, prior to surgery or other invasive procedure, these patients should be commenced on the MRSA care bundle.

Being MRSA positive is not an indication for delaying surgery or procedures. Always discuss results with the clinical team and seek advice from the Consultant Microbiologist and Infection Control team

- All pre-op/assessment MRSA screens need to be coded, under clinical details scribe **P.E.M.S** or alternatively use the stamps provided this is to enable the trust to track and maintain DoH initiative that all elective patients will be screened DoH (2008)
- The patient will be supplied with information leaflet on MRSA screening (appendix 7 and available to order from supplies) to ensure the patient is aware of the reasons for pre- admission screening
- The MRSA screen above, hair line swabs to be taken for ophthalmic surgery only.
- Patients previously MRSA positive but found to be negative for this admission should still be treated as previously positive on admission and commenced on the MRSA care bundle prior to surgery.
- Patients found to be MRSA positive will require treatment prior to admission. A member of the admitting surgical team, e.g. pre-assessment nurse /Consultant will arrange for treatment to be prescribed.
- It is the responsibility of the admitting surgical team to make the decision when to admit the patient for surgery following MRSA decolonisation
- The minimum treatment for all positive patients will be Octenisan body wash. (Oral and/or nasal antibiotic therapy may also be required.)
- In most cases the patient will not require re-screening – the patient should be advised to re-commence the treatment for 5 days prior to admission for surgery
- For MRSA positive Vascular, Orthopaedic and other patients requiring implant surgery complete the treatment as above and include Bactroban nasal ointment

- Isolate or cohort nurse as applicable on admission to clinical areas to reduce the risk of cross infection
- Antibiotic prophylaxis at surgery for patients found to be positive MRSA, or who have been previously positive to MRSA should be discussed with the Consultant Microbiologist, to ensure that the most appropriate antibiotics are used. Results and actions should be documented in the patient's notes

All patients should have a bath or shower with Chlorhexidine or Triclosan product (e.g. Hibiscrub or Octenisan solutions) whatever their MRSA status, prior to any surgery/ invasive procedure. Cover all lesions/wounds with impermeable dressing and ensure area adjacent to wound, is cleaned with Chlorhexidine or Triclosan prior to surgery to reduce the risk the risk of contamination of surgical wounds.

Justification for Document

LINKS TO STANDARDS/PERFORMANCE INDICATORS

The Health Act: Code of Practice for the Prevention and Control of Health Care Associated Infections (2008)

The purpose of the Code is to help NHS bodies plan and implement how they can prevent and control HCAI. It sets out criteria by which managers of NHS organisations are to ensure that patients are cared for in a clean, safe environment, where the risk of HCAI is kept as low as possible. Failure to observe the Code may either result in an Improvement Notice being issued by the Healthcare Commission, or in the Trust being reported for significant failings and placed on 'Special Measures'.

The Code relates to healthcare provided by all NHS bodies. Each NHS body is expected to have systems in place sufficient to comply with the relevant provisions of the Code, so as to minimise the risk of HCAI to patients, staff and visitors.

The Trust Board must have an agreement outlining its collective responsibility for minimising the risks of infection and the general means by which it prevents and controls such risks. Effective prevention and control of HCAI must be embedded into everyday practice and applied consistently by all staff following policies and protocols which based on evidence based research to reduce the risk of infection

Infection Prevention and Control is a key Performance Indicator for Monitor, the Commissioning PCT and the Strategic Health Authority, therefore strict compliance with Infection Prevention and control protocols is monitored by the Trust board on a monthly basis by considering current infection rates and compliance with policies and protocols.

RESPONSIBILITIES

The Trust Board is responsible for:

- Providing strategic leadership for the effective delivery and management of patient safety in relation to infection prevention and control.
- Ensuring the provision of appropriate resources, training and information to all staff involved in exposure prone procedures, clinical duties, and other high-risk activities;

- Ratifying this Policy

The Infection Control Committee is responsible for

- Approving this policy prior to ratification by the Quality Governance Board and to receive and review audit reports in relation to this policy and monitoring progress against related action plans.

Clinical Management Team Managers and Heads of Nursing are responsible for ensuring that:

- All staff involved in any clinically based duties are identified, are proficient in safe working practices and understand and adhere to the Trust's Infection Control Policies;
- Staff within their areas of responsibility have read and understood this policy;
- Ensuring that RCA is completed for MRSA bacteraemias and that completed action plans are completed in a timely manner to ensure lessons are learnt and shared across the whole Trust
- All staff (including bank, agency, locum, independent contractors and visiting health care workers) are made aware of the policy

Consultants and Clinical Directors are responsible for;

- Ensuring compliance with this policy within their clinical teams.

The Occupational Health Department

- Information given to the Occupational Health Department is confidential, and will not be released to the employer without the permission of the individual concerned, except in very exceptional circumstances;

Quality Governance Department is responsible for

- Monitoring compliance with the Policy which will be presented to the infection control committee as part of the monthly surveillance completed by the Infection prevention and Control team.
- Reports from the Committee will be reported to HMB and QGB and in turn to the trust Board

The Infection Control Team are responsible for;

- Supporting managers to implement this policy by assisting with training and education and are responsible for updating and reviewing this policy every two years.
- The contents of the Protocol should be included in induction training for new staff and in mandatory infection control updates
- Providing ad hoc practical sessions as required following outbreaks, hot spots and spot check sessions
- Auditing compliance with the policy via a number of audits including – ICP compliance, Isolation Policy compliance included in the annual programme of work and audit schedule.

Ward and Department Managers

- Ward and Department Managers are responsible for ensuring that staff are compliant with the policy
- Ward and Department Managers are responsible for identifying the training needs of staff in their area and liaising with IPaCT to ensure that appropriate training programmes are delivered.
- Ward and Department Managers are responsible for provision of appropriate resources including personal protective equipment to be available in the workplace at appropriate locations.

Health Care Workers

- All health care workers are under an over-riding ethical as well as legal duty to protect the health and safety of their patients and themselves by:
 - Following the policy
 - Keeping updated on codes of professional conduct and any current guidelines
 - Not carrying out procedures in a way that might place patients or colleagues at risk

Information for patients, visitors and staff

Information available in a number of leaflets;

- MRSA (*Meticillin Resistant Staphylococcus Aureus*) and Screening
- What is MRSA? A simple Guide
- Care of your cannula

Infection control protocols and information leaflets are also available on the Trust internet site

Reasonable interpreting support will be provided to ensure that there is effective in-person communication between staff providing services and service users. Reasonable information support will be provided to service users, in formats which can be easily understood. Where there is a provision of service by the Trust followed by provision by other organisations, service staff should ensure that the referral process is 'seamless'. There should be no hindrance or delay in the person receiving services from the organisation to which referrals are made

Infection control protocols and information leaflets are also available on the Trust internet site. The Trust will provide information support to service users, in formats which can be easily understood

Training and Education

- The contents of this policy will be included in the mandatory infection control induction for all trust staff and annual updates in accordance with the Training Needs Analysis by Staff Development.
- Staff Development will keep accurate and up to date training records to be made available to each CMT of all staff attending these training sessions
- The Infection Prevention and Control Department will maintain records of staff attending ad hoc training

- Staff will be trained to a standard of equality and diversity training which is commensurate with their grading

Stakeholders and Consultation

- Director of Nursing, Midwifery and Quality
- Heads Of Nursing
- Infection Prevention and Control team
- Consultant Microbiologists
- Occupational Health Manager
- Members of the Infection Control Committee

Responsibility for Document Development

- Lead Executive – Director of Nursing & Quality
- Author – Pam Howe Lead Nurse for Infection Prevention and Control
- DIPC- Dr Manjula Natarajan
- Committee – KGH Infection Control Committee

Approval and Ratification Process

Policy will be approved and ratified through the Infection Control Committee and KGH Quality Governance Board.

