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AUTHOR: Sarah Kay Sonya Magrath	**JOB TITLE:** Matron Lead Nurse	**DIVISION:** Corporate	**DEPARTMENT:** Infection Prevention & Control
REPLACES: MRSA Procedure V7.1		**HEAD OF DEPARTMENT:** Sarah Kay, Matron for Infection Prevention & Control	
VALIDATED BY: Infection Prevention and Control Committee (IPCC)		**DATE:** 17 September 2018	
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(NOTE: Review dates may alter if any significant changes are made).		**REVIEW DATE:** 31 December 2021	

AMENDMENT HISTORY				
Version No.	**Date of Issue**	**Page/Selection Changed**	**Description of Change**	**Review Date**
7.1	2 May 2019	Appendix 12, page 34	Insertion of hyperlink to Patient and Carer information leaflet	31 Dec 21
7.2	29.08.2019	Removed appendix 13 and updated Appendix 9	Updated care plan information and removed paper care plans as they are now electronic	31 Dec 21

Does this document meet the requirements of the Equality Act 2010 in relation to Race, Religion and Belief, Age, Disability, Gender, Sexual Orientation, Gender Identity, Pregnancy & Maternity, Marriage and Civil Partnership, Carers, Human Rights and Social Economic Deprivation discrimination? Yes
Document for Public Display: Yes
Evidence reviewed by Library Services 09/07/2018

HOW THE NHS CONSTITUTION APPLIES TO THIS DOCUMENT

WHICH PRINCIPLES OF THE NHS CONSTITUTION APPLY? Click here for guidance on Principles	Tick those which apply	WHICH STAFF PLEDGES OF THE NHS CONSTITUTION APPLY? Click here for guidance on Pledges	Tick those which apply
1. The NHS provides a comprehensive service, available to all.	√	1. Provide a positive working environment for staff and to promote supportive, open cultures that help staff do their job to the best of their ability.	√
2. Access to NHS services is based on clinical need, not an individual's ability to pay.	√	2. Provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.	√
3. The NHS aspires to the highest standards of excellence and professionalism.	√	3. Provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.	√
4. The patient will be at the heart of everything the NHS does.	√	4. Provide support and opportunities for staff to maintain their health, wellbeing and safety.	√
5. The NHS works across organisational boundaries.	√	5. Engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.	√
6. The NHS is committed to providing best value for taxpayers' money.	√	6. To have a process for staff to raise an internal grievance.	√
7. The NHS is accountable to the public, communities and patients that it serves.	√	7. Encourage and support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Employment Rights Act 1996.	√

WHICH AIMS OF THE TRUST APPLY? Click here for Aims	Tick those which apply	WHICH AMBITIONS OF THE TRUST APPLY? Click here for Ambitions	Tick those which apply
1. To offer excellent health care and treatment to our local communities.	√	1. Consistently deliver excellent care.	√
2. To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria.	√	2. Great place to work.	√
3. To drive innovation through world-class education, teaching and research.	√	3. Deliver value for money.	√
		4. Fit for the future.	√

Appendix 1: MRSA SCREENING PATHWAY FOR ADULTS & PAEDIATRICS

Screen all patients admitted to the trust as an inpatient

Screen all patients identified as previously colonised or infected with MRSA (check Quadramed) **Symbol in Quadramed**

SCREEN (ADULT & PAEDIATRICS)
High Risk

Previously colonised or infected with MRSA
All Intensive Care Units (adult and paediatric including Critical Care unit, Coronary care unit, Neonatal unit
Burns and Plastics
Neurosurgery
Trauma and Orthopaedics
Renal
Vascular surgery
All Surgical Wards
Haematology/ Oncology
Patients admitted from other hospitals and overseas

SCREEN (ADULT & PAEDIATRICS)
Low risk

Day Surgery (for exemptions see exemption box)
Gynaecology (excluding pregnancy related)
All Medical Wards

EXEMPTIONS: unless other factors designate the patient high risk

All day cases below:

- Ophthalmology
- Dentistry
- Endoscopy (upper/lower GI)
- Bronchoscopy,
- Cystoscopy
- Dermatology
- Pain day case
- Paediatrics
- Maternity/ obstetrics
- Radiology

Universal Decolonisation

ICU only
Renal Patients with a line in

SITES TO BE SCREENED

- Nose (one swab both nares)
- Groin/Perineum (one swab both groins)
- Skin lesions and/or wounds (one swab from each site clearly identifying site)
- Insertion sites (for devices in situ at time of screen e.g. IV, PEG, tracheostomy sites and urinary catheters).

NEGATIVE RESULT

No further action unless on weekly screens

If Patient is having orthopaedic implant, give 5 days' decolonisation therapy up to day of procedure

POSITIVE RESULT

All patients with a positive MRSA screening result should have adapted perioperative antibiotics.
This should be discussed with the Consultant Microbiologist.

