The Newcastle upon Tyne Hospitals NHS Foundation Trust

Methicillin Resistant Staphylococcus Aureus (MRSA) Policy

<table>
<thead>
<tr>
<th>Version No.:</th>
<th>11.0</th>
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<tbody>
<tr>
<td>Effective From:</td>
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<td>Ratified By:</td>
<td>Infection Prevention and Control Committee</td>
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1 Introduction

The Newcastle upon Tyne Hospitals (NuTH) NHS Foundation Trust recognises that the effective prevention and control of healthcare associated infection (HCAI) is essential to patient and staff safety and to the overall performance of the organisation.

Staphylococcus aureus (S. aureus) is a bacterium that commonly colonises human skin and mucosa (e.g. inside the nose) without causing any problems. Although most healthy people are unaffected by S. aureus, it can cause disease, particularly if there is an opportunity for the bacteria to enter the body, for example through broken skin or during a medical procedure.

Meticillin Resistant Staphylococcus aureus (MRSA) is a type of S. aureus that is primarily resistant to flucloxacillin and some other antibiotics. It is transmitted in the same way as other strains of S. aureus and can cause the same range of infections and serious illness. However, due to its resistance to the more commonly used antibiotics, every effort is made to prevent its spread.

This policy is underpinned by the following national guidelines:
- Guidelines for the control and prevention of MRSA in healthcare facilities (2006)
- Guidance on the reporting and monitoring arrangements and post infection review process for MRSA bloodstream infections from April 2014 (version 2)
- Implementation of modified admission MRSA screening guidance for NHS (2014)
- UK Standards for Microbiology Investigations (SMIs); SMI B 29: Investigation of specimens for screening for MRSA (April 2014)

2 Scope

This policy applies to all healthcare professionals working across acute and community services within NuTH. This includes medical staff, nurses, allied health professionals, students and temporary clinical staff working in the Trust or those working in the Trust from other organisations.

3 Aim

The aim of this policy is to promote prompt detection and safe management of patients and staff with MRSA. It identifies processes for screening, detection, treatment and prevention of MRSA.
The main objectives of this policy are to ensure that:

- transmission of MRSA within NuTH is minimised
- all staff deliver high quality safe care
- all patients/staff are protected from infection or colonisation with MRSA
- all patients/staff who are confirmed to have MRSA are managed safely and appropriately, and receive sufficient information about their condition
- all staff are aware of their responsibilities through generic and specific education and training programmes

4 Duties - Roles and Responsibilities

4.1 The Chief Executive has overall responsibility for implementation, monitoring and review of this policy. This responsibility is delegated to the Director of Infection Prevention and Control (DIPC).

4.2 The Infection Prevention and Control Committee (IPCC), chaired by the Director of Infection Prevention and Control (DIPC), will review this policy and any new evidence base within the time frame set out in the policy, ensuring an effective and integrated approach to support a sustained reduction in MRSA incidence and a zero tolerance approach to MRSA bloodstream infections.

4.3 The Microbiologists are responsible, when required, for providing guidance and expert advice on management and treatment of patients and staff with confirmed MRSA.

4.4 The Infection Prevention and Control Nursing (IPCN) Team are responsible for providing expert advice in accordance with this policy, to support staff in its implementation and assisting with risk assessment where complex decisions are required.

4.5 The IPC Healthcare Scientist is responsible for ensuring that microbiology samples are processed in accordance with national guidance and maintains quality service provision which allows accurate diagnosis of MRSA.

4.6 The Information and Development Support Manager is responsible for developing and improving reporting, analysis and learning from MRSA bloodstream infections.

4.7 Patient Services Co-ordinators (PSC) in collaboration with clinical staff and IPCNs, are responsible for ensuring patients are placed in accordance with this policy. In any situations where recommended practice cannot be achieved; this may be escalated to site IPC Doctor, DIPC and Senior Nursing Team where appropriate.

4.8 On–Call Managers and Directors are responsible, in the out-of-hours period, for providing senior and executive leadership to ensure implementation of this policy and for ensuring infection prevention and control risks are fully
considered and documented when complex decisions need to be made regarding capacity and patient flow.

4.9 **Occupational Health Services** (OHS) are responsible for ensuring, where appropriate, staff are screened, treated and managed in accordance with this policy.

4.10 **Directorate Managers, Clinical Directors and Matrons** are responsible for on-going development, review and monitoring of Directorate HCAI Action Plans ensuring there are effective prevention and control processes in place to prevent MRSA acquisition.

4.11 It is the responsibility of **Line Managers and Heads of Department** to ensure that policies, procedures and access to education and training are made available to all staff to minimise the risk of infection and ensure clinical practice is in line with policy.

4.12 It is the responsibility of all staff to ensure that they understand and implement this policy and attend mandatory and other training sessions as specified in their role.

5 **Definitions**

The following terms are helpful in understanding the effects of MRSA:

**Colonisation** - area of skin or mucus membrane in which organisms are multiplying but without any host response i.e. disease or symptoms, causing no tissue invasion or damage. It can become part of the body’s flora.

**Infection** - generally used to refer to the deposition and multiplication of bacteria and other micro-organisms in tissues or surfaces of the body with associated host response, causing tissue damage. An infection may remain localised or it may be spread through the blood or lymphatic vessels to become systemic.

**MRSA Bacteraemia** - is a blood stream infection that can lead to a life threatening sepsis which can be fatal if not diagnosed and treated effectively.

6 **MRSA Management**

6.1 **MRSA Surveillance**

Nationally, annual rates of MRSA bacteraemia have decreased over the past decade. There has also been a significant decline in surgical site infections (SSIs) where MRSA has been attributed as the causative organism.

From continuous local surveillance of MRSA bacteraemia cases, monthly reports are disseminated to all Directorates and included in the IPCC and Trust Board meetings. In addition, a report of all cases (in all age groups) is circulated to Directorates, wards and units with analysis of trends and
exceptional events on a quarterly basis via Quarterly HCAI Report; this also includes a summary of all new HCAI MRSA acquisitions.

6.2 MRSA Screening - patients

A patient MRSA screen in this Trust comprises nose, throat, groin, invasive devices, sputum if productive, catheter specimen of urine (CSU) where applicable, wounds and chronic skin conditions as a minimum. Screening regimens differ in some Trusts e.g. a nasal/perineum swab may represent a full screen. This Trust will accept these results in advance of admission providing a full screen in accordance with this Trust’s policy is undertaken on admission. These swabs must be sent within 48 hours of admission, correctly labelled to the Microbiology Laboratory.