Review and Revision Arrangements

Review of the policy will happen 2 yearly unless further guidance is received from the Department Health and revised by the policy lead.

Dissemination and Implementation – Policy for standard precautions

The Infection Prevention and Control team will ensure that the contents of this protocol will be included in the mandatory infection control induction for all trust staff and annual updates in accordance with the Training Needs Analysis by Staff Development.

Ward managers and Head of Nursing for each CMT have responsibility for ensuring local implementation and compliance of staff working in the trust

Monitoring Compliance and Effectiveness

The Quality Governance Department will monitor compliance with the policy through monthly Saving Lives Audits and report results to the Director of Nursing and Quality and Heads of Nursing for each CMT

The results will in turn be fed back through the Infection Control Committee. Compliance with the policy will be monitored via infection rates which will be reported monthly to the Infection Control Committee.

Practice Facilitators for Infection Control

Will have responsibility of monitoring and ensuring compliance in their clinical areas of work. They will provide support to colleagues in ensuring that they are fully aware of the content of the policy

DOCUMENT CONTROL AND ARCHIVING

The policy will be kept electronically on the shared folder for Infection prevention and control and published on the Trust web intranet site

REFERENCES

Coia, J. Duckworth, G. Edwards, D. Farrington, M. Fry, C. Humphreys, H. Mallaghan, C. Tucker, D. (2006)

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Department of Health

Department of Health (2008) *MRSA Screening – Operational Guidance*

Letter to CEOs Department of Health

Duckworth, G. Cookson, B. Humphreys, H. Heathcock, R. (1998) Revised Methicillin Resistant *Staphylococcus aureus* Infection Control Guidelines for Hospitals. *Journal of Hospital Infection* 39: 253-290.

KGH (2009) *Antibiotics; Empiric treatment of common conditions, antibiotic prophylaxis in surgery and other issues relating to the use of antibiotics in adults*

KGH (2001) *Nursing and Midwifery Policy 1.5 Record Keeping*

Meticillin Resistant *Staphylococcus aureus* Care Plan

MRSA Emergency Admission Care Bundle	
MRSA Positive Care Plan	

On admission all patients should be started on the care bundle with Hibiscrub body wash
Care Plan to be recorded daily – see reverse

Patient Name
 DOB
 Hosp No.
 NHS No

Ward/ Unit _____ Date Commenced ----/----/----

On admission	Yes/No	Date & Time	Sign
Take full screen of High Risk Patients - Previously Positive MRSA, admitted from care home, admission in last year, aged over 65 yrs, Long term invasive device, chronic condition, acute/chronic wound (Within 6 hrs of decision to admit) Nose and groin. (Include wounds, invasive devices, sputum if productive cough present and CSU if catheterised)			
Provide patient information leaflet			
Does the patient have chronic long term condition/chronic wounds/long term invasive devices?			
Does the patient care for anyone with chronic long term condition/immuno-compromised/ chronic wounds/long term invasive devices?			

All emergency admission patients will be commenced on **Hibiscrub** antiseptic body wash for 5 days decolonisation – follow care bundle on reverse
Octenisan antiseptic body wash will be used for all patients found to be MRSA positive on admission screen, or those known to be previously positive
 Bactroban - ointment should be prescribed for all patients nose positive, if they have an invasive device, surgical or chronic wound or will have surgery involving an implant. Contact the Infection Prevention and Control team for further advice

Record MRSA result (-ve or +ve)	Nose	Perineum or groin	Wound Specify location	Urine (indicate if it is a CSU or an MSU)	Cannula	CVP	Other Specify	Date and Sign
Admission screen								
Screen day 8								
Patient informed of result	YES / NO	Date & sign						
If pos full ICP started with Octenisan	YES / NO	Date & sign						

Day/date	Full screen of patient	Daily wash / bath patient with Hibiscrub or Octenisan	Patients own bottle of body wash with Pt ID label	Daily change of bed linen	Wash hair with Hibiscrub days 2 and 4	Administer additional treatment	Display Contact Precautions If positive (Blue)	Gloves/ aprons and hand sanitiser available	Inform Housekeeper BD clean of surfaces and equipment	Record results of Screen	Sign Name & Job Title
Day 1	///////// /////////				///////// /////////					///////// /////////	
Day 2	///////// /////////									///////// /////////	
Day 3	///////// /////////				///////// /////////					///////// /////////	
Day 4	///////// /////////									Admission screen	
Day 5	///////// /////////				///////// /////////						
Day 6	///////// /////////	///////// /////////			///////// /////////					///////// /////////	
Day 7	///////// /////////	///////// /////////			///////// /////////					///////// /////////	
Day 8		///////// /////////			///////// /////////					///////// /////////	
Day 9	///////// /////////									///////// /////////	
Day 10	///////// /////////				///////// /////////					///////// /////////	
Day 11	///////// /////////				///////// /////////					///////// /////////	
Day 12	///////// /////////				///////// /////////					Screen day 8	
Day 13	///////// /////////										
Day 14	///////// /////////										
Activity for transfer					Time & Date		Sign		Comments		
Receiving ward aware of status											
Receiving ward informed of precautions required. e.g. colonised nurse by sink, clinical spec requires isolation											
Receiving ward aware of current ICP (if applicable)											

Additional Weekly Screening;

For patients previously positive to MRSA with negative screens on admission and following one cycle of the ICP

