Somerset Partnership NHS
NHS Foundation Trust

MRSA
(METICILLIN RESISTANT STAPHYLOCOCCUS AUREUS) POLICY

DETECTION & MANAGEMENT (INCLUDING SCREENING AND DECOLONISATION OF URINARY TRACT)

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DOCUMENT CONTROL

Reference	**Version**	**Status**	**Author**
KA/Mar13/MRSA	6	Final	Infection Prevention Control and Decontamination Lead

Amendments: name of policy has been changed to reflect the purpose of the document. Spelling of Meticillin has also been changed throughout the document. Treatment for MRSA has been updated as has the screening of MRSA in line with Government objectives. Policies reviewed by IPC lead post acquisition to ensure all contents are applicable and current to the Trust as a whole. 5.2 - Routine planned update, details of urinary and wound decolonisation clarified		
Document objectives: to provide all staff with clear instructions for the detection & management of Meticillin Resistant Staphylococcus Aureus (MRSA) to reduce potential risk.		
Intended recipients: whatever their grade, role or status. Permanent, temporary, full-time or part-time staff including locums, bank staff, volunteers, trainees and students. This Policy will be available to the general public on the Trust Internet.		
Committee/Group Consulted: Infection Prevention and Control Implementation Group		
Monitoring arrangements and indicators: See relevant section		
Training/resource implications: See relevant section		
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Lead Director	Director of Nursing and Patient Safety	

CONTRIBUTION LIST Key individuals involved in developing the document

Name	**Designation or Group**
Karen Anderson	Infection Prevention Control and Decontamination Lead
Lisa Stone	Senior Infection Prevention and Control Nurse
Andrew Sinclair	Equality and Diversity Lead
Michelle Barnham &Nikki Hall	Infection Prevention and Control Nurses
All Members	Infection Prevention and Control Group
All Members	Clinical Policy Review Group
All Members	Clinical Governance Group

CONTENTS

1. INTRODUCTION

1.1 Colonisation by Meticillin Sensitive *Staphylococcus Aureus* (MSSA) can be harmless and asymptomatic to the patient, but in a small number of cases it can cause infection ranging from minor skin infections to blood stream infections (bacteraemia)

1.2 A small number of *Staphylococcus Aureus* are resistant to Meticillin (MRSA)

1.3 Colonisation by MRSA can be a significant issue in healthcare settings because:

- Patients colonised with MRSA who undergo invasive procedures are at risk of developing an MRSA bloodstream (bacteraemia) infection
- The presence of patients colonised with MRSA in hospitals is a potential source of infection for other patients
- Should MRSA infections develop they are harder to treat as the antibiotics they are susceptible to are more limited

1.4 MRSA colonisation can be asymptomatic and therefore can only be identified by taking swabs from appropriate sites

2. PURPOSE & SCOPE

2.1 The purpose of this policy is to control the spread of MRSA and prevent bacteraemia (Blood Stream Infection) due to MRSA

2.2 This policy sets out the requirements for all healthcare workers involved in the care and management of patients who may potentially be colonised with MRSA

2.3 The approach to the control of MRSA in any setting is based on the level of risk of transmission, the likelihood of infection and the impact on patient care. It is expected therefore that there is a degree of variation in the intensity of approach dependent on the degree of risk and the changing epidemiology of the organism

2.4 Further advice may be obtained from the Trust's Infection Prevention and Control Team or Infection Control Doctor

2.5 This procedural document applies to all staff including Temporary, Locum, Bank, Agency and Contracted staff

3. DUTIES AND RESPONSIBLITIES

3.1 The Trust Board, via the Chief Executive is responsible for:

- Ensuring there are effective and adequately resourced arrangements for the detection and management of MRSA within the Trust
- Identifying a Trust Board Lead for Infection Prevention and Control
- Ensuring the role and functions of the Director of Infection Prevention and Control are satisfactorily fulfilled by appropriate and competent persons as defined by the Department of Health, (2015)

3.2 Director for Infection Prevention and Control Implementation Group is responsible for:

- Overseeing the local control of and the implementation of the MRSA (Meticillin Resistant Staphylococcus Aureus) Policy – Detection and Management

3.3 The Trust Infection Prevention and Control Assurance Group is responsible for:

- Ensuring procedures for the implementation of the MRSA (Meticillin Resistant Staphylococcus Aureus) Policy – Detection and Management are continually reviewed and improved within the Trust
- Ensuring that lessons learned from any Staphylococcus Aureus bacteraemias are actioned and learning is disseminated throughout the Trust

3.4 Infection Prevention and Control Team are responsible for:

- Assisting with root cause analysis of any Staphylococcus Aureus bacteraemia (sensitive or resistant) and sharing results including lessons learned with the Trust Board, Service and Ward managers and Infection Prevention and Control Implementation Group
- Undertaking mandatory reporting any Staphylococcus Aureus bacteraemia (sensitive or resistant) to the Acute NHS Trust, responsible for database management
- Surveillance of MRSA and identification of potential outbreaks
- Education and training in the detection of MRSA in all relevant patients, either within inpatient settings or community based healthcare environments
- Education and training in the Infection Prevention and Control management of MRSA infected or colonised patients

- Monitoring and audit of isolation practice of patients isolated with suspected MRSA colonisation

- Advising patients if requested by staff on any issues relating to MRSA

- Liaising with the Trust Occupational Health Provider, as appropriate, when MRSA is detected in staff

3.5 **The Ward /Service Manager or their deputy is responsible for:**

- Ensuring infection prevention and control precautions are implemented as detailed in this policy

- Ensuring MRSA screening is undertaken as detailed within this policy

- Instigating remedial action to address any issues around screening compliance in their area

- Instigating remedial action to address any issues around infection prevention and control practice compliance, as detailed in this policy, in their area

- Ensuring staff are aware of the policy and requirements for attending training as identified in the Training Matrix. Managers will ensure staff have attended all relevant training and have current updates

- Ensuring staff are released to attend relevant training and for recording attendance at training in local training records. All non-attendance at training will be followed up by managers

- Ensuring individual staff and team's training needs are met through appraisal and in line with the Training Matrix Training information should be passed to the Learning and Development. Training Department who will update the electronic staff record

3.6 **Ward/ Clinical staff are responsible for:**

- Adhering to the Infection Prevention and Control precautions detailed in this policy

- Adhering to the MRSA screening guidelines as detailed in this policy

- Ensuring patients with a confirmed positive MRSA status (infection or colonisation) are highlighted to all other RiO users via the 'Alert' function

- Ensuring communication of suspected or confirmed MRSA status of patient is transferred to another NHS body or healthcare facility

- Booking themselves onto initial and update mandatory training and for attending mandatory training, regardless of their grade, role or status, including permanent, temporary, full-time, part-time staff and locums, bank staff, volunteers, trainees and students

In addition, (Mental Health Directorate) the admitting nurse is responsible for:

- Completing the Infection Prevention and Control Risk Assessment on admission and taking appropriate action depending on results

- Ensuring that 'High MRSA Risk' patients as detailed in this policy are identified and MRSA screening is attempted within 48 hrs of admission (as per Physical Assessment Policy)

