UKSH

Title: Meticillin Resistant Staphylococcus Aureus (MRSA) Screening Policy Date of Implementation: December 09			
Policy No:	IPC 25	Copy No:	
Version:	1	Review Date:	December 2012
Issue Date:	15.12.2009		
1 Compiled by: P Vaughan-Brookes Date: December 09	Signature:	2 Approved By: Date:	Signature:
3 Presented to Board / Committee: UKSH Board Date: December 09	Signature:	4 Authorised by: UKSH Board Date: December 09	Signature:
National Minimum Standard (2002)		NHSLA	

Document Control: This policy replaces the following policy

Title: Infection Control–Meticillin Resistant Staphylococcus Aureus (MRSA) Screening Policy			
Policy No:	CR26a	Copy No:	
Version:	1	Review Date:	April 2012
Issue Date:	April 2009		
Archived By:	C Farnworth-Newman	Date:	15.12.2009

This policy is applicable to:

Location

- ☒ All UKSH locations
- ☒ UKSH Head Office
- ☒ Shepton Mallet
- ☒ Emersons Green
- ☒ Devizes
- ☒ Cirencester

Staff

- ☒ All Staff
- ☐ All non-clinical staff
- ☐ All clinical staff
- ☐ Medical staff
- ☐ Nursing staff
- ☐ Allied Health Professionals
- ☐ Administrative staff
- ☐ Facilities staff
- ☐ Managers/Heads

Department

- ☒ All Departments
- ☐ All Clinical Departments
- ☐ All Administration
- ☐ Radiology
- ☐ Theatres
- ☐ Out Patients
- ☐ Ward
- ☐ Pharmacy
- ☐ CSSD
- ☐ Physiotherapy
- ☐ Supplies
- ☐ Kitchen

1 Objective

The aim of this policy is to reduce the risk of infection from MRSA for all patients who access the services of UKSH Treatment Centres. This policy aims:

- to reduce the risk of patients who are carriers of (or colonised with) MRSA developing an infection and
- reduce the risk of non-colonised patients becoming colonised.

Screening for MRSA allows the detection of patients colonised with MRSA so that precautions can be taken to reduce the risk of infection for the patient and precautions can be taken to reduce the risk of transmission of MRSA to other patients

2 Scope

This policy details the requirements for all staff involved in the screening of patients for MRSA. However, this policy does not address the management of those patients identified as being colonised by MRSA

2.1 Introduction

Staphylococcus aureus is a common bacteria and between 30 and 40% of the population may be colonised. Staphylococcus aureus is a common cause of wound infections. Meticillin Resistant Staphylococcus aureus is a strain that is resistant to many of the antibiotics used to treat infections. Therefore, infections caused by MRSA are difficult to treat, may cause serious potentially life threatening illness and significantly increase the costs of healthcare.

Colonisation of MRSA is harmless in the healthy individual but may become highly problematic in healthcare settings as:

- Patients colonised with MRSA who undergo invasive procedures are at risk of developing an MRSA infection.
- Presence of patients colonised with MRSA in hospitals is a potential source of infection for other patients.
- Should MRSA infections develop they are harder to treat as the antibiotics they are susceptible to are more limited.

MRSA colonisation is asymptomatic and may only be identified by taking swabs from appropriate sites. It is therefore important that patients who may be colonised with MRSA are identified so that:
a) Appropriate action can be taken to minimise the risk of post operative infection and
b) Action can be taken to protect other patients from acquiring the MRSA.

2.2 Definition of Terms

Staphylococcus aureus (Staph aureus)A gram positive bacterium frequently found on the skin or in the nose, axilla and / or perineum.

MRSA A strain of Staph aureus that is resistant to many antibiotics (particularly Flucloxacillin) that are uses in the treatment of infections.

MRSA Colonisation. When MRSA is present on / in an individual and is not causing any symptoms of infection, the individual is considered to be colonised.

MRSA Infection. When MRSA gains access to tissues beneath the skin and mucosa (for example, a surgical wound) and produces symptoms then an infection is defined.

Screening. Testing for the presence of MRSA by taking swabs from the most commonly colonised body sites, such as the nose.

MRSA contact. A patient who has been residing in the immediate vicinity of a MRSA positive patient for 48 hours or longer.

Contact screening. Screening of MRSA contact patients.

3 Policy responsibilities

Head of Nursing and Clinical Services
Is responsible for providing, via the Registered Manager, assurance to the UKSH Board that MRSA screening is being implemented as required by Department of Health guidance.

Infection Prevention and Control Team (IPC Team)
Are responsible for:

- Advising and training clinical staff on MRSA screening protocols.
- Advising patients on issues pertaining to MRSA and screening processes as may be requested by clinical staff.
- Monitoring screening compliance at UKSH Treatment Centres through audit conducted at regular intervals.

Ward and Department Managers
Are responsible for:

- Ensuring their staff understand and implement the screening practices as stated in this policy.
- Undertaking screening compliance audits in their areas at regular intervals.
- Instigating remedial action as necessary to address screening compliance issues within their department.

Medical Director
Is responsible for ensuring all medical staff (including locums) understand and implement the screening practices as stated in this policy.

All Clinical Staff
Are responsible for:

- Complying with all aspects of this policy.
- Ensuring that all patients are screened as required and results checked

4 Procedure

4.1 Who should be screened for MRSA?

Elective Admissions

All elective inpatient and day case admissions will be screened in advance of admission in line with Department of Health guidelines The Department of Health allows for the following exclusions:

- Day case ophthalmology
- Day case dental
- Day case endoscopy
- Minor dermatology procedures eg warts or other liquid nitrogen applications
- Children
- Maternity / obstetrics

However, the exclusions apply where there are no known risk factors and patients being treated at UKSH Treatment Centres will be assessed by on an individual basis.

Long Stay Patients

All patients that have extended inpatient stays (greater than one month) will be rescreened at 28 day intervals until such time as they are discharged.

Out Patients.

Patients attending Out Patient Clinic for consultations only, need not be screened. However, all patients who receive treatment in clinics for instance injections to joints, are classed as day case patients and must be screened.

Staff Screening

Routine screening of staff is unnecessary. Screening is usually only advised in the event of an MRSA outbreak where the organism spreads despite the control measures.

Any screening programme that involves staff will be co-ordinated by Occupational Health services.

Investigation and treatment of staff is the responsibility of Occupational Health with support from the IPC team. Confidentiality must be maintained at all times.

Healthcare staff with infected skin lesions should report to Occupational Health via their line manager.

Healthcare staff, including those outside of UKSH Treatment Centres, who present for surgery, should be screened after they have been away from their place of work for a minimum of 48 hours. This will distinguish between chronic colonisation, which will require suppression and transient colonisation which is self limiting and therefore would not be treated.

Contact Screening

Individuals in prolonged contact with MRSA are at increased risk of colonisation. Therefore, any patient who has been nursed in the same room as an MRSA positive patient will require rescreening.

4.2 Which sites should be screened for MRSA?

Inpatient admissions will undergo a full MRSA screen which will include swabs being taken from the following sites:

- Nose - one side only from 1cm inside the nostril
- Groin – one side only
- All broken areas of skin – wounds
- Catheter Specimen Urine (CSU) – only if indwelling catheter in situ
- Sputum – only if productive cough present

Day case admissions should be risk assessed to determine whether a full screen is necessary. If the patient is deemed to be low risk then a nose swab alone will be sufficient. Further guidance is given in Appendix 1 – Pre operative assessment MRSA flowchart.

4.3 Procedure for Screening

When taking swabs from dry areas of the body, for example the groin, the swab must be moistened with sterile water or saline prior to obtaining the sample.

