Infection Prevention and Control
MRSA Policy
Policy Title: MRSA Policy

Executive Summary: The purpose is to clearly define for all Trust staff who have direct and indirect contact with patients the guidelines and management of MRSA. This policy is an amalgamation of the management of MRSA on all patients who are admitted to the Trust both electively and as an emergency admission.

Supersedes: MRSA and MRSA Screening policies 2012

Description of Amendment(s): Updated to reflect National guidelines and Organisational changes

This policy will impact on: Clinical Staff

Financial Implications: Increased Screening due to identification of new cases

Policy Area: Infection Prevention and Control Trust Wide

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Review Date: September 2018

Authors: Anita Swaine
Lead Nurse Infection Prevention and Control

Impact Assessment Date: April 2016

APPROVAL RECORD

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<td>April 2016</td>
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<td>Infection Prevention and Control Group</td>
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| Approved by:                                          | April 2016 |
| Date                                                  |            |
| Infection Prevention and Control                       |            |

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| Service Line SQS Groups                                |            |</p>
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1. Introduction

MRSA stands for Meticillin Resistant Staphylococcus aureus. (‘Meticillin’ has replaced the more familiar ‘Methicillin’) in accordance with international recommendations.

Staphylococcus aureus is a gram positive bacterium found on the skin and in the nose of approximately 30% of the population. Staphylococcus aureus can cause a variety of infections. These range from mild infections such as boils, abscesses and impetigo to severe infections of wounds, prosthesis and septicemia. In very rare cases these infections can be fatal.

MRSA is a type of Staphylococcus aureus that is resistant to most of the standard antibiotics used to treat staphylococcal infections. However, it is not resistant to all antibiotics and several options for treating MRSA infections remain available.

MRSA is generally thought not to be more virulent than other strains of Staphylococcus aureus.

Panton-Valentine Lukocidin (PVL) is a toxin which destroys white blood cells and is a virulence factor in some strains of Staphylococcus aureus, any reported cases will be followed up by Public Health England (for further information refer to Appendix 1)

There has been a national reduction in the number of MRSA blood stream infection (BSI) over recent years, however it remains unacceptable for a patient to acquire an MRSA BSI whilst receiving healthcare. To reduce this risk all healthcare providers are required to have systems and processes in place which protect the patient and ensure quality care provision.

The most common mode of transmission is by direct contact, usually hands. Spread may also occur via staff clothing, bedding and ward dust containing skin squames. MRSA can survive in dust for many months. Therefore direct contact with the patient and his/her bed linen or equipment, and dust-raising activities may lead to MRSA colonising staff member’s nostrils, hands and clothing with consequent spread to other patients. Appropriate use of aprons and gloves for patient contact and invasive procedures is important to minimise spread.

2. Purpose

The purpose is to clearly define for all Trust staff who have direct and indirect contact with patients the guidelines and management of MRSA. This policy details the management of MRSA on all patients who are admitted to the Trust both electively and as an emergency admission.

MRSA screening is predominantly undertaken in 3 clinical areas as per the Department of Health (DH) Guidelines (2013); enabling staff to risk assess and isolate patients with either suspected or confirmed MRSA in order to reduce the risk of transmission whilst in a health care setting:

I. Preoperative assessment for identified high risk patients
II. Admission as an emergency patient either via the emergency floor or directly into ICU
III. Following identification of a new MRSA isolate within the clinical area.
3. Roles and Responsibilities

3.1 Responsibilities

- **The Chief Executive**: has ultimate responsibility for the implementation and monitoring of the policies in use in the Trust. This responsibility may be delegated.

- **The Director of Nursing, Performance and Quality, Director of Infection Prevention and Control (DIPC)**: has strategic responsibility for Infection Prevention and Control within the Trust and will take the lead responsibility for the development and implementation of this policy with support of the Lead Nurse - Infection Prevention and Control, and the Infection Prevention and Control Doctor.

- **Consultant Microbiologist, Infection Control Dr**: has the role of providing clinical advice within the Trust and to GP’s, and to ensure the accuracy of pathology results.

- **Antimicrobial Pharmacist**: To monitor best practice when antimicrobial and suppression therapy is prescribed.

