University Hospital of South Manchester NHS
NHS Foundation Trust

MRSA SCREENING DECLARATION

At its meeting on 23 December 2010, the Board resolved that the following statement of compliance shall be published on the UHSM website:-

Declaration by the Board

UHSM has reviewed its MRSA Screening Policy in December 2010. Minor amendments have been made to the policy. The current version 'MRSA Screening Policy (Version 1.1)' is in place across UHSM. It has been communicated to all employees and is in line with the prevailing March 2010 Department of Health guidance. UHSM's MRSA Screening Policy (Version 1.1) is available for the public to download from the web site at:
http://www.uhsm.nhs.uk/patients/Infection%20Control/MRSA%20Screening%20Policy%20V1.00.pdf

UHSM considers it is, and will continue to be compliant with the 'DoH March 2010 MRSA screening - Operational Guidance 3' as set out in UHSM's MRSA Screening Policy v 1.1

Board of Directors
23 December 2010.

For further information, please contact the Foundation Trust Secretary
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UHSM
Your Hospital

University Hospital of South Manchester NHS
NHS Foundation Trust

UHSM Policy for MRSA Screening

Version:	1.1
Ratified by:	Infection Prevention Control Committee
Date ratified:	15th December 2010
Name of originator/author/job title:	Head of Nursing- Infection Prevention & Control Audit & Surveillance officer
Name of responsible committee/individual:	Infection Prevention committee Head of Nursing- Infection Prevention & Control Infection Control Doctor
Date issued:	December 2010
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Target audience:	All Staff in the Trust

University Hospital of South Manchester NHS Foundation Trust

VERSION CONTROL SCHEDULE

Version number	Issue Date	Revisions from previous issue	Date of approval by Committee
1	10/2010	February 2009	February 2009
1.1	12/2010	December 2010	December 2010

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1 Introduction

1.1 Since November 2006, the FT has embarked on an extended MRSA screening programme. This has been based on the recommendations following a Department of Health review of the FT (November 2006), correspondence from the Chief Medical Officer and Chief Nursing Officer (November 2006), recommendations from the Greater Manchester Pathology Network, and local risk assessment.

Screening for MRSA in elective high risk surgery (such as vascular, cardiac and orthopaedics) has been well established within the FT and has recently been extended to include other relevant elective and emergency surgery patients.

Correspondence from the Department of Health (July 2008) [1] and the Health and Social Care Act (2008)[4] outlines MRSA screening guidance that states that all relevant elective admissions should be screened by March 2009, exceptions to this are listed below in section 3. The correspondence goes on to discuss the approved suitable screening methods and how the organisation will be performance managed on this process.

In addition, the FT is required to introduce MRSA screening for all relevant emergency admissions as soon as practical within the next three years. In response to this and the FTs MRSA bacteraemia trajectory, the FT adopted screening of emergency admissions from 1st December 2008.

2 Purpose

2.1 This policy highlights the patients that should be screened for MRSA. This policy should be used in conjunction with the H7 Policy, The Prevention of Healthcare Associated Infections [2] and the policy for the Management of patients with Meticillin Resistant *Staphylococcus aureus* (MRSA), found within the infection prevention and control website [3].

Patients that are screened and recommended exclusions are based on recommendations within the Health and Social Care Act (2008) [4], DoH guidance on MRSA screening (July 2008) [5 & 6] and local risk assessment.

3 Duties

3.1 **Patients screened at UHSM** (See Appendix 1)

Elective patients[6]

All elective surgical admissions must be screened at pre-op assessment clinic/out-patients clinic within 6 weeks of their planned admission.

Non-surgical elective admissions are screened on admission to the FT unless they have been screened within 6 weeks at UHSM.

As recommended by the DH guidance on MRSA screening (July 2008), the following patient groups who should **not** be routinely screened (exclusions):

- Day-case ophthalmology, dental and endoscopy
- Minor dermatology procedures eg, warts, liquid nitrogen applications
- Children/Paediatrics unless already in a high risk group
- Maternity/Obstetrics except for elective/emergency caesareans and high risk cases.
- Mental Health Patients

Emergency patients[8]

All *relevant* emergency admissions as listed below must be screened at the earliest opportunity within one day of the admission date by the nurse in charge of the patients care. If patients are admitted through A&E they must be screened by A&E or the admitting ward, usually in the Urgent Care Directorate. If patients are admitted through Clinic, GP referrals, bed bureau or other means, the first receiving ward must undertake the screen.

The *relevant* admissions

- All patients admitted through A&E.
- Patients admitted via clinic on the same day as the appointment
- Patients admitted via G.P referrals.
- Patients admitted by the bed bureau.

High risk* patients

This refers to their risk for acquisition of MRSA i.e. past history of MRSA, hospital admissions within last 3 months, admitted from a nursing or residential home, transfer from another hospital. These patients are screened on admission.

