



MRSA POLICY

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Policy Owner	Chief Nurse including Midwifery and Allied Health Professionals
Policy Author	Infection Prevention and Control Team
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'During the COVID19 crisis, please read the policies in conjunction with any updates provided by National Guidance, which we are actively seeking to incorporate into policies through the Clinical Ethics Advisory Group and where necessary other relevant Oversight Groups'

DOCUMENT HISTORY

(Procedural document version numbering convention will follow the following format. Whole numbers for approved versions, e.g. 1.0, 2.0, 3.0 etc. With decimals being used to represent the current working draft version, e.g. 1.1, 1.2, 1.3, 1.4 etc. For example, when writing a procedural document for the first time – the initial draft will be version 0.1)

Date of Issue	Version No.	Date Approved	Director Responsible for Change	Nature of Change	Ratification / Approval
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24 Oct 14	4.1		Executive Director of Nursing & Workforce	Revised in line with new Department of Health guidelines	Ratified by Infection Prevention Control Committee
05 Dec 14	4.1		Executive Director of Nursing & Workforce		Ratified at Clinical Standards Group
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19 May 15	6.0	19 May 15	Executive Director of Nursing & Workforce	Amendments made to current Policy	Approved at Policy Management Group
12 Apr 15	6.1	12 Apr 16	Executive Director of Nursing	Minor amendment;	Approved at Policy Management Group subject to being put into current template
5 May 16	6.2		Executive Director of Nursing	Policy re-formatted into current template	
10 May 16	7.0	12 Apr 16	Executive Director of Nursing	Approved 12/04/2016- as no content has been changed does not need to be seen again	Policy Management Group
14 May 19	7.1	14 May 19	Director of Nursing/ Director of Infection Prevention and Control	Minor amendments	IPCC members
31 May 19	7.1		Director of Nursing	Endorsed at	Clinical Standards Group
24 June 19	8.0	24 June 19	Director of Nursing	Approved at	Policy Management Sub-Committee
29 Jan 2021	8.0	24 June 19	Chief Nurse including Midwifery and Allied Health Professionals	12 month blanket policy extension due to covid 19 applied with author review date set 6 months prior to Valid to Date.	Quality & Performance Committee
14 May 2021	8.0	24 June 19	Chief Nurse including Midwifery and Allied Health Professionals	Extended policy uploaded and linked back with new cover sheet	Corporate Governance

NB This policy relates to the Isle of Wight NHS Trust hereafter referred to as the Trust

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1 Executive Summary

This policy defines the actions required to reduce risk for healthcare associated infections (HCAI), by reducing risk for transmission of MRSA and preventing cross infection within the healthcare environment in line with the requirements of the Health and Social Care Act Code of Practice. The screening strategy is in line with that recommended by the Department of Health in 2014.

See <https://www.gov.uk/government/collections/staphylococcus-aureus-guidance-data-and-analysis> for further information about MRSA

2 Introduction

2.1 MRSA

Staphylococcus aureus (*S.aureus*) is a bacterial organism carried in the nose of about 30% of the population and remains the commonest cause of skin sepsis and surgical site infection. Meticillin resistant *Staphylococcus aureus* (MRSA) is a type of *S. aureus* resistant to many antibiotics, including flucloxacillin, cephalosporins and often macrolides (e.g. erythromycin).

2.2 Transmission of MRSA

Staphylococci are commonly found in the anterior nares and in skin folds, such as the perineum or axillae. They will also colonise chronic wounds, long-term indwelling devices such as feeding tubes, clothing and the environment. Colonisation may result in infection.

2.3 Infection versus colonisation

The presence of MRSA will not always indicate the presence of infection as individuals can have asymptomatic carriage of MRSA known as 'colonisation'. This may not pose a problem to the individual but can act as a reservoir for the bacterium within a healthcare setting.

3 Definitions

MRSA	Meticillin resistant <i>Staph.aureus</i>
MSSA	Meticillin sensitive <i>Staph.aureus</i>
HCAI	Healthcare Associated Infection
IPCT	Infection prevention and control team
SIRI	Serious incident requiring investigation
PHE	Public Health England
RCA	Root Cause Analysis
PIR	Post Infection Review

4 Scope

4.1 Applies to all Trust staff including agency, bank and locum staff; applies in all Trust healthcare settings.

5 Purpose

5.1 The purpose of the policy is:

- To protect patients from infection or colonisation with MRSA
- To ensure patients who are confirmed to have MRSA are managed safely and appropriately and receive adequate information about their condition.

6 Roles and Responsibilities

6.1 It is the responsibility of all healthcare staff to comply with the Trust's infection control policies.

- **Director of Infection Prevention & Control (DIPC):** Responsible for ensuring the policy is implemented.
- **Heads of Clinical Services** Responsible for ensuring the policy is implemented within their areas.
- **Modern Matrons/Ward Sisters/Charge Nurses** are responsible for promoting compliance with infection control guidelines and ensuring MRSA risk assessment and appropriate screening is completed within their areas (including completion and monitoring of monthly MRSA risk assessment audits, leading on actions where poor compliance identified). They should take the lead on root cause analyses (RCA) and the Post Infection Review (PIR) for MRSA bacteraemias.
- **Ward clinical staff** and PAAU clinic staff are responsible for implementing MRSA screening policy, performing assessment of risk for MRSA, checking and documenting the results and acting appropriately on results.
- **Microbiology laboratory staff** are responsible for processing MRSA screens.
- **Consultant Medical Microbiologists** are responsible for advising on management of MRSA infections and infection prevention and control precautions.
- **Infection Prevention & Control Team (IPCT)** are responsible for advising on the MRSA screening process, updating the policy and patient information, providing advice on infection prevention and control precautions and MRSA reduction therapy. IPCT should ensure MRSA positive patients have the appropriate flag on the electronic patient record, are responsible for reporting MRSA bacteraemias to Public Health England (and CCG where appropriate) and prompting and supporting the RCA investigation process (and Post Infection Review (PIR) if required by PHE) for Trust attributed MRSA bacteraemias, as well as investigating potential incidents of MRSA cross infection.
- **Occupational Health** are responsible for advising staff on working practices and management where MRSA infection or carriage is identified.