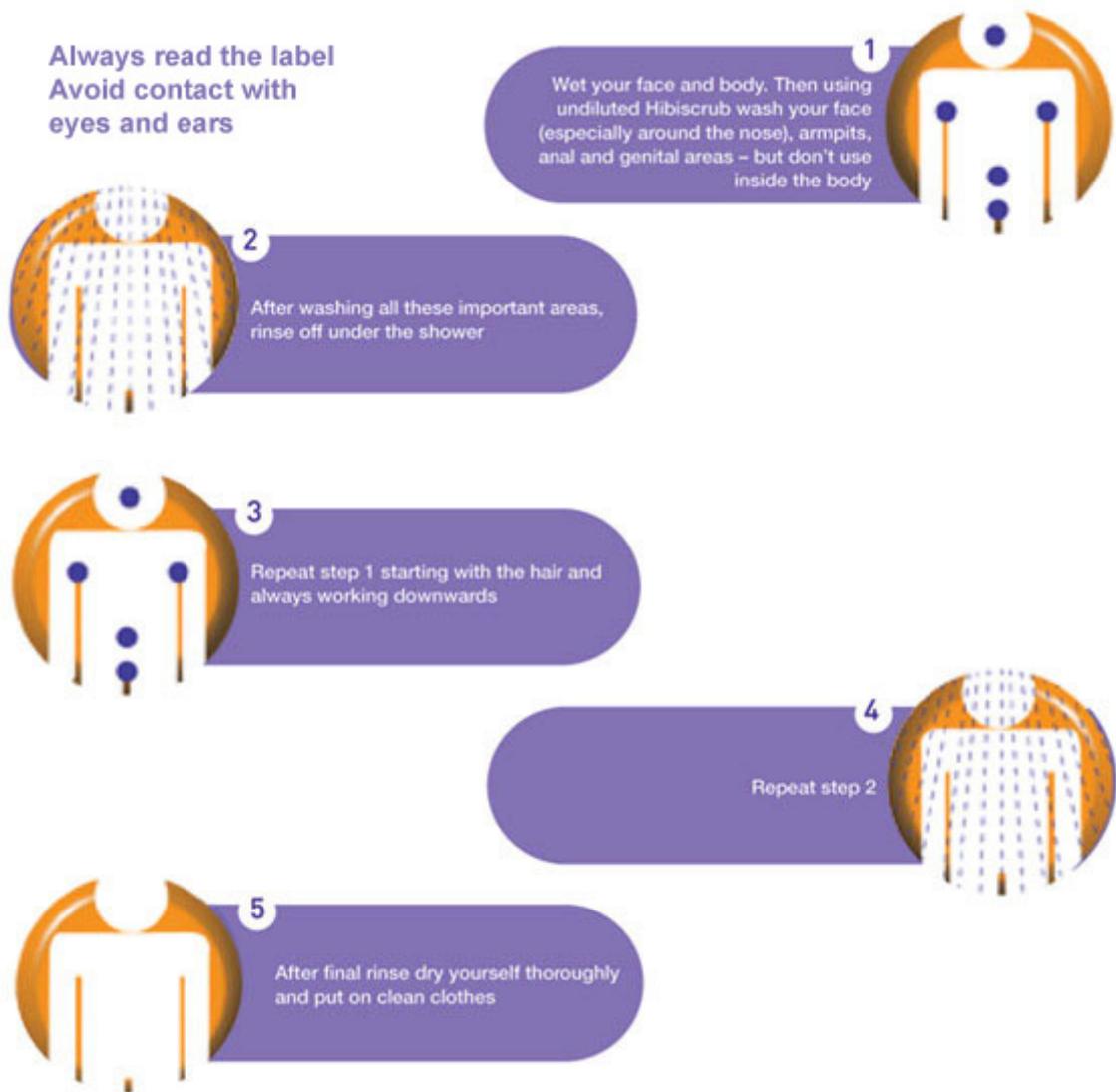
Monthly Screen

For all patients , with negative screen on admission but remaining in hospital for over 28 days

Results of weekly / monthly screen					
Date	Specimen	Result	Date	Specimen	Result
	Nose			Nose	
	Perineum/groin			Perineum/groin	
	Wound			Wound	
	Catheter			Catheter	
	Urine			Urine	
	Cannula			Cannula	
	CVP			CVP	
	Manipulated site			Manipulated site	
	Other			Other	

Results of weekly / monthly screen					
Date	Specimen	Result	Date	Specimen	Result
	Nose			Nose	
	Perineum/groin			Perineum/groin	
	Wound			Wound	
	Catheter			Catheter	
	Urine			Urine	
	Cannula			Cannula	
	CVP			CVP	
	Manipulated site			Manipulated site	
	Other			Other	

Results of weekly / monthly screen					
Date	Specimen	Result	Date	Specimen	Result
	Nose			Nose	
	Perineum/groin			Perineum/groin	
	Wound			Wound	
	Catheter			Catheter	
	Urine			Urine	
	Cannula			Cannula	
	CVP			CVP	
	Manipulated site			Manipulated site	
	Other			Other	

