The Shrewsbury and Telford Hospital NHS Trust

# Human Resources Policy No. HR48

# Managing MRSA within the Workforce

**Additionally refers to:**

HR01 Equality and Diversity
HR02 Management of Corporate & Local Induction
HR31 Managing Sickness Absence
HR32 Ill Health Retirement

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## 1. POLICY STATEMENT

This policy outlines the role and responsibilities of different staff groups in relation to managing MRSA within the workplace. It outlines the process for dealing with an outbreak of MRSA within the workforce and the screening and treatment of staff who may have become infected with MRSA.

## 2. INTRODUCTION

2.1. As outlined in the attached document (Appendix A) there is an obligation on all NHS Trusts and on individual clinical staff (medical and nursing) to take all necessary and appropriate measures to protect patients from potential harm, in this case from infection from MRSA.

2.2. In seeking to manage and control the outbreak and spread of MRSA, the Trust will require the co-operation of all staff. In doing so the Trust will take care to protect the rights of individuals.

2.3. The Trust recognises the importance of having a proactive heath and safety culture within the hospitals and its responsibility to maintain, as far as is reasonably practicable, a healthy and safe working environment for all staff, patients, visitors and contractors.

2.4. It is anticipated that in the vast majority of cases, treatment will enable MRSA to be cleared and individuals will be able to continue to carry out their work as normal. It is only in **very exceptional cases** that individuals will be unable to fulfil their substantive role.

## 3. SCOPE

3.1. This policy applies to all staff including “bank” staff and those employed on fixed term contracts.

3.2. The policy also applies to individuals employed by agencies and other contractors.

3.3. In implementing this policy, managers must ensure that all staff are treated fairly, equitably and within the provisions and spirit of the Trust’s Equality and Diversity Policy (HR01). Special attention should be paid to ensuring the policy is understood when using it for staff new to the Trust or the NHS, by staff whose literacy or use of English is weak or for persons with little experience of working life.

## 4. GENERAL PRINCIPLES

4.1. As part of the Trust’s strategy to manage risk of infection, effective systems will be put in place to promote high standards of cleanliness and good infection control practices.

4.2. Managers will handle issues for all staff in their area in a positive, supportive, fair and consistent way, taking account of relevant circumstances in each individual case.

4.3. The need for confidentiality will be respected in all cases. Information regarding an individual will be made available only on a need to know basis.

4.4. Staff are required to observe this policy and comply with all reasonable management requests.

4.5. Any individual required to attend a formal management meeting to discuss their health and attendance at work will be entitled to be accompanied by an accredited representative of a Trade Union or Professional Organisation or by a colleague employed by the Trust.

4.6. Any members of staff, particularly those with health conditions such as eczema or psoriasis, who are concerned about caring for patients with MRSA are encouraged to seek advice from the Occupational Health Department, Infection Prevention and Control Team or their GP.

## 5. ORGANISATIONAL APPROACHES

### 5.1. Induction Requirements

- To ensure the safety of patients and service users it is essential that all members of staff that are new to the organisation are inducted locally within each area as soon as possible. Appendix A of the Management of Corporate & Local Induction policy (HR02) contains a New Employee Induction Checklist
- Unless there are exceptional circumstances, the local Induction should be delivered on the first day of employment. The corporate induction should be attended as soon as possible. (See Management of Corporate & Local Induction policy (HR02))
- The new member of staff should have outlined to them their personal responsibilities in relation to Infection Control processes and procedures.