7 Policy detail/Course of Action

7.1 Assessing Risk for MRSA

Assessing risk for MRSA is important in hospital care settings to ensure appropriate precautions including screening are implemented to minimize the risk of MRSA transmission to those at highest risk of infection.

The MRSA risk assessment (in the adult inpatient risk assessment book) must be completed for all adult inpatient admissions. See appendix B.

Department of Health guidance in 2014 recommended a move away from universal admission screening to only screening patients in a high risk location (orthopaedics and areas of higher dependency) or patients who are known to have been previously carrying MRSA (this will be recorded in the eCare Logic alert flag section).

See sections 7.3 and 7.4 for details on screening and actions based on result of patients before elective procedures and emergency admissions respectively.

7.2 Screening for MRSA

Before taking swabs for screening a full explanation of why the test is required and how it will be performed should be given to the patient (give patient information leaflet "Meticillin Resistant Staphylococcus aureus"(MRSA) and MRSA testing) and their informed consent obtained.

- Use standard sterile swabs for MRSA screening. Moisten with sterile saline solution prior to use if swabbing a dry area.
- Nose and groin swabs are the minimum required for MRSA screening. See 'Sites to screen' in box below).
- Use appropriate MRSA screening request form (emergency or elective)

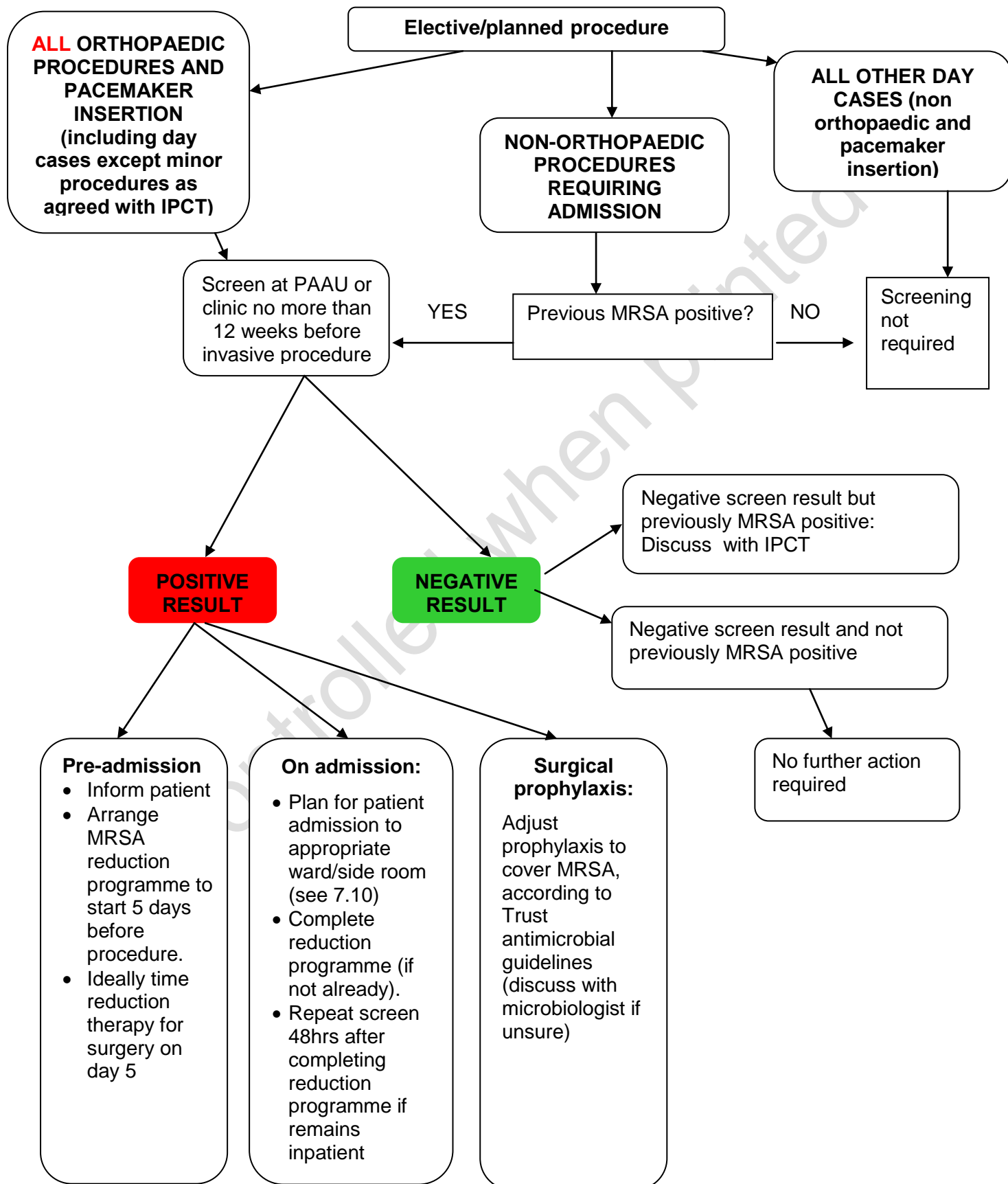
Sites to screen

- Nose – (use one swab for both nostrils) - gently insert swab into anterior nares (inside the nostril), perform circular motion x 3 and repeat in the other nostril using the SAME swab.
- Groin – use one swab for both groins.

