Leicestershire Partnership NHS Trust

Meticillin Resistant *Staphylococcus* Aureus Policy (MRSA)

This policy identifies the key processes and protocols for patients colonised or infected with meticillin resistant staphylococcus aureus (MRSA), including the management and screening of patients.

Key Words:	MRSA, decolonisation treatment, risk factors, resistant bacteria	
Version:	11	
Approved by:	Infection Prevention and Control Assurance Group	
Ratified by:	Quality and Safety Committee	
Date this version was Ratified:	27 July 2023	
Please state if there is a reason for not publishing on website	Not applicable	
Review date:	January 2026	
Expiry date:	June 2026	
Type of Policy	Clinical **X**	Non-Clinical

Contents

1.0 Quick Look Summary

This policy provides all staff employed by LPT with the key processes and protocols required to enable them to care for patients who are colonised or infected with MRSA and to ensure that other patients are not put at undue risk.

Healthcare associated infection (HAI) risk assessments are undertaken to determine the risk of a patient contracting or spreading an infection, and aids care planning and patient placement, transfer or discharge.

Screening for MRSA was adapted in 2014 after advice and publication from an expert committee. This guidance for the NHS in England is applicable to all in-patient areas (inc. Mental health) and has been streamlined to;

1. All patients admitted to *high risk units
2. All patients previously identified as colonised with or infected by MRSA
3. For diagnostic reasons (i.e. signs and symptoms of infection are present, as appropriate depending on clinical presentation)
    - Device entry sites
    - Wounds
    - Urine
    - Sputum

Screening swabs from the nose and groin should be taken as a minimum and further swabs from the list above if for diagnostic reasons.

Decolonisation treatment aims to eradicate or significantly reduce the carriage of MRSA when a positive MRSA result has been received.

Treatment should commence at the earliest possible opportunity, ensuring that the patient is informed of the treatment and its purpose. Decolonisation guide can be located in appendix 1.

The patient should be reswabbed a minimum of 24 hours after the first round of Decolonisation treatment has been completed. If the patient remains positive a second course of treatment may be considered, this should be discussed with the IPC team.

PLEASE NOTE THAT THIS LIST IS DESIGNED TO ACT AS A QUICK REFERENCE GUIDE ONLY AND IS NOT INTENDED TO REPLACE THE NEED TO READ THE FULL POLICY

1.1 Version Control and Summary of Changes

Version number	Date	Comments
	January 2010	Policy review – Amalgamation of: Infection control guidelines for the management of patients with MRSA in in-patient settings (NP 0167 2007) and guidelines for the management of patients in primary care (NP 0168). Reviewed to meet Department of Health MRSA screening operational guidance (2006). Reviewed to meet NHSLA requirements. Reviewed to meet the Health and Social Care Act (2008)
Version 2	March 2010 May 2010	Circulated for consultation to all members of the LCCHS infection control sub-committee. Circulated to Dr Debbie Modha (consultant microbiologist UHL) for consultation
Version 3	July – November 2010	LLR WHE discussion and proposal regarding emergency screening. Proposals approved by LLR DIPAC and Leicester City and Leicestershire County infection prevention and control commissioning group. Proposals incorporated into the policy
Version 4	November 2010	Circulated for consultation to all members of the LCCHS infection control sub-committee
Version 5	December 2010	Comments received and incorporated into document and forwarded to LCCHS infection control sub-committee
Version 6	March 2012	Incorporation of adult mental health, mental health services for older persons and learning disability services Department of Health screening requirements
Version 7	August 2014	Review of policy. Deletion of advice relating to theatres, day surgery and endoscopy services that are no longer under the care of LPT infection prevention and control services
Version 8		Review of policy
Version 9	November 2021	Reviewed and update of policy in line with national guidance
Version 10	October 2022	Reviewed and updated in line with national guidance
Vesion 11	May 2023	Reviewed and updated in line with screening requirements