### 5.2. Training Framework

The content for a suitable and appropriate programme of learning should include learning on:

- Communicable Diseases
- Hand Hygiene
- Personal Protective Clothing
- Disposal of hazardous and non hazardous waste
- Spillages of blood and body fluids
- Blood borne viruses
- Safe disposal of sharps
- Management of innoculation injury

## 6. RESPONSIBILITIES

### 6.1. Director of Infection Prevention and Control

It is the responsibility of the Director of Infection Prevention and Control to:

- Promote high standards of hygiene and good practice in infection control
- Ensure that there is training in standards of hygiene, infection control and screening procedures
- Regularly monitor trends
- Determine protocols for screening and treatment programmes
- Identify specific outbreaks and determine strategies for handling them
- Liaise with the Medical Director and Director of Operations to agree action plans to manage outbreaks
- Inform the Executive Team of any outbreaks and of action to be taken to manage the situation
- Make formal requests to staff identified as requiring to be screened in order to manage and control outbreaks of MRSA

- Ensure that screening and treatment programmes are carried out in accordance with appropriate protocols
- Liaise with Occupational Health staff to ensure appropriate screening and treatment programmes are available for staff

### 6.2. Occupational Health

It is the responsibility of the Occupational Health Team to:

- Carry out screening and treatment programmes under the direction of the Director of Infection Prevention and Control and in accordance with appropriate protocols
- Liaise with the Infection Prevention and Control Team on the results of screening tests and appropriate action to be taken
- Notify the individual and the Infection Prevention and Control Team of any positive results
- Notify the appropriate Line Manager if management action is necessary

### 6.3. Medical Director and Director of Operations

It is the responsibility of the Medical Director and the Director of Operations to:

- Support the Director of Infection Prevention and Control in ensuring strategies and action plans to manage and control outbreaks of MRSA are carried out in a timely and efficient manner
- Ensure that all staff comply with this policy

### 6.4. Centre Chiefs and Line Managers

It is the responsibility of Centre Chiefs and Line Managers to:

- Ensure high standards of hygiene and good practice in infection control are promoted and maintained in their area of control
- Ensure that all staff identified as at risk are screened within two working weeks
- Liaise with the Director of Infection Prevention and Control regarding risk assessments for individuals identified as carrying MRSA
- To manage staff in line with policy and procedure
- To regularly audit, in line with local policy, all health care associated infection control processes for the organisation
- To Quality Assure the processes and the practice of their staff to ensure due diligence is being observed
- To notify the Infection Prevention and Control team of any occurrence of notifiable diseases or outbreaks of infection
- To nominate a senior nurse or other responsible person who will take a particular interest in infection control and will act as the infection control liaison for the ward/department

### 6.5. Personal Responsibilities

It is the responsibility of all staff to:

- undertake all learning and development provided to them by their employer and apply this learning to their role
- achieve appropriate qualifications where required
- report all incidents related to the management and control of health care associated infection
- gain an understanding of all policies and procedures, their application and be accountable for their own actions in assisting the reduction of health and social care associated infection

- Ensure high standards of hygiene and good practice in infection control are promoted and maintained in their area of control
- Co-operate with any and all efforts to reduce or eliminate the risk of spread of MRSA
- Participate in any screening programmes initiated by the Director of Infection Prevention and Control

## 7. PROCEDURE

### 7.1. Screening in response to an outbreak of MRSA

7.1.1. Routine screening of staff is NOT recommended practice. The purpose and objective in carrying out screening and treatment programmes is to protect the safety of patients, visitors and staff and as far as possible to eradicate MRSA from the Trust. The co-operation of all staff in achieving this is essential.

7.1.2. A decision to pro-actively manage any outbreak will be taken by the Director of Infection Prevention and Control, in conjunction with the Medical Director and Director of Operations.

7.1.3. If it has been determined by the Director of Infection Prevention and Control that an outbreak of MRSA requires management action, s/he will notify the Executive Team and agree with the Medical Director and the Director of Operations what action is to be taken.

7.1.4. The requirement for staff screening is only indicated if transmission continues on a unit despite active control measures, or if epidemiological aspects of an outbreak are unusual or if they suggest persistent MRSA carriage by staff.

