

Reference Number: UHW 004 Version Number: 5	Date of Next Review: 12/2020 Previous Trust/LHB Reference Number: UHW 004
<p align="center">INFECTION CONTROL PROCEDURE FOR METICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA) IN ACUTE HOSPITALS</p>	
<p>Introduction:</p> <p>This procedure sets out the requirements for MRSA screening plus the management of patients found to be MRSA positive.</p> <p>Patients may be carriers of MRSA or contract it through transmission from another, affected person. MRSA can cause wound, respiratory, urinary or blood stream infections.</p> <p>Following the clinical risk assessment in this procedure ensures staff screen patients that are at a higher risk of infection from MRSA (for example, previous history or admission for high risk surgery).</p> <p>The 'Implementation of modified admission MRSA screening guidance for NHS' from the Department of Health in 2014 wanted MRSA screens for acute and elective admissions in England to be streamlined to the following:</p> <ul style="list-style-type: none"> • All patients admitted to high risk units. • All patients previously identified as colonised with or infected by MRSA. <p>Cardiff and Vale UHB include the above as part of the MRSA admission screening as already advised from a CMO/CNO letter issued in February 2013 in addition to the following:</p> <ul style="list-style-type: none"> • is resident in a care home, other institutional setting or is a transfer from another hospital; • has a wound or in-dwelling device (e.g. gastrostomy, urinary catheter, long term intravascular device) present on admission to the UHB. <p>The single most important measure in the containment of MRSA is proper hand decontamination.</p> <p>Control measures include:</p> <ul style="list-style-type: none"> • Hand hygiene • Appropriate use of protective equipment • Maintenance of appropriate cleaning procedures (and correct use of appropriate cleaning products) • Rational use of antibiotics • Appropriate disposal of waste <p>This procedure describes the screening, precautions and decolonisation procedures relevant to each Risk Area.</p>	

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Screening should be carried out as directed by the Infection Prevention and Control Team (IPCT). A patient screen should only include the following:

- Nose
- Perineum/groin
- Any wounds or abnormal skin lesions, including IV sites, catheter sites or other medical device sites.
- Umbilicus (in neonatology ONLY).

If a patient is colonised with MRSA, a single room is preferred. Decisions on individual cases should be risk assessed by clinicians/patient access with the support of IPCT.

The standard decolonisation regime recommended is topical application of Mupirocin 2% to the nose plus skin decolonisation with an Antimicrobial Body Wash.

Aim:

To provide structured and appropriate guidance to staff for the prevention and management of MRSA colonisation and management in all UHB hospitals.

Objectives

To outline the procedure for screening patients for MRSA.

To describe the actions required when a case of MRSA is identified either on admission or subsequently.

To provide advice on the action required during an infectious incident or outbreak situation caused by MRSA (see also the Infection Control Procedure for Infectious Incidents and Outbreaks).

To provide advice on the management if a staff member becomes colonised with MRSA.

Scope

This procedure applies to all staff in all locations including those with honorary contracts and students on placement at Cardiff and Vale UHB.

Equality and Health Impact Assessment

An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be no impact.

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Documents to read alongside this Procedure	Procedure for Infectious Incidents and Outbreaks Procedure for Hand Decontamination
Approved by	<i>Infection Prevention & Control Group</i>

Accountable Executive or Clinical Board Director	<i>Ruth Walker, Executive Nurse Director</i>
Author(s)	<i>Director of IPC, Senior Nurse IPC, Clinical Nurse Specialist in IPC</i>
<p style="text-align: center;"><u>Disclaimer</u> If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.</p>	

Summary of reviews/amendments			
Version Number	Date of Review Approved	Date Published	Summary of Amendments
4	02/12/14	09/12/2014	<i>Revised document to incorporate CMO/ CNO letter (4,2 2013).</i>
5	12/2018	28/02/2019	Clarification for areas exempt from MRSA screening Clarification for length of pre op screen validity

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GENERAL GUIDANCE

- 1.1 *Staphylococcus aureus* (*S. aureus*) colonises the skin or anterior nares (nose) of approximately 20 - 30% of healthy individuals but this percentage can rise in hospitalised patients. The organism can cause abscesses, wound infections and septicaemia. One strain of *S. aureus* known as meticillin resistant *Staphylococcus aureus* (MRSA) is resistant to an antibiotic called meticillin and other antibiotics used to treat infection. This strain accounts for 2 – 3% of all *S. aureus* strains but is no more virulent or more readily spread than meticillin sensitive *S. aureus* (MSSA).
- 1.2 Guidelines for the specific control of MRSA were first published in 1986 and have been revised on a number of occasions since then. The CMO (4) / CNO (2) letter issued in February 2013 states that NHS bodies with in-patient beds are required to **review local policy on MRSA screening** to ensure that - **as a minimum** - it includes:
 - a requirement to use Clinical Risk Assessment (CRA) to assess each admission as to whether the patient:
 - has a past history of colonisation/*infection* with MRSA at any time;
 - is resident in a care home, other institutional setting or is a transfer from another hospital;
 - has a wound or in-dwelling device (e.g. gastrostomy, urinary catheter, long term intravascular device) present on admission to the UHB.
 - a requirement to swab screen any patient who answers yes to any of the above questions using a minimum of 2 swab sites (nasal/perineum or nasal/throat if perineum is deemed difficult or unacceptable);
 - a record of the assessment and results of the swab;
 - prioritisation (within existing schemes of prioritisation) for pre-emptive isolation/cohorting pending swab results;
 - a local written policy specifying units/specialities that require universal admission swab screening - that should include **as a minimum** renal, cardiothoracic/vascular, intensive care and orthopaedics; and consideration of using Clinical Risk Assessment (CRA) in units/specialities in which there is universal admission swab screening, to direct prioritisation of pre-emptive isolation/cohorting in these units.