1.2 Key individuals involved in developing and consulting on the document.

Name	Designation
Anne Scott	Director of Nursing, AHP's and Quality
Emma Wallis	Deputy Director of Nursing and Quality
Wider consultation	Infection Prevention and Control Assurance Group
Implementation Lead	Head of Infection Prevention and Control
Core policy reviewer group	Infection Prevention and Control Assurance Group
Wider consultation	Infection Prevention and Control Assurance Group members
Trust Policy Group	

1.3 Governance

Level 2 or 3 approving delivery group	Level 1 Committee to ratify policy
Infection Prevention and Control Assurance Group	Quality and Safety Committee

1.4 Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

1.5 Due Regard

LPT will ensure that Due regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010. This process will help to ensure that:

- Strategies, policies and procedures and services are free from discrimination.
- LPT complies with current equality legislation.
- Due regard is given to equality in decision making and subsequent processes.
- Opportunities for promoting equality are identified.

Please refer to due regard assessment (Appendix 4) of this policy

1.5 Definitions that apply to this Policy

Bacteraemia	The presence of bacteria in the blood
Colonisation	Where an infection is present in the nose and on the skin but causing no harm to the person. People who are colonised will not display signs or symptoms of infection. People who are colonised with MRSA are often called MRSA carriers (carriage)
Decolonisation (in relation to MRSA)	The reduction or elimination of MRSA skin carriage through the use of antibacterial washes and nasal preparations in conjunction with increased infection prevention and control and hygiene measures. It aims to eradicate or significantly reduce the carriage of MRSA. Decolonisation treatment reduces the risk to the patient and others and if successful the patient may not require further isolation.
Heavily exfoliating skin condition (i.e. eczema or psoriasis	A skin condition that creates a large amount of shedding skin, which then contaminates the environment.
Heavily exudating wound	A wound that produces discharge or exudate which cannot be contained within a dressing and necessitates a change of dressing every 24 hours or sooner.
MRSA (Meticillin resistant Staphylococcus aureus)	A type of Staphylococcus aureus bacteria resistant to certain antibiotics, including Meticillin and many other commonly prescribed antibiotics.
MSSA (Meticillin sensitive Staphylococcus aureus)	A type of staphylococcus aureus bacteria that is sensitive to many antibiotics. It is an opportunist pathogen. It can either be colonized or infected.
MRSA screening	The taking of swabs from patients to test for the presence of MRSA. This will be nasal screening for those patients screened as laid out in the Department of Health requirement and screening of risk factors for other patients where appropriate.
Opportunistic infection	(Bacteria, viruses, fungi, or protozoa) that take advantage of an opportunity not normally available, such as a host with a weakened immune system, an altered microbiota (such as a disrupted gut flora) or breached integumentary barriers.
Outbreak/increased incidence	The occurrence of two or more cases of the same infection, linked in time and place, or a situation where the observed number of cases exceeds the number expected.
Personal protective equipment (PPE)	Specialised clothing or equipment worn by employees for protection against health and safety hazards and includes nitrile gloves, aprons, masks, and eye protection.
Productive cough	A cough that produces sputum.

2.0. Purpose and Introduction

This policy has been developed to give clear guidance to staff employed by LPT in relation to the procedure for the management of patients with Meticillin Resistant Staphylococcus Aureus (MRSA). It describes the process for ensuring the delivery of effective infection prevention and control precautions for patients colonised or infected with MRSA.

This policy forms part of the organisations compliance with the Health & Social Care Act (2015) and the Department of Health (DH) guidance on screening
Staphylococcus aureus (S. aureus) is a bacterium that is present on the skin and in the nose and throat of approximately 30% of the health population. On intact skin it presence is harmless. It is the most common cause of localised wound and skin infections. Meticillin Resistant Staphylococcus aureus (MRSA) is a strain of staphylococcus aureus that is resistant to

commonly used antibiotics, e.g., flucloxacillin. Approximately 6% of the population are asymptomatic carriers of MRSA. MRSA is no more virulent than an antibiotic sensitive staphylococcus aureus; the options for treatment of infection are more limited.

This policy provides all staff employed by LPT with the key processes and protocols required to enable them to care for patients who are colonised or infected with MRSA and to ensure that other patients are not put at undue risk.

