METICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)

Amendments

<table>
<thead>
<tr>
<th>Date</th>
<th>Page(s)</th>
<th>Comments</th>
<th>Approved by</th>
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<tbody>
<tr>
<td>June 07</td>
<td></td>
<td>Updated in line with the revised MRSA guidance (2006)</td>
<td>Michaela Morris, Director of Nursing &amp; Operations</td>
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<tr>
<td>April 08</td>
<td>138</td>
<td>Updated in line with the revised Health Act in January 2008 The</td>
<td>Michaela Morris, Director of Nursing &amp; Operations</td>
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<td></td>
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<td>reporting of MRSA bacteraemias by the Chief Executive</td>
<td>27th June 2007</td>
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<td>June 10</td>
<td></td>
<td>Updated in line with Trust's Policy Writing &amp; Ratification Policy.</td>
<td>Caroline Becher, Chief Nurse</td>
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<tr>
<td>June 12</td>
<td></td>
<td>Updated to include Real Time.</td>
<td>Suzanne Rankin, Chief Nurse</td>
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<tr>
<td>March 14</td>
<td></td>
<td>Policy merged with the MRSA Screening Policy.</td>
<td>Suzanne Rankin, Chief Nurse</td>
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</tbody>
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Compiled by: The Infection Control Team
In consultation with: Control of Infection Committee
Ratified by: Clinical Governance Committee
Date ratified: November 2007
1st Review: April 2008
2nd Review: June 2010
3rd Review: June 2012
4th Review: March 2014
Reviewed by: Linda Towey
Review date: March 2016
Target audience: All Trust staff
Impact Assessment carried out by: Linda Towey, Consultant Nurse, Infection Prevention & Control
Comments on this document to: Linda Towey, Consultant Nurse, Infection Prevention & Control
1. INTRODUCTION

Certain strains of Staphylococcus aureus have developed resistance to the more commonly used antibiotics, e.g. penicillin and flucloxacillin. These are now referred to as MRSA (Meticillin Resistant Staphylococcus Aureus) as meticillin is used to test for resistance to flucloxacillin. Concern about the transmission of MRSA is related to the potential spread of this organism in hospital and the limited number of antibiotics available to treat infections caused by MRSA.

MRSA can infect or colonise damaged skin, e.g. wounds, ulcers, cannula sites or abnormal skin, e.g. eczema, dermatitis and psoriasis.

It can also cause more serious infections such as septicaemia, (mortality 60%) endocarditis, pneumonia and osteomyelitis.

Healthy people are not normally affected but may carry the organism in their nose or on their skin. Although healthy people can suffer skin infections such as boils from Staphylococcus aureus, there is no evidence that MRSA poses a significant risk to health care workers and their families.

2. PURPOSE

To ensure that there is a robust procedure in place for screening in accordance with Department of Health guidance and as required and external agencies to ensure correct management of patients either colonised or infected with MRSA to prevent spread of the organism.

3. SPREAD OF THE ORGANISM

Clinical infection with MRSA (including MRSA bacteraemia) occurs either from the patient’s own resident MRSA (if he/she is an asymptomatic carrier) or by cross infection from another person who can also be an asymptomatic carrier or have a clinical infection.

Hands are the main route for the transmission of most bacteria including MRSA.

Transient hand carriage by staff is the most likely route of spread from patient to patient.

Staff may colonise themselves by touching or rubbing their noses with unwashed hands after contact with MRSA positive patients or their immediate environment. Staff may also acquire MRSA colonisation if they have skin wounds, or dermatitis or bitten nails and nail beds. MRSA may also be transferred in the dust. The front of a uniform may also become contaminated especially if damp.

Shared equipment such as stethoscope bell, sphygmomanometer cuff, radio ear phones or tourniquets may transmit MRSA between patients. Ideally use the equipment dedicated to known colonised patients on them only. Use a dedicated stethoscope or disinfect the bell of your stethoscope with 70% alcohol after use (e.g. 70% alcohol wipe), between ALL patients. When the
colonised patient is discharged equipment must be cleaned and disinfected according to Trust policy.

Airborne spread can occur, especially if MRSA is in the sputum or on desquamating skin scales (e.g. in patients with eczema). Thus isolation has an important role in preventing spread.