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- 1.3 MRSA is resistant to all beta-lactam antibiotics (penicillins, cephalosporins and carbapenems) and may at times be resistant to other classes of antibiotics (multiple-resistant MRSA). Some strains of MRSA are epidemic in character and may cause serious outbreaks of infection in hospitals. MRSA can be colonised on both patients and staff and may also be isolated from the hospital environment.
- 1.4 The reason for the continuing effort to control MRSA is to prevent its occurrence in clinical areas and to minimize the incidence and clinical impact if it has occurred.
- 1.5 This procedural document gives advice on dealing with MRSA. However, each situation must be dealt with individually and more detailed advice should be obtained from the IPCT if necessary.

2. PATIENT SCREENING

- 2.1 Screening should be carried out according to the guidance below or as directed by the IPCT. A patient screen should only include:
 - Nose
 - Perineum/groin
 - Any wounds or abnormal skin lesions including IV sites, catheter sites or other medical device sites.
 - Umbilicus (in neonatology ONLY)
- 2.2 Specimens other than those listed above will not be processed as an MRSA screen unless prior arrangements have been made with the IPCT/Microbiology Laboratory.
- 2.3 Charcoal (black) swabs should be moistened with sterile saline or sterile water prior to use.
- 2.4 "MRSA screen" should be clearly marked in the investigation required box on the Bacteriology Request Form. It is essential that ward staff clearly indicate the type of investigation required; samples for MRSA screening investigations are processed differently in the laboratory to clinical samples for routine microbiological investigation.
- 2.5 The clinician requesting the investigation must sign all forms and provide the relevant clinical information.

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2.6 A Clinical Risk Assessment should be conducted on **all inpatients** to establish whether or not a patient has/is:

- a past history of colonisation/*infection* with MRSA at any time;
- resident in a care home, other institutional setting
- a wound or in-dwelling device present on admission to the UHB;
- all transfers from other hospitals (outside of the UHB)
- all admissions from care homes (nursing or residential)

2.7 Any patient who answers yes to any of the above questions **MUST** have an MRSA screen.

2.8 Pre-admission/pre-surgical screening is required for patients being admitted for:

- Cardio-thoracic surgery
- Orthopaedic Surgery
- Vascular surgery
- Breast surgery
- Oncology Surgery
- Other surgical specialties **if there is evidence of increasing rates**

2.9 Screening of patients admitted to the following areas is also required:

- Critical Care
- Neonatal
- Haematology and stem cell transplant
- Renal medicine and transplant
- Neurosurgery
- Trauma wards

All these areas should have clear local screening protocols in place developed through their Clinical Boards in conjunction with the IPCT and should use a CRA process to pre-emptively isolate any patients thought to be at high risk of being colonised with MRSA.

2.10 **Areas that are exempt from risk assessment/screening:**

- Outpatients (unless pre admission for surgery as above)
- Day surgery (unless admission is over 24 hours)
- Dental
- Ophthalmology

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- 2.11 Emergency/Acute admission screens should be carried out within 48 hours of patients admissions.
- 2.12 Negative pre admission screens for surgery are valid for **12 weeks**, as long as the patient has not had a hospital admission within this time.
- 2.13 The screening of family members/close contacts is not routinely recommended unless in special circumstances and under the direction of IPCT/Consultant Microbiologist.

3. CONTROL MEASURES

- 3.1 The primary objective of infection control is the prevention of acquiring and subsequent spread of infection in patients and staff.
 - 3.1.1 Infection prevention and control is the responsibility of all staff. A high standard of infection control is required in all areas and is an important part of total patient care. However, the priority areas for control are high-risk units such as Critical Care and Neonatal Units, and for patients who are particularly susceptible to infection.
- 3.2 CONTACT ISOLATION
 - 3.2.1 Contact precautions/isolation is used for the control of MRSA (spread usually via direct hand contact). If a patient is colonised with MRSA, a single room is preferred but not always required. Decisions on individual cases should be made by risk assessment by clinicians/bed managers with support from IPCT when necessary. Individual rooms should preferably have their own toilet facility. The door of the room should be kept closed unless the clinical need of the patient dictates otherwise.
 - 3.2.2 Prior to transferring the patient to a single room, the implications of MRSA colonisation, infection and treatment should be clearly explained to the patient or relative. Leaflets which provide information on MRSA should be available on all wards.
 - 3.2.3 Cohorting of a group of patients may be considered on discussion with the IPCT.
 - 3.2.4 A contact isolation sign should be displayed on the door (appendix 1).
 - 3.2.5 Patients should not leave the room/ward area to attend other departments without prior arrangement/notification with the receiving department.
 - 3.2.6 Visitors and members of staff from other departments must report to the nurse-in-charge before entering the room.

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3.3 HAND DECONTAMINATION

3.3.1 Hands must be decontaminated by either washing with liquid soap and water and then applying an alcohol rub or washing with a hand disinfectant.