In the event of patient refusal of MRSA screening this must be documented on either the MRSA Care Pathway or the medical notes if the patient does not have a history of MRSA. If the patient is to undergo surgery/invasive procedure, the clinician/surgeon must undertake a risk assessment based on the risk of MRSA colonisation and risk of the procedure. Prophylaxis and eradication may be considered.

6.2.1 Pre-assessment and Admission Screening

In 2009 and 2010 mandatory MRSA screening was introduced for elective and emergency admissions. The national guidance in England (2014) recommends a more focused screening strategy, targeting high-moderate risk areas to focus and maximise the clinical impact for patients who are most likely to benefit.


Based on this guidance and following a risk assessment by IPCC, the following clinical areas must submit MRSA screens at pre-assessment and on patient admission (see Table 1).

6.2.2 Pre-assessment and Out-patient Screening

All patients attending pre-assessment clinic (with the exception of Ophthalmology) must be screened for MRSA regardless of speciality; this may also include day case admissions. Patients attending out-patient clinics who go on to be listed for elective procedures (but do not attend a pre-assessment clinic prior to procedure), do not routinely require screening for MRSA unless the patient is deemed to be high risk e.g. previous history of MRSA.
6.2.3 Admission Screening

The table below identifies the clinical areas required to submit MRSA screens on admission; this includes all patients admitted to these areas.

Table 1

<table>
<thead>
<tr>
<th>CLINICAL AREAS REQUIRED TO SUBMIT MRSA ADMISSION SCREENS</th>
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<tbody>
<tr>
<td>Intensive Care Units (adult, paediatrics* &amp; neonatal)</td>
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<tr>
<td>Coronary Care Units</td>
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<tr>
<td>Cardiology</td>
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<tr>
<td>Cardiothoracic Surgery (including paediatric Dental patients with congenital heart problems)</td>
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<tr>
<td>Cystic Fibrosis Units (adult and paediatrics)</td>
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<tr>
<td>Burns and Plastics Units (adult and paediatrics)</td>
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<tr>
<td>Transplant Units</td>
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<tr>
<td>Older People’s Medicine</td>
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</table>

In addition to these clinical areas the following groups of patients must also be screened on admission regardless of admitting speciality

- all patients transferred from other healthcare facilities or care homes
- all patients with a history of MRSA (unless regular day case attenders admitted for non-interventional procedures e.g. infusion change, chronic pain management)

* Patients transferred to FH PICU for PDA ligation do not require admission screens.

** Patients attending for cyclical treatment must be screened before invasive procedures and routinely every 3 months.

*** Dialysis patients must be screened before invasive procedures and routinely every 6 months.

All patients screened at pre-assessment prior to admission to any of the high/moderate-risk areas will still require screening on admission if the admission occurs more than 48 hours after pre-assessment screening (unless standard eradication therapy is in progress (see Section 6.5.1).
In cases of urgent transfer, where possible, seek the MRSA status of the patient at the time of transfer in from other Trusts. RVI Assessment Suite (AS) and GNCH Ward 6, are not required to obtain groin swabs on admission, however staff must ensure a full screen is submitted within 48 hours of admission, either on AS, GNCH Ward 6 or base ward.

Planned day cases that go on to require an in-patient admission must be screened.

Patients going on weekend leave do not need to be re-screened on return if they have been screened within the previous 48 hours.

All other clinical areas are not required to routinely submit MRSA screens on admission (see Table 2).

Table 2

<table>
<thead>
<tr>
<th>CLINICAL AREAS NOT REQUIRED TO SUBMIT MRSA ADMISSION SCREENS</th>
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<tbody>
<tr>
<td>Day cases (from all specialities with the exception of Cardiology)</td>
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<tr>
<td>Dermatology</td>
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<tr>
<td>Interventional Radiology</td>
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<tr>
<td>Endoscopy</td>
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<tr>
<td>Observation bay ED</td>
</tr>
<tr>
<td>Dental</td>
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<tr>
<td>Cyclical Chemotherapy</td>
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6.3 MRSA Screening - staff

Routine screening of staff for MRSA carriage is not recommended practice although the IPC Team may request screening when there are particular epidemiological features to indicate that a staff member or members may be a potential source(s) of linked cases of MRSA infection (see Section 6.15).

It is recommended that when requested, screening swabs from staff are taken by themselves unless they are under OHS management.

PLEASE NOTE: A staff MRSA surveillance screen in this Trust comprises nose and throat; additional sites may be screened at the request of the IPC Team/OHS. Where a member of staff receives MRSA Standard Eradication Therapy, at least 48 hours post decolonisation, 3 sets of negative screens comprising nose, throat, groin and/or wounds/chronic skin conditions must be obtained a minimum of 48 hours apart.
6.4 Detection

When a patient is found to be MRSA positive an “Alert” (clinical risk) will be added to e-Record by the IPCN, identifying the MRSA positive onset date; clinical staff must review the alert status of all patients on admission.

An MRSA Care Pathway must be commenced for all in-patients where the patient has a history of, or is currently MRSA positive.

Patients who are known to have a history of MRSA but have at least 3 negative screens at weekly intervals must be screened on a monthly basis whilst an in-patient.

6.5 Treatment and Decolonisation

6.5.1 Pre-assessment

Any patient with a known history of MRSA, regardless of proposed procedure and even if 3 sets of weekly, negative screens have been obtained, must commence Standard Eradication Therapy prior to surgery. Routinely, the patient should be advised to commence Standard Eradication Therapy three days prior to procedure, on the day of the procedure and three days thereafter, however in certain circumstances this may be extended e.g. due to the use of Naseptin in Maternity (see Appendix 1).

It is important to continue to locally risk assess all patient admission groups for additional screening and/or topical treatment according to risk. Where MRSA is confirmed in patients undergoing procedures where deep wound or implant surgery is anticipated e.g. vascular, orthopaedic, neuro and cardiothoracic surgery; the clinician should review the patient and where possible commence Standard Eradication Therapy prior to admission, and at the clinicians discretion, attempt to obtain three sets of negative screening swabs taken at weekly intervals.