- It identifies the main risk factors for cross contamination of MRSA and when source isolation precautions are required for patients and the screening requirements of those patients.

- It gives information regarding what precautions and screening are required for those patients for whom source isolation precautions are not necessary as they are colonised and do not present with the risk factors for transmission.

The risk of acquiring an MRSA infection in the community and primary care is acknowledged as being low and is usually related to a recent hospital or nursing home admission. However, with the early discharge of patients from hospital and the increase in minor surgery and invasive procedures now undertaken in primary care, there is the potential for an increase in MRSA infection in the community if the general principles of infection prevention and control are not applied in all healthcare facilities.

MRSA is transmitted primarily by person to person spread, most often on the hands of healthcare workers (HCW) which may have been transiently contaminated by contact with infected or colonised patients.

In most cases where infection is present, these infections are minor and remain localised to the area of broken skin and can be treated quickly and effectively. In some circumstances infection with MRSA may be problematic, particularly in the elderly and debilitated people and in people with a lowered resistance to infection. In these instances, the organism can cause more widespread infection such as septicaemia. This potentially life-threatening infection is more likely to affect people who already have a serious underlying condition which has weakened the body's defence mechanism and urgent treatment is necessary.

The mainstay of treatment for many years for S. aureus infections has been the antibiotics such as Meticillin and flucloxacillin but strains resistant to these agents have become increasingly prevalent, hence the term MRSA. It causes the same range of infections as other S. aureus but is much more difficult to treat because of their resistance to many antibiotics.

There is also evidence to suggest that that the environment can act as a reservoir for MRSA, as such; MRSA may be acquired by indirect contact. Because MRSA can colonise a patient's skin it can then subsequently be dispersed on their skin scales. This may lead to contamination of the environment. Therefore, high standards of environmental cleanliness within community settings, particularly on horizontal surfaces should be encouraged, to keep dust (and micro-organisms) to a minimum.

If the basic principles of infection prevention & control are practiced, regardless of the type of healthcare setting, the risks can be effectively minimised, and people colonised with MRSA will not be a hazard to other members of their family, visitors, other residents or staff in nursing or residential homes. This includes healthy babies, children, and well pregnant women. S. aureus organisms, resistant or otherwise are opportunist pathogens and intact skin is an extremely effective barrier.

3.0 The Management of MRSA

3.1 MRSA blood stream infection (BSI)

MRSA bacteraemia (MRSA BSI) is when MRSA has been detected in a patient's blood stream following blood cultures being taken and cultured within a pathology laboratory. All NHS trusts across the country have a "zero tolerance" for all MRSA bloodstream infection cases from April 2013. Case definitions for MRSA bacteraemia are:

- Community acquired (acquired outside of a hospital or healthcare)
- Community-associated (detected in an outpatient or within 48 hours of a hospital admission)
- Healthcare-associated (detected more than 48 hours after hospital admission)

If the case is identified as healthcare-associated, then a post infection review (PIR) should be completed to identify any possible failings and to identify any improvements required. The PIR process will.

- Help identify factors that may have contributed to a MRSA BSI
- Help to identify any part of the patients pathway which may have contributed to the infection.
- Identify any areas of non-optimal practice or care delivery.
- Identify lessons from learning to improve practice and prevent re-occurrence.

Healthcare associated infection (HAI) risk assessments are undertaken to determine the risk of a patient contracting or spreading an infection, and aids care planning and patient placement, transfer or discharge.

Screening for MRSA was adapted in 2014 after advice and publication from an expert committee. This guidance for the NHS in England is applicable to all in-patient areas (inc. Mental health) and has been streamlined to;

4. All patients admitted to *high risk units.
5. All patients previously identified as colonised with or infected by MRSA.
6. For diagnostic reasons (i.e., signs and symptoms of infection are present, as appropriate depending on clinical presentation)
    - Device entry sites
    - Wounds
    - Urine
    - Sputum

Screening swabs from the nose and groin should be taken as a minimum and further swab from the list above if for diagnostic reasons.

MRSA swabs (blue top) should be pre-moistened with sterile water or sodium chloride 0.9%, if the site to be swabbed is dry i.e., nose and perineum. The moisture will help any bacteria adhere to the swab.