7.1.5. The Director of Infection Prevention and Control will inform the appropriate Clinical Director and/or Line Manager that action is to be taken. They will then provide lists of names of those staff to be screened for the Director of Infection Prevention and Control. The list may include any staff who work in or have regular access/contact with the areas affected.

7.1.6. The appropriate Centre Chief and/or Line Manager will contact each member of staff listed, request that they be screened and make arrangements to ensure that they are screened within two weeks.

7.1.7. The Director of Infection Prevention and Control will write to those staff identified who have not submitted a screen to formally request that they be screened and inform the Centre Chief and/or Line Manager that they have done so.

7.1.8. If an agency worker or contractor is working in an area where an outbreak has been confirmed and screening is required, they will be required to comply with any formal request to be screened. If they refuse to co-operate, their contract will be terminated immediately in accordance with the appropriate agency agreement. If, on being screened, they are found to be colonised with MRSA, the Director of Infection Prevention and Control will determine, based on a risk assessment, whether the individual may continue to work in the role whilst they are being treated, or whether their employment will be terminated immediately in accordance with the appropriate agency agreement.

7.1.9. If any individual fails to comply with a request made by the Director of Infection Prevention and Control the Medical Director or Director of Operations will be informed and they will write to the individual requiring them to be screened and explaining the Trust’s duty of care and explaining the consequences of failing to do so. Consequences may include action taken in accordance with the Trust’s Disciplinary Procedure (HR36).

7.1.10. No further action will be taken until the results of the screening are known.

7.2. **Treatment of those staff identified as carrying MRSA**

7.2.1. The purpose of any screening and treatment programme will be to eradicate infection. The Trust will provide support to any individual requiring treatment.

7.2.2. Staff screening will be carried out in accordance with protocols determined by the Director of Infection Prevention and Control.

7.2.3. If, as a result of screening, a member of staff is found to be carrying MRSA, a programme of treatment will be determined by the Director of Infection Prevention and Control who will inform the Occupational Health Team.

7.2.4. Individuals will be expected to start their programme of treatment immediately

7.2.5. In most circumstances staff can continue to work whilst on treatment. However, where this is considered by the Director of Infection Prevention and Control to present an unacceptable risk to patients, temporary alternative employment may be identified, which should not be unreasonably refused. For medical staff their Job Plan will be modified to temporarily withdraw risk activities. Payment during this period will continue as if the individual were employed and working in their permanent role i.e. without withdrawal of their additional or enhanced payments.

7.2.6. Prescriptions for the programme of treatment will be issued by the Occupational Health Department and dispensed from the Trust's Pharmacy Department free of charge.

7.2.7. If an individual who, having been found to be carrying MRSA, then unreasonably refuses to accept a programme of treatment, they will be dealt with in accordance with Section 7.3 of this policy.

7.2.8. Where an individual persistently fails to respond to treatment and is considered to present an on-going risk to patients, temporary alternative employment or for medical staff modification of their Job Plan may be identified in an attempt to support them whilst efforts are made to eradicate the infection. Any offer of temporary alternative employment should not be unreasonably refused. If MRSA is not eradicated after a reasonable period, the individual will be dealt with in accordance with Section 7.6 of this policy. Payment during this period will continue as if the individual were employed and working in their permanent role i.e. without withdrawal of their additional or enhanced payments.

7.3. **Failure to co-operate with action proposed by management**

7.3.1. If an individual who is required to be screened unreasonably refuses to do so, s/he may be subject to action in accordance with the Trust's Disciplinary Procedure (HR36). During this process s/he may be temporarily redeployed to an alternative post, in order to control the spread of MRSA. Payment during this period will continue as if the individual were employed and working in their permanent role.

7.3.2. Any member of the Medical and Dental workforce unreasonably refusing to co-operate with screening programmes will be reported to the GMC under their Fitness to Practise Procedures and other healthcare registered staff will be reported to their regulatory body.

