

## MRSA PROCEDURE

### PROCEDURE FOR THE MANAGEMENT OF PATIENTS COLONISED/INFECTED WITH METHICILLIN - RESISTANT *STAPHYLOCOCCUS AUREUS*

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## RISK MANAGEMENT PROCEDURE CLINICAL



Risk Management Procedures are enabled by the Trust Risk Management Strategy. They are designed to effect the procedural requirements of relevant approved Policies which themselves outline the overarching principles involved.

Risk Management Procedures are also instrumental in meeting the requirements of Clinical Governance and Safety and Environmental Governance.

This Procedure is mandatory and is to be followed by all Trust employees. The content is based on the legal requirements imposed by both primary and secondary legislation, approved codes of practice and/or evidence based guidelines. They are published following consultation with relevant staff and management groups/committees, prior to final approval by the relevant governance committee(s) and the appending of the Chief Executive's signature.

Source information and relevant legislative requirements are listed as an appendix to each of the procedures.

<b>This Procedure was produced in consultation with:</b>	
	Infection Prevention & Control Team
Dr John Cheesbrough	Consultant Microbiologist

<b>Other Trust Policies/Procedures associated with this document include:</b>
Standard (Universal) Precautions Guidance
Procedure for the identification, risk assessment and management of patients where isolation is indicated
Airborne Infection Policy Theatres
Cleaning and decontamination of ward areas where patients have been source isolated

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## ASSURANCE STATEMENT

The RMP provides guidance on the detection and management of MRSA. Implementation of the policy will protect against the risks of acquiring Health Care Associated Infections (HCAI). Implementation of the policy will demonstrate compliance with the 'Hygiene Code' (DH 2006 and 2008) and compliance with the NHS operating Framework (2008).

### 1. Purpose

#### 1.1. Summary

This is a RMP relating to the detection and management of MRSA. It will be supported where necessary by directorate specific guidance developed by clinical teams in collaboration with medical and nursing members of the Infection, Prevention and Control Team (IPCT). All supporting procedures will adhere to the key principles stated within this Trust document.

The responsibility for this RMP rests with the DIPC and Associate DIPC. Responsibility for development of specific MRSA procedures at directorate level rests with those specific management teams supported by the IPCT. In the absence of specific local guidance this RMP will apply.

#### 1.2. Objectives/success factors

The objectives of this RMP are:

- To ensure the spread of MRSA within LTHTR is minimised
- 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

### 2. Scope of this RMP

This RMP includes:

- Detection of MRSA by screening patients
- Actions to be taken when patients who have or may have MRSA are admitted
- Appropriate placement of patients with MRSA
- Decolonisation of patients with MRSA
- Actions required to reduce the risk of infection in patients who are already colonised with MRSA
- Actions that should be taken to ensure safe, appropriate treatment of MRSA infection
- Communication of infection status on transfer or discharge

### 3. Links to other key RMPs

- Standard (universal) precautions
- Hand hygiene
- Isolation
- Aseptic Non Touch technique (ANTT)
- Procedures and guidelines for management of IV devices (peripheral and central, including tunnelled lines)
- Work wear policy
- Trust Infection Prevention Action Plan
- Antimicrobial Prescribing Guidelines for prevention and management of MRSA infection

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#### 4. Breach of this RMP and responsibilities of all staff

- **All staff working** on Trust premises, including Trust employed staff, contractors staff, agency and locum staff are responsible for adhering to this RMP, and for reporting breaches of this to the person in charge and to their line manager
- **Ward and Department Managers** are responsible for ensuring implementation within their area, and for ensuring all staff who work within the area adhere to the principles at all times
- **Consultant Medical Staff** are responsible for ensuring their junior staff read and understand this RMP, and adhere to the principles contained in it at all times
- **Directorate Management Teams** are responsible for monitoring implementation of this RMP and for ensuring action is taken when staff fail to comply with it.
- **Site Managers and Bed Managers** are responsible for ensuring patients are placed in accordance with this RMP, and for escalating any situations where safe placement cannot be achieved.
- **On-call Managers and the On-call Executives** are responsible for providing senior and executive leadership to ensure implementation of this RMP, and for ensuring infection risks are fully considered and documented when complex decisions need to be made regarding capacity and patient flow.
- **The IPCT** is responsible for providing expert advice in accordance with this RMP, for supporting staff in its implementation, and assisting with risk assessment where complex decisions are required. They are also responsible for ensuring this RMP remains consistent with the evidence-base for safe practice, and for reviewing it on a regular basis.

**Non-compliance with this RMP may result in disciplinary action.**

#### 5. Principles

Safe, effective and prompt detection and management of patients with MRSA requires adherence to the following principles:

##### 5.1. Antimicrobial Prescribing

- Avoid unnecessary antibiotic prescribing to reduce selection pressure for resistant organisms including MRSA
- Reduce the use of broad spectrum antibiotics to reduce emergence of multiply resistant organisms
- Consider the risk of MRSA as a potential pathogen and prescribe appropriate antimicrobial therapy or surgical prophylaxis when indicated
- Limit the use of glycopeptide antibiotics to reduce development of resistant organisms

##### 5.2. Surveillance of MRSA

- Surveillance will be performed in order to monitor trends in MRSA and facilitate prevention and control measures

##### 5.3. MRSA Screening

- Screen patients by taking specimens from the correct sites, and labelling them correctly
- Screening of all patients prior to elective procedures (except those identified in Appendix 1)
- Screening of all non-elective patients on admission (except those identified in Appendix 1)

##### 5.4. MRSA Decolonisation

- Prescribe and administer MRSA topical decolonisation therapy correctly in line this RMP
- Ensure patients who are MRSA positive prior to elective procedures receive appropriate decolonisation; either to eradicate MRSA or to reduce the bio burden and risk of infection

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### 5.5. MRSA Isolation Care

- Ensure all patients are cared for as required by this RMP: for most areas this will require isolation in a single room. This must be supported by an isolation risk assessment (see note 4, p14) which must be documented in the clinical records.

### 5.6. MRSA Documentation

- Ensure the MRSA status of all patients is accurately recorded, including information on topical decolonisation, specimen results and the isolation risk assessment score

### 5.7. Communication and Patient Information

- Provide patients and visitors with accurate information on MRSA, including the risk of infection and management of those who are positive. Every patient who has MRSA should be given a Trust MRSA leaflet.
- Ensure accurate information on MRSA status is recorded and communicated to other wards and departments within LTHTR in order to facilitate safe care.
- Ensure accurate information on MRSA status including information on topical decolonisation and specimen results, is recorded and communicated to staff in primary and community care upon transfer to another organisation or discharge home.

## 6. Standards to be followed

### 6.1. Antimicrobial Prescribing

- All directorates must put into place guidelines for effective antimicrobial prescribing and these guidelines must be agreed with the relevant Consultant Medical Microbiologist. Adherence to antimicrobial prescribing guidelines will be monitored by ward pharmacists and nonadherence referred to weekly microbiology ward rounds or more urgently to a medical microbiologist if required.
- Guidelines for surgical prophylaxis must include recommended choice of agents and regimens for patients known to be colonised or infected with MRSA
- The guidelines must be audited quarterly to demonstrate effective prescribing patterns are maintained. Responsibility for this rests with the Directorate Clinical Director.
- All Consultant medical staff are responsible for ensuring appropriate antimicrobial prescribing by their junior staff. This includes ensuring courses of antimicrobial agents are prescribed for the correct duration and dosage and this includes topical decolonisation agents.
- Nursing staff are responsible for ensuring prescribed antimicrobial agents are given at the correct time and the correct dosage. This includes topical decolonisation agents – see guidance note 2; page 11

### 6.2. Surveillance of MRSA

- The IPCT will perform surveillance for new MRSA isolates routinely as part of alert organism surveillance. Clinical areas will be informed of all newly-identified MRSA-positive patients by IPCT/microbiologist.
- The IPCT will perform enhanced surveillance of MRSA Bacteraemia in line with the Department of Health requirements. The results of this surveillance will be fed back to Clinical and Management Teams for action.
- Clinical and Management Teams are responsible for ensuring review of each clinical case of MRSA Bacteraemia and implementation of local action plans to improve practice.
- MRSA surveillance data will be reported and reviewed by the Infection Control Committee and via Directorate Governance arrangements.

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### 6.3. MRSA Screening

Patients will be screened for MRSA in order to improve patient safety, for the following reasons:

- Patients found to be positive can be managed to minimise the of MRSA infection during their treatment. This may require different antimicrobial prescribing, topical decolonisation prior to a procedure, or other measures.
- To protect other patients from the risk of colonisation or infection with MRSA during their treatment.