3.3.2 Hand decontamination should be performed in accordance with CAV UHB Hand Decontamination Procedure (2017).

1. Before patient contact.
2. Before aseptic task
3. After body fluid exposure risk
4. After patient contact
5. After contact with patient surroundings



3.4 PERSONAL PROTECTIVE EQUIPMENT (PPE)

3.4.1 Gloves should be worn if there is any risk of contact with blood and body fluids. If gloves have been worn they should be removed and hands decontaminated before leaving the room/area.

3.4.2 Plastic aprons must be worn when direct contact with the patient or the patients equipment is anticipated.

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3.4.3 Face protection e.g. masks, visors/goggles must be worn if there is a risk of aerosol production or splashing from blood or body fluids and secretions.

3.4.4 All PPE should be disposed of before leaving the room and hand decontamination performed.

3.5 DISPOSAL OF WASTE

3.5.1 All infected waste should be disposed of into the appropriate clinical waste bag (HTM 07-01 Safe Management of Healthcare Waste 2006)

3.6 LINEN

3.6.1 All linen should be placed in the appropriate bag for infected linen and returned to the laundry.

3.6.2 Curtains, including window curtains, adjacent to MRSA positive patients should be changed when a patient has been transferred/discharged or when visibly soiled.

3.7 INSTRUMENTS OR EQUIPMENT

3.7.1 Whenever possible instruments and equipment such as writing materials, sphygmomanometers and stethoscopes should be designated for MRSA positive patients.

3.7.2 If this is not possible, such items should be cleaned and disinfected before use on another patient. For more information, see the Cardiff and Vale UHB Decontamination of Reusable Medical Devices Procedure (2016).

3.8 CLEANING

Daily cleaning

3.8.1 If the patient is in a single room, the nurse-in-charge must ensure that the appropriate cleaning is carried out by liaising with ward housekeeping staff.

3.8.2 If the patient is not in a cubicle, the bed space where the patient is present should be cleaned twice a day with a combined detergent and chlorine releasing disinfectant (e.g. Actichlor+).

Cleaning on discharge

3.8.3 The patient's room must be cleaned thoroughly with a combined detergent and

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chlorine releasing disinfectant at 1,000 ppm (e.g. Actichlor +). Curtains will also need to be changed.

- 3.8.4 All hospital furniture (e.g. bed frame, tables) and any dust collecting ledges should also be wiped with a chlorine releasing disinfectant.
- 3.8.5 The mattress should be decontaminated with a chlorine releasing disinfectant solution (1,000 ppm) and the mattress checked.
- 3.8.6 Hydrogen Peroxide Vapour (HPV) clean should then be carried out in accordance to instructions.

4. DECOLONISATION OF MRSA POSITIVE PATIENTS

(For Healthcare Personnel see section 8).

- 4.1 All patients found to be MRSA positive should be decolonised for five days. Contact IPCT if advice required.
- 4.2 Complete eradication of carriage of MRSA may fail. This is especially the case in patients with multiple co-morbidities, when patients are colonised at sites other than the nose and when patients have multiple sites of MRSA colonisation. Systemic treatment may sometimes be necessary for eradication of colonisation but this must be considered carefully and should only be employed if eradication with topical agents has failed. A risk assessment should be made in conjunction with the IPCT as to whether the benefits of decolonisation outweigh the risks. It is important to discuss this with the affected patient.
- 4.3 For decolonisation of neonates, discussion with IPCT is advised and the use of Octenisan is suggested.
- 4.4 DECOLONISATION OF CARRIERS

RECOMMENDATIONS FOR MRSA DECOLONISATION
<p><i>Nasal decolonisation</i></p> <p>Mupirocin 2% (eg Bactroban Nasal) TDS for 5 days topically</p> <p><i>Superficial decolonisation/suppression</i></p> <p>Antibacterial Body Wash (eg Skinsan, Octenisan) topically as a body wash for 5 days.</p> <p>Hair wash to be included on two non consecutive days</p> <p>Do not dilute.</p>

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4.4.1 Nasal carriage

The most effective treatment for nasal carriage is 2% Mupirocin - Bactroban Nasal. As a paraffin base preparation, it is applied to the anterior nares using a cotton wool swab three times daily for five days (available from pharmacy). Prolonged (more than seven days) or repeated courses (more than two per hospital admission) of Mupirocin must be avoided to prevent the development of resistance.

4.4.2 Other sites

The staphylococcal load on the skin may be reduced by using an antiseptic for skin and hair washing. Antibacterial Body Wash (eg Skinsan, Octenisan) is used for this purpose, attention should be given to the manufacturer's instructions. Special attention should be paid to axilla, groin, perineum and buttocks.

Mupirocin (Bactroban) in a polyethylene glycol base is particularly effective in removing staphylococci from lesions such as eczema and small pressure sores, but should be avoided on burns and large raw areas.

During the decolonisation course and after it has been completed, clean clothing, bedding and towels should be provided.

4.5 TESTS FOR CLEARANCE FOLLOWING DECOLONISATION

4.5.1 Following decolonisation, the nose, perineum, skin lesions, and other sites that were previously positive in colonised or infected patients should be sampled two days after the completion of the decolonisation regimen. Any further sampling will be advised by the IPCT.

4.5.2 Three negative MRSA clearance screens are NOT required for transfer of a colonised patient from an isolation room to other wards/hospitals, or for discharge. Ideally MRSA positive patients should not be moved around the hospital, but where clinical need requires a move the MRSA status of the patient should not hinder patient care. However, the receiving hospital or unit should be informed of the current status of the patient.