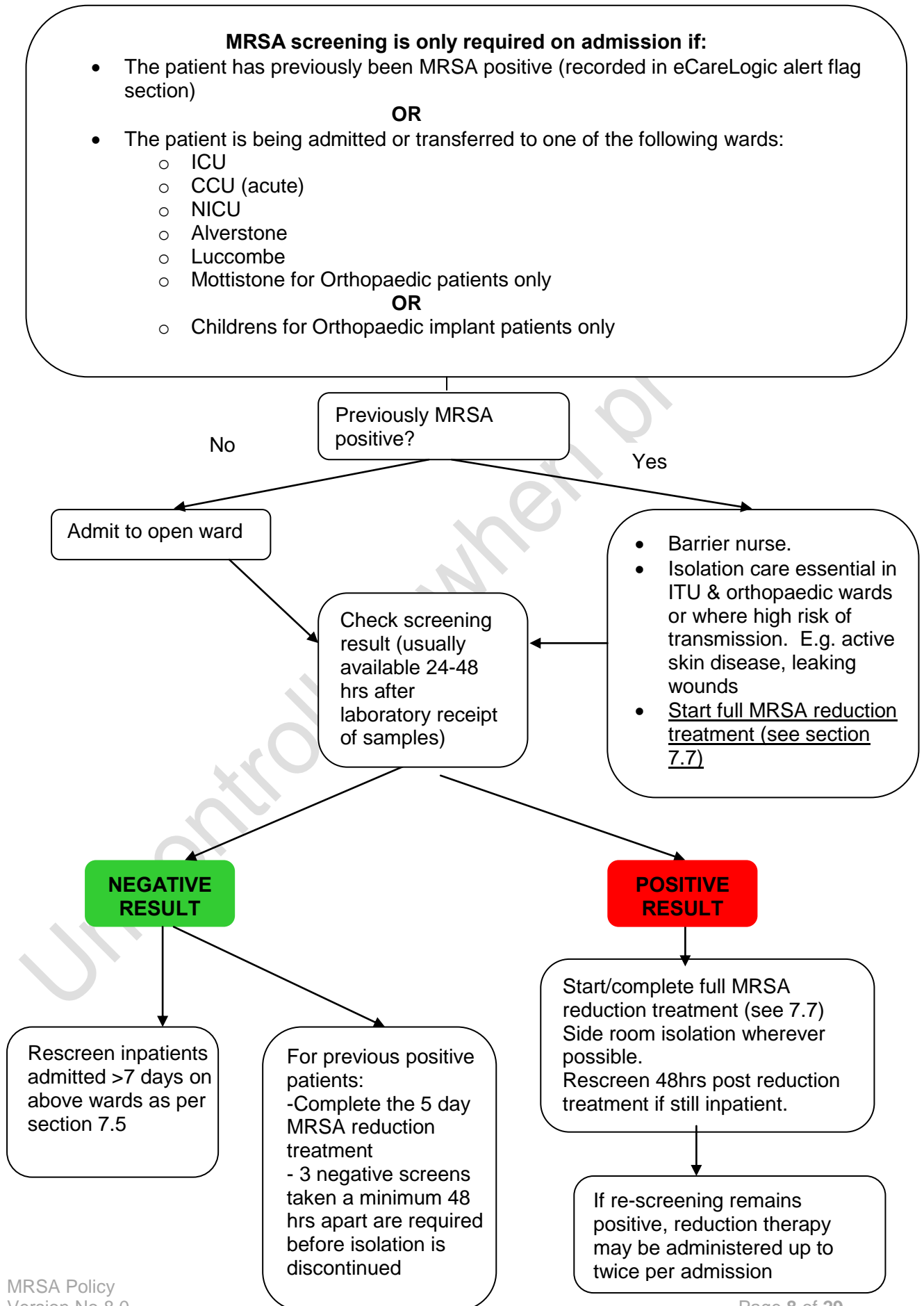
In addition, take swabs from the following sites if present:

- Wound and skin lesions.
- Site of previous MRSA colonisation
- Invasive devices e.g. PEG site, tracheostomy (IV line dressings should not be disturbed for routine swabs due to risk of introducing infection).
- Catheter urine sample (CSU) (not swab) if urinary catheter in situ.
- Sputum if expectorating

7.3 MRSA Pre-admission Screening for Elective Procedures/Surgery



7.4 MRSA Screening of Emergency Admissions



7.5 Rescreening of Inpatients for MRSA

Rescreen all patients weekly on the following wards:

Ward/Patient category	Frequency of rescreening for inpatients
<ul style="list-style-type: none">• ICU• NICU• CCU (acute patient)• Alverstone• Luccombe• Orthopaedic patients on Mottistone Unit• Childrens (orthopaedic implants)	Weekly (on set day for ward)

- Discharge screening is not indicated unless advised by IPCT.

