

Cardiac Telephone Pre-assessment MRSA Screening

Date	Version	
April 2014	1	
Purpose		
<p>This standard operating procedure aims to:</p> <ul style="list-style-type: none"> • Ensure all PHNT staff are up to date with current MRSA screening practice relevant to their role in telephone pre assessment • Ensure that patients infected with MRSA receive effective and appropriate treatment, and reduces their risk of developing further infection • Reduce the transmission of MRSA • Provide clear guidance to the MRSA screening of telephone pre-assessed patients 		
Who should read this document?		
<p>This standard operating procedure is applicable to All PHNT professionals involved in cardiac laboratory telephone pre-assessment and the organisation of the telephone pre- assessment.</p>		
Key messages		
<p>MRSA is a common type of bacteria that is often carried on the skin, If MRSA bacteria gets into a break in the skin, it can cause life-threatening infections, for more information see (appendix1).</p> <p>All PHNT staff undertaking telephone pre assessment is responsible for ensuring they are aware of the PHNT infection control policies relevant to the clinical role.</p>		
Accountabilities		
Production	Zoe-Louise Smethurst Cardiac Catheter Lab Staff nurse	
Review and approval	Caroline Atkinson Sister Cath Lab	
Ratification	Theatre Board	
Dissemination	Senior Matron Theatre and Anaesthetic Centre	
Compliance	Senior Matron Theatre and Anaesthetic Centre	
Links to other policies and procedures		
Saving lives our healthier nation 2010		
Version History		
V1	19.09.13	Minor Adjustment
V1.2	17.04.14	Approved
Last Approval		Due for Review
April 2014		April 2017

The Trust is committed to creating a fully inclusive and accessible service. By making equality and diversity an integral part of the business, it will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination,

regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available on the Trust Documents. Larger text, Braille and Audio versions can be made available upon request.

Standard Operating Procedures are designed to promote consistency in delivery, to the required quality standards, across the Trust. They should be regarded as a key element of the training provision for staff to help them to deliver their roles and responsibilities.

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Standard Operating Procedure (SOP) TELEPHONE PRE ASSESSMENT MRSA SCREENING

1 Purpose and Scope

Introduction

This SOP covers the process of MRSA screening patients in the community; it applies to cardiac telephone pre-assessment only. It is applicable to all PHNT staff undertaking or involved in cardiac telephone pre assessment, and is limited to this area of pre assessment

2 Definitions

MRSA is a common type of bacteria that is often carried on the skin, If MRSA bacteria gets into a break in the skin; it can cause life-threatening infections (appendix 1).

Our aim is to prevent patients developing life threatening infection through the appropriate screening tools available.

MRSA screening using the broth system (appendix 2) is a tool used throughout the trust to screen patients coming in for elective admissions, the aim is to identify patients that are colonised or infected with MRSA and to treat them with the MRSA suppression therapy to reduce the risk of complex infections.

If a patient has previously tested positive to MRSA they must be re screened and assumed to be colonised with MRSA and treated accordingly (appendix 2).

Telephone pre-assessed patients will screen themselves using swabs supplied in the information packs provided by the hospital, they will receive these packs when they receive their letter inviting them to have a telephone pre assessment (appendix3).

The letter advises them to take their completed swabs to the GP practice before the date of the telephone pre assessment but if they have any problems or concerns to wait until they are contacted by the nurse telephone pre assessing. These swabs will be couriered to Derriford so that a result of positive or negative can be provided.

If a patient tests positive the GP practice will be contacted by microbiology electronically.

3**Regulatory background**

This SOP has been developed upon reviewing

- Department of Health, November 2006. Screening for Methicillin-resistant *Staphylococcus Aureus* (MRSA) colonisation: A strategy for NHS Trusts: a summary of best practice.
- Trust protocol for screening elective patient for MRSA and MSSA
- Department of Health, 2009. Health and Social Care Act 2008. Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance.
- NMC Code of conduct

4**Key Duties**

Administration staff are responsible for ensuring that the swabs and appropriate information is sent out to the patient with their letter inviting them to have a telephone pre assessment, (appendix 3)

Nursing staff carrying out the telephone pre assessment are responsible for checking that the patient has swabbed themselves and returned them to their GP. The nurse can give any additional information required at this point.