4.5.3 It must be remembered that screening samples should be clearly marked "MRSA Screen" on the Bacteriology Request form.

4.5.4 Repeated sampling for MRSA is **not** necessary for patients in whom decolonisation is not carried out.

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5. SURGICAL OPERATIONS

5.1 Every effort, taking into account the needs of the patient e.g. emergency surgery, should be made to eliminate or suppress colonisation or infection with MRSA before surgery. As part of the pre-operative preparation:

- bathe/shower the patient with an antiseptic solution (eg Skinsan), applied direct to dampened skin as a wash, and rinsed off.
- cover affected lesions with an impermeable dressing.
- apply mupirocin to the nose before the operation if the patient is a nasal carrier
- consideration may be given to placing the patients at the end of the theatre list. However, with effective theatre ventilation systems, there should be an adequate number of air exchanges to provide a safe environment within 15 minutes of removal of the MRSA patient from the operating theatre.
- theatre surfaces in close contact or near the patient, such as the operating table or instrument trolley, should be decontaminated with a combined detergent and chlorine releasing product such as actichlor plus before being used for the next patient.
- patients may be allowed to recover after surgery in the operating theatre or an area not occupied by other patients to avoid possible contamination of the usual recovery area. If this is not possible, the patients should be segregated as far as possible within the recovery area, and nursed by staff dedicated to their care, employing contact precautions.

5.2 Surgical antibiotic prophylaxis may need to be adjusted for patients colonised or infected with MRSA, particularly in high-risk surgery such as implant surgery. This should be discussed with a Consultant Microbiologist.

6. TRANSFER OF COLONISED OR INFECTED PATIENTS

6.1 The ward manager or nurse-in-charge of the ward has the responsibility to ensure that the necessary information regarding an infected/colonised patient is passed on to a senior member of staff of the receiving ward/department or other healthcare establishment, prior to transfer and be part of patient handover.

6.2 WITHIN THE HOSPITAL

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6.2.1 Unnecessary movement within the ward area should be avoided if at all possible, as should transfers to other wards. If transfer has to be effected then the receiving ward should be informed of the current status of the patient. If the patient has been cleared of infection/colonisation then they should be bathed, given clean clothing and transferred to a clean bed. Lesions should be occluded with an impervious dressing.

6.2.2 After transfer, all linen should be treated as infected and the trolley/chair should be wiped down with detergent and water and disinfected with a chlorine releasing disinfectant (Actichlor +).

6.3 VISITS TO THE OTHER DEPARTMENTS

6.3.1 Visits to other departments by patients colonised with MRSA should be kept to a minimum and risk assessed. When visits are essential, prior arrangements should be made with the senior staff of the department concerned. Patients may be seen at any time during the normal working session but should spend the minimum time in the department. They should be sent for when the receiving department is ready and not left in a waiting area with other patients. Equipment used and the number of staff attending the patient should be kept to a safe minimum, and the equipment should be disinfected after use.

6.4 AMBULANCE TRANSPORTATION

6.4.1 The ambulance service should be notified prior to transfer. Further information for the ambulance service should be obtained from Public Health Wales (029 20402478).

6.5 TRANSFERS TO OTHER HOSPITALS

6.5.1 Inter-hospital movements should be kept to the minimum possible. It is the responsibility of the transferring ward to identify the patient as MRSA positive and to highlight it in the patient's notes. Patients that are discharged from high-risk areas should have their status established on discharge. This can either be done by the discharging or receiving hospital by arrangement. There is however no need to delay or prevent discharge while waiting for the results as long as the receiving unit is aware of the current status.

6.6 TRANSFERS TO NURSING/RESIDENTIAL HOMES

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- 6.6.1 Public Health Wales have advised long term community care facilities that they **should** accept MRSA positive patients. Colonisation with MRSA should not delay patient discharge from the hospital.

6.7 DISCHARGE OF PATIENTS

- 6.7.1 The General Practitioner, other health care and relevant social agencies involved in the patient's care should be informed and advised of any on-going decolonisation procedures. Ward staff should inform patients that there is no risk to healthy relatives. Whilst an attempt should be made to decolonise the patient in hospital, it is important to note that continued MRSA carriage does not preclude discharge from hospital. If decolonisation has not been completed during the patient's hospital stay, it should be continued after discharge until the course has been completed.

6.8 DECEASED PATIENTS

- 6.8.1 Inform the mortuary. Precautions taken should be the same as when the patient was alive. Any lesions should be covered with impermeable dressings. Plastic body bags are not necessary.

7. HEALTHCARE PERSONNEL

- 7.1 Routine screening of staff is not recommended but may be considered in an outbreak situation or if transmission continues on a unit despite active control measures.
- 7.2 It must be emphasised that MRSA colonisation poses a little to no risk to healthy individuals. If a staff member does become colonised and shares accommodation with other healthcare workers or other vulnerable individuals (e.g. immunocompromised), they should contact the IPCT for further advice.
- 7.3 Decolonisation of known MRSA positive staff members is attempted to prevent transmission of MRSA to vulnerable patients.
- 7.4 All decolonisation and follow-up screening is undertaken by the Occupational Health Department and not done at ward level. Occupational Health should be informed immediately when a staff member is known to be MRSA positive.
- 7.5 NASAL CARRIAGE

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7.5.1 Nasal carriers should be given 2% Mupirocin (Bactroban Nasal), which is part of the decolonisation pack obtainable via Occupational Health on prescription. If the staff member works in a non-high risk area they can continue to work once treatment has started. If they work in a high-risk area e.g. Critical Care, the IPCT, in conjunction with Occupational Health will review their work status on an individual basis.