4. **RISK CLASSIFICATION**

The MRSA Working Guidelines (2006) proposes that preventative strategies be directed primarily by acute clinical areas. Long stay and mental health areas adopt less stringent strategies.

Therefore the Trust’s MRSA Policy reflects this by categorising clinical areas into three risk categories. The risk category reflects the screening required, decolonisation treatment and isolation requirements.

<table>
<thead>
<tr>
<th>Risk Classification</th>
<th>Clinical area</th>
<th>Screening</th>
<th>Topical Decolonisation</th>
<th>Isolation</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIGH</td>
<td>ICU NICU/SCBU</td>
<td>Screen all patients on admission and then weekly, Screen on admission</td>
<td>Commence on topical decolonisation treatment (see section 16). Stop if patient is found to be negative. THIS DOES NOT APPLY TO NICU/SCBU.</td>
<td>Isolate MRSA positive patients</td>
</tr>
<tr>
<td></td>
<td>MHDU Orthopaedic/ Emergency</td>
<td>Screen on admission</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Orthopaedic Elective Vascular Surgery Implant Surgery (Breast, Pacemakers) Major Urology Surgery</td>
<td>Screen on admission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MEDIUM</td>
<td>MAU and SAU General Surgery – Non implant Urology (non-major) Paediatrics Oncology/Haematology Maternity Medicine Elderly Care</td>
<td>Screen on admission all emergency patients and any patient who is undergoing an implant of an invasive device. All elective surgery or medical procedures must be screened prior to admission in pre assessment or the relevant clinic except paeds and maternity. Planned C section to be screened.</td>
<td>As soon as a patient is found to be MRSA positive topical decolonisation treatment must be commenced. See section 17. All patients undergoing implant surgery, including joint surgery, to be prescribed antibacterial wash 48hrs prior to procedure i.e. wash daily for 2 days.</td>
<td>Isolate MRSA positive patients. Risk assessment may be necessary.</td>
</tr>
<tr>
<td>LOW RISK</td>
<td>Mental Health Long Stay Elderly Care Unit</td>
<td>Screen in accordance with local policy.</td>
<td>Not routinely required, risk assess.</td>
<td>Usually not required.</td>
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</table>
5. **SCREENING**

The transmission of MRSA and the risk of MRSA infection (including MRSA bacteraemia) can only be addressed effectively if measures are taken to identify MRSA carriers as potential sources and if they are treated to reduce the risk of transmission. This requires screening of patient populations for MRSA carriage either before or on admission to identify carriers and implement a decolonisation regimen. Therefore all elective and emergency admissions must be screened.

6. **PATIENTS WHO DO NOT REQUIRE MRSA SCREENING**

The following patient groups **DO NOT** routinely require to be screened:
- Day Case Ophthalmology
- Day Case Dental
- Day Case Endoscopy
- Minor dermatology procedures i.e. warts or liquid nitrogen applications
- Children/paediatrics not already in high risk group
- Maternity/obstetrics except planned Caesarean sections (see 3.8)
- Day case infusions e.g. blood transfusions, methylprednisolone

7. **PATIENTS WHO DO REQUIRE MRSA SCREENING**

**ALL ELECTIVE ADMISSIONS**
(Whether as day cases or for admissions)

- All planned admissions for surgery
- All planned admissions for medical patients
- Patients being admitted as surgical day cases
- Patients being admitted as medical day cases e.g. lumbar puncture

Screening should be undertaken at pre-assessment clinic or outpatients or at the time of consultation when the decision is made to electively admit the patient.

An explanation of why the screen is being undertaken must be discussed with the patient and a patient information leaflet provided which is available on TrustNet.

If a patient is found to be MRSA positive he/she will undergo decolonisation treatment prescribed by the patient’s GP.

Any elective orthopaedic patient undergoing joint surgery or osteotomy will be prescribed antibacterial wash, to commence 48 hours prior to surgery.

A negative MRSA screen is applicable for a maximum of 18 weeks assuming the patient has had no admissions to a healthcare institute in the meantime. After this time or any admissions the screen must be repeated.

Patients who attend A&E and are discharged to be readmitted days later must also be screened i.e. dislocated shoulder, fractured wrist.
Healthcare staff should be screened a week prior to the operation/procedure date in addition to pre-admission.

All transfers from hospitals abroad or hospitals in the UK.

8.  **ALL EMERGENCY ADMISSIONS**

All emergency admissions to be screened within 24 hours of admission.