5**Monitoring and assurance**

- It is an NMC requirement that all registered professionals are accountable for their actions and omissions (ref 5). Therefore, all registered staff are accountable for ensuring that the cardiothoracic centre integrated care pathway is completed correctly, thus highlighting any issues with MRSA screening and ensuring that the patient has been MRSA screened in an effort to reduce infection risk.
- Nursing staff on the ward of admission are responsible for highlighting when MRSA screening has not been carried out, this must be highlighted to the Cardiac Cath Lab before the patients procedure.
- Cardiac Cath Lab staff is also responsible for ensuring that there is an MRSA status, if there is not this will then need to be highlighted to their co-ordinate in charge who will act accordingly.
- An audit should be carried out by the Cardiac Cath Lab team (appendix 5) of this process within the first 6 months of implementation, assessing its effectiveness and compliance, any issues should be highlighted to be raised with the Cardiac Cath Lab manager where results can be reviewed and action plan put in place if required. This will be reported to the Governance Committee and Cardiology service line.
- When shortfalls are identified such as a patient is not pre-screened an incident form should be raised as per trust policy.
- Learning will take place by reviewing and assessing the audit and implementing any further action that is required.

Main step 1

The patient will be put onto a list for a telephone pre assessment four weeks before the date of their procedure. At this point the letter inviting them to have telephone pre assessment and the MRSA pack will be sent out. The telephone pre assessment will be no later than one week before the procedure date.

The person placing them on this list is responsible for sending them a letter to invite them to have a telephone pre assessment along with the MRSA pack, which will consist of MRSA swabs a microbiology request form, and a covering letter and picture explanation of how to take the swabs (appendix 2)

Main step 2

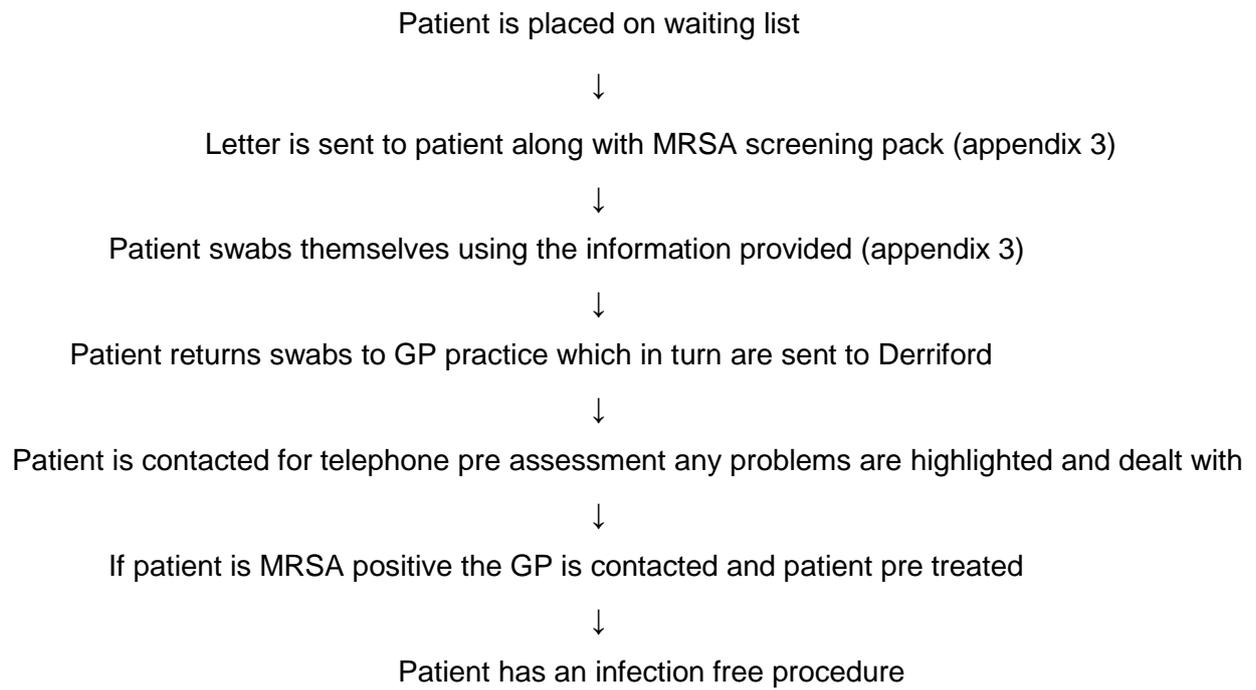
The patient will be contacted for telephone pre assessment.

