QUALITY & PATIENT SAFETY AUDIT
FINAL AUDIT REPORT – EXECUTIVE SUMMARY

Audit Title:	Admission and discharge communication between acute hospitals and residential facilities for older persons regarding patients/residents MRSA status		
Audit Number:	QPSA 013/2012		
Audit Timeframe:	July – November 2012		
Audit Requester:	Dr. Fidelma Fitzpatrick, HSE Clinical Lead – Prevention of HCAI and Consultant Microbiologist, Beaumont Hospital & Health Protection Surveillance Centre (HPSC) Dublin		
Audit Team Members:	1) Patricia McNamara (Lead Auditor)		
	2) Denise McArdle		
Audit Sponsor:	Ms. Edwina Dunne – Director of Quality & Patient Safety Audit		
Source of Evidence	**Type**	**Location**	**Date**
	Email Questionnaire	41 Acute Hospitals and 127 Public Residential Facilities for Older Persons	August 2012
	12 Site Visits	See below	August – September 2012
	Audit Tool for Site Visits	Site Visits	August – September 2012
	Review of Healthcare Records	Site Visits	August – September 2012
Date of Issue of Final Report:	15th November 2012		

1. AUDIT BACKGROUND/RATIONALE

Multi-drug resistant organism transmission and infection are among the most important current issues in all healthcare settings, including long-term care facilities for older persons. Although there are many multi-drug resistant organisms that may cause infection in residents of these facilities, methicillin resistant *Staphylococcus aureus* (MRSA), is one of the most prevalent and persistent of these significant pathogens (APIC; MRSA in Long-term care, 2009).

Communication between facilities is essential to provide information about patients being admitted or transferred, so that appropriate arrangements (such as room assignments and cohorting) can be coordinated. It is preferred best practice to notify the receiving facility about a patient known to have MRSA (either colonised or infected) before the patient arrives.

One of the recommendations made by the Health Protection Surveillance Centre (HPSC) in relation to screening is that *'Healthcare facilities should be informed on admission and discharge of recent MRSA screening results, decolonisation treatments received and any requirement for post decolonisation screening'.*

It is reported that an estimated 80 percent of serious medical errors involve miscommunication between

caregivers when patients are transferred or 'handed-off'. When a patient moves from one care setting to another, poor communication can result in patient harm, increased costs, and patient dissatisfaction.

A hand-off process involves "senders," the caregivers transmitting patient information and transitioning care of a patient to the next clinician, and "receivers," the caregivers who accept the patient information and care of the patient. Senders and receivers both have key contributing factors to an effective hand-off.

2. AUDIT OBJECTIVES

The objective is to audit the communication process between healthcare facilities (acute hospitals and residential facilities for older persons' services) regarding patients/residents who have been identified as colonised/infected with MRSA. This communication should include detail of MRSA screening results, decolonisation regimes, etc.

To audit compliance with the:

- National Standards for the Prevention and Control of Healthcare Associated Infections, (HIQA 2009). Standard 5: Communication Management, Criterion 5.1 – 5.5
- National Standards for Safer Better Healthcare, (HIQA, 2012), Theme 2 and Theme 3.

3. SIGNIFICANT FINDINGS

A total of 41 acute hospitals and 127 public residential facilities for older persons were requested to complete a questionnaire designed by the audit team, to capture information on communication of MRSA (HCAI) status and compliance with Standard 5 of the National Standards for PCHCAI. For site visits, the audit team randomly selected one acute hospital in each HSE area along with two residential facilities that admit and discharge patients to and from that acute hospital. Overall, a total of four acute hospitals and eight residential facilities were selected (total site visits = 12) as follows:

HSE Dublin Northeast	HSE Dublin Mid-Leinster	HSE West	HSE South
Mater Misericordia Hospital, Dublin (MMUH)	Naas General Hospital, Naas, Co. Kildare (NGH)	Midwestern Regional Hospital, Limerick (MWRHL)	Kerry General Hospital, Tralee, Co. Kerry (KGH)
St. Clare's Home, Glasnevin, Dublin 9	Maynooth Community Care Unit, Maynooth, Co. Kildare (MCCU)	St. Joseph's Hospital, Ennis, Co. Clare (SJH)	Listowel Community Hospital, Listowel, Co. Kerry
Seanchara Unit, Glasnevin, Dublin 9	St. Vincent's Hospital, Athy, Co. Kildare (SVH)	St. Ita's Hospital, Newcastle West, Co. Limerick (SIH)	St. Columbanus Hospital, Killarney, Co. Kerry

Site visits took place in August and September 2012.

- All twelve sites audited were found to have infection prevention and control (IPC) policy, procedure and guideline documents in place, which include communication of HCAI with service users/relatives/carers. However, a single communication strategy document was evidenced in only one acute hospital site.
- The audit team evidenced educational material for service users in various formats in the reception/admission areas and signage relating to infection prevention and control of HCAI in all twelve sites visited.
- There is documentary evidence of some reporting of incidents, adverse events, near misses, concerns and complaints in relation to HCAI; however anecdotal evidence indicates there are more incidents than are reported. Verbal accounts were given to the audit team of inadequate information on MRSA (HCAI) status being provided at times and/or inadequate communication regarding MRSA status upon patient transfer. However, it was stated at several sites that these occurrences seldom happen and although they are generally not formally reported, staff do make phone calls to clarify the information and then formally document it in the HCR.
- Various patient transfer forms/letters were observed across the 12 sites audited. Some forms had no

spaces for documenting information on HCAI was noted on others.

- The audit team evidenced a range of computer systems which have an alert for HCAI status, across the four acute hospitals audited. The two residential facilities in one HSE area have a network link to the acute hospital system in their area; the other six residential facilities audited do not have a link to the acute hospitals in their respective areas.
- Regional IPC committees have been set up recently. They have an integrated focus between the acute hospital and the residential facilities. The regional IPC committees provide a forum whereby members can communicate about various IPC topics including quality improvement initiatives, effective communication and multidisciplinary and multi-site team working.

A service user perspective on communication of MRSA status was sought by the audit team. The service user interviewed conveyed that communication should occur as early as possible, that it should be repeated over and over again and that it should occur mainly with family member(s) and/or carers while a patient is seriously ill; because from his own experience, he stated, he was not able to process a lot of information at the point in time when he was quite ill. He also felt that more 'monitoring' of hand hygiene for patients, family, carers, staff and visitors alike should be taking place due to the fact that antibiotic-resistant organisms like MRSA are transmitted patient to patient, most often by contaminated hands.

4. RECOMMENDATIONS

Recommendations made by the audit team are as follows. It is also acknowledged that some of the recommendations may have been/or are being addressed at the hospital/facilities audited.

Communication Management

1. A specific '*Communication Strategy'* document must be developed locally, (where one does not exist) encompassing the communication management of transmissible infections.

Education/Training and Auditing

2. Incident management and reporting should be reinforced by management in order to foster a culture of quality and safety and learning from incidents.

3. The audit team recommends that more staff are instructed as 'train the trainer' to carry out hand hygiene compliance audits in each area/ward/department of the hospitals and residential facilities, where needed. It also recommends one area auditing another on a rotating basis to get training requirements up-to-date or to maintain IPC training requirements.

Internal Processes

4. The audit team recommends use of a standardised national infection prevention and control patient transfer form in all acute hospital sites.

5. The audit team recommends formal documentation of: 'infection status was discussed with patient' in the HCR with the inclusion of a date and signature by the medical team.

6. In general, the presence of a specific area for recording HCAI on any newly developed and/or revised admission, discharge and transfer forms should occur, in all sites.

7. The audit team recommends national, regional and local implementation of the *Inter-facility Infection Control Transfer Form* (see Appendix F). This form must be completed by the *accepting facility* prior to a patient transfer. It assists in fostering communication during transitions of care and the tool can be modified and adapted for use in *all* healthcare settings to improve communication about HCAI.

Policies/Procedures/Guidelines

8. Audit of the communication of HCAI section of the local IPC Guidelines should be carried out annually within each region to determine the effectiveness of communication across facilities.

Other communication structures and processes

9. Regional IPC committees should oversee the development of shared IPC documents, as much as possible, in order to facilitate a coordinated and seamless approach to communication in the region.

10. Service users should be included on acute hospital and residential facility IPC committees.

Effective Care and Support

11. The audit team recommends that in order to facilitate optimal information exchange and problem-solving, team members should: use standardised terminology, standardised patterns of communication, concise communication and confirm and cross-check information. The audit team recommends implementing the evidence based SBAR technique which helps team members to accurately share information. SBAR includes:

Situation: What is going on with the patient?

Background: What is the clinical background or context?

Assessment: What do I think the problem is?

Recommendation: What would I do to correct it?

5. CONCLUSION

Having conducted the twelve site visits and spoken with staff, it is clear that communication of MRSA status is being taken seriously in all facilities, whether an acute hospital or a public residential facility for older persons. Most of the acute hospitals and residential facilities do not, however, use a shared, integrated regional patient discharge transfer letter/form which has prompts for healthcare associated infection (HCAI) information.

There is some evidence of a concerted approach to transfer and exchange of information on MRSA status amongst nursing staff and IPC teams. However, while a number of staff have adopted the process of communicating thoroughly with other facilities, full commitment from others seems to be falling short of optimal and in particular from the medical staff.

The overall findings of this audit demonstrate considerable commitment to the further development of communication of MRSA status between facilities and to the continuation and/or enhancement of a number of good practices and initiatives in the acute hospitals and facilities audited. However, there is room for improvement in some areas. With continued development of shared documents with HCAI prompts, used locally, regionally and nationally and commitment from *all* staff, further improvements in communication of MRSA status are foreseeable across *all* hospitals and residential facilities.

6. ACKNOWLEDGEMENT

The audit team wish to acknowledge the cooperation and goodwill afforded them by all persons who participated in this audit and in particular the nominated liaison persons.