Shropshire Community Health
NHS Trust

Document Details	
Title	Meticillin Resistant *Staphylococcus aureus* (MRSA) Policy
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Local Ref (optional)	
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Who is the document aimed at?	All staff who undertake direct patient care within Shropshire Community Health Trust
Author	Head of Infection Prevention and Control
Approval process	
Who has been consulted in the development of this policy?	This policy has been developed by the IPC team in consultation with appropriate senior Operations and Quality managers, Locality Clinical Managers, Specialist Nurses, Medicine Management and Public Health England
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No	Date	Amendment
1	December 2018	Amended to reflect changes in MRSA bacteraemia post infection review and reporting timescales, amendments to periods of increased resistance, general review and update
2	June 2021	Amended to reflect changes to decolonisation of MRSA, and screening pre catheter change.

Contents

Policy on a page

Meticillin Resistant *Staphylococcus aureus* (MRSA) Management

History of MRSA

Mupirocin resistant / multi resistant

Mupirocin sensitive

NO

Nurse in an open bay while awaiting nose screen results

Isolate patient in a single sideroom and await admission screen results

If screening results are negative after three consecutive weekly screens, the patient can be moved out of isolation

Patient has lesions or catheter

Negative results nurse in open bay

Yes

Isolate in a single sideroom await admission screening results

Please note screening must be carried out within **24** hours and includes:

- Nose
- Wounds all types including Percutaneous Endoscopic Gastrostomy (PEG) site, Suprapubic (SP) catheter site- wounds will automatically be screened for MRSA when swabbed

(These can be swabbed at the next dressing change)

- CSU (Uretheral and SP catheter) the form must state MRSA screen otherwise this will be missed

IPC team must be notified of **all** positive MRSA results including those on the monthly screens

Positive result- to remain in isolation and commence treatment as per policy, inform IPC team

Isolation audit to be completed on isolation and weekly thereafter

Patients treated for Mupirocin Resistant/Multi Resistant must remain in isolation regardless of treatment and negative screens

Please discuss with IPCT in hours or Microbiology out of hours (01743 261000) if there is an issue with isolation

Once treatment for Mupirocin Sensitive MRSA complete:

Wait **48** hours post treatment and carry out first screen (to include nose, wounds and send a CSU if applicable)

The screens need to be taken weekly for three consecutive weeks and all be negative before a patient can be moved out of isolation

Staff to discuss with IPCT if there is an issue with isolating the patient

GP is to contact Microbiology if the patient remains positive post treatment and to discuss oral antibiotic use.

This applies to all strains of MRSA

1 Introduction

Staphylococcus aureus is a common micro-organism found on the skin and in the nostrils of about a third of healthy people. Meticillin Resistant *Staphylococcus aureus* (MRSA) is a variety of *Staphylococcus aureus* that has developed resistance to meticillin (an antibiotic that used to be used in laboratories to test sensitivity to flucloxacillin) and some other antibiotics that are used to treat infections. Meticillin Resistant *Staphylococcus aureus* is spread from person to person either by direct or indirect contact. In a health care setting, MRSA is most commonly spread on the hands of health care workers; patients' equipment can also be a route of spread if not adequately decontaminated between patients. Patients with MRSA are likely to contaminate objects and their environment. This contamination can be transferred to other patients, visitors and staff.

Health care workers may infrequently become nasopharyngeal carriers of MRSA, but only rarely become infected – and even then they most often have minor skin infection. Nevertheless, such carriers can sustain the spread of MRSA.

It is important to ensure the spread of MRSA is minimised, to protect patients from infection or colonisation with MRSA and to ensure those who are confirmed with MRSA are managed safely and appropriately. In order to achieve this, all in-patient admissions, both elective and emergency and certain elective day case admissions/attendees to Shropshire Community Health NHS Trust (SCHT) Community Hospitals will require an MRSA screen.

2 Purpose

The policy is intended to provide SCHT staff with the information required to identify and manage patients and staff who are colonised or infected with MRSA and those who are at high risk of being so. It is also intended to provide guidance on the appropriate use of screening and to ensure all staff are fully informed of the appropriate actions that are required to manage the prevention of MRSA transmission to patients and staff.

3 Definitions

Term / Abbreviation	Explanation / Definition
Bacteraemia	Blood stream infection
CA-MRSA	Community-associated MRSA
CAUTI	Catheter Associated Urinary Tract Infection
CCG	Clinical Commissioning Group
Colonised	Carrier – no active infection
DIPC	Director of Infection Prevention and Control
GP	General Practitioner
HCAI	Healthcare Associated Infection
IPC	Infection Prevention and Control
LCM	Locality Clinical Manager
MC&S	Microscopy Culture and Sensitivity
MRSA	Meticillin Resistant *Staphylococcus aureus*
MSSA	Meticillin Sensitive *Staphylococcus aureus*
Mup I	Mupirocin-Intermediate MRSA
Multi-MRSA	Resistance to Mupirocin, Tetracycline/Doxycycline, Gentamicin and/or Neomycin
Mup S	Mupirocin-Sensitive MRSA
Mup R	Mupirocin-Resistant MRSA
OHD	Occupational Health Department

OPD	Outpatients Department
Outbreak	Two or more people experiencing similar symptoms in time and place e.g. patients and/or staff
PEG	Percutaneous Endoscopic Gastrostomy
PGD	Patient Group Directive
PHE	Public Health England
PIR	Post Infection Review
PPE	Personal Protective Equipment
PVL positive MRSA	Panton-Valentine Leukocidin (PVL) is a toxin produced by some strains of *Staphylococcus aureus* which is associated with an increased ability to cause disease. PVL positive MRSA refers to a type of MRSA which produces the PVL toxin. These PVL MRSA strains are also commonly referred to as Community-associated MRSA (CA-MRSA)
PII	Period of Increased Incidence – two or more new cases occurring more than 48 hours after admission in a 28 day period
RCA	Root Cause Analysis – now known as Post Infection Review (PIR)
SaTH	Shrewsbury and Telford Hospitals
SIP	Service Improvement Plan
SP	Suprapubic

4 Duties

4.1 The Chief Executive

The Chief Executive has overall responsibility for ensuring infection prevention and control (IPC) is a core part of SCHT's governance and patient safety programmes.

4.2 Director of Infection Prevention and Control

The Director of Infection Prevention and Control (DIPC) is responsible for overseeing the implementation and impact of this policy, make recommendations for change and challenge inappropriate IPC practices and procedures.

4.3 Infection Prevention and Control Team

The IPC team is responsible for providing specialist advice in accordance with this policy, for supporting staff in its implementation, and assisting with risk assessment where complex decisions are required.

The IPC team will ensure this policy remains consistent with the evidence-base for safe practice, and review in line with the review date or prior to this in light of new developments.

4.4 Managers and Service Leads

Managers and Service Leads have the responsibility to ensure that their staff including bank and locum staff etc. are aware of this policy, adhere to it at all times and have access to the appropriate resources in order to carry out the necessary procedures.

Responsible for ensuring that systems are in place to ensure that IPC policies, practices and guidance are carried out reliably within their area of responsibility; completion and return of service improvement plans (SIPs) following IPC audits; local investigation of

infection and highlighting areas of practice or the environment which presents a risk to patient safety.

Managers and Service Leads will ensure compliance with this policy is monitored locally and they have a responsibility to ensure that their staff attend the relevant IPC training.

4.5 Staff

All staff have a personal and corporate responsibility for ensuring their practice and that of staff they manage or supervise comply with this policy.

4.6 Committees and Groups

4.6.1 Board

The Board has collective responsibility for ensuring assurance that appropriate and effective policies are in place to minimise the risks of healthcare associated infections.

4.6.2 Quality and Safety Committee

Is responsible for:

- Reviewing individual serious incidents/near misses and trends/patterns of all incidents, claims and complaints and share outcomes and lessons learnt
- Agreeing and escalating key risks/items of concern to the appropriate Directors and/or the SCHT Board

4.6.3 Infection Prevention and Control Governance Meeting

Is responsible for:

- Advising and supporting the IPC team
- Reviewing and monitoring individual serious incidents, claims, complaints, reports, trends and audit programmes
- Sharing learning and lessons learnt from infection incidents and audit findings
- Agreeing and escalating key risks/items of concern to the appropriate Directors and/or the Quality and Safety Committee
- Approval of IPC related policies and guidelines

MRSA can cause infection, particularly when there is an opportunity for the bacteria to enter the body, for example accidental cuts and grazes or wounds, ulcers, deep abscesses and via invasive devices. It may spread further into the body and cause serious disease such as bloodstream infections (bacteraemia).

5 MRSA Colonisation

The majority of patients/clients who are MRSA positive will be colonised. Colonisation is when a person carries any bacteria (including MRSA and MSSA) on areas of their body such as the nose and the skin, and occasionally in folds such as the axilla or groin without active infection. About 30% of the general population are colonised with *Staphylococcus aureus.* It can live on a healthy body without causing harm (asymptomatic) and most people who are colonised do not go on to develop infection.

5.1 Patients at Greatest Risk are those with:

- Invasive devices e.g. urinary catheters, intravenous devices including cannula
- Skin lesions, wounds, ulcers
- Chronic skin conditions

5.2 Medical Conditions which place patients at higher risk include:

- Diabetes
- Chronic Renal Failure
- Immunosuppression including Human immunodeficiency virus (HIV)
- Chronic Obstructive Pulmonary Disease (COPD)

6 MRSA Bacteraemia

MRSA bacteraemia is when MRSA is present in the blood. This can occur from the patient's own resident MRSA if they are an asymptomatic carrier (colonisation); from a local infection or by cross-infection. Sepsis can follow. The symptoms are not specific to MRSA and can be the same for other bacteria that cause septicaemia. Typically, symptoms include high fever, a high white cell count, rigors, disturbance of blood clotting with a tendency to bleed and failure of vital organs. This type of MRSA infection has the highest death rate.

7 Meticillin Sensitive *Staphylococcus aureus* (MSSA)

Staphylococcus aureus which is not resistant and is known as Meticillin Sensitive *Staphylococcus aureus* (MSSA) behaves in exactly the same way as MRSA.

8 MRSA Screening

The transmission of MRSA and the risk of MRSA infection (including MRSA bacteraemia) can only be addressed effectively if measures are taken to identify MRSA carriers as potential sources and treat them to reduce the risk of transmission. This requires screening of patient populations for MRSA carriage either before or on admission to identify carriers and implement treatment. A 97% threshold for compliance for screening patients on admission to SCHT Community Hospitals is currently set by the local Clinical Commissioning Groups (CCGs).

8.1 Who, When and Where to Screen

8.1.1 In-patient

All in-patients admitted to a community hospital bed must be screened for MRSA within 24 hours of admission and on a monthly basis thereafter during their stay. This will include all patients admitted on an emergency basis regardless of route of attendance e.g. through Minor Injuries Unit, GP or Out Patient Department (OPD) clinics. See Policy on a Page for admission screening information. If any patient is found to be positive the appropriate treatment must be prescribed (see Section 12 below), and the MRSA Integrated Care Pathway must be followed. Please see Appendix 1 for an example. Appendix 2 to be followed for decolonisation using Octenisan wash.

8.1.2 Day Case

All relevant day cases will be screened as part of the routine pre-operative process, which allows enough time for MRSA screening swabs to be taken, analysed and decolonisation treatment to be to be prescribed and commenced 5 days prior to the day case procedure. The MRSA screen should be taken no longer than 28 days prior to the procedure.

Appendix 3 lists details of Day Case Procedures and the requirement for MRSA screening.

To summarise, the procedure list stipulates that all patients will require screening with the exception of:

- Ophthalmology procedures
- Dental procedures

- Endoscopy procedures
- Minor dermatology procedures including those undertaken as minor surgery e.g. removal of lumps and bumps, liquid nitrogen applications
- Gynecological procedures where no wound is generated e.g. Dilatation and Curettage
- Pain management therapy
- Blood transfusions

In the event of a procedure not being detailed above or in Appendix 3, advice should be sought from the IPC team.

The only time it may be necessary to screen patients attending for elective day case procedures who are normally excluded, as previously listed, would be if they present with the following risk factors:

- Patients from the community presenting with invasive devices
- Patients with a chronic wound
- Patients residing in a nursing or residential home
- Patients who are known to be previously MRSA positive
- Patients who have had a hospital admission in the last 12 months
- Patients who are working in care settings or who are providing care for relatives with MRSA

It is not anticipated that screening and prescription of antimicrobial agents will lead to cancellation of day case procedure/surgery.

Please refer to Appendix 4 for algorithm relating to day case screening process.

8.1.3 Patients with Urethral/Supra Pubic Catheter

8.1.3.1 Catheter Change

A CSU is no longer required to screen for MRSA pre catheter change. The need for the catheter should be reviewed and removed if no longer required. Should the patient show signs of a CAUTI then a CSU should be taken and treatment should commence as per antibiotic guidelines. See Appendix 5.

Traumatic catheter change to be discussed with the GP and Microbiology. The patient and carer are to be made aware of symptoms of a CAUTI and who to contact.

A CSU should be taken if patient displays signs of a CAUTI and antibiotic prescribed as per antibiotic guidelines.

9 How to Screen

Screening swabs should be taken from the:

- Anterior nares of the nose – for advice on how to take a **nose swab** see Appendix 6

In addition to the nose swab other areas should be included in the screen are:

- Any areas of broken skin, wounds or lesions (at first dressing change following admission)
- All sites of invasive devices if present e.g. enteral feeding tube (PEG), supra pubic catheter
- Sputum if productive cough

For collection of the above specimens please refer to SCHT Collection, Packaging, Handling, Storage and Transportation of Laboratory Record the area the specimen/swab was taken from on both the container and the microbiology request form, as it is important to clearly identify the site. A separate form must be completed for each specimen.

Note that for wound swabs, if you request an MRSA screen the lab will **NOT** look for any other pathogens **ONLY** MRSA. If you want the laboratory to look for other pathogens e.g. from an infected wound, request Microscopy Culture and Sensitivity (**MC&S**) on the form.

The lab will always report MRSA if it is present.

However, on urine specimens please state "MRSA Screen" as it may otherwise be missed if it is present in mixed growth.

Swabs from perineum, hairline, wrist and axilla should **NOT** be taken as part of the MRSA screening, as they are unproductive.

Swabs taken from the patient nose must first be moistened with sterile water. **Do NOT** use saline or tap water as this may inhibit the growth of bacteria. See Appendix 7 for MRSA screening SOP.

Routine screening for patients in their own home is not usually required.

10 Laboratory Results

All results will be returned to the requesting source for appropriate action to be taken.

10.1 Day Case

10.1.1 Pre-Op MRSA Screen Negative

Go ahead with procedure(s) as planned unless patient has a history of previous MRSA Carriage, in which case they will require 3 negative screens each a week apart.

10.1.2 Pre-Op MRSA Screen Positive

Staff working within the OPD/pre-op/admission clinic will be responsible for:

- Informing the Medical Secretaries of laboratory results and sensitivities to allow the correct letter to be sent to the patient and their GP.

Medical Secretaries locally will be responsible for:

- Notifying the patient's GP of the patient's MRSA positive results together with the antimicrobial sensitivities and the date of the planned procedure. This will enable appropriate decolonisation/suppression treatment to be prescribed and commenced 5-7 days prior to the procedure.
- Informing patients with MRSA positive laboratory results, requesting they contact their GP to obtain and commence treatment 5-7 days prior to their day case procedure.
- Notifying the patient's medical team of MRSA positive results together with the antimicrobial sensitivities.

See Section 12 for advice regarding treatment.

10.2 In-patient

Ward staff will be responsible for following up screening results, communicating the results to the patient and to the medical team in charge of the patients care.

10.2.1 MRSA positive result available after patient discharged home

Ward staff should notify healthcare and social care colleagues as appropriate (this will depend on place of discharge). The GP may need to prescribe treatment depending on

the result and type of specimen. In addition the IPC team will either write to or telephone the patient's GP to inform them of the positive result.

11 Isolation Precautions for Positive Cases within Inpatient Areas

- Nurse patient in a single room with source isolation precautions.
- Clear signage to be displayed on the door to alert staff and visitors i.e. red source isolation sign.
- If insufficient single rooms and more than one patient is infected with the same strain they can be nursed in a separate bay (cohorted).
- Strict compliance with the SCHT Hand Hygiene Policy.
- Wear Personal Protective Equipment (PPE) appropriate for the task.
- Keep environment and equipment clean and dust free using Tristel. Refer to SCHT's Cleaning and Disinfection policy and Community Hospital Cleaning policy.
- Inform patients and their relatives of the infection control measures.
- Issue the MRSA information leaflet to patient and relatives.
- Use of the MRSA Integrated Care Pathway. Please see Appendix 1 for an example.
- Inform all multidisciplinary members, temporary staff and volunteers of source isolation precautions.
- Used linen to be removed immediately and not left in patient's room.
- Door should be closed where possible – if there a reason why the door cannot be kept closed, a risk assessment must be made and it must be documented in the patient's notes and on the MRSA Integrated Care Pathway. Please see Appendix 1 for an example. An example of this may be that the patient is at risk of falls or is clinically unwell. However, the door must be closed when any patient activity takes place in the room.
- Fans must not be used to control the patient's temperature.
- Due to the limited number of single rooms, there may be times when patients who require isolation are nursed in open bays. A risk assessment must be undertaken. Please see SCHT Isolation Policy for Risk Assessment tool.
- If a single room cannot be identified it must be recorded in the patient's notes, a Datix incident form completed and the IPC team informed. If advice is required out of hours, please contact the on-call Consultant Microbiologist via Shrewsbury and Telford Hospital (SaTH) switchboard (01743) 261000.

Patients should not be isolated for longer than is necessary and should be reassessed during and following treatment.

For further details regarding isolation please refer to the SCHT Isolation Policy.

11.1 Psychological Effects of Isolation

Isolation affects individual patients in different ways and as social beings, humans generally do not like being isolated from others.

Isolation and fear of being infectious can be particularly stressful for some patients. Staff must be sensitive to actions that increase anxiety, such as lack of communication, the use of excessive protective clothing or an inconsistency in the use of protective clothing, which can be confusing. Isolation procedures should not greatly interfere with a patient's rehabilitation.

12 Treatment of Infected or Colonised Patients

There are 5 various types of MRSA:

- Mupirocin-Sensitive MRSA (Mup S). These patients' results show sensitivity to Mupirocin.
- Mupirocin-Intermediate (MupI). These patients' results indicate intermediate sensitivity to Mupirocin.
- Mupirocin-Resistant MRSA (Mup R). These patients' results show resistance to Mupirocin.
- Multi-MRSA. These patients' results show resistance to Mupirocin, Tetracycline/Doxycycline, Gentamicin and/or Neomycin.
- PVL MRSA. These patients' results show resistance to Flucloxacillin and will be marked "PVL MRSA".

12.1 MRSA Treatment

It is the responsibility of the ward or department to initiate the decolonisation/treatment regimen not the IPC team. However, if you are in doubt about which regimen to use, especially if the patient has a particularly resistant strain, seek advice from the IPC team or out of hours the Consultant Microbiologist via SaTH switchboard (01743) 261000.

For patients with severe exfoliative skin conditions such as psoriasis, the most successful strategy is to treat the underlying skin condition as effectively as possible after which an attempt should be made to decolonise the patient. Decolonisation alone is unlikely to succeed.

If two attempts to clear the patient have failed, further attempts are unlikely to be successful and may lead to the development of more resistant strains. However, it might be worth a further attempt if conditions change, e.g. a wound or pressure ulcer has healed, or skin conditions such as psoriasis are much improved, or they are soon to have surgery. If in doubt, please discuss with the IPC team or a Consultant Microbiologist at SaTH.

NB: The medicines used to treat MRSA are Prescription Only Medicines (POMs) and therefore must only be used for a patient against an official authority to administer i.e. a prescription or Patient Group Directive (PGD).

12.2 Mupirocin-sensitive MRSA (Mup S) Decolonisation

12.2.1 Nose Only Positive and no Lesions

Apply Mupirocin 2% nasal ointment ('Bactroban Nasal') twice a day. Apply a match-head size portion of ointment to inside the anterior nares, using the tip of the patient's little finger or on a disposable cotton swab, **twice daily** for **5 days**. If the ointment is effectively applied the Mupirocin should be detectable by a taste at the back of the throat. Hands must be washed before and after application.

The same regimen may be used for Mup I MRSA though the success rate is lower.

See section 12.4 for additional treatment requirement

12.2.2 Lesion(s)/CSU Positive/Nose negative or Nose and Lesion(s)/CSU Positive

Apply Mupirocin 2% nasal ointment ('Bactroban Nasal'), whether or not the nose is positive twice daily for 5 days. Appropriate topical or dressing to skin lesions/ulcers for 5 days

Mupirocin 2% nasal ointment ('Bactroban Nasal') **should not** be used for more than two courses of treatment without consulting the IPC team or Consultant Microbiologist for advice, as continual or repeated use can lead to resistance.

If a wound/lesion appears clinically infected it may require tissue viability input and treatment as per antibiotic policy. Routine oral antibiotics are not advised unless directed by Microbiology, following discussion of patient condition. See section 12.4 for additional treatment requirement

12.3 Mupirocin-resistant MRSA (Mup R) Decolonisation

As Mupirocin cannot be used, less effective alternatives must be used to clear nasal carriage. A systemic agent will be required as these other nasal ointments are seldom successful alone. If the strain is sensitive to neomycin use the regimen below:

- Neomycin-chlorhexidine nasal ointment (Naseptin[1])
    - applied 4 times a day for 10 days
    - If a wound/lesion appears clinically infected itmay require tissue viability input and treatment as per antibiotic policy. If resistant to one or both or it is contraindicated, seek advice from the Consultant Microbiologist about which agents should be used. If lesions are severely infected, more effective agents such as Vancomycin or Linezolid may be needed if this is the case it must **NOT** be given at the same time as Doxycycline.

NB: No more than two courses of treatment should be repeated without consulting the Consultant Microbiologist for advice, as continual or repeated use can lead to resistance.

Refer to the SCHT Community Antibiotic Policy.

See section 12.4 for additional treatment requirement.

12.4 Octenisan Treatment

Octenisan body wash is to be used for 5 days for all MRSA strains (hair must be also washed at least twice in a 5 day period) please see staff zone, Infection prevention and control page for decolonisation patient leaflet SCHT Staff Zone (shropcom.nhs.uk) and Appendix 2 for decolonisation protocol.

In-patient areas have grab bags which contains Mupirocin, Octenisan and the relevant paperwork. Patients living at home and within care homes to follow the same decolonisation procedures and GP to discuss with Microbiology should oral antibiotic be required.

Octenisan wash is safe to use within the prison environment, prisoners to be given clear instruction from healthcare with regards to application in the shower.

13 Clearance Screens

13.1 In-patient – Mupirocin-Sensitive MRSA

Three sets of clearance screens should be taken one week apart starting at least 48 hours after the decolonisation regimen has finished. If lesions have completely healed they do not need to be swabbed. However, any new breaks in the skin should be swabbed.

Patients may be nursed in an open ward following the first negative screen.

13.2 Community Patients – Mupirocin-Sensitive MRSA

Clearance screens are not routinely required post decolonisation for SCHT patients in the community. However, if the patient is receiving treatment from another Trust (who have different policies) and they requested the specimen, they may need to be contacted for clarification.

[1] Naseptin contains arachis (peanut) oil, cetostearyl alcohol

13.3 In-patient – Mupirocin-Resistant MRSA

Three sets of clearance screens should be taken one week apart starting at least 48 hours after the decolonisation regimen has finished. If lesions have completely healed they do not need to be swabbed. However, any new breaks in the skin should be swabbed.

If the patient has had three negative screens they can be nursed in an open ward and do not require isolation.

13.4 Community Patients – Mupirocin-Resistant MRSA

Clearance screens are not routinely required post decolonisation for SCHT patients in the community. However, if the patient is receiving treatment from another Trust (who have different policies) and they requested the specimen they may need to be contacted for clarification and swabbing requirement.

13.5 Day Case – Mupirocin-sensitive MRSA and Mupirocin-Resistant MRSA

Clearance swabs are not routinely required post decolonisation.

13.6 On Admission of an In-patient with a History of Mupirocin-Resistant or Multi-MRSA

Patients with a history of Mup-R MRSA or Multi-MRSA should be nursed in a single room and require three negative screens taken one week apart on this admission before they can be taken out of single room isolation. If positive on this admission, screening should start 48 hours after decolonisation regimen has finished.

Seek Consultant Microbiologist's advice regarding treatment regimen for Multi-MRSA.

13.7 Patients with a History of Mupirocin-Sensitive MRSA

Patients with a history of Mup S MRSA only require one negative screen on admission and can be nursed in an open/shared room and do not require isolation whilst awaiting the results. However, if they have any invasive devices and or skin lesions/wounds they should be nursed in a single room until screening results are available. If negative they can be taken out of isolation; if positive they must remain in isolation and commence treatment as appropriate.

14 Patient Refusal for Screening and/or Decolonisation/Treatment

In the unlikely event that a patient refuses to be screened or to receive MRSA decolonisation/treatment the consequences of this should be explained to them by a senior member of the nursing staff and or GP/Medical Advisor and further advice **must** be sought from the IPC team or Consultant Microbiologist. The refusal must be documented in the patient's medical records.

15 Community Hospital In-Patients found to be MRSA Positive during this Admission i.e. Following Routine Monthly Screening or Clinical Indication for Specimen Taken

The following procedure must be instigated and followed by ward staff:

1. Isolate patient in a single room and instigate MRSA treatment as appropriate.
2. Request Terminal clean of vacated bed space.
3. Complete I am Clean Bed Space tool
4. Clean remainder of bay with Tristel.
5. Review all patients in affected bay/room.
6. Inform IPC team who will assess if a Period of Increased Incidence (PII).
7. Screening of patients in shared bay/room may need to be considered.

16 Period of Increased Incidence (PII)

Where 2 or more cases of the same organism are identified which are linked in time and place (2 cases within 28 days of each other on the same ward/area) the IPC Team will:

- seek advice from the Consultant Microbiologist at SaTH.
- Contact the ward/area involved who will be required to report the incident via Datix.
- Contact the laboratory will be requested to send all positive specimens for typing.
- Contact the ward/area will be required to complete an
    - IPC self-audit/ Isolation audit
    - Additional Hand Hygiene, Bare Below the Elbow and Personal Protective Equipment Observations (HHOT tool)
    - A Cleanliness Monitoring audit
- The ward area will also be requested to complete an RCA on each patient involved.
- An OHD assessment will be required of any staff with skin conditions/legions.
- A deep clean of a bay and/ or the ward may be also be requested by IPC team.

The IPC team will notify the DIPC, Deputy Directors, Divisional Manager and relevant LCMs and CCG IPC Lead, (PHE may also need to be notified depending on numbers and timeframes).

IPC Team will continue to liaise with the ward and monitor.

A PII meeting will be arranged following the completion of the documentation to review any lapses in care and lessons learned to be shared.

The PII meeting minutes will be presented at the SCHT Serious Incidents and Lessons Learned Group.

17 Documentation

The MRSA status of all patients must be accurately recorded in medical and nursing notes, including information on specimen results and for day cases, referral to the patient's GP for decolonisation treatment.

The MRSA Integrated Care Pathway provides a framework, which is aimed at improving care delivery for MRSA positive patients within in-patient areas. Please refer to Appendix 1 for an example of the MRSA Integrated Care Pathway.

18 Electronic Patient Record

18.1 Alert on RiO

Patients who are diagnosed with MRSA or have had a previous diagnosis of MRSA must have an alert placed on their RiO electronic patient record with the date of diagnosis the site of the positive specimen e.g. nose, urine, wound and a review date set for 5 years' time.

19 Communications, Patient, Relatives and Visitors Information

Patients must be provided with accurate information on MRSA screening, result and subsequent treatment. This is the responsibility of the medical and nursing team working within the ward and OPD/pre-op/admission clinic. To support this, MRSA and Pre-operative MRSA Screening information leaflets are available on the IPC page on the SCHT website SCHT Staff Zone (shropcom.nhs.uk) . It is important that staff ensure that the patient and/or their carers fully understand the content of the leaflet.

The information that should be given to all patients includes the risk of infection during procedures and information on their care, treatment and management if they are found to be MRSA positive following screening.

Social visitors (family etc.) need not wear PPE unless they assisting with patient care. However, they must be asked to wash their hands with soap and water or apply alcohol hand rub before and after leaving the patient's room.

Both relatives and patients themselves are often anxious because staff appear to take more precautions. It is important to explain that relatives visit only one person and do not move from one patient to another with the risk of spreading MRSA.

Patients and relatives must not be made so anxious by staff that they overestimate the significance of MRSA. The IPC team are available for additional information and support for staff, relatives and the patient.

20 Prevention of Spread

- Adopt standard infection prevention and control precautions at all times – refer to SCHT Standard Precautions including Surgical Hand Scrub, Gowning and Gloving policy.
- A clean outfit or uniform should be worn for every shift, and staff must adopt a 'bare below the elbows' policy for care interventions and in all clinical areas.
- The hands of staff and visitors should be disinfected by an application of alcohol hand rub, before and after contact with the patient or their immediate environment.
- If hands are visibly dirty, liquid soap and water must be used for hand decontamination and may be followed by alcohol hand rub.
- If the hand wash facilities are poor in the patient's home, staff must use liquid soap and paper towels or skin cleansing wipes as supplied by SCHT.
- Disposable single use gloves and aprons must be worn when contaminated dressings or linen are handled.
- It is not necessary to wear surgical masks for MRSA unless it is advised i.e. during a pandemic, very occasionally they may be advised for procedures that may generate staphylococcal aerosols e.g. sputum suction, chest physiotherapy, or procedures on patients with exfoliative skin conditions.
- Disposable plastic aprons must be worn by staff and visitors providing health care when in contact with the patient.
- Aprons and gloves MUST be disposed of after use on each patient and not worn between patients. This is standard infection control practice and applies whether MRSA is present or not.
- Inform carers, patients and their relatives of effective hand hygiene and cleaning of the environment.
- The patient's environment must be kept clutter free, clean and dust free – clean and disinfect the environment at least daily using Tristel.
- Staff with eczema and psoriasis conditions should be managed carefully. Advice from OHD should be sought during exacerbation of any skin condition.
- All cuts and abrasions should be covered with a waterproof dressing.
- Patients must be informed of the importance of their own hand hygiene and detergent hand wipes available at the bedside of in-patients.
- On commencement of isolation and at weekly intervals for the duration of isolation, an isolation checklist (available on the IPC web page) SCHT Staff Zone

(shropcom.nhs.uk) should be performed by ward staff for assurance that all IPC precautions are in place.

21 Infection Risks within the Patient's Home

Infection risks in the home are minimal. Patients with MRSA at home should have no restrictions on their daily life. However, as MRSA survives in dust, thorough and regular cleaning of the home environment is advised, and the patient should have daily change of towels and use a disposable cloth when washing. If preferred a reusable cloth can be used and with towels advise they are washed at a minimum temperature of 60ºC. As mentioned above patients must be informed of the importance of their own hand hygiene.

22 Transfer or Discharge of Patients with MRSA

Staff in the receiving hospital or healthcare service must be informed of the patient's MRSA status prior to their transfer. Clear and timely communication will reduce misunderstanding and confusion. Where possible, prior to a planned discharge and where a patient is MRSA positive the receiving healthcare facility/GP/Community Nurse/Care agency etc. should be notified by the transferring staff. The transfer of care form must be fully completed and accompany the patient to the respective hospital or community setting.

MRSA is not a contraindication for the transfer of the patient to a residential/nursing home or care agency, but staff at the home/agency should be informed of their MRSA status.

23 Travel by Ambulance

MRSA is classified as an ambulance "Category One" and the ambulance personnel are not at risk. If the patient has skin lesions, these must be covered with an occlusive dressing.

Patients with MRSA may be transported with other patients.

Plastic aprons are only required by staff having direct contact. Ambulance personnel must decontaminate their hands after transfer is completed. Gloves are only required if there is a risk of contact with blood or body fluids.

The ambulance does not require special cleaning after transport of a patient with MRSA.

24 Visiting Other Departments

Transfer of patients to other wards or departments should be kept to a minimum and be carefully supervised. Any discharging lesions should be occluded with an impermeable dressing. The patients should be given clean clothing and transferred to a clean bed.

If the patient needs to visit a diagnostic department, the staff of the department concerned must be informed so that IPC measures for that department can be implemented.

25 Care of Deceased Patients Colonised/Infected with MRSA

The same source isolation precautions must continue after the patient has died. As a routine, bodies are enclosed in a plastic body bag before it is transported to the mortuary.

Providing standard precautions are routine, no additional precautions are required to be taken in the mortuary or by the undertakers.

26 MRSA Integrated Care Pathway

The MRSA integrated care pathway provides a framework which is aimed at improving care delivery for MRSA positive patients within in-patient areas. Please refer to Appendix 1 for an example of the MRSA Integrated Care Pathway.

27 Staff and MRSA

- Microbiological swabs should NOT routinely be taken from SCHT staff.
- Swabs from staff should only be taken on the advice of the IPC team and/or Consultant Microbiologist and in conjunction with OHD.
- Staff who have any pre-operative screening and found to be positive must obtain treatment from their GP.
- Staff who have any pre-operative screening and found to be positive in their nose only, can still go to work.
- Staff who have any pre-operative screening and found to be positive must take advice from the OHD.

Health care workers may infrequently become nasopharyngeal carriers of MRSA but only rarely become infected – and even then they most often have minor skin infection. Efforts to prevent spread should be concentrated on emphasising good personal hygiene and maintaining clean equipment and a clean environment.

Minor skin sepsis or skin lesions such as eczema, psoriasis, or dermatitis amongst staff can result in widespread dissemination of staphylococci. Staff with any of these conditions must contact OHD for assessment and may be checked for carriage of MRSA.

27.1 Screening in Response to an Outbreak of MRSA

Routine MRSA screening of staff is NOT recommended practice nor is it carried out routinely within SCHT. The purpose and objective in carrying out any screening and decolonisation programme is to protect the safety of patients, visitors and staff and as far as possible to eradicate MRSA. The co-operation of all staff in achieving this is essential.

A decision to pro-actively manage any outbreak of MRSA will be taken by the IPC team and Consultant Microbiologist.

If it has been determined by the IPC team that an outbreak of MRSA requires management action, they will notify the DIPC, Director of Nursing and Operations, the Medical Director and OHD on what action is to be taken.

The requirement for staff screening is only indicated if transmission continues on a unit despite active control measures, or if epidemiological aspects of an outbreak are unusual or if they suggest persistent MRSA carriage by staff.

The IPC team will inform the appropriate Manager or Service Lead that action is to be taken in line with relevant Human Resources policy.

The IPC team will inform the OHD of the planned screening of all the staff on a particular ward or department.

The Manager or Service Lead will provide a list of staff to be screened including nursing, agency, medical, physiotherapy, domestic and clerical staff to the IPC team and OHD. The list should include any staff that work in or have regular access/contact within the areas affected.

The Manager will inform all members of their staff that they need to be screened for MRSA colonisation and make arrangements with OHD to ensure that they are screened.

No further action will be taken until the results of the screening are known.

27.1.1 How to Screen Staff

Staff screens are essentially taken in the same way as for patients. Staff screening means that the nose and any skin lesions should be swabbed. Groin/ perineal, axilla, hairline, or hand swabs are **not** needed for staff screening. See Appendix 6 how to take a nose swab.

Staff cannot adequately swab their own noses and any samples should preferably be taken by the OHD staff.

Staff screening must only take place at the beginning of a shift, or when the member of staff has been **off duty** for at least 12 hours to stop detection of transient carriage.

The OHD **not** the ward must be named as the origin of any specimens taken. Every effort will be made to ensure strict confidentiality when a member of staff is found to be colonised with MRSA. For agency staff, their management will be informed and are responsible for contacting the member of staff concerned and ensuring treatment is obtained.

27.1.2 Communicating Results of Staff Screening

The results of screening will usually be available within approximately 4 days. However, preliminary positive results may be available within 24 hours.

Results should go to the OHD. However, if the ward location is put on the request form in error, the result may be sent to the ward. In this case staff must be reminded that results are confidential and must not be reported to anyone other than the member of staff, OHD or the IPC team.

27.2 Prescriptions for Treatment of Carriage

Staff will be advised to contact their GP to prescribe treatment. Ward nursing and medical staff must not prescribe for each other. The cost of treatment for staff will be reimbursed following submission of a SCHT request for manual payment form (see Appendix 8) a receipt for payment is required.

27.3 Exclusion from Work

This is rarely necessary. The staff member must start the MRSA decolonisation regimen as soon as possible

27.4 Treatment of Those Staff Identified as Carrying MRSA

The purpose of any screening and decolonisation programme will be to eradicate colonisation/infection. SCHT will provide support to any individual requiring treatment.

Staff screening will be carried out in accordance with protocols determined by IPC team.

If, as a result of screening, a member of staff is found to be carrying MRSA, OHD will contact the individual staff member and invite them to the department to commence their decolonisation treatment as soon as possible.

In most circumstances staff can continue to work whilst on treatment. However, where it is considered to present an unacceptable risk to patients, temporary alternative employment or temporary modification of the role may be identified, which should not be unreasonably refused.

Medical/Clinical staff will have their Job Plan temporarily modified where at risk activities are identified.

Payment for all staff during this period will continue as if the individual were employed and working in their permanent role i.e. without withdrawal of their additional or enhanced payments.

Staff will be advised to contact their GP to prescribe decolonisation treatment.

Where an individual persistently fails to respond to treatment and is considered to present an on-going risk to patients, temporary alternative employment or for medical/clinical staff modification of their Job Plan, may be identified in an attempt to support them whilst efforts are made to eradicate the infection. If MRSA is not eradicated after a reasonable period, the individual will be dealt with in accordance with Section 27.8 of this policy.

27.5 Failure to Co-operate with Action Proposed by Management

If any individual fails to comply with a request made by the OHD and or IPC team, the Medical Director or Executive Director of Nursing, Quality and Operations will be informed and they will write to the individual informing them of the requirement to be screened and explaining SCHT's duty of care and the potential consequences of failing to do so.

If an agency worker or contractor is working in an area where an outbreak has been confirmed and screening is required, they will be required to comply with any formal request to be screened. If they refuse to co-operate, their contract will be terminated in accordance with the appropriate agency agreement. If, on being screened, they are found to be colonised with MRSA, the IPC team will determine, based on a risk assessment, whether the individual may continue to work in the role whilst they are being treated, or whether their employment will be terminated in accordance with the appropriate agency agreement.

If any individual continues to unreasonably refuse to be screened and/or decolonised, s/he may be subject to action in accordance with SCHT's Disciplinary Procedure and will be reported to the relevant regulatory body in line with their fitness to practice regulations.

27.6 Infection or Treatment Resulting in Sickness Absence

Where an individual falls ill as a result of contracting MRSA or the treatment they receive and are prevented by the illness from attending for work, they will be dealt with in accordance with SCHT's Managing Attendance Policy, with particular account being taken of the reasons for the absence.

27.7 Temporary Alternative Employment

If an individual is found to be colonised with MRSA, a risk assessment will be undertaken by the IPC team liaising with the ward/department manager and microbiology to determine the risks associated with them continuing to carry out their normal day to day duties.

If it is considered that an individual cannot carry out their normal day to day duties due to the risk of cross infection, the individual should be referred to the OHD who will liaise with the Line Manager and the IPC team regarding medical redeployment for a temporary period whilst the individual is undergoing decolonisation and further screening. This may be in the immediate work area but not in direct contact with patients or it may be to a different work area.

Any offer of temporary alternative employment or modification of their Job Plan should not be unreasonably refused.

The individual will start working under the alternative arrangements immediately and these arrangements will continue until the individual has had three negative MRSA swabs. During this period, they will continue with their existing terms and conditions, although working arrangements such as hours of work may be changed. Payment during this period will continue as if the individual were employed and working in their permanent role i.e. without withdrawal of their additional or enhanced payments.

If no temporary alternative employment can be found or if an individual refuses to work under alternative arrangements during this period, they will be medically suspended from duty immediately on grounds of ill health until they have had three negative MRSA swabs. Payment during this period will continue as if the individual were employed and working in their permanent role.

At any meeting to discuss redeployment or suspension the individual may be accompanied by an accredited Trade Union representative or colleague employed by SCHT.

27.8 Permanent Redeployment

Where an individual fails to respond to the programme of treatment and where the risks of them continuing in their current role are unacceptable for reasons of patient safety, then SCHT will seek to identify suitable permanent alternative employment. Early retirement on the grounds of ill-health may be requested by the individual and will, in these special circumstances, have the full support of the SCHT. However, as with all cases of Ill Health Retirement, the final decision will rest with the NHS Pensions Agency (see SCHT Managing Attendance Policy).

Only in this last resort of a staff member being a persistent carrier who could not be decolonised and who is also shown to be a specific risk to their patients would consideration have to be given to permanent restriction of practice and the possible need for retraining for practice in which carriage did not pose a risk to patients.

Where an individual is retained in employment under such alternative arrangements, he/she will be employed on the terms and conditions applicable to the new role.

28 Post Infection Review (PIR) Formerly Known as Root Cause Analysis (RCA)

The Government considers it unacceptable for a patient to acquire a MRSA bacteraemia while receiving care in any healthcare setting. It has set healthcare providers the challenge of demonstrating zero tolerance of MRSA bacteraemias through a combination of good hygienic practice, appropriate use of antibiotics, improved techniques in the care and use of medical devices as well as adherence to best practice guidance. For further information see NHS England 2014 Guidance on the Reporting and Monitoring arrangements and post infection review process for MRSA bloodstream from April 2014.

The zero-tolerance approach to MRSA was been re-iterated in Everyone Counts: Planning for Patients 2014/15 to 2018/19.

The PIR process will:

- help identify factors that may have contributed to a MRSA bacteraemia case
- help to identify any parts of the patient's care pathway which may have contributed to the infection, in order to prevent a similar occurrence
- help providers of healthcare and CCGs to identify any areas of non-optimal practice that may have contributed to the MRSA bacteraemia
- help to identify promptly the lessons learned from the case, thereby improving practice for the future
- identify the organisation best placed to ensure that any lessons learnt are acted on

28.1 Post Infection Review Process:

The purpose of the PIR is to identify how a case occurred and to identify actions that will prevent similar cases reoccurring in the future. Therefore the process requires strong partnership working by all organisations involved in the patient's care pathway - Refer to Appendix 9: MRSA BSI Reporting Arrangements and Timeline Flow Diagram.

Following detection of an MRSA BSI, SaTH will notify SCHT and the CCG IPC teams the next working day;

The organisation with responsibility for leading the PIR will be:

If a patient was not an inpatient of an acute Trust (for example a GP took the sample):	PIR to be led by the CCG

If the patient was an inpatient in SaTH or RJAH and if the sample was taken on:

Day of admission: (Day 1)	PIR to be led by the CCG
Day of admission: Day +1 (Day 2)	PIR to be led by the CCG
Day of admission: Day +2 (Day 3)	PIR to be led by SaTH or RJAH

The PIR will be initiated and completed within 14 working days using the MRSA BSI PIR Template (V1 - April 2018) (Appendix 10);

The appropriate Service Manager(s)/Service Lead(s) will be contacted by the SCHT IPC team to take responsibility for the investigation. Initial contact will usually be by telephone, followed up by email with details of the date of specimen, patient details and initial understanding of the infection. The MRSA PIR review Toolkit will be attached to the email.

The IPC team will notify the DIPC, Deputy Directors, Divisional Manager and relevant Locality Clinical Managers (LCMs). The clinical team(s), supported by the IPC team, will lead a comprehensive in depth collection of information to complete the relevant sections of the Toolkit https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2014/02/post-inf-guidance2.pdf MRSA Bloodstream Infection: Post Infection Review Template (V1 - April 2018) and return to SCHT IPC team within the timescale requested.

The SCHT IPC team will collate all returned toolkits into one document and forward to the CCG IPC team within the timescale given.

The CCG IPC team will collate the data from all organisations involved and the completed toolkit will be discussed at a PIR review meeting.

The PIR meeting will be undertaken within the next 5 working days to acknowledge areas of good practice and any possible failings in care and to identify the organisation best placed to ensure improvements are made.

The PIR meeting will attempt to establish how the case occurred, the actions that will help prevent it re-occurring and agree the organisation to which the case should be finally assigned. Public Health England (PHE) will be informed by the CCG IPC team.

From April 2018, MRSA BSIs will be reported by time of infection onset versus time of patient admission. Cases where the infection onset is >2 days after admission will be considered hospital-onset cases; all other cases will be considered to be community-onset.

Using the infection-onset based method, it will not be possible to categorise a case as 'Third Party' so this option will no longer be used. An arbitration process lead at regional level can be instigated by the CCG in the event that the review panel is unable to determine which organisation is responsible for the MRSA bacteraemia.

A review of good practice will also be discussed at the PIR review meeting and shared as deemed appropriate

If required a service improvement plan (SIP) will be developed following the review meeting to address any issues identified during the PIR review process.

The appropriate Managers/Service Leads will ensure the agreed SIP is fully implemented and through local governance structures ensure lessons learnt are shared across SCHT to prevent any further similar cases. The question will be posed of whether existing policies would have prevented the infection or whether new and or amendment of existing policies should be developed.

If the outcome of the review meeting finds that there were failings in care provided by SCHT, a Serious Incident will be reported via Datix and the case will be counted against SCHT's target as agreed by CCG.

A post review meeting will be chaired by the CCG IPC team to discuss the SIP and gain assurance that actions have been implemented.

The Service Manager/Lead will monitor progress on the SIP and present a summary report to the next IPC meeting either in person or through their Service Representative.

29 Consultation

This policy has been developed by the IPC team in consultation with appropriate LCMs, Consultant Microbiologist, Day Surgery Unit Sister, Continence and Tissue Viability Leads, Human Resources and Workforce, OHD, lead Pharmacist and PHE.

A total of three weeks consultation period was allowed and comments incorporated as appropriate.

29.1 Approval Process

The IPC Governance Meeting members will approve this policy and its approval will be notified to the Quality and Safety Operational Group.

30 Dissemination and Implementation

This policy will be disseminated by the following methods:

- Managers informed via Datix who then confirm they have disseminated to staff as appropriate
- Staff - via Team Brief and Inform
- Awareness raising by the IPC team
- Published to the Staff Zone of SCHT's website

The web version of this policy is the only version that is maintained. Any printed copies should therefore be viewed as 'uncontrolled' and as such, may not necessarily contain the latest updates and amendments. When superseded by another version, it will be archived for evidence in the electronic document library.

30.1 Advice

Individual Services' IPC link staff act as a resource, role model and are a link between the IPC team and their own clinical area and should be contacted in the first instance if appropriate.

Further advice is readily available from the IPC team or the Consultant Microbiologist.

30.2 Training

Managers and service leads must ensure that all staff are familiar with this policy through IPC induction and update undertaken in their area of practice.

In accordance with SCHT's mandatory training policy and procedure the IPC team will support/deliver training associated with this policy. IPC training detailed in the core mandatory training programme includes standard precautions and details regarding key IPC policies. Other staff may require additional role specific essential IPC training, as identified between staff, their managers and / or the IPC Team as appropriate. The systems for planning, advertising and ensuring staff attend are detailed in the Mandatory Training Policy and procedure. Staff who fail to attend training will be followed up according to the policy.

Further training needs may be identified through other management routes, including PIR following an incident/infection outbreak or audit findings. By agreement additional ad hoc targeted training sessions will be provided by the IPC team.

31 Monitoring Compliance

- Hand hygiene will be audited in accordance with the Hand Hygiene Policy and via peer Hand Washing Assessments
- Cleaning standards within Community Hospitals will be monitored in accordance with the Publicly Available Specification (PAS) 5748 framework
- Environmental and patient equipment cleaning will be monitored as part of local routine cleanliness audits
- Audited locally using the HCAI Prevention audits undertaken by the IPC team and by staff as Self- audits as part of the IPC audit programme
- Additional periodic auditing and self-audits by clinical teams
- The IPC Governance Meeting will monitor compliance of the cleanliness audit scores and the IPC team audit programme
- Antimicrobial prescribing will be monitored in accordance with the Community antibiotic guidance.
- Compliance with MRSA screening of elective and emergency admissions will be monitored by the Board using InPhase the performance management software and monthly reports issues to LCMs by the Head of IPC and reported to the IPC bi-monthly meeting.
- Assurance of correct isolation practices by ward staff using the self-checklists adapted from the DH Savings Lives High Impact Intervention care bundle isolation practices.

The IPC team will monitor related incidents reported on SCHT Incident Reporting System and liaise with the Risk Manager to put appropriate remedial actions in place.

As appropriate the IPC team will support Services Leads to undertake IPC PIRs. Managers and Services Leads will monitor subsequent service improvement plans and report to the IPC Group.

Knowledge gained from PIR/RCA, IPC audits, and Self-checklists will be shared with relevant staff groups using a variety of methods such as reports, posters, group sessions and individual feedback. Compliance with this policy will be monitored locally by managers and by the IPC team as part of the standing audit programme using adapted Department of Health and Infection Prevention Society audit tools.

Attendance at IPC training, which includes Standard Precautions will be monitored by and reported to the Organisational Development Department and the IPC meeting.

32 References

Coia JE, Duckworth GJ, Edwards DI, et al (2006) Guidelines for the control and prevention of meticillin-resistant *Staphylococcus aureus* (MRSA) in healthcare facilities. Joint Working Party of BSAC/HIS/ICNA. *Journal of Hospital Infection*. Volume 63. Supplement 1, S1-44

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Department of Health. (2010). Saving Lives: reducing infection, delivering clean and safe care. Screening for meticillin-resistant *Staphylococcus aureus* (MRSA) colonisation.

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Joint Working Party of the British Society of Antimicrobial Chemotherapy, the Hospital Infection Society, and the Infection Control Nurses Association (2006). Guidelines for the control and prevention of methicillin-resistant Staphylococcus aureus (MRSA) in healthcare facilities. *Journal of Hospital Infection*. 63S: S1-S44

Loveday, H.P., Wilson, J.A., Pratt, R.J., Golsorkhi, M.,Tingle, A., Bak, A., Browne, A., Prieto, J., Wilcox, M. (2014) epic3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England. Journal of Hospital Infection 86 (Supplement 1) (2014) S1–S70

NHS England (2014) Guidance on the reporting and monitoring arrangements and post infection review process for MRSA bloodstream infections from April 2014 (version 2)

NHS England (2013) Everyone Counts: Planning for Patients 2014/15 - 2018/19

NHS Improvement (2018) Update on the reporting and monitoring arrangements and post-infection review process for MRSA bloodstream infections

NICE (2018) MRSA in Primary Care, https://cks.nice.org.uk/topics/mrsa-in-primary-care/

Screening for Meticillin-resistant Staphylococcus Aureus (MRSA) colonisation: a strategy for NHS Trusts – a summary of best practice. DH Health Service Guidelines 2006

The Royal Marsden (2015) Hospital Manual of Clinical Nursing Procedures (Ninth Edition). Wiley-Blackwell

33 Associated Documents

This policy should be read in conjunction with the following SCHT:

- Collection, Packaging, Handling, Storage and Transportation of Laboratory Specimens
- Community Antibiotic Prescribing Guidance
- Hand Hygiene policy
- Isolation policy
- Linen Handling and Laundry policy
- Managing Attendance policy
- Outbreak policy
- Patient Group Directive (PGD) Mupirocin 2% nasal ointment
- Standard Precautions including Surgical Hand Scrub, Gowning and Gloving policy
- Waste Management policy

Appendices

Appendix 1 – MRSA Integrated Care Pathway – EXAMPLE

MRSA Integrated Care Pathway
Single eradication regimen

Name: _____
Unit Number: _____
Ward: _____
DOB: _____

please affix name label

Indicate why this pathway is being commenced

On admission, and previously known to be MRSA positive.

Found on admission screen, or during present inpatient stay, to be MRSA positive

Date Ward Aware that Patient has MRSA:		☐ **Mupirocin Sensitive** ☐ **Mupirocin Resistant**	**Site(s) (please indicate side if appropriate).**		
			1.	**2.**	**3.**

1. Actions - Nursing Staff		Date	Comment here if any variance ***and associated actions*** (further space overleaf if required).	Signature
1.1 Isolate Patient	☐ Yes ☐ No		(If 'No.' ensure clinical incident completed).	
1.2 Source Isolation Sign fixed to patient door	☐ Yes ☐ No			
1.3 Verbal explanation given to patient	☐ Yes ☐ No		Ensure patient aware that night clothes and bedding should be changed daily	
1.4 MRSA Information leaflet given to patient (on intranet)	☐ Yes ☐ No			
1.5 Next of kin informed (with patient consent)	☐ Yes ☐ No			
1.6 Indicate on front of drug chart that this MRSA pathway is in use.	☐ Yes ☐ No			

2. Actions – Nursing Staff										
2.1 Patient washed all over in bath/shower/bed (if immobile) using disposable wipes/new towel	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2.2 Night clothes and bedding changed daily	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

2.3 Room/bed space cleaned daily with Tristel (including floors, locker and table) and de-cluttered	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No
Initials (2.1, 2.2 and 2.3)										

3. Please refer to MRSA policy or Community Antibiotic Prescribing Guidelines for MRSA treatment regimen, and prescribe on prescription chart.

4. Post eradication screening, results and associated actions

Site(s) (indicate side if necessary)	**1st Screen (48 hrs post eradication)**			**2nd Screen** (1 week after 1st screen)			**Final Screen** (1 week after 2nd screen)			**Actions if screens are negative.**	
	Date taken	*Initials*	*Result*	*Date taken*	*Initials*	*Result*	*Date taken*	*Initials*	*Result*		
			□ Positive □ Negative			□ Positive □ Negative			□ Positive □ Negative	Remove patient from isolation	□ Yes □ No
			□ Positive □ Negative			□ Positive □ Negative			□ Positive □ Negative	Inform domestic supervisor that room needs to be terminal cleaned	□ Yes □ No
			□ Positive □ Negative			□ Positive □ Negative			□ Positive □ Negative		

Please note:

Mup S patients with no invasive device and or wounds do not require isolation following first negative screen

Mup S patients with invasive devices/ wounds and **Mup R** patients require isolation until 3 negative screens

5. Variance table (complete for any no responses on this page)

Reference Number	Date	Variance	Action	Initials

Appendix 2 – MRSA Decolonisation Protocol

Patient Label

MRSA Decolonisation Protocol

Prior to commencing decolonisation protocol, ensure that a full set of screening swabs have been collected from nose, wounds and sites of indwelling devices to determine the degree of colonisation with MRSA.

	Site		Date and nurse's initials									
			Day 1		Day 2		Day 3		Day 4		Day 5	
1.	**Nose** *(treatment for five days)*	**Date:**	**Time**	**Signature**	**Time**	**Signature**	**Time**	**Signature**	**Time**	**Signature**	**Time**	**Signature**
	Undertake with drugs round.		**Please ensure drug chart is completed and signed on each occasion for nasal treatment**									
2.	**Skin** *(treatment for five days)*											
2a)	Wash once daily with: Octenidine (Octenisan®) • The skin should be moistened and the undiluted antiseptic solution applied thoroughly to all parts of the skin before rinsing in the bath or shower (recommended contact time 1 minute) • Do NOT dilute antiseptic solution in bath water as the concentration is insufficient. • A disposable sponge or flannel should be used to apply the antiseptic solution and discarded after use. • Special attention should be paid to sites such as axillae, groin, perineum and buttock areas and other skin folds. Creams, lotions and other skin care products/cosmetics should be single patient use and labelled.		**10.00 (approx)**		**10.00 (approx)**		**10.00 (approx)**		**10.00 (approx)**		**10.00 (approx)**	

		Date and nurse's initials									
		Day 1		Day 2		Day 3		Day 4		Day 5	
2b)	Dry patient with a clean towel. Change towel daily.										
2c)	Change bed linen whilst patient is in the bath or immediately after the wash (if able to do so)										
2d)	Change patient's underwear and clothes daily. Put on clean clothes after the daily bath or wash.										
3.	**Hair**										
	Wash hair twice weekly. Use as shampoo: Octenidine (Octenisan®) Record on appropriate day when hair wash completed Ordinary conditioner can be used after the shampoo if desired, as the antiseptic solutions can be drying to the hair.										

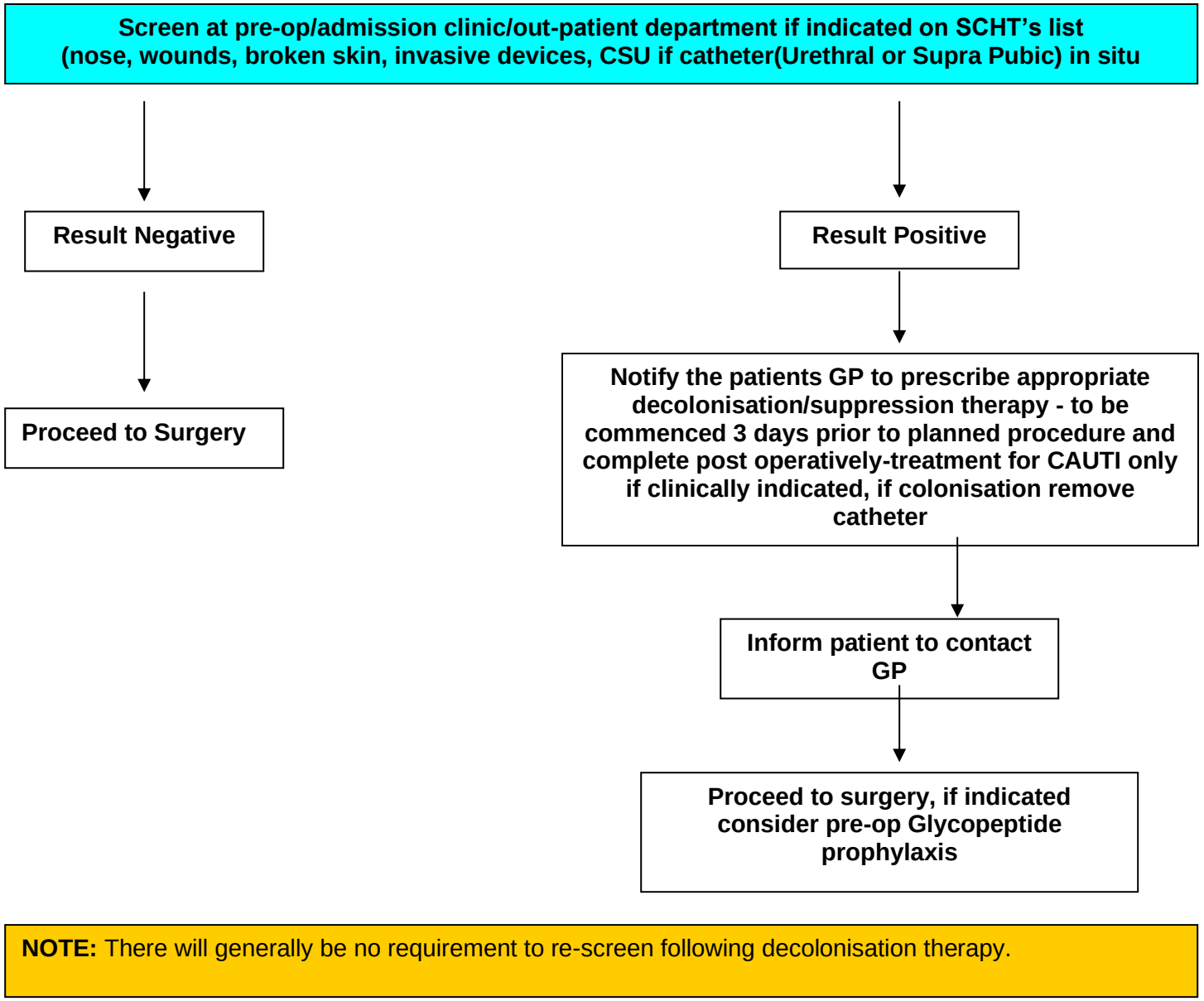
Notes:

Usually skin cleanser (face). Must not be used whilst following the decolonisation protocol.

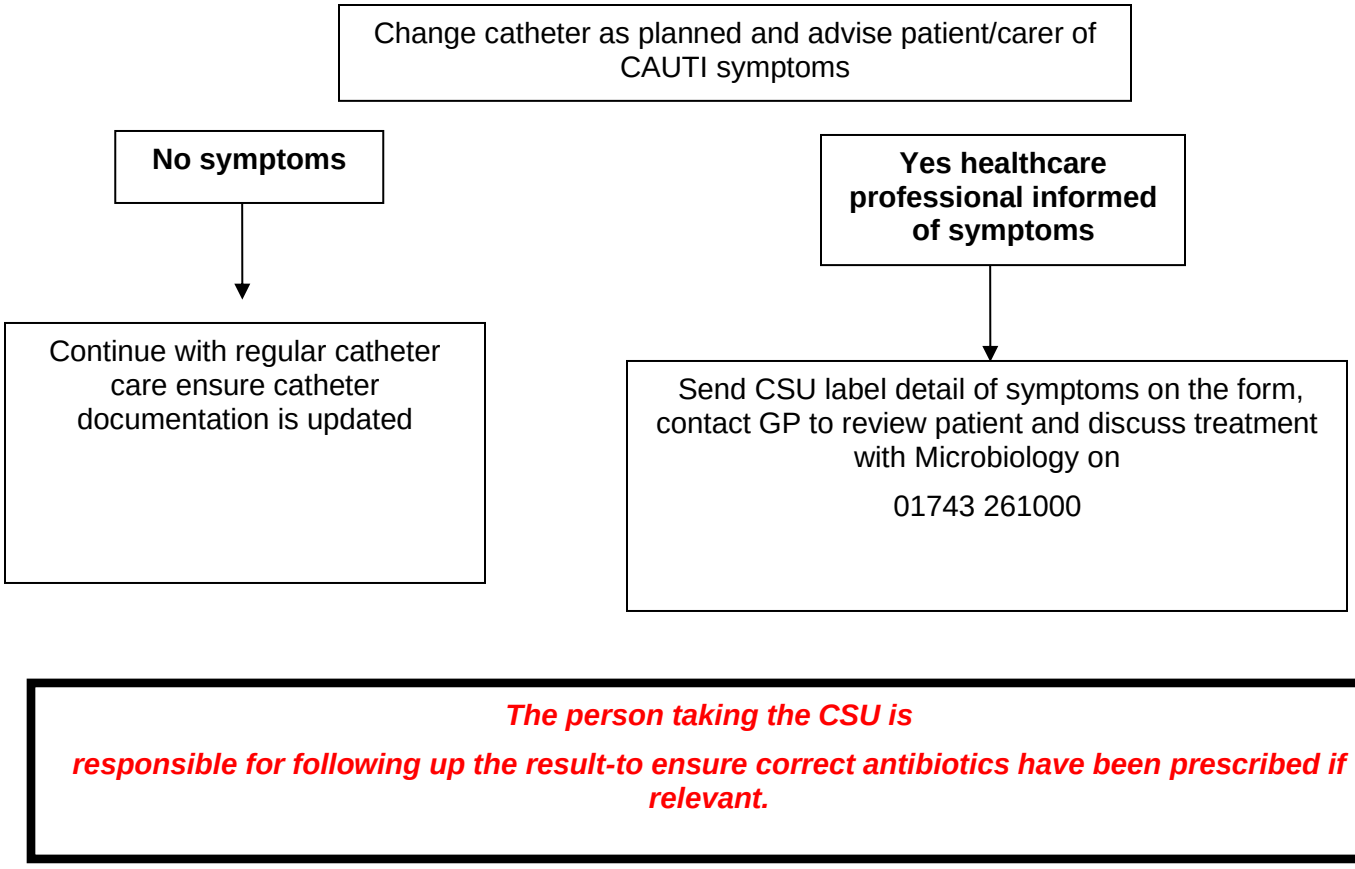
Appendix 3 – List Detailing Day Case Procedures and Requirement for MRSA Screening