The nurse undertaking telephone pre assessment will review the patient's alerts on PIMS and follow trust policy where a previous positive result has been alerted (appendix 2)

On page 6 of the of the south west cardiothoracic centre integrated care pathway MRSA Screening is assessed and documented. All staff undertaking telephone pre assessment is responsible for asking these questions and ensuring that screening has been carried out or is going to be carried out in a timely manner,

The patient should be screened no less than one week before the date of the procedure when inside of this date the nurse will need to inform the patient to attend their local GP practice and follow trust policy of pre-treatment when a patient is due in within 72 hours,

If a patient is unable to screen themselves then the nurse will need to arrange for the patient to attend Derriford where necessary or advise the patient to attend their local GP practice.



7 Document Ratification Process

The design and process of review and revision of this procedural document will comply with The Development and Management of Trust Wide Documents.

The review period for this document is set as default of three years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.

This document will be approved by the Theatre Central Governance Committee and ratified by the Theatre Board.

Non-significant amendments to this document may be made, under delegated authority from the director or senior matron, by the nominated author. These must be ratified by the director or senior matron and should be reported, retrospectively, to the governance committee.

Significant reviews and revisions to this document will include a consultation with named groups, or grades across the Trust. For non-significant amendments, informal consultation will be restricted to named groups, or grades that are directly affected by the proposed changes

8 Dissemination and Implementation

Following approval and ratification, this procedural document will be published in the Trust's formal documents library and all staff will be notified through the Trust's normal notification process, currently the 'Vital Signs' electronic newsletter.

Document control arrangements will be in accordance with The Development and Management of Trust Wide Documents.

The document author(s) will be responsible for agreeing the training requirements associated with the newly ratified document with the director or senior matron and for working with the Trust's training function, if required, to arrange for the required training to be delivered.

1. ref one <http://www.nhs.uk/Conditions/MRSA/Pages/Introduction.aspx>
2. Department of Health, November 2006. Screening for Meticillin-resistant *Staphylococcus aureus* (MRSA) colonisation: A strategy for NHS Trusts: a summary of best practice. Available at <http://www.dh.gov.uk/>
3. Trust protocol for screening elective patient for MRSA and MSSA available at: <http://staffnet.plymouth.nhs.uk/DocumentLibrary/TrustDocuments.aspx#dltop>
4. Department of Health, 2009. Health and Social Care Act 2008. Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance. Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093762
5. NMC Code of conduct available at <http://www.nmc-uk.org/Publications/Standards/The-code/Introduction/>
6. NICE consults on new advice on preventing and controlling healthcare-associated infection
<http://www.nice.org.uk/newsroom/pressreleases/HCAIConsultation.jsp>

Introduction

MRSA

MRSA is a type of bacterial infection that is resistant to a number of widely used antibiotics. This means it can be more difficult to treat than other bacterial infections.

The full name of MRSA is methicillin-resistant staphylococcus aureus. You may have heard it called a superbug.

Staphylococcus aureus (also known as staph) is a common type of bacteria. It is often carried on the skin and inside the nostrils and throat, and can cause mild infections of the skin such as boils and impetigo.

If staph bacteria get into a break in the skin, they can cause life-threatening infections, such as blood poisoning or endocarditis (an infection of the inner lining of the heart).

Read more about the symptoms of a staph infection.

How bacteria become resistant to antibiotics

Antibiotic resistance can occur in several ways.

Strains of bacteria can mutate and over time become resistant to a specific antibiotic.

Alternatively, if you are treated with an antibiotic, it can destroy many of the harmless strains of bacteria that live in and on the body. This allows resistant bacteria to quickly multiply and take their place.

The overuse of antibiotics in recent years has played a major part in antibiotic resistance and superbugs. This includes using antibiotics to treat minor conditions that would have got better anyway and not finishing a recommended course of antibiotics.

How do you get MRSA?

MRSA infections are more common in people who are in hospital or nursing homes. Doctors often refer to this as healthcare-associated MRSA (or HA-MRSA).

