Trust Policy

For

METICILLIN RESISTANT STAPHYLOCOCCUS AUREUS

A policy recommended for use

In: All Clinical settings

By: Staff who are caring for patients in clinical settings

For: All patients

Key Words: MRSA, Mupirocin, Isolation, Handwashing, Protocol

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Equality Impact Assessment

This document has been reviewed in line with the Trust's Equality Impact Assessment guidance and no detriment was identified. This policy applies to all regardless of protected characteristic - age, sex, disability, gender-re-assignment, race, religion/belief, sexual orientation, marriage/civil partnership and pregnancy and maternity.

Dissemination and Access

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Associated Documentation

Linked to:

CSEC 011 - Hand Hygiene Policy
CSEC 032 - Isolation Policy
CSEC 033 - Standard Precautions Policy

Review

This document will be reviewed within two years of issue, or sooner in light of new evidence.
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SECTION 1 - MANAGEMENT OF THE PATIENT WITH METICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)

1. INTRODUCTION

Strains of *Staphylococcus aureus* that are resistant to many antibiotics, including meticillin and flucloxacillin are known by the term MRSA. Concern about the transmission of MRSA is related to the potential spread of this organism in hospital and the limited number of antibiotics available to treat infections caused by MRSA.

2. OBJECTIVES

Early identification, treatment where appropriate and to reduce the bioburden within the Trust with particular emphasis on the vulnerable patient.

Patients should NEVER be refused emergency or routine admission on the grounds of their MRSA status.

3. RISK CLASSIFICATION

Following the report from the Department of Health’s (2014) expert advisory committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) significant changes have been suggested in the way patients are risk assessed for colonisation of MRSA. These changes are based on the outcome of the NOW study commissioned in 2011 to assess the impact on guidance issued in April 2009 and December 2010 to screen all emergency and elective patients respectively.

The latest report has advised that screening should be targeted to high risk areas and patients known to be positive.

In the revised MRSA Working Party Guidelines (2006) it is proposed that preventative strategies be directed primarily to acute clinical areas. Long stay and mental health areas will be able to adopt less stringent strategies.
## 4. WHO TO SCREEN

### All ELECTIVE & EMERGENCY High Risk Patients in the categories below:
- Previous MRSA positive (check for MRSA alert on PAS)
- Admission to any hospital (UK or abroad) in the past year
- Resident in a Nursing or Residential Home

### All other Elective and Emergency patients in the Specialities below:
- Vascular patients
- Orthopaedics/trauma
- Renal/dialysis
- Haematology/Oncology
- Critical Care/High Dependency
- Neonatal Intensive Care Unit patients
- Cardiac Unit patients (Coronary Care)

### Note:
- Chemotherapy patients will be screened on commencing course(s) of treatment only, not at each treatment session.
- Renal patients will be screened on a rolling 3 month programme.
- If a patient in a bay is found to have MRSA, the remainder of the patients in the bay must be screened and isolation precautions taken until the results are known, i.e. a cohort bay.

### Rescreening of in–patients
- All HIGH risk and designated speciality patients screened on admission will require inter-ward screens.
- Critical care & neonatal patients weekly
- Any positive MRSA patient who does not clear after 2 protocols continue to rescreen weekly whilst an in-patient.
PROCEDURE FOR HIGH RISK PATIENTS:

**Admit to Side Room**
- Document if not able to isolate
- Inform Bed manager and escalate as per Isolation Policy

**Standard Isolation Precautions**
Ensure signage. If unable to close door written risk assessment required.

**Screen:**
Nose & Groin
(Also wounds, invasive devices, pus and sputum if present. Urine if catheterised.)

- Ifnegative de-isolate & inform patient in writing of negative result
- Negative Results
- Positive

**If MRSA Isolated From Any Site:**
Continue Standard Isolation Precautions
Start 5 Day Topical Treatment Protocol

If urine positive, review need for urinary catheter.
If wound positive assess for signs of clinical infection and If present discuss appropriate antibiotics with a Consultant Microbiologist.

- Review Antibiotics if Indicated

**Rescreen 2 days after protocol finishes**

If persistently colonised, discuss with Infection Prevention & Control Team

**If MRSA not isolated after 3 consecutive weekly screens**
De-isolate but continue weekly screens

**No further treatment. Patient should remain in isolation and commence weekly screens**
All patients must be risk assessed for isolation priority (if required) by the Bed Management Team in conjunction with the Infection Prevention & Control Team.

It is the responsibility of the patient’s clinician to follow up results of discharged patients.

The Infection Prevention & Control will inform patient’s G.P.s and patients of their results by letter if already discharged from hospital before result known.

5. HOW TO TAKE A MRSA SCREEN

- Use one swab for both nostrils. Insert tip into nostril and rub in a circular fashion.
- Use one swab for both groins/perineal area
- Use an individual swab for each wound
- Use universal container for urine/sputum/pus

NOTE – Do not collect a throat swab – this no longer forms part of a MRSA screen

Washing or personal hygiene will not interfere with results. Swabs can be taken at any time of the day.

Ordering MRSA screens on ICE Ordercomms

- Search for and then select the correct patient
- Click on requesting
- New request
- MRSA
- Request any other sites or CSU if required.
- Continue request – complete as appropriate including requesting copy of result and location to which copy is to be sent if required.
- Ensure all swabs are labelled with patient label and site of swab.

6. MRSA ALERT SYSTEM ON PAS

All patients found to be MRSA positive from screening will have an ‘MRSA Alert’ placed on their PAS records. This alert will remain on the patient’s records even after they have had 3 or more negative MRSA screens and therefore indicates that the patient is an ‘MRSA risk’ and not necessarily ‘MRSA positive’.

It is the responsibility of clinical staff to check for an alert on PAS when the patient is admitted and isolate the patient until the screen results are known.
7. PRACTICE FOR MRSA ELECTIVE (ADULT) SCREENING IN OUT-PATIENT SETTING FOR PREVIOUSLY KNOWN POSITIVE PATIENTS

On arrival to the screening room the patient will receive an explanatory leaflet detailing – why screening is necessary and how screening is done.

ICE report generated Using elective screening box.

Specimens labelled - nose & groin (any open wound or CSU’s).

All results can be accessed through Ice and should be checked by the Preadmission staff and followed up

For all patients with positive results complete MRSA screening form & place in patient’s notes. Ensure decolonisation protocol started at appropriate time (see paragraph 9).

Patient seen in OPD decision made for admission. (To either main Trust or Treatment Centre)

At this time ALL patients 'who fit the WHO to screen criteria' in this group will irrespective of pathway will go to local Pre-op Admissions Hub – in hours (except obstetrics who will go to ante-natal clinic). Out of hours all will be swabbed by OPD Nurse at the time. All HCH and MVCC patients will be swabbed at the time locally

On arrival to the screening room the patient will receive an explanatory leaflet detailing – why screening is necessary and how screening is done.

ICE report generated Using elective screening box.

Specimens labelled - nose & groin (any open wound or CSU’s).

All results can be accessed through Ice and should be checked by the Preadmission staff and followed up

For all patients with positive results complete MRSA screening form & place in patient’s notes. Ensure decolonisation protocol started at appropriate time (see paragraph 9).
8. MANAGING OUTPATIENTS WHO FALL IN TO THE ‘WHO TO SCREEN CRITERIA’ ELECTIVE SCREENING RESULTS

- It is the responsibility of the designated person or area to check the results daily and contact the patients.

- The person receiving the result will contact the patient, inform them of the result and arrange for the patient to attend a clinic where they will be given information both written and verbal and a decolonisation pack. **The patient will be instructed to use the pack for 5 days, starting two weeks prior to admission (except Surgicentre).**

- Patients from HCH will attend HCH. Lister patients will go Pre-op Admissions Hub, Treatment Centre patients will go to the Treatment Centre.

- Obstetric patients will follow pathway for all general patients being followed up at antenatal clinic and decolonisation arranged 2 weeks prior to booked admission time.

- Medical patients will follow respective OPD pathways.

**Cancellations or delayed elective admissions who required screening**

- All patients who have had their surgery delayed or cancelled so they breach the 18 week rule for admission must be rescreened.

**On Admission following a positive result**

All patients will be treated in accordance with the MRSA and Isolation Policy and be isolated as ‘previously known positive’. The Bed Manager must be informed to identify a side room or cohort the patient as possible. If no side room is available the patients need for a side room must be escalated in accordance with the Isolation Policy located in the Infection Prevention and Control Manual and on the Infection Prevention and Control Knowledge Centre site.

Patients do not routinely require rescreening following decolonisation prior to admission with the exception of **orthopaedic joint replacements**. All known positive patients when admitted should be isolated and rescreened.

It is the doctor’s responsibility to ensure that MRSA positive patients receive appropriate antibiotic prophylaxis if indicated, and the choice of antibiotic covers MRSA. (refer to antibiotic guidelines).

**Managing previously known positive patients requiring renal dialysis as outpatients**

Patients undergoing renal dialysis as outpatients in Trust managed units previously known to be MRSA positive should be assessed for isolation needs.