*Orthopaedic trauma and emergency admissions*

Many patients in this group are elderly and may be resident in nursing or care homes or have regular contact with hospital or healthcare services, therefore the risk of them being colonised with MRSA is increased. Therefore as screening test results will not be available immediately, it is advised that these patients are prescribed decolonisation treatment on admission. This can be discontinued if screening results are negative.

9.  **CRITICAL CARE UNITS**

- Intensive Care
- Neonatal Intensive Care Unit (NICU)

Patients in these areas have the highest risk of MRSA transmission and developing MRSA bacteraemia.

The risk factors are either patients on the unit with established MRSA infection (who will be known to staff) or patients admitted with asymptomatic MRSA carriage which may cause subsequent infection in themselves or be transmitted to other patients.

As screening test results will not be available immediately, it is advised that these patients are prescribed decolonisation treatment on admission. This can be discontinued if screening results are negative. This will not apply to neonates admitted to NICU.

**Follow up screen**

All patients admitted to intensive care and NICU must be screened on admission and thereafter weekly.

10.  **ALL PATIENTS KNOWN TO BE PREVIOUSLY POSITIVE**

Treat as a positive case until result known.

11.  **LONG TERM INPATIENTS**

All long term inpatients to be screened every four weeks.

12.  **ONCOLOGY AND CHEMOTHERAPY PATIENTS**

These patients are at particular risk of MRSA bacteraemia due to their immuno-suppression and procedures for vascular access that are an essential part of their treatment. To be screened prior to invasive procedures, start of a course of chemotherapy and when clinically indicated i.e. signs of sepsis.
These patients must have at least 48 hours of decolonisation treatment (antibacterial body wash and antibacterial nasal cream) prior to insertion of long term access lines i.e. Hickman line, if this is not undertaken, decolonisation must start as soon as possible.

13. **INTER HOSPITAL TRANSFERS**
All inter hospital transfers between both sites must be screened.

14. **IMPLEMENTATION OF INVASIVE DEVICES**
Patients who are having implantation of invasive device e.g. inserting pacemakers, central lines, stents, PEGs must be screened beforehand, especially if they have had frequent contact with other hospital/healthcare environment. This includes all patients having angiography.

Patients who have an existing invasive device replaced must also be screened.

Positive patients must have 48 hours of decolonisation treatment and antibiotic cover prior to procedure.

15. **ELECTIVE CAESAREAN SECTIONS**
All patients who are having a planned caesarean section delivery must be screened. Screening will be undertaken in the clinic when the Caesarean section is booked. If the patient is found to be positive they will undergo decolonisation treatment, this will be overseen by the Ante Natal Clinic.

16. **SCREENING METHOD**

**SAMPLE COLLECTION**

It is the responsibility of the staff member admitting the emergency patients or running the pre admission clinic, booking clinic to screen the patient.

**SITES TO SAMPLE**

An MRSA screen should include:
- Both nostrils (1 swab both nostrils)
- Groin (1 swab both sides of groin)
- Any skin lesions
- Sites of catheters i.e. I.V. CVC, PEG
- CSU
- Umbilicus of neonates

Send swabs to Microbiology with the Order Comms request form.

**SWAB RESULTS**
Patients who are found to be MRSA positive must be commenced on decolonisation immediately or 5 days prior to the procedure if not an inpatient at the time the result is available. No MRSA positive patients may be admitted to Dickens ward which is “MRSA free”. Patients who have had 3 consecutive negative screens may be admitted to side rooms on Dickens. Patients in high risk areas will already have commenced treatment.

In addition Infection Control Alerts for MRSA which are held on PAS are fed through to RealTime from the interface. This shows the patient has a history of MRSA. For patients who are active positive MRSA for the current admission the alert flag will be added by the Infection Control Team.

17. **DECOLONISATION**

As soon as a patient is identified as an MRSA carrier a decolonisation regime should be started. Alternatively if the patient has not yet been admitted and with the agreement of the patient's consultant, the regime may be started 5 days prior to the procedure – this does not apply to patients due to be admitted to Dickens ward which is ringfenced as MRSA free.