7.6 OTHER SITES

7.6.1 The Director of Infection Prevention and Control/Consultant Microbiologist and Occupational Health will review the management of colonisation or infection of other body sites on an individual basis.

8. RESOURCES

8.1 The necessary resources for the management, training, risk assessments, monitoring and auditing for MRSA control are already in place and the implementation of this procedure will not entail additional expenditure.

9. TRAINING

9.1 Mandatory Infection and Prevention and Control training updated every two years.

9.2 Further departmental based training as identified by training needs analysis.

10. IMPLEMENTATION

10.1 The document will be available on the UHB Intranet site and the Infection Prevention and Control clinical portal site. Individual Clinical Boards will be responsible for the implementation of the procedure document in clinical areas.

11. FURTHER INFORMATION

11.1 Revised guidelines for the control of MRSA infection in hospitals were released in 2006 by the joint Working Party of the Hospital Infection Society, British Society for Antimicrobial Chemotherapy, and the Infection Control Nurses Association. The advice given in this procedure takes into account the revised guidance and local circumstances within Cardiff and Vale University Health Board.

12. EQUALITY

12.1 This procedure has had an equality impact assessment and has shown there has been no adverse effect or discrimination made on any particular individual or group

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13. AUDIT

- 13.1 Audit of compliance with the procedure document, will be carried out by the Infection Prevention and Control Department, as part of their procedure audit programme.

14. REVIEW

- 14.1 This procedure will be reviewed every three years or sooner if the national guidelines are updated.

15. REFERENCES

- 15.1 Guidelines for the control and prevention of meticillin-resistant *Staphylococcus aureus* (MRSA) in healthcare facilities by the Joint BSAC/HIS/ICNA Working Party on MRSA. Journal of Hospital Infection 2006; 63S: S1 – S44.
- 15.2 Cardiff and Vale UHB Decontamination of Reusable Medical Devices Procedure (2016).
- 15.3 Cardiff and Vale UHB Hand Decontamination Procedure (2017).
- 15.4 HTM 07-01. Safe Management of Healthcare Waste 2006
- 15.5 Health and Safety at Work etc Act 1974.
- 15.6 Control of Substances Hazardous to Health Regulations 2002, SI 2002 No 2677.
- 15.7 NHS Scotland MRSA Screening Pathfinder Programme (2011), available at: <http://www.hps.scot.nhs.uk/haic/sshaip/mrsascreeningprogramme.aspx>
- 15.8 CMO(4); CNO(2) Letter February 2013: MRSA screening.
- 15.9 DoH England, MRSA Screening Guidance (2014)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/345144/Implementation_of_modified_admission_MRSA_screening_guidance_for_NHS.pdf

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APPENDIX 1

STOP

Contact isolation **KEEP DOOR CLOSED**

unless ward sister/charge nurse instructs otherwise








Instructions for all staff and visitors

Hands must be washed
when entering and before leaving room

↓

Wear orange plastic apron
when entering the room

↓

Wear gloves when risk of contamination
from blood, body fluids or secretions

↓

Wear Goggles/Visor
if there is a risk of splashing from blood or body fluids

↓

PPE disposal:
Dispose of gloves, apron and face protection
into orange labelled waste bin before leaving room.

↓

Wash your hands before leaving room



Bwrdd Iechyd Prifysgol
Caerdydd a'r Fro
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cleanyourhands®
campaign



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Equality & Health Impact Assessment for

MRSA Procedure

Please read the Guidance Notes in Appendix 1 prior to commencing this Assessment

Please note:

- The completed Equality & Health Impact Assessment (EHIA) must be
 - Included as an appendix with the cover report when the strategy, policy, plan, procedure and/or service change is submitted for approval
 - Published on the UHB intranet and internet pages as part of the consultation (if applicable) and once agreed.
- Formal consultation must be undertaken, as required¹
- Appendices 1-3 must be deleted prior to submission for approval

Please answer all questions:-

1	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	INFECTION CONTROL PROCEDURE FOR METICILLIN RESISTANT <i>STAPHYLOCOCCUS AUREUS</i> (MRSA) IN ACUTE HOSPITALS
2	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Corporate Directorate Faye Mortlock CNs for IP&C Extension 25512

¹http://nww.cardiffandvale.wales.nhs.uk/portal/page?_pageid=253,73860407,253_73860411&_dad=portal&_schema=PORTAL