7.6 MRSA Screen Results

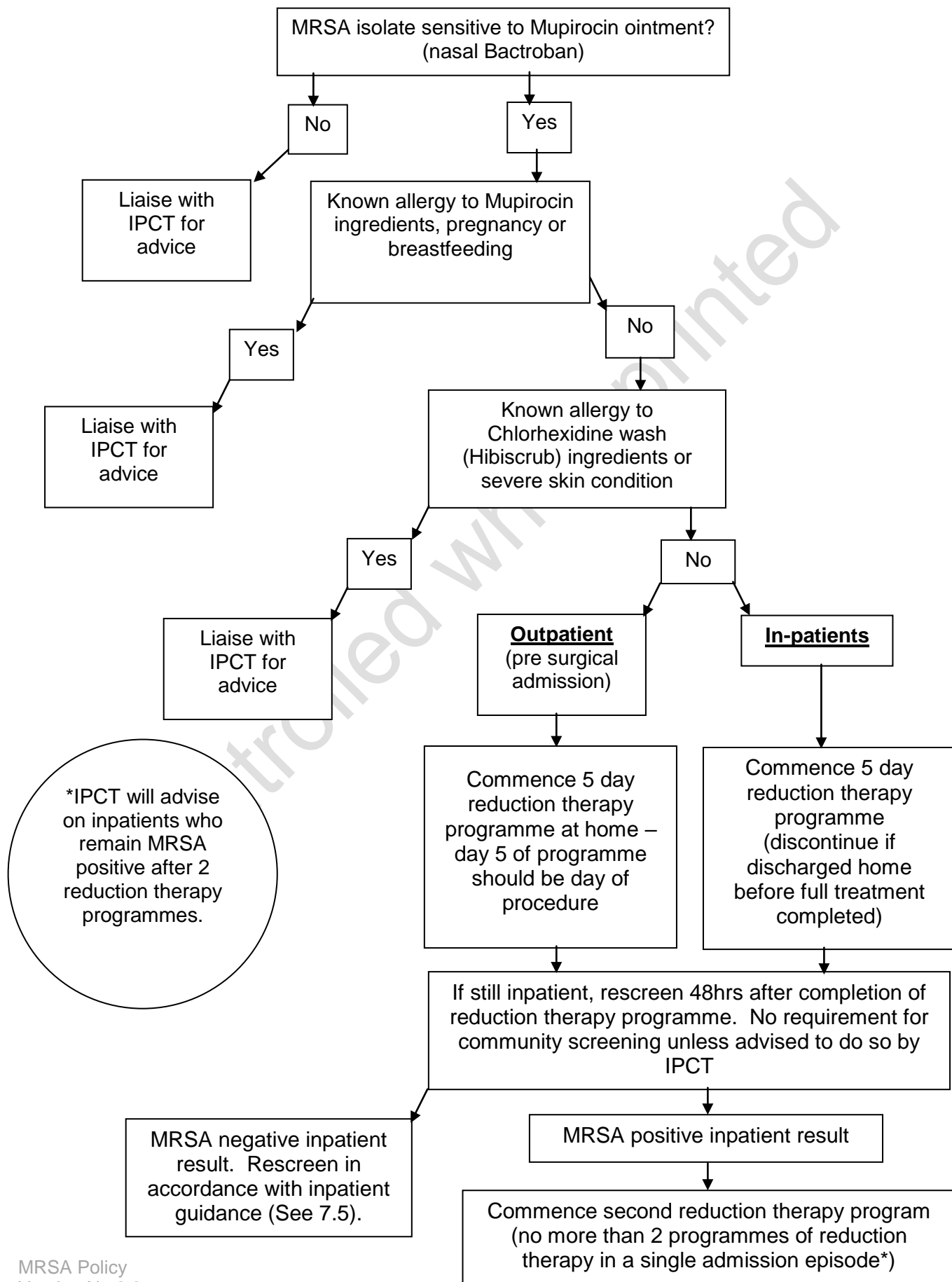
- For emergency admission screens, it is the responsibility of the clinical team caring for the patient to follow up any MRSA screening results which will be available on the laboratory computer system usually 24-48 hours after laboratory sample receipt.
- For elective admission screens, it is the responsibility of the PAAU/clinic requesting the screen to follow up any MRSA screening results
- Positive MRSA results will be telephoned by the infection control team, during office hours, to inpatient locations as stated on the request form.

7.7 MRSA Reduction Therapy

Reduction therapy should be prescribed on the drug chart or appropriately trained nursing staff in PAAU may use a Patient Group Direction (PGD). See:

<http://it-intranet-apps/guidelines/PGD%20IC001%20Mupirocin%20%20MRSA.pdf>

Reduction Therapy for MRSA Positive Result or previous Known MRSA Positive Status – Planned and Emergency Admissions



7.8 Communication of MRSA Status

7.8.1 Healthcare professionals

Both hospital and general practitioners need to be aware of the MRSA status; this may also affect choice of antibiotic should the patient develop clinical signs of infection.

- Flag in electronic record (IPCT will arrange for newly identified patients to have MRSA risk recorded in the Patient Centre special register which can be viewed in the “Alerts and allergies” section on eCareLogic).
- In Primary care, record the MRSA status in the patient’s electronic record
- At handover ensure that healthcare staff are made aware of the patient’s MRSA status and of the importance of taking the necessary infection control precautions.
- Document MRSA status in Discharge summary when patient leaves hospital.

7.8.2 Patient/family information

Ward/clinic staff must provide patients with appropriate information about MRSA. This should include information about colonisation versus infection and what can be done to minimise risk for infection.

- Patients with MRSA must be given the appropriate MRSA patient information leaflet (available from print room).
- Explain to the patient and their relatives/carers about MRSA

7.9 Preventing Transmission of MRSA

Strategies to protect inpatients from infection (HCAI) with MRSA

- Identify those inpatients most at risk by screening and give reduction treatment as described above to reduce bioburden.
- Ensure consistent good hand hygiene, aseptic technique and PVAD (Peripheral venous access device) care management to reduce risk of transmission and infection.
- Prevent contamination of the patient care environment through high standards of cleanliness and equipment decontamination.

7.10 Inpatient Care: Placement of Patients with MRSA

Patients with confirmed or suspected MRSA colonisation or infection require segregation from vulnerable patients and contact precautions.

- The patient should be cared for in a side room wherever possible.
- If there are insufficient side rooms prioritisation must be made, depending on risk for transmission of MRSA. The choice of placement must be considered and risk assessment made, taking into account: site of MRSA colonisation or infection, mode of transmission and the level of risk of spread (see below); the patient’s ability to comply with infection prevention strategies (e.g. confusion, incontinence).
- For patient placement on elective orthopaedic wards, see Appendix C
- Complete incident form (DATIX) if a side room cannot be made available for a patient with MRSA.

High risk patients who MUST be cared for in side room (preferably with en-suite) include the following:

- Respiratory tract: MRSA in sputum with cough and/or MRSA in tracheotomy site.
- Skin: MRSA positive with skin shedding (e.g. eczema or psoriasis) and/or MRSA in open discharging wound.
- Heavily colonised patients who are unable to undergo MRSA reduction therapy regime.

Isolation procedures

- If the patient is in a side room, the door should be kept CLOSED. The patient should be encouraged to stay inside. (If this is likely to compromise care, e.g. in the elderly / confused, clearly document in patient notes and seek advice from IPCT). Bays used for cohort care within wards should have the doors closed to provide physical separation from other patients.
- The door of the side room or bay must have clear signage to alert staff and visitors to requirements for infection control precautions.
- Side rooms or bays used for isolated patients should have en-suite facilities or if not should have a designated WC or commode.
- Notes/charts should be kept *outside* the room or bay.
- Cohort patients with MRSA should be cared for by designated staff.
- Fans should not be used in isolation rooms.
- The number of persons entering the side room/bay should be kept to a reasonable minimum.

The isolated/cohort patient with MRSA:

- Should be actively encouraged to keep the bed-space free from clutter to facilitate cleaning.
- Must be actively discouraged from touching wounds.
- Must be encouraged to observe good hand hygiene practice (use bedside hand sanitiser gel).