- **The Infection Prevention and Control Team (IPCT)** has responsibility for ensuring that the policy is implemented and monitored across the Trust:
  - Day to Day advice and support from 8am- 5pm (Out of hours support via the on-call microbiologist)
  - Training and education to support clinical staff in implementing the policy
  - Implementing any changes to the Policy in light of new guidance
  - Ensuring compliance with the policy as part of a sustainable audit programme

- **Bed Managers/Site Managers** are responsible for ensuring patients are placed in accordance with this policy, and escalating to the IPCT any situations where safe placement cannot be achieved.

- **All Employees** are responsible for ensuring that standards of Infection Prevention and Control are maintained in line with Trust policy and procedures. Infection Prevention and Control training and standards will be monitored via the appraisal process

- **Occupational Health** are responsible for providing confidential advice and support to staff relating to MRSA screening and treatment, consulting with the Consultant Microbiologist as appropriate.

4. Who to Screen for MRSA

4.1 MRSA screening on Admission

DH (2014) screening guidance recommends MRSA screening of patients deemed as “High Risk for MRSA” based on local risk assessments. The Trust therefore has implemented the following screening criteria:

- All admissions via the emergency floor (MAU, AAU, A/E)
- All admissions to ICU
- All transfers in from another organisation including SCBU
- All patients admitted to Chemo therapy pathway
• All previously known MRSA positive patients
• Prior to the insertion of a long line

4.2 Pre-admission screening
This will be undertaken as part of the elective admission pathway relating predominantly to surgical patients within the following categories:
• Orthopaedic joint surgery e.g. hips, knees
• All inpatient surgical patients’ e.g. large bowel surgery, hysterectomy
• All previously known MRSA positive patients.

4.3 Do we need to screen in-patients with MRSA?
In patients are not routinely screened for MRSA, any patient identified as MRSA positive (Colonisation or Infection) must be rescreened as per the suppression regime (Terms and Definitions Appendix 2)

Patients who have been transferred from high risk areas such has ICU, Renal, (excluding intermediate care) and continue to remain inpatients beyond 4 weeks from their last screen should be screened fortnightly. This would also apply to severely immunocompromised patients and neonates who have tested positive either at birth or afterwards. This will be requested by the IPCN/Consultant Microbiologist, this request will be documented in the patient’s notes.

Further screens will be requested by the IPCN/Consultant Microbiologist, this request will be documented in the patient’s notes.

Where a patient has been identified as either MRSA colonisation/infection in a main bay, contact screening will be required for the remaining patients in the bay.

Effective hand hygiene after direct patient contact will prevent the spread of MRSA from patient to patient.

4.4 Should staff be screened for MRSA?
Routine screening of staff for carriage of MRSA is not required as a routine process. The Consultant Microbiologist in co-ordination with Occupational Health may implement screening for staff based on the epidemiological pattern of increased isolates within a clinical area.

4.5 Which patients don’t require MRSA screening (unless previous MRSA history)
• Children under 16 (unless transferred from another healthcare organisation).
• Day case surgery
• Day case endoscopy
• Day case dental
• Day case ophthalmology

4.6 Can a Patient refuse to have an MRSA screen?
Patients have the right to refuse an MRSA screen; staff should explain the rationale behind the screening process and try to understand the patient’s concerns. Further advice and support can be obtained from the Infection Prevention and Control team. The details relating to the refusal must be clearly documented in the patients’ medical notes.
4.7 Which Sites do I take swabs from?
All patients who require an MRSA screen must have a screen taken from the following sites:
- Nose
- Groin or Perineum
- Any skin lesions from any site- e.g. broken or damaged skin, wounds, IV sites etc. Any areas of eczema or psoriasis. NB please do not remove dressings to swab or wound or site please swab when the dressing is next changed.
- Urine, if catheterised
- Sputum, if the patient has a productive cough
- Tracheal/ endotracheal aspirate where applicable.

4.8 How to take an MRSA Swab
For routine MRSA screens e.g. nose, groin, wounds etc. use one dedicated pathology request card. It is acceptable for all the screens to be sent off for laboratory testing together providing the swabbing sites are clearly documented on the pathology request card and specimen swab / container.