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3	Objectives of strategy/ policy/ plan/ procedure/ service	<p>This procedure describes and demonstrates how and when MRSA screening and decolonisation should be carried out within the clinical environment of C&V UHB.</p> <p>Aims/Objectives: To provide all employees of the UHB with an understanding of what MRSA is and the implications of a positive result on both patients and staff. To ensure all staff are aware of the CRA to be used on admission of all patients and it's use where applicable. To ensure staff fully understand how and when to carry out correct MRSA screening on a patient and the necessary treatment following a positive result.</p>
4	<p>Evidence and background information considered. For example</p> <ul style="list-style-type: none"> • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge 	<p>Cardiff and Vale University Health Board accepts its responsibility under the Health and Safety at Work Act 1974 and the Control of Substances Hazardous to Health Regulations 2002, to take all reasonable precautions to prevent exposure to an infectious disease in patients, staff and other persons working at or using its premises.</p> <p>In order to prevent the possible spread of infection amongst patients and staff it is recognised that the UHB requires procedural documents to ensure effective management of infection.</p> <p>The procedure is supported by the UHB's:</p> <p>PROCEDURE FOR THE PREVENTION, CONTROL & MANAGEMENT OF MULTI DRUG RESISTANT ORGANISMS (MDRO) INCLUDING CARBAPENEMASE RESISTANT ORGANISMS (CRO), METICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA) AND GLYCOPEPTIDE RESISTANT ENTEROCOCCI (GRE) (2018).</p> <p>Please be advised that all the below lists and links are not an exhaustive list of the available evidence and information but provides an indicative summary of the evidence and information applicable to this policy.</p> <p>An internet search was conducted in April 2018 using the following search terms in combination "MRSA", "MRSA Screening", "Procedure", "Policy" and "Equality Impact". The search revealed several equality impact assessments. Examples can be found by following the links below:</p> <p>Tameside Hospital NHS Foundation Trust 'Policy for the Management of MRSA' (2016)</p>

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<ul style="list-style-type: none"> list of stakeholders and how stakeholders have engaged in the development stages comments from those involved in the designing and development stages <p>Population pyramids are available from Public Health Wales Observatory² and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need³.</p>	<p>https://www.tamesidehospital.nhs.uk/documents/MRSAPolicy.pdf</p> <p>Royal Devon and Exeter NHS Foundation Trust 'MRSA Policy' (2017) http://www.rdehospital.nhs.uk/docs/patients/services/infection_control/mrsa-policy.pdf</p> <p>West Hertfordshire NHS Trust 'Trust Policy for MRSA' (2017) http://www.westhertshospitals.nhs.uk/foi_publication_scheme/documents/trust_policies/C198-MRSA_Policy_v2.pdf</p> <p>East Cheshire NHS Trust 'Infection Prevention and Control MRSA Policy' (2016) http://www.eastcheshire.nhs.uk/About-The-Trust/policies/I/IC%20MRSA%20Policy%20ECT2507.pdf</p>
5 Who will be affected by the	This procedure applies to all staff in all locations including those with honorary contracts and students on placement at Cardiff and Vale UHB.

² <http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf>

³ <http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face>

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strategy/ policy/ plan/ procedure/ service	Patients, their visitors and UHB staff will benefit from compliance with the policy in that the risk of transmission of infection will be reduced by ensuring they carry out hand hygiene in the clinical environment where necessary. The UHB will benefit organisationally and financially from reducing the impact and cost of the transmission of infection.
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6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: <ul style="list-style-type: none"> under 18; between 18 and 65; and over 65 	No evidence to suggest that there would be any impact, positive or negative, on any age group.		
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions	No evidence to suggest that there would be any impact, positive or negative, to any person with a disability defined		

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
such as diabetes	in the Equality Act 2010.		
6.3 People of different genders: Consider men, women, people undergoing gender reassignment NB Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	No evidence to suggest that there would be any impact, positive or negative, on either gender group.		
6.4 People who are married or who have a civil partner.	No evidence to suggest that there would be any impact, positive or negative, on anyone who is married/civil partnership.		
6.5 Women who are expecting a baby, who are on a break	No evidence to suggest that		

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	there would be any impact, positive or negative, on anyone is pregnant, had a baby or who are breastfeeding.		
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	No evidence to suggest that there would be any impact, positive or negative, on any different race, nationality, colour, culture or ethnic origin.		
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	No evidence to suggest that there would be any impact, positive or negative, on any religion or belief.		

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.8 People who are attracted to other people of: <ul style="list-style-type: none"> the opposite sex (heterosexual); the same sex (lesbian or gay); both sexes (bisexual) 	No evidence to suggest that there would be any impact, positive or negative, on heterosexuals, lesbian/gay or bisexuals.		
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	The format of this policy is in the English language only.	To consider the UHB procedures bilingually online.	For consideration at the IPCG/UHB.
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are	No evidence to suggest that there would be any impact, positive or negative, depending on		

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
unable to work due to ill-health	their income status.		
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	No evidence to suggest that there would be any impact, positive or negative, depending on where they live.		
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	No evidence to suggest that further groups will be impacted, positively or negatively.		

7. HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	No evidence to suggest that there would be any impact, positive or negative, depending on where they live or experiencing health inequalities.		
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also	No evidence to suggest that there would be any impact, positive or negative, depending on their lifestyles.		

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales	No evidence to suggest that there would be any impact, positive or negative, depending on income or employment status.		
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of	No evidence to suggest that there would be any impact, positive or negative, depending on		

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales	where the use of the physical environment.		
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer	No evidence to suggest that there would be any impact, positive or negative, depending social and community influences on health.		

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities			
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	No evidence to suggest that there would be any impact, positive or negative, depending on macro-economic, environmental and sustainability factors.		

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Please answer question 8.1 following the completion of the EHIA and complete the action plan

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	The MRSA Procedure will ensure that MRSA screening and potential necessary treatment in the clinical area is correctly adhered to. The procedure also supports other infection prevention and control policies and procedures. The positive impact that the procedure will have is to support the aim of the UHB to reduce Healthcare Acquired Infections.
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Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	Limited impact identified.			
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	Limited impact identified so a further EQIA will not be required.			