Hospital inpatient:

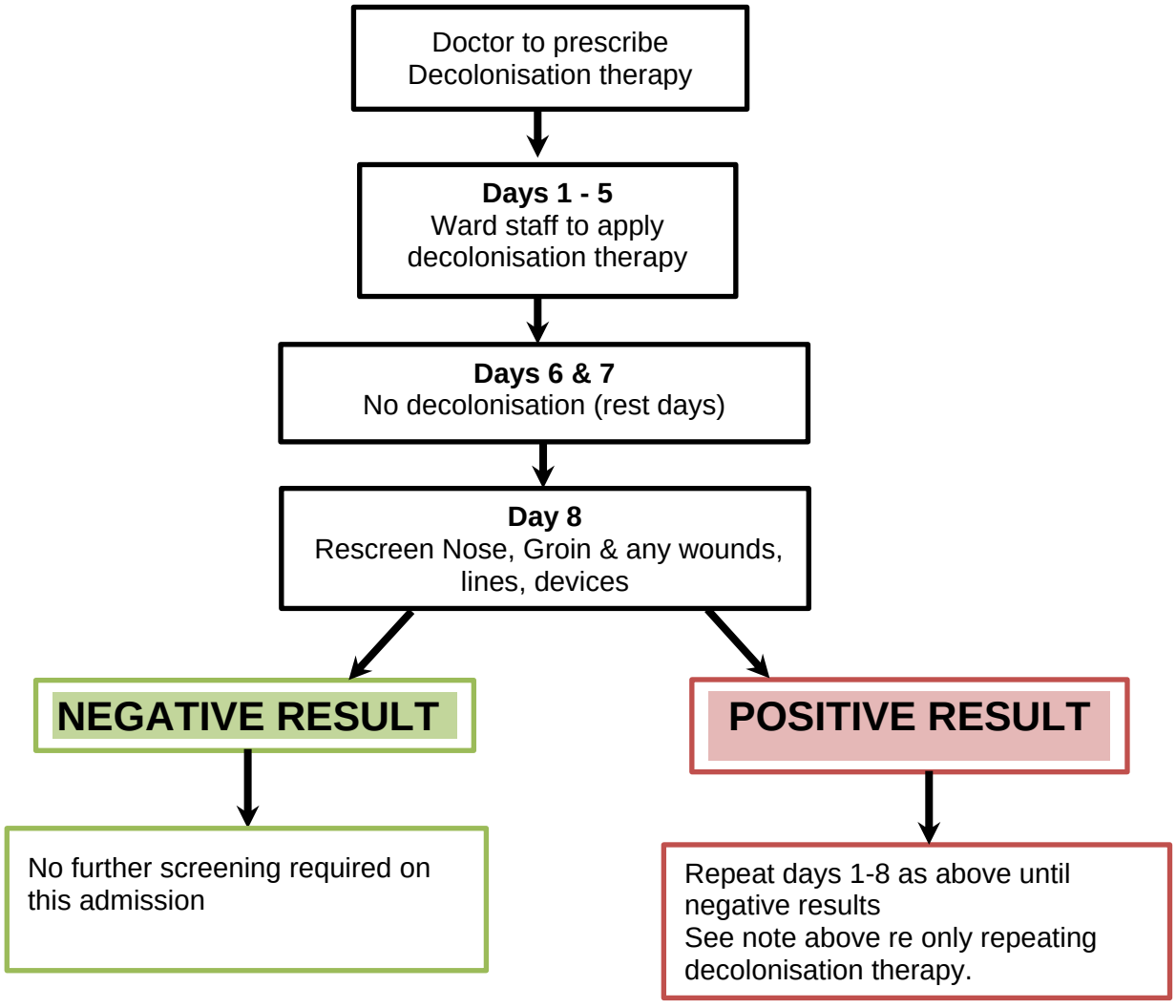
- Inform patient of result
- Source isolate if possible
- Apply contact precautions
- Start MRSA care plan
- Start **5** days of decolonisation therapy
- 2 rest days
- Rescreen Day 8

Pre Op admission screens:

- Pre-op staff are responsible for following up results
- Pre Op clinic to inform patient of results
- Pre Op clinic to arrange for patient to receive suppression therapy and usage instructions
- Patient to use decolonisation therapy for **5** days up to the day of the procedure.

Appendix 2: MRSA RESCREENING PATHWAY

- All inpatients on the high risk units (previously identified) should be screened monthly whilst inpatients (excluding ICU and NICU who need weekly screening)
- All previously identified MRSA patients should be screened until negative MRSA results are obtained. If this is not obtained after 2 courses of decolonisation therapy please consult the Infection Prevention Team or Consultant Microbiologist out of hours for further advice.
  (Repeated courses of suppression therapy can disrupt protection from normal flora and increase risk of Mupirocin resistance.)
- Patients with a history of MRSA require a minimum of three full screens, each screen 7 days apart.
- Patients with no previous history of MRSA only require one full screen.



IMPORTANT

- If patient remains on antibiotics at the time of the rescreen the antibiotics must be documented on the lab request form.
- It is highly unlikely that patients with extensive wounds and/or indwelling devices, which have an external surface (e.g. PEG) will become free of MRSA after decolonisation therapy
- Continued use of decolonisation therapy will alter the patient's normal flora and increase the risk of Mupirocin resistant organisms.

CONTENTS

1. SUMMARY

The Government considers it unacceptable for a patient to acquire an MRSA bloodstream infection (MRSA BSI) while receiving care in a healthcare setting. It has set healthcare providers the challenge of demonstrating zero tolerance of MRSA BSI 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.

