



Introduction

Methicillin-resistant Staphylococcus Aureus (MRSA) refers to a group of gram-positive bacteria that are genetically distinct from other strains of Staphylococcus Aureus. MRSA is responsible for several difficult-to-treat infections in humans and is transmitted from person to person by direct contact with the skin, inhaling droplets from coughing, or items touched by someone who has MRSA (for example, sink, bench, bed, and hospital equipment). Great emphasis on hand hygiene compliance has been put in place to curb hospital acquired infection, however our active surveillance of MRSA nosocomial infection rates has not dropped. Ward 44 (Gynaecology) was chosen as the pilot ward as it was one of the designated wards for Ministry of Health's MRSA Surveillance Program.

Objectives

- ❖ Reduce incident of Hospital acquired MRSA infection
- ❖ Reduce risk of cross infection due to non compliance of wiping of BP cuff in between patients
- ❖ Enhance patient safety and staff satisfaction level

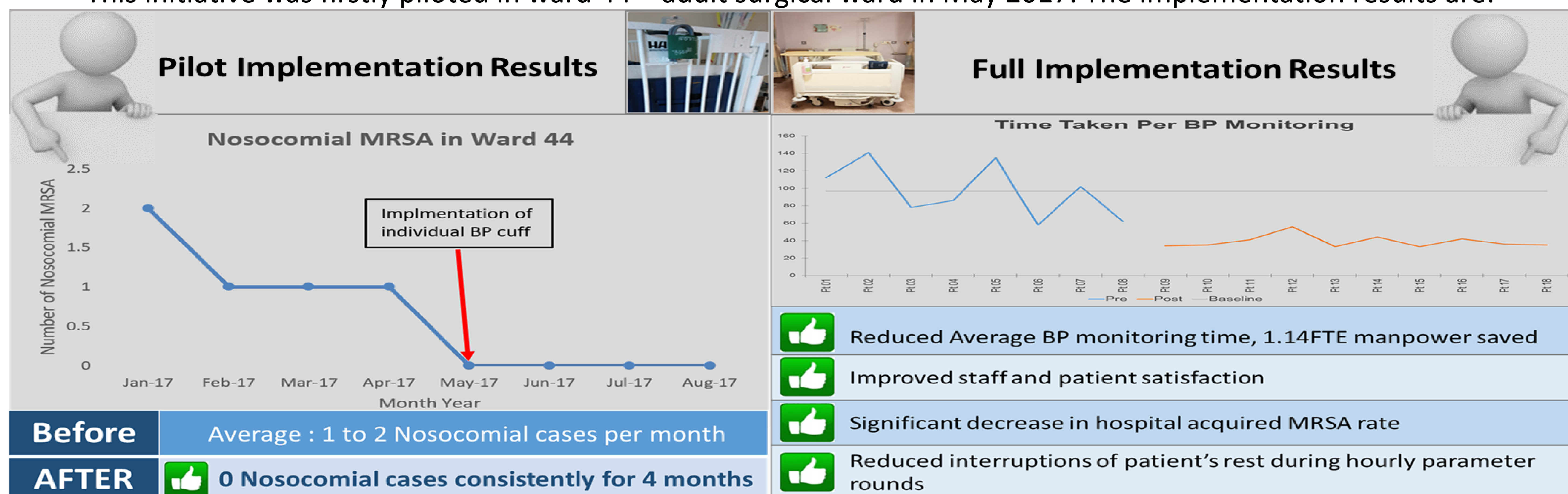
Methodology

The PDCA cycle method was adopted to initiate and implement change for improvement to achieve this project's aims. A pre-assessment was done on existing BP machines, cuffs connectors and BP monitoring processes. The following are the observations and proposed solutions:

BEFORE Implementation - Observations & Proposed Solutions			
Observations		Recommended Solutions	
	Different brand of BP Machine with different hose and connectors		Standardized BP machine with one generic type of connector and hose
	BP cuff shared amongst patients		One cuff for one patient is issued upon patient admission
	Inconsistent wipe down of cuff in between patient due to time factor		BP cuff is being thoroughly wiped down after patient discharge and keep centrally in the ward for next use
	Disturbance of patient sleep when putting on and removing cuff after monitoring		No disturbance of patient's rest as BP cuff can be left on patient's arm till the next monitoring is due

Results

This initiative was firstly piloted in ward 44 – adult surgical ward in May 2017. The implementation results are:



Hospital-Wide Spreadability

We are able to implement "One patient, One cuff" to all inpatient wards in KKH with the exception of a small number of Non-Accidental Injury cases in the Children's Wards where the BP cuff is not attached to the bed for safety reasons.

Conclusion

As a step towards preventing transmission of MRSA, implementing individual BP cuff for all inpatient is imperative. This has shown our commitment not only to provide better care but also target zero harm to our patients.