

Prevention and Management of Methicillin-Resistant Staphylococcus aureus (MRSA)	Clinical Guidelines Register No: 04075 Status: Public
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1. Purpose

- 1.1 To comply with the requirements of the Department of Health guidance (2008 and 2014) regarding screening of patients for Meticillin Resistant *Staphylococcus aureus* (MRSA) on admission.
- 1.2 To identify MRSA positive patients so that the MRSA decolonisation protocol can be administered to reduce the burden of bacteria on their skin and therefore reduce the risk of MRSA bacteraemia
- 1.3 To identify the MRSA status of patients so that appropriate infection prevention precautions can be put in place to prevent person to person spread, minimise environmental contamination and ensure appropriate side room/ward allocation takes place.
- 1.4 To identify the MRSA positive patient so that appropriate prophylactic treatment and/or antibiotic can be given appropriately.
- 1.5 To explain the screening methodology to be used.
- 1.6 To set out the process to be followed when a positive result is identified.
- 1.7 To comply with the Health and Social Care Act 2008. Trusts must have and adhere to policies designed for the individual's care that will help to prevent and control infections.

2. Introduction

- 2.1 *Staphylococcus aureus* is a bacterium known to colonise the nose, throat and skin of almost a third of the population. It has the potential to cause disease, particularly in the vulnerable hospitalised patient where it can cause serious infections such as endocarditis, pneumonia and septicaemia.
- 2.2 MRSA is a particular strain of *Staphylococcus aureus* that has become resistant to penicillins (including Flucloxacillin and Augmentin) and cephalosporins. It is often resistant to other antibiotics, making infections caused by MRSA difficult to treat.
- 2.3 MRSA and Meticillin sensitive *Staphylococcus aureus* (MSSA) cause the same range of infections, but due to antibiotic resistance, infections caused by MRSA are more difficult to treat.
- 2.4 The main route of MRSA transmission in healthcare settings is via contaminated hands of healthcare workers. Inadequately decontaminated shared equipment is also a significant mode of transmission. MRSA may also be transmitted via the airborne route on shed skin squames but this only presents a significant risk if the patient has an excessive exfoliating skin condition (e.g. eczema or psoriasis).
- 2.5 MRSA remains endemic in many UK hospitals. Specific guidelines for control and prevention are justified because MRSA causes serious illness and results in significant additional healthcare costs

2.6 In 2008 it became mandatory for all admissions (with some exclusions) to be screened for MRSA. In 2014, Department of Health Guidance has relaxed with recommendations for patients in high risk areas to be screened. The trust has considered both approaches and this policy describes the screening of all admissions as previously, but widening the exclusion zone, depending on the risk posed to the individual and to others.

3. Scope

3.1 This guidance applies to all healthcare staff employed by the Trust on a substantive and temporary basis.

3.2 This guidance applies to all patients who fall into the high risk group. (See Section 6)

4. Equality and Diversity

4.1 The Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

5. Responsibilities

5.1 Chief Executive

- The Chief Executive has overall responsibility for ensuring that the Trust has the necessary management systems in place to enable the effective implementation of this policy and overall responsibility for the health and safety of staff, patients and visitors

5.2 Chief Nurse

- The Chief Nurse has strategic responsibility for ensuring systems are in place to facilitate nursing staff awareness of this Policy, and to ensure appropriate support is given to enable staff in delivering practice as outlined in this guidance.

5.3 Chief Medical Director

- The Chief Nurse has strategic responsibility for ensuring systems are in place to facilitate nursing staff awareness of this Policy, and to ensure appropriate support is given to enable staff in delivering practice as outlined in this guidance.

5.4 Director of Infection Prevention and Control (DIPC)

- The DIPC will have operational responsibility for the effective implementation of this Policy
- The DIPC will give expert advice to medical teams when required to advise on treatment for patients who are MRSA positive
- The DIPC will liaise with GPs when required to advise on treatment for patients who are MRSA positive

5.5 Infection Prevention and Control Team (IPT)

- Will ensure all staff are made aware of this Policy (see section 28)
- Will inform clinical staff of positive results and advise on the precautions and decolonisation protocol required
- Will inform the Consultant and the pre-assessment nurse for the relevant clinic in the case of pre-elective positive results. The patient and their GP will also be informed so that treatment can be arranged prior to admission.
- Where the positive result is obtained after discharge, the IPT will arrange for the result and covering letter to be sent to the patient's GP with the appropriate patient information leaflets (Appendix 1 and 2).
- Will update PAS with new MRSA cases
- To support medical and nursing staff in explaining the result to the patient if required
- Will update Extramed bed management system with positive MRSA results where the patient is still an inpatient

5.6 Microbiology staff

- Process all screening samples
- Ensure that the results of microbiology samples are uploaded onto MEHT Review in a timely manner

5.7 Clinical Operating Managers

- Ensure appropriate ward allocation of emergency admissions. Trauma orthopaedic cases are not to be admitted to John Ray Ward
- Comply with Bed Management Policy

5.7 Heads of Nursing

- Ensure systems are in place whereby all relevant elective and emergency cases are screened in a timely manner and followed up appropriately

5.8 Pre assessments clinics

- Comply with this guideline
- Gain verbal consent for screening, inform the patient why screening is required and how to follow up their results and what to expect if a screening result is positive. This information is summarised in the patient information leaflet in Appendix 2
- Provide information on how to use the Octenisan body wash (Appendix 1)

5.9 **Waiting list departments**

- Send out the patient information leaflet in Appendix 3 with each admission letter
- Check screening results if patients are brought in at short notice so that correct ward allocation takes place. Patients with unknown screen results must not be allocated to John Ray Ward

5.10 **Hotel Services Manager**

- Organises and manages any additional cleaning requirements requested by the IPT

5.11 **All staff**

- Comply with this policy and ensure that all elective and emergency admissions are screened prior to or on admission (see sections 6 and 7) and Extramed is updated
- Check the MRSA status of a patient due to be admitted to ensure appropriate management of the patient
- Ensure appropriate precautions are taken to manage high risk patients and those with positive results
- Liaise with the IPT if advice and support is needed to explain the need for screening or a positive result to a patient and treatment required
- Ensure that infection prevention is embedded into their everyday practice and applied consistently at all times
- Ensure that high risk MRSA patients are put on the MRSA Care Pathway (see high risk group in section 6 and care pathway in Appendix 4) and are admitted into a side room where appropriate. Refer to Isolation Policy to assist with risk assessment required to assist with allocation of side rooms. Liaise with the Infection Prevention Team if advice required regarding side room allocation.