<table>
<thead>
<tr>
<th>Formulation</th>
<th>Frequency</th>
<th>Duration</th>
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</thead>
<tbody>
<tr>
<td>Bactroban Nasal Ointment (Mupirocin 2%) For Mupirocin resistance use chlorhexidine nasal cream e.g. Naseptin</td>
<td>Three times a day</td>
<td>5 days</td>
</tr>
<tr>
<td>Chlorhexidine Gluconate 4% Hibiscrub</td>
<td>Daily</td>
<td>5 days</td>
</tr>
<tr>
<td>Shampooing of hair Chlorhexidine Gluconate 4% Hibiscrub</td>
<td>At least twice weekly</td>
<td>5 days</td>
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The purpose is to reduce the risk of:

- Patients developing an MRSA infection with their own MRSA during medical or surgical treatment.
- Transmission of MRSA to another patient.

The decolonisation regime is only 50-60% effective for long term clearance, but as soon as the procedure is implemented the presence and shedding of MRSA are reduced significantly and the risk of the above is much reduced. Only two attempts at decolonisation to be undertaken to prevent the risk of resistance occurring unless advised otherwise by the Consultant Microbiologist.

Change bed linen and towels daily whilst on topical decolonisation.

A **maximum** of two 5 day topical decolonisation protocol can be given in one admission.

Rescreen patient 48 hours after completing protocol.

Obtain three negative MRSA screens prior to the removal of patient from isolation or discuss with the Infection Prevention and Control Team.

There must be at least four days between each set of swabs.
Note: The patient should not be screened if receiving antibiotic therapy for an MRSA infection as this can give a false negative result.

Further advice can be obtained from the Infection Control Team/Consultant Microbiologists.

18. **ANTIBIOTIC TREATMENT FOR MRSA POSITIVE PATIENTS**

Refer to the Antibiotic Policy or discuss with the Consultant Microbiologists.

19. **REPORTING OF NEW ISOLATES**

MRSA positive screens are phoned to the wards by the ICNs. If a patient has already been discharged, a letter is sent to the GP and a patient information letter enclosed for forwarding to the patient if the GP deems that this is appropriate for the patient.

20. **INFECTION CONTROL PRECAUTIONS**

**Hand hygiene**
Handwashing is the single most important measure in preventing the spread of infection, especially between patients.

**Isolation**
Patients who are suspected or proved to be MRSA positive should be risk assessed for nursing in a side room. A risk assessment should be documented in the nursing or medical notes.

**MRSA bed management**
The following table demonstrates how inpatients with MRSA should be allocated beds. Risk assessment is important and the outcome documented in patients notes.

<table>
<thead>
<tr>
<th>Priority Order</th>
<th>Known MRSA or previously positive MRSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Single side room within the ward/speciality</td>
</tr>
<tr>
<td>2</td>
<td>Cohort nurse with other MRSA positive patients unless advised otherwise by the Infection Control Team</td>
</tr>
<tr>
<td>3</td>
<td>Open bay next to a handwashing sink with strict standard precautions</td>
</tr>
</tbody>
</table>

MRSA positive patients with eczema/psoriasis (skin shedders), heavily exuding wounds and patients with MRSA in the sputum with active productive cough should be given priority for single rooms. Doors of single rooms should be kept closed for these patients, especially for episodes of care including changing of bedlinen.

**Protective Clothing**

Risk assess the level of protective clothing required. Gloves and aprons should be worn by all staff undertaking patient care. Gloves and aprons are single patient, single procedure items. These should be removed directly after the patient episode and disposed of into the clinical waste bin. Hands must be washed using soap and water.
If protective clothing is not required, hands must be cleaned using alcohol sanitiser when leaving the isolation room.
Face/eye protection is only required after risk assessment for patients who are MRSA sputum positive and are actively coughing and require suctioning and there is a risk of spray or splash or from other bodily fluids.

Clinical waste and linen

Waste should be disposed of into an orange clinical waste bag.

Used linen should be placed in an alginate stitched bag inside the room and then placed in an outer white plastic bag (outside the room if patient is in isolation).

Change bed linen daily.

Do not sit on beds as clothing is likely to become contaminated.

21. CLEANING OF THE PATIENT ENVIRONMENT AND EQUIPMENT

The management of the environment and equipment is vital in minimising the spread of MRSA. Cleaning regimens should focus on the minimisation of dust and therefore it is essential that dust is kept to a minimum. This is a two fold approach to the management of the occupied facility with daily cleaning and then the terminal clean after discharge of the patient.