Any patient known in the past to be MRSA positive that has been screened quarterly whilst undergoing dialysis and found to have been negative for the past 4 consecutive screens does not require routine isolation but standard precautions must continue to be taken.

These same patients should be free of high shedding skin conditions. Patients with leg ulcers should be swabbed by their district nurse quarterly at the time of dressing change. These results should be checked by the renal unit. If negative, isolation is not required.
9. INFECTION CONTROL PRECAUTIONS IN THE CLINICAL ENVIRONMENT

Mode of Transmission

- Hands are the major method for the transmission of most bacteria, including MRSA. Staff may colonise themselves by touching or rubbing their noses with unwashed hands after contact with MRSA positive patient or their immediate environment. Staff may also acquire MRSA colonisation of skin wounds or dermatitis, or in bitten nails and nail beds.

  **Good hand-washing is the single most important measure in preventing the spread of infection, especially between patients. See Trust Hand Hygiene Policy.**

Patient Isolation

**Standard isolation precautions in side room**

- Always inform the bed manager of any side room used for isolation and if a side room is required escalate using the Trust Isolation Policy criteria (see escalation process appendix 1 in the Trust Isolation Policy located in the Infection Prevention and Control Manual and on the Knowledge Centre)
- Patients with eczema/psoriasis (skin shedders) should have priority for side rooms.
- **Ensure the door is always kept closed.**
- Complete Adverse Incident Form for patients that you are not able to isolate due to lack of facilities.

Protective Clothing

- All staff entering the isolation room or cohorted bay must be ‘naked below the elbows’ i.e. must have short sleeves, no bracelets, watches, false nails or nail varnish.
- All staff must comply with Uniform & Dress Code for Clinical Staff.
- Disposable plastic aprons and gloves must be put on before entering the isolation area.
- Gloves may need to be changed between procedures and hands decontaminated prior to placing a new set of gloves on.
- In the case of cohorted patients, gloves and aprons must be changed and hands decontaminated between contact with each patient and patient environment.
- Eye protection must be worn when performing any aerosolising procedure, e.g., chest physiotherapy and suctioning.
- Protective clothing must be removed directly after each episode of patient care, and be disposed of appropriately in a clinical waste bin. Hands must then be decontaminated.
Clinical Waste and Linen

- Disposal of waste must conform to the **Trust Waste Policy** located in the Infection Prevention and Control Manual and on the Knowledge Centre.

- All waste from isolation areas should be placed in an orange clinical waste bag in side room, then placed into a clean waste bag outside the room.

- Used linen, including patient clothing owned by the Trust, must be considered to be contaminated/infected and placed in a red alginate bag, prior to being placed into a white bag as per **Trust Management of Linen Policy** located in the Infection Prevention and Control Manual and on the Knowledge Centre.

- Any linen held in the isolation area should be sent to the laundry when the patient is de-isolated, using the same process as above.

- Clean linen should not be stored outside the isolation rooms and areas on trolleys.

- Towels and bed linen should be changed daily.

- Do not sit on beds, as clothing is likely to become contaminated.

- Relatives should be offered a dissolvable ‘patient property’ bag for personal linen for home laundry.

Cleaning

- All staff should report inadequate cleaning to the cleaning company in the first instance and then to the matron if a sustained improvement is not seen.

- All isolation rooms should be cleaned as per **Appendix 11 – Cleaning of Isolation Facilities within the Trust Isolation Policy** located in the Infection Prevention and Control Manual and on the Knowledge Centre.

Visitors

- Visitors do not need to wear protective clothing for social contact.

- They should be advised to decontaminate their hands using the alcohol-based hand sanitizer or soap and water on entering and exiting patient area.

- They should be requested not to sit on beds.
Access to information

- All patients should be given an information leaflet available from the knowledge centre under Infection Prevention & Control.
- Or the Department of Health information leaflet available from the IP&C Team or available via the Health Protection Agency website www.hpa.org.uk.

Screening of contacts of new cases

- If a patient in a bay is found to have MRSA, the remainder of the patients in the bay must be screened and isolation precautions taken until the results are known i.e. a cohort bay.

10. PATIENT SAFETY/PSYCHOLOGICAL ASPECTS OF ISOLATION

- Patient safety is paramount and all patients should be assessed for their suitability for isolation.
- Careful consideration of the mental health of the patient is paramount. Any patient with an identified risk if placed in isolation for example risk of falling out of bed, anxiety around isolation or claustrophobia must have a written risk assessment in their nursing notes.
- Regular re-assessment and timely screening of patients should occur in order that patients may be de-isolated as soon as possible.

11. CLINICAL MANAGEMENT OF THE MRSA POSITIVE PATIENT

Medical Treatment of Patients

- The advice of the Consultant Microbiologist should be sought in ALL instances where an MRSA positive patient may require antibiotics. The resistance patterns of MRSA vary from one patient to another and it is impossible to give blanket advice on appropriate antibiotic treatment.
- The inappropriate and prolonged use of any antibiotics to which MRSA is resistant may contribute to the resistance and spread of MRSA within the Trust (Boyce, 2001).
- Topical treatment protocol is designed for patients who are colonised or infected with MRSA in any site, and is recommended for all such patients, with the exception of neonates.
- If the first indication of MRSA in a patient is from either urine, a wound swab or blood the complete protocol is still required (as well as appropriate antibiotic) irrespective of subsequent surface site results.
- The topical treatment protocol can be given a maximum of twice per admission (2 five day courses) (BNF, March 2013).
- If skin irritation occurs, discontinue the use of Hibiscrub (Chlorhexidine gluconate 4% w/v) and/or Mupirocin (Bactroban). A Consultant Microbiologist will advise on alternative treatment.
There is little data available regarding the safety or efficacy of using Mupirocin around PEG tubes, tracheostomy tubes, catheters and similar devices. A single course of Mupirocin (5 days) may be considered on an individual patient basis by the Infection Prevention & Control Team. This may be subject to change in the light of new research or national guidelines.

Commence MRSA Care Pathway. The prescription for the protocol below is part of the Pathway document.

All Patients must be risk assessed for sensitivities/allergies to chlorhexidine. Those patients identified as at risk should be prescribed Octenisan as an alternative to chlorhexidine.

### Topical Treatment Protocol

<table>
<thead>
<tr>
<th>Formulation</th>
<th>Frequency</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nasal Mupirocin (Bactroban) 2% nasal ointment</td>
<td>Three Times Daily</td>
<td>5 days</td>
</tr>
<tr>
<td>Mupirocin 2% cream for secondarily infected traumatic lesions (not greater than 10cm² in area or 10cm in length)</td>
<td>Up to 3 Times Daily</td>
<td>May be given up to 10 days, but re-evaluate after 3-5 days</td>
</tr>
<tr>
<td>Body Wash- Hibiscrub (Chlorhexidine gluconate 4% w/v ) or Octenisan (for Chlorhexidine sensitive)</td>
<td>Daily, apply to skin before entering bath or shower</td>
<td>5 Days</td>
</tr>
<tr>
<td>Shampooing Hibiscrub (Chlorhexidine gluconate 4% w/v ) or Octenisan (for Chlorhexidine sensitive)</td>
<td>At Least Twice Weekly</td>
<td>5 Days</td>
</tr>
</tbody>
</table>
After protocol, apply clean clothing, bedding and supply clean towels.

Disposable flannels should be used for washing patients.

Disposable washbowls must be used for MRSA positive patients.

For high level Mupirocin resistance, Naseptin may be advised nasally 4 times a day for 10 days per protocol in place of Mupirocin (NB: Naseptin contains peanut oil).

Topical treatment for patients with High Shedding skin conditions for example: eczema, dermatitis & psoriasis.
1. Seek advice from Consultant Dermatologist with view to protocol of Oilatum bath additive or Oilatum plus (with added benzalkonium chloride 6% & Triclosan).

2. This should only be prescribed by a Consultant Dermatologist.

3. Treat underlying skin condition.

- Children and neonates are not routinely given decolonisation protocols. In the event of an outbreak this will be reviewed and decided on an individual basis by the Infection Control Team managing the outbreak.

- The management of breast milk expressed from MRSA colonised mothers or babies will be advised on an individual basis by the Infection Prevention & Control Doctor/Consultant Microbiologist.

The prescription chart in the MRSA Care Pathway document must be signed when each protocol is given. Failure to do so is a drug error.

Post Treatment Screens

Screening should commence 48 hours after protocol has finished, and screened weekly thereafter. After 3 consecutive negative screens the patient can be de-isolated but must continue with weekly screens.

Patients with Wounds

- Patients with MRSA colonisation of wounds can have daily baths as outlined above if the condition of their wounds permits.

- Seek advice from the Tissue Viability Nurse, particularly for the management of complicated wounds.

- Mupirocin 2% cream may be used on secondarily infected traumatic lesions not greater than 10cm² in area or 10cm in length.

- If signs of infection are present, discuss appropriate treatment with a Consultant Microbiologist.

- All wound dressings should be performed using strict aseptic technique.

Urine/Sputum

- The Consultant Microbiologist will advise on treatment if it is clinically indicated.

