Mid Essex Hospital Services NHS
NHS Trust

PREVENTION AND MANAGEMENT OF MRSA (METHICILLIN RESISTANT STAPHLOCOCCUS AUREUS) IN MATERNITY	CLINICAL GUIDELINES Register No: 07002 Status: Public

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Related Trust Policies (to be read in conjunction with)	04071 Standard Infection Prevention 04072 Hand Hygiene 06036 Guideline for Maternity Record Keeping including Documentation in Handheld Records 04075 Prevention and management of methicillin resistant staphylococcus aureus (MRSA) MRSA Information for patients 06030 Management of vaginal birth after caesarean section

Document History Review:

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1.0	Karen Smith	November 2009
2.0	Carol Hunt	January 2010
2.1	Sarah Moon – Clarification to 8.2	July 2010
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4.1	Carol Lowry – Clarification to point 15 and Appendix A	14 June 2016
5.0	Sarah Moon	7 November 2017

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1.0 Purpose

1.1 To provide clear guidelines to all maternity clinical staff.

1.2 Ensure all pregnant patients at risk of carrying methicillin resistant staphylococcus aureus (MRSA) are screened.

1.3 MRSA positive patients are decolonised.

1.4 This guideline is to comply with DoH guidelines Saving Lives High Impact Intervention Number 4 (HII4) 'Preoperative Actions, MRSA screening and MRSA decolonisation.

2.0 Equality and Diversity

2.1 Mid Essex Hospital Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

3.0 Scope

3.1 This guideline is to comply with High Impact Intervention Number 4 'Pre-operative actions, MRSA screening and MRSA decontamination' and is to be read in conjunction with the guideline for the ‘Prevention and management of methicillin resistant staphylococcus aureus’ (MRSA); register number 04075 and the MRSA information leaflet.

3.2 This guideline is aimed at all maternity clinical staff. Key staff such as those working within the community and antenatal clinics, involved with booking patients for their maternity care, will be informed as a group on the guideline and the use of the care pathway.

3.3 All routine Infection Prevention procedures must be followed.

4.0 Background and Incidence

4.1 Methicillin Resistant Staphylococcus aureus (MRSA) is an important cause of Health Care Associated Infections. Identification and the correct management of patients who are colonised with MRSA will reduce the risk of patients developing complications.

4.2 Approximately 25 to 30 % of the population are carriers of staphylococcus aureus, they are healthy and unaffected by it; this is called colonisation. Individuals who are colonised are referred to as 'carriers'.

4.3 Clinical infection with MRSA (including MRSA bacteraemia) occurs either from the patient’s own resident MRSA (if an asymptomatic carrier) or by cross-infection from another person, who could be an asymptomatic carrier or have a clinical infection.

5.0 Staff Responsibilities

5.1 **Maternity administrative staff** should identify pregnant patients that have a history of being screened MRSA positive with an alert on the PAS system and should notify the Midwife responsible.

5.2 It is the **midwife's responsibility** to:

- Identify pregnant patients at booking who will require MRSA screening at 36 weeks
- Reassess if MRSA screening is required at all antenatal visits by the midwife
- Ensure pregnant patients that are high risk of carrying MRSA have been screened
- Ensure that all patients readmitted are screened

5.3 When an inpatient the **obstetric registrar/senior house officer/consultant on call** should ensure that pregnant patients are adequately decolonised and prescribe appropriate medication.

5.4 The **infection prevention team**, identify pregnant patients whose screen is MRSA positive and inform the patient and their GP to arrange decolonisation.

6.0 Consent

6.1 Patients should have an understanding of the reasons for MRSA screening and they should have the opportunity to read the Leaflet MRSA screening in Maternity.

6.2 Verbal consent should be obtained for screening and recorded in the patient's health care records. (Refer to the 'Guideline for maternity record keeping including documentation in handheld records'; register number 06036)

6.3 All patients should be actively encouraged to be MRSA screened. If they refuse the risk to themselves and other patients should be explained.

6.4 Document in the patient's health care records if screening has been refused.

7.0 Method of Screening for MRSA

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

This is the anterior nares, there is no need to introduce the swab further into the nose.

7.2 Using the Blue transport swab and additional sterile swab stick, both nostrils should be swabbed with the same swab, the remaining swab should be used for the groin.

7.3 Complete the order coms form for MRSA screen, label the swabs and send the swabs to microbiology.

7.4 If the patient has any other wounds or lesions then these should be swabbed for microbiology; culture and sensitivity using the blue swab and sent to microbiology.

7.5 Patients should be advised that they will be contacted if the results are positive and that they do not need to ring for the results.

8.0 Screening of Pregnant Patients

8.1 At booking – patients who have the following risk factors should be identified and screened for MRSA at 36 weeks gestation.
(Refer to Appendix A)

8.2 Risk Factors:

- Known to be MRSA positive
- All pregnant patients who have had previous hospital admissions in the past 6 months, this excludes general maternity admissions
- Any patient with a skin condition i.e. psoriasis or eczema
- Any patient who is employed in a health care setting (including residential or nursing homes, the community and hospital)
- Any patient who is a carer of a friend or relative in the home environment who is MRSA positive
- Immuno-compromised patients, i.e. HIV positive
- No request from a patient to be screened for MRSA should be declined
- Chronic diabetic patients (not gestational diabetes)
- Patients with a raised BMI more than 35
- Vaginal Birth after Caesarean Section (VBAC) patients
  (Refer to the guideline for the 'Management of vaginal birth after caesarean section', register number 06030)

8.3 During the antenatal booking appointment, the midwife should assess the MRSA risk and complete the appropriate section on of the patient's hand held records.

8.4 If the patient requires an MRSA screen at 36 weeks gestation refer to the patient's handheld health care records (in the section actions/special Instructions) document 'for MRSA screen at 36 weeks'.

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8.5 At 36 week during the antenatal examination a review of the patient's notes should be made and if indicated the patient should be screened for MRSA.

8.6 Screening of healthcare workers should not be undertaken until on maternity leave as they may become colonised after the swab has been taken. These patients will be asked to swab themselves.

8.7 Patients who require screening for MRSA:

- Patients who present in early labour before 36 weeks gestation
- Patients for booked for external cephalic version (ECV).
- Patients booked for induction of labour
- Any patient whose baby is likely to be admitted to the neonatal unit (NNU)
- Patients who have had an inpatient episode in an acute setting in the last 6 months

8.8 Patients undergoing an **emergency caesarean section** should be screened if possible before going to theatre or as soon as is possible following surgery, before being admitted to the postnatal ward.

9.0 Communication of MRSA Positive results

9.1 **Outpatient:**

- Positive results are sent to the infection prevention team who will contact the patient and her GP to arrange treatment and advise the patient about the decolonisation procedure.
- An alert will be placed on the Lorenzo computer system
- The positive result should be recorded in the Pregnancy / special instructions for birth section of the hand held notes.
- The patient should be given the maternity MRSA screening a positive result leaflet advising about testing positive

9.2 **In-Patient:**

- The ward staff should be advised by a member of the infection prevention team Monday to Friday the woman will be offered a visit from a member of the Infection Prevention Team. If a result is phoned at the weekend then leave a message on the Infection Prevention Team answer phone ext 6398
- An alert will be placed on the Lorenzo system
- The positive result should be recorded in the hand held notes under
- The midwife caring for the patient will inform the patient as soon as is possible and arrange for the patient to be cared for in a side room and explain the isolation precautions to the patient and her visitors.
- Standard Isolation poster to be placed outside the patient's door.
- The obstetric SHO/registrar on call should be notified to ascertain if antibiotic therapy should be reviewed

- On discharge the room should be terminally cleaned

9.3 Patients who are at high risk of carrying MRSA should be advised to use an antibacterial wash from 37weeks gestation until delivery and until any wounds including perineal wounds have healed.

9.4 Patients from 37 weeks gestation should be advised not to shave or wax the pubic area to comply with Saving lives HII4.

10.0 Planned Caesarean Section

10.1 Patients should be asked to purchase their own antibacterial wash such as Octenisan or an antibacterial soap such as Cidal.

10.2 Advice should be given not to shave or wax the site of the operation for at least five days prior to the date of the planned caesarean section.

10.3 Patients should be advised to use the antibacterial wash every day for five days and adhere to the following:

- Ensure body and hair is wet
- Put 30ml of Octenisan on to a clean cloth
- Apply to body paying particular attention to armpits, navel and groin
- Rinse it off after 1 minute
- Wash hair on second and fourth days in Octenisan, then use patient's regular shampoo and conditioner as usual.
- Dry with a clean towel
- Change bed linen, underwear and put on clean night wear every day
- On the morning of admission use the antibacterial wash.

10.4 Following surgery the patient should be advised to continue to use the antibacterial wash until the wound has healed. This should be indicated in the patients postnatal health care records (under 'antibacterial wash' as part of the midwives postnatal check).

11.0 Planned Caesarean Section and MRSA positive

11.1 If possible the patient should complete the five day decolonisation protocol (described above), and following advice from consultant microbiologist apply Bactroban to nostrils three times a day for 5 days.

11.2 A small amount of ointment, about the size of a match head, should be placed on a cotton bud or on the finger and applied to the inside of each nostril (apply to the front part of the nostril). The nostrils should be closed by pressing the sides of the nose together this will spread the ointment through the nostrils.