*High risk is defined as vascular, renal/dialysis, neurosurgery, cardiothoracic surgery, haematology/oncology/bone marrow transplant, orthopaedics/trauma and all intensive care units.

Please see appendix 1a for patients in mental health services

3.2 Patient placement

The optimal placement for a patient with a known infection is a single room with en-suite facilities. MRSA is a contact transmission and therefore requires the appropriate PPE in line with standard precautions. (refer to the LPT PPE policy). Enhanced PPE would only be required for a patient with an infectious pneumonia and/or productive cough.

3.3 Decolonisation treatment

Decolonisation treatment aims to eradicate or significantly reduce the carriage of MRSA when a positive MRSA result has been received.

Treatment should commence at the earliest possible opportunity, ensuring that the patient is informed of the treatment and its purpose. Decolonisation guide can be located in appendix 1b.

The patient should be reswabbed a minimum of 24 hours after the first round of decolonisation treatment has been completed. If the patient remains positive a second course of treatment may be considered, this should be discussed with the IPC team.

Where a screening swab is negative, but the patient has a wound bed that tests positive, then the practitioner managing the wound must arrange an assessment to determine the need for an antibiotic treatment. In many cases, particularly chronic wounds, the wound bed is colonised with MRSA rather than infected. Clinical assessment is essential and only if there are signs of infection should antimicrobial chemotherapy be considered.

3.4 Discharge

Effective and timely communication is essential for the successful management of patients with MRSA colonisation/infection. Prior to a patient being discharged from hospital who has been found to be colonised or infected with MRSA, it is the responsibility of the ward nursing/medical staff to ensure that the GP and/or district nurse or residential/nursing home is informed. This is particularly important if the patient has commenced decolonisation treatment and may require assistance with applying the products.

There is no reason to delay or refuse treatment, investigations, therapy or discharge home/nursing/residential home. Patients should be encouraged to continue with their normal activities and visitors should be assured that they are normally at no special risk. If a relative is immunocompromised or awaiting surgery and requires further advice, they should discuss this with their GP or practice nurse.

Patients colonised or infected with MRSA may be transported with others in the same ambulance without any special precautions, it is important that this is discussed first with the ambulance service. Any wounds are to be covered with an impermeable dressing. However, if this is not possible advice should be sought from the Infection Prevention and Control Team.

3.5 Environmental Management

a. Room Cleaning

When cleaning rooms, separate equipment should be used and the environment cleaned using detergent, paying special attention to dust collecting areas and horizontal services. Curtains must be laundered (if reusable) and visible splashes on

walls will be washed (full wall washing is not required). If disposable curtains are in use, these must be changed.

b. Decontamination of medical equipment and devices

LPT employers are required to maintain the safety of all patients, colleagues and visitors by adhering to safe systems as detailed within the LPT Medical Devices policy. This will ensure that all medical equipment and reusable medical devices are properly decontaminated prior to use or repair and that the risks associated with decontamination facilities and processes are well managed (MHRA 2006).

c. Linen and clothing (where applicable)

Only need to be placed in a red alginate and white plastic bags if the linen is soiled or the patient has an exfoliating skin condition, leaking wound or is undergoing decolonisation therapy. Removing and bagging linen should be performed to minimise dispersal of MRSA from the bed linen and clothing. Gloves do not need to be worn for handling unsoiled linen.

3.6 Community Nursing Teams including paediatrics.

It needs to be recognised that many clients being cared for in their own homes will have long standing complex health conditions that place them at higher risk of MRSA acquisition. Some clients will have chronic MRSA colonisation which in turn suggests that the home itself will be colonised. It is therefore important for staff to adhere to strict infection prevention and control precautions to prevent onward transmission of MRSA to other clients.

Hand hygiene needs to be carried out on entering and leaving the patients home as well as prior to any episodes of care. Staff need to be 'bare below the elbow' for any episodes of clinical care.

If it is not possible to use the hand washing facilities within a patient's home following risk assessment, then individual hand wipes should be used prior to using the alcohol hand sanitiser.