7.4. **Infection or treatment resulting in sickness absence**

7.4.1. Where an individual falls ill and is prevented from attending work through contracting MRSA or the treatment they receive, they will be managed in accordance with the Trust's Managing Sickness Absence Policy (HR31), with particular account being taken of the reasons for the absence.

7.4.2. It should be noted that **all** such cases **must** be referred to the Medical Director or Chief Executive by the relevant line senior Manager **before** implementing **any** reduction in sick pay. The Medical Director/Chief Executive will look at each case on its merits and consider using discretion to extend the period of paid sickness absence.

7.5. **Temporary Alternative Employment**

7.5.1. If an individual is found to be colonised with MRSA, a risk assessment will be undertaken immediately by the Occupational Health Department in liaison with the Infection Prevention and Control Team to determine the risks associated with them continuing to carry out their normal day to day duties.

7.5.2. If it is considered that an individual cannot carry out their normal day to day duties, the Occupational Health Department will advise their Line Manager who will arrange to meet with them at the earliest opportunity to determine what work could be undertaken without risk and to identify temporary alternative employment. This may be in the immediate work area but not in direct contact with patients or it may be to a different work area. The individual may be accompanied by an accredited Trade Union representative or colleague employed by the Trust at this meeting.

7.5.3. Any offer of temporary alternative employment or for medical staff modification of their Job Plan should not be unreasonably refused. If it is unreasonably refused then action may be taken in accordance with the Trust's Disciplinary Procedure (HR36).

7.5.4. The individual will start working under the alternative arrangements immediately and these arrangements will continue until the individual has been tested clear of MRSA. During this period, they will continue with their existing terms and conditions, although working arrangements such as hours of work may be changed. Payment during this period will continue as if the individual were employed and working in their permanent role i.e. without withdrawal of their additional or enhanced payments.

7.5.5. If no temporary alternative employment can be found or if an individual refuses to work under alternative arrangements during this period, they will be excluded from duty immediately on grounds of ill health until they have been tested clear of MRSA and have returned to work. Payment during this period will continue as if the individual were employed and working in their permanent role i.e. without withdrawal of their additional or enhanced payments. However, section 7.5.3 will apply.

7.5.6. At any meeting to discuss this the individual may be accompanied by an accredited Trade Union representative or colleague employed by the Trust.

7.6. **Permanent Redeployment**

7.6.1. Where an individual fails to respond to the programme of treatment, or where an individual refuses to accept a programme of treatment and where the risks of them continuing in their current role are unacceptable for reasons of patient safety, then the Trust will seek to identify suitable permanent alternative employment. If an individual unreasonably refuses to accept a programme of treatment action may be taken in accordance with the Trust's Disciplinary

Procedure (HR36). Early retirement on the grounds of ill-health may be requested by the individual and will, in these special circumstances, have the full support of the Trust. However, as with all cases of Ill Health Retirement, the final decision will rest with the NHS Pensions Agency (see Human Resources policy HR32 Ill Health retirement).

7.6.2. Only in this last resort of a staff member being a persistent carrier who could not be decolonised and is also shown to be a specific risk to their patients would consideration have to be given to restriction of practice and the possible need for retraining for practice in which carriage did not pose a risk to patients.

7.6.3. Where an individual is retained in employment under such alternative arrangements, he/she will be employed on the terms and conditions applicable to the new role.

## 8. REVIEW PROCESS

8.1. The Human Resources Department is responsible for the monitoring of compliance with this policy and will raise any significant issues arising with the TNCC and LNC.

8.2. In order that this document remains current, any of the appendices to the [policy/ guideline / procedure] can be amended and approved during the lifetime of the document without the document strategy having to return to the ratifying committee.

## 9. EQUALITY IMPACT ASSESSMENT (EQIA)

This policy applies to all employees equally and does not discriminate positively or negatively between protected characteristics.