Description of Procedure	MRSA Screening Required? YES ✓ No X
MEDICAL PROCEDURES	
Blood transfusions	**X**
Pain management therapies	**X**
GENERAL SURGERY	
Hernia repair (all types)	**✓**
Varicose veins	**✓**
Vasectomy	**X**
Excision of lipoma	If minor no All others yes
GYNAECOLOGY	
Laparoscopic sterilization	**X**
Laparoscopy /proceed	**X**
Dilation & Curettage	**X**
Insertion of intrauterine contraceptive device	**X**
ORTHOPAEDIC	
Arthroscopy	**✓**
Carpel tunnel decompression	**✓**
Dupuytren's release	**✓**
Manipulation under anaesthetic	**✓**
Amputation of digits	**✓**
Ulna nerve decompression	**✓**
Trigger finger release	**X**
Removal of ganglion	If minor no All others yes
PODIATRIC SURGERY	
1st met osteotomy	**✓**
Amputation of metatarsal	**✓**
Arthrodesis of metatarsal	**✓**
1st Metarsal joint replacement	**✓**
Excision of neuroma	**✓**
ENDOSCOPIC PROCEDURES	
Fibre optic endoscopic procedures	**X**
Diagnostic endoscopic procedures	**X**
Diagnostic examination of lower bowel with fibre optic sigmoidoscope	**X**
Extirpation/lesion lower bowel using fibre optic sigmoidoscope	**X**
In the event of a procedure not being detailed above advice should be sought from the Infection Prevention and Control Team on 01743 277671	

Appendix 4 – Algorithm for Day Case Screening Process



Appendix 5– Flow Chart for Urethral/Supra Pubic Catheter Change



The person taking the CSU is

responsible for following up the result-to ensure correct antibiotics have been prescribed if relevant.

Appendix 6 – Taking a Nasal Swab

- Explain procedure and gain verbal consent from patient
- Optionally moisten with sterile water (tap water or saline must not be used)
- Insert swab horizontally into the anterior nares and direct upwards into the tip if the nose (gently rotating the swab)
- One swab can be used to sample both nostrils
- It is imperative that care is taken to avoid contaminating either cotton bud tip or the shaft of the swab with your own skin flora or contaminants from the environment
- Replace swab in charcoal transport tube
- All samples must be clearly labelled with patient details and site of swabs
- A separate microbiology request form is needed for each sample
- Fully complete microbiology form clearly stating standard patient details, details of the swab enclosed, any other relevant information including history in relation to MRSA and current antibiotics. It is also essential the patient's location is clearly identified on the samples and on the microbiology form i.e. ward and hospital name or OPD pre-op screen and hospital name
- Send to the laboratory
- All results will be returned to the requesting source for appropriate action to be taken. It is the responsibility of the staff taking the specimen to review the result.

Appendix 7 – MRSA screening SOP

Standing Operating Procedure for MRSA Admission Screening

Document Details		
Title		**MRSA Admission Screening**
Trust Ref No		2122-51067
Author		IPC Team
Related Trust Policy		MRSA Policy
Approval process		
Approved by (Committee/Director)		Infection Prevention and Control Governance Meeting
Approval Date		July 2021
Review date		July 2024
Amendments History		
No	Date	Amendment
1	June 2021	Update of contacts and CSU form instructions
2	February 2019	Amendments to Community Hospital link staff Roles and Responsibilities
3	October 2016	New SOP

Infection Prevention and Control

Standard Operating Procedure for MRSA Admission Screening

Objectives: - To minimise infection risk to patients, staff and visitors. To identify any opportunities to treat and decolonise patients who have a positive result for MRSA. To obtain MRSA screenings as per the SCHT MRSA policy and ensure specimens are collected and reviewed in a timely manner.

Action	**Responsibility of**
During the admission process the patient should be screened for MRSA during the first 24 hours of admission. A screening swab should be obtained from the nose, all wounds, areas of open skin and a catheter specimen of urine should be obtained, as per the MRSA policy available on the SCHT intranet. A separate swab needs to be taken for each wound and the nose. Each swab needs to be labelled and the specimen form fully completed with • Patient's correct name (not the name that they are known by e.g. Mr John James known as Jock, the specimen will need to be labelled as Mr John James)	Admitting staff member

• Address • Unit No. • NHS No. • DOB • Date • Time • Location of the patient e.g. Bridgnorth Community Hospital and the ward • Site of the specimen e.g. nose swab/CSU/ulcer Right leg • Person requesting the swab • Specimen request e.g. MRSA screening If the dressings are not due to be renewed on arrival e.g. surgical wounds, wound screenings can be taken when the wound is next redressed but this must be recorded in the patient's notes. CSUs can be obtained in the morning so that the freshest sample is sent to the laboratory for analysis e.g. admission over the weekend the CSU may be obtained first thing on a Monday morning or following a Bank Holiday but this must be documented in the patient's notes. The form must state for MRSA screen otherwise this will not be tested correctly. Routine MSUs and lab stick urine tests are not required to be obtained as part of the admission process. MSUs should only be sent if patient is clinically unwell and signs and symptoms recorded on the microbiology form. The form should **not** be completed with *positive lab stick/positive dipstick*	
Specimens need to be placed in the collection point ready for transportation to the lab. Each Community Hospital has a dedicated time for specimen collection by hospital transport during the week and ward mangers need to ensure that all staff are aware of the collection points and time for collection.	Ward Manager
The specimens obtained above need to be recorded • In the patient's notes • On the VTE form on the ward • In the specimens book	Admitting staff member or member of staff who obtained the swab
Results must be checked on SaTH REVIEW daily and recorded in the patient's notes. Staff must not wait for the copy of the paper results or a telephone call from the lab or IPC team before actioning the result.	It is the responsibility of the staff member who obtained the specimen to ensure that the specimen is reviewed and to act on the result and if that person is not available a system must be in place to ensure that the above is actioned.
IPC Link staff should review the admissions to the Community Hospital wards once a week to ensure that MRSA specimens have been obtained and if there is any doubt or the specimen or result cannot be traced, a repeat set of	Link staff/ Ward Manager or nominated person

admissions screenings must be obtained to ensure the missed screening period is a maximum of 7 days.	
All missed screenings should have a DATIX completed	Ward Manager or staff member
On the first day of the month the VTE forms should be reviewed by the ward managers, or other staff nominated to complete this. The patient's NHS number should be used not their Patient ID number. THE VTE form should detail the specimens obtained for each person.	Ward Manager or nominated person
VTE forms should be forwarded to Angel Cook and the IPC team for verification of the data by the 4th of the month.	Ward Manager or nominated person
The IPC team will review the MRSA screening to check for any missed screenings.	IPC team
The ward managers and LCMs will be notified of any anomalies in the data by the IPC Team for review and action and response.	IPC team
MRSA screening stats will be uploaded to InPhase by 8th of the month.	IPC team
IPC team to forward details to the community hospitals, LCMs, Head of Nursing and Deputy Director of Operations and DIPC for information.	IPC team
Infection Prevention and Control Secretary to ensure that MRSA screening details are published on public facing page and the staff page of the SCHT website.	Infection Prevention and Control Secretary
Infection Prevention and Control Secretary to notify IPC lead when this has been completed	Infection Prevention and Control Secretary
IPC lead to ensure that all MRSA screening figures are reported to the Board via Quality and Safety Committee and Infection Prevention and Control Governance Meeting and in the IPC Annual Report.	IPC lead

Signatures of staff who are using the SOP

Name	Designation	Signature	Date

Appendix 8 – Request for Reimbursement of Prescription Cost

Shropshire Community Health NHS Trust

Request For Manual Payment

Supplier/Payee _____

Address _____

_____

_____

_____

Payment In Respect of _____

_____

		£	p
Budget Code	- - / - -	_____	:_____
	- - / - -	_____	:_____
	- - / - -	_____	:_____
	- - / - -	_____	:_____
	- - / - -	_____	:_____
	- - / - -	_____	:_____
	- - / - -	_____	:_____
	- - / - -	_____	:_____
	Total Amount	_____	:_____