Uniforms must be protected by a plastic apron when close contact with the client or environment is anticipated.

Equipment utilised by staff should be kept in good condition and cleaned regularly, refer to decontamination policy or contact IPCT for advice.

Community staff are encouraged to discuss any concerns regarding care of MRSA colonised/infected clients with the IPCT. It may be necessary to formulate an individual plan for that person.

Previous history of MRSA should always be considered as relevant.

Chronic wounds are a potential cause of skin and soft tissue infections as there is an increase in bacterial burden often including MRSA. It is therefore necessary to adhere to the principles of asepsis for wound care.

Wound swabs should be taken if there are signs and symptoms of infection i.e., redness, inflammation, discharge or non-healing persists.

Any waste generated by a healthcare worker as a result of wound care in a domestic setting

that is considered to be infected by MRSA will need to be disposed of following the correct infected waste collection service.

When taking a swab, the wound should be cleaned first to remove surface contaminants and any slough.

A brief history of the patient and current or recent antibiotic treatment should be included on the laboratory request form.

Results of wound swabs should be obtained as soon possible so that there is no delay in the correct treatment being prescribed if needed.

3.7 Podiatry services

Podiatry services provide care for many patients with increased risk of developing infection in chronic wounds. Diabetes in particular will be of significance as raised blood glucose levels increase risk of ulceration and infection. Diabetes can also cause suppression to normal inflammatory responses that may mask signs of infection so this needs to be taken into account when assessing a wound.

When high risk interventions are being considered it is recommended that the MRSA status of the patient is reviewed. If positive or previously positive, then suppression therapy and antibiotic prophylaxis may be considered on an individual basis and for further advice contact IPCT or Microbiologist.

Wound care needs to be carried out using the principles of asepsis in accordance with the Aseptic Technique Policy. This will prevent the introduction of pathogens to the site.

Every attempt needs to be made to ensure that requests for swabs or antibiotic treatment is timely so that treatment when necessary, can commence at the earliest opportunity.

Due to the invasive nature of some podiatry procedures, there is a risk of contamination of inanimate objects such as couches etc with body fluids. Therefore, the correct cleaning/disinfection materials need to be at hand and used correctly following risk assessment.

Wound swabs should be taken if there are signs and symptoms of infection i.e., redness, inflammation, discharge or non-healing persists.

When taking a swab, the wound should be cleaned first to remove surface contaminants and any slough

A brief history of the patient and current or recent antibiotic treatment should be included on the laboratory request form to aid a more comprehensive laboratory report.

Results of wound swabs should be obtained as soon as possible so that there is no delay in the correct treatment being prescribed if needed.

3.8 Outbreaks of MRSA

An outbreak may be declared if there is an exponential rise in the number of cases in one

area.

Assessment and management of the outbreak will be led by the IPCT in consultation with a consultant microbiologist and DIPC.

Screening of staff will only be carried out following the decision of a Microbiologist/IPCT.

4.0 Duties within the Organisation

Duties in regard to this policy can be located in the LPT Infection Prevention and Control Assurance Policy

Consent

- *Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered. Consent can be given orally and/ or in writing. Someone could also give non-verbal consent as long as they understand the treatment or care about to take place. Consent must be voluntary and informed, and the person consenting must have the capacity to make the decision.*
- *In the event that the patient's capacity to consent is in doubt, clinical staff must ensure that a mental capacity assessment is completed and recorded. Someone with an impairment of or a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following:*

- Understand information about the decision.
- Remember that information.
- Use the information to make the decision.
- Communicate the decision.

5.0 Monitoring Compliance and Effectiveness

Compliance with this policy is outlined in LPT's Infection Prevention and Control Assurance Policy

6.0 References and Bibliography

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Appendix 1a

NHS England Midlands

MRSA Guidance- Regional Approach for Mental health and Community Trusts- July 2022

Targeted Testing Only

- Patients admitted with medical devices
- Patients admitted with wounds

Other patients can be tested on risk assessment against national guidance/ local prevalence

No repeat testing unless patient has undergone decolonisation therapy

Sites to Test

- Nose
- Medical device site/ wound site

(it is not appropriate to test the perineum of patients in this setting)

Decolonisation Therapy

- Octenisan products *(this is in line with all current local policies for these settings in the region)*
- Test 2-3 days after treatment has completed
- Ensure patients are aware that decolonisation therapy may not result in complete eradication but should achieve temporary suppression, which is sufficient in many circumstances

Appendix 1b

Making a new referral to Infection Prevention and Control Team

Choose one of 3 methods below if a patient has an infection / suspected infection or is a known carrier.