Hospital patients are more at risk because:

- they often have an entry point for the bacteria to get into their body, such as a surgical wound
- many patients are older and weaker, which makes them more vulnerable to infection
- they are surrounded by a large number of people, which means bacteria can easily spread through direct contact with other patients or staff or contaminated surfaces

More recently, MRSA has been known to develop outside hospitals and nursing homes. This is known as community-associated MRSA (or CA-MRSA). It is more common in crowded environments where there is frequent skin-to-skin contact and hygiene is poor, such as sports teams, gyms, homeless shelters or army bases.

Read more about the possible [causes of MRSA](#).

Preventing MRSA

In recent years, rates of MRSA have fallen because of increased awareness of the infection by both medical staff and the public. However, MRSA still places a considerable strain on healthcare services.

To reduce your risk of an MRSA infection:

- wash your hands before and after visiting someone in a care home (many hospitals provide antibacterial gel in wards)
- if you are going into hospital for an operation, ask to be screened for MRSA (see below)
- don't be afraid to speak to your nurse or doctor if you have any concerns about hygiene in your hospital
- put all disposable items, such as dressings, into the appropriate bins promptly

Read more about [preventing MRSA](#).

Screening for MRSA

Most NHS patients who are admitted to hospital for a planned procedure are screened for MRSA. This helps reduce the chance of patients developing an MRSA infection or passing an infection on to other patients.

An MRSA infection is most commonly diagnosed using a blood, urine, tissue or sputum (spit) culture.

This involves taking a sample of one or more of these substances and placing them in a dish of nutrients. This should encourage any staph bacteria that are present to reproduce and grow.

If the bacteria develop, different antibiotics can be directed at them to see if the bacteria have developed resistance to the antibiotics.

Read more about [NHS screening for MRSA](#).

Treating MRSA

Minor skin infections may not require any treatment other than draining away any pus from the site of the infection.

Otherwise, infections can be treated with antibiotics that MRSA has not yet developed resistance to. The exact antibiotic used will depend on the specific strain of MRSA involved.

Depending on the severity of your symptoms, antibiotic tablets or injections will be used and you may need to have a much longer course of treatment compared to a normal staph infection.

Read more about [treating MRSA](#).

Common questions about MRSA

- [Can someone with an MRSA infection have visitors?](#)
- [What are the risks of MRSA during pregnancy?](#)

[**http://www.nhs.uk/Conditions/MRSA/Pages/Introduction.aspx**](http://www.nhs.uk/Conditions/MRSA/Pages/Introduction.aspx)

Viewed 25/09/ 1312.45

Protocol for Screening of Elective Patients for MRSA Page 1

Guidelines Title: Protocol for Screening of Elective Patients for MRSA

6 November 2012 V3.1

This protocol aims to:

1. Ensure that patients colonised or infected with MRSA receive effective and appropriate care
2. Minimise the risk of transmission of MRSA.

These guidelines are applicable to all staff, to include Ministry of Defence (MOD) personnel; contractors, those employed on a fixed term contract; honorary contract; agency or locum staff, and students affiliated to educational establishments and volunteers.

MRSA is usually transmitted on the hands of Health Care Workers. Certain clinical conditions, such as pneumonia or exfoliating skin disease, increase the risk of extensive environmental contamination with subsequent increase in hand-borne transmission and the potential for airborne spread.

Production Dr Peter Jenks, Director of Infection Prevention & Control **Review and approval** Infection Control Committee – 6 November 2012 **Ratification** Dr Alex Mayor, Medical Director **Dissemination** Trust-wide **Compliance** NHSLA 1.2.8 & 2.2.8 CQC Essential Standards of Quality & Care The Hygiene Code
Infection Control Manual – G:\TrustDocuments\Documents\Infection Control
CLI.INF.PRO.492.3 Protocol for Screening of Elective Patients for MRSA
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3.1 November 2012 Update of version 2

6 November 2012 November 2017

The Trust is committed to creating a fully inclusive and accessible service. By making equality and diversity an integral part of the business, it will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available on the Trust Documents Network Share Folder (G:\TrustDocuments). Larger text, Braille and Audio versions can be made available upon request.