The zero tolerance approach to MRSA has been re-iterated in Everyone Counts: Planning for Patients 2014/15 to 2018/19[1]

This is a procedure 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.

2. PURPOSE

Good infection prevention and cleanliness are essential to ensure that people who use health and social care services receive safe and effective care. Effective prevention and control of infection must be part of everyday practice and be applied consistently by everyone. (Department of Health, 2008).

Good management and organisational processes are crucial to make sure that high standards of infection prevention and cleanliness are maintained. (DoH 2008)

The Health and Social Care Act 20082 Code of Practice on the Prevention and Control of Infections stipulates the requirement for an MRSA policy to be in place to help prevent and control infection.

The objectives of this procedure 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.

3. SCOPE

This procedure is intended to guide practice of all members of staff within Lancashire Teaching Hospitals (LTHTR)

The purpose of the procedure is to identify and manage patients affected with Methicillin Resistant Staphylococcus aureus (MRSA) in order to prevent and control the spread of MRSA and to promote effective evidence based patient care.

This procedure should be used in conjunction with the following LTHTR policies, procedures and clinical guidelines:

- Hand Hygiene procedure
- Isolation Procedure
- Procedure for Cleaning and Decontamination of Patient Care Items and Medical Equipment
- Aseptic Non Touch Technique (ANTT) procedure
- Standard Precautions Procedure and Personal Protective Equipment (PPE) for Healthcare Workers
- Waste Management Policy
- Antimicrobial Prescribing Guidelines for Prevention and Management of MRSA Infection

4. DUTIES AND RESPONSIBILITIES

- All staff entering clinical areas are responsible for complying with this procedure and for reporting breaches of this to the person in charge and their line manager.
- Ward and department managers are responsible for ensuring implementation within their area and for ensuring all staff who work within their area adhere to the principles at all times.
- Consultant Medical Staff are responsible for ensuring their junior staff their junior staff read and understand this procedure and adhere to the principles at all times.
- Divisional Management Teams are responsible for monitoring implementation of this procedure and for ensuring action is taken when staff fail to comply with it.
- Clinical Site Managers are responsible for ensuring patients are placed in accordance with this procedure and for escalating any situations where safe placement cannot be achieved.
- On-call Managers and On-call Executives are responsible for providing senior and executive leadership to ensure implementation of this procedure and for ensuring infection risks are fully considered and documented when complex decisions need to be made regarding capacity and patient flow.
- The Infection Prevention & Control Team (IPCT) is responsible for providing expert advice in accordance with this procedure, for supporting staff in its implementation and assisting with risk assessment where complex decisions are required. They are also responsible for ensuring this procedure remains consistent with the evidence base for safe practice and for reviewing it at a regular basis.
- The Director of Infection Prevention and Control should provide assurance to the Trust Board on the level of compliance with the local policy on MRSA screening /decolonisation.

- The Trust Board- are required to support the control and reduction of MRSA by ensuring that the policy is appropriately reviewed and ratified by the clinical management team

NON-COMPLIANCE WITH THIS PROCEDURE MAY RESULT IN DISCIPLINARY ACTION

5. PROTOCOL

What is MRSA?

Staphylococcus aureus (S. aureus) is a common bacterium that is carried on the skin of approximately 30% of the population, usually in moist sites such as the nose, axilla and perineum, without causing any problems. It is capable of surviving for long periods on dry surfaces, including hands, equipment and in dust (Blake 2005). If the bacteria invades the skin or deeper tissues and multiplies an infection may develop.

Methicillin is an antibiotic that was commonly used to treat *S. aureus* until some strains of the bacteria developed resistance to it. These resistant bacteria are called Methicillin Resistant *Staphylococcus aureus* (MRSA).

MRSA is generally considered to be a problem of cross infection rather than one of repeated evolution of resistance. Spread of MRSA from one healthcare setting to another has been aided where patients are moved at short notice and with inadequate communication and preparation. Effective control of MRSA is dependent on high standards of infection prevention and control.
The precautions used to control MRSA are essentially the same as those used to control other infections. Implementing these in a proactive manner will help prevent and control the spread of MRSA, as well as contain outbreaks. Adhering to standard infection prevention precautions and communicating effectively with all those involved, including patients and their relatives and between primary, secondary and independent care settings, will help to reduce anxiety and promote good practice.

Many infection prevention interventions were introduced due to concerns about high levels of MRSA infection between 2001 and 2004. One of the interventions to reduce rates of MRSA infection was the mandatory MRSA screening in England, which was introduced for all elective and emergency admissions in 2009 and 2010 respectively. Annual MRSA BSI rates fell from 17.7 to 3.2 cases per 100,000 bed days from 2006 to 2012.

The mandatory screening guideline was updated in 2014 to reflect the new data provided by National One Week MRSA Prevalence study (NOW) commissioned by the Department of Health (DH) in 2011.

This procedure is based on the updated ‘Implementation of modified admission MRSA screening guidance for NHS’ (2014). This guidance has moved towards a more focussed screening programme to promote a more efficient and effective method for identifying and managing high risk MRSA positive patients.

Early identification of MRSA and commencement of suppression therapy may prevent the patient from becoming infected. It will also protect other patients from the risk of colonisation or infection.