Cleaning standards must be monitored. Clean and safe equipment management can only be achieved if responsibility for cleaning is well defined. It is the ward manager/clinical nurse leader’s responsibility to ensure staff understand the elements of cleaning and the frequencies.

Daily cleaning of the room/area needs to be undertaken with detergent and water. Baths/showers should be cleaned after each patient with detergent and hot water, followed by a Clorox wipe (5,200ppm chlorine).

On discharge contact the Housekeeping department for a terminal clean. Ensure all the nursing equipment including bed linen has been removed.

Equipment should be removed from the room and should be wiped over with a detergent wipe, followed by a Clorox wipe (5,200ppm chlorine) or in accordance with manufacturer’s instructions.

22. PATIENTS RESPONSIBILITY DURING THEIR STAY

The patients, where possible:

- Must be actively encouraged to keep their bed space clutter free to enable cleaning of a high standard to be undertaken.
- Discourage family and friends from bringing in flowers and numerous gifts which cause clutter.
- Must dispose of tissues immediately into waste bag provided.
- Must be actively discouraged from touching wounds.
- Must be actively encouraged to observe good hand hygiene at every opportunity including using the alcohol sanitiser at the bedside.
- If able challenge poor hand hygiene practice.
• If able report concerns about cleaning standards.
• When on decolonisation treatment patients must not use their own flannels and towels. The ward must supply disposable wipes and clean towels daily.

23. VISITORS

Visitors must adhere to the following guidance:
• Visitors must wash/sanitise their hands on entering the clinical area/room and immediately prior to leaving.
• The nurse in charge should be consulted prior to entering the isolation area/room.
• Outdoor coats and baggage should be left outside the isolation room.
• Visitors do not need to wear gloves and apron for social contact.
• Visitors must not sit on patients’ beds.

24. ACCESS TO INFORMATION

The Trust’s MRSA information leaflet is available on TrustNet.

Helpful websites include: www.hpa.org.uk, www.ips.co.uk, www.amm.co.uk

If you require more information contact the Infection Control Team.

25. TRANSFERRING MRSA POSITIVE PATIENTS

The transferring of MRSA patients to other wards/departments should be minimised to reduce the risk of spread, but this should not compromise other aspects of care such as rehabilitation.

Staff transferring patients to another ward/department or healthcare facility must:
• Inform the receiving area of the patients MRSA status
• Complete the appropriate transfer documentation informing of the patient status
• The receiving area has the appropriate level of isolation nursing available if appropriate
• If the patient is on decolonisation treatment then this must be sent with the patient, including the protocol sheet
• Any lesions must be covered with an impermeable dressing
• Portering staff who are transferring patients do not need to wear gloves provided they have intact skin. However they must decontaminate their hands before and after the transfer.
• Wheelchairs and trolleys must be cleaned after use with detergent wipe.

26. VISITS TO OUTPATIENTS AND SPECIALIST DEPARTMENTS

The receiving department must be informed of the patient’s MRSA status so that infection control measures for that department can be implemented. These include:
• Patients attending the outpatients department do not need to be seen first or last. Standard precautions should be undertaken in clinics and decontamination of hands between all patient contacts must be undertaken.

• Whenever possible MRSA positive patients must be seen at the end of the working session for specialist departments i.e. Radiology.

• Patients must be seen as soon as possible.

• Staff giving direct hands on care must wear disposable aprons and gloves.

27. **MRSA IN THE OPERATING THEATRE**

Every effort should be made to eliminate MRSA before surgery/procedure; however this will not always be possible therefore:

• MRSA positive patients should be scheduled for surgery at the end of the theatre session.

• Bath/shower the patient with antiseptic detergent e.g. chlorhexidine gluconate 4% (Hibiscrub) 48 hours prior to surgery (daily for 2 days)

• Put clean linen on the bed, ensure the bed is clean and dust free

• Cover affected lesions that are not involved in the surgical procedure with an impermeable dressing.

• Apply Mupirocin to the nose 48 hours before the operation if Mupirocin sensitive (three times a day for two days). Naseptin is used if Mupirocin resistant.

• Follow the recommendations for antibiotic prophylaxis in the Antibiotic Guidelines.

• MRSA positive patients to be recovered in the theatre or in a segregated area in recovery and nursed with strict standard precautions.