5.12 **Occupational Health Department**

- Is responsible for the screening of staff members identified by the IPT for MRSA screening
- Follow the same protocol as identified in section 9 for taking nose / groin swabs from staff members
- Undertakes counselling of staff members found to be MRSA positive.

6. MRSA High Risk Group

6.1 The following are the MRSA high risk group that is most likely to be already colonised or infected when admitted to hospital. Patients in this group need to be identified and managed according to section 11.

- Known to be MRSA positive
- Identified as being MRSA positive in the past
- From a nursing home/residential home
- Has been a patient in any hospital in last 6 months
- Any healthcare worker – community or acute setting
- Patient has been transferred from hospital abroad
- Immuno-compromised patients – Long term steroid use
- Diabetic patients
- Renal dialysis patients
- Patient with long term invasive device e.g. urinary catheter
- Patient with chronic skin breaks, to include pressure sores
- Patient with dermatological condition including cellulitis
- Detainee admitted from any prison
- If partner/spouse known to be MRSA
- If carer of person known to be MRSA
- Patient being admitted for insertion or reinsertion of a PEG tube

7. MRSA Screening

7.1 Patients admitted to hospital either electively or as an emergency must be screened for MRSA. Exceptions to this can be seen below.

7.2 Basic screening specimens for MRSA are nose and groin / perineum swabs.

7.2.1 If the patient has an indwelling device such as a long term urethral catheter a catheter specimen of urine should be obtained. The sites of other invasive devices (e.g. Hickman line, percutaneous endoscopic gastrostomy (PEG) tube) should also be swabbed.

7.2.2 Any skin breaks should be swabbed using a blue-topped microbiology swab.

7.2.3 If the patient has a productive cough a sputum sample should be obtained.

7.3 Patients being admitted for **elective surgery**;

- Should be screened in the 13 weeks prior to admission up to and including day of admission if required
- A checklist for assessment of patients pre admission can be seen in Appendix 5
- Certain elective patients do not require screening unless they fit in the high risk group (see 6.1). These are;
 - Children

- Day case dental
 - Day case endoscopy
 - Maternity except for elective caesarean cases
 - Minor dermatological procedures (any none surgical dermatological procedure) – more invasive surgery requires local assessment to determine if screening is required
 - Day case ophthalmic patients - **cataract surgery only** (see Appendix 10)
- In cases where the MRSA screen has been taken > 13 weeks prior to admission, arrangements should be made to rescreen the patient
 - If a patient returns as an elective admission for a further procedure, even if within the 13 week time frame, they must be rescreened because of a recent hospital admission.
 - Day cases to the Chemotherapy Unit are screened on the first visit, not on successive visits unless preceded by a hospital admission
 - Where elective patients are screened in a satellite clinic and the result is known, but has not been processed by the laboratory at MEHT, the patient must be screened again on day of admission for screening compliance purposes.
 - Patients attending the Pain Clinic do not require MRSA screening unless admitted to the ward

7.4 Patients admitted as an **emergency**;

- Screening is required at the point of the decision to admit unless included in the exclusion criteria (below)
- Patients who have had an MRSA screen taken for any reason in the 10 days preceding an emergency admission (e.g. by a GP or in the Emergency Department, but not admitted) will not need to be screened again.
- Evidence of screening must be documented in the nursing records and where applicable recorded on Extramed
- Some emergency admissions **do not** require screening unless in the high risk group or being admitted to a high risk area e.g. burns ward:
 - Emergency transfers from other hospitals where it is **known** that the patient is MRSA positive
 - Children (from birth to 16 years)
 - Maternity
 - Mental health/learning disabilities
- Patients admitted to the Ambulatory care unit or Emergency Assessment Unit whilst awaiting review of test results and discharged within 6 hours do not need to be screened

- Severely ill patients who are admitted and transferred to other healthcare centres or who die soon after admission will not be included in the screening criteria. This includes;
 - Patients admitted to General ITU and being transferred to an alternative healthcare facility or dying within 6 hours
 - Patients admitted to Burns ITU and being transferred to an alternative healthcare facility or dying within 24 hours
- Other patients may be considered for exclusion from the screening criteria. An assessment of the risk to the patient and risk of spread to other must be undertaken and the exclusion agreed with the Infection Prevention Group.

7.5 Patients who screen negative on admission but are in hospital for more than three weeks should be screened every three weeks.

8. Consent

8.1 The reason for MRSA screening must be explained to the patient by the pre-assessment nurse or the member of staff caring for the patient.

8.2 Verbal consent should be obtained for screening.

8.3 If a patient refuses to be screened, the possible consequences of this must be explained to the patient by nurse caring for the patient or the pre-operative assessment nurse. In the case of pre-elective patients who refuse to be screened, the nurse must inform the medical team so that this can be documented on the consent form. Any patient refusing to be screened cannot be admitted to the John Ray Ward.

8.4 If a patient lacks the mental capacity to consent to screening, refer to the Mental Health Capacity Act 2005 policy. This states a mental capacity assessment must be carried out and a decision in the best interests of the patient must be made.

8.5 Where children are being screened, parental consent must be obtained.

9. Swabs and specimens required for MRSA screening

9.1 Appendix 6 sets out the screening protocol and which swabs to use.

9.2 *Staphylococcus aureus* including MRSA, is usually found in the anterior nares (nose) and perineum (groin).



This is the anterior nares. Put swab 0.5 – 1cm into the front of each nostril, not to the sides. There is no need to introduce the swab further into the nose. 1 swab for both nostrils

9.3 Two swabs are required to carry out a basic MRSA screen;

- A blue topped swab should be used to screen the nose. Moisten the swab in the transport medium before sampling both nostrils.
- A separate individually wrapped swab should be used for the groins or perineum. Generally this swab does not need to be moistened.
- Both swabs must be placed in the same swab container after sampling. Ensure the buds of the swabs are in the transport gel before breaking off the end of the individual swab so that it fits in the container. Breaking the stick with your hands will not contaminate the swab.