The decision to proceed to planned intervention after an unsuccessful attempt at MRSA eradication must be made by the clinician responsible for overall care, weighing up the risks of continued MRSA carriage against the benefits of intervention along with the risks of delay of that intervention required for patient care. The clinician should consult with a Microbiologist who will advise on appropriate prophylactic antibiotics where necessary.

A patient information leaflet, Treatment of MRSA Instruction leaflet for Pre-admission Patients should be given to all patients where appropriate.
6.5.2 Out-patients

Any patient found to be MRSA positive from swabs submitted via out-patients will be reviewed by the consultant in charge of their care, assessing the need for eradication therapy or treatment. If a patient is to be admitted for a procedure, the consultant must liaise with the patients GP to arrange eradication therapy (see Appendix 1). If there are no planned procedures, eradication therapy will not routinely be required. If there is a clinical indication e.g. infection, the clinician may be required to commence antibiotic treatment as required.

6.5.3 In-patients

All patients identified as MRSA positive must receive MRSA Standard Eradication Therapy unless contra-indicated, (see Appendix 2); this treatment should be administered within 12 hours from receipt of a positive result and must be prescribed via e-Record where available. A Datix incident form should be completed by the clinical team in circumstances where there has been a delay of ≥ 24 hours in commencing Standard Eradication Therapy. A patient information leaflet ‘Treatment of MRSA Instruction leaflet for In-patients’ should be given to all patients or their relatives/carers where appropriate.

Treatment of MRSA infection, as opposed to eradication of colonisation, will require antibiotic therapy. Each case must be considered individually since the antibiotic sensitivities of the organism may vary. Where patients are prescribed long term antibiotics, topical antiseptic washes may also be advised on a case by case basis. Advice can be obtained from an IPCN or Microbiologist.

A full re-screen must be undertaken 48 hours after stopping Standard Eradication Therapy. If these results are negative, screens should be repeated at weekly intervals for a further 2 weeks until 3 sets of negative screens (at weekly intervals) are obtained.

Negative screens obtained whilst on Standard Eradication Therapy/partial eradication therapy/some antibiotics will be discounted as this may be a false negative result.

In-patients with a history of chronic colonisation must be screened on a monthly basis despite attainment of ≥3 negative screens following eradication. If these patients are deemed high risk, for example have invasive devices in situ, they may also remain on Chlorhexidine washes as advised by an IPCN.

6.5.3.1 Failed Course(s) of Standard Eradication Therapy

If the first course of MRSA Standard Eradication Therapy fails i.e. positive culture from any site obtained from any of the post
Standard Eradication Therapy screens, a second course of treatment should be commenced. If the second course fails, the following actions should be taken:

- on advice of an IPCN, the patient should receive a third course of MRSA Standard Eradication Therapy unless contra-indicated
- submit full re-screen 48 hours after ceasing the third course of treatment
- re-screen at weekly intervals until 3 sets of negative screens are obtained
- if a third course of MRSA Standard Eradication Therapy fails (any site) or the patient has already received three courses of Standard Eradication Therapy in the previous 6 months, refer to the IPCN or Microbiologist for further advice

6.5.4 Exceptions and Contraindications to Standard Eradication Therapy

There may be exceptions or contra-indications to the MRSA Standard Eradication Therapy; the rationale for not prescribing all of the elements must first be discussed with the IPC Team and recorded by the clinical team on the MRSA Care Pathway or in the patient’s notes if not an in-patient.

Patients with multiple invasive devices, particularly devices in the airway, e.g. endotracheal tube, nasogastric tube, will be risk assessed for suitability of full topical eradication therapy; this may be deferred until devices removed. Small babies should not be prescribed nasal ointment or throat spray if there is a risk the treatment will occlude the airway.

6.5.5 Standard Eradication Therapy and Oxygen administration

Following risk assessment, use of oil- or paraffin-based nasal products e.g. Mupirocin and Naseptin, are not contra-indicated for patients who are receiving oxygen therapy.

6.6 Isolation

Isolation must continue for all patients known to be MRSA positive until 3 sets of negative screens at weekly intervals have been obtained, unless the patient is in a community setting or following discussion with an IPCN/Microbiologist. There are specific areas where MRSA positive patients must only be admitted to standard isolation in a cubicle, e.g. cardiology, vascular surgery. In these circumstances, patients must not be isolated in a bay unless there has been a review by a senior clinician and Microbiologist.

Nursing patients in isolation for very long periods of time (several weeks or more) can have a psychological impact or may impact on rehabilitation. It may
be acceptable in some cases, to leave the isolation room door open allowing the patient to socialise with others or to facilitate rehabilitation allow patients to attend communal areas such as the gym. **This should only be done after discussion with the IPC Team and documented on the patient’s MRSA Care Pathway.** Isolation methods are no different for MRSA than for other conditions requiring standard isolation (refer to **Isolation Policy**). Effective hand washing is essential to prevent cross infection. Refer to **Hand Hygiene Policy**.

### 6.7 Transfers (Internal/External)

Transfer to another ward/department in the Trust should not be delayed because a patient is MRSA positive. However, it is extremely important that when a MRSA positive patient is transferred from one area to another, the receiving ward or department must be informed of the patient’s MRSA status and the MRSA Care Pathway completed.

When a patient is transferred, the following measures must be taken:

- patient must be screened on transfer between wards unless the patient has already been screened within 48hrs of transfer. Transfer screens should be submitted by the receiving ward to avoid duplication and unnecessary screening
- prior to transfer, inform the receiving ward or department that the patient is MRSA positive so that isolation can be arranged where appropriate
- information on progress with standard eradication therapy must be communicated on transfer and all documentation complete
- accompanying persons should wear a disposable plastic apron and gloves only if close contact (e.g. moving and handling) is anticipated, otherwise these are not required. The trolley or chair must be cleaned with combined detergent/chlorine releasing agent 1000 ppm (Refer to **Use / Provision and Management of Trust Wheelchairs Policy**)
- visits to other departments and specialist areas (e.g. Radiology) should be kept to a minimum and based on clinical need
- for departmental visits, where possible the patient should attend at the end of the session
- the patient is to spend as little time as possible in the department and not wait for long periods with other patients

MRSA is not a reason to halt or delay transfer of a patient to another Trust. The care of the patient must take priority. However, it is vital that the transferring ward/department inform the receiving ward/department in advance, that the patient is MRSA positive and complete the relevant documentation detailed in the **Transfer Policy**.