See guideline 1 p8 for details of screening requirements for different patient groups and swabs to be taken.

### 6.4. MRSA Decolonisation

- All patients found to be MRSA positive will be considered for topical decolonisation in an attempt to eradicate MRSA, and reduce the subsequent risk of infection.
- A risk based approach will be used, focussing on prevention of infection with MRSA during invasive procedures. See guidance note 2, p11

### 6.5. Isolation Care

#### Isolation precautions

- All patients found to be MRSA positive will have an alert placed on the PAS system. Responsibility for checking for this rests with medical and nursing staff who admit the patient.
- All patients with MRSA will be managed with standard infection control precautions.
- In addition, contact precautions will be implemented in all wards and departments unless stated otherwise in local policy and approved by the IPCT. See guidance note 4 p14
- An isolation risk assessment must be performed for all MRSA positive patients, and this must be recorded in the clinical notes. The score must be reviewed weekly.
- Single room isolation will be implemented for all patients in accordance with the isolation risk score.
- Where single room isolation cannot be achieved an MRSA cohort bay must be established, and Bed Management and Site Management Teams informed.

#### Diagnostic Investigations and Treatment in other Departments

- All patients with MRSA may visit other departments for investigations or treatment provided the department is informed of the patient's MRSA status in advance. Though standard precautions are usually adequate in most departments for most investigations, this information will allow staff in these departments to call the patient in a timely manner and to take appropriate additional infection control precautions if necessary during the procedure.
- The patient can be seen at any time during the working session provided contact precautions are implemented by staff who have hands-on contact with the patient.
- Equipment used on the patient must be cleaned after use.
- Gloves and aprons **should not be worn** to push the bed or trolley through the hospital.
- Hand hygiene using alcohol gel is sufficient in this situation.

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## 6.6. Theatres

- MRSA positive patients can be placed anywhere on the operating theatre list provided all surfaces and equipment are cleaned between the MRSA positive patient and the next patient.
- Routine cleaning measures should be adequate provided 15 minutes elapses between the MRSA patient leaving the theatre and the next patient entering in conventionally ventilated theatres. This allows sufficient time for adequate air change between patients (Coia et al 2006).
- Airflows in ultra-clean theatres make a minimum time unnecessary.
- MRSA positive patients may be recovered in recovery units, providing contact precautions are adhered to, and equipment in contact with the patient is cleaned after use using detergent/water or detergent wipes.

## 6.7. Documentation

- The MRSA status of all patients must be accurately recorded in medical and nursing notes, including information on including topical decolonisation, specimen results and the isolation risk assessment score. This is the responsibility of the medical and nursing teams caring for the patient, and is essential to ensure safe, effective care.
- All MRSA positive patients will be alerted on the Quadramed CPR system by the IPCT. This will allow staff to identify patients previously known to be MRSA positive.

## 6.8. Communication and Patient Information

- Patients and visitors must be provided with accurate information on MRSA. This is the responsibility of the medical and nursing team admitting or providing care for the patient.
- This includes information for all patients on the risk of infection during procedures, and information for those found to be positive on their management. Information leaflets are available on intranet.
- Accurate information on MRSA status must be recorded and communicated to other wards and departments within LTHTR in order to facilitate safe care.
- Accurate information on MRSA status including information on topical decolonisation and specimen results, must be recorded and communicated to staff in primary and community care upon transfer to another organisation or discharge home.

## 6.9. Staff and MRSA

7. Where there are concerns about MRSA in staff, these will be handled by the Occupational Health Department, in strict confidence

## 8. Key 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 by the Joint BSAC/HIS/ICNA Working Party on MRSA. *Journal of Hospital Infection*. 63 (Supplement 1)

Dept of Health (2006) Screening for Meticillin-resistant *Staphylococcus aureus* (MRSA) colonisation. A strategy for NHS trusts: a summary of best practice. London. Dept of Health

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## Guidance notes

### Guidance Note 1: MRSA Screening

There is a commitment in the 2008/09 Operating Framework to introduce MRSA screening for all elective admissions from 2008/9 and for all emergency admissions as soon as practicable within the next three years (DoH 2008). LTHTR are committed to screen all patients regardless of admission status by March 2009.

Adherence to this screening policy is monitored monthly and reported to the Trust board via the ICC. In addition monthly returns are submitted to the DoH. Results should be fed back through Directorate Governance arrangements.