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	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
<p>8.4 What are the next steps?</p> <p>Some suggestions:-</p> <ul style="list-style-type: none"> Decide whether the strategy, policy, plan, procedure and/or service proposal <ul style="list-style-type: none"> continues unchanged as there are no significant negative impacts adjusts to account for the negative impacts continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) stops. Have your strategy, policy, plan, procedure and/or service proposal approved Publish your report of this impact assessment Monitor and review 	<p>This procedure will be reviewed in 3 years time.</p>			

Appendix 1

Equality & Health Impact Assessment

Developing strategies, policies, plans and services that reflect our Mission of 'Caring for People, Keeping People Well'

Guidance

The University Health Board's (the UHB's) Strategy 'Shaping Our Future Wellbeing' (2015-2025) outlines how we will meet the health and care needs of our population, working with key partner organisations to deliver services that reflect the UHB's values. Our population has varied and diverse needs with some of our communities and population groups requiring additional consideration and support. With this in mind, when developing or reviewing any strategies, policies, plans, procedures or services it will be required that the following issues are explicitly included and addressed from the outset:-

- Equitable access to services
- Service delivery that addresses health inequalities
- Sustainability and how the UHB is meeting the requirements of the Well-being of Future Generations (Wales) Act (2015)⁴

This explicit consideration of the above will apply to strategies (e.g. Shaping Our Future Strategy, Estates Strategy), policies (e.g. catering policies, procurement policies), plans (e.g. Clinical Board operational plans, Diabetes Delivery Plan), procedures (for example Varicella Zoster - chickenpox/shingles - Infection Control Procedure) and services /activity (e.g. developing new clinical services, setting up a weight management service).

Considering and completing the Equality & Health Impact Assessment (EHIA) in parallel with development stages will ensure that all UHB strategies, policies, plans, procedures or services comply with relevant statutory obligations and responsibilities and at the same time takes forward the UHB's Vision, 'a person's chance of leading a healthy life is the same wherever they live and whoever they are'. This process should be proportionate but still provide helpful and robust information to support decision making. Where a more detailed consideration of an issue is required, the EHIA will identify if there is a need for a full impact assessment.

Some key statutory/mandatory requirements that strategies, policies, plans, procedures and services must reflect include:

- All Wales Standards for Communication and Information for People with Sensory Loss (2014)⁵
- Equality Act 2010⁶

⁴ <http://thewaleswewant.co.uk/about/well-being-future-generations-wales-act-2015>

⁵ <http://gov.wales/topics/health/publications/health/guidance/standards/?lang=en>

- Well-being of Future Generations (Wales) Act 2015⁷
- Social Services and Well-being (Wales) Act 2015⁸
- Health Impact Assessment (non statutory but good practice)⁹
- The Human Rights Act 1998¹⁰
- United Nations Convention on the Rights of the Child 1989¹¹
- United Nations Convention on Rights of Persons with Disabilities 2009¹²
- United Nations Principles for Older Persons 1991¹³
- Welsh Health Circular (2015) NHS Wales Infrastructure Investment Guidance¹⁴
- Welsh Government Health & Care Standards 2015¹⁵
- Welsh Language (Wales) Measure 2011¹⁶

This EHIA allows us to meet the requirements of the above as part of an integrated impact assessment method that brings together Equality Impact Assessment (EQIA) and Health Impact Assessment (HIA). A number of statutory /mandatory requirements will need to be included and failure to comply with these requirements, or demonstrate due regard, can expose the UHB to legal challenge or other forms of reproach. This means showing due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation;
- advance equality of opportunity between different groups; and
- foster good relations between different groups.

EQIAs assess whether a proposed policy, procedure, service change or plan will affect people differently on the basis of their 'protected characteristics' (i.e. their age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion, sex or sexual orientation) and if it will affect their human rights. It also takes account of caring responsibilities and Welsh Language issues.

They provide a systematic way of ensuring that legal obligations are met and are a practical means of examining new and existing policies and practices to determine what impact they may have on equality for those affected by the outcomes.

HIAs assess the potential impact of any change or amendment to a policy, service, plan, procedure or programme on the health of the population and on the distribution of those effects within the population, particularly within vulnerable groups. HIAs help identify how people may be affected differently on the basis of where they live and potential impacts on health inequalities and health equity. HIA increases understanding of potential health impacts on those living in the most deprived communities, improves service delivery to

⁶ <https://www.gov.uk/guidance/equality-act-2010-guidance>

⁷ <http://gov.wales/topics/people-and-communities/people/future-generations-act/?lang=en>

⁸ <http://gov.wales/topics/health/socialcare/act/?lang=en>

⁹ <http://www.wales.nhs.uk/sites3/page.cfm?orgid=522&pid=63782>

¹⁰ <https://www.equalityhumanrights.com/en/human-rights/human-rights-act>

¹¹ <http://www.unicef.org/UNICEFs-Work/UN-Convention>

¹² <http://www.un.org/disabilities/convention/conventionfull.shtml>

¹³ <http://www.ohchr.org/EN/ProfessionalInterest/Pages/OlderPersons.aspx>

¹⁴ <http://www.wales.nhs.uk/sites3/Documents/254/WHC-2015-012%20-%20English%20Version.pdf>

¹⁵ <http://gov.wales/topics/health/publications/health/guidance/care-standards/?lang=en>

¹⁶ <http://www.legislation.gov.uk/mwa/2011/1/contents/enacted>

ensure that those with the greatest health needs receive a larger proportion of attention and highlights gaps and barriers in services.