Routine admission MRSA screening sites
<table>
<thead>
<tr>
<th>Nose - both nostrils</th>
<th>Wounds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Groin / perineum</td>
<td>Skin lesions e.g. eczema</td>
</tr>
</tbody>
</table>

MRSA enhanced / contact screening sites
<table>
<thead>
<tr>
<th>Cannulae</th>
<th>Tracheostomy sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSU / CSU from urethral catheters</td>
<td>Sputum if possible</td>
</tr>
<tr>
<td>Umbilicus in infants</td>
<td></td>
</tr>
</tbody>
</table>

Equipment
- Non sterile examination gloves and apron (sterile glove if undertaking ANTT)
- One Transwab® Amies Charcoal wound swab per swabbing site
- Sterile universal container if pus / urine samples are required
- Pathology request card & bag

How to perform nasal screen
- Tilt the patient’s head back to 70 degrees. Insert swab less than one inch into the nostril (until resistance is met at the turbinate) and gently rotate the swab. Rotate the swab several times against the nasal wall and repeat in other nostril using the same swab.
- When completed insert swab back into the transport medium securely and annotate with patient details & site of screen.

How to perform groin screen
- Rotate swab side to side in groin, using same swab repeat on other side.
- When completed insert swab back into the transport medium securely and annotate with patient details & site of screen.

How to perform wound swab
- Obtain the specimen prior to any dressing or cleaning procedure of the wound. This will maximise the material obtained and prevent killing of the organism by the use of antiseptics.
• Rotate on the area to collect exudate from the wound and place into the transport medium securely.
• Where there is a pus collection, place as much pus as possible into a sterile container (do not use a swab), annotate with patient details and sample site and send to the laboratory.

**Urine specimen**

• Midstream urine or 'clean catch' specimen - this is the most popular non-invasive method.
• Ensure that the patient’s genitalia has been thoroughly washed with soap and water and sufficiently dried.
• In the female encourage separation of the labia whilst passing urine.
• In the male encourage retraction of the prepuce, if appropriate, whilst passing urine.
• Ask the patient to void a small amount of urine into the toilet first then to urinate 10-20 ml directly into the specimen container.
• Place the lid securely on the specimen container. Wipe the outside of the container with a detergent / disinfectant wipe, annotate with patient details.
• Label each Transwab® Amies Charcoal swab and pathology card with the patient details.
• A minimum of three patient identifiers must be evident on the pathology request form to ensure the specimen is processed. Include all clinical and antibiotic information.

Organise for specimens to be sent to the laboratory. Do not place in ward fridge.

**4.9 Suppression Therapy for patients with MRSA**

All inpatients with MRSA colonisation/infection must be reviewed for Suppression therapy this includes newly identified MRSA patients. Decolonisation should be implemented once an initial full set of screening results has been received.
SUPPRESSION THERAPY FOR CARRIAGE OF MRSA
(To be kept with nursing records)

The following suppression therapy is recommended by the Consultant Microbiologist or Infection Prevention and Control Team.

Please ask the relevant medical staff write up the following on the patient’s drug chart:

<table>
<thead>
<tr>
<th>Body Treatment</th>
<th>Start Date</th>
<th>Finish Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Octenisan Wash Lotion</td>
<td></td>
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<tr>
<td>Wash daily for 5 days including hair washing on day 2 and 4. Apply neat (do not dilute) to a damp washcloth and rub onto areas of the body to be cleansed. Ensure 1 minute contact time, then wash off. OR Use in the shower in the same way as commercial hair and skin washing preparations, apply neat (do not dilute), ensure 1 minute contact time, then wash off.</td>
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</table>

<table>
<thead>
<tr>
<th>Nasal Treatment</th>
<th>Start Date</th>
<th>Finish Date</th>
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<tbody>
<tr>
<td>Octenisan Nasal Gel*</td>
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<tr>
<td>Apply a small amount twice a day for 5 days to the inner surface of each nostril using a cotton bud or little finger. Press the sides of the nostrils together and massage gently to distribute the gel. Do not insert too high into the nose. *Suitable for use in patients with a peanut allergy or chlorhexidine sensitivity and is paraffin-free so compatible with oxygen use.</td>
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</tbody>
</table>

Wounds

Treatment of a wound
Wounds colonised with MRSA do not routinely require treatment. Infected wounds warrant systemic antibiotic treatment. Furthermore, topical applications cause disruption of the healing environment of the wound and unnecessary dressing changes. Seek specialist advice on suitable dressings and the management of complex wounds from Tissue Viability Nurse.