Visitors and MRSA

Visitors of patients with MRSA should not be discouraged, especially if the patient is in a side room.

- The nurse in charge should be consulted before entering the isolation area.
- Visitors must wash/decontaminate hands before entering the area and immediately before leaving.
- Visitors do not need to wear personal protective equipment (unless providing direct patient care).
- Visitors who assist with a patient's direct care or who have more extensive patient contact (including those who visit other patients within hospital) should be advised to wear disposable apron and gloves for the care contact (dispose of PPE *before* leaving the room/bay and then clean hands, as advised by Nurse in charge).

7.11 Transmission (Contact) Precautions

Contact precautions

Contact precautions are fundamental to the prevention of transmission of MRSA and protecting vulnerable patients from infection.

Hand hygiene

High standards of hand hygiene minimise the risk of transmission of infection.

Consistent compliance with hand hygiene is essential in all healthcare settings:

- Decontaminate hands before and after each direct patient contact (or contact with the immediate patient care environment).
- Hand sanitiser gel is as effective as washing with soap and water, provided hands are not visibly soiled.
- Decontaminate hands after removing gloves

Personal Protective Equipment (PPE):

Disposable gloves and aprons must be used by staff for contact with the patient and their immediate environment. (Use in accordance with the Infection Control PPE Policy).

7.12 MRSA and the Environment

Equipment decontamination

Patient care equipment must be fit for purpose. There must be enough equipment items to enable single patient use and between-patient decontamination to the standards required.

- Use disposable single use items wherever possible.
- Reusable items and equipment where used *should be single patient use wherever possible, designated solely to the patient with MRSA* (e.g. stethoscopes, sphygmomanometer cuffs, lifting slings, mobility aids). After use they must be decontaminated as per policy before use by any other patient.
- A disposable tourniquet must be used

Environmental Cleaning

Hospital / Clinic settings

As with equipment, cleaning and management of the environment is essential to minimising transmission of MRSA.

- As MRSA may survive in dust, cleaning regimens must pay particular attention to removal of dust and dust traps.
- Clean side rooms (or isolation bay/area) at least once daily in hospital (*Actichlor plus*).

Terminal cleaning

After patient discharge, transfer or death

Standard terminal cleaning procedures should be followed using *Actichlor plus*, as per the Trust Clean Patient Environment Policy.

7.13 MRSA in Specialist Areas

Obstetric Unit

- See Appendix C.

Neonatal Unit

- **See Appendix D.**

Operating theatre and recovery

- Every effort should be made to reduce risk of MRSA colonisation or infection before surgery or invasive procedure.
- A patient's MRSA status should not prejudice their surgical management.
- Theatre staff should be informed in advance of the patient's MRSA status. Equipment and staff attending the patient should be kept to minimum, without compromising patient care. All equipment must be cleaned after the case.
- MRSA positive patients can be scheduled for surgery at any time on the list provided the required decontamination can be achieved between cases (see below). Extra time may be needed to allow appropriate cleaning of the area e.g. skin shedding patient.
- Cover any skin lesions (other than those involved in the procedure) with an impermeable dressing.
- If the procedure requires antibiotic prophylaxis, ensure that an agent active against MRSA is used (e.g. vancomycin/teicoplanin – see antibiotic guidelines and discuss with Consultant Microbiologist if unsure).
- After the procedure: Surfaces in direct contact with the patient skin and all equipment must be decontaminated using detergent/1,000-ppm chlorine solution (Actichlor plus); allow to dry before the next patient.
- Decontaminate theatre trolley by cleaning with detergent wipes after use
- Recovery: Staff caring for an MRSA positive patient must adhere to contact and standard infection control precautions. MRSA patients with extensive skin lesions (i.e. may be a skin shedder) should be segregated wherever feasible.

Ambulance Services

- Standard precautions and good hand hygiene must be followed.
- MRSA positive patients may be transported with other patients in the same ambulance (unless advised by IPCT or ward of an exceptional infection hazard where segregation may be advisable*)
- Change the bedding after every patient use.
- After transporting an MRSA positive patient standard cleaning and decontamination procedures MUST be followed.

*e.g. a patient with extensive weeping and/or extensive exfoliating skin lesions with MRSA (Ward staff should inform IPCT and Ambulance service in advance) IPCT can advise on any necessary additional precautions.

Residential and Nursing Homes

- Carriage of MRSA is not a valid reason for exclusion from residential or care homes.
- People with MRSA do not present a risk to the community at large and should continue their normal lives without restriction. MRSA positive residents should not be treated differently to other residents.

- For further information and guidance, residential and Nursing Homes are referred to 'Prevention and Control of Infection in Care Homes – an information resource'. Department of Health and Health Protection Agency Feb 2013 and their local Infection Prevention & Control support service.

For Trust staff attending patients in residential / nursing home settings:

- Comply with standard precautions at all times; including hand hygiene practice (see policy).
- If clinical procedures are necessary on a resident with MRSA (e.g. open wound present):
 - Complete any procedures on other residents before attending to dressings or carrying out clinical procedures on a resident with MRSA.
 - Carry out clinical procedures/dressings on a resident with MRSA in the resident's own room where possible

7.14 Patients with MRSA Infection (including MRSA bacteraemia)

MRSA can cause the same types of infection as meticillin sensitive *S.aureus* (MSSA), including bloodstream infection (bacteraemia). A patient with serious signs of sepsis requiring empiric antibiotic should always be reviewed for MRSA risk:

- If a patient is colonised with MRSA (or assessed as 'high risk' for carriage of MRSA) an antibiotic active against MRSA should be used. (See also antibiotic guidelines and discuss with Consultant Microbiologist if unsure which antibiotic is appropriate). Blood cultures should be collected by aseptic no touch technique before starting antibiotic therapy (see blood culture policy).
- MRSA bacteraemias are reported to Public Health England (PHE) as part of the Trust's participation in the mandatory HCAI surveillance scheme and strategy to reduce healthcare associated Infections (HCAI).
- All Trust attributed MRSA bacteraemia cases must undergo the Root Cause Analysis (RCA) processes.
- The IPCT will notify the relevant clinical team and matron of the MRSA bacteraemia and complete the Datix incident form. The matron is responsible for organising the RCA meeting, including time line completion. The RCA meeting must take place within the allotted time scale for feedback to the CCG and NHSI.
- Clinicians involved in the direct clinical care of the patient are expected to fully participate in the above processes.
- For community attributed MRSA bacteraemia cases, Trust staff must cooperate with the CCG team investigating the case as required, including the dissemination of relevant lessons to be learnt.