Pre-operative preparation for known MRSA positive patients

- Every effort should be made to decolonise patients pre-operatively and/or suppress infection with MRSA before surgery (see Surgical Site Infection High Impact Intervention located on the Knowledge Centre for further information).

- Bathe/shower the patient with Hibiscrub (Chlorhexidine gluconate 4% w/v) applying it directly to the skin as a wash and then rinse off. Do not pour in to the bath or bowl. Patients who cannot tolerate Chlorhexidine Gluconate should be bathed in Octenisan.
• Cover affected lesions with an impermeable dressing.
• Apply Mupirocin 2% nasal ointment to nose pre-operatively (if nasal carrier).
• If prophylactic antibiotic cover is indicated for a surgical procedure this must be discussed with a Consultant Microbiologist.
• Place patient last on the list to enable recovery in the operating theatre.
• Theatre surfaces in close contact or near the patient, such as operating table or instrument trolley, should be decontaminated with hot water and detergent, followed by alcohol wipe before the next patient.
• Recover in the operating theatre after surgery, or area not occupied by other patients to avoid possible contamination.
• Portering staff to wear personal protective equipment (P.P.E.).

12. VISITS TO OTHER DEPARTMENTS

• When MRSA positive patients require investigation in another department the doctor making the request on the department request form MUST state that the patient is MRSA positive (e.g. X-ray, Theatres Endoscopy, Outpatients, Physiotherapy and Occupational Therapy). In addition to this the department must be informed in advance by the ward staff.

• Patients are not to be left in a corridor waiting to enter the respective departments.

• Wearing of protective clothing should conform to Trust Standard Precautions Policy located in the Infection Prevention and Control Manual and on the Infection Prevention and Control site on the Knowledge Centre. Portering staff must wear gloves when handling the patient’s bed and/or equipment and apron, if they are required to assist the patient manually into a wheel chair. Hands must be decontaminated after the removal of protective clothing.

• Staff working in departments coming in to physical contact with either the patient or their equipment must wear disposable gloves and aprons.

• Hands must be washed between all patients (with liquid soap and water or alcohol foam on socially clean hands).

• All equipment with which the patient has had direct contact, e.g., examination couch, needs to be cleaned with general purpose detergent and water, detergent wipes or with the recommended cleaning agent for the equipment.

• Linen, contaminated instruments and waste must be processed in accordance with relevant policies.

• Extra floor cleaning is only required for blood and body fluid spillage. (Follow the procedure for Spillage of blood and body fluids in the Standard Precautions Policy which is located in the Infection Prevention and Control Manual and on the Knowledge Centre.)

• The trolley or wheelchair used for transportation must be cleaned with neutral detergent and water or detergent wipes by personnel working in that department.
13. TRANSFER OR DISCHARGE TO OTHER HOSPITALS

- Identification of infected or colonised patients depends primarily on the transferring hospital. The clinician responsible for the patient should contact the Medical Team at the receiving hospital to inform them of the patient's MRSA status. Additionally, the nursing staff should inform the ward staff of the receiving hospital. Transfer form should be completed.

- When receiving a patient from another hospital, request the patient's MRSA status and inform the Bed Manager that they will require a side room.

- The Royal Free Hospital, Brompton, and Harefield Hospitals request that patients who are due for transfer to these hospitals undergo a full screen before the patient is transferred.

- Inform the ambulance crew if an MRSA positive patient has a desquamating skin condition, e.g., eczema. These patients should not be transported in the same vehicle with other patients. If the MRSA positive patient does not have a skin condition, then they may travel along with other patients. Wounds must be covered. If a patient has open skin lesions that are unable to be covered with an impermeable dressing, the advice of the Infection Control Team should be sought. This may result in the patient travelling alone in the ambulance. (National Guidance and Procedures for Infection Prevention and Control by Ambulance Association 2004).

- Unless there is blood/body fluid spillages, no extra decontamination of the ambulance is usually required after transporting an MRSA positive patient.

14. DISCHARGE OF PATIENTS INTO THE COMMUNITY SETTING

- All patients discharged into the community should have their MRSA status included in their discharge summary. State the number of protocols administered. Inform if currently on a protocol which requires completion and request any further screening required.

- Most patients who have MRSA are generally not followed up in the community. MRSA Treatment Protocol and swabs for MRSA should only be arranged if clinically required e.g., patient is to be re-admitted for surgery.

- Inform and involve Community Liaison Nurse, Primary Care Trust (PCT) IPCN, General Practitioner, District Nurse and Home Care Team where appropriate, so that they can take appropriate precautions. This is important in case clinical infection develops when MRSA can then be considered and appropriate antibiotics given.

- Inform Nursing/Residential Home. Carriage of MRSA should NOT prevent transfer of a patient to a nursing, residential or convalescent home. In the event of any difficulties with placement of a patient, contact the Health Protection Unit (HPU) Infection Prevention & Control Nurse or the Consultant in Communicable Disease Control, telephone 0300 303 8537 and or the CCG Lead IPCN on 07500952019.

- Patients should be advised that if they are readmitted to hospital at any time they should inform staff to ensure they are appropriately managed.
15. TRANSFER TO DISCHARGE LOUNGE

- Inform staff in discharge lounge of patient’s MRSA status.
- Comply with MRSA policy.
- Terminally clean on discharge.

16. LAST OFFICES

- The precautions for the laying-out of deceased patients should be the same as those observed during life. Plastic body bags are NOT necessary, unless the patient suffered from another condition requiring them, or leakage of body fluids is anticipated.
- Any lesion should be covered by an impermeable dressing.

17. CLINICAL GOVERNANCE - POST INFECTION REVIEW

- A Post Infection Review (PIR) is required following any MRSA bacteraemia. All MRSA bacteraemias are considered an internal ‘Never-Event’. A 72-hour report and Route Cause Analysis (RCA) will be performed lead by the Infection Prevention & Control Doctor including the clinical team admitting or caring for the patient, within five days of result. The purpose of this is to identify the most probable cause and implement any learning strategies that can be made from such analysis.
- All MRSA bacteraemias are reported as Serious Incidences.
- Should it be identified that the patient was in fact admitted with the MRSA bacteraemia, the PIR, once complete, should be passed on to the CCG Infection Prevention & Control Nurse.
- An Adverse Incident Form must be completed by the clinical team for every hospital acquired MRSA bacteraemia.

18. AN OUTBREAK OF MRSA

Definition

- An outbreak is defined as two or more related cases of MRSA (with the same sensitivity/typing pattern) in one clinical area.

In the event of an outbreak the Trust Policy for the Management of Outbreaks will be adopted.

Immediate management

- If possible, all patients known to have MRSA should be nursed in a side room or cohort bay and the treatment protocol should be initiated.
- If the patient’s clinical condition allows they can be discharged from hospital.
MAJOR OUTBREAK

Definition

- Should an outbreak spread beyond the confines of a cohort, a major outbreak may be declared.

- The Infection Prevention & Control Team will state when a major outbreak has occurred and the Trust Policy for the Management of Outbreaks will be implemented (see Infection Prevention & Control Manual or the Infection Prevention & Control site on the Knowledge Centre).

19. TRUST STAFF SCREENING

- Healthcare staff may be screened during outbreaks of MRSA.

- Staff screening will be carried out at the discretion of the Infection Prevention & Control Team/Occupational Health Department and in compliance with Infection Control Issues for Staff Health Policy located on the Knowledge Centre.

- Staff must not screen themselves without prior arrangement with the Occupational Health Department.

- Treatment of MRSA colonised staff will be in accordance with the Topical Treatment Protocol.

- The Occupational Health Department will advise staff who are MRSA positive on an individual basis whether they need to be excluded from work.

For any queries contact the Infection Prevention and Control Team
Lister Ext: 5383 or bleep 5383
SECTION 2 – MANAGEMENT OF VISA/GISA AND VRSA

1. INTRODUCTION

Vancomycin intermediate-susceptible *Staphylococcus aureus* (VISA), Glycopeptide intermediate-susceptible *S. aureus* (GISA) and Vancomycin resistant *S. aureus* (VRSA) infections remain relatively rare today. However the literature suggests these strains may become more prevalent in the future. Infections with these organisms usually occur in patients who had previous MRSA colonisation/infection and have received long and repeated courses of glycopeptide therapy.

Therefore risk factors are:

1. Antecedent vancomycin/teicoplanin use.
2. MRSA infection 2-3 months prior to VISA/GISA/VRSA infection.

2. INFECTION PREVENTION & CONTROL PRECAUTIONS IN THE CLINICAL ENVIRONMENT

Since, by definition, there are fewer antibiotics available with which to treat VISA, GISA and VRSA, it is important that the extra measures set out below are strictly adhered to, to ensure spread does not occur.

**Healthcare workers**

- The number of healthcare workers caring for the patient should be reduced.
- Healthcare workers with chronic skin conditions, e.g., eczema or psoriasis, should not be involved in direct care of the patient.
- All staff caring for the patient must be aware of how the organism is transmitted and the precautions necessary to prevent this.

**Isolation precautions**

The patient must be isolated and priority must be given over other infections.

- Fans must not be used to control the patient’s temperature.
- Standard precautions must be used be EVERYONE ENTERING the room.
- Staff should wear scrub suits to prevent them taking uniforms home to launder.
- All scrub suits must be laundered as per the Trust Management of Linen Policy located in the Infection Prevention and Control Manual and on the Infection Prevention and Control site on the Knowledge Centre for further information.
- Disposable masks and eye protection should be worn by carers for procedures likely to generate aerosols/splashing.
- Hand hygiene must be performed using alcohol gel before and after each patient contact. Visibly soiled hands should be washed with soap and water.
• All non-disposable items that cannot be easily decontaminated must be kept for the sole use of the patient.

• All patient charts must be kept outside the room.

• All linen must be treated as infected and placed into alginate bags inside the room and red bags outside the room.

• All waste should be discarded into a clinical waste bag inside the room.

• Transfers of colonised/infected patients within and between institutions should be avoided unless essential. The receiving institution must be made aware of the patients' infection/colonisation status.

• After discharge of the patient the room should be terminally cleaned with special attention to the horizontal surfaces (see Trust Terminal Cleaning Policy located in the Infection Prevention and Control Manual and on the Infection Prevention and Control site on the Knowledge Centre for further information).

Screening of patients

• Nose, perineum, skin lesions and manipulated sites of the index case and all other patients in the unit (and any other unit the patient visited during their current admission) should be screened for carriage of VISA/GISA or VRSA.

Screening of staff

• Agreement with staff on the need for screening should be sought.

• Nose, perineum and any skin lesions of healthcare workers and others with close physical contact with the case should be screened for carriage of VISA/GISA and VRSA.

• Healthcare workers who maintain contact with the patient will require weekly screening.

• Colonised staff should be excluded from work until eradication of carriage is achieved.
SECTION 3 - REFERENCES AND BIBLIOGRAPHY

Ayliffe GAJ, Lowbury EJL, Geddes AM and Williams JD, 1992, Control of Hospital Infections, a practical handbook, Chapman Hall Medical, London.


Boyce J. (2001) MRSA patients: proven methods to treat colonization and infection. Journal of Hospital Infection 48 (Supplement A): S9-S14

British National Formulary BNF 46 September 2003


PHLS (1999) Investigation of specimens for screening for MRSA, PHLS Standard operating procedure Public health Laboratory Service Board.


Department of Health, Elective implant and Emergency Admissions 2006

Department of Health Saving Lives ‘Screening for Meticillin-resistant staphylococcus aureus (MRSA) colonisation strategy for NHS Trusts: a summary of best practice 2007
Department of Health MRSA Screening – Operational guidance Gateway reference number 10324 (July 2008)

Department of Health MRSA Screening – Operational guidance 2 Gateway reference number 11123 December 2008

Department of Health MRSA Screening – Operation guidance 3 Gateway reference number 13482 March 2010

NHS Commissioning Board (March 2013) – Guidance on the reporting and monitoring arrangements and post infection review process for MRSA bloodstream infections from April 2013.

APPENDIX 1

MRSA / CRE
Checklist and Screening Record for both Emergency and Elective Admissions as per Policy

Please ✓ all the relevant boxes and give further information as required. Pt = Patient NK = Not known

**Site:** Lister □ MVCC □ QEII □ Ward:

**Date of Admission:** …… / …… / ……..

**MRSA**

1. Has the Pt been an In-patient in any hospital (UK or abroad) within the past 12 mths? Yes* □ No □

2. Does the patient live in a Residential/Nursing Home? Yes* □ No □

3. Has the patient been informed that they were previously positive (check for MRSA Alert on PAS)? Yes* □ No □

4. All other Elective and Emergency Patients admitted in the specialities below:
   - Vascular Patients
   - Orthopaedic/Trauma
   - Renal/Dialysis
   - Haematology/Oncology
   - Critical Care/HDU
   - Neonatal ICU
   - Cardiac Unit Patients

*If the answer to any of the above is ’Yes’, this Pt is at High Risk of MRSA and the Bed Manager must be informed that an isolation room is required & isolation precautions must commence.

If results subsequently show Pt is + ve for MRSA, decolonisation must be attempted immediately and Infection Prevention & Control Team informed about this patient.

**Does the patient have any of the following:** (Pse ✓ all that apply)

- Wound/lesion □
- Urinary catheter □
- Productive cough □
- Tracheostomy/Stoma □

**Patient swabbed for MRSA?** Yes* □ No □ *If Yes, Date of swab/s: …… / …… / ……..

**Swab/s or sample/s taken from:** (Pse ✓ all that apply)

- Nose □
- Perineum/Groin □
- Wound/lesion (including MC&S) □
- Catheter urine □
- Sputum □
- Tracheostomy/Stoma site □
- Other □ Specify:

**Carbapenem-Resistant Enterobacteriaceae (CRE)**

1. Has the Pt been an In-patient or had renal dialysis in any hospital abroad, London, Manchester or the North West, within the past 12 mths? Yes* □ No □

2. Has the Pt ever been told they were positive to CRE? Yes* □ No □

3. Has the Pt been in close contact with anyone known to be positive to CRE? Yes* □ No □

*If the answer to any of the above is ’Yes’, this Pt is at High Risk of CRE and the Bed Manager must be informed that an isolation room is required & isolation precautions must commence.

2 stool samples are required, at least 2 days apart

If results subsequently show Pt is + ve for Carbapenem-Resistant Enterobacteriaceae, screening of contacts and effective treatment (in case of infection) must be commenced immediately.

The Consultant Microbiologists and the Infection Prevention & Control Team must be informed about this patient.
Stool specimen taken for CRE? Yes* □ No □ *If Yes Date of sample ……../…….…….…….
or
Rectal swab with visible faeces taken for CRE? Yes* □ No □ *If Yes Date of swab/s: ……../……/…….

Patient swabbed for CRE? Yes* □ No □ *If Yes, Date of swab/s: ……../……/…….
Swab/s or sample/s taken from: (Pse ✓ all that apply) Wound/lesion (including MC&S) □ Catheter urine □
Sputum □ Tracheostomy/Stoma site □ Other □ Specify:

Checklist completed by: Name:……………………………………………… grade…………………………
Signature:……………………………………………………………………………………………………………………

[ NB See below for Recommended Sampling Sites for use in MRSA and CRE Screening]

SCREENING CARRIED OUT by: Name:………………………………………………. grade…………………………
Signature:……………………………………………………………………………………………………………………

SCREENING RESULTS:

  MRSA POSITIVE □ MRSA NEGATIVE □ If positive commence on MRSA Care Pathway.
  CRE POSITIVE [1] □ CRE NEGATIVE [1] □ If positive discuss with Microbiologist

Results completed by: Name: ………………………………………………… Grade:
Signature: ………………………………………………………………………………………………………………………


Results completed by: Name: ………………………………………………… Grade:
Signature: ………………………………………………………………………………………………………………………

Recommended Sampling Sites for use in MRSA / CRE Screening

MRSA
Sampling sites for initial screening for all patients are:
  • Nose
  • PERINEUM OR GROIN
  • ANY WOUNDS OR LESIONS

CRE
Sampling sites for initial screening for all High Risk patients
  • Rectal swab (must have visible faecal matter)
or Stool specimen
  • Any wounds or lesions (if possible)
  • ANY MEDICAL DEVICE INSERTION SITES (IF POSSIBLE)

Additional sampling/testing for both MRSA and CRE screening should also be carried out as follows:
  • If the patient has a urinary catheter, a sample of the catheter urine should be collected and sent for testing
  • If the patient has a productive cough, a sample of the sputum should be collected and sent for testing
  • If the patient has a tracheostomy, the tracheostomy site should be swabbed
  • If the patient has any stoma, the stoma site should be swabbed
APPENDIX 2

OBSTETRICS & GYNAECOLOGY

Pre-Admission
- Only previously known positive (check on PAS)
- Admitted to another hospital (UK or abroad) in last 12 months

MRSA & CRE SCREENING RECORD

Proposed operation/procedure: .................................................................
Date of proposed operation/procedure: ....................................................
Consultant: ...................................................................................................