On completion of the above suppression course, wait for 2 days and then repeat MRSA screening. Nose, perineum, any wounds and previously positive sites.

Date post suppression screen due:

- If any irritation or adverse reaction occurs - STOP USE IMMEDIATELY. Inform the patient’s doctor and the Infection Prevention and Control Team.
- If the patient is discharged home or into a community care setting whilst receiving treatment, please send a copy of this to the district nurse/GP or the Nurse/Manager in charge of the care facility.
- If you have any queries please contact the Infection Prevention and Control Team on ext.1597 or bleep 3034 and 3449.

Signed Date
4.10 Actions required for patients identified as MRSA positive via pre-operative assessment clinic

- ICNET letter taken by the ICT to pre-operative clinic advising them of positive MRSA result.
- Preoperative assessment clinic contacts patient and advises them of positive MRSA result.
- Preoperative assessment staff to arrange for patient to have decolonisation for five days prior to admission with day five being the day of admission.
- Appropriate ALERTS added to patient records and CRIS system.
- Patient to be listed last on the list for surgery unless the Surgeon identifies this would be a clinical risk.

Further advice from the Consultant Microbiologist re additional treatment (antibiotics) should be sought prior to the patient’s procedure.

5. Actions to take for Patients identified as MRSA positive

All patients identified as MRSA positive (infection or colonisation) must have the following actions implemented (Prevention and Control Measures appendix 3)

- ALERT sticker placed on the front cover of patients medical notes, the full details must be recorded in the appropriate section of the inside cover.
- Identification on the CRIS bed management system.
- Patient must be allocated a side-room on admission/ identification of positive specimen.
- Commenced on an MRSA care pathway
- Reviewed with the IPCT/ Consultant Microbiologist to establish if Suppression therapy is required

5.1 When are patients classed as MRSA clear?

This will be advised by the Infection Prevention and Control Team:

- The first post treatment screen must be taken 48 hours after stopping eradication treatment, then at weekly intervals thereafter (three negative consecutive screens)
- Time intervals for the screen will be advised by the IPCT, this is usually 7 days apart
- All sites must be re-screened, not just the positive sites
- If one of the clearance screens is positive seek advice from the IPCT

6. Isolation requirements for Patients with MRSA (as per Isolation Policy)

- Isolate the patient into a single room, ideally with en-suite facilities and with the door closed. If this is likely to compromise patient care, then a risk assessment must be undertaken and documented in the patients’ medical notes.
- Display the relevant Infection Control signage on the door
- The named nurse must notify the Healthcare Cleaning Manager of the need for additional cleaning (as per the Cleaning policy).
- If a patient is identified as MRSA positive in a main bay they should be moved to a side room and standard isolation precautions commenced.
- If the patient has been in the bay for more than 24hrs contact screening will be required from the remaining patients in the bay.
• Isolation precautions may be discontinued only after consultation with the IPCT this is usually on the receipt of negative MRSA screens.

Please note on occasions following the identification of other microorganisms for example Clostridium difficile or VRE a risk assessment of side rooms may be required. This should be undertaken in conjunction with the Nurse in Charge, Bed manager and during core hours the IPCT.

6.1 Where do I get advice on treating an MRSA Infection?
If a patient is suspected of having an MRSA infection the patient's medical team must discuss treatment options with the Consultant Microbiologist and refer to the Antimicrobial policy and guidelines.

6.2 What actions need to be taken for a patient going to theatre?
• Patients who are known MRSA positive and admitted for surgery must be placed last on the list.
• Topical suppression and prophylactic antimicrobial chemotherapy must be considered to minimise the risk of infection this should be discussed with the Consultant Microbiologist.
• Staff must wear the required PPE (as per Standard Precautions Policy)
• All equipment and surface areas must be cleaned with sanitising wipes e.g. Clinell detergent/disinfectant wipe
• Recovery should occur, as far as practicable, separate from other patients.
• Minimal equipment must be left in the recovery area
• Strict hand hygiene must be practiced, using the five moments of hand hygiene as per hand hygiene policy.
• If the patient spends a prolonged period in the recovery area advice should be sought from the ICT on levels of cleaning required in accordance with theatre cleaning SOP.

7. What actions do I take if the patient is identified with an MRSA Blood stream infection (BSI)
All MRSA BSI must have a Post Infection Review (PIR) to identify how the case occurred, identifying any actions to reduce the risk of a reoccurrence in the future (NHS England 2014).

This review will attribute which organisation is responsible for the case (Pre 48hrs CCG, Post 48 hrs acute provider), and identify the cause of and any contributing factors either directly or indirectly related to the development of an MRSA BSI:
• MRSA BSI must be recorded on DATIX by the clinical area receiving the result as this will be escalated as a serious untoward incident.
• A formal review must be undertaken within 10 days of the trust notification of the positive blood cultures. This is a multidisciplinary review incorporating the IPCT, Clinical staff including the Consultant responsible for Patient care, Matron and CCG representative.
• Outcome of the PIR must be documented on Public Health England HCAI data collection system.
8. **Can a patient with MRSA be discharged?**

- Patients can be discharged to another care provider however the MRSA status must be clearly detailed in the EDNF.
- If suppression therapy has not been completed details re completion of this must be included in the patients discharge information to enable them to complete the course of treatment at home.
- Patients can be discharged to their own homes without any additional requirements, they should be advised to continue with good hand hygiene, general cleaning (no specific products are required).
- Patients should be reassured that they pose no danger to their family members and offered an MRSA patient information leaflet.
- If a patient is discharged home and requires additional support from District nurses, or other support service they **MUST** be informed of the patient’s MRSA status as they may not see the EDNF.
- All wounds and/or invasive devices must be managed in accordance with the principles of ANTT.
- Advice on clinical signs of infection in the community should be obtained from the patients GP, additional advice re antimicrobial management can be obtained from the Consultant Microbiologist.

9 **Training**

All clinical staff must undertake Trust infection control mandatory training annually. Additional training on MRSA management will be provided by the IPCT

10 **Monitoring Compliance**

The infection prevention and control team will review and investigate incidents reported relating to this policy and audit departments compliance as part of the annual audit programme.

Failure to follow the guidance in this policy will be reviewed as part of the Post Infection Review process and consideration given if this constitutes a Lapse in Care contributing to the development of an infection. This will be monitored through the Infection Prevention and Control Committee.

Non-compliance with the policy will be managed via the staff disciplinary route; this will be supported by the Director of Nursing, Quality, Performance, DIPC, and the Medical Director.

This policy should be read in conjunction with (but not exclusively):

- Standard Precautions policy
- Isolation Policy
- Outbreak Policy
- ANTT Policy
- Blood Culture policy
Legislation, Guidance and References


NICE quality standard(2014) Guidelines for Infection Prevention and Control

Appendix 1

<table>
<thead>
<tr>
<th>Diagnosis and management of Panton-Valentine Luckocidin (PVL) positive Staphylococcal Infections</th>
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<tr>
<td><strong>Background</strong></td>
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<tr>
<td><strong>Skin Infections</strong></td>
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<tr>
<td><strong>Screening and decolonisation of contacts</strong></td>
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</table>
### Infection Prevention and Control

Patients must be screened (nose, groin and skin lesions) for *Staphylococcus aureus* carriage. Suppression is the same as that for MRSA. Suppression may need to be used to eradicate skin or upper respiratory carriage. In healthcare settings contact precautions must be maintained, use of personal protective equipment, effective hand hygiene and an increased cleaning regime.

Surgical masks must be worn during intubation and physiotherapy.

Closed tracheal suction must be used since secondary cases may occur.

### Necrotising pneumonia

PVL-positive strains of *Staphylococcus aureus* have been associated with a rapidly progressive, haemorrhagic, necrotising community-acquired pneumonia in young immunocompetent patients which has 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. **Treatment must be discussed with the Consultant Microbiologist.**

### Staff contacts

Further actions will be decided by the Consultant Microbiologist in conjunction with Occupational Health.
### Appendix 2 – terms and definitions