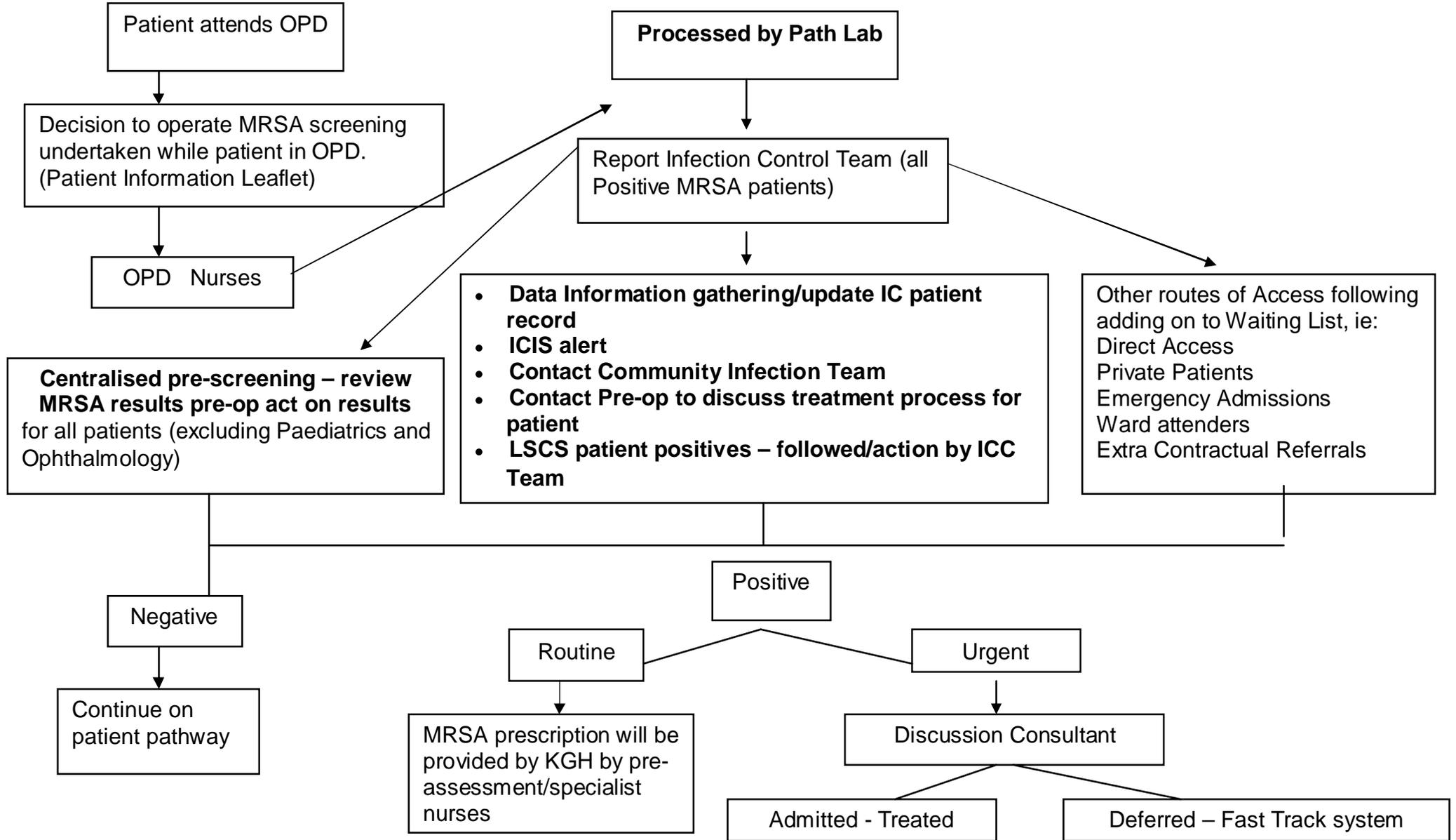


How to use the body wash

1. Wet your face and body, use undiluted body wash all over your body paying particular attention to the nose, armpits and groin and genital areas. Do not use inside the body.
2. After washing all these areas well, rinse off in the shower
3. Repeat as above. On day 2 and 4 damp hair and apply the body wash as a shampoo.
4. After washing all over rinse your body and hair as before
5. After a final rinse, dry carefully and put on clean clot

MRSA SCREENING ELECTIVE PATIENT PATHWAY

(For addition to Waiting List from OPD)



What is MRSA

We all carry bacteria on and in our bodies. MRSA (Meticillin Resistant *Staphylococcus aureus*) is a bacteria which can cause infections. About 3% of us are carriers of MRSA. This is called colonisation and means it lives harmlessly on the skin and in our noses. As there are no symptoms, the only way to know if you are a carrier is to be tested. It is not normally a problem to the general public or people in their own homes but it can affect those who are ill.

Commonly MRSA can cause boils, infected wounds, abscesses, chest and urine infections and blood stream infections.

MRSA has become resistant to the majority of antibiotics. There are 2 reasons why this happens

1. a course of antibiotics is not finished as prescribed
2. antibiotics are over used allowing the bacteria to develop resistance

How do people get MRSA

Although MRSA is carried in the nose and other body sites without causing problems, the germs can spread easily from one person to another by hands or clothes

MRSA can also be spread by

- people infecting themselves by touching breaks in the skin
- passing it on to others by touching a wound or handling equipment around them

- people coming into direct contact with carriers or those diagnosed with MRSA
- through contact with individuals who have not cleaned their hands - either by washing or using hand gel
- via indirect contact with contaminated environment.

It is important for patients, staff and visitors to help prevent the germ spreading by careful hand washing, using hand gel and good housekeeping to control dust.

Is MRSA treatable?

Yes, if you are found to be a carrier, decolonisation treatment for MRSA includes an antiseptic body wash and ointment for the nose.

Those found to be infected with MRSA in a wound, urine, sputum or blood require antibiotics prescribed by your doctor. Treatment can take place in hospital, residential or care home or your own home.

Why do you need to be tested for MRSA?

If you are coming to hospital for surgery or other procedure, when you attend for your pre-operative assessment appointment it may be necessary to take some swabs from several areas of the body to test for MRSA.

From Dec. 31st 2010 the majority of patients being admitted to the hospital in an emergency will be screened for MRSA.

For both groups of patients, these swabs may include the nose, groin and any wounds (a small cotton bud will be used to take the sample) or urine from a catheter.

This will not hurt you and takes only a few seconds, the results of which will not be known immediately. The test will help us to find out if you carry MRSA and is done to ensure we give you appropriate treatment before or when you come into hospital should it be needed.

Importance of screening

If a patient coming into hospital is found to be an MRSA carrier, they will require treatment. This will either be organised by your pre-assessment nurse or your GP. If due for surgery this could mean delaying the operation for a few days (this depends on the type of surgery and will be decided by your consultant).

On admission the treatment will be repeated and specific antibiotics may be given which will reduce the risk of infection.

What does the treatment involve?

The five day treatment, or decolonisation, will consist of an antibacterial liquid soap used as a shower gel, and, for some people, an ointment for your nose.

This can be completed whilst you are at home, before you are admitted for your operation, or as soon as you come into hospital.

PROCESS FOR NURSE PRESCRIBING OF MRSA DECOLONISATION THERAPY IN PRE-OPERATIVE ASSESSMENT CLINIC

Patient identified as MRSA positive on pre-operative screening

Infection control notify Pre-assessment (x3318)

Has the patient been assessed by a nurse prescriber?

YES

NO

Can the patient get to KGH for an assessment?

YES

NO

Book POA appointment with Nurse Prescriber

Appendix 6

Pre-operative assessment to contact GP and ask them to prescribe eradication therapy as below

Is the patient high risk (orthopaedic/vascular implants/cataract surgery?)

YES

NO

Octenisan wash AND Bactroban Nasal Ointment for 5 days.
Re-swab day 8.

Octenisan wash for 5 days.
ONLY USE BACTROBAN NASAL OINTMENT if nose positive.
Do not reswab.

Negative swab?

YES

NO

3 negative swabs (Consultant dependant)

YES

Repeat decolonisation therapy for a maximum of 3 cycles. If remains positive discuss with IPaCT

Patient to restart decolonisation therapy 5 days prior to admission, continuing for 5

MRSA Emergency Screening Pathway

For emergency admissions – excluding paediatrics and maternity

Identified **High Risk Patients** being admitted for over 12 hours need to be Emergency MRSA screened. If the patient is in the medical day case, Centenary Wing or CDU for less than 12 hours and are then going to be discharged, they do not need to be screened.

Patient admitted as an emergency via any route, e.g. MAU, SAU, A & E and including OPD

For identified High Risk patients initiate Emergency MRSA Screening care plan. Complete screen, sign and date. Provide Hibisrub body wash for MRSA decolonisation following ICP, provide patient information leaflet for **all** patients

General Screen; Nose and groin.

(Include wounds, invasive device insertion points, e.g. PEG site, Supra pubic catheter site, CSU if catheterised and sputum (if productive cough present

When the patient is transferred to a ward ensure transfer information on the care plan is completed to inform admitting ward of current status

Results

Monday to Friday: wards will be immediately informed of positive results by Infection Prevention and Control Team
Week ends or Bank Holidays: The microbiology lab will inform the Site Management Team on bleep 835 of positive results to inform ward staff to action accordingly.
 If patient has been discharged, Site Management will leave message on IPaCT answer phone x 2482 to action on following Monday. Results will also be picked up via ICNet

Patients with negative admission screens will not require further decolonisation. Patients with negative screens but admitted for over 28 days will require screening monthly

Action for confirmed positive patients

- Isolation if appropriate (clinical specimen positive) or next to a sink (colonised)
- Ensure nasal Bactroban is prescribed if the patient has; invasive devices or chronic or surgical wounds
- If patient is going to or has been to theatre, inform the Doctor on call who should discuss appropriate action with the on-call Consultant Microbiologist
- Complete the initial 5 day ICP if Bactoban not required, re-screen on day 8 and await results or start printed ICP as Trust Protocol
- Repeat screen results will be provided by IPaCT or via results reporting Out of hours or at week -ends

IPaC teams at NGH and Community teams to be informed of all new MRSA positive results to record on their patient alert systems

Actions for those patients whose positive MRSA results are only known following discharge

MRSA positive emergency admission screen of patient already discharged will be picked up by IPaCT either on ICNet results system or following phone message left by Site Management out of hours

All MRSA emergency admission screening results for patients discharged before the results were known will be phoned through to the Community Infection Prevention and Control team who will be informed of risk assessment comments for decision regarding commencement of treatment

IPaC team at KGH will send a letter to the GP to inform them of the positive MRSA screen. Information will be provided regarding the result of the risk assessment for decision regarding commencement of treatment. A copy of the letter will be sent to the patient so they are aware of the results and can contact their GP to arrange treatment 2-7 days from receipt of this letter

IPaC team will inform the secretary of the admitting consultant by telephone of the positive MRSA screen.