### 6.8 Ambulance Transport

Colonisation or infection with MRSA is not a bar to ambulance transportation. Most MRSA positive patients can be transported in the same ambulance as other patients. In some circumstances, for example heavy shedders of MRSA,
the Trust IPC Team may advise the use of a separate ambulance for sole transportation of the patient.

6.9 Discharge

On discharge of an MRSA positive patient, the following action should be taken:

- inform the IPC Team if being discharged to another healthcare facility
- consultant in charge of patient to inform the patient’s GP if patient found to be MRSA positive on admission/during in-patient stay
- clinical staff to advise on eradication therapy/antibiotic therapy and follow up MRSA screening programme if appropriate, in Trust Discharge/Summary letter
- clinical staff to inform all relevant external health and social care providers where appropriate, ensuring all relevant documentation is complete
- if MRSA Standard Eradication Therapy is not yet complete ward staff to provide the patient with any treatment necessary to complete the current course
- ensure a Terminal Clean is undertaken (See Decontamination of the Patient Environment (including Terminal and Deep Cleaning))

If a patient is found to be MRSA positive following discharge, the IPCN will inform both the patient and the GP via a standard letter; the patient’s consultant will be informed via email (see Section 6.15.3).

Routine discharge screens are not required from any patient unless requested by the IPC Team. This may be initiated by the Site IPC Doctor where there is an increased prevalence of MRSA or there is evidence of healthcare associated infection on a particular ward or department (see Section 6.11).

6.10 Management of deceased patient

Measures to be taken:

- cover any lesions with impermeable dressings
- cadaver bags are not necessary (refer to Care of the Cadaver Policy
- ensure a Terminal Clean is undertaken (See Decontamination of the Patient Environment (including Terminal and Deep Cleaning))

In cases of MRSA bacteraemia, Clinical Risk and Governance Department (CGARD) will report cases where MRSA is implicated in patient’s death and if it is recorded on either Part 1 or Part 2 of the death certificate.

6.11 Outbreaks/Periods of Increased Incidence (PII)

Most incidents where MRSA is detected will not require an Outbreak Control Team (OCT) to be formed. However, in the case of a PII involving patients and/or staff, particularly if the incident is likely to have an effect on the
provision of clinical services by the ward/department, a formal OCT will be established. This will normally be convened on the advice of the Site IPC Doctor and IPCN, who will arrange meetings.

Where there is evidence of MRSA acquisition, all patient contacts nursed in the same bay as the index case for more than 48 hours will be screened. The IPCN will be responsible for forwarding patient contact screening details to the laboratory to monitor results.

If there is evidence of further MRSA transmission, at the discretion of the Site IPC Doctor and DIPC, an enhanced screening programme may be initiated. This may include screening of all current in-patients and commencement of discharge screening for two weeks. In addition environmental and staff screening may be carried out.

The enhanced screening programme will be co-ordinated by the Microbiology laboratory staff and weekly updates will be provided via email to the Matron and Directorate Lead Consultant, Directorate Manager, Site IPC Doctor and IPCN. If staff screening has been requested and is incomplete after 4 weeks then the information is copied to the DIPC, Site IPC Doctor, Matron IPC and relevant IPCN for action and resolution of issues.

Ward closure is an act of last resort to control an outbreak of MRSA. The decision to close a ward will always be taken by the OCT after an assessment of risk and full discussion and consultation with all interested parties, refer to Closure of Beds, Wards and Departments Policy.

A number of factors will influence the decision to recommend ward closure:

- risk of cross infection inherent in the strain of MRSA involved, especially if one of the ‘epidemic’ strains of MRSA is implicated
- continuing occurrence of new cases of MRSA, particularly if these occur in patients and staff who have previously been MRSA negative on screening
- nature of the clinical unit which affects the risk of serious infection in patients: surgical wards/departments may, for example, pose a greater risk than medical wards/departments. However, some wards/departments provide a critical service which cannot be withdrawn

### 6.12 MRSA Bacteraemia and Serious Infection Review

Microbiologist/IPCN will confirm each case of MRSA bacteraemia to the clinical staff and corporate team. If the case occurs on day 3 of admission or thereafter, the bacteraemia will provisionally be assigned to NuTH, if the bacteraemia occurs prior to this, the case will automatically be provisionally assigned to the Clinical Commissioning Group (CCG) responsible for the patient. Refer to Bacteraemia Review Process (see Appendix 3a and 3b).

Following an MRSA Bacteraemia, a MRSA Rapid Review must be completed by the staff responsible for providing care for the patient, Deputy Director of Nursing and IPCN. Where possible this must be completed and returned to
the Information and Development Support Manager within 24 hours of a confirmed result. An incident form is to be completed by the relevant Matron and submitted via Datix.

In addition to the Rapid Review, the Directorate is responsible for completing a Post Infection Review (PIR) Toolkit (see Appendix 4 for guidance notes). This should be led by the patient’s consultant, Matron (or deputy) with support from IPCN and consultant Microbiologist/DIPC. This multi-disciplinary review may also include representatives from the CCG and/or any other department/organisation involved in the patient’s care. The completed PIR must be returned to the Information and Development Support Manager within 5 working days of a confirmed result.

The PIR summary is submitted to Public Health England (PHE) Data Capture System (DCS) by the DIPC, Matron IPC and the Information and Development Support Manager within 14 days of a confirmed result.

If a patient is diagnosed with an MRSA bacteraemia within the first 48 hours (day 1 or day 2) of admission to a NuTH in-patient area, the CCG responsible for the patient will lead completion of the PIR Toolkit; NuTH staff may be involved in this process where appropriate.

The MRSA bacteraemia should be finally assigned to the relevant organisation within 14 days of initial assignment; the outcome of the PIR should establish which organisation this should be. Where it is not possible to determine which organisation should be assigned the case, the Regional Medical Director or Regional Director of Nursing will convene a review panel to assess the evidence presented in the PIR. The result of the review panel (final assignment) will be reported within 28 days of notification to the panel. In certain cases, ‘Third Party’ assignment may be used where previously, assignment may have occurred by default, or where there is clear evidence there were no failings in care.

All MRSA bacteraemia attributed to the Trust will be reviewed at the Serious Infection Review meeting which provides a forum for clinical teams (Clinical Director, Director of Nursing and Patient Services, DIPC, Site IPC Doctor, Matron IPC, Consultant, Matron and Sister) to review each case of MRSA bacteraemia to enable discussion and learning.