Patients with a history of MRSA

These patients are screened on admission and then at weekly intervals whilst an in-patient at UHSM

Long stay patients

Adult patients who are not known to be MRSA positive and are in-patients for greater than 2 weeks are screened at 2 weekly intervals.

Patients in high risk areas.

Patients admitted to Augmented care areas, for example those in ICU, CTCCU, NNU and Burns Centre should be screened weekly.

The FT will continue to locally assess admission groups for screening according to risk.

3.2 Information for patients who are to be screened

It must be explained to the patient that the screen is being taken to check whether or not the patient has MRSA The result of the screen will take 24-48 hours to process and the patient will be notified if the result is positive. It must be stressed to the patient that the result of the screen will in no way be detrimental to the care they receive whilst an in-patient at the Trust [3 & 7].

N.B. The patient must also be informed that a negative screen on admission does not imply that they do not have MRSA but that it may be present in such small quantities that it has not been detected. All patients that are screened for MRSA must be given an information leaflet that explains the facts of MRSA to patients who are being screened (see Appendix 1).

3.3 Taking a screen for MRSA

Take a full screen for MRSA from the patient. The following sites are recommended for sampling MRSA:

- Nose and Groin/perineum
- Plus, diagnostic specimens as appropriate (e.g. lesions or wounds, eczema or psoriasis, Intravenous, invasive device sites from IV catheters, stoma sites, urine from catheterised patients, tracheotomies and sputum if the patient has a productive cough).

Pre moisten swabs should be done by dipping them in transport media, sterile water or saline prior to swabbing.

Use the same swab to sample symmetrical sites e.g.

- Single swab for right and left nostril
- Single swab for right and left groin

One request card can be used for multiple swabs as long as swab is clearly

identified with each patient details and site from which taken and identified as 'MRSA screen'.

3.4 Interim management of patients pending screening results

In line with MRSA policy patients should not be treated with decolonisation therapy pending results of the MRSA screen results unless they have had a previous history of MRSA or are in a high risk category.

3.5 Notification of results

All final results will be available on Anglia ICE in addition to the following;

Monday – Friday 8am – 4pm - All presumptive positive and confirmed results will be phoned through to the ward by the Infection Prevention and Control Nurse. (A paper copy will follow). MRSA care pathway for the management of patient who are MRSA positive will then be instigated by the nurse in charge of the patient on the ward.

Weekends and Bank Holidays – All presumptive positive results from ward areas will be phoned through to the ward by the Microbiology Laboratory.

Negative results will only be phoned if the presumptive positive is confirmed as negative through to the ward. All other negative results will be available after 24hours on Anglia Ice. A paper copy will also be sent from the laboratory to the ward where the screen was taken.

4.0 Process for monitoring the compliance with this policy.

The Department of Health request that each NHS organisation that admits and treats NHS elective patients will have to assure itself, its patients, commissioners and the Department of Health that it is delivering the MRSA screening commitment. As part of preparation for elective and emergency admission, the number of MRSA screening tests completed and comparison against the actual total number of relevant admissions or attendances in the same period will be monitored by the Infection Prevention and Control team. In addition, UHSM have agreed with Commissioners a cohort of patients that should be screened and report on these each month and Divisional internal objectives will be set to support assurance in compliance.

4.1

The Audit and Surveillance Officer for the UHSM monitors all compliance of **elective** and **emergency** admissions.

Every patient listed as a relevant **Elective Admission** on the Lorenzo system is matched with the Pathology Telepath System as having had a MRSA screen. If there is a screen showing and the screen was carried out on the day of admission or in the six weeks prior to admission, then that patient in counted as having as having been screened for the elective admission. If the screen was more that 6 weeks prior to admission or after the day of admission, the screen will not be counted. Any elective patient seen as an excluded area or undergoing a procedure that is not required to be screened is

listed in Appendix 1.

Every patient listed as a relevant **Emergency Admission** on the Lorenzo system is matched with the Pathology Telepath System as having had a MRSA screen. If there is a screen showing and the screen was carried out on the day of admission or the day after admission, then that patient in counted as having as having been screened for the emergency admission. If the screen was more that 2 days after admission, the screen will not be counted. Any emergency patient seen in an excluded area or undergoing a procedure that is not required to be screened is listed in Appendix 1.

5.0 Dissemination, Implementation and Access to this Document

This Policy will be launched via members of the IPC and be cascaded to multi-professional staff across the organisation. (Appendix 3)

The Policy will be available on the Trust Intranet site and global email notification shall be undertaken.

The Trusts infection prevention and control communications campaign shall be used to ensure the policy is cascaded (these will include Team Brief, Message of the Day and Infection Prevention and Control Newsletters).

6.0 Review, Updating and Archiving of this Document

This policy will be subject to review annually or more frequently if legislation or authoritative guidance changes.

The IPT will review and evaluate the Infection prevention annual plan and performance in line with the Health and Social Care Act (2008).

This process will be monitored by the IPC and Board of Directors meetings.

Monthly reports will be developed and presented to the Board of Directors by the DIPC.

Assurances will also be obtained by the completion of internal audits and external inspections by the Care Quality Commission and NHSLA

6.0 References and Bibliography

1. Department of Health (July 2008) MRSA Screening – Operational Guidance. Gateway reference number 10324

2. H7 Policy for the Prevention and Control of Healthcare Associated Infections (HCAIs)

3. Meticillin Resistance Staphylococcus aureus (MRSA) and MRSA screening:

Information for Patients

4. Department of Health (2009) The Health and Social Care Act (2008). A Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance.

5. Department of Health (2007) Screening for meticillin-resistant *Staphylococcus aureus* (MRSA) colonisation: A strategy for NHS Trusts: a summary of best practice. www.clean-safe-care.nhs.uk

6. Department of Health (December 2008) MRSA Screening–Operational Guidance 2 Gateway reference number 11123

7. Department of Health (2007) Isolating Patients with healthcare-associated infection. A summary of best practice. www.clean-safe-care.nhs.uk

8. Department of Health (March 2010) MRSA Screening–Operational Guidance 3 Gateway reference number 13482

7.0 Appendix

Appendix 1

Summary MRSA screening at UHSM form 1st December 2010

Directorate	Wards	Relevant Elective Admission	Relevant Emergency Admission
Clinical Support	Critical care units: CTCCU/ ICU/HDU	Screened on admission and at weekly intervals. Pain Clinic patients are not required to be screened.	All patients are screened on admission by A&E or the admitting ward.
	Theatres	All patients six weeks prior to admission or screened on admission.	All patients are screened on admission by A&E or the admitting ward.
Cardio Thoracic	F1N, F6, JQ	All patients six weeks prior to admission or screened on admission.	High risk* patients are screened.
	ACCU	Screened on admission and at weekly intervals	All patients are screened on admission by A&E or the admitting ward.
Womens & Children	F16	All patients six weeks prior to admission or screened on admission	All emergency caesareans and high risk of complications in mother or baby are screened
	Delivery Suite, Antenatal, C2, C3, F15, Birth Centre,	All non elective patients are screened as antenatal screens procedure.	
	NNU	Screened on admission and at weekly intervals	All patients are screened on admission by A&E or the admitting ward.
	Nightingale & Womens Health Suite	Patients are screened if undergoing a high risk invasive procedure or if prophylaxis.	
	Paediatric medical or surgical	High risk* patients are screened	High risk* patients are screened
Surgery	A3, A4, A5, A6-SAU, F1S, F3, PIU, Urology, Lithotripter.	All patients six weeks prior to admission or screened on admission.	High risk* patients are screened.
Head & Neck/ Burns &	A2, Burns, F9	All patients six weeks prior to admission or screened on	High risk* patients are screened

Plastics		admission.	
Urgent Care	A&E, A10, AMRU, CDU, A8	-	All patients are screened on admission by A&E or the admitting ward.
Complex Health & Social Care	A1, A9, F4, F7, F10, Dis	All patients six weeks prior to admission or screened on admission.	High risk* patients are screened.
Respiratory	Sleep Services, Pearce, Aspergillus Centre, Bronochoscopy Unit	All patients six weeks prior to admission or screened on admission. Endoscopy Patients are not required to be screened.	
	CF Outpatients	All patients' sputum samples are screened.	

High risk* patients - this refers to risk for MRSA i.e. past history of MRSA, hospital admissions within last 3 months, nursing home, transfer from another hospital.

Patients with a history of MRSA - are screened at weekly intervals whilst an in-patient at UHSM

Long stay patients - (adult patients who are not known to be MRSA positive and are in-patients for greater than 2 weeks) - are screened at 2 weekly intervals

Appendix 2

Equality Impact Assessment Tool

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

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	Race	No	
	Ethnic origins (including gypsies and travellers)	No	
	Nationality	No	
	Gender	No	
	Culture	No	
	Religion or belief	No	
	Sexual orientation including lesbian, gay and bisexual people	No	
	Age	No	
	Disability	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?**	No	
4.	**Is the impact of the policy/guidance likely to be negative?**	No	
5.	**If so can the impact be avoided?**	N/a	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	N/a	

		Yes/No	Comments
7.	**Can we reduce the impact by taking different action?**	N/a	

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Infection Prevention and Control Nurses ext 2630 together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the Infection Prevention and Control Nurses ext 2630.

Appendix 3

Plan for Dissemination of Policy or procedural documents

4.1 Monitoring, evaluation, review and assurance

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

Title of document:			
Date finalised:		**Dissemination lead:** **Print name and contact details**	Head of Nursing, Infection Prevention and Control (X 2630)
Previous document already being used?	**Yes / No** (Please delete as appropriate)		
If yes, in what format and where?			
Proposed action to retrieve out-of-date copies of the document:			
To be disseminated to:	**How will it be disseminated, who will do it and when?**	**Paper or Electronic**	**Comments**

Dissemination Record - to be used once document is approved.

Date put on register / library of policy or 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**