Part 3

Guidance on diagnosis and management of Panton Valentine Leukocidin (PVL) -associated Staphylococcal infections in the UK

Background

A new pattern of disease due to Panton – Valentine Leukocidin (PVL) – positive strains of *Staphylococcus aureus* is emerging in the UK and world-wide. PVL is a toxin, which destroys white blood cells, making the infected person less able to fight infection and is carried by less than 2% of clinical isolates of *S. aureus*. PVL can be detected in both meticillin sensitive *S. aureus* (MSSA) and meticillin resistant *S. aureus* (MRSA). To date the majority of isolates causing infection in the UK have been MSSA. Community-associated MRSA (CA-MRSA) are more likely to produce PVL than hospital-associated MRSA. PVL-positive *S. aureus* are normally associated with pus producing skin infections such as boils and abscesses, necrotising pyogenic cutaneous infections and occasionally with cellulitis or tissue necrosis. However, they can cause other severe invasive infections such as septic arthritis, bacteraemia, purpura fulminans or community-acquired necrotising pneumonia.

Skin infections

PVL-associated staphylococcal infection will be suspected if a patient has recurrent furunculosis (boils) or abscesses, especially if they are in a high risk group e.g. participants in close-contact sports e.g. rugby, Judo etc, the military, member of a gym, care or residential homes including prisons. More often affects young, normally healthy individuals.

Diagnosis

Diagnosed by an unusual antibiotic sensitivity pattern and must be confirmed by Reference Laboratory at HPA.

Clinical Management

Abscesses should be drained surgically and then treated with systemic anti-staphylococcal antibiotics - choice depending on susceptibility testing, discuss treatment with Consultant Microbiologist. Currently, most UK PVL-positive *staphylococcal aureus* strains are susceptible to flucloxacillin and usually sensitive to erythromycin and clindamycin. Consider combinations of doxycycline and rifampicin for CA-MRSA. Topical decolonisation using Chlorhexadine body wash should be commenced following systemic treatment.

Screening and decolonisation of contacts

The Regional Health Protection Unit will follow-up any contacts or clusters. Risk assessment of household contacts and history of close contacts within high risk groups must be assessed. Screening should include anterior nares (nose), damaged skin and any lesions. Contacts found to be positive should be decolonised. Households should be decolonised simultaneously.

Clusters can occur in 'social groups' as indicated in the risk factors e.g. Care and residential facilities, nurseries and schools, gyms and sports facilities.

Detection and Management of Patients Colonised / Infected with MRSA Version 2.2

Infection Control

Patients should be screened (nose, perineum and skin lesions) for *S. aureus* carriage and decolonisation regimens such as those used for MRSA decolonisation may need to be used to eradicate skin or upper respiratory carriage.

In healthcare settings contact precautions should be maintained, use of personal protective equipment, thorough hand hygiene, and increased cleaning regime.

Necrotising pneumonia

PVL – positive strains of *S. aureus* have been associated with a rapidly progressive, haemorrhagic, necrotising community-acquired pneumonia in young immunocompetent patients, and a high fatality rate. Most patients developing necrotising pneumonia have no history of skin sepsis but commonly have a preceding 'flu-like' illness.

Early clinical diagnosis is difficult but essential for survival. Typically the following features in a previously fit young patient suggest the diagnosis; haemoptysis, hypotension and severe sepsis following a 'flu like' illness warrants prompt referral to hospital. Once admitted, the constellation of findings strongly suggests the diagnosis:

- Multilobar infiltrates on chest X-ray, usually accompanied by effusions, and later cavitation
- Haemoptysis
- Hypotension
- Marked leucopenia
- Very high C-reactive protein level (more than 250-300 g/L) (not found in viral infections)
- Gram film of sputum reveals sheets of staphylococcal-like Gram-positive cocci
- Non-specific findings of flu-like illness, (fever of more than 39°C, tachycardia more than 140 beats/min, myalgia, chills). Diarrhoea and vomiting may be due to associated toxic shock, which in the setting of a significantly raised serum creatine kinase suggests myositis.

N.B. The CURB score may be misleadingly low in young adults on admission.

Clinical Management (mainly supportive)

- Admit to Intensive Care
- Administer aggressive antibiotic therapy - see below
- Consider treatment with activated Protein C (but not appropriate in active pulmonary haemorrhage)
- Give intravenous immunoglobulin (IVIG) - see below

There is a wide range of potentially useful antibiotics for treatment. It is important to check the susceptibility of individual isolates. Combinations including vancomycin, clindamycin, linezolid, rifampicin and/or co-trimoxazole in high doses have been used, treatment must be discussed with the Consultant Microbiologist.

Vancomycin should not be used alone. Linezolid can be used to cover MRSA pending antibiotic susceptibility results; clindamycin (1.2 gm qds), like linezolid, has the added advantage of suppressing toxin production.

Infection Control

Detection and Management of Patients Colonised / Infected with MRSA Version 2.2

Surgical masks should be worn during intubation and physiotherapy. Closed tracheal suction should be used since secondary cases may occur.

Screening of nose, perineum and skin lesions of close contacts for carriage of PVL-positive *S. aureus* should be initiated. Contacts found to be positive should be decolonised. Households should be decolonised simultaneously.

Staff Contacts

For patients with Necrotising pneumonia, should hospital staff have close contact with nasal or pharyngeal secretions aerosols, for example during active resuscitation then decolonisation of these staff should be considered.

Please contact IMPaCT for further management of patients and staff contacts

Reference

PVL sub-group on HCAI (2008) Guidance on the diagnosis and Management of PVL-associated *Staphylococcus aureus* infections (PVL-SA) in England

Appendix One – Check list for all policies and strategies for QGB or HMB approval

This checklist must be completed and provided as the front cover when seeking ratification.

