Meticillin Resistant Staphylococcus Aureus (MRSA) Policy

V9.1

December 2018
Summary

Guidance on Use of Suppression Therapy on Receipt of Screening Results for **ADULTS**

**PATIENT IDENTIFIED AS MRSA POSITIVE FROM:**

- **Positive elective screen pre-admission**
- **Previous positive MRSA identified from patient medical records/PAS**
- **Identified MRSA positive from emergency admission screen**

**Positive screen**
Mupirocin nasal ointment to be prescribed for a maximum of 10 days only (If not Mupirocin resistant or had mupirocin within last 3 months) Chlorhexidine 4% Daily washes until discharged from hospital.

**Negative screen**
Continue Chlorhexidine 4% daily washes until discharged from hospital

**Screen for MRSA**
Start Chlorhexidine 4% daily washes

**Mupirocin ointment TDS for 5 days and chlorhexidine 4% washes commencing 5 days prior to admission**

**Continue Chlorhexidine 4% daily washes (Mupirocin completed prior to admission) until discharged from hospital**

**Criteria for inclusion:**
- Patients found to be colonised with MRSA confirmed by microbiology
- Aged 18 years or over

**Criteria for patient exclusion:**
- Burns patients
- Patients from whom the nurse has any concerns as to the safety or appropriateness of the treatment
MRSA screening of CHILDREN (excluding Neonates)

When:
- Elective admissions (chronic complex health needs only / e.g. cystic fibrosis, oncology patients) at pre-op assessment clinic or during outreach visit.
- Transfers in from other hospitals/abroad on admission
- Children with chronic complex health needs on admission (or every 3 months)

Screen using red swab (Nose and one other site plus indwelling device sites and wounds if present, sputum if productive cough)

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**Negative**
- No further action until in-patient for 30 days
- Rescreen at 30 days and weekly until discharge

**Positive**
- If hospitalised, isolate and treat with Octenisan* washes. Mupirocin nasal ointment for 5 days if Mupirocin sensitive. If mupirocin resistant discuss with microbiologist. Discuss with lead paediatrician and IP&C re-screening further patients. If patient is not hospitalised, discuss with lead paediatrician.
- Continue with washes for duration of hospital stay*
- Seek advice from Microbiologist regarding further treatment and prophylaxis if major interventions (surgery/central line insertions) are planned

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*Antiseptic solutions are drying to the skin and may cause allergic reaction
Assess the child’s skin condition daily – stop washes if any concerns and document.
MRSA screening of **NEONATES**

**Screen on admission to unit** using fine bore swab.

- Admissions from Delivery Suite, following home birth or from peripheral units
  - Deep ear and umbilicus
  - **Negative**
    - Re-screen at weekly intervals until discharge.
  - **Positive**
    - Ring Infection Prevention & Control
      - Screen mother, father and siblings and treat as per MRSA policy. Screen all babies in the nursery if not found as part of the weekly screening process.
      - Isolate baby and treat with Octenisan* washes and Mupirocin for 5 days if Mupirocin sensitive. If mupirocin resistant, discuss with microbiologist.
      - Continue octenisan washes for the duration of hospital stay.

- Transfers from hospitals outside of Cornwall
  - Nose and one other site plus indwelling device site if appropriate
  - Isolate if possible
    - Use contact precautions
      - **Negative**
      - **Positive**

* Antiseptic solutions are drying to the skin and may cause allergic reaction
  - Assess the baby’s skin condition daily – stop washes if any concerns and document

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1. **Introduction**

1.1. The normal habitat of Staphylococcus aureus (S. aureus) is human skin, in particular the anterior nares (nostrils). Other sites may also be colonised such as groin, axillae, perineum and throat, and there may be a reservoir in the gut. S. aureus is carried in the nose of about 30% of the population and is the most common cause of skin sepsis, wound and surgical site infection. These infections are usually caused by the organism carried by the patient, although cross-infection from others does occur.

1.2. Meticillin-resistant Staphylococcus aureus (MRSA) has appeared sporadically since the 1960s. Hospital epidemics were reported in the 1970s and 1980s, and became endemic (present all the time) in hospitals in most countries of the world in the 1990s. MRSA is important because it can cause serious infections; it is often difficult to treat because it is multiple antibiotic resistant as well as meticillin resistant. As with Meticillin-sensitive Staphylococcus aureus (MSSA), more people are colonised than infected, but colonisation usually precedes infection.

1.3. Hospital acquired MRSA is largely preventable by good infection prevention and control practices.

1.4. This version supersedes any previous versions of this document.

2. **Purpose of this Policy/Procedure**

This policy has been developed to provide staff with the necessary information and knowledge to effectively reduce the risk of MRSA introduction to the Trust, and to put in place systems to control and contain cases of MRSA as and when they occur. The policy provides the background, rationale and management of Meticillin resistant Staphylococcus aureus (MRSA) within the Trust.

3. **Scope**

This policy applies to all staff working within Royal Cornwall Hospitals NHS Trust.

4. **Definitions / Glossary**

- **MRSA** – Meticillin resistant *Staphylococcus aureus*, an organism that is resistant to a number of antibiotics.

- **Screening** – process of obtaining microbiological swabs to identify presence of MRSA in order to suppress the bacteria by prescribed treatment.

5. **Ownership and Responsibilities**

5.1. **Role of the Chief Executive**

The Chief Executive Officer (CEO) is responsible for ensuring that there are effective arrangements for infection control within the Trust. This includes determining the mechanisms by which the Trust Board ensures that there are adequate resources available to secure effective prevention and control of healthcare associated infections.
5.2. **The Director of Infection Prevention and Control (DIPC)**
The DIPC is responsible for overseeing the implementation of the policy, for reporting any concerns and performance in infection prevention and control to the Trust Board and CEO, and for challenging inappropriate clinical practice and antibiotic prescribing.

5.3. **Role of the Managers**
- Divisional Managers are responsible for monitoring implementation of this policy and for ensuring action is taken when staff fail to comply with the policy.
- Ward Sisters/ Charge Nurses, Department Managers, Matrons, Associate Directors of Nursing are responsible for ensuring implementation within their area, and for ensuring all staff who work within the area adhere to the principles at all times.

5.4. **Role of the Infection Prevention and Control (IPAC) Steering Group**
The IPAC Steering Group is responsible for the implementation and monitoring of this policy.

5.5. **Role of the Hospital Infection Prevention and Control Committee**
The Hospital Infection Prevention and Control Committee is responsible for approving this document.

5.6. **Role of individual staff members**
All staff members working on Trust premises, including Trust employed staff, contractor staff, agency and locum staff are responsible for:
- adhering to this policy, and
- for reporting breaches of this policy to the person in charge and to their line manager.

5.7. **Consultant Medical Staff**
Are responsible for ensuring their junior staff read and understand this policy, and adhere to the principles contained in it at all times.

5.8. **The Infection Prevention and Control Team**
Is responsible for providing expert advice in accordance with this policy, for supporting staff in its implementation, and assisting with risk assessment where complex decisions are required. The team is also responsible for ensuring this policy remains consistent with the evidence-base for safe practice, and for reviewing the policy on a regular basis.

5.9. **The Occupational Health Department**
Is responsible for providing confidential advice and MRSA screening and treatment for staff if indicated.

5.10. **Site co-ordinators**
Are responsible for ensuring patients are placed in accordance with this policy, and for escalating any situations where safe placement cannot be achieved.
5.11. **Chief Operating Officer/Senior Manager on Call**
Is responsible for providing senior and executive leadership to ensure implementation of this policy, and for ensuring infection risks are fully considered and documented when complex decisions need to be made regarding capacity and patient flow.

6. **Standards and Practice**

6.1. **Screening**

6.1.1. **Elective admissions**

6.1.1.1. The purpose of pre-operative screening is to minimise the risk of the patient becoming infected with his or her own MRSA and to minimise the risk of transmission of MRSA to other vulnerable patients.

6.1.1.2. All patients attending an out-patient appointment, who may need to be admitted for an elective procedure or surgery, must be screened for MRSA. This should be recorded on the MRSA screening list held in the department.

6.1.1.3. All patients attending a pre-operative assessment clinic who require an MRSA screen and have not been screened at a previous out-patient visit must be screened for MRSA. This should be recorded on the pre-operative assessment documentation.

6.1.1.4. All patients electively admitted by agreement between a consultant and a GP must be screened for MRSA. It is the responsibility of the consultant to ensure that these patients have had an MRSA screen prior to admission.

6.1.1.5. The MRSA screening result will remain valid for maximum of 9 month pre-operative period; i.e. once a decision has been made to carry out a procedure and a MRSA screen is taken either at outpatient clinic or pre-operative assessment clinic, the swab result will remain valid until such time as the procedure is carried out. The exceptions to this are:

- When a patient has been admitted to hospital during this period. The patient should be screened again once discharged. The patient should be notified at the time of their initial pre-op screen that a repeat screen is required if they are admitted to hospital and who to contact to arrange this.
- If the patient is taken off the waiting list, a new screen must be carried out again once back on the waiting list.
- Any elective patient, who has not been screened prior to admission, unless they are identified in the list below, must be screened on admission. All patients who have not been screened, including those on the exclusion list below and are admitted to a high risk area must be isolated until the result of the screen is known. The Surgeon responsible for the patient must be informed that the patient has not had an MRSA screen (patients not on the exclusion list only).
6.1.2. Patients excluded from elective screening
- All day cases with the exception of orthopaedics, any cases requiring implant, arterial vascular cases and all cases scheduled for admission to St Michael’s hospital.
- All dermatology procedures with the exception of Mohs’ micrographic surgery
- Children/paediatrics unless already in a high risk group
- Maternity/obstetrics
- Termination of Pregnancy (unless other risk factors are present).
- Any patient who has been previously identified as having MRSA should, however, be screened prior to any of the above.

6.1.3. Patients included as part of a local decision:
- Patients attending for cystoscopy
- Patients having elective insertion of percutaneous endoscopic gastrostomy (PEG)

6.1.4. Unplanned/emergency admissions
All patients who are admitted as emergencies or as unplanned direct referrals must be screened by the admitting ward within 24 hours of admission and the screen recorded in the Risk Assessment part of the nursing documentation. Exceptions to this include:
- Obstetric patients
- Children unless they have chronic complex health needs e.g. cystic fibrosis, oncology patients

Those patients who are admitted to high risk areas (orthopaedic wards and critical care areas) should commence chlorhexidine skin washes until the results of the screening swabs are known.

6.1.5. Additional Screening:
6.1.5.1. All patients who have been in-patients for 30 days must be screened at weekly intervals. Any patient who is receiving chlorhexidine washes should discontinue this for 2 days prior to screen being taken.

6.1.5.2. All patients on Critical Care must be screened at weekly intervals and continue on chlorhexidine washes for the duration of their stay on the unit.

6.1.5.3. Patients who are regular or frequent elective attendees (e.g. for repeat cystoscopy) must be screened on initial visit and then 3 monthly, or at the next out-patient attendance (it is acceptable to screen at discharge from the ward).

6.1.5.4. Patients attending for renal dialysis must be screened 3 monthly (if the patient has any wounds that are being managed by another healthcare provider they should be informed of when a screen is due to allow the wound to be swabbed at the same time).

6.1.5.5. All babies on the neonatal unit should be screened weekly.
6.1.5.6. Any patient due to commence chemotherapy via a Hickman line and at 3 monthly intervals during the course of their treatment (if the patient has any wounds that are being managed by another healthcare provider they should be informed of when a screen is due to allow the wound to be swabbed at the same time).

6.1.5.7. Any patient who is an in-patient and has a severe skin condition resulting in numerous lesions should be screened on a weekly basis.

6.1.6. Patients who refuse to have MRSA screen
Patients who do not consent or are unable to consent to MRSA screening will be considered to be chronic carriers of MRSA and isolated in order to protect other patients. The patient should have the risks explained to them.

6.2. Screening Sites

6.2.1. Swabs must be taken from the nose and one other site e.g. axilla, groin, throat. In addition:

6.2.1.1. A urine sample should be obtained:
- If the patient is catheterised
- They have had a previous urine sample which has been positive for MRSA
- If they are to undergo cystoscopy

6.2.1.2. Wounds/lesions should be swabbed if present (including tracheostomy, stoma, PEG) vascular access device site. If this is covered by a dressing this should be removed at the earliest opportunity and the site swabbed.

6.2.1.3. Sputum should be taken if productive cough present.

6.2.2. If it is not possible to obtain a nasal swab due to patient’s clinical condition, the throat should be swabbed plus one other site as above.

6.2.3. One swab can be used for both nostrils and one swab for both axillae. For all other sites, separate swabs should be taken using the red swabs, moistened with sterile saline or water, but sent together with one form. Each site should be clearly labelled on the request form.

6.3. Request forms
Microbiology request forms must be marked according to the table below.

<table>
<thead>
<tr>
<th>Patient Group</th>
<th>Request</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective admissions</td>
<td>ELECTIVE MRSA SCREEN (sticker may be used)</td>
</tr>
<tr>
<td></td>
<td>identify sites which have been swabbed</td>
</tr>
<tr>
<td>Frequent attendees</td>
<td>ELECTIVE MRSA SCREEN (sticker maybe used)</td>
</tr>
<tr>
<td></td>
<td>identify sites that have been swabbed.</td>
</tr>
<tr>
<td>Emergency admissions</td>
<td>EMERGENCY MRSA SCREEN identify sites that</td>
</tr>
<tr>
<td></td>
<td>have been swabbed</td>
</tr>
</tbody>
</table>
Weekly screens | MRSA SCREEN identify sites that have been swabbed
---|---
All other groups | MRSA SCREEN identify sites that have been swabbed.

NB when requesting an MRSA screen, MRSA is the only organism that will be looked for. If a full culture and sensitivity is required, this must be requested separately and the black charcoal swabs used.

6.4. **Re-screening inpatients**

It is considered that patients found to be positive for MRSA carriage during an admission are unlikely to be cleared of carriage whilst in hospital. Accordingly, unless directed otherwise by the infection prevention and control team, MRSA positive patients should be put on a continuous regimen of skin decontamination in order to suppress rather than eliminate carriage. Skin integrity must be assessed daily and advice sought regarding continuation of this treatment if necessary. Furthermore MRSA colonised patients do not need to be re-screened during that admission, unless for clinical reasons. A repeat screen will be required if a patient has been in hospital for 30 days and at weekly intervals thereafter if the 30 day screen is negative.

6.5. **Communication of the results**

6.5.2. **Elective admissions**

The Infection Prevention and Control Department will produce a list of all positive MRSA results received from out-patient departments on a weekly basis. This list will be forwarded to all the Consultant Surgeons secretaries to ensure the Consultants are aware of any positive results. Pre-operative assessment unit staff are responsible for ensuring that patients are contacted about their MRSA status and suppression therapy and that a letter is sent to the patient if they cannot be contacted by telephone. At admission, staff must ascertain whether the patient has been screened and record their positive/negative status on the admission documentation.

6.5.3. **Emergency admissions**

The nurse or medical team responsible for the care of the patient is responsible for checking all swab results taken on or following admission to hospital via the Winpath system. The medical team responsible for the care of the patient is responsible for informing the patient of a positive result. If the results are MRSA positive, the patient should be informed and commenced on the suppression regime. If the patient is discharged prior to the results being known, the patients GP will be informed of the results via the pathology Winpath system.

6.6. **Patient involvement**

Patients should be informed about MRSA and how it will be treated. They should be advised that they will only be notified of a positive result. Where treatment decisions are made, this must be in negotiation with the patient. If a patient or family member has concerns about MRSA that nursing staff cannot resolve, the Infection Prevention and Control Nurses should be contacted for advice.

An MRSA patient information leaflet must be given to the patient.
6.7. Treatment and Suppression

6.7.2. Elective admissions

6.7.2.1. Patients attending pre-assessment clinics: suppression treatment will be prescribed and issued via a patient group directive, if the positive result is known at this time.

6.7.2.2. All other elective patients: suppression therapy to be ordered via MRSA treatment proforma. The proforma must be faxed to pharmacy. Treatment will be sent out to GP practice and collected there by the patient/patient representative. Two packs are available for suppression therapy:

Pack A – contains chlorhexidine only and is to be used for those patients previously known to have had MRSA, screened positive on this occasion and have received mupirocin nasal ointment within the last three months, or are previously known to have had MRSA and have screened negative on this occasion.

Pack B – contains chlorhexidine washes and mupirocin nasal ointment and is to be used for those patients who screen positive on this occasion and have never received suppression therapy or have screened positive on this occasion and have not received mupirocin nasal ointment in the last three months.

Patients should be advised to commence treatment 5 days prior to their scheduled admission date.

6.7.3. Emergency admissions

Chlorhexidine washes should be commenced for all patients previously known to have had MRSA and continued for the duration of their hospital stay.

Patients found to have a positive MRSA screening result must be informed of the result and prescribed suppression treatment by the ward doctor.

Those patients who screen negative on admission but are at higher risk of acquiring MRSA should not be nursed in bays with other patients who have screened positive for MRSA previously or currently. If this situation occurs, the IPAC team should be contacted for further advice. The following groups of patients are considered to be at higher risk of acquiring MRSA:

- Oncology patients
- Haematology patients
- Renal dialysis patients
- Diabetic patients
- Any patient who has open wounds or invasive devices
- Any patient who is due to have surgery involving the insertion of any prosthesis.
- Any patient with a severe skin condition resulting in numerous lesions

6.8. Suppression of MRSA

The following is the recommended suppression therapy protocol.
6.8.2. **Hygiene**

6.8.2.1. Patients should be advised to bath/shower daily using Chlorhexidine 4% body wash. For those patients who are unable to shower/bath, a bed bath should be performed. Chlorhexidine body wash should be applied undiluted direct to wet skin with a moistened cloth, (do not use patient’s flannel). It should not be used as a bath/bowl additive.

6.8.2.2. In cases of known sensitivity to Chlorhexidine or sensitive skin, Octenisan skin cleanser is the recommended alternative.

6.8.2.3. Patients with significant skin disease should be referred for dermatological review for definitive advice on suppression of skin carriage.

6.8.2.4. The patient’s bed linen and night clothes should be changed daily.

6.8.2.5. Hair should be washed at least twice a week with Chlorhexidine 4% or Octenisan

6.8.3. **Nasal Treatment**

This should be carried out for no more than 10 days per episode of care and for no more than 10 days in a three month period.

- Mupirocin nasal ointment is the ointment of choice; however high-level resistance is not uncommon. Due to increasing antibiotic resistance treatment may vary. It is important that the sensitivity is checked and advice sought from Medical Microbiology as necessary. **Mupirocin must not be prescribed in cases of Mupirocin resistance. Seek advice from Infection Prevention and Control team or Microbiologist.**

- Mupirocin nasal ointment should be prescribed 3 times a day, **for a maximum of 10 days.**

- A match head size portion of ointment should be applied to each nostril on the tip of a little finger or on a disposable cotton swab.

6.8.4. **Children and neonates**

Suppression therapy will be dependant on age and whether there are any underlying skin conditions. Recommended treatment is usually Mupirocin and Octenisan. However, all treatment should be discussed with Microbiologists. (See Summary at the beginning of the Policy.)

6.8.5. **Ordering Suppression Therapy**

- Chlorhexidine 4% (Hibiscrub) available from supplies/top up (one bottle per patient)
- Octenisan available from Pharmacy
- Mupirocin nasal ointment available from Pharmacy
6.9. **Infection**  
Treatment of MRSA infection is the responsibility of the clinical team, who should discuss antimicrobial therapy with the Medical Microbiologist as necessary.

6.10. **Prophylaxis**  
6.10.2. Patients either colonised or infected with MRSA undergoing a procedure which normally requires antimicrobial prophylaxis may need a different prescription to the standard prophylaxis for the procedure. Please refer to the Antimicrobial guidelines/Trust formulary and contact Microbiology if the correct prescription is not clear. Prophylaxis is advised where patients have a positive urine culture and experience a traumatic catheterisation. Advice should be sought from the Microbiologist.

6.10.3. **Wound Treatment**  
- The treatment of wounds is dependent on whether the wound is infected or colonised with MRSA.
- In general the following principles can be applied:
  - If required the wound should be cleansed with sterile water
  - Antimicrobial preparations should be used, where possible, for 1 week.
  - The wound should be covered with an appropriate secondary dressing
  - Silver dressings must NOT be used in the treatment field of patients undergoing radiotherapy as it causes a severe reaction
  - Persons under going MRI should not have silver dressings insitu.

6.11. **Management of the positive inpatient (those patients who have screened positive on the current admission)**

6.11.2. If a patient is known to have had MRSA previously, they should ideally be isolated, prior to receiving the results of the MRSA screen (unless they have had at least three consecutive negative MRSA screens within a 2 year period).

6.11.3. The proper management and placement of patients with infectious conditions is essential in minimising the impact and potential transmission of any infectious condition. This includes MRSA. There is evidence to suggest that certain interventions can substantially reduce MRSA even in settings with a high level of endemic MRSA. Given that MRSA is widespread within the NHS, the course of action taken for the management of patients colonised or infected with MRSA depends on a variety of factors including:

- Type of ward
- Facilities available for patient isolation
- Design of the ward
- Whether affected patients are likely to be heavy shedders of MRSA
- Resistance pattern, virulence and potential transmissibility of the organism

Each patient should be individually assessed against the above. Advice should be sought from the Infection Prevention and Control Team as required.

6.11.4. For all adult patients who screen positive for MRSA or have a previous history of MRSA a MRSA screening and suppression therapy care plan CHA2755 should be commenced.
6.11.5. Wherever possible, standard source isolation procedures (see Isolation Policy and Patient Placement and Movement Policy) should be instituted especially in high risk areas (table 1 below). The implication of MRSA colonisation, infection and treatment should be explained to patients and relatives.

When single room facilities are not available affected patients should be cohort nursed together subject to any impact of moving patients out of their specialist area.

Risk Categories – patient areas (table 1)

<table>
<thead>
<tr>
<th>High risk</th>
<th>Moderate</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intensive care</td>
<td>General surgery</td>
<td>Rehabilitation</td>
</tr>
<tr>
<td>High Dependency Unit</td>
<td>Urology</td>
<td>Long stay facilities</td>
</tr>
<tr>
<td>Neonatal Intensive Care Unit</td>
<td>Obstetrics</td>
<td></td>
</tr>
<tr>
<td>Special care baby units</td>
<td>Gynaecology</td>
<td></td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>Paediatrics</td>
<td></td>
</tr>
<tr>
<td>Trauma</td>
<td>General medical</td>
<td></td>
</tr>
<tr>
<td>Vascular</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renal Units</td>
<td></td>
<td></td>
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<tr>
<td>Theatres</td>
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</tr>
</tbody>
</table>

Whether a patient is nursed in a single room facility or on the ward, basic control measures must be adhered to:

6.11.6. **Hand Decontamination**

High standards of hand decontamination are required to minimise the risk of cross infection. Hands should be adequately decontaminated before and after patient contact and on leaving an isolation facility/ward. Hand decontamination should be by thorough washing with soap and water, or the application of a 70% alcohol hand rub. Bacterial counts increase when the skin is damaged therefore care must be taken to maintain skin integrity. It is important that a good quality Trust approved hand cream is applied regularly throughout the shift e.g. beginning and end and when a break is taken.

6.11.7. **Protective Clothing**

- **Aprons** – all staff handling the patient or having contact with their immediate environment should wear disposable aprons. This also applies to visitors who assist with patient care. Visitors who only have social contact with the patient, such as shaking hands do not need to wear protective clothing but do need to decontaminate their hands after leaving the room.

- **Gloves** – gloves do not obviate the need for hand decontamination and should only be worn when there is contact with body fluids.

6.11.8. **Linen**

All linen should be sent to the laundry as infected/soiled linen in a red alginate bag placed in a red plastic bag. Curtains should be changed on discharge or transfer.
6.11.9. Waste
All waste produced in the area where the patient is being treated, should be designated as ‘infectious clinical waste’ and treated according to the Trust ‘Waste Management Policy’.

6.11.10. Additional measures
6.11.10.1. The door should be kept closed to minimise spread to adjacent areas. If this is likely to compromise patient care, for instance in the elderly confused patient, a risk assessment should be made as to whether the door may be kept open. Such patients often benefit from being nursed together in a cohort with other MRSA patients. The side-room door must be kept closed during procedures that may generate staphylococcal aerosols, such as chest physiotherapy, or bed making etc.

6.11.10.2. Visitors to the cubicle or ward and staff from other wards and departments, e.g. physiotherapists, radiographers, other medical teams, students, should only enter after permission and instruction from the nurse in charge.

6.11.10.3. Instruments or equipment (e.g. sphygmomanometers, stethoscopes, lifting slings, and physiotherapy exercise machines) should preferably be single-patient use, or designated for MRSA patients. Multiple-patient use items should be decontaminated appropriately before use on another patient in accordance with manufacturer’s instructions.

6.11.10.4. Organise ward rounds/visits/appointments, etc. to ensure that infectious/colonised patients are examined last.

6.11.10.5. Do not transfer affected patients unnecessarily to other wards/departments. Where this is unavoidable, instruct staff on necessary precautions.

6.11.10.6. When a patient has been identified as having MRSA and they have been in hospital for more than 48 hours, all patients in the bay should be screened. Where this is a neonate, the parents and siblings should also be screened.

6.11.11. Identification of MRSA Patients

6.11.11.1. The patient's electronic record will be marked with the MRSA alert above the patient's name. (Usually added by the infection control administrator) It is the responsibility of ward, clinic or department staff to check the patient’s records for evidence of a previous MRSA history and whether the patient is Mupirocin resistant (this information can be found on the Winpath system).

6.11.11.2. The front cover of the case notes should be marked, by ward clerk, with self-adhesive label identifying that the patient has an alert. Labels are available via medical records Medical Records.

6.12. Transfer of patients with MRSA - to other wards/departments.
6.12.1. Transfer of MRSA affected patients to other wards or departments within the county should be minimised to reduce risk of spread but this should not compromise other aspects of care such as the need for clinical investigations, high dependency nursing, rehabilitation or placement in the appropriate care environment. Transfer out of county for specialist care must not be delayed.

6.12.2. Receiving staff should be informed in advance that the patient is MRSA colonised and this should be recorded on the inter-healthcare transfer form.

6.12.3. Attendants who may be in direct contact with the patient should wear disposable aprons and gloves. These should be removed when contact with the patient has finished and disposed of as clinical waste.

6.12.4. Gloves and aprons are not required by staff transporting patients unless direct contact is made with the patient.

6.12.5. The trolley or chair should be cleaned with multi-surface detergent wipes.

6.12.6. Staff should wash their hands thoroughly after cleaning the chair.

6.13. Discharge

6.13.1. Each patient should be given discharge advice regarding any continuing MRSA treatment. All should be advised of the need for good standards of general hygiene. The patient should also be advised that there is only a very small risk to healthy relatives or others outside the hospital.

6.13.2. An inter-hospital transfer form must be completed when transferring a patient to other acute hospitals, community hospitals/hospice or nursing homes.

6.13.3. The general practitioner, or other healthcare agencies involved in the patient's care, should be informed in writing that the patient has or has had MRSA as part of the discharge letter from the clinical team or inter healthcare transfer letter from the nursing team.

6.13.4. Continued carriage of MRSA is not a contraindication for the transfer of the patient to a nursing or convalescent home (Department of Health, Infection Control Guidance for Care Homes, 2006).

6.13.5. If an MRSA positive result is received after the patient has been discharged or transferred the responsibility to inform either the GP or receiving unit lies with the clinician who requested the specimen. An automatic copy of the positive result will be forwarded to the patients GP via the microbiology results service.

6.13.6. Any equipment used by the patient or within his/her bed space area or side room should be decontaminated before use on another patient. Any supplies which cannot be decontaminated (e.g. syringes, gauze packets) should be disposed of.

6.13.7. After discharge, the patient's room or bed area should undergo terminal cleaning. (See Terminal Cleaning protocol). The nurse in charge must check that this clean meets hospital standards before admitting another patient to the area.
6.13.8. To minimise the risk of confusion over instructions, patients or their carers should be given an information leaflet with specific precautions highlighted, together with a contact number for further advice.

6.14. **Transporting By Ambulance or Car**

6.14.1. Where clinical condition allows, patients with MRSA can be transported in an ambulance with other patients as long as any wounds are covered with an appropriate dressing and the ambulance crew maintains standard infection control precautions.

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

6.15. **Outpatient Departments / Clinics/ Theatre**

6.15.1. Wounds colonised or infected with MRSA must be covered with an appropriate dressing whilst waiting in communal areas.

6.15.2. Known MRSA patients should be seen last in the clinic if possible and at the end of the theatre list.

6.15.3. The number of staff attending to the patient should be kept to a minimum and there must be strict attention to hand hygiene.

6.15.4. There is no need to remove equipment from the consulting rooms. Surfaces that the patient has had direct contact with e.g. examination couch, should be decontaminated after use, using warm water and detergent or detergent wipes. If the patient is a heavy skin scale shedder additional cleaning of floor and other surfaces may be necessary - it is advisable to see such patients at the end of the clinic, to ensure adequate time for cleaning.

6.15.5. Equipment and staff in the theatre should be kept to a minimum and all surfaces cleaned with Actichlor plus following surgery.

6.15.6. Where possible the patient should be recovered in theatre rather than recovery.

6.16. **Staff**

6.16.1. **Pregnant Staff**
There is no reason to exclude pregnant staff from caring for patients with MRSA.

6.16.2. **Staff Carriage of MRSA**

6.16.2.1. MRSA rarely causes infection in healthy people. Transmission of MRSA, from patient to staff or vice versa, may occasionally occur via close contact. However, staff usually have transient carriage only and, by the time they return to work after the previous shift, no longer carry MRSA. Staff undergoing MRSA screening as a result of elective or emergency admission should not be screened during or immediately after a shift of work. If staff screen positive for MRSA close to a shift they should undergo re-screening.
6.16.2.2. Treatment of staff that screen positive for MRSA, as a result of elective screening, should be provided with suppression treatment, by either the pre-assessment clinic or the GP surgery, in accordance with the MRSA screening policy. Any member of staff who has a positive MRSA result should inform occupational health who will undertake a risk analysis with the support of the infection prevention and control team where necessary.

6.16.2.3. Colonised or infected staff rarely transmit infection to patients therefore routine MRSA screening of staff is not conducted within the Trust.

6.16.3. MRSA screening of staff secondary to outbreaks

6.16.3.1. During outbreaks the infection control team may decide to screen staff if the epidemiology suggests this is necessary. Staff screening will be coordinated through the Occupational Health Department to ensure staff confidentiality.

6.16.3.2. Staff found to be positive for MRSA carriage will be started on the MRSA suppression protocol and will be removed from duty for the first 24 hours. Staff working in high-risk environments, (e.g. operating theatres, wound management, intensive care) may be restricted from performing high risk activities and may be re-deployed until they are screen-negative.

6.16.3.3. For details of staff management in an outbreak situation please see Appendix 9 of this policy

6.16.4. Incidental finding of MRSA in staff

Staff who discover that they are positive for MRSA by any means other than screening secondary to an outbreak situation (i.e. as a result of elective or emergency admission screening) should contact the Occupational Health Dept for advice.

6.17. Post Infection Review (PIR) Process for MRSA bloodstream infections

6.17.1. The planning guidance Everyone Counts: Planning for Patients 2013/14 sets out a requirement to institute a Post Infection Review in all cases of MRSA bloodstream infection. The purpose of this review is to identify how a case occurred and to identify actions that will prevent it reoccurring.

6.17.2. The PIR will be conducted by a multidisciplinary clinical team who will review the bloodstream infection event and identify the factors that contributed to it. The PIR will also determine to which organisation the bloodstream infection will be assigned.

The process for the PIR can be found in Appendix 8.
7. Dissemination and Implementation
This policy will be implemented via the following routes:

- Information regarding the policy will be disseminated to the Infection Prevention and Control Link Practitioners during their quarterly updates.
- The policy will be included in the Trust’s Document Library
- The policy will be circulated to all Ward Sisters/departmental Managers and Matrons

8. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA Screening of a selection of elective admissions and emergency admission.</td>
<td>Louise Dickinson (Consultant Nurse/Joint DIPC)</td>
</tr>
<tr>
<td>Lead</td>
<td>Review of all eligible patients for screening</td>
</tr>
<tr>
<td>Tool</td>
<td>Monthly</td>
</tr>
<tr>
<td>Frequency</td>
<td>To be reviewed and scrutinised at the Infection Prevention and Control Steering Group</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>The Infection Prevention and Control Steering Group will undertake subsequent recommendations and action planning for any or all deficiencies and recommendations within reasonable timeframes</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>Required actions will be identified and completed within a month.</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>Required changes to practice will be identified and actioned immediately where necessary. The ward Sister/Charge Nurse will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.</td>
</tr>
</tbody>
</table>

9. Updating and Review
This policy will be reviewed within three years

10. Equality and Diversity
10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Diversity & Human Rights Policy' or the Equality and Diversity website.

10.13. Equality Impact Assessment
The Initial Equality Impact Assessment Screening Form is at Appendix 2.
### Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Meticillin Resistant Staphylococcus Aureus (MRSA) Policy V9.1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date Issued/Approved:</strong></td>
<td>14 May 2018</td>
</tr>
<tr>
<td><strong>Date Valid From:</strong></td>
<td>12 November 2018</td>
</tr>
<tr>
<td><strong>Date Valid To:</strong></td>
<td>13 May 2021</td>
</tr>
</tbody>
</table>
| **Directorate / Department responsible (author/owner):** | Louise Dickinson  
Consultant Nurse/Joint DIPC |
| **Contact details:** | Louise Dickinson 01872 254969 |
| **Brief summary of contents** | This policy has been developed to provide staff with the necessary information and knowledge to effectively reduce the risk of MRSA introduction to the Trust, and to put in place systems to detect, control and contain cases of MRSA as and when they occur. |
| **Suggested Keywords:** | MRSA, Meticillin-resistant Staphylococcus aureus, Meticillin, Infection Control, Infection Prevention |
| **Target Audience** | RCHT  
CFT  
KCCG  
✓  
|
| **Executive Director responsible for Policy:** | Chief Nurse |
| **Date revised:** | 20.08.18 |
| **This document replaces (exact title of previous version):** | Meticillin Resistant Staphylococcus Aureus Policy V9.0 |
| **Approval route (names of committees)/consultation:** | Hospital Infection Prevention and Control Committee |
| **Divisional Manager confirming approval processes** | Louise Dickinson |
| **Name and Post Title of additional signatories** | Not Required |
| **Name and Signature of Divisional/Directorate Governance Lead confirming approval by specialty and divisional management meetings** | {Original Copy Signed}  
Louise Dickinson |
| **Signature of Executive Director giving approval** | {Original Copy Signed} |
| **Publication Location (refer to Policy on Policies – Approvals and Ratification):** | Internet & Intranet  
✓  
Intranet Only |
**Document Library Folder/Sub Folder**
Clinical / Infection Prevention & Control

**Links to key external standards**


**Related Documents:**

**Training Need Identified?**
No

**Version Control Table**

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
</tr>
</thead>
<tbody>
<tr>
<td>17.11.2007</td>
<td>1</td>
<td>New Policy</td>
<td>IPAC team</td>
</tr>
<tr>
<td>18.08.2009</td>
<td>2</td>
<td>Re-formatted.</td>
<td>IPAC team</td>
</tr>
<tr>
<td>7.10.2010</td>
<td>3</td>
<td>Reviewed and amended in accordance with changes to screening programme. MRSA Screening policy incorporated into document</td>
<td>Louise Dickinson Consultant Nurse</td>
</tr>
<tr>
<td>06.01.2012</td>
<td>4</td>
<td>Monitoring and review section strengthened to reflect requirements of NHSLA</td>
<td>Louise Dickinson Consultant Nurse</td>
</tr>
<tr>
<td>12.06.12</td>
<td>5</td>
<td>Section on informing patient of results and recording the process of taking screen strengthened.</td>
<td>Louise Dickinson Consultant Nurse</td>
</tr>
<tr>
<td>10.04.14</td>
<td>7</td>
<td>Minor changes to screening and management of patients following actions from MRSA bacteraemia PIR. Formatted in new template.</td>
<td>Louise Dickinson Consultant Nurse</td>
</tr>
<tr>
<td>Date</td>
<td>Page</td>
<td>Notes</td>
<td>Signature</td>
</tr>
<tr>
<td>--------</td>
<td>------</td>
<td>-----------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>02.02.15</td>
<td>8</td>
<td>6.1.5 liaise with other healthcare providers when carrying out 3 monthly screen if wound present. 6.1.2 and 6.1.4 – obstetrics removed from screening programme.</td>
<td>Louise Dickinson</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Consultant Nurse</td>
</tr>
<tr>
<td>09.05.18</td>
<td>9</td>
<td>Full Review. Reformatted to new Trust template. Elective screening section updated. Monitoring section updated. Appendix on staff suppression removed.</td>
<td>Louise Dickinson</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Consultant Nurse</td>
</tr>
<tr>
<td>20.08.18</td>
<td>9.1</td>
<td>Amendment to section 6.1.1. Reworded section relating to MRSA screening in Pre-Operative assessment clinic and Elective admissions. MRSA screening result will remain valid for the duration of the pre-operative period usually 9 months.</td>
<td>Jean James</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>IPAC Lead Nurse</td>
</tr>
</tbody>
</table>

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.
This document is only valid on the day of printing

Controlled Document
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# Appendix 2. Initial Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Name of Name of the strategy / policy / proposal / service function to be assessed</th>
<th>Meticillin Resistant Staphylococcus Aureus (MRSA) Policy V9.1</th>
</tr>
</thead>
</table>

## Directorate and service area:
**Infection Prevention and Control**

<table>
<thead>
<tr>
<th>Name of individual completing assessment:</th>
<th>Louise Dickinson</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Is this a new or existing <em>Policy</em>?</th>
<th>Existing</th>
</tr>
</thead>
</table>

**Telephone:**

| 01872 254969 |

### 1. Policy Aim*

**Who is the strategy / policy / proposal / service function aimed at?**

To provide staff with the necessary information and knowledge to effectively reduce the risk of MRSA introduction to the Trust, and to put in place systems to control and contain cases of MRSA as and when they occur.

### 2. Policy Objectives*

To reduce MRSA infections.

### 3. Policy – intended Outcomes*

To reduce the levels of MRSA

### 4. *How will you measure the outcome?*

Mandatory reporting of MRSA bacteraemia.

### 5. Who is intended to benefit from the policy?

All staff and patients.

### 6a Who did you consult with

<table>
<thead>
<tr>
<th>Workforce</th>
<th>Patients</th>
<th>Local groups</th>
<th>External organisations</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**b). Please identify the groups who have been consulted about this procedure.**

| Infection Prevention and Control Steering Group |
| Hospital Infection Prevention and Control Committee |

### What was the outcome of the consultation?

The procedures were agreed
7. The Impact
Please complete the following table. **If you are unsure/don’t know if there is a negative impact you need to repeat the consultation step.**

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>✓</td>
<td></td>
<td></td>
<td>Infections may affect any age</td>
</tr>
<tr>
<td>Sex (male, female, trans-gender/gender reassignment)</td>
<td>✓</td>
<td></td>
<td></td>
<td>Infections may affect any gender</td>
</tr>
<tr>
<td>Race / Ethnic communities /groups</td>
<td>✓</td>
<td></td>
<td></td>
<td>Infections may affect any groups.</td>
</tr>
<tr>
<td>Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions</td>
<td>✓</td>
<td></td>
<td></td>
<td>Infections may affect all regardless of disability</td>
</tr>
<tr>
<td>Religion / other beliefs</td>
<td>✓</td>
<td></td>
<td></td>
<td>Infections may affect any religion</td>
</tr>
<tr>
<td>Marriage and Civil partnership</td>
<td>✓</td>
<td></td>
<td></td>
<td>Infections may affect all people – married or otherwise</td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td>✓</td>
<td></td>
<td></td>
<td>Infections may affect any pregnant woman. Pregnant members of staff may need to take additional precautions depending on the organism involved.</td>
</tr>
<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
<td>✓</td>
<td></td>
<td></td>
<td>Infections may affect all regardless of sexual orientation</td>
</tr>
</tbody>
</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:
- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation - this excludes any policies which have been identified as not requiring consultation. or
- Major this relates to service redesign or development

8. Please indicate if a full equality analysis is recommended.  
   - Yes  
   - No  ✓

9. If you are not recommending a Full Impact assessment please explain why.

None of the equality strands have been identified in the initial impact assessment.
Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead  
c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa,  
Truro, Cornwall, TR1 3HD  

This EIA will not be uploaded to the Trust website without the signature of the  
Human Rights, Equality & Inclusion Lead.  

A summary of the results will be published on the Trust’s web site.  

Signed Louise Dickinson  

Date  09.05.2018
Appendix 3. MRSA Screening, Wound Swabbing and Suppression Treatment with Wounds

The following flow chart is to be used to identify effective screening for MRSA in patients with wounds and to ensure appropriate wound management for MRSA positive patients.

All wounds should be included in the MRSA screen. If the dressing is easy to change and the wounds needs a review please swab as part of the full MRSA screen. If the wounds are not causing a clinical concern and are dressed i.e. venous leg ulcers in intact compression bandages (which are not due to be changed on the day of the screening) please leave bandages in situ and swab at next dressing change.

Use **red** swabs – request form to indicate that swabs are being sent for MRSA screening

Suppression Treatment of an MRSA Positive Patient with Wounds

MRSA positive result indicates need for active wound treatment of all wounds even if they were not swabbed at initial screening.

Ward to contact equipment library for Acticoat/Acticoat Absorbent dressing, depending on level of exudate (Ext 3049 or Bleep 2951)

Acticoat/Acticoat Absorbent is sent to the ward (Wards will be cross charged for all Acticoat/Acticoat Absorbent Dressings)

Acticoat/Acticoat Absorbent is used on the wounds as part of suppression therapy and renewed every 3 days (Unless strikethrough indicates an increase in the number of dressing changes)

Review wounds and discontinue Acticoat dressings after 5 days.

If symptoms of increased bacterial colonisation such as odour, increased exudate and erythema of wound margins persist, continue Acticoat/Acticoat Absorbent dressings for a maximum of 2 weeks or obtain advice from the tissue viability team.
Appendix 4. Post Infection Review Process

Day 0
Confirmation of Specimen. RCHT IPAC team to contact PCH IPAC team and KCCG DIPC with patient details and arrange Day 1 phone call

Day 1
Phone call to determine who will lead the RCA process and arrange date of RCA review meeting. This should ideally be within 5 working days

Day 4
Teleconference RCHT, PCH IPAC teams and KCCG DIPC.

RCA review meeting
Ideally within a week of confirmation of the result. Review meeting with all clinical parties in attendance. Identify lessons learnt and complete action plan. Determine which Trust the result is attributable to.

Review of Actions
Actions to be reviewed at PCH Infection Control Committee and RCHT Infection Prevention and Control Steering Group Meeting.