Phone: 0116 295 1668 (Answerphone service)

Staffnet: Send an automated email alert to IPC via Staffnet.
https://staffnet.leicspart.nhs.uk/support-services/infection-prevention-control/contact-us/ipcform/

E-Referral on SystmOne:

Patients with a lifelong infection will have this icon  in the demographic box on SystmOne, if missing contact the IPC Team.

The electronic patient system (HISS) will also alert staff of patients previously identified as MRSA carriers. The HISS system identifies the patient details and will display SR MRSA on screen.

The special register within HISS is updated by the microbiology department at UHL and therefore relies upon the samples being processed within Leicester, Leicestershire, and Rutland.
It is imperative that staff check the infectious status of all patients when they first come under their care.

If staff do not have access to HISS, they can contact the Infection Prevention and Control Team within LPT who will be able to undertake this for them. However, as discussed above only those samples that have been sent to the microbiology department at UHL will be entered onto HISS.

Appendix 1c

Infection Prevention and Control Team

Guidance for the use of Antibacterial Body Wash/Shampoo and Bactroban Nasal Ointment

Antibacterial Body Wash/Shampoo

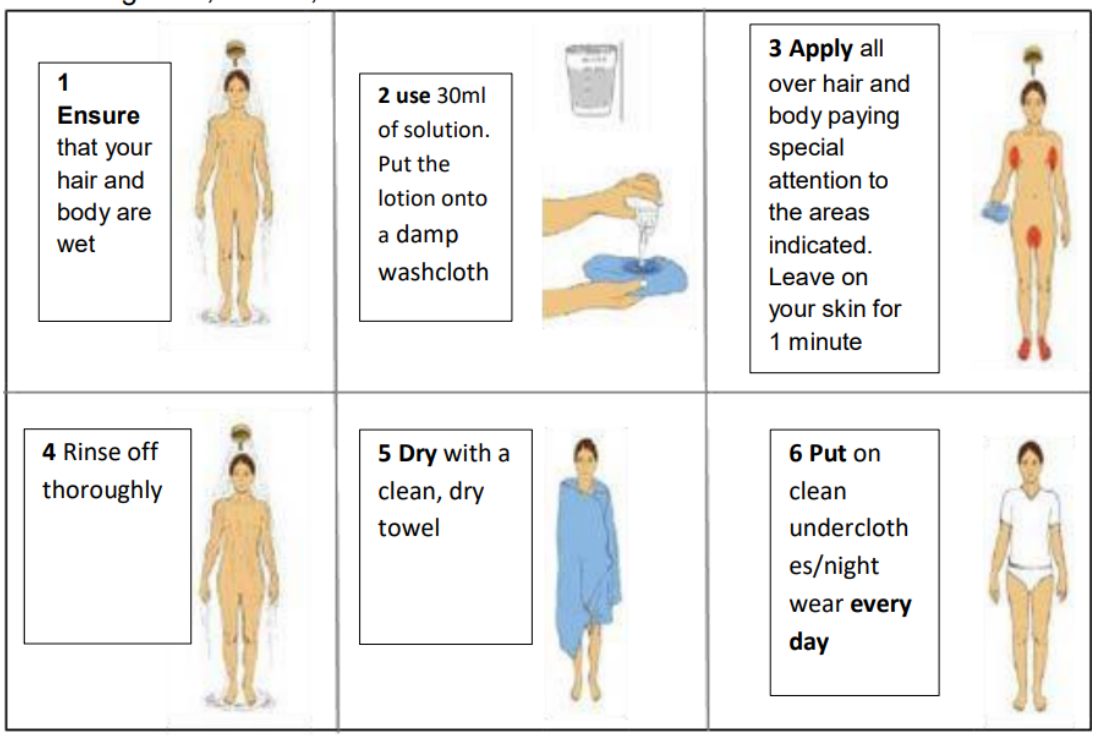
How to use the body wash/shampoo

- Use the antibacterial body wash everyday as a liquid soap, for a shower, bath, or wash. Avoid direct contact with eyes when washing
- Use the antibacterial body wash as a shampoo to wash hair twice a week