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1 Patient categories

Patient categories

This protocol covers the MRSA screening of elective patients, including those seen in the Pre-Operative Assessment and Outpatient Clinics. Patients admitted for certain procedures are not screened for MRSA and these are given in Appendix A. While this protocol is applicable to any type of admission, it makes special reference to those admitted for surgical or other invasive procedures. There are three main categories of patients:

1. Patients already known to be MRSA-positive

Patients who are known to have been MRSA-positive at some point in the past **should be considered as colonised with MRSA**. These patients will have an 'Alert' sticker on their notes:

and on their electronic record:

Patients who are known to have been MRSA-positive in the past, should be screened to determine their current colonisation status, but should be assumed to be colonised with MRSA, and receive suppression therapy and appropriate prophylaxis. Patients admitted from nursing or residential homes are at high risk of being colonised with or acquiring MRSA between being screened and subsequently admitted to hospital. For the purposes of this protocol, these patients also should be assumed to be colonised with MRSA and receive suppression therapy and appropriate prophylaxis (see below).

2. Patients of unknown MRSA status undergoing joint replacement and vascular graft surgery. Separate screening protocols for these patients should be followed.

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3. All other patients of unknown MRSA status. These should be screened for MRSA using this protocol.

Screening method

MRSA screening should be performed when the decision to treat is made.

Patients seen **between 5 and 91 days** before their procedure should be screened by three-site (nose, throat and groin/perineum) broth enrichment culture. For some patients, local risk assessment may determine that screening of the nose only is required

Patients seen **less than 5 days** before their procedure should be screened using the Polymerase Chain (PCR) Reaction method. A nose swab should be performed using the red-topped swabs. If swabs arrive in Microbiology by 13:00 a result should normally be available by the end of the same working day.

Any patient whose procedure is within 72 hours should be treated as if MRSA-positive following the protocol below.

All swabs processed by PCR are also routinely cultured. Most patients who have a positive PCR result ('presumptive positives') will also have a positive culture result. A few will have a negative culture result, indicating that the PCR result was a false positive and that the patient was **not** colonised with MRSA. If the PCR result is positive (a 'presumptive positive') and the **date of the procedure is within 72 hours** then treat as if MRSA-positive following the protocol below. If the PCR result is positive (a 'presumptive positive') and the date of the procedure is **more than 72 hours away, then wait for the confirmatory culture** result and treat as negative or positive depending on this result.

MRSA screening results

1. Negative

If the screening result is negative, give standard peri-operative antibiotic prophylaxis. If patients have previously been colonised or infected with MRSA, they should be treated as if they are still colonised with MRSA regardless of any subsequent screening results (see below).

2. Positive, unknown status or previously colonised with MRSA

This group include the following patients:

- a) Patients known to be currently colonised or infected with MRSA
- b) Patients previously known to have been colonised or infected with MRSA regardless of any subsequent screening results
- c) Patients of unknown MRSA status (e.g. those with results pending or who have not been screened)
- d) Patients admitted from home for whom 91 days or more has elapsed since there they were last screened (even if this was negative) CLI.INF.PRO.492.3 Protocol for Screening of Elective Patients for MRSA CLI.INF.PRO.492.3 Protocol for Screening of Elective Patients for MRSA Protocol for Screening of Elective Patients for MRSA Page 6
- e) Patients admitted from a nursing or residential home or who have been hospitalised since they were last screened (even if this was negative)
- f) Patients who have been on the ward for more than 96 hours since their last screen (even if this was negative).

When a patient is identified as an MRSA carrier the Consultant Surgeon or Consultant performing the procedure should be contacted so that a risk assessment can be undertaken as to the appropriateness of surgery.

These patients should

a) Commence topical Mupirocin and 4% chlorhexidine for 48 hours prior to surgery and continue until 72 hours after surgery (i.e. a total of 5 days):

- **Generic name Propriety name usual dose Notes**

- 4% chlorhexidine
- Hibiscrub
- Daily for five days
- Apply directly to skin as liquid soap on a sponge or flannel & lather well prior to rinsing
- 4% chlorhexidine
- Hibiscrub
- Shampoo on days one and five of treatment. Other bathing products may be used after chlorhexidine
- Rinse hair with normal shampoo after applying chlorhexidine to scalp
- Mupirocin
- Bactroban nasal ointment
- Apply thrice daily for five days
- Place a pea-sized amount of ointment on the squamous portion of each nostril and massage gently upwards.

b) Receive a **single dose of Teicoplanin 400 mg** at induction if anti-staphylococcal prophylaxis is indicated. This should be in addition to **standard prophylaxis**.