<table>
<thead>
<tr>
<th>Definitions</th>
<th>MRSA</th>
<th>Meticillin-resistant <em>Staphylococcus aureus</em></th>
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<tbody>
<tr>
<td>MRSA BSI</td>
<td>Bloodstream infection, signs and symptoms of sepsis.</td>
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<tr>
<td>Colonisation</td>
<td>MRSA is found on the skin or mucous membranes but there are no signs or symptoms of infection. These patients generally do not require any treatment</td>
<td></td>
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<tr>
<td>Infection</td>
<td>The presence and multiplication of pathogenic microorganisms in the body, causing specific signs and symptoms. These may include local evidence of inflammation e.g. redness, swelling, tenderness, heat and pain</td>
<td></td>
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<tr>
<td>Pathogenic</td>
<td>Potential to cause infection</td>
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<tr>
<td>Cohort nursing</td>
<td>Nursing of patients with the same type of infection in the same bay cared for by staff dedicated for that area</td>
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<tr>
<td>HCAI</td>
<td>Health Care Associated Infection acquired following the interventions of healthcare staff in either hospital or community settings</td>
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<td>PHE</td>
<td>Public Health England</td>
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<tr>
<td>ALERTS</td>
<td>Orange coloured sticker placed on the front of patients notes indicating there is a particular risk, this risk can be an Infection, Drug allergy etc. In addition to the sticker the Alert section on the inside of the notes must be completed</td>
<td></td>
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Appendix 3 – Actions to take for Patients identified as MRSA positive

<table>
<thead>
<tr>
<th>Prevention and Control Measures</th>
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<tr>
<td><strong>General Measures</strong></td>
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<tr>
<td>As some patients with MRSA may already be established within a clinical area prior to their MRSA positive status being recognised, the importance of maintaining a high standard of infection prevention and control within all clinical areas at all times cannot be over emphasised. This includes good hand hygiene practice, appropriate use of protective clothing and thorough environmental cleaning.</td>
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<tr>
<th>Source Isolation Procedures</th>
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<tr>
<td><strong>Patient Placement</strong></td>
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<tr>
<td>When Isolation of MRSA positive in-patients is indicated the in a single room using Source isolation Precautions. The room must have hand washing and toilet facilities. The appropriate infection prevention and control signs must be displayed outside the door. Equipment must be kept to a minimum as this will need to be decontaminated/ disposed of once the patient is discharged. Mattress and pillow covers must be intact. A clinical waste bin must be placed in the room.</td>
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<table>
<thead>
<tr>
<th>Hand Washing</th>
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<tbody>
<tr>
<td>Hands must be decontaminated using liquid soap and water on entering and leaving the side room</td>
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<tr>
<th>Gloves</th>
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<tr>
<td>Gloves must be worn when undertaking direct patient care or contact with their immediate environment. These must be changed between patient care activities that may result in gross contamination, e.g. faeces, wound exudates. Gloves must be removed before leaving the room and discarded into clinical waste bins provided. hand must then be decontaminated with liquid soap and water.</td>
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<thead>
<tr>
<th>Aprons</th>
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<tr>
<td>A yellow disposable plastic apron must be worn for activities that will involve close contact with the Patient or their immediate environment. The apron must be removed on leaving the room and discarded into the clinical waste bin provided.</td>
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<table>
<thead>
<tr>
<th>Linen</th>
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<tbody>
<tr>
<td>Linen must be placed in the red plastic bag</td>
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<table>
<thead>
<tr>
<th>Cleaning</th>
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<tbody>
<tr>
<td>During patients inpatient stay Infection clean X1 daily (Including dedicated bathroom / toilet) using Sporicidal e.g. Tristal. Equipment can be cleaned after use with detergent wipes e.g. Clinnell green. On discharge the room will require a post infection clean which must be requested via ISS. Any unused single patient use equipment e.g. wipes, dressings must be disposed of into the correct waste stream.</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Crockery and cutlery</th>
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</thead>
<tbody>
<tr>
<td>No special measures are required these can be sent back to the kitchen as per all other returns</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Waste</th>
</tr>
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<td>Sharps must be disposed of into the sharps bin within the room. Clinical waste should be place into the clinical waste bag.</td>
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</table>
Equality Analysis (Impact assessment)
Please START this assessment BEFORE writing your policy, procedure, proposal, strategy or service so that you can identify any adverse impacts and include action to mitigate these in your finished policy, procedure, proposal, strategy or service. Use it to help you develop fair and equal services.
Eg. If there is an impact on Deaf people, then include in the policy how Deaf people will have equal access.