Document Title and Version

Detection and Management of Patients Colonised / Infected with MRSA Version 2.2

Author - Pam Howe- Lead Nurse Infection Prevention and Control

	Yes/ No/ Unsure	Comments & Comment Author
1. Title		
Is the title clear and unambiguous?	Yes	
If the document has been updated, has the title been changed?	No	
Is it clear whether the document is a guideline, policy, protocol, procedure or guideline?	Yes	
2. Rationale		
Are reasons for development of the document stated?	Yes	
3. Development Process		
Is the method described in brief?	Yes	
Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
Is there evidence of consultation with stakeholders, users, patients, public, voluntary groups or other Trusts or organisations?	Yes	
The names of those involved in developing/contributing to the document have been Included	Yes	
The lead Director has been identified and has approved and signed the document off.	Yes	
The author has been identified and their job title included	Yes	
4. Content		
Is the content of the document clear?	Yes	
Are the intended outcomes described?	Yes	
Are the statements clear and unambiguous?	Yes	

	Yes/ No/ Unsure	Comments & Comment Author
The document cross references to the Outcome numbers within the CQC Registration Requirements to demonstrate where the document satisfies these requirements.	Yes	
5. Evidence Base		
Is the type of evidence to support the document identified explicitly?	Yes	
References to any documents consulted in formulating the document have been made and cross checked to those included in the Schedule of Applicable Publications where applicable	Yes	
Are supporting documents referenced?	Yes	
6. Approval	Yes	
The name of the local committee approving the document and date of approval have been added	Yes	
Does the document identify which committee/group will approve it?	Yes	
If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	Yes	
7. Dissemination and Implementation		
Is there an outline/plan to identify how this will be done?	Yes	
Does the plan include the necessary training/support to ensure compliance?	Yes	
8. Document Control		
Does the document identify where it will be held?	Yes	
Have archiving arrangements for superseded documents been addressed?		
A check has been made and the author can confirm that no similar documents exist	Yes	
If the document is a procedure, protocol or guideline it should cross reference to a policy	Yes	
The document has been created using version control.	Yes	
Is the document presented in the agreed corporate style and format? (Title page, contribution page, Arial 12, numbered paragraphs, justified etc)	Yes	

	Yes/ No/ Unsure	Comments & Comment Author
The document review and expiry dates have been completed	Yes	
9. Process to Monitor Compliance and Effectiveness		
Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Yes	
Has a method of monitoring been agreed with timescales?	Yes	
Is there a plan to review or audit compliance with the document?	Yes	
10. Review Date		
Is the review date identified?	Yes	
Is the frequency of review identified? If so is it acceptable?	Yes	
11. Overall Responsibility for the Document		
Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the documentation?	Yes	
12. Impact assessment		
Has it been equality impacted including the completion of the assessment tool?	Yes	
The name, job title and department of the person completing the impact assessment along with the date the assessment was completed has been added	Yes	

Before publishing the document the name of the committee providing ratification and the date the document was ratified is to be completed. Incomplete documents may not be published.

Individual Approval			
If you are happy with this document, please sign, date it and forward to the chair of the committee/group where it will hopefully receive final approval.			
Returned to author for amendments date:			
Name		Date	
Signature			

1 Appendix Two – Checklist for creating Procedural Documents for QGB / HMB and local CMT (Governance) Committees

Title of Document and version number: Detection and Management of Patients Colonised / Infected with MRSA Version 2.2		
Date checklist completed: Aug 2011	Name of person checking document: Pam Howe	
Core Standard	Comments & Comment Author	
Is the document presented in the agreed corporate style and format and the template has been used? (Title page, contribution page, Arial 12, numbered paragraphs, justified etc)	Yes	
Is this policy needed?	Yes	
Has a check been made if the policy already exists in this or similar form?	Yes	
Does it link to another policy/document?	Yes	
Is there a clear introduction?	Yes	
Is there a definition section to explain terms used?	Yes	
Is there evidence that consultation has taken place?	Yes	
Has an appropriate review period been identified?	Yes	
Have monitoring tools for compliance been identified within the document?	Yes	
Does it state how the document will be disseminated and is this appropriate?	Yes	
Have arrangements been made for retrieval and archiving?	Yes	
Are associated documents cited and referenced correctly?	Yes	

How will the effectiveness of the procedural document be measured?	Yes
Title of Document and version number: Detection and Management of Patients Colonised / Infected with MRSA Version 2.2	
Date checklist completed:	Name of person checking document:
Core Standard	Comments & Comment Author
Has the document been impact assessed and any necessary action taken as a result of this?	
Has the data been inserted into the document properties?	
Is the filename compliant and, if an update, the same as the original file?	
Is the content correctly paginated?	
Are references to documents reviewed in the document production referenced?	
Have the Registration outcomes been correctly identified?	

Equality Impact Assessment (EqIA) Template for *Policies and Functions

Instructions: You are assessing your policy / function against six benchmarks of good practice. Please answer the questions shown under each of the benchmarks. In respect of the policy the assessment is against the affects of the policy in practice.

Policy	X	Function	<input type="checkbox"/>	New Policy	<input type="checkbox"/>	Existing Policy	X	New Function	<input type="checkbox"/>	Existing Function	<input type="checkbox"/>
Staff member completing assessment: Pam Howe						Storage location of policy / function information: Infection prevention and Control					
Name of policy / function: Detection and Management of Patients Colonised / Infected with MRSA											
Summary of policy / function: Detection and Management of Patients Colonised / Infected with MRSA											
<p>This policy incorporates all the necessary procedures and guidelines needed so that all patients with MRSA colonisation, infection or at risk of developing MRSA, will receive appropriate treatment or prophylaxis to reduce the risk of infection</p> <p>By following the policy Staff will reduce the risk of cross infection between patients by helping to identify those patients most at risk and ensure treatment is implemented in a timely fashion</p> <p>By following the policy Staff will be able to provide the correct and most current information for staff caring for patients with MRSA</p>											
Who are the end beneficiaries of the policy / function?			Staff	Patients	Carers	Visitors	Other (please specify)				
			<input type="checkbox"/>	X	<input type="checkbox"/>	<input type="checkbox"/>					
Policy / Function review date:						Date for repeating impact assessment:					
Date policy / function impact assessment completed Oct 2011						Signature of staff member completing assessment: <i>Pam Howe</i>					
Date impact assessment signed off by Equality & Diversity Lead: Chaman Verma (On behalf of Equality and Diversity Steering Group)						Signature of Equality and Diversity Lead: <i>Chaman Verma</i>					
This policy or function is not intended (or ultimately intended) to engage with or involve beneficiaries (i.e. patients, staff, carers, members of the public or visitors) hence the rest of the template has not been completed <input type="checkbox"/> (please tick box if applicable)											

1. Effective communication between staff and service users, from separate physical locations (e.g. from home to service within the hospital and vice versa or between different services within the hospital and its various service annexes)

1(a) Is this benchmark relevant to this policy or function? Yes No If No, go to the next benchmark

1(b) If the benchmark is relevant, please tick the equality group which may require additional support/ resources/ reasonable adjustments, in order to achieve it

Age <input type="checkbox"/>	Gender <input type="checkbox"/>	Disability <input checked="" type="checkbox"/>	Race <input checked="" type="checkbox"/>	Sexuality <input type="checkbox"/>	Religion/ Beliefs <input type="checkbox"/>	Other (please specify)
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1(c) *In respect of the equality groups which may require support / resources / reasonable adjustments, what does the Trust have in place?

Communication of results to the patient via a copy of letter to GP. Also information sent to Community Infection Prevention and Control team so that patients receiving letters informing them of positive results can contact the team for advice.