In general, operations where a cephalosporin or penicillin is usually indicated also require teicoplanin added if the above criteria are met. Procedures **NOT** requiring teicoplanin prophylaxis include:

Procedures for which prophylaxis is not usually indicated e.g. clean operations not involving an implant Per vaginal procedure where the normal prophylaxis (if indicated) is metronidazole and doxycycline Urological procedures that usually receive gentamicin prophylaxis ERCP

For further detail on which prophylaxis to use please see the Trust policy on Trustnet

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Further advice

Further advice is available from the Infection Prevention and Control Team (xtn. 32115) or the on-call Microbiologist (xtn. 52387).

2 Bibliography/references

- Department of Health, November 2006. Screening for Meticillin-resistant *Staphylococcus aureus* (MRSA) colonisation: A strategy for NHS Trusts: a summary of best practice. Available at <http://www.dh.gov.uk/assetRoot/04/14/08/48/04140848.pdf>
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Elective patients who will not be routinely screened for MRSA

Under normal circumstances, the following elective admissions will not routinely be screened for MRSA:

Day case ophthalmology Day case dental Day case endoscopy Minor dermatology procedures (e.g. warts or other liquid nitrogen applications) Children/paediatrics (excluding children in high-risk groups) Maternity/obstetrics except for elective caesareans and any high risk cases (i.e. high risk of complications in the mother and/or potential complications in the a baby (e.g. likely to need SCBU, NICU because of size or known complications or risk factors) Mental Health Patients Those for whom a formal risk assessment has been performed that demonstrates a minimal risk of MRSA carriage and minimal risk of MRSA infection post-procedure (e.g. day case coronary angiograms).

However, these patients should be screened for MRSA if advised by the Infection Prevention and Control Team or if any of the following apply:

Readmission of a patient known to have previously been colonised or infected with MRSA
Patients who have been resident within the last six months in long stay healthcare facilities including other hospitals and nursing homes. This includes direct admissions from other hospitals or nursing or residential homes

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Document Title Protocol for Screening of Elective Patients for MRSA **Date Finalised** 6 November 2012 **Dissemination Lead** Dr Peter Jenks, Director of Infection Prevention & Control **Previous document in use?** Yes **Action to retrieve old copies.** Archived electronically by the IPCT Also held by the Trust **Document Controller** **Recipient(s) When How Responsibility Progress update**
CLI.INF.PRO.492.3 Protocol for Screening of Elective Patients for MRSA
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Title

Is the title clear and unambiguous?
Yes

Is it clear whether the document is a policy, procedure, protocol, framework, APN or SOP?
Yes

Does the style & format comply?
Yes

Rationale

Are reasons for development of the document stated?
Yes

Development Process

Is the method described in brief?
Yes

Are people involved in the development identified?
Yes

Has a reasonable attempt has been made to ensure relevant expertise has been used?
Yes

Is there evidence of consultation with stakeholders and users?
Yes

Content

Is the objective of the document clear?

Yes

Is the target population clear and unambiguous?

Yes

Are the intended outcomes described?

Yes

Are the statements clear and unambiguous?

Yes

Evidence Base

Is the type of evidence to support the document identified explicitly?

Yes

Are key references cited and in full?

Yes

Are supporting documents referenced?

Yes

Approval

Does the document identify which committee/group will review it?

Yes

If appropriate, have the joint Human Resources / staff side committee (or equivalent) approved the document?

Yes

Does the document identify which Executive Director will ratify it?

Yes

Dissemination & Implementation

Is there an outline/plan to identify how this will be done?

Yes

Does the plan include the necessary training/support to ensure compliance?

Yes

Document Control

Does the document identify where it will be held?

Yes

Have archiving arrangements for superseded documents been addressed?

Yes

Monitoring Compliance & Effectiveness

Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?

Yes

Is there a plan to review or audit compliance with the document?

Yes

Review Date

Is the review date identified?

Yes

Is the frequency of review identified? If so is it acceptable?

Yes

Overall Responsibility

Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?

Yes

CLI.INF.PRO.492.3 Protocol for Screening of Elective Patients for MRSA

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Manager Claire Hail, Nurse Consultant IPCT **Directorate** Clinical Support Services

Date 6 November 2012 **Title** Protocol for Screening of Elective Patients for MRSA

What are the aims, objectives & projected outcomes? These guidelines have taken into consideration the cultural/religious and gender needs of patients.