Outbreaks associated with MRSA

Seek advice from a member of the Infection Prevention and Control team.
Refer to Outbreak Policy.

Patient with Glycopeptide resistant or intermediate MRSA (GISA)

- Follow advice from Consultant Microbiologist and IPCT

- Patient in hospital with GISA must have single room isolation care with door **CLOSED** and strict compliance with enhanced contact precautions.

7.15 Movement of MRSA Positive Patients

Patient movement within hospital

Transfer and movement should be kept to a minimum to reduce the risk for transmission of infection and should only be undertaken for clinical reasons. (This must not compromise patient care and should be determined by clinical need).

Portering staff who transfer patients; do not need to wear gloves or PPE. They **MUST** clean hands before and after the transfer using soap and water or hand sanitiser gel

Staff who are transferring patients must ensure that:

- The receiving area is informed of the patient's MRSA status.
- The patient is moved to a single room where possible.
- Wherever possible, the patient should be transferred on a clean trolley to a clean bed in the receiving area.
- Lesions are covered with an impermeable dressing where possible.
- MRSA positive patient are not put next to patients with open wounds, lesions or high-risk patients or transferred into a ring fenced MRSA free area.
- All transfer equipment is decontaminated before and after transfer. Equipment used in the transfer e.g. chair/trolley should be decontaminated by cleaning thoroughly with detergent wipes and before use by any other patient.

Death of patient with MRSA

Standard Precautions should be taken to manage the deceased patient known to be MRSA positive.

7.16 Discharge of MRSA Positive Patient

On discharge from hospital

The clinical staff responsible must inform other agencies of the patients MRSA status before discharge:

- Clearly state in Discharge summary.
- Verbal handover to nursing and residential homes.
- Arrange for terminal ('barrier') clean – see page 15
- If further specialised care is needed relating to the patient's MRSA status (e.g. wound management or antibiotic therapy) this should be discussed with the GP prior to discharge.

Pre transfer to another hospital

- Screening is not routinely indicated.
- Pre-transfer screening may be requested if the patient is being transferred to an acute clinical risk area (e.g. ICU or before referral for specialist surgery: cardiothoracic or orthopaedics) and has not had an MRSA

screen within the past seven days. Arrange for results to be sent to the receiving ward or unit.

- Waiting for results of MRSA screen should not delay transfer if there is clinical need and a bed is available

7.17 Occupational Health

Screening for MRSA

- *Screening of Healthcare Staff for MRSA is not routinely performed.* This is in line with national guidance.
- In exceptional circumstances, based on evidence and risk (for example in event of an outbreak or problem with MRSA in a particular clinical area) the Microbiologist may advise screening of groups of staff. (Where indicated, this will be arranged confidentially via Occupational health).

Staff with MRSA

- A staff member identified as having MRSA will be assessed by Occupational Health (OH) and will normally be offered MRSA reduction therapy (where appropriate. It is not necessary to be away from work once suppression therapy has commenced).
- Further Occupational Health advice (in conjunction with advice from IPCT) and follow-up will depend on individual risk assessment.
- Staff with eczema or chronic skin lesions should seek advice from OH.

8 Consultation

- 8.1 Policy revision distributed to members of Infection Prevention and Control Committee for consultation.

9 Training

- 9.1 This MRSA Policy does have a mandatory training requirement which is detailed in the Trust's mandatory training matrix and is reviewed on a yearly basis. The Mandatory Infection Prevention and Control training for all staff covers this policy. There is a non-mandatory training MRSA e-learning package available

10 Monitoring Compliance and Effectiveness

- 10.1 Monitoring of MRSA blood stream infection (bacteraemia) cases forms part of the Trust quality performance reporting process against the nationally agreed MRSA objective.

The following will be monitored at Infection Prevention and Control Committee:

- Statistics for compliance with MRSA screening requirements.
- Mandatory surveillance of MRSA bloodstream infections (HCAI data capture), completion and outcomes of RCAs and their action plans

- Compliance and completion of the MRSA risk assessment audits including follow up of action plans

11 Links to other Organisational Documents

Antibiotic Resistant Bacteria policy
 Clean Patient Environment Policy
 Code of Practice for Prevention and Control of Healthcare Associated Infection policy
 Hand Hygiene Policy
 Healthcare Associated Infection (HCAI) policy for reporting
 Use of Personal Protective Equipment – Standard (Universal) Precautions policy
 Isolation policy
 Outbreak policy – including Bed Closure policy

Patient Information leaflets:

Meticillin Resistant *Staphylococcus aureus* (MRSA) and MRSA testing
 Information for inpatients and relatives on MRSA Reduction Therapy
 Information for patients and relatives on MRSA Reduction Therapy Planned Surgical Patients
 Meticillin Resistant *Staphylococcus aureus* (MRSA) and MRSA testing Planned Surgical Patients

Patient Group Directive:

MRSA (Methicillin Resistant *Staphylococcus aureus*) Reduction Therapy consisting of: 1) Mupirocin 2% Nasal Ointment (Bactroban Nasal) 2) Chlorhexidine Gluconate 4% Solution (Hibiscrub)

12 References

1. Department of Health expert advisory committee on Antimicrobial Resistance and Healthcare associated Infection (ARHAI) MRSA Screening Implementation Group. Implementation of modified admission MRSA screening guidance for NHS (2014). <https://www.gov.uk/government/publications/how-to-approach-mrsa-screening>
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5. Department of Health. Screening for Meticillin-resistant Staphylococcus aureus (MRSA) colonisation: a strategy for NHS trusts - a summary of best practice 2006. Available at:
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6. Department of Health. Reducing health care associated infections guidance 2011. MRSA screening. Available at:
<http://webarchive.nationalarchives.gov.uk/20120118164404/http://hcai.dh.gov.uk/whatdoido/mrsa-screening/>
7. NHS improvement. Update on the reporting and monitoring arrangements and post-infection review process for MRSA bloodstream infections. 2018. Available at: <https://improvement.nhs.uk/resources/mrsa-guidance-post-infection-review/>