Race (Patient/ family/carer who does not speak English)

Language Line can be used to overcome language barriers to establish effective telephone based communication. Subject to abiding by the Trust's Confidentiality Policy, relatives or friends could be used to communicate via telephone with the person who doesn't speak English. Staff need to ensure that relatives and parents are happy to do this and also have the skills to do this.

Disability (Patient/family/carer with speech or hearing impairment)

Type Talk (national telephone relay service), email, fax and text messaging via mobile phones.

Disability (Patient/ family/carer who has learning disability)

Advocacy services are available, including Independent Mental Capacity Advocates. Subject to abiding by the Trust's Confidentiality Policy, relatives or friends could be used to communicate with a person who has learning disability. Staff need to ensure that relatives and parents are happy to do this and also have the skills to do this.

1(d) Additional information (e.g. recommendations for improvement, changes to policy / function, etc.):

This policy lays out changes in the process for informing patients found to be MRSA positive of the result and is dependant on open communication between Acute and Community IPaC teams and GPs.

2. Service users can successfully travel to Hospital/Annex and within specific area of building where service is provided (Physical Access)						
2(a) Is this benchmark relevant to this policy or function?				Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	If No, go to the next benchmark
2(b) If the benchmark is relevant, please tick the equality group which may require additional support/ resources/ reasonable adjustments, in order to achieve it						
Age <input type="checkbox"/>	Gender <input type="checkbox"/>	Disability <input type="checkbox"/>	Race <input type="checkbox"/>	Sexuality <input type="checkbox"/>	Religion/ Beliefs <input type="checkbox"/>	Other (please specify)
2(c) *In respect of the equality groups which may require support / resources / reasonable adjustments, what does the Trust have in place?						
2(d) Additional information : (e.g. recommendations for improvement, changes to policy / function, etc):						
3. Effective in-person communication between staff and service users						
3(a) Is this benchmark relevant to this policy or function?				Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>	If No, go to the next benchmark
3(b) If the benchmark is relevant, please tick the equality group which may require additional support/ resources/ reasonable adjustments, in order to achieve it						
Age <input type="checkbox"/>	Gender <input type="checkbox"/>	Disability <input type="checkbox"/>	Race <input type="checkbox"/>	Sexuality <input type="checkbox"/>	Religion/ Beliefs <input type="checkbox"/>	Other (please specify)
3(c) *In respect of the equality groups which may require support / resources / reasonable adjustments, what does the Trust have in place?						
Race (family/carer who does not speak English)						
Interpreters are used to communicate with the person who doesn't speak English (including bi-lingual staff). Subject to abiding by the Trust's Confidentiality Policy, relatives or friends are also used to communicate with the person who doesn't speak English.. Language Line is available where time constraints prevent the services of an interpreter being obtained.						
Disability (family/carer with speech or hearing impairment)						
British Sign Language, Sign Supported English, Makaton and Lip Reading interpreters are available. The Trust has static and portable hearing loops to assists people with partial loss of hearing. Pen and paper are used in some circumstances. Computer with a screen and keyboard can be used to type communication messages, where time constraints prevent the services of an interpreter being obtained.						
Disability (family/carer who has learning disability)						
Use of 'Grab Sheets' which may give information about specific needs of person with learning disability. The hospital has access to Makaton interpreters. There is also a 'Hospital Communication Book' for supporting people with learning disability. The Trust uses advocates, support workers, carers, etc to support communication. Subject to abiding by the Trust's Confidentiality Policy, relatives or friends are used to communicate with a person who has learning disability.						

**Some examples of support / resources / reasonable adjustments that can be provided are shown on page 5*

3(d) Additional information (e.g. recommendations for improvement, changes to policy / function, etc):

4. Service users can understand information provided

4(a) Is this benchmark relevant to this policy or function?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>	If No, go to the next benchmark
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4(b) If the benchmark is relevant, please tick the equality group which may require additional support/ resources/ reasonable adjustments, in order to achieve it

Age <input type="checkbox"/>	Gender <input type="checkbox"/>	Disability <input checked="" type="checkbox"/>	Race <input checked="" type="checkbox"/>	Sexuality <input type="checkbox"/>	Religion/ Beliefs <input type="checkbox"/>	Other (please specify)
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4(c) *In respect of the equality groups which may require support / resources / reasonable adjustments, what does the Trust have in place?

Race (Patients for whom English is not their first language):

A patient information leaflet is available in the English language; this has been revised and passed by PIC and is being sent to be printed. There is a gap in the provision of providing the information contained in this leaflet to patients who do not read English. I will be Liaising with Denise Thompson (Patient Information Manager) to address this issue over the next 6 months. However similar information leaflets are available through the HPA in a number of Languages

Disability (Patients with visual disability):

Documents can be made available in large font with a choice of preferred coloured back ground

Disability (Patients with learning disability):

The Trust has access to advocates and support workers; these can also be used for communication purpose

4(d) Additional information (e.g. recommendations for improvement, changes to policy / function, etc):

5. Taking into account cultural norms, preferences and practices of equality groups (e.g. preference for same sex service staff, dress code, key religious days and practices, food choices, etc.)

5(a) *Is this benchmark relevant to this policy or function?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	If No, go to the next benchmark
--	------------------------------	--	---------------------------------

5(b) If the benchmark is relevant, please tick the equality group which may require additional support/ resources/ reasonable adjustments, in order to achieve it

Age <input type="checkbox"/>	Gender <input type="checkbox"/>	Disability <input type="checkbox"/>	Race <input checked="" type="checkbox"/>	Sexuality <input type="checkbox"/>	Religion/ Beliefs <input type="checkbox"/>	Other (please specify)
---------------------------------	------------------------------------	--	--	------------------------------------	---	------------------------

5(c) *In order to take into account cultural norms, preferences and practise of relevant equality groups, what support / resources / reasonable adjustments, does the Trust have in place?

5(d) Additional information (e.g. recommendations for improvement, changes to policy / function, etc):

*Further information about this benchmark is available on the Trust's Equality and Diversity section of the intranet and from the Equality and Diversity Lead

6. Addressing any adverse affects

6.a. In respect of each equality group, do the Trust's *audits (e.g. Serious Untoward Incident, PALS, Complaints, Grievances, Satisfaction Surveys, Workforce Statistics, Patient and Carer Equitable Access to Service and Outcome, Physical Access, Patient Equipment, etc.) show any of the equality groups to be more adversely affected in comparison with other equality groups within the Trust, within the region and within the country?

**Recommend under section 6.d. that an audit should be carried if it isn't available or it doesn't provide data on all equality groups*

6.b. If so, how is this higher level of adverse affect justified?

6.c. If it is not justified, then, what action has the Trust taken / will be taking regarding reducing / eliminating the adverse affect?