MRSA
Date patient swabbed: … / … / … By whom? (Print and sign name) … … / … …
Date results received back: … / … / … Checked by? (Print and sign name) … … / … …

MRSA SCREENING RESULTS (✓ and date as appropriate and specify wound/stoma site)

<table>
<thead>
<tr>
<th>Site</th>
<th>Swabbted</th>
<th>Negative</th>
<th>Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perinium/Groin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CSU</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sputum</td>
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<td></td>
<td></td>
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<tr>
<td>Wound/Stoma 1:</td>
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<td>Wound/Stoma 1:</td>
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<tr>
<td>Wound/Stoma 1:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MRSA sticker put on inside cover of patient’s notes: Yes ☐ No ☐
Consultant informed of +ve result? : Yes ☐ No ☐. If yes: DATE: … / … / …
Patient informed of +ve result? : Yes ☐ No ☐. If yes: DATE: … / … / …
Date agreed for decolonisation treatment to start: … / … / …

MRSA Pack

Written information given to patient: MRSA leaflet? : Yes ☐ No ☐ User protocol? Yes ☐ No ☐
Date MRSA Pack given to patient: … / … / …
Hibiscrub (Chlorhexidine gluconate 4% w/v) Batch number: ………………… Expiry Date: … / … / …
Mupirocin batch number: ………………… Expiry Date: … / … / …
Patient’s identity confirmed? Yes ☐ No ☐
Qualified Nurse/Midwife: Signature: ………………… Printed name: …………………
Re-screening date: On admission
Any other comments/information: …………………

Order code:
Carbapenem-Resistant Enterobacteriaceae (CRE)
Risk Assessment Form

For all Obstetric & Gynaecology Patients requiring admission
Please ✓ all the relevant boxes and give further information as required. Pt = Patient

Ask all Obstetric & Gynaecology Patients requiring admission:
1. Have you been an inpatient or had renal dialysis in any overseas hospital, London, Manchester or the North West of England during the past 12 months? Yes ☐ No ☐
2. Have you ever been told you were positive to CRE? Yes ☐ No ☐
3. Have you been in close contact with anyone known to be positive to CRE? Yes ☐ No ☐

* YES = HIGH RISK
If the patient answers yes to any of these questions, see action plan below.

<table>
<thead>
<tr>
<th>Action plan for patients identified as being ‘at high risk’ of CRE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two stool specimens are required, at least 48 hours apart</td>
</tr>
<tr>
<td>• Give patient 2 stool specimen pots and information/instruction leaflet</td>
</tr>
</tbody>
</table>

NO
If the Pt answers ‘No’ to ALL 3 questions, then no further questions need be asked, the patient is NOT considered to be at risk of CRE.

The planned procedure may take place following the usual Infection Prevention and Control procedures.

Sign and date this form below, and file it in the Pt’s health record.

SCREENING RESULTS [1]:
CRE POSITIVE** ☐ CRE NEGATIVE ☐
Results [1] completed by: Name: .......................................................... Grade: .................
Signature: ........................................................................................................ DATE: ...... / .... / ....

*If positive, inform: Patient’s Consultant ☐ Consultant Microbiologist ☐ Bed Management Team ☐
Contact Waiting List: ☐ Theatres ☐

SCREENING RESULTS [2]:
CRE POSITIVE** ☐ CRE NEGATIVE ☐ If positive discuss with Microbiologist
Results [2] completed by: Name: .......................................................... Grade: .................
Signature: ........................................................................................................ DATE: ...... / .... / ....

*If positive, inform: Patient’s Consultant ☐ Consultant Microbiologist ☐ Bed Management Team ☐
Contact Waiting List: ☐ Theatres ☐

This form should be filed in the patients health records under “Nursing/other notes” section

NB Follow Trust’s Multi-Resistant Gram-Negative Bacteria Policy and document the Patient’s CRE risk status in his/her Medical Record

CHECKLIST COMPLETED BY: NAME: .......................................................... GRADE: .................
SIGNATURE: ........................................................................................................ DATE: ...... / .... / ....
APPENDIX 3

Pre Operative Assessment Clinic
for elective surgery including Endoscopy
MRSA / CRE / CJD Screening Record

File in patients health records once risk assessments and appropriate actions completed

Consultant: .........................................................

Date patient swabbed: ........ / ...... / ...... by whom? (Print and sign name)........................................

Date results received back: ...... / ...... / ...... Checked by? (Print and sign name)......................................

MRSA Screening Results (√ and date as appropriate and specify wound/stoma site)

<table>
<thead>
<tr>
<th>Site(s) – See MRSA Policy for further guidance</th>
<th>Swabbed</th>
<th>Negative</th>
<th>Positive</th>
<th>Ortho joint Pt’s re-screen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nose</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perineum/Groin</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>CSU</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Sputum</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wound/Stoma 1:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wound/Stoma 2:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Positive result pathway

Consultant informed of +ve result? Date: 

Patient informed of +ve result? Date: 

Start date for decolonisation therapy Date:

Decolonisation therapy pathway

Confirm patient’s identity and that they do not have a sensitivity to Chlorhexidine*

Decolonisation therapy administered to patient: (*if the patient confirms that they have a Chlorhexidine sensitivity - see MRSA policy for guidance) Date: RN Print name: 

RN signature:

Patient information leaflets given to patient: MRSA leaflet Date: User protocol Date:

Hibiscrub (Chlorhexidine gluconate 4% w/v) as per PGD Batch number Expiry Date

Mupirocin as per PGD Batch number Expiry Date

Rescreen date for Orthopaedic patients having joint surgery: Date:

Rescreen all MRSA +VE patients on admission, documenting action taken in the MRSA MDT ICP

Free text comments below pertaining to either pathway:

This form should be filed in the patients health records under “Nursing/other notes” section
## Carbapenemase-resistant Enterobacteriaceae (CRE) Risk Assessment Form

Please **✓** all the relevant boxes and give further information as required.  Pt = Patient

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you been an <strong>inpatient</strong> or had <strong>renal dialysis</strong> in any overseas hospital, London, Manchester or the North West of England during the past 12 months?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Have you ever been told you were positive for <strong>CRE</strong>?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Have you been in close contact with anyone known to be positive to <strong>CRE</strong>?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please **✓** yes or no and follow actions below the relevant answer

**YES = HIGH RISK**  
If the patient answers yes to any of these questions, see action plan below.

**NO**  
If the Pt answers ‘No’ to ALL 3 questions, then no further questions need be asked, the patient is NOT considered to be at risk of CRE.

The planned procedure may take place following the usual Infection Prevention and Control procedures.

Sign and date this form below, and file it in the Pt’s health record.

---

**NB**  
Follow Trust’s Multi-Resistant Gram-Negative Bacteria Policy and document the Patient’s CRE risk status in his/her Medical Record

---

### CHECKLIST COMPLETED BY: NAME: ...........................................  GRADE: ....................

**SIGNATURE:** .................................................................  **DATE:** ...... / ...... / .....

### SCREENING RESULTS [1]:

**CRE POSITIVE** ☐  **CRE NEGATIVE** ☐

Results [1] completed by: Name: ...............................................  Grade: ....................

Signature: .............................................................................  **DATE:** ...... / ...... / .....

**If positive, inform: Patient’s Consultant ☐  Consultant Microbiologist ☐  Bed Management Team ☐  Contact Waiting List: ☐  Theatres ☐

### SCREENING RESULTS [2]:

**CRE POSITIVE** ☐  **CRE NEGATIVE** ☐  If positive discuss with Microbiologist

Results [2] completed by: Name: ...............................................  Grade: ....................

Signature: .............................................................................  **DATE:** ...... / ...... / .....

**If positive, inform: Patient’s Consultant ☐  Consultant Microbiologist ☐  Bed Management Team ☐  Contact Waiting List: ☐  Theatres ☐

*This form should be filed in the patient’s health records under “Nursing/other notes” section*
# CJD and vCJD Risk Assessment Form

For all **Surgical** and **Endoscopy Patients** – excluding “high risk” Ophthalmology

This form must be completed for all surgical and endoscopy patients having, or scheduled to have, a procedure requiring **reusable surgical equipment**

Please √ all the relevant boxes and give further information as required. Pt = Patient

| Date risk assessment completed: | | |
|-------------------------------|------------------|

| Proposed operation/procedure: | | To be arranged |
|-------------------------------|------------------|

| Date of proposed operation/procedure: | | |
|---------------------------------------|------------------|

Ask **all Surgical and Endoscopy Patients** the following question:

**Have you ever been notified that you are at increased risk of CJD or vCJD for public health purposes?**

Please √ yes or no and follow actions below the relevant answer

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

If Pt answers ‘Yes’, then please ask them to explain further and document responses in comments field overleaf. *(NB It is important to get full details of the patient’s risk factors to determine if they are at risk from sporadic or new variant CJD. Refer to the template in the TSE Policy Appendix 4 also located on the Knowledge Centre.)*

If the Pt answers ‘NO’, then no further questions need be asked, the patient is **NOT** considered to be at risk of CJD or vCJD. The planned procedure may take place following the usual Infection Prevention and Control procedures. Sign and date this form below, and file it in the Pt’s health record.

## Action plan for patients identified as being ‘at high risk’ of CJD or vCJD

Send a copy of the completed risk assessment **ASAP** to all parties listed below. Tick and date all relevant boxes to indicate that the necessary action(s) have been undertaken and that the escalation process has been completed prior to filling the risk assessment in the Patient’s health records.