13 Appendices

Patient's name IW number <p style="text-align: center;">AFFIX ADDRESSOGRAPH</p>	<h2 style="margin: 0;">MRSA Risk Assessment</h2> <p style="color: red; font-weight: bold; margin-top: 10px;">Must be completed for ALL admissions and transfers.</p>
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1. Risk assessment – Part 1	Yes	No	Signature and date
Has your patient previously been MRSA positive? Check ISIS/Patient Centre for "flag" alert	<input type="checkbox"/>	<input type="checkbox"/>	
If yes , isolate in single room, undertake full MRSA screen, commence full MRSA reduction therapy programme*, ensure patient has received appropriate information and undertake subsequent rescreens in accordance with MRSA policy. Datix must be submitted where single room not available and advice sought from the Infection Prevention & Control Team. Completion of Part 2 is not necessary. If no , proceed to Part 2.			

2. Risk assessment – Part 2	Yes	No	Signature and date
Is the patient being admitted to Intensive Care Unit, Neonatal Unit** or Orthopaedic Unit, are they an acute patient on Coronary Care Unit or an orthopaedic patient on Mottistone Suite?	<input type="checkbox"/>	<input type="checkbox"/>	
Subsequent transfers to one of the above areas.	<input type="checkbox"/>	<input type="checkbox"/>	
Subsequent transfers to one of the above areas.	<input type="checkbox"/>	<input type="checkbox"/>	
Subsequent transfers to one of the above areas.	<input type="checkbox"/>	<input type="checkbox"/>	
If yes , undertake full MRSA screen. If no , further action not necessary. If positive result received, isolate in single room, commence full MRSA reduction therapy programme*, provide patient with appropriate information and undertake subsequent rescreens in accordance with MRSA policy. Datix must be submitted where single room not available and advice sought from the Infection Prevention & Control Team. If negative result received rescreen in accordance with MRSA policy.			

As long as answers to part 1 and 2 remain 'No' during the inpatient episode, no special precautions are necessary.

* Please be aware that chlorhexidine has the potential to cause anaphylactic reaction. Ensure that patient allergy status is known and recorded and that medical attention is sought in the event of unexplained reaction after chlorhexidine used. Seek advice from the Infection Prevention & Control Team if the patient has known allergy or a severe skin condition preventing use of chlorhexidine.

** Chlorhexidine not used in neonatal MRSA reduction therapy programme. See local protocol or seek advice from Infection Prevention & Control Team.

MRSA Screening Results					
Date	Sites screened	Result	Date	Sites screened	Result

ORTHOPAEDIC UNIT AND 'RING-FENCING' PROTOCOL

'Ring-fencing' orthopaedic areas for patients at risk of acquisition of MRSA (patients having joint replacement surgery).

Beds on Alverstone Ward or other allocated ward (currently Mottistone) are ring-fenced for elective orthopaedic surgical patients and other selected orthopaedic patients (screened MRSA negative) to reduce risk for infection.

Admission to ring fenced area

- Patients must NOT be admitted to ring-fenced beds from other non-orthopaedic wards within the hospital.
- Selected orthopaedic patients from other orthopaedic ward may be transferred to ring fenced ward provided MRSA negative and all defined criteria are met:

No transfers to ring fenced area from other orthopaedic ward unless:

- Patient has had negative MRSA screen within past 7 days
- No previous positive MRSA at any time in past.
- Move is clinically appropriate and in the patient's nursing care interests (i.e. the patient is not long stay, non-weight bearing, on traction with continuing care or with other complex needs).
- Patient has no unhealed surgical wound (i.e. any surgical wound is dry/stable).
- Patient has no open/chronic pressure sore, venous ulcers or chronic skin conditions.
- Patient has no documented infection & no recent culture results with *S.aureus* or other pathogen.
- Requires risk assessment by ward nurse in charge
- No transfer to ring fenced area must take place unless *all* of the above criteria are met.

MRSA SCREENING IN THE OBSTETRIC UNIT

MRSA screening should only be performed for:

- High risk maternal cases where there is a **high likelihood of complications** in mother and/or baby e.g. **likely to need NICU care** (e.g. women expecting more than one baby, diabetic women)
OR
- Women who have been MRSA positive previously:

The need for screening should be assessed at the first midwife review. Where the woman meets any of the above criteria, the MRSA screen should be arranged to be taken from 32 weeks. Screens should be taken as per the main policy

The pregnant woman with MRSA

For pregnant women who are found to be carrying MRSA, the IPCT should be consulted regarding further management plans, including the timing of reduction therapy (it should be noted that nasal mupirocin is not advised in pregnancy).

The woman should be reassured that the risk of MRSA to the baby is extremely low and that reduction therapy will be used to minimise spread of the MRSA and reduce her risks for a wound infection with MRSA.

MRSA Prevention and Management in the Neonatal Unit

Prevention

Good hand hygiene technique and scrupulous attention to the prevention of cross contamination remain the mainstay in the prevention of MRSA colonisation and infection.

Admission Screening

All babies admitted to the neonatal unit have admission and discharge swabs for carriage of MRSA.

Swabs must be taken from the following sites:

- Nose (both nostrils)
- Perineum
- Umbilicus
- Wound sites if present

Additionally weekly microbiological surveillance swabs are taken from all inpatients.

All babies repatriated to this unit will also have MRSA swabs taken, and must be barrier nursed until results show negative

Management of MRSA colonised babies

Colonised babies must be barrier nursed and should undergo a decolonisation (suppression) regimen.

No regimen is a 100% effective, and some babies may require more than one decolonisation course.

A combination of washing the skin daily with OCTENISAN and nasal Mupirocin for a total of 5 days is used

50:50 dilution in water does not appear to reduce the octenisan effectiveness, but it can be used undiluted if MRSA clearance becomes a problem.

Smaller babies will be less able to tolerate decolonisation due to thermal control.

- Dilute 50;50 with water before use.
- Days 1, 3 and 5: wash body, neck and face.
- Days 2 and 4 wash the whole body including the hair

Mupirocin nasal ointment 2% in white paraffin

Apply nasally 3 times a day for 5 days.

Skin lesions 3 times a day for up to 10 days

Octenisan wash:

- Warm the solution.
- Place infant on a clean towel and remove bedding
- Wipe the skin with cotton wool soaked in octenisan, leave in contact with skin for one minute
- Wipe with clean water
- Dry baby.
- Dress in clean clothes.
- If on High flow therapy or nasogastric tube is in situ, replace these each time the Mupirocin is used.
- At the final wash change all the Vapotherm circuit, change the incubator, and the nasogastric tube and nasal prongs.

After decolonisation:

- Re-swab 48 hrs post treatment (sites as above),
- If negative, re-swab at further 48 hrs, and if again negative, re-swab at a further 48 hrs.
- Barrier nurse until x 3 negative consecutive screens (each taken 48 hrs apart).
- If any positive swabs, continue to barrier nurse and discuss with infection control team.

MRSA Suppression Therapy

	Yes	No	Date Commenced	Date Completed
Suppression Commenced				
Suppression Completed				

MRSA screens taken and Results

Date	Nose	Perineum	Umbilicus	Other Sites	Other Sites	Date Next Screen Due	Signature	

Inform any other care setting of MRSA Status if transferred elsewhere and record below:

Financial and Resourcing Impact Assessment on Policy Implementation

NB this form must be completed where the introduction of this policy will have either a positive or negative impact on resources. Therefore this form should not be completed where the resources are already deployed and the introduction of this policy will have no further resourcing impact.

Document title	MRSA Policy
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Totals	WTE	Recurring £	Non Recurring £
Manpower Costs		0	
Training Staff		0	
Equipment & Provision of resources		0	

Summary of Impact:

Risk Management Issues:

Benefits / Savings to the organisation:

Equality Impact Assessment

- Has this been appropriately carried out? YES
- Are there any reported equality issues? NO

If "YES" please specify:

Use additional sheets if necessary.

Please include all associated costs where an impact on implementing this policy has been considered. A checklist is included for guidance but is not comprehensive so please ensure you have thought through the impact on staffing, training and equipment carefully and that ALL aspects are covered.

Manpower	WTE	Recurring £	Non-Recurring £
Operational running costs		0	
Totals:		0	

Staff Training Impact	Recurring £	Non-Recurring £
	0	
Totals:	0	

Equipment and Provision of Resources	Recurring £ *	Non-Recurring £ *
Accommodation / facilities needed	0	
Building alterations (extensions/new)	0	
IT Hardware / software / licences	0	
Medical equipment	0	
Stationery / publicity	0	
Travel costs	0	
Utilities e.g. telephones	0	
Process change	0	
Rolling replacement of equipment	0	
Equipment maintenance	0	
Marketing – booklets/posters/handouts, etc	0	
Totals:	0	

- Capital implications £5,000 with life expectancy of more than one year.

Funding /costs checked & agreed by finance:	N/A
Signature & date of financial accountant:	N/A
Funding / costs have been agreed and are in place:	N/A
Signature of appropriate Executive or Associate Director:	N/A



Equality Impact Assessment (EIA) Screening Tool

Document Title:	MRSA Policy
Purpose of document	To protect patients from infection or colonisation with MRSA To ensure patients who are confirmed to have MRSA are managed safely and appropriately and receive adequate information about their condition.
Target Audience	Applies to all Trust staff including agency, bank and locum staff; applies in all Trust healthcare settings
Person or Committee undertaken the Equality Impact Assessment	Dr Emily Macnaughton

1. To be completed and attached to all procedural/policy documents created within individual services.
2. Does the document have, or have the potential to deliver differential outcomes or affect in an adverse way any of the groups listed below?

If no confirm underneath in relevant section the data and/or research which provides evidence e.g. JSNA, Workforce Profile, Quality Improvement Framework, Commissioning Intentions, etc.

If yes please detail underneath in relevant section and provide priority rating and determine if full EIA is required.

		Positive Impact	Negative Impact	Reasons
Gender	Men	NO	NO	
	Women	NO	NO	
Race	Asian or Asian British People	NO	NO	
	Black or Black British People	NO	NO	
	Chinese people	NO	NO	
	People of Mixed Race	NO	NO	

	White people (including Irish people)	NO	NO	
	People with Physical Disabilities, Learning Disabilities or Mental Health Issues	NO	NO	
Sexual Orientation	Transgender	NO	NO	
	Lesbian, Gay men and bisexual	NO	NO	
Age	Children	NO	NO	
	Older People (60+)	NO	NO	
	Younger People (17 to 25 yrs)	NO	NO	
Faith Group		NO	NO	
Pregnancy & Maternity		NO	NO	
Equal Opportunities and/or improved relations		NO	NO	

Notes:

Faith groups cover a wide range of groupings, the most common of which are Buddhist, Christian, Hindus, Jews, Muslims and Sikhs. Consider faith categories individually and collectively when considering positive and negative impacts.

The categories used in the race section refer to those used in the 2001 Census. Consideration should be given to the specific communities within the broad categories such as Bangladeshi people and the needs of other communities that do not appear as separate categories in the Census, for example, Polish.

3. Level of Impact

If you have indicated that there is a negative impact, is that impact:			
		YES	NO
Legal (it is not discriminatory under anti-discriminatory law)		N/A	N/A
Intended			

If the negative impact is possibly discriminatory and not intended and/or of high impact then please complete a thorough assessment after completing the rest of this form.

3.1 Could you minimise or remove any negative impact that is of low significance? Explain how below:
3.2 Could you improve the strategy, function or policy positive impact? Explain how below:

3.3 If there is no evidence that this strategy, function or policy promotes equality of opportunity or improves relations – could it be adapted so it does? How? If not why not?	
Scheduled for Full Impact Assessment	Date:
Name of persons/group completing the full assessment.	
Date Initial Screening completed	

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