6.d. Additional information (e.g. recommendations for improvement, changes to policy / function, etc):

By January 2011, all adult patients being admitted to the Trust (excluding those admitted into maternity) will be screened for MRSA
The Infection Prevention and Control Team annual audit plan currently includes quarterly audits relating to practice against the previous MRSA protocol. Until present, there has not been an opportunity to examine this data to ensure that there is no adverse effect on any equality groups

However details pertaining to equality groups could be collected during the next round of audit. March 2011 Results of the completed audit analysis will be fed back to the ICC by the lead Nurse for Infection prevention and Control

Some examples of support / resources / reasonable adjustments that can be provided to equality groups, in order to enable them to achieve benchmarks, are shown below:

- Interpreting and Language Line Services can be used to establish telephone communication with people who don't speak English
- British Sign Language, Lip Reading Interpreting Service, Text phones (also called Minicomms) and Type Talk (national telephone relay service) can be used to establish communication with people who have speech and hearing impairments
- Provision of static and portable hearing loops can assist people with partial loss of hearing in communicating with hospital staff
- Printed material in English with a paragraph in the person's own language (detailing how they can obtain information in their own language) can be used to enable people from some ethnic minority communities, who don't read English, to have access to understandable information
- Use of signage in Braille and tactile format around the hospital can assist people with total sight loss to get to service delivery areas
- Nearby parking spaces, ramps, lifts and yellow nosed steps are some of the reasonable adjustments that can be made for people with physical disabilities to get to service delivery areas
- Use of large font printed material, picture based communication and 'Easy Read' language material are some of the ways to provide understandable information to people with learning disability

More examples are shown in the document 'Barriers and Solutions – Barriers equality groups may experience in using the NHS and some solutions to eliminating them'. This can be found in the Equality and Diversity section of the Trust's intranet. A copy can also be obtained by contacting Michelle Tyler on Ex. 1596

Implementation Plan For : Detection and Management of Patients Colonised / Infected with MRSA

	ACTION	LEAD	TIMESCALE	PROGRESS/ OUTCOME	EVALUATION/ EVIDENCE	RAG RATING
<p>Co-ordination of Implementation</p> <ul style="list-style-type: none"> How will the implementation plan be co-ordinated? <p>(Clear co-ordination is essential to monitor and sustain progress against the implementation plan and resolve and other further issues that may arise)</p>	<p>Previous MRSA policy already in place and staff generally compliant. Need to ensure changes to be implemented due to DH guidance are understood by all affected</p>	PH	Dec 2011	<p>Education regarding high risk MRSA Emergency screening until new processes implemented and shown to be embedded in working practices</p>	<p>PCT and SHA returns will demonstrate 100% compliance with new process</p>	
<p>Engaging Staff</p> <ul style="list-style-type: none"> Who is affected directly or indirectly by the policy? Are the influential staff involved in the implementation? <p>(Engaging staff and developing strong working relationships will provide a solid foundation for changes to be made)</p>	<p>MRSA Emergency processes implemented, but require some changes. Influential staff part of team</p>	PH	Dec 2011	<p>New High Risk MRSA Emergency screening processes to be presented at PFFIC study day November 2011 and roll out in admission areas the same month</p>		
<p>Involving Service Users and Carers</p> <ul style="list-style-type: none"> Is there a need to provide information to service users and carers regarding this policy? Are there service users, carers, representatives or local organisations 	<p>New patient information leaflet developed. Patient forum have been consulted over</p>	PH	Dec 2011 Maintenance	<p>Education regarding high risk MRSA Emergency screening until new processes implemented and</p>	<p>IPaCT MRSA ICP audits will demonstrate compliance</p>	

<p>who could contribute to the implementation? (Involving service users and carers will ensure that any actions taken are in the best interest of service users and carers and that they are better informed about their care)</p>	new leaflet			shown to be embedded in working practices		
<p>Communicating</p> <ul style="list-style-type: none"> What are the key messages to communicate to the different stakeholders? How will these messages be communicated? <p>(Effective communication will ensure that all those affected by the policy are kept informed thus smoothing the way for any changes. Promoting achievements can provide encouragement to those involved)</p>	Fortnightly Bug Bulletins remind all staff of any changes required in practice Education sessions at Induction and Yearly Refresher for all Trust staff	PH	Dec 2011- Maintenance	Staff will be complaint with new processes	IPaCT MRSA ICP audits will demonstrate compliance	
<p>Training</p> <ul style="list-style-type: none"> What are the training needs related to this policy? Are people available with the skills to deliver the training? <p>(All stakeholders need time to reflect on what the policy means to their current practice and key groups may need specific training to be able to deliver the policy)</p>	Fortnightly Bug Bulletins remind all staff of any changes required in practice Education sessions at Induction and Yearly Refresher for all Trust staff Ad hoc sessions for staff if any failures in practice are identified	PH	Maintenance As required	Staff will be complaint with new processes	IPaCT MRSA ICP audits will demonstrate compliance	
<p>Resources</p> <ul style="list-style-type: none"> Have the financial impacts of any changes been established? 	Potentially reduction in costs due to	PH	April 2012		Lab will report reduction in screening	

<ul style="list-style-type: none"> Is it possible to set up processes to re-invest any savings? Are other resources required to enable the implementation of the policy e.g. increased staffing, new documentation? <p>(Identification of resource impacts is essential at the start of the process to ensure action can be taken to address issues which may arise at a later stage) (Engaging staff and developing strong working relationships will provide a solid foundation for changes to be made)</p>	targeted high risk screening				processing numbers	
<p>Securing and Sustaining Change</p> <ul style="list-style-type: none"> Have the likely barriers to change and realistic ways to overcome them been identified? Who needs to change and how do you plan to approach them? Have arrangements been made with service managers to enable staff to attend briefing and training sessions? Are arrangements in place to ensure the induction of new staff reflects the policy? <p>(Initial barriers to implementation need to be addressed as well as those that may affect the on-going success of the policy)</p>	Regular staff reminders of practices required to ensure maintenance of compliance with policy Fortnightly Bug Bulletins remind all staff of any changes required in practice Education sessions at Induction and Yearly Refresher for all Trust staff	PH	Dec 2010- Maintenance	Staff will be compliant with new processes	IPaCT MRSA ICP audits will demonstrate compliance	
<p>Evaluating</p> <ul style="list-style-type: none"> What are the main changes in practice that should be seen from the 	Targeted High Risk emergency admissions will	PH	Dec 2011- Maintenance	Staff will be compliant with new processes	IPaCT MRSA ICP audits will demonstrate	

<p>policy?</p> <ul style="list-style-type: none"> • How might these changes be evaluated? • How will lessons learnt from the implementation of this policy be fed back into the organisation? • What is the plan to audit the implementation of this policy? • What will the reporting process be for the results of the audit? <p>(Evaluating and demonstrating the benefits of new policy is essential to promote the achievements of those involved and justifying changes that have been made)</p>	<p>be screened, staff will need re-training re- new ICP layout</p>				<p>compliance</p>	
<p>Rick Management Issues</p> <ul style="list-style-type: none"> • What are the risks for any changes to practice or patient care? • How are these risks going to be managed? <p>(It is important to understand if there are any clinical risks to patients as a result of the introduction of this policy and, if so, the risks need to be thoroughly assessed and mitigating actions put into place)</p>	<p>N/A</p>					
<p>Other consideration</p>						

KEY* RAG RATING =



= NOT STARTED



= IN PROGRESS



= COMPLETED