6.13 MSSA Bacteraemia

In addition to investigating all MRSA bacteraemia, a MSSA RCA must be completed for all MSSA bacteraemia occurring 48-hours post admission (see Appendix 3a). This review should be led by the patient’s consultant, Matron (or deputy) and Sister or Charge Nurse with support from a Consultant Microbiologist and IPCN. Following RCA, any cases of concern will be reviewed at the Serious Infection Review meeting which provides a forum for clinical teams (Clinical Director, Director of Nursing and Patient Services, DIPC, Site IPC Doctor, Matron IPC, Consultant, Matron and Sister) to review each case to enable discussion and learning.
6.14 Community settings

Refer to MRSA Guidance Flow Chart (community) for patients in non acute provider settings (see Appendix 5).

Patients cared for in their own homes do not require additional IPC precautions. Restrictions should not be placed on the normal social activity of any person living in the community because they have or previously had MRSA.

If possible patients should be the last visit in the morning or afternoon. If this is not possible, a risk assessment must be undertaken ensuring high risk susceptible patients are seen before a patient known to be MRSA positive. Staff attending to these patients must always ensure they adhere to standard IPC practices.

Carers, clients and relatives should be advised how to wash and dry their hands properly.

Equipment taken into the home to be used in patient care must be cleaned with a universal sanitising wipe after use. Staff should avoid taking other non-essential equipment into the home.

If a patient is to be admitted/readmitted to hospital it is the responsibility of the admitting healthcare worker to notify the receiving ward or department of the MRSA status so that isolation can be considered. This is a requirement for all patients whether being admitted to NuTH or another healthcare facility.

Patients attending health centres/clinics and general practice who are known to be positive and would normally attend a clinic, health centre or GP practice for their treatment can continue to do so. Wherever possible these patients who are MRSA positive, should be seen at the end of a morning or afternoon session.

Following treatment in a clinical area all equipment used, including treatment couches, footstools and trolleys must be cleaned where possible with a combined detergent and chlorine releasing agent 1000 ppm where available. Within some community premises the preparation of a chlorine releasing agent on a daily basis is prohibited due to lack of appropriate environment i.e. lack of sluice facilities, adequate ventilation and third party users. Where it is not possible to use a chlorine releasing agent, universal sanitising wipes must be used.

6.14.1 Management of residents in care homes

"MRSA is not a contraindication to admission to a home or a reason to exclude an affected person from the life of a home". (Department of Health 2006)
Residents in care homes are at no greater risk of MRSA infection than the general population. Many residents who have been previously decolonised e.g. during hospital admission, are at risk of re-colonising due to environmental factors within the home. However these residents do not pose a risk to others.

Residents should be encouraged to live a normal life without any restriction and they do not need to be isolated unless clinically indicated. They can join other residents in communal areas, receive visitors and go out of the home for visits.

If a resident has MRSA the following will be advised:

- do not share a room with another resident (unless a partner/spouse) who has an invasive device in situ e.g. catheter
- any ulcers or wounds should be covered with an appropriate dressing as per assessment
- clinical procedures and dressings should be carried out in the residents own room. The door should also be closed during care activities
- dressings/procedures on other residents should be undertaken before attending to dressings for MRSA positive residents
- bed linen should not be carried around the care home it must be put straight into a bag or skip to take to the laundry for washing

6.15 Management of Staff

Staff (including medical students, locum and agency staff) are not routinely screened for MRSA at pre-employment assessment. Clinical observers, visiting staff (including company representatives and undergraduate students) do not require MRSA screening in advance of observing theatre cases but their name must be entered onto the relevant theatre’s register.

All staff are required to provide screening specimens upon request e.g. during enhanced surveillance. Failure to do so may result in the Clinical Director being informed and possible disciplinary action taken.

The IPC Team will inform OHS via the MRSA Notification Sheet (see Appendix 6) of any staff confirmed MRSA positive. This will include guidance on restrictions from work based on a risk assessment (see Table 3). The IPC Team may advise additional restrictions to clinical activity whilst on eradication therapy and/or until three complete, negative screens are obtained. This may include restriction of invasive and aseptic procedures.

Staff who are MRSA positive on screening will be informed by OHS, who will provide advice on management including arrangement of decolonisation therapy and follow-up screens. Treatment is provided free of charge to staff and the cost is met by their Directorate (see Appendix 7).
### Table 3

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<tr>
<th>Risk Category</th>
<th>High</th>
<th>Moderate</th>
<th>Low/Minimal</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>(Critical Care, Special Care Nurseries, Burns, Transplant, Oncology/ Clinical Haematology, Renal Dialysis, Theatres/ Anaesthetics)</td>
<td>(Surgery, Neurosciences, Womens’ Services, Trauma and Orthopaedics, ENT, Dermatology, Ophthalmology, Children’s Services)</td>
<td>Medicine including Older Peoples Medicine, Dental, Community</td>
</tr>
<tr>
<td>Staff who are positive</td>
<td>Staff who are positive (nose/groin only) may work in low-risk or non-clinical areas during the first 48 hours treatment, and may then return to usual clinical duties. Three sets of negative screening swabs, taken at 48 hour intervals must be obtained on completion of Standard Eradication Therapy.</td>
<td>Staff who are positive (throat carriage) will be restricted from normal duties but may work in low-risk or non-clinical areas while receiving Standard Eradication Therapy. Staff may return to normal duties following exclusion once three sets of negative screening swabs, taken at 48 hour intervals are obtained on completion of Standard Eradication Therapy.</td>
<td>Staff are not routinely excluded whilst on Standard Eradication Therapy except on advice from the IPC Team. Three sets of negative screening swabs, taken at 48 hour intervals must be obtained on completion of Standard Eradication Therapy.</td>
</tr>
<tr>
<td>(from any carriage site)</td>
<td>will be restricted from normal duties but may work in low-risk or non-clinical areas while receiving Standard Eradication Therapy. Staff may return to normal duties following exclusion once three sets of negative screening swabs, taken at 48 hour intervals are obtained on completion of Standard Eradication Therapy.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Staff with known active infection with Staph. aureus should not be engaged in direct clinical work until their lesions are healed.

It is important that staff that contract MRSA are appropriately managed, both for their own, and for their patients, safety.

In addition, there is an obligation on the Trust and on individual clinical staff members to take all necessary and appropriate measures to protect their patients from potential harm, in this case, infection from MRSA.