1. What is being assessed?

**MRSA Policy**

Details of person responsible for completing the assessment:

- **Name:** Anita Swaine
- **Position:** Lead Nurse Infection Prevention and Control
- **Team/service:** Infection Prevention and Control

State main purpose or aim of the policy, procedure, proposal, strategy or service: (usually the first paragraph of what you are writing. Also include details of legislation, guidance, regulations etc which have shaped or informed the document)

The purpose is to clearly define for all Trust staff who have direct and indirect contact with patients the guidelines and management of MRSA. This policy is an amalgamation of the management of MRSA on all patients who are admitted to the Trust both electively and as an emergency admission

2. Consideration of Data and Research
To carry out the equality analysis you will need to consider information about the people who use the service and the staff that provide it. Think about the information below – how does this apply to your policy, procedure, proposal, strategy or service

2.1 Give details of RELEVANT information available that gives you an understanding of who will be affected by this document

Cheshire East (CE) covers Eastern Cheshire CCG and South Cheshire CCG. Cheshire West & Chester (CWAC) covers Vale Royal CCG and Cheshire West CCG. In 2011, 370,100 people resided in CE and 329,608 people resided in CWAC.

**Age:** East Cheshire and South Cheshire CCG’s serve a predominantly older population than the national average, with 19.3% aged over 65 (71,400 people) and 2.6% aged over 85 (9,700 people).

Vale Royal CCGs registered population in general has a younger age profile compared to the CWAC average, with 14% aged over 65 (14,561 people) and 2% aged over 85 (2,111 people).

Since the 2001 census the number of over 65s has increased by 26% compared with 20% nationally. The number of over 85s has increased by 35% compared with 24% nationally.
Race:
- In 2011, 93.6% of CE residents, and 94.7% of CWAC residents were White British
- 5.1% of CE residents, and 4.9% of CWAC residents were born outside the UK – Poland and India being the most common
- 3% of CE households have members for whom English is not the main language (11,103 people) and 1.2% of CWAC households have no people for whom English is their main language.

Gender:
- In 2011, c. 49% of the population in both CE and CWAC were male and 51% female. For CE, the assumption from national figures is that 20 per 100,000 are likely to be transgender and for CWAC 1,500 transgender people will be living in the CWAC area.

Disability:
- In 2011, 7.9% of the population in CE and 8.7% in CWAC had a long term health problem or disability
- In CE, there are c.4500 people aged 65+ with dementia, and c.1430 aged 65+ with dementia in CWAC. 1 in 20 people over 65 has a form of dementia
- Over 10 million (c. 1 in 6) people in the UK have a degree of hearing impairment or deafness.
- C. 2 million people in the UK have visual impairment, of these around 365,000 are registered as blind or partially sighted.
- In CE, it is estimated that around 7000 people have learning disabilities and 6500 people in CWAC.
- Mental health – 1 in 4 will have mental health problems at some time in their lives.

Sexual Orientation:
- CE - In 2011, the lesbian, gay, bisexual and transgender (LGBT) population in CE was estimated at18,700, based on assumptions that 5-7% of the population are likely to be lesbian, gay or bisexual and 20 per 100,000 are likely to be transgender (The Lesbian & Gay Foundation).
- CWAC - In 2011, the LGBT population in CWAC is unknown, but in 2010 there were c. 20,000 LGB people in the area and as many as 1,500 transgender people residing in CWAC.

Religion/Belief:
The proportion of CE people classing themselves as Christian has fallen from 80.3% in 2001 to 68.9% In 2011 and in CWAC a similar picture from 80.7% to 70.1%, the proportion saying they had no religion doubled in both areas from around 11%-22%.

- Christian: 68.9% of Cheshire East and 70.1% of Cheshire West & Chester
- Sikh: 0.07% of Cheshire East and 0.1% of Cheshire West & Chester
- Buddhist: 0.24% of Cheshire East and 0.2% of Cheshire West & Chester
- Hindu: 0.36% of Cheshire East and 0.2% of Cheshire West & Chester
- Jewish: 0.16% of Cheshire East and 0.1% of Cheshire West & Chester
- Muslim: 0.66% of Cheshire East and 0.5% of Cheshire West & Chester
- Other: 0.29% of Cheshire East and 0.3% of Cheshire West & Chester
• **None:** 22.69% of Cheshire East and 22.0% of Cheshire West & Chester
• **Not stated:** 6.66% of Cheshire East and 6.5% of Cheshire West & Chester

Carers:
- In 2011, nearly 11% (40,000) of the population in CE are unpaid carers and just over 11% (37,000) of the population in CWAC.