**Emergency patients** should be screened on decision to admit to hospital.

**Elective patients** should be screened on decision to add to waiting list (in OPD) or in pre-assessment clinics if available and should be included as part of routine pre-assessment procedures. An elective admission refers to all electives, including surgical and medical day cases. The following patient groups **should not be routinely screened**:

- Day case ophthalmology
- Day case dental
- Day case endoscopy
- Minor dermatology procedures, e.g., warts or other liquid nitrogen applications
- Children/paediatrics unless already in a high risk group
- Maternity/obstetrics except for elective caesareans and any high risk cases, i.e. high risk of complications in the mother and/or potential complications in the baby, (e.g. likely to need SCBU, NICU because of size or known complications or risk factors.)
- Radiological patients should not be routinely screened

#### 18 Weeks

The requirement to screen elective admissions is not expected to nor should it have an impact on the delivery of the 18 weeks target.

#### Specimens

Staff must ensure correct specimens are requested for MRSA screening, as listed below:

- **Nose:** All patients as listed in policy: one swab used inside both anterior nares (fleshy part of the nose).
- **Groin/perineum:** All patients as listed in policy: one swab used
- **Skin Lesions and/or Wounds:** one swab from each site; clearly identifying sites
- **Insertion sites** for devices in-situ at time of screening i.e. IVs, PEG sites and tracheostomy.
- **CSU:** A CSU from patients who have catheters in situ at the time of screening. This must be taken using correct technique, not from the bag.
- **Any other site that has been previously positive** if the patient has had MRSA previously, i.e. stoma
- Specimens must be correctly labelled with patient details. The laboratory will reject unlabelled specimens.
- Clinical details must include current antibiotic therapy
- Specimen requests must clearly identify the reason for the screening request.
- Specimens requested without an indication for screening may be rejected by the laboratory.

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## Ongoing Surveillance

As part of ongoing surveillance and monitoring of control measures patients in the following clinical areas are screened on the following basis:

- Critical Care Unit, RPH - On admission and weekly
- Intensive Care Unit, CDH - On admission and weekly
- Neurosurgery RPH - On admission and weekly
- Renal Patients - On admission and weekly. All patients should be screened for MRSA prior to creation of vascular or peritoneal access.
- Chemotherapy Patients - On admission (first attendance) only.

The above programmes are reviewed at regular intervals by the Infection Control Team and the clinical area consulted about any proposed changes.

Additional screening may be implemented on the advice of the Infection Control Team.

## Contact Screening

A single contact screen for patients exposed to someone found to have MRSA will be performed in all areas of the hospital. Contact screening will not be performed in very high risk areas that are sending weekly screens already, unless advised by the IPCT (i.e: during an outbreak)

Results must be recorded in the notes, and the patient informed if the result is positive.

## Transfers to other care groups from Medicine and Elderly Care

The National MRSA Guidelines (Coia et al 2006) consider the impact of MRSA in medical and elderly care wards to be of a medium risk category, recommending that the control measures that need to be applied should be determined locally by risk assessment in accordance with the MRSA burden and the facilities available. Therefore local guidelines for the care group focus on ensuring the appropriate management, through risk assessment, of those patients colonised/infected with MRSA where the risk of transmission is increased, or those patients who have increased MRSA resistance.

Medical/Elderly care patients who are transferred from the medical/elderly care group will be considered to have been in contact with MRSA and therefore a high risk for MRSA carriage. Therefore the following measures must be taken for these patients when moved to a different care group;

- Transfer to a single room, or a cohort bay of other medical patients (not known to be MRSA positive)
- Screen on arrival
- Implement contact precautions until results of the screen are known
- Once results are available the patients will either be managed as MRSA positive or negative, as per this policy

## Testing for MRSA clearance after antiseptics and/or antibiotics

It is customary to regard patients who have had 3 consecutively negative screens at least one week apart as no longer requiring source isolation. However, experience shows that such patients may still be colonised with small numbers of residual MRSA (and may sometimes re-acquire MRSA from other sources). Clearance swab sites must include nose, Groin/Groin/perineum, any wounds/lesions, or manipulated sites, e.g. tracheostomy, intravascular catheter sites. Patients

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must have stopped antiseptics and/or antibiotics at least two days prior to the swabs being obtained.

Testing for MRSA clearance is not usually essential or required if the patient is well enough to be discharged from hospital. Screening, if carried out, should be in the patient's interest. ***It is highly unlikely that patients with indwelling devices, which have an external surface (e.g. PEG) will become free of MRSA after treatment, whilst the device remains insitu.***

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## Guidance Note 2: Prescribing of topical decolonisation for eradication of MRSA

### Pre-Admission Elective Patients

- If a patient is found to be MRSA positive the following actions must be performed:-
  - Patient, Consultant and GP should be notified by the IPCT decolonisation team
  - The alert triangle will be activated on the Quadramed CPR system.
  - An attempt should be made to decolonise the patient. This will be co-ordinated and carried out by the IPCT decolonisation team
  - Repeat screening should be performed a minimum of 48 hours after treatment has stopped
  - If repeat screening is negative, a further 2 screens are required before clearance can be considered.
  - **If the repeat screen is positive the treatment may be repeated on one further occasion 4 days prior to admission. The patient should be managed as MRSA positive on admission.**
- Successful decolonisation is unlikely in patients with chronic wounds, permanent tracheostomy, and long-term indwelling devices. Where these risk-factors for long-term carriage are present the patient should be managed as listed immediately below and in Guidance note 3.
- If it is not possible to clear a patient of MRSA prior to the admission for an elective procedure, if they have already had multiple decolonisation attempts previously or if they have other factors which make successful decolonisation unlikely, bio burden reduction should be commenced 4 days pre-operatively in order to reduce the level of MRSA at the time of the procedure.
- These patients must be admitted and managed as MRSA positive.

### Prescribing of topical agents to reduce the level of MRSA during procedures (bioburden reduction).

When eradication of MRSA cannot be achieved, the regime below should be used for 4 days prior to planned invasive procedures or surgery in order to reduce the bio burden and the risk of infection

### All other admissions

These patients must be cared for as per guidance on MRSA positive patients on page 14 of this policy.

All patients found to be newly MRSA positive will commence a topical decolonisation regime – see below. In addition, patients who are newly confirmed to be MRSA positive in the following sites will need additional specific measures:

- Chronic wounds including leg ulcers
- Peg sites
- Tracheostomy sites
- Other long term device insertion sites

Specific measures to reduce colonisation of these risk sites should be considered as per guidance note 3 p 13.

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When topical decolonisation is performed in an attempt to eradicate MRSA, the nose, skin and hair must all be treated using the following regime:

<b>MRSA DECOLONISATION REGIME</b>			
Procedure	Product	Directions	Duration
Daily shower / bath / bed bath	Octenisan	Apply product directly to wetted skin using a disposable cloth, left for 3 minutes and rinsed off with clear water.	For 5 days (longer courses are not More effective)
Wash hair twice during period	Octenisan	Wash hair with product in place of shampoo	On 2 and day 4 of treatment
Nasal clearance	Mupirocin cream 2% (Bactroban®)	Applied to nostrils 3 times a day	For 5 days or stop sooner if found to be MRSA negative

**Clean clothing / night wear and bedding should be used each day and at the end of the decolonisation therapy.**

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### **Guidance Note 3: Management of MRSA in wounds and invasive device insertion sites, etc**

The following options should be reviewed for each of the specific issues listed:

#### **Chronic Wounds, such as leg ulcers**

- Consider use of wound dressings that have good anti-staphylococcal activity: options include:
  - Aquacel Ag for moderate / high exudate wounds only
  - Silver impregnated foam Biatain Ag / Allevyn Ag
  - Other products as advised by Tissue Viability or Pharmacy
- The wound and product should be reviewed weekly to ensure wound healing is taking place.
- Tissue viability advice should be sought in situations where the wound does not improve within 2 weeks of commencing treatment.

#### **Wounds healing by primary intention, but infected with MRSA**

- In general there should be no need to select a specific dressing to tackle MRSA in wounds healing by primary intention.
- The wound should be monitored regularly, and if there is evidence of cellulitis, further wound breakdown, or delayed healing advice should be sought from medical staff as antibiotics may be required.

#### **PEG sites, Suprapubic catheter sites**

- Insertion sites for indwelling devices such as PEG tubes and suprapubic catheters can provide a focus for infection, and provide a route for MRSA to track along and potentially cause deep infection.
- Where sites are well-healed they can be treated as 'normal' skin during topical decolonisation for MRSA, and washed using decolonisation solutions.
- If the insertion site is infected with MRSA medical advice should be sought as antibiotics may be required.
- Use of an appropriate dressing with anti-staphylococcal activity on the site/around the device should also be considered. Advice must be taken from Pharmacy on the compatibility of the dressing to be used and the material the device is made from, due to the possibility that some chemical agents may damage indwelling devices and cause them to rupture.

#### **Infected IV Insertion sites in patients known to have MRSA**

- Remove line and re-site if access is still required
- Swab the site for culture and sensitivity
- Dress the site using an appropriate dressing; if the patient has MRSA a dressing with anti-staphylococcal activity should be selected if possible.
- Document the actions taken including choice of dressing

#### **Tracheostomy sites**

- Once the exposed edge of a permanent/long term tracheostomy site is 'healed' it should be carefully cleaned daily as part of normal hygiene of the stoma.
- There is nil else that can be specifically done to reduce MRSA colonisation from this site

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## Guidance Note 4: Isolation Risk Assessment for MRSA

### Risk Assessment using an Isolation Priority Scoring System.

Infection control management of patients from whom MRSA has been isolated must be based on the assessment of the risk of MRSA being spread from such patients to others and the risk MRSA acquisition to those patients.

This isolation priority scoring system has been adapted from a risk assessment system designed by Dr. Gopal Rao. The scoring system is based on factors likely to influence the transmission of MRSA and its impact e.g., pathogenic potential, mechanism of transmission, antibiotic resistance, susceptibility of other patients, prevalence in hospital. All patients suspected or known to be colonised or infected with MRSA must be risk assessed and assigned a score using the Isolation Priority Scoring System. The level of priority: high, medium or low, can be determined depending on the score and the appropriate isolation facility assigned:

Score	Priority	Appropriate Facility
>45	High	Side-room on main ward +/- Bathroom facilities
26 - 44	Medium	Cohort bay and standard precautions
<25	Low	Standard precautions in Main ward area

Staff caring for the patient should undertake the risk assessment. The isolation risk assessment score must be documented in the patients nursing notes. Depending on the outcome of the risk assessment the patient will either need to be in Source Isolation (see Source Isolation Policy), nursed in a cohort bay or may be managed using standard precautions (see Standard (Universal) Precautions RMP) in the general ward area. The risk assessment score should be reviewed and documented weekly to ensure that optimal use is made of the isolation facilities and to ensure that patients are not kept in isolation for longer than necessary. See next page for MRSA-specific isolation risk assessment. **Help and advice is available from Infection Control/Microbiology.**

### Action to take if there is no isolation room available

When single rooms/isolation rooms are not available and where several patients with the same confirmed organism have been identified these patients may be nursed together in a bay on a ward, known as cohort nursing. This may include MRSA. A trust IR1 form should be completed if there are any delays in isolating a patient or if isolation facilities are unavailable as risk assessed.

### Action to take if patients' medical condition is compromised.

If any patients clinical condition is deemed such that isolation would compromise their safety consultation must be made with the Infection Control Team to ensure a full risk assessment is made with infection control advice. Actions/decisions must be documented in patient medical notes and a trust IR1 form should be completed. The patient must be isolated at the earliest opportunity.

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### Isolation Risk Assessment Table for MRSA

Condition or Infection	Route of transmission	Evidence for spread in hospital	Antibiotic resistance	Variable factors e.g.: patient susceptibility, dispersal risk	Score	Length of isolation	Risk category
Current endemic UK MRSA strains (MRSA 15 or 16)	Contact	Strong	Moderate	Skin shedder (e.g. eczema, psoriasis) or sputum colonised	<b>45</b>	Until 3 x negative screens	<b>MEDIUM</b>
				More than 1 site colonised (excluding sputum), uncovered wound	<b>35</b>	Until 3 x negative screens	<b>MEDIUM</b>
				Nose positive only; post full screen and on mupirocin	<b>0</b>	Continue screening, aim to clear	<b>LOW</b>
MRSA with extended resistance profiles or PVL  <b>OR</b> Patients who have had recent travel abroad	Contact	Strong	Serious	Skin shedder (e.g. eczema, psoriasis)	<b>50</b>	Until 3 x negative screens	<b>HIGH</b>
				Sputum colonised	<b>50</b>	Until 3 x negative screens	<b>HIGH</b>
				Not a skin shedder	<b>40</b>	Until 3 x negative screens	<b>MEDIUM</b>

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