11.3 The patient should be nursed in the high dependency area of the Delivery Suite.

11.4 Standard isolation poster should be placed on the door.

11.5 Obstetric theatre staff should be informed.

11.6 Following surgery the patient should be advised to continue to use the antibacterial wash until the wound has healed. This should be indicated in the 'Postnatal Care Record – Maternal' as part of the midwife's postnatal check.

11.7 Bed linen should be changed daily.

12.0 Prophylaxis at Induction

12.1 If the patient is MRSA positive or old MRSA positive give teicoplanin 400mg in addition to augmentin at induction

13.0 Care of the Baby

13.1 Roomed with the mother and will not require antibacterial wash.

14.0 Postnatal Readmissions

- Patients should be nursed in a side room on the Postnatal ward
- The patient should be screened for MRSA on admission; any wounds however, should be swabbed for MC&S and sent to microbiology
- Antibiotic therapy should be reviewed
- If the patient is readmitted due to possible wound infection she should be advised to continue to use the antibacterial wash.
- The baby should only be screened for MRSA if the mother is MRSA positive.
- The swabs should be taken from the umbilicus and the ear.

15.0 Emergency MRSA Screening:

- To arrange for an MRSA/MSSA, PCR. When you have identified a need for this test you must telephone the Microbiology Department with details of the patients demographics and write clearly on the request form that it is for MRSA/MSSA, PCR (this is so that we can get the laboratory equipment ready and because the laboratory receives up to 300 MRSA swabs per day).
- Arrange for a porter to bring the sample directly to the Microbiology Department C352 – do not use the routine Pathology transport system or Vacuum delivery system.
- Sample – this must be a nose swab using a blue top Amies Transport Swab.
- Availability Monday to Friday only
  There are two batches per day
  - AM – Swab(s) must be in the Microbiology Department by 10:30
  - PM – Swab(s) must be in the Microbiology Department by 14:00
- The assay takes around 2 – 2.5 hours to run

15.0 Staffing and Training

15.1 All midwifery and obstetric staff must attend yearly mandatory training which includes highlighting the guideline and care pathway during infection prevention session.

15.2 All midwifery and obstetric staff are to ensure that their knowledge and skills are up-to-date in order to complete their portfolio for appraisal. Remedial updating will be given if required.

16.0 Professional Midwifery Advocates

16.1 Professional Midwifery Advocates provide a mechanism of support and guidance to women and midwives. Professional Midwifery Advocates are experienced practising midwives who have undertaken further education in order to supervise midwifery services and to advise and support midwives and women in their care choices.

17.0 Audit and Monitoring

17.1 Infection prevention lead midwife should be informed of every maternity patient commenced on the MRSA Care Pathway.

17.2 All wards should conduct a monthly MRSA audit which is reported on the HCA score card.

17.3 To comply with Saving Lives HII 4 the relevant Maternity areas complete this audit monthly.

17.4 Audit of compliance with this guideline will be considered on an annual audit basis in accordance with the Clinical Audit Strategy and Policy (register number 08076), the Corporate Clinical Audit and Quality Improvement Project Plan and the Maternity annual audit work plan; to encompass national and local audit and clinical governance identifying key harm themes. The Women's and Children's Clinical Audit Group will identify a lead for the audit.

17.5 The findings of the audit will be reported to and approved by the Multi-disciplinary Risk Management Group (MRMG) and an action plan with named leads and timescales will be developed to address any identified deficiencies. Performance against the action plan will be monitored by this group at subsequent meetings.

17.6 The audit report will be reported to the monthly Directorate Governance Meeting (DGM) and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.

17.7 Key findings and learning points from the audit will be submitted to the Patient Safety Group within the integrated learning report.

18.0 Guideline Management

18.1 As an integral part of the knowledge, skills framework, staff are appraised annually to ensure competency in computer skills and the ability to access the current approved guidelines via the Trust's intranet site.

18.2 Quarterly memos are sent to line managers to disseminate to their staff the most currently approved guidelines available via the intranet and clinical guideline folders, located in each designated clinical area.

18.3 Guideline monitors have been nominated to each clinical area to ensure a system whereby obsolete guidelines are archived and newly approved guidelines are now downloaded from the intranet and filed appropriately in the guideline folders. 'Spot checks' are performed on all clinical guidelines quarterly.

18.4 Quarterly Clinical Practices group meetings are held to discuss ‘guidelines’. During this meeting the practice development midwife can highlight any areas for further training; possibly involving ‘workshops’ or to be included in future ‘skills and drills’ mandatory training sessions.

19.0 Communication

19.1 A quarterly ‘maternity newsletter’ is issued and available to all staff including an update on the latest ‘guidelines’ information such as a list of newly approved guidelines for staff to acknowledge and familiarise themselves with and practice accordingly.

19.2 Approved guidelines are published monthly in the Trust’s Staff Focus that is sent via email to all staff.

19.3 Approved guidelines will be disseminated to appropriate staff quarterly via email.

19.4 Regular memos are posted on the ‘Risk Management’ notice boards in each clinical area to notify staff of the latest revised guidelines and how to access guidelines via the intranet or clinical guideline folders.

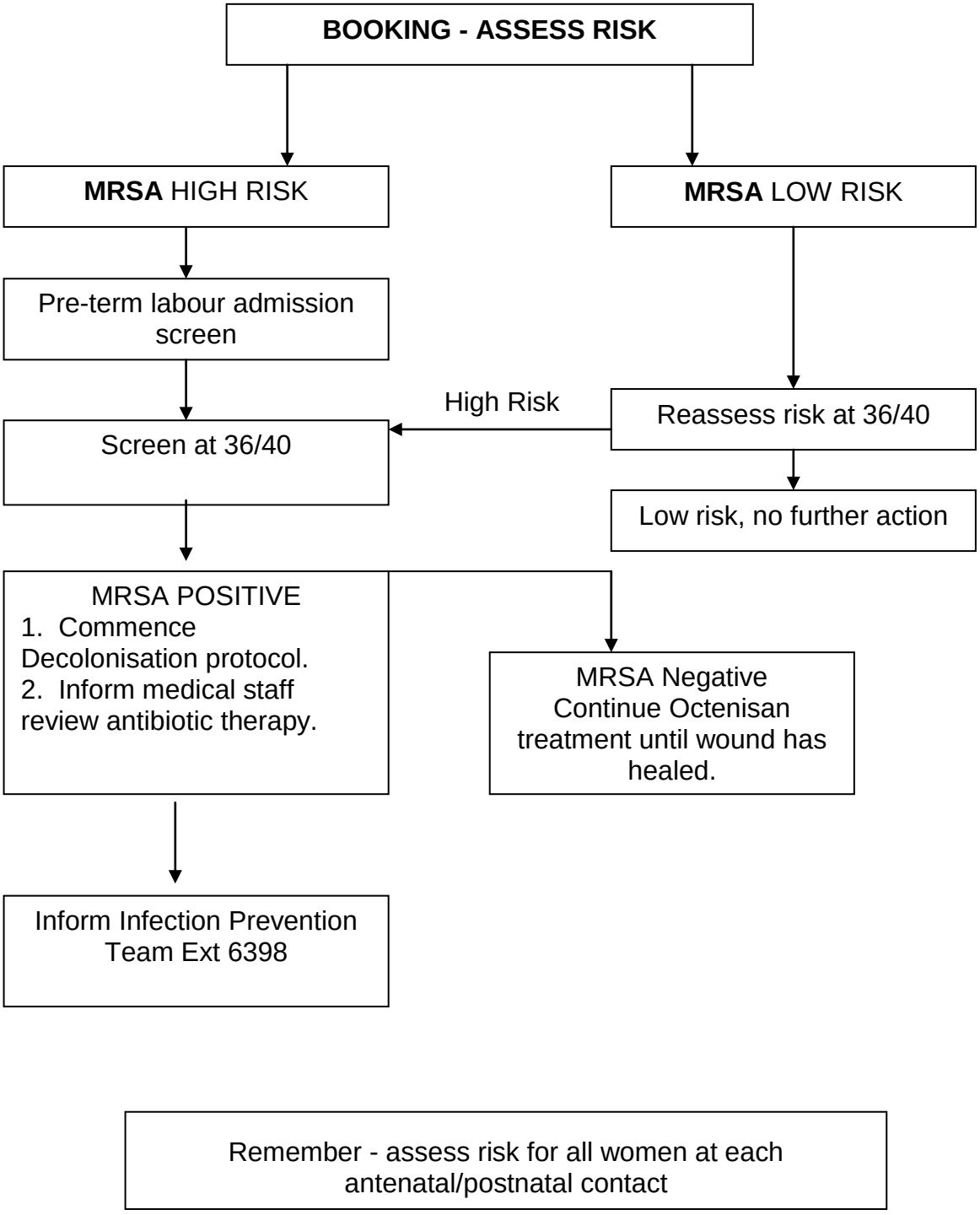
20.0 References

Department of Health (2007) Saving lives, Reducing Infection, Delivering clean and safe care. DoH

With thanks to Kingston Hospital for their guideline reference.

Appendix A

Flow Chart for Screening Pregnant Patients for MRSA



Remember - assess risk for all women at each antenatal/postnatal contact