Bactroban nasal ointment (Mupirocin 2%)

How to use the Bactroban nasal ointment

- Place a small amount of ointment (about the size of a match head) on a cotton bud, swab or on a gloved finger and apply to the front part of the nostril
- If the patient is self-administering and does not have access to gloves, then a clean finger can be used.
- Close the nostrils by pressing the sides of the nose together – this will spread the ointment through the nostrils
- Remove gloves, if used, and wash hands



Day 1	Day 2	Day 3	Day 4	Day5
Body	Body & hair	Body	Body & hair	Body

Appendix 2 Training Requirements

Training Needs Analysis

Training topic:	MRSA
Type of training: (see study leave policy)	☐ Mandatory (must be on mandatory training register) X Role specific ☐ Personal development
Directorate to which the training is applicable:	X Mental Health X Community Health Services ☐ Enabling Services X Families Young People Children / Learning Disability Services ☐ Hosted Services
Staff groups who require the training:	*Clinical Staff*
Regularity of Update requirement:	Role specific
Who is responsible for delivery of this training?	IPC team
Have resources been identified?	TBC
Has a training plan been agreed?	TBC
Where will completion of this training be recorded?	☐ ULearn X Other (please specify)
How is this training going to be monitored?	TBC

Appendix 2 The NHS Constitution

- The NHS will provide a universal service for all based on clinical need, not ability to pay.
- The NHS will provide a comprehensive range of services.

Shape its services around the needs and preferences of individual patients, their families and their carers	☐
Respond to different needs of different sectors of the population	☐
Work continuously to improve quality services and to minimise errors	☐
Support and value its staff	☐
Work together with others to ensure a seamless service for patients	☐
Help keep people healthy and work to reduce health inequalities	☐
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	☐

Appendix 3 Due Regard Screening Template

Section 1	
Name of activity/proposal	MRSA policy
Date Screening commenced	16 June 2023
Directorate / Service carrying out the assessment	Enabling
Name and role of person undertaking this Due Regard (Equality Analysis)	Amanda Hemsley Head of Infection Prevention and Control
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: To ensure the policy meets the need of the patients receiving care within LPT, in relation to MRSA	
OBJECTIVES: Review and ensure compliance with updated treatment guidance Identify treatment and care pathways	

Section 2	
Protected Characteristic	If the proposal/s have a positive or negative impact please give brief details
Age	
Disability	
Gender reassignment	
Marriage & Civil Partnership	
Pregnancy & Maternity	
Race	
Religion and Belief	
Sex	
Sexual Orientation	
Other equality groups?	

Section 3	
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.	
Yes	No X
High risk: Complete a full EIA starting click here to proceed to Part B	Low risk: Go to Section 4.

Section 4			
If this proposal is low risk please give evidence or justification for how you reached this decision:			
Current policy in place, minimal changes to update, which are in line with national guidance.			
Signed by reviewer/assessor	See main IPC Policy	Date	
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed		Date	

Appendix 4 Data Privacy Impact Assessment Screening

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy.
The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.

Name of Document:	**Meticillin Resistant Staphylococcus Aureas Policy**	
Completed by:	**Amanda Hemsley**	
Job title	**Head of Infection Prevention and Control**	**Date 16 June 2023**

Screening Questions	**Yes / No**	**Explanatory Note**
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.	No	
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.	No	
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?	No	
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?	**No**	
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.	No	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?	No	
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.	No	
8. Will the process require you to contact individuals in ways which they may find intrusive?	**No**	

If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk
In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.

Data Privacy approval name:	**N/A**
Date of approval	

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust