Guidance on the reporting and monitoring arrangements and post infection review process for MRSA bloodstream infections from April 2013
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# 1. Contents

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2. Executive summary

The purpose of this guidance is to support commissioners and providers of care to deliver zero tolerance on MRSA bloodstream infections, as set out in the planning guidance *Everyone counts: Planning for Patients 2013/14*.

The planning guidance sets out a requirement to institute a Post Infection Review in all cases of MRSA bloodstream infection and the purpose of the review is to identify how a case occurred and to identify actions that will prevent it reoccurring.

The outcome of the Post Infection Review will be to attribute responsibility for MRSA bloodstream infections. It relies on strong partnership working by all organisations involved in the patient’s care pathway, to jointly identify and agree the possible causes of, or factors that contributed to, the patient’s MRSA bloodstream infection.

The guidance also supports the identification, data exchange and reporting of cases of MRSA bloodstream infection to help Clinical Commissioning Groups (CCGs) and healthcare providers conduct the Post Infection Review.
Guidance on the reporting and monitoring arrangements and post infection review process for MRSA bloodstream infections from April 2013

**Status:** Best Practice

**Purpose:** The principal purpose of the Post Infection Review (PIR) guidance is to support commissioners and providers of care to deliver zero tolerance on MRSA bloodstream infections, as set out in the Planning Guidance *Everyone counts: Planning for Patients 2013/14*. The purpose of the PIR is to identify how a case of MRSA bloodstream infection occurred and to identify actions that will prevent it reoccurring.

**Audience:**
- Clinical Commissioning Groups (CCGs)
- Commissioning Support Units (CSUs)
- Providers.
3. Introduction

This guidance facilitates delivery of the NHS Commissioning Board’s zero tolerance MRSA objective set out in the NHSCB Planning Guidance Everyone counts: Planning for Patients 2013/14.

The Government considers it unacceptable for a patient to acquire an MRSA bloodstream infection (MRSA BSI) while receiving care in a healthcare setting. It has set healthcare providers the challenge of demonstrating zero tolerance of MRSA BSI through a combination of good hygienic practice, appropriate use of antibiotics, improved techniques in the care and use of medical devices as well as adherence to best practice guidance.

4. What Clinical Commissioning Groups need to do

For Clinical Commissioning Groups this guidance provides an opportunity to collaborate closely with the organisations involved in providing patient care, to jointly identify and agree the possible causes of, or factors that contributed to, the patient’s MRSA bloodstream infection. Clinical Commissioning Groups will lead the Post Infection Review in the circumstances set out in the illustration below. They will be able to use the results of the Post Infection Review to log the information on the new mandatory healthcare associated infections reporting system. See section 6 for further information.

5. What providers need to do

Providers of healthcare\(^1\) will be expected to follow the approach set out in this guidance on MRSA BSI to deliver the aspiration and ensure the infections become exceptional events (i.e. events that could not have been prevented).

To facilitate this process the Health Protection Agency and Public Health England will be introducing a new Data Capture System (DCS) for recording surveillance data relating to healthcare associated infections (HCAI).

Further details about the new DCS:
http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HCAI/HCAIDataCaptureLaunchNHSWorkshop/

6. Reporting MRSA BSI

Where an MRSA BSI has been identified, it is the responsibility of the organisation from which the sample originated to ensure that the full mandatory data set is recorded on the new DCS (for example, in the case of a GP, the CCG is the responsible organisation and will involve any

\(^1\) For the purposes of the PIR, a “provider” is the legal entity with which commissioners contract and which is registered by CQC to provide certain regulated activities in certain settings.
other provider organisation as necessary)\(^2\). The acute trust hosting the laboratory that processes the sample will usually undertake the actual data entry.

Where the organisation from which the sample originated uses the services of private laboratories, that organisation should ensure the contract requires that the laboratories record the full mandatory dataset on the DCS.

7. The purpose of the Post Infection Review

The approach called "zero tolerance" will involve a Post Infection Review (PIR) for all MRSA bloodstream infection cases from April 2013. The PIR must be undertaken on all MRSA BSI cases using the toolkit at Annex 1 to identify any possible failings in care and to identify the organisation best placed to ensure improvements are made. The toolkit will ensure consistency in approach and improve the quality of data provided. The PIR replaces the current requirement to undertake Root Cause Analysis (RCA). MRSA BSIs RCAs will still be required for other HCAIs (currently MSSA and \(E. \text{ coli}\) BSIs and \(Clostridium \text{ difficile}\) infections).

In view of the small numbers of MRSA bloodstream infections currently reported, it is expected that the number of Post Infection Reviews will be correspondingly small. This will not impose a large burden on any individual organisation.

The PIR will be conducted by a multidisciplinary clinical team that will review the bloodstream infection event and identify the factors that contributed to it.

The PIR process will:

- help identify factors that may have contributed to a MRSA BSI case;
- help to identify any parts of the patient’s care pathway which may have contributed to the infection, in order to prevent a similar occurrence;
- help providers of healthcare and CCGs to identify any areas of non-optimal practice that may have contributed to the MRSA BSI;
- help to identify promptly the lessons learned from the case, thereby improving practice for the future;
- Identify the organisation best placed to ensure that any lessons learnt are acted on.

The PIR process requires strong partnership working by all organisations involved in the patient’s care pathway. This close collaboration will enable organisations to jointly identify and agree both the possible causes and any factors contributing to the patient’s MRSA BSI.

Where an MRSA BSI is identified, the DCS will automatically and provisionally assign an organisation with the responsibility for leading the PIR process. This does not necessarily assume that the organisation was responsible for the BSI, but considers that they are best placed to lead and coordinate the PIR process.

\(^2\) Current guidance on reporting MRSA can be found on the HPA website.
If an MRSA BSI sample was taken from the patient on or after the third day of the admission to an acute trust, (where the day of admission is Day 1), the acute trust will be required to lead the PIR.

For all other MRSA BSI cases, the CCG responsible\(^3\) for the patient will be required to lead the PIR. *This will include in particular any patients not admitted at the time the specimen was taken, for example those in Accident and Emergency or outpatients.)*

8. Illustration

<table>
<thead>
<tr>
<th>If a patient was not an inpatient of an acute trust (for example a GOP or non-acute hospital took the sample):</th>
<th>• PIR to be led by the CCG</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>If the patient was an inpatient in an <strong>acute</strong> trust, and if the sample was taken on:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Day of admission: (Day 1)</td>
<td>PIR to be led by the CCG</td>
</tr>
<tr>
<td>Day of admission: Day +1 (Day 2)</td>
<td>PIR to be led by the CCG</td>
</tr>
<tr>
<td>Day of admission: Day +2 (Day 3)</td>
<td>PIR to be led by acute trust</td>
</tr>
</tbody>
</table>

The schematic diagrams attached at Annex 2 to the guidance explain this in more detail and outline:
- The method of determining who is responsible for carrying out the PIR
- Who is responsible for inputting the PIR data on the DCS.

Additionally:
- The organisation with responsibility for conducting the PIR will automatically be notified as such by the new DCS.
- If an acute trust is leading the PIR the CCG with responsibility for the patient will also be notified that a PIR has been initiated;
- Similarly, if a CCG is leading a PIR for a case where the patient is an inpatient at the reporting trust the trust will also be notified.

Once the lead organisation has been notified by the DCS that they will be coordinating a PIR they will begin to call on the necessary multidisciplinary expertise. This will include, but is not limited to:

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\(^3\) The responsible CCG is the CCG of the GP Practice with which the patient is registered. If the responsible CCG cannot be determined (eg because the patient is not registered with a GP) the case will be assigned based on the CCG where the patient is usually resident, or the CCG containing the reporting trust.
The staff who provided care | Any other organisation recently involved (e.g. in the last two weeks) in the care of the patient;
---|---
Local infection prevention and control (IPC) team | Director of Infection Prevention and Control (DIPC)
The CCG responsible for the patient; | Public Health England (PHE) *(in some circumstances)*

The CCG will also use the DCS PIR information to demonstrate their adherence to good practice to the NHS Commissioning Board with respect to patient safety under the Mandate.

**9. Assigning MRSA BSI cases**

The organisation to which the case is initially assigned (either the acute trust or CCG) will be the lead organisation responsible for completing a PIR within one week of the date of assigning. The outcome of the PIR should establish the organisation to which the BSI should be finally assigned. The final assignment will identify the organisation best placed to ensure that any lessons learned are acted upon. The final assignment must be logged on the DCS within seven days of the initial assigning.

The head of the organisation (e.g. Chief Executive) or a designated nominee will need to record on the DCS the "outcome" of the PIR, that is the set of summary fields and the agreed organisation to which the MRSA BSI will be finally assigned for surveillance purposes.

If the duly assigned organisation is the same as the organisation leading the PIR this will end the process of recording the data on the DCS.

If the duly assigned organisation is different from the organisation leading the PIR, the system will notify the duly assigned organisation and they will need to indicate on the DCS that they agree with the outcome of the PIR.

**10. Involvement of the Director of Public Health (DPH)**

In exceptional cases, where the acute trust or the CCG is unable to determine within one week which organisation should be assigned a case of MRSA BSI, the DPH of the local authority responsible for the CCG of the patient will be informed and is expected to then lead a review panel to assess the evidence presented in the PIR. The DPH can call on the assistance of CCGs, DIPC or equivalent, PHE and others as appropriate.

The DCS will automatically notify the relevant DPH if no final assignment has been made within seven days of the PIR being initiated.
The result of the DPH’s PIR Panel will be reported on the DCS within 14 days of the notification to the DPH, and the outcome discussed with the relevant Trust and CCG. If it emerges that there are some incidents which require reporting to other authorities these should be agreed at the DPH-led panel meeting.

The data from the PIR process will help the DPH assure themselves that the infection prevention and control processes of providers and commissioners within their areas are targeting any systemic weaknesses in infection prevention and control at a local level.

As part of their oversight remit, protecting public health under the new healthcare system, the DPH may wish to conduct regular audits of cases within their local areas, to ensure that the patients are being managed appropriately, that the PIRs are being conducted properly and that all is being done to reduce infections. The data from the PIRs held on the DCS should be used to help to fulfill this function.

In cases where a PIR has not been submitted by the due deadline, the DCS system will inform the DPH of the Local Authority containing the CCG with responsibility for the patient who will decide on the final assigning of the case.

11. Information on the Data Capture System

The outcome summary of the PIR will result in information recorded on the DCS by the local provider, DIPC/equivalent or the DPH, which can then be requested by CQC, CCGs, Monitor, NQB and PHE. If users wish to complete the whole PIR directly onto the DCS, they will be able to do so. Only the recording of the summary information on the DCS will be mandatory.

If the entire PIR is logged on the DCS by the organisation that is responsible for conducting the PIR it can only be viewed by the following:

- The acute trust entering the mandatory dataset, if the patient is an inpatient at that trust.
- The CCG on any input concerning one of their patients.
- The DPH, who can look at all PIRs from all CCGs in their areas.
- PHE systems staff in cases of technical difficulties only (see below).

Details of the PIR information will not be accessible by PHE, except to resolve system queries raised by the inputting organisation. CCGs, LAs and acute trusts will have the same access to PIR summary information that they have to the mandatory data sets for the patients.
12. The Key Points of the PIR process

The PIR process will:
- Enable organisations involved to understand the causes of the MRSA BSI;
- Establish where it happened;
- Establish why it happened;
- Establish what went well with the care given;
- Establish what could be improved;
- Understand the expectations and perspectives of all those involved;
- Generate insight into lessons learned, and
- Lead to greater awareness, changed behaviours and agreed improvements in care.

Successful use of this tool depends on the PIR:
- Being done quickly;
- Being open and honest;
- Being multidisciplinary, all professions and grades contribute as experts in their field;
- Yielding lessons that will be acted on to drive improvements in care,
- Being integrated into governance systems.

Communication with patients:
- When an MRSA BSI is identified, notify the patient (and/or family) promptly of the infection.
- Advise the patient that a PIR will be undertaken to understand why the infection occurred.
- Advise the patient that the DPH in the Local Authority and PHE will be notified of all cases.
- Assure the patient of the confidentiality attributed to the information gathered.
- Ideally share the PIR outcome/summary with the patient/family, as they may aid understanding and discussion of the process.
ANNEX 1: MRSA BLOODSTREAM INFECTION: POST INFECTION REVIEW TOOLKIT
The purpose of this toolkit is to help staff conduct their post infection review in the case of an MRSA bloodstream infection*. Some sections may be more relevant than others, and staff are encouraged to exercise their discretion/clinical judgement in completing the form.

<table>
<thead>
<tr>
<th>Organisation</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Site/Location where the specimen was taken</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Ward/area</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Nature of incident*</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of incident</th>
</tr>
</thead>
</table>

* NOTE: Contaminants should continue to be reported as part of the mandatory reporting on the Data Capture System (DCS). Do not complete the full PIR for cases of contamination where there is clear evidence this is not a true MRSA bacteraemia. In such cases, the PIR process is not appropriate, but separate locally agreed procedures should be used to identify and address any issues that arise from the contamination (for example, if the patient was then subsequently inappropriately prescribed antibiotics). If the contaminated specimen was taken in an acute trust, it must be assigned to that trust. In all other cases, it must be assigned to the Clinical Commissioning Group (CCG). The summary information must be completed indicating an agreed contaminant.
1. Write a brief narrative of the incident, including likely source and any underlying clinical, social or behavioural factors of the patient, patient management, outcome.

INSERT INFORMATION HERE

A. CASE DETAILS

1. DCS Case number/reference*  

1.1 Name of patient (this information can only be accessed locally)

1.2 Date of Birth (DOB)  

1.3 Sex  

SELECT M/F

1.4 Date specimen was taken

1.5 Location where the specimen was taken

---

* This number is a unique case identifier that the DCS gives to every case of MRSA bloodstream infection input.
2. Please supply a ‘timeline’ for patient movement over the last 2 weeks (e.g. admission and discharge dates for inpatient stays, Outpatient or A&E attendances, GP attendances, attendances for dialysis or other therapy.).

INSERT INFORMATION HERE

3. Contact with:

- Nursing/residential care/sheltered housing? If so, for how long?
- Contact with respite care? If so, for how long?
- Continence clinic? If so, for how long?
- Podiatry/leg ulcer/diabetic foot clinic? If so, for how long?
- Other organisation relevant to the case If so, for how long

4. Any medical conditions relevant to this case of MRSA bloodstream infection?

INSERT INFORMATION HERE

5. Other relevant co-morbidities
### 6. Likely outcome from this episode prior to the patient being infected with an MRSA BSI?

**INSERT INFORMATION HERE**

### B. SCREENING FOR INFECTION/COLONISATION

7. For admitted patients, and in line with national MRSA screening guidance and your local protocols, was the patient eligible to be screened for MRSA colonisation prior to, on or during admission?

SELECT YES/NO

8. If so, were they screened?

SELECT YES/NO

9. If yes, and the patient tested positive for MRSA colonisation, was decolonisation prescribed?

SELECT YES/NO

10. Was the recommended decolonisation process followed by the patient?

SELECT YES/NO

11. Please supply relevant screening and decolonisation history.

**INSERT INFORMATION HERE**
12. Was the patient aware of any previous MRSA colonisation/infection?
SELECT YES/NO

13. Could any deficiencies in screening have contributed to the incident?
SELECT YES/NO

C. DEVICES USED IN RELATION TO PATIENT
14. Please list any devices used in a prior period relevant to this case in the events that led to the infection.

<table>
<thead>
<tr>
<th>Device</th>
<th>Date of insertion</th>
<th>Date of removal</th>
<th>In line with local policy, was the device:</th>
</tr>
</thead>
<tbody>
<tr>
<td>INSERT DEVICES USED HERE</td>
<td>DD/MM/YY</td>
<td>DD/MM/YY</td>
<td>Used appropriately? SELECT YES/NO</td>
</tr>
<tr>
<td>DD/MM/YY</td>
<td>DD/MM/YY</td>
<td>Correctly inserted? SELECT YES/NO</td>
<td></td>
</tr>
<tr>
<td>DD/MM/YY</td>
<td>DD/MM/YY</td>
<td>Correctly maintained? SELECT YES/NO</td>
<td></td>
</tr>
<tr>
<td>DD/MM/YY</td>
<td>DD/MM/YY</td>
<td>Correctly removed? SELECT YES/NO</td>
<td></td>
</tr>
<tr>
<td>DD/MM/YY</td>
<td>DD/MM/YY</td>
<td>Correctly removed? SELECT YES/NO</td>
<td></td>
</tr>
</tbody>
</table>

15. Please provide a summary of any deficiencies in device usage that may have contributed to this incident
INSERT INFORMATION HERE

D. ANTIMICROBIAL THERAPY
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>16. During the patient pathway under review, was the patient prescribed any antibiotics?</strong></td>
<td>SELECT YES/NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>16a. If yes, which antibiotics were prescribed?</strong> (you may wish to consider noting details of the prescribers and the dates of the prescriptions)</td>
<td>INSERT ANTIBIOTICS PRESCRIBED</td>
</tr>
<tr>
<td></td>
<td><strong>17. Was the appropriate antibiotic type prescribed?</strong></td>
<td>SELECT YES/NO</td>
</tr>
<tr>
<td></td>
<td><strong>17a. Was the appropriate dosage prescribed?</strong></td>
<td>SELECT YES/NO</td>
</tr>
<tr>
<td></td>
<td><strong>18. If no, could this have been a contributory factor for the MRSA BSI?</strong></td>
<td>SELECT YES/NO</td>
</tr>
</tbody>
</table>
### E. SKIN INTEGRITY

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>19. Did the patient have any breach in skin integrity (e.g. pressure sores/ulcers, leg ulcers, eczema)?</td>
<td>SELECT YES/NO</td>
</tr>
<tr>
<td>19a. If there was a surgical wound, were any of the correct surgical processes not followed using optimal practice?</td>
<td>SELECT YES/NO/N/A</td>
</tr>
<tr>
<td>19b. If a chronic wound, was it appropriately managed?</td>
<td>SELECT YES/NO/N/A</td>
</tr>
<tr>
<td>19c. If a chronic wound, was it colonised with MRSA?</td>
<td>SELECT YES/NO/N/A</td>
</tr>
<tr>
<td>20. Could any deficiencies in the management of skin integrity have contributed to the incident?</td>
<td>SELECT YES/NO</td>
</tr>
</tbody>
</table>
F. RISK FACTORS FOR TRANSMISSION

21. Is there any evidence of new colonisation by MRSA during the period of care that led to the current MRSA BSI?
SELECT YES/NO

22. Was the patient appropriately isolated?
SELECT YES/NO

23. Any other factors that may have contributed to transmission?
INSERT INFORMATION HERE

G. HAND HYGIENE

24. Was there evidence of any deficiencies in hand hygiene compliance in the areas of the pathways of care during this period?
SELECT YES/NO

24a. If “YES”, please provide details.
INSERT INFORMATION HERE

H. OTHER FACTORS

25. Were there any deficiencies in environmental or equipment cleaning during this period, and could these have contributed to this incident?
INSERT INFORMATION HERE

26. Were there any other factors (avoidable or unavoidable) relating to this patient’s overall management that could have contributed to the incident?
SELECT YES/NO
26a. If “YES”, please provide details

INSERT INFORMATION HERE

27. If “YES”, could these have been avoided?

SELECT YES/NO

I. ORGANISATIONAL ISSUES

28. Were staff to patient ratios appropriate or at least in line with local agreement in the areas where this patient was managed prior to the incident?

INSERT INFORMATION HERE

29. Were there any specific issues with staffing capacity during the period prior to this incident?

INSERT INFORMATION HERE

30. Were there any likely deficiencies of training in infection control in the areas covered by the patient pathway of care?

INSERT INFORMATION HERE

J. GOVERNANCE ISSUES

31. Is there evidence from any of the organisations responsible for the patient's care:

- Of formal and informal audits of relevant clinical practice being undertaken and used to drive improvement?
- Of processes in place to check effectiveness of clinical practice controls e.g. additional spot checks, use of safety thermometer, intentional walk rounds by matron/lead nurse/board member?
- That ownership of infection prevention and control is evident in individual staff members, teams and management structures and mandated within their governance structures and processes when undertaking PIR/RCAs/Serious Incidents?
32. Is there evidence of infection control policies for the relevant issues identified and have these been reviewed in accordance with the organisation's requirements?

33. Summary to inform development of action plan for learning outcomes

<table>
<thead>
<tr>
<th>Using the boxes below, please provide summary of factors A to J.</th>
<th>Were any of the factors contributing to the infection identified in this section?</th>
<th>Using the free text boxes below, please state whether the factors that contributed to the infection could have been prevented.</th>
<th>Recommended actions agreed to prevent recurrence.</th>
<th>If examples of sub-optimal practice have been detected, but did not contribute to this infection, please insert details here. Please indication what corrective action is being/has been taken.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agreed contaminant Please insert “Y/N/DK”</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A - Case details</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B – Screening for Infection/colonisation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C – Devices</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D – Antimicrobial therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E - Skin Integrity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F – Risk factors for Transmission</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G – Hand Hygiene</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
H – Other factors
I – Organisational issues
J – Governance

K. STATEMENT OF GOOD PRACTICE

34. Are the patient and appropriate relatives/carers fully aware of this incident?
SELECT YES/NO

35. PLEASE SUMMARISE THE LEARNING OUTCOMES FROM THIS POST INFECTION REVIEW (using the free text box below)

L. AFTER CONDUCTING THE POST INFECTION REVIEW, THIS CASE SHOULD BE FINALLY ASSIGNED

Assigned organisation is (please tick one box):

<table>
<thead>
<tr>
<th>Acute trust</th>
<th>□</th>
<th>No agreement between CCG and trust</th>
<th>□</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG</td>
<td>□</td>
<td>Decision by DPH if Case referred for arbitration (select trust or CCG)</td>
<td>□</td>
</tr>
</tbody>
</table>
Annex 2: Process maps for Post Infection Review
Who inputs the core dataset to the DCS?

Who takes the sample?

- Acute trust (whether inpatient, day case, A&E etc)
- GP (including cases in Nursing Homes, or taken by a nurse responsible to a GP)
- Non-acute hospital trust (eg Mental health trusts, community trusts)

Who processes the sample?

- Sample processed by Acute trust
- Sample processed by GP
- Sample processed by Non-acute hospital trust

Who is responsible for ensuring data is input to DCS?

- Acute Trust taking sample is responsible for ensuring data is input
- CCG taking sample is responsible for ensuring data is input, probably by the acute trust
- Provider taking sample is responsible for ensuring data is input, possibly by the laboratory via contract

Who will actually enter the data on the DCS? (Alternatives)

- Acute Trust taking sample
- Acute Trust processing sample
- Acute Trust processing sample
- Provider taking sample
MRSA BLOODSTREAM INFECTION (BSI): GENERAL REPORTING ARRANGEMENTS FROM 2013

TIMELINE

Day 1

MRSA BSI FIRST DETECTED BY LAB USED BY PROVIDER

POSITIVE MRSA BSI RESULT RECORDED ON DCS BY THE LAB. PROVISIONAL ALLOCATION TO EITHER PROVIDER OR CCG ON THE DCS

POSITIVE SPECIMEN TAKEN ON OR AFTER DAY 3 – PROVISIONALLY ASSIGNED TO PROVIDER ON DCS

POSITIVE SPECIMEN ON DAY 1 OR DAY 2 – PROVISIONALLY ASSIGNED TO CCG ON THE DCS

TRUST TO LEAD PIR WITH CCG AND OTHER ORGANISATIONS AS NECESSARY

IF TRUST HAS HAD NO RECENT CONTACT WITH PATIENT, THEN CCG TO LEAD JOINT PIR WITH TRUST AND PHE

LOCAL PIR UNDERTAKEN BY LEAD ORGANISATION (i.e. PROVIDER OR CCG)

PROVISIONAL ASSIGNMENT IS CONFIRMED: LOG ON DCS

PROVISIONAL ASSIGNMENT IS CHANGED: MODIFY RECORD & LOG ON DCS

NO AGREEMENT ON ASSIGNMENT OF CASE. DPH TO CONVENE REVIEW PANEL AND ADJUDICATE (WITHIN TWO WEEKS). DPH CAN CALL ON TRUST, CCG OR PHE TO ASSIST

THE DPH REVIEW OUTCOME: MRSA BSI SHOULD BE ASSIGNED TO ORIGINAL ORGANISATION

THE DPH REVIEW OUTCOME: MRSA BSI SHOULD NOT BE ASSIGNED TO ORIGINAL ORGANISATION

THE DPH LOGS RESULT ON THE DCS AND GIVES FEEDBACK/LEARNING TO LOCAL ORGANISATION ON CORRECTIVE MEASURES TO PREVENT RECURRENT

AS PART OF GOOD PRACTICE, DPH WILL ALSO BE EXPECTED TO CARRY OUT REGULAR AUDITS/QA OF LOCAL DECISIONS

Within one week

Next day