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

6. ANTIMICROBIAL PRESCRIBING

Consider the risk of MRSA as a potential pathogen and prescribe appropriate antimicrobial therapy or surgical prophylaxis when indicated. The Trust antimicrobial guidelines for the treatment of infection and prophylaxis detail which agents to use in patients who are MRSA positive.

All Consultant medical staff are responsible for ensuring appropriate antimicrobial prescribing by their junior staff. This includes ensuring antimicrobial agents are prescribed in compliance with Trust antimicrobial guidelines 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.

7. SURVEILLENCE

Surveillance will be performed in order to monitor trends in MRSA and facilitate prevention and control measures.
In line with PHE guidance the IPCT will perform Post Infection Reviews 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 screening data will be reported and reviewed by the Infection Prevention & Control Committee and via Directorate Governance arrangements.

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	-	On admission and weekly
Neurosurgery	-	On admission and weekly
Neonatal Unit	-	On admission and weekly
Haemodialysis Patients	-	To be completed in line with Surveillance, Decolonisation and Suppression of Staphylococcus Aureus in Haemodialysis Patients

The programmes are reviewed at regular intervals by the Infection Prevention & Control Team (IPCT) and the clinical area consulted about any proposed changes. Additional screening may be implemented on the advice of the IPCT.

8. MODE OF TRANSMISSION

8.1 Direct Contact

- Hands provide the most common form of contact between people and their potential contamination with MRSA. It is essential that good standards of hand hygiene are maintained.
- Equipment that is contaminated may also act as a reservoir for MRSA. Any piece of equipment that comes in to contact with a patient should be cleaned in between each use, as per Trusts Decontamination procedure.
- Environmental contamination – Staphylococci survives well in the environment, on skin scales and in dust and can be transferred via hands.

8.2 Airborne

MRSA frequently colonises skin and can be dispersed into the environment and onto equipment when skin scales are shed (DH 2004).

9. COLOISATION AND INFECTION

- Colonisation means that MRSA is present on or in the body without causing any clinical symptoms. Simple hygiene measures such as hand washing can reduce spread.
- Infection means that the MRSA is present on or in the body and is multiplying in the tissues causing clinical changes which will be indicated by two or more of the following; inflammation, pus, pyrexia, pain and swelling.

10. DIFFERENT TYPES OF INFECTION

- Wound Infection – MRSA is the commonest cause of wound infection. This shows as a red, inflamed wound with maybe yellow pus seeping from it. The wound may break open or fail to heal and an abscess may develop.
- Superficial ulcers – pressure ulcers, varicose and diabetic ulcers are often sites of MRSA infection.
- Deep abscesses – The patient will be very unwell and may have rigors (shivers) and low blood pressure (shock). This is usually linked with an associated septicaemia.
- Intravenous line infections – MRSA may infect the entry site of an intravenous line causing local inflammation with pus from which the MRSA can enter the blood stream to cause a bacteraemia (blood stream infection).
- MRSA blood stream infection (BSI) – MRSA can enter the normally sterile blood stream either from a local site of infection (wound, ulcer, and abscess) or via intravenous catheter. MRSA BSI (bacteraemia) describes the presence of MRSA in the blood. Typically symptoms can include high fever, raised

white cell count, rigors, disturbance of blood clotting with a tendency to bleed and a failure of vital organs.

11. PATIENTS AT HIGH RISK OF MRSA INFECTION

- Patients with an underlying illness.
- Patients who are immunocompromised.
- Patients who have invasive devices e.g. urinary catheter, IV lines.
- Patients with wounds.
- Patients known to have been previously infected or colonised with MRSA.
- Frequent healthcare facility users.
- Patients with recent travel abroad.
- Patients from residential care facilities.

The clinical care of any patient should not be compromised because of MRSA colonisation or infection, and no patient be denied any necessary diagnostic or therapeutic procedure.

12. UNIVERSAL DECOLONISATION

Universal decolonisation is used in Intensive care Unit only.

- Patients admitted to ICU to commence decolonisation of antimicrobial wash only (no mupirocin Nasal cream) Ensure the patient is screened prior to commencing the wash.
- If positive result from screen then to commence Mupirocin Nasal cream also.

13. ISOLATION / CONTROL MEASURES

Single room isolation will be implemented for all patients unless they are admitted to medical or elderly care wards.

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 this patient group focus on ensuring the appropriate management, through risk assessment, of those patients colonised/infected with MRSA where the risk of transmission or virulence is increased, or those patients who have increased MRSA resistance. These patients will be individually risk assessed by the IPCT.

In addition, a risk assessment must be made by both the clinical team caring for the patient and the Infection Control Team if the condition of a patient dictates (i.e. it is unsafe for the patient to be in a single room as they require close supervision) or if there are insufficient side-rooms and an enhanced level of care cannot be provided. The reason for not isolating must be documented in the patient's health record.

Where single room isolation cannot be achieved in Surgical and high risk areas Infection Prevention and Control must be informed and Bed Management and Site Management Teams informed.
MRSA positive patients should be nursed using contact precautions.

- Ensure patient is in an isolation room if possible.

- When isolation rooms are at a premium, priority should be given to those with infected or extensively colonised wounds, exfoliating skin conditions (psoriasis, eczema) or chronic respiratory disease.

- If an isolation room is not immediately available an MRSA positive patient may be nursed in a bay if a risk assessment has been undertaken in the patients' notes by nursing staff. The patient should be moved into an isolation room as soon as one is available. (Refer to Isolation Room Procedure document). This should be reviewed no less than at every shift change.

- All patients found to be MRSA positive will be considered for topical skin decolonisation which includes hair washing in an attempt to eradicate or reduce the level of colonisation (also known as bio burden). In addition, the following will apply:

- All patients found to be MRSA positive will have an alert placed on the Quadramed system. Responsibility for checking for this rests with the admitting medical and nursing staff and the team responsible for the patient care.

If patients remain positive after topical decolonisation treatment then the patients should be treated as MRSA positive until negative result or discharge.

If the wound is MRSA positive please refer to Tissue Viability Team re: suitability for Octenilin irrigation or Octenilin gel (see appendix 1)

If the patient remains positive after treatment and then requires an invasive procedure the IPCT should be contacted for advice.

14. MRSA DECOLONISATION THERAPY

- MRSA suppression therapy is performed to reduce the bacterial load of MRSA and therefore reduce the risk of transmission and prevent infection for patients.
- MRSA carriers also serve as reservoirs for further transmission as they move through and across healthcare facilities.
- Remember: when providing suppression therapy, irrespective of positive site, antibacterial body wash and Mupirocin nasal ointment should always be used simultaneously i.e. one should not be used without the other.

- Suppression therapy should be prescribed and administered as any other treatment – Appendix 5

14.1 Nasal Treatment

- Apply a small amount of Mupirocin (Bactroban Nasal) to inside of both nostrils with a gauze swab 3 times per day for 5 days.
- If the strain is resistant to Mupirocin (Bactroban Nasal) further advice should be sought from the microbiologist.
- Mupirocin (Bactroban Nasal) should always be used in conjunction with skin wash, either Octenisan (0.3% Octenidin), 4% Chlorhexidine, 7.5% Povodine iodine, 2% Triclosan. The product of choice is Octenisan.
- If MRSA is still present the treatment may be repeated on one further occasion. Repeated courses of suppression therapy can lead to Mupirocin resistance.

14.2 Skin Treatment

Patients suffering from chronic skin conditions should only be treated once advice is sought from Microbiologist.

Patients with eczema, dermatitis or other skin conditions are likely to require treatment for these before eradication therapy. The Dermatology Department should be consulted for advice.

The standard antiseptic skin wash is “Octenisan” containing 0.3% octenidin hydrochloride. Alternative preparations that can be used in case of intolerance/allergy or product non-availability are available, discuss with IPCT or Consultant Microbiologist.

If patients are discharged from LTHTR on a decolonisation programme they should be provided with instructions to be followed within the community setting, however this is not common practice as treatment does not usually occur in the community.

Octenisan 5-day decolonisation protocol:

Day 1 – Body
Day 2 – Body & Hair
Day 3 – Body
Day 4 – Body & Hair
Day 5 – Body

For bed bath procedure use a disposable damp cloth to apply Octenisan directly to the skin leave on for 1 Minute then wash off. Do not pour body wash into bowl of water. Keep patient covered with a clean towel whilst waiting for the minute before rinsing. Do not reuse the towel. Use a separate clean towel to dry patient.

For shower and hair use in the same way you would use normal preparations of shower gel and shampoo, apply Octenisan directly to the skin leave on for 1 Minute then wash off.

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

Re – swab after 48 hours post completion of treatment, if patient is on any antibiotics these must be declared on the lab request form.

15. DECOLONISATION REGIME

MRSA DECOLONISATION REGIMEN			
Procedure	**Product**	**Directions**	**Duration**
Daily shower/bath/bed bath	Octenisan	Apply product directly to wetted skin using a disposable cloth, left for 1 minute 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®) **OR** Octenisan® Nasal Gel	Applied to nostrils 3 times a day Applied to nostrils 2 times a day	For 5 days or stop sooner if found to be MRSA negative

* The specific nasal cream / gel will be supplied by pharmacy as stocks allow – either of the above may be supplied.

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

16. DOCUMENTATION

All patients with MRSA should have a completed care plan and clinical entry on Quadramed.

All previously known MRSA positive patients will have a ‘Red Triangle’ alert noted by the IPC team on Quadramed.

Microbiology records all new positive MRSA results on Swiss lab and Quadramed in ‘Pathology’ section.

IPC team will record electronically through ICNet and Quadramed.

17. COMMUNICATION AND PATIENT INFORMATION

Patients and visitors must be provided with accurate information on MRSA. This includes those patients at risk during a procedure and those found to be positive on their management.

Staffs need to be sufficiently knowledgeable and confident to invite patients' and carers' questions and communicate information in a sensitive way.

Information leaflets are available on the 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.

Staff should access advice from the senior nurse on duty if support is required when answering patient or relatives questions.

18. DIAGNOSTIC INVESTIGATION AND TREATMENT IN OTHER DEPARTMENTS AND TRANSFER TO THE OTHER WARD

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. This information will allow staff in these departments to call the patient in a timely manner and to ensure standard precautions and appropriate additional contact precautions during the procedure.

The patient can be seen at any time during the working session provided contact precautions are implemented by staff that have hands-on contact with the patient.

Equipment used on the patient must be cleaned after use with Clinell Universal wipes.

Gloves and aprons must not be worn to push the bed or trolley through the hospital. Good Hand Hygiene is sufficient.

Hand hygiene using alcohol gel is also sufficient in this situation.

19. BREACH OF THIS PROCEDURE AND RESPONSIBILITIES OF ALL STAFF

All staff working on Trust premises, including Trust employed staff, contractor's staff, agency and locum staff are responsible for adhering to this Procedure, 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 procedure, and adhere to the principles contained in it at all times

Clinical Business Management Teams are responsible for monitoring implementation of this procedure 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 procedure, 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 procedure, and for ensuring infection risks are fully considered and documented when complex decisions need to be made regarding capacity and patient flow.

The Infection, Prevention & Control Team (IPCT) is responsible for providing expert advice in accordance with this procedure, for supporting staff in its implementation, and assisting with risk assessment where complex decisions are required. They are also responsible for ensuring this procedure remains consistent with the evidence-base for safe practice, and for reviewing it on a regular basis.

20. AUDIT AND MONITORING

Aspect of compliance or effectiveness being monitored	Monitoring method	Individual responsible for the monitoring	Frequency of the monitoring activity	Group / committee which will receive the findings / monitoring report and act on findings.	Group / committee / individual responsible for ensuring that the actions are completed
Compliance data of MRSA screening	Inspection	Matron for Infection Prevention & Control	Monthly	Infection Prevention and Control Committee	Infection Prevention and Control Committee

21. TRAINING

TRAINING Is training required to be given due to the introduction of this policy? Yes		
Action by	**Action required**	**Implementation Date**
IPC Team	Update all clinical staff on changes to the policy	04/12/2018

22. DOCUMENT INFORMATION

ATTACHMENTS	
Appendix Number	Title
Appendix 1	MRSA Screening Pathway for Adults and Paediatrics
Appendix 2	MRSA Rescreening Pathway
Appendix 3	MRSA E-Swabbing Method
Appendix 4	Octenisan 5 day Antimicrobial Wash Protocol
Appendix 5	Screening Procedures
Appendix 6	Control Measures in Theatre and Recovery
Appendix 7	Management of MRSA in Wounds
Appendix 8	Management of MRSA in Invasive Devices, Insertion Sites
Appendix 9	MRSA Care Plan
Appendix 10	Decolonisation Care Plan
Appendix 11	Competency Document
Appendix 12	Patient Information Leaflet
Appendix 13	Equality, Diversity & Inclusion Impact Assessment Form

OTHER RELEVANT / ASSOCIATED DOCUMENTS	
Unique Identifier	Title and web links from the document library
RMP-C-18	Standard Precautions Procedure and Personal Protective Equipment (PPE) use for Healthcare Workers
RMP-C-100	Procedure for Cleaning and Decontamination of Patient Care Items and Medical Equipment Devices
RMP-C-03	Isolation Procedure
RMP-C-27	Hand Hygiene Procedure
RMP-C-114	Procedure for Prescribing Antimicrobials

SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS
References in full

Number	References
1	NHS England (2013) Everyone counts: planning for patients 2014/15 to 2018/19. Available online at: https://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf (accessed 15.07.18)
2	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)
3	Loveday et al (2014) Epic3: National evidence-based guidelines for preventing healthcare-associated infections in NHS hospitals in England. Available From: https://improvement.nhs.uk/documents/847/epic3_National_Evidence-Based_Guidelines_for_Preventing_HCAI_in_NHSE.pdf (Accessed:

	18.07.18)
4	Department of Health (2014) Implementation of modified admission MRSA screening guidance for NHS. Available From: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/345144/Implementation_of_modified_admission_MRSA_screening_guidance_for_NHS.pdf (Accessed: 18.07.18)

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NHS Improvement (2018) Update on the reporting and monitoring arrangements and post-infection review process for MRSA bloodstream infections. Available From: https://improvement.nhs.uk/documents/2512/MRSA_post_infection_review_2018_changes.pdf (Accessed: 18.07.18)

National Institute for Health and Care Excellence (2016) Healthcare-associated infections https://www.nice.org.uk/guidance/qs113/resources/healthcareassociated-infections-pdf-75545296430533 (Accessed: 18.07.18)

DEFINITIONS / GLOSSARY OF TERMS

Abbreviation or Term	Definition
MRSA	Methicillin Resistant Staphylococcus Aureus
ICU	Intensive Care Unit
PEG	Percutaneous Endoscopic Gastrostomy
BSI	Body Substance Isolation
IPCT	Infection, Prevention And Control Team
DoH	Department Of Health
BSI	Body Substance Isolation
PHE	Phenylalanine (Amino Acid)
ANTT	Aseptic Non Touch Technique
PPE	Personal Protective Equipment

CONSULTATION WITH STAFF AND PATIENTS

Enter the names and job titles of staff and stakeholders that have contributed to the document

Name	Job Title	Date Consulted
Sarah Kay	Matron for Infection Prevention and Control	24.07.18
Sonya Magrath	Lead Nurse for Infection Prevention and Control	24.07.18
Pauline Jumaa	Consultant Microbiologist DIPC	24.07.18