CLI.INF.PRO.492.3 Protocol for Screening of Elective Patients for MRSA

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Hospital No:

NHS No:

Derriford Hospital

Derriford Road

PLYMOUTH

PL6 8DH

Switchboard: 0845 155 8155

Textphone (for Deaf and hard of hearing people) number: 0845 155 8281

Mr

Dear MR,

We have arranged an appointment for you to have a telephone pre-assessment to prepare you for your producer.

This appointment has been arranged for you. Please be available on the you will be contacted via the telephone number we have for you.

Please have a list of all the current medications you are taking. This appointment will last no longer than half an hour.

Please also find attached a letter with regards to MRSA swabbing that we kindly ask you to complete and return to your GP surgery before your telephone pre assessment if you have any problems with the screening process please wait until you are contacted by the nurse telephone pre assessing you.

We use a reminder service to advise patients of their appointments. You will receive a telephone call from an operator or a pre-recorded message a few days before your scheduled appointment. If you do not wish to receive a reminder, please let us know.

If you are unable to attend this appointment or you have any questions or concerns, please contact us on **01752 439196** without delay so that we can help you or your appointment can be used by another patient.

Your date for a Coronary Angiogram

We have arranged an admission date for you to have the Coronary Angiogram. Please come to **Fal Ward, Zone B, Level 4**, Derriford Hospital at **8:00 am** on . This procedure will be performed in the morning and you should be able to go home later that day.

Please take the time to read any enclosed information leaflet and visit our website at **www.plymouthhospitals.nhs.uk** for further information, including details of the facilities available and travel advice.

We are a teaching hospital training medical and other health professionals for the future. We might ask you whether you mind having students present during your appointment or procedure. If you are not happy with this, please tell us when you arrive.

Sent on behalf of Plymouth Hospitals NHS Trust

INFORMATION FOR PATIENTS

Pre-procedure Instructions

Please read the following information before you attend the pre-assessment clinic. If you have any questions about these instructions please raise them at the clinic.

Please bring an overnight bag with you just in case you need to stay in hospital and any medication you are taking including a dressing gown and slippers. A small amount of money may be useful, but try to avoid bringing other valuables.

Please be **nil by mouth** for food from 12 midnight. However, you may **continue to drink clear fluids (water)** and take any medication on the morning of admission as normal with a glass of water.

If you are currently taking Warfarin, please stop as advised by your consultant.

If you are currently taking Metformin, please stop taking Metformin 2 days before your admission.

Please bring your normal medication with you to hospital. You will be asked to keep it in your bedside locker and take your normal doses at the appropriate times. If in doubt, there are nursing staff on the ward to advise you.

You are asked not to drive home after the procedure, therefore, please do not plan to drive yourself into hospital, please arrange for a relative or friend to drive you home.

What is Coronary Angiography?

It is a specialised x-ray examination of the blood vessels that supply the heart muscle. These blood vessels are quite small (only 1-3 mm across) but are very important and feed into the heart muscle itself. The heart muscle acts as a pump which pumps blood around the body and without an adequate supply of blood it may give rise to discomfort or pain, which is felt in the chest, or to shortness of breath. These symptoms, known as angina pectoris, are usually most marked on exertion.

What happens during the procedure?

During the procedure you will lie on a special table and heart monitor leads will be attached. No pre-medication is usually necessary. You will receive a local anaesthetic injection in the groin or in the wrist, usually on the right side, after it has been cleaned with antiseptic solution. This is a little uncomfortable and similar to the local anaesthetic injection you may have received when visiting your dentist. After this injection the procedure should be painless. You will be awake throughout the procedure and may be aware of some pushing at the top of your leg and some “bumps” (or palpitation) in your chest.

A small tube called a catheter is introduced into the blood vessel either at the top of your leg or in the wrist, and under x-ray control, guided to the opening of each of the two main arteries supplying blood to your heart in turn (the coronary arteries). The room will be darkened, an x-ray camera will move over your chest and a small amount of colourless liquid which shows up on x-rays (contrast media) will be injected down the cardiac catheter and into the coronary artery. At the same time x-ray images are recorded to document the outline of the coronary vessels. This injection is usually painless but may rise to a little discomfort or angina, similar to that which you may already experience.

The catheter in your groin or wrist will probably be changed on two occasions during the procedure and you may be aware of some pressure, but no pain, at the top of your leg. After the second change, the catheter will be introduced into the main pumping chamber of the heart (the left ventricle) and this may cause a few “bumps” in your chest, but again is quite painless. Contrast media will be injected down the catheter to outline this pumping chamber and immediately following this you will be aware of the sensation of a hot flush which is usually felt all over your body and lasts some 20-30 seconds. This will usually mark the end of the procedure, which, under normal circumstances, will have taken some 20-30 minutes.

From our experience, patients find that the procedure was not as bad as they expected and they hadn't realised how straight forward it was going to be. If you feel at all worried or uncomfortable during the procedure please do not hesitate to say so. We hope you will find all the staff looking after you, helpful, friendly and willing to answer your questions. As the procedure is performed under sterile conditions, the staff doing the procedure will be wearing operating theatre gowns and masks.

Thank you for reading these instructions

Are there any risks involved in the procedure?

Like any other medical procedure, there is always an element of risk, but every effort is made to minimise problems occurring. Only about one or two patients in every thousand have a serious complication and these tend to occur in those patients with the most severe cardiac disease. Minor changes such as bruising are more common and indeed a little bruising and a small lump (or haematoma) at the puncture site is to be expected. Once the procedure is finished, the tube (catheter) will be removed and pressure applied to the top of your leg for about ten minutes, or a tourniquet is fitted to your wrist.

What will happen after the procedure?

You will be taken back to the ward where you will need to lie down for about 4-6 hours if your angiogram has been performed via your groin. If it is performed via your wrist you are able to rest on the bed or in the chair. One of the doctors will visit you after the cardiac catheterisation to discuss the results and treatment options. He or she will explain the risks and benefits of your treatment options and answer any questions you may have.

Normally you will be able to travel home on the same evening. Please **DO NOT** consider driving yourself home as the continual leg/arm movement could cause problems at your puncture site, such as bleeding.

You will be given an advice sheet on leaving the Ward. You should rest at home for 24 hours after the procedure. If all is well, normal activities can then be resumed.

What shall I do in the event of problems?

Prior to your coronary angiogram appointment, if you are unable to attend please contact:

- Cardiac Catheter Lab Administrator
- Tel: **01752 439196**

In the unlikely event of a problem arising after you have left the hospital, please contact your own General Practitioner.

Dear sir/madam

MRSA SWABS

Your MRSA swabs are now due.

I have enclosed 3 swabs for MRSA testing i.e. Nose, throat and groin

Could you please follow the instructions below?

Throat – Take a **pink** swab. Hold the end of the stick, (avoid touching the swab with fingers)

- Insert the swab into mouth to the back of throat
- Rotate swab 5 times
- Place swab into the bottle , and move it around vigorously in the liquid, then discard the swab

Groin – Take the **pink** swab. Hold the end of the stick (avoid touching the swab with fingers)

- Insert swab to crease of the groin with your pants on
- Swab 5 times each side,
- Place swab into the bottle , and move it around vigorously in the liquid, then discard the swab

Nose – Take the yellow swab. Hold the end of the stick (avoid touching the swab with fingers)

- Insert the swab 1 inch into each nostril
- Rotate swab 5 times in each nostril
- Place swab into the bottle and snap off the end so that the bottle can be closed with the swab remaining inside. Write your name, date of birth and hospital number on the bottle, then place the bottle into the plastic wallet,

Important – if the bottle is not labelled as above, the samples may be rejected by microbiology.

Please place the wallet in the envelope and return the envelope to your local GP practice.

Yours sincerely

e-Swab – Sample Collection Guide

e-Swab Pink Cap – Liquid Amies, 3 x Regular Swabs for MRSA screening (Sterilin code. 493CE03)



Collection from:

- Throat, perineum and nose

Use for:

- Routine MRSA screening

Maximise Performance:

- Pre-moistening of the swab significantly improves pick up of MRSA

Directions for Use



Open the peel pouch



Take a pink swab to collect the first sample (throat)



If a site is DRY, moisten the swab with a drop of saline



Uncap the tube and insert the swab into the medium – 'swirl' for total release. Remove and discard the first pink swab and replace the cap



Take a second pink swab for the second sample (perineum). Unscrew cap, insert in the medium and 'swirl'. Remove and discard swab



Take the white swab (with marked breaking point) MOISTEN with a drop of saline and collect final sample from the nose



Unscrew cap and break swab into tube



Re-cap the tube with the swab inside. Write patient info OR APPLY BAR CODE LABEL VERTICALLY



Now sold under the Thermo Scientific brand