2.2 **Evidence of complaints on grounds of discrimination:** (Are there any complaints or concerns raised either from patients or staff (grievance) relating to the policy, procedure, proposal, strategy or service or its effects on different groups?)

| None |

2.3 Does the information gathered from 2.1 – 2.3 indicate any negative impact as a result of this document?

| None |

3. **Assessment of Impact**

Now that you have looked at the purpose, etc. of the policy, procedure, proposal, strategy or service (part 1) and looked at the data and research you have (part 2), this section asks you to assess the impact of the policy, procedure, proposal, strategy or service on each of the strands listed below.

**RACE:**
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, racial groups differently?

Yes ☐ No √

**Explain your response:** For any patient whose first language is not English, as information needs to be provided and understood, staff will follow the trust interpretation policy.

**GENDER (INCLUDING TRANSGENDER):**
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, different gender groups differently?

Yes ☐ No √

**Explain your response:** No impacts identified.

**DISABILITY**
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, disabled people differently?

Yes √ No ☐

**Explain your response:** Clinical staff will need to implement support for patients in isolation as this is a mandatory requirement of this policy.
Staff should follow the trust interpretation policy for people who are Deaf and involve the health facilitators for people with learning disabilities.

**AGE:**
From the evidence available does the policy, procedure, proposal, strategy or service, affect, or have the potential to affect, age groups differently?  
Yes □ No √

**Explain your response:** Visitors at the extremes of the age range should be discouraged from visiting as they may be more susceptible.

**LESBIAN, GAY, BISEXUAL:**
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, lesbian, gay or bisexual groups differently?  
Yes □ No √

**Explain your response:** No impacts identified.

**RELIGION/BELIEF:**
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, religious belief groups differently?  
Yes □ No √

**Explain your response:** No impacts identified.

**CARERS:**
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, carers differently?  
Yes √ □ No

**Explain your response:** May need to be involved in the support of the patient during admission and post discharge. Therefore staff must ensure they receive the appropriate information on management of Isolation precautions and the management of a particular organism. On occasions language may be a barrier to the information required therefore Clinical staff should access interpreter services as per Trust guidelines.

**OTHER:** EG Pregnant women, people in civil partnerships, human rights issues.
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect any other groups differently?  
Yes □ No √

**Explain your response:** No other impacts identified.

4. Safeguarding Assessment - CHILDREN
a. Is there a direct or indirect impact upon children?  
   Yes ☐  No ☐

b. If yes please describe the nature and level of the impact (consideration to be given to all children; children in a specific group or area, or individual children. As well as consideration of impact now or in the future; competing / conflicting impact between different groups of children and young people:

c. If no please describe why there is considered to be no impact / significant impact on children. This policy applies the same as for adult patients. If any concerns are noted with any child these would be escalated via the appropriate channels. Information would be provided to relatives to ensure they understand VRE, the need for screening and isolation.

5. Relevant consultation
   Having identified key groups, how have you consulted with them to find out their views and that the made sure that the policy, procedure, proposal, strategy or service will affect them in the way that you intend? Have you spoken to staff groups, charities, national organisations etc?

   This policy has been ratified by the ICG which includes a member of the public. As with the majority of IC policies it is acknowledged that staff need to support individuals who require Isolation, any variance to this must be clearly documented in the patients notes as part of their clinical care.

6. Date completed: 27/5/2016  
   Review Date: 27/2/2018

7. Any actions identified:
   Have you identified any work which you will need to do in the future to ensure that the document has no adverse impact?

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<th>Action</th>
<th>Lead</th>
<th>Date to be Achieved</th>
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8. Approval:
   At this point, you should forward the template to the Trust Equality and Diversity Lead lynbailey@nhs.net

   Approved by Trust Equality and Diversity Lead:

   Date: 16.5.16