DISTRIBUTION PLAN	
Dissemination lead:	Sarah Kay
Previous document already being used?	Yes
If yes, in what format and where?	Procedure for the Management of Patients Colonised/ Infected with Methicillin – resistant Staphylococcus Aureus. Procedure on Heritage
Proposed action to retrieve out-of-date copies of the document:	Remove previous copies from document library
To be disseminated to:	Trust wide
Document Library	
Proposed actions to communicate the document contents to staff:	Include in the LTHTR weekly Procedural documents communication– New documents uploaded to the Document Library

Appendix 3: MRSA E SWABBING METHOD

Step 1 Open swab packaging, checking expiry date, remove swab from packaging

Taking a nasal swab

Step2 **Insert swab 2 cm into one naris (nostril), rotate against the anterior nasal mucosa for 3 seconds, repeat this procedure using the same swab in the second naris,(nostril)**

Taking an Axilla/Groin swab

Step 2 **The swab should be rubbed and rotated 10-20 times over the sample area. One swab can be used for both left and right Axillae, or similarly, for left and right groin areas**

Taking a Wound swab

Step 2 **Decontaminate the skin with sterile saline, sample the exudate from the base or margin of the lesion by firmly applying the swab to it.**

Step 3 Without contaminating swab, place in the culture medium provided

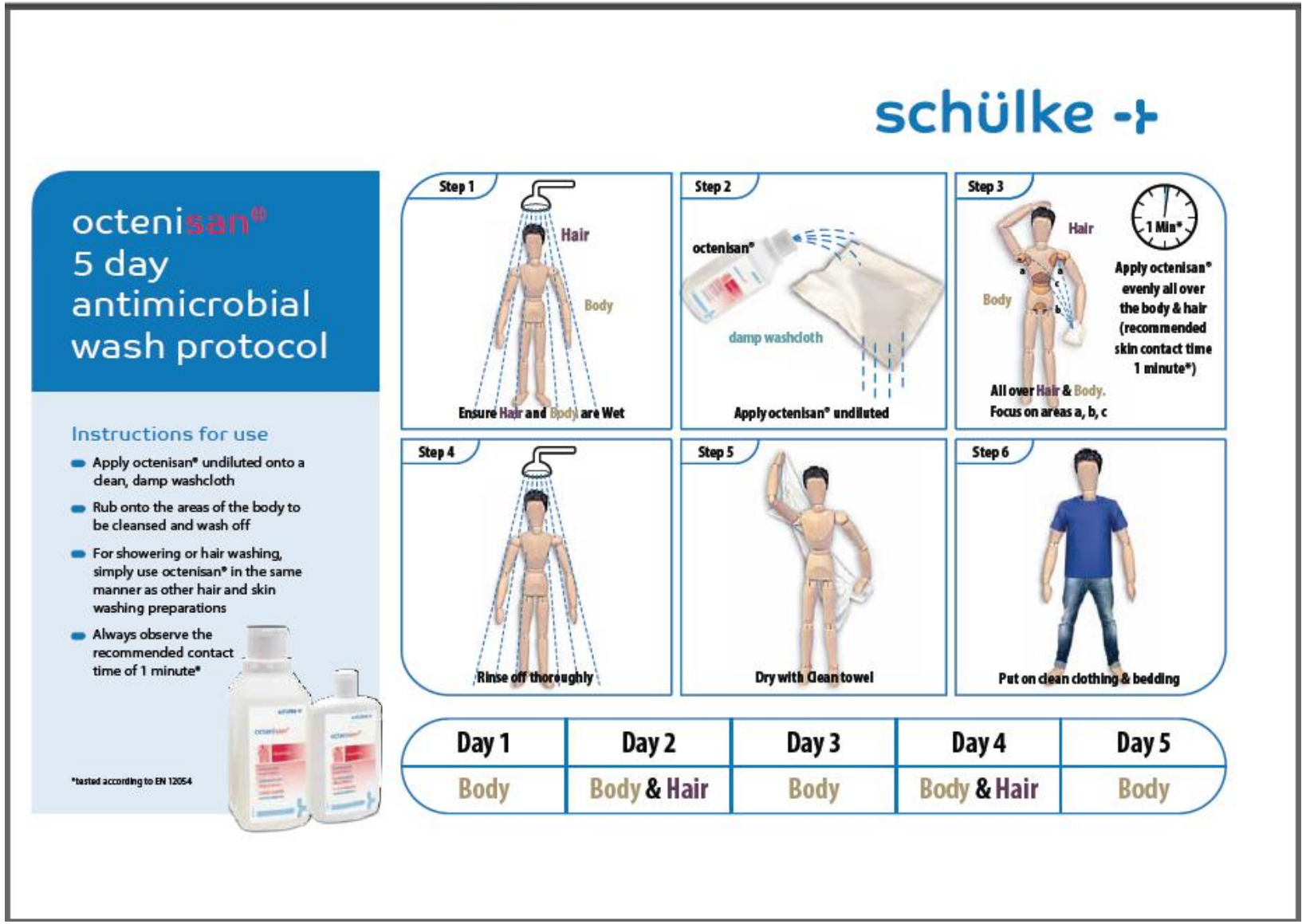
Step 4 Fasten cap carefully

Step 5 **Label swab container** correctly, make sure the details on the request form match sample

Full name of the patient or code identifier **and date of specimen collection**

Plus one of the following: NHS number or equivalent, RTX Number or Date

Appendix 4: OCTENISAN® 5 DAY ANTIMICROBIAL WASH PROTOCOL



Appendix 5: SCREENING PROCEDURES

The admitting ward/ department are responsible for completing screening as specified in the MRSA screening pathway.

Admitting department/ward staff should

- Check the Quadramed system for admitted patients to identify if the patient has a previous history of MRSA
- 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 MRSA screening pathway)
- Screening of all non-elective patients on admission (except those identified in the MRSA screening pathway)
- It is the responsibility of the medical and nursing team admitting or providing care for the patient to access the results of the MRSA screen and to notify the patient of the result.

Staff screening:

- MRSA does not generally affect healthy individuals and therefore routine staff screening should not be undertaken.
- In an outbreak situation, following consultation with the Consultant Microbiologist / IPCT, staff screening may be instituted. This will be managed by Occupational Health with support from the IPCT.
- How to take an MRSA screening swab see Appendix 2.

Once the need for MRSA screening has been identified. Screens should be taken from:

- Nose (one swab both nares)
- Groin (one swab both groins)
- Skin lesions and/or wounds (one swab from each site clearly identifying site)
- Insertion sites (for devices in situ at time of screen e.g. IV, PEG, tracheostomy sites and urinary catheters).
- See MRSA E- swabbing method for instruction on how to swab (Appendix 3).

Specimen container must be correctly labelled and include:

- Patient's full name or code identifier
- Date of specimen collection
- Plus one of the following:
- NHS number or equivalent
- Hospital number
- Date of birth

Specimen request form must be correctly labelled
The full name of the patient, (surname followed by forename) or code identifier for G.U.M. and Family Planning Clinic patients

- The hospital unit number (RTX Number), NHS number.

- Date of birth
- Sex of patient
- Ward or department
- Consultant's name
- Name of the requester
- Tests required (MRSA Screen)
- Date of specimen
- Relevant clinical information (any antibiotic history)

IMPORTANT – If an infection is suspected also include:

- Reason for swab, clearly state 'Swab – Query Infection'
- Site of specimen (i.e. Wound right lower leg)
- Clinical detail including antibiotic history
- Include the patient's symptoms (e.g. Temp, swelling, pain, pus)

The IPCT and Consultant Microbiologists can be contacted for further advice.

Appendix 6

CONTROL MEASURES IN THEATRE AND RECOVERY

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).

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 Clinell Universal wipes.

Appendix 7

MANAGEMENT OF MRSA IN WOUNDS

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

Chronic Wounds, such as leg ulcers

- Tissue viability advice should be sought for advice on dressings on 3285

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Wounds healing by primary intention, but colonised with MRSA

- In general there should be no need to select a specific dressing to tackle MRSA in wounds healing by primary intention.

All wounds 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.

Appendix 8:

MANAGEMENT OF MRSA IN INVASIVE DEVICES, INSERTION SITES

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.

Appendix 9:

CARE PLANS

MRSA care plan now live on Quadramed. Please ensure this is completed on admission.

Appendix 10: COMPETENCY DOCUMENT

https://intranet.lthtr.nhs.uk/download.cfm?doc=docm93jijm4n17849.pdf&ver=25920

Appendix 11: PATIENT INFROMATION LEAFLET

Click here for Information Leaflet for Patients and Carers

Appendix 12

Lancashire Teaching Hospitals NHS Foundation Trust

Equality, Diversity & Inclusion Impact Assessment Form

Department/Function	Infection Prevention & Control			
Lead Assessor	Sarah Kay			
What is being assessed?	MRSA Management, Screening and Suppression			
Date of assessment	01/09/2018			
What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process.	Equality of Access to Health Group	☐	Staff Side Colleagues	☐
	Service Users	☐	Staff Inclusion Network/s	☐
	Personal Fair Diverse Champions	☐	Other (Inc. external orgs)	☐
	Please give details:			

1) What is the impact on the following equality groups?			
Positive: ➢ Advance Equality of opportunity ➢ Foster good relations between different groups ➢ Address explicit needs of Equality target groups		**Negative:** ➢ Unlawful discrimination, harassment and victimisation ➢ Failure to address explicit needs of Equality target groups	**Neutral:** ➢ It is quite acceptable for the assessment to come out as Neutral Impact. ➢ Be sure you can justify this decision with clear reasons and evidence if you are challenged
Equality Groups	**Impact** (Positive / Negative / Neutral)	**Comments:** ➢ Provide brief description of the positive / negative impact identified benefits to the equality group. ➢ Is any impact identified intended or legal?	
Race (All ethnic groups)	Neutral		
Disability (Including physical and mental impairments)	Neutral		
Sex	Neutral		
Gender reassignment	Neutral		
Religion or Belief (includes non-belief)	Neutral		
Sexual orientation	Neutral		
Age	Neutral		
Marriage and Civil Partnership	Neutral		

Pregnancy and maternity	Neutral	
Other (e.g. caring, human rights, social)	Neutral	

2) In what ways does any impact identified contribute to or hinder promoting equality and diversity across the organisation?	

3) If your assessment identifies a negative impact on Equality Groups you must develop an action plan **to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised.**

- This should include where it has been identified that further work will be undertaken to further explore the impact on equality groups
- This should be reviewed annually.

ACTION PLAN SUMMARY

Action	Lead	Timescale