## 10. PROCESS FOR MONITORING COMPLIANCE

| Aspect of compliance or effectiveness being monitored | Monitoring method | Responsibility for monitoring (job title) | Frequency of monitoring | Group or Committee that will review the findings and monitor completion of any resulting action plan |
|---|---|---|---|---|
| To ensure the consistent and fair treatment of staff with MRSA by following the process for managing an outbreak of MRSA within the workforce. | Review of any known cases and determine compliance with process. | HR Team | Annual Review of Cases | TNCC |

## 11 TRAINING

There is no mandatory training associated with this guidance. If staff have queries about its operation, they should contact their line manager in the first instance

## 12 REFERENCES

http://www.dh.gov.uk/health research on MRSA screening and results

# 13 APPENDICES

**Appendix A**

## SCREENING OF STAFF FOR MRSA CARRIAGE

There is an obligation on NHS Trusts and on individual clinical staff (medical and nursing) to take all necessary and appropriate measures to protect their patients from potential harm, in this case infection with MRSA. The following sequence sets out the circumstances under which it may be necessary and appropriate to screen clinical staff for MRSA carriage and the potential outcomes for individuals.

1. Approximately 30-35% of the general population are carriers of *Staphylococcus aureus;* the figure may be higher in hospital populations (staff and patients). Of these, in the hospital setting, about 10% are likely to be MRSA; i.e. overall 3-5% of hospital staff may be expected to carry MRSA.

2. Many carriers are short-term or intermittent carriers. A few may be long-term carriers.

3. Carriage does not necessarily mean a high risk of transmission to patients if good hand hygiene is observed and no-touch aseptic techniques are applied for clinical procedures.

4. A small proportion of S. *aureus*/MRSA carriers may be heavier ‘shedders’ of the bacteria (e.g. those with skin conditions such as psoriasis and eczema) and these could be associated with greater risk of transmitting infection.

   HOWEVER, in terms of staff screening policies:

5. Routine screening of staff for MRSA carriage is not recommended practice.

6. Screening may be advised by the Infection Prevention and Control Team when there are particular epidemiological features to indicate that a staff member or members may be the source of linked cases of MRSA infection. Examples would include:

   - A cluster of cases over a relatively short period with the same MRSA type/ sub-type following operations by the same surgeon/surgical team.

   - An increased number of cases of MRSA infection of the same type/sub-type in a ward or unit being cared for by a specific team of medical and nursing staff.

7. In most cases, staff found to be carriers (specifically of the particular type/sub-type) can continue their normal duties. Where this is not appropriate, they will be found temporary alternative employment for a short period of decolonisation treatment, i.e. use of antibacterial soap/ shampoo/ shower gel, nasal treatment with, e.g. mupirocin. They would usually have three post-treatment screens to show absence of MRSA before returning to normal duties.

8. This decolonisation regimen eliminates current carriage for most people. Most colonised staff would be clear after treatment. It does not prevent re-colonisation, but that in itself is not a specific risk to patients unless further clusters of linked cases were to occur.

9. Decolonisation is not effective in every case and a small number of staff could be long-term carriers resistant to decolonisation. This would only be significant if they were also

heavy shedders of their MRSA and could be epidemiologically linked to cases of infection in their patients.

10. Only in this last resort of a staff member being a persistent carrier who could not be decolonised and is also shown to be a specific risk to their patients would consideration have to be given to restriction of practice and the possible need for retraining for practice in which carriage did not pose a risk to patients.

It is not known if this final possibility has ever actually happened and the likelihood is very small. Nevertheless, if there are epidemiological and infection control reasons for needing to screen staff members for MRSA carriage as part of the investigation of cases of MRSA infection refusal to participate in screening would be incompatible with the duty of care that doctors and nurses owe to their patients. The situation can be considered to be analogous to that with hepatitis B infection where clinical staff who are found to be potentially infectious carriers are restricted from performing exposure prone procedures and in some circumstances have to undergo retraining for other types of clinical practice.