Vat Recoverable Y/N *

Date _____

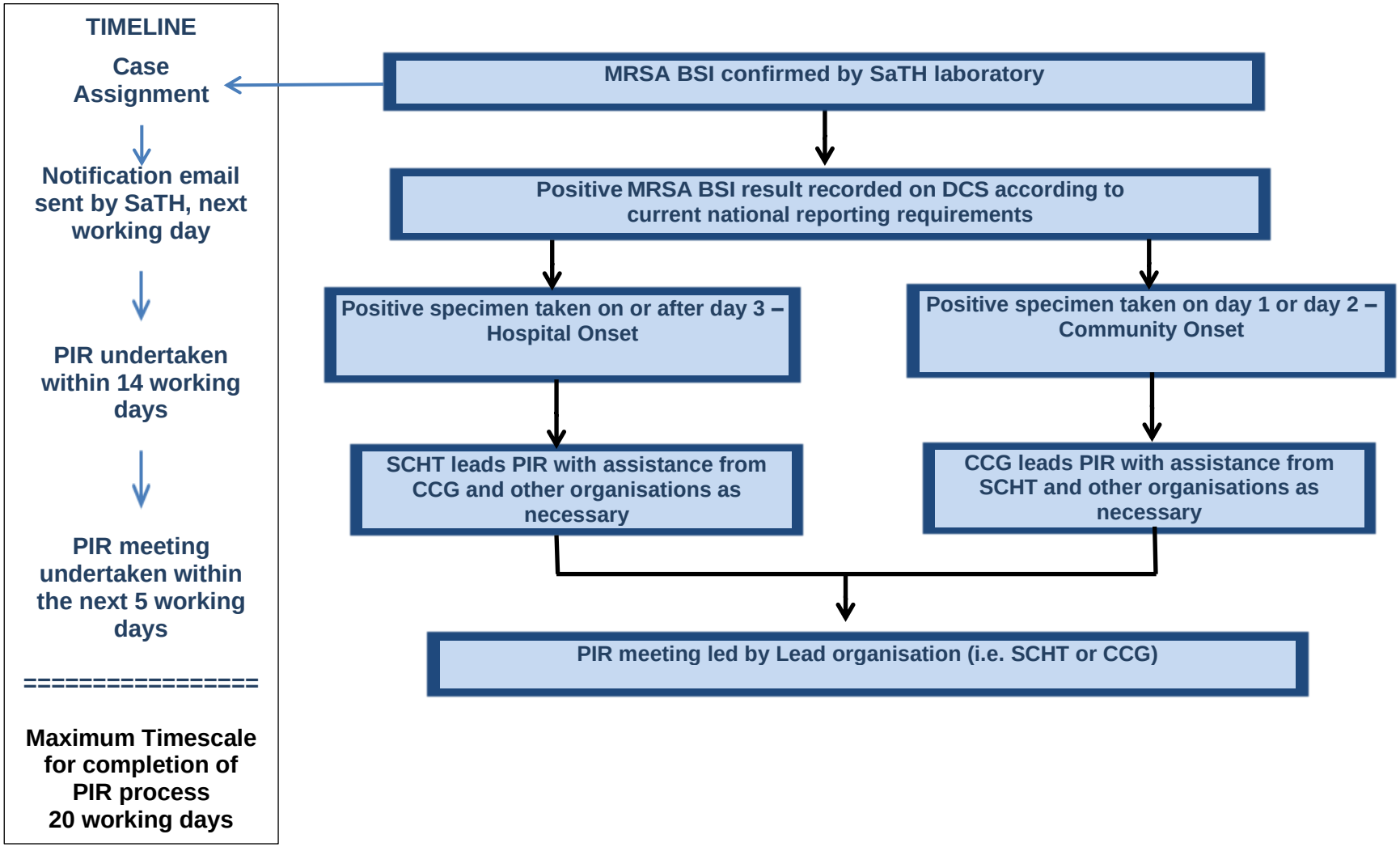
Prepared by _____

Authorised by _____

Please tick box if the payment is URGENT ☐

* Delete as appropriate

Appendix 9 – MRSA BLOOD STREAM INFECTION (BSI) Reporting Arrangements and Timeline Flow Diagram



Appendix 10– MRSA Bloodstream Infection: Post Infection Review Template (V1 - April 2018)

The purpose of this template is to help staff conduct their post infection review in the case of an MRSA bloodstream infection*. Some sections may be more relevant than others, and staff are encouraged to exercise their discretion/clinical judgment in completing the form.

Organisation
Site/Location where the specimen was taken
Ward/area
Nature of incident*
MRSA bacteraemia
Date of incident

* NOTE: Contaminants should continue to be reported as part of the mandatory reporting on the Data Capture System (DCS). DO NOT complete the full PIR for cases of contamination where there is clear evidence this is not a true MRSA bacteraemia. In such cases, the PIR process is not appropriate, but separate locally agreed procedures should be used to identify and address any issues that arise from the contamination (for example, if the patient was then subsequently inappropriately prescribed antibiotics). If the contaminated specimen was taken in an *acute trust*, it must be assigned to that trust. In all other cases, it must be assigned to the Clinical Commissioning Group (CCG). The summary information must be completed indicating an agreed contaminant.

1. Write a brief narrative of the incident, including likely source and any underlying clinical, social or behavioural factors of the patient, patient management, outcome.

A. CASE DETAILS

1. DCS Case number/reference[2]
1.1 Name of patient (this information can only be accessed locally)

[2] This number is a unique case identifier that the DCS gives to every case of MRSA bloodstream infection input.

1.2 Date of Birth (DOB)	**1.3 Sex**
1.4 Date specimen was taken	
1.5 Location where the specimen was taken	

2. Please supply a 'timeline' for patient movement over the last 2 weeks (e.g. admission and discharge dates for inpatient stays, Outpatient or A&E attendances, GP attendances, attendances for dialysis or other therapy,).

TIMELINE		
DATE	**TIME**	**EVENT**

3. Contact with:	
○ Nursing/residential care/sheltered housing?	If so, for how long?
○ Contact with respite care?	If so, for how long?
○ Continence clinic?	If so, for how long?
○ Podiatry/leg ulcer/diabetic foot clinic?	If so, for how long?
○ Other organisation relevant to the case	If so, for how long?

4. Any medical conditions relevant to this case of MRSA bloodstream infection?

5. Other relevant co-morbidities

6. Likely outcome from this episode prior to the patient being infected with an MRSA BSI?

B. SCREENING FOR INFECTION/COLONISATION

7. For admitted patients, and in line with national MRSA screening guidance and your local protocols, was the patient eligible to be screened for MRSA colonisation prior to, on or during admission?
YES/NO
8. If so, were they screened?
YES/NO
9. If yes, and the patient tested positive for MRSA colonisation, was decolonisation prescribed?
YES/NO
10. Was the recommended decolonisation process followed by the patient?
YES/NO
11. Please supply relevant screening and decolonisation history.
12. Was the patient aware of any previous MRSA colonisation/infection?
YES/NO

13. Could any deficiencies in screening have contributed to the incident?

C. DEVICES USED IN RELATION TO PATIENT

14. Please list any devices used in a prior period relevant to this case in the events that led to the infection.

Device INSERT HERE	**Date of insertion**	**Date of removal**	**In line with local policy, was the device:**	
			Used appropriately?	YES/NO
			Correctly inserted?	YES/NO
			Correctly maintained?	YES/NO
			Correctly removed?	YES/NO
			Used appropriately?	YES/NO
			Correctly inserted?	YES/NO
			Correctly maintained?	YES/NO
			Correctly removed?	YES/NO
			Used appropriately?	YES/NO
			Correctly inserted?	YES/NO
			Correctly maintained?	YES/NO
			Correctly removed?	YES/NO

15. Please provide a summary of any deficiencies in device usage that may have contributed to this incident

D. ANTIMICROBIAL THERAPY

16. During the patient pathway under review, was the patient prescribed any antibiotics?
YES/NO
16a. If yes, which antibiotics were prescribed? (you may wish to consider noting details of the prescribers and the dates of the prescriptions)
INSERT ANTIBIOTICS PRESCRIBED
17. Was the appropriate antibiotic type prescribed?
YES/NO
17a. Was the appropriate dosage prescribed?
YES
17b. If no, could this have been a contributory factor for the MRSA BSI?
N/A

E. SKIN INTEGRITY

18. Did the patient have any breach in skin integrity (e.g. pressure sores/ulcers, leg ulcers, eczema)?
YES/NO
18a. If there was a surgical wound, were any of the correct surgical processes not followed using optimal practice?
YES/NO
18b. If a chronic wound, was it appropriately managed?

YES/NO/N/A
18c. If a chronic wound, was it colonised with MRSA?
YES/NO
19. Could any deficiencies in the management of skin integrity have contributed to the incident?
YES/NO

F. RISK FACTORS FOR TRANSMISSION

20. Is there any evidence of new colonisation by MRSA during the period of care that led to the current MRSA BSI?
YES/NO
21. Was the patient appropriately isolated?
YES/NO
22. Any other factors that may have contributed to transmission?

G. HAND HYGIENE

23. Was there evidence of any deficiencies in hand hygiene compliance in the areas of the pathways of care during this period?
YES/NO
23a. If "YES", please provide details.

H. OTHER FACTORS

24. Were there any deficiencies in environmental or equipment cleaning during this period, and could these have contributed to this incident?
YES/NO
25. Were there any other factors (avoidable or unavoidable) relating to this patient's overall management that could have contributed to the incident?
YES/NO
25a. If "YES", please provide details

26. If "YES", could these have been avoided?
YES/NO

I. ORGANISATIONAL ISSUES

27. Were staff to patient ratios appropriate or at least in line with local agreement in the areas where this patient was managed prior to the incident?
28. Were there any specific issues with staffing capacity during the period prior to this incident?
29. Were there any likely deficiencies of training in infection control in the areas covered by the patient pathway of care?

J. GOVERNANCE ISSUES

30. Is there evidence from any of the organisations responsible for the patient's care: • Of formal and informal audits of relevant clinical practice being undertaken and used to drive improvement? • Of processes in place to check effectiveness of clinical practice controls e.g. additional spot checks, use of safety thermometer, intentional walk rounds by matron/lead nurse/board member? • That ownership of infection prevention and control is evident in individual staff members, teams and management structures and mandated within their governance structures and processes when undertaking PIR/RCAs/Serious Incidents?
31. Is there evidence of infection control policies for the relevant issues identified and have these been reviewed in accordance with the organisation's requirements?

32. Summary to inform development of action plan for learning outcomes

*Using the boxes below, please provide summary of factors **A to J.***	*Were any of the factors contributing to the infection identified in this section?*	*Using the free text boxes below, please state whether the factors that contributed to the infection could have been prevented.*	*Recommended actions agreed to prevent recurrence.*	*If examples of sub-optimal practice have been detected, but did not contribute to this infection, please insert details here. Please indication what corrective action is being/has been taken.*
Agreed contaminant	**Please insert Y/N/DK**			
A - Case details				
B – Screening for Infection/colonisation				
C – Devices				
D – Antimicrobial therapy				
E - Skin Integrity				
F – Risk factors for Transmission				
G – Hand Hygiene				
H – Other factors				
I – Organisational issues				
J - Governance				

K. STATEMENT OF GOOD PRACTICE

33. Are the patient and appropriate relatives/carers fully aware of this incident?
YES/NO
34. PLEASE SUMMARISE THE LEARNING OUTCOMES FROM THIS POST INFECTION REVIEW (using the free text box below)

L. AFTER CONDUCTING THE POST INFECTION REVIEW, THE ORGANISATIONS BEST PLACED TO ADRRESS ANY FAILINGS IN CARE ARE.

Organisation (please tick box/boxes)	**FAILINGS IN CARE:**
Acute Trust ☐	
CCG ☐	
Other (name) ☐	

SERVICE IMPROVEMENT PLAN

Issues Identified	Action(s) to address Issue	Person(s) Responsible for Improvements	Date to be Completed	Date Completed