Staff who require MRSA decolonisation will receive this via OHS.
6.15.1 Persistent Carriage of MRSA

Occasionally MRSA Standard Eradication Therapy may fail, with the staff member becoming a long-term carrier of MRSA. Staff in this position will be advised on an individual basis. The Directorate will consult with relevant parties to review clinical history and associated risk factors; best practice would be to arrange a ‘case conference’ this will include the staff member, their manager, senior HR representative, Consultant Microbiologist, IPCN and OHS to consider employment implications. This may include temporary or permanent redeployment. Staff who may have an underlying health condition which could be the source of colonisation, or increase the risk of continued carriage, may be referred for specialist management e.g. Ear, Nose and Throat, Dermatology. This would normally be through liaison with OHS and the employees GP; OHS will seek to expedite any such referral.

6.15.2 Bank Nurses

Bank nurses may care for known MRSA positive patients. Bank nurses who are known to be colonised should be managed as any other colonised staff. Units/wards/departments in which MRSA is known to be present may continue to use bank staff after discussion with the IPC Team. Bank staff are awaiting screening results may not work on high risk units during that time.

6.15.3 MRSA positive patients who are staff

In circumstances where staff are identified as MRSA positive whilst undergoing treatment as a patient, the staff member will be treated as per patient MRSA pathway. The individual staff member is responsible for informing OHS prior to returning to clinical duties. Where necessary, OHS may undertake further screening and seek advice from Microbiology/IPCN where treatment and possible restriction from duty is required. When MRSA is confirmed post-discharge, a letter confirming MRSA positive status is sent to both the patient and their GP. The letter to the patient requests, if they are a healthcare worker, as part of the professional responsibilities they should contact OHS for advice (see Section 6.9).

7 Training

All staff working on Trust premises, including Trust employed staff, agency and locum staff are responsible for accessing IPC Policies via the intranet in order to assist in the management of their patients.

IPC principles are incorporated in to all statutory and mandatory IPC e-Learning training programmes; MRSA management is incorporated into IPC programmes for community, nursing and medical staff. It is the responsibility of the departmental/service leads to ensure that training is completed by all relevant staff.
8    Equality and Diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way
we provide services to the public and the way we treat our staff reflects their
individual needs and does not discriminate against individuals or groups on any
grounds. This policy has been appropriately assessed.

9    Monitoring

The Trust Secretary reports MRSA statistics to Monitor on a monthly basis.

<table>
<thead>
<tr>
<th>Standard / process / issue</th>
<th>Monitoring and audit</th>
<th>Method</th>
<th>Committee</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuous monitoring of standards</td>
<td>Clinical Assurance Tool</td>
<td>Matron</td>
<td>Trust Executive Team, IPCC</td>
<td>Monthly</td>
</tr>
<tr>
<td>MRSA statistics</td>
<td>HCAI scorecard</td>
<td>Information and Development Support Manager</td>
<td>Trust Executive Team, IPCC</td>
<td>Monthly</td>
</tr>
<tr>
<td>MRSA admission screening</td>
<td>MRSA Admission Screening compliance Report</td>
<td>Senior Information Analyst / Matron IPC</td>
<td>Reported to Directorates</td>
<td>Monthly</td>
</tr>
<tr>
<td>Monitoring of PIR outcomes</td>
<td>HCAI Report</td>
<td>Information and Development Support Manager</td>
<td>IPCC</td>
<td>Quarterly</td>
</tr>
</tbody>
</table>

10 Consultation and review

Consultation of this policy was undertaken by members of IPCC and IPCNs. This policy will be reviewed annually by IPCC or as and when significant changes make earlier review necessary.

11 Implementation of policy (including raising awareness)

This policy is a revision of a previous Control of MRSA Policy. Clinical Directors/Matrons/Sisters/Charge Nurses and Clinical Leads should ensure that staff are aware of this policy. This policy is available for staff to access via NUTH intranet.

12 References

- Guidance on the reporting and monitoring arrangement and post infection review process for MRSA bloodstream infections from April 2014 (version 2).

13 Associated documentation

- Asepsis Policy
- Care of the Cadaver
- Cleaning and Disinfection Procedure
- Closure of beds, Wards and Departments Policy
- Control of Infection in Healthcare Workers
- Decontamination of Healthcare Equipment Prior to Service and Repair
- Decontamination of the Patient Environment (including terminal and deep cleaning)
- Hand Hygiene Policy
- Healthcare Associated Infections, Prevention and Control Strategy
- Infection Control Practice in the Operating Department
- Infection Control Standard Precautions
- Isolation Policy
- Major Outbreaks of Infection: Investigation and Control Policy
- Transport of Clinical Specimens
- Used laundry management policy
- Use / Provision and Management of Trust Wheelchairs Policy

Author: Matron Infection Prevention and Control
Appendix 1

Flow Chart for Screening of Patients Prior to Elective Admission for Meticillin Resistant Staphylococcus aureus (MRSA)

**ELECTIVE**

Screen in Pre-assessment

- **MRSA positive**
  - IPCN informs pre-assessment nurse of result verbally; this is followed by an email to the pre-assessment nurse and co-ordinator

- **MRSA negative but known history of MRSA (≤ 3 negative screens or ≥ 3 negative screens)**
  - Pre-assessment nurse informs consultant of positive result and arranges eradication therapy via NuTH or GP (standard letter) in accordance with policy

- **MRSA negative with no previous MRSA history, continue with clinical care as planned**

  - If 3 negative screens required prior to admission, pre-assessment nurse will arrange via NuTH or liaise with GP (Re-screening at the discretion of the consultant)

  - All patients with a history of MRSA require eradication therapy to be commenced 3 days prior to admission, on the day of surgery and 3 days after procedure

Screen in Out-patients

- **MRSA positive**
  - IPCN informs consultant of confirmed result via email

  - Consultant undertakes a review to identify if standard eradication therapy is appropriate

  - Consultant arranges eradication therapy via GP (standard letter) in accordance with policy. If 3 negative screens required prior to admission, the consultant liaises with the GP

  - Consultant secretary informs waiting list clerk when admission date available. IPCN informed patient admitted via powerchart alert on eRecord

Pre-assessment nurse informs patient of all stages of management plan:
- Result
- Eradication Therapy
- Screening if required
- Information leaflet
## Appendix 2

NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST

MRSA Standard Eradication Therapy

<table>
<thead>
<tr>
<th>Standard Therapy</th>
<th>Alternatives</th>
<th>Notes</th>
</tr>
</thead>
</table>
| **Nose** | Mupirocin 2% nasal ointment applied to the inside of both nostrils 3 times daily for 5 days | Naseptin cream (Chlorhexidine 0.1% plus 0.5% Neomycin) 4 times daily for 10 days | In pregnancy and breastfeeding use Naseptin  
Patients with known or suspected peanut allergy MUST NOT be prescribed Naseptin |
| **Skin** | Chlorhexidine 4% surgical scrub (e.g. Hibiscrub)  
Daily application of neat solution applied directly to wet skin, using as a soap substitute for 5 days | Triclosan 1% skin cleanser (Skinsan) or Povidone Iodine 7.5% surgical scrub | |
| **Hair** | Chlorhexidine 4% surgical scrub (e.g. Hibiscrub)  
Daily application of neat solution applied directly to wet hair, use on alternate days for 5 days | Triclosan 1% skin cleanser (Skinsan) | |
| **Throat** | Chlorhexidine 0.2% throat spray (Corsodyl)  
12 sprays twice daily to throat for 5 days, 5 minutes after brushing teeth (rinse mouth with water before using spray) | Chlorhexidine 0.2% mouthwash 10mls, gargled twice daily  
(rinse mouth with water before using mouthwash) | Patients with dentures should clean these in the normal way and use the Chlorhexidine throat spray prior to placing the dentures in the mouth  
For Paediatric patients please see note 1 &2 below |

### Notes

1. The decision to eradicate throat carriage in children should be made on an individual basis by the team looking after the patient and as required in consultation with the IPCT, as administration could be difficult due to the age and cooperation of the child. Nasal ointment and throat spray should not be given to small babies if there is a risk the treatment will occlude the airway.
2. Neonates should always be discussed on an individual basis. A neonate is defined as being less than four weeks post term equivalent.
3. Treatment should not be given for more than three courses to individual patients in any one episode to avoid the development of resistance, and should not be given for courses longer than those shown in the table unless agreed by a Microbiologist.
4. Eradication Therapy is not always successful. It is most likely to be successful in patients with only nasal carriage. Contact the IPCT for advice on the management of persistent carriage of MRSA.
Bacteraemia Review Process

Bacteraemia identified

**MSSA**
- Clinical team (nursing and medical), Microbiologist and IPCN to complete RCA for all cases occurring 48-hours post admission; to be returned to Information and Development Support Manager within 5 working days of RCA request. Datix to be completed
- All cases of concern to be discussed at Serious Infection Review Meeting

**MRSA**
- Clinical team (nursing and medical), Deputy Director of Nursing and IPCN to complete RCA for all cases occurring 48-hours post admission; to be returned to Information and Development Support Manager within 5 working days of confirmed result. Datix to be completed
- Consultant, Matron, IPCN and Microbiologist/DIPC to complete PIR Toolkit for all NuTH assigned cases (and as requested by CCG). To be returned to Information and Development Support Manager within 5 working days of case being assigned to NuTH
- PIR summary to be submitted to PHE DCS by DIPC, Matron IPC and Information and Development Support Manager within 14 days of initial case
- All cases to be discussed at a Serious Infection Review Meeting

**E. coli**
- All cases will be reviewed by a Microbiologist

**Lessons Learnt Feedback:**
- IPCC
- Safety Briefing
- Matrons IPC Forum
- CPG
- IPC Team
Appendix 3b

MRSA BLOODSTREAM INFECTION (BSI): REPORTING ARRANGEMENTS

TIMELINE

1. MRSA BSI confirmed by healthcare providers' laboratory
2. Positive MRSA BSI result recorded on DCS. Provisional allocation to either Acute Trust or CCG
3. Positive specimen taken on or after day 3 – Provisionally assigned to the Acute Trust
4. Positive specimen taken on day 1 or day 2 – Provisionally assigned to the CCG
5. Trust leads PIR with assistance from CCG and other organisations as necessary
6. CCG leads PIR with assistance from Trust and other organisations as necessary
7. Local PIR undertaken by Lead organisation (i.e. Acute Trust or CCG)
8. Provisional assignment is confirmed. PIR process complete
9. Leading organisation does not agree with the provisional assignment
10. No agreement on the assignment of the case
11. Assisting organisation agrees to the case. PIR process complete
12. Arbitrator to convene a review panel and adjudicate (within 28 days). The panel can call on the Acute Trust, CCG or PHE to assist
13. The panel review outcome: MRSA BSI assigned to the original provisional assignment; the leading organisation
14. The panel review outcome: MRSA BSI assigned to the assisting organisation
15. The panel review outcome: MRSA BSI assigned to the organisation where the blood specimen was tested, as this was a contaminant case
16. The panel review outcome: MRSA BSI assigned to a Third Party
17. Arbitrator gives feedback/learning to local organisation on corrective measures to prevent recurrence. As part of good practice, Arbitrator will also be expected to carry out regular audits/QA of local decisions
Appendix 4  Post Infection Review (PIR) Toolkit and guidance notes

The purpose of this toolkit is to help staff conduct their post infection review in the case of a MRSA bloodstream infection (MRSA BSI). Some sections may be more relevant than others, and staff are encouraged to exercise their discretion/clinical judgement in completing the form. This process is about being open and honest to drive improvements in care and governance systems.

The PIR process will:

- enable organisations involved to understand the causes of the MRSA BSI
- establish where and why it happened
- establish what went well with the care given and what could be improved
- understand the expectations and perspectives of all those involved
- generate insight into lessons learned
- lead to greater awareness, changed behaviours and agreed improvements in care

In bacteraemia cases that occur within 48 hours of admission to NuTH, the CCG responsible for the patient will lead the PIR; Trust staff may be requested to participate in this review where necessary.

The PIR is to be conducted by a multi-disciplinary team for all MRSA bacteraemia provisionally assigned to the Trust (> 48 hours post admission) and this is to be led by the consultant responsible for the patient’s care.

The Consultant’s secretary will be requested to arrange a PIR meeting ensuring the toolkit is completed within 5 working days of a positive result. Those in attendance to include Consultant, Matron, IPCN, Consultant Microbiologist / DIPC and members of CCG or other Healthcare providers as necessary.