9.4 The renal and orthopaedic units require both *Staph aureus* (MSSA) and MRSA screen. The same specimen can be used, and it is essential to click on the MSSA screen tab as the MSSA screen is mutually inclusive of MRSA. (MSSA screen will identify if the patient has MRSA)

9.5 Localised decisions to take *Staph aureus* screens may be made e.g. for vascular surgery.

9.6 In the Neonatal Unit, babies admitted require a nasal *Staph aureus* screen and an ear and umbilical swab for MC&S using blue top swabs. This is repeated every seven days throughout their admission.

10. The procedure for screening and the follow-up of results

10.1 The flow chart in Appendix 8 sets out the procedure for screening all inpatients and the follow up of these patients' results.

10.2 In order to follow up patients who have been identified as MRSA positive prior to an elective procedure, the flowchart in Appendix 11 should be followed (i.e. notifying the patient, G.P., pre-assessment nurses and the Patient Access (Admission/Waiting list) department).

10.3 A negative result will be available the next working day. A positive result will normally be available in three working days.

11. Management of high risk patients admitted as an emergency

11.1 The following should occur:

- Screen
- Isolate if necessary based on a risk assessment – refer to the isolation policy. If patient has shedding skin or a productive cough they should be isolated (liaise with IPT for advice)
- Commence MRSA care pathway and explain to the patient the need to wash daily with Octenisan (explain how to use Octenisan – refer to leaflet in Appendix 3). Ensure the Octenisan bottle is clearly labelled with the patient's name. This is a single patient use product.

- Medical team to consider MRSA as the cause of infection if antibiotics are required
- Review indwelling devices daily and remove as soon as no longer clinically indicated

12. Management of patients with a positive screen result

- 12.1 The IPT will inform the ward and medical team of a positive result, advise on 10 day decolonisation protocol (Appendix 7) and update Extramed and the Patient Administration System (PAS).
- 12.2 The patient should be isolated if not already in a side room and the MRSA care pathway maintained (or commenced if not identified as high risk initially).
- 12.3 Nursing/medical staff caring for the patient should explain the result and the decolonisation protocol using the Trust's MRSA information leaflet in Appendix 9, found on the Intranet under Infection Prevention / Patient Information Leaflets. The IPT will also assist with this if requested.
- 12.4 If the patient was in a bay prior to the result, ensure other patients in the bay are using Octenisan body wash daily and document this on the negative MRSA care pathway found on the Intranet under Infection Prevention, Commonly Used Forms. Explain to these patients why the above is required.
- 12.5 The IPT will request a terminal clean of that bay once the patient is isolated. This must be recorded on Extramed when complete.
- 12.6 The medical team will review any current antibiotics in view of the MRSA positive result and will liaise with microbiologist if advice is required.
- 12.7 The medical team will also prescribe the decolonisation protocol.
- 12.8 Clinical staff will ensure that the need for indwelling devices is reviewed daily and ensure that they are removed as soon as no longer clinically indicated.
- 12.9 The condition of the patient's skin must be reviewed regularly. Intact skin will reduce the patient's risk of an MRSA infection/bacteraemia.
- 12.10 If patient has dry skin use a moisturiser. If patient has broken skin/wounds, seek advice from the Tissue Viability Team.
- 12.11 If patient has been discharged before the result is known the result will be forwarded to their GP with the covering letter and advice sheets.
- 12.12 Re-screening is not usually performed following treatment, but the patient should be re-screened if admitted or due to be admitted to hospital. Previously MRSA positive individuals should be isolated on admission and commenced on the MRSA care pathway.

13. MRSA decolonisation protocol / antibiotic treatment

- 13.1 Decolonisation refers to the elimination of MRSA through the use of topical antibacterial applications.

13.2 The following decolonisation protocol to be commenced on receiving a positive MRSA result:

- Nasal Mupirocin 2% (Bactroban) ointment three times a day for ten days. Apply the cream to the anterior nares (see 9.2) and gently pinch the sides of the nose together after application to ensure an even distribution of the ointment
- The patient should continue on Octenisan washes until discharge or until wounds have healed following discharge (see Appendix 1 or 3 for the correct use of Octenisan)
- Medical staff to liaise with Duty Consultant Microbiologist if antibiotic treatment needs to be instigated or current treatment needs reviewing

14. Prophylaxis for Invasive Procedures/Surgery

14.1 Patients who are known to be colonised with MRSA, or who are a high risk patient and their status is not currently known, must receive intravenous Teicoplanin 400mg IV on induction.

15. Treatment of Mupirocin-resistant strains

15.1 Mupirocin can be replaced with Naseptin cream to be applied to the anterior nares four times a day for ten days. However, this contains peanut oil so must not be used on individuals with a nut allergy.

15.2 Polyfax ointment is another alternative if Naseptin is unsuitable. This should be applied to the anterior nares three times a day for ten days

16. Treatment of MRSA Infection

16.1 If MRSA infection is suspected, advice on antibiotic treatment should be sought from the Duty Consultant Microbiologist.

17. Preventing the Spread

17.1 Standard infection prevention precautions such as hand hygiene, appropriate use of personal protective equipment (PPE), environmental cleaning and restriction of antibiotics, have been shown to be effective in preventing transmission.

17.2 Hand Hygiene

- Hand hygiene is a simple and effective infection prevention and control intervention. Hand washing with soap and water is effective; however alcohol hand rubs are a quick and accessible alternative when hands are not visibly soiled and are very effective at killing MRSA when used correctly. Improving hand hygiene compliance will significantly reduce the risk of healthcare associated infection.
- It is vital to perform hand hygiene before and after each patient contact

regardless of glove usage and other protective measures

- Hands must be cleansed with alcohol hand rub immediately after leaving the isolation room
- Visitors should be instructed to decontaminate their hands on entry and when leaving the isolation room

17.3 Isolation

- The decision to isolate a patient should be based on the infection risk and routes of transmission should be considered. The risk assessment tool in the isolation policy should be used to assist with prioritisation of side room allocation. Liaise with the Infection Prevention Team for advice. This assessment must be documented in the nursing notes.
- Isolate the patient preferably in a single room, ideally with en-suite facilities according to the isolation policy. If a toilet is not available a commode must be designated for the sole use of that patient. It must be thoroughly cleaned after each use. A standard isolation poster must be placed on the outer door of the single room. This can be found in the isolation policy and on the Intranet under Infection Prevention, Posters.
- Minimum supplies of stock items to be kept in all rooms. **Any remaining items which cannot be decontaminated are to be disposed of when patients are discharged.**
- If more than one patient is infected colonised, these may be cohort nursed in a bay provided they are in an area which can be contained e.g. doors can be shut. Dedicated nursing staff are essential if cohort nursing is to be undertaken as detailed in the isolation policy.

17.4 Personal protective equipment (PPE)

- Disposable aprons should be used by all staff having 'hands on' care of the isolated patient, thereby having direct contact with the patient or with their immediate surroundings (bed, chair etc)
- Disposable gloves and apron should be worn where there is contact with bodily fluids and when handling contaminated items e.g. dressings
- Visitors only need to wear PPE (gloves and apron) when appropriate i.e. when carrying out 'hands on' care such as bed bathing or toileting
- For standard isolation, protective clothing is not required if entry to the room merely involves delivering meals, drugs or simply talking to the patient. However, hand hygiene must be undertaken on entry and exit of the room.
- Prior to exit from the room, aprons and gloves must be removed and placed in a clinical waste bin followed by thorough hand decontamination. Alcohol hand rub must be applied after leaving the room.

17.5 Disposal of faeces/urine

Excreta can be disposed of directly into the toilet adjoining the room. If no toilet is available, a designated commode should be used. Refer to the isolation policy for the correct procedure on how to dispose of bedpan contents.

17.6 Disposal of clinical waste

Orange clinical waste bags should be used to dispose of any waste generated within an isolation room.

17.7 Cutlery/crockery

Machine dish wash on ward or in central kitchen as normal.

17.8 Medical equipment

- Reusable equipment should ideally be designated to the patient for the admission episode, and cleaned and disinfected on discharge. If unable to designate the equipment for the sole use of the patient, then it must be appropriately decontaminated prior to use by others. See the trust's decontamination policy.
- The manufacturers' instructions must be followed when using and decontaminating medical equipment.

17.9 Room cleaning

Rooms must be cleaned daily, paying special attention to dust-collecting areas and horizontal surfaces according to the Cleaning Policy and Isolation Policy.

17.10 Linen

- Change bed linen daily
- Use a red water-soluble bag then put into the laundry's white bag (refer to the Isolation Policy and Linen policy for the correct procedure).

17.11 Clothing

Change night clothes daily after wash.

17.12 Relatives and visitors

- Patients should be informed that there is no risk to healthy relatives including children or others outside the hospital
- Visitors must not have contact with other patients in the ward or hospital. If visiting more than one patient, they must visit the isolated patient last.
- Visitors need only wear protective clothing if they are going to be involved in 'hands on' care as above

- Visitors should be instructed to decontaminate their hands on entry and leaving the room

18. Mobilisation

- 18.1 Patients colonised or infected with MRSA can leave the isolation room to allow mobilisation along hospital corridors, preferably following daily decolonisation treatment.

19. Transporting Patients to Other Departments

- 19.1 It is preferable that patients are moved as little as possible but if clinical need dictates, this will have priority and the move(s) may take place.
- 19.2 Before transferring a patient with MRSA: inform IPT, bathe and wash hair with Octenisan put on clean clothing and transfer to a bed with clean linen.
- 19.3 The receiving department should be notified in advance so that appropriate facilities are available and the necessary precautions are applied. If patient is a heavy disperser then they need to be seen at the end of a list/session, following which a deep clean is required.
- 19.4 Ward staff should advise of any necessary precautions. The same precautions taken on the ward should be carried out in the department.
- 19.5 In order to minimise contact and reduce the risk of cross-infection, isolated patients should be taken directly to and from other departments and not left in waiting areas.
- 19.6 Porters do not need to wear protective clothing unless they are assisting in transferring a patient to trolley or wheelchair or likely to come into contact with infectious material. Protective clothing is not required for just pushing a bed or wheelchair.
- 19.7 Following transport, the mode of transport (trolley, chair, etc) should be cleaned.
- 19.8 Correct hand decontamination before and after transport of the patient is essential.

20. Patient Discharge or Transfers

- 20.1 The presence of MRSA must not impede the discharge of the patient to their own home or alternative care facilities. However if the patient is discharged to alternative care facilities then the presence of MRSA must be communicated to the GP and the admitting facility in the discharge summary. If the patient is discharged to another hospital then the Infection Prevention Team of the receiving hospital should be informed.
- 20.2 Following discharge or transfer, a terminal cleaning of the room is required according to the Cleaning Policy. The curtains must also be changed. The isolation card must remain on the door of the isolation room until the terminal

clean has been completed and the clean must be documented on Extramed.

- 20.3 Following discharge from the Regional Burns Unit, the inlet and outlet vents need to be cleaned by the Works Department.

21. Re-admission of patients previously found to be MRSA positive

- 21.1 If previously MRSA positive screen, isolate in a side room and commence MRSA care pathway.

22. Ambulance transport for patients with MRSA

- 22.1 Ambulance services have their own protocols for the safe transport of MRSA patients. Please inform transport when booking to allow for adequate time so control measures can be put in place.

23. Care of the Deceased

- 23.1 The infection control precautions for handling deceased patients are the same as those used in life.
- 23.2 No body bag is required unless patient has significant oozing lesions or bleeding.

24. Staff Members with MRSA

- 24.1 In line with national guidance, MEHT does not routinely screen staff for MRSA.
- 24.2 However staff may be screened occupationally on advice from the IPT in liaison with Occupational Health.
- 24.3 Staff members recently found to be MRSA positive as either part of a preoperative assessment or clinically via their GP will be given the necessary treatment including decolonisation protocol.
- 24.4 Members of staff identified above must not return to work, until 48 hours post commencement of decolonisation protocol and provided their skin is intact.
- 24.5 All staff must endeavour to keep their skin in good condition and report to Occupational Health if dermatological conditions develop.

25. Surveillance

- 25.1 As per mandatory requirements, surveillance is performed on all MRSA bacteraemia cases.
- 25.2 Each MRSA bacteraemia case has root cause analysis investigation carried out. This should be led by the team in charge of the care of that patient, facilitated by the IPT. Post-48 hour cases will also be reviewed by a post infection review panel consisting of the IPT, clinicians caring for the patient, a member of the Clinical Commissioning Group and any other representatives thought to be necessary. This panel will discuss the case, identify any learning points / actions to be taken and , if all care complies with the trust guidance

will decide if there is any potential to appeal against attribution of the case.

26. Audit and Monitoring

- 26.1 Compliance with this policy will be monitored as part of the Infection Prevention and Control audit programme and results reported in the Director of Infection Prevention and Control report and discussed at directorate governance meetings. Directorates are required to develop localised action plans as appropriate.
- 26.2 Audit of compliance with the MRSA care pathway is audited by directorates and submitted for inclusion in the Director of infection Prevention and Control Report each month. Results and actions planned to improve compliance (where required) are discussed at governance meetings for each directorate
- 26.3 The Infection Prevention and Control Group reviews the Infection Prevention and Control policies.

27. Implementation and Communication

- 27.1 This Policy will be issued to the following staff groups to disseminate. These individuals will ensure their staff are made aware of the Policy:
- Ward Sisters/Charge nurse – issue to relevant nursing staff within their ward
 - Departmental Managers – issue to relevant nursing staff within their department
 - Pre-assessment clinics
 - Bed Management Team/Service Co-ordinators
 - Heads of Nursing
 - Lead Nurses
 - Consultants – to issue to relevant medical staff
 - Waiting list departments
- 27.2 The guideline will also be issued via the Staff Focus, made available on the Intranet and discussed at the Infection Prevention Link Practitioners meetings.

28. Training

- 28.1 All training will be delivered in accordance with the Mandatory Training Policy and Training Needs Analysis.

29. References

Department of Health (2014) Implementation of modified admission MRSA Screening Guidance for NHS (2014). Department of Health expert advisory committee on antimicrobial resistance and healthcare associated infection (ARHCAI)

Department of Health (July 2008) MRSA Screening Operational Guidance, Gateway reference 10324

Department of Health (February 2009), Screening for MRSA – FAQs, Gateway

Reference 081111

Department of Health (December 2008) Screening Operational Guidance 2,
Gateway reference 11123

Department of Health (March 2010) MRSA Screening Operational Guidance 3,
Gateway reference 13482

Department of Health Care Act/Hygiene Code 2010

Department of Health (2007) Saving Lives: reducing infection, delivering clean
and safe care. Screening for Meticillin-resistant *Staphylococcus aureus*
(MRSA) colonisation and High Impact Intervention 4

Nice Guidelines 65

Nice Guideline – prevention and treatment of surgical site infections

Guidelines for the Control and Prevention of MRSA in Healthcare Facilities
(2006) G.J Duckworth et al. Working Party Report. Journal of Hospital
Infection 1-44

Patient Information

Octenisan Body Wash**How to use Octenisan body wash**

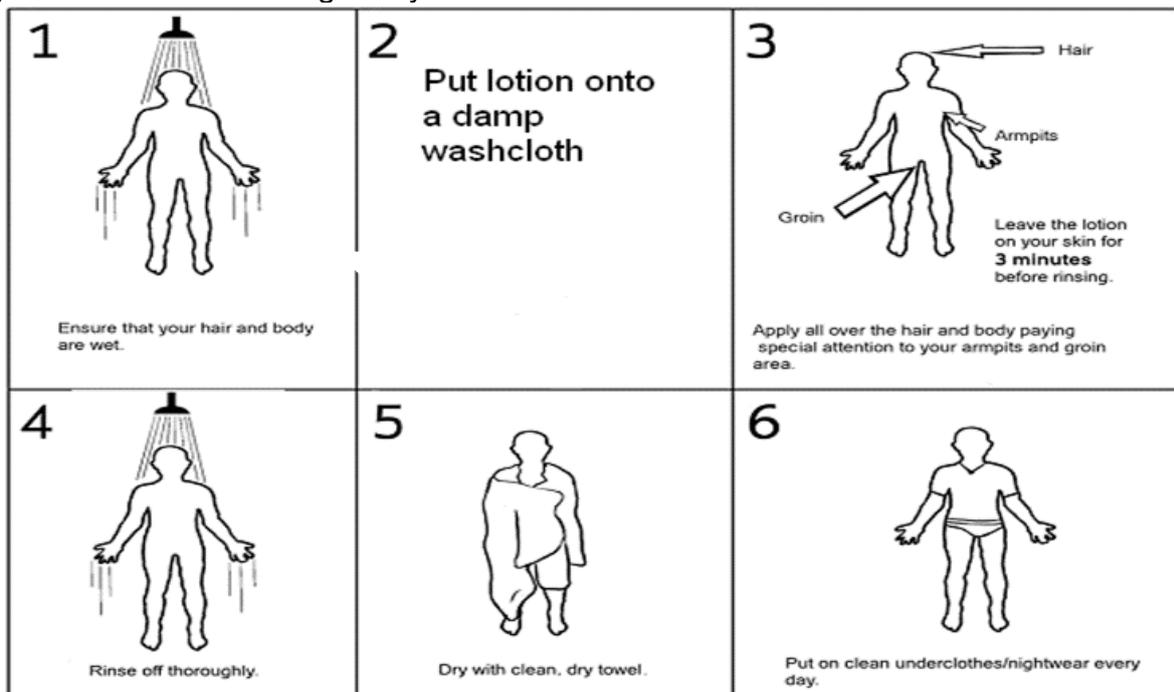
Octenisan is an antibacterial liquid soap for both skin and hair. The aim of using the wash is to reduce the number of bacteria on your skin to reduce the risk of you picking up an infection.

It is effective against Meticillin Resistant *Staphylococcus aureus* (MRSA) and Meticillin Sensitive *Staphylococcus aureus* (MSSA).

Please wash with this every day either in the shower or as part of a strip wash for **5 days** prior to coming into hospital.

- **Wet your skin**
- **Apply Octenisan to a damp washcloth**
- **Apply to skin and hair. Use the Octenisan as a shampoo daily. You can then use your regular shampoo and conditioner after each Octenisan hair wash.**
- **Leave for 3 minutes**
- **Rinse off**

If your skin is dry use a moisturiser. If it becomes irritated by the Octenisan, contact your GP who will arrange for you to have an alternative wash.



You will be contacted by an Infection Prevention Nurse if the MRSA swabs taken at your pre-assessment appointment are positive and treatment advice will given as below.

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Patient Information

What is the Treatment for MRSA and MSSA?

You will be given two treatments:

- Wash daily as instructed over the page with the Octenisan body wash. You should continue to use this wash daily until your wound has healed.
- A nasal ointment called Bactroban (or Mupirocin), use three times a day, for five days as below.

How to apply Bactroban Nasal Ointment (Mupirocin 2%) (use three times a day, for five days)

- **Wash hands before applying**
- **Apply a pea-sized amount of ointment on a cotton bud or on your finger to the inside of each nostril and massage gently upwards**
- **The nostrils should be closed by pressing the sides of the nose together for a moment, this will spread the ointment inside each nostril**
- **Wash your hands following use**

You need to change your bedding at the start of treatment, and towels and underwear every day for five days.

After you have had your surgery continue to use the wash daily until your wound has healed.

Document history

Authors	Infection Prevention Team
Department	Infection Prevention
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Department of Health MRSA Patient Information Leaflet: MRSA – A Positive Result



Patient Information Leaflet to accompany admission letter



Care Pathway for MRSA Patients

Patient Name
Number
(fix Identity label)

Ward /Department.....

Date commenced.....

Aims; Effective management of MRSA colonised patient, preventing transmission and maintaining a safe environment

Triggers to MRSA Care Pathway	Tick those that apply	
High Risk Groups;	* Identified as MRSA positive in the past	
	* From a nursing / residential home	
	* Been in hospital in last 6 months	
	* Healthcare worker or other carer	
	* Transferred from another hospital (UK or abroad)	
	* Frequent attenders	
	*Patients with a long term invasive device	
	*Patients with chronic wounds	
*Patients with cellulitis		

ALL High Risk patients should be washed in Octenisan from admission

MRSA Screen taken	Y	N	Date	Result
Nose and groin				
CSU (if long term)				
Sputum (if productive cough)				
Wounds (specify);				

If all results are NEGATIVE, continue to wash patient in Octenisan and file care pathway in notes

If any of the results are POSITIVE continue below;

	Date	Signature
Standard Isolation (inform Infection Prevention if this is unsafe)		
Explain reason for isolation to patient and give them an information sheet		
Review of current antibiotic therapy (ensure any antibiotic used covers MRSA)		
Commence nasal Mupirocin (Bactroban) for 10 days.		
Octenisan washes to be continued (and prescribed)		
Terminal Clean of room on discharge including curtain change		

The following should also be adhered to for MRSA positive patients;

- Clean nightclothes every night
- Clean bedding every day (including pillowcases and counterpanes)
- Daily clean of room with Tristel

Comments - if any elements cannot be achieved;

PRE-ADMISSION MRSA/MSSA SCREENING FOR ADULTS

Standard: All elective admissions in the agreed categories will be screened for MRSA and have a nasal and perineum/groin swab taken prior to admission (ophthalmology nasal only). Certain groups will have an MSSA screen taken.

All high risk patients will commence Octenisan body wash 5 days prior to date of surgery/ procedure. Refer to Octenisan Body Wash Patient Information Leaflet.

High Risk Patients	Tick
• Known to be MRSA positive	
• Identified as being MRSA positive in the past	
• From a nursing home/ • residential home	
• Has been a patient in any hospital in last 6 months	
• Any healthcare worker – community or acute setting	
• Patient has been transferred from hospital abroad	
• Immuno-suppressed patients – Long term steroid use	
• Diabetic patients	
• Renal dialysis patients	
• Patient with long term invasive device e.g. urinary catheter	
• Patient with chronic skin breaks, to include pressure sores	
• Patient with dermatological condition including cellulitis	
• Detainee admitted from any prison	
• If partner/spouse known to be MRSA	
• If carer of person known to be MRSA	
• Patient being admitted for insertion or reinsertion of a PEG tube	
Low risk patients – to purchase antibacterial wash from any chemist.	
High risk patients – to purchase Octenisan from the Hospital pharmacy or any chemist	

Sign to confirm the screening process has been explained to you

Patient signature..... Date..... Nurse.....

Hospital No:

Surname:

First Name:

Fix a patient label in this space (complete manually only if patient label is not available)

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Information for all patients undergoing planned surgery or a procedure

All patients are advised to use an antibacterial soap for showering/ bathing including hair wash for 5 days before your procedure or operation takes place.

You need to change your bedding at the start of treatment, towels and underwear every day for 5 days.

For high risk patients (see front of sheet), an explanation on how to use the Octenisan Body Wash will be given to you and also an Octenisan Body Wash Information Leaflet.

All patients are advised to stop shaving or waxing the operation site for 5 days prior to surgery. Shaving or waxing prior to surgery increases the risk of developing a wound infection.

If hair removal is required, it will be carried out using electric clippers with single-use head on the day of your operation/procedure.

Please stay warm before surgery as this helps to lower the risk of complications. Please bring additional clothing such as a dressing gown (freshly laundered) and slippers to help you to keep comfortably warm.

You should tell staff if you feel cold at any time during your hospital stay

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PRE-ADMISSION MRSA/MSSA SCREENING FOR CHILDREN

Standard: The following high risk patients will be screened for MRSA and have a nasal and groin swab taken prior to admission

All high risk patients will commence Octenisan body wash 5 days prior to date of surgery/ procedure. Refer to Octenisan Body Wash Patient Information Leaflet.

High Risk Patients	Tick
• Children from residential care homes	
• Identified as being MRSA positive in the past	
• Children who have been an inpatient in any hospital within the last 6 months. Only include babies born in hospital less than 6 months ago born by caesarean section	
• Children whose parents are MRSA positive	
• All children of healthcare workers – community or acute setting	
• All children for Burns Reconstructive Surgery	
• Children who attend hospital regularly e.g. chemotherapy patients, renal patients, long term steroid use	
• Children with an indwelling device e.g. catheter or PEG	
• All children with chronic skin breaks/chronic wounds including cellulitis	
Low risk patients – to purchase antibacterial wash from any chemist.	
High risk patients – to purchase Octenisan body wash from the Hospital pharmacy or any chemist	

Sign to confirm the screening process has been explained to you

Patient signature..... Date..... Nurse.....

<p>Hospital No:</p> <p>Surname:</p> <p>First Name:</p> <p>Fix a patient label in this space (complete manually only if patient label is not available)</p>

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PROTOCOL FOR MRSA SCREENING – WHICH SWABS ARE REQUIRED

The overall aim of screening is to identify carriers of MRSA, isolate and decolonise using appropriate prophylactic treatment. This will reduce the prevalence in the wider community and reduce the risk of MRSA transmission.

- Swabs from the anterior nares and perineum or groin must be swabbed as these are the normal carriage sites for MRSA.
- In addition any skin breaks must be swabbed.

All MEHT wards and departments MUST use the following methodology when screening for MRSA:

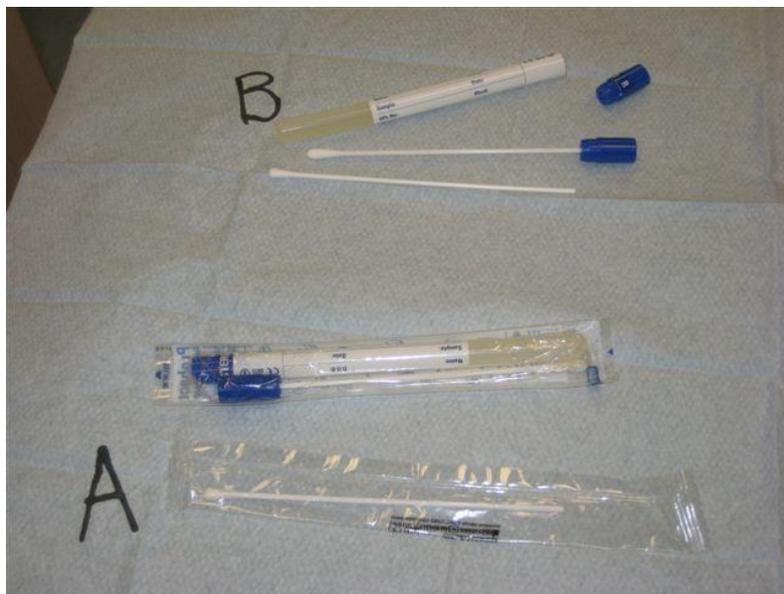
Where the Pathology Indigo Order Comms system is available it must be used to request the MRSA screen. The system has been modified to speed up the ordering process for MRSA swabs so that only one request is required for the Nose and Groin swabs.

There are two options:

- MRSA Screen – should be used to order nose/groin swab
- MRSA Skin Break – should be used for any skin breaks

Two swabs are required to carry out a basic MRSA screen (see picture below);

- A blue topped swab should be used to screen the nose. Moisten the swab in the transport medium before sampling both nostrils.
- A separate individually wrapped swab should be used for the groins or perineum. Generally this swab does not need to be moistened.



- Both swabs must be placed in the same swab container after sampling. Ensure the buds of the swabs are in the transport gel before breaking off the end of the individual swab so that it fits in the container. Breaking the stick with your hands will not contaminate the swab.

Skin breaks should be swabbed using the regular blue top bacterial transport swabs.

Request test on Pathology Indigo System and generate barcoded stickers

Stick one sticker on the yellow Microbiology Specimen Request Form

Remove swab from outer packaging and stick the other sticker on the swab container

Remove swabs from container and snap off one of the swabs and swab the nose and use the second to swab the groin.



This is the anterior nares. Put swab 0.5 – 1cm into the front of each nostril, not to the sides. There is no need to introduce the swab further into the nose. 1 swab for both nostrils

Replace both inoculated swabs into the swab container, place into specimen transport bag together with request form and arrange transport to Microbiology Department.

Please use one specimen request form and one specimen transport bag for each sample.

Patient Information

Octenisan Body Wash

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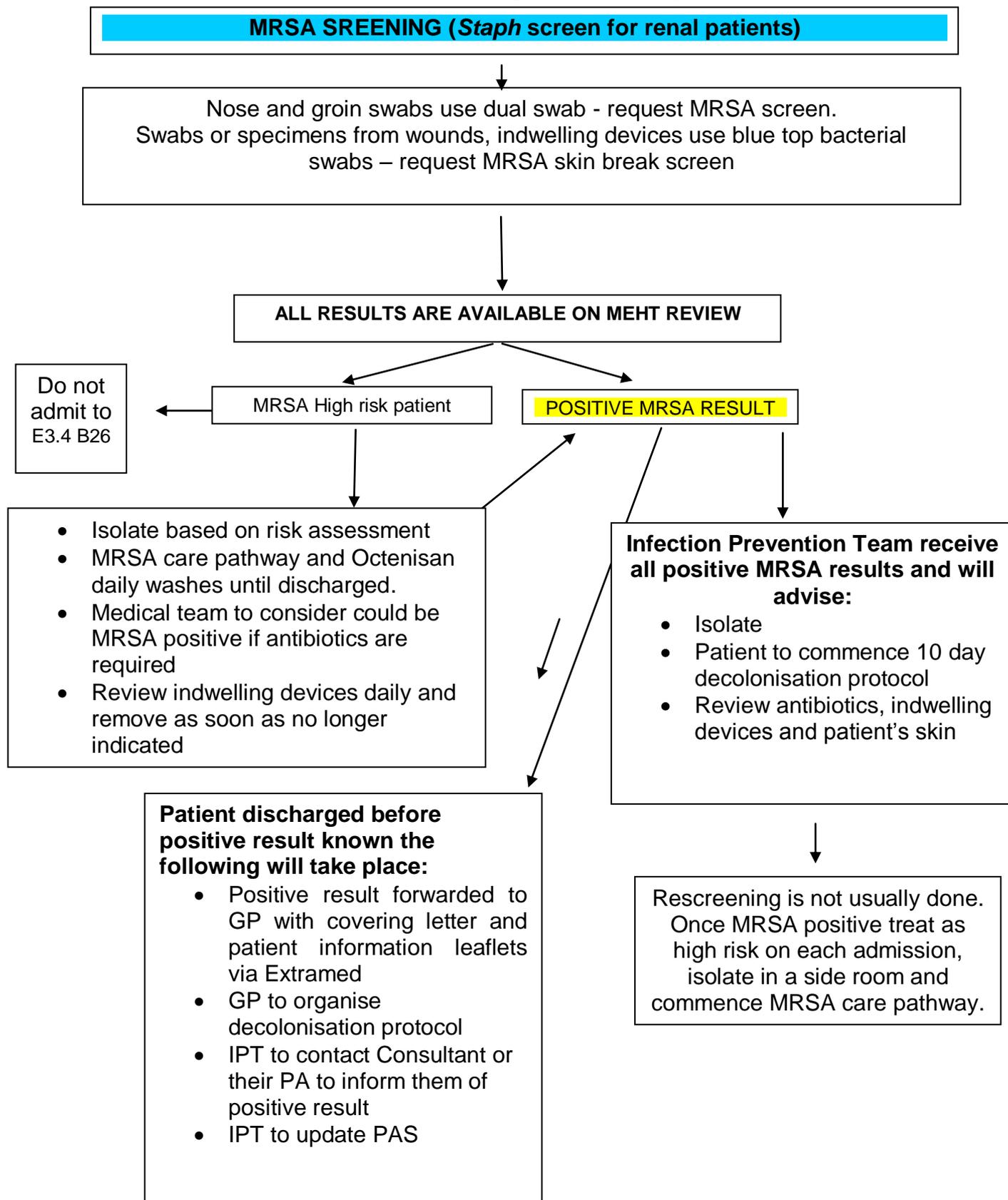
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If the MRSA swabs taken on your hospital admission are MRSA positive, the treatment is as below.

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MRSA Screening and Follow Up

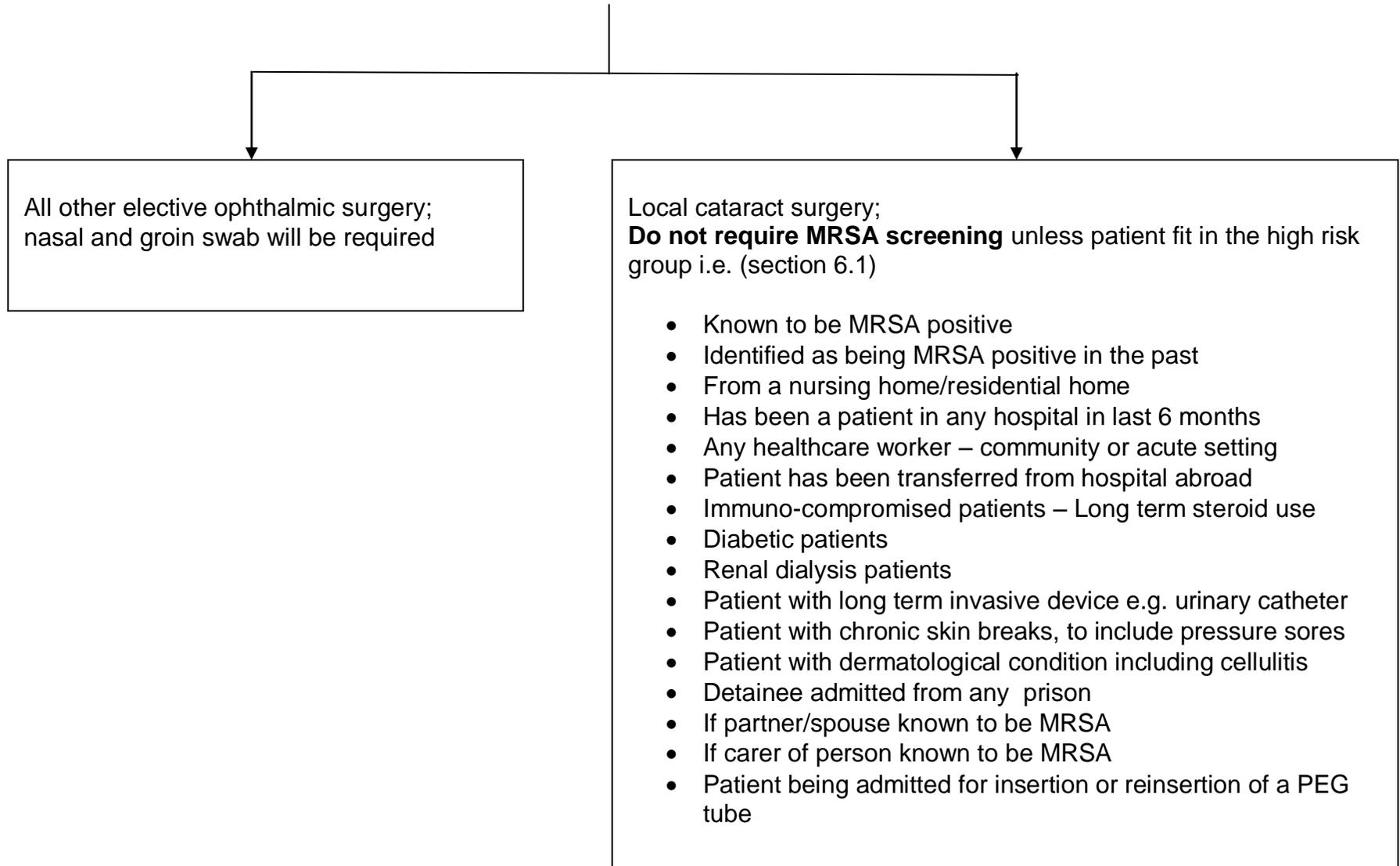


MEHT MRSA Patient Information Leaflet



S:\
InfectionControlDept'

MRSA screening for elective ophthalmic surgery



MRSA alerts follow-up of results process