The **EHIA** brings together both impact assessments in to a single tool and helps to assess the impact of the strategy, policy, plan, procedure and/or service. Using the EHIA from the outset and during development stages will help identify those most affected by the proposed revisions or changes and inform plans for engagement and co-production. Engaging with those most affected and co-producing any changes or revisions will result in a set of recommendations to mitigate negative, and enhance positive impacts. Throughout the assessment, 'health' is not restricted to medical conditions but includes the wide range of influences on people's well-being including, but not limited to, experience of discrimination, access to transport, education, housing quality and employment.

Throughout the development of the strategy, policy, plan, procedure or service, in addition to the questions in the EHIA, you are required to remember our values of *care, trust, respect, personal responsibility, integrity and kindness* and to take the Human Rights Act 1998 into account. All NHS organisations have a duty to act compatibly with and to respect, protect and fulfil the rights set out in the Human Rights Act. Further detail on the Act is available in Appendix 2.

Completion of the EHIA should be an iterative process and commenced as soon as you begin to develop a strategy, policy, plan, procedure and/or service proposal and used again as the work progresses to keep informing you of those most affected and to inform mitigating actions. It should be led by the individual responsible for the strategy, policy, plan, procedure and/or service and be completed with relevant others or as part of a facilitated session. Some useful tips are included in Appendix 3.

For further information or if you require support to facilitate a session, please contact Susan Toner, Principal Health Promotion Specialist (susan.toner@wales.nh.uk) or Keithley Wilkinson, Equality Manager (Keithley.wilkinson@wales.nhs.uk)

Based on

- Cardiff Council (2013) Statutory Screening Tool Guidance
- NHS Scotland (2011) Health Inequalities Impact Assessment: An approach to fair and effective policy making. Guidance, tools and templates¹⁷
- Wales Health Impact Assessment Support Unit (2012) Health Impact Assessment: A Practical Guide¹⁸

¹⁷ <http://www.healthscotland.com/uploads/documents/5563-HIIA%20-%20An%20approach%20to%20fair%20and%20effective%20policy%20making.pdf> (accessed 4 January 2016)

¹⁸ <http://www.wales.nhs.uk/sites3/page.cfm?orgid=522&pid=63782> (accessed on 4 January 2016)

Appendix 2 – The Human Rights Act 1998¹⁹

The Act sets out our human rights in a series of 'Articles'. Each Article deals with a different right. These are all taken from the European Convention on Human Rights and are commonly known as 'the Convention Rights':

1. Article 2 Right to life. NHS examples: the protection and promotion of the safety and welfare of patients and staff
2. Article 3 Freedom from torture and inhuman or degrading treatment. NHS examples: issues of dignity and privacy, the protection and promotion of the safety and welfare of patients and staff, the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers, issues of patient restraint and control
3. Article 4 Freedom from slavery and forced labour
4. Article 5 Right to liberty and security. NHS examples: issues of patient choice, control, empowerment and independence, issues of patient restraint and control
5. Article 6 Right to a fair trial
6. Article 7 No punishment without law
7. Article 8 Respect for your private and family life, home and correspondence. NHS examples: issues of dignity and privacy, the protection and promotion of the safety and welfare of patients and staff, the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers, the right of a patient or employee to enjoy their family and/or private life
8. Article 9 Freedom of thought, belief and religion. NHS examples: the protection and promotion of the safety and welfare of patients and staff, the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers
9. Article 10 Freedom of expression. NHS examples: the right to hold and express opinions and to receive and impart information and ideas to others, procedures around whistle-blowing when informing on improper practices of employers where it is a protected disclosure
10. Article 11 Freedom of assembly and association
11. Article 12 Right to marry and start a family
12. Article 14 Protection from discrimination in respect of these rights and freedoms. NHS examples: refusal of medical treatment to an older person
13. solely because of their age, patients presented with health options without the use of an interpreter to meet need, discrimination against UHB staff on the basis of their caring responsibilities at home
14. Protocol 1, Article 1 Right to peaceful enjoyment of your property
15. Protocol 1, Article 2 Right to education
16. Protocol 1, Article 3 Right to participate in free elections
17. Protocol 13, Article 1 Abolition of the death penalty

¹⁹ <https://www.equalityhumanrights.com/en/human-rights/human-rights-act>

Appendix 3

Tips

- Be clear about the policy or decision's rationale, objectives, delivery method and stakeholders.
- Work through the Toolkit early in the design and development stages and make use of it as the work progresses to inform you of those most affected and inform mitigating actions
- Allow adequate time to complete the Equality Health Impact Assessment
- Identify what data you already have and what are the gaps.
- Engage with stakeholders and those most affected early. View them as active partners rather than passive recipients of your services.
- Remember to consider the impact of your decisions on your staff as well as the public.
- Record which organisations and protected characteristic groups you engaged with, when you engaged with them and how you did so (for example, workshop, public meeting, written submission).
- Produce a summary table describing the issues affecting each protected group and what the potential mitigations are.
- Report on positive impacts as well as negative ones.
- Remember what the Equality Act says – how can this policy or decision help foster good relations between different groups?
- Do it with other people! Talk to colleagues, bounce ideas, seek views and opinions.

