

Policy for the Screening, Management and Control of MRSA

Devon Provider Services

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Please Note the Intention of this Document

This document has been developed with the aim of providing a 'model document template', based on the minimum requirements of the National Health Service Litigation Authority (NHSLA) Risk Management Standards.

1.0	Introduction
<p>From December 2010, routine screening for MRSA must include all relevant NHS emergency admissions. Admissions include those patients being admitted to hospital on an emergency basis regardless of the route of attendance e.g. through A&E, MIU, GP or other route such as an outpatient or rapid access unit.</p>	
2.0	Purpose
<p>The aim of the guidance and this local policy is to reduce transmission of Meticillin (formerly known in the UK as methicillin) resistant <i>Staphylococcus aureus</i> (MRSA) within healthcare settings and reduce the risk of infection for those who are carriers of the organism.</p>	
<p>Previous guidance has been updated to reflect national guidance and, in particular, screening requirements. However, these guidelines continue to take into consideration the prevalence of MRSA in the healthcare community, current systems of healthcare delivery and the impact of control measures on the patient's physical and psychological wellbeing.</p>	
3.0	Definitions
<p>Definitions: Colonisation versus Infection</p>	
<p>Transient carriage occurs when MRSA is present on the hands, arms, face or inside the nose for a short period of time, i.e. a few hours. Staff often become transient carriers when caring for patients with MRSA.</p>	
<p>Colonisation with MRSA occurs when it is present on, or in, the body for a significant period of time but causes no ill effects.</p>	
<p>Patients may be colonised with MRSA, sometimes for several months or years, without it being a problem to them. However, if a colonised patient requires surgery or other invasive procedures, MRSA may be introduced inside the body where it may cause infection.</p>	
4.0	Responsibilities
<p>4.1 Managers/ team leaders/ professional heads and team leaders will ensure that all staff within their sphere of responsibility are</p> <ul style="list-style-type: none"> • informed of this policy • adhere to this policy • take action if non compliance is reported 	
4.1	Role of the Author
<p>The Lead Nurse as author for this policy is responsible for:</p> <ul style="list-style-type: none"> ▪ Ensuring that the procedural document is required and does not duplicate national or local work, confirming the need with the sponsoring committee / Assistant Director ▪ Ensuring that key stakeholders, are consulted with and involved in the development of the procedural document including staffside considerations. 	

- Undertaking an equality impact assessment
- Following the agreed approval and ratification processes
- Ensuring the procedural document is disseminated and describing the arrangements for implementation
- Maintaining the document control record and ensuring that the document is archived
- Describing how the procedural document will be monitored for compliance and effectiveness
- Ensuring the ratified procedural documents are made available on InfoPoint where appropriate
- Reviewing the procedural document at the agreed interval

In cases where there is more than one author, all contributors should be recorded and a main author identified on the document control report.

The Trust expects the author of a procedural document to involve stakeholders, including service users, in the development of procedural documents where appropriate. The author should ensure that Staffside have an opportunity to comment on policies during the development process.

The author is responsible for ensuring that there are effective communication arrangements in place relating to the development, consultation, approval, implementation and ongoing audit of procedural documents including training requirements.

4.2 Role of Assistant Director Sponsor

Each policy must have an identified Assistant Director sponsor. For all clinical policies this will normally be the Assistant Director of Professional Practice, for non clinical policies, it will be the dependant on the subject of the policy.

The Assistant Director of Professional Practice as sponsor of this policy is responsible for:

- Ensuring the policy is approved and presented for ratification
 - Acting as a second point of contact to support the author of the policy
 - Ensuring that a replacement main author is identified should the original author be re-deployed or leave the organisation
-

4.3 Role of the Heads of departments, services, teams and professional groups

For non-policy procedural documents, the heads of departments, services, teams and professional groups are responsible for:

- Ratifying local non-policy procedural documents developed within the department, service, team or professional group
 - Ensuring the document control record for local non-policy procedural documents is maintained and that there is a robust archiving system in place
 - Implementing the relevant local non-policy procedural documents
 - Ensuring there is a local system for auditing or reviewing compliance with
-

non-policy procedural documents

4.4 Role of the Sponsoring Committee

Each policy must have an identified Sponsoring Committee, the Devon Provider Services Infection Prevention and Control Committee is the approving committee for this policy.

The Approving Committee is The Devon Provider Services Infection Prevention and Control Committee is responsible for:

- Ratifying the organisation's policies, using the Checklist for the Review and Approval of Procedural Documents
 - Referring policies back to the author for amendment if the policy does not meet the requirements of the Policy for the Development and Management of Procedural Documents or the intended purpose of the policy
 - Seeking assurance that the systems for the development and management of procedural documents are robust and effective
-

4.5 Role of the Patient Safety & Quality Facilitator

The Patient Safety & Quality Facilitator is responsible for:

- Ensuring all ratified policies are logged on the Policy database and published on InfoPoint.
 - Maintaining the system for alerting authors of due review dates for procedural documents held on InfoPoint
 - Maintaining an archive of all current and superseded policy
-

4.6 Role of Line Management

Line managers are responsible for:

- Engaging as stakeholders in the development process
 - Ensuring staff are aware of the Trust's policies and of the relevant non-policy procedural documents
 - Raising awareness of new policies through management meetings and supervision.
 - Implementing the procedural documents for the areas in which they apply
-

4.7 Role of Staff

All staff are responsible for:

- Participating in the development and consultation process where appropriate
- Making themselves aware of the procedural documents that relate to their role and responsibilities
- Complying with the agreed NHS Devon policies
- Complying with non-policy procedural documents where they apply

Reporting incidents where non-compliance with procedural documents is noted and represents an actual incident or a near miss, using the Trust's agreed Incident Reporting Policy.

5.0 Practice

GENERAL INFORMATION

Staphylococcus aureus is a bacterium that can be carried, asymptotically, in the nose, perineum and skin. *Staphylococcus aureus* can cause a spectrum of illness, ranging from trivial skin infections to life-threatening conditions such as bacteraemia, endocarditis and pneumonia. A small proportion of *Staphylococcus aureus* is resistant to meticillin. Meticillin is an antimicrobial agent used in the laboratory to determine sensitivity to flucloxacillin. Hence, Meticillin Resistant *Staphylococcus aureus* (MRSA) is a strain of the bacterium that has developed resistance to flucloxacillin, the usual antibiotic used for treatment of staphylococcal infection, and all other related antibiotics e.g. cephalosporins. Other antibiotics that can be used to treat an MRSA infection are usually expensive and difficult to administer. Additionally, they often have toxic side effects.

METICILLIN RESISTANCE = FLUCLOXACILLIN RESISTANCE

5.1 TRANSMISSION

Contact:

The main route of transmission in healthcare settings is via contact with the uncleansed hands of healthcare workers. Inadequately decontaminated shared equipment is also a vehicle for transmission.

Airborne:

This is a much LESS IMPORTANT mode of transmission. MRSA may be transmitted via the airborne route on skin scales but this is only a significant risk if the patient has an excessive exfoliating skin condition such as eczema or psoriasis. However, the organism may remain viable in the environment for a long period of time (i.e. months) – thus keeping dust to a minimum is crucial.

5.1.1 Definitions: Colonisation versus Infection

Transient carriage occurs when MRSA is present on the hands, arms, face or inside the nose for a short period of time, i.e. a few hours. Staff often become transient carriers when caring for patients with MRSA.

Colonisation with MRSA occurs when it is present on, or in, the body for a significant period of time but causes no ill effects.

Patients may be colonised with MRSA, sometimes for several months or years, without it being a problem to them. However, if a colonised patient requires surgery or other invasive procedures, MRSA may be introduced inside the body where it may cause infection.

Infection with MRSA occurs when the presence of MRSA causes clinical consequences, e.g. inflammation, swelling and pus formation. For instance, MRSA infection can occur in the skin and soft tissues, lungs, bones and joints or in the blood stream i.e. MRSA bacteraemia.

5.2. IDENTIFYING MRSA COLONISATION OR INFECTION

When any infection is suspected it is normal practice to obtain a relevant specimen for microscopy, culture and sensitivity. This may identify MRSA as the infecting organism. Subsequent screening of carriage sites (see below) on the same patient may identify skin or nasal colonisation.

5.3 SCREENING

There are four categories of MRSA screening:

- Screening for patients with risk factors for MRSA carriage (refer 5.3.1)
- Subsequent to a clinical isolate (refer 5.3.2) or following completion of the decolonisation/suppression therapy.
- Prior to an elective admission (refer 5.3.3)
- Emergency admissions (refer 5.4)

5.3.1 Screening for patients with risk factors for MRSA carriage

- Both anterior nares (one swab will do for both – first moisten the swab with sterile saline)
- Throat
- Perineum (first moisten swab with sterile saline)
- Any wound, ulcer or other area of broken skin/skin lesion

In addition, obtain the following specimens:

- CSU - if catheterised
- Sputum - if expectorating

Make sure the swabs are labelled with the patient's details and sent to the laboratory with a completed microbiology request form - the investigation required is 'MRSA screen.' If the patient has a history of MRSA carriage then please indicate this on the form as the specimen will be processed differently in the laboratory, expediting the result.

N.B. When requesting an MRSA screen, that is the only organism that will be looked for. If you actually require full culture and sensitivity then this must be requested. Alternatively you can request both on the same specimen e.g. MC&S and MRSA.

5.3.2 Following isolation of MRSA as a clinical isolate

Screen as per Section 5.3.1

5.3.3 Pre admission - Patients for elective admission

Guidance from the DH (Gateway reference 10324) has identified that all elective admissions should be routinely screened prior to admission with the exception of

EXCLUDED PROCEDURES

- Day case ophthalmology
- Day case dental
- Day case endoscopy
- Minor dermatology procedures, e.g., warts or other liquid nitrogen applications

- Children/paediatrics unless already in a high risk group
- Termination of Pregnancy
- Maternity/obstetrics, except for elective caesareans and any high risk cases, i.e. high risk of complications in the mother and/or potential complications in the baby, (e.g. likely to need SCBU, NICU because of size or known complications or risk factors.)

The rationale for pre admission screening is to identify MRSA carriers, enabling the application of the MRSA decolonisation or suppression protocol immediately prior to admission and the use of appropriate systemic antimicrobial prophylaxis at time of procedure, if relevant.

NB – Pre admission identification of MRSA carriage will not result in a delay to the admission. There is no intention to demonstrate clearance of MRSA carriage prior to the admission - The assumption is that identification of MRSA and perioperative decolonisation treatment and surgical prophylaxis will reduce the risk of MRSA infection for the carrier and reduce the risk of transmission to other patients. For further guidance please see the specific pathway information below.

Screening, for preadmission purposes, would consist of:

- Both anterior nares (one swab will do for both – first moisten the swab with sterile saline)
- Throat
- Any wound, ulcer or other area of broken skin/skin lesion

Make sure the swabs are labelled with the patient's details and sent to the laboratory with a completed **Elective Preadmission MRSA screening** request form.

5.3.4. Specific Pathways for Elective Cases

Pathway for elective surgical day cases

- a) Patient is referred to and seen in Outpatients Department
- b) Consultant decides that an elective admission is required and indicates this using the outpatient 'Outcome Slip' (already in use)
- c) Outpatient staff will screen the patient using the special laboratory form designed for this purpose. This is recorded in the clinical record. Patients are provided with an information leaflet which explains the rationale for screening, the implications of both a 'positive' and 'not detected' result and the MRSA decolonisation/suppression protocol they will undergo if found to be MRSA positive.
- d) Positive results are returned to relevant Consultant and the Infection Control Dept. The infection control secretary will enter an infection control alert on PAS.
- e) Infection Control Team secretary will generate a letter to the patient's GP (cc. Consultant) advising that the GP should arrange for the patient to receive decolonisation which should commence 2 days prior to planned date of admission.
- f) 'Not detected' results are available from the laboratory system.
- g) Pre admission assessment clinic practitioners can check that screen

has been completed and check the results if patient attends for pre admission assessment. This can be achieved by:

- Asking the patient
 - Checking the clinical record
- h) For those not seen for pre admission assessment the ward will check MRSA status on admission and for all MRSA positive patients will check that the patient has commenced the decolonisation protocol.
- i) In the event of a failure to screen prior to admission, screening will commence on admission and decolonisation commenced immediately. Decolonisation therapy will be stopped if MRSA is not detected. At least one dose of 2% mupirocin will be provided prior to surgery/invasive procedure.
- j) If MRSA positive patients have not commenced decolonisation prior to admission, a 5 day course will be commenced on admission with at least one dose of 2% mupirocin provided prior to surgery.
- k) Patient identified prior to admission as MRSA positive will receive appropriate systemic antimicrobial prophylaxis, if relevant to their procedure.

Pathway for Haematology day case patients receiving chemotherapy, blood transfusion or other supportive therapies

- a) These patients will be screened on the first day of their programme of treatment, in the relevant treatment unit, using the special laboratory form designed for this purpose. This will be recorded in the clinical record. Patients will be provided with an information leaflet which explains the rationale for screening and the implications of both a 'positive' and 'not detected' result and the MRSA decolonisation/suppression protocol they will undergo if found to be MRSA positive.
- b) Positive results are returned to the relevant Consultant and the Infection Control Dept. The infection control secretary will enter an infection control alert on PAS.
- c) Staff will check the results of the MRSA screen on the Pathology system on the subsequent attendance
- d) All patients receiving ongoing treatment, regardless of the result of the initial screen, will need to be regularly screened over the course of their treatment. The frequency of screening will be approximately monthly but will be determined at a local level to fit in with attendance and treatment programmes. This will be recorded in the clinical record.

Pathway for haemodialysis day case patients

- a) These patients will be screened at their first dialysis session, using the special laboratory form designed for this purpose. This will be recorded in the clinical record. Patients will be provided with an information leaflet which explains the rationale for screening and the implications of both a 'positive' and 'not detected' result and the

MRSA decolonisation/suppression protocol they will undergo if found to be MRSA positive.

- b) All patients receiving haemodialysis, regardless of the result of their initial screen, will be re screened on a monthly basis using the special laboratory form designed for this purpose. This will be recorded in the clinical record.
- c) Positive results are returned to the relevant Consultant and the Infection Control Dept. The infection control secretary will enter an infection control alert on PAS.
- d) Patients identified as MRSA positive will be provided with decolonisation/suppression products on the unit, when attending for their next dialysis session.

Pathway for peritoneal dialysis patients

- a) These patients will be screened for MRSA at home when being assessed for home peritoneal dialysis. (in addition to the MRSA screen, an additional set of swabs are required for MC&S in accordance with national guidance for PD). The MRSA screen must be submitted using the special laboratory form designed for this purpose i.e. separate from the swabs for MC&S. This will be recorded in the clinical record. Patients will be provided with an information leaflet which explains the rationale for screening and the implications of both a 'positive' and 'not detected' result and the MRSA decolonisation/suppression protocol they will undergo if found to be MRSA positive.
- b) All patients receiving peritoneal dialysis, regardless of the result of their initial screen, will be re screened on a regular basis (frequency will fit in with planned home visits/appointments but should be no more frequent than monthly) using the special laboratory form designed for this purpose. This will be recorded in the clinical record.
- c) Positive results are returned to the relevant Consultant and the Infection Control Dept. The infection control secretary will enter an infection control alert on PAS.

5.4 Emergency admissions

From December 2010, routine screening must include all relevant NHS emergency admissions. Admissions include those patients being admitted to hospital on an emergency basis regardless of the route of attendance e.g. through A&E, MIU, GP, hospital transfer or other route such as an outpatient or rapid access unit.

Unless identified by current Trust and national policies as high risk the following WILL NOT be routinely screened if admitted as emergencies:

EXCLUDED GROUPS:-

- Children under the age of 16 years
- Maternity
- Mental health/learning disabilities patients.

5.4.1 When to screen:

Screening should be undertaken as soon as practicable in the admission process but should not delay admission or urgent clinical treatment.

5.4.2 Sites to be screened

- Both anterior nares (one swab will do for both – first moisten the swab with sterile saline)
- Perineum
- Any wound, ulcer or other area of broken skin/skin lesion
- Sites of catheters
- SCU's
- Sputum if patients have a productive cough

5.5 Clearance screen following decolonisation

Screen as per 3.1. Three consecutive negative screens **taken, as a minimum, at weekly intervals** need to be obtained before decolonisation is considered effective (i.e. total removal of MRSA).

First screen: Obtain swabs/specimens a minimum of 48 hours after the decolonisation regimen (and any oral/IV antibiotics) has ceased.

Second screen: If 1st screen results are negative then obtain second screen.

Third Screen: If 2nd screen results are negative then obtain third screen.

There are some occasions when this process may be expedited by obtaining three screens over a shorter period of time - but discuss with the Infection Control Team first.

5.6 Results

MRSA is reported in three ways but the meaning is the same:

- 1) *Staph aureus* – Flucloxacillin resistant
- 2) MRSA isolated
- 3) MRSA Pre-elective screen positive /negative

6 PATIENT/SERVICE USER INFORMATION

It is vital that patients/service users are provided with accurate information about MRSA and what it means for them and their family. Many will have heard about MRSA through the media and may be very worried. Patients/service users should also be given an explanation of how MRSA is transmitted, the rationale for isolation (if applicable) and why there are variations in the control measures required depending on the healthcare setting and level of contact.

Following the verbal explanation an appropriate leaflet must be offered to the patient/family. Two leaflets are available:

- MRSA Information Leaflet, available from HPA

- MRSA Screening RD&E Ref No: DG 09 001 001 (This relates to preadmission screening of elective admissions)
- MRSA screening (Emergency Admissions) RD&E Ref no DG 10013001

7. TREATMENT

7.1 Systemic antimicrobial therapy

If the patient is clinically infected and not simply colonised, the duty medical microbiologist can be consulted for advice on appropriate systemic antibiotic therapy. Patients will also require topical treatment as described below.

7.2 Topical treatment of adults and children

If the patient is otherwise well but colonised, or as an adjunct to systemic antimicrobial therapy, topical treatment will be required. Decolonisation is not usually achieved for the types of patients listed below but topical treatment is still useful to:

reduce the risk of cross infection to others and to reduce the risk of the patient developing an MRSA infection from their own MRSA during medical or surgical treatment:

- Patients with long term indwelling devices (for example, urinary catheters and PEG feeding tubes)
- Patients with chronic wounds, such as pressure sores or leg ulcers
- Patients with throat carriage
- Patients who are sputum positive and still expectorating*
- Patients with large or deep unhealed wounds*

*Once sputum production has ceased (or reduced to patient's norm) or wound has improved, successful decolonisation may be achieved.

The 5-day decolonisation protocol consists of all or some of the following products, depending on colonised sites:

- **4% Chlorhexidine Skin Cleanser** for bathing/showering/washing for five days (for patients with nasal and/or skin carriage). Use as liquid soap with a disposable wipe. Do not use patient's flannel. If the patient's condition allows, also use to wash hair. Specialist dermatology advice should be sought prior to decolonising patients with skin disorders, e.g. eczema, psoriasis.
- **Mupirocin 2% (Bactroban) Nasal Ointment** applied to each nostril three times daily (for patients with nasal carriage and /or skin carriage). Apply using a cotton bud or gloved fingertip.
- **Mupirocin 2% (Bactroban) cream** applied to small superficial wounds three times a day. If wounds are healing despite the presence of MRSA, it will probably be more harmful to disturb the wound three times a day to apply mupirocin – in which case normal wound care should continue. Bactroban is not appropriate for large or complex wounds.

Other products that can be used will not eradicate the organism but may help

reduce numbers and thus dissemination, e.g.

- **Dressings containing povidone-iodine** e.g. Inadine or Iodosorb, applied daily to colonised wounds.
- **Silver dressings e.g.** Acticoat absorbent, Silvercell

N.B. It is important that the patient's bed linen and towels are changed each day in hospital following antiseptic bathing/washing/showering and as frequently as possible at home.

The decolonisation protocol is stopped for 2 days, at the end of which the patient is re-screened as described in Section 3.2.1. Three consecutive negative screens are required for a previously MRSA positive patient to be considered MRSA negative.

No more than two attempts will be made to achieve decolonisation in one episode of hospital care. If screens are positive after two attempts at decolonisation, the patient will be considered a chronic carrier.

Elective admissions should commence decolonisation two days prior to their admission, i.e. the day of their procedure will be day 3. Staff should check on admission that the patient has commenced the protocol and if they have not, it should be commenced at that time, with the first treat the patient has their procedure and continued for the five days as per the protocol.

Emergency admissions considered to be a high risk of carriage/infection should commence decolonisation at the time of admission i.e. screen and then commence decolonisation whilst awaiting results. If the screen is negative the decolonisation treatment can be stopped. If the result is positive, it continues for the full five days of the protocol.

7.3 Topical treatment of neonates

The decision to decolonise will depend on the age and condition of the neonate. Octenisan may be used for skin cleansing. Chlorhexidine powder (CX Powder) can be applied to umbilicus, buttocks, perineum and flexures at every nappy change. Use of 2% mupirocin may be considered. However, the decision to apply some or all of these products must be made on a case by case basis.

8. MAINTAINING STANDARDS OF CARE

It is important to remember that control measures should not compromise standards of care or the need for urgent specialist care. The patient's overall needs must take precedence.

Strict adherence to standard infection control precautions and aseptic procedures is necessary to reduce the risk of transmission of MRSA to other patients and to vulnerable body sites on same patient, in particular:

- hand hygiene before and after each patient contact,
- appropriate use of personal protective equipment e.g. gloves and aprons. Gloves must be worn when contact with blood or body fluids is anticipated, for sites e.g. wounds, PEG sites. Aprons must be worn to protect clothing for bed making and direct patient care.
- maintaining a clean environment to minimise dust accumulation

- decontaminating shared equipment between patient uses
- handling used linen carefully to reduce dispersal of skin squames

The patients identified in the table below are more likely to be colonised with MRSA than other admissions and should as part of the emergency screening protocol commence decolonisation immediately after screening.

Patients with risk factors for MRSA carriage	Accommodation and precautions
Known to be infected or colonised in the past. (Check notes/IC alert on PAS)	Single room if possible, Standard precautions.
Transfers from hospitals abroad	Single room. Standard precautions.
Transfers from other hospitals within and outside the NHS Devon Healthcare Community	Standard precautions in bay.

8.1 Contact screening

Only necessary if advised by the Infection Control Team.

8.2 Isolation of patients considered high risk of or confirmed as MRSA positive

It is preferable to nurse the patient in a single room but not essential in community hospitals. If nursed in a single room the patient need not remain within the room at all times. However, activities that are particularly likely to result in skin scale dispersal should be undertaken at the bedside, e.g. washing and dressing, wound dressings, examinations, etc. Gloves and aprons should be worn by staff during these procedures. However, gloves must be removed and hands washed between procedures on the same patient. After these activities are complete, the patient should be allowed to use the day room, dining room and other communal areas. Open wounds should be covered with a dressing.

8.3 Action to take if the number of patients to be isolated exceeds the number of single rooms available

Contact the Infection Control Team for advice who will ask/help you to do the following:

- Review existing patients in single rooms and decide if they need to be there. Move a patient out if possible.
- If movement is not possible, consider making a cohort of patients in a bay or double side-room.
- If neither of the above is possible, prioritise who should have a single room by assessing cross infection risks.

Examples:

- MRSA positive patient with an exfoliating skin condition takes priority over others
- A patient with MRSA in multiple sites takes priority over a patient with nasal carriage only
- Patients who are being decolonised are less of a risk than those who

cannot be decolonised

- Having decided which patient will remain within the bay; also assess the vulnerability of other patients in the same bay. Move particularly vulnerable patients to another bay or at least as far away as possible, e.g. patients with central lines, patients with open wounds, patients with urinary catheters. (This assessment may need repeating with the movement of patients into/out of the bay over a period of time).
- Ensure that alcohol hand rub and protective clothing is readily available to facilitate compliance with standard precautions.

8.4 Stopping isolation

The need for a single room will cease when either the patient has been successfully decolonised or other clinical factors dictate the need to move the patient into a bay.

8.5 Clinical investigations

Patients can undergo investigations in all departments, provided the department has been informed in advance. It is recommended that patients are dealt with promptly to minimise delay in returning to the ward. Standard infection control precautions should be practised by staff within the department. Equipment should be decontaminated, in accordance with the decontamination policy, before use on the next patient.

8.6 Transfers to other wards

Patients can be transferred from one ward to another ward or unit, if clinical need dictates. The receiving area must be informed in advance of the MRSA status to ensure that the appropriate facilities are available and the required precautions are applied (Refer Section 15).

8.7 Mobilisation

If mobilisation is required when a patient is isolated in a single room, the patient can leave the room to allow mobilisation in an area away from the ward, e.g. main corridor. This does not mean that the patient can wander freely around the ward where close contact with other patients is inevitable. The distinction must be explained carefully to patients who may find it confusing.

8.8 Personal Hygiene

If *en suite* facilities are not available, patients may use communal facilities but these must be cleaned thoroughly with routine cleaning products after use. If patients are leaving an isolation room for this purpose, they must be advised this does not mean they can move freely around the ward.

8.9. Physiotherapy/Occupational Therapy

Please refer to Appendix 1. – this has been omitted from this version

8.10 Use of cars for home visits

Refer Section 16

9. VISITORS IN HOSPITAL

It is unnecessary for the patient's relatives and friends to wear protective clothing when visiting in hospital as they do not subsequently deliver care to other patients. As long as the visitors are healthy, MRSA is unlikely to pose a risk to them. However, they should be advised of the importance of hand hygiene.

10. ROUTINE AND TERMINAL CLEANING

It is very important to minimise dust through frequent and thorough cleaning, whether the patient is nursed in a single room or in an open ward area. Frequency of routine cleaning may need to be increased, particularly if the patient has an exfoliating skin condition.

Isolation rooms and bed spaces in bays must be terminally cleaned on discharge in accordance with the Source Isolation Policy and/or the terminal cleaning procedure.

11. LAST OFFICES

No special precautions are required.

12. PERIOPERATIVE CARE

MRSA positive patients who are to have surgery may need prophylactic topical decolonisation and appropriate systemic antibiotic prophylaxis.

Theatres must be informed in advance, preferably the day before, of the patient's MRSA status. To allow for thorough cleaning of surfaces within the operating room it is preferable to put the patient at the end of the list. However, this is only to facilitate cleaning and, if it is more important clinically, that the patient is operated on earlier in the list than clinical need takes priority, but enough time must be allowed prior to the next patient for cleaning. Surfaces should be cleaned using warm water and detergent or detergent wipes. There is no need to let the theatre 'rest' as an adequate number of air changes will have occurred within 15 minutes of the MRSA +ve patient being removed from the operating theatre. Therefore, once cleaning is complete, the theatre can be used immediately.

12.1 Transfers to/from theatre

Gloves and aprons are not required for pushing a wheelchair, trolley or bed or for social contact e.g. hand holding, brief contact when guiding patient into a chair. However, hands must be cleaned with alcohol hand rub after such contact.

The theatre orderly should wear gloves and apron if having more significant patient contact i.e. holding the patient against their body when moving them onto a trolley or into a wheelchair. Protective clothing must be removed prior to leaving the isolation room and hands cleansed.

It is preferable to avoid taking the bed from an isolation room to theatre, however if this cannot be avoided clean bed linen must be used and the bed frame should be dust free.

12.2 Recovery

Patients can be nursed in Recovery but the practitioner caring for the patient should not simultaneously attend other patients. Gloves and aprons should be worn by the practitioner. The trolley and trolley space in recovery must be cleaned thoroughly

using detergent wipes or warm water and detergent following the patients return to the ward. There is no need to change curtains unless the patient has remained in recovery for several hours (e.g. an overflow patient when ITU is full) at which point the terminal cleaning procedure for an isolation room should be followed (refer Source Isolation Policy).

13. OUTPATIENTS

Patients visiting outpatients, who are known to be colonised or infected with MRSA, should be seen at the end of the clinic list, **where this is practicable**. Wounds should be covered with a dressing whilst waiting in communal areas. The number of staff attending to the patient should be kept to a minimum and there must be strict attention to hand hygiene.

There is no need to remove equipment from the consulting rooms. Surfaces that the patient has had direct contact with e.g. examination couch, should be decontaminated after use, using warm water and detergent or detergent wipes.

13.1 Dental Clinics/Dental Access Centres

In accordance with the British Dental Association infection control guidance, no additional precautions are required.

14. SURGICAL DAY CASE UNITS/DAY SURGERY UNITS

If a single room is available this should be used. If not, the patient can be managed on the main unit, pre and post procedure, with strict adherence to standard precautions, in particular hand hygiene. To allow for thorough cleaning after the case, it is preferable, but not vital, to put the patient at the end of the list. The patient can be recovered in Recovery but the nurse caring for the patient should not simultaneously attend other patients (Also refer Section 10).

15. PORTERING OF PATIENTS WITHIN THE HOSPITAL

Porters should cleanse their hands using either alcohol hand gel or soap and water after contact with the patient but are NOT required to wear gloves and/or aprons to push trolleys or wheelchairs. Wheelchairs/trolleys must be cleaned with detergent wipes after use.

16. TRANSPORTING BY AMBULANCE OR CAR

If their clinical condition allows, patients with MRSA can be transported in an ambulance with other patients as long as any wounds are covered with an occlusive dressing and the ambulance crew maintains standard infection control precautions.

Likewise, outpatients can be transported in cars without concern for the driver or subsequent passengers, as long as wounds are covered.

17. DISCHARGE OF MRSA POSITIVE PATIENTS

Whilst treatment of MRSA infection may result in a prolonged hospital stay,

the discharge of patients colonised with MRSA should not be delayed. Good communication is essential to ensure that the patient is managed safely across all healthcare settings.

However, if the decolonisation protocol is to be started/continued at home, it may be necessary to arrange for community nursing input to achieve this effectively. MRSA

positive patients can be transferred from the ward to communal waiting areas whilst awaiting transport home. MRSA is not a reason for patients to be refused admission to a nursing or residential home. If difficulties to nursing homes are experienced the Infection Control Team should be informed.

18. INDIVIDUALS DIAGNOSED IN THE COMMUNITY

Open wounds will often be colonised with micro-organisms including MRSA, although this does not mean that the wounds will go on to develop a clinical infection. Many of these wounds will continue to heal despite the colonisation and no specific treatment is required other than good wound management.

It is only when a wound is failing to heal and showing signs of critical colonisation and infection that treatment of micro-organisms including MRSA should be considered using topical antimicrobials and antibiotics when clinical infection is identified.

Routine swabbing to determine if MRSA is present in a wound is not advocated. Wound swabbing should only be carried out when clinical signs of infection are present.

Patients with clinical infection caused by MRSA should always be treated promptly. If they are receiving systemic antibiotics but the wound remains clinically infected following the completed course of treatment, a wound swab should be taken 48 hours after treatment is completed.

Individuals/patients in the community who are colonised with MRSA will not generally require decolonisation unless it is known that they will be admitted to hospital in the foreseeable future.

19. MRSA AND STAFF

MRSA rarely causes infection in healthy people. Transmission of MRSA, from patient to staff or vice versa, may occasionally occur via close contact. However, staff usually have transient carriage only and, by the time they return to work after the previous shift, no longer carry MRSA. Colonised or infected staff rarely transmit infection to patients.

19.1 Staff Screening

Staff screening is rarely indicated and will only be initiated by the Infection Control Team in conjunction with the Occupational Health Department. When screening is required it must be undertaken at the beginning of a shift to reduce the risk of transient carriage being identified. Swabs will be taken by an Occupational Health Advisor (or in exceptional circumstances by the member of staff's GP).

The following sites need to be swabbed:

- Nose

- Throat
- Perineum
- Skin lesions/wounds

Staff found to be positive on the initial screening should have another full screen undertaken including the sites identified as MRSA positive (to exclude transient carriage).

19.2 Exclusion from work

Infected lesions/wounds

Staff should be examined for infected lesions and, if present, should be removed from duty if working in a high or moderate risk area. In a low or minimal risk area advice should be sought from the infection control team.

Skin carriage (e.g. colonised skin lesion or perineum)

Skin carriers should be treated with 4% chlorhexidine gluconate (Hibiscrub) and mupirocin 2% (Bactroban Nasal Ointment) as recommended for patients. If an alternative skin cleanser is required the infection control team will advise or a suitable product. If appropriate skin lesions or small wounds can be treated with mupirocin 2% cream. (Mupirocin Cream).

In high risk areas (which includes operating theatres), skin carriers should be excluded from work or given alternative duties that do not involve contact with patients until they have been successfully decolonised and have had three consecutive negative screens.

In other clinical areas, staff who are skin carriers can work whilst they undertake the decolonisation protocol unless they have an exfoliating skin condition.

Nasal and/or throat carriage only

Nasal carriers should be treated with mupirocin 2% (Bactroban nasal ointment) and 4% chlorhexidine gluconate (Hibiscrub) as recommended for patients. If an alternative skin cleanser is required the infection control team will advise or a suitable product.

In high risk areas (which includes operating theatres) they should be excluded from work for 48 hours from the start of mupirocin treatment or given alternative duties that do not involve contact with patients.

In other clinical areas, staff carriers can continue working whilst on mupirocin treatment if the strain is susceptible.

19.3 Clearance

Three negative screens taken at weekly intervals will indicate clearance of MRSA. Screens must be obtained by the Occupational Health Nurse or GP, with the agreement of the Occupational Health Department.

Difficulties achieving clearance must be discussed with the Infection Control Team/Microbiologist.

19.4 MRSA and Pregnant Staff

There is no reason to exclude pregnant or breast feeding staff from caring for patients with MRSA.

6.0	Development processes
The numbering needs attention	<p>This policy was originally developed by the RDE and formally adopted by Devon Provider Services Infection Prevention and Control Committee in January 2009. It has been reviewed as a result of the DoH revised guidance. As part of its development it has been circulated to:-</p> <ul style="list-style-type: none"> • Devon Provider Services Infection Prevention and Control Committee • Adult Professional Council • Community Hospital and Community Nursing Matrons and Team Leaders
6.1	Prioritisation of Work
	<p>The development of Devon Provider Services as a separate organisation requires the review and development of policy and procedural documentation. The development of this Policy supports this process. The ratified policy will then be used as a basis for a phased approach to reviewing and revising existing policies and procedural documentation.</p>
6.2	Consultation and Communication with Stakeholders
	<p>All clinicians will be consulted through the respective Professional Councils and all other staff through the Staff Side forum.</p>
6.3	Approval and ratification process
	Approval
	<ul style="list-style-type: none"> ▪ This policy will go to Adult and Children's Professional Council
	Ratification
	<p>This policy will be submitted to the Assistant Director Of Professional Practice/ shadow DIPC for ratification.</p>
6.4	Review and revision arrangements
	<p>This Policy will be reviewed in 2 years from the date of ratification or earlier if it is required through new directives or evidence based practice.</p>
6.5	Dissemination and implementation
	<p>This policy will be disseminated through the Clinical Leads and Interim Medical Director</p>
	<p>Line managers are responsible for ensuring this policy is implemented across their area of work.</p>
	<p>Support for the development and management of procedural documents will be provided by the Patient Safety and Quality Team on request.</p>
6.6	Document control including archiving arrangements
	<p>The author is responsible for recording, storing and controlling this policy.</p>

Once the final version has been ratified, the author will provide a PDF copy of the current policy to the Patient Safety & Quality Facilitator so that it can be placed on InfoPoint. Any future revised copies will be provided to ensure the most up-to-date version is available on InfoPoint.

The policy will be logged on the policy database which is held by the Patient Safety and Quality team.

6.7 Archiving Arrangements

All versions of this policy will be archived in electronic format within the Patient Safety & Quality archive. Archiving will take place by the Patient Safety & Quality Facilitator once the final version of the policy has been issued.

Revisions to the final document will be recorded on the document control report. Revised versions will be added to the policy archive held by Patient Safety & Quality Facilitator.

6.8 Process for Retrieving Archived Documents

To obtain a copy of the archived policy, contact should be made with the Patient Safety & Quality Facilitator.

7.0 Monitoring compliance and effectiveness

Monitoring will be through the normal management arrangements for all staff by line managers on a day to day basis.

Within the clinical areas compliance will be observed through the observed practice process undertaken by link nurse, specialist nurses and hotel services team leaders

- monthly Lewisham Hand Hygiene audits,
- quarterly Credits for Cleaning audits
- annual Infection Prevention and Control audits
- six monthly Essential Steps audit
- annual Clean Hospital audit
- annual PEAT audits
- formal sign off after terminal and deep cleans

The results of these audits are all reported via monthly reports which are circulated to Matrons, Patient Safety and Quality Committee, Adult Professional Council, Devon Provider Services Infection Prevention and Control Committee and Health Care Acquired Infection Committee

8.0 Standards / Key Performance Indicators

Key performance indicators comprise:

- monthly Lewisham Hand Hygiene audits,
 - quarterly Credits for Cleaning audits
 - annual Infection Prevention and Control audits
 - six monthly Essential Steps audit
 - annual Clean Hospital audit
-

- annual PEAT audits
- formal sign off after terminal and deep cleans

9.0 References

1. Department of Health: (2008) *The Health and Social Care Act 2008: A Code of Practice for health and adult social care on the prevention and control of infections and regulated guidance*. London. Department of Health 2008.

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Harbarth S and Pittet D. 2003 Control of Nosocomial Methicillin-Resistant *Staphylococcus aureus*: Where Shall We Send Our Hospital's Director Next Time? *Infection Control Hospital Epidemiology*. 3.4-316.

Lessing MPA, Jordens JZ, Bowler ICJ. When should healthcare workers be screened for methicillin-resistant *Staphylococcus aureus*? *J Hosp Infect*1996;**34**:205-10.

Muto CA, Jernigan JA, Ostrowsky BE *et al.* 2003 SHEA Guideline for Preventing Nosocomial Transmission of Multidrug Resistant Strains of *Staphylococcus aureus* and *Enterococcus*

Sherertz RJ, Reagan DR, Hampton KD, *et al.* 1996 A cloud adult: The *Staphylococcus aureus* - virus interaction. *Ann. Intern Med* **124**: 539-547

Solberg CO. 1973 A study of carriers of *Staphylococcus aureus*. *Acta Med Scand* 1965; 178(suppl).

Working Party Report of the British Society for Antimicrobial Chemotherapy, the Hospital Infection Society and the Infection Control Nurses' Association. 1998 Revised guidelines for the control of methicillin-resistant

Staphylococcus aureus infection in hospitals. *JHI* 39: 253-290. (Updated 1999) Available at <<http://www.his.org.uk/>>

10.0 Associated documentation

All NHS Devon Infection Prevention and Control Policies on infopoint

11.0 Equality Impact Assessment

The assessment has identified some potential impact for those with particular disabilities and religious needs. Therefore this policy will go to Staff Side forum for consultation.

“The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. An Equality Impact Assessment has been undertaken and insert summary here.”

Appendices

Appendix A

The appendices should contain example forms and other supporting documentation, including the completed Equality Impact Assessment.

Checklist for the Review and Approval of Procedural Documents

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

	Title of document being reviewed:	Yes/No/Unsure	Comments
1.	Title		
	Is the title clear and unambiguous?	yes	
	Is the title page document detail table completed?	yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	yes	
2.	Purpose		
	Are reasons for development of the document stated?	yes	
3.	Responsibilities		
	Have the individuals responsible for the document been identified?	yes	
3.	Development Process		
	Is the method described in brief?	yes	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	Are individuals involved in the development identified?	yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	yes	
	Has an Equality Impact Assessment been completed and included with the document?	yes	
	Is there evidence of consultation with stakeholders and users?	yes	
4.	Content		
	Is the objective of the document clear?	yes	
	Is the target population clear and unambiguous?	yes	
	Are the intended outcomes described?	yes	
	Are the statements clear and unambiguous?	yes	
	Is the document written in plain English and abbreviations explained?	yes	
5.	Evidence Base		
	Is the type of evidence to support the document identified explicitly?	yes	
	Are key references cited?	yes	
	Are the references cited in full using the Harvard method?	yes	
	Are local/organisational supporting documents referenced?	yes	
6.	Approval		
	Does the document identify which committee/group will approve it?	yes	
	If appropriate, has the joint HR/staff side committee 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?	yes	
9.	Process for Monitoring Compliance		
	Are there measurable standards /	yes	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	competences or KPIs to support monitoring compliance of the document?		
	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 coordinating the dissemination, implementation and review of the documentation?		

Individual Approval

If you are happy to approve this document, please sign and date it and forward to the chair of the committee/group where it will receive approval.

Name		Date	
------	--	------	--

Signature	
-----------	--

Committee Approval

If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.

Name		Date	
------	--	------	--

Signature	
-----------	--

Assistant Director Ratification

If the Assistant Director is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.

Name		Date	
------	--	------	--

Signature	
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Acknowledgement: Cambridgeshire and Peterborough Mental Health Partnership NHS Trust

Appendix B

Plan for dissemination and implementation of procedural documents

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

Acknowledgement: University Hospitals of Leicester NHS Trust

Title of document:	Policy for the Screening, Management and Control of MRSA		
Date finalised:		Dissemination lead:	Jane Barr
Previous document already being used?	Yes	Print name and contact details	janebarr@nhs.net
If yes, in what format and where?	On infopoint under NHS Devon Infection Control Policy Section		
Proposed action to retrieve out of date copies of the document:	Delete on infopoint and E mail thought Clinical Cascade		
To be disseminated to:	How will it be disseminated, who will do it and when?	Format (i.e. paper or electronic)	Comments:
Community Hospital matrons	Via internal policy update process	electronic	
Community Nurse Tam Leads	Via internal policy update process	electronic	
Professional Heads	Via internal policy update process	electronic	
Interim Medical Director	Via internal policy update process	electronic	

Dissemination Record - to be used once document is approved

Date put on register / library of procedural documents:		Date due to be reviewed:	
--	--	---------------------------------	--

Disseminated to: (either directly or via meetings, etc.)	Format (i.e. paper or electronic)	Date Disseminated:	No. of Copies Sent:	Contact Details / Comments:

Appendix B

Plan for dissemination and implementation of procedural documents

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

Acknowledgement: University Hospitals of Leicester NHS Trust

Title of document:	Policy for the Screening, Management and Control of MRSA		
Date finalised:		Dissemination lead: Print name and contact details	Jane Barr janebarr@nhs.net
Previous document already being used?	Yes		
If yes, in what format and where?	On infopoint under NHS Devon Infection Control Policy Section		
Proposed action to retrieve out of date copies of the document:	Delete on infopoint and E mail thought Clinical Cascade		
To be disseminated to:	How will it be disseminated, who will do it and when?	Format (i.e. paper or electronic)	Comments:
Community Hospital matrons	Via internal policy update process	electronic	
Community Nurse Tam Leads	Via internal policy update process	electronic	
Professional Heads	Via internal policy update process	electronic	
Interim Medical Director	Via internal policy update process	electronic	

Dissemination Record - to be used once document is approved

Date put on register / library of procedural documents:		Date due to be reviewed:	
--	--	---------------------------------	--

Disseminated to: (either directly or via meetings, etc.)	Format (i.e. paper or electronic)	Date Disseminated:	No. of Copies Sent:	Contact Details / Comments:

Equality Impact Assessment Tool**SCREENING FORM ONE – To be completed for all Policies, Strategies & Service Development**

Name of strategy, policy or project: Policy for Screening, Management and Control of MRSA
Locality and service area covered: <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Employees <input checked="" type="checkbox"/> Patients/clients/service users <input checked="" type="checkbox"/> Partnerships/organisations <input checked="" type="checkbox"/> Visitors <input checked="" type="checkbox"/> Staff from other organisations
Name and contact details of officer completing assessment: Jane Barr Telephone no:01392208634 Email address:jane.barr@nhs.net
1. To document the processes for What is the main purpose of the strategy/policy/project (or the changes you want to make to it)? The purpose of the Policy is to set out the procedures to be followed following changes to DoH guidance on MRSA.
2. What are the main activities of the strategy/policy/project? Reduce risk, ensure adherence to national guidance and to ensure patient safety.
3. Who is intended to benefit from the strategy/policy/project, and how? Patients and staff, by reducing the risk of infection where possible.
4. Is the strategy/policy/project consistent with the Trust's equality policies? e.g. Acceptable Behaviour, Whistle Blowing, Zero Tolerance, Equal Opportunities <input type="checkbox"/> Yes
5. Is responsibility for the strategy/policy/project shared with another service, Trust or organisation? <input type="checkbox"/> No
6. If yes, what responsibility and which bodies?
7. Have they completed an EINA? Please provide a copy

8. What impact is the strategy/policy/project likely to have on different sections of the community or employees? **Please use the table below**

	Impact – ✓ box	Reason	Are there additional factors that could contribute to the negative impact? If so, what are they?	Evidence/Consultation
Gender	+ - none			
• Women	none			
• Men	none			
Ethnic Group				
• Asian or Asian British people	none			
• Black or Black British people	none			
• Chinese people	none			
• Gypsy or Roma People	none			
• Irish People	none			
• People of Mixed Heritage	none			
• White People	none			
• People of other ethnic backgrounds	none			
Asylum Seekers and Refugees	none			
People with physical disabilities	none			
People with sensory or learning disabilities	none			
Deaf People who use British Sign Language	none			

People with mental health needs	none			
	Impact – ✓ box	Reason	Are there additional factors that could contribute to the negative impact? If so, what are they?	Evidence/Consultation
Lesbians, gay men and bisexual people	none			
Trans people	none			
Age	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
• Older people (60+)	none			
• Younger people (17-25) and children	none			
People of different faith groups or beliefs including non-believers	none			
Travellers	none			
Other (please specify)	none			
Carers	none			

Notes:

- Faith groups cover a wide range of groupings, the most common of which are Muslims, Buddhists, Jews, Christians, Sikhs and Hindus. Consider faith categories individually and collectively when assessing positive and negative impacts.
- The categories relating to ethnicity include those used in the 2001 census. Consideration should be given to the needs of specific communities within the broad categories such as Bangladeshi people and to the needs of other communities such as Turkish/Turkish Cypriot, Greek/Greek Cypriot and Polish that do not appear as separate categories in the census.

- An adverse impact does not necessarily require action to be taken. Actions must remain in proportion with the benefits that could be achieved and resources available to complete them. If adverse impacts are identified and actions for improvement are not proportionate, the reasons for not taking action should be detailed and open to challenge.

<p>9. Will this policy/service consultation be available in other formats, other languages? Braille, British Sign Language. Audio/video tape or statement acknowledging services are available in other formats. Please detail formats that are available</p> <p>The policy will not initially be put into other formats but transcription can be arranged if necessary.</p>
<p>10 a) Could you minimise or remove any negative impact?</p> <p>Explain how: No</p>
<p>10 b) Could you improve the strategy, project or policy's positive impact?</p> <p>Explain how: No</p> <p><i>You may wish to use the action sheet at the end of Section Two.</i></p>

Please sign and date this form. One copy should be attached to the original policy/strategy/service change and published on the Trust website and Infopoint. An electronic copy should be e-mailed to Andrew Barge, Equality and Human Rights Manager at andrew.barge@nhs.net If you need any further assistance please call 01392 356929..

EQUALITY IMPACT NEEDS ASSESSMENT FORM
Race, Religion/Belief, Disability, Age, Gender
SCREENING SUMMARY EVIDENCE AND CONSULTATION

Name of the Function/Policy/Project:

	<p align="center">Does the Function/Policy/Project</p> <p>1. Eliminate discrimination? 2. Promote equal opportunities? 3. Promote good community relations? 4. Not applicable</p>	<p align="center">Is there evidence or reason to believe that some groups could be negatively affected?</p> <p align="center">How much evidence do you have?</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <tr><td>0</td><td>None</td></tr> <tr><td>1</td><td>Little</td></tr> <tr><td>2</td><td>Some</td></tr> <tr><td>3</td><td>Substantial</td></tr> </table>	0	None	1	Little	2	Some	3	Substantial	<p align="center">Is there any public concern that the function or policy is being carried out in a discriminatory way?</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <tr><td>0</td><td>None</td></tr> <tr><td>1</td><td>Little</td></tr> <tr><td>2</td><td>Some</td></tr> <tr><td>3</td><td>Substantial</td></tr> </table>	0	None	1	Little	2	Some	3	Substantial	<p align="center"><u>Priority</u></p> <p align="center">(add columns 2 & 3)</p>
0	None																			
1	Little																			
2	Some																			
3	Substantial																			
0	None																			
1	Little																			
2	Some																			
3	Substantial																			
RACE	1	2	0	2																
DISABILITY	2	0	0	2																
GENDER male/female	4	0	0	0																
Lesbian Gay Bisexual Transsexual	4	0	0	0																
RELIGION / BELIEF	2	2	0	2																
AGE	4	0	0	0																

IF THE PRIORITY SCORE IS GREATER THAN OR EQUAL TO 3 THEN PLEASE COMPLETE A LEVEL 2 EINA ASSESSMENT

Please sign and date this form. One copy should be attached to the original policy/strategy/service change.

Signed:

Date:

