# Meticillin-Resistant Staphylococcus Aureus (MRSA) Policy

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<tr>
<th>Post holder responsible for Policy</th>
<th>Judy Potter, Lead Nurse and Director of Infection Prevention &amp; Control</th>
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<td>Author of Policy</td>
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<td>Contact details</td>
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Other (please specify): The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance

**Note:** This document has been assessed for any equality, diversity or human rights implications

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Meticillin-Resistant Staphylococcus Aureus (MRSA) Policy

Ratified by: Infection Control & Decontamination Assurance Group: 24th January 2017
Review Date: July 2021

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Associated Policies:
- Antimicrobial Policy
- Antimicrobial Guidelines
- Guideline for the Management of Panton-Valentine Leukocidin (PVL) and other High Risk Staphylococcus aureus Infections in the Hospital Environment
- Guidelines for Terminal Cleaning Coordination
- Incident Reporting Analysing Investigating and Learning Policy
- Standard Infection Control Procedures & Policy (Including Hand Hygiene)
- Linen Services Policy
- Patient Placement & Movement Policy (Infection Control)
- Source Isolation Procedures

In consultation with and date:
- Infection Control Operational Group – 14th November 2016
- Community Professional Leads, Senior Nurses and Matrons: 19th December 2016
- Infection Control & Decontamination Assurance Group: 24th January 2017
- Policy Expert Panel: 1st February 2017

Contact for Review:
- Lead Nurse, Infection Prevention & Control

Executive Lead Signature:
(Only applicable for Strategies & Policies)

Medical Director
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1. INTRODUCTION

1.1 *Staphylococcus aureus* is a bacterium that can be carried, asymptomatically, in the nasopharynx, perineum and skin.

1.2 It can cause a spectrum of illness, ranging from trivial skin infections to life-threatening conditions such as bacteraemia, endocarditis and pneumonia.

1.3 A small proportion of *Staphylococcus aureus* is resistant to meticillin. Meticillin is an antimicrobial agent used in the laboratory to determine sensitivity to flucloxacillin. Hence, Meticillin Resistant *Staphylococcus aureus* (MRSA) is a strain of the bacterium that has developed resistance to flucloxacillin, the usual antibiotic used for treatment of staphylococcal infection, and all other related antibiotics. Other antibiotics that can be used to treat an MRSA infection may be difficult to administer. Additionally, they often have more toxic side effects.

1.4 MRSA is spread from person to person either by direct or indirect contact. In a hospital environment, MRSA is most commonly spread on the hands of healthcare workers. In addition, patients with MRSA are likely to contaminate objects and the hospital environment in their vicinity. Subsequently, this contamination can be transferred to other patients.

1.5 Panton-Valentine Leukocidin (PVL) is a toxin that destroys white blood cells and is excreted by some strains of *Staphylococcus aureus* (SA). This is associated with community strains of both MRSA and MSSA and is characterised by skin infections such as boils and in more severe cases necrotising pneumonitis. It may be necessary in such cases to also treat household contacts. Further information can be found in the Guideline for the Management of Panton-Valentine Leukocidin (PVL) and other High Risk *Staphylococcus aureus* Infections in the Hospital Environment.

1.6 Failure to comply with this policy could result in disciplinary action.

2. PURPOSE

2.1 Provide Royal Devon & Exeter NHS Foundation Trust (hereafter referred to as “the Trust”) staff with the information they need to identify and manage patient/s that are colonised or infected with MRSA, and those who are at high risk of being so.

2.2 Provide staff with the screening process for elective and emergency admissions to hospital.

2.3 Ensure that patients with MRSA have effective and appropriate care wherever that care is delivered.

2.4 Reduce the risk of transmission of infection from MRSA.

3. DEFINITIONS

3.1 **Transient carriage** occurs when MRSA is present on the hands, arms, face or inside the nose for a short period of time, i.e. a few hours. Staff often become transient carriers when caring for patients with MRSA.
3.2 **Colonisation/carriage** with MRSA occurs when it is present on, or in, the body for a significant period of time but causes no ill effects. Patients may be colonised with MRSA, sometimes for several months or years, without it being a problem to them. However, if a colonised patient requires surgery or other invasive procedures, MRSA may be introduced inside the body where it may cause infection.

3.4 **Infection** with MRSA occurs when the presence of MRSA causes clinical consequences, e.g. inflammation, swelling and pus formation. MRSA infection can occur in the skin and soft tissues, lungs, bones and joints or in the blood stream i.e. MRSA bacteraemia.

4. **DUTIES AND RESPONSIBILITIES OF STAFF**

4.1 **Board of Directors**
The Board of Directors, through the Chief Executive and the Medical Director, will delegate to the Joint Directors of Infection Prevention and Control responsibility for supporting and encouraging compliance by:

- Regarding lapses in compliance with this policy as a serious issue
- Supporting education at induction for all staff and appropriate updates for staff involved in direct patient contact
- Ensuring that appropriate facilities are provided for the management of patients with MRSA
- Involving the Infection Prevention and Control Team in the planning process for new construction and refurbishment work so that advice can be given on appropriate isolation facilities as emphasised by “Infection Control in the Built Environment” (NHSE Estates, 2013) and the Health and Social Care Act 2008 - Code of Practice on the prevention and control of infections and related guidance (DH 2015)

4.2 **Divisional Directors, Associate Medical Directors and Assistant Directors of Nursing**

4.2.1 Each divisional management team is responsible for:

- Ensuring that there is process in place for all relevant staff, including junior medical staff, to complete infection control training and annual updates
- Providing facilities and equipment for appropriate placement of patients with MRSA.
- Ensuring that MRSA bacteraemia investigations/post infection reviews happen in a timely manner, involve the relevant clinical staff and any action plans are completed, and reported in accordance with the NHS Commissioning Board (2014) Guidance on the reporting and monitoring arrangements and post infection review process for MRSA bloodstream infections
- Ensure that MRSA surveillance results and post infection review action plans are monitored at Divisional Governance Group meetings as part of the infection control standing agenda item and reported and investigated in accordance with the Incident Reporting, Analysing, Investigating and Learning Policy.
4.3 **Infection Prevention and Control Team (IPCT)**
The IPCT is responsible for:

- Providing advice on appropriate placement of patients with MRSA in hospital
- Producing timely feedback on surveillance of MRSA acquisition for wards/units, directorates and Trust
- Ensuring that patients with first time isolates of MRSA have an Infection Control (IC) alert placed on PAS and on the IT system for the out of hours GP service in Devon
- Ensuring that general practitioners are informed about their patients following identification of MRSA either in pre admission assessment clinics or when the patient has been an in-patient but the results only became available after discharge

- Producing reports to relevant committees and groups and for the Trust Board on MRSA
- Ensuring that all MRSA bacteraemias are reported on the Public Health England (PHE), data capture system.
- Supporting the investigation of and learning from MRSA bacteraemia post infection reviews
- Investigating suspected incidents of cross infection

4.4 **Microbiology Department**
The microbiology laboratory and medical microbiologists are responsible for:

- Ensuring that appropriate tests are available for identification of MRSA
- Ensuring that results are communicated promptly to clinical teams
- Providing timely advice to clinicians regarding appropriate treatment, where relevant
- Monitoring the use of antimicrobial agents within the Trust and feedback on areas for improvement

4.5.2 **Occupational Health Service**
The Occupational Health Service are responsible for:

- Screening staff for MRSA carriage when this is indicated by the IPCT, i.e. in the event of an outbreak where staff may be considered a source of MRSA to patients
- Advising managers on restrictions to work activities if a member of staff is found to be colonised or infected with MRSA
- Prescribing topical decolonisation products for members of staff
- Providing follow up screening on completion of decolonisation treatment

4.6 **Matrons and Other Registered Nurses**
Matrons and other registered nurses are responsible for:

- Ensuring that relevant patients are screened for MRSA on admission or pre admission to hospital
- Ensuring that arrangements are in place to check for an IC alert on PAS/Whiteboard to identify patients with a history of MRSA carriage/infection on admission or pre admission to hospital
- Ensuring the infection control risk assessment is completed on admission to hospital or to community caseload.
- Ensuring that, if no evidence exists to demonstrate three full negative screens following a positive result, that an MRSA care plan is implemented for in-patients
- Ensuring that patients are provided with adequate information, including provision of a relevant information leaflet.
- Initiating, under the relevant Patient Group Directive, the MRSA decolonisation/suppression protocol if appropriate
- Administering prescribed treatment for MRSA infection
- Ensuring that ward bed spaces/rooms vacated and associated equipment used by patients with MRSA are terminally cleaned and disinfected prior to use by another patient.
- Ensuring that MRSA status is communicated at the time of referral to community teams who will care for the patient in their own home.
- Engaging in the investigation of MRSA bacteraemias and learning from root cause analyses events

4.7 **Consultant and Other Medical Staff including GPs**
Consultants and other medical staff are responsible for:

- Prescribing antimicrobial agents prudently
- Complying with Trust Antimicrobial Policy and guidelines taking into consideration MRSA history
- Commencing treatment of patients with MRSA in accordance with this policy or microbiology advice
- Engaging in the investigation of MRSA bacteraemias and learning from root cause analyses events.

4.8 **Site Management Team**
The site management team is responsible for:

- Assisting ward staff to identify single room accommodation for patients with suspected or confirmed MRSA where risk assessment has shown that this is appropriate.

4.9 **Housekeepers and Domestic/Hotel Services**
House keepers and domestic service assistants are responsible for:

- Routinely maintaining a clean environment to reduce level of environmental contamination with MRSA in hospital
- Providing terminal cleaning/disinfection of vacated bed spaces/isolation rooms on discharge/transfer of patients with MRSA using products advised by the Infection Prevention and Control Team

4.10 **All Staff**
All staff have a personal and corporate obligation to comply with best practice in the prevention of infection and comply with this and all other related policies.

4.11 **Infection Control and Decontamination Assurance Group (ICDAG)**
ICDAG is responsible for:

- Ratifying the MRSA policy
- Escalating issues and concerns about MRSA performance to the Safety and Risk Committee
• Reviewing the MRSA policy every five years and making any necessary revisions in light of local surveillance and national evidence based guidance

5. **IDENTIFYING MRSA COLONISATION OR INFECTION**

5.1 **Clinical Isolates**

5.1.1 When any type of infection is suspected it is normal practice to obtain a relevant specimen for microscopy, culture and sensitivity. This may identify MRSA as the infecting organism. Subsequent screening of common carriage sites on the same patient may subsequently identify skin or nasal colonisation.

5.2 **Screening to Identify MRSA Colonisation (Carriage) – hospital attenders**

5.2.1 MRSA colonisation can be identified by screening patients prior to or on admission.

5.2.2 The rationale for screening is to identify MRSA carriers at the earliest opportunity. Identification will trigger the prescription and administration of topical MRSA decolonisation/suppression protocol, inform the selection of appropriate systemic antimicrobial prophylaxis for surgical procedures, inform the selection of appropriate empirical antimicrobial treatment in the event of subsequent sepsis, and inform decision making regarding appropriate patient placement in hospital.

5.2.3 The following patients will be screened for MRSA:

- all patients with a previous history of MRSA should have a full screen carried out on admission, whether they are elective or emergency admissions (refer Appendix 1 Section 1).
- all relevant emergency in-patient admissions as part of the admission process (refer Appendix 1 Section 2).
- elective orthopaedic, gynaecology, and surgical in-patients and orthopaedic day cases as part of the pre-admission process (refer Appendix 1 Section 3).
- regular attenders - i.e. patient attending regularly for programmes of treatment such as dialysis, chemotherapy (refer Appendix 1 Section 4).
- All admissions to community hospitals

5.2.4 Patients in their own homes do not normally require MRSA screening unless requested by the IPCT

6. **TREATMENT**

6.1 **Systemic Antimicrobial Therapy**

If the patient is clinically infected and not simply colonised, the duty medical microbiologist can be consulted for advice on appropriate systemic antibiotic therapy. Patients will also require topical treatment.

6.2 **Topical Treatment of Adults and Children**

6.2.1 Whether colonised or infected, topical treatment should be provided to
patients with MRSA. Eradication of MRSA is often not achieved particularly for the types of patients listed below but topical treatment is still useful to suppress the growth of MRSA and thus, reduce the risk of endogenous infection and the risk of cross infection to others in hospital care settings.

- Patients with long term indwelling devices (for example, urinary catheters and gastrostomy feeding tubes)
- Patients with chronic wounds, such as pressure sores or leg ulcers
- Patients with throat carriage
- Patients who are sputum positive and still expectorating*
- Patients with large or deep unhealed wounds*

*Once sputum production has ceased (or reduced to patient’s norm) or wound has improved, successful decolonisation may be achieved.

6.2.2 For the 5-day decolonisation/ suppression protocol refer Appendix 2.

6.2.3 For decolonisation/suppression protocol for patients with cystic fibrosis or non-CF bronchiectasis refer Appendix 3.

7. **PATIENT INFORMATION**

7.1 It is vital that patients/service users are provided with accurate information about MRSA and what it means for them and their family. Many will have heard about MRSA through the media and may be very worried. Patients/service users should also be given an explanation of how MRSA is transmitted, the rationale for isolation (if applicable) and why there are variations in the control measures required depending on the healthcare setting and level of contact.

7.2 Following the verbal explanation an appropriate leaflet must be offered to the patient/family. Four leaflets are available from the Photographics Department at the Royal Devon and Exeter Hospital:

- A Guide to MRSA (Ref. DG 09 002 001)
- MRSA screening - information for elective patients (Ref. No. DG 09 001 001)
- MRSA screening (emergency admissions) - information for patients (Ref. DG 10 013 001)
- MRSA screening - information for renal patients (Ref DG 09 005 001)

7.3 If the patient/family has further questions that cannot be addressed by the clinical team, the Infection Prevention and Control Team should be contacted.

8. **CONTROL MEASURES**

8.1 It is important to remember that control measures should not compromise usual standards of care and discharge or delay urgent specialist care or clinical investigations (refer Appendix 4).

8.2 **Standard Infection Control Precautions**

Whether the patient with MRSA is an in-patient, out-patient, day case or a patient in their own home strict adherence to standard infection control precautions and aseptic procedures are necessary to reduce the risk of
transmission of MRSA to other patients and to vulnerable body sites on the same patient, in particular:

- Adherence to the ‘5 moments’ for hand hygiene (refer to standard infection control policy & procedures (including hand hygiene)
- Appropriate use of personal protective equipment e.g. gloves and aprons. Gloves must be worn for contact with colonised/infected body sites e.g. wounds, gastrostomy sites. Aprons must be worn to protect clothing when bed making and providing direct patient care.
- Maintaining a clean environment to minimise dust accumulation.
- Decontaminating shared equipment between patient uses.
- Handling used linen carefully to reduce dispersal of skin squames.

8.3 **In-patient wards and in-patient units**
(Also refer flow chart at Appendix 5)

8.3.1 **In addition to standard infection control precautions** for source isolation in a single room may be required. The need depends on a variety of factors including:

- whether affected patients are likely to be heavy shedders of MRSA, e.g. those with burns or infected eczema or multiple wounds
- vulnerability of other patients in the same area to develop infection, e.g. surgical patients may be more vulnerable than general medical patients who, in turn, are more vulnerable than those in rehabilitation settings.
- the patient’s other physical and psychological needs, e.g. the need to mobilise and socialise in a rehabilitation ward or the need for close observation in a high dependency setting, both of which may be hindered by isolation in a single room
- the facilities available for patient isolation

8.3.2 Single room isolation is more important in specialties where acquisition of MRSA is more likely to have serious consequences e.g. surgical specialties (in particular, orthopaedics, vascular surgery, breast surgery, major plastic surgery), ITU, the neonatal unit, Creedy ward (renal).

8.3.3 Single room isolation is also important in wards/units where MRSA colonisation is a less common phenomenon within the patient group, to ensure that it remains so, e.g. neonatal unit, antenatal/postnatal ward, Wynard ward and Bramble Unit.

8.3.4 If source isolation in a single room cannot be provided either because a single room is not available refer Appendix 6 for action required.

8.3.5 If placement in a single room will be detrimental to the safety of the patient then the risk to other patients in the same bay, must be assessed and the risk reassessed when new patients are admitted or the condition of existing patients changes. If the assessment suggests that the risk to others is significant then the need to ‘special’ the MRSA positive patient in a single room must be escalated to senior nursing staff.
8.4 **Routine and Terminal Cleaning – in-patient areas**

8.4.1 It is very important to minimise dust accumulation through frequent and thorough cleaning, whether the patient is nursed in a single room or in an open ward area.

8.4.2 Frequency of routine cleaning may need to be increased, particularly if the patient has an exfoliating skin condition. Isolation rooms and bed spaces in bays must be terminally cleaned on discharge in accordance with the Source Isolation Procedures and/or the terminal cleaning procedure.

8.5 **Theatres, Recovery and Day Surgery Units**

Refer Appendix 7

8.6 **Outpatient Departments**

Refer Appendix 8

8.7 **Physiotherapy/Occupational Therapy**

Refer Appendix 9

9. **MRSA AND STAFF**

Refer Appendix 11

10. **ARCHIVING ARRANGEMENTS**

The original of this policy will remain with the author, Lead Nurse/Director for Infection Prevention and Control. An electronic copy will be maintained on the Trust Intranet (A-P – Policies (Trust-wide) – M - MRSA. Archived copies will be stored on the Trust’s “archived policies” shared drive, and retained indefinitely. A paper copy, where one exists, will be held for 10 years.

11. **PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE POLICY**

11.1 In order to monitor compliance with this policy, the auditable standards will be monitored as follows:

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<td>1.</td>
<td>Compliance with MRSA screening of elective and emergency admissions will be monitored monthly with feedback to Matrons and Divisional Management Teams</td>
<td>Distribution of audit results to Matrons and Divisional Management Team</td>
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<tr>
<td>2.</td>
<td>Antimicrobial prescribing will be audited in accordance with the Antimicrobial Policy</td>
<td>Results of monthly antimicrobial prescribing policy included on Infection Control dashboard</td>
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3. Patients with MRSA will be placed appropriately in single rooms in high risk areas or in a bay in lower risk areas with evidence of risk assessment

| Annual audit of Patient Placement, isolation facilities and infection risk assessment. |

4. Hand hygiene compliance will be above the agreed minimum standard as identified in the Hand Hygiene Policy

| Monthly hand hygiene audit reports included in Ward to Board reports |

5. The environment and patient equipment will be maintained in a hygienic condition

| Cleanliness standard audit results |

11.2 **Frequency**
In each financial year, the Lead Nurse/Director of Infection Prevention and Control will ensure that results of the auditable standards are included in the annual report of the Joint Directors of Infection Control which is presented to the Board of Directors.

11.3 **Undertaken by**
Lead Nurse/Director of Infection Prevention and Control

11.4 **Dissemination of Results**
Results from reporting will be discussed at Infection Control Operational Group meetings, through Divisional Governance Group meetings and escalated to the Infection Control and Decontamination Assurance Group if compliance with the minimum standards not achieved.

11.5 **Recommendations/ Action Plans**
Implementation of the recommendations and action plan will be monitored by the Infection Control and Decontamination Assurance Group, which meets quarterly.

11.6 Any barriers to implementation will be risk-assessed and added to the risk register.

11.7 Any changes in practice needed will be highlighted to Trust staff via the Governance Managers’ cascade system.

12. **REFERENCES**


- **Dept of Health 2008 MRSA Screening - Operational Guidance 2. Gateway reference 10324.**

- **Dept of Health 2008 MRSA Screening - Operational Guidance. Gateway reference 11123.**

- **Dept of Health 2010. MRSA screening Operational guidance 3. gateway reference 13482.**


NHS Commissioning Board (2014) Guidance on the reporting and monitoring arrangements and post infection review process for MRSA bloodstream infections from April 2014

APPENDIX 1: SCREENING PROCEDURES

SCREENING PROCEDURES

1. SCREENING OF PATIENTS WITH MRSA HISTORY (EMERGENCY OR ELECTIVE ADMISSIONS)

1.1 Full Screening Method

1.2 If at any point prior to, on or during admission a patient with a history of MRSA carriage requires screening, make sure that a full screen is obtained.

1.3 Using charcoal swabs, take the following swabs:

- Both anterior nares (use one swab for both nostrils—first moisten the swab with sterile saline)
- Throat
- Perineum (first moisten swab with sterile saline)
- Any wound, ulcer or other area of broken skin/skin lesion (moisten first if lesions are dry)

1.4 In addition, obtain the following specimens:

- CSU - if catheterised
- Sputum - if expectorating

1.5 Make sure that the specimens are labelled with the patient’s details and sent to the laboratory with a completed general pathology request form or make an electronic request on the order communication system (OCS).

N.B. Please indicate in the clinical details section that the patient has a history of MRSA, otherwise perineum swabs will be discarded.

2. SCREENING OF EMERGENCY ADMISSIONS - NO KNOWN HISTORY OF MRSA

2.1 Inclusion Criteria for Emergency Admission Screening

2.2 With a small number of exceptions, all emergency admissions will be screened as part of the admission process. The following sub sets of patients will not usually be screened:

- Children on Bramble Unit*
- Maternity*
- Patients in ED who are ‘admitted for observation’ (AFO)
- Gynaecology patients admitted for scan/similar investigations and then discharged immediately (i.e. those with a ‘zero day’ length of stay)

* If patients in these sub sets have risk factors for MRSA colonisation (refer 2.3) they should be screened on admission.
2.3 **RISK FACTORS FOR MRSA COLONISATION/CARRIAGE**

The following factors make risk of MRSA carriage more likely:

- Past history of MRSA
- Residence in a nursing or care home
- Chronic leg ulcers, pressure sores or other chronic wounds
- Presence of long term indwelling devices e.g. urinary catheter, gastrostomy feeding tube, central line
- Hospitalisation in previous 12 months
- Transfers from another hospital
- Children with special needs who regularly attend residential respite care e.g. children at Honeylands and Meadowpark.

2.4 **Screening Method**

Make sure the specimens are labelled with the patient’s details including location (Community Hospitals should not send as a GP request) and sent to the laboratory with a completed general pathology request form or make an electronic request on the order communication system (OCS). The investigation required is MRSA Screen Emergency Admission

2.4.1 Using charcoal swabs, a screen consists of:

- Both anterior nares (use one swab for both nostrils– first moisten the swab with sterile saline)
- Throat

2.4.2 In addition, if the patient has a chronic wound/skin lesion supplement the nose and throat swabs with a wound swab which will be ordered separately on OCS.

2.4.3 If the patient has been discharged before the results are known, the Infection Prevention and Control Team will communicate positive results (first time isolates) to the GP with a copy of the communication to the patient. For CF patients, the result will be communicated to the Respiratory Physician as this will require specialist follow up.

3. **SCREENING AND MANAGEMENT OF ELECTIVE ADMISSIONS**

3.1 Identification of MRSA carriage, perioperative decolonisation/suppression therapy and appropriate surgical prophylaxis will reduce the risk of MRSA infection for the carrier and reduce the risk of transmission to other patients. There is no intention to demonstrate clearance of MRSA carriage prior to the admission, therefore identification of MRSA carriage will not result in a delay to the admission, unless the consultant responsible for the patient assesses that this is justified clinically.

3.2 **Inclusion Criteria for Pre-admission Elective Admission Screening**

3.2.1 The following patients will usually be screened prior to elective admission:
Appendix 1

- All surgical in-patients
- All orthopaedic day case and in-patients (excluding day case patients for infusions/joint injections)
- All gynaecology in-patients
- All dialysis patients undergoing fistula or graft formation
- Any patient with risk factors for MRSA carriage who will undergo a surgical procedure (refer section 2.2 of this appendix)

3.2.2 These elective patients are referred to as relevant patients in the care pathways below.

3.3 Screening Method

3.3.1 Make sure the swabs are labelled with the patient’s details and sent to the laboratory with a completed Elective Preadmission MRSA screening request form or make an electronic request on the order communication system (OCS).

3.3.2 Screening, for preadmission purposes, consists of:

- Both anterior nares (one swab will do for both – first moisten the swab with sterile saline)
- Throat

In addition, if the patient has a chronic wound/skin lesion supplement the nose and throat swabs with a wound swab which will be ordered separately on OCS.

3.4 Pathway for Relevant Elective Surgical Admissions

3.4.1 Patient is referred to and seen in Outpatients Department

3.4.2 Consultant decides that an elective admission is required and indicates this using the outpatient ‘Outcome Slip’

3.4.3 Outpatient staff will screen the patient if the patient is not going to be seen in a pre operative assessment clinic. If the patient will be seen for pre admission assessment the screen will be undertaken in that clinic. This is recorded in the clinical record.

3.4.4 Patients will be provided with an information leaflet which explains the rationale for screening, the implications of both a ‘positive’ and ‘not detected’ result and the MRSA decolonisation/suppression protocol they will undergo if found to be MRSA positive.

3.4.5 Positive results are returned to relevant Consultant and the Infection Prevention and Control Team (IPCT). The IPCT will enter an infection control alert on PAS which then automatically appears on e-whiteboard in the ‘planned’ column prior to admission and on the in-patient section once admitted.

3.4.6 IPCT will generate a letter to the patient’s GP (cc Consultant, patient and medical records) advising that the GP should arrange for the patient to
receive topical decolonisation/suppression treatment which should commence 2 days prior to planned date of admission and continue for 5 days.

3.4.7 Not detected' results are available from the laboratory system/OCS.

3.4.8 The admitting unit/ward will check the MRSA status on admission and, for all MRSA positive patients, will check that the patient has commenced the decolonisation/suppression protocol.

3.4.9 In the event of a failure to screen prior to admission, screening will take place on admission and consideration given to starting decolonisation/suppression protocol. The decolonisation treatment will be stopped if MRSA is not detected. At least one dose of 2% mupirocin should be provided prior to surgery/invasive procedure.

3.4.10 If MRSA positive patients have not commenced decolonisation prior to admission, a 5 day course will be commenced on admission with at least one dose of 2% mupirocin provided prior to surgery.

3.4.11 Patients identified prior to admission as MRSA positive will receive appropriate systemic antimicrobial prophylaxis, if relevant to their procedure.

4. SCREENING AND MANAGEMENT OF REGULAR ATTENDERS

4.1 Screening Method

Screening consists of:

- Both anterior nares (one swab will do for both – first moisten the swab with sterile saline)
- Throat
- Any wound, ulcer or other area of broken skin/skin lesion

Make sure the swabs are labelled with the patient’s details and sent to the laboratory with a completed Elective Preadmission MRSA screening request form or make an electronic request on the order communication system (OCS).

4.2 Pathway for Oncology Day Case Patients Started on a Programme of Chemotherapy or Supportive Therapies

4.2.1 Preadmission screening will be undertaken in the outpatient setting when the decision to treat has been made. This will be recorded in the clinical record. Patients will be provided with an information leaflet which explains the rationale for screening and the implications of both a ‘positive’ and ‘not detected’ result and the MRSA decolonisation/suppression protocol they will undergo if found to be MRSA positive.

4.2.2 In the event of a positive result the IPCT will enter an infection control alert on PAS which then automatically appears on the e-whiteboard should the patient be admitted as an in-patient.

4.2.3 Cherrybrook staff will check the results of the MRSA screen on OCS or Pathology system on the first day of treatment. If there is no evidence that
the patient has been screened previously, a screen will be undertaken at this stage.

4.2.4 Patients identified as MRSA positive will be provided with decolonisation/suppression products on Cherrybrook (small supplies will be kept on the Unit for this purpose).

4.2.5 All patients receiving ongoing treatment, regardless of the result of the initial screen, will need to be regularly screened over the course of their treatment. The frequency of screening will be approximately monthly but will be determined at a local level to fit in with attendance and treatment programmes. This will be recorded in the clinical record.

4.3 Pathway for Haematology Day Case Patients Receiving Chemotherapy, Blood Transfusion or Other Supportive Therapies

4.3.1 These patients will be screened on the first day of their programme of treatment, in the relevant treatment unit. This will be recorded in the clinical record. Patients will be provided with an information leaflet which explains the rationale for screening and the implications of both a ‘positive’ and ‘not detected’ result and the MRSA decolonisation/suppression protocol they will undergo if found to be MRSA positive.

4.3.2 In the event of a positive result the IPCT will enter an infection control alert on PAS which then automatically appears on the e-whiteboard should the patient be admitted as an in-patient.

4.3.3 Staff will check the results of the MRSA screen on OCS or Pathology system on the subsequent attendance.

4.3.4 Patients identified as MRSA positive will be provided with decolonisation/suppression products on Yarty Day case (small supplies will be kept on the Unit for this purpose).

4.3.5 All patients receiving ongoing treatment, regardless of the result of the initial screen, will need to be regularly screened over the course of their treatment. The frequency of screening will be approximately monthly but will be determined at a local level to fit in with attendance and treatment programmes. This will be recorded in the clinical record.

4.3.6 Patients admitted as day cases to community hospitals for blood transfusions do not require routine screening. Standard precautions should be applied.

4.4 Pathway for Haemodialysis Day Case Patients

4.4.1 These patients will be screened at their first dialysis session. This will be recorded in the clinical record. Patients will be provided with an information leaflet which explains the rationale for screening and the implications of both a ‘positive’ and ‘not detected’ result and the MRSA decolonisation/suppression protocol they will undergo if found to be MRSA positive.

4.4.2 All patients receiving haemodialysis, regardless of the result of their initial screen, will be re-screened on a monthly basis using the special laboratory form designed for this purpose. This will be recorded in the clinical record.
4.4.3 Positive results are returned to the relevant Consultant and the Infection
Control Dept. The IPCT will enter an infection control alert on PAS which
then automatically appears on the e-whiteboard.

4.4.4 Patients identified as MRSA positive will be provided with
decolonisation/suppression products on the unit, when attending for their next
dialysis session.

4.5 Central Venous Catheter Insertion for Dialysis

4.5.1 These patients will be screened on admission but prior to line insertion. This
will be recorded in the clinical record. Patients will be provided with an
information leaflet which explains the rationale for screening and the
implications of both a ‘positive’ and ‘not detected’ result and the MRSA
decolonisation/suppression protocol they will undergo if found to be MRSA
positive.

4.5.2 All patients will receive nasal 2% mupirocin after the screen is obtained and
prior to line insertion.

4.5.3 In the event of a positive result the infection control secretary will enter an
infection control alert on PAS which then automatically appears on the e-
whiteboard should the patient be admitted as an in-patient.

4.5.4 Patients identified as MRSA positive will be provided with decolonisation/
suppression products when they next attend for dialysis.
APPENDIX 2: TOPICAL DECOLONISATION/SUPPRESSION PROTOCOL

1. Protocol for Adults and Children (excluding neonates)

   1.1 Specialist dermatology advice should be sought prior to treating patients with skin disorders, e.g. eczema, psoriasis. For patients with a known chlorhexidine sensitivity, alternative products to 4% chlorhexidine skin cleanser can be prescribed e.g. Octenisan® wash lotion.

   1.2 The 5 day decolonisation/suppression protocol consists of all or some of the following products, depending on colonised sites:

   - **4% Chlorhexidine Skin Cleanser** for bathing/showering/washing for five days (for patients with nasal and/or skin carriage). Use as liquid soap with a disposable wipe. Do not use patient’s flannel. If the patient’s condition allows, also use to wash hair twice during the 5 day period.

   - **Mupirocin 2% (Bactroban) Nasal Ointment** applied to each nostril three times daily (for patients with nasal carriage and/or skin carriage). Apply using a cotton bud or gloved fingertip.

   - **Mupirocin 2% (Bactroban) cream** applied to small superficial wounds three times a day. If wounds are healing despite the presence of MRSA, it will be more harmful to disturb the wound three times a day to apply mupirocin – in which case normal wound care should continue. Bactroban is not appropriate for large or complex wounds.

   1.3 Other wound products can be used that may help suppress MRSA growth e.g.

   - **Dressings containing povidone-iodine** e.g. Inadine or Iodosorb, applied daily to colonised wounds.

   - **Silver dressings e.g.** Acticoat absorbent, Silvercell

   1.4 It is important that the patient’s bed linen and towels are changed each day in hospital following antiseptic bathing/washing/showering and as frequently as possible in patients’ own homes.

   1.5 No more than two attempts will be made to achieve decolonisation in one episode of hospital care. If screens are positive after two attempts at decolonisation, the patient will be considered a chronic carrier.

2. Neonates

2.1 The decision to decolonise will depend on the age and condition of the neonate. Octenisan® may be used for skin cleansing. Chlorhexidine powder (CX Powder) can be applied to umbilicus, buttocks, perineum and flexures at every nappy change. Use of 2% mupirocin may be considered. However, the decision to apply some or all of these products must be made on a case by case basis by the neonatologist.
3. Clearance Screen Following Treatment

3.1 Clearance screening is often not indicated, particularly if the patient has been discharged from hospital. However, if clearance screening is indicated, use the full screening method detailed in Appendix 1 Section 1.1. Three consecutive negative screens need to be obtained before topical treatment can be considered to have been effective. Even if MRSA is not detected on three consecutive screens, the patient may recolonise over a longer period and therefore is always considered a risk for MRSA carriage on subsequent admissions to hospitals.

- **First screen**: Obtain swabs/specimens a minimum of 48 hours after the decolonisation regimen (and any oral/IV antibiotics) has ceased.

- **Second screen**: If 1st screen results are negative then obtain second screen.

- **Third Screen**: If 2nd screen results are negative then obtain third screen.
APPENDIX 3: MRSA PROTOCOL FOR CF & NON-CF BRONCHIECTASIS PATIENTS

1. INTRODUCTION / BACKGROUND

1.1 Cystic fibrosis (CF) patients infected with MRSA have a decreased lung function, and an increased rate of hospitalisation. In addition, MRSA infection is a risk factor for failure to recover lung function after an acute pulmonary exacerbation (Goss et al, 2011).

1.2 There is a strong rationale to attempt MRSA decolonisation in CF/non-CF bronchiectasis patients when first colonised. Those who have a new isolate of MRSA from their sputum should in addition to topical decolonisation, also be offered nebulised vancomycin – both to reduce future morbidity in the individual patient, and to reduce the risk of cross infection.

2. IDENTIFICATION OF MRSA

2.1 Identification of patients will occur from standard screens, and/or a sputum sample sent to Microbiology. Sputum samples must be labelled as CF or non-CF bronchiectasis sputum to ensure complete range of Microscopy Culture & Sensitivity (MC&S)

2.2 On confirmation of a new MRSA isolate, the relevant CF consultant will be informed as communication of the result to the patient requires specialist input and follow up by the CF physician.

2.2 On confirmation of a new MRSA isolate from sputum, a full MRSA screen MUST be performed to determine the presence or absence of nose/throat and/or skin carriage. The screen must include nose, throat, perineum, any wound/ulcer/area of broken skin and any line/drain sites.

2.3 After a full screen has been performed start the FIVE day decolonisation/suppression protocol.

2.4 Topical decolonisation must be used while awaiting results of the full MRSA screen. If, once the full screen has been reported MRSA is only isolated from sputum and not from any other body site then topical decolonisation may stop.

2.5 Although clearance of MRSA is unlikely once chronic colonisation has occurred, whilst in hospital it is worth using topical agents to reduce bacterial load and hence limit spread of infection to other patients/staff.

3 TREATMENT

3.1 Standard decolonisation/suppression protocol should be used for 5 days including:

- **Chlorhexidine 4% skin cleanser**: use to wash (shower or bath) OD
- **Mupirocin 2% nasal ointment**: applied to both nostrils TDS
- **Mupirocin 2% cream**: can be applied TDS to small superficial wounds if present
3.2 If the following inclusion criteria are met, commence nebulised Vancomycin (in addition to topical decolonisation):

- Clinically confirmed CF or CT confirmed diagnosis of non-CF bronchiectasis
- Have isolated MRSA in sputum AND are either MRSA naïve (i.e. have never previously isolated MRSA) OR were MRSA free (i.e. have been MRSA free over the preceding 12 months).

3.2.1 Nebulised Vancomycin

a. The first dose must always be administered in hospital.

b. Respiratory function must be monitored by a suitable trained specialist.
   - **Adults**: Carry out spirometry at baseline, and 15 & 30 minutes post dose.
   - **Paediatrics**: Perform chest auscultation and where possible spirometry (as for adults).

c. In adults and children nebulised vancomycin may be preceded by an inhaled bronchodilator e.g. Salbutamol.

d. Dose:
   - **Paediatrics**: Vancomycin neb 5mg/kg bd – qds (max 250mg qds) for 14 days
   - **Adults**: Vancomycin neb 250mg bd – qds for 14 days
   - **To prepare the dose**: Dissolve Vancomycin 500 mg Powder for solution for infusion in 10 ml of sterile water for injection (to give a solution of vancomycin 50mg/ml). Draw up the required dose (volume can be made up to 5mls with sodium chloride 0.9% if required). Keep the vial in the fridge for second daily dose (discarded if not used within 24 hours).

e. Administer the vancomycin via a ventstream nebuliser over 10 minutes.

f. A mouthpiece is preferable to a mask to maximise pulmonary deposition.

g. Ideally nebulised antibiotics should be taken after physiotherapy to ensure maximum deposition.

h. Monitor for side effects including: severe allergic reaction, cough, wheeze, chest tightness, breathlessness & bronchospasm.

3.2.2 Nebulised vancomycin is not intended for patients who:

- **Do not** have a confirmed diagnosis of CF/non-CF bronchiectasis
- MRSA decolonisation has previously failed (when prescribed & given in accordance with the regimen in sections 2 & 3 above)
- Known to be chronically colonised with MRSA

3.2.3 Contra indications:

- Hypersensitivity to vancomycin
3.3 **Systemic antimicrobial therapy**

3.1 May be indicated for the treatment of infection.

3.2 May be given in conjunction with the decolonisation regime above.

3.3 May be considered to clear persistent carriage in some individuals where eradication is deemed necessary – consult microbiology.

3.4 Review appropriateness of any systemic anti-staphylococcal antibiotics currently prescribed (prophylaxis or treatment) in view of new MRSA isolate from sputum.

4. **RE-SCREENING/SURVEILLANCE**

4.1 Send a full screen (including sputum: request MRSA screen) for MRSA 48 hours after completion of the decolonisation regimen (to assess efficacy of decolonisation).

4.2 If the post-decolonisation MRSA screen is negative, two further screens will be required - one at three and one at six months to establish that MRSA has been successfully eradicated.
APPENDIX 4: MAINTAINING STANDARDS OF CARE

1. CLINICAL INVESTIGATIONS

1.1 Patients can undergo investigations in all departments, provided the department has been informed in advance. It is recommended that patients are dealt with promptly to minimise delay in returning to the ward. Standard infection control precautions should be practised by staff within the department. Equipment should be decontaminated, in accordance with the Decontamination Policy, before use on the next patient.

2. TRANSFERS TO OTHER WARDS

2.1 Patients can be transferred from one ward to another ward or unit, if clinical need dictates. The receiving area must be informed in advance of the MRSA status to ensure that the appropriate facilities are available and the required precautions are applied. Movement for non clinical reasons, e.g. outlying MRSA +ve medical patients to surgical wards to increase bed availability in medicine, should be avoided.

3. MOBILISATION

3.1 If mobilisation is required when a patient is isolated in a single room, the patient can leave the room to allow mobilisation in an area away from the ward, e.g. main corridor. This does not mean that the patient can wander freely around the ward where close contact with other patients is inevitable. The distinction must be explained carefully to patients who may find it confusing.

4. PERSONAL HYGIENE

4.1 If en suite facilities are not available, in-patients may use communal facilities but these must be cleaned thoroughly using a chlorine-containing agent after use. If patients are leaving an isolation room for this purpose, they must be advised this does not mean they can move freely around the ward.

5. SCHOOLING ON BRAMBLE UNIT

5.1 Children may go to the schoolroom as long as they do not have an exfoliating skin condition. Any wounds must be covered with an occlusive dressing as should the wounds of other children. Children with MRSA positive sputum who are expectorating should be managed in the separate area within the schoolroom.

6. PATIENTS’ VISITORS

6.1 It is unnecessary for the patient’s relatives and friends to wear protective clothing when visiting in hospital, or in a patient’s own home, as they do not subsequently deliver care to other patients. As long as the visitors are healthy, MRSA is unlikely to pose a risk to them. However, they should be advised of the importance of hand hygiene.
7. **LAST OFFICES**

7.1 No special precautions are required - follow care of the deceased adult patient’s policy

8. **TRANSPORTING BY AMBULANCE OR CAR**

8.1 Patients with MRSA can be transported in an ambulance with other patients as long as any wounds are covered with an occlusive dressing and the ambulance crew maintains standard infection control precautions.

8.2 Likewise, outpatients can be transported in cars without concern for the driver or subsequent passengers, as long as wounds are covered.

9. **DISCHARGE AND COMMUNITY CARE**

9.1 Whilst treatment of MRSA infection may result in a prolonged hospital stay, the discharge of patients colonised with MRSA should not be delayed.

9.2 MRSA is not a reason for patients to be refused admission to a nursing or residential home. Inform the Infection Prevention and Control Nurse, if difficulties are encountered as a result of a patient’s MRSA status.

9.3 If the decolonisation protocol is to be started/continued at home, it may be necessary to arrange for health or social care input to achieve this effectively.

9.4 MRSA positive patients can be transferred from the ward to communal waiting areas whilst awaiting transport home.

9.5 Health and social care workers providing care in patients own homes should be informed of any infection control risks prior to discharge. Standard infection control procedures are sufficient to prevent transmission in patients own homes and care home settings. Where possible community visits to patients known to be colonised/infected with MRSA should be undertaken at the end of a shift. This is preferred where there is likely to be close clinical contact e.g. infected wounds or personal care in a patient with exfoliating skin.
APPENDIX 5: MANAGEMENT OF AN IN-PATIENT COLONISED OR INFECTED WITH MRSA

MRSA Positive swab/specimen

Acute in-patient - high risk ward/unit: e.g. orthopaedics, vascular surgery, breast surgery, major plastic surgery, neonatal unit, Creedy ward antenatal/postnatal ward, Wynard ward and Bramble Unit, ITU.

Place in a single room with source isolation precautions.

If S/R not available:
- Review existing patients’ need for a S/R and move out if possible.
- Consider a cohort
- Contact Site Management Team re. S/R availability elsewhere.

Acute in-patients – lower risk acute ward/unit i.e. those not listed as high risk:
Preferably, place in a single room (S/R) with isolation precautions.

If S/R not available:
- Review existing patients’ need for a S/R
- Consider a cohort
- Contact Site Management Team re. S/R availability elsewhere.
- If none of the above is an option, prioritise S/R use by assessing risk of cross-infection then manage lowest risk patient in bay. Refer Appendix 6.

Non acute in-patient Area e.g. Rehabilitation and Community Hospital medical wards
Single room isolation not usually necessary unless open wounds, exfoliating skin or expectorating profusely. Avoid bedroom sharing with patients with indwelling devices, or wounds.

If original sample not part of full screen, take full screen.

Commence 5-day topical decolonisation/suppression protocol

Rescreen all sites 48 hours (minimum) after completion of protocol and any systemic antibiotics

Await results

Arrange terminal clean of room/bed space and all equipment

Positive screen: Contact Infection Prevention and Control Team with regard to repeating decolonisation.

Negative result: Allow one week to elapse from previous screen date and then re-screen all sites

When three consecutive negative full screens have been received, discontinue any isolation precautions

MRSA Policy
Ratified by: Infection Control Operational Group: 14th November 2016
Review Date: July 2019
APPENDIX 6: SINGLE ROOM NOT AVAILABLE FOR SOURCE ISOLATION - ACTION REQUIRED

1. If the number of patients to be isolated exceeds the number of single rooms available you should do the following (with the assistance of the Infection Prevention and Control Team, if required):

   - Review the existing patients in single rooms and decide if they need to be there. Move a patient out if possible.
   - If movement is not possible, consider making a cohort of patients with MRSA in a bay or double side-room.
   - If neither of the above is possible, contact the site management team to determine if a single room is available on another ward.
   - If a single room is not available on another ward or it would be detrimental to move the patient to another ward, prioritise who should have a single room by assessing cross infection risks.

 Examples:

   - Transmission of MRSA from a patient with an exfoliating skin condition is extremely likely and therefore a carrier with such a condition takes priority for a single room over others.
   - A patient with MRSA in multiple sites takes priority over a patient with nasal carriage only.
   - Patients who are being decolonised (who do not have an exfoliating skin condition) are less of a risk than those who cannot be decolonised.

2. If a patient with MRSA stays in a bay, assess the vulnerability of the other patients. Move particularly vulnerable patients, e.g. patients with central lines or open wounds, to another bay or at least as far away as possible.

3. Forewarn the patient remaining in the bay that s/he may be moved into a single room if one becomes available.

4. Document decision-making process.
APPENDIX 7: CONTROL MEASURES IN THEATRE, RECOVERY AND DAY SURGERY UNITS

1. THEATRES

1.1 MRSA positive patients requiring surgery will need prophylactic topical decolonisation and, if relevant to the procedure, appropriate systemic antibiotic prophylaxis.

1.2 Theatres must be informed in advance of the patient’s MRSA status.

1.3 To allow for thorough cleaning of surfaces within the operating room it is preferable to put the patient at the end of the list. However, this is only to facilitate cleaning and, if it is more important clinically, that the patient is operated on earlier in the list then clinical need takes priority, but enough time must be allowed prior to the next patient for cleaning.

1.4 Theatre surfaces must be cleaned using a combined detergent and chlorine releasing agent e.g. Chlorclean 1000ppm. There is no need to let the theatre ‘rest’ as an adequate number of air changes will have occurred within 15 minutes of the MRSA +ve patient being removed from the operating theatre. Therefore, once cleaning is complete, the theatre can be used immediately.

1.5 Transporting a patient with MRSA to/from theatres in a wheelchair, trolley or bed is a low risk activity and gloves and aprons are not required. However, hands must be cleaned with alcohol hand rub after such contact.

1.6 It is preferable to avoid taking the bed to theatre, however if this cannot be avoided clean bed linen must be used and the bed frame must be dust free.

2. RECOVERY

2.1 Patients can be nursed in Recovery but the practitioner caring for the patient should not simultaneously attend other patients.

2.2 Gloves and aprons should be worn by the practitioner.

2.3 The trolley and trolley space in recovery must be cleaned thoroughly using a combined detergent and chlorine releasing agent e.g. Chlorclean 1000ppm following the patients return to the ward. There is no need to change curtains unless the patient has remained in recovery for several hours (e.g. an overflow patient when ITU is full) at which point the terminal cleaning procedure for an isolation room should be followed (refer Source Isolation Policy).

3. DAY SURGERY UNITS

3.1 If a single room is available this should be used. If not, the patient can be managed on the main unit, pre and post procedure, with strict adherence to standard precautions, in particular hand hygiene.
APPENDIX 8: CONTROL MEASURES IN OUTPATIENT AND MEDICAL AMBULATORY CARE SETTINGS

1. OUT-PATIENT CLINICS AND MEDICAL AMBULATORY CARE UNITS

1.1 Strict adherence to standard precautions is required. There is no need to remove equipment from the consulting rooms. Surfaces that the patient has had direct contact with e.g. examination couch, treatment chairs should be decontaminated after use, using a combined detergent and chlorine releasing agent e.g. Chlorclean 1000ppm.

1.2 In dressing clinics, wounds should be covered with a dressing whilst waiting in communal areas.

2. DENTAL CLINICS/DENTAL ACCESS CENTRE

2.1 In accordance with the British Dental Association infection control guidance (British Dental Association, 2003), no additional precautions are required.
APPENDIX 9: PHYSIOTHERAPY AND OCCUPATIONAL THERAPY GUIDANCE

Patient known to be MRSA positive

Where does therapy need to take place?
(Room restriction only required if patient has uncovered wounds, exfoliating skin or expectorating profusely)

- Patient’s Room
  - Insignificant or no contact
    - e.g. verbal assessment, breathing exercises
  - Significant contact
    - e.g. chest physiotherapy, any “hands-on” contact
- Therapy Room, Gym, Other areas
  - Insignificant or no contact
    - e.g. walking with supervision, kitchen assessment
  - Significant contact
    - e.g. any hands on contact, transfers etc.

Gloves/aprons not required
Wash hands thoroughly or use alcohol gel/rub

Gloves/aprons to be worn
(Consider wrap-around aprons for dependent stroke patients and chest physio)

Gloves/aprons not required
Wash hands thoroughly or use alcohol gel/rub

Gloves/aprons to be worn
(Consider wrap-around aprons for dependent stroke patients)

N.B. IF KNEELING ON THE BED TO GIVE THERAPY, PLACE CLEAN TOWEL OR CLEAN CONTINENCE PAD ONTO THE SHEET TO AVOID CONTAMINATION OF UNIFORM

In patient’s own homes gloves/aprons are only required if having close contact and patients have uncovered wounds, exfoliating skin or are expectorating profusely. Where possible see the patient at the end of the shift. Wash hands thoroughly or use alcohol gel/rub.
APPENDIX 10: MRSA & STAFF

1. **Staff Screening**

1.1 Staff screening is rarely indicated and will only be initiated by the Infection Prevention and Control Team in conjunction with the Occupational Health Department. When screening is required it must be undertaken at the beginning of a shift to reduce the risk of transient carriage being identified. Swabs will be taken by an Occupational Health Advisor (or in exceptional circumstances by the member of staff’s GP).

1.2 The following sites need to be swabbed:

- Nose
- Throat
- Perineum
- Skin lesions/wounds

1.3 Staff found to be positive on the initial screening should have another full screen undertaken including the sites identified as MRSA positive (to exclude transient carriage).

2. **Exclusion from work**

2.1 **Infected lesions/wounds**

2.2 Staff with MRSA carriage should be examined for infected lesions and, if present, should be removed from duty if working in a high risk area eg. theatres, ITU, neonatal unit, maternity, surgical wards, orthopaedics. In other areas, advice should be sought from the infection prevention and control team.

2.3 **Skin carriage (e.g. colonised skin lesion or perineum)**

2.3.1 Skin carriers should be treated with 4% chlorhexidine gluconate (Hibiscrub) and mupirocin 2% (Bactroban Nasal Ointment) as recommended for patients (refer Appendix 2).

2.3.2 In high risk areas skin carriers should be excluded from work or given alternative duties that do not involve contact with patients until they have been successfully decolonised and have had three consecutive negative screens.

2.3.3 In other clinical areas, staff who are skin carriers can work whilst they undertake the decolonisation protocol unless they have an exfoliating skin condition.

2.4 **Nasal and/or throat carriage only**

Nasal carriers should be treated with mupirocin 2% (Bactroban nasal ointment) and 4% chlorhexidine gluconate (Hibiscrub) as recommended for patients (refer appendix 2).
In high risk areas they should be excluded from work for 48 hours from the start of mupirocin treatment or given alternative duties that do not involve contact with patients.

In other clinical areas, staff carriers can continue working whilst on mupirocin treatment if the strain is susceptible.

2.5 Clearance

Three negative screens taken at weekly intervals will indicate clearance of MRSA. Screens must be obtained by the Occupational Health Nurse or GP, with the agreement of the Occupational Health Department.

Difficulties achieving clearance must be discussed with the Infection Prevention and Control Team/Microbiologist.

2.6 MRSA and Pregnant Staff

There is no reason to exclude pregnant or breast feeding staff from caring for patients with MRSA.
APPENDIX 11: COMMUNICATION PLAN

The following action plan will be enacted once the document has gone live.

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<thead>
<tr>
<th>Staff groups that need to have knowledge of the strategy/policy</th>
<th>All staff</th>
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<td>The key changes if a revised policy/strategy</td>
<td>Adapted to take community services into consideration</td>
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<tr>
<td>The key objectives</td>
<td>The purpose of this policy is to:</td>
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<td></td>
<td>• Provide staff with the information they need to identify and manage patient/s that are colonised or infected with MRSA, and those who are at high risk of being so.</td>
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<td>• Provide staff with the screening process for elective and emergency admissions to hospital.</td>
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<td></td>
<td>• Ensure that patients with MRSA have effective and appropriate care wherever that care is delivered.</td>
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<td></td>
<td>• Reduce the risk of transmission of infection from MRSA.</td>
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<td>How new staff will be made aware of the policy and manager action</td>
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<td>No new issues</td>
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<td>Location of hard / electronic copy of the document etc.</td>
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APPENDIX 12 RAPID IMPACT ASSESSMENT SCREENING FORM

<table>
<thead>
<tr>
<th>Name of document</th>
<th>MRSA Policy</th>
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<tbody>
<tr>
<td>Division/Directorate and service area</td>
<td>Specialist Services, Infection Control</td>
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| Name, job title and contact details of person completing the assessment | Judy Potter  
Lead Nurse/Joint Director for Infection Prevention and Control |
| Date completed: | 28/11/2016 |

The purpose of this tool is to:

- **identify** the equality issues related to a policy, procedure or strategy
- **summarise the work done** during the development of the document to reduce negative impacts or to maximise benefit
- **highlight unresolved issues** with the policy/procedure/strategy which cannot be removed but which will be monitored, and set out how this will be done.

1. **What is the main purpose of this document?**

The purpose of this policy is to:

- Provide staff with the information they need to identify and manage patient/s that are colonised or infected with MRSA, and those who are at high risk of being so.
- Provide staff with the screening process for elective and emergency admissions to hospital.
- Ensure that patients with MRSA have effective and appropriate care wherever that care is delivered.
- Reduce the risk of transmission of infection from MRSA.

2. **Who does it mainly affect?** *(Please insert an “x” as appropriate:)*

   Carers □ Staff X Patients X Other (please specify)

3. **Who might the policy have a ‘differential’ effect on, considering the “protected characteristics” below?** *(By differential we mean, for example that a policy may have a noticeably more positive or negative impact on a particular group e.g. it may be more beneficial for women than for men)*

   Please insert an “x” in the appropriate box (x)
4. Apart from those with protected characteristics, which other groups in society might this document be particularly relevant to… (e.g. those affected by homelessness, bariatric patients, end of life patients, those with carers etc.)?  

N/A

5. Do you think the document meets our human rights obligations?  Yes

Older people are at greater risk of infection than younger adults. Identifying MRSA carriage through screening will reduce risk of MRSA infection

6. Looking back at questions 3, 4 and 5, can you summarise what has been done during the production of this document and your consultation process to support our equality / human rights / inclusion commitments?

The content of this policy is not new but now makes specific reference to community services. Previous discussions with the Equality and Diversity Manager did not identify any issues relating to equality, diversity and inclusion commitments other than a positive impact on older people who are more vulnerable to MRSA infection. The policy has been circulated to all members of the Infection Prevention and Control Team which includes Specialist Nurses and Medical Microbiologists for consultation, including those working in the community setting, and has been considered by the Infection Control Operational Group which includes widespread representation from clinical, managerial and support staff.
7. If you have noted any ‘missed opportunities’, or perhaps noted that there remains some concern about a potentially negative impact please note this below and how this will be monitored/addressed.

<table>
<thead>
<tr>
<th>“Protected characteristic”:</th>
<th>N/A</th>
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<tbody>
<tr>
<td>Issue:</td>
<td></td>
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<tr>
<td>How is this going to be monitored/ addressed in the future:</td>
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<tr>
<td>Group that will be responsible for ensuring this carried out:</td>
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