• At the end of the operating session the table, anaesthetic equipment and other equipment must be cleaned using detergent and water, dried and wiped with 1,000ppm chlorine (Haz-Tab) or use Chlor-Clean solution.

28. **WOUND MANAGEMENT**

Advice on the treatment of wounds can be sought from the Tissue Viability Nurse.

29. **PATIENT DISCHARGE**

MRSA patients should be discharged promptly from hospital when their clinical condition allows.

The General Practitioner and other healthcare agencies involved in the patients care must be informed.

MRSA carriers will not normally require special treatment after discharge from hospital. If a treatment course needs to be completed, ensure the community services are aware. Ensure the patient understands the requirements of their continued care.

If a patient is discharged to a residential care facility the medical/nursing staff must be informed. Carriage of MRSA is NOT a contraindication to the transfer of a patient to a nursing or residential home. MRSA is not a reason for the care home to refuse the patient admission. If there are problems contact Public Health England on 0845 8942944.
Discharge documentation must have the patient’s MRSA status recorded on it.

Patients found to be MRSA positive (new cases) after discharge will have a letter sent to their GP informing them of the finding and a letter for the patient to either duly discuss or forward onto the patient if deemed appropriate.

30. AMBULANCE TRANSPORTATION

Most MRSA carriers may be transported with other patients in the same ambulance without any special precautions, other than changing the bedding used by the carrier. High-risk categories of susceptible patients should not be transported in the same ambulance as a known MRSA-positive patient. Lesions should be covered.

The ambulance service should be notified in advance by the ward staff.

There is no evidence that ambulance staff or their families are put at risk by transporting patients with MRSA.

To minimise the risk of cross-infection with any infectious agent, ambulance staff should use an alcohol hand sanitiser after contact with all patients as part of standard precautions.

If further measures are required in special circumstances, the Infection Control Team will inform the ambulance service.

No additional cleaning of the ambulance is required after transporting an MRSA-positive patient.

31. DECEASED PATIENTS

The infection control precautions for handling deceased patients are the same of those used in life. Any lesions should be covered with an impermeable dressing. A plastic body bag is NOT required unless the patient suffered from another condition requiring one or there is severe leakage of body fluids.

32. TRUST STAFF SCREENING

Routine staff screening is not recommended. Staff screening is only indicated if transmission of MRSA continues in an area despite active infection control measures or if epidemiological aspects of an outbreak are unusual or they suggest persistent MRSA carriage by staff.

This will be instigated by the Infection Control Team and facilitated by the Occupational Health Department.

Staff with skin lesions, chronic skin conditions or excoriated skin have a higher risk of being colonised with MRSA. If staff are concerned about the condition of their skin they should discuss this with the Occupational Health department or GP.

If the Infection Control Team decide staff screening is indicated, nurses, doctors, physiotherapist and other allied healthcare professionals and non clinical support staff should be considered for screening. Staff screening is usually best achieved by screening staff as they begin their duty before any patient or equipment contact. This will be undertaken under the auspice of the Occupational Health department.
33. REPORTING OF HEALTHCARE ASSOCIATED INFECTIONS (HCAI) MRSA BACTERAEMIAS

It is a mandatory requirement that the Trust’s Chief Executive reports all cases of Meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemias to Public Health England (PHE) as directed by the Department of Health. All new cases are entered onto the HCAI Data Capture System by the Director of Infection Prevention & Control (DIPC). This is then signed off by the Chief Executive.

34. DISSEMINATION AND IMPLEMENTATION

The policy has been written by the Infection Control Team, been agreed by the Control of Infection Committee and ratified by the Clinical Governance Committee. The policy will be available on TrustNet.

35. PROCESS FOR MONITORING COMPLIANCE WITH THE EFFECTIVENESS OF POLICIES

All patients who are MRSA positive whether a new isolate or readmission are followed up daily by the Infection Control Nurses.

36. EQUALITY IMPACT ASSESSMENT

The Trust has a statutory duty to carry out an Equality Impact Assessment (EIA) and an overarching assessment has been undertaken for all infection control policies.

37. ARCHIVING ARRANGEMENTS

This is a Trust-wide document and archiving arrangements are managed by Quality Dept. who can be contacted to request master/archived copies.

38. REFERENCES

- Coia et al. 2006. Guidelines for the control and prevention of Meticillin-resistant *Staphylococcus aureus* (MRSA in healthcare facilities).