1. **The patients Consultant / Endoscopist** *(If Consultant not present at clinic and informed at the time)*

   - YES
   - NO – Detail why?
   - Date sent:

2. **The Lead Nurse for Infection Prevention and Control (IP&C) Team** - Location code L80

   - YES
   - NO – Detail why?
   - Date sent:

3. **The appropriate Theatre Manager, endoscopy unit manager* or senior midwifery manager**

   Please identify appropriate Theatre by ticking relevant box from list below

<table>
<thead>
<tr>
<th>Lister</th>
<th>QEII</th>
<th>LTC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Inpatient Theatre (L45)</td>
<td>Main Inpatient Theatre (Q45)</td>
<td>Main Theatres</td>
</tr>
<tr>
<td>Maternity Theatre (L58B)</td>
<td>Queen’s Wing / Essendon DSU Theatres (Q60)</td>
<td>Copy to: Theatre Manager</td>
</tr>
<tr>
<td>Copy to: Theatre Manager</td>
<td>Princes Wing Theatre (Q54)</td>
<td></td>
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<tr>
<td></td>
<td>Copy to: Theatre Manager</td>
<td></td>
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</tbody>
</table>

   *(Theatre Manager to discuss decontamination issues with IP&C Team)*

*See Endoscopy section (p.20 onwards) and table 7 (p.24) of the Transmissible Spongiform Encephalopathy (TSE) policy for a summary of the procedure to be taken

---

**This form should be filed in the patient’s health records under “Nursing/other notes” section**

**CHECKLIST COMPLETED BY: NAME:** ............................................................... **GRADE:** .........................

**SIGNATURE:** .................................................................................. **DATE:** …… / …… / ……
MRSA Screening
Patient information Leaflet

What is MRSA?
MRSA is a germ that can live on the skin of healthy people usually with no knowledge or bad effect on them. It can be a problem if you become unwell and the germs manage to enter your body and cause an infection.

Why do I need to be screened for MRSA?

To reduce the number of possible infections of our patients and to comply with a Department of Health decision we are taking swabs of all patient’s noses and groins who fall into the high risk category, i.e. previously MRSA positive, live in a residential or nursing home or have been in hospital in the UK or abroad during the past twelve months. We are also swabbing certain groups of surgical patients as recommended by the Department of Health. If you have a wound or broken skin these will also need to be swabbed.

Patients with any type of tube in through their skin will need to be swabbed around the tube or in the case of a urinary catheter a specimen will be taken from it.

Taking swabs will inform the hospital whether you have MRSA on your skin. For your best possible outcome we need to remove as much of the MRSA as possible before your operation to reduce the chance of acquiring an infection afterwards.

What will happen if MRSA is found?

You will be contacted by the hospital and given an antiseptic body wash and nasal cream to put just inside your nostrils for 5 days two weeks prior to your admission.

Will I be checked to see if it has gone?

You will be re-swabbed on the day of your admission to check whether it has gone.

Will my operation be cancelled?

It is not expected that your operation or procedure will be cancelled.

Please note that if your MRSA result is negative you will not be contacted by the Trust. However, the negative results will be filled in your medical notes for our reference.

If you have any queries, please speak to a member of nursing staff.
APPENDIX 5

Ward

METICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)
Multi-disciplinary Integrated Care Pathway (ICP)

PATIENT DETAILS (affix label)

Name
Hospital No
D.O.B
Address

Standard:
Previously known or newly diagnosed MRSA positive patients will be placed appropriately, receive timely and effective information, treatment and undergo follow up screening.

Inclusion criteria
All in-patients with a positive MRSA result
All previously known positive renal patients

Exclusion Criteria
Decolonisation protocol should not be used for children under 1 year (inc. neonates) seek advice from Infection Prevention & Control Team (IPCT)

INSTRUCTIONS FOR USING THIS ICP

- Each professional making an entry in this ICP must complete the signature sheet at the bottom of this page after which they should use their initials when making an entry
- When activities are completed you must initial in the box provided and enter the date and time
- If the activity is not completed or you initial in the ‘NO’ box, then you must record this as a variance in the space provided at the bottom of each page and write the actions taken and initial
- Any extra care provided to the patient must be entered in the patient notes
- This document should be used in conjunction with the Trust Infection Prevention & Control Policies
- It is the responsibility of the clinician to document on the Trust Drug Chart that the ICP must be followed

ALL PERSONS COMPLETING THIS ICP MUST SIGN BELOW

<table>
<thead>
<tr>
<th>NAME</th>
<th>SIGNATURE</th>
<th>INITIALS</th>
<th>DESIGNATION</th>
<th>Bleep//Ext</th>
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<tbody>
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</tbody>
</table>
CARE PATHWAY FOR MRSA

<table>
<thead>
<tr>
<th>Initial Details &amp; Actions</th>
<th>Date</th>
<th>Time</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA colonisation/infection (including bacteraemia) identified:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>From admission screening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>From clinical specimen during inpatient admission</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>From ward/bay screening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A full MRSA screen is obtained</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full screen must be obtained prior to starting protocol (with exception of Renal)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sites of initial screening (from full screen)</th>
<th>Positive/ negative result or NA</th>
<th>Date</th>
<th>Time</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nose</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Groin</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Wound (state site)</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Wound (state site)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catheter Specimen Urine</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Sputum</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Invasive device (state site e.g., PVC, suprapubic catheter, Percutaneous Endoscopic Gastrostomy (PEG) site, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Variance and actions</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

Communication at time of positive result
If not met document reasons in the variance section | Yes/No | Date | Time |
<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Initials</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Infection Prevention & Control Team
MRSA alert placed on PAS & ICE by IPCT? | | | |
| A record of the result is recorded by the IPCT in the current nursing and medical notes & ICNet? | | | |

Ward Staff
Has the patient been informed and have they fully understood the explanation given? | | | |
The patient is informed of the isolation measures to be taken and the rationale? | | | |
MRSA leaflet given to patient, and relatives if patient consents to reinforce the above? | | | |
Are there any concerns that the patient may not be compliant with the isolation measures (record in variance and actions)? | | | |
Does the patient have any questions? If yes specify in patient’s own words in variance and actions section. | | | |
Is ‘Stop and Think’ card is displayed on the room door? | | | |
Have the domestic staff been informed of the isolation cleaning requirements using the request form in Appendix 11 of the Isolation Policy? | | | |
### Ward Staff

<table>
<thead>
<tr>
<th>Has the consultant and his/her medical team been informed of the patient’s MRSA positive status?</th>
<th>Yes/No</th>
<th>Initials</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the patient’s nursing team been alerted to the positive MRSA result?</td>
<td>Yes/No</td>
<td>Initials</td>
<td>Date</td>
<td>Time</td>
</tr>
</tbody>
</table>

### Medical Staff

| Has the MRSA positive result been discussed with the patient? | Yes/No | Initials | Date | Time |
| Does the patient have any questions? If yes specify in patient’s own words in ‘Variance section’ | Yes/No | Initials | Date | Time |

<table>
<thead>
<tr>
<th>Date</th>
<th>Variance and actions</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment / Decolonisation plan **</th>
<th>Yes</th>
<th>No*</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the Patient Allergic to Mupirocin/Chlorhexidine</td>
<td>Yes</td>
<td>Initials</td>
<td>Date</td>
<td>Time</td>
</tr>
<tr>
<td>Is the MRSA resistant to Mupirocin (IPCT to complete)</td>
<td>No*</td>
<td>Initials</td>
<td>Date</td>
<td>Time</td>
</tr>
<tr>
<td>If MRSA is Mupirocin resistant alternative protocol sticker to be placed on prescription by IPCT. If Chlorhexidine sensitive, prescribe alternative treatment.</td>
<td>Yes</td>
<td>No*</td>
<td>Initials</td>
<td>Date</td>
</tr>
<tr>
<td>Has the patient been isolated in a single room? (if no have patient access and IPCT been informed). Document reason why patient has not been isolated in ‘Variance section’</td>
<td>Yes/No</td>
<td>Initials</td>
<td>Date</td>
<td>Time</td>
</tr>
<tr>
<td>Personal Protective Equipment (PPE) is available</td>
<td>Yes</td>
<td>No*</td>
<td>Date</td>
<td>Time</td>
</tr>
<tr>
<td>• Disposable plastic aprons</td>
<td>Yes</td>
<td>No*</td>
<td>Initials</td>
<td>Date</td>
</tr>
<tr>
<td>• Eye protection (suction required)</td>
<td>Yes</td>
<td>No*</td>
<td>Initials</td>
<td>Date</td>
</tr>
<tr>
<td>Patient specific equipment is available i.e.</td>
<td>Yes</td>
<td>No*</td>
<td>Date</td>
<td>Time</td>
</tr>
<tr>
<td>• Stethoscope</td>
<td>Yes</td>
<td>No*</td>
<td>Initials</td>
<td>Date</td>
</tr>
<tr>
<td>• Blood pressure cuff</td>
<td>Yes</td>
<td>No*</td>
<td>Initials</td>
<td>Date</td>
</tr>
<tr>
<td>• Moving sheets/slings</td>
<td>Yes</td>
<td>No*</td>
<td>Initials</td>
<td>Date</td>
</tr>
<tr>
<td>• Sharps Bin inside the room</td>
<td>Yes</td>
<td>No*</td>
<td>Initials</td>
<td>Date</td>
</tr>
<tr>
<td>Alcohol hand gel is available:</td>
<td>Yes</td>
<td>No*</td>
<td>Date</td>
<td>Time</td>
</tr>
<tr>
<td>• At end of bed</td>
<td>Yes</td>
<td>No*</td>
<td>Initials</td>
<td>Date</td>
</tr>
<tr>
<td>• Outside isolation room/area</td>
<td>Yes</td>
<td>No*</td>
<td>Initials</td>
<td>Date</td>
</tr>
<tr>
<td>The patient’s medical team has discussed systemic treatment with the clinical microbiologist if infection suspected? Document discussions on variance section.</td>
<td>Yes</td>
<td>No*</td>
<td>Date</td>
<td>Time</td>
</tr>
<tr>
<td>Systemic treatment prescribed - if indicated</td>
<td>Yes</td>
<td>No*</td>
<td>Date</td>
<td>Time</td>
</tr>
<tr>
<td>Stop date recorded.</td>
<td>Yes</td>
<td>No*</td>
<td>Initials</td>
<td>Date</td>
</tr>
<tr>
<td>Treatment for topical decolonisation is prescribed for 5 days. Stop date recorded.</td>
<td>Yes</td>
<td>No*</td>
<td>Initials</td>
<td>Date</td>
</tr>
<tr>
<td>Treatment started within 24hrs of positive result</td>
<td>Yes</td>
<td>No*</td>
<td>Initials</td>
<td>Date</td>
</tr>
</tbody>
</table>