The PIR is to be returned electronically to the Patient Services Data Manager within 5 working days of a confirmed result.

PIR summary to be submitted to PHE Data capture System by DIPC, Matron IPC and Patient Services Data Manager within 14 days of a confirmed result; final assignment of the bacteraemia occurs at this stage. Where it is not possible to reach agreement on final assignment of the case, this will be referred to the Regional Medical Director or Regional Director of Nursing to convene a review panel to finally assign the bacteraemia.
Appendix 5  

MRSA Guidance Flow Chart (NuTH Community Staff)

MRSA isolated from specimen (any site)

Area colonised with MRSA

If patient is not expected to have a planned elective admission no further treatment is required

If patient has elective admission, eradication therapy should be given as per relevant admitting healthcare provider’s regime. For NuTH elective admissions refer to Appendix 3

If wound is colonised with MRSA the aim is to promote healing and prevent infection. Only re-sample if clinically indicated e.g. wound not healing, increased exudate, pain, erythema

If wound is infected it should be managed in line with NuTH wound formulary and when necessary following advice from Tissue Viability

If wound is healing there is no need to re-sample

Patients with MRSA infection: Discuss appropriate treatment required e.g. antibiotics with GP/medical staff/microbiologist

If a patient is to attend an out-patient department whenever possible staff should inform the relevant department of MRSA status

Whenever practicable patients should be seen at the end of a caseload or clinical session

Normal social activity should be encouraged with any person living in the community who has a history of MRSA or who currently is known to have MRSA
## MRSA notification

<table>
<thead>
<tr>
<th>Name of staff member:</th>
<th>DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward/Dept.:</td>
<td>Site:</td>
</tr>
<tr>
<td>Date and carriage site &amp; result:</td>
<td></td>
</tr>
<tr>
<td>Work Restrictions (as per MRSA Policy):</td>
<td></td>
</tr>
<tr>
<td>IPCN contact:</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 7  Flow Chart for Management of MRSA positive staff (following enhanced surveillance staff screening)

1. IPCN requests ward/department manager initiate enhanced MRSA surveillance (staff screening) - routinely NOSE and THROAT screens only

2. IPCN informs Microbiology Laboratory enhanced MRSA screening has been initiated. IPC Healthcare Scientist or Healthcare Scientist Associate send (via NuTH email) blank spreadsheet to ward/department manager with a request to populate spreadsheet with staff details

3. IPCN informs OHS (via Newcastle.ohs@nhs.net) enhanced MRSA surveillance has been initiated on relevant ward/department

4. IPC Healthcare Scientist or Healthcare Scientist Associate review spreadsheet on a weekly basis until all screens are submitted (non-submission escalated to Directorate)

5. Individual MRSA positive results reported to IPCNs via lab. If a staff member is confirmed MRSA positive, IPCN emails completed MRSA Notification Sheet to OHS for action via a secure method (encryption if NuTH to nhs.net account).

6. Newcastle OHS contact the staff who are MRSA positive, review and undertake further screening if required, organise eradication therapy and arrange post-treatment screening. OHS will advise manager if alternative work can be carried out within the department until clearance screens obtained (refer to Table 3)

7. OHS will coordinate screening plan - full screen, minimum 48-hour intervals. Once staff member is MRSA negative and able to return to work, OHS will advise the Manager via telephone. This will be followed up by a standard email back to the staff member, Manager and IPCN with regards their ability to return to clinical duty

8. If staff remains MRSA positive despite eradication therapy, OHS will consult with Site IPC Doctor for further advice. If there is significant impact to employment a case conference approach with Manager, HR, IPC and OH may be required
The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality Analysis  Form A

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

PART 1

1. **Assessment Date:** 26/10/2016

2. **Name of policy / strategy / service:** MRSA Policy

3. **Name and designation of Author:** Louise Hall, Matron IPC

4. **Names & designations of those involved in the impact analysis screening process:** Dr Ashley Price, DIPC

5. **Is this a:**
   - Policy
   - Strategy
   - Service

   **Is this:**
   - New
   - Revised

   **Who is affected:**
   - Employees
   - Service Users
   - Wider Community

6. **What are the main aims, objectives of the policy, strategy, or service and the intended outcomes?** (These can be cut and pasted from your policy)
   
   The aim of this policy is to promote effective, prompt detection and safe management of patients and staff with MRSA. It identifies processes for elective and emergency screening, detection, treatment and prevention of MRSA.

7. **Does this policy, strategy, or service have any equality implications?** Yes [X] No

   If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:
## 8. Summary of evidence related to protected characteristics

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>Evidence, i.e. What evidence do you have that the Trust is meeting the needs of people in various protected Groups</th>
<th>Does evidence/engagement highlight areas of direct or indirect discrimination? If yes describe steps to be taken to address (by whom, completion date and review date)</th>
<th>Does the evidence highlight any areas to advance opportunities or foster good relations. If yes what steps will be taken? (by whom, completion date and review date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race / Ethnic origin (including gypsies and travellers)</td>
<td>Provision of Interpreting service E&amp;D Training</td>
<td>Studies show that when interpreters were provided, patients had a better understanding of their diagnoses and treatment plan than patients without interpreters. <strong>Action</strong> Ensure communication support is available.</td>
<td>None</td>
</tr>
<tr>
<td>Sex (male/ female)</td>
<td>Male and female practitioners are available to promote the dignity of patients when required</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Religion and Belief</td>
<td>Chaplaincy service provided with links to leaders of major faiths</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Sexual orientation including lesbian, gay and bisexual people</td>
<td>HIV listening service which is peer listening/support service for people diagnosed HIV positive – provides annual training events to support listening skills.</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Age</td>
<td>Innovations to support people with Dementia</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section</td>
<td>Provision of BSL Signers and Deaf Blind Guides LD Liaison Nurse Links to Psychological and Mental Health Services Involving family is included in the policy</td>
<td>Information in appropriate formats is needed to support effective treatment. <strong>Action</strong> Ensure communication support is available</td>
<td>None</td>
</tr>
<tr>
<td>Gender Re-assignment</td>
<td>Gender Identity sub group to identify and address needs in relation to</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
9. Are there any gaps in the evidence outlined above? If ‘yes’ how will these be rectified?

No

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

Do you require further engagement? Yes ☐ No ☒

11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?)

No

PART 2

Name: Louise Hall

Date of completion: 26/10/2016

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)