The following process must be adopted when obtaining a swab:

- Decontaminate hands using soap and water and/or alcohol gel before swabbing
- Sites should be swabbed using an aseptic technique to avoid erroneous results
- Moisten swabs as necessary
- Rub and rotate the swab firmly on each area
- For nasal swabs only one nostril is required. Do not penetrate further than 1cm
- Place swab in the medium tube and write on patient details. Do not use an addressograph label
- Each patient screen must be accompanied by a microbiology form that is labelled 'MRSA screen'. All screening swabs may be entered onto a single form.
- NB: If a sample is sent for MRSA screen this is the only organism that will be identified.

4.4 Patient Information

A Department of Health (updated 4.2.09) patient information leaflet on MRSA screening is available in Appendix 2. This should be used as guidance only as further individual information and advice may be sought from the Infection Prevention and Control Team.

4.5 Audit and Compliance Monitoring

IPC Team will undertake monthly auditing of MRSA screening compliance. Results will be included in the monthly governance report.

Remedial actions that are highlighted from the audits will be addressed through Governance.

4.6 Evaluation and Review

This policy will be reviewed in three years. Review will be sooner should major changes to practice require it.

5. Associated Policies

This policy should be read in conjunction with the following related policies:

- Group Framework for the Management of Infection Prevention Policy
- Principles and Surveillance Policy
- MRSA Management Policy

6. References

Controlling the Risk of MRSA Infection: Screening and Isolating Patients, 2005. L. Bissett. *British Journal of Nursing,* 14 (7).

EPIC 2: National Evidence Based Guidelines for preventing Healthcare Associated Infections in NHS Hospitals in England 2007.

Guidelines for the Control and Prevention of MRSA in Healthcare Facilities, 2006. J.E. Coia, G.J Duckworth, D.I Edwards, M. Farrington, C. Fry, H. Humpreys, C. Mallaghan, D.R. Tucker. *Journal of Hospital Infection 63S, S1-S44.*

Our NHS Our Future – NHS next stage review. Interim Report DH October 2007.
Saving Lives: Reducing Infection, delivering clean and safe care. DH 2007

7. Appendices

Appendix 1 Equality Impact Assessment Tool
Appendix 2 Checklist for the Review and Ratification of Procedural Document

Appendix 1

Equality Impact Assessment Tool

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

<table>
<tr><td colspan="4">Title: Meticillin Resistant Staphylococcus Aureus (MRSA) Screening Policy

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		Yes/No	Comments / Actions
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	• Race, nationality, ethnic origin, culture	No	
	• Gender	No	
	• Religion or belief	No	
	• Sexual orientation	No	
	• Age	No	
	• Disability - learning / physical , sensory impairment and mental health problems	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	N/A	
4.	**Is the impact of the policy/guidance likely to be negative?**	No	
5.	**Can the impact be avoided?**	N/A	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	N/A	
7.	**Can the impact be reduced by taking different action?**	N/A	

Appendix 2

Checklist for the Review and Ratification of Procedural Document

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	Title of document being reviewed:	**Yes/No/ Unsure**	**Comments**
1	Is the title clear and unambiguous?	Yes	
2	Are reasons for development of the document stated?	Yes	
3	Are people involved in the development identified?	Yes	
4	Has relevant expertise been used?	Yes	
5	Is there evidence of consultation with stakeholders and users?	Yes	
6	Is the objective of the document clear?	Yes	
7	Has the target audience been identified?	Yes	
8	Are the intended outcomes described?	Yes	
9	Are the statements clear and unambiguous?	Yes	
10	Is the type of evidence to support the document identified explicitly?	Yes	
11	Are key references cited?	Yes	
12	Are the references cited in full?	Yes	
13	Does the document identify which committee/group will approve it?	Yes	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
14	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/A	
15	Is there an outline/plan to identify how the policy will be disseminated?	Yes	
16	Does the plan include the necessary training/support to ensure compliance?	Yes	
17	Have archiving arrangements for superseded documents been addressed?	Yes	
18	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Yes	
19	Is there a plan to review or audit compliance with the document?	Yes	
20	Is the review date identified?	Yes	
21	Is the frequency of review identified? If so is it acceptable?	Yes	
22	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Yes	

Committee Approval			
Name	F Calnan	Date	Dec 2009
Signature			