In addition, (Community Health Directorate) the admitting nurse is responsible for:

- Screening all patients within 48 hours of admission

3.7 **Medical Staff**

- Are responsible for screening podiatry surgery patients pre-operatively

- Are responsible for ensuring their junior staff understand and implement the screening practices outlined in this policy

- Are responsible for ensuring their staff understand and implement the care and management of patients with MRSA as outlined in this policy

3.8 **Learning and Development Training Team are responsible for:**

- Recording attendance at Mandatory Training and will advise Operational Managers of non-attendance

3.9 **Trust Occupational Healthcare Provider is responsible for:**

- Ensuring that any staff identified as MRSA positive are decolonised appropriately and are aware of their management plan

- Liaising with ward managers regarding management of staff identified as MRSA positive if appropriate and with full consent of the staff member

- Liaising with Infection Prevention and Control team regarding management of staff identified as MRSA positive if appropriate and with full consent of the staff member

4. EXPLANATIONS OF TERMS USED

4.1 **The Trust –** Somerset Partnership NHS Foundation Trust

4.2 ***Staphylococcus Aureus* -** a Gram positive bacterium often found on the skin or in the nose of individuals. It may also be found in some foodstuffs and is known to cause food poisoning on occasions

4.3 **MRSA - Meticillin Resistant Staphylococcus Aureus –** a strain of *Staphylococcus Aureus* that is resistant to Flucloxacillin and other antibiotics commonly used to treat infections

4.4 **Colonisation with MRSA –** When MRSA is present on humans and not causing symptoms of infection an individual is regarded as colonised

4.5 **Infection with MRSA –** Localised Infections can occur if MRSA gains access to tissues beneath the skin or mucosa. An infection should be suspected when MRSA is isolated and the patient shows clinical signs of infection

4.6 **MRSA Infection –** MRSA is a significant cause of healthcare associated infection (HCAI). It can result in blood stream infection that can be life threatening. MRSA can also cause skin and wound infections, urinary tract infections and pneumonia. These infections require treatment with antibiotics

All MRSA blood stream infections are reported under the national mandatory surveillances scheme to Public Health England

4.7 **MRSA Bacteraemia –** when MRSA gains access via the bloodstream

4.8 **MRSA Colonisation –** in many cases MRSA is asymptomatic colonisation (bacterium detected on a body site not resulting in infection). These patients are decolonised with MRSA eradication regime of topical antiseptic agents

4.9 **Screening –** is the testing of patients for the presence of MRSA on the most common body sites it is known to be colonised

4.10 **Meticillin –** was a narrow spectrum beta-lactam antibiotic of the penicillin class which has now been discontinued. The term Meticillin Resistant Staphylococcus Aureus (MRSA) continues to be used to describe resistant strains of Staphylococcus Aureus. Flucloxacillin is the clinical equivalent to Meticillin.

4.11 **MRSA Contact –** a patient who has been residing in the same immediate vicinity as an MRSA positive patient for 48 hours or longer

4.12 **Contact Screening –** screening of MRSA contact patients

4.13 **High Risk Inpatients –** patients identified as being at higher risk of colonisation or who are currently at greater risk of developing bacteraemia (see Section 5 for further details)

4.14 **Transient Carriage of MRSA –** when MRSA is carried on the skin such as on the face, hands, arms, inside the nose for a short period of time

4 15 **Systemic Infection –** Infection that is widespread throughout the body, affecting many body organs causing the individual to be acutely unwell

5. INPATIENT MRSA SCREENING

5.1 **Community Health Directorate** - All inpatients whether following elective or emergency admission should undergo screening for MRSA within 48 hours of admission

5.2 **Mental Health Directorate** – All 'high risk' inpatients should be screened for MRSA. 'High Risk' inpatients are defined as

- Those who have any kind of indwelling device eg urinary catheter or PEG
- Those who have a break in the skin, which would include acute, chronic and 'slow to heal' wounds regardless of cause
- History of admission (excluding A&E attendance) to any other hospital or residential setting within one month (a residential setting includes residential care and nursing care homes and prison/young offenders institutions)
- History of surgery (including Minor and Day surgery) within one month

5.3 All patients should be screened within 48hrs of admission in line with the Trust physical assessment guidance

5.4 Any patient presenting with signs and symptoms of localised infection should have appropriate specimens collected as part of the admission process. The specimens should be sent the same day if possible. Microbiology, culture and sensitivity (M, C&S) should be requested on all specimens as this will isolate any bacterial growth including MRSA. The patient should receive medical review as soon as possible following admission, as per policy

5.5 Swabbing may be undertaken by any grade of staff who have received appropriate training and regard themselves as competent in the procedure. Appropriate training may be provided by the ward based Link Practitioner, by the Infection Prevention and Control Team, or a competent Registered General Nurse

5.6 Swabbing may also be undertaken by the patient under direct supervision and guidance by staff who have received appropriate training and regard themselves as competent in the procedure

5.7 A member of the Infection Prevention and Control Team will train the ward based link Practitioners, or any other staff member who requests

5.8 Patients in Community Hospitals who have extended in-patient stays (longer than 1 month), are to be screened at 28 day intervals or within one calendar month

6 PRE-OPERATIVE SCREENING

6.1 All patients admitted for Podiatric Surgery are to be screened pre operatively

7 STAFF SCREENING (see also Section 21)

7.1 Routine staff screening is not necessary but may occur as part of an outbreak investigation with guidance sought via the Trust Infection Prevention and Control Doctor and the Infection Prevention and Control Team

7.2 Any screening programme involving staff will be co-ordinated by the Trust's Occupational Health provider

7.3 Investigation and treatment of healthcare personnel is the responsibility of the Occupational Health provider. Staff confidentiality will be maintained at all times

7.4 Healthcare staff should report infected skin lesions to their Line Manager, and referral to the Occupational Health advisor maybe considered

7.5 Healthcare workers who require elective surgery should have their pre-operative screen taken when they have been away from their workplace for a minimum of 24 hours

8 CONTACT SCREENING

8 1 Inpatients who have prolonged contact with MRSA positive patients are at risk of becoming colonised and will need to be screened (even if they have previously had a negative admission screen)

8.2 Any patient who has been in the near vicinity (the same bay or for nightingale wards within 2 bed spaces either side) of the MRSA positive patient for 48 hours or longer must be screened

8.3 Contact time is reduced to 24 hours if the contact patient has a wound, indwelling device or is immunocompromised (including long term high dose steroids)

8.4 The Infection Prevention and Control Team will investigate any possible cross transmission should a further patient be found to be MRSA positive

9 WHAT SITES SHOULD BE SCREENED FOR MRSA?

9.1 All high MRSA risk inpatients should have a full MRSA screen, which includes swabs from all the following sites:

- Nose – one side only from 1cm inside the nostril
- Groin – one side only, (*axilla – one side only, may be used as an alternative especially where there is a history of abuse or where the patient expresses an explicit preference);* Mental Health patients only
- All broken areas of skin / wounds including. acute, surgical and chronic wounds, and insertion sites for indwelling devices, PEG, Supra pubic catheter, cannula and PICC sites etc.
- Catheter Specimen Urine (CSU) – only if indwelling catheter present
- Sputum – only if productive cough present

10 CONSENT

10.1 A written consent for MRSA screening on admission is not required (verbal and non verbal consent is adequate). However, an explanation of need and an information leaflet should still be given as a matter of good nursing practice. All healthcare notes should document this conversation fully in the Rio notes

10.2 For patients unable to give consent please refer to the Trust Safeguarding, Best interest and Consent Policies

10.3 Information leaflets are available in other formats and languages on request

10.4 Interpreters are available for any clients whose first language is not English

11 SCREENING PROCEDURE

11.1 When swabs are taken from dry parts of the body the swab must be moistened prior to sampling using the swab medium, sterile water or sterile saline

11.2 The following steps should be taken when obtaining a swab:

- Decontaminate hands immediately before swabbing
- Moisten swabs if necessary
- Rub and rotate the swab firmly on each area
- For nasal swabs only swab 1 nostril. It is not necessary to enter the anterior nares (nostril) more than 1 cm

- Place swab in the tube and label

11.3 A microbiology request form labelled ‘MRSA screen’ should accompany each patient screen. Swabs for the screen, on a single patient, may be entered on a single form

12 TESTING METHODS AND RESULTS

12.1 The laboratory staff at Southwest Pathology Services will phone MRSA results, once known to the Ward

12.2 The inpatient area may also be contacted by a member of the Infection Prevention and Control Team to advise of confirmed positive screening results

13 MRSA TRANSMISSION

13.1 Contact

Contaminated hands are the main route of spread for MRSA in healthcare settings. Contamination of the patient environment may also result in transmission of MRSA e.g. via inadequately decontaminated equipment

13.2 Airborne

MRSA can be transmitted via the airborne route but is only a significant risk when a patient has a skin shedding condition such as exfoliating eczema or psoriasis or where MRSA is isolated within the sputum of a patient with an active, productive cough

14 MANAGEMENT OF MRSA POSITIVE PATIENTS

14.1 MRSA positive patients will be risk assessed and isolated if appropriate and nursed using standard precaution

14.2 Patients likely to present a greater risk of spreading MRSA must take priority for an isolation room, i.e., sputum positive patients with a productive cough, patients with skin conditions such as psoriasis

14.3 Where isolation is risk assessed as being required but is not possible, the placement of the patient should be such that the risks of transmission are minimised, i.e.,

- In a cohort with others colonised with MRSA
- In a bed adjacent to a hand wash basin
- In an area where others do not have indwelling devices/chronic wounds/skin conditions/reduced immune response

- If staff are unable to isolate a patient who has been risk assessed as requiring, then a DATIX incident form should be submitted

14.4 Signage on the isolation room door should indicate to any healthcare worker that isolation precautions should be used

14.5 The door to the isolation room must be closed unless a risk assessment indicates that to do so would present a significant patient safety issue
OR
the patient has requested that the door remains open. This should be fully recorded within the RiO notes

14.6 Standard infection Prevention and control precautions (see Infection Control: Standard Precautions Policy)

- Disposable aprons and gloves must be worn for all activities

- Adherence to the Trust Hand Hygiene policy, is the prime intervention for reducing further spread. An effective technique using soap and running water will remove transient organisms from the hands. Alcohol gel can be used as a substitute on visibly clean hands and will effectively remove MRSA. Please refer to the Trust Hand Hygiene Policy for further guidance

- Visitors do not need to wear protective clothing whilst visiting a patient in isolation unless they are helping with direct patient care

14.7 Patient charts must remain outside the room IF POSSIBLE

14.8 Patients receiving topical antimicrobial decolonisation therapy should have clean bed sheets daily

14.9 Ideally, each isolation room should have en-suite facilities, if not, a dedicated bath/shower room and toilet must be allocated or commode left in room. Whenever possible the room must have its own dedicated patient use equipment, but where this is not possible the equipment must be decontaminated before and after use in the single room. Further advice about the appropriate decontamination method can be obtained from the Trust Decontamination of Medical Devices Policy

15. MRSA DECOLONISATION AND TREATMENT

15.1 If a clinical infection is suspected the medical staff must discuss treatment options with a Consultant Microbiologist

15.2 During normal office hours MRSA decolonisation should be obtained from pharmacy as a patient specific prescription, all MRSA decolonisation requires prescription:

- Mupirocin (Bactroban) Nasal Ointment x 3 daily to nostrils

- Octenisan x 1 daily wash - include at least 1 hair wash during the 5 day treatment plan (Use as a liquid soap – do not dilute in water)

- Doxycycline oral antibiotic therapy x 5 days if indicated for urinary or wound colonisation (Doxycycline is the first choice assuming MRSA strain is sensitive to it – all antimicrobial therapy should be based on antimicrobial sensitivities and if sensitivities are not available advice should be sought from a consultant microbiologist). See also Appendix E for urinary colonisation.

15.3 Community Health Hospitals will stock a limited number of MRSA decolonisation TTO packs (Octenisan and Bactroban only) in order to commence decolonisation over weekends and bank holidays. Mental Health Units should contact the On Call manager who will ensure access to one of these packs. If used TTO packs should be labelled with the Patient's details prior to use.

15.4 The treatment is applied for 5 days then stopped for 2 days and the patient is re-screened on day 8, 15 and 22 to determine if the MRSA has been successfully eradicated. The treatment regime should be recorded on the Topical MRSA prescription chart (see Appendix G). If any specimen is positive, recommence decolonisation regime as described (no more than 3 courses should be given in total) or discuss further options with the Infection Prevention and Control Team

15.5 Occasionally, there is a requirement to use an alternative decolonisation treatment, patient allergy, underlying pathogenic resistance or supply issues for example. In these instances full guidance on an alternative will be given by the Infection Prevention and Control Team

15.6 Specific protocols are in place for the enhanced treatment and management of patients with MRSA urine carriage **and** an indwelling urinary catheter. Treatment should start at the same time as the topical skin treatment and is detailed in the Decolonisation of MRSA Positive Urine Colonisation Protocol, (found in Appendix E)

15.7 If MRSA is isolated in a wound (acute or chronic), a suitable topical antimicrobial wound dressing (e.g. silver or honey) should be used. In addition, if the organism is sensitive to Tetracycline, a 5 day oral course of Doxycycline should be commenced as part of the decolonisation treatment. If used, this should be started at the same time as the topical skin treatment. (Please see note regarding prescribing antimicrobial therapy in 15.2 and contact the Consultant Medical Microbiologist if the patient has resistance / allergy to Doxycycline).

15.8 It may be beneficial, for chronic wounds critically colonised with MRSA, to delay the commencement of decolonisation treatment until the wound has undergone significant healing. The optimal time for commencement of decolonisation therapy should be assessed by the Infection Control Team on a case by case basis in liaison with the relevant clinical staff. If

decolonisation treatment is delayed an antiseptic body wash (e.g. Octenisan) should continue during this time

15.9 Any additional guidance maybe sourced via the Infection Prevention and Control Team

15.10 It is vital that the course of decolonisation treatment is completed as per policy, as failure to do so will increase the chances of resistance to the decolonisation medication. Staff must ensure that the client fully understands and agrees to comply with the treatment in full before it commences

16 CLEANING AND DECONTAMINATION

16.1 Cleaning services are an essential part of the multidisciplinary approach to tackling Health Care Acquired Infections

16.2 Isolation rooms require enhanced daily cleaning using a Trust approved Chlorine based product in line with the Isolation Policy and Trust Cleaning Manual

16.3 Patient equipment must be capable of being decontaminated before use with other patients (please follow the Cleaning of Equipment and Decontamination Policy)

16.4 Once the patient has been discharged the room must be terminally cleaned in line with the Isolation Policy

17. PATIENT MOVEMENT

17.1 Patients known or suspected of having MRSA can undergo investigations in other departments/hospitals. The receiving department/hospital must be made aware of the patient's MRSA status by the ward in advance of the planned investigation. The staff in the receiving department/hospital must practise standard infection Prevention and Control precautions. When the patient leaves the area, horizontal surfaces and equipment must be thoroughly cleaned before the next patient is seen. Short-term exposure to other patients in clinics is not generally a problem unless the MRSA patient is sputum positive and coughing, or has exposed skin sites. In these situations the ward and receiving department/hospital should arrange for the patient to be seen straight away on entry to the department to avoid waiting in areas with other patients

17.2 Patients with MRSA can be transported in an ambulance with other patients as long as any wounds are covered with an occlusive dressing and the ambulance crew maintain standard infection control precautions. Similarly patients with MRSA can be transported via hospital car service as long as wounds are covered. The Ambulance Control must be advised prior to transport

17.3 Arrangements for transfer to other wards or healthcare facilities e.g. hospitals / care homes etc must include notification of the individuals MRSA status. MRSA is not a reason for patients to be refused admission to a care home and failure of a home to accept a patient on these grounds should be discussed with the IPC team

18. DISCHARGING MRSA POSITIVE PATIENTS

18.1 The presence of MRSA in all patients where it has been identified must be included within any correspondence to other healthcare professionals on discharge, regardless if successfully decolonised. Patients undergoing decolonisation at the time of discharge should continue the course until completion and it is important that community staff are aware of any actions taken by the Inpatient service. The need for completion of a decolonisation course alone should not prevent discharge from hospital

18.2 It is the responsibility of the discharging nurse to ensure that arrangements are in place to continue the decolonisation course, including any discharge medication. This must be included in the discharge summary with details of when the course was started and when the patient needs to be rescreened

19. REFUSAL

19.1 As is the general principle with many forms of medical testing and treatment the first assumption is that the patient generally has the right to refuse. However, good practice, clear and sensitive explanation and discussion often help allay the anxieties of patients who might otherwise refuse. Despite this there may be rare occasions where patients still refuse testing and treatment. In such cases careful consideration needs to be given to the patient's views, be they perceived as reasonable or unreasonable. The patient and their views should be treated with respect

19.2 The response to patients who are difficult to manage will be a team based decision, involving the key worker, team manager, Infection Prevention and Control and medical team based on the individual risks and circumstances that apply to that patient. These discussions should be documented within the patient's records and should include any dissenting clinical views, other options considered, reasons other options were not adopted and the eventual decisions that were made

20 MRSA POSITIVE PATIENTS IN THE COMMUNITY

20.1 The Inpatient and Community treatment and topical decolonisation regimes are identical

20.2 Good hand hygiene practice is required before, during and after staff contact with all patients

20.3 Personal protective equipment (PPE) is only required if staff are providing physical care or treatment where the patient has had an MRSA positive

screen and has either not been decolonised or has been classed as being a chronic carrier

20.4 Routine visits to any patient with known colonisation or infection should be the last visit of the day

21. MRSA IN STAFF (see also section 7)

21.1 Transmission of MRSA can occur from patient to staff to patient via close contact. Carriage is usually transient, in that by the time staff return to work after a previous shift, they no longer carry MRSA

21.2 Routine staff screening is not necessary but may occur as part of an outbreak investigation or at the discretion of the Infection Prevention and Control Doctor

21.3 Decolonisation therapy for individual staff is the same as for patients, as detailed in section 14. The treatment is applied for 5 days then stopped for 2 days and re-screened on day 8 to determine if still MRSA positive

21.4 Staff can return to work 24 hours after commencing decolonisation therapy. Each case will be managed by the Trust's Occupational Health provider

21.5 Any difficulties in achieving MRSA clearance will be discussed with the trust Occupational Health Provider and General Practitioner

21.6 There is no reason to exclude pregnant or breast-feeding staff from caring for patients with MRSA

22. MRSA BACTERAEMIA (Bloodstream Infection)

22.1 The identification of a Staphylococcus Aureus (Meticillin resistant or sensitive) bacteraemia (BSI) is a significant event. The Consultant Microbiologist will liaise directly with the patient's clinical team advising on the best course of treatment, although it is likely that due to the clinical condition, the patient will be transferred to an Acute NHS trust

22.2 On identification of a Staphylococcus Aureus (Meticillin resistant or sensitive) BSI a root cause analysis (RCA) will be initiated to identify the factors contributing to the infection. The Infection Prevention and Control Team will assist the inpatient staff in the collation of RCA information. The investigation must be commenced within 24 hours of notification of the MRSA BSI and completed within seven working days

22.3 The actions to be taken will be advised by the Infection Prevention and Control team

23. TRAINING REQUIREMENTS

23.1 The Trust will work towards all staff being appropriately trained in line with the organisation's Staff Training Matrix (training needs analysis). All training documents referred to in this policy are accessible to staff within the Learning and Development Section of the Trust Intranet

- Trust Induction Training
- Hand Washing Training
- Infection Prevention and Control Training
- Untoward Event Training

24. EQUALITY IMPACT ASSESSMENT

24.1 All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. In addition, the Trust has identified Learning Disabilities as an additional tenth protected characteristic. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Equality and Diversity Lead who will then actively respond to the enquiry

25. MONITORING COMPLIANCE AND EFFECTIVENESS

25.1 Monitoring arrangements for compliance and effectiveness

- Overall monitoring will be by the Clinical Governance Group

25.2 Responsibilities for conducting the monitoring

- The Infection Prevention and Control Assurance Group will monitor procedural document compliance and effectiveness where they relate to clinical areas

25.3 Methodology to be used for monitoring

- Complaints monitoring
- Incident reporting and monitoring
- Clinical Audit

25.4 Frequency of monitoring

- The Infection Prevention and Control Group provides quarterly reports to the Clinical Governance Group

25.5 **Process for reviewing results and ensuring improvements in performance occur**

Audit results will be presented to the Senior Managers Operational Group for consideration, identifying good practice, any shortfalls, action points and lessons learnt. This Group will be responsible for ensuring improvements, where necessary, are implemented

Lessons learnt will be forwarded to the Corporate Governance Administrator who will add to the Corporate Register of Lessons Learnt and filed on the Intranet
A brief of the audit will be provided to staff to raise awareness through the Trust What's On newsletter with a hyperlink to the updated Corporate Register of Lessons Learnt

26. COUNTER FRAUD

26.1 The Trust is committed to the NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document

27. RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS

27.1 Under the **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3), the fundamental standards** which inform this procedural document, are set out in the following regulations:

Regulation 9:	Person-centred care
Regulation 11:	Need for consent
Regulation 12:	Safe care and treatment
Regulation 16:	Receiving and acting on complaints
Regulation 20:	Duty of Candour

27.2 Under the **CQC (Registration) Regulations 2009 (Part 4)** the requirements which inform this procedural document are set out in the following regulations:

Regulation 18:	Notification of other incidents

27.3 Detailed guidance on meeting the requirements can be found at http://www.cqc.org.uk/sites/default/files/20150311%20Guidance%20for%20providers%20on%20meeting%20the%20regulations%20FINAL%20FOR%20PUBLISHING.pdf

Relevant National Requirements

Saving Lives: Reducing Infection, delivering clean and safe care;
EPIC 3: National Evidence Based Guidelines for preventing Healthcare Associated Infections in NHS Hospitals in England 2015;

Department of Health (2008) MRSA Screening Operational Guidance 2.
NHE (2014) Guidance on the reporting and monitoring arrangements and post infection review process for MRSA bloodstream infections from April 2014 version 2
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 (ARHAI)

28. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

28.1 References

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Our NHS Our Future – NHS next stage review. Interim Report DH October 2007

Department of Health (2015) The Health and Social Care Act 2008, Code of Practice on the prevention and control of infections and related guidance.

28.2 Cross reference to other procedural documents

Cleaning of Equipment and Decontamination Policy

Consent and Capacity to Consent to Examination and Treatment Policy

Healthcare Clinical Waste Policy

Infection Control Standard Precautions Policy

Isolation Policy

Learning Development and Mandatory Training Policy

Non Clinical Waste Policy

Risk Management Policy and Procedure

Serious Incidents Requiring Investigation (SIRI) Policy

Staff Mandatory Training Matrix (Training Needs Analysis)

Untoward Event Reporting Policy and Procedure

National Health Service Cleaning Manual

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.

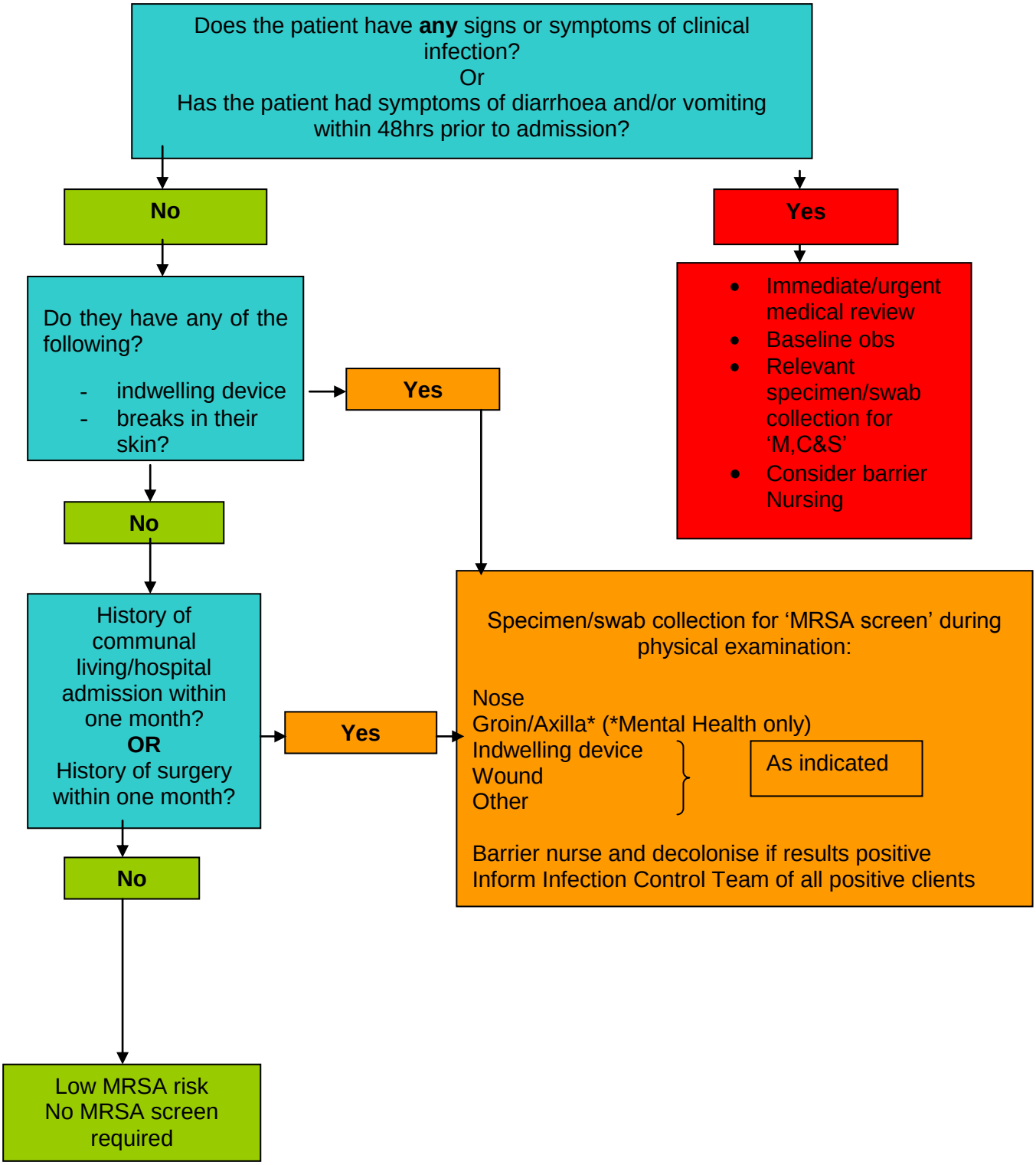
29. APPENDICES

29.1 For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such.

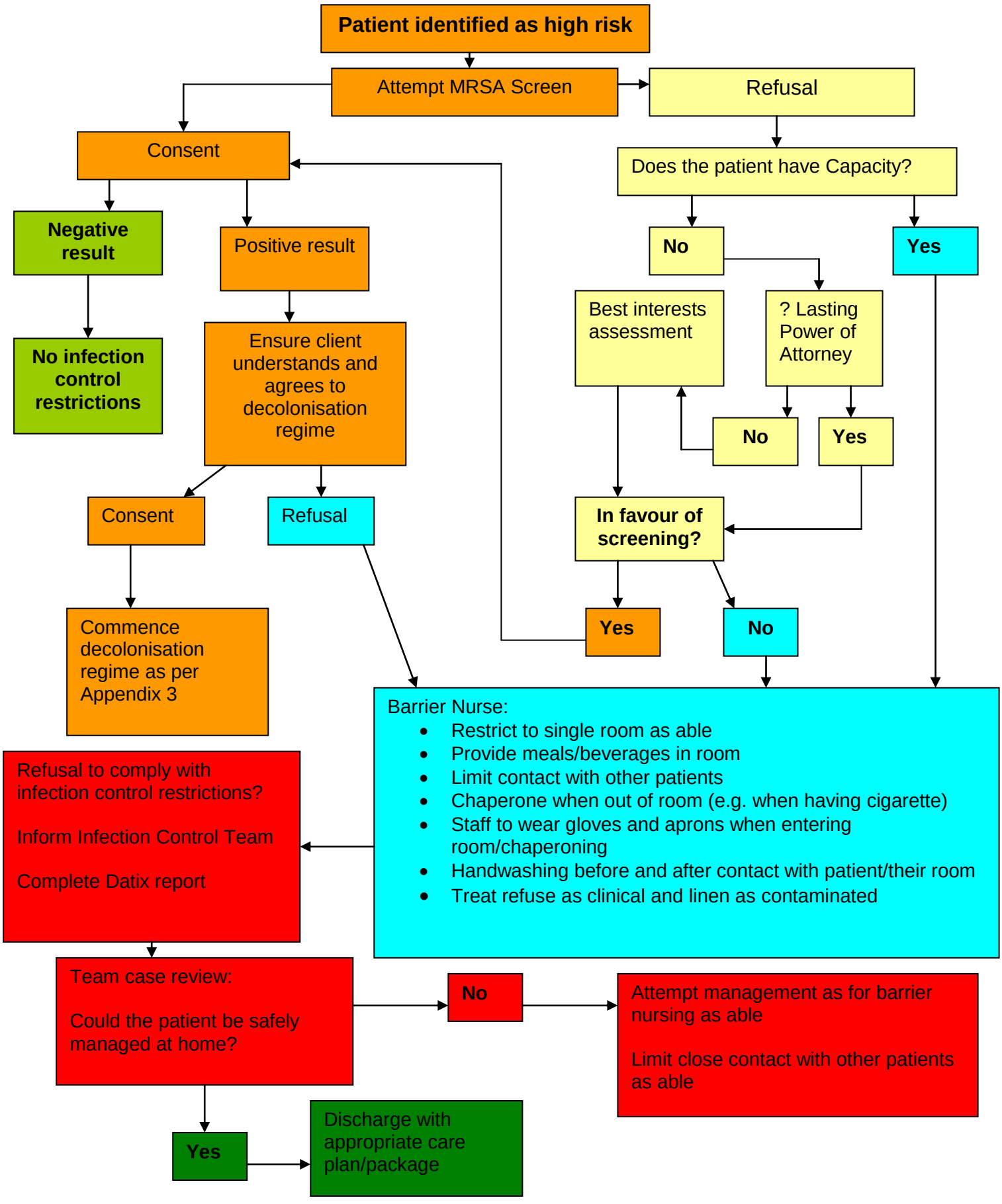
Appendix A	Infection Risk Admission Assessment Flow Chart; for Mental Health only
Appendix B	MRSA Positive Patient Management Flow Chart
Appendix C	Decolonisation Flow Chart
Appendix D	Pre-Assessment MRSA Screening Leaflet
Appendix E	Decolonisation of Urinary Tract
Appendix F	Decolonisation of Urinary Tract Flow Chart
Appendix G	MRSA Topical Decolonisation Record

APPENDIX A

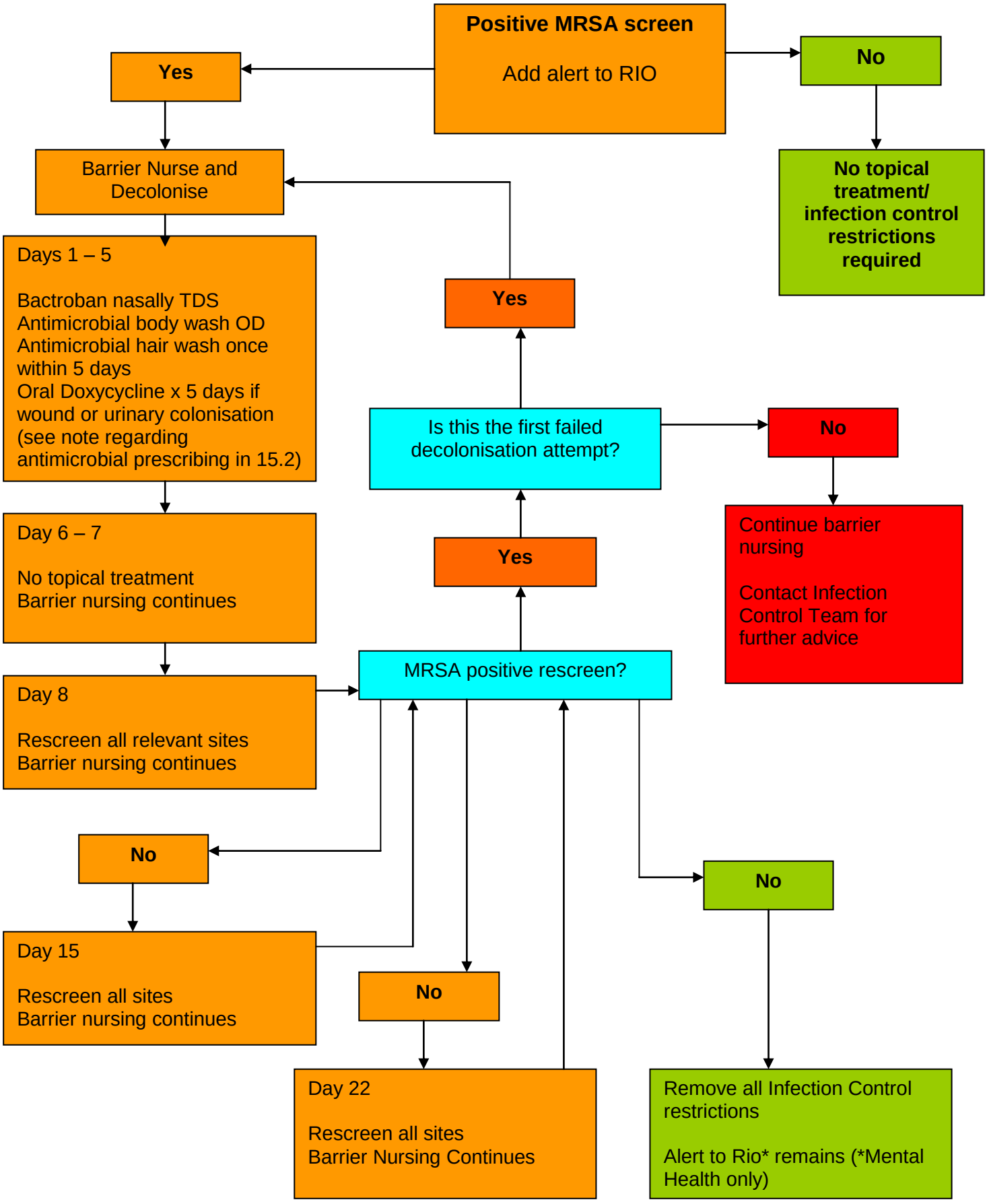
Infection Risk Admission Assessment Flow Chart
MENTAL HEALTH ONLY



MRSA Positive Patient Management Flow Chart



Decolonisation Flow Chart



Somerset Partnership NHS
NHS Foundation Trust

How can MRSA affect me?

MRSA can cause colonisation or infections.

Colonisation

Most people who have MRSA are colonised. This means that MRSA is present in the nose and skin but is not harmful. People who are colonised will have no signs or symptoms of infection and will feel fine.

It is not generally necessary to treat MRSA colonisation. However, if you are coming into the hospital for surgery and you are found to be colonised, you will need to use the treatment prescribed.

When MRSA causes an infection this means that bacteria are making you ill. The infection can be mild causing redness and inflammation at a wound site. It can also cause more serious infection, such as septicaemia (infection of the blood).

If you have an infection caused by MRSA then antibiotics, other than Methicillin, can be used. These are given by injection or drip into a vein.

Somerset Partnership

Service contact details

Infection Control Team
Telephone No: 01278 432132

This leaflet is available in other formats, including
easy read summary versions and other languages
upon request. If this would be helpful to you, please speak to a member of staff.

Date Issued:
Review Date:
Impact Assessed:
Author:
Ref:

Headquarters:
Somerset Partnership NHS Foundation Trust
2nd Floor, Mallard Court, Express Park,
Bristol Road, Bridgwater TA6 4RN

Tel: 01278 432 000 Fax: 01278 432 099
Email: foundationtrust@sompar.nhs.uk
Web: www.sompar.nhs.uk

Somerset Partnership

Pre-Assessment MRSA Screening

Information for Patients

Somerset Partnership

Introduction

Somerset Partnership NHS Foundation Trust takes MRSA and healthcare associated infections extremely seriously. We are committed to reducing infections and giving our patients high quality healthcare.

What is MRSA

MRSA is short for Methicillin Resistant Staphlococcus Aureus. It is a type of bacteria that has become resistant to most antibiotics. Approximately 30% of the population carry Staphylococcus Aureus either in their nose, throat or skin.

In healthy people this bacteria is not harmful. However, it can be a problem in hospitals where people are recovering from opeartions and illnesses and are much more vulnerable to infections.

More information can be obtained from the leaflet, MRSA – Information for Patietns. You can find this leaaflet on the Trust's website at http://www1.sompar.nhs.uk/patients/patient_information_leaflets. Alternatively please ask a member of staff to provide you with one.

Why do we screen for MRSA?

There are many people in the community who have MRSA bacteria without showing any symptoms. By screening at the pre-assessment clinics, we can find out if you are carrying the bacteria and then provide treatment before you are admitted to hospital.

As part of the pre-opeartive process, some patients will routinely be screened for MRSA, depending on the type of surgery. This helps to prevent the bacteria spreading and lowers the risk of complications occuring whilst you are recovering.

What tests are done?

The nurse in the pre-assessment clinic will take a swab from your nose. A cotton bud swab will be placed in and around your nose. This will not hurt but might feel a little uncomfortable. The swab is then sent to the laboratory for testing.

What happens next?

If your swabs are found to be MRSA negative (this means no MRSA was detected) then you can proceed with your surgery as planned.

If your swabs are found to be MRSA positive, your GP will be informed. They will contact you to arrange treatment before your surgery:

- you will be given antiseptic body wash to use and an ointment to apply to your nostrils
- you need to continue the treatment for five days
- you will then have repeat swabs at weekly intervals
- if MRSA is detected again you will have another course of treatment
- if you have a history of MRSA you may be given special antibiotics while in theatre. This will be assessed by your doctors and is dependent on the type of operation you are having

DECOLONISATION OF MRSA IN THE URINARY TRACT

1 INTRODUCTION

1.1 Urinary catheters represent a significant risk of community and hospital acquired infection. The use of all urinary catheters should be reviewed when Methicillin-Resistant *Staphylococcus Aureus* (MRSA) is identified from the urine as removal of urinary catheter represents the best chance of preventing systemic infection. This protocol should be used if the patient has a urinary catheter and MRSA has been isolated from the urine and it is not possible to remove the catheter

1.2 It has been recognised that the urinary tract of catheterised patients is a common source of MRSA bloodstream infections. These patients may be colonized in the urine for many weeks prior to invasion into the bloodstream

1.3 The protocol should be used in conjunction with the usual MRSA decolonisation treatment of the nose and skin

2 MRSA POSITIVE RESULT

2.1 If a patient has MRSA positive in their urine and has an indwelling urinary catheter in situ, an oral course of appropriate antibiotics will be recommended by the consultant Microbiologist (see section 3)

2.2 Skin and nasal decolonization should be commenced as soon as the results of MRSA positive being present are known, with 2% mupirocin (Bactroban) to the nose three times daily plus daily body and hair washes with Octenisan for a total of 5 days. The indwelling urinary catheter should be changed on day three of the treatment

2.3 Antibiotic and topical decolonisation therapy should commence at the same time and run concurrently

2.4 If the patient remains positive after the first course of decolonization a further full course of topical treatment should be carried out as previously described (including a further catheter change on day 3 of treatment), followed by a further screen (refer to point 6.1). If the second course of topical treatment is unsuccessful the Infection Prevention and Control Team must be contacted to discuss further options

2.5 Subsequent courses of antibiotics should be discussed with a consultant microbiologist

2.6 If a patient is found to have MRSA in their urine then a full MRSA screen is required prior to commencing topical decolonisation. This will include swabbing the nose and groin and sputum specimen if the patient is expectorating and swabbing all breaks in the skin including ulcers and insertion sites for indwelling medical devices

3 SYSTEMIC ANTIBIOTIC TREATMENT

3.1 The sensitivities of the MRSA should first be checked for the following antibiotics: trimethoprim, doxycycline and nitrofurantoin. The first of these antibiotics to which the organism is sensitive should be given for 5 days. Hence usually patients should be prescribed trimethoprim 200mg twice daily by mouth. If trimethorim resistant use doxycycline 200mg daily. Nitrofurantoin may be used third line at a dose of 100mg four times a day. Nitrofurantoin should be taken with food to reduce gastrointestinal side effects. The dose of nitrofurantoin may be reduced to 50mg if the patient experiences nausea

4 CHANGE OF CATHETER

4.1 Consideration should be given to the potential for trial without catheter and the patient should be assessed as per the 'catheter – free' hospital protocol

4.2 If urinary catheter is clinically indicated it should be changed on day 3 of the decolonisation regime

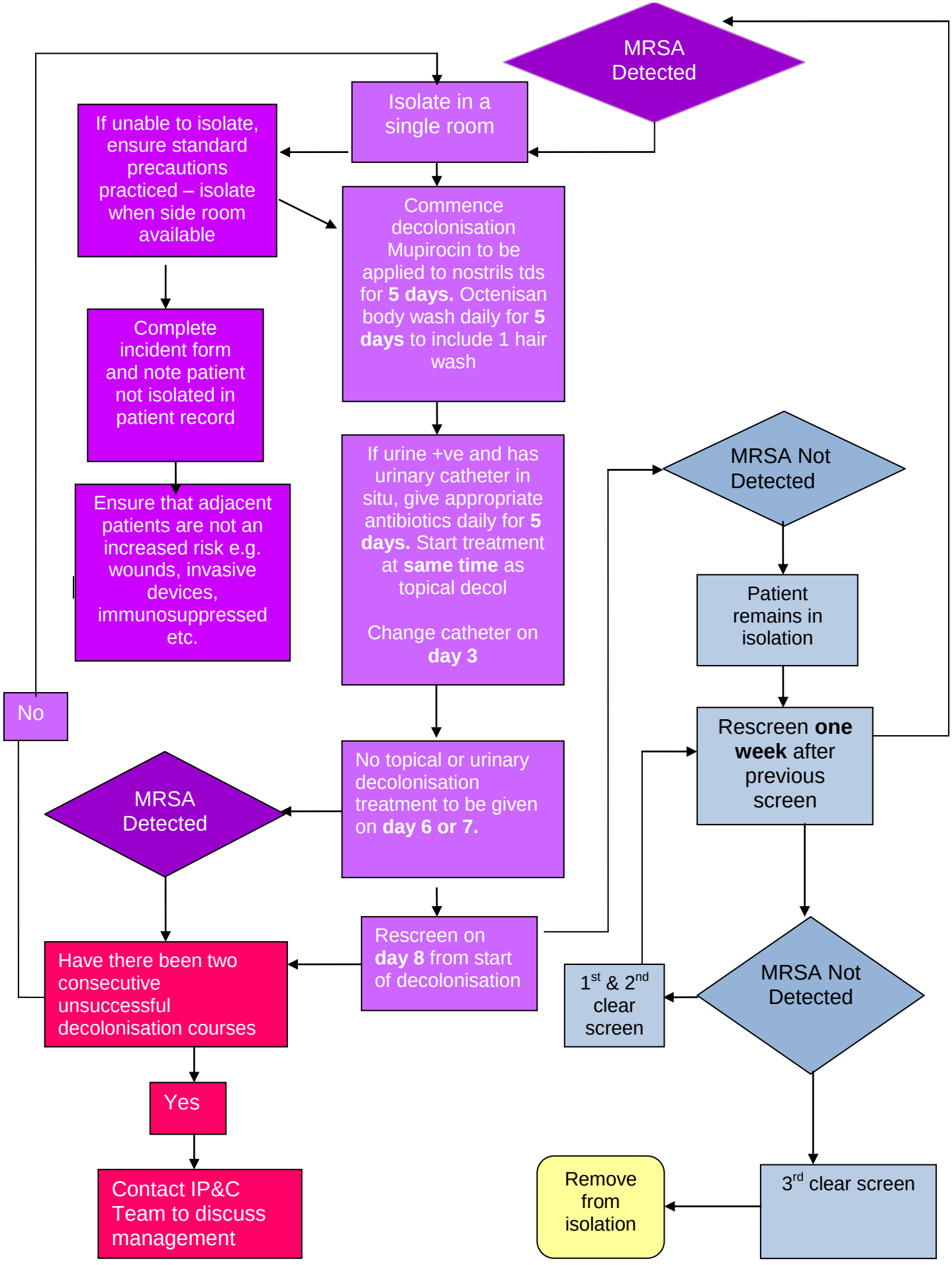
5 FOLLOW UP SCREENING

5.1 The full MRSA screen, including urine, should be repeated two days **after stopping the trimethoprim / doxycycline /nitrofurantoin** on day eight. If the screen is clear then two further screens should be taken at weekly intervals

6 IF DECOLONISATION FAILS

6.1 If, post-decolonisation, the urine remains positive for MRSA then the protocol may be restarted with nasal Bactroban, Octenisan body washes, a single catheter change on day 3 and oral antibiotics as recommended by consultant microbiologist. If the patient remains positive despite two treatments, staff should discuss the case with the Infection Prevention and Control Team

6.2 If part of the post-decolonisation screen is still positive but the urine does not contain MRSA then the protocol of nasal Bactroban and Aquasept should be repeated once. If the patient remains positive despite two treatments then clinical staff should discuss the case with the Infection Prevention and Control Team


MRSA Detected
Isolate in a single room
If unable to isolate, ensure standard precautions practiced – isolate when side room available
Commence decolonisation Mupirocin to be applied to nostrils tds for **5 days.** Octenisan body wash daily for **5 days** to include 1 hair wash
Complete incident form and note patient not isolated in patient record
Ensure that adjacent patients are not an increased risk e.g. wounds, invasive devices, immunosuppressed etc.
If urine +ve and has urinary catheter in situ, give appropriate antibiotics daily for **5 days.** Start treatment at **same time** as topical decol
Change catheter on **day 3**
MRSA Not Detected
Patient remains in isolation
Rescreen **one week** after previous screen
No
No topical or urinary decolonisation treatment to be given on **day 6 or 7.**
MRSA Detected
Rescreen on **day 8** from start of decolonisation
Have there been two consecutive unsuccessful decolonisation courses
1st & 2nd clear screen
MRSA Not Detected
Yes
Contact IP&C Team to discuss management
Remove from isolation
3rd clear screen

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MRSA TOPICAL THERAPY CHART

Surname:	**NHS No:**	**Date of onset of Treatment:**
Forename:	**Date Of Birth:**	**GP:**
Address	**Site of MRSA:**	**Other risks: e.g. catheter, wounds, PEG sites**

Date Day		1	2	3	4	5	6 Stop Treatment	7 Stop Treatment	8 Re-screen Due
Mupirocin 2%	08								
(nasal)	14								
	20								

Octenisan Body Wash	Suitable Time								

Wound dressing **Please state site and type of dressing**	Suitable Time								

SEE OVERLEAF FOR IMPORTANT NOTES ON MRSA POLICY

Important Notes on MRSA Decolonisation.

- Give 5 day's topical therapy and stop. **(All treatment should be used. In the event that any remain, all unused treatments should be removed)**
- 48 hours after treatment has discontinued (72 hours if the course finishes on a Friday) rescreen all sites – swab nose, groin, any wounds (identify each swab with wound site), sputum if patient is expectorating, CSU if catheterised.
- If all specimens are negative for MRSA then continue to re-screen at weekly intervals until 3 negative results obtained

  If any specimen is positive, recommence decolonisation regime as described (no more than 3 course should be given in total) or discuss further therapy with the Infection Prevention and Control Team

- **Urine**
  Please discuss with Consultant Microbiologist or the Infection Prevention and Control Team if treatment is contemplated.

- **Wounds**
  Mupirocin is not to be applied directly to wounds unless discussed and agreed with the infection control team.

  Medihoney or Silver Dressings are advised. Please consult the MRSA Wound Management protocol available from the Trust website or contact the Infection Prevention and Control Team.

- **Antibiotic Advice**
  Please contact the Consultant Microbiologist or the Infection Prevention and Control Team if systemic antibiotics are considered.

- **Other Treatment and management**
  To be discussed with the Infection Prevention and Control Team.

If any further assistance is required Monday - Friday 08.30-17.00 please contact:

Lisa Stone: Senior Infection Prevention and Control Nurse Somerset Partnership NHS Foundation Trust on 07825 656426

Michelle Barnham: Infection Prevention and Control Nurse Partnership NHS Foundation Trust 07824 864947

Nikki Hall: Infection Prevention and Control Nurse Partnership NHS Foundation Trust 07795 841259

Karen Anderson: Infection Prevention and Control/Decontamination Lead, Somerset Partnership NHS Foundation Trust 07768 703715