* Document as variance at bottom of page

** A full decolonisation protocol is required irrespective of site positive
Isolation Care Reminders:
- Keep isolation room doors closed at all times and especially during bed-making, physiotherapy and wound dressing changes.
- If nursing patient in an open bay due to lack of single room – signage must be evident to ensure all staff are aware of the need for additional precautions.
- Decontaminate any clinical equipment used by or on the patient as per Trust Decontamination policy before use on any other patient, or designate patient specific equipment.
- Hands must be decontaminated prior to wearing gloves & after removing them.
- Use disposable gloves and aprons when entering isolation room/area and delivering clinical care.
- PPE must be removed and hands washed before leaving the isolation room/area.
- Hand hygiene before and after each patient contact is the most effective way to prevent cross-infection.
- Inform other wards/departments of patient’s MRSA status prior to transfer/booking procedure. This is the responsibility of the person booking the procedure.

<table>
<thead>
<tr>
<th>Isolation Care Reminders:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keep isolation room doors closed at all times and especially during bed-making, physiotherapy and wound dressing changes.</td>
</tr>
<tr>
<td>If nursing patient in an open bay due to lack of single room – signage must be evident to ensure all staff are aware of the need for additional precautions.</td>
</tr>
<tr>
<td>Decontaminate any clinical equipment used by or on the patient as per Trust Decontamination policy before use on any other patient, or designate patient specific equipment.</td>
</tr>
<tr>
<td>Hands must be decontaminated prior to wearing gloves &amp; after removing them.</td>
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<td>Use disposable gloves and aprons when entering isolation room/area and delivering clinical care.</td>
</tr>
<tr>
<td>PPE must be removed and hands washed before leaving the isolation room/area.</td>
</tr>
<tr>
<td>Hand hygiene before and after each patient contact is the most effective way to prevent cross-infection.</td>
</tr>
<tr>
<td>Inform other wards/departments of patient’s MRSA status prior to transfer/booking procedure. This is the responsibility of the person booking the procedure.</td>
</tr>
</tbody>
</table>

Topical Five Day Decolonisation Checklist: 1st Treatment Cycle

**Drug hypersensitivity:** Please state if none

<table>
<thead>
<tr>
<th>Start date:</th>
<th>Stop date:</th>
</tr>
</thead>
</table>

**Prescribers Signature**

(This is a prescription therefore lack of signature is a drug error)

| Hair washed using Hibiscrub (Chlorhexidine gluconate 4% w/v) or Octenisan for sensitive patients, as shampoo (twice only) – Initial date performed. |
| Patient has a shower / bath using Hibiscrub (Chlorhexidine gluconate 4% w/v) as shower gel (use disposable wipes and clean towel) |
| Topical Mupirocin 2% ointment to nose as per prescription TDS (Must commence 9am Day 1) |
| Patient’s nightclothes and bedding changed each day following bath / shower |

**Authorisation to administer/supply on discharge:** Signature Date:

<table>
<thead>
<tr>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day &amp; Initial</td>
<td>Day &amp; Initial</td>
<td>Day &amp; Initial</td>
<td>Day &amp; Initial</td>
<td>Day &amp; Initial</td>
</tr>
</tbody>
</table>

**Patient has a two day rest period from topical treatment**

**Post 1st Treatment Screening Schedule**

Take 1st on day 3 after completing protocol. Screen weekly until 3 consecutive negative screens are obtained from all relevant screening sites. *If any of the screens are positive – commence 2nd five-day decolonisation programme*

<table>
<thead>
<tr>
<th>Screen</th>
<th>Date taken &amp; Initial</th>
<th>Nose</th>
<th>Groin</th>
<th>CSU</th>
<th>Wound (state site)</th>
<th>Wound (state site)</th>
<th>Invasive device (state site)</th>
<th>PEG site</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>+ - + - + -</td>
<td>+ -</td>
<td>+ -</td>
<td>+ -</td>
<td>+ -</td>
<td>+ -</td>
<td>+ -</td>
<td>+ -</td>
<td>+ -</td>
</tr>
<tr>
<td>2</td>
<td>+ - + - + -</td>
<td>+ -</td>
<td>+ -</td>
<td>+ -</td>
<td>+ -</td>
<td>+ -</td>
<td>+ -</td>
<td>+ -</td>
<td>+ -</td>
</tr>
<tr>
<td>3</td>
<td>+ - + - + -</td>
<td>+ -</td>
<td>+ -</td>
<td>+ -</td>
<td>+ -</td>
<td>+ -</td>
<td>+ -</td>
<td>+ -</td>
<td>+ -</td>
</tr>
</tbody>
</table>

If all three screens are negative re-integrate back into the ward (pg)

<table>
<thead>
<tr>
<th>Initial</th>
<th>Date</th>
</tr>
</thead>
</table>

Is the patient to be discharged with protocol to finish the course Yes ☐ No ☐
### Topical Five Day Decolonisation Checklist: 2nd Treatment Cycle (to be given if screening sites are +ve post 1st protocol.)

**Prescribers signature**

(This is a prescription therefore lack of signature is a drug error)

<table>
<thead>
<tr>
<th>Hair washed using Hibiscrub (Chlorhexidine gluconate 4% w/v), or Octenisan for Chlorhexidine sensitive patients, as shampoo (Twice only) - Initial date performed</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Patient has a shower / bath using Hibiscrub (Chlorhexidine gluconate 4% w/v) as shower gel (use disposable wipes and clean towel)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Topical Mupirocin 2% ointment to nose as per prescription TDS (Must commence 9am Day 1)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Patient’s nightclothes and bedding changed each day following bath / shower</th>
</tr>
</thead>
</table>

**Authorisation to administer/supply on discharge: Signature**

**Date:**

<table>
<thead>
<tr>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day &amp; Initial</td>
<td>Day &amp; Initial</td>
<td>Day &amp; Initial</td>
<td>Day &amp; Initial</td>
<td>Day &amp; Initial</td>
</tr>
</tbody>
</table>

---

### Post 2nd Treatment Screening Schedule

Take 1st on day 3 after completing protocol. Screen weekly until 3 consecutive negative screens are obtained from all relevant screening sites.

<table>
<thead>
<tr>
<th>Screen</th>
<th>Date taken &amp; Initial</th>
<th>Nose</th>
<th>Groin</th>
<th>CSU</th>
<th>Wound (state site)</th>
<th>Wound (state site)</th>
<th>Invasive device (state site)</th>
<th>PEG site</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>+ -</td>
<td>+ -</td>
<td>+ -</td>
<td>+ -</td>
<td>+ -</td>
<td>+ -</td>
<td>+ -</td>
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<td>2</td>
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<td>+ -</td>
<td>+ -</td>
<td>+ -</td>
<td>+ -</td>
<td>+ -</td>
</tr>
</tbody>
</table>

If all three screens are negative re-integrate back into the ward (pg)

If any sites are still positive after 2nd treatment cycle, continue to nurse in isolation and screen for MRSA weekly. Record results on weekly screen chart

**Is the patient to be discharged with protocol to finish the course**

Yes [ ] No [ ]

---

**Date**

**Variance and actions**

**Initials**
### Re-integration back into ward / clinical area

<table>
<thead>
<tr>
<th>Ward Staff</th>
<th>Yes</th>
<th>No</th>
<th>Date</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>The patient has had 3 consecutive negative MRSA screen?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The negative results and changes to care have been explained to the patient?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has the patient been advised that re-colonisation may occur?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the patient have any questions? If yes, specify in patient’s own words on ‘Variance section’..</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient has been reintegrated back into the ward/clinical area?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domestic staff have been informed and the room needs to be terminally cleaned?</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### Date | Variance and actions | Initials
---|----------------------|----------

### Discharge/Transfer to another hospital

<table>
<thead>
<tr>
<th>Date</th>
<th>Initials</th>
</tr>
</thead>
</table>

1. GP/Transfer letter outlines MRSA status and all associated treatment

2. District nurses/community team (including IPCN), if applicable, are informed of the MRSA status and any treatments given

3. Patient and carers/family are fully informed and written information has been given

4. Unused disposable equipment from isolation room is discarded

5. All reusable patient equipment has been decontaminated as per Trust Decontamination Policy

6. The Infection Prevention & Control Team are aware of the patient’s discharge/transfer
**Weekly Screening - whilst in-patient**

*If any sites are found to be positive on weekly screening – recommence isolation precautions*

<table>
<thead>
<tr>
<th>Week</th>
<th>Date taken &amp; Initial</th>
<th>Nose</th>
<th>Groin</th>
<th>CSU</th>
<th>Wound (state site)</th>
<th>Wound (state site)</th>
<th>Invasive device (state site)</th>
<th>PEG site</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>+</td>
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<td>+</td>
<td>-</td>
<td>-</td>
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APPENDIX 6

MRSA

Information for patients in hospital

What is MRSA?

There are lots of micro-organisms (germs) on our skin and in the environment around us. Most of them are harmless, some are beneficial and a very small proportion can cause harm. *Staphylococcus aureus* is a common germ that is found on the skin and in the nostrils of about a third of healthy people. It can cause infections.

MRSA stands for meticillin (M) resistant (R) *Staphylococcus (S) aureus (A)*. MRSA are varieties of *Staphylococcus aureus* that have developed resistance to meticillin (a type of penicillin) and some other antibiotics that are used to treat infections.

MRSA is not new. It was first found in the 1960s following the widespread use of antibiotics. MRSA is found in many countries. Some people carry MRSA on their skin or in their nostrils. They are described as being colonised with MRSA. Some people carry MRSA for a few hours or days, while others carry it for weeks or months. People are unaware that they carry MRSA because it does not harm them and they have no symptoms, unlike people who are infected with MRSA.

MRSA can cause harm when it gets an opportunity to enter the body. It can cause simple local infections such as pimples and boils, or more serious problems such as wound infections, chest infections or blood stream infections.

MRSA and other germs cause problems in hospitals. This is because people who are ill are more vulnerable to infections. Complicated medical treatments including operations and intravenous lines (drips) provide opportunities for germs to enter the body.

How do people get MRSA?

MRSA is usually spread by touch. If a person gets MRSA on their hands, they can pass it to people and things that they touch. It may then be picked up and passed on to others.

How can you tell if someone has MRSA?

People who carry MRSA do not look or feel different from anyone else and they do not have any symptoms. Patients who have an infection caused by MRSA may have signs and symptoms of infection. They develop a high temperature, or a fever, or their wound becomes red and sore and discharges pus. Many other germs can cause these signs and symptoms. Laboratory tests are carried out to find out which germs are causing infection.

What happens when a patient gets MRSA?

MRSA can spread to other patients. Hospital staff need to take special precautions with patients who have MRSA in order to stop it spreading. Policies for treating patients who carry MRSA or who have an MRSA infection vary according to the local situation and the individual patients affected. You can ask your infection control team about local policies.

The following simple hygiene measures can reduce the risk of spreading MRSA

- Everyone should clean their hands before and after touching patients
- Hands can be cleaned with soap and water, or an alcohol gel, or hand rubs
Staff will wear gloves and aprons when they care for a patient who has MRSA. A patient who has MRSA may be moved to a room on their own or into a separate area for people who have MRSA or other infections. It is very important that the doors to the single room or area remain closed at all times. This is to reduce the risk of MRSA spreading into the general environment.

**How is MRSA treated?**

People who get MRSA can be treated. If a patient carries MRSA, a nurse may take swabs to check which parts of the body have MRSA. Treatment with nasal cream and an antiseptic shampoo and body wash can help to reduce or remove MRSA from hair, skin and nostrils. A patient who has an MRSA infection is usually treated with an antibiotic given through an intravenous line (drip).

**Can MRSA harm family and friends?**

MRSA does not usually harm healthy people, including elderly people, pregnant women, children and babies. MRSA can affect people who have certain long-term health problems, particularly people who have chronic skin conditions or open wounds.

Ask the infection control nurse for advice if someone who has a long-term health problem wants to visit a patient who has MRSA.

Visitors can reduce the possibility of spreading MRSA to other people if they do not sit on the bed and if they clean their hands at the end of the visit. If a patient who has MRSA wants to visit another patient in the hospital, they should ask the infection control nurse for advice.

**Do patients who get MRSA have to stay longer in hospital?**

Patients who carry MRSA do not usually have to stay longer in hospital. The infection control team will decide whether or not they need treatment. This sometimes depends on whether the patient is likely to need further or repeated hospital care. Patients who have an MRSA infection may have to stay in hospital until they have completed the course of antibiotics and their infection shows signs of clearing up. Alternatively, they may need to continue treatment when they go home. A patient who is going to a nursing home or residential home can be cared for safely using simple hygiene measures.

**How is MRSA monitored?**

Infection control teams monitor MRSA in their own hospitals. NHS hospitals in England send information about MRSA blood stream infections (the most serious MRSA infections) to the Health Protection Agency. The Department of Health publishes figures for individual NHS trusts and the Health Protection Agency publishes national and regional figures. Hospitals can compare their own figures with these national and regional figures to check their progress in reducing MRSA.
APPENDIX 7

Instruction Sheet for MRSA Pack

The screening test carried out at your recent Pre-operative Assessment Clinic visit showed that you are currently carrying MRSA. This does not mean that you are infected with MRSA and is not anything to worry about. You would not normally require any treatment for this but, as you are due to come into hospital for an operation, we would like to try and eradicate it beforehand.

You have been given an MRSA Pack containing Hibiscrub (Chlorhexidine gluconate 4% w/v), or Octenisan for Chlorhexidine Sensitive patients, Body Wash and 'Mupirocin' Nasal Ointment – instructions for use are given below. Please use them exactly as directed.

When you come in to hospital for your operation, you will be re-screened to see whether the MRSA has cleared.

How to use your MRSA Pack Body Wash and Nasal Ointment

**Body Wash:**

- Use the Body Wash **once a day for 5 consecutive days**
- Apply the Body Wash **directly** on to your body, and then wash off using water
- Apply the Body Wash **all over** your body – including your back
- **Do not pour** the Body Wash into the water in your bath or sink/basin as this will dilute it and make it less effective
- **Do not use** bubble bath or shower gel with the Body Wash
- You may use a **flannel**, but this must be **changed each day** for a clean one
- You should also use a **clean towel** every day
- On just **one** of the 5 days use the Body Wash as a shampoo – eg on Day 5 (You may put conditioner on your hair afterwards if you wish)

**Nasal Ointment:**

- Put a small amount of the Nasal Ointment inside each nostril **three times a day**
- **Wash your hands** after each application

**After 5 days:**

- **Stop** the use of the Body Wash and Nasal Ointment

**Your 5-Day Programme ‘At a Glance’**

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<tr>
<th>Day 1</th>
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APPENDIX 8
IMPLEMENTATION AND MONITORING EFFECTIVENESS OF THE MRSA POLICY

1. The policy can be accessed via the Trust Knowledge Centre or by hard copy, located in all clinical areas.

2. Policy review occurs every two years unless national guidance changes.

3. Compliance with the MRSA Policy is an integral component of the infection prevention & control programme and annual report.

4. Training in compliance with the MRSA Policy is embedded into all infection prevention & control training sessions for all staff as identified in the infection prevention & control Training Needs Analysis (TNA). This includes core-training sessions, such as mandatory update and induction. The content of these sessions is normally reviewed annually.

5. The nurse education and training department follows up mandatory update and induction non attendees.

6. Clinical Governance:
   - Annual Audit Programme including Isolation, Hand Hygiene, Linen, Environmental, Patient Equipment and MRSA Integrated Care Pathway.
   - Results are reported to all Ward Managers, Matrons and General Managers
   - They are also discussed at Divisional Infection Prevention and Control monthly meetings
   - When compliance is unacceptable an action plan is required from the clinical area and the outcome is monitored by the Infection Prevention and Control Team

7. The process for monitoring the effectiveness of compliance with MRSA policy occurs by the following methods:
   - Link Person Update
   - Nurses & Midwives Mandatory Update
   - Nursing Executive Committee
   - Sisters Meetings
   - Senior Management Team Meetings
APPENDIX 9

NATIONAL HEALTH SERVICE LITIGATION AUTHORITY (NHSLA) RISK MANAGEMENT STANDARDS FOR ACUTE TRUSTS

Roles and responsibilities (duties) of East and North Hertfordshire NHS Trust:

Chief Executive
- Ensure that functioning infection control team is in place
- Ensure that a Director of Infection Prevention Control (DIPC) has been appointed
- Ensure that an Infection Control Doctor (ICD) has been appointed

Infection Prevention and Control Team (IPCT)
- Staff training
- Policy formulation
- To provide specialist advice to clinical areas covered in this policy
- Dissemination of Infection Control audit results

All Trust Employees
